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CALIFORNIA

HEALTH CARE ALMANAC

California Health Care Foundation

California's Uninsured: Coverage Expands, but Millions Left Behind

MARCH 2016

Introduction

After the implementation of the Affordable Care Act (ACA), the uninsured rate in California dropped from 16% in 2013 to 11% in 2014. However, 3.8 million Californians under 65 still remained uninsured.

California's Uninsured: Coverage Expands, but Millions Left Behind provides a look at California's uninsured population after the first year of full implementation of the ACA.

KEY FINDINGS INCLUDE:

- From 2013 to 2014, the percentage of Californians who had individually purchased insurance or Medi-Cal increased.
- Californians age 21 to 24 experienced the largest drop of any nonelderly age group in the percentage that was uninsured, from 25% in 2013 to 16% in 2014.
- Of the state's remaining uninsured, 1 in 4 was between the age of 25 and 34, and more than half (57%) were Latino.
- Within the employed population, over 2 million workers, about 1 in 8, were uninsured.

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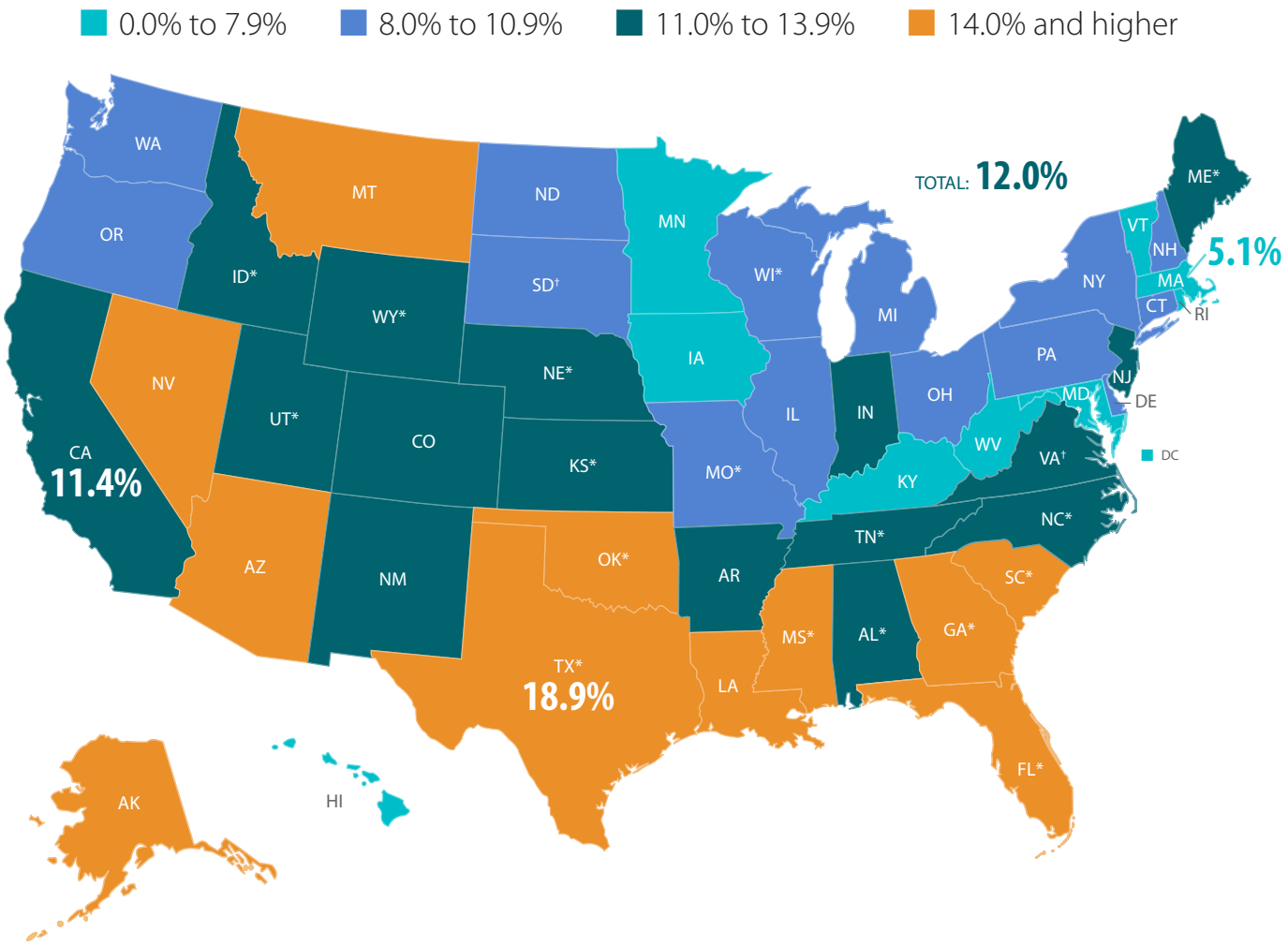
National Comparison of the Uninsured
2014

PERCENTAGE OF UNINSURED RESIDENTS



*Have not adopted Medicaid expansion under the ACA (17 states). †Medicaid expansion is under discussion (2 states).

Note: All numbers reflect population under age 65.

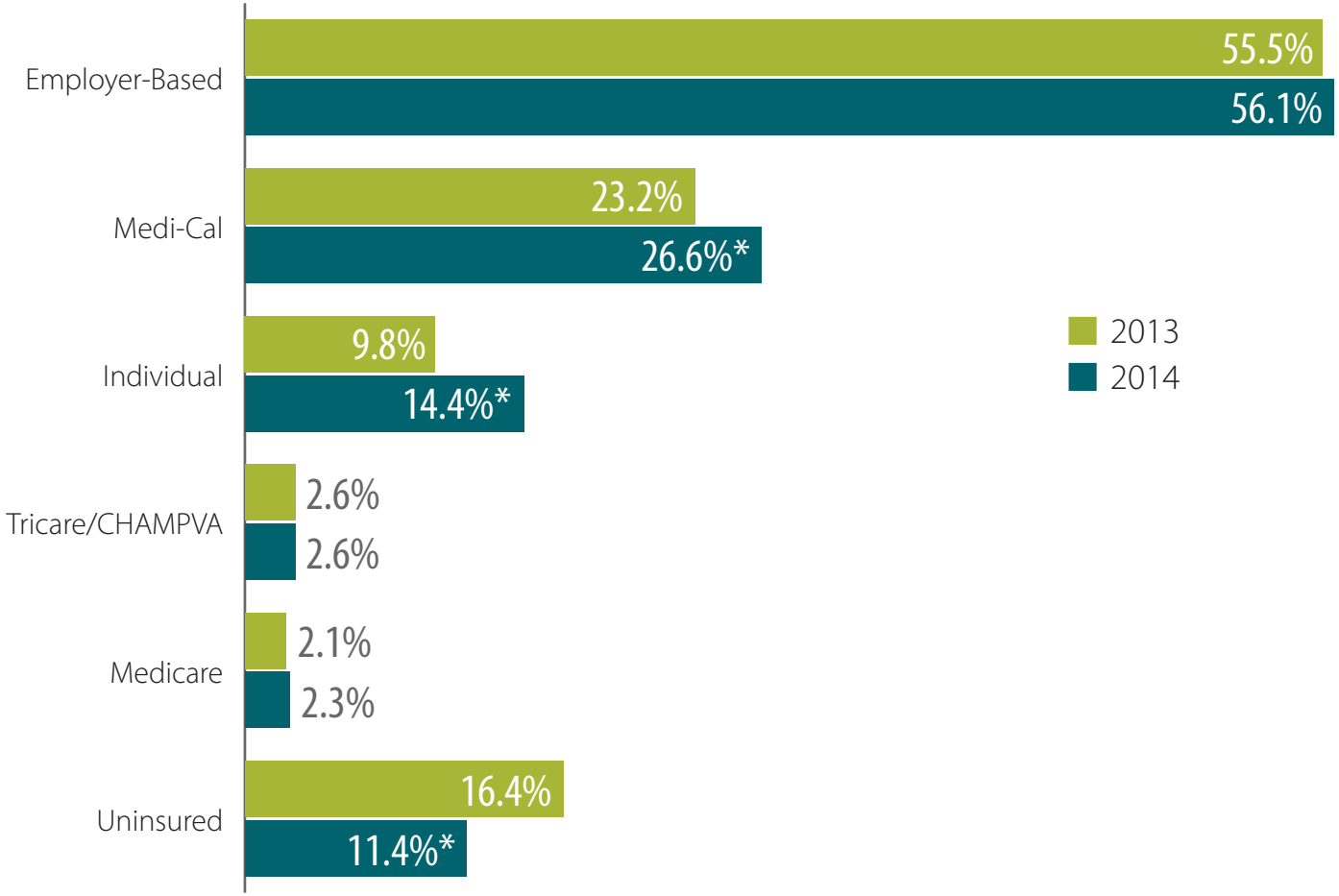
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

California's Uninsured
Comparison to Other States

In 2014, Massachusetts had the lowest rate of uninsured residents (5%) of all states, and Texas had the highest (19%). California's rate dropped from 16% in 2013 (not shown) to 11% in 2014.

Health Insurance Sources

California, 2013 and 2014



*Estimate for 2014 is statistically different from estimates for 2013 at $p <= .05$ level.

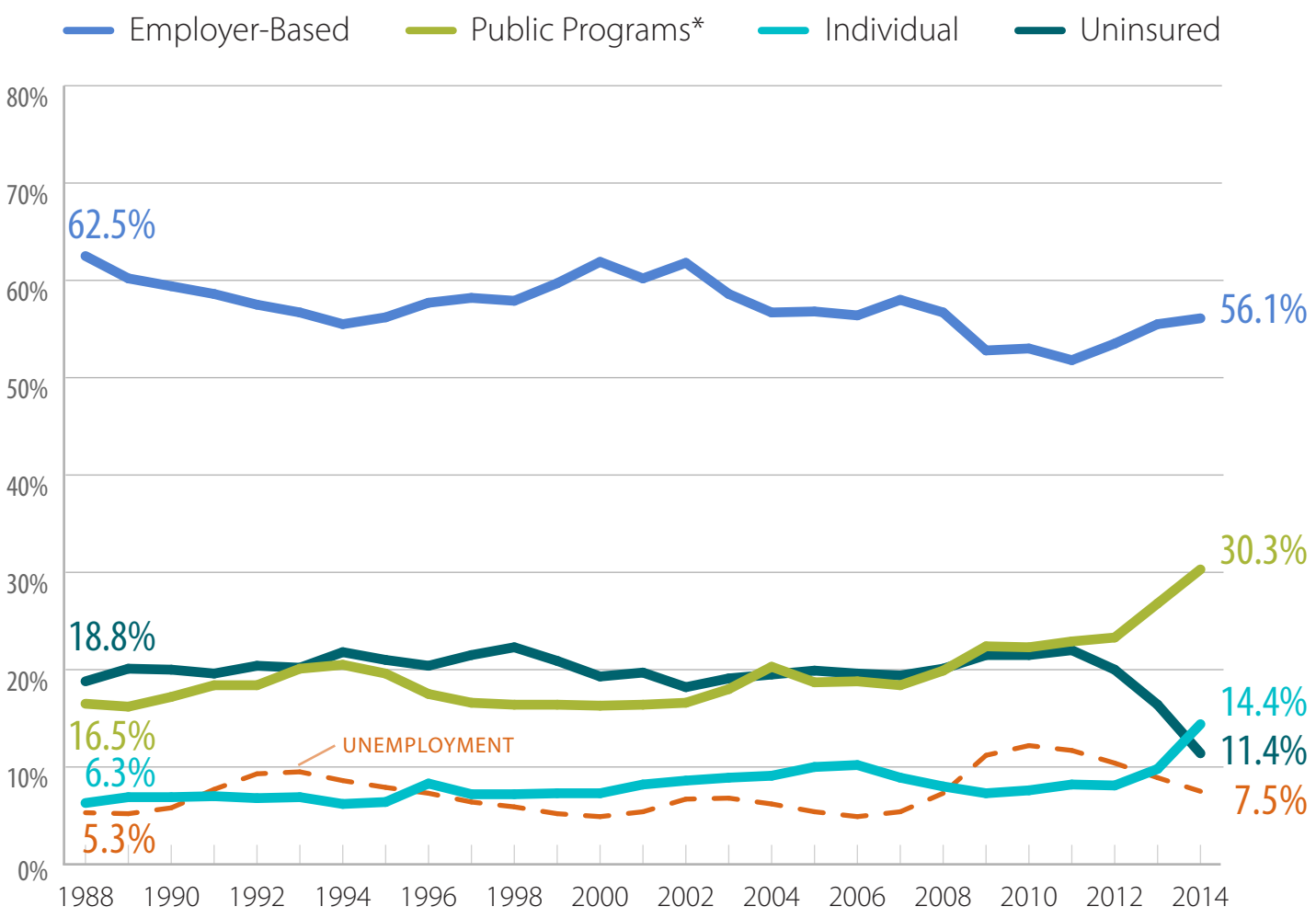
Notes: All numbers reflect the population under age 65. Details may not add to totals because individuals may receive coverage from more than one source. TRICARE (formally known as CHAMPUS) is a program administered by the Department of Defense for military retirees and family members of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2014 and 2015 March supplements.

From 2013 to 2014, the uninsured rate in California dropped five percentage points. This decrease was mainly due to increases in Medi-Cal (3.4 percentage points) and individually purchased insurance (4.6 percentage points).

Insurance Coverage Source and Unemployment Trends

California, 1988 to 2014



*Includes Medi-Cal, Healthy Families, Medicare, and Tricare/CHAMPVA.

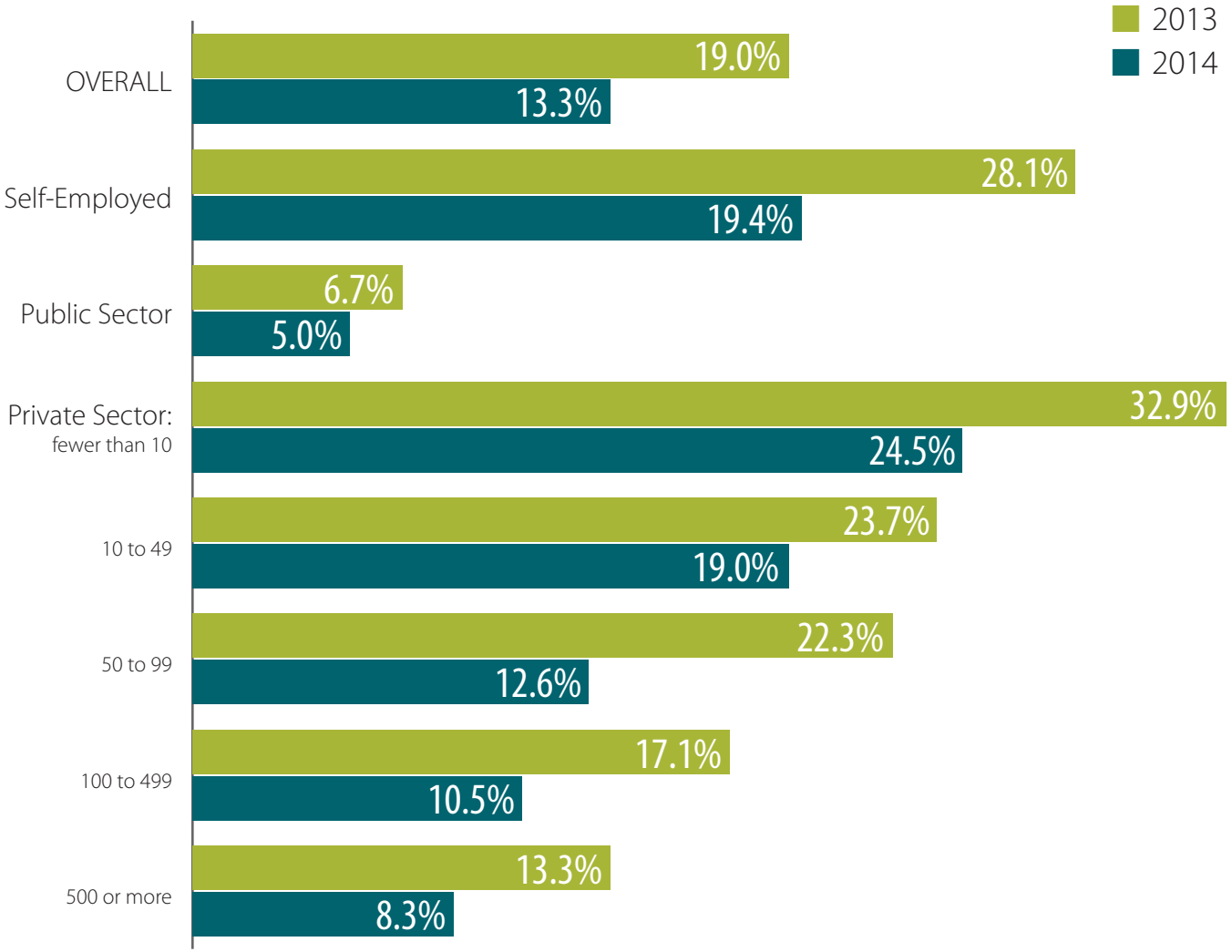
Notes: All numbers reflect the population under age 65. 1988-1998 data are not directly comparable with 1999-2012 data, which are not comparable with 2013-2014 data because of a methodological change in the way individuals with coverage were counted. Unemployment rates are annual averages without seasonal adjustment.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1988-2015 March supplements.

More than half of Californians received health insurance through employer-based coverage.

Likelihood of Workers Being Uninsured

by Employer Size and Type, California, 2013 and 2014



Notes: All numbers reflect the working population, age 18 to 64. Private sector sorted by number of workers.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

California's Uninsured

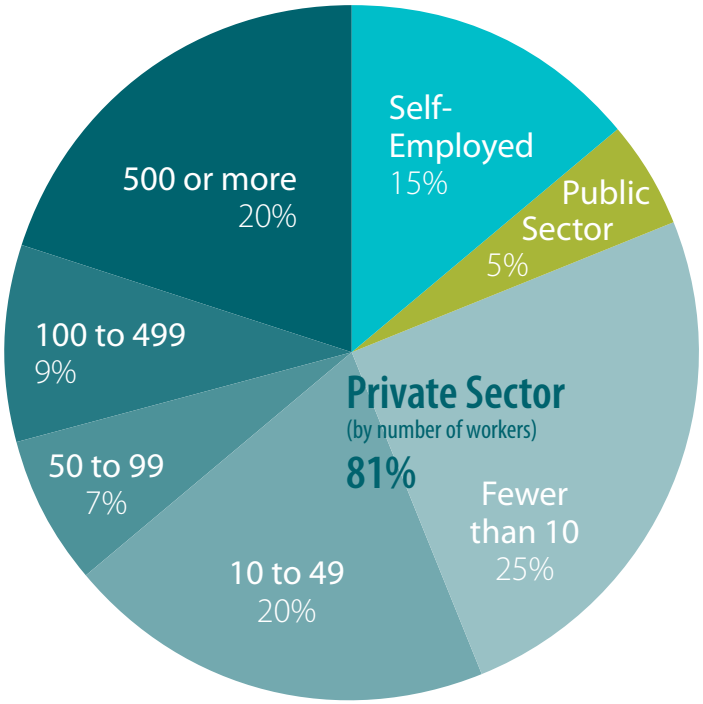
by Employer Size and Type

All workers in California were less likely to be uninsured in 2014 than in 2013. One in 4 workers in private firms with fewer than 10 workers and 1 in 5 self-employed workers were likely to be uninsured in 2014.

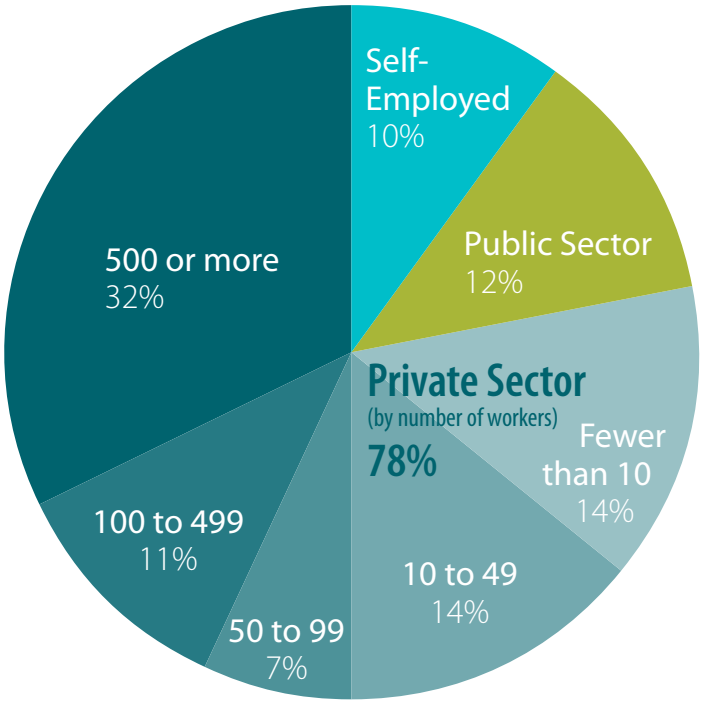
Uninsured Workers vs. Total Workers

by Employer Size and Type, California, 2014

Uninsured Workers
N = 2.4 million



Total Workers
N = 17.9 million



Notes: All numbers reflect the working population, age 18 to 64. Segments may not total 100% due to rounding.

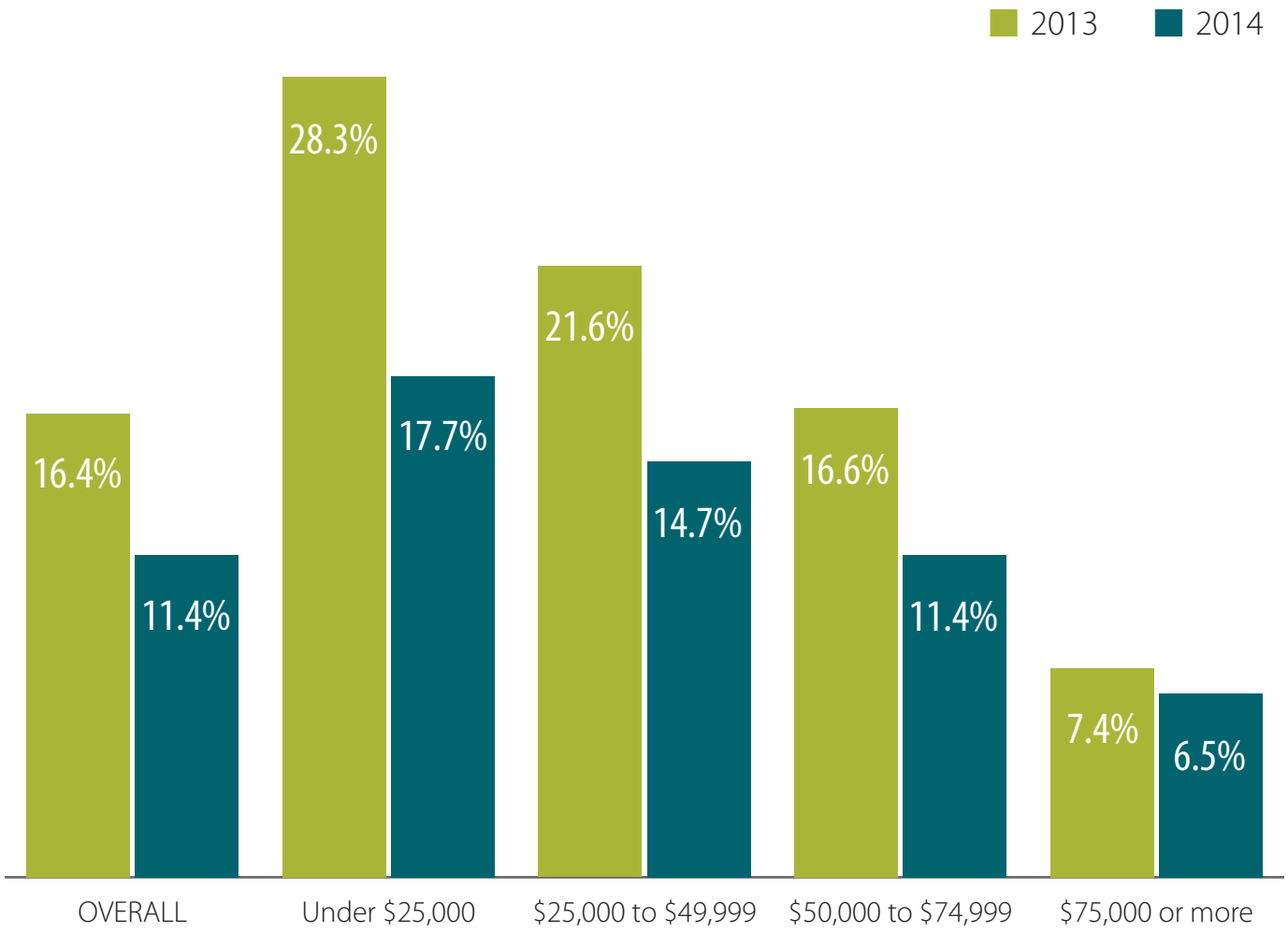
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

California's Uninsured
by Employer Size and Type

Nearly 30% of California's uninsured workers were employed by private companies with at least 100 workers. Overall, about 1 in 8 workers was uninsured.

Likelihood of Being Uninsured, by Family Income

California, 2013 and 2014



Note: All numbers reflect population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

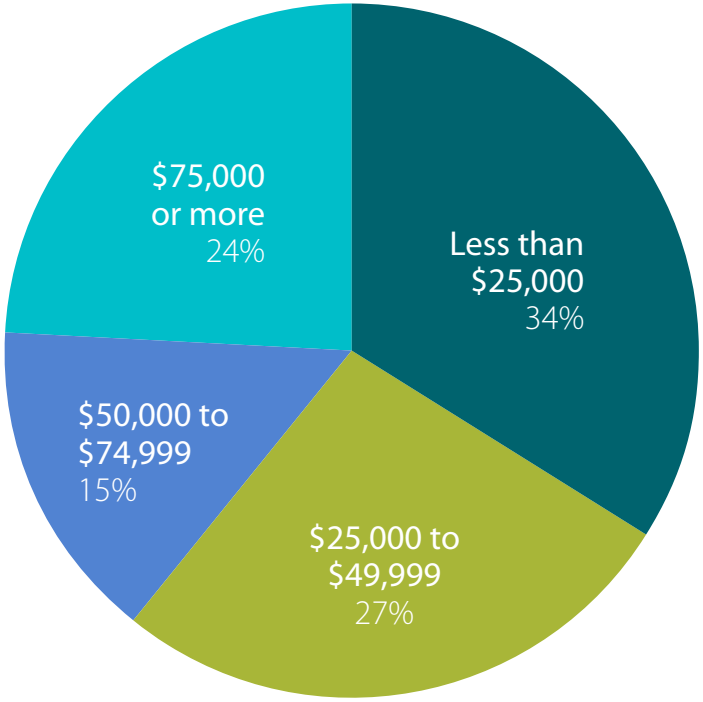
California's Uninsured
by Family Income

Californians with family incomes under $25,000 experienced the largest drop in the likelihood of being uninsured from 2013 to 2014. Still, about 1 in 5 Californians with incomes under $25,000 was uninsured compared to about 1 in 15 with incomes of $75,000 or more.

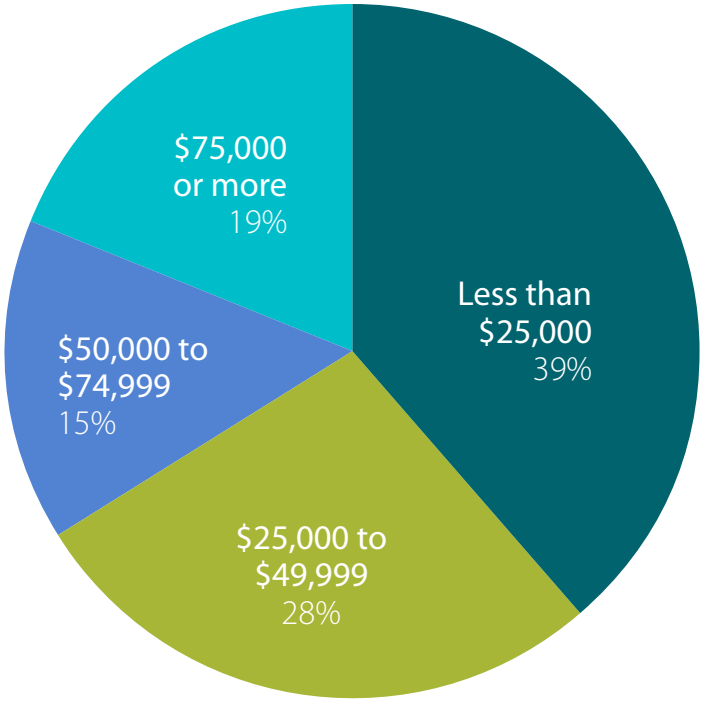
Family Income of the Uninsured

California vs. United States, 2014

California
N = 3.8 million



United States
N = 32.3 million



Notes: All numbers reflect population under age 65. Segments may not total 100% due to rounding.

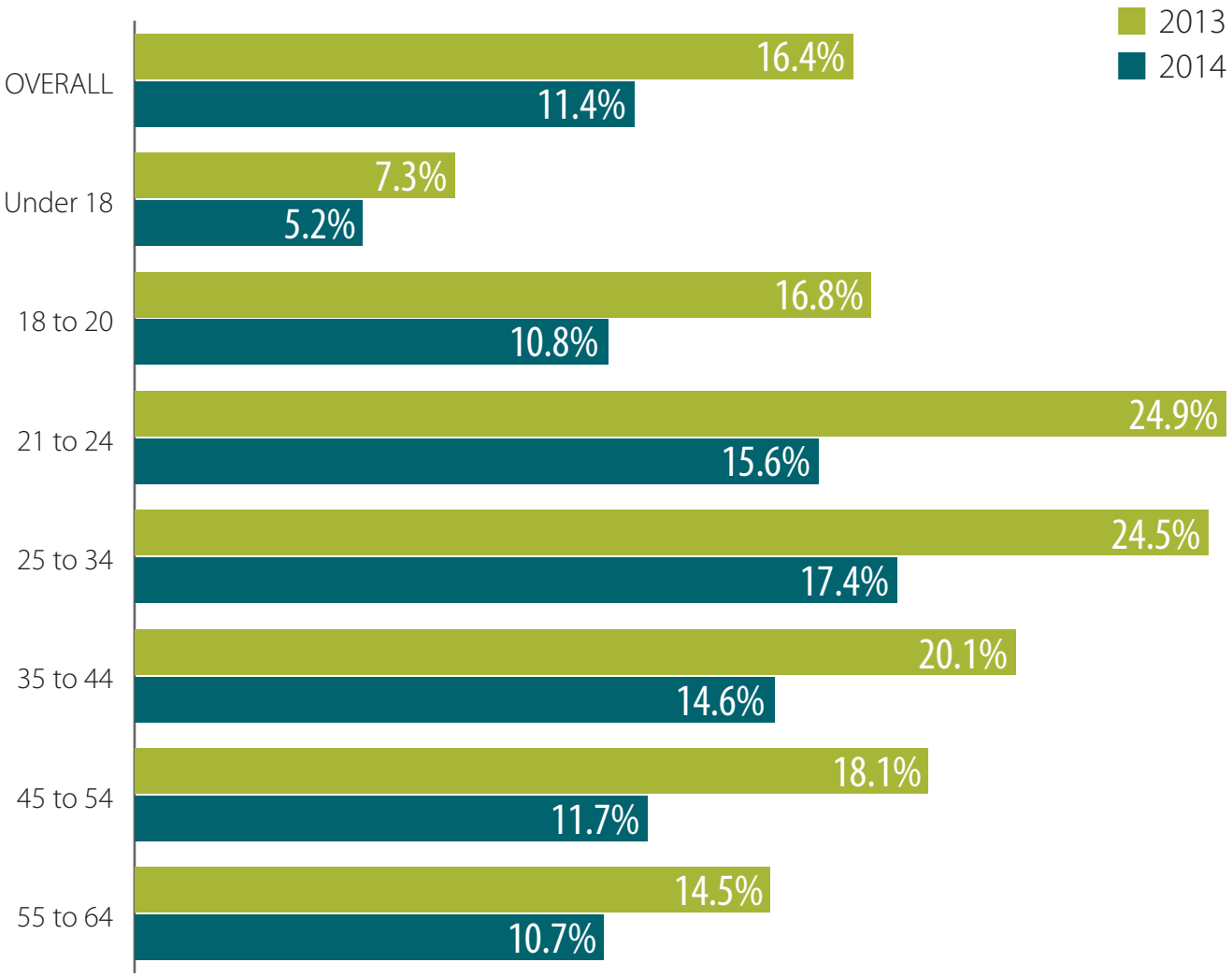
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

California's Uninsured
by Family Income

Nearly 25% of the uninsured in California had annual family incomes of $75,000 or more, versus 19% nationally.

Likelihood of Being Uninsured, by Age Group

California, 2013 and 2014



Note: All 2014 numbers are statistically significant from 2013 numbers at $p <= .05$ level.

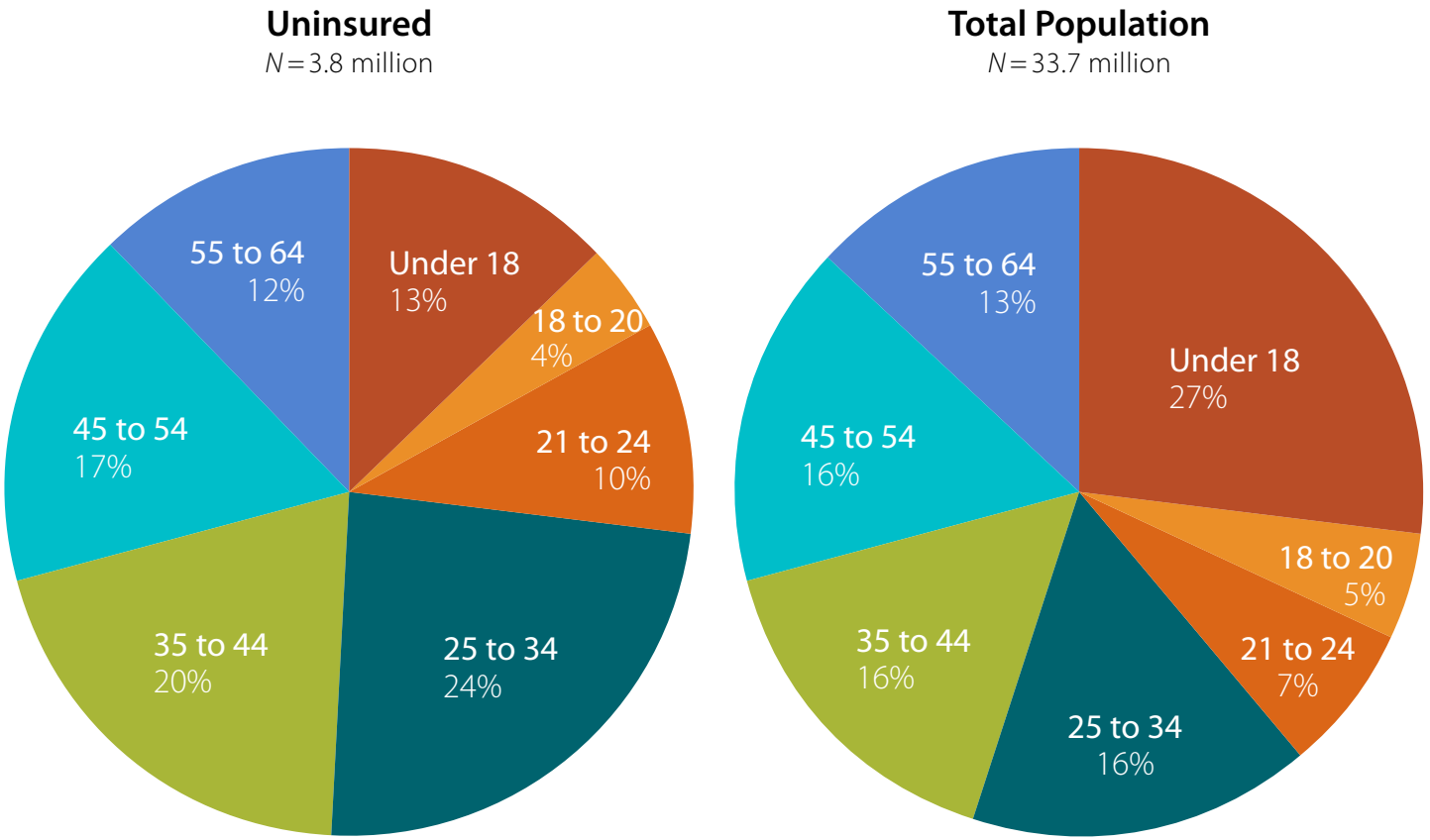
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2014 and 2015 March supplements.

California's Uninsured
by Age Group

Californians age 21 to 24 experienced the largest drop of any age group in the percentage of uninsured from 2013 to 2014.

Age Group of the Uninsured vs. Total Population

California, 2014



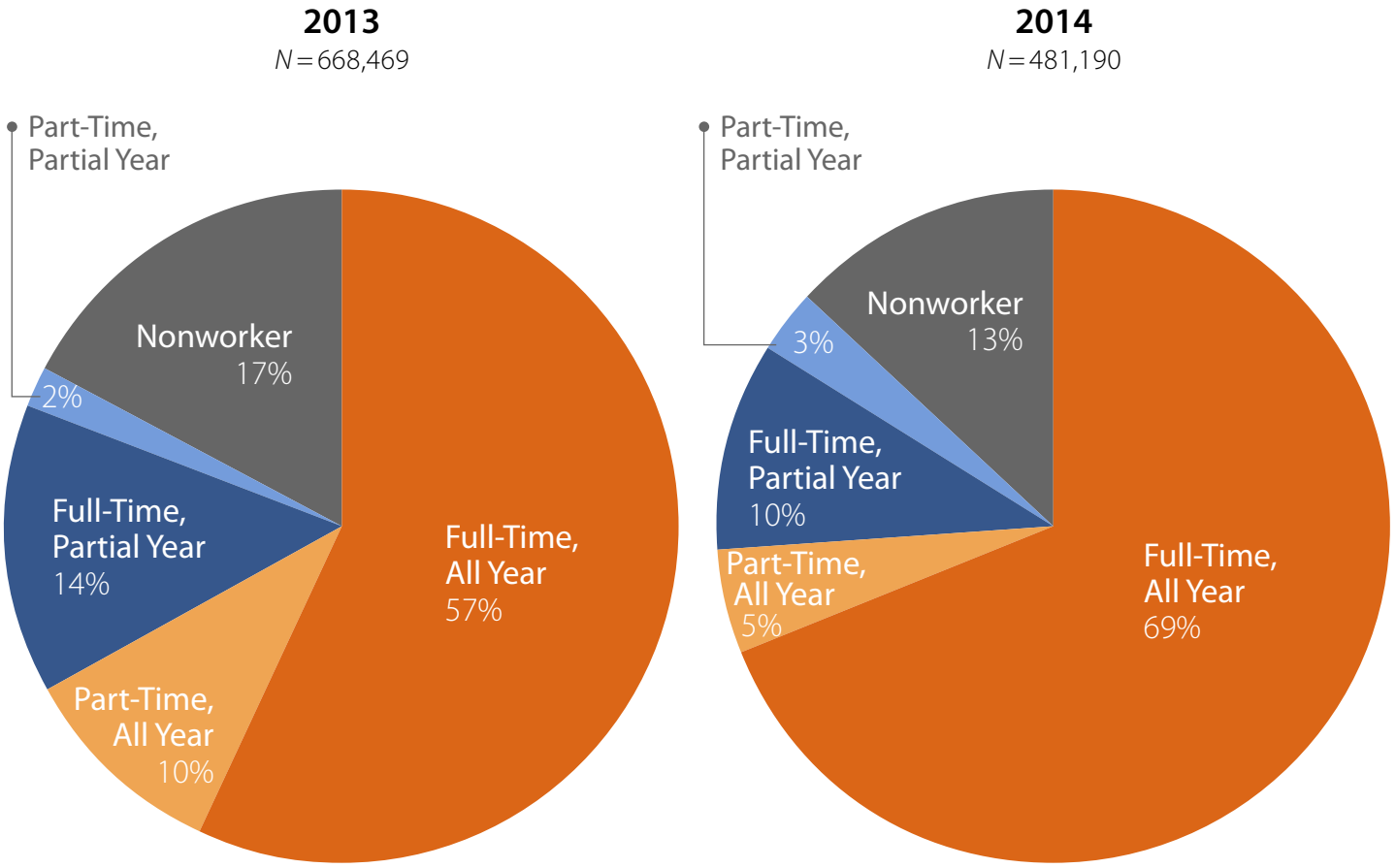
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

California's Uninsured
by Age Group

One in four of California's uninsured was between the age of 25 and 34, despite large decreases in the percentage of uninsured in this age group. Children accounted for 13% of the uninsured population but made up 27% of the state's nonelderly population.

Uninsured Children, by Work Status of Head of Household

California, 2013 and 2014



Note: All numbers reflect the population under age 18.

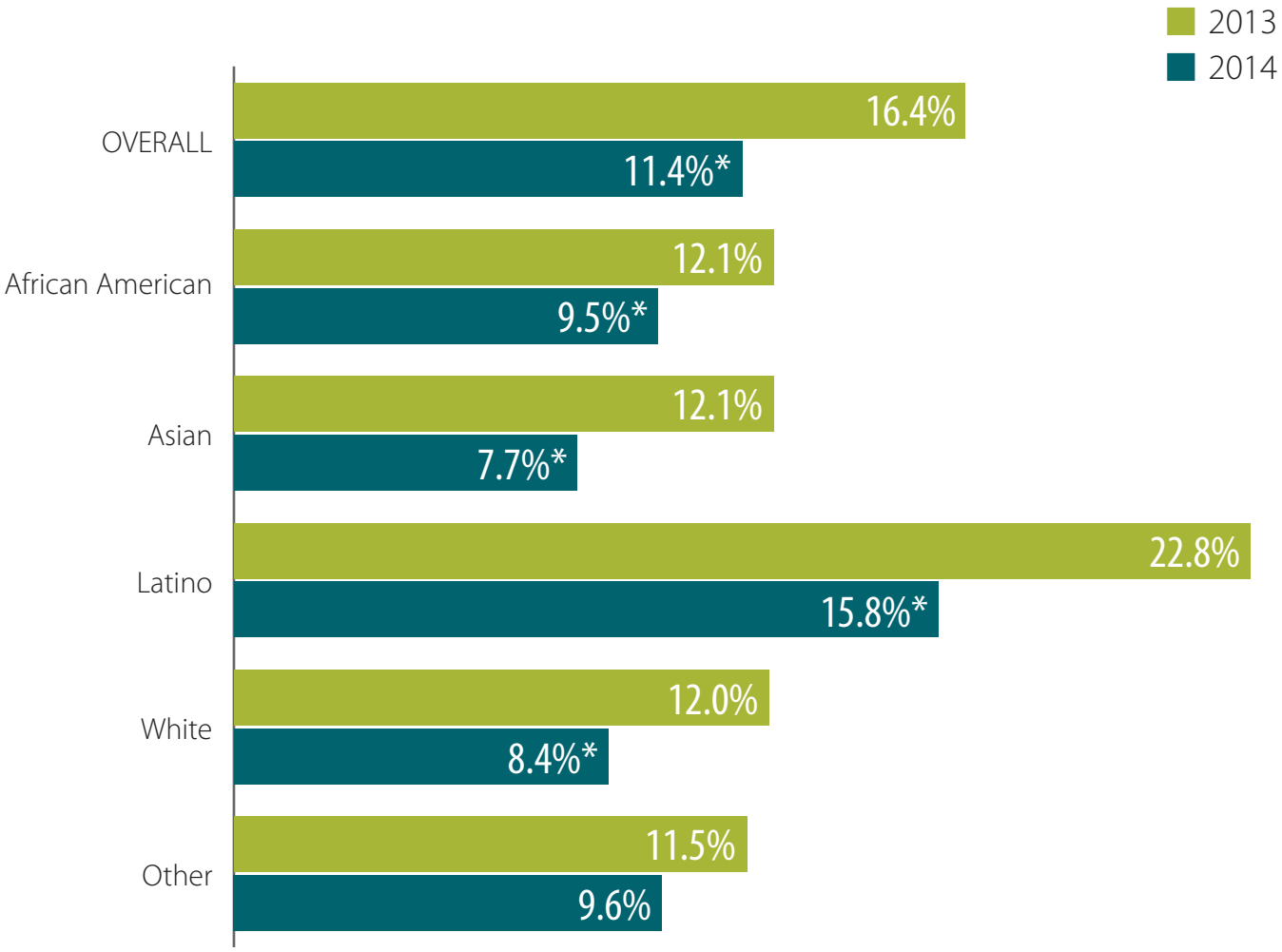
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

California's Uninsured
by Work Status

The number of uninsured children dropped by 187,000 from 2013 to 2014. Among the nearly half-million remaining uninsured children in California, almost 70% lived in families where the head of household worked full-time throughout the 2014 calendar year.

Likelihood of Being Uninsured, by Race/Ethnicity

California, 2013 and 2014



*Statistically significant from 2013 numbers at the $p <= .05$ level.

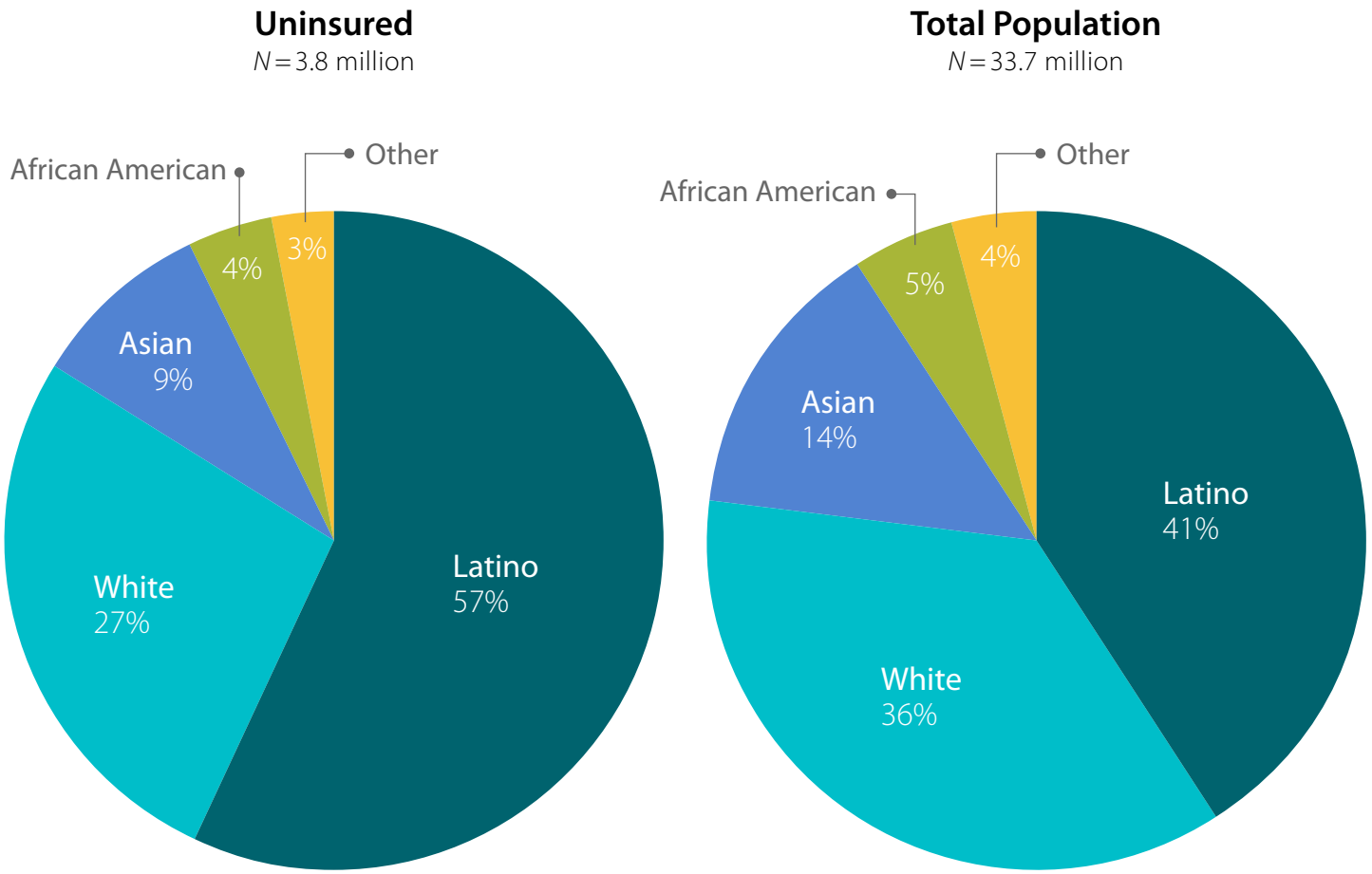
Note: All numbers reflect population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2014 and 2015 March supplements.

Latinos experienced the largest drop in percentage points in the uninsured rate from 2013 to 2014. However, they remain the ethnic group with the greatest likelihood of being uninsured.

Race/Ethnicity of the Uninsured vs. Total Population

California, 2014



Note: All numbers reflect population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

California's Uninsured
by Race/Ethnicity

In California, Latinos represented 41% of the total population but accounted for 57% of the uninsured.

Highest Uninsured Noncitizen Rates

by State, Compared to United States, 2014

	TOTAL POPULATION		PERCENTAGE UNINSURED	
	IN MILLIONS	NONCITIZENS	CITIZENS	NONCITIZENS
United States	**269.3**	**7.8%**	**10.3%**	**32.8%**
Texas	23.4	11.8%	14.9%	48.7%
New Jersey	7.6	11.3%	8.5%	42.3%
Nevada	2.4	10.9%	12.2%	33.7%
Arizona	5.7	11.7%	12.4%	28.1%
California	**33.7**	**13.6%**	**9.2%**	**25.3%**

Notes: All numbers reflect population under age 65. Includes only states with at least 10% noncitizens and at least 75,000 noncitizens.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2015 March Supplement.

California's Uninsured
by Citizenship

While California had the largest population of noncitizens in the nation, Texas had the largest percentage of noncitizens that were uninsured. Nearly half of noncitizens in Texas were uninsured compared to one-fourth of noncitizens in California.

Health Status, by Insurance Source

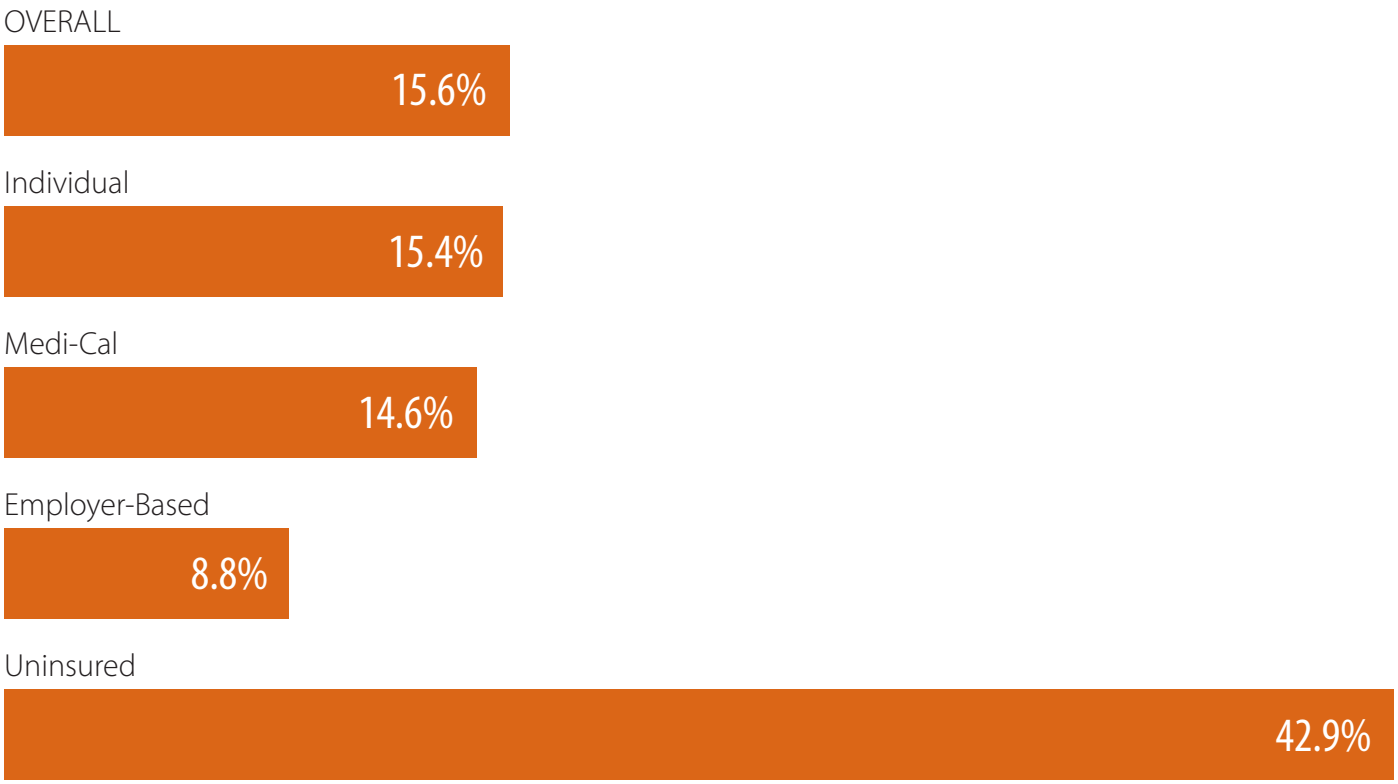
California, 2014

Note: Segments may not total 100% due to rounding.

Source: UCLA, California Health Interview Survey (CHIS), 2014.

Uninsured Californians were more likely to report that their general health was fair or poor, compared to residents with insurance.

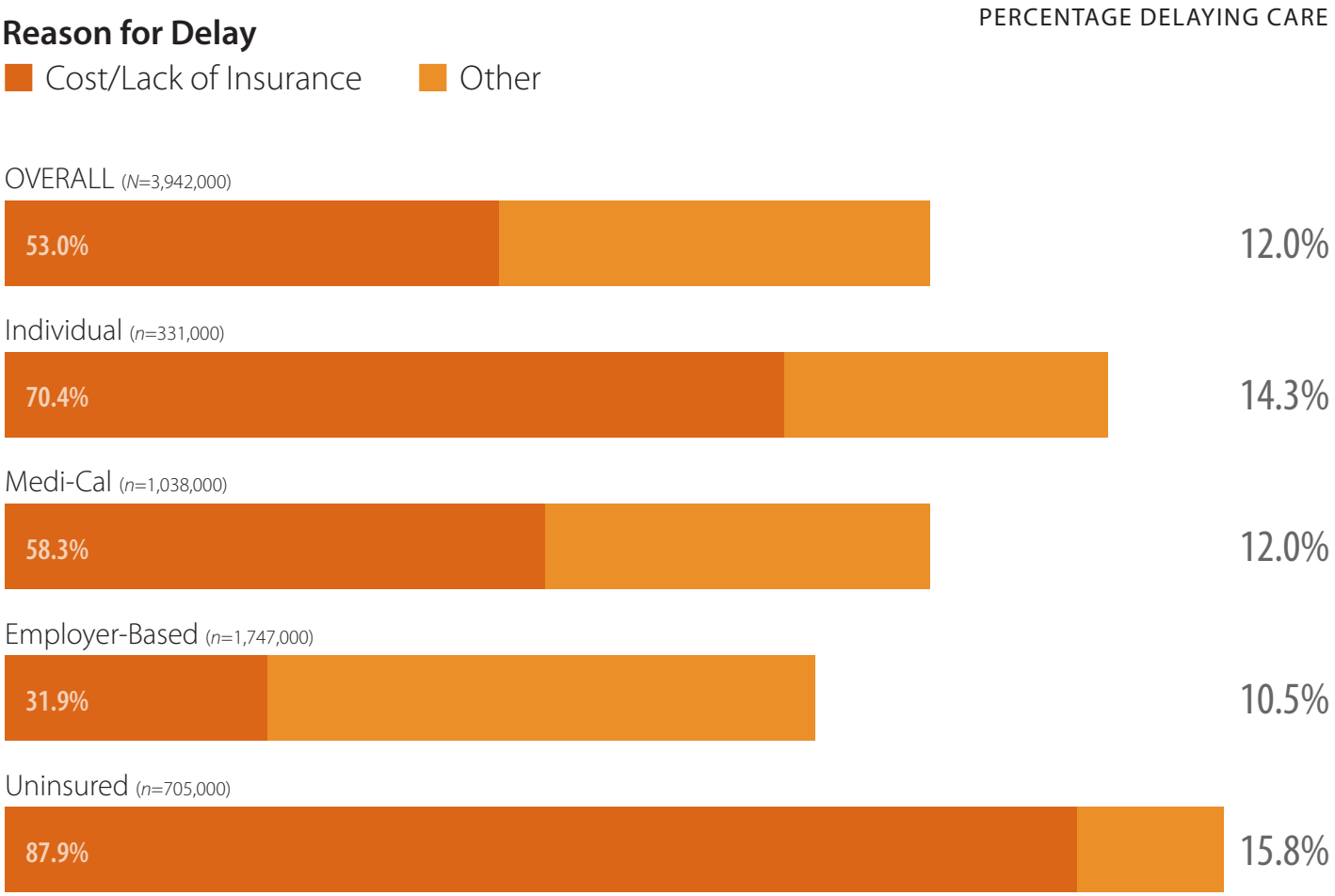
No Usual Source of Care, by Insurance Source
California, 2014



More than 4 in 10 Californians without health insurance reported that they had no usual source of care.

Source: UCLA, California Health Interview Survey (CHIS), 2014.

Delayed Care, by Insurance Source
California, 2014

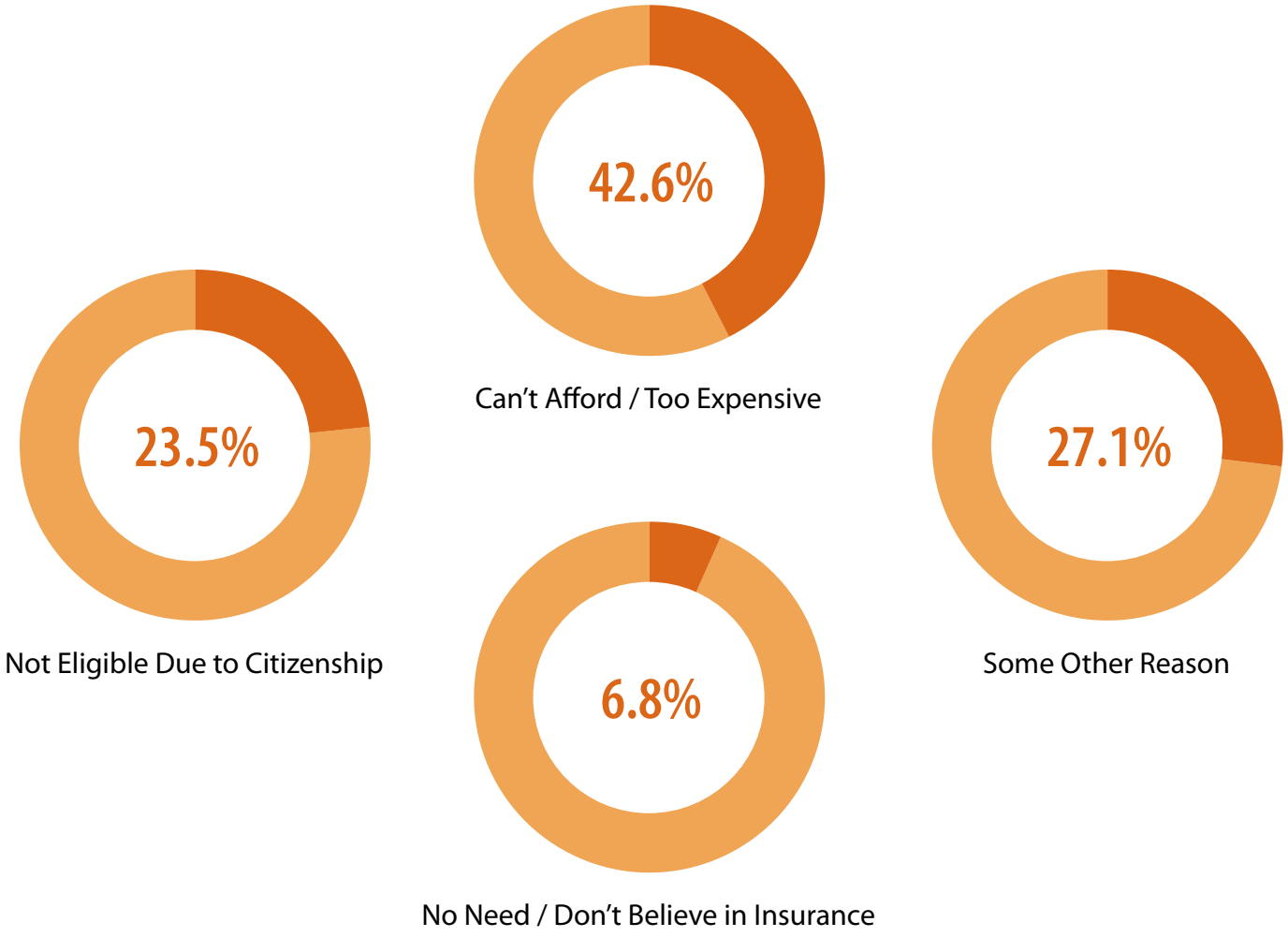


Note: Other public not shown, but included in "OVERALL."

Source: UCLA, California Health Interview Survey (CHIS), 2014.

Californians without insurance were slightly more likely than others to delay medical care. Those without insurance were more likely to cite cost of lack of insurance as the main reason for delaying care.

Reasons Cited for Lack of Insurance
California, 2014



Notes: All numbers reflect population under age 65. Other reasons for not having insurance include: can get health care for free / pay for own; not offered at job; delay due to switching insurance companies; family situation changed; not eligible due to working status; in process of looking for / getting insurance; can't qualify for public program coverage; don't know where or how to get insurance; health insurance was canceled/dropped; procrastination; and falsely thinking oneself insured.

Source: UCLA, California Health Interview Survey (CHIS), 2014.

Among uninsured Californians, lack of affordability was the main reason cited for going without health insurance.

About the Data

The majority of the data presented in this report come from the March Supplement to the Current Population Survey (CPS) conducted by the US Census Bureau for the Bureau of Labor Statistics. The monthly CPS is the primary source of data on labor force characteristics of the US civilian, noninstitutionalized population. It is also the official source of data on unemployment rates, poverty, and income in the US. Approximately 100,000 households, representing nearly 200,000 individuals, were interviewed in March 2015 as part of the CPS.

Data from the California Health Interview Survey (CHIS) were used to report on health status and access issues.

Measures used to calculate uninsured rates vary by source. To calculate uninsured rates in this publication, the authors used CPS data. In CHCF's ACA 411 tool, uninsured rates were based on CHIS data.

ABOUT THIS SERIES

The California Health Care Almanac is an online clearinghouse for data and analysis examining the state's health care system. It focuses on issues of quality, affordability, insurance coverage and the uninsured, and the financial health of the system with the goal of supporting thoughtful planning and effective decisionmaking. Learn more at **www.chcf.org/almanac**.

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State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
March 2016

Budget Savings and Revenue Gains

Early Data Shows Consistent Economic Bene ts Across Expansion States

Prepared by ***Deborah Bachrach, Patricia Boozang, Avi Herring****, and* ***Dori Glanz Reyneri****, Manatt Health*

Data regarding Medicaid expansion in 11 states—Arkansas, California, Colorado, Kentucky, Michigan, New Mexico, Oregon, Maryland, Pennsylvania, Washington state, and West Virginia—and the District of Columbia confirm that states continue to realize savings and revenue gains as a result of expanding Medicaid.

Findings show that every expansion state should expect to:

- Achieve savings related to previously eligible Medicaid beneficiaries now eligible for the new adult group under expansion
- Reduce state spending on programs for the uninsured
- Bring in additional revenue from existing insurer or provider taxes

Evidence from states that have expanded Medicaid consistently shows that expansion generates savings and revenue which can be used to finance other state spending priorities or offset much, if not all, of the state costs of expansion. Medicaid expansion is also bringing hundreds of millions of federal dollars annually to states, which ripples through state economies, creates jobs, and strengthens struggling and rural hospitals. Recent research shows that:

- State Medicaid spending grew more slowly in states that expanded than in those that did not. State Medicaid spending in expansion states grew by half as much as spending in non-expansion states between FY 2014 and FY 2015 (3.4% compared to 6.9%).[1]

For more information, please contact Patricia Boozang at *PBoozang@manatt.com* or 212-790-4523, or Deborah Bachrach at *DBachrach@manatt.com* or 212-790-4594.

[1] Kaiser Family Foundation. "Medicaid Enrollment & Spending Growth: FY 2015 & 2016." (October 2015). Available online at: *http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2015-2016/*.

Robert Wood Johnson Foundation

- Medicaid expansion states see more jobs in the health sector. On average, the states that expanded Medicaid in January 2014 saw jobs grow by 2.4 percent during 2014, while jobs in states that did not expand grew by only 1.8 percent in the same year.[2]
- Coverage expansions are contributing to a national reduction in hospital uncompensated care costs. Hospitals' uncompensated care costs are estimated to have been $7.4 billion (21%) less in 2014 than they would have been in the absence of coverage expansions.[3] In 2014, expansion states saw a reduction in uncompensated care costs of 26 percent, compared to a 16 percent reduction in non-expansion states.
- As of September 2015, the percentage of rural hospitals at risk of closure is about twice as high in non-expansion states in comparison to expansion states (based on measures of financial strength, quality and outcomes, inpatient/outpatient share, and population risk).[4]

This report, an update to an April 2015 Robert Wood Johnson Foundation *State Health Reform Assistance Network* issue brief on the impact of Medicaid expansion,[5] examines the budget impact of expansion in a sample of 11 states from all regions of the country, as well as in the District of Columbia. Based on budget information provided by state officials, the authors documented state budget implications for state fiscal year (SFY) or calendar year (CY) 2014 and projected savings for SFY/CY 2015[6] in several categories of expenditures. State variations in Medicaid payment, Medicaid eligibility, and population size make it difficult to directly translate expansion state savings to states that have not yet expanded. However, every state can expect to see savings and revenue in many, if not most, of the categories outlined below. It is important to note that many states interviewed for this report had not examined potential savings in all categories, and as a result, this report reflects only partial savings estimates for most states. The two exceptions are Arkansas and Kentucky, both of which have done comprehensive assessments of expansion related savings and revenue gains. Based on feedback from states that did more comprehensive analyses, projected expansion related savings and revenue gains are expected to offset costs of expansion in many states for several years. Findings in Arkansas and Kentucky, for example, revealed state budget savings and revenue gains sufficient to offset state costs attributable to expansion at least through SFY 2021.

Savings and increased revenue seen in expansion states fall into three major categories:

- **State Savings From Accessing Enhanced Federal Matching Funds:** In the past, states often used waivers or specialized Medicaid eligibility categories to provide coverage to high-need enrollees, such as "medically needy" individuals, pregnant women, and individuals with disabilities. States historically have been responsible for 30 to 50 percent of the cost of covering such individuals. *With expansion, many individuals who were previously eligible for limited Medicaid benefits under pre-Affordable Care Act (ACA) eligibility categories are now eligible for full Medicaid coverage in the new adult group—which means the state will receive enhanced federal funding (100% in the first three years of expansion, phasing down to 90% in 2020) for providing full Medicaid benefits to these populations.*

---

[2] Families USA. "Medicaid Expansion States See Financial Savings and Health Care Jobs Growth." (March 2015). Available online at: .

[3] Assistant Secretary for Planning and Evaluation. "Economic Impact of the Medicaid Expansion." (March 2015). Available online at: .

[4] iVantage Health Analytics. "Vulnerability to Value: Rural Relevance under Healthcare Reform." (2015). Available online at: *http://cdn2.hubspot.net/hubfs/333498/2015_Rural_Relevance_Study_iVantage_04_29_15_FNL.pdf?__hssc=31316192.5.1430489190714&__hstc=31316192.d0dce9fb5dcfbb09eef9f204e5d14c27.1429107453775.1429107453775.1430489190714.2&hsCtaTracking=dd32f7fe-5998-4036-9323-7ca31df2f112%7Cc2f8e10f-6a96-4635-a8bc-e460abdc35fe*.

[5] State Health Reform Available online at: *http://statenetwork.org/wp-content/uploads/2015/04/State-Networ s-and-Revenue-Gains-April-20152.pdf*.

[6] . Please see the tables in the appendix of this report for details on the time period for savings

- **State Savings From Replacing General Funds With Medicaid Funds:** Historically, many states have supported programs and services for the uninsured—mental and behavioral health programs, public health programs, and health care services for prisoners—with state general fund dollars. *With expansion, many of the beneficiaries of these programs and services are able to secure Medicaid coverage in the new adult category, which means states can fund these services with enhanced federal—not state—dollars.*

- **Revenue Gains:** Nearly all states raise revenue through assessments or fees on providers and/or health plans. *As provider and health plan revenues increase with expansion, this translates into additional revenue for states.*

The appendix (page 7) provides detailed tables on the savings and revenues identified for each state highlighted in this report, along with a more complete description of the areas in which states identified expansion-related savings and new revenues. It is important to note that many of the states in this report have not yet completed their analyses of expansion savings and revenue gains, so more savings may be identified as states continue to assess the impact of expansion.

Examples of state savings from accessing enhanced federal matching funds

States highlighted in this report identified savings from the use of new enhanced federal matching funds. **Every expansion state should expect to see savings as individuals who were previously eligible for limited Medicaid benefits under pre-ACA eligibility categories transition to full Medicaid coverage in the new adult group, with enhanced federal funding.**

Savings From Covering Pregnant Women in the New Adult Group

Many women who are enrolled in the new adult group and become pregnant will remain in the new adult group, where the states receive the enhanced federal match for their services, at least until women renew their coverage. Savings occur even if states maintain their previous Medicaid eligibility levels for pregnant women. While not every state in this report captured these savings in their budget estimates, all expansion states should experience savings in this area.

- **Maryland** estimated savings of $8.2 million in SFY 2015, as women enrolled in the new adult group who became pregnant remained enrolled in the new adult group.

- **West Virginia** estimated that it saved $3.8 million in spending for services to pregnant women in CY 2014.

- **Washington state** saved $6.8 million in pregnant women related spending in SFY 2014 (six months of savings), and projected savings of $31.5 million in SFY 2015.

- **Arkansas** saved $15.2 million in pregnant women related spending in SFY 2015, representing a 50 percent decrease in spending. The state projects savings of $24.4 million in pregnant women related spending in SFY 2016.

Savings From Covering Medically Needy/Spend Down Enrollees in the New Adult Group

High-need and high-cost individuals who previously would have only qualified for Medicaid by "spending down" their incomes to the medically needy eligibility group instead were able to enroll in the new adult group, where the federal government provides enhanced match for their services. This is a significant area of savings for states with medically needy programs, given the high per-beneficiary cost of this population. Savings occur without any reductions in medically needy eligibility levels.

- **Washington state** expected savings of $11.5 million in SFY 2014 and $35 million in SFY 2015, as medically needy individuals who previously would have had to "spend down" to be eligible for Medicaid enrolled in the new adult group.

- **Kentucky** saved $2.4 million on coverage for medically needy enrollees in SFY 2014 (six months of savings) and expected to save $14 million in SFY 2015.

Savings From Covering High-Need Enrollees in the New Adult Group
With expansion, low-income individuals who previously would have had to pursue a disability determination to qualify for Medicaid are able to enroll into the new adult group based on income alone. As a result, early expansion states are reporting sharp drops in the number of individuals seeking disability determinations. In the near-term, states see savings from the reduced administrative costs of conducting disability determinations, and in the longer-term, from fewer individuals in the disability category (where the state receives regular FMAP).

- **Kentucky** saved $1.7 million in SFY 2014 (six months of savings) and expected to save $7.9 million in SFY 2015 related to spending on disabled enrollees, as enrollees who previously would have had to pursue a disability determination to be eligible for Medicaid under the disabled category enroll in Medicaid through the new adult group.
- **Arkansas** saved $17.1 million in SFY 2015 related to spending on disabled enrollees. Spending on the state's Supplemental Security Income (SSI) disabled group had historically grown annually by about 5 percent prior to expansion. In SFY 2015, SSI disabled group spending decreased by 0.02 percent, and the state reduced spending by 6 percent on its non-SSI disabled population. Arkansas projects savings of $45.4 million in spending on disabled enrollees in SFY 2016.
- **Oregon** has seen a dramatic drop in the number of individuals seeking disability determinations, from 7,000 in CY 2013 to 1,400 in CY 2014.

One other key area of savings related to accessing enhanced federal match are savings related to adults enrolled in Medicaid waivers enrolling through the new adult group:

- **California** expected to save $250 million through 2015, as childless adults previously enrolled through a 2010 "early expansion" waiver transitioned to the new adult group.
- **Colorado** saved $136.6 million in CY 2014 and expected to save $148.4 million in CY 2015 as adults and parents previously enrolled through Medicaid waivers transition to the new adult group.
- **Maryland** saved $50 million in SFY 2014 and estimated savings of $101 million in SFY 2015 as childless adults receiving a limited benefits package through a Medicaid waiver transitioned to the new adult group.

Examples of state savings from replacing general funds with Medicaid funds

Several states highlighted in this report identified savings related to beneficiaries of state-funded health programs and services who secure Medicaid coverage under expansion. **All expansion states should expect to reduce state spending on programs for the uninsured as expansion increases the ranks of the insured in states.**

Savings From Behavioral Health Programs
The largest savings in this category come as individuals who previously relied on state-funded behavioral health programs and services—including mental health and substance use disorder services—are able to secure Medicaid coverage in the new adult group, which means states can fund these services with federal—not state—dollars without reducing services.

- **Michigan** projected savings of $190 million in SFY 2015 by transitioning enrollees in a state-funded program that provided targeted services for the seriously mentally ill into the new adult group.
- **Kentucky** saved $9 million in SFY 2014 (six months of savings) and expected to save $21 million in SFY 2015 in state mental and behavioral health spending.

Savings From Enrolling Inmates in Medicaid Upon Release From Jail or Prison

Medicaid's "inmate exclusion" prohibits payment of care of services for any individual who is an inmate of a public institution. However, Medicaid will cover services provided to an inmate during an inpatient stay of at least 24 hours in a medical institution such as an acute care facility.[7] To qualify, the inmate must be otherwise Medicaid-eligible. Expansion states are seeing health care related savings in their correction budgets for newly Medicaid-eligible prisoners who are treated in an inpatient medical facility outside of the state correctional system. Additionally, inmates are now eligible for Medicaid upon release from jail or prison and can receive coverage for a broad range of treatments for mental illness, substance use disorders, and chronic and communicable diseases. Studies indicate that providing treatment for mental health and substance use disorders may decrease recidivism and reduce the number of new entrants into jail and prison.[8] Since expansion, a number of states have enrolled inmates in Medicaid while they are still incarcerated, with coverage that takes effect soon after their release.[9] This approach facilitates continuity of care for inmates upon their return to the community.

- **Michigan** projected a reduction in state correctional spending of $19 million in SFY 2015, as the federal government picks up the hospital inpatient costs for incarcerated individuals who are Medicaid-eligible through the new adult group.
- **Colorado** expects savings of $5 million per year in state correctional spending.

Other states reduced state spending on public health programs and for uncompensated care:

- **Arkansas** was able to reduce state spending on community health centers and local health units by $6.4 million for SFY 2015 without reducing services, because these facilities now receive Medicaid payments for services provided to previously uninsured patients who are eligible as new adults.
- **California** estimated that it will save $750 million through 2015 due to decreased need for funding to counties for providing indigent care to adults previously ineligible for Medicaid. Many of these individuals transitioned to the expansion group.
- **Pennsylvania** estimated savings of $108 million in SFY 2015, as beneficiaries of a state-funded medical assistance program transitioned to the expansion group.
- **Maryland** reduced state uncompensated care funding to hospitals by more than $13.6 million in SFY 2015 because hospitals saw fewer uninsured patients.

Examples of state revenue gains

Six of the 11 states and the District of Columbia highlighted in this report (Arkansas, California, Maryland, Michigan, New Mexico, and Washington state) found that expansion increased state revenue from existing assessments on insurers and providers. These gains occurred as local insurer and provider revenues increased, resulting in higher state collections on insurer and provider assessments. **All states except Alaska have existing insurer or provider taxes,[10] and can expect to see revenue gains because of Medicaid expansion.**

- **California** expected more than $985 million in additional revenue through 2015 due to increased revenue from insurer and provider taxes.

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[7] 42 U.S.C. 1396a(a)(29)(A).

[8] Washington State Department of Social and Health Services Research and Data Analysis Division. "Chemical Dependency Treatment, Public Safety: Implications for arrest rates, victims, and community protection." (February 2009).

[9] State Health Reform Assistance Network. "Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States." (November 2015).

[10] National Conference of State Legislatures. "Health Provider and Industry State Taxes and Fees." (December 2015). Available online at: *http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx*.

- **New Mexico's** CY 2014 premium tax revenues were $30 million greater due to increased revenue related to expansion adults, and the state projects continued revenue gains of $30 million in CY 2015.
- **Maryland** estimated an additional $26.6 million in revenue in SFY 2015 because of greater revenue from an insurer tax.
- **Michigan** expected revenue gains of $26 million in SFY 2015 from the state's Health Insurance Claims Assessment.

Conclusion

States that have expanded Medicaid continue to report financial benefits related to expansion. Expansion states generate savings and revenue that can be used for other state priorities or, starting in 2017, can offset the state costs of expansion. Beyond the state budget benefits, Medicaid expansion states are seeing broader benefits including job growth, deep reductions in uninsurance, and related decreases in hospital uncompensated care costs. In turn, the climbing rate of insured patients is helping to stabilize struggling hospitals, particularly rural facilities.

Appendix

DETAILED TABLES ON SAVINGS AND REVENUES IDENTIFIED IN EXPANSION STATES

The following charts summarize in detail the early results on savings and revenue gains for each of the states highlighted in this report. Note that the costs of newly eligible enrollees are paid entirely by the federal government in FY 2014 and 2015. Savings and revenue gains, on the other hand, accrued to state budgets.

ARKANSAS[11]		SFY 2014[12]	SFY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	200,700	248,000
	Per Member Per Year (PMPY) Cost	$5,200	$6,100
	Total Cost of Newly Eligible Enrollees	***$362,660,000[13]***	***$1,378,600,000***
	Newly Eligible FMAP	***100%***	***100%***
Source of Savings/Revenues		**SFY 2014**	**SFY 2015**
State Savings From Enhanced Federal Matching Funds	ARHealthNetwork[14]	$5,700,000	$14,200,000
	Medically Needy[15]	$1,650,000	$15,600,000
	Disabled Adults[16]	$2,250,000	$17,100,000
	Pregnant Women[17]	$4,900,000	$15,150,000
	Family Planning[18]	$780,000	$1,550,000
	Breast & Cervical Cancer Treatment Program	$2,200,000	$4,350,000
	Tuberculosis Program[19]	$10,000	$20,000
	Total Savings From Enhanced Federal Matching Funds	***$17,500,000***	***$67,970,000***
Savings From Replacing State General Funds With Medicaid Funds	Uncompensated Care Funding to Hospitals	N/A	$17,200,000
	State Mental/Behavioral Health Spending[20]	N/A	$7,100,000
	State Public Health Spending[21]	N/A	$6,350,000
	Hospital Inpatient Costs of Prisoners	N/A	$2,750,000
	Total Savings From Replacing State General Funds With Medicaid Funds	***$13,300,000***	***$33,400,000***
Estimated Revenue Gains	Revenue From Insurer Assessment	$4,700,000	$29,700,000
	Total Revenue Gains	***$4,700,000***	***$29,700,000***
Total Arkansas Estimated Savings and Revenues Related to Expansion		***$35,500,000***	***$131,070,000***
Arkansas' State-Only Medicaid Budget		***$1,541,000,000***	***$1,537,000,000***
Arkansas' Regular Federal Medical Assistance Percentages (FMAP)		***70.10%***	***70.88%***

[11] All numbers are budget estimates, and are based on expansion experiences to date.

[12] SFY

[13] Total costs are lower than the product of the number of enrollees and the average annual cost due to rapid enrollment growth during this time period.

[14] ARHealthNetwork was a Section 11 to their employees. The program was discontinued, and its enrollees transitioned into ACA coverage, in January 2014.

[15] Arkansas did not reduce or eliminate eligibility for medically needy spend down populations.

[16] These costs result from reductions in spending on Aged, Blind, and Disabled populations, and from reductions in disability enrollment growth.

[17] Arkansas did not reduce eligibility levels for pregnant women.

[18] Arkansas discontinued its family planning waiver program in 2014 as a result of expansion.

[19] Arkansas used Medicaid funding to provide limited services to those with Tuberculosis, but discontinued this program in 2014 as a result of expansion.

[20] Savings resulted in reductions in state spending on community mental health centers.

[21] Savings resulted in reductions in state spending on community health centers and local health units.

CALIFORNIA		CY 2014	CY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	1,839,566	2,291,947
	PMPY Cost	$5,421	$6,742[22]
	Total Cost of Newly Eligible Enrollees	***$9,971,763,000***	***$15,453,318,000***
Source of Savings/Revenues		**CY 2014**	**CY 2015**
State Savings From Enhanced Federal Matching Funds	Low Income Health Program[23]	$0	$250,000,000
	Total Savings From Enhanced Federal Matching Funds	***$0***	***$250,000,000***
Savings From Replacing State General Funds With Medicaid Funds	Realignment Funding for Medically Indigent Adults[24]	$0	$750,000,000
	Total Savings From Replacing State General Funds With Medicaid Funds	***$0***	***$750,000,000***
Estimated Revenue Gains	Insurer Assessment	$369,696,000	$515,427,000
	Provider Assessment	$0	$100,000,000
	Total Revenue Gains	***$369,696,000***	***$615,427,000***
Total California Estimated Savings and Revenues Related to Expansion		***$369,696,000***	***$1,615,427,000***
California's State-Only Medicaid Budget (SFY)[25]		***$21,398,000,000***	***22,298,000,000***
California's Regular FMAP		***50.00%***	***50.00%***

COLORADO		CY 2014	CY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	244,000	341,900
	PMPY Cost	$5,000	$5,600
	Total Cost of Newly Eligible Enrollees	***$1,220,000,000[26]***	***$1,930,000,000***
	Newly Eligible FMAP	***100%***	***100%***
Source of Savings/Revenues		**CY 2014**	**CY 2015**
State Savings From Enhanced Federal Matching Funds	Childless Adults Early Expansion Waiver	$96,300,000	$96,300,000
	Breast and Cervical Cancer Treatment Program	$1,100,000	$603,000
	Early Expansion for Parents	$40,300,000	$52,100,000
	Pregnant Women[27]	$206,000	$903,000
	Total Savings From Enhanced Federal Matching Funds	***$137,900,000***	***$149,900,000***
Savings From Replacing State General Funds With Medicaid Funds	State Mental/Behavioral Health Spending[28]	N/A	N/A
	Hospital Inpatient Costs of Prisoners	$5,000,000	$5,000,000
	Old Age Pension—Targeted State Funded Program	$4,500,000	$5,400,000
	Total Savings From Replacing State General Funds With Medicaid Funds	***$9,500,000***	***$10,400,000***
Total Colorado Savings and Revenues Related to Expansion		***$147,400,000***	***$160,300,000***
Colorado's State-Only Medicaid Budget		***$3,225,000,000***	***$3,498,000,000***
Colorado's Regular FMAP		***50.00%***	***51.01%***

[22] California operates on a cash budget. Some of the PMPY increase is explained by lags in payment that cross over years.

[23] California, an "early expansion" state, expanded Medicaid in 2010 at the county level through a Section 1115 waiver. The program ended in December 2013, when enrollees transitioned to the new adult group.

[24] California state law requires that counties provide health care services to Medically Indigent Adults (MIAs) that are not eligible for Medicaid. The state then funds a portion of these costs through a broader funding mechanism called realignment. As many MIAs gained coverage through the new adult group, the state decreased realignment funding targeted to the MIA population at the county level.

[25] National Available online at: *http://www* . Figures represent total state Medicaid spending.

[26] 2014 numbers are actuals.

[27] .

[28] Colorado estimates a decrease of 2,000 utilizers of Medicaid-funded behavioral health services in SFY 2014, and a decrease of 4,000 utilizers in SFY 2015, relative to prior years.

KENTUCKY[29]		SFY 2014[30]	SFY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	311,000	393,000
	PMPY Cost	$5,923	$6,868
	Total Cost of Newly Eligible Enrollees	***$921,000,000***	***$2,699,000,000***
	Newly Eligible FMAP	***100%***	***100%***
Source of Savings/Revenues		**SFY 2014[31]**	**SFY 2015**
State Savings From Enhanced Federal Matching Funds	Medically Needy	$2,400,000	$14,000,000
	Disabled Adults	$1,700,000	$7,900,000
	Breast and Cervical Cancer Treatment Program	$400,000	$1,300,000
	State Transitional Assistance Program	$1,900,000	$9,000,000
	Total Savings From Enhanced Federal Matching Funds	***$7,400,000***	***$33,300,000***
Savings From Replacing State General Funds With Medicaid Funds	State Mental/Behavioral Health Spending	$9,000,000	$21,000,000
	Hospital Inpatient Costs of Prisoners	$5,400,000	$11,000,000
	Public Health Programs	$4,000,000	$6,000,000
	Uncompensated Care Funding to Hospitals[32]	N/A	$11,800,000
	Total Savings From Replacing State General Funds With Medicaid Funds	***$18,400,000***	***$49,800,000***
Total Kentucky Savings and Revenues Related to Expansion		***$25,800,000***	***$83,100,000***
Kentucky's State-Only Medicaid Budget		***$1,980,000,000[33]***	***$2,080,000,000[34]***
Kentucky's Regular FMAP		***69.83%***	***69.94%***

MARYLAND		SFY 2014	SFY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	205,496	218,121
	PMPY Cost	N/A	$8,584
	Total Cost of Newly Eligible Enrollees	***N/A***	***$1,872,350,664***
Source of Savings/Revenues		**SFY 2014**	**SFY 2015**
State Savings From Enhanced Federal Matching Funds	Primary Adult Care Program[35]	$50,000,000	$101,000,000
	Breast and Cervical Cancer Treatment Program	$402,887	$926,264
	Pregnant Women	N/A	$8,180,552
	Total Savings From Enhanced Federal Matching Funds	***$50,402,887***	***$110,106,816***
Savings From Replacing State General Funds With Medicaid Funds	Uncompensated Care[36]	N/A	$13,610,000
	Total Savings From Replacing State General Funds With Medicaid Funds	***$0***	***$13,610,000***
Estimated Revenue Gains	Insurer Assessment	N/A	$26,600,000
	Total Revenue Gains	***N/A***	***$26,600,000***
Total Maryland Estimated Savings and Revenues Related to Expansion		***$50,402,887***	***$150,316,816***
Maryland's State-Only Medicaid Budget		***$4,102,000,000***	***$4,219,650,145***
Maryland's Regular FMAP		***50.00%***	***50.00%***

[29] Deloitte. "Commonwealth of Kentucky Medicaid Expansion Report." (February 2015). Available online at: *http://jointhehealthjourney ear_Study_FINAL.pdf*.

[30] Kentucky'

[31] Kentucky'

[32] Trust Funds to cover economically disadvantaged populations.

[33] 2014-2016 Budget of the Commonwealth. Operating Budget Volume I. (Part B). Page 158, available online at: *http://osbd.ky.gov/Archives/Pages/Budget-Period-2014-2016.aspx*.

[34] Id.

[35] Maryland's Primary Adult Care (PAC) program was an 11 16 percent of the federal poverty level (FPL). This program was discontinued in January 2014, and the entire PAC population transitioned to the ACA expansion group. SFY 2014 represents six months of savings. Figures are estimates from a 2012 Hilltop Institute study.

[36] Maryland builds uncompensated care costs into hospital rates as part of its all-payer model. The hospital rates set by the Maryland Health Services Review Commission were reduced by $166 million in FY 2015 to account for savings from lower uncompensated care levels. Medicaid pays for roughly 20 percent of hospital charges in Maryland and has a blended federal matching rate of approximately 59 percent.

MICHIGAN		SFY 2014	SFY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	275,000[37]	588,000
	PMPY Cost	$4,800	$4,900
	Total Cost of Newly Eligible Enrollees	***$1,320,000,000***	***$1,347,500,000***
	Newly Eligible FMAP	***100%***	***100%***
Source of Savings/Revenues		**SFY 2014[38]**	**SFY 2015**
State Savings From Enhanced Federal Matching Funds	aiver Program[39]	$17,000,000	$34,000,000
	Family Planning[40]	$700,000	$1,400,000
	Total Savings From Enhanced Federal Matching Funds	***$17,700,000***	***$35,400,000***
Savings From Replacing State General Funds With Medicaid Funds	Hospital Inpatient Costs of Prisoners	N/A	$19,000,000
	State Mental/Behavioral Health Spending[41]	$180,000,000	$190,000,000
	Total Savings From Replacing State General Funds With Medicaid Funds	***$180,000,000***	***$209,000,000***
Estimated Revenue Gains	Revenue From Insurer Assessment	N/A	$26,000,000
	Total Revenue Gains	***$0***	***$26,000,000***
Total Michigan Savings and Revenues Related to Expansion		***$197,000,000***	***$270,400,000***
Michigan's State-Only Medicaid Budget		***$2,200,000,000***	***$2,300,000,000***
Michigan's Regular FMAP		***66.32%***	***65.54%***

NEW MEXICO			
Source of Savings/Revenues		**CY 2014**	**CY 2015**
Estimated Revenue Gains	Revenue From Insurer Assessment[42]	$30,000,000	$30,000,000
	Total Revenue Gains	***$30,000,000***	***$30,000,000***
Total New Mexico Savings and Revenues Related to Expansion		***$30,000,000***	***$30,000,000***
New Mexico's State-Only Medicaid Budget		***$1,100,000,000***	***$1,100,000,000***

OREGON		CY 2014	CY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	328,000	315,000
	PMPY Cost	$7,000	$7,100
	Total Cost of Newly Eligible Enrollees	***$2,280,000,000***	***$2,240,000,000***
	Newly Eligible FMAP	***100%***	***100%***
Source of Savings/Revenues		**CY 2014**	**CY 2015**
State Savings From Enhanced Federal Matching Funds	aiver Program[43]	$137,500,000	$137,500,000
	Family Planning[44]	N/A	N/A
	Total Savings From Enhanced Federal Matching Funds	***$137,500,000***	***$137,500,000***
Total Oregon Savings and Revenues Related to Expansion		***$137,500,000***	***$137,500,000***
Oregon's State-Only Medicaid Budget		***N/A***	***N/A***
Oregon's Regular FMAP		***63.14%***	***64.06%***

[37] This is the SFY 2014 actual number of newly eligible enrollees.

[38] Michigan's SFY begins on October 1, and Michigan expanded Medicaid effective April 1, 2014; SFY

[39] Michigan's

[40] Michigan discontinued its family planning waiver program in 2014.

[41] These savings resulted as Michigan transitioned enrollees in a state-funded program providing targeted services for the seriously mentally ill into the new adult group.

[42] New Mexico estimates an increase in revenue from premium taxes related to the additional managed care organization (MCO) premium revenue for the new adult group under expansion.

[43]

[44] While Oregon has not yet accounted for savings from reductions in spending on disabled populations in their budget projections, the state has seen a dramatic drop in disability determination applications, from 7,000 in 2013 to 1,400 in 2014.

enue Gains

PENNSYLVANIA		SFY 2014	SFY 2015[45]
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	N/A	476,774
	PMPY Cost	N/A	$9,271
	Total Cost of Newly Eligible Enrollees	***N/A***	***$2,209,969,216***
Source of Savings/Revenues		**CY 2014**	**CY 2015**
State Savings From Enhanced Federal Matching Funds	Select Plan for Women[46]	N/A	$588,000
	Total Savings From Enhanced Federal Matching Funds	***N/A***	***$588,000***
Savings From Replacing State General Funds With Medicaid Funds	State-Funded General Assistance Population[47]	N/A	$108,000,000
	Total Savings From Replacing State General Funds With Medicaid Funds	***N/A***	***$108,000,000***
Total Pennsylvania Estimated Savings and Revenues Related to Expansion		***N/A***	***$108,588,000***
Pennsylvania's State-Only Medicaid Budget[48]		***$10,528,000,000***	***$10,706,000,000***
Pennsylvania's Regular FMAP		***53.71%***	***52.25%***

WASHINGTON STATE		SFY 2014[49]	SFY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	343,000[50]	480,000
	PMPY Cost	$8,300	$6,100
	Total Cost of Newly Eligible Enrollees	***$1,420,000,000***	***$2,830,000,000***
	Newly Eligible FMAP	***100%***	***100%***
Source of Savings/Revenues		**SFY 2014**	**SFY 2015**
State Savings From Enhanced Federal Matching Funds[51]	Medically Needy	$11,500,000	$35,000,000
	Breast and Cervical Cancer Treatment Program	$700,000	$3,600,000
	Family Planning	$500,000	$1,000,000
	Pregnant Women[52]	$6,700,000	$31,500,000
	Adult Waiver Populations[53]	$34,000,000	$69,100,000
	Presumptive Supplemental Security Income (SSI) – Expansion State Designation[54]	$38,100,000	$109,800,000
	Total Savings From Enhanced Federal Matching Funds	***$91,500,000***	***$250,500,000***
Savings From Replacing State General Funds With Medicaid Funds[55]	State Mental/Behavioral Health Spending	$13,400,000	$51,200,000
	Hospital Inpatient Costs of Prisoners	$700,000	$1,400,000
	State Public Health Spending	$2,600,000	$5,800,000
	Other State Funded Programs[56]	$4,000,000	$9,700,000
	Total Savings From Replacing State General Funds With Medicaid Funds	***$20,700,000***	***$68,100,000***
Estimated Revenue Gains[57]	Revenue From Insurer Assessments	N/A	$33,900,000
	Total New Revenues	***N/A***	***$33,900,000***
Total Washington Savings and Revenues Related to Expansion		***$112,200,000***	***$352,500,000***
Washington's State-Only Medicaid Budget		***N/A***	***N/A***
Washington's Regular FMAP		***50.00%***	***50.03%***

45 Pennsylvania expanded Medicaid on January 1, 2015.

46 Pennsylvania's Select Plan for Women was an 1115 waiver that provides family planning services to women ages 18-44 up to 214 percent FPL. Starting July 1, 2015, family planning services are provided through the ACA Family Planning Services State Plan option. Savings are expected to reach $2 million by FY 2016.

47 Pennsylvania provided state-funded General This program ended on January 1, 2015. Savings for FY 2016 are expected to reach $626 million.

48

49 Washington'

50

51 Kaiser Family Foundation. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." (March 2015). Available online at: *http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/*.

52

53 s Medical Care Services, Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), and Basic Health Plan program enrollees into the new adult group.

54 of 75 percent, increased from 50 percent.

55 Kaiser Family Foundation. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." (March 2015). Available online at: *http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/*.

56 , and labor and industries programs outside of Medicaid.

57 Id.

WASHINGTON, D.C.		SFY 2014[58]	SFY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	52,773	61,948
	PMPY Cost	$3,976	$5,267
	Total Cost of Newly Eligible Enrollees[59]	***$209,840,423***	***$326,304,349***
Source of Savings/Revenues		**SFY 2014**	**SFY 2015**
Savings From Replacing State General Funds With Medicaid Funds	D.C. Alliance Program[60]	$40,700,000	$41,300,000
	Total Savings From Enhanced Federal Matching Funds	***$40,700,000***	***$41,300,000***
Total Washington, D.C. Estimated Savings and Revenues Related to Expansion		***$40,700,000***	***$41,300,000***
Washington, D.C.'s State-Only Medicaid Budget		***$714,600,000***	***$685,500,000***
Washington, D.C.'s Regular FMAP		***70.00%***	***70.00%***

WEST VIRGINIA		SFY 2014	SFY 2015
Cost of Newly Eligible Enrollees	Number of Newly Eligible Enrollees	130,400	150,000
	PMPY Cost	$983	$4,350
	Total Cost of Newly Eligible Enrollees	***$128,200,000***	***$652,600,000***
	Newly Eligible FMAP	***100%***	***100%***
Source of Savings/Revenues		**CY 2014[61]**	**CY 2015**
State Savings From Enhanced Federal Matching Funds[62]	Breast and Cervical Cancer Treatment Program	$25,000	N/A
	Family Planning	$6,000	N/A
	Pregnant Women	$3,800,000	N/A
	Total Savings From Enhanced Federal Matching Funds	***$3,831,000***	***N/A***
Total West Virginia Savings and Revenues Related to Expansion		***$3,831,000***	***N/A***
West Virginia's State-Only Medicaid Budget		***$933,000,000***	***$956,800,000***
West Virginia's Regular FMAP		***71.09%***	***71.35%***

on states

STATE SAVINGS FROM ACCESSING ENHANCED FEDERAL MATCHING FUNDS

- **Adults Enrolled Through Waivers.** Many states have used 1115 waivers to provide limited-benefit coverage to childless adults or parents who were not otherwise Medicaid-eligible. If they did not qualify for full Medicaid benefits under pre-ACA rules, these individuals are eligible for full Medicaid coverage in the new adult group, and the state is able to secure enhanced federal matching funds on their behalf.
- **Breast and Cervical Cancer Treatment Program.** States may cover individuals who are in need of treatment for breast or cervical cancer through the Breast and Cervical Cancer Treatment Program.[63] To be eligible, individuals must be under age 65 and uninsured or not otherwise eligible for Medicaid. Individuals receive full Medicaid coverage during the period that they need cancer treatment. State expenditures are matched at the state's Children's Health Insurance Program (CHIP) enhanced federal match rate. In expansion states, individuals with incomes below 138 percent of the federal poverty level (FPL) who might previously have been found eligible through the Breast and Cervical Cancer Treatment Program, often end up being covered as a newly-eligible adult prior to their diagnosis.
- **Disabled Individuals.** Prior to the expansion of Medicaid eligibility, individuals who were disabled were able to secure coverage under the category range of disability-based Medicaid categories. To be eligible

[58] The W

[59] Total costs are slightly different than the product of the number of enrollees and the average annual cost due to rounding.

[60] The D.C. Healthcare that were not eligible for Medicaid. Washington, D.C. expanded Medicaid early in 2010, at which time Healthcare Alliance recipients eligible for the expansion group transitioned to Medicaid.

[61] West Virginia' 2014 spending compared to CY 2013 spending.

[62]

[63] 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII); 1396a(aa).

under these categories, individuals are required to be low-income and to seek either a federal or state disability determination. States receive their regular FMAP for these eligibility groups. In expansion states, individuals with incomes up to 138 percent of the FPL are eligible for Medicaid under the new adult group without a disability determination. As a result, individuals who previously sought a disability determination solely to secure health coverage no longer must do so in Medicaid expansion states, resulting in fewer individuals enrolled in the disabled category at the regular match.

- **Family Planning Services.** States may offer family planning services to individuals under the Family Planning optional eligibility category or under a waiver. To be eligible, individuals must not be pregnant and may have incomes up to the income eligibility limit for pregnant women. States receive an enhanced federal match of 90 percent for family planning services, and the state's regular federal match for family planning-related services such as treatment for sexually-transmitted diseases.[64] Individuals with incomes below 138 percent of the FPL who might have qualified for Family Planning coverage now often end up enrolled in the new adult group with the enhanced federal matching rate.

- **Medically Needy Spend Down Program.** States have the option of covering individuals through a medically needy program.[65] The medically needy are individuals who are eligible for an eligibility category such as the Aged, Blind, or Disabled but their incomes or resources exceed maximum allowable limits. Applicants may become Medicaid-eligible by "spending down" their income to the state's medically needy threshold and submitting incurred medical expenses to the state. States receive the regular federal match for medically needy programs. In expansion states, individuals with incomes above the medically needy threshold but below 138 percent of the FPL are eligible for the new adult group.

- **Pregnant Women.** Women who are enrolled in the new adult group and become pregnant remain in the new adult group and are eligible for enhanced federal match until such time that they report their pregnancy (generally at renewal). In addition, some states are evaluating whether to reduce income eligibility limits for pregnant women to 138 percent of the FPL given the availability of federal subsidies in health insurance marketplaces.

- **Tuberculosis Program.** A state may opt to cover non-disabled individuals who are infected with tuberculosis (TB).[66] Eligible individuals may receive coverage limited to their TB treatment such as TB-related prescriptions, physician services, and outpatient hospital treatment. Very few individuals are currently receiving coverage under this Medicaid category. In expansion states, individuals with incomes below 138 percent of the FPL who have TB will receive coverage under the new adult group.

STATE SAVINGS FROM REPLACING GENERAL FUNDS WITH MEDICAID FUNDS

- **Corrections Savings.** Medicaid's "inmate exclusion" prohibits payment of care of services for any individual who is an inmate of a public institution. However, Medicaid will cover services provided to an inmate during an inpatient stay of at least 24 hours in a medical institution such as an acute care facility.[67] In expansion states, state correction budgets may be reduced to the extent that newly Medicaid-eligible prisoners are treated in an inpatient medical facility outside of the state correctional system.

[64]

[65] 42 U.S.C. 1396a(a)(10)(C); 42 C.F.R. § 435.300-350.

[66] 42 U.S.C. 1395a(a)(10)(A(ii)(XII).

[67] 42 U.S.C. 1396a(a)(29)(A).

- **State Mental Health and Substance Abuse Spending.** States have allocated state and local funding to support mental health and substance abuse treatment for uninsured individuals. In states that expand Medicaid, previously uninsured individuals who were recipients of these state funded mental health and substance abuse services are now eligible for full coverage under the new adult group.
- **Uncompensated Care Funds.** The expansion of Medicaid to adults with incomes up to 138 percent of the FPL has resulted in fewer patients who are unable to pay their medical bills because they are uninsured. As a result, expansion states are able to reduce or repurpose state expenditures for uncompensated care provided by hospitals and other health care providers.

latory pathways are too slow (even as the FDA adds ever more ways to approve or provide access to investigational therapeutics more quickly).

Add to the mix a dose of stem cells, and one has a recipe for more medical tourism, fed by clinics seeking profits and patients seeking cures. When older gene-editing technologies were used to engineer intestinal stem-cell organoids in the search for cystic fibrosis treatment,[4] a headline on futuremedicine.com read, "Fixing stem cells via genome editing: hope for cystic fibrosis?" If new is better, then new-squared, with two high-profile fields combined to address chronic, degenerative, and fatal diseases currently lacking cures, may be well nigh irresistible to patients and to clinics that would abuse their trust.

It will take a concerted effort by researchers, journal editors, companies, investors, and the media to find the fine line between hope and hype and to keep explaining why the best way to find safe, effective cures is through the careful steps of clinical trials and treatment monitoring. Editors need to ensure that headlines are more carefully written, scientists need to be careful about how they allow themselves to be quoted, and regulators need to collaborate with one another and with patient groups, so that misleading claims on the Internet can be checked or withdrawn. On the research side, national academies of science and medicine in Europe, Asia, and the United States have begun projects examining potential applications, regulatory pathways, and means to predict and measure precision, accuracy, and off-target effects. And proposals are being made regarding educating patients before any gene-editing–therapy trial begins.[5]

Participation in responsibly designed research is not at odds with promoting innovative medicine; it provides the data needed to confirm that innovative methods are effective. Nor is it at odds with compassion or an awareness of the different risk–benefit balance at play in terminal illnesses, which is why regulators provide pathways for access to investigational products. But the absence of good research undermines any effort to separate real from illusory therapeutic claims. Patients may be tempted by Willie Nelson, who "can't wait to get on the road again," but real progress is more like the Beatles' "long and winding road."

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Toward Lower Costs and Better Care — Averting a Collision between Consumer- and Provider-Focused Reforms

Elliott S. Fisher, M.D., M.P.H., and Peter V. Lee, J.D.

Over the past 20 years, two major approaches to slowing the growth of health care costs have emerged. One focuses on the delivery system, encouraging physicians, hospitals, and others to improve the way they deliver care. The other targets consumers, hoping to turn patients into more price-sensitive shoppers. Although both have had some success, it's increasingly clear that these approaches are on a collision course: poorly structured benefit designs will sharply limit the effectiveness of efforts to promote higher-value care through payment and delivery-system reform. But a crash is not inevitable.

Interest in reforming care delivery grew out of observations regarding the relative efficiency of integrated medical group practices, growing concern about variation in quality of care, and evidence that the greater use of specialist and hospital-based care in high-cost U.S. regions and health systems did not translate

into better quality or superior health outcomes.[1] Reform initiatives focused on both support for practice transformation and changing payment systems to reward better care and lower costs — now widely referred to as "value-based payment." One example of these efforts is the patient-centered medical home (PCMH) model, which has been broadly adopted, with millions of patients now receiving care through practices certified by the National Committee on Quality Assurance. Another is the recent growth of accountable care organizations (ACOs), which now provide care to more than 26 million Americans. These approaches are rooted in the notion that improved delivery of effective primary care and better coordination of patient care over time are essential to improving quality and reducing costs.

California's example suggests that it's possible to avoid a collision between consumer- and provider-focused efforts to improve care and reduce cost growth.

The consumer-focused strand of activity largely emerged from the private sector. These efforts were spurred by the Rand Health Insurance Experiment, a randomized trial that demonstrated that cost sharing reduced utilization (and thus spending) with no apparent adverse health effects on the average participant but with potential negative effects on low-income participants with chronic illnesses.[2] Because benefit design as a lever for constraining health care spending has been readily accessible to both large, self-insured employers and health plans serving small businesses, cost sharing has increased dramatically. Since 2006, the proportion of Americans with employer-sponsored coverage involving deductibles of over $1,000 has increased from 10% to 46%, and many of these enrollees must fully meet their deductible before receiving any coverage for primary care. In addition, 93% of covered workers must pay a portion of the costs for primary care visits in the form of either coinsurance or copayments, with copayments now averaging $24.[3]

The conflict between these two approaches is clear. The success of provider-focused reform strategies, such as ACOs and PCMHs, depends directly on having patients engaged with their care team — usually a primary care practice. Early evidence suggests that ACOs achieve their substantial successes in improving quality (including improvement on measures of patient experience, clinical outcomes, and readmission rates) by ensuring that primary care patients receive needed preventive and chronic disease care.[4] Their modest successes in controlling costs appear to be generated by more effective referrals (for commercial populations) and better care coordination (for high-cost Medicare beneficiaries). Substantial or poorly targeted cost sharing could easily undermine these approaches. Numerous studies have shown that cost sharing is a blunt instrument, causing patients to cut back on both needed and wasteful care. A recent study showed that the adoption of a high-deductible health plan in a relatively high-income population led to a 10% reduction in the use of preventive services and an 18% drop in physician visits, with the greatest reductions occurring in the sickest quartile of patients.[5]

Although trends in benefit design are worrisome, the Affordable Care Act (ACA) set some important requirements for health plans offered in both the employer and individual markets, including mandatory coverage for medical and mental health care and provision of free preventive care services. In the employer market, however, the ACA largely leaves benefit designs unregulated, aside from imposing minimum value requirements. The individual insurance marketplaces, dominated by the state-based and federal exchanges, go a few steps further: products must fall into one of four tiers of actuarial value, ranging from "platinum" products with comprehensive benefits but high premiums, through "gold" and "silver," down to "bronze" products with thinner benefits but low premiums. Though all products must include a defined set of essential health benefits and none may impose cost sharing exceeding a defined annual maximum for in-network care, states can determine how much flexibility to allow health plans in setting deductibles, copayments, and coinsurance.

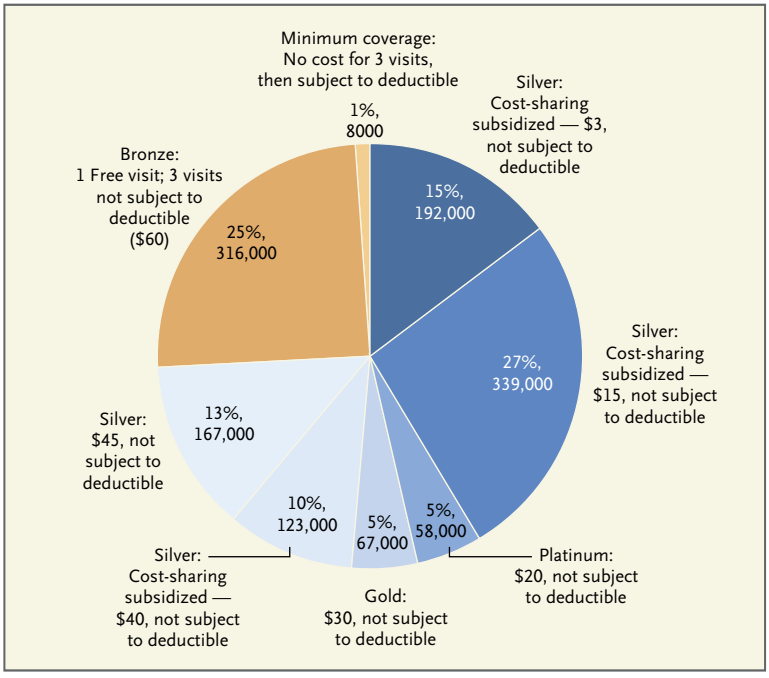
Because most exchanges do not standardize the benefit designs health plans can offer, consumers face a confusing array of products, many of which will undermine initiatives in delivery-system reform. For example, in Colorado

— whose exchange gives health plans free rein on benefit designs — Denver residents can choose from 35 different silver products offered by eight health plans. Of these products, 15 require the consumer to meet the deductible before insurance kicks in to cover outpatient care. In 2015, for example, the lowest-cost silver plan had a premium for a 30-year-old of $183 per month, half as much as that of the most expensive silver product. In the lowest-cost plan, however, all outpatient services other than the required free preventive services and generic drugs are subject to a $3,900 deductible.

California has taken a different approach. As an active purchaser, Covered California, the state's insurance exchange, opted to standardize the designs of deductibles, copayments, and other cost sharing for all its contracted health plans within each of the four tiers. The aim is to enable consumers to make apples-to-apples comparisons among plans based on cost and network composition (rather than hard-to-interpret differences in deductibles and copayments) and to ensure that consumers do not face undue financial barriers to receiving primary and other high-value care.

The pie chart shows the levels of cost sharing for the exchange's 1.3 million enrollees. Those who select a silver product face no deductible and modest copayments for physician visits and other outpatient services; subsidies further reduce copayments for lower-income enrollees. Anyone selecting a bronze plan receives one free primary care visit and three visits that are not subject to the annual deductible.

Other elements of California's approach include encouraging



Costs to Covered California Enrollees for Primary Care Visits, June 2015.

The blue segments represent enrollees (75% of the total) who can obtain primary care without being subject to a deductible. Numbers and percentages have been rounded.

plans to support PCMH and ACO models. For instance, Covered California currently requires plans to report the percentage of enrollees receiving their care from either type of organization and intends to require increasing use of such integrated delivery systems in coming years. Many of the exchange's consumers are therefore enrolled in ACOs and PCMHs that have multiple public and private ACO contracts.

A few other states — including Connecticut, Oregon, and Massachusetts — have adopted standardized benefit designs, and the federal marketplace recently indicated that it's starting down this path by making a standardized design voluntary for plans in 2017. The exchanges, however, cover only 10.2 million Americans, or 4% of the population under 65 years of age. If meaningful health care reform is to reach a critical mass, more employers will need to partner with health plans to engage their employees in more integrated delivery models.[4]

California's example suggests that it's possible to avoid a collision between consumer- and provider-focused efforts to improve care and reduce cost growth. Benefit designs encouraging utilization of high-quality, accessible primary care that's supported by an effective organizational structure should help consumers better manage their health risks and chronic conditions and more effectively navigate the challenges of serious illness. At the same time, carefully designed cost sharing may help motivate patients to work in partnership with their primary care physician and others to make wise decisions about what discretionary care they truly need and want.

Whether we can slow the growth of health care spending while improving both health and health care is far from certain. This outcome is much more likely, however, if leaders in the public and private sectors strive to align benefit designs with delivery-system reforms.

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The Physician Payments Sunshine Act — Two Years of the Open Payments Program

Shantanu Agrawal, M.D., and Douglas Brown, M.H.S.

The Physician Payments Sunshine Act, part of the Affordable Care Act, requires public reporting of payments made to physicians and teaching hospitals by medical product manufacturers and group purchasing organizations.[1] In the Open Payments program, we at the Centers for Medicare and Medicaid Services (CMS) receive reports from industry on relevant financial interactions and make the information available on a public website. The first round of data, released on September 30, 2014, included financial interactions from August through December 2013. These payments totaled $3.4 billion, from 1347 companies to more than 470,000 physicians and 1019 of the approximately 1200 U.S. teaching hospitals. The second round, published on June 30, 2015, included all reported payments for 2014 — about $6.5 billion from 1444 companies to more than 600,000 physicians and 1100 teaching hospitals (see Table 1).

Table 1. Details of Open Payments Data Reported in 2013 and 2014.*

Variable	2013 (August–December)	2014
General financial interactions	$972 million	$2.56 billion
Research-related financial interactions	$1.55 billion	$3.23 billion
Ownership or investment interest	$908 million	$703 million
No of companies reporting data	1347	1444
No. of physicians covered	470,000	607,000
No. of teaching hospitals covered	1019	1121
Research interactions withheld from public release	$454 million	$1.3 billion

* Research interactions withheld from public release are in addition to the publicly released data, as of July 2015; information on about 4300 payments from 2013, totaling about $39 million, that was initially withheld from public reporting per program specifications was allowed by the 81 reporting companies to be published in 2014.

Industry–physician financial relationships have garnered much attention in recent years. A 2007 Institute of Medicine report, citing concern about potential conflicts of interest, called for a national transparency program, as have reports from the Medicare Payment Advisory Commission.[2,3] Several states have required public reporting of financial relationships for years, and others are implementing or considering policies for augmenting Open Payments. Several countries are considering similar policies.

Much of the work done to date on financial relationships and conflicts of interest has lacked context on the type and scope of the interactions. In deploying the Open Payments program to fill this gap, CMS has prioritized three strategic goals. First, we seek to assemble a complete, unbiased database to inform public analyses and discourse. CMS

ACA Implementation—Monitoring and Tracking

Marketplace Plan Choice: How Important Is Price? An Analysis of Experiences in Five States

March 2016

John Holahan, Linda J. Blumberg, and Erik Wengle

Robert Wood Johnson Foundation

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

EXECUTIVE SUMMARY

In this paper, we provide detailed data on marketplace premiums and enrollment by insurer (and by plan when available) and plan tier (bronze, silver, gold, and platinum) in California, Rhode Island, New York, Maryland, and Connecticut; sufficient data are not yet available for other states. We find that individuals' choices, both in choosing silver or bronze plans and in selecting the lowest-cost plans within those tiers, are heavily determined by price. But considerable evidence suggests that significant numbers of consumers choose plans based on other factors, such as previous coverage with insurers, name recognition, perceptions of customer service, and perceived breadth of provider networks.

In California, the marketplace insurers with the lowest 2015 premiums (for silver plans, Health Net in Los Angeles and the Chinese Community Health Plan in San Francisco) had substantial enrollment, but many consumers also chose higher-cost insurers such as Blue Shield, Kaiser, and Anthem.

In Rhode Island, Neighborhood Health Plan (NHP) had the lowest silver plan premiums and the highest marketplace enrollment in 2015. Having lowered its premiums considerably below Blue Cross Blue Shield's 2015 premiums, NHP experienced a huge increase in market share at the expense of Blue Cross Blue Shield, the largest insurer in the state.

In New York, Medicaid insurers now competing in the marketplace and Health Republic (the state's co-op that stopped operation at the end of 2015) were the lowest-priced insurers in the New York City, Long Island, and Buffalo rating regions in 2015. Those insurers together enrolled the bulk of consumers in these highly competitive markets. But large insurers such as Empire, and to a lesser extent Emblem, also earned significant enrollment despite higher premiums.

In Maryland, CareFirst had the highest 2015 enrollment by far despite increasing premiums substantially and although Kaiser offered a modestly lower average premium statewide. Those enrollments may reflect reluctance to switch insurers and provider networks (CareFirst tends to offer a broader choice of providers than Kaiser) for relatively small differences in premiums.

In Connecticut, HealthyCT decreased its average silver plan premium substantially for 2015 and saw its market share increase from 1.3 percent to 17.9 percent. ConnectiCare and Anthem held premiums fairly steady but saw their market shares decrease. However, their average premiums were only modestly higher than that of HealthyCT and their market shares remained considerably higher than that of their lower-cost competitor.

Our analysis indicates that consumers are generally quite sensitive to premium price and that lower-cost insurers tend to enroll the largest percentage of marketplace participants. However, premiums are not the only driver of consumer decisions. Small differences in premiums do not appear sufficient to alter insurance choices, and smaller but still significant numbers of enrollees choose higher-priced options. We do not have sufficient information to discern whether choosing higher-priced options tends to be motivated by satisfaction with prior experience with those insurers, perceived quality differences, brand name recognition, or other concerns. Additional plan-specific enrollment data from more states, as well as detailed information that allows for the analysis of decisions to switch plans or newly enroll, would be valuable to further understand consumer priorities.

INTRODUCTION

An abundance of evidence now shows that marketplace premiums have been lower than originally expected[1] and have continued their relatively slow growth in 2016 (at least in larger, more competitive markets).[2] Keeping premium increases moderate in many areas seems to be tied to the strong incentives in the managed competition structure in the marketplaces. Advanced premium tax credits, which are premium subsidies, are tied to the second-lowest silver plan premium available to the eligible enrollee; this premium is known as the benchmark premium. Individuals who want more expensive coverage must pay 100 percent of the cost difference between the plan they choose and the benchmark. Those who enroll in a less costly plan can pocket the savings.

Insurers thus have a strong incentive to set premiums at or near those of the lowest cost silver plans because price-sensitive consumers tend to gravitate toward options at that price level to avoid additional costs. This approach is one component of the Affordable Care Act's cost containment strategy, which encourages more cost-conscious private decisions by consumers while encouraging health care industry stakeholders to innovate to improve efficiency. The net result should be to slow the rate of growth in national health expenditures over time. In fact, early aggregate evidence supports the notion that many marketplace consumers have chosen their plans while focusing on price.[3] In many markets across the country this consumer focus seems to have caused many insurers to develop more-limited network products and conduct aggressive negotiations with providers, thereby creating lower-cost insurance products.

For these system incentives to continue to slow the rate of growth in per capita health spending, a significant portion of individuals must continue to shop among insurers and plans offered in their marketplaces and choose plans based on price, even if that means switching to new plans across years. All enrollees need not choose the lower-cost plans, but for the efficiency incentives to remain strong for insurers and providers, substantial segments of marketplace consumers will have to enroll in plans at least close in price to the lower-cost options. If this cost-conscious plan choice behavior is reasonably prevalent, insurers will continue competing to develop and offer products designed to deliver care more efficiently. If, however, consumers are driven more strongly by insurer brand name, breadth of provider network, perceptions of quality differences, or other considerations, the incentive to develop lower-cost products will be much weaker.

In this paper we look at the limited available data on the intersection of insurers, premiums, and enrollment to assess whether marketplace consumers are choosing lower-cost plans and whether they are willing to change plans in successive years when competing plan premiums change. All of the data studied here come from state-based marketplaces.

Ideally, we would like to have premium and enrollment data across insurers by metal tier and rating region and within individual insurers by plan and plan characteristics (such as deductibles, consumer out-of-pocket limits, and provider networks). Further, we would like to have data on how often enrollees in particular plans in one year move to a different plan in the next year, allowing us to see both how much of each plan's enrollment is attributable to consumers new to the marketplace rather than previous enrollees moving to other options and the premium comparisons for those plans. However, states vary significantly in the information they provide publicly on enrollment, and what is available falls considerably short of what is desirable.[4] Consequently, we focus our analysis on five states that provide at least a portion of these data in a form that allows some insights into marketplace plan choice and switching behavior. These states are California, Connecticut, Maryland, New York, and Rhode Island.

We find that individuals are selecting insurers largely based on price, as evidenced by the high proportions choosing silver or bronze plans and the largest shares of consumers selecting plans offered by one of the lowest-cost insurers. But a significant segment of consumers are selecting plans offered by large, well-known insurers, including Kaiser Permanente and those affiliated with Blue Cross Blue Shield, even when those insurers are priced considerably higher.

DATA

No insurer-level enrollment data is currently available for states using Healthcare.gov. Even among states providing data, none provide data at the plan level for 2015 except California and Rhode Island. Rhode Island and California both provide premium and enrollment data by insurer and plan and metal tier for 2015,[5] and Rhode Island provides a chart showing aggregate market share by insurer in 2014 and 2015. California provides premiums and enrollment at the insurer level, by plan tier, and by rating region and plan for 2015.[6] Because plan design is standardized in California, most insurers only offer one plan option in each tier.[7] The data California provides are equivalent to those provided by Rhode Island. Consequently, we can directly associate plan enrollment with the premium for that plan in both of these states. In both of these states, we focus for the sake of simplicity of exposition on the silver tier because it has by far the highest enrollment.[8]

The remaining state marketplaces studied do not provide data on enrollment and premiums by insurer, by plan, and by region simultaneously. As a result, for each state we identify proxy premium values to associate with available enrollment data for each insurer. The approach differs somewhat by state depending on how each provides its enrollment information.

New York provides 2015 enrollment data by county and insurer, and we then aggregate the county-level enrollment into rating regions. The state provides enrollment separately by plan tier but does not provide enrollment by insurer and plan tier simultaneously.[9] We collected data on the lowest-cost silver plan premium offered by each insurer in each rating region in the state (premiums in the nongroup market in New York do not vary by age), and we use those data to proxy the relative price of different insurers in each region. Although 58 percent of marketplace enrollees choose silver plans (making this a reasonable proxy to rely upon), insurers' relative premium rankings do not necessarily stay consistent across tiers. For example, an insurer that offers the lowest-premium silver plan may not offer the lowest-premium bronze or gold plan even in a given rating region.

Maryland provides enrollment data by insurer at the state level but not simultaneously by rating region or county and does not provide insurer level enrollment data by plan tier at all.[10] We compiled data in each rating region for each participating insurer's lowest-cost silver premium. For each insurer we use these premiums to compute a statewide average of the insurer's lowest-premium silver plan (weighted by rating region population) and use this as a proxy premium when comparing statewide enrollment figures across the marketplace's insurers. The limitation of having enrollment data only at the state level necessitates using a statewide average premium, but doing so introduces potential interpretation errors because the premium hierarchy and the concentration of enrollment may vary significantly across the state's rating regions. However, all insurers participating in the Maryland marketplace participated in all of the state's rating regions in 2015; if they had not, we would not be able to draw even suggestive conclusions from the state's data.

Connecticut has two years of data that provide some insight into how plan choices have changed between 2014 and 2015.[11] The state provides enrollment data by insurer and plan tier in both years simultaneously, but the data are statewide and not separated by rating region or plan. We compute a statewide average premium (weighted by rating region population) for each Connecticut marketplace insurer's lowest-cost silver option. As with Maryland, the state's marketplace participating insurers sold coverage in each of the state's rating regions in 2015.

We order the insurers in a given area (state or rating region, depending upon data availability) by the premium measure assigned to it (as described for each state above and shown in tables 1–6). For example, we refer to an insurer as being the second-lowest cost insurer if its premium or proxy premium is the second lowest among the relevant competitors. Insurers that provided coverage through Medicaid but not to private-sector purchasers before 2014 are hereafter referred to as Medicaid insurers. Unless otherwise specified, premiums shown are monthly and represent the cost of single coverage for a 40-year-old nonsmoker. Because all states use fixed age-rating curves, the age chosen to show premiums across insurers does not affect the relative ordering of the insurers by price.

RESULTS

Table 1 shows that in 2015 about 60 percent of marketplace enrollees in each state enrolled in silver plans; the next highest was bronze which averaged about 20 percent. Thus, even for the two states for which enrollment data by insurer and plan tier are available (California and Rhode Island), we focus our discussion on silver plans only. In the other three states, enrollment in silver plan coverage dominates the other tiers and we therefore use silver plan premiums (as described in the previous section) to construct premium proxies for each insurer. The high rate of silver and bronze plan choice in itself speaks to the importance consumers place on price . But as we will show, price is not the only factor in plan choice.

Table 1. Share of State's Marketplace Enrollment by Coverage Tier, Selected States, 2015

	Tiers of Coverage				
State	Catastrophic	Bronze	Silver	Gold	Platinum
California	0.6%	24.9%	64.7%	5.3%	4.5%
Connecticut	2.0%	22.4%	59.5%	15.1%	1.0%
Maryland	2.1%	22.2%	62.1%	8.7%	4.9%
New York	2.0%	18.0%	58.0%	10.0%	12.0%
Rhode Island	1.0%	22.0%	65.0%	13.0%	0.0%

Sources: 2015 Active Member Profiles. Covered California. http://hbex.coveredca.com/data-research/; HealthSource RI. *Open Enrollment II*. Providence, RI: HealthSource RI; 2015. http://healthsourceri.com/wp-content/uploads/2015/09/OpenEnrollment2_report.pdf; New York State of Health. *2015 Open Enrollment Report*. New York State of Health; 2015. http://info.nystateofhealth.ny.gov/2015OpenEnrollmentReport; Maryland Health Benefit Exchange. *600,000 Marylanders Have Enrolled in Health Insurance through MarylandHealthConnection.gov for 2015*. Baltimore: Maryland Health Benefit Exchange; 2015. http://www.marylandhbe.com/wp-content/uploads/2015/08/081815_EnrollmentReport.pdf; Access Health CT. Board of Directors Meeting March 26. Hartford, CT: Access Health CT; 2015. http://www.ct.gov/hix/lib/hix/PRESENTATION03232015VerIII.pdf.

California

Table 2 shows 2015 premiums for each insurers' silver plan as well as silver tier enrollment in three California rating regions: East Los Angeles, West Los Angeles, and San Francisco. These rating regions were selected because they span the largest metropolitan areas in the northern and southern parts of the state.

California marketplace consumers overall show an interesting combination of purchasing priorities. For silver plans, the lowest-priced insurer (Health Net in the two Los Angeles rating regions and the Chinese Community Health Plan in San Francisco) enrolls 30 to 44 percent of enrollment in that tier. The brand name options of Blue Shield in the Los Angeles rating regions and both Kaiser and Blue Shield in San Francisco attract significant enrollment even if they offer significantly more expensive options; this is not the case for lesser-known insurers. Anthem tends not to carry the same attraction for California consumers in these rating regions as do Blue Shield and Kaiser Permanente (though with one exception, Anthem earns market shares of 10 percent or more). LA Care and Molina, both Medicaid insurers, draw extremely little market share among silver-plan purchasers even when their plans are priced significantly below those of Kaiser and Blue Shield. Health Net, which offers coverage in all three rating regions, competes well against Kaiser and Blue Shield for enrollees in the two regions in which it offers the lowest-priced plan (both Los Angeles rating regions). But in San Francisco, Health Net is a high-priced option and gets almost no enrollment.

In East Los Angeles, Health Net had the lowest silver plan premium ($230) followed by Anthem ($257); Blue Shield and Kaiser's silver plan premiums were $270 and $287 respectively. Health Net, having the lowest premium by a significant margin, had the largest share of silver plan enrollment (44.4 percent). But Blue shield, with one of the highest-priced premiums in the region (one that is significantly more expensive than the lowest-cost option), had 35.1 percent of enrollment. Anthem, the second-lowest-cost silver plan insurer in the region, only had 9.8 percent of enrollment (for its standard and multistate plans combined), and Kaiser, with the highest premiums in the region, similarly had 9.2 percent of total silver plan enrollment—their lowest market share across the four rating regions.

In West Los Angeles, Health Net was also the lowest-cost silver insurer ($247 per month premium) and had by far the largest share of silver plan enrollment (43.9 percent). Molina, a Medicaid insurer, was the second-lowest-cost insurer ($259 per month for their lowest-cost option), but had less than 1 percent of regional silver plan enrollment. Blue Shield, in contrast, was the second-highest-cost silver plan insurer in the rating region ($308) but had the second-highest share of silver plan enrollment (21.9 percent). Anthem had another 11.0 percent of silver plan enrollment in its traditional plan and another 9.2 percent in the Anthem multistate plan.[12] Kaiser, also relatively highly priced in this region, attracted 11.9 percent of the market for silver plans. Thus, although individuals showed a strong preference for the lowest-cost premiums (as shown by the large concentration of enrollment in Health Net silver plans), the results show notable attraction to the brand names and other benefits considerations associated with the Blue Shield plan and, to a lesser extent, the Kaiser, Anthem, and Anthem multistate plans.

In San Francisco, the Chinese Community Health Plan offered the lowest-premium option among silver plans, but their silver-plan enrollment was on par with that of Kaiser and Blue Shield, both of which had significantly more expensive premiums ($393 and $401, respectively, compared with $356 for the Chinese Community Health Plan plan). This could reflect the Chinese Community Health Plan's ethnic community focus. Anthem's multistate plan had a significant share of silver plan enrollment as well (11.6 percent) despite being the second-highest cost insurer; Health Net's enrollment barely registered (less than 1 percent) given its much higher premium ($449). A note on Healthcare.gov reveals concern that consumers may mistakenly assume multistate plans have out-of-state provider networks. Some multistate plans do have such networks, but many do not. If that perception is widely held, it may explain the significant enrollment in Anthem's multistate option despite its relatively high cost for the area.

Thus, throughout these large California rating regions, consumers pulled strongly toward the lowest-cost silver plan options offered, but those consumers also had considerable attraction to the brand name options of Blue Shield, Kaiser, and to a lesser extent Anthem. This could reflect inertia from pre-2014 enrollment, name recognition, better product designs, broader networks, or customer service.

Although 2016 enrollment data specific to plan, tier, and rating region are not yet available for California, the marketplace has made available insurer enrollment data by rating region across all tiers.[13] From that data (not shown), we see that Molina decreased both its silver plan premiums significantly in West Lost Angeles, making it the lowest-cost insurer in that market and substantially increasing its enrollment and market share. Enrollment in East Los Angeles increased appreciably this year in Blue Shield plans, corresponding to significant premium decreases in the insurer's silver plans. In San Francisco, Blue Shield gained enrollment and market share by decreasing its silver plan premium; Anthem lost market share and enrollment there with a silver plan premium increase of about 10 percent. These continuing changes indicate that insurers continue to adjust premiums relative to each other amidst reasonably price-sensitive consumers.

Table 2. Monthly Premiums and Enrollment in California, 2015
Silver plans in three rating regions

East Los Angeles (rating area 15)			
Insurer	**Silver premium**	**Silver tier enrollment**	**% of silver tier enrollment**
Health Net	$230	51,520	44.4%
Anthem	$257	6,650	5.7%
Anthem MSP	$296	4,690	4.0%
Molina	$259	180	0.2%
LA Care	$265	1,610	1.4%
Blue Shield	$270	40,780	35.1%
Kaiser	$287	10,730	9.2%
		116,160	100.0%
West Los Angeles (rating area 16)			
Insurer	**Silver premium**	**Silver tier enrollment**	**% of silver tier enrollment**
Health Net	$247	57,920	43.9%
Molina	$259	750	0.6%
Anthem	$270	14,470	11.0%
Anthem MSP	$336	12,210	9.2%
LA Care	$278	2,110	1.6%
Kaiser	$300	15,650	11.9%
Blue Shield	$308	28,910	21.9%
		132,020	100.0%
San Francisco (rating area 4)			
Insurer	**Silver premium**	**Silver tier enrollment**	**% of silver tier enrollment**
Chinese Community	$356	5,990	29.9%
Kaiser	$393	6,130	30.6%
Blue Shield	$401	5,480	27.3%
Anthem MSP	$414	2,330	11.6%
Health Net	$449	130	0.6%
		20,060	100.0%

Source: 2015 Active Member Profiles. Covered California. *http://hbex.coveredca.com/data-research/*.

Notes: Premium information is for a 40-year-old nonsmoking individual. Rounded to the nearest dollar. CoveredCA uses standardized plan designs. Each insurer offers one plan per coverage tier. Premium and enrollment data are plan specific.

Rhode Island

Table 3 provides data made available by HealthSource RI, the Rhode Island health insurance marketplace. The data include each insurer's marketplace enrollment in each offered plan in each tier of coverage; Rhode Island and California are the only states to provide this much enrollment detail. They also provide the premium for a 21-year-old single adult for each plan option offered by each insurer. For consistency with other states' data, we converted these premiums to those for a 40-year-old single

adult using the standardized age rating curve. Rhode Island has one premium rating region encompassing the entire state. We again focus our analysis on silver plans, which account for 65 percent of 2015 Rhode Island marketplace enrollment.

Three plans participated in the state's marketplace in 2015: Neighborhood Health Plan (NHP), Blue Cross Blue Shield of Rhode Island, and United Healthcare (United). NHP and United each offered two silver plans and Blue Cross Blue Shield offered three. NHP offered silver plans with monthly premiums of $244 and $259, the two lowest-priced silver plans in the region, and NHP had 60.2 percent of silver plan enrollment. NHP's $244 premium silver plan enrolled almost five times as many individuals as the $259 premium silver plan. Blue Cross Blue Shield plans had silver plan premiums ranging from $285 to $321 and had 36.7 percent of Rhode Island's silver plan enrollment. Its lower-cost option was significantly more popular than its two higher-priced alternatives. United's silver plans offered premiums of $271 and $289, but they each had very little enrollment. Interestingly, the two highest-cost Blue Cross Blue Shield options enrolled significantly more marketplace consumers than both of United's offerings despite their higher cost. Thus, although the lowest-cost NHP plans attracted the bulk of Rhode Island's silver plan enrollees, differences between United and Blue Cross other than price played a noticeable role in other consumers' choices. United was new to the Rhode Island marketplace in 2015, and reluctance to switch plans likely played at least some role in its low enrollment numbers.

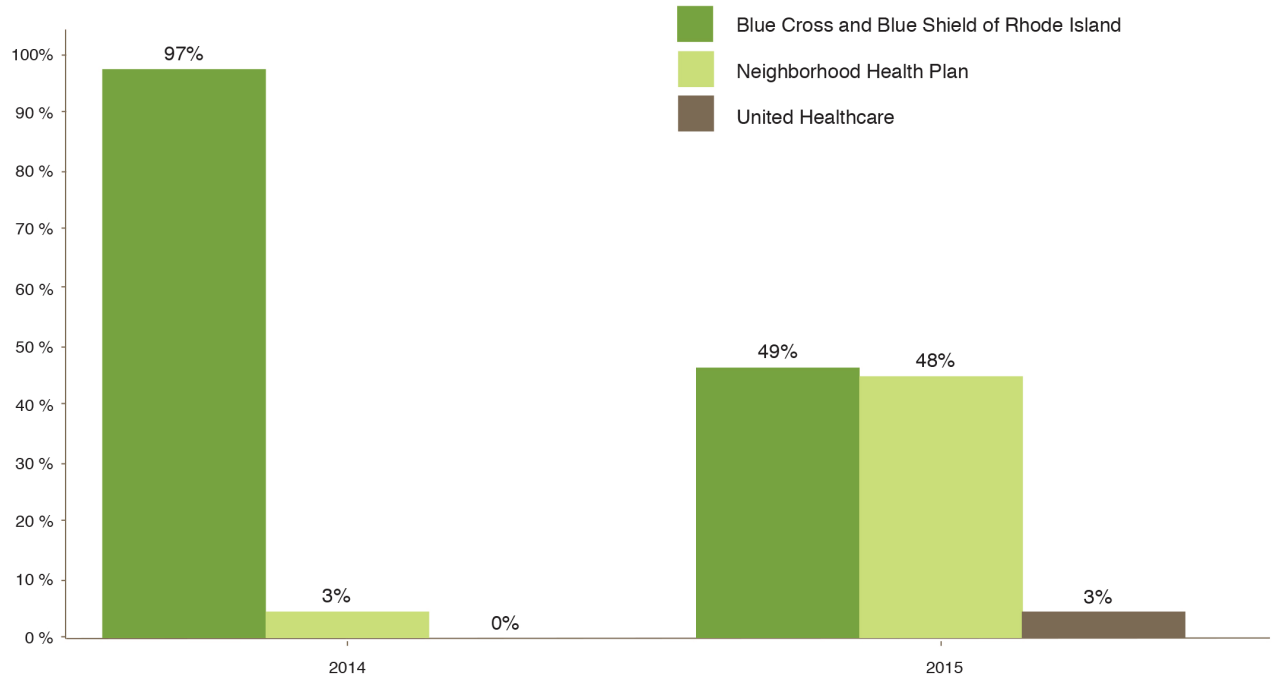
In 2014, NHP offered coverage only to those with incomes below 250 percent of the federal poverty level. NHP's 2014 lowest-cost silver plan premium was 7.5 percent more than that of Blue Cross Blue Shield. The state released data showing that Blue Cross Blue Shield had 97 percent of enrollment in 2014 and NHP had 3 percent. But NHP lowered its lowest-cost silver plan premiums considerably below Blue Cross Blue Shield's in 2015 ($244 compared with $285) and made coverage available to all marketplace consumers. As shown in figure 1, both insurers' market shares shifted considerably between 2014 and 2015: across all plan tiers, Blue Cross Blue Shield had a 49 percent market share and NHP 48 percent in 2015. United Healthcare had the remaining 3 percent. As NHP lowered its premiums relative to Blue Cross Blue Shield, total enrollment in HealthSource RI increased as well. Of the 30,000 enrollees at the end of the 2015 open enrollment period, 9,150 were new customers and 20,851 were renewing customers. Consequently, it is unclear how much of NHP's increase in enrollment in 2015 was attributable to new enrollees and how much was attributable to price-sensitive consumers switching from Blue Cross Blue Shield plans. However, it is clear that NHP now offers serious competition to Blue Cross Blue Shield in the state. United's experience in Rhode Island, enrolling fewer than 1,000 people in 2015, suggests an uphill battle for insurers that enter marketplaces late without offering substantial savings over known options. Blue Cross Blue Shield decreased its lowest-cost silver plan premium in the state substantially in 2016, matching that of NHP,[14] so enrollment may be affected by changes in premiums.

Table 3. Monthly Premiums and Enrollment in HealthSource RI, 2015 Silver Plans

Insurer	Plan name	Premium	Plan enrollment	% of enrollment in the tier
Neighborhood Health Plan	Neighborhood Community	$244	9,678	49.7%
Neighborhood Health Plan	Neighborhood Value	$259	2,040	10.5%
United Healthcare	Silver Compass HSA 2000	$271	537	2.8%
Blue Cross Blue Shield of Rhode Island	BlueSolutions for HSA Direct 2600/5200	$285	4,475	23.0%
United Healthcare	Silver Compass 3500	$289	78	0.4%
Blue Cross Blue Shield of Rhode Island	Vantage Blue Direct Plan 3000/6000	$317	1,569	8.1%
Blue Cross Blue Shield of Rhode Island	Vantage Blue SelectRI 3000/6000	$321	1,097	5.6%
			19,474	100.0%

Source: HealthSource RI. *Open Enrollment II*. Providence, RI: HealthSource RI; 2015. http://healthsourceri.com/wp-content/uploads/2015/09/OpenEnrollment2_report.pdf.
Notes: Premium information is for a 40-year-old nonsmoking individual. Rounded to the nearest dollar. Rhode Island has one statewide rating region, so these premiums apply across the state.

Figure 1. HealthSource RI Enrollment by Health Insurer: 2014 versus 2015



Source: HealthSource RI. *Open Enrollment II*. Providence, RI: HealthSource RI; 2015. http://healthsourceri.com/wp-content/uploads/2015/09/OpenEnrollment2_report.pdf.

New York

New York only provides enrollment data for each insurer by rating region aggregated across all plan tiers (table 4). Because the largest share of New York State of Health enrollees choose silver plans[15] we use the lowest-cost silver plan premium offered by each insurer as a proxy for relative pricing of that insurer's plan offerings in a given rating region. We include the three largest New York state rating regions by population: New York City, Long Island, and Buffalo.

In New York City, 12 insurers offered silver plans in the marketplace in 2015. Affinity, a Medicaid insurer, had the lowest silver plan premium ($372) in 2015 but had only 7.6 percent of the city's marketplace enrollees overall. Three other Medicaid insurers, HealthFirst, MetroPlus, and Fidelis, had 16.6 percent, 14.8 percent, and 17.0 percent of enrollees, respectively; their lowest silver plan premiums were slightly higher than Affinity's (ranging from $383 to $387). Health Republic, a co-op with a silver plan premium of $380, had 11.8 percent of the rating region's marketplace enrollees (Health Republic left the marketplace before the end of the 2015 plan year because of substantial financial losses, and the insurer no longer operates in the state at all). Thus, nearly 68 percent of marketplace enrollees in the New York City rating region chose one of these five low-cost insurers, with 56.0 percent enrolled in the four Medicaid insurers. Large commercial plans, such as Emblem and Empire Blue Cross, had an additional 9.7 percent and 10.0 percent of enrollees, respectively. Emblem's and Empire Blue Cross's lowest-premium silver plans were priced well above those of the Medicaid insurers and Health Republic, as were those of United Healthcare, Wellcare of NY, and MVP. So although 67.8 percent of enrollees chose an insurer priced within $15 of the insurer with the lowest-priced silver plan, more than 20 percent of enrollees chose insurers at the top of the pricing hierarchy.

A similar picture emerges in Long Island, where nine insurers competed in the marketplace in 2015. All those insurers offering coverage in Long Island also offered coverage in New York City, and they charged the same premiums for their lowest-cost silver plans in both rating regions. Of the three insurers that offered coverage in New York City but not in Long Island, only one, MetroPlus, had significant market share. So besides MetroPlus, the marketplace offerings looked essentially identical. Focusing on the nine insurers selling in both rating regions with the same lowest-cost silver plan pricing, it is clear that preferences for the insurers differed quite a bit between the localities. Long Island enrollees clustered heavily among Fidelis, Empire BCBS, and Health Republic, each enrolling 21 to 22 percent of marketplace enrollees or 65.6 percent of total enrollment in the rating region. Both Fidelis and Health Republic were among the lowest-cost silver plans in the Long Island rating region. But Empire was among the highest-priced

insurers and had much higher market share than it did in New York City. Long Island marketplace enrollees were substantially less likely to enroll in HealthFirst and more likely to enroll with North Shore-LIJ, both mid-priced insurers, although neither had high enrollment relative to the most popular three insurers. About 58 percent of Long Island's marketplace enrollees chose an insurer with a premium within $15 of the lowest-priced plan.

The participating insurers and their premiums differed much more in Buffalo, with six insurers selling coverage in the marketplace there. Health Republic, Fidelis, and Blue Cross Blue Shield of Western New York had virtually identical premiums for their lowest-cost plans. Health Republic enrolled 43.4 percent of the marketplace enrollees in that rating region. Fidelis had a slightly lower premium ($337) but was only the third most popular insurer in the rating region, enrolling 17.5 percent of the marketplace's customers. Blue Cross Blue Shield of Western New York matched Health Republic in premium for its lowest-cost silver plan ($342) and enrolled 20.3 percent of the marketplace. Other factors than price appear to be at play for a noticeable segment of the population in these decisions, yet over 80 percent of enrollees chose one of the three closely priced lowest-cost options.

Because the data provided by New York are aggregated across all of an insurer's plans in a rating region, our proxy silver plan premium for each insurer may disguise that different insurers may be offering more price-competitive options in other tiers of coverage, and we cannot take into account that enrollment for some insurers may be high for their plans that are priced significantly higher than their lowest-cost plan. Despite these limitations, however, we believe this analysis indicates a strong preference among consumers for the insurers priced close to the lowest-cost insurer (although not necessarily for the absolute lowest-cost plan) and highlights that the price competitiveness appears to be a more important factor in plan choice in some regions than in others.

Table 4. Monthly Premiums and Enrollment in New York State of Health, 2015
Lowest-cost silver plan premiums and enrollment across all coverage tiers, by insurer, in three rating regions

New York City			
Insurer	**Lowest silver plan premium offered**	**Enrollment across all tiers**	**% of total**
Affinity	$372	15,967	7.6%
Health Republic	$380	24,859	11.8%
MetroPlus	$383	31,138	14.8%
Fidelis	$384	35,874	17.0%
HealthFirst	$387	35,048	16.6%
Oscar	$394	15,308	7.3%
North Shore-LIJ	$394	2,689	1.3%
Emblem	$407	20,487	9.7%
MVP	$417	794	0.4%
Empire BCBS	$448	21,123	10.0%
Wellcare of NY	$472	314	0.1%
United Healthcare	$545	7,465	3.5%
		211,066	100.0%

Table 4 Continued...

Long Island			
Insurer	**Lowest silver plan premium offered**	**Enrollment across all tiers**	**% of total**
Affinity	$372	2,978	3.8%
Health Republic	$380	16,414	21.0%
Fidelis	$384	17,321	22.2%
HealthFirst	$387	8,389	10.8%
North Shore-LIJ	$394	5,368	6.9%
Oscar	$394	5,119	6.6%
Emblem	$407	2,656	3.4%
Empire BCBS	$448	17,486	22.4%
United Healthcare	$545	2,283	2.9%
		78,014	100.0%
Buffalo			
Insurer	**Lowest silver plan premium offered**	**Enrollment across all tiers**	**% of total**
Fidelis	$337	4,706	17.5%
Health Republic	$342	11,651	43.4%
BCBS of Western NY	$342	5,446	20.3%
MVP	$365	834	3.1%
Independent	$428	3,591	13.4%
Univera	$474	636	2.4%
Excellus		1	0.0%
		26,865	100.0%

Source: New York State of Health. 2015 Open Enrollment Report. New York State of Health; 2015. *http://info.nystateofhealth.ny.gov/2015OpenEnrollmentReport*.
Notes: BCBS = Blue Cross Blue Shield. Nongroup premiums in New York are pure community rated and therefore do not very by age or smoking status.

Maryland

Maryland provides enrollment data by insurer for the entire state, but not by region or by plan tier. Similar to other states, about 62 percent of Maryland marketplace enrollees purchased silver plans (table 1), and we therefore use each insurer's lowest-priced silver plan premium as a proxy for insurer pricing in the state. In table 5 we show a weighted average of each insurer's lowest-price silver premium across all four of the state's rating regions along with each insurer's statewide marketplace enrollment. Silver plan premiums for the two insurers with the highest enrollment were within $10 of each other. By far the highest enrollment was with CareFirst, the insurer with the second-lowest-cost silver plan in 2015 by our measure ($236). That average monthly premium was only $10 higher than the lowest–cost silver plan offered in the region, Kaiser ($226), which had 16.4 percent of the state's enrollment. CareFirst had 77.5 percent of marketplace enrollment in the state. The four remaining insurers were substantially less popular with consumers. Evergreen, a co-op, was the third-lowest-cost insurer (with a $246 average low cost silver plan premium) but had only 2.8 percent of enrollees; it is followed by United with 2.5 percent of enrollees (with a $256 average low cost silver plan premium). CareFirst offered the lowest premiums in 2014 (not shown),[16] and their continued high enrollment in 2015 could reflect some unwillingness of consumers to switch insurers, possibly because of brand name or provider network attachment.

Although the data provided by the Maryland Health Connection are aggregated more than desired, applying our proxy premium measure to them does suggest the vast majority of marketplace enrollees (93.9 percent) chose plans offered by the two lowest-priced insurers. Those two insurers had very similar average premiums, but it was the second-lowest cost insurer (CareFirst) who enrolled the lion's share (78 percent) of marketplace business. CareFirst has broader provider networks than Kaiser, and this may have affected consumer preferences between the two. Unfortunately, we are unable to observe whether enrollees tended to choose the lowest-cost options these insurers offered or diversified their plan preferences across prices.

CareFirst increased the premium for its lowest-cost silver plan by over 20 percent in 2016.[17] The large CareFirst price increases could reflect concerns about the health status of their current enrollees, an assumption that individuals would be hesitant to switch plans, or both. Perhaps CareFirst's new price positioning relative to its competitors led to more insurer switching in 2016, but that remains to be seen.

Table 5. Monthly Premiums and Enrollment in Maryland Health Connection, 2015 Statewide average of each insurer's lowest silver premiums and statewide enrollment across all coverage tiers

Insurer	Lowest silver plan premium	Enrollment across all tiers	% of total statewide enrollment across all tiers
Kaiser	$226	20,272	16.4%
Carefirst	$236	95,880	77.5%
Evergreen	$246	3,440	2.8%
United Healthcare	$256	3,036	2.5%
All Savers	$315	347	0.3%
Cigna	$340	698	0.6%
		123,673	100%

Source: Maryland Health Benefit Exchange. *600,000 Marylanders Have Enrolled in Health Insurance through MarylandHealthConnection.gov for 2015*. Baltimore: Maryland Health Benefit Exchange; 2015. *http://www.marylandhbe.com/wp-content/uploads/2015/08/081815_EnrollmentReport.pdf*.

Notes: Premiums are for a 40-year-old nonsmoking individual. Averages are calculated across an insurer's lowest-premium silver plan in each of the state's four rating regions. Averages are weighted by each rating region's population.

Connecticut

Connecticut, a relatively high marketplace premium state, provided insurer-level statewide marketplace enrollment data for both 2014 and 2015 by plan tier but did not provide rating region–specific data.[18] We focus on silver plan enrollment because it accounts for 60 percent of the state's marketplace enrollment (table 1), and we compute an average lowest-cost silver plan premium for each insurer (weighted by rating region population) as an indicator of the insurers' relative pricing.

By this statewide average silver plan premium measure, ConnectiCare had the lowest premiums in 2014 ($350) and had substantial enrollment with 48.2 percent of the state's enrollees (table 6). Anthem Blue Cross and Blue Shield's average low-cost silver plan premium was only $11 higher ($361), and that insurer enrolled about the same share of marketplace business, 50.5 percent that year. HealthyCT priced its silver plans considerably higher than those of the other two insurers and had very little enrollment in 2014.

In 2015, HealthyCT's average lowest-priced silver plan premium was substantially lower than those of the previous year, dropping from $396 per month in 2014 to $355 per month in 2015, and it became the insurer offering the lowest–priced silver plan, and it increased its marketplace enrollment share from 1.3 percent to 17.9 percent. ConnectiCare and Anthem's average silver plan premium increased very little in 2015; both saw their market shares fall, but they remained the largest marketplace insurers. Although marketplace enrollment increased in 2015, Anthem actually saw its enrollment decrease by almost 4,500 individuals.

Although limits on the enrollment data Connecticut made available may disguise important enrollment decision differences across rating regions and across each insurers'

multiple plan offerings, the patterns shown here are suggestive. Anthem's modest loss of enrollment but larger loss of market share may indicate strong price sensitivity for new marketplace enrollees and a reasonably strong reluctance of previous enrollees to change insurers unless the savings from doing so would be substantial. United Healthcare, entering the Connecticut marketplace in 2015 with much higher premiums than the other three close price competitors, had extremely little enrollment.

Table 6. Monthly Premiums and Enrollment in Access Health CT, 2014 and 2015
Statewide average of each insurer's lowest silver premiums and total silver tier enrollment

2014			
Insurer	**Average lowest silver plan premium**	**Silver tier enrollment**	**% of enrollment**
HealthyCT	$396	715	1.3%
ConnectiCare	$350	26,476	48.2%
Anthem BCBS	$361	27,744	50.5%
United Healthcare	NA	NA	NA
		54,935	100.0%

2015			
Insurer	**Average lowest silver plan premium**	**Silver tier enrollment**	**% of enrollment**
HealthyCT	$355	11,718	17.9%
ConnectiCare	$360	29,436	44.9%
Anthem BCBS	$366	23,276	35.5%
United Healthcare	$390	1,087	1.7%
		65,517	100.0%

Source: Access HealthCT Board Presentation http://www.ct.gov/hix/lib/hix/PRESENTATION03232015VerIII.pdf.

Note: BCBS = Blue Cross Blue Shield. Premiums are for a 40-year-old nonsmoking individual. Averages are calculated across an insurer's lowest-premium silver plan in each of the state's eight rating regions. Averages are weighted by each rating region's population.

CONCLUSION

Individuals are clearly sensitive to price when choosing marketplace plans. This is evident in the high percentages of total marketplace enrollees choosing silver and bronze plans and in the large numbers selecting the lowest-cost insurers within those tiers. Individuals appear willing to enroll with lesser-known insurers if provided substantial savings, although enrollment is shared more equally across insurers when price differences are small. Significant but smaller shares of enrollees choose Blue Cross affiliates even when premiums are well above the benchmark, indicating a continued market for plans that might provide consumers with advantages beyond price, such as perceptions of broader networks, better customer service, or other benefit structure differences. Enrollees recognizing insurer names or maintaining insurers with whom they had pre-reform coverage may also be playing a significant role, particularly in these early years of reform. The reason behind the apparent "stickiness" in a significant segment of consumers is not discernible from these data,

but the subject is worthy of further investigation. Depending upon the reasons behind it, the stickiness may well lessen over time as new insurers gain name recognition and if they earn positive reputations in the community. Additional information provided on marketplace websites in the future, such as insurer ratings by customer satisfaction, quality of providers, and additional transparency of insurer practices (such as rates of claims denials, speed of provider payment, and administrative costs), may also change choices significantly over time. More-detailed data on consumers' plan choices (as opposed to simply insurer choices) by rating region and plan tier, such as those provided by California and Rhode Island, would allow for clearer identification of preferences. Data that separate new marketplace consumers from those changing decisions from the prior year would be ideal because the factors influencing new enrollees' decisions may differ significantly from the factors influencing those renewing their coverage.

Of course, not all enrollees have to make plan choices based on price for the market to provide incentives for insurers to price aggressively. Strong evidence suggests marketplaces are providing the necessary incentives to provide low-cost insurance options while at the same time providing options to satisfy some of the preferences of those less sensitive to price.

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U.S. Department of Health and Human Services

Office of Inspector General

HealthCare.gov

CMS Management of the Federal Marketplace

A Case Study

February 2016 | OEI-06-14-00350

Daniel R. Levinson | Inspector General

OFFICE OF INSPECTOR GENERAL

http://oig.hhs.gov

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EXECUTIVE SUMMARY

HealthCare.gov: Case Study of CMS Management of the Federal Marketplace OEI-06-14-00350

FOREWORD

This case study examines implementation of HealthCare.gov and the Federal Marketplace by the Centers for Medicare & Medicaid Services (CMS), from passage of the Affordable Care Act (ACA) in 2010 through the second open enrollment period in 2015. As required by the ACA, HealthCare.gov is the Federal website that facilitates purchase of private health insurance for consumers who reside in States that did not establish health insurance marketplaces. At its launch on October 1, 2013, and for some time after, HealthCare.gov users were met with website outages and technical malfunctions. After corrective action by CMS and contractors following the launch, CMS ended the first open enrollment period with 5.4 million individuals having selected a plan through the Federal Marketplace.

In our oversight role for the Department of Health and Human Services (HHS), the Office of Inspector General (OIG) has a significant body of ongoing and planned audits and evaluations regarding the Federal Marketplace and other ACA provisions of high interest and concern to HHS, Congress, and other stakeholders. These include reviews and suggestions for improvements related to the accuracy of Federal financial assistance payments; verifications of eligibility determinations for insurance, premium tax credits, and cost-sharing reductions; and CMS's management of marketplace contracts and the security of personal information. OIG reports about the marketplaces are available online at www.oig.hhs.gov/reports-and-publications/aca/, and additional information about our planned and ongoing work is available online in OIG *Work Plan* documents at http://www.oig.hhs.gov/reports-and-publications/workplan/index.asp.

ABOUT THIS CASE STUDY

The objective of this case study was to gain insight into CMS implementation and management of the Federal Marketplace, focusing primarily on HealthCare.gov. Our review spans 5 years, providing a chronology of events and identifying factors that contributed to the website's breakdown at launch, its recovery following corrective action, and implementation of the Federal Marketplace through the second open enrollment period. OIG calls on CMS to address identified problems and employ lessons learned from management of this project to avoid future problems with program implementation and to further strengthen CMS. In conducting this review, we interviewed 86 current and former HHS and CMS officials, staff, and contractors involved with the development and management of the website. We also reviewed thousands of HHS and CMS documents, including management reports, internal correspondence, and website development contracts.

WHAT'S INSIDE THIS REPORT

- Detailed chronology of CMS's development and implementation of the Federal Marketplace and HealthCare.gov in four chapters:
  - Preparation & Development
  - Final Countdown to Launch
  - Launch, Correction, & First Open Enrollment
  - Turnaround & Second Open Enrollment
- Key Contributing Factors to the website breakdown and recovery
- Call for continued progress with Lessons Learned for ongoing CMS management of HealthCare.gov
- Glossary of key terms

WHAT WE FOUND

The development of HealthCare.gov faced a high risk of failure, given the technical complexity required, the fixed deadline, and a high degree of uncertainty about mission, scope, and funding. Still, we found that HHS and CMS made many missteps throughout development and implementation that led to the poor launch. Most critical was the absence of clear leadership, which caused delays in decisionmaking, lack of clarity in project tasks, and the inability of CMS to recognize the magnitude of problems as the project deteriorated. Additional HHS and CMS missteps included devoting too much time to developing policy, which left too little time for developing the website; making poor technical decisions; and failing to properly manage its key website

development contract. CMS's organizational structure and culture also hampered progress, including poor coordination between policy and technical work, resistance to communicating and heeding warnings of "bad news," and reluctance to alter plans in the face of problems. CMS continued on a failing path to developing HealthCare.gov despite signs of trouble, making rushed corrections shortly before the launch that proved insufficient. These structural, cultural, and tactical deficiencies were particularly problematic for HealthCare.gov given the significant challenges of implementing a new program involving multiple stakeholders and a large technology build.

Following the launch on October 1, 2013, CMS and contractors pivoted quickly to corrective action, reorganizing the work to focus on key priorities and to improve execution. This required significant and focused effort to measure website performance, correct problems with website capacity and functions, and establish a new project structure. Key factors that contributed to recovery of the website included CMS adopting a "badgeless" culture for the project, wherein all CMS staff and contractors worked together as a team, and a practice of "ruthless prioritization" that aligned work efforts with the most important and achievable goals. CMS recovered the HealthCare.gov website for high consumer use within 2 months, and adopted more effective organizational practices, such as closer integration of policy and technical functions, developing redundancies in anticipation of problems, and flexibility in learning from and modifying processes.

CALL FOR CONTINUED PROGRESS

CMS continues to face challenges in implementing the Federal Marketplace, and in improving operations and services provided through HealthCare.gov. As of February 1, 2016, CMS reported that over 9.6 million consumers had selected a health plan through the Federal Marketplace or had their coverage automatically renewed. As CMS moves forward, challenges include completing the automated financial management system and continuing to address areas OIG has identified in past reports as problematic or needing improvement. The agency has focused on this project for years and now must keep attuned to these challenges as it shifts focus to other work.

OIG calls on CMS to continue progress in applying lessons learned from HealthCare.gov to avoid future problems and to maintain improvement across the agency. These lessons comprise core management principles that address both specific project challenges and organizational structure, and could apply to other organizations. CMS concurred with OIG's call for continued progress, stating that it will continue to employ the lessons below and that, since OIG's review, it has implemented several initiatives to further improve its management.

LESSONS LEARNED

1. **Leadership**
   Assign clear project leadership to provide cohesion across tasks and a comprehensive view of progress.
2. **Alignment**
   Align project and organizational strategies with the resources and expertise available.
3. **Culture**
   Identify and address factors of organizational culture that may affect project success.
4. **Simplification**
   Seek to simplify processes, particularly for projects with a high risk of failure.
5. **Integration**
   Integrate policy and technological work to promote operational awareness.
6. **Communication**
   Promote acceptance of bad news and encourage staff to identify and communicate problems.
7. **Execution**
   Design clear strategies for disciplined execution, and continually measure progress.
8. **Oversight**
   Ensure effectiveness of IT contracts by promoting innovation, integration, and rigorous oversight.
9. **Planning**
   Develop contingency plans that are quickly actionable, such as redundant and scalable systems.
10. **Learning**
    Promote continuous learning to allow for flexibility and changing course quickly when needed.

KEY CONTRIBUTING FACTORS TO BREAKDOWN

PREPARATION & DEVELOPMENT

March 2010–December 2012

Policy Development Delays

Initial work to create the Federal Marketplace required extensive policy development that delayed HHS and CMS in planning for the technical and operational needs of the HealthCare.gov website.

Poor Transition to CMS

A poor transition of the Federal Marketplace from HHS to CMS early on caused inefficiencies that resulted in communication breakdowns and needlessly complex implementation.

Lack of Clear Leadership

HealthCare.gov lacked clear project leadership to give direction and unity of purpose, responsiveness in execution, and a comprehensive view of progress.

Mismanagement of Key Contract

CMS mismanaged the key website development contract, with frequent changes, problematic technological decisions, and limited oversight of contractor performance.

FINAL COUNTDOWN TO LAUNCH

January 2013–September 2013

Compressed Timeline for Technical Build

CMS continued to change policy and business requirements, which compressed the timeframe for completing the website's technical development.

Resistance to Bad News

CMS leaders and staff failed to recognize the magnitude of problems, became resistant to bad news about the website's development, and failed to act on warnings and address problems.

Path Dependency

As problems worsened, CMS staff and contractors became path dependent, continuing to follow the same plan and schedule rather than change course as circumstances warranted.

Corrections Weak and Late

CMS attempted last-minute corrections that were weak and too late to effect change, retaining a fixed deadline for launch, despite poor progress.

KEY CONTRIBUTING FACTORS TO RECOVERY

LAUNCH, CORRECTION, & FIRST OPEN ENROLLMENT

October 2013–March 2014

Quick Pivot to New Strategy

CMS and its contractors began correction of website problems immediately following launch, making a quick pivot to change their strategy.

Adoption of Badgeless Culture

CMS and its contractors adopted a badgeless culture that encouraged full collaboration by CMS staff and contractors regardless of employer status and job title, fostering innovation, problem solving, and communication among teams.

Integration of All Functions

CMS integrated all functions into its organizational structure to align with project needs, enhancing CMS and contractor accountability and collaboration.

Planning for Problems

CMS planned for problems, establishing redundant (backup) systems in the event of further breakdowns, and restructuring its key development contract to ensure better performance.

TURNAROUND & SECOND OPEN ENROLLMENT

April 2014–February 2015

Ruthless Prioritization

CMS adopted a policy of ruthless prioritization to reduce planned website functionality, focusing resources on the highest priorities.

Quality Over On-Time Delivery

CMS prioritized quality over on-time delivery, employing extensive testing to identify and fix problems and delaying new website functionality if unready for perfect execution.

Simplifying Processes

CMS simplified systems and processes to enable closer monitoring of progress, increased transparency and accountability, and clearer prioritization.

Continuous Learning

CMS adopted continuous learning for policy and technological tasks, balancing project plans with system and team capacity, and changing course as needed to improve operations.

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BACKGROUND

OBJECTIVE

To evaluate the Department of Health and Human Services' (HHS or the Department) and Centers for Medicare & Medicaid Services' (CMS or the agency) implementation and management of the Federal Marketplace, focused primarily on the development and operation of its website, HealthCare.gov.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010.[1] The ACA expanded access to health insurance coverage by enacting insurance reforms, requiring many businesses to offer health insurance coverage, and requiring most individuals to obtain coverage. Generally, those who do not comply must pay a penalty.[2] The ACA also required, and provided Federal funding for, the establishment of a health insurance exchange (marketplace) in each State that would be operational on or before January 1, 2014.[3] For States that elected not to establish their own marketplaces, the Federal Government was required to operate a marketplace on behalf of the State.[4] The marketplaces provide those seeking health insurance a single point of access to view qualified health plan (health plan)[5] options, determine eligibility for coverage, and purchase insurance coverage. Individuals also use the marketplaces to determine eligibility for insurance affordability programs (e.g., Medicaid, premium tax credits, and cost-sharing reductions) that lower insurance premiums and costs of care.[6] At the beginning of the third open enrollment period, November 1, 2015, the Federal Government operates a marketplace (Federal Marketplace) for 38 States, including 7 State-partnership marketplaces for which HHS and the State share responsibilities for core functions and 4 Federally supported State marketplaces in which States perform most marketplace functions.[7] Thirteen States (including the District of Columbia) operate their own marketplaces.[8]

The ACA required the Secretary of HHS to specify an initial open enrollment and annual open enrollment periods each subsequent year during which individuals may enroll in a health plan.[9] The first open enrollment period was 6 months in duration, lasting October 1, 2013–March 31, 2014.[10] The second open enrollment period was 3 months in duration, lasting November 15, 2014–February 15, 2015.[11] Special enrollment periods (SEP) allow consumers who experience certain life changes or other circumstances to purchase insurance outside of open enrollment,[12] and CMS has several times offered SEPs to provide other consumers additional time to purchase plans when situations beyond their control limited their ability to select a plan during open enrollment.[13]

After several challenges to the ACA, the Supreme Court heard two cases about the constitutionality of certain provisions of the Act. In June 2012, the Court upheld the mandate that most individuals must have health insurance, but ruled unconstitutional the requirement that States expand their Medicaid programs.[14] The Court ruled in June 2015 that the ACA provides premium tax credits for insurance purchased through all marketplaces, Federal and State.[15] Several Federal court challenges to the ACA are pending.

CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS, an agency within HHS, has had responsibility for managing the marketplace programs since January 2011.[16] CMS manages more than 85 percent of HHS's $1.2 trillion budget, primarily for operation of the Medicare and Medicaid programs.[17] To implement the ACA provisions related to the marketplaces, CMS worked in collaboration with public and private entities, including other Federal agencies as required by the ACA,[18] State Medicaid agencies, private contractors, health insurance issuers (issuers), and not-for-profit organizations.

CMS has core responsibility for operation of the Federal Marketplace. In this role, CMS must ensure accurate eligibility determinations, process enrollments, facilitate Medicaid enrollment for those who qualify, and communicate timely

and accurate information to issuers and consumers. CMS also provides support functions for the State marketplaces and administers Federal financial assistance and premium stabilization programs related to the marketplaces. See Appendix A for a list of the referenced HHS and CMS divisions involved in the Federal Marketplace.

HEALTHCARE.GOV

HealthCare.gov is the public website for the Federal Marketplace through which individuals can browse health insurance plans, enroll in coverage plans, and apply for Federal financial assistance to help cover the premium and other costs. The Federal Marketplace links consumers from HealthCare.gov to multiple supporting systems that facilitate the enrollment process and payment to issuers. For purposes of this report, key components of HealthCare.gov and the Federal Marketplace include:

- **Enterprise Identity Management (EIDM) system**, which was used during the first and second open enrollment periods to enable consumers to create accounts and verify their identities. The EIDM was developed to support multiple CMS systems.
- **Federally-facilitated Marketplace (FFM)**, the core of the overall Federal Marketplace system, which includes three main subcomponents to facilitate various aspects of acquiring health insurance:
  - *Eligibility and Enrollment* determines consumer eligibility for health plans and Federal financial assistance and manages enrollment transactions with issuers,
  - *Plan Management* coordinates with issuers to determine coverage specifics, and
  - *Financial Management* tracks effectuated enrollments (wherein the consumer has selected a plan and also paid the premium), and manages payments to issuers for Federal financial assistance (premium tax credits and cost-sharing reductions) and premium stabilization.
- **Data Services Hub (Hub)** routes information requests from the Federal and State marketplaces and Medicaid/ Children's Health Insurance Program (CHIP) agencies to other Federal agencies and back, such as to and from the Internal Revenue Service (IRS) and the Social Security Administration (SSA).

SCOPE

This case study evaluates HHS and CMS implementation and management of the Federal Marketplace, primarily the website HealthCare.gov. Our review is limited to the actions of HHS and CMS personnel and divisions and their contractors, spanning from passage of the ACA in March 2010 through the end of the Federal Marketplace second open enrollment period in February 2015. See Appendix B for a timeline of key implementation dates.

METHODOLOGY

To evaluate HHS and CMS management of HealthCare.gov, we based our review on analysis of data from three sources:

- **Interviews with officials and staff from HHS, CMS, contractors, and other stakeholders**: We conducted interviews with 86 respondents, individually or in small groups, regarding their roles and involvement during the implementation of the Federal Marketplace, the strategy for development, factors that contributed to the website problems, and actions taken to address those problems. We present interview data in the report in both aggregate analysis and individual quotations.
  - *HHS senior leadership at the time of the HealthCare.gov launch*—respondents included the Secretary, Deputy Secretary, Assistant Secretary for Administration, Assistant Secretary for Financial Resources, Senior Counselor, Chief Information Officer (CIO), and Chief Technology Officer (CTO).
  - *CMS senior leadership at the time of the HealthCare.gov launch and after*—respondents included the Administrator, Principal Deputy Administrator and Acting Administrator, Chief of Staff, Chief Operating

Officer (COO), Chief Financial Officer (CFO), and Deputy Administrators for the Center for Consumer Information and Insurance Oversight (CCIIO) and Center for Medicaid and CHIP Services (CMCS).

- *CMS leadership and CMS staff*—respondents included Directors and Deputy Directors for the Office of Information Services (OIS) and Office of Acquisition and Grants Management (OAGM), Director for the Office of Communications (OC), and Deputy Directors for CCIIO. We also interviewed key staff such as a Regional Administrator managing the Consortium for Medicare Health Plans Operations, and CMS Government Task Leaders who were the technical representatives responsible for monitoring HealthCare.gov contractors' technical progress.
- *Contractor representatives*—respondents included representatives from Accenture Federal Services, LLC (Accenture); CGI Federal Services, Inc. (CGI Federal); Quality Software Services, Inc. (QSSI); and Terremark Federal Group, Inc. (Terremark).
- *Other stakeholders*—respondents included a small number of others involved in the HealthCare.gov project or in a position to observe the project, including navigators hired to assist consumers in selecting plans and research organizations studying the ACA.

› **Documents from HHS and CMS**: We used records management software to search through approximately 2.5 million project management documents and correspondence. The documents included presentations, memorandums, emails, meeting agendas, status reports, technical requirement documents, and documentation exchanged between CMS and other entities, such as contracts and Technical Direction Letters.

› **External documents and witness testimony**: We reviewed independent research and analysis about the Federal Marketplace and the implementation of large information technology (IT) projects from other Government agencies and independent research organizations. We also reviewed written and oral testimony to Congress by HHS and CMS staff and other stakeholders regarding HealthCare.gov.

LIMITATIONS

Although we believe the nature and extent of our review provided a sufficient basis for our findings, we note two potential limitations: (1) we purposively selected respondents at HHS, CMS, contractors, and stakeholders for interviews based on our review of HHS and CMS documentation and discussions with experts, but we did not interview all persons involved; and (2) CMS provided access to a large number of documents on the basis of search terms and parameters provided by OIG. We reviewed documents selectively on the basis of relevance to our objective as determined by OIG.

RELATED OFFICE OF INSPECTOR GENERAL REPORTS

This report is one in a series of OIG reports that evaluate the Federal and State marketplaces. OIG found a number of problems with CMS's implementation of the Federal Marketplace, including that CMS did not adequately plan for and monitor contracts and that CMS could not verify the accuracy of payments to issuers. OIG also identified areas for improvement in CMS eligibility verification and information security controls. OIG posts all ACA-related reports on its website (www.oig.hhs.gov/reports-and-publications/aca/) and continues its oversight of the marketplaces as articulated in the OIG *Work Plan* (http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf) and the Health Reform Oversight Plan (http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/health-reform-plan-2015.pdf).

STANDARDS

This study was conducted in accordance with the Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

"The clock was already ticking."
–Former CCIIO Official

CHAPTER 1

PREPARATION & DEVELOPMENT

March 2010–December 2012

"Marketplace" *as a label for the insurance program evolved over time. Early implementation used the term "exchange" or "HIX" for Health Insurance Exchange.*

The ACA's system for individuals to purchase private health insurance and enroll in Medicaid was a topic of heated debate in Congress, States, and the media before and after the law's passage. Twenty-six States filed suit against the Federal Government regarding various aspects of the ACA within the first year after passage, and in the 6 years since, the U.S. House of Representatives has taken more than 60 votes to change or repeal the ACA.[19] Those in HHS responsible for execution of the program reported that these debates and uncertainties over the ACA's policies had ramifications throughout development and implementation of the Federal Marketplace. As is often the case with complex legislation, many regulations and other guidance documents were needed to implement the ACA. HHS had significant responsibility for implementing marketplace operations in accordance with statutory requirements and timeframes. The ACA provided for significant flexibility in implementation, for example, leaving States to decide whether they would operate their own marketplaces or participate in a national, Federally-run marketplace.[20]

HHS initially housed the marketplace project in a new office that made early gains, but was hindered by limited resources and competing expectations

The "first" HealthCare.gov
HealthCare.gov "Plan Finder" was an early browsing website created by HHS in 3 months and cost approximately $17 million.

HHS launched the HealthCare.gov "Plan Finder" website and established a new office to manage the marketplaces. From the outset, implementing the ACA required HHS to meet multiple priorities, including many provisions unrelated to the marketplaces. A former HHS official reflected, "There were hundreds of things that needed to be done, and the Marketplace was just one." A number of ACA provisions had early delivery dates for HHS. This included the initial HealthCare.gov website, "Plan Finder," a browsing website to provide health plan information to consumers but without the functionality to purchase plans or apply for Federal financial assistance.

The ACA required that HHS establish the browsing website by July 1, 2010.[21] A small team of technical experts from HHS and the White House worked "around the clock" to complete the HealthCare.gov Plan Finder website. The website launched in July 2010 with general plan information, and was upgraded in December 2010 with functionality for consumers to enter

information about themselves and receive an estimate of their health plan premiums.[22] HHS reported that the website functioned smoothly and received approximately 2 million visitors from July 2010 to July 2011.[23] HHS and CMS staff later said that the relative ease with which HHS built the browsing website may have contributed to underestimation of the resources and time required to build the much more complex full HealthCare.gov website planned for launch on October 1, 2013.

HealthCare.gov Plan Finder Homepage, July 1, 2010.

At the same time that HHS was developing the browsing website, it began planning for the establishment of the Federal and State marketplaces that would facilitate health plan coverage for consumers by January 1, 2014. In April 2010, HHS created the Office of Consumer Information and Insurance Oversight (OCIIO) to oversee implementation of the ACA provisions related to private insurance.[24] Meanwhile, HHS continued its broader focus on all provisions of the law. OCIIO was to serve as a coordination point between the Department, issuers, and other Federal (e.g., IRS, SSA) and State partners, and to begin putting into operation the way in which individuals would purchase insurance.

> *"The single most important thing was the insurance part had to work."*
>
> —Former HHS official

HHS officials indicated that the private insurance aspect led HHS to establish OCIIO as its own staff division in the Office of the Secretary, rather than assign the program to CMS, its Medicare and Medicaid operating division. HHS staffed OCIIO with both long-time Federal employees, many from CMS, and those with expertise in the private insurance market, such as former officials of State Departments of Insurance. OCIIO in 2010 had direct hiring authority that allowed flexibility to assist HHS in expeditiously filling vacant positions when facing a critical hiring need. OCIIO focused largely on developing and obtaining approval for the many regulations required to implement private insurance reforms and establish the Federal and State marketplaces.[25] It also worked with a contractor to create an initial blueprint of critical tasks.

According to interview respondents who worked in OCIIO at that time, the focus was on policy development and not yet on operational issues, such as development of the full website intended for the 2013 launch.

OCIIO's chief objectives, according to former officials, were to publish the regulations that laid out how the Federal and State marketplaces would work, and to coordinate the participation of the partners necessary to make the marketplaces work, including States, issuers, consumers, other Federal agencies, and private entities.[26] Former OCIIO officials reported in interviews they were most concerned with ensuring the participation of issuers, which were needed to submit health plans for purchase on the marketplaces. Officials worried that issuers would be reluctant to submit plans due to concern about new requirements for coverage, the process for marketplaces to approve plans, and uncertainty about establishing premium rates not knowing the size of the population to be covered and what health care services this new insurance population required. A former OCIIO official later discounted concern over issuer participation, stating, "Of course issuers were going to participate. It is a huge new market where people are compelled to buy this new product. There was money to be made." Still, at a minimum, OCIIO was tasked with developing a new and complex system that required the collaboration of multiple entities, each with its own incentives and requirements.

> *"Of course issuers were going to participate. It is a huge new market where people are compelled to buy this new product. There was money to be made."* —Former OCIIO official

We didn't want people to walk into the store and not have anything on the shelf.
–Former HHS official

HHS officials had competing predictions for whether marketplaces would be State or Federal. Both HHS and States faced uncertainty regarding whether States would build their own marketplaces or default to the Federal Marketplace. Interviews with former OCIIO officials indicated that the conventional wisdom among leadership at HHS in 2010 was that most States would choose to establish their own marketplace, with as few as eight States participating in the Federal Marketplace. They reasoned that State leaders would want autonomy and to avoid participating in a large Federal program, and that States would be enticed by Federal Establishment Grants that provided money to build and operate State marketplaces. To build their own marketplace, States had to complete a considerable number of tasks, including passing State legislation in some cases. Interviews and documentation indicated that some in HHS focused on encouraging States to build their own systems, while others in HHS predicted that it would be too difficult for State Governments to build individual marketplaces, politically and operationally, so they would default to the Federal Marketplace. HHS officials recalled an expected sense of failure among some States that opted to join the Federal Marketplace because they "did not think they could pull it off, were too small, and didn't have the issuer base to finance the user fees." In other cases, State legislatures did not authorize the creation of a State marketplace. One HHS official explained that some States "did not want to touch Obamacare." (HHS delayed the deadline for States to make this

decision several times, and it was ultimately early 2013 before it was clear which States would join the Federal Marketplace for the first open enrollment period.[27])

HHS determined that OCIIO was ill-equipped to manage such a large and complex project. Although OCIIO provided HHS with a program and staff focused on the marketplaces, it had a relatively small number of staff and lacked the infrastructure and budget of an operating division. OCIIO did not possess basic in-house operations, including contracting and technological support. It also had few technical staff, rendering it ill-equipped, in HHS's view, to manage such a large project. CMS's decades-long experience administering large Government programs made it the frontrunner to replace OCIIO in managing the marketplaces. CMS had a large infrastructure from which the Federal Marketplace program could benefit, including technical and operational staff. Some in favor of assigning the Federal Marketplace operations to CMS wanted to employ existing expertise and infrastructure rather than build the Federal Marketplace program from scratch, with one CMS official arguing that the Medicare program had "much of the same operational DNA" that would be needed for the Federal Marketplace. Other officials in HHS argued against the move to CMS, contending that identification with CMS (as the operator of Medicare and Medicaid) might cloud the program's objective as a market for private insurance.

In January 2011, 10 months after OCIIO's inception, HHS transitioned the marketplace project from OCIIO in the Office of the Secretary to CMS.[28] Those involved in the decision reported that it was driven largely by the idea that CMS's available funding and substantial existing infrastructure could help support marketplace functions. The ACA provided a $1 billion Health Insurance Reform Implementation Fund to help pay for the administrative costs of implementation of ACA, but HHS ceded over half of these funds to the IRS and other Departments to support ACA implementation.[29] Given that the Congressional Budget Office predicted a $5-10 billion cost of implementation to HHS over the 2010–2019 period, HHS faced a substantial funding shortfall.[30] In addition, several HHS officials perceived that embedding the project in CMS may have helped those responsible for developing the marketplaces to avoid distractions from ongoing debate about the ACA. They believed that incorporating the project into the larger organization might help to avoid line-item scrutiny of its budget execution by critics.

Integrating into a large organizational structure at CMS brought new challenges to the Federal Marketplace project, primarily caused by unclear project leadership

The move to CMS separated marketplace staff into different divisions. The transition to CMS after 10 months in the Office of the Secretary under OCIIO provided the expected benefits of greater resources, but also brought drawbacks. Most OCIIO staff and leadership previously working together were split into two CMS divisions: (1) policy and business operations management staff went to the newly created CMS CCIIO, responsible for establishing Federal and State marketplace policies; and (2) technical and contract management staff went to the existing OIS, which coordinated the technical aspects of the HealthCare.gov website development (website build). Other Federal Marketplace responsibilities were folded into existing CMS divisions. Most notably, the CMS Office of Acquisition and Grants Management

(OAGM) was responsible for managing the Federal Marketplace contracts, the Office of Financial Management (OFM) was responsible for the Federal Marketplace budget, and the Office of Communications (OC) was responsible for interaction with consumers. CMS's Center for Medicaid and CHIP Services (CMCS) also played an important role in coordinating the application form that marketplace consumers would use to apply for assistance. The application would enable consumers to apply for: coverage in a health plan, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP. Given the shared application form, CMCS had much to gain from a successful Federal Marketplace that effectively facilitated Medicaid enrollment.

In addition, key Federal Marketplace staff were located in offices apart from either CMS or HHS headquarters, which contributed to communication problems and a sense of separateness. The office space for both CCIIO and OIS staff assigned to the marketplaces remained in the existing OCIIO space in Bethesda, MD, a 45-minute drive from the main CMS campus in Baltimore, MD. The decision to stay in the existing location rather than move to CMS's main campus was attributed to the desire to retain former private sector employees who lived in the greater Washington, DC, area and were unwilling to travel to suburban Baltimore. Some CMS staff reported that the separate location in Bethesda may have exacerbated problems communicating with other CMS divisions, particularly in the case of OIS technical development staff located in Bethesda but reporting to the larger OIS organization in Baltimore. The use of multiple locations in the Washington, DC metropolitan area was not new for CMS, with its agency headquarters in several separate buildings in Baltimore and senior officials in Washington, DC (in addition to substantial staff in 10 regional offices throughout the country). Many rooms were equipped for video conferencing, and staff had access to daily shuttles between locations and remote access to computer systems. Still, even with these technical capabilities, the Bethesda location for CCIIO, particularly in the critical first year following integration, appears to have contributed to a sense of separateness between the new program and the larger agency.

There were two different conversations going on and they were not married up.
–CMS official

More important than integration of CCIIO staff within the larger CMS organization was a lack of unity among those responsible for pieces of the marketplace development. Marketplace staff in CCIIO, OIS and the other divisions had different operating procedures, reporting structures, and lines of authority. Project management documents indicated efforts throughout 2011–2012 to bridge these gaps, such as regular meetings between project leaders in the various divisions. These documents also revealed major differences in understanding between the divisions regarding shared responsibilities and assessments of project progress. In interviews, staff in CCIIO and OIS gave very different descriptions of each other's tasks and in some cases could not identify the staff positions or subdivisions responsible for critical project tasks. This lack of unity and dispersion of responsibility had serious consequences, resulting in difficulty tracking progress and enforcing accountability.

Merging a "start-up" organization with a large bureaucracy created tension. The integration of the Federal Marketplace project into CMS provided a broader infrastructure for the program, but some marketplace officials reported that they struggled to fit into the CMS organizational culture. One explanation offered by several officials was that the marketplace program and development of the HealthCare.gov website required a "start-up" mentality that encouraged creativity and innovation to support something new and unique. Yet the CMS organizational culture was that of a more traditional government bureaucracy, based on rigid management methods and an established hierarchy. In their view, those working on the marketplace program had to straddle the two cultures and this exacerbated difficulties meeting the already-challenging schedule and tasks. As one long-time CMS policy official serving in CCIIO reflected, "We were never fully accepted by CMS as a whole. Every new program feels that way, but this was a special case. The objective was too different and not well understood [at CMS]."

> *"We were never fully accepted by CMS as a whole."*
>
> —CCIIO official

Transition to CMS heightened differences regarding program mission. The uncertainty about whether States would choose to operate their own marketplaces or join the Federal Marketplace continued after the Federal Marketplace project was transitioned into CMS. The lines in this debate were drawn largely between long-time CMS staff who were in favor of building a large-capacity Federal Marketplace, and newer staff with State or private insurance experience who were in favor of encouraging States to establish their own systems. Given that the marketplace program had already used almost a year of scarce implementation time, resolving these conceptual differences took on a new urgency. CMS had yet to develop and publish a large number of pressing regulations, some of which were tri-departmental regulations with the Departments of Labor and Treasury and therefore potentially faced more hurdles in coordination.[31]

CMS had also not begun planning in earnest for how the Federal Marketplace would operate. The debate about the role and need for State and Federal marketplaces played out in issues across the policy spectrum, affecting decisions about health plan requirements, benefits, and financial assistance. Some of these differences involved ACA provisions about consumer protections that were not specific to the Federal Marketplace and HealthCare.gov, such as premium rate reviews and essential health benefits.[32] Several CMS officials indicated that disagreement about these issues complicated decisionmaking about the Federal Marketplace, and may have contributed to delays in decisionmaking. One CCIIO official from a State background complained that these ancillary issues caused CMS staff sometimes to lose focus on the key Federal Marketplace mission to facilitate buying and selling of insurance: "We've built up the marketplace to be something grander than it is. It's a store."

Another point of contention between some long-time CMS staff and newer employees was that CMS staff tended to rely on past experience implementing Government health care programs, such as the launch of the Medicare Part D prescription drug program in 2006. The Part D program was a large project that required collaboration with private issuers to create competition among plans, so it is reasonable that the launch of the Part D program provided

CMS staff with relevant expertise and experience. Also, the Part D program had problems at launch that required quick correction.[33] Still, creation of the Federal Marketplace was a larger and more complex project. Further, prior programs, such as Part D and Medicare Advantage, were built for the existing Medicare population, rather than a new market. Comparisons of the marketplaces to existing CMS programs were perceived by those new to CMS as demonstrating a lack of understanding about the larger scope and complexity of the Federal Marketplace program. As one CMS official reflected, "I learned to never bring up the Part D example."

Who was in charge?

When asked who led the Federal Marketplace project, several staff named positions that were unfilled. When asked what division led the project, staff named four different CMS divisions.

Lack of leadership caused problems integrating Federal Marketplace staff into CMS. CMS interviews and documentation indicated that the chief cause of organizational problems was CMS's failure to complete two critical tasks: assign clear and dedicated leadership for the marketplace program, and fully assess project needs to determine how to best establish the marketplace program in CMS. In CMS, there was no single official early on, below the CMS Administrator, responsible for the Federal Marketplace, and the officials responsible for different pieces often reported to the CMS Administrator through several layers of management. Throughout this early development period and into implementation and the first open enrollment period, CMS senior leadership never declared a clear "business owner" with overall responsibility for the Federal Marketplace. This issue of leadership was more straightforward for OCIIO as a small organization: the Director of OCIIO reported directly to the HHS Secretary, whereas in CMS those active in planning for the marketplaces were spread throughout the organization and reported through the CMS Administrator.

The marketplace program was a complex task for an organization that was already responsible for implementation of many other ACA provisions and managing Medicare and Medicaid, programs with combined expenditures exceeding $900 billion in fiscal year 2014—about one-third of total U.S. health care expenditures.[34] Adding to this, the CMS Administrator and the second-in-command Principal Deputy Administrator were both new to CMS, joining CMS in 2010 and 2011, respectively, in the first year of CMS's enormous tasks to implement the ACA.[35] To undertake the project without assigning leadership was to underestimate the project's difficulty. Lack of clear and effective leadership and thoughtful consideration of project and organizational structure characterized the preparation and development period, and had long-term negative consequences for the program's success. This insight was not only true in retrospect. In late 2011, the White House CIO expressed concern to HHS and CMS officials that leadership for the program was fragmented and recommended appointing a Chief Executive Officer (CEO) to oversee the project.

CMS struggled to provide timely guidance to States, secure future funding for the development of HealthCare.gov, and retain key staff for the project

Lack of clear direction and continued uncertainty delayed guidance to States. Several State officials criticized CMS for being slow to provide regulations and guidance for developing State marketplaces. The ACA required CMS to provide criteria for State marketplaces and required States to demonstrate their readiness to operate on the basis of these criteria.[36] Pieces of the regulations and guidance were due throughout 2011 and 2012, but most were delayed several times. In October 2012, a State Governor wrote to the Secretary explaining that the delay in guidelines contributed to the State deciding to join the Federal Marketplace. "There is simply not enough valid information to make an informed choice for such an important decision."[37] Around the same time, a State insurance commissioner testified before Congress that "the lack of detailed information from HHS has put [us] in a very difficult position."[38] In fact, CMS did not finalize its regulations for State marketplace oversight and program integrity standards until October 2013,[39] 10 months after the State deadline to submit plans for a State marketplace.[40]

CMS officials indicated that the delays were caused, in part, by efforts to provide greater flexibility for States to establish their own marketplaces or to use the Federal Marketplace in a way that suited their needs. According to CMS staff, when States objected to a policy, CMS sometimes revised the policy to provide additional flexibility. This in turn required changes to the "business requirements" (provisions that articulate to developers the processes the website would support), and potential delays in software development. CMS officials did not have a good sense of which or the number of States that would build their own marketplaces, causing consternation about scale, budget, and coordination with States. As observed by an HHS official, "Whether 1 State or 50, we knew we had to build the functionality, but the scale shifted many times by an order of magnitude and made it more complicated."

> *"CMS was convinced that [we] had to build the perfect policy and did not leave time to implement."*
> *–CMS Administrator*

Political context and funding uncertainties also affected CMS's development of the Federal Marketplace program. CMS officials and staff reported that they felt the political importance of the ACA throughout marketplace implementation. CMS officials described White House staff as being substantially involved throughout policy development and as the clear policy leads. A Deputy Director at CCIIO reported, "There was constant contact with the White House. The White House was in charge." It appears that for high-level CMS officials the interaction was expected, but lower-level CMS staff were unaccustomed to working so closely with White House staff and the lack of clarity and experience around this process led to some confusion and delays. Specifically, some CMS staff expressed frustration that the close involvement of White House staff and HHS officials resulted in a complex process for making decisions and caused delays in completing policy work. They were particularly frustrated when they perceived heavy involvement about what they believed were relatively small issues. For example, emails between HHS and CMS staff revealed CMS staff frustration with the discussion around changing the term "nationwide health insurance" to "health insurance" in official documents. Others defended the high level of involvement given the importance of the ACA to the White House. The CMS Administrator also reported perceiving the White House involvement as collaborative and helpful, particularly in making policy decisions. Other

high-level CMS officials agreed, indicating that most understood the strong interest in details. As one CMS official noted, "This was the President's achievement. It raised the stakes. It meant that people at my level had a lot of bosses."

Others at CMS identified occasional challenges in meeting White House and HHS direction during the development and implementation of the Federal Marketplace. For example, according to some CMS policy officials, White House staff and HHS officials expressed concern that planning and educational documents for key stakeholders might be overly complex and could discourage participation. CMS, CCIIO, and OIS staff reported that a White House policy official requested that some policy and technical documents be simplified or not used. As an example of these requests, CCIIO produced a Federal Marketplace "concept of operations" document in 2011 to educate States and issuers about Federal Marketplace operations that was perceived by CCIIO staff as critical to these stakeholders understanding the planned operations, but the document was not distributed as planned.

Another complication stemming in part from the political contention surrounding the ACA was lack of certainty regarding future Federal Marketplace funding. Although initial resources were improved with the move to CMS, it was unknown to HHS and CMS officials how much funding Congress would provide for development in future budgets. CMS officials reported that this uncertainty about future funding for implementing the Federal Marketplace and other ACA programs made decisionmaking more difficult, particularly determining how to prioritize different aspects of the website build and provide overall project direction. CMS officials also reported that this uncertainty delayed establishing contracts and moving forward with the technical build. As one CMS contracting official explained, "I cannot put [a contract] on the street without [funding]. . . . We didn't know when we were going to get [funding] or what we can use it for." HHS officials expected user fees to make Federal Marketplace largely self-sustaining by the end of 2015, but ensuring that funding was available for the build was cause for concern. One HHS official reported that CMS completed a budget in mid-2012 that showed a sizeable gap between the amount of money forecasted to complete the technical build and the amount available for use.

> *"Every time I turned around, I had to brief new people. This project is so complex you have to be immersed. –CMS official*

CMS experienced high turnover in Marketplace staff. The Federal Marketplace program experienced significant staff turnover after the project moved to CMS in 2011, particularly in CCIIO management positions. Officials in Director- and Deputy-level positions in CCIIO in 2011–2015 often had a tenure of less than 1 year. One Director-level position was filled by seven different people during our study period. As many as two-thirds (30 of 45) of the Director- and Deputy-level positions were vacant at some point during our study period, many for an extended time. These vacancies were filled by staff who were temporarily moved from other parts of CMS to serve in an "acting" capacity. In many instances, individuals in these temporary slots divided their attention with a second, or even third, leadership position. One important position responsible for establishing premium rates was vacant for a total of 24 months spanning 2011–2013. CMS also experienced a high turnover of staff responsible for managing and overseeing key Federal Marketplace contracts.[41] CMS staff reported that the high turnover and lack of permanent managers in key positions hindered program and organizational knowledge while making building relationships among management and staff

more difficult. CMS officials later attributed the high turnover to a number of factors, including that former State and private sector employees intended to serve for only a short time to participate in the launch and that the workload was considered by some to be unsustainable. A former CCIIO director stated that "CCIIO was a rewarding place to work but was not sustainable based on the hours needed and timeframes to get the job done."

IT contracting for the FFM encountered significant problems, including limited bids, uncertainty in funding, and disjointed CMS contract management

92%
of contracts
for the Federal Marketplace were awarded under previously established contracts.

CMS selection of contractors and type of contracts limited the number of bids. As CMS worked to finalize policies and standards for the marketplaces through 2012, it awarded key IT contracts for the Federal Marketplace largely on the basis of existing contracts. Prior OIG work on Federal Marketplace contracts found that of the 60 Federal Marketplace contracts, 55 were awarded under previously established contracts.[42] CMS contracted the core pieces for the FFM and Hub in 2011, and the EIDM in 2012, using Indefinite Delivery Indefinite Quantity (IDIQ) contracts. Contracting through an IDIQ is generally more streamlined and faster than the processes for other types of contracts because CMS can choose from pre-qualified companies that are familiar with CMS's systems and procedures without having to follow all Government acquisition regulations, such as completing acquisition plans.[43] CMS hired CGI Federal to build the core of the overall Federal Marketplace system, the FFM, which consisted of three main subcomponents: eligibility and enrollment, plan management, and financial management subcomponents. CGI Federal's responsibility also included developing the website interface (functions that support consumer interaction) and online application for consumers. CMS also hired QSSI to build the Hub and the EIDM. The Hub enabled the Federal Marketplace to check application information such as income and citizenship, and the EIDM provided identity management services that enabled consumers to create accounts and verify their identities. The EIDM was built for account-creation functions in multiple CMS programs, including Medicare.

Use of the IDIQ contracts limited the number of companies allowed to submit proposals to the 16 companies previously awarded an IDIQ contract, but uncertainty surrounding the ACA may also have limited contractor interest in the project.[44] One CMS official later reflected that uncertainty about ACA requirements and funding may have further reduced the field of companies willing to vie for the contracts: "We had problems getting people to bid on contracts without assurances that the law would continue." Ultimately, only four contractors submitted proposals for the FFM build, and only that of CGI Federal was deemed technically acceptable.[45]

CMS did not use an acquisition strategy to develop contracts and select contractors. In addition to the limited number of companies under consideration, the CMS process for establishing these key contracts included three factors that may have further hindered contractor selection and later results. First, as OIG previously reported, CMS did not develop an acquisition strategy for Federal Marketplace contracts, nor did it perform a thorough review of contractor past performance beyond the basic requirement to consider past performance on prior task orders awarded under the IDIQ.[46] An acquisition strategy is an

overall plan for satisfying the project mission in the most effective, economical, and timely manner.[47] Having an acquisition strategy would have provided a framework for CMS to precisely assess project needs and make a systematic assessment of the contractors' ability to meet those needs. Not developing such a strategy likely limited CMS's ability to fully and systematically assess proposals. Second, CMS chose to structure the FFM contract with CGI Federal as "cost-plus-fixed-fee." OIG work from January 2015 reported that this type of contract pays the contractor a prenegotiated award fee amount, requiring the contractor to bill as it incurs additional labor and material expenses.[48] A cost-plus-fixed-fee contract is typically selected when the tasks are so uncertain that accepting a contract on the basis of an end product would pose undue risks for contractors. The drawback is that it provides the contractor with less incentive to control costs and provide high quality products.[49] Third, CMS did not define important aspects of the Federal Marketplace functionality in its original statements of work to some contractors. For example, CGI Federal reported that their statement of work for the FFM contract . . . "contained very broadly defined general technical requirements, task order management expectations, and work activities." Officials and staff from both CMS and CGI Federal indicated that this lack of specificity created misperceptions about CGI Federal's responsibilities, resulting in delays and additional work.

> *"October 2013 seemed a long way off."* —CMS official

Unclear division of staff responsibilities led to disjointed contract management by CMS. In addition to the barriers presented by contract selection practices, confusion over the roles of contract managers hampered contract management. Staff within OIS's Consumer Information and Insurance Systems Group (CIISG) in CMS was responsible for managing the technical aspects of the contracts to ensure they met specifications; most importantly, the Government Task Leaders (GTL) within CIISG monitored contract progress and contractors' deliverables.[50] At the same time, CMS contracting officers (CO) in OAGM were responsible for authorizing, administering, and terminating CMS contracts.[51] COs appoint Contracting Officer's Representatives (COR) to assist in the technical monitoring of a contract.[52] The CO is the only CMS official authorized to make modifications to the contract.[53] Contractors reported that they had difficulty determining where GTL responsibilities left off and the CO or COR picked up, and they received "inconsistent direction" when asking the same question of the GTL, CO, or COR.

Such poor coordination between the GTLs and the contracting office also led to key staff discussing changes with contractors outside of formal channels, causing tension between CMS offices and lack of clarity to contractors. Previous OIG work determined that CIISG and OAGM did not adequately maintain contracting records or always monitor contractor performance.[54] Part of the problem was that the CO did not always designate and authorize the COR in writing, and did not always document the specific duties and responsibilities assigned for each contract. Regarding these challenges, the CMS Deputy CIO wrote, "This is an epidemic of anemic management and leadership and it is much worse in our case because of the relative book of work that needs to be accomplished."

Continued insufficient coordination and direction by CMS led to delays in guidance to contractors, and set the stage for problems with HealthCare.gov operations

Solidifying business requirements and technical specifications was slow and involved much iteration. Although the contractors had begun the website technical build, CMS was still making key regulatory and policy decisions and in many cases had not finalized the business requirements and the technical specifications needed to develop the software. Writing the business requirements is an iterative process, with policy experts and technical staff refining the technical specifications to meet the functional needs. In December 2011, a CMS technical official expressed frustration over the lack of a single leader to make decisions and sign off on business requirements, indicating that the lack of leadership resulted in mid-level staff and managers having difficulty coordinating and lacking authority to make decisions.

> *"We had an overall vision for functionality, but we were not sure how to get there."* —CMS technical staff

> *"When they started the build, the requirements they knew were in the middle. Things at the beginning, such as the application, were still being decided and were not solved until very late in the process.* –*CMS contractor staff*

For the Federal Marketplace, the back-and-forth (between CMS policy and technical staff and CMS and contractors) was substantial because CMS was still making regulatory and policy decisions. Contractors reported that they immediately identified the lack of business requirements as a problem and that the extent of iteration was unusual. This likely reflects CMS's lack of clarity in defining key marketplace functions, which traces back to conflicting statutory interpretation and debates about policy choices. In addition, the pending Supreme Court case regarding whether individuals would be mandated to purchase health insurance created further uncertainty, given its potential to alter implementation of the ACA.[55] One contractor noted that continued legal uncertainties surrounding the ACA also slowed progress. For example, in the contractor's view, "regulations slowed to a trickle" while waiting for the ruling.

Supreme Court Upholds Health Care Law, 5-4

–The New York Times, 06/28/2012

This lack of clarity forecasted problems to come. A CCIIO official sent the following email in late 2011 to officials in CCIIO and OIS: "I am growing increasingly worried that our [marketplace] work is off track. We have not been effective in communicating the importance of finalizing policy timely so that operational decisions can be made and processes built." Several CMS staff reported that they believed that stronger CMS leadership could have prevented some problems by mandating that no additional changes to business requirements be made at a certain point. CMS technical staff were often caught in the middle between policymakers and contractors, moving forward on the basis of assumptions but without a clear plan. By the time the June 2012 Supreme Court ruling confirmed the legality of the individual mandate, CMS had already lost critical months toward focused development of the Federal Marketplace and HealthCare.gov.

"Agile" *is a method of software development that breaks larger tasks into smaller increments that are then completed and tested.*

The selected method of software development made it easier for policymakers to seek frequent and late changes. In its contract proposal to build the FFM, CGI Federal indicated its intent to use the "agile" method of software development, which separates development of pieces of the build such that developers can begin on some components while business requirements for other components are still being finalized. This method is commonly used when some pieces are not well-understood at the outset. An advantage of agile development is that each increment, often completed in two-week "sprints," results in a functioning product that can be tested, so that the business owners (in this case, CMS staff) responsible for a particular process can assess whether the software meets the project's needs and adjust business requirements accordingly. This ability to adjust, however, enabled policymakers to frequently change business requirements and technical specifications on an ongoing basis. Changes made through the agile development process must still be properly considered, documented, and communicated. Managers at CGI Federal reported in interviews that the frequency of CMS's requests for change resulted in too much change too late in the process, contributing to delays. For example, CGI Federal managers reported that CMS did not define business requirements at the beginning of each sprint and often made changes throughout the sprint, which inhibited the agile method and resulted in incomplete development. An agile method also allows for pieces of the build to be completed out of order, but this also caused problems for the FFM in that some earlier pieces that were still undecided affected the build of subsequent components.

Key technological choices and poor execution also inhibited the website build. A number of technological decisions hampered development, including selecting a nontraditional technology that did not align with the expertise available. CGI Federal indicated in its final FFM contract proposal that it would use a combination of two types of "database platforms" (the digital structure upon which the website is built): a traditional "relational" platform such as Oracle that uses tables to store data; and a nontraditional "NoSQL" platform that uses non-tabular documents to store data. Given that each type has different benefits, CMS indicated in its evaluation of CGI Federal's contract proposal that use of both Oracle and NoSQL databases was a strength. The key benefit of the traditional relational platform is its wide use, with most developers experienced in Oracle. The key benefit of the nontraditional NoSQL platform is its potentially greater capability, in that it can allow more data to be transferred at a time and can be easily expanded to include more data or users. However, NoSQL platforms were used less frequently and fewer developers had experience building on and maintaining them.

Although CGI Federal's final contract proposal, accepted by CMS, indicated partial use of a NoSQL platform, it did not specify the brand of platform it would use—over 100 vendors provide NoSQL platforms. In November and December 2011, CGI Federal met with one of the oldest NoSQL vendors, MarkLogic, to better understand the risks and benefits of MarkLogic's platform. Following these meetings, CGI Federal managers expressed concern to CMS about using MarkLogic's platform. Interviews and documentation indicated that few at CGI Federal and CMS had development experience with the platform. In a presentation to CMS technical managers in January 2012, CGI Federal indicated that its lack of experience with MarkLogic's

platform could affect the timely development of the FFM. CGI Federal reported to CMS that it would be unable to fully replace staff expertise on traditional databases with equivalent expertise with MarkLogic's NoSQL platform and recommended that CMS develop a contingency plan.

Despite CGI Federal's reluctance to use the platform, CMS notified CGI Federal of the selection of MarkLogic in a January 2012 Technical Direction Letter (TDL). A TDL is used to clarify or give specific direction to the contractor within the scope of the statement of work and cannot alter the contract cost. The TDL directed CGI Federal to use MarkLogic's platform and to obtain staffing support from MarkLogic to help implement the change. In a February 2012 presentation to CMS, CGI Federal reiterated its concerns about the use of the platform. CGI Federal managers contended later that use of a TDL demonstrated that CMS did not recognize the importance of the platform choice, and use of a more formal Contract Change Order would have allowed both parties to fully vet the decision and possible consequences. A Contract Change Order directs the contractor to make a change that may increase the contract cost, change the terms of the contract (e.g., extend the length of the contract), or be outside the existing scope of the statement of work. CGI Federal hired additional staff trained in the platform and subcontracted with MarkLogic for technical assistance, but staff from both CMS and MarkLogic reported that CGI Federal never retained the number of experts needed to configure and integrate the MarkLogic technology.

> *"From a design, development, and integration standpoint, MarkLogic is vastly different from Oracle [the prior relational platform]."*
>
> —CGI Federal presentation

Both CMS and CGI Federal staff reported that use of MarkLogic's platform caused development problems throughout the remainder of the FFM build. Although QSSI used the platform for development of the Hub, CMS and QSSI did not report the same problems as CGI Federal had using the platform to develop the FFM. CMS documentation indicated that QSSI hired an adequate number of additional staff from MarkLogic to work on the Hub development and operations, as CMS had directed CGI Federal to do in the TDL.

Another technical decision with the website build may have compounded problems with the platform. CGI Federal included in its final contract proposal for the FFM the use of automatically generated software code called Model-Driven Architecture (MDA), typically used in conjunction with developer-written code to save time and reduce human error. According to a CMS official, CGI Federal was committed to this technique and referred to MDA as their "bread and butter." Although CMS approved the use of MDA in the contracting process, the CMS GTL responsible for monitoring the technical progress of CGI Federal's contract later reported that it was one of the biggest culprits in the coding problems. The GTL explained that CGI Federal used MDA for perhaps too much of the build (estimated at 60-70 percent), and did not build the MDA code effectively or coordinate it properly with developer-written code. The GTL also came to believe that use of MDA created additional

problems in the "last mile" of development because it was difficult to modify when late changes were needed.

Poor CMS management of changes to the website build created delays and confusion. Each development team maintained detailed schedules to manage system development, which were summarized into an integrated master schedule to track development of all Federal Marketplace systems. The integrated master schedule was maintained by CIISG, which served as the CMS IT project management office for the Federal Marketplace. CMS required that CMS staff and contractors working on the website submit changes in business requirements or technical specifications for approval by a Change Control Board if the change could alter the project cost, scope, or schedule. The Change Control Board was mostly comprised of representatives from OIS, CCIIO, OC, and CMCS who were to make these decisions and log changes in a central repository accessible to both CMS and contractors. CMS's central repository stored a variety of information about the Federal Marketplace project, including not only business requirements and technical specifications, but also archived software code, infrastructure descriptions, testing results, and past defects that were identified and resolved.[56] Part of the purpose of the central repository was to enable CMS staff managing contracts to analyze and compare technical specifications to ensure that the technical build met business requirements.

However, the Change Control Board and central repository processes were not effectively managed, leading to delays and confusion about tasks and progress. In interviews, CMS staff said that difficulty tracking and responding to revisions to the business requirements may have concealed problems with production and schedule. First, project documentation and email correspondence revealed that CMS's Change Control Board frequently cancelled decision meetings and did not promptly address change requests. Second, when changes were approved, contractors were not always informed immediately, resulting in further delays. Third, CMS and contractors did not always log approved changes in the central repository, as required. Fourth, CMS staff did not appear routinely to review documents in the repository to identify problems, as intended by CMS. Email correspondence indicated that by mid-2013 there were several thousand documents in the central repository, and CMS staff raised concerns that the documents were not well organized and there was no evidence of review by the Change Control Board. This failure to approve changes promptly and track changes in the repository also inhibited the "agile" development process that was used to build the FFM. As part of the Change Control Board process, developers were required to submit changes before they could begin the next sprint, so delays in the board approval process delayed the daily work of the software build.

> *"If we had the requirements sooner, we would had discovered the problems sooner. The flux in the requirements allowed the developers to hide, to not come clean.*
> *–CMS technical staff*

Additionally, CMS staff and contractors sometimes circumvented the Change Control Board process, making changes without board approval or the knowledge of affected CMS staff and contractors. Between March and December 2012, CMS staff not authorized to modify the contract added numerous work items to CGI Federal's contract.[57] The CO and initial COR responsible for CGI Federal's contract were unaware of the additional items added to the contract until a newly assigned COR discovered the contract overrun, referred to as an "unauthorized commitment," which violates the Federal Acquisition Regulation.[58] However,

an unauthorized commitment may later be approved under certain circumstances.[59] In this instance, CMS was able to modify CGI Federal's contract to fund the unauthorized changes, but bypassing the Board created confusion among stakeholders about which changes were implemented.

According to both CGI Federal and CMS staff, this continued alteration of business requirements through 2012 and into 2013 resulted in significant delays in website development. Additionally, CMS was still making policy decisions late in development that changed technical specifications and created additional work. One example was CMS OC's decision to change the website interface long after CGI Federal had begun development. Another late policy decision that changed the website build was the determination of whether only one member or all family members needed identity verification.

CGI Federal advised CMS staff numerous times in weekly status reports beginning in February 2012 that delays in finalizing business requirements were affecting the development timeline, yet the changes continued. CGI Federal managers indicated in interviews that they now believe they should have alerted the CMS Administrator directly regarding the depth of the problems and spoken more candidly and earlier to other CMS officials. A CGI Federal official stated, "We should have been more emphatic in warning CMS of the risks of launching." CGI Federal managers reflect now that they did not do so primarily in order to follow the standard "chain of command" in reporting problems to CMS.

> *"We should have been more emphatic in warning CMS of the risks of launching."*
>
> —CGI Federal official

KEY FACTORS CONTRIBUTING TO BREAKDOWN

› POLICY DEVELOPMENT DELAYS

Implementing the Federal Marketplace required substantial policy development and decisionmaking to inform technical planning and implementation of the website. This included not only writing regulations to govern the marketplaces, but also establishing partnerships with other entities involved in implementation, such as other departments, States, and issuers. This policy work was made more difficult and protracted by a lack of certainty regarding the mission, scope, and funding for the Federal Marketplace and website, which was caused in part by varying expectations for the marketplaces and a contentious political environment. This time spent developing regulations resulted in further delays later in the process, such as States deciding whether to join the Federal Marketplace and technical needs for website contracts. These delays used valuable time and made an already compressed timeframe more difficult.

› POOR TRANSITION to CMS

The transition of the Federal Marketplace to CMS after 10 months in HHS OCIIO resulted in problems that lasted long after the move. HHS OCIIO made significant strides in establishing the policy framework, but did not focus attention on planning for the project's longer-term technical and operational needs. CMS had to reconfigure roles and timelines, determine how it would leverage its resources, and begin work behind schedule. Further, while CMS's infrastructure and experience provided greater resources for the project, it also required the Federal Marketplace to operate within a large bureaucratic structure that separated contract, policy, and technical staff, causing further diffusion to the project team and making implementation needlessly more complex. Interviews and documentation indicate that CMS leadership failed to address this diffusion by fostering effective collaboration, particularly between CMS policy and technical staff and contractors.

› LACK of PROJECT LEADER

CMS's failure to immediately assign a project leader was particularly problematic for HealthCare.gov. Clear leadership alone may have corrected many of the project's deficiencies. As a new project with staff spread across CMS, the HealthCare.gov team needed unity and identity within the larger organization. The project also needed quick decisionmaking and flexibility, made easier when a single lead entity is responsible rather than multiple entities with organizational layers. Effective project leadership would have enabled a comprehensive view across the project to better assess progress, identify problems, and determine priorities. Leadership was also lacking beneath the senior executive level, with high turnover among officials in CCIIO and high-level CMS technical officials involved in the HealthCare.gov build.

› MISMANAGEMENT of KEY WEBSITE CONTRACT

Mismanagement of the FFM contract with CGI Federal was a key problem for CMS in development up through the launch. The contracting process suffered from a limited number of bids and uncertainty about funding and technical specifications, and CMS contract oversight was disjointed and lacking. CMS made frequent changes to contracted work, some of which represented questionable technical decisions, and did not communicate effectively with CGI Federal about the changes and any resulting effects on staffing and schedules. Interviews and documentation indicate that CGI Federal made missteps as well; for example, the company did not adequately increase staffing and expertise when changes were made and progress began to deteriorate. Still, poor CMS management of the contract substantially contributed to problems building the FFM, a critical component of HealthCare.gov.

"Hope is not a strategy."
–Former CCIIO staff

CHAPTER 2

FINAL COUNTDOWN TO LAUNCH

January 2013–September 2013

By January 2013, CMS knew that 34 of the eventual 36 States would participate in the Federal Marketplace for the first open enrollment period, finally giving contractors the knowledge of needed scope and capacity. Still, inability to finalize business requirements continued to hamper the website build into 2013. Some of these requirements were delayed because CMS had not yet completed the underlying program policies. For example, CMS did not finalize decisions about some aspects of the program—benefits required for health plans and using a single, streamlined Medicaid application—until February and June 2013.[60] In other cases, such as Medicaid eligibility exceptions, CMS abandoned the goal of creating new policies and reverted to former practices because it lacked the time to solidify new policies.

18
Documented Warnings
with concerns regarding the HealthCare.gov build

Several entities voiced concerns about the status of HealthCare.gov, but warnings were either not fully communicated or not acted upon

A CMS technical advisor and two consulting firms identified specific problems that threatened a successful launch. Throughout the course of the HealthCare.gov build, staff at HHS and CMS, as well as outside entities, identified problems with the program and warned that these problems warranted action. By January 2013, the most common advice given to CMS senior leadership was that the program needed a single lead entity and that CMS should stop revising policy. During June–October 2012, the technical advisor hired by CMS to assess HealthCare.gov progress prepared six reports for the CMS Administrator and CCIIO leadership, laying out problems in explicit detail after reviewing project documentation. CMS also hired outside firms to assess progress. Throughout 2012 and 2013, a series of 11 technical reports from the firm TurningPoint Global Solutions gave scathing reviews, including a progress report in April 2013 that listed the Top 10 Risks of the website build, such as inadequate planning for website capacity and deviation from IT architectural standards. In addition, in early 2013, the Secretary hired McKinsey Consulting to review the program and make recommendations to improve CMS management of the project. In all, CMS received 18 "documented warnings" of concerns regarding the HealthCare.gov build between July 2011 and July 2013, all containing substantial detail about the project's shortcomings and formally submitted to CMS senior leadership or project managers at CMS.

Among the recommendations was to assign a single project leader for the Federal Marketplace, the same advice given earlier by the U.S. CTO. However, these reports were not shared broadly with CMS leadership and technical staff. The TurningPoint reports were presented only to CMS technical staff, such as the CMS Deputy CIO, and McKinsey's recommendations were presented only to senior CMS officials such as the Administrator. The CMS Deputy CIO, the chief CMS technician on the HealthCare.gov build, specifically reported that technical staff did not receive or even have knowledge of the McKinsey report findings.[61]

Attempts by CMS to take action on recommendations were poorly executed. CMS officials were repeatedly made aware of problems with the development of HealthCare.gov and attempted to take corrective action, but these efforts were largely unsuccessful because they were not fully and diligently executed. For example, after criticism that there was not clear leadership, CMS assigned its newly appointed COO (previously the Deputy COO) in early 2013 to head the Federal Marketplace program, but the assignment was not formally announced, the position was not supported by clear responsibilities, and the designee had an already large responsibility as CMS COO. In addition, the Deputy COO position remained vacant until November 2013, which meant even greater responsibility for the new COO. Reflecting after the launch, CMS officials pointed to this assignment as an example of underestimating the enormity of the task. The COO's assignment also was not formally communicated to other CMS leadership and staff, although staff indicated later that "the group sort of knew."

"Who is tracking?"

Although CMS staff in both its technical and policy divisions were assigned to oversee contracts, documentation indicated little formal corrective action or even communication with contract managers in 2012 and early 2013.

As another example, a CMS advisor recommended that the project hire a technical systems integrator[62] and CMS officials and contractors discussed this need at several points in the project. However, in correspondence and congressional testimony, it was clear CMS technical leadership perceived that CMS itself was already serving in that role.[63] CGI Federal managers reported that the lack of a true systems integrator created extra work that was outside the scope of their contract. For example, CGI Federal reported having to assist CMS with defining the business requirements to mitigate problems with interdependency of various Federal Marketplace computer systems and avoid losing more time for system development and testing. Although the systems integrator need not be a contractor, CMS staff and contractors later identified two barriers to CMS serving in this capacity: they reflected that few at CMS had the necessary experience integrating a project of this size and complexity, and that CMS leadership did not recognize the need to clearly outline responsibilities and delineate this role from other CMS tasks.

CMS failed to effectively manage poor contractor performance with HealthCare.gov, and did not take sufficient action when aware of problems. In February 2013, independent reviewer TurningPoint Global Solutions determined that the FFM had a high number of coding defects. CMS staff later reported that CGI Federal's coding quality did not improve later in development. In an onsite review in August 2013, just over 1 month before the HealthCare.gov launch, CMS staff discovered that CGI Federal developers did not follow some best practices for making late-stage coding changes, resulting in software code conflicts between some systems. First, CMS discovered that CGI Federal was not following a standardized process for documenting development of code, which resulted in very limited information available in the CMS Central Repository. As a reviewer reported, "[CGI Federal]

was making changes on the fly without documenting them up until the launch. They were breaking, from an industry perspective, every golden rule." Second, CMS observed developers modifying the system without assessing the impact to other parts of the system, resulting in coding defects that required weeks to troubleshoot. Third, CMS observed developers using an outdated version of code to continue building the website and deploying incorrect versions of code. Fourth, CMS discovered that development teams were making system modifications that produced inefficiencies that required additional computing resources to process the code.

In one technical example revealed in interviews, CMS discovered after the October 1 launch that in some instances the website software requested to access information from the FFM database over 100 times for a single operation that should require 1 or 2 requests. Compounding this problem was the fact that the requested information from the FFM database used what one CMS staffer called a "bloated data model" that made the information "10 times the ideal size" and larger with each request. Therefore, each of the numerous requests made to the database would have retrieved ever larger records and required more capacity to process. According to CMS documentation of its correspondence with CGI Federal, CMS noted delays and performance problems, but did not issue a Corrective Action Plan when performance did not meet the contractual commitments.[64] Correspondence among CMS staff indicated that some believed CGI Federal "needed to have more skin on the line" to help ensure on-time delivery of functionality, implying that the cost-plus-fixed-fee contract type or lax contract oversight may have weakened project management.

> *"We are in bad shape. Perhaps worse than ever and we are not even touching the hard stuff yet."*
>
> —Email from CMS technical staff

CMS senior leadership failed to fully grasp the poor status of the website build, and to alter its course. Interviews indicated that at this point in time, CMS senior leadership believed that the technical work was still on schedule or close enough that concerted effort would ensure delivery at launch. An official in CCIIO reflected in an interview that "[CMS senior officials] would sit in meetings across from me and not know there is an enormous fire burning behind them." It is not clear why CMS senior leadership failed to grasp the poor status or why those who felt the project was in danger failed to communicate their opinions more forcefully. When CMS requested a live demonstration for leadership of the online health insurance application 1 month before first open enrollment, CGI Federal presented snapshots of the software rather than a demonstration of the functionality. A CMS technical official commented, "You can't test drive a Ferrari just by looking at pictures of a Ferrari going fast." CGI Federal ultimately staged two successful live demonstrations in the weeks before first open enrollment, but the failed demonstration the prior week, which did not show actual functionality, did not indicate to CMS leadership that the Federal Marketplace was in trouble.

"Path Dependency" *is an unfounded reliance on former ways of doing things that prevents adaptation to new conditions.*

CMS leadership, staff, and contractors became fixed or dependent on an organizational "path" to complete the website build, failing to adequately consider new information and alter course as needed. CMS has a long history of administering large programs, such as Medicare and Medicaid, but the organizational structure used to manage those programs was insufficient for developing and implementing the innovative technology solutions required for the website build. Part of the problem was poor communication across divisions and between CMS and contractors in an environment where project status changed quickly. As previously stated, CMS technical staff often received different messages from policymakers and contractors, and were forced to develop ad hoc strategies that were then not well-documented and unlikely to evolve further. CMS staff and contractors reflected that they had failed to coordinate the work, did not adhere to a clear schedule, and failed to track progress and changes.

The HealthCare.gov website build was alarmingly behind schedule, with CMS scrambling for "minimal functionality"

Communication deteriorated further as problems worsened, with a critical early piece of HealthCare.gov failing in July 2013 and more problems arising through the summer. By summer 2013, responsible CMS staff had been warned of problems repeatedly and knew the website build was in trouble. Still, both leadership and responsible staff did not fully grasp the extent of problems and the degree to which the build was behind. Reflecting afterward, those involved reported that communication deteriorated as the situation worsened. Interviews and documentation revealed this was due to a number of factors: the range and number of technical problems made it difficult for nontechnical staff and officials to gauge the enormity and impact of problems, negative reports about progress became so common that they lost their power to alert, and information was not communicated comprehensively to demonstrate the extent of the problems across the build.

> *"The level of complexity was greater than what we originally anticipated."* —CMS official

This lack of recognition changed somewhat in July 2013, when CMS received a tangible sign of problems: an early component of the website build failed immediately. One of CGI Federal's significant deliverables for summer 2013 was the pre-enrollment account creation system, Account Lite. In comparison to the overall website build, the functionality for Account Lite was fairly simple and straightforward. Still, it posed a challenge to deploy, in part because CMS did not request this functionality until May 2013 with an expected launch date of July 1, 2013. CGI Federal delayed delivery of the system past the July date, and then requested the assistance of CMS technical staff.

When CGI Federal finally demonstrated the product, it performed poorly. A top OIS official indicated that a week past the date Account Lite was supposed to launch, OIS found 105 defects with the Account Lite system. The extent of problems with Account Lite raised alarm throughout OIS, CCIIO, and OC, and began a shift in thinking that would lead to reducing planned functionality for HealthCare.gov. As a CCIIO official later noted, "That was our first

inkling into how bad things were. If they couldn't even deliver Account Lite, where were we on the build?"

CMS technical staff began to avoid reporting further bad news about the website build, leading to greater disconnection as problems worsened. Despite knowledge that the project was going poorly, many of the CMS and contracted staff responsible for the Federal Marketplace build were averse to alerting those in leadership positions that there were problems with the build. Correspondence indicated that this was driven in large part by the belief that they would be able to succeed in the end, and thus there was little benefit to causing alarm. It also indicated that CMS technical staff were so busy attempting to complete the build that they were reluctant to take time reporting to executives and answering questions. During this timeframe, HHS IT leadership requested more information from CMS, but did not receive the information requested. The reluctance to convey information included the critical topic of website security, even though security testing ran well behind schedule and identified possible risks. The top CMS security official later testified to Congress that "[CMS leadership] was not properly briefed or properly portrayed, [about] the issues that were happening that week during security testing."[65] During the Account Lite problems, a CMS official's correspondence indicated that those responsible kept "thinking and hoping that the next thing will solve more issues and we'll be okay."

117%
Increase
in CMS technical staff to support the Federal Marketplace project during August 2013, nearly all reassigned from other CMS projects.

Despite the importance of the mission, a small number of CMS staff carried responsibility. Had communication about the project's status been more open at this stage, leadership at CMS and contractors might have been prompted to add additional staff to the website development earlier; they did not add substantially to staffing until less than 2 months before launch. CMS officials reflected later that in summer 2013, there were still relatively few people working on the project given its size and slippage in the schedule, and experienced technical staff and others in CMS were not called to assist. Officials and staff not included in the development of HealthCare.gov included CMS's CTO, responsible for technological innovation and strategy, CMS's CIO, responsible for operating CMS technological systems, and most of the staff of CMS OIS. Additionally, HHS technical officials and staff could seemingly have been called in to assist, including the HHS CTO, the HHS CIO, and others. CMS documentation indicated that CGI Federal did not make requests during this period for more staffing or more time.

By late July 2013, HealthCare.gov technical managers were requesting assistance from others in their divisions; as one stated, "You know it has to be bad if I am requesting help." Two months before the October 1 launch, CMS temporarily assigned 60 additional staff from other projects within OIS (39 staff) and in other parts of CMS (21 staff) to assist the 51 staff already working on the Federal Marketplace, a 117 percent increase (see Figure 1). Some involved in the project reported that it felt too late to involve others, given the steep learning curve, and that they were embarrassed to "add others into a mess." As late as mid-September 2013, there were calls for establishing contingency plans, including pulling in additional staff and even CMS staff taking the project over from contractors.

Figure 1: Increase in CMS staff dedicated to Federal Marketplace, July–August 2013.

Source: OIG analysis of 2013 CMS organizational charts, 2015.

> *We contemplated [as late as August 2013] whether we would scrap the whole thing and start over.*
> *–CMS technical staff*

Last minute attempts to correct and avoid further problems with HealthCare.gov were ad hoc and insufficient

CMS continued to prioritize functions and cut those it could not complete, including the Spanish language website and the "anonymous shopper" function. CMS focused by mid-August on determining the minimum that could be delivered by October 1, holding "reprioritization" meetings to further reduce the scope of the HealthCare.gov build to deliver basic functionality. Part of the reprioritization process involved collaborating with CGI Federal to establish a list of "minimum essential capabilities" and a timeline for FFM development. There was an attempt at this time to recognize problems and renew project unity and mission. The CMS COO, assigned to serve as the single project lead, announced at an August 2013 meeting, "This is a blame-free zone. We are a team. This is the President's number one priority and we will make it happen, but we must be open and honest with each other." The revised scope and functionality of the website was reduced to only what CMS considered necessary: accepting information, determining eligibility, and selecting a plan. There was skepticism among CMS staff regarding whether even that could be completed: "Around the table, people were saying, how are we going to get this done?" There was also discussion about whether the existing pieces were so flawed that CMS should begin developing some pieces anew rather than improve upon the existing structure. Reprioritization resulted in reductions to planned scope and functionality of the website. In August 2013, CMS called on CGI Federal to develop a definitive plan for the final 40 days. The CMS Deputy CIO instructed them, "Don't dwell. Don't debate. Don't be in denial. Come up with a plan, however thin it is because it certainly is better than an unrealistic plan." The reprioritization included delaying the Spanish language website, CuidadoDeSalud.gov, a tool that correspondence indicated was particularly important to White House staff. Meeting notes from this time period revealed that the CMS Administrator was notified of this decision, made by other senior CMS officials, on September 3, 2013.

After consulting with technical staff, the CMS Administrator communicated to HHS and White House officials that CuidadoDeSalud.gov would be working by October 15, 2013. (It was later delayed further and was not working until early December 2013.) The Secretary of HHS and the U.S. CTO expressed concern about losing consumers and asked CMS to provide additional call center support for Spanish speakers, which it did. CMS also announced on September 26, 2013, that it would delay until November 2013 its completion of the Small Business Health

Options Program (SHOP) website, a companion website to HealthCare.gov.[66] SHOP provides health plan selection and enrollment for businesses with 50 or fewer full-time-equivalent workers. (The SHOP website was further delayed until second open enrollment, opening in November 2014 then adding further consumer tools in February 2015.)

62%

of Americans did not know the exchanges were opening October 1, 2013.

–Kaiser Family Foundation

Needing even further reductions in technical scope, CMS also delayed a tool to identify and compare health plan information that CMS had dubbed "anonymous shopper," as well as parts of the Eligibility and Enrollment functionality. The anonymous shopper tool would have allowed consumers to view some targeted health plan information, including premiums estimates, without completing a full application. (The tool was not truly "anonymous" in that consumers would still have to create an account.) Testing of the anonymous shopper tool during August–September 2013 revealed that it did not provide accurate information and would require significant rework.

Since CMS did not consider the tool to be critical for the launch, it delayed the completion until after October 1, 2013. Parts of the Eligibility and Enrollment system that were delayed until later included the automated functionality enabling the FFM to send and receive enrollment information to issuers regarding enrollee status (e.g., payment of premium, plan cancellation, changes in circumstance) and the resolution of complex application inconsistencies (e.g., income, whether applicant is lawfully present in the U.S.), which can occur when Federal data available through the Hub do not exist or do not match an applicant's information. A CMS official reflected later that reducing scope "seemed reasonable and normal before a launch of this size." However, project documents and correspondence indicated the lateness and depth of these reductions was not planned.

Final State Count

For the first open enrollment period, 36 States, including 7 State-partnership marketplaces, used the Federal Marketplace, and 15 States had established State marketplaces.

CMS and contractors recognized they would not finish system functionality testing before the launch, but prioritized delivering the product on time over testing and resolving problems. By August it was clear to both CMS technical staff and contractors that the system would not be fully tested for functionality before October 1, 2013. As one contractor remarked, "You can't test what is not built." Issuers complained about testing delays and problems conducting tests due to incomplete and malfunctioning software and unavailable testing environments (the computing and storage space to run tests). This lack of system capacity to conduct testing affected those who were building website pieces because the agile development process relies on testing of each increment as it is completed to ensure it functions correctly. In addition, according to CMS and contracted staff, CMS was never able to complete full end-to-end testing that identifies problems in how the pieces work together, because the component pieces arrived too late. Regardless of the development process used, complete end-to-end testing is the final, and a critical, step in simulating consumer use of all functions. One technology contractor involved in the build reported, "End-to-end testing is critical. It's suicide not to do it." CMS staff did not appear to consider the lack of functionality testing to be a dire situation. The CMS technical team reported they considered launching the website on time the priority over testing for and resolving performance problems. One CMS technical official characterized the launch itself as a test of the system and indicated that CMS planned to resolve problems after launch, as CMS had done with other large programs, such as Medicare Part D.

CMS prepared to launch HealthCare.gov on October 1, 2013, as planned, optimistic in spite of problems and never seriously considering delay

CMS leadership held no formal discussion of delaying the website launch date, despite poor progress. There were many discussions in the months leading up to the launch that the HealthCare.gov build was behind schedule, including multiple presentations to CMS leadership. Still, documents and interviews indicated that no one among CMS leadership, or seemingly even among CMS staff, seriously discussed delaying the October 1 launch date.[67] This may be in part because some CMS staff and contractors working on the build were under the misimpression that the deadline for website functionality was statutory when, in fact, the ACA required that health plan coverage begin by January 1, 2014.[68] Moreover, some HHS and CMS staff feared that due to the high expectations and the contention surrounding the marketplaces, if HealthCare.gov did not launch as planned it might fuel efforts in Congress to repeal the ACA.

> *"People needed insurance. In the absence of major problems, it was important to move forward."*
> —HHS official

Several key CMS technical staff reported they never discussed the launch date with CMS leadership, neither when the date was set in 2012 nor leading up to the launch. Some staff at CMS complained in correspondence to each other that the timeframe was unrealistic and that leadership was bent on moving forward despite the significant workload and problems. CGI Federal reported that it did not request additional time or formally request that CMS delay the launch because it believed CMS would not delay due to the White House's public commitment to launch on October 1, 2013. Many CMS staff reported later that they were eager to launch HealthCare.gov despite concerns shortly before launch, and were optimistic about its success. Some may have assumed the launch would be delayed at the last minute if functionality did not operate correctly; the Medicare Part D website launch was delayed several times, on its proposed launch date and two other promised dates, ultimately launching three weeks after originally planned.[69]

> *"The launch was alpha version 1 of the [Federal] Marketplace. You would expect version 1 to do exactly what it did . . . launching to 300 million Americans on day one was a crazy idea.* –*HHS official*

Not delaying the launch resulted in a race to complete what was possible before the deadline. By September, concern grew to the degree that officials with little prior involvement in the Federal Marketplace, including managers from other programs at CMS, technical officials from HHS and other Federal agencies, and the U.S. CTO, began asking responsible CMS and contractor staff for more detailed progress reports and offered their assistance. At this point, CGI Federal and CMS technical offices were filled with staff and experts from multiple Government and contractor offices, including support staff from software vendors and CMS technical staff who had no prior knowledge of the Federal Marketplace program and therefore were not optimally prepared to contribute quickly. CMS OC also began notifying stakeholders and consumers through messages on the website and outreach to media to potentially expect some problems. As one OC official noted, "It was never a matter of whether we moved forward, it was only how to message about what the public and others could expect to reduce poor reactions."

CMS moved HealthCare.gov forward to launch with an interim authorization to operate and concerns about incomplete security testing. Federal guidelines require that a senior official or executive assume responsibility for operating an information system at an acceptable level of risk by signing an Authorization to Operate (ATO).[70] ATOs are typically signed by the CMS CIO, last for 1–3 years, and include supporting documentation of security testing.[71] Each part of the Federal Marketplace system (e.g., FFM, Hub, and EIDM) required an ATO before operating. Full, 3-year ATOs for the EIDM and Hub were completed and signed by the CMS CIO (on March 22, 2013, and September 6, 2013, respectively).

"Authorization to Operate" *is a declaration stating publicly that the launching organization (e.g., CMS) has deemed the functionality sufficient and is accepting any associated risk to the organization's operations or to others involved.*

On September 24, 2013, just days before the launch, CMS's chief information security officer raised concerns that the FFM did not reasonably meet CMS's security requirements, citing specific concerns about the lack of security testing. Given this information, and the high profile of HealthCare.gov, the CMS Administrator, CIO, and COO determined that a higher official than the CIO should sign an interim (short-term) ATO that would require completed security testing within 6 months of launch. On September 27, 2013, the CMS Administrator signed the interim ATO, which allowed the FFM to operate for 6 months provided that the security risks were reduced by employing a mitigation plan that included completing additional security testing and installing continuous monitoring. Additional security testing was conducted in December 2013 and a full, 1-year ATO was signed by the CMS CIO on March 12, 2014.

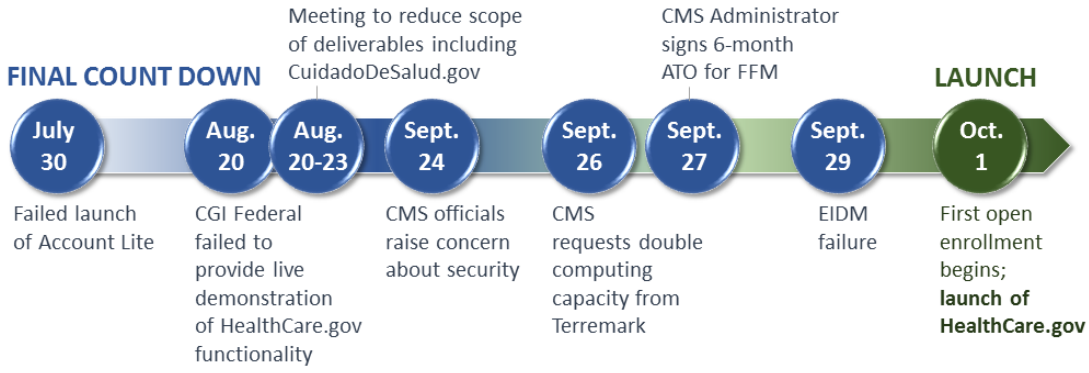
Shortly before launch, CMS determined that the system had much lower capacity than anticipated and requested that the contractor double capacity in 3 days. On September 26, 2013, CMS technical officials visited CGI Federal offices to assess progress on the FFM build and conduct testing. They conducted limited performance testing and determined that the website capacity could support far fewer concurrent (simultaneous) users than planned. The low capacity available was in part because the software code required more infrastructure capacity for execution than CMS anticipated.

72 hours *before launch of HealthCare.gov, CMS requested the contractor to* ***double computing capacity*** *on September 26, 2013.*

According to CMS and contractor staff, the CMS officials drove immediately to the offices of Terremark, the main contractor for HealthCare.gov computing capacity and infrastructure, and informed its project managers that the project would require double the capacity already purchased by CMS for the launch. A Terremark manager reported in interviews that "The request was to double everything 72 hours from launch. We had done an extremely large build for months. We were pulling gear from all over the world, renting planes to get hardware here that was intended for other clients." The request for a 72-hour buildup was made on September 26 (4.5 days from launch) to allow for at least 1 day of testing. Terremark added more than double the capacity during this time, and by September 29, testers indicated that the concurrent user limit was raised substantially. A CMS technical official communicated to the CMS Administrator and U.S. CTO over the course of September 29-30 that capacity was no longer a critical problem.

Technical problems continued in the final days before launch. The EIDM account and identity management system suffered outages on September 29, and contractors reported later that they anticipated continued problems. (See Figure 2 for a timeline of the final countdown to launch, July–October 2013.) Still, the CMS Administrator emailed the Office of the Secretary and the U.S. CTO on September 29 that the website would be ready to launch on October 1. CMS officials later reflected that they were nervous about the launch, but were still excited to move forward and that they did not understand the depth of the technical problems or predict the poor outcome. As one CMS official reflected later, there was a sense that "it is always like this on major projects, with tight deadlines and complex delivery."

Figure 2: Timeline of Final Countdown to Launch, July–October 2013.



Source: OIG analysis of CMS project management documents, 2015.

KEY FACTORS CONTRIBUTING TO BREAKDOWN

› COMPRESSED TIMEFRAME for TECHNICAL BUILD

The final months of development and implementation for HealthCare.gov were chaotic for CMS staff and contractors. The 9 months from January–September 2013 provided, from the outset, very little time to accomplish the tasks remaining. These included tasks critical to success, such as testing website functionality and security, and ensuring adequate capacity for users. Changes in policy and scope continued into early 2013, with the States' deadline to establish their own marketplaces or join the Federal Marketplace moved to December 2012 and many decisions remaining regarding the content of the website. CMS made changes to business requirements and technical specifications well into 2013, delaying development to a point where it was not feasible to complete and test the website as initially planned.

› RESISTANCE to BAD NEWS

CMS leadership and staff were warned of trouble prior to the launch of HealthCare.gov, both formally with reports from outside entities hired to assess the project and informally, through meetings and emails. Despite this awareness, those knowledgeable at CMS did not ensure that the bad news prompted appropriate change. CMS leadership and staff took little action to respond to warnings, remaining overly optimistic about the launch, and developing few contingency plans. As the project degraded further and problems became more well-known, CMS officials and staff appear to have become desensitized to bad news about progress. The problems were layered and complex, and information became unwieldy and difficult to prioritize. Also, the CMS officials were used to problems implementing large projects, particularly with technology, causing them to fail to recognize the extent of problems with HealthCare.gov.

› PATH DEPENDENCY

In early 2013, problems with the HealthCare.gov build deepened and CMS did little to improve management. Through most of the year, CMS continued with the same plans for a full launch and even added an early implementation of the Account Lite creation function. Given the technology and complex systems involved, changing the project's path would have required a leader or team to conduct a comprehensive assessment of status, and to either possess the authority to alter tasks and processes or to fully communicate that assessment to leaders with that authority. Absent this, CMS staff and contractors continued with the initial strategy and goals, falling further behind schedule, with largely the same leadership, staff, and plan.

› CORRECTIONS WEAK and LATE

By the time CMS took action to change the project's path in August and September of 2013, it was too late to adequately affect change given the substantial need for progress and improved execution. For example, the CMS Administrator placed the CMS COO as head of the project without establishing a clear agenda or communicating the decision to the full team. CMS cut functionality that was at one time considered critical to a successful launch, such as the Spanish language and SHOP websites, to divert resources to the main build. This occurred in the last few weeks before launch, when developers and testers reported they were months behind. The rush to launch affected all aspects of the build, including moving forward with only an interim authorization to operate and requesting double computing capacity late in September. Leaders sought to deliver "minimal functionality" but without a comprehensive and thoughtful strategy. The corrections were too weak and late to avert the poor outcome.

"CMS didn't need a technological surge, we needed an organizational surge."
–CMS Official

CHAPTER 3

LAUNCH, CORRECTION, & FIRST OPEN ENROLLMENT

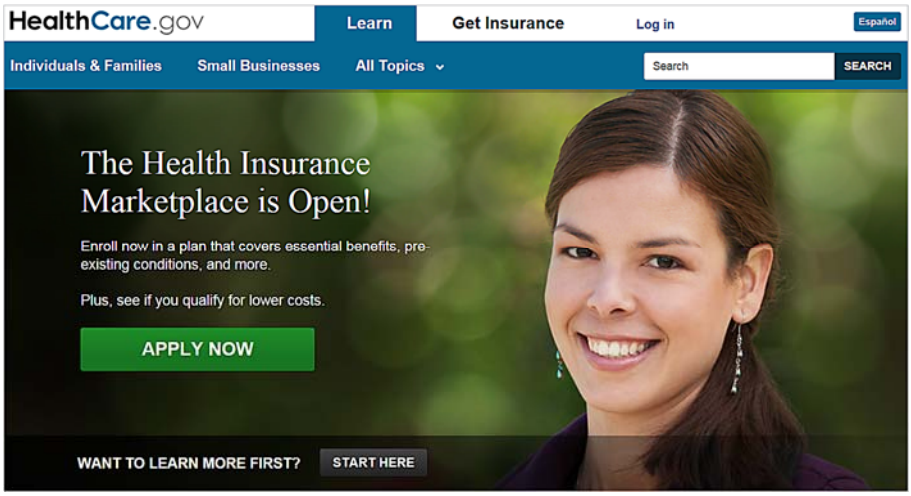
October 2013–March 2014

The HealthCare.gov launch quickly revealed multiple problems with the website, and initial efforts to fix the problems were hampered by lack of coordination

Problems with HealthCare.gov were apparent immediately after launch. On October 1, 2013, HealthCare.gov experienced 250,000 concurrent users, much greater than the planned capacity. Website outages began within 2 hours of launch, preventing many consumers from logging in and signing up for health insurance. In reporting to the public, the U.S. CTO attributed the problems to high volume, which was five times the number of simultaneous users anticipated.[72] It was soon clear to CMS and contracted operators that the HealthCare.gov issues were not caused solely by a higher number of visitors to the website but also by core problems in website performance. In the end, only six consumers were able to submit an application and select a plan on the first day of the first open enrollment. The problems at launch created a firestorm of negative stakeholder response and media attention chronicling the website problems. Within days of the HealthCare.gov launch, CMS leadership dispatched additional CMS and contractor staff to be onsite at the CGI Federal command center in Herndon, VA to correct software defects and improve system performance. Those onsite were largely staff from CMS and CGI Federal, joined gradually by additional staff from a number of contractors involved with the build.

"We were sitting in the office at midnight when it started running and it wasn't looking good. Everything was turning red on our screens." —EIDM contracted staff

Homepage of HealthCare.gov at launch, October 1, 2013.



CMS and contractors identified the most immediate performance problem as the EIDM, the website entry system used for establishing accounts and verifying consumer identity, a problem caused in part by CMS not adequately communicating with contractors about overall system functionality. The lack of capacity on the part of the EIDM created a bottleneck to consumers reaching website functions and information. As one CMS official explained, "It was like having a small, one-lane onramp to a major highway." The EIDM bottleneck also caused problems for developers; since the EIDM served as an entry point to the website, coders assigned to fix errors could not easily access the website themselves to see and correct other problems. As one CMS technical official reported, "The FFM was actually the bigger problem, but we could not see the magnitude of the coding problems in the FFM and begin fixing until we got through the EIDM problem." CMS directed QSSI to fix the EIDM and at the same time directed CGI Federal to construct a new portal for website entry and account creation, to be used if QSSI was not able to fix the EIDM. The work on a new portal expended CGI Federal coding time that could have been devoted to other website fixes, but an HHS technical advisor reflected later that the redundancy was a reasonable strategy given the importance of the website entry function and uncertainty about the viability of the EIDM.

Software, Design Defects Cripple Health-Care Website
–The Wall Street Journal 10/6/2013

QSSI, the contractor responsible for developing the EIDM, reported later that they did not know that all visitors to the website would have to enter through the EIDM system and, therefore, underestimated the capacity needed. QSSI officials reported in interviews that they believed the anonymous shopper tool would enable individuals to view health plan information without creating an account, and that CMS's decision to postpone implementation of the tool contributed to the EIDM experiencing heavier than expected traffic. CMS officials later confirmed that the (poorly named) anonymous shopper tool would not have been truly "anonymous" and would have required individuals to create an account through the EIDM even if they only wanted to view plans. (Later in October, CMS launched a limited, temporary shopping tool to allow consumers to view health plan information without establishing an account.)

Initial efforts to fix the website were hampered by lack of information and coordination among CMS and contracted operators. Also hampering diagnosis and correction of the website was a lack of coordination among CMS and contractors in monitoring website performance. CMS technical staff later reported that ensuring comprehensive and coordinated monitoring was not a priority before the launch because resources were focused on completing the build of the website. CMS, CGI Federal, QSSI and other contractors continued adding staffing resources prior to and following the launch, but there was no clear entity or system to coordinate and monitor their efforts. A CMS technical official reported that prior to the launch, contractors were responsible for monitoring their own systems and unable to see other systems, which was a problem because the systems worked together. As a result, there were teams from CMS and contractors in different locations functioning as separate "command centers," including the CGI Federal command center in Herndon and a QSSI command center in Columbia, MD. These centers had a variety of tools for monitoring outages, response time, and errors in loading and processing information, but there was not a single, systems-wide leader or team with an overview of the project and ability to take action. While the CGI Federal command center was still considered the primary location for operating HealthCare.gov, it did not house all CMS and contracted staff relevant to the website's operations. It did not include development teams or contractors responsible for the Hub, EIDM, and data centers, and it did not have an entity serving formally as systems integrator to coordinate these functions.

Federal Government-wide shutdown further complicated CMS's management of the launch. The morning of the launch, the Federal Government was shut down due to lack of funding.[73] The Government shutdown was not certain until late the prior evening. Thus, CMS officials had to manage both the launch and implementing the shutdown, such as distributing notices to staff and managing orderly shutdown processes. The shutdown lasted for 16 days and affected critical Federal Marketplace staff, complicating implementation. CMS officials reported that staff in key offices responsible for Federal Marketplace functions, including CCIIO, OIS, and OC, was reduced to approximately one-third its pre-shutdown levels and in some subgroups, closer to one-tenth of pre-shutdown levels. Contractors continued to work on HealthCare.gov during the shutdown, but they reported that they were hampered by CMS staff not able to work and by the general disruption of processes and communication brought on by the shutdown.

After initial difficulties, CMS and contractors worked with outside experts to repair HealthCare.gov, instilling changes in the project culture and work processes

CMS reconfigured HealthCare.gov operations to improve the website, establishing clearer leadership and consolidating technical operations. On October 22, three weeks after the launch, HHS announced new leadership for the HealthCare.gov fix, appointing a well-known Federal manager to oversee efforts to improve the website and facilitate enrollment.[74] At the same

> *"This was the hardest thing I have ever done and I hope nothing ever comes close to it again."*
>
> —Member of ad hoc technology team

time, the U.S. CTO recruited an ad hoc technology team comprised of several leaders and engineers from top technology firms who were not involved with the Federal Marketplace development.[75] HHS and CMS officials made improving the website a top priority. The Administration assigned an official with business operations experience as the project lead, responsible for managing daily operations and reporting back to White House staff. CMS also filled the Deputy COO position, which had remained vacant leading up to October 1, to provide assistance to the COO. Some from the ad hoc technology team also took lead roles, identifying problems and organizing daily tasks. In combination with the HHS and CMS leadership already involved, this made for a multi-layered group of managers and advisors that could have resulted in difficulties determining which leader would make key decisions. Yet all interview respondents involved in this period reported that it was a productive and efficient environment, with few if any problems of delegation or workflow.

According to CMS staff and contractors, the productive environment was due to several factors: the willingness of CMS and CGI Federal staff to open their work processes to input and work side-by-side with the new ad hoc technology team; the tight structure and discipline brought by the new leadership and engineers, several with extensive expertise working with successful private sector companies; and the shared sense of mission and urgency involved to make the website work for consumers. As observed by a leader of the ad hoc technology team, "Some of the very best engineers and troubleshooters in the world willingly put their lives on hold to dedicate their time to this very difficult problem. . . . They found Government officials and contractors, who also wanted nothing more than to fix the site and who were ready and willing to work together."[76] Similarly, CGI Federal managers reported that their staff felt strongly about fixing the website and "finishing the job we started." Still, the task at hand was difficult and those onsite experienced many successes and failures in improving the software and systems.

By late October, CMS and contractors began to move command center operations residing at the CGI Federal facility in Herndon and other locations to QSSI's Columbia location, establishing what would ultimately become the formal HealthCare.gov command center—the Exchange Operations Center (XOC). The structure at the XOC was based on active coordination between technical and policy staff, a key component missing during the website preparation and development. The structure ensured that technical solutions aligned with the functionality consumers needed to apply for and select plans. A member of the ad hoc technology team explained, "We had policy folks figuring out the error messages. What did the code do or not do? What was supposed to happen?" Lack of tools for website monitoring was still a problem for those repairing the website, particularly as it concerned consumer use. A member of the ad hoc technology team noted that in the absence of comprehensive monitoring tools, "There was no place to look to find out whether the site was up today or not except CNN, which was literally how we found out about problems a good part of the time in the beginning."[77]

> *"There was no place to look to find out whether the site was up today or not except CNN."*
>
> —Member of ad hoc technology team

Contractors and the ad hoc team of technical experts recommended that CMS obtain monitoring tools for a variety of functions, including website traffic, capacity use, speed of file transfers to States, and website security. During the period of October 1–December 1, 2013, and shortly after, CMS purchased new monitoring tools that provided at-a-glance statistics (dashboard) of website performance.

"Badgeless Culture" *is a term used by CMS to signify all CMS and contracted staff operating as a team regardless of their employer status or job title.*

The technical staff were divided by function, with one group focused on capacity and speed, and another on defects in the software code. Assignments were made by skill and availability, irrespective of whether the person was employed by CMS or any of the contractors. This effort was the beginning of a "badgeless, titleless" culture at the XOC, meaning an environment in which all staff were to operate as a team regardless of their job title or whether they were a CMS employee or a contractor. Nontechnical CMS staff and contractors were also present at the XOC, or actively communicating with technical staff located at the center. For example, the call centers were linked to the XOC to provide information about problems their staff heard about from consumers.

CMS made key decisions to build on current systems rather than create new ones, to develop contingency plans, and to hire a technical systems integrator. CMS leadership, in consultation with the ad hoc technology team, made a key early decision to refactor (correct and streamline the code for) the existing software code rather than rebuild from scratch. Those involved reported that the decision was based on the tremendous time investment required to start over and the willingness of CMS and contractor staff to work together with the ad hoc technology team to identify and solve problems.[78]

At the same time these repairs were underway, CMS began to develop redundancies for core operations in the event of future problems. CMS's contingency plan up to this point was to ask consumers to fill out paper applications through call-center assistance if the website went down. The new contingency planning focused on establishing redundant systems to keep the website up if the primary systems failed. CMS hired separate groups of developers to begin creating new systems to replace three key components of HealthCare.gov. These were an account creation system, the Scalable Log-In System (SLS) that, unlike the CMS-wide EIDM (the EIDM was developed to support multiple CMS programs), was created exclusively for HealthCare.gov; a streamlined application, Application 2.0 (App 2.0); and Plan Compare 2.0, a new shopping tool that provided more robust information about health plans and premiums, and did not require consumers to create an account. Lastly, CMS hired three companies to run data centers to provide system capacity, placing various data functions at different centers so that, as a CMS official stated, CMS would "not put all our eggs in one basket" and have a greater range of data resources to call upon.

A key decision by CMS during this time was to hire QSSI as technical systems integrator to serve as an advisor in coordinating technical tasks and resources. By all accounts, this action led to greater coordination between and among contractors and CMS technical staff, and enabled project leaders to more quickly and clearly identify and correct problems and allot resources. The job of the systems integrator is to coordinate operations, ensuring that those responsible for various aspects of the project communicate their activities, schedules, and

needs to each other. Some in CMS and outside the agency had raised the idea of contracting a systems integrator at various times since 2011, but the concept was not widely discussed. According to CMS officials, for past projects such as the Medicare Part D implementation, CMS coordinated contract activities themselves, but the agency had not implemented a project with the scope and complexity of the Federal Marketplace. A CMS official reported that, in hindsight, CMS had a difficult time performing the systems integrator role and that it plans to keep a HealthCare.gov systems integrator for the foreseeable future.

> *"We put eyes on everything. We deployed tools that enabled us to see ahead of time if the server would get overloaded. We threw everything up on a monitor to see what was going on."*
>
> —QSSI, technical systems integrator

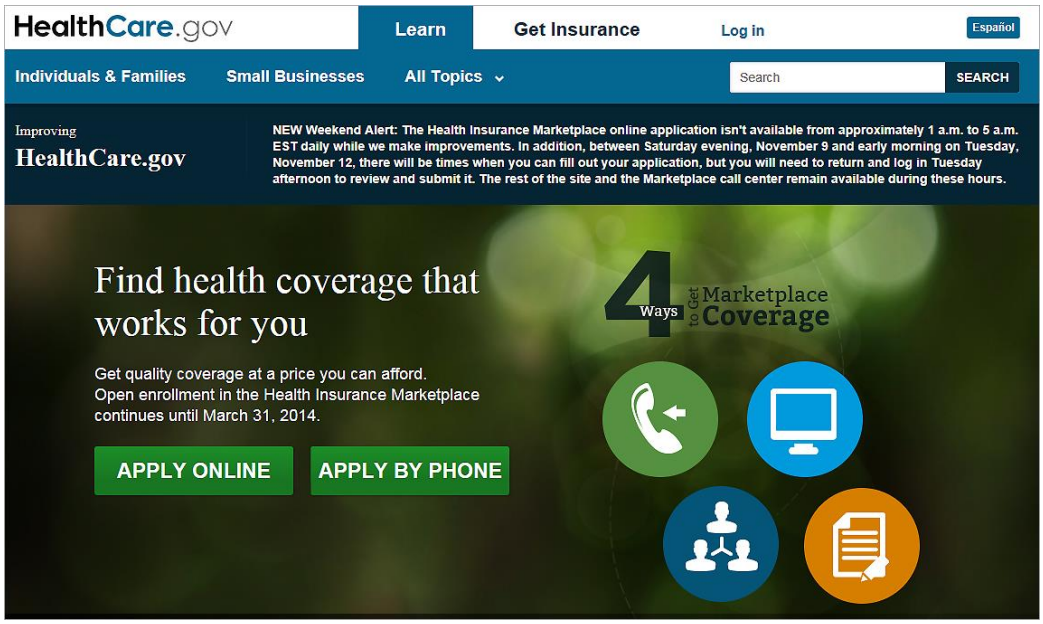
HHS officials provided information to Congress and the public. At the same time as CMS staff and contractors were fixing the website, the HHS Secretary and White House staff were managing much of the public fallout following the launch. The website problems were front-page news and generated substantial debate among all manner of stakeholders, including Congress.[79] This culminated in 10 congressional hearings before the end of November, with testimony from the HHS Secretary, CMS staff, IRS, and contractors.[80]

> *"Nobody could have felt worse than the people at CMS did. It was their responsibility to stand it up. They want to never have this happen again.* –*HHS Official*

During this time, the CMS OC was responsible for providing updates to the White House, HHS, and the public, holding daily briefings to indicate project status. OC also managed the call centers, adding thousands of call center operators after the first week of operations and transmitting information to technical staff about problems reported by website users to the call-center staff. The website difficulty also affected the call centers and staff in external organizations that helped consumers enroll, such as navigators. In interviews and external studies, navigators reported that technical difficulties with the website and long wait times at the call centers increased the amount of time needed with each applicant. One external study found that approximately 25 percent of assisters (such as navigators) spent more than 2 hours, on average, with each applicant.[81] Developers also made improvements that instructed consumers when the online application was unavailable and provided the call center number as an alternative for consumers to apply for coverage.

HHS announced an improvement benchmark, that the website would "relaunch" and work smoothly for the vast majority of users by the end of November, a date many believed was necessary, given that the ACA required coverage by January 1, 2014.[82] Public reports indicated that the new target date was made on the basis of assurances that the ad hoc technology team made to the White House.[83]

HealthCare.gov consumer message, November 10, 2013.



Those responsible for repairing the website reported that although daily operations of fixing and operating the website were going fairly smoothly, lack of communication among some HHS and CMS senior leadership was still a problem. For example, CMS leaders at the XOC reported that they were not involved in discussions about whether the end of November was reasonable from a technological perspective, and that HHS informed them only after the decision was made. The deadline created further pressure to improve, with one HHS official later reflecting in an interview that "the December 1 assurance for improvement seemed ambitious." Sporadic outages of Terremark's equipment challenged these efforts, including two outages in late October 2013 that led to website downtimes of 24 and 36 hours.

HealthCare.gov downtime message, October 30, 2013.

The system is down at the moment.

We are experiencing technical difficulties and hope to have them resolved soon. Please try again later.

In a hurry? You might be able to apply faster at our Marketplace call center.

Call 1-800-318-2596 to talk with one of our trained representatives about applying over the phone.

Inadequate website capacity continued to be a challenge, limiting computing and storage infrastructure for developers to make changes. By mid-November, Terremark had increased capacity to a point at which these challenges were lessened and progress accelerated.[84] The work to improve website performance continued at a strenuous pace, with some CMS staff and contractors reporting they slept in nearby hotels and worked 24-hour shifts. In the meantime, HealthCare.gov went down several times, and press reports and public dialogue were highly critical of the website. As one CMS official stated, "those were dark days." CMS also continued to reduce the scope of the HealthCare.gov build, for example announcing on November 27, 2013, that the SHOP website promised for that month would be delayed until the second open enrollment period a year later.[85]

CMS and the expanded technical team improved HealthCare.gov by December 1, 2013 and continued improvements through early 2014

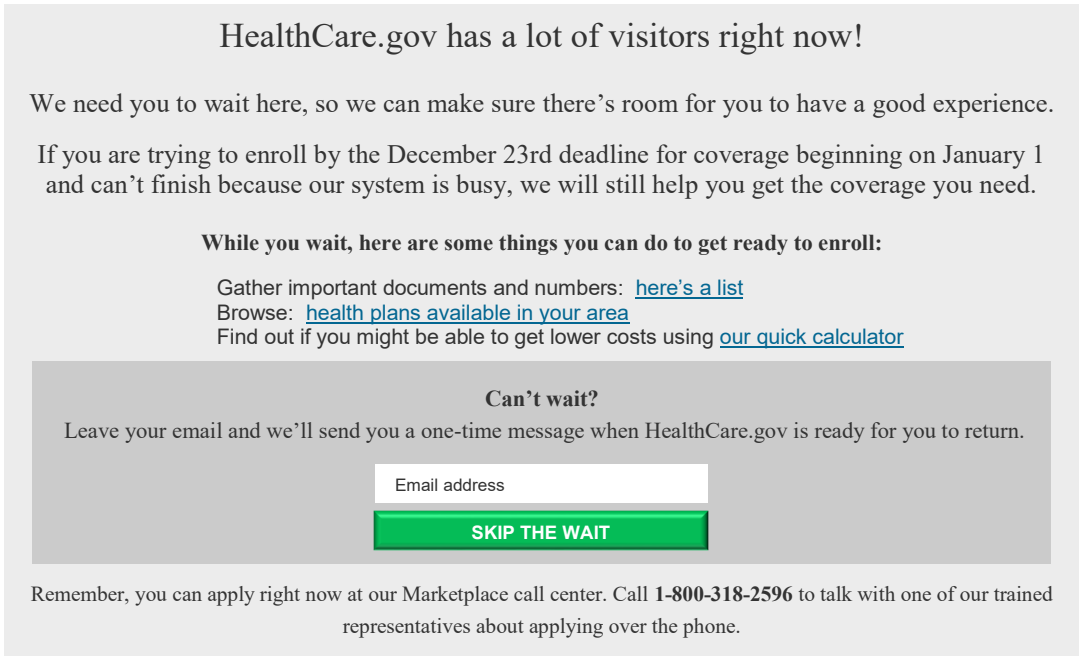
Even with HealthCare.gov substantially improved, CMS faced large challenges to further improve operations. CMS improved website performance by December 1, 2013, as promised by HHS. Also in December, CMS enhanced its shopping tool that allowed consumers to shop for health plans without creating an account. CMS staff and contractors continued website corrections through the end of first open enrollment (March 31, 2014). The proportion of time that the website was functioning went from 42 percent in early November to over 90 percent at the end of November (see Figure 3).[86]

Figure 3: Percent of time HealthCare.gov functioned during November 2013.

Source: CMS, HealthCare.gov Progress and Performance Report, December 1, 2013.

The website could now handle more than 35,000 concurrent users without crashing, and technical glitches were less frequent.[87] The XOC had project-wide monitoring systems and website performance dashboards. When capacity was overloaded, CMS could place consumers in "waiting rooms" that inhibited navigating further to complete tasks until website traffic was reduced. When placed in a waiting room, consumers were given an option to receive email notification to return to the website when capacity was available or to contact the call center to apply.

HealthCare.gov waiting room message, December 23, 2013.



As the technical staff fixed defects and improved performance, staff at CCIIO and OC were focused on retaining and assisting consumers by resolving problems with individual cases identified by call centers, navigators, and issuers. CMS also extended the period for signing up for health insurance coverage that would be effective beginning January 1, 2014, by 9 days (shifting from December 15, 2013, to December 24, 2013) so that those who encountered difficulty enrolling could have more time.[88] On the final day, HealthCare.gov experienced 49,156 concurrent users, and approximately 1.2 million consumers selected a plan through HealthCare.gov by December 28, 2013.[89]

As the end of the first open enrollment period neared, other issues emerged. As of February 2014, CMS reported that the Federal Marketplace was unable to resolve about 2.6 million of 2.9 million application inconsistencies, which occur when a marketplace cannot verify an applicant's information (e.g., Social Security number, citizenship, income, family size) through available data sources, such as IRS or SSA.[90] CMS reported that as of February 2014, the Federal Marketplace computer systems lacked the capability to resolve inconsistencies and that CMS would retain any documents submitted to resolve inconsistencies until CMS's eligibility system had that capability.[91,92,93] In addition, subsequent OIG work determined that not all of the Federal Marketplace's internal controls were effective in ensuring that consumers were properly determined eligible for health plans and insurance affordability programs.[94] For example, OIG found that the Federal Marketplace did not always validate an applicant's Social Security number when the applicant provided the number at the end of, rather than the beginning of, the application process.[95]

After January 1, 2014, and through the remainder of the first open enrollment period, CMS and contractors continued to work on system improvements, preparing for the expected surge of HealthCare.gov users enrolling before the March 31, 2014, deadline. After meeting the improvement benchmark on December 1, 2013, CMS finalized the designation of the XOC in Columbia as the command center for CMS staff and contractors supporting HealthCare.gov. CMS developed a new and more standardized routine for monitoring the website and managing contracted work, with the XOC serving as the focal point for monitoring and coordinating systems during the remainder of the first open enrollment period. The XOC was staffed by CMS technical staff and contractors involved with multiple aspects of the system (e.g., FFM development, EIDM operations, website capacity, security), and operated 24 hours a day during open enrollment. The XOC also employed new monitoring tools, including an application monitoring tool that updates information about website functionality every 5 seconds. These tools allowed the staff to identify problems more quickly and acquire baseline data to track further performance improvements.

CMS and contractors reflected later that this period represented a shift away from "putting out fires" and toward establishing standard operating procedures that would give the work more form and structure. As during policy development in 2012–2013, CMS temporarily reassigned staff from other divisions to the Federal Marketplace to supplement technical and contractor staff. Some technical problems continued throughout the first open enrollment period, with another outage of EIDM in March 2014 placing incoming users in waiting rooms for up to 45 minutes. To better address challenges as they arose, CMS reorganized its management structure to create formal chains of communication for task areas such as eligibility and data centers to help address these concerns. CMS and contractors set up integrated teams, called "towers," centered on a single project area, such as eligibility.

CMS also more tightly coordinated changes with contractors, in particular aligning contract obligations to meet changing needs, what HHS refers to as "change control." The essence of change control is that the contractor and agency both agree to changes in the contractor's scope of work and document how those changes play out in cost and deliverables. The Change Control Board began meeting daily (compared to initial development, when meetings were infrequent and often cancelled) to review system changes, and coordinated with contractors to prioritize fixes that would have the highest positive impact. As a CMS technical official stated of the prelaunch time period, "In the beginning, we were too busy making sure there was even a product to launch to properly track changes. . . . [After the launch,] the problems came from so many directions . . . we worked with the Change Control Board to make a list of the most important things to fix."

CMS hired a new FFM software contractor, restructuring the FFM contract to better account for high-quality delivery. At the same time CMS hired QSSI as the HealthCare.gov systems integrator, CMS officials decided to consider other contractors to replace CGI Federal. CMS expedited the contracting process by issuing a "letter contract" that was awarded without a full and open competition. Ultimately, the letter contract was finalized into a sole source contract that describes justifications for other than full and open competition. The new FFM contractor, Accenture, had experience with several State marketplaces and had previously built the IRS connection to the Hub. The company presented a proposal to CMS in December 2013 that focused on increasing the technical discipline, clarity of leadership, and decisionmaking authority of leaders. They began work in January 2014 by "shadowing" CGI Federal staff. CGI Federal officials reported that they learned of the switch from reading the *Washington Post* just days before Accenture's arrival.

> *"We were equal partners. . . . We knew that we were all successful or no one was successful."* —Accenture staff

The transition operated in three phases: first, CGI Federal continued in the lead role through February with Accenture in support; second, Accenture acted as the lead with CGI Federal in support for March; and third, after the close of first open enrollment, Accenture fully performed tasks and consulted with CGI Federal as technical experts as needed. Managers from both contractors reported the transition went smoothly, with CGI Federal dedicated to assisting and Accenture to learning and improving the project. Staff from both companies and CMS reported pressure from the public conversation. As one contractor noted, "This was the most visible project in the world." Part of Accenture's task was to refactor the software and institute a way of overseeing and running the project to facilitate rapid decisionmaking.

The Federal Marketplace project and development of HealthCare.gov came at a substantial cost financially and organizationally to CMS

CMS met key enrollment goals for first open enrollment, but incurred higher than expected costs in contracts and fees paid for correcting defects. CMS ended the first open enrollment period with 5.4 million individuals having selected a plan through the Federal Marketplace, a technologically workable system (albeit with limited functionality), a clearer policy framework, and a stronger management structure.[96] However, the attention to the Federal Marketplace effort (including reconstruction of the website systems and other compensatory actions resulting from the launch) had costs for CMS, its programs, and staff.

CMS contract costs for the Federal Marketplace project were ultimately much higher than initially estimated by CMS, but the total contract amount would have been expected to rise from the initial allotment. CMS originally estimated the contract value for six key Federal Marketplace contracts to be $464 million.[97] As of early 2014, CMS had updated the estimated value of these contracts to $824 million.[98] The value more than tripled for the FFM contract awarded to CGI Federal, from $58 million to $207 million.[99] In addition, the value for the Hub

contract more than doubled, from $69 million to $180 million. The remaining four contract values increased between 1 and 54 percent.[100]

> *"We are defined by the person who couldn't enroll, not the 99 percent who could enroll."*
>
> —CMS official

The initial estimated value of a contract may increase after award for a number of reasons, including tasks added to the contract or increases in the cost of scheduled work. CMS reported that contract requirements changed during the implementation of the Federal Marketplace and that not all of these requirements were known at the time of award. That said, some of the increased costs were fees that CMS paid to contractors for correcting defects. Also, CMS's decision to select a cost-plus-fixed-fee contract with CGI Federal for the FFM contract under which CMS assumed the risk for cost increases meant that it was obligated to pay all allowable costs associated with correcting defects. Previous OIG work determined that from October 2013–February 2014, CMS paid CGI Federal for charges associated with hours worked to correct defects for work associated with the FFM contract.[101]

The website breakdown and recovery effort also affected CMS staff, many of whom worked under high pressure for long periods or were redirected from other CMS programs. CMS staff in CCIIO and OIS in particular had been working long hours since receiving the Federal Marketplace program from HHS in 2011, working under tight deadlines on difficult aspects of policy development and the technical build. Now in 2014, both CMS staff and contractors reported difficulty maintaining focus and energy. Compounding this were increased staff turnover and vacancies, causing a greater workload for those that remained and also a loss of organizational knowledge and relationships. For example, as previously stated, one Director's position in CCIIO was filled by seven different people during our review period.

Focus on HealthCare.gov also required CMS to redirect staff from other CMS programs. CMS assigned staff from other divisions to help build and repair the Federal Marketplace. CMS officials said this resulted in a fairly modest cost to other programs, with one senior official observing: "We have enough capacity to absorb extra work for a while. We were not cut to the bone in an organization as big as ours." In assessing this impact, it is important to note that the effect of diverted staff may have been somewhat amplified by more general reductions in CMS staff. According to agency documentation, the number of staff in all CMS offices decreased by about 20 percent between 2011 and 2014, due in large part to a CMS-wide hiring freeze (and normal attrition, such as retirements). Whether due to diverted staff or overall staff reductions, CMS officials noted that fewer staff required that management strategically prioritize what had to be done by postponing some items.

A sense of CMS staff fatigue is unlikely to be abated in the near future with an aggressive schedule for the Federal Marketplace planned through 2016. CMS staff and contractors reported great difficulty completing FFM-related tasks under current time and resource constraints and expressed concern that the prolonged high intensity work could hamper successful operations in the short- and long-term. CMS leadership indicated an awareness of

these problems and have encouraged staff to take earned leave, communicate more openly, and set realistic deadlines that recognize limitations. Leaders have also taken steps to improve morale by recognizing staff who performed well in challenging positions and by establishing and maintaining clearer program objectives and guidance. Still, some key staff have left CMS or transferred out of the Federal Marketplace program to avoid the strain, and others reported they may do so after they feel the program is more fully established.

> *"The imperative for CMS staff was not the publicity and the embarrassment, it was the mission. CMS is accustomed to taking hits. We wanted to fulfill the mission.*
> *–CMS official*

Many CMS officials and staff reported in interviews that they stayed at CMS despite the large workload, pressure, and reassignments because they were committed to seeing a successful Federal Marketplace project. HHS and CMS staff reported that one of the most painful aspects of the post-launch fallout during the first open enrollment period was that they believed much of ACA implementation had gone smoothly, as had, in their view, nontechnological aspects of the Federal Marketplace, such as issuer participation and establishment of benchmarks for essential health benefits. While press reports and outside stakeholders appeared overwhelmingly to perceive the launch as an unacceptable failure, a number of CMS technical staff in interviews defended not only the correction period and ongoing work on the website, but also the efforts leading up to the 2013 launch. They alluded to the project's difficulty, arguing that the complex technology, fixed deadline, and multiple systems and stakeholders would have made execution difficult for any entity responsible. Several CMS officials and staff members who were brought into the Federal Marketplace program after the launch suggested that the difficulty of the project itself was as much a cause of the initial website failure as poor communication and project management, believing that people by-and-large did their best under tough circumstances. Current CMS officials acknowledged CMS made major missteps, but they focused on learning from the experience rather than casting blame on individuals responsible.

KEY FACTORS CONTRIBUTING TO RECOVERY

› QUICK PIVOT to NEW STRATEGY

CMS and contractors quickly brought in new staff and expertise following the launch, developing an all-hands environment wherein fixing problems with HealthCare.gov was the key agency mission. Most of the additional staffing came to the project within 3 weeks, including technological and project management experts from CMS, contractors, and the private sector. Working collaboratively under new leadership, the team simplified processes and consolidated operations. These changes allowed CMS to make quick progress in identifying the source of problems and developing a strategy forward. The team demonstrated a strong sense of urgency to take action, and quickly accepted new work processes. The widespread attention to the launch and the number of parties involved could have created bureaucratic paralysis, but those working on the repairs directed their attention to immediate action and improved the HealthCare.gov website substantially in 2 months.

› ADOPTION of a BADGELESS CULTURE

The enhanced team of CMS staff, contractors, and technological experts correcting problems with HealthCare.gov included people at all levels of CMS and contracted entities, and with varied experience on the project. Before the launch, artificial distinctions and divisions among staff contributed to poor collaboration, lack of communication, disjointed management, and slow progress. Following the launch, first with the technological team and then more broadly, CMS promoted a horizontal culture that was "badgeless" and "titleless," meaning all of those on the Federal Marketplace project were encouraged to collaborate as a single team, regardless of employer or job title. CMS leadership promoted a culture wherein all team members could speak out about problems and develop creative solutions. In interviews, CMS leaders and staff later reflected that this change in culture fostered a greater sense of mission and teamwork that further improved daily operations.

› INTEGRATION of ALL FUNCTIONS

The Federal Marketplace needed expertise and personnel across CMS, including policy, technical, contracting and communications staff, as well as many contractors. Prior to the launch, some functions had no formal connection, despite their interdependency. Key to the correction, CMS integrated the various functions both operationally and technically, improving daily work and promoting the larger project mission. CMS assigned clear project and technical leadership, and restructured its divisions to allow for greater visibility and oversight of technical staff and contractors by senior leadership. This integration allowed CMS to identify and address problems more quickly, make informed decisions, and provide clearer direction to those involved in the website development and operations.

› PLANNING for PROBLEMS

CMS began to plan for and mitigate potential problems by considering contingencies, building redundant systems, and increasing capacity. CMS's lack of contingency plans before the launch meant that CMS had few options when the functionality and computing capacity of HealthCare.gov encountered problems. Given limited resources, CMS leadership had to analyze past problems with HealthCare.gov and carefully consider how and to what extent it would develop new systems and strategies, such as enhancing training for call center staff. Key to success was identifying all possible problems and developing systems and strategies specific to the concern.

"We don't only have a better product. We are a better organization."
–CMS Official

CHAPTER 4

TURNAROUND & SECOND OPEN ENROLLMENT

April 2014–March 2015

In April 2014, CMS turned to preparing for the next open enrollment and added functionality, sharply prioritizing to limit scope and focus resources

"Ruthless Prioritization" *is a CMS term for determining the most critical elements of a project to be completed given the available time and budget.*

CMS worked to limit the scope of work required for second open enrollment. By the end of the first open enrollment period, CMS had a stable website that functioned well at high capacity, but planned components had yet to be completed. CMS needed to make significant upgrades to the account creation, application, and plan selection subcomponents, and to complete the financial management system that would track effectuated (paid) enrollments and manage payments to issuers for Federal financial assistance and premium stabilization. The day after first open enrollment closed, April 1, 2014, CMS began substantive planning for the second open enrollment period of HealthCare.gov to occur 7 months later on November 15, 2014. Federal Marketplace managers from OIS, CCIIO, OC, and the Office of the [CMS] Administrator met in a 3-day session for what they termed "ruthless prioritization" to consider which elements were most important to include for the second open enrollment period and what funds were available. CMS leadership requested that managers provide a list of technological needs, then technical and business management staff evaluated the personnel, time, and other resources needed to complete each task. According to officials, the group debated and then cut about half of the items requested.

50%
Estimated Cut *from list of additional functionality for second open enrollment in April 2014.*

These cuts included key elements of the Federal Marketplace system, including completion of the automated financial management sytem and tools for existing plan holders to reenroll. CMS initially planned for the automated financial management system to be completed for the first open enrollment period, then delayed the project to focus resources on items considered essential for the website's 2013 launch. In the interim, CMS established a manual process to track effectuated enrollments and manage payments to issuers, which an OIG audit later found did not have effective internal controls in place to detect possible payment errors.[102] In addition to cutting automated financial management, CMS cut components of the automated reenrollment functionality that would have redetermined the eligibility of existing enrollees who did not make an active plan selection on or before December 15, 2014.

CMS had not yet developed this component because the first open enrollment had only new customers and did not require reenrollment. CMS also scoped out planned website tools intended to help consumers make health plan purchasing decisions.

This process for strategic and organized prioritization marked a significant improvement over the reprioritization meetings that occurred prior to the launch. The 2013 prelaunch reprioritization was performed late (August 2013, less than 2 months prior to launch), resulting in rushed and poorly informed decisions, and did not cut enough functionality to alter the negative outcome. For 2014, CMS officials and contractors allowed for more time, fully engaged officials from across the organization, and conducted a close examination of resource costs and program implications.

"Pens Down" *is the term CMS used for signifying the final date for technical staff to make system coding changes.*

Informed in part by problems in 2013, CMS set an aggressive schedule to make technical improvements in every area. Also in April 2014, CMS leaders went over the schedule with Accenture, QSSI, and other key contractors to ensure adequate time for testing before second open enrollment. Recalling the 2013 problems with policy changes requiring changes to the software late in the build, CMS established a more formal process for "change management," the task of completing and communicating changes in policy, business requirements, and technical specifications. Part of this process was to bring problems to managers more quickly and to include more detail in technical reports and presentations. A CMS technical official indicated that during this time period, CMS and Accenture were still correcting coding problems that were not fully resolved during the recovery period after first open enrollment. CMS also set a firm "pens down" date of October 7, 2014, for system coding, meaning no additional system changes were to be made other than to address problems found during testing. Another barrier to testing in 2013 was coordinating testing environments to provide enough computing and storage space to run tests. To improve this for the second open enrollment, CMS increased its infrastructure available for testing, and staff at the XOC worked in conjunction with QSSI, the systems integrator, to schedule use of testing environments among the CMS staff and contractors working on various pieces of the build.

CMS also refined processes for the XOC, which was now able to shift its focus from fixing problems to training and establishing longer-term processes. As a CMS official at the XOC stated, "We tried to step away from heroics." CMS managers conducted readiness reviews that identified weaknesses in the XOC's ability to operate during open enrollment. Two key changes resulted, both regarding leadership: CMS designated the role of the Pit Boss, a contracted employee who manages incidents and ensures that system changes are coordinated across teams; and instituted a Floor General position, a CMS employee who reports status and problems to a CMS Executive On Call and coordinates the XOC workflow.

Other changes to management of XOC operations included hiring a permanent team of "site reliability engineers" to provide technical guidance focused on maintaining service; additional training, such as simulation drills to existing staff; and enhanced monitoring tools for "real-time" tracking of functions, such as the application process. They also coordinated closely with other Federal agencies, such as SSA and IRS, regarding system downtimes and technical changes in interrelated systems. CMS established a new Open Enrollment

Coordination Center to coordinate the nontechnological aspects of open enrollment, such as consumer and issuer experiences, and relay information from this vantage point to the XOC to improve operations (see Figure 4). Overall, these enhancements strengthened CMS's ability to respond to operational issues with the website.

Figure 4: Description of Open Enrollment Coordination Center.

TYING IT ALL TOGETHER—OECC

In September 2014, CMS created the Open Enrollment Coordination Center (OECC), an entity that serves as the "business version of the XOC" and operates out of the policy office, CCIIO. The OECC placed the communication and coordination of all project components into a single office with a small group of staff. The key tasks of the OECC are to monitor and coordinate resolution of all open enrollment issues by translating information to and from the policy, operations, communications, and technical teams. The creation of the OECC allowed the XOC to focus only on technical systems. The OECC works closely with the call centers that receive information from consumers and issuers about problems, then feeds the information back to the systems operators at the XOC. The OECC keeps an "open bridge" telephone line with the XOC and determines how consumers and issuers might be affected by technical problems.

Second open enrollment was complicated by the need for reenrollment of existing plan holders, requiring new website functions and communication to consumers. As previously stated, CMS had to implement new technology for the second open enrollment that enabled existing plan holders to reenroll, either in their prior plan or a new plan by December 15, 2014.[103] Existing plan holders could access the site to compare and consider selecting a different plan for their second year, but CMS officials wanted an automated reenrollment process that could also redetermine whether the plan holder was eligible to receive Federal financial assistance. This would be convenient for consumers who did not want to reapply to stay enrolled in their current, or equivalent, plan and continue to receive financial assistance. Auto-reenrollment would also reduce the number of users on the HealthCare.gov website, therefore reducing capacity needs, which had been such a problem during the first open enrollment period.

Year two was arguably tougher than year one because of the complexity of adding reenrollment. –CMS staff

Reenrollment and redetermination of existing plan holders raised other complexities beyond the technical development; existing plan holders would require different information from CMS than did new consumers. Updated regulations required the Federal Marketplace to send notices to all individuals who received financial assistance and describe the annual redetermination process for financial assistance.[104] During summer 2014, CMS provided enrollees with the benefits of each option, (i.e., automatically reenrolling or reviewing plan options) by letter and email. This information explained that if a consumer's income or household size had not changed, then they could choose to do nothing and HealthCare.gov would automatically renew their coverage. (Changes in income or household size could result in new monthly premium rates or changes to eligibility for financial assistance.) Several media reports criticized CMS for encouraging consumers to do nothing. Eventually, CMS leadership came to believe that consumers would be best-served by logging back into HealthCare.gov to

decide whether to change plans. In October 2014, CMS revised its message on the website and in other materials to emphasize that consumers would benefit from updating their personal information on the website and reconsidering health plan options.[105]

Timeframes were tight for final website improvements, but CMS execution was much improved in comparison to 2013. In addition to addressing the new challenge of auto-reenrollment, CMS made other changes, including improving the waiting room system during heavy-use periods. CMS also implemented changes to accommodate two States (Nevada and Oregon) that began using the Federal Marketplace for certain functions and one State (Idaho) that left the Federal Marketplace to build a State marketplace.[106] (Thirty-seven States used the Federal Marketplace during the second open enrollment.[107]) Other aspects of the HealthCare.gov operations were still in flux weeks before the second open enrollment period, and contractors conducted some system testing behind the original schedule. For example, testing was delayed for the new function to notify issuers whether their existing plan holders would be automatically reenrolled in their previous health plan or chose a different plan through HealthCare.gov; this testing was delayed from August to October 2014, just a month before the second open enrollment period. To handle the additional tasks, CMS augmented its staff in the final weeks before second open enrollment, including adding staff to the call center and redirecting some technical staff from other divisions, as in 2013.

CMS management of the project leading up to the second open enrollment period again stood in contrast to the 2013 launch. Project documentation indicated that in 2013, CMS and contractors were frantic to establish basic website functionality. As a result, they pushed forward faulty and untested functionality and hoped to fix it after the launch. Project documentation indicated that in 2014, CMS maintained a more disciplined project schedule, meeting deadlines with a goal to implement only technology that had what project documentation referred to as "perfect execution." When this standard could not be met in time, CMS identified problems more quickly to allow time to employ contingency plans. For example, the new account creation and identity verification system, SLS, was deemed unready in late summer 2014, so CMS and contractors re-engineered a portion of the existing system, EIDM, to serve as a dedicated account creation and identity verification system called Insurance Marketplace Authentication System (IMAS).

> *"App 2.0 went into production 30 days early so we could see it in the wild (during special enrollment). It was very successful. –CMS staff*

One of the causes of problems with the EIDM in 2013 was that it was designed to provide identity management services to multiple CMS programs rather than exclusively for HealthCare.gov. CMS technical staff and contractors re-engineered IMAS specifically for HealthCare.gov so that it allowed consumers to create an account, but avoided the EIDM entry bottleneck. IMAS was in testing by September and complete by October 2014. CMS continued to develop and test the SLS, launching it in February 2015 and completing the transition in March 2015. CMS also deferred a new tool called Plan Compare 2.0, which was designed to provide a more comprehensive comparison of health plans and premiums than the temporary shopping tool established after the launch. CMS suspended work on Plan Compare 2.0 in summer 2014 to focus on what they perceived to be more critical: the new streamlined App 2.0 consumer application. CMS conducted a "soft launch" of App 2.0 to special enrollment period consumers in September 2014, then used App 2.0 for all new

consumers during second open enrollment with high performance results, according to CMS documentation. As an illustration of improved planning and organization, CMS made the decision to defer a portion of Plan Compare 2.0 fully 5 months before second open enrollment began as compared to a decision regarding the similar "anonymous shopper" tool that CMS deferred 11 days prior to first open enrollment.

Year one we focused on fixing the technology, for year two we focused on the consumer.
–CMS marketing staff

CMS focused increasingly on consumer outreach and assistance, including improvements to the navigation and content of HealthCare.gov. Leading up to and during the second open enrollment period, CMS placed greater focus on expanding outreach to eligible consumers and to assisting consumers with enrollment. "There is less happening now on the policy side, so our focus can be on consumers," explained a CCIIO official. The direction for these efforts was led in part by feedback CMS received from navigators and call center representatives, and from information gleaned by HHS and CMS officials from stakeholders such as issuers, community organizations, and the public. CMS OC also conducted market research to identify barriers to enrollment.

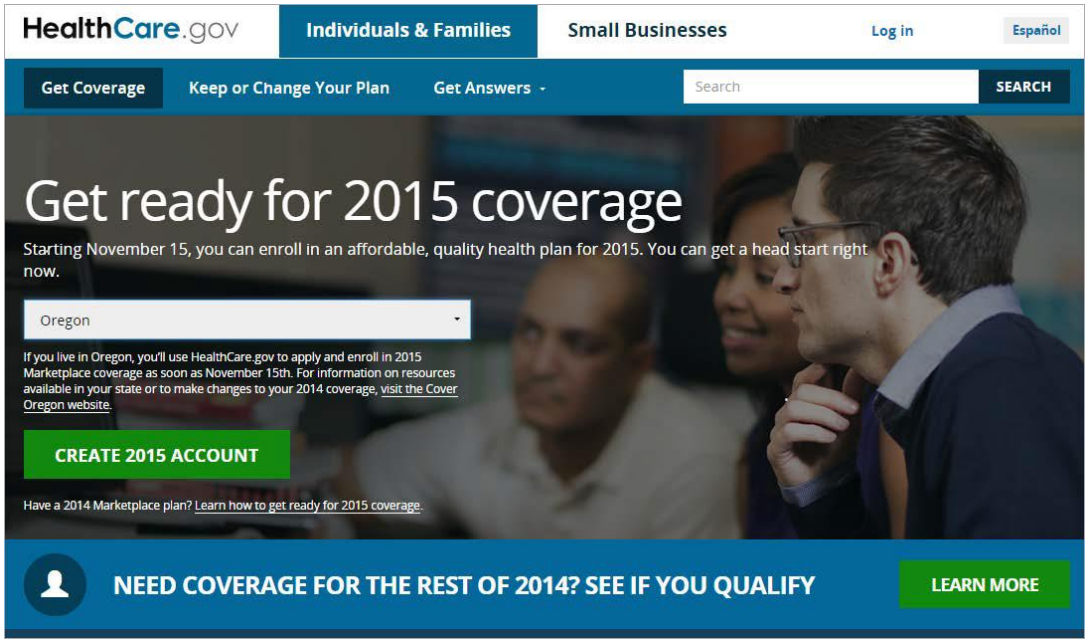
Strategies differed for existing HealthCare.gov plan holders and potential new consumers. CMS sent existing plan holders letters, email, texts, and telephone calls to encourage re-review of plan options, and remind them of the auto-reenrollment process to take place on December 16, 2015 and other key dates. CMS also reached out directly to consumers who started applications on the website but left them incomplete, encouraging them to return to the website to purchase plans. To encourage new consumers, CMS conducted public enrollment events, many featuring the HHS Secretary and other officials, purchased advertising, and invested further in local navigators. In addition to information about the Federal Marketplace and HealthCare.gov, these efforts sought to address needs in consumer health literacy, such as instruction in health plan and coverage terminology. In interviews, CMS senior leadership indicated this was in part to increase enrollment in the marketplaces but also to improve overall public knowledge of health care and insurance, regardless of where it is purchased. As a senior CMS official observed, "We could be a resource for 300 million people, not just 10 million."

> *"Now that operations are stable, that frees us up to do more."*
> —CMS consumer staff

To improve the usefulness of the HealthCare.gov website, CMS sought to sharpen its visual appearance, navigation, and content. For example, CMS improved navigation tools to engage consumers to access additional information without leaving the home page. CMS also replaced question-based categories ("Am I enrolled?") with simpler topic-based labels to reduce confusion. The HealthCare.gov home page also clarified what actions consumers could take immediately and on key future dates, and updated these instructions (e.g., from "Get Ready" steps prior to open enrollment to "Act Now" steps during open enrollment). CMS sought to improve website navigation in particular for complicated households, such as blended families covered in part by employer insurance or government programs, and added substantially to HealthCare.gov website content, including more thorough explanations of coverage, improved tools to compare plans, and consumer case

examples. CMS also launched the SHOP website, which enables small businesses and their employees to browse plan offerings and enroll in coverage online, to apply for Small Business Health Care Tax Credits, and to obtain personalized assistance.[108]

HealthCare.gov homepage encouraging consumers to get ready for the second open enrollment period, October 3, 2014.

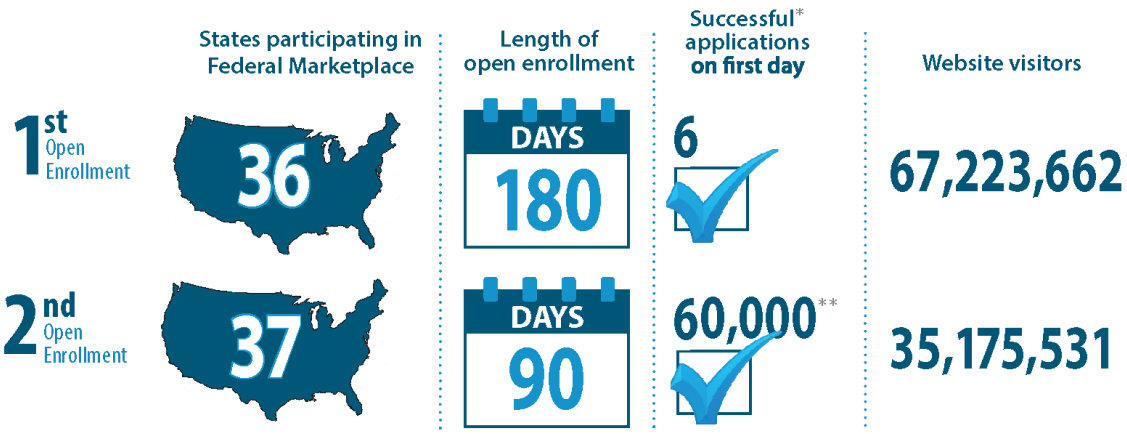


CMS also sought to address prior difficulties that many consumers had regarding premium tax credits. CMS regional office staff reported increasing communication in 2014 to make consumers aware of the importance of making updates to their income estimates. Early external reports indicated that the income estimates of half of consumers were too low during the first year of enrollment and these consumers consequently owed income taxes for 2014 following the first year of reconciling estimated to actual income.[109] In interviews, a sample of navigators indicated that they were not equipped to field questions regarding the tax implications of enrollment decisions, and that CMS could have provided more information and guidance about tax-related issues.[110,111] Also, according to the navigators, CMS did not provide consumers with adequate guidance about the need for consumers to update their income information.

Second open enrollment operations of HealthCare.gov ran smoothly, with high use and no CMS system outages. The second open enrollment period began November 15, 2014, and CMS documentation indicated the technical aspects of the website and supporting systems performed well, with no system outages and few consumer reports of problems applying or selecting plans. On the first day of second open enrollment, the website had approximately 34,000 accounts created, approximately 60,000 applications submitted, and over 650,000 unique visitors.[112] HealthCare.gov response times were also quicker with a 3.21 second median time for logging in during the second open enrollment compared to 18.46 seconds during the first open enrollment.[113] The highest number of users on a single day to

HealthCare.gov during second open enrollment was 1.86 million,[114] with capacity to support a high of 250,000 concurrent users without an outage. See Figure 5 for a comparison of selected statistics for HealthCare.gov between first and second open enrollment.

Figure 5: Comparison of selected HealthCare.gov statistics.



Source: CMS and HHS project management timelines and benchmark reports.
* Successful applications are those accepted by the issuer.
** Approximate number.

CMS highlighted what it considered key successes across the first two open enrollments. A June 2015 analysis showed that approximately 9.9 million consumers had signed up and paid the premium for a health plan on HealthCare.gov or a State marketplace during second open enrollment, surpassing the Department's revised projections of 9 million enrollees but falling short of the Congressional Budget Office's projection of 13 million enrollees.[115] During that same period, CMS reported that increased competition in the Federal Marketplace provided consumers, on average, with 25 percent more health plans to choose from while minimizing premium increases to 2 percent for the benchmark plan in each State used to calculate premium tax credits.[116]

Changes made by CMS during preparation for second open enrollment also focused on longer-term improvements to the Federal Marketplace and throughout CMS

CMS further formalized HealthCare.gov project leadership. Improved technical execution was due in part to changes made by CMS to Federal Marketplace management. CMS continued its contract with QSSI as technical systems integrator in September 2014, and the CMS Administrator sustained daily, hands-on leadership through mid-2014. In June 2014, the agency hired a Principal Deputy Administrator who had served as a key contracted manager during the website recovery period and was knowledgeable about the project and its responsible staff.[117] The responsibilities of the position extended beyond HealthCare.gov, but interviews with the then-new Principal Deputy Administrator indicated a focus on HealthCare.gov through the second open enrollment period. In August 2014, CMS hired a formal "Marketplace CEO," selecting the former director of a State marketplace.[118] These new officials, in conjunction with the CMS Administrator, coordinated Federal Marketplace tasks across CMS divisions responsible for various aspects of CMS's functions, such as OIS for

information technology, OC for communications, and OAGM for contracting. In interviews, a senior CMS official described this as a "re-boot" of its prior "enterprise" (organization-wide) management strategy that relies on sharing services across the organization and its programs. The CMS COO reflected that the prior enterprise strategy itself was not faulty, given the need for specialization across a large, complex organization, but in this case, the unclear leadership and communication across divisions had diminished its effectiveness, made worse by the lack of integration among multiple contracted entities. Other CMS officials and staff stated similar views, contending that the success of the enterprise structure is dependent on leaders managing projects globally across functions so that they can assess overall progress and identify gaps.

CMS renewed its focus on contract management, particularly emphasizing the agency and contractor relationship. HHS and CMS changed core contracting policies that had compounded problems with contract management to work more closely with contractors and better ensure project tracking and performance. To improve its management of contracts, HHS instituted in April 2014 new acquisition planning guidance and is amending the HHS Acquisition Regulation, the Department's rules for conducting acquisitions, with the goal of improving efficiency and effectiveness of various phases of the acquisition process.[119] CMS officials reported several changes to its contract procurement and oversight strategy, including better defining individual roles and responsibilities and transitioning to a "program management" structure for managing all IT-related investments, including the FFM. This structure requires program managers to maintain responsibility for the overall success and management of the IT systems that support the program.[120] According to CMS, the goal of the policy is to develop a program management culture that ensures everyone involved is working to meet the needs of the project and organization. CMS had already addressed another key problem in contract management: adding to the scope of the contract ("unauthorized commitments"); prior to the first open enrollment period in April 2013, the Director of OAGM issued a guidance memorandum in response to CMS staff having modified the scope of contractor work without authority to do so.

> *"We had to change the mindset without changing good governance . . . [to emphasize that you need] good relationships with contractors."*
>
> —CMS official

Part of CMS's problem in managing contracts before the launch may have been a lack of understanding by CMS staff regarding the agency-contractor relationship. According to interviews and correspondence, some CMS staff were reluctant to work too closely with contractors for fear of violating Government contracting rules. For example, CMS staff working on the website sometimes requested that contractors not participate in meetings or receive information. These actions resulted in a sense that CMS and contractors were not a team working toward the same goals and hampered the agency and contractor relationships that would promote communication and progress. As one CMS official noted, "We had to change the mindset without changing good governance . . . [to

emphasize that you need] good relationships with contractors." To achieve this, CMS leadership more clearly instructed staff who were coordinating technological work and supervising contracts about rules and provisions related to contracted work, and also instructed contractors to work more collaboratively with each other and the CMS divisions. For an agency in which much of the work is performed through contractors, this represented more of a cultural shift than a change in policy.

Communication improved among CMS divisions as the agency focused on merging policy with operations, and encouraging identification of problems and sharing bad news. CMS management focused on better blending the policy and technical components of CMS with a greater sense of what CMS leaders called "the physics of operations" or "operational awareness." Policymakers acquired a better understanding of the effort required to effectuate policy decisions, both in terms of time and resources, so that those considerations could better inform decisionmaking. According to interviews with long-time staff members, CMS has always had a bifurcation between operations and policy, but during our report period, leadership appeared to be changing this. One long-time staff member observed: "[CMS] leadership now is more focused on how to think of the end-to-end process."

> *"You can't over communicate. Over communication is never a problem."* —HHS official

This close interaction between CMS officials and staff also required a willingness to solicit and accept bad news, such as negative assessments of progress and performance. CMS officials recognized that they needed to actively look for problems, and CMS employed a policy of encouraging staff and contractors to do so. CMS staff shifted from following known processes to continually assessing outcomes and progress. For example, CMS identified a number of problems in the lead-up to the second open enrollment through "deep dives," assigning staff to scrutinize the performance of a specific area or function (such as eligibility) and bring to CMS leadership their assessments of weaknesses. This approach provided a way for staff to move bad news to leadership and provided a more formal record of problems to better ensure resolution. Seeking bad news and changing course as needed takes, according to one CMS senior leader, "a conscious effort" with buy-in and follow-through from all levels.

Another change in approach was to conduct financial budgeting for the Federal Marketplace project as a single process rather than manage separate budgets across the various CMS divisions and functions. Leading up to the launch of HealthCare.gov, CMS had separate budgets for the policy and technological work in the two key divisions of CCIIO and OIS. This led to confusion over which division covered which costs and responsibilities and resulted in inefficiencies. In preparation for the second open enrollment period, the Federal Marketplace budget was combined into a single process, meaning that both IT and non-IT costs and benefits would be more clearly assessed together, and each division better understood the activity of the other and potential tradeoffs for decisions and additional expenditures. As a CMS financial officer noted, "If the call centers needed more money, we could push back on some IT activities."

CMS management focused on realistic alignment of project goals and resources, and straightforward measurement of outcomes to avoid "artificial progress." Two key aspects of CMS's operational strategy during this period were to more carefully align project needs with organizational resources and to monitor use of resources and progress more closely. CMS officials spoke in interviews of avoiding the prior problems of CMS staff and contractors working at cross-purposes and on tasks that did not clearly promote core objectives. They observed that the prior approach created an environment of "artificial progress" that created unwarranted optimism and masked problems. "[We are] outcome driven . . . [meaning] no hiding," noted a CMS official.

If we have a challenge, we talk about it daily. If we have a really big challenge, we talk about it twice a day.
–CMS official

QSSI, the systems integrator, played a large role in increasing rigor in aligning project goals and resources. QSSI continually assessed project progress and weak points and connected with staff to resolve discrepancies or potential breakdowns. As a CMS official reflected, "[QSSI] lifted up the specifics to flag problems and bring them to leadership, preventing silos and poor communication. People don't always want to take problems to [leadership], so the systems integrator did so." CMS officials credited QSSI with easing the process of executive decisionmaking when decisions required the input of CMS leadership. QSSI handled much of the "executive reporting" function previously held by CMS division leaders, which saved time for those working on various pieces of the website and program, and also provided an easier and more objective method for bringing forth problems.

> *"People don't always want to take problems to [leadership], so the systems integrator did so."*
>
> —CMS official

CMS senior leadership was actively involved in daily project work for HealthCare.gov, easing aspects of project management but likely not sustainable over time. Another noteworthy difference in project management during this period was the degree to which senior CMS executives handled day-to-day operations for the Federal Marketplace. The CMS "C Suite" of Administrator, Principal Deputy Administrator, COO, CIO, Chief of Staff, and other leaders routinely attended Federal Marketplace meetings. Senior leaders alternated as the Executive On Call, serving 24-hour shifts to make decisions more rapidly, regardless of the time of day. As a result, even specific problems reached the top; for example, an issue that concerned a single health plan in one State was raised to the Administrator and resolved within hours. For the most part, CMS staff touted the senior-level involvement as positive and welcome, enabling quicker decisionmaking and greater unity across divisions. CMS senior leadership and staff also noted that this involvement likely raised the sense of urgency to collaborate and to complete tasks timely and well. As one CMS official noted, "If people know that problems will be elevated to the top levels quickly, the incentive to reach consensus and move forward is very high."

> *"If people know that problems will be elevated to the top levels quickly, the incentive to reach consensus and move forward is very high."*
>
> —CMS official

CMS officials reflected that there were also drawbacks to such concentrated involvement by senior CMS leaders and that it was likely not sustainable indefinitely. A few officials and staff expressed concern that CMS senior leadership had overcorrected their prior lack of involvement, and that continued heavy involvement could lead to a narrow focus on daily chores and "managing to a punch list" at the expense of broader organizational needs such as strategy and goal-setting. As one official stated, "We got a more granular operational awareness, but sometimes at the expense of a broader view." CMS officials noted an awareness of this drawback and indicated they would reassess the level of senior leadership involvement as the Federal Marketplace system matured. As one CMS official reflected, "When you have the problems we had, you are going to see more time and depth of senior leadership involvement. As we move to a more mature program, we will see less of that."

> *"We got a more granular operational awareness, but sometimes at the expense of a broader view."*
>
> —CMS official

CMS expects its restructuring to improve operations across the organization. CMS changed its organizational structure in February 2015 to improve governance (oversight of processes) and make more efficient use of resources. These changes included segregating IT operations and governance to preserve impartiality in making IT decisions, promoting shared use of services such as IT and contracting, and elevating the usefulness of its data analytics functions. To preserve impartiality in making IT decisions and governing those decisions, CMS divided two functions from OIS into separate groups: IT operations (e.g., networking and hardware) and IT governance (e.g., software architecture and security). The new Office of Technology Solutions is responsible for IT operations while the broader Office of Enterprise Information is responsible for IT governance, under the leadership of the CMS CIO. Also, CMS established an information security team under the CIO that monitors and tracks corrective plans for security vulnerabilities and ensures the plans are completed.[121,122]

Marketplace has quickly become an incubator wherein we lead change to other areas of the organization.
–CMS official

To promote the enterprise structure and sharing use of services such as IT and contracting, CMS leadership formed a Strategic Planning and Management Council comprised of five workgroups: appeals, eligibility and enrollment, plan oversight, security and privacy, and workforce planning. The workgroups include leaders from each of CMS's programs with the goal of mapping out operational similarities and developing opportunities to share resources. For example, several CMS programs, including the Federal Marketplace, provide support for beneficiaries, providers, and suppliers to appeal coverage and payment decisions. The appeals workgroup outlined similar appeals processes across programs and combined operations where appropriate. Finally, CMS placed its new Chief Data Officer and data analytics and research group within the Office of the Administrator to further integrate the use of data into CMS management and decisionmaking.[123]

Challenges remain for CMS in operating HealthCare.gov, with public scrutiny high and the website and other automated functions not yet complete

Public scrutiny of HealthCare.gov is still high, and periodic problems continue to raise concern from stakeholders. Public attention to the performance of HealthCare.gov diminished even before the start of the second open enrollment period. The website was perceived as working well, but criticism of the launch and the cost of recovery remains in the public dialogue. Some CMS officials reflected this was likely due in part to the continuing political contention over the ACA and marketplaces. An April 2015 Kaiser Family Foundation poll found that the public's opinion of the ACA remains divided, but the overall view turned favorable for the first time since November 2012 with 43 percent reporting a favorable view of the law and 42 percent an unfavorable view.[124] The margin between positive and negative views remains slight; January 2016 results from the same survey indicated that overall public opinion turned negative again, with 44 percent reporting an unfavorable view and 41 percent a favorable view.[125]

> *"We are in a fishbowl. In the private sector, no one knows your mistakes, but everything we do is visible."* —CMS official

Much of the public dialogue has surrounded the extent to which Government officials and contractors should be held accountable for mistakes leading up to and at the launch. There were calls from Congress and the media for Government officials to be fired over the website failures. Most notably, CGI Federal lost its role as the primary contractor for the FFM.[126] Additionally, some HHS and CMS officials and staff did resign or retire following the launch, and others were reassigned to different positions or their responsibilities were revised. CMS staff reported that these changes were due to a range of factors, including differences in approach regarding the project's direction and management, concerns about poor performance, exhaustion following the intense work leading up to and following the launch, and changes that occur in the normal course of business during a reorganization. CMS officials indicated in interviews that the fact that more CMS staff involved in the launch did not leave their positions immediately was due in part to CMS's need to implement post-launch corrections and retain already low staffing levels.

CMS continued through 2014 to face issues related to HealthCare.gov, which led to substantial media interest and congressional inquiry. Most were resolved, although they likely led to some continued public concern about HealthCare.gov operations. For example, in mid-2014, a hacker breached a HealthCare.gov test server, causing CMS and observers to question security, although there was no known compromise of private information.[127] In another example, media discovered that CMS allowed third-party content providers, hired by CMS to monitor consumer use of HealthCare.gov, to share personal information of HealthCare.gov users with other entities.[128] Although CMS contended that this was a fairly common practice for public websites, the agency curtailed sharing of information in response to the concern. Errors also continued to occur in providing enrollment and other data to stakeholders. The most publicized of these errors was an overstatement by the CMS

Administrator in testimony to Congress in September 2014 of the number of individuals enrolled in health plans, an error that CMS later attributed to a staff error in interpreting the data. And in early 2015, the FFM sent incorrect tax forms, later corrected, to thousands of consumers who received tax credits, prompting the IRS to provide more time for consumers to file their taxes.[129] These errors resulted in questions about the accuracy of HealthCare.gov enrollment figures overall and more stakeholder inquiry.[130]

CMS has not fully implemented the Federal Marketplace automated financial management functions. The most significant technical challenge facing CMS is completing implementation of the automated financial management system. CMS planned to complete the automated system prior to the first open enrollment period, then delayed the system's projected completion date several times to prioritize other aspects of the Federal Marketplace project. OIG audits found that with the manual system CMS used in the interim, CMS could not confirm the accuracy of payments at the individual, policy-based level[131] and could not ensure that payments are made only for enrollees who paid their premiums.[132]

CMS has continued work on the automated system, now called Enrollment and Payment System (EPS). When fully implemented, EPS will automate all financial functions of the Federal Marketplace, including tracking effectuated (paid) enrollments, managing payments to issuers for financial assistance and premium stabilization, and managing user fees. In January 2016, CMS transitioned most issuers to the portion of EPS that calculates payment amounts and enrollment numbers, replacing the manual calculation method with a more precise, policy-based method.[133] CMS continues to add issuers to the automated system as they meet the agency's criteria for readiness to transition. The agency plans to complete the remaining EPS functions within 2016, hoping to make financial management of the Federal Marketplace more efficient and lower cost, and to improve the accuracy of payments and data. Even with the full automation, CMS staff acknowledged in interviews that there will always be some need for data reconciliation between Federal Marketplace and issuer data to ensure that issuers have accurate consumer information. CMS reported that it plans to continue conducting internal validation checks to ensure issuers submit accurate information.

In addition to completing the website build, CMS must continue to address technical and operational challenges. CMS has continued to correct technical problems with the website, some dating back to the original 2013 framework. As with earlier problems, changes to the system still require development of business requirements, technical development, website performance and security testing, and reconfiguration of monitoring and operations, such as website capacity. In interviews, CMS officials indicated they perceived the third cycle of open enrollment as the "first full enrollment period" because this is the first open enrollment period for which they will have data to predict consumer use of the website for both first-time enrollees and re-enrollees. These estimates of website user behavior should allow for more precise measurement of needs for

> *"The complexity of the systems is surprising. . . . You could have a Ph.D. in [Federal] Marketplace data file transfer."*
>
> —CMS technology official

website capacity and consumer support. There are other, ongoing challenges, such as improving the transfer of account information to issuers and consumers. As one CMS technology official who was new to the project noted, "The complexity of the systems is surprising. . . . You could have a Ph.D. in [Federal] Marketplace data file transfer." Depending upon the data issue, this task is shared by CMS policy and technical staff, with CCIIO focused on conducting outreach and casework with issuers and consumers, and the Office of Technology Solutions focused on data transmittal. CMS reported that it also hopes to continue increasing enrollment among eligible consumers who have not purchased health plans. Prior to the third open enrollment period, an estimated one-third of eligible consumers had enrolled in health plans through the Federal or State marketplaces.[134]

CMS must also improve the accuracy of critical Federal Marketplace functions such as determining who is eligible and amounts paid to issuers. Previous OIG work based on data from the first open enrollment period concluded that CMS should strengthen its internal controls for determining eligibility for enrollment and Federal financial assistance, and for resolving inconsistencies in enrollment information submitted by applicants.[135] In response, CMS reported that it works continuously to ensure that the Federal Marketplace accurately determines eligibility and resolves inconsistencies, including making regular updates to the system to resolve issues. As an example, CMS created a new "pop-up" message in the HealthCare.gov application to encourage consumers to enter a Social Security number on the application, which CMS believes should decrease the number of data-matching issues from that of the first open enrollment.

Open enrollment for the third coverage year of the Federal Marketplace was originally to begin on October 1, 2015 (see Figure 6 for open enrollment dates);[136] CMS moved the start date by 1 month to November 1, 2015, in order to complete the build of additional functionality and for new issuers to submit and refine plan data. CMS also extended the end date of open enrollment to January 31, 2016, to provide 3 months, the same duration as the second open enrollment period.[137] CMS plans to continue open enrollment for annual 3-month periods, unfolding a multi-year IT approach to continue improvement, such as enhancing plan selection tools for consumers.

Figure 6: Periods of first–third open enrollment for the Federal Marketplace, 2013–2016.

Source: 45 CFR § 155.410.

KEY FACTORS CONTRIBUTING TO RECOVERY

› RUTHLESS PRIORITIZATION

Because the timeframe and resources available to prepare for the second open enrollment period were fixed, CMS focused on reducing scope to meet deadlines. The day after first open enrollment closed, CMS leadership met to employ "ruthless prioritization" of tasks to focus on the most urgent needs and functionality. These decisions and resulting changes were then locked down and measured for progress and results. CMS was not able to deliver some functionality as planned, with full automation of the financial management system still in development at the end of second open enrollment. Ruthless prioritization served, though, to align goals with the resources available, guide daily work and accountability, and temper unrealistic expectations about results.

› QUALITY OVER ON-TIME DELIVERY

CMS adopted a project management approach of going live with website functionality only when it could ensure what one CMS official called "perfect execution." This was in contrast to the launch of HealthCare.gov, wherein CMS delivered what it knew was faulty functionality, planning to improve the website later. In the case of the new HealthCare.gov consumer application, App 2.0, delivery was tested through a "soft launch" prior to open enrollment. As with the prioritization process, this approach meant that CMS did not always deliver according to schedule. For example, CMS did not launch its new account creation system as planned when problems arose. CMS leaders and contractors said in interviews that this policy of requiring optimal functioning before delivery led to improved practices overall, such as targeting earlier deadlines for delivery and imposing stricter testing standards.

› SIMPLIFYING PROCESSES

Large organizations are vulnerable to creating unneeded organizational structures that can cause staff to lose sight of project goals. During the 2013 launch of HealthCare.gov, CMS divisions, particularly policy and technical teams that were responsible for various pieces of the project, operated separately and did not communicate well with other teams. This led to delays and lack of accountability. CMS simplified both technical aspects of the build and the organizational structure of the agency itself by closely monitoring progress and results with daily reports and close communication with contractors. This made the work more transparent and aided in prioritizing goals, reducing the common problem of "artificial progress" that large, complex projects have—many parties completing tasks, but not moving forward toward the project goals. Reduced complexity in tasks and organizational structure made it easier for CMS to identify those responsible for carrying out tasks and to track progress toward goals.

› CONTINUOUS LEARNING

A culture of continuous learning encourages open communication and active monitoring of performance and progress, allowing for a change in course as the facts dictate. In preparation for the second open enrollment period, much about the HealthCare.gov project was still unfolding. For example, CMS did not know how much website capacity consumers would require, and it was still developing and testing new and improved functionality in the final weeks before open enrollment. Given that the design and proportion of the project was evolving, it was critical to CMS's success that the organization continuously learn as the project progressed. As the HealthCare.gov project matured, CMS's knowledge and experience became more concrete and its planning more effective, but the project continued to require adaptation.

CALL FOR CONTINUED PROGRESS

"We need a sense of urgency without crisis. It is a marathon, not a sprint."
–CMS official

Does real change require a crisis?

We asked this of CMS officials, and the general consensus was that change does not require a sentinel event, but that the website breakdown expedited organizational changes already underway. Still, some thought the high visibility of the breakdown was critical to prompting change, such as the CMS senior official who stated, "Sometimes an organization has to get a wake-up call."

CMS continues to face challenges in implementing the Federal Marketplace, and in improving operations and services provided through HealthCare.gov. As of February 1, 2016, CMS reported that over 9.6 million consumers had selected a health insurance plan through the Federal Marketplace or had their coverage automatically renewed.[138] As CMS moves forward, challenges include improving the website and systems as planned, such as completing the automated financial management system and improving consumer tools to select plans. CMS must also continue to address areas OIG has identified in past reports as problematic or needing improvement, including contract oversight, the accuracy of payments and eligibility determinations, and information security controls.

CMS's experience with HealthCare.gov provides lessons for HHS and other organizations in navigating program implementation and change. These lessons comprise core management principles that, had they been applied earlier, could have avoided problems in execution. CMS's use of these principles following the breakdown enabled the organization to recover the website and improve management and culture.

Given CMS's large organization and complex mission, prior management problems could resurface and new problems could emerge. CMS placed intense organizational focus on the Federal Marketplace during the recovery of the website. This level of focus will, by necessity, change in the face of new challenges and priorities within CMS, and inevitably officials and staff with key expertise and deep knowledge of the Federal Marketplace will leave CMS or the project. Such changes in priorities and resources reinforce the need for CMS to fully embed core management principles in its daily work. CMS's continued application of these lessons will promote further improvement to the Federal Marketplace and also foster future success in managing other large projects and CMS programs.

OIG calls for CMS to continue applying lessons from the HealthCare.gov recovery in its management of the Federal Marketplace and broader organization

LESSON 1

Assign clear project leadership to provide cohesion across tasks and a comprehensive view of progress.

CMS's failure to assign a project leader below the Administrator hobbled the preparation and launch of HealthCare.gov. Personnel across CMS were needed, including policy, technical, contracting and communications staff, and a range of contractors. Lack of clarity about roles and the absence of a clear project structure led to staff working at cross-purposes and to managers and leaders receiving poor and incomplete information. Clear visibility, what one of the ad hoc team of technical experts called "viewing through a single pane of glass," is central

to leadership. This requires that leadership have a view that includes all functions, and that it have the authority to implement and enforce changes when needed.

To enable this single view and authority during recovery, the CMS Administrator stepped into the role of Federal Marketplace leader, attending detailed briefings and making large and small decisions about correcting the website's management. Later, an experienced new CMS Principal Deputy Administrator largely filled that role. Finally in August 2014, 3 months before the start of the second open enrollment period, CMS hired a Marketplace CEO to serve in that role and also as Director of CCIIO. The program CEO structure was unusual for CMS, but it answered the call for a single leader to manage across the various project operations.

LESSON 2

Align project and organizational strategies with the resources and expertise available.

Sound planning for a major project begins, at its earliest stages, with an analysis of project needs and how best to align them with the organization and resources. In its planning stages, the HealthCare.gov project faced considerable challenges, including a fixed deadline and uncertain funding. However, in developing policy and establishing goals early in the Federal Marketplace project, CMS did not adequately assess the technical and operational tasks required. Poor early decisions included underestimating operational requirements, selecting technical components not previously tested on a similar scale, and not securing technology capable of increasing website capacity. CMS was continually correcting for problems, using resources to make up ground rather than move forward.

The lack of effective planning was caused in part by project uncertainties. The Department invested substantial time resolving policy issues that reduced time for the website build. CMS reported that funding uncertainties made it difficult to determine and prioritize scope in contracting, in staffing, and in providing overall direction to the project. Government projects commonly face funding uncertainty given the nature of Federal budget decisions. Thus, it is imperative to develop management strategies and contingency plans to account for these uncertainties.

In the crisis of the recovery period, CMS prioritized getting the website functioning well enough to enroll consumers in time for them to gain coverage. Immediately after the first open enrollment period ended, CMS made a systematic effort to assess and prioritize operational needs, further develop contingency plans, tie policy to operations through establishment of the XOC and OECC, and deploy resources to meet goals for the second open enrollment period. CMS's effort to align resources with needs and ruthlessly prioritize was critical to improving problems with HealthCare.gov. Improvement required leadership to gain clear and accurate information about costs and benefits, and make well-informed use of the limited time and resources available and embed prioritization decisions in all aspects of planning, execution, and measuring results.

LESSON 3

Identify and address factors of organizational culture that may affect project success.

Developing the Federal Marketplace within CMS's enterprise structure both helped and hindered the project. It was useful to gain the expertise of policy and technical staff across divisions, but difficult for a new program to establish the needed relationships and lines of communication. When the project was placed in CMS, insufficient attention was paid to the cultural shift required to facilitate a new type of program and development approach. CMS's cultural preference for established structures, contained groups, and inflexible procedures was often at odds with the needs of a major technological start-up project, which required more creativity and flexibility. Also, divisions among CMS staff and between CMS staff and contractors inhibited collaboration and slowed progress.

Once CMS established clear project leadership, it made a cultural shift toward improved communication and transparency, quick assessment of problems, and openness to change. A key to success was incorporating these values in daily work, such as encouraging a badgeless, titleless culture that allowed CMS staff and contractors to work together regardless of their employer or rank, and the use of data to define results, so that information was tangible and objective. This horizontal structure extended to CMS leadership as officials became more deeply engaged with daily staff and contractor work. CMS documentation and interviews indicated a deliberate effort by leadership to engage with all parties, create organizational unity, and increase interaction between CMS leadership and staff. Maintaining this movement toward a more open work environment will require CMS to continually assess cultural factors and seek feedback from staff and other stakeholders as the project matures, CMS takes on new tasks, and the organization continues to evolve.

LESSON 4

Seek to simplify processes, particularly for projects with a high risk of failure.

Large and complex IT projects need constant attention to simplify design and operations. From inception, nearly every aspect of the Federal Marketplace project was complex and the risk of failure was high. CMS's missteps further complicated the project both conceptually and technologically. Conceptual examples included placing policy and technical staff in separate CMS divisions and using many contractors and subcontractors to complete aspects of the website build. Technological examples identified by experts included use of an unsuited, inefficient identity management system and an overly complex application process, as well as employing poor coding practices and using multiple entities to monitor different aspects of the website's performance while not communicating with each other.

In contrast, CMS leadership, staff, and contractors emphasized simplicity during the recovery. CMS established a single, comprehensive command center with robust and accessible monitoring tools. CMS also simplified processes when developing new systems. For example, App 2.0, the new application process, reduced the maximum number of web pages required to submit an application from 72 to 16. The new Scalable Login System for identity management was built exclusively for the Federal Marketplace project and therefore did not need to include functionality for other purposes that had made the EIDM difficult to modify and repair when needed.

LESSON 5

Integrate policy and technological work to promote operational awareness.

Throughout the development of HealthCare.gov, progress was thwarted by changing policy and business decisions. This began in the early stages with problems and delays in issuing program regulations and guidance and continued as CMS policy and technical staff revisited decisions throughout the website build. Further, CMS policy and technical staff and contractors often did not communicate decisions and problems promptly, resulting in later complications.

In the preparation for second open enrollment, CMS systematically determined and prioritized desired functionality and quantified the labor required. This led to a more even distribution of work with greater efficiency and less need for rework. CMS also sought to more effectively communicate to program staff what was required technologically to execute policy changes. For example, the XOC and OECC enabled policy and technical staff to identify and solve problems together during the second open enrollment period.

LESSON 6

Promote acceptance of bad news and encourage staff to identify and communicate problems.

Key officials failed to recognize the enormity and range of problems with the HealthCare.gov website's development and execution. Communication was fragmented, meaning that not all officials received the same information at the same time, but warnings were significant enough to warrant further inquiry and action. However, CMS leadership became desensitized to bad news. CMS's history of overcoming problems likely increased the desensitization. Despite tasking multiple entities to assess the project's status, many of whom reported potential failure, CMS leadership did not collectively take action or share that with the technical staff who might have been able to correct the problems. CMS staff who were aware of problems were reluctant to sound the alarm bell to leadership because they overestimated their ability to correct the problems and meet project deadlines.

During the website recovery, CMS leadership and staff moved to solicit bad news from all levels at CMS and contractors. CMS staff and contractors were encouraged to find and communicate problems. More straightforward communication enabled leaders to better assess needs and problems. It also enabled leaders to set more practical and realistic goals for progress, prioritize problem areas, and to better align resources with project needs.

LESSON 7

Design clear strategies for disciplined execution, and continually measure progress.

At several junctures, CMS was made aware of problems with the development of HealthCare.gov and attempted to take corrective action, but these efforts were largely unsuccessful because they were not fully executed. For example, after criticism that there was not clear leadership, the CMS Administrator assigned its COO to head the Federal Marketplace project, but the assignment was not formally announced, the position was not supported by clear responsibilities, and the designee had an already very large scope of responsibility. The action was taken, but was not executed successfully. As another example, several key officials and entities advised CMS to use a technical systems integrator. CMS's solution was to continue serving as its own systems integrator, but it did not sufficiently

delineate or execute this role. In both cases and in other examples, CMS made decisions with incomplete information, inadequate execution, and insufficient monitoring of results.

During the website recovery, CMS took steps toward establishing clearer strategies and higher standards for execution, and also implemented routine and objective monitoring. CMS rectified key deficiencies by hiring a systems integrator. CMS also revamped its organization, staffing, and monitoring of the website at the XOC, and created stronger lines of communication between responsible parties in policy, technical, and communications divisions. This interconnectedness and commitment to measurement led to greater accountability for completed tasks and a sense of shared ownership critical to execution and success.

LESSON 8

Ensure effectiveness of IT contracts by promoting innovation, integration, and rigorous oversight.

The most publicly discussed aspect of the HealthCare.gov launch in its aftermath may have been the perception that HHS and CMS did not contract and hire for the degree of technological expertise required for such a large and complex project. For HealthCare.gov, IT procurement decisions limited the number of companies that CMS solicited for contract proposals, and CMS may have over-specified technological approaches in the contracts that resulted in use of technology that was poorly matched to the project. CMS did not fully assess the project's IT needs and did not strategize in a way that emphasized innovation and current practices; CMS's contract management failed to assess the effectiveness of technological decisions, comprehensively plan for coordinating technological work across contractors, and sufficiently react to late and deficient products.

In contrast, in fixing the website, CMS management promoted communication and integration among its team of technical experts, CMS, and contracted staff. In addition, CMS redesigned its command center, the XOC, to implement cutting-edge monitoring tools and methods of detecting and resolving problems. CMS also made changes to its management and oversight of contracts by establishing new acquisition planning guidance that more clearly defined responsibilities of the CMS contracting office and staff; CMS pursued a program management culture that ensures that work meets the needs of the project and organization.

LESSON 9

Develop contingency plans that are quickly actionable, such as redundant and scalable systems.

Problems with complex projects are likely inevitable, yet contingency planning for HealthCare.gov was almost nonexistent prior to the breakdown and was late in some aspects during and after the website recovery. This lack of planning meant that CMS had few options when HealthCare.gov failed. Contingency planning enables a realistic assessment of work to be completed, and better ensures meeting program objectives, despite problems. Contingency plans are only effective, though, if they are practical, evolve as a system matures, and are adequately funded for speedy approval of contract changes and other costs.

Following the launch, CMS more rigorously prepared to mitigate potential problems by considering contingencies, building redundant systems, and increasing capacity. Additional

contingency planning should include clear and actionable plans, stakeholder communication strategies, and also funding, given that the process for approving additional funds is often delayed and may not be available mid-project due to budget fluctuations.

LESSON 10

Promote continuous learning to allow for flexibility and changing course quickly when needed.

HealthCare.gov was a novel and complex project that operated with multiple, sustained uncertainties. As CMS moved through development and launch of HealthCare.gov, it relied on an existing management and operations structure that could not easily incorporate new information and strategies. CMS staff and contractors continued to carry out plans made early in the process, and change did not begin until lack of progress on the project made the status quo untenable. At that point, changes were made in haste, without careful consideration, and too late in the process. CMS leadership neither recognized that changes were needed nor employed strategies to change course quickly and thoughtfully.

Following the launch, CMS and contractors were faced with an urgent need for widespread and deep change to processes and technology. CMS adopted a more open culture of continuous learning and quicker acceptance of change, using the website breakdown as an inflection point to create a new path. Leaders also redefined the project scope to set more realistic expectations and continued to revise scope as they prepared for the second open enrollment period, better ensuring that staff and contractors could execute tasks effectively. An environment of continuous learning is especially important when course correction is so integral to the project results.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with OIG's call for continued progress in applying the lessons that CMS learned from the HealthCare.gov recovery in its management of the Federal Marketplace and CMS's broader organization. CMS stated that since the OIG review, it has implemented several initiatives to improve its management, striving to incorporate principles aligned with this report's lessons learned in its culture, operations, and daily work. These principles include a focus on leadership and accountability, continuous reevaluation of priorities and how the project could be more efficient, program measurement, and a flexible and evolving IT strategy aligned with policy requirements. Additionally, CMS stated that it is further developing a culture wherein it embraces bad news to help identify and address risks. CMS notes that these guiding principles are likely applicable for other large organizations—private or public—that undertake large, complex projects with limited time and resources.

APPENDIX A

LIST OF KEY ENTITIES IN IMPLEMENTATION AND OPERATION OF THE FEDERAL MARKETPLACE, 2010–2015

U.S. Department of Health and Human Services (HHS): The ACA tasked HHS to develop the Federal Marketplace.

- **OCIIO**—OFFICE OF CONSUMER INFORMATION AND INSURANCE OVERSIGHT: responsible for overseeing implementation of ACA provisions related to private insurance, coordination between HHS, issuers, and other Federal and State partners, and development of the Federal Marketplace. OCIIO dissolved in January 2011 when HHS moved the Federal Marketplace project to CMS.

Centers for Medicare & Medicaid Services (CMS): In January 2011, HHS transferred responsibilities of the marketplaces to its largest operating division, CMS, which also administers Medicare and Medicaid.

- **CCIIO**—CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT: responsible for establishing Federal and State marketplace policies and developing business requirements for the website build.
- **OAGM**—OFFICE OF ACQUISITION AND GRANTS MANAGEMENT: responsible for developing and overseeing CMS acquisition efforts and awarding and administering Federal Marketplace contracts.
- **OC**—OFFICE OF COMMUNICATIONS: responsible for CMS internal and external communications, including managing call-center operations and HealthCare.gov design and appearance.
- **OIS**—OFFICE OF INFORMATION SERVICES: responsible for coordinating the technical aspects of the HealthCare.gov website build and for implementing and supporting IT needs and enterprise (organization-wide) services throughout CMS. During the January 2015 reorganization, CMS divided OIS responsibilities for IT operations (e.g., computer networks and hardware) and IT governance (e.g., software architecture and security) into two separate groups rather than placing both in OIS. The Office of Technology Solutions now has responsibility for IT operations and the Office of Enterprise Information has responsibility for IT governance.

Contractors: CMS relied extensively on contractors for most of the design, development, testing, software licensing, IT security, and support services in the development of the Federal Marketplace. Key contractors included:

- **Accenture**—ACCENTURE FEDERAL SERVICES, LLC: responsible for developing the Federally-facilitated Marketplace (FFM), in January 2014, including the FFM's three components, Eligibility and Enrollment, Financial Management, and Plan Management, as well as website support and operations, from January 2014–present.
- **CGI Federal**—CGI FEDERAL SERVICES, INC.: responsible for developing the FFM from award of the initial contract through the launch and early months of the first open enrollment period, September 2011–early January 2014, then serving as consultants to Accenture for the FFM, January–March 2014.
- **QSSI**—QUALITY SOFTWARE SERVICES, INC.: responsible, from September 2011–present, for developing the Enterprise Identity Management System (EIDM) that enables consumers to create accounts and verify their identities on HealthCare.gov and the Hub that routes information requests from the Federal Marketplace to other Federal agencies. Also became the HealthCare.gov systems integrator following the launch, from October 2013–October 2015.
- **Terremark**—TERREMARK FEDERAL GROUP, INC.: responsible, from November 2012–present, for ensuring adequate computing capacity and for hosting the infrastructure of large components of the Federal Marketplace, including the FFM and the Hub.

APPENDIX B

TIMELINE OF KEY EVENTS IN CMS IMPLEMENTATION OF THE FEDERAL MARKETPLACE, 2010–2015

2010

March 23 ACA signed into law

April 19 HHS created OCIIO

July 1 HHS launched HealthCare.gov Plan Finder website

2011

January 26 HHS moved Federal Marketplace from OCIIO in the Office of the Secretary into CMS

September 30 CMS hired CGI Federal to build the FFM and QSSI to build the Hub

2012

January 3 CMS notified CGI Federal of the selection of MarkLogic in a TDL

June 18 CMS hired QSSI to build the EIDM

June 28 Supreme Court upheld ACA individual mandate

September 7 TurningPoint issued first of 11 assessment reports

December 14 Deadline for States to submit plans to operate a State marketplace

2013

January 1 Deadline for CMS to approve or conditionally approve State marketplaces

March 22 CMS CIO signed 3-year ATO for the EIDM

April 30 CMS finalized HealthCare.gov application and released to States

May CMS requested CGI Federal deliver Account Lite

July 26 HealthCare.gov technical managers requested assistance from other divisions

July 30 Failed launch of Account Lite

August CMS conducted onsite review of CGI Federal and found poor management practices

August 20 CGI Federal presented snapshots of software rather than a live demonstration

August 20-23 CMS meeting to reduce scope of HealthCare.gov including CuidadoDeSalud.gov

September 6 CMS CIO signed 3-year ATO for Hub

September 20 CMS meeting to reduce scope of HealthCare.gov including anonymous shopper tool

September 26 CMS requested double computing capacity

September 27 CMS Administrator signed 6-month interim ATO for the FFM

October 1 Beginning of first open enrollment; HealthCare.gov launch

October 1–16 Government shutdown

October 24 CMS hired QSSI as technical systems integrator

December 1 CMS improved HealthCare.gov performance

2014

January 11 Accenture Federal Services began work as FFM contractor

March 12 CMS CIO signed 1-year ATO for FFM

March 31 End of first open enrollment

April 8–10 CMS meeting to prioritize elements most important to build for second open enrollment

June 20 CMS hired new Principal Deputy Administrator

August 5 CMS identified concerns at XOC

August 26 CMS hired Marketplace Chief Executive Officer

September CMS created OECC

September 7 CMS soft launch of Application 2.0 for most enrollment consumers

September 27 CMS launched IMAS

October 7 Pens Down for technical system changes; CMS began end-to-end testing of the FFM

November 15 Beginning of second open enrollment

December 16 Beginning of auto-reenrollment

2015

February CMS made substantial organizational structure changes

February 15 End of second open enrollment

February 21 CMS launched SLS

March 15–April 30 CMS provided a SEP to consumers who did not understand implications of tax penalty

June 25 Supreme Court allowed premium tax credits for insurance purchased through all marketplaces

November 1 Beginning of third open enrollment (closed January 31, 2016)

Listed Acronyms

ACA: Patient Protection and Affordable Care Act

ATO: Authorization to Operate

CMS: Centers for Medicare & Medicaid Services

HHS: Department of Health and Human Services

Hub: Data Services Hub

EIDM: Enterprise Identity Management

FFM: Federally-Facilitated Marketplace

IMAS: Insurance Marketplace Authentication System

OCIIO: Office of Consumer Information and Insurance Oversight

OECC: Open Enrollment Coordination Center

SLS: Scalable Log-In System

SEP: Special Enrollment Period

TDL: Technical Direction Letter

XOC: Exchange Operations Center

APPENDIX C

GLOSSARY OF SELECTED FEDERAL MARKETPLACE TERMS

Term	Definition
Account Lite	System used to create accounts in HealthCare.gov prior to the first open enrollment period
acquisition strategy	An overall plan for satisfying the project mission in the most effective, economical, and timely manner
ad hoc technology team	Group of technology experts recruited by the White House to help repair problems with HealthCare.gov after the October 1, 2013 launch
Advance Premium Tax Credit (APTC)	Tax credit for qualifying marketplace consumers, paid monthly to the issuer by the Federal Government to offset a portion of the enrollee's premium cost
agile development	Method of software development that breaks larger tasks into smaller increments that are then completed and tested
Affordable Care Act (ACA)	Legislation that required establishment of a health insurance exchange for each State
anonymous shopper tool	Tool enabling consumers to view some health plan information on the HealthCare.gov website without creating an account
Authorization to Operate (ATO)	Declaration stating publicly that the launching organization (e.g., CMS) has deemed functionality of a system to be sufficient and is accepting any associated risk to the organization's operations or to others involved
badgeless culture	Term used by CMS to signify that all CMS and contracted staff operate as a team regardless of their job titles or employer status
breakdown	Timespan from passage of the ACA in March 2010 through the HealthCare.gov launch on October 1, 2013
business requirements	Provisions that articulate to developers the program goals, processes, and functionality needed for an IT project such as a website
Change Control Board	Group comprised of representatives across CMS divisions who review and approve project changes submitted by CMS staff and contractors that could alter the project cost, scope, or schedule of work
Contract Change Order	Written order, signed by the contracting officer, directing the contractor to make a change that may affect the cost, scope, schedule, or other conditions of the work
CMS senior leadership	Term used to collectively describe the highest leadership in CMS, including the CMS Administrator, Principal Deputy Administrator, Chief of Staff, Chief Operating Officer and Chief Information Officer, and in some cases division Directors
concurrent users	Website-reporting measurement indicating the number of simultaneous users accessing a website at a given time
consumer	Individual using the HealthCare.gov website to create an account, obtain information about health plans, apply for Federal financial assistance, and purchase a plan

Term	Definition
Corrective Action Plan	Contract management document that includes improvements required by contractors to meet deliverables with adequate quality and timeliness
cost-sharing reductions	Federal financial assistance for qualifying marketplace consumers that lowers out-of-pocket expenses for health care, including deductibles, coinsurance, and copayments
cost-plus-fixed-fee contract	Type of contract that pays the contractor a prenegotiated award fee amount, requiring the contractor to bill as it incurs additional labor and material expenses; typically selected when the tasks are so uncertain that accepting a contract on the basis of an end product would pose undue risks for contractors, but also thought to provide the contractor with less incentive to control costs and provide high quality products
CuidadoDeSalud.gov	Spanish translation of the HealthCare.gov website that operates at its own web address and contains separate provisions for functionality and capacity
data center	Physical location containing computer servers that provide data storage and processing capacity for HealthCare.gov
Data Services Hub (Hub)	System that routes information requests from the Federal and State marketplaces and Medicaid and CHIP agencies to other Federal agencies and back
effectuated enrollment	Number of individuals that are enrolled in marketplace health plans and have paid their first month's premiums
Enterprise Identity Management (EIDM)	System that enabled consumers to create accounts and verify their identities before they applied for Federal financial assistance and purchase a plan; used by CMS during first and second open enrollment of the Federal Marketplace
enterprise management structure	Management strategy that relies on sharing services, such as technology, financial management, and contracting services, across the organization and its programs
Enrollment and Payment System (EPS)	System designed to fully automate the financial functions of the Federal Marketplace, including payments to issuers for Federal financial assistance and premium stabilization
Exchange Operations Center (XOC)	Facility in Columbia, MD that serves as the primary HealthCare.gov technological command center, staffed by CMS and contractors to coordinate system development, operations, maintenance, and testing
Federal Marketplace	Marketplace operated by the Federal Government for consumers in States that do not operate a website for residents to enroll in qualified health plans
Federally-facilitated Marketplace (FFM)	System that serves as the core of the Federal Marketplace system, including three subsystems that (1) determine consumer eligibility for health plans and Federal financial assistance and facilitate enrollment in health plans (Eligibility and Enrollment); (2) manage health plans with issuers (Plan Management); and (3) track and facilitate payments to issuers, including any insurance affordability payments (Financial Management)
functionality	Range of operations that can be performed on a computer or other system; examples of HealthCare.gov functionality include operations that enable consumers to obtain information about health plans, apply for Federal financial assistance, and purchase a plan

Term	Definition
HealthCare.gov launch	Date on which CMS first opened HealthCare.gov for consumer use to enroll in health plans and apply for Federal financial assistance, October 1, 2013
Indefinite Delivery Indefinite Quantity (IDIQ) contract	Type of contract that provides for an indefinite quantity of services for a fixed time period and is used when the Government cannot determine above a specified minimum the precise quantities and/or delivery times of supplies or services that it will require
Insurance Marketplace Authentication System (IMAS)	Re-engineered portion of the EIDM that served as a dedicated account creation and identity verification system during second open enrollment
Issuers	Insurance companies that offer health plans to consumers through HealthCare.gov
letter contract	Written preliminary contractual agreement that authorizes a contractor to begin immediately manufacturing supplies or performing services
marketplace	Health insurance exchange wherein individuals can obtain information about health plans, apply for Federal financial assistance, and purchase a plan
Medicare Part D	CMS program to subsidize the costs of prescription drugs and prescription drug insurance premiums for Medicare beneficiaries; Medicare Part D was implemented in 2006
minimum essential capabilities	HealthCare.gov functionality that CMS considered necessary for the first open enrollment period, including allowing consumers to create an account, obtain information about health plans, apply for Federal financial assistance, and purchase a plan
Model-Driven Architecture (MDA)	Approach to software development that uses models to automatically generate computer code for system development; typically used in conjunction with developer-written code to save time and reduce human error
navigators	Individuals or organizations, funded through Federal grants, that help consumers enroll in health plans through the Federal Marketplace or State marketplaces, and provide guidance and education to raise awareness about the marketplaces
NoSQL database platform	Nontraditional, document-oriented database platform that uses nontabular records, unlike a relational database that uses tables to store and index data
Open Enrollment Coordination Center (OECC)	Subgroup within CMS CCIIO created by CMS in September 2014 to monitor and coordinate resolution of all open enrollment issues by translating information to and from the policy, technology, and operations teams
open enrollment period	Period of time during which individuals may enroll in a health plan; dates included: – First open enrollment: October 1, 2013–March 31, 2014 – Second open enrollment: November 15, 2014–February 15, 2015 – Third open enrollment: November 1, 2015–January 31, 2016
path dependency	Unfounded reliance on former ways of doing things that prevents adaptation to new conditions
pens down	Term CMS used for signifying the final date for technical staff to make system coding changes prior to testing

Term	Definition
Plan Finder website	Browsing website created in 2010 that provided health plan information to consumers but without the functionality to purchase plans or to apply for Federal financial assistance
qualified health plan (health plan)	Private health insurance plan offered through a marketplace and certified by CMS or States as meeting certain standards and that cover a core set of benefits, including doctor visits, preventive care, hospitalization, and prescriptions
rate review	Analysis by experts to ensure that proposed rate increases of marketplace health plans by issuers are based on reasonable cost assumptions
recovery	Timespan from October 1, 2013 through the end of second open enrollment
refactor	Technique used to restructure existing computer software code in order to correct and streamline the code
reprioritization meeting	Meetings held prior to the first open enrollment period in summer 2013 to further reduce the scope of the HealthCare.gov build to deliver only essential functionality
ruthless prioritization	Method for determining the most critical elements of a project to be completed, given the available time and budget; used to make dramatic cuts to the HealthCare.gov project scope in preparation for the second open enrollment period
Scalable Login System (SLS)	New account creation and authentication system created exclusively for HealthCare.gov to improve website performance and its ability to accommodate large changes in number of users (replaced EIDM)
Small Business Health Option Program (SHOP)	Program that provides health plan selection and enrollment for employees of companies with fewer than 50 full-time-equivalent workers
sole source contract	Contract used when an agency's need for certain supplies or services is of such an unusual and compelling urgency that the Government would be seriously injured unless the agency is permitted to limit the sources from which it solicits bids or proposals
special enrollment period	Time period outside of normal open enrollment period during which consumers who experience certain life changes or other circumstances can purchase health insurance
start-up	Type of work environment or culture that encourages creativity and flexibility over rigid management methods and an established hierarchy
State marketplace	Marketplace operated by a State for its residents to obtain information about health plans, apply for Federal financial assistance, and purchase a plan
statement of work	Contract management document that includes contractor work to be performed; location of work; period of performance; schedule for completion (delivery) of work; applicable performance standards; and any special requirements (e.g., security clearances, travel)
technical direction letter (TDL)	Technical guidance provided to a contractor that is meant to clarify, define, or give specific direction within the scope of the contract as written; does not result in changes to the cost, terms, or conditions of the contract

Term	Definition
technical specifications	List of the exact functions, derived from the business requirements, that are used by developers to write software code that creates and supports the website systems
technical systems integrator	Entity that coordinates operations, ensuring that those responsible for various technical aspects of the project communicate their activities, schedules, and needs to each other and that work aligns with project goals
testing environment	Computing and data storage resources devoted to website system testing
towers	CMS teams that include staff and contractors from various offices working together regarding a particular aspect of the project
unauthorized commitment	Contract agreement that is not binding solely because the Government representative who made it lacked the authority to enter into that agreement on behalf of the Government
waiting room	Website function used when HealthCare.gov website traffic overloaded capacity; consumers placed in a waiting room were unable to navigate further in the website until website traffic had reduced

Source: HHS and CMS project management documentation and correspondence, 2015.

APPENDIX D

COMMENTS FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES, OCTOBER 7, 2015

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

OCT - 7 2015

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Breakdown and Recovery of Healthcare.gov: CMS Management of the Federal Marketplace" (OEI-06-14-00350)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Department of Health and Human Services (HHS) Office of Inspector General's (OIG) draft report on CMS's implementation and management of HealthCare.gov. In the five years since the passage of the Affordable Care Act, CMS has worked hard to implement the law. That hard work has paid off – more than 16 million Americans have gained health coverage, and the uninsured rate has decreased by about one-third since October 2013, which is the largest decline in decades. Millions of Americans now rely on the health and financial security that comes from affordable coverage obtained through the Marketplaces.

CMS appreciates the thorough review and documentation of the challenges of the first Open Enrollment period, the turnaround and recovery effort, and how the lessons learned were applied for the second Open Enrollment period. As the draft report describes, in part because the team embraced the challenges and worked collaboratively, CMS was able to execute significant improvements within two months of launch. By the end of the first Open Enrollment period, the website was handling over 125,000 concurrent users and overall nearly 5.5 million people were able to select a plan using HealthCare.gov. Those improvements continued through the second Open Enrollment period when over 8.84 million people were able to select a plan or automatically reenroll using HealthCare.gov.

CMS appreciates the detailed accounting of the challenges and also appreciates the recognition of the efforts of the talented and dedicated public servants who worked tirelessly as a team and created the path to the successes that followed.

As CMS' mission requires us to frequently take on ambitious projects of significant complexity and tight timeframes, we must continue to be committed to high levels of accountability, execution, and continuous improvement. This can best happen in an environment when challenges can be publicly acknowledged and criticism can be acted upon. Overcoming challenges and delivering results in this transparent manner will continue to make CMS a stronger agency. CMS is committed to continuing to meet challenges head on in our aim to exceed the expectations of the millions of Medicare, Medicaid and Marketplace beneficiaries we serve every day.

OIG's recommendation and CMS' response is below.

OIG Recommendation

The HHS OIG recommends that CMS continue to apply lessons from the HealthCare.gov recovery in its management of the Federal Marketplace and broader organization.

CMS Response

CMS strongly concurs with this recommendation. As the HHS OIG noted in its draft report, CMS's application of the management lessons and principles arising from HealthCare.gov's recovery enabled the organization to make a strong turnaround, not only successfully re-launching HealthCare.gov but also improving agency management and culture.

Since the HHS OIG conducted their review, CMS has implemented several initiatives to improve its management. The ten lessons the HHS OIG describes in the draft section, "Call for Continued Progress," are closely aligned with the core principles CMS strives to embed in its culture, operations and daily work. Those principles include a focus on leadership and accountability, continuous prioritization and streamlining, strong program deliverables and measurement, and a flexible and evolving IT strategy aligned with policy requirements. Finally, both through leadership and circumstance, CMS is further developing a culture where bad news is actively solicited and risks are identified and addressed.

As a final note, CMS would like to thank the HHS OIG for its collaboration during this investigation, during which, as the HHS OIG notes, HHS made more than 80 personnel available for interviews and provided approximately 2.5 million documents and communications for review and quotation. The result of this transparency, cooperation, and collaboration have been a report with important guiding principles for CMS and any large organization – private or public—who undertakes a large, complex project with limited time and resources.

ACKNOWLEDGEMENTS

This report was prepared under the direction of Kevin Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Ruth Ann Dorrill, Deputy Regional Inspector General.

Ruth Ann Dorrill served as the team leader for this study, and Ben Gaddis and Jennifer Hagen served as the lead analysts. Other Office of Evaluation and Inspections staff from the Dallas regional office who conducted the study include Amy Ashcraft, Malinda Hicks, and Jeremy Moore. Office of Counsel staff who provided support include Juliet Hodgkins, Elizabeth Holahan, Lonie Kim, Andrew VanLandingham, and Paul Westfall. Other OIG staff who provided support include Assistant Inspector General Erin Bliss, Heather Barton, Rose Folsom, Evan Godfrey, and Maria Maddaloni.

ENDNOTES

[1] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively referred to as the Affordable Care Act (ACA).

[2] Ibid. §§ 1501, 1513.

[3] Ibid. § 1311(a), (b).

[4] Ibid. § 1321(c).

[5] Private health insurance plans certified as meeting certain standards and covering a core set of benefits including doctor visits, preventive care, hospitalization, and prescriptions.

[6] ACA §§ 1401, 1402.

[7] The Henry J. Kaiser Family Foundation, *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion*, December 17, 2015. Accessed at http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/ on January 6, 2016. CMS, *Hawaii: For 2016 insurance coverage, use HealthCare.gov to apply and enroll*. Accessed at https://www.healthcare.gov/hawaii-2016/ on January 6, 2016.

[8] Ibid.

[9] ACA § 1311(c)(6)(A),(B).

[10] 45 CFR § 155.410.

[11] Ibid.

[12] CMS, "Special Enrollment Period." Accessed at https://www.healthcare.gov/glossary/special-enrollment-period/ on February 12, 2016.

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[14] *National Federation of Independent Business v. Sebelius,* 132 S. Ct. 2566 (June 28, 2012).

[15] *King v. Burwell,* 135 S. Ct. 2480 (June 25, 2015).

[16] 76 Fed. Reg. 4703 (Jan. 26, 2011).

[17] HHS, *HHS Fiscal Year (FY) 2016 Budget in Brief*. Accessed at http://www.hhs.gov/about/budget/fy2016/budget-in-brief/index.html#overview on August 14, 2015.

[18] ACA §§ 1411, 1412.

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[20] ACA § 1321.

[21] ACA § 1103.

[22] CMS, "HHS Launches New Consumer Focused Health Care Website www.HealthCare.gov," July 1, 2010. Accessed at http://wayback.archive-it.org/3926/20131018160711/http://www.hhs.gov/news/press/2010pres/07/20100701h.html# on September 14, 2015.

[23] OIG, *Oversight of Private Health Insurance Submissions to the HealthCare.gov Plan Finder*, OEI-03-11-00560, April 2013.

[24] 75 Fed. Reg. 20364 (April 19, 2010).

[25] These regulations were often tri-department regulations issued in conjunction with other Federal agencies.

[26] 45 CFR part 155 and part 156 generally describe marketplace establishment standards and functions and issuer standards and responsibilities.

[27] CMS, Technical Implementation Letters. Accessed at https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/ on August 14, 2015.

[28] 76 Fed. Reg. 4703 (Jan. 26, 2011).

[29] The $1 billion Health Insurance Reform Implementation Fund (HIRIF) was created and funded by Section 1005 of Health Care and Education Reconciliation Act of 2010.

[30] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, February 2014*. Accessed at https://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf on February 8, 2016.

[31] The Departments of Labor, HHS, and Treasury published joint regulations relating to group health plans and health insurance issuers in the group and individual markets.

[32] Section 1302(b) of ACA directs the Secretary of Health and Human Services to define essential health benefits. Non-grandfathered plans in the individual and small group markets both inside and outside of the marketplaces, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the essential health benefits beginning in 2014. Section 1302(b)(1) provides that essential health benefits must include items and services within at least the following 10 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.

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[39] 78 Fed. Reg. 65046 (Oct. 30, 2013).

[40] The deadline for States to submit a Blueprint application for State marketplaces was December 14, 2012. *See* CMS Technical Implementation Letters, *Letter to the Governors on Exchange Blueprints*, November 9, 2012. Accessed at https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/exchange-blueprint-letter.pdf on August, 21, 2015.

[41] OIG, *CMS Did Not Always Manage and Oversee Contractor Performance for the Federal Marketplace as Required by Federal Requirements and Contract Terms*, A-03-14-03001, September 2015. Interviews with CMS staff and CMS correspondence.

[42] OIG, *Federal Marketplace: Inadequacies in Contract Planning and Procurement*, OEI-03-14-00230, January 2015.

[43] Ibid.

[44] Ibid. Although CMS's contracting approaches were permitted under Federal regulations, its procurement decisions may have limited the number of qualified companies that competed for contracts and the number of technically acceptable proposals from which CMS could choose.

[45] Ibid.

[46] Ibid.

[47] Federal Acquisition Regulation (FAR) § 34.004.

[48] OIG, *Federal Marketplace: Inadequacies in Contract Planning and Procurement*, OEI-03-14-00230, January 2015.

[49] FAR § 16.306(a).

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[51] FAR § 1.602. See also HHS Acquisition Regulation (HHSAR), 48 CFR subpart 342.70. See also CMS, *Active Contributors*. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/SystemLifecycleFramework/downloads/ActiveContributors.pdf on August 10, 2015.

[52] FAR §§ 1.602-2(d), 1.604.

[53] FAR § 43.102(a).

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[56] CMS's central repository is referred to as the Collaborative Application Lifecycle Tool (CALT).

[57] CGI Federal initially estimated a cost overrun of $36 million, but ultimately the overrun was $28 million. *See* OIG, *CMS Did Not Always Manage and Oversee Contractor Performance for the Federal Marketplace as Required by Federal Requirements and Contract Terms*, A-03-14-03001, September 2015.

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[59] FAR § 1.602-3. HHSAR 301.602-3.

[60] 78 Fed. Reg. 12834 (Feb. 25, 2013); CMS, *Guidance on State Alternative Applications for Health Coverage,* June 2013. Accessed at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-06192013.pdf on January 22, 2016.

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[62] Entity that coordinates operations, ensuring that those responsible for various aspects of the project communicate their activities, schedules, and needs to each other.

[63] U.S. House of Representatives, House Energy and Commerce Committee, *PPACA Implementation Failures: Answers from HHS,* October 30, 2013. Interviews with CMS staff and CMS correspondence.

[64] A Corrective Action Plan is a contract management document that includes improvements required by contractors to meet deliverables with adequate quality and timeliness.

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[75] The technical experts recruited by the White House largely volunteered their time, but in keeping with Federal employment standards were employed at an hourly rate by QSSI.

[76] The White House, "An Improbable Public Interest Start Up," January 2015. Accessed at https://www.whitehouse.gov/blog/2015/01/21/improbable-public-interest-start on August 14, 2015.

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[78] *Time*, "Code Red: Nightmare Launch of HealthCare.gov and the Team that Figured Out How to Fix It." Issue 183, no. 9. March 4, 2014. Interviews with CMS staff and CMS correspondence.

[79] *The New York Times*, "From the Start, Signs of Trouble at Health Portal," October 12, 2013. Accessed at http://www.nytimes.com/2013/10/13/us/politics/from-the-start-signs-of-trouble-at-health-portal.html?_r=0 on October 13, 2015. *The Washington Post*, "Meet CGI Federal, the company behind the botched launch of HealthCare.gov," October 16, 2013. Accessed at http://www.washingtonpost.com/news/wonkblog/wp/2013/10/16/meet-cgi-federal-the-company-behind-the-botched-launch-of-healthcare-gov/ on October 13, 2015. *The Wall Street Journal*, "Federal Health Site Stymied by Lack of Direction," October 28, 2013. Accessed at http://www.wsj.com/articles/SB10001424052702304682504579158043537719338 on October 13, 2015.

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[89] HHS, ASPE, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*, May 1, 2014. Accessed at http://aspe.hhs.gov/sites/default/files/pdf/76876/ib_2014Apr_enrollment.pdf on October 9, 2015.

[90] An inconsistency does not mean that an applicant provided incorrect information or is receiving Federal financial assistance inappropriately.

[91] OIG, *Marketplaces Faced Early Challenges Resolving Inconsistencies with Applicant Data*, OEI-01-14-00180, June 2014.

[92] Without the ability to resolve inconsistencies, the marketplace cannot ensure that an applicant meets each of the eligibility requirements for enrollment in a health plan.

[93] CMS reported that although not fully automated, the eligibility system was completed in May 2014 and that contractors then began processing the outstanding inconsistencies. CMS reported that by September 2014, they had resolved the majority of inconsistencies and sent coverage termination notices to the 115,000 individuals who failed to submit supporting documentation.

[94] OIG, *Not All of the Federally Facilitated Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible for Qualified Health Plans and Insurance Affordability Programs*, A-09-14-01011, August 2015.

[95] CMS concurred with OIG's recommendation that CMS take action to improve the Federal Marketplace's internal controls related to verifying applicants' eligibility and resolving and expiring inconsistencies. CMS replied that it has an extensive resolution process in place to resolve data matching issues and is continuously improving and refining those processes. For example, even when a consumer is not legally required to provide a Social Security number (SSN), CMS highly recommends to consumers that they provide an SSN as part of the application process for everyone on the application who has one, since providing an SSN enables the FFM to use more efficient electronic verification processes. This should decrease the number of data matching issues.

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[97] OIG, *Federal Marketplace: Inadequacies in Contract Planning and Procurement*, OEI-03-14-00230, January 2015.

[98] Ibid.

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United States Government Accountability Office

Report to Congressional Requesters

February 2016

PATIENT PROTECTION AND AFFORDABLE CARE ACT

CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk

GAO-16-29

February 2016

PATIENT PROTECTION AND AFFORDABLE CARE ACT

CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk

GAO Highlights

Highlights of GAO-16-29, a report to congressional requesters

Why GAO Did This Study

PPACA provides for the establishment of health-insurance marketplaces where consumers can select private health-insurance plans. The Congressional Budget Office estimates the cost of subsidies and related spending under PPACA at $37 billion for fiscal year 2015. GAO was asked to examine the enrollment process and verification controls of the federal Marketplace. For the act's first open-enrollment period ending in March 2014, this report (1) examines the extent to which applicant information is verified through an electronic system, and the extent to which the federal Marketplace resolved "inconsistencies" where applicant information does not match information from federal data sources and (2) describes, by means of undercover testing and related work, potential vulnerabilities to fraud in the federal Marketplace's application, enrollment, and eligibility verification processes. GAO analyzed 2014 data from the Marketplace and federal agencies, interviewed CMS officials, and conducted undercover testing. To perform the undercover testing, GAO submitted or attempted to submit 12 fictitious Marketplace applications. The undercover results, while illustrative, cannot be generalized to the full population of enrollees.

What GAO Recommends

GAO makes eight recommendations, including that CMS consider analyzing outcomes of the verification system, take steps to resolve inconsistencies, and conduct a risk assessment of the potential for fraud in Marketplace applications. The Department of Health and Human Services concurred with GAO's recommendations.

View GAO-16-29. For more information, contact Seto J. Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

What GAO Found

The Patient Protection and Affordable Care Act (PPACA) requires applicant information be verified to determine eligibility for enrollment or income-based subsidies. To implement this verification process, the Centers for Medicare & Medicaid Services (CMS) created an electronic system called the "data services hub" (data hub), which, among other things, provides a single link to federal sources, such as the Internal Revenue Service and the Social Security Administration, to verify consumer application information. Although the data hub plays a key role in the eligibility and enrollment process, CMS does not, according to agency officials, track or analyze aggregate outcomes of data hub queries—either the extent to which a responding agency delivers information responsive to a request, or whether an agency reports that information was not available. In not doing so, CMS foregoes information that could suggest potential program issues or potential vulnerabilities to fraud, as well as information that might be useful for enhancing program management. In addition, PPACA also establishes a process to resolve "inconsistencies"—instances where individual applicant information does not match information from marketplace data sources. GAO found CMS did not have an effective process for resolving inconsistencies for individual applicants for the federal Health Insurance Marketplace (Marketplace). For example, according to GAO analysis of CMS data, about 431,000 applications from the 2014 enrollment period, with about $1.7 billion in associated subsidies for 2014, still had unresolved inconsistencies as of April 2015—several months after close of the coverage year. In addition, CMS did not resolve Social Security number inconsistencies for about 35,000 applications (with about $154 million in associated subsidies) or incarceration inconsistencies for about 22,000 applications (with about $68 million in associated subsidies). With unresolved inconsistencies, CMS is at risk of granting eligibility to, and making subsidy payments on behalf of, individuals who are ineligible to enroll in qualified health plans. In addition, according to the Internal Revenue Service, accurate Social Security numbers are vital for income tax compliance and reconciliation of advance premium tax credits that can lower enrollee costs.

During undercover testing, the federal Marketplace approved subsidized coverage under the act for 11 of 12 fictitious GAO phone or online applicants for 2014. The GAO applicants obtained a total of about $30,000 in annual advance premium tax credits, plus eligibility for lower costs at time of service. The fictitious enrollees maintained subsidized coverage throughout 2014, even though GAO sent fictitious documents, or no documents, to resolve application inconsistencies. While the subsidies, including those granted to GAO's fictitious applicants, are paid to health-care insurers, and not directly to enrolled consumers, they nevertheless represent a benefit to consumers and a cost to the government. GAO found CMS relies upon a contractor charged with document processing to report possible instances of fraud, even though CMS does not require the contractor to have any fraud detection capabilities. CMS has not performed a comprehensive fraud risk assessment—a recommended best practice—of the PPACA enrollment and eligibility process. Until such an assessment is done, CMS is unlikely to know whether existing control activities are suitably designed and implemented to reduce inherent fraud risk to an acceptable level.

Contents

Figures

Abbreviations

APTC	advance premium tax credit
CMS	Centers for Medicare & Medicaid Services
CSR	cost-sharing reduction
data hub	data services hub
DHS	Department of Homeland Security
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
Marketplace	Health Insurance Marketplace
PPACA	Patient Protection and Affordable Care Act
PUPS	Prisoner Update Processing System
SSA	Social Security Administration

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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February 23, 2016

Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, expands the availability of subsidized health-care coverage, and provides for the establishment of health-insurance exchanges, or marketplaces, to assist consumers in comparing and selecting among insurance plans offered by participating private issuers of health-care coverage.[1] Under PPACA, states may elect to operate their own health-care marketplaces, or may rely on the federally facilitated marketplace, or Health Insurance Marketplace, known to the public as HealthCare.gov.[2] The Centers for Medicare & Medicaid Services (CMS), a unit of the Department of Health and Human Services (HHS), is responsible for overseeing the establishment of these online marketplaces, and the agency maintains the federally facilitated marketplace.

PPACA provides subsidies to those eligible to purchase private health-insurance plans who meet certain income and other requirements. With those subsidies and other costs, the act represents a significant, long-term fiscal commitment for the federal government. According to the Congressional Budget Office, the estimated cost of subsidies and related spending under the act is $37 billion for fiscal year 2015, rising to $105 billion for fiscal year 2025, and totaling $880 billion for fiscal years 2016–2025. While subsidies under the act are not paid directly to enrollees, participants nevertheless benefit through reduced monthly premiums or lower costs due at time of service, such as copayments.[3] Because

[1]Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010). In this report, references to PPACA include any amendments made by HCERA.

[2]Specifically, the act required, by January 1, 2014, the establishment of health-insurance marketplaces in all states. In states not electing to operate their own marketplaces, the federal government was required to operate a marketplace.

[3]Enrollees can pay lower monthly premiums by virtue of a tax credit the act provides. They may elect to receive the benefit of the tax credit in advance, to lower premium cost, or to receive it at time of income tax filing, which reduces tax liability. See discussion of the premium tax-credit reconciliation process later in this report.

subsidy costs are contingent on eligibility for coverage, enrollment controls that help ensure only qualified applicants are approved for coverage with subsidies are a key factor in determining federal expenditures under the act.[4] A central feature of the enrollment controls is the federal "data services hub" (data hub), which, among other things, provides a vehicle to check applicant-provided information against a variety of data sources.

In light of the government's substantial fiscal commitment under the act, you asked us to examine enrollment and verification controls of the federal Health Insurance Marketplace (Marketplace). In July 2014, we presented testimony on the results of our work up to that time, focused on application for, and approval of, coverage for fictitious applicants for the 2014 coverage year.[5] In July 2015, we further testified on results of that work, including the maintenance of the fictitious applicant identities and provision of coverage through 2014 and into 2015, and the Marketplace's verification process for applicant documentation.[6] In this review, we

1. examine the extent to which applicant information is verified through the data hub—the primary means for verifying eligibility—and the extent to which the federal Marketplace resolved "inconsistencies" where applicant information does not match information from federal data sources available through the data hub; and
2. describe, by means of undercover testing and related work, potential vulnerabilities to fraud in the federal Marketplace's application, enrollment, and eligibility verification processes, for the act's first open-enrollment period, for 2014 coverage.

To examine outcomes of the data hub applicant verification process, we obtained summary data from key federal agencies involved in the

[4]According to Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) data, about 11.7 million people selected or were automatically reenrolled into a 2015 health-insurance plan under the act. A high fraction of those enrollees—87 percent, in states using the HealthCare.gov system—qualified for the premium tax-credit subsidy provided by the act.

[5]GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act,* GAO-14-705T (Washington, D.C.: July 23, 2014).

[6]GAO, *Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health-Care Coverage and Consumer Subsidies Provided under the Act*, GAO-15-702T (Washington, D.C.: July 16, 2015).

process—the Social Security Administration (SSA), the Internal Revenue Service (IRS), and the Department of Homeland Security (DHS)—on the nature and extent of their responses to electronic inquiries made through the data hub, for the 2014 and 2015 coverage years.[7] We also interviewed agency officials and reviewed statutes, regulations, and other policy and related information. In addition, we obtained applicant data on inconsistencies, subsidies awarded, and submission of required verification documentation, from CMS data systems. We also interviewed CMS officials to obtain an understanding of the application data that CMS maintains and reports.

To determine the reliability of the agency summary data on data hub responses, we interviewed officials responsible for their respective data and reviewed relevant documentation. To determine the reliability of the CMS applicant data on inconsistencies, we performed electronic testing to determine the validity of specific data elements we used to perform our work. We also interviewed CMS officials and reviewed relevant documentation. For both sets of data, based on the reliability examination we undertook for each, we concluded that the data we used for this report were sufficiently reliable for our purposes. For a full discussion of our scope and methodology, including our assessments of data reliability, see appendix I.

To perform our undercover testing of the Marketplace application, enrollment, and eligibility verification process for 2014, we created 12 fictitious identities for the purpose of making applications for individual health-care coverage by telephone and online.[8] Because the federal government, at the time of our review, operated a marketplace on behalf of the state in about two-thirds of the states, we focused our work on those states. We selected three of these states for our undercover

[7]In this report, we use "outcomes" to mean results obtained from inquiries made through the data hub, and not any ultimate determination made whether an applicant inconsistency exists.

[8]For all our applicant scenarios, we sought to act as an ordinary consumer would in attempting to make a successful application. For example, if, during online applications, we were directed to make phone calls to complete the process, we acted as instructed.

applications, and further selected target areas within each state.[9] The results obtained using our limited number of fictional applicants are illustrative and represent our experience with applications in the three states we selected. They cannot, however, be generalized to the overall population of all applicants or enrollees. Our undercover work did not determine the effectiveness of any particular control.

In these 12 applicant scenarios, we chose to test controls for verifications related to the identity or citizenship/immigration status of the applicant.[10] This approach allowed us to test similar scenarios across different states. We made half of these applications online and half by phone.[11]

For both objectives, we reviewed statutes, regulations, and other policy and related information. We also used federal internal control standards and GAO's fraud risk management framework to evaluate CMS's controls.[12]

[9]We based the state selections on factors including range of population size, mixture of population living in rural versus urban areas, and number of people qualifying for income-based subsidies under the act. We selected target areas within each state based on factors including community size. To preserve confidentiality of our applications, we do not disclose here the number or locations of our target areas. We generally selected our states and target areas to reflect a range of characteristics.

[10]As described later in this report, to be eligible to enroll in a qualified health plan offered through a marketplace, an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges). Marketplaces, in turn, are required by law to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies.

[11]In addition to these 12 scenarios, we also created an additional 6 undercover applicant scenarios to examine enrollment through the Marketplace. We sought to determine the extent to which, if any, in-person assisters might encourage our undercover applicants to misstate income in order to qualify for either of the income-based PPACA subsidies. These scenarios and their outcomes are not presented in this report, but are fully described in GAO-15-702T.

[12]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999) and *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 2015), respectively. The internal control standards are a framework for establishing and maintaining internal control, and for identifying and addressing major performance and management challenges and areas at greatest risk of fraud, waste, abuse, and mismanagement. The fraud framework identifies leading practices and presents them in risk-based format to aid program managers in managing fraud risks.

We conducted our performance audit from January 2014 to February 2016 in accordance with 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 based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

Under PPACA, health-care marketplaces were intended to provide a single point of access for individuals to enroll in private health plans, apply for income-based subsidies to offset the cost of these plans—which are paid directly to health-insurance issuers—and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid or the Children's Health Insurance Program. CMS operates the federal Marketplace in about two-thirds of the states.[13]

To be eligible to enroll in a qualified health plan offered through a marketplace, an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges). Marketplaces, in turn, are required by law to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies.[14] These verification steps include validating an applicant's Social Security number, if one is provided;[15] verifying citizenship, status as a national, or lawful presence by comparison with SSA or DHS records; and verifying

[13]Specifically, in 34 states, the federal government operated individual marketplaces. Two states operated their own marketplaces, but applicants applied through HealthCare.gov. As of March 2015, the number of states had grown to 37, according to HHS's Office of the Assistant Secretary for Planning and Evaluation, with the Marketplace accounting for 76 percent (8.8 million) of consumers' plan selections.

[14]42 U.S.C. § 18081(c); 45 C.F.R. §§ 155.310, 155.315, 155.320.

[15]A marketplace must require an applicant who has a Social Security number to provide the number. 42 U.S.C. § 18081(b)(2) and 45 C.F.R. § 155.310(a)(3)(i). However, having a Social Security number is not a condition of eligibility.

household income and family size by comparison against tax-return data from IRS, as well as data on Social Security benefits from SSA.[16]

In particular, PPACA requires that consumer-submitted information be verified, and that determinations of eligibility be made, through either an electronic verification system or another method approved by HHS. To implement this verification process, CMS developed the data hub, which acts as a portal for exchanging information between the federal Marketplace, state-based marketplaces, and Medicaid agencies, among other entities, and CMS's external partners, including other federal agencies. The Marketplace uses the data hub in an attempt to verify that applicant information necessary to support an eligibility determination is consistent with external data sources.

For qualifying applicants, the act provides two forms of subsidies for consumers enrolling in individual health plans, both of which are paid directly to insurers on consumers' behalf. One is a federal income tax credit, which enrollees may elect to receive in advance, which reduces a consumer's monthly premium payment.[17] This is known as the advance premium tax credit (APTC). The other, known as cost-sharing reduction (CSR), is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments.

Under PPACA, an applicant's filing of a federal income tax return is a key element of "back-end" controls—those that occur later in the application or enrollment process, versus those occurring at the outset, or "front end." When applicants apply for coverage, they report family size and the amount of projected income. Based, in part, on that information, the Marketplace will calculate the maximum allowable amount of APTC. An applicant can then decide if he or she wants all, some, or none of the

[16]For further background, see Department of Health and Human Services, Office of Inspector General, *Not All of the Federally Facilitated Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible for Qualified Health Plans and Insurance Affordability Programs*, A-09-14-01011 (Washington, D.C.: August 2015); GAO, *Patient Protection and Affordable Care Act: IRS Needs to Strengthen Oversight of Tax Provisions for Individuals*, GAO-15-540 (Washington, D.C.: July 29, 2015); and GAO, *Healthcare.gov: CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices*, GAO-15-238 (Washington, D.C.: Mar. 4, 2015).

[17]If enrollees do not choose to receive the income tax credit in advance, they may claim it later when filing tax returns.

estimated credit paid in advance, in the form of payment to the applicant's insurer that reduces the applicant's monthly premium payment.

If an applicant chooses to have all or some of his or her credit paid in advance, the applicant is required to "reconcile" on his or her federal tax return the amount of advance payments the government sent to the applicant's insurer on the applicant's behalf with the tax credit for which the applicant qualifies based on actual reported income and family size.[18]

To facilitate this reconciliation process, the Marketplace sends enrollees Form 1095-A, which reports, among other things, the amount of APTC paid on behalf of the enrollee. This information is necessary for enrollees to complete their tax returns. The accuracy of information reported on this form, then, is important for determining an applicant's tax liability, and ultimately, government revenues.[19]

[18]To receive advance payment of the tax credit at time of application, applicants must attest they will file a tax return. The actual premium tax credit for the year will differ from the advance tax credit amount calculated by the Marketplace if family size and income as estimated at the time of application are different from family size and household income reported on the tax return. If the actual allowable credit is less than the advance payments, the difference, subject to certain caps, will be subtracted from the applicant's refund or added to the applicant's balance due. On the other hand, if the allowable credit is more than the advance payments, the difference is added to the refund or subtracted from the balance due.

[19]For more information on IRS implementation of the APTC reconciliation process, see GAO-15-540. This report detailed, among other things, that as of July 2015, incomplete and delayed marketplace data limited IRS's ability to match taxpayer premium tax-credit claims to marketplace data at the time of tax-return filing. In addition, IRS did not know the total amount of advance premium tax-credit payments made to insurers for 2014 marketplace policies, because marketplace data were incomplete. Without this information, IRS did not know the aggregate amount of the advance tax credit that taxpayers should have reported on 2014 tax returns, or the extent of noncompliance with the requirement for recipients of advance premium tax credits to accurately report those amounts on their tax returns.

CMS Does Not Analyze Data Hub Responses Used to Verify Applicant Information and Did Not Resolve One-Third of 2014 Federal Marketplace Applicant Inconsistencies

CMS Does Not Analyze the Extent to Which the Data Hub Provides Applicant Verification Information

As noted, PPACA requires that consumer-submitted information in applications for health-care coverage be verified, and CMS uses the data hub to check external data sources when making eligibility determinations. Hence, the extent to which federal agencies that support the verification system can provide or verify applicant information is a key element of the eligibility and enrollment process.

Under the data hub process, verification efforts include the following:

- **SSA:** The agency responds to data hub inquiries with information from its records on applicant citizenship status, Social Security number, incarceration status, and death. In responding to data hub inquiries, SSA employs a two-step process: It first seeks to match an applicant's name, Social Security number, and date of birth. If SSA can successfully establish this initial match, it will then seek to respond to other requests from the data hub for information, if made, based on specifics of a particular application, such as an applicant's citizenship status. SSA also provides CMS with information on monthly and annual Social Security benefits paid to individuals under

the Old Age, Survivors, and Disability Insurance program, if necessary to determine eligibility.[20]

- **IRS:** The agency provides federal tax information on household income and family size, to be used for determining eligibility for insurance affordability programs, including the APTC and CSR subsidies.

- **DHS:** The agency provides applicant citizenship and immigration status information. If SSA cannot verify citizenship (as described above) and an applicant has also provided an immigration document number relating to citizenship, DHS will be asked to verify the applicant's citizenship, or other immigration status. Or, if applicants have identified themselves as eligible noncitizens and provide immigration document information, DHS will be asked to verify that status.

If the eligibility information applicants provide to the federal Marketplace cannot be verified through the external sources, such as SSA, IRS, and DHS, an inconsistency will result. In particular, an inconsistency can arise when the data hub query process yields no information; or when information is available through the data hub, but it does not match information the applicant has provided.[21]

CMS officials told us the key performance measures for the data hub are computer system availability and the extent to which transmissions of queries and responses are successfully accomplished; that is, that an

[20]According to SSA officials, the agency also has in its records an indicator that signals when there is an issue with a Social Security number, such as if it is stolen and compromised or when an individual has multiple Social Security numbers. These indicator codes, however, are not transmitted to CMS under the data hub system, per CMS-defined system requirements, the officials said. According to the officials, CMS and SSA are exploring whether transmitting such information in data hub responses would be useful. However, the number of records with such codes is currently small—only about 3,000 to 4,000, among the millions of Social Security accounts, they said.

[21]When an inconsistency is generated, the Marketplace is to proceed with determining other elements of eligibility using the attestations of the applicant, and ensure that subsidies are provided on behalf of the applicant, if he or she is qualified to receive them, while the inconsistency is being resolved. As part of this resolution process, the applicant is generally required to submit documentation to substantiate eligibility for the program. In the case of the federal Marketplace, CMS uses a document-processing contractor, which reviews documentation applicants submit, by mail or online upload, to resolve inconsistencies. Inconsistencies are discussed more fully later in this report.

inquiry is made and a corresponding reply received, without regard to content. According to CMS officials, the data hub only captures a code for type of reply that is generated when agencies respond to the inquiries, and those codes are not associated with any other applicant-identifying information or information that may have been provided in response to the query. There are no additional data kept on what information might have been transmitted in the source agency's response, such as income or family size. Likewise, the data hub does not track whether information provided through the data hub matches information originally provided by the applicant, the officials said.

Overall, although the data hub plays a key role in the eligibility and enrollment process, CMS officials said the agency does not track the extent to which the federal agencies deliver responsive information to a request, or, alternatively, whether they report that information was not available. From the standpoint of data hub operations, either outcome is valid, CMS officials told us, and the agency does not focus on the distinction. Additionally, CMS officials said they do not analyze data provided in response to data hub inquiries. By design, the data hub does not store individual transactional data that could be collectively analyzed over time. For policy reasons, the officials said, the agency did not want the data hub to become a data repository itself, and in particular, a repository of sensitive personal data.[22] The CMS officials also said the agency is barred legally from maintaining IRS taxpayer information in the data hub.

With CMS unable to provide us with information on data hub inquiry outcomes, we sought available information from the responding federal agencies. SSA, IRS, and DHS officials generally told us they do not analyze outcomes of data hub inquiries. Instead, they focus on responding to inquiries received. Our review also found that SSA, IRS, and DHS had limited information on the nature and extent of the inquiries made by the data hub. According to the three agencies, available statistics reflect data hub inquiries in general, and cannot be broken out by program, such as a qualified health plan or Medicaid. In addition,

[22]In particular, according to CMS officials, the data hub does not read and store the content of requests received. It only validates message structure and determines routing information to send the request to the correct destination. The data hub next returns the response it receives to the requester. The data hub stores data such as transaction identifier for each request. By CMS requirements, the data hub cannot store privacy data, the officials said.

according to agency officials, an unknown number of data hub applicant inquiries were duplicates, which we could not eliminate from our examination.[23] Instead, agency officials told us, they generally process inquiries sequentially as they are received from the data hub. Thus, while the agencies can provide some information on data hub queries, they cannot provide comprehensive information specifically on number of inquiries and individuals represented by those queries.

Our examination of available statistics from SSA, IRS, and DHS, subject to the limitations noted, showed that while the agencies could successfully provide applicant verification information in a large percentage of cases, they nevertheless did not have data in their records to verify information for millions of data hub inquiries.

SSA. According to statistics provided by SSA, the agency accomplished its match on name, Social Security number, and date of birth in a large majority of cases for PPACA's first enrollment cycle, for 2014 coverage, as shown in table 1.

Table 1: Results of SSA Matching, First Patient Protection and Affordable Care Act (PPACA) Enrollment Cycle (2014 Coverage Year)

Marketplace	Total transactions	Name / Social Security number / date of birth matches	Percentage matched	Number unmatched
Federal Marketplace	**36,431,004**	34,311,390	94.2	2,119,614
State marketplaces	**48,934,452**	46,694,023	95.4	2,240,429
Total	**85,365,456**	**81,005,413**	**94.9**	**4,360,043**

Source: Social Security Administration (SSA) | GAO-16-29

However, for about 4.4 million inquiries—or about 5 percent of the total—the applicant information did not match SSA records. In addition, after completion of the name, Social Security number, and date of birth match, when SSA attempted to verify additional information, the agency could not confirm citizenship in about 8.2 million inquiries where individuals claimed they were citizens.[24] We also obtained updated figures for the

[23]The agencies could not comprehensively identify the number of duplicates: SSA and IRS officials told us they could not identify the number, while DHS officials estimated the duplication rate at about two-thirds of overall queries.

[24]For applicants claiming U.S. citizenship, SSA is the agency where initial verification requests are routed. Lawful presence inquiries go to DHS.

second enrollment cycle—for 2015 coverage. SSA's total matching percentage was slightly higher (96.1 percent vs. 94.9 percent), and the number of unsuccessful citizenship queries was lower (3.6 million vs. 8.2 million), according to available data from SSA.[25]

IRS. According to IRS, household income and family size information was not available for inquiries representing about 30.7 million people,[26] including the following:

- Inquiries representing about 25 million people for whom tax-return information was unavailable, primarily because, according to IRS, no tax returns were found in agency records or there was a mismatch between taxpayer identification number and name.[27]

- Inquiries representing about 3.2 million people where spouse information reported on an application does not match spouse information on file. A spouse mismatch may occur when one partner remarries, or ceases to be a spouse, IRS officials told us.[28]

[25]The open-enrollment period for 2015 coverage ran from November 15, 2014, through February 15, 2015 and was extended for certain qualifying applicants from March 15, 2015, through April 30, 2015. For the 2015 query data here, we obtained information from the agencies for the November 15–April 30 period, except that SSA data were unavailable for November 15–30, 2014, SSA officials told us. Excluding those 2 weeks, SSA's total transactions were 84,884,178.

[26]According to IRS staff, agency statistics on data hub inquiry outcomes are available only on the basis of number of people involved, and not by number of applications. As noted earlier, an unknown number of data hub inquiries were duplicates. Thus, while IRS reports inquiry outcomes on the basis of number of people involved, the figures do not necessarily represent the number of unique individuals.

[27]For the 2013–2014 enrollment cycle, inquiries to IRS were for the two most recently available tax years—tax years 2012 and 2011.

[28]According to IRS, when couples file a joint return, all income is considered joint, so amounts cannot be separated and applied to one spouse or the other. When a PPACA applicant has filed as married filing jointly, and the spouse is not on the application, IRS cannot provide income information for either spouse, because, as noted, income cannot be attributed to one spouse or the other.

- Inquiries representing about 1.3 million people involved in identity theft—victims themselves, or those associated with people who are victims.[29]

For 2015 coverage, the total figure for which IRS was unable to provide income and household size verification information was similar, at 29.2 million people versus 30.7 million people, according to IRS data.

DHS. Among the major federal agencies involved in the data hub process, DHS handled the smallest number of inquiries during the first enrollment cycle—approximately 3.5 million, regarding applicant immigration status.[30] Of these, DHS provided applicant status information through its automated inquiry process in about 3 million inquiries. It could not initially provide information through the data hub process for approximately 510,000 inquiries, or about 15 percent, of the total.[31] For 2015 coverage, the figure for unresolved queries was about the same: status information provided in about 3.5 million inquiries, but with about 634,000, or about 15 percent, initially unresolved, according to DHS data. According to DHS, the reasons for failure to obtain an automated resolution are: a mismatch between reported name and date of birth; inability to find the identifying number of immigration documentation

[29]IRS officials told us the agency maintains taxpayer identity theft indicators independent of PPACA, but that if such an indicator is present on a tax return, IRS does not return income information to the data hub for anyone on the return.

[30]In addition, if SSA cannot verify an applicant's citizenship, and the applicant provides an immigration document number, DHS can respond to an inquiry, according to DHS officials.

[31]According to DHS officials, about one-third of the 510,000 inquiries involved determinations that further research was needed. In the remaining two-thirds of cases, the system identified the possibility of a data entry error, such as name or date of birth. In these cases, according to the officials, the inquiring agency is given the opportunity to correct such an error or submit the query in its original form if the submitting agency believes the information is correct. The officials said records indicate CMS did not make any attempts at correction or to submit queries in their original form. Many of these inquiries could have been successfully verified automatically if CMS had made corrections where DHS had detected an error, DHS officials told us. It is also possible CMS started entirely new inquiries in response, DHS officials said.

supplied by the applicant; expired documentation; and missing information on the legal category used to admit an immigrant.[32]

As noted earlier, CMS does not analyze outcomes of the data hub query process. A variety of standards, however, call for agencies to routinely examine performance and progress toward key goals. Internal control standards for the federal government require that departments and agencies assess program quality and performance over time and work to address any identified deficiencies. In addition, management must continually assess and evaluate controls to assure that the activities the agency employs to implement its controls are sufficient and effective. In particular, information critical to achieving agency objectives, including information related to critical success factors—such as, in this case, the effectiveness of PPACA's primary enrollment control process—should be identified and regularly reported to management.[33] In addition, according to GAO's fraud framework, it is a leading practice to conduct ongoing monitoring and periodic evaluations, to, among other things, provide assurances to managers they are effectively preventing, detecting, and responding to potential fraud, and also to support decisions about allocating resources. Monitoring activities, because of their ongoing nature, can serve as an early warning system for managers to help identify and promptly resolve issues and ensure compliance with current law, regulations, and standards. Moreover, monitoring enables a program to quickly respond to emerging risks to minimize the impact of fraud.[34] A centerpiece of federal management and accountability standards, the Government Performance and Results Act, requires regular review of progress in achieving objectives, including data-driven analysis on progress toward key performance goals and management-improvement priorities.[35] Further, creation of a written plan and timetable for actions to monitor and analyze outcomes of the data hub query process would

[32]In addition to the automated inquiry process, DHS has two additional manual steps for verification inquiries. In August 2015, CMS informed DHS that CMS would no longer automatically proceed to the second verification step when prompted by DHS in cases where the requesting marketplace or agency had not developed second-step capability, DHS officials told us.

[33]GAO/AIMD-00-21.3.1.

[34]GAO-15-593SP.

[35]Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (Aug. 3, 1993), as amended by the GPRA Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (Jan. 4, 2011).

demonstrate organizational commitment to program oversight and improvement, move such actions closer to fruition, and establish a schedule for accountability.

By not assessing the extent to which data hub–provided data matches consumer–provided information, CMS foregoes analysis of the extent to which responding agencies successfully deliver applicant verification information in response to data hub requests. In doing so, CMS foregoes information that could suggest potential program issues or potential vulnerabilities to fraud, as well as information that might be useful for enhancing program management. In addition, to the extent hub inquiries cannot provide requested verification information—leading to generation of applicant inconsistencies—there is a greater burden on both the agency and the applicant to resolve the inconsistency. Also, as our enrollment testing work showed (see discussion later in this report), the inconsistency resolution process that occurs after the initial application is vulnerable to fraudulent submission of applicant documentation. Thus, analysis of data hub query outcomes could be used to assess whether additional data sources or processes could be used to improve the front-end verification process.

CMS officials acknowledged that the current system often leads to generation of inconsistencies because information applicants submit often is more current than information maintained by the federal agencies.[36] By analyzing the outcomes of data hub inquiries, and in particular, clarifying the nature and extent of inconsistencies arising from this process, CMS could, for example, assess whether other sources of data, such as the National Directory of New Hires, could be useful for more current applicant information on income.[37] Similarly, CMS could analyze the

[36]For example, IRS household income information can be up to 2 years old. To the extent there are differences in what applicants report their income to be compared to what CMS can obtain from IRS, inconsistencies, and the need to resolve them, will arise.

[37]The National Directory of New Hires is maintained by the federal Office of Child Support Enforcement within HHS to assist state child support agencies in locating parents and enforcing child support orders. The database contains new hire, quarterly wage, and unemployment insurance information. Congress has authorized specific state and federal agencies to receive information from the database for authorized purposes. More current applicant information on employment and wages would be helpful, CMS officials told us, and that is why CMS has explored the possibility of using the new hire database. The officials declined to elaborate on how serious their exploration has been, but noted CMS would need statutory authority for any such change.

information to examine whether other sources of citizenship information, such as the Department of State's passport data, could be used to aid in verifying applicant citizenship.

The data hub's limited capture of transactional details also means there is not a detailed audit trail between health marketplaces and the federal agencies responding to inquiries, to determine whether a query was appropriately handled. Finally, information that federal agencies maintain, but that is not currently part of the inquiry response process, could also enhance the verification process. For example, on the key variable of household income, IRS reports a limited number of response codes to the data hub when it cannot provide information in response to a hub inquiry. Among them is a generalized description that tax-return information is unavailable. Internally, however, IRS tracks more specific reasons for why tax-return information is unavailable, such as no tax return on file or a mismatch between name and taxpayer identification number.

As for feasibility of scrutinizing data hub inquiry outcomes, CMS officials told us that, as currently operated, the data hub is not equipped to allow such analysis, and that the time required for any such analysis would likely hinder a key data hub goal of providing real-time responses. Further, they said, in some cases, analysis within the data hub would not be possible—for example, as noted earlier, the data hub cannot store protected taxpayer information. We note, however, that any such analysis need not take place within the data hub itself. CMS officials agreed it is possible that such analytical work could be performed on outcomes of hub operations outside the data hub itself, but cautioned that attempting to institute performance criteria could be challenging because success of data hub queries is inherently limited by data available in the source agencies. A comprehensive feasibility study of actions CMS could take to monitor and analyze data hub query outcomes, both quantitatively and qualitatively, would provide a means for the agency to assess a key operation, as standards provide, and could also lead to improved program performance and accountability. Such a study, at the least, could examine not only baseline performance of the data hub process in delivering usable information for applicant verification, but also examine data more qualitatively, such as to identify trends or patterns that could suggest improvements in verification or actions that could reduce the number of inconsistencies that require further attention.

The Federal Marketplace Did Not Resolve About One-Third of Applicant Inconsistencies for Coverage Year 2014, Involving $1.7 Billion in Associated Subsidies

As part of our review, we obtained data from CMS on applicant inconsistencies generated for the federal Marketplace and the value of APTC and CSR subsidies associated with them, for the 2014 coverage year.[38] In particular, to observe the number of inconsistencies created and subsequently resolved, we examined applications that were awarded subsidies and that were created and submitted during the 2014 open-enrollment period plus a special enrollment period extension that followed.[39]

Overall, based on this population, we identified about 1.1 million applications with a total of about 2 million inconsistencies.[40] These applications had combined APTC and CSR subsidies of about $4.4 billion associated with them for coverage year 2014. We found, based on our analysis of CMS data, that the agency resolved about 58 percent of the total inconsistencies, meaning the inconsistencies were settled by consumer action, such as document submission, or removed due to events such as life change, application deletion, or consumer cancellation. Meanwhile, our analysis found about 34 percent of inconsistencies, with about $1.7 billion in associated subsidies, remained open, as of April 2015—that is, inconsistencies still open several months following the close of the 2014 coverage year.

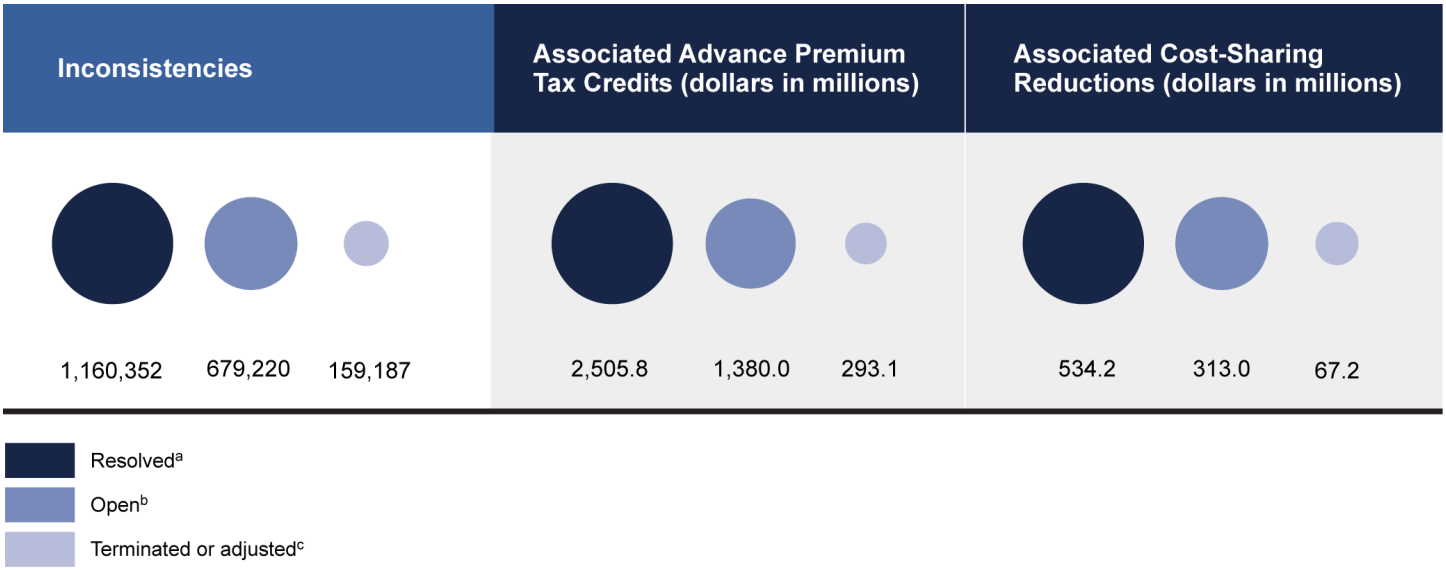
Figure 1 shows the total number of inconsistencies included in our analyses, plus their resolution status and associated subsidy amounts.

[38]To distinguish, we note that the previous section on data hub inquiries focuses on aggregate analysis; this section focuses on resolution of applicant-level inconsistencies that result following the electronic verification process conducted through the data hub.

[39]The open-enrollment period ran from October 1, 2013, to March 31, 2014, and the extension was through April 19, 2014. We also excluded from our analysis applications modified after submission, because CMS officials told us that inconsistencies can be generated or resolved based on consumer actions, such as updating of application information. We selected the unmodified applications that had received subsidies as presenting the simplest case for examining inconsistency generation and subsequent resolution.

[40]Our selection criteria meant excluding 17 percent of the total number of applications with subsidies and data-matching inconsistencies because they had been modified. A single application may reflect more than one person, each of whom might have different inconsistencies in different stages of resolution. The CMS data provided the APTC and CSR amounts at the application level. Consequently, the results of our analysis are not mutually exclusive by type of inconsistency, and applications and their associated subsidy amounts may be represented in multiple categories.

Figure 1: Total Inconsistencies for Unmodified Applications, Subsequent Resolutions, and Terminations or Adjustments, with Associated Subsidy Amounts, for the Federal Marketplace First Enrollment Period, as of April 2015



Sources: GAO (analysis); Centers for Medicare & Medicaid Services (CMS) (data). | GAO-16-29

Notes: Inconsistency status is as of April 2015. Because subsidy information is at the application level, subsidy amounts are not mutually exclusive by resolution status. Data reflect inconsistencies associated with applications made during the 2014 open-enrollment period—October 1, 2013, to March 31, 2014—plus a special enrollment period extension into April 2014; and, in addition, only applications that were not subsequently modified. Based on these criteria, the analysis examined 1.1 million unmodified applications with at least one inconsistency. These applications had total associated advance premium tax credit (APTC) subsidies of almost $3.6 billion and cost-sharing reduction (CSR) subsidies of about $781 million. For a complete breakdown of all inconsistency types in this population, and their resolution status, see app. II.

[a]Resolved status indicates inconsistencies resolved by consumer action, such as document submission, or removed due to events such as life change, application deletion, or consumer cancellation.

[b]Open status indicates applications with inconsistencies that had no reported resolution as of April 2015.

[c]Terminated/adjusted status indicates the federal Health Insurance Marketplace has terminated policies or adjusted subsidies based on failure to submit documentation to resolve inconsistencies.

- Among all applications in our analysis, we identified approximately 690,000 applications with about 1.2 million inconsistencies that had been resolved through consumer or other actions. The subsidies associated with these applications were about $2.5 billion for APTC and $534 million for CSR.

- We also identified about 431,000 applications that had about 679,000 unresolved inconsistencies as of April 2015. These applications had

associated with them subsidy amounts of about $1.4 billion for APTC and $313 million for CSR, for a total of about $1.7 billion.

- CMS, through its contractor, terminated or adjusted the subsidies for about 128,000 other applications based on failure to submit required documentation. These terminated or adjusted applications had about 159,000 inconsistencies. The total value of subsidies associated with these applications was about $360 million, with about $293 million in APTC and $67 million in CSR subsidies.

Appendix II presents further details of our analysis of application inconsistencies, including breakouts by number and category of inconsistencies.

Because unresolved inconsistencies can lead to termination or adjustment of subsidies, which in turn affects government costs for the program, we asked CMS for details of such actions. CMS officials told us the agency does not track the value of APTC or CSR subsidies that change when CMS terminates or adjusts subsidy amounts. Instead, CMS compiles the number of individuals or households affected by such actions. According to federal internal control standards, managers should obtain financial information to make operating decisions, monitor performance, and allocate resources.[41] Tracking the amount of subsidies eliminated or reduced would provide financial information on direct cost to the federal government for such subsidies in a manner that tallies of individuals or households cannot. Hence, by not tracking the magnitude of such subsidy changes, CMS does not collect and have available key financial information relevant to effective program management. In addition, according to GAO's fraud framework, it is a leading practice to assess expected costs and benefits of control activities, to determine whether a particular control is cost-effective.[42] The costs to the government for these subsidies would be a key element of an assessment of the cost-effectiveness of eligibility and enrollment control activities. By not tracking such costs, CMS cannot make a fully informed judgment on best implementation of such control activities.

[41]GAO/AIMD-00-21.3.1.

[42]GAO-15-593SP.

Relatedly, we also identified that, unlike APTC subsidies, CSR subsidies are not subject to a recapture process at the individual level, such as reconciliation on the taxpayer's federal income tax return. In particular, in discussions with CMS and IRS officials, we found that no entity has established a process to identify and recover the value of CSR subsidies. The CSR subsidies increase government costs; and, according to IRS, excess CSR payments, if not recovered by CMS, would be taxable income to the individual for whom the payment was made. CMS officials told us the agency plans to reconcile CSR payments made from the government to insurers. But CMS officials said neither PPACA nor its implementing regulations currently provide for reconciliation or recapture of CSR subsidies at the individual level.

According to federal internal control standards, program managers should be effective stewards of public resources and detect or prevent unauthorized use of agency assets.[43] In addition, according to GAO's framework for managing fraud risk in federal programs, it is a leading practice for program managers to seek to ensure program integrity by, among other things, ensuring that funds are spent effectively and assets are safeguarded. While there is already a recapture process for APTC subsidies, CMS has not evaluated the feasibility, including whether new statutory authority would be required, as well as the expected costs and benefits, of creating a mechanism to recapture CSR subsidies. By doing so, the agency can be more assured it is fulfilling its responsibility to spend funds effectively. Given the multiagency approach to reconciling APTC, any such feasibility evaluation could likewise involve another agency. Further, to the extent that recapture is feasible or reasonable under current statutory authority, creation of a written plan and timetable for providing such a process would demonstrate organizational commitment to fiscal responsibility, move such a project closer to fruition, and establish a schedule for accountability.

CMS Did Not Terminate Coverage or Adjust Subsidies for Certain Types of Inconsistencies

In addressing inconsistencies, CMS decided not to seek terminations of policies or adjustments to subsidies for certain inconsistency types for 2014 and 2015 enrollment. CMS officials told us that their system did not have the capability to take action related to a number of different inconsistency types. As shown in our analysis of 2014 data, CMS did not

[43]GAO/AIMD-00-21.3.1.

terminate or adjust subsides for any applications with incarceration or Social Security number inconsistencies, plus other inconsistencies.[44] Further, CMS officials told us that they currently do not plan to take any actions on individuals with unresolved incarceration or Social Security number inconsistencies.[45]

Social Security Number Inconsistencies

Under PPACA, applicants with a Social Security number must provide it, to allow for verification of citizenship or immigration status. However, having a Social Security number is not a condition of eligibility. Under CMS regulations, the Marketplace must validate all Social Security numbers provided by submitting them to SSA along with other identifying information. If the Marketplace is unable to validate the Social Security number, it must follow the standard process for resolving all types of inconsistencies.[46]

In our inconsistency analysis (discussed in further detail in app. II), we identified about 35,000 applications having an unresolved Social Security number inconsistency, which were associated with about $154 million in combined subsidies. CMS officials told us they did not take action to terminate coverage or adjust subsidies during 2014 based on Social Security number inconsistencies. They said this decision was because

[44]In addition:

- These other inconsistencies relate to American Indian status, and presence of qualifying employer-sponsored coverage or other minimum essential coverage.
- CMS told us that although it checks applicants or enrollees against death information maintained by SSA, it currently does not have the systems capability to change coverage if a death is indicated. Instead, CMS officials told us, the Marketplace has established a self-reporting procedure for individuals to report a consumer's death in order to remove the consumer from coverage. Hence, such cases are not part of the usual inconsistency process.
- Another eligibility criterion in PPACA is that, generally, consumers must reside or work in the service area where they receive coverage, and that the Marketplace must verify applicant-reported residence. CMS officials told us that rather than seek to verify residency, the Marketplace elected to accept applicant attestations of residency without further verification, made under penalty of perjury, as permitted by regulation. This decision was because no acceptable data sources have been identified, the officials said. As a result, there has been no residency inconsistency process, the officials told us, and likewise, no terminations or adjustments of subsidies based on residency.

[45]CMS officials told us that as of July 2015, system capability became available to act on other types of data-matching issues, and the Marketplace would implement that capability for the 2016 open-enrollment period.

[46]45 C.F.R. § 155.315(b).

such inconsistencies are generally related to other inconsistencies, such as citizenship or immigration status, and that document submissions for citizenship or immigration status may also resolve Social Security number inconsistencies. Overall, CMS officials told us they do not consider missing or invalid Social Security number information to be a stand-alone inconsistency that must be resolved, and do not take adverse action in such cases. However, CMS regulations state that "to the extent that the [Marketplace] is unable to validate an individual's Social Security number through the Social Security Administration," the Marketplace must follow its standard inconsistency procedures.[47] Further, when promulgating this regulation, CMS explained that transmission of Social Security numbers to SSA for validation "is separate from the [PPACA] provision regarding citizenship verification, and only serves to ensure that SSNs provided to the [Marketplace] can be used for subsequent transactions, including for verification of family size and household income with IRS."[48]

However, our analysis found more than 2,000 applications with Social Security number inconsistencies that had no corresponding citizenship or immigration inconsistencies. We also identified nearly 5,500 applications with Social Security number inconsistencies that had no corresponding income inconsistency. These applications had total subsidies of about $10 million and $31 million associated with them, respectively. They indicate that Social Security number inconsistencies can stand alone, unrelated to other inconsistencies. Moreover, as discussed in our July 2015 testimony and summarized later in this report, we successfully enrolled and received subsidies for eight undercover identities that either did not provide a Social Security number or had an invalid Social Security identity.[49] Thus, we view unresolved Social Security inconsistencies as a potential fraud vulnerability in the application process.

Social Security number inconsistencies also affect tax compliance. As noted earlier, if an applicant chooses to have all or some of his or her premium tax credit paid in advance, the applicant must reconcile the amount of APTC with the tax credit for which he or she ultimately qualifies based on actual reported income and family size. Although CMS officials told us they do not consider missing or invalid Social Security number

[47]45 C.F.R. § 155.315(b).

[48]77 Fed. Reg. 18310, 18355 (Mar. 27, 2012).

[49]GAO-15-702T.

information to be a stand-alone inconsistency that must be resolved, IRS officials told us a valid Social Security number is critical to tax compliance efforts.

In particular, according to the officials, IRS receives applicant information, including amount of APTC subsidy received, from the federal Marketplace and state-based marketplaces. If this information does not include a Social Security number, or has an invalid Social Security number, IRS cannot use the marketplace data to verify that taxpayers have properly filed APTC information on their tax returns.

Specifically, according to IRS officials, Social Security numbers are a key identifier for tax reconciliation under the act. If a health-insurance marketplace does not provide valid Social Security information to IRS, but a taxpayer nevertheless reports receipt of APTC on his or her tax return, IRS can then contact the taxpayer, the officials told us. This situation results in greater burden on the taxpayer and IRS to resolve the discrepancy. However, if a marketplace does not provide Social Security information to IRS, and a taxpayer does not report receipt of APTC—as a fraudulent filer might do—then IRS is unable to identify unreported APTC benefits (that should be subject to reconciliation) at the time of filing, the officials said.

In addition, a missing or invalid Social Security number impairs IRS outreach to taxpayers who have received the APTC subsidy, IRS officials told us. IRS uses information from the marketplaces to identify those who received APTC, but who did not file a tax return, or who did file a return but requested a filing deadline extension. After close of the filing deadline, IRS sends letters to these taxpayers, reminding them to file a return and reconcile the APTC amount. Without Social Security number information, IRS cannot know who filed a tax return, and thus does not include those taxpayers in its APTC outreach efforts, officials told us.

Thus, according to IRS officials, it is important for tax compliance efforts that CMS validate Social Security numbers—for reconciling APTC, and for outreach efforts. If IRS does not receive valid Social Security numbers, the key back-end control intended by the tax reconciliation process can be frustrated, they said. If IRS is unable to reconcile APTC subsidies, that inability could lead to loss of tax revenue that should otherwise be collected by the government. We asked IRS whether it could provide information on the amount of APTC that went unreconciled, or outreach efforts foregone, due to missing or invalid Social Security

numbers, but officials told us such information was not readily available and would take substantial effort to obtain.

CMS could make greater efforts to resolve Social Security number inconsistencies within its existing system and in the same fashion as it handles other inconsistencies. According to data we reviewed for our inconsistency analysis (discussed earlier), Social Security number inconsistencies are separately identified. In addition, Social Security documents, such as a Social Security card or Social Security benefits letter, are already among acceptable forms of documentation that applicants can provide in response to Marketplace requirements.

Incarceration Inconsistencies

As noted earlier, PPACA provides that incarcerated individuals are not eligible to enroll in a qualified health plan through a marketplace, with the exception of those incarcerated pending disposition of charges. CMS currently uses SSA's Prisoner Update Processing System (PUPS) database to generate incarceration inconsistencies when there are indications an applicant may be incarcerated. As part of the inconsistency resolution process, the Marketplace notifies applicants to send documentation to resolve the inconsistency. To do so, consumers can submit documentation such as release papers, CMS officials told us.

The PUPS system contains information on incarcerated individuals in all 50 state corrections departments, the Federal Bureau of Prisons, and local and other facilities.[50] According to SSA, it is the only national database with records of federal, state, and local incarcerations. SSA uses PUPS to identify individuals who may no longer be eligible for SSA benefits due to incarceration.[51] In addition to SSA, other federal programs, such as Medicare, use PUPS data.

[50]Also included in reporting entities are the District of Columbia and U.S. territories and commonwealths.

[51]According to SSA, the agency suspends Social Security benefits for beneficiaries convicted of a criminal offense and imprisoned for more than 30 continuous days. For Supplemental Security Income, the agency suspends payments for recipients imprisoned throughout a full calendar month. To reinstate benefits and payments after release, beneficiaries and recipients must visit an SSA office and provide a copy of release documents. The Supplemental Security Income program pays monthly benefits to people with limited income who are disabled, blind, or age 65 or older. Blind or disabled children may also receive benefits. Unlike Social Security benefits, Supplemental Security Income benefits are not based on the work history of a beneficiary or a beneficiary's family member.

In its 2013 computer-matching agreement with CMS, SSA acknowledged that PUPS is not as accurate as other SSA data and contains information that SSA may not have independently verified. Thus, the agreement states that CMS will independently verify information it receives from PUPS and will provide individuals an opportunity to contest an incarceration inconsistency before any adverse action in an eligibility determination. Overall, according to SSA officials, PUPS information can be used to identify individuals who require additional follow-up to determine eligibility.

In our inconsistency analysis (discussed in app. II), we identified about 22,000 applications having an unresolved incarceration inconsistency, which were associated with about $68 million in combined subsidies. CMS officials, however, told us they did not terminate eligibility for incarceration inconsistencies, because the agency determined in fall 2014 that PUPS was unreliable for use by the Marketplace. Specifically, CMS determined that PUPS data were not sufficiently current or accurate for use by the Marketplace after receiving reports that people were misidentified as incarcerated, officials told us. PUPS data for inmate release were also unreliable, they said. As a result, CMS officials told us the agency elected to rely on applicant attestations on incarceration status.[52] Under this approach, CMS officials told us, the Marketplace continues to make an initial verification attempt using the PUPS data. If a consumer maintains he or she is not incarcerated, CMS will rely on that representation and not take adverse action, regardless of what PUPS indicates, officials told us. According to HHS officials, the Marketplace no longer requires applicants to submit documentation on incarceration status.

SSA officials told us that CMS did not communicate concerns about reliability of PUPS data to them until after CMS had determined the data to be unreliable. They told us CMS requested a modification to the PUPS data that would result in fewer false positives—where a person is identified as incarcerated but actually has never been so, according to the SSA officials. SSA estimated a cost of $100,000 to provide the

[52]The Marketplace must verify an applicant's attestation that he or she meets the incarceration eligibility requirement, by relying on any electronic data sources available to the Marketplace that HHS has approved for this purpose. However, in the absence of an approved data source, the Marketplace may accept applicant attestation on incarceration status without further verification, unless the attestation is not reasonably compatible with other information in its records. See 45 C.F.R. § 155.315(e).

modification. However, according to SSA officials, CMS was unable to fund the modification and thus deferred the enhancement until after 2016 enrollment.

SSA officials also noted to us that although CMS has expressed concerns about use of PUPS data under PPACA, it continues to use PUPS for the Medicare program. CMS officials explained that PUPS data are acceptable for Medicare because that program uses the data to determine whether Medicare payments are prohibited for claims (regulations generally bar Medicare payments for those jailed), but not for determining overall Medicare eligibility.[53]

SSA considers PUPS data to be accurate for its purposes, because it verifies information about its beneficiaries before taking action, agency officials told us. SSA provides more information to CMS through the data hub than is actually validated by SSA. As a result, SSA officials told us it is imperative that an agency obtaining PUPS information take steps to verify that information. CMS officials told us that, thus far, the agency has not used PUPS data as an indicator for additional follow-up on individual applicant information. Reflecting SSA's use of its PUPS data as a lead for further investigation, a relatively small portion of prisoner alerts generated eventually led to benefit suspensions, according to agency officials. PUPS generated about 1.01 million alerts from October 2012 to August 2015, which prompted notices being sent to beneficiaries. Ultimately, SSA officials said the agency suspended about 131,000 Social Security and 237,000 Supplemental Security Income beneficiaries.

Our review of documentation CMS provided for its decision to take no adverse action on incarceration inconsistencies showed it did not contain key information supporting the agency's decision to not use PUPS data. Specifically, the documentation did not provide specific details on why, or to what extent, people were misidentified as incarcerated; why CMS also judged inmate release information to be unreliable; any criteria or assessment employed to conclude that the PUPS data were not sufficiently current or accurate; or the potential cost associated with not verifying incarceration status. According to federal internal control standards, significant events must be clearly documented, and the

[53]We note that under this reasoning, CMS may not be properly paying Medicare providers for beneficiaries who are erroneously reported as incarcerated.

documentation should be readily available for examination.[54] Without clearly identifying such elements as analysis, scope, and costs of significant decisions, CMS is at greater risk of providing benefits to ineligible applicants, and also may undermine confidence in the applicant verification process and compromise overall program integrity. Although SSA acknowledges that PUPS has a lower level of reliability than other SSA data sources, CMS nevertheless could use information from PUPS in the manner in which it was intended to be used—as a lead for further investigation—to identify individuals who may be required to provide additional documentation for their eligibility determinations. By not using PUPS data in such a fashion, and by relying on applicant attestation in the alternative, CMS may be granting eligibility to, and making subsidy payments on behalf of, individuals who are ineligible to enroll in qualified health plans.

Further, if CMS has determined that PUPS or other data sources are not sufficiently reliable, CMS is maintaining an inconsistency resolution process that is not necessary, given the decision to ultimately rely on applicant attestation. As a result, in continuing to identify incarceration inconsistencies and directing applicants to submit documentation to resolve them, and then processing that documentation, CMS imposes unnecessary cost and burden on both applicants and the Marketplace. In light of the decision to accept applicant attestation, the inconsistency resolution process, whatever its outcome, is not necessary for continued coverage.

[54]GAO/AIMD-00-21.3.1.

Vulnerabilities in Federal Marketplace Enrollment Processes Allowed Subsidized Coverage for 11 of 12 Fictitious Applicants in 2014, with Coverage Continuing into 2015

As described in our July 2015 testimony, we identified vulnerability to fraud, and other issues, when we obtained, through undercover testing, federal Marketplace approval of subsidized coverage for 11 of 12 fictitious applicants for 2014 coverage.[55] In particular, as we reported in our testimony:

- We obtained the APTC subsidy in all cases, totaling about $2,500 monthly, or about $30,000 annually, for all 11 approved applicants. We also obtained eligibility for CSR subsidies.[56] Appendix III summarizes outcomes for all 12 of our phone and online applications, and shows the fictitious applicant scenarios we used to attempt the applications.

- In all 11 cases in which we obtained coverage, the Marketplace directed us, either orally or in writing, to send supporting documentation. However, the Marketplace did not always provide clear and complete communications. As a result, during our testing, we did not always know the current status of our applications or specific documents required in support of them.

- Our 11 fictitious enrollees maintained subsidized coverage throughout 2014, even though we sent fictitious documents, or no documents, to resolve application inconsistencies.

- Following our document submissions, the Marketplace told us, either in writing or in response to phone calls, that the required documentation for all our approved applicants had been received and was satisfactory, even when we had sent no documentation. CMS officials told us that call center representatives do not have available to them information on current status of inconsistencies and applicant submission of documents. The CMS officials said the agency hopes to add the ability to provide inconsistency status information to the call

[55]For full details of our undercover testing for the 2014 coverage year, see GAO-15-702T.

[56]The APTC and CSR subsidies are not paid directly to enrolled consumers; instead, the federal government pays them to issuers of health-care policies on consumers' behalf. However, they represent a benefit to consumers—and a cost to the government—by reducing out-of-pocket costs for medical coverage. Because the benefit realized through the CSR subsidy can vary according to medical services used, the value to consumers of such subsidies can likewise vary. Even if not obtaining subsidies, applicants can also benefit if they obtain coverage for which they would otherwise not qualify, such as by not being a U.S. citizen or national, or lawfully present in the United States.

center representatives, but they did not know how long this would take.[57]

- There have been no cases of fraudulent applications or documentation referred to the U.S. Department of Justice or the HHS Office of Inspector General, because CMS's document-processing contractor has not identified any fraud cases to CMS. However, the contractor is not required to detect fraud, nor is it equipped to do so.[58] Instead, CMS requires the contractor only to inspect for documents that have obviously been altered. Overall, according to CMS officials, the agency has limited ability to detect and respond to attempts at fraud. They told us CMS must balance consumers' ability to "effectively and efficiently" select Marketplace coverage with "program-integrity concerns."

- As explained later in this section, CMS effectively waived certain applicant documentation requirements for 2014, which likely accounted for some of our applicants' ability to retain coverage. Specifically, for the 2014 coverage year, CMS directed its document contractor not to terminate policies or subsidies if an applicant submitted any documentation to the Marketplace. Typically, applicants submit documentation after receiving a notice from the Marketplace. Thus, if an applicant submitted at least one document, whether it resolved an inconsistency or not, that would be deemed a sufficient good-faith effort so that the Marketplace would not terminate either the policy or subsidies of the applicant, even if other documentation had initially been required.[59]

[57]After we provided CMS with a draft version of this report, the agency said that call center representatives currently receive daily updates on the status of eligibility documentation, but that CMS continues working to provide the representatives with real-time status information.

[58]Fraud involves obtaining something of value through willful misrepresentation. Whether conduct is in fact fraudulent is a determination to be made through the judicial or other adjudicative system. For information generally on fraud controls, see GAO-15-593SP.

[59]For example, in the case of an income inconsistency, contractor procedures stated there will not be action taken "if the consumer or anyone in the household has sent any supporting document … regardless of the relevance of the document to the Annual Income inconsistency." Specifically, for instance, there will be no action on the income issue "if the consumer or household member has sent a document relating to immigration, even though that document cannot be used to resolve the Annual Income inconsistency."

- The Marketplace automatically reenrolled coverage for all 11 fictitious applicants for 2015.
- Although tax filing information is key to reconciling APTC, we found errors with the information CMS reported on 1095-A forms for 3 of our 11 fictitious applicants.[60]
- The Marketplace later terminated subsidized coverage for 6 of our 11 applicants in early 2015, but after contacts with Marketplace representatives, we restored coverage for 5 of these applicants—with larger subsidies.

Inability to Provide Information on Status of Document Submissions Is a Vulnerability and Could Lead to Consumer Frustration

In the case of call center representatives not having current information on consumer document submissions, internal control standards for the federal government call for agency management to ensure there are adequate means of communicating with, and obtaining information from, external stakeholders that may have a significant impact on the agency achieving its goals.[61] In addition, CMS has noted the importance of the quality of consumers' experiences with the Marketplace, particularly in dealing with call centers. The inability of call center representatives to obtain current document status information after the application process is complete is not only a potential vulnerability for efficient and effective operation of the system, but can also be a frustration for consumers attempting to provide requested eligibility information, and could cause them to not file documentation as appropriate. In turn, that could affect CMS's goal of extending health-insurance coverage to all qualified applicants. Given CMS officials' stated desire to add the ability to provide

[60]The errors we encountered were of a different type than those announced by CMS in February 2015, when the agency said about 800,000 tax filers had received Forms 1095-A that listed incorrect benchmark plan premium amounts. For details, see http://blog.cms.gov/2015/02/20/what-consumers-need-to-know-about-corrected-form-1095-as/, accessed on June 30, 2015. In addition to the errors we identified in our undercover applicants' tax-reporting forms, GAO has also identified other concerns with the tax reconciliation process. Among other things, as of July 2015, incomplete and delayed marketplace data limited IRS's ability to match taxpayer premium tax-credit claims to marketplace data at the time of tax-return filing. In addition, IRS did not know the total amount of APTC payments made to insurers for 2014 marketplace policies, because marketplace data were incomplete. Without this information, IRS did not know the aggregate amount of APTC that taxpayers should have reported on 2014 tax returns, or the extent of noncompliance with the requirement for recipients of APTC to accurately report those amounts on their tax returns. See GAO-15-540.

[61]GAO/AIMD-00-21.3.1.

inconsistency status information to the call center representatives, creation of a written plan and timetable for doing so would demonstrate organizational commitment, move such a project closer to completion, and establish a schedule for accountability.

Although Fraud Prevention and Program Integrity Are Stated Key Goals, CMS Has Not Taken the Initial Step of Conducting a Fraud Risk Assessment

Regarding fraud vulnerability an agency may face, federal internal control standards provide that a key internal control is to assess risks an agency faces from both internal and external sources.[62] Similarly, a strategic goal for HHS, CMS's parent agency, is to strengthen program integrity and responsible stewardship by, among other things, fighting fraud and focusing on performance and risk management. In addition, according to GAO's framework for managing fraud risks in federal programs, it is a leading practice for agencies to regularly assess risks to determine a fraud risk profile.[63] As part of that process, agencies should identify inherent fraud risks to their programs and determine the likelihood and impact of those risks on program objectives. In addition to financial impacts, fraud risks can affect a program's reputation and compliance with statutes and regulations.

We asked CMS to provide us with any fraud risk assessment for the eligibility and enrollment process the agency may have conducted. Agency officials were unable to provide us with any such assessment. CMS officials did tell us the agency plans to conduct an assessment of the Marketplace's eligibility determination process, including the application process and the inconsistency resolution process. CMS officials did not provide a firm date for completion. We note, however, that while such work could be constructive, it would not necessarily constitute the type of thorough fraud risk assessment as provided in GAO's fraud framework. In addition, CMS officials told us the agency is beginning to perform risk assessments of the accuracy of payments made to insurers to fund APTC and CSR subsidies. Again, while such work could be

[62]GAO/AIMD-00-21.3.1.

[63]GAO-15-593SP.

constructive, we distinguish this from a fraud risk assessment of the eligibility and enrollment process.[64]

As previously noted, we retained coverage and subsidies for all 11 applicants originally covered, even though we had submitted fictitious documents or no documents to resolve application inconsistencies.[65] These results, while not generalizable, nevertheless illustrate that the Marketplace enrollment process is vulnerable to fraud. Without conducting a fraud risk assessment—as distinct from a more generalized review of the eligibility determination process, as described earlier—CMS is unlikely to know whether existing control activities are suitably designed and implemented to reduce inherent fraud risk to an acceptable level. Moreover, CMS is at greater risk of improperly providing benefits as well as facing reputational risks to the program through perceptions that program integrity is not a priority.

CMS Effectively Waived Certain Document Filing Requirements for 2014, and Did Not Fully Analyze the Effects of the Decision

In the case of CMS effectively waiving certain document submission requirements, PPACA authorized the agency, for the 2014 coverage year, to extend the period for applicants to resolve inconsistencies unrelated to citizenship or lawful presence.[66] Additionally, regulations provide that CMS may extend the period for an applicant to resolve any type of inconsistency when the applicant demonstrates a "good-faith effort" to submit the required documentation during the resolution period.[67] CMS officials told us that the submission of a single document served as sufficient evidence of a good-faith effort by the applicant to resolve all

[64]According to GAO's fraud risk management framework, the key steps for effective fraud risk management are the following:

- Commit to combating fraud by creating an organizational culture and structure conducive to fraud risk management.
- Plan regular fraud risk assessments and assess risks to determine a fraud risk profile.
- Evaluate outcomes using a risk-based approach and adapt activities to improve fraud risk management.
- Design and implement a strategy with specific control activities to mitigate assessed fraud risks and collaborate to help ensure effective implementation.

[65]Thus, regarding our analysis of unresolved inconsistencies presented earlier in this report, we note that resolution of an inconsistency could itself be accomplished by fraudulent means, such as our filing of fictitious documents.

[66]42 U.S.C. § 18081(e)(4)(A).

[67]45 C.F.R. § 155.315(f)(3).

inconsistencies, and CMS therefore extended the inconsistency resolution period through the end of 2014. Hence, CMS did not terminate coverage for any applicant who made such an effort in 2014.

Our analysis of CMS documentation of the agency's application of the good-faith effort regulation showed CMS did not sufficiently analyze or document its decision and its impact. Specifically, documentation CMS provided to us did not include information on key factors including the number of applications and inconsistencies this decision affected or was expected to affect; expected costs associated with the decision; or an explicit rationale, created at the time of the decision, for why partial submission of documents constituted a "good-faith effort" sufficient to resolve all inconsistencies.

According to federal internal control standards, significant events—in this case, applying CMS's good-faith regulation to effectively waive submission of satisfactory documents to resolve application inconsistencies—must be clearly documented, and the documentation should be readily available for examination. All such documentation and records should be properly managed and maintained.[68] To the extent CMS's implementation of the good-faith effort regulation allows otherwise ineligible applicants to obtain and maintain subsidized coverage, it contributes to what has been called a practice of "pay and chase"—attempting to recover overpayments (potentially obtained through fraud) once they have already been made. Without clearly identifying and fully documenting, on a contemporaneous basis, the policy objectives, supporting analysis, scope, and expected costs and effects of implementing the good-faith effort, or other significant decisions on enrollment and eligibility matters, CMS undermines transparency and ability to communicate most effectively with both internal and external stakeholders, and also may undermine confidence in the applicant verification process and compromise program integrity.

HHS did provide us with an explanation of the agency's decision to apply the good-faith effort regulation in such a way that certain applicant document submission requirements were effectively waived. Due to what an HHS official said were "resource limitations and operational challenges," the Marketplace had limited ability to provide assistance to

[68]GAO/AIMD-00-21.3.1.

applicants with data matching issues in 2014. According to the official, the Marketplace often had no ability to identify and match which applicants had even submitted documentation until well after the 90-day inconsistency resolution period. Further, once the Marketplace was able to increase its capacity to match applications with applicant-submitted documentation, it still took months to catch up, the official said. Compounding the difficulties, the official said, was that the Marketplace's initial guidance to consumers needing to submit verification documentation was not sufficiently specific.

The result, according to HHS, was that applicants were effectively denied the statutorily mandated period to resolve inconsistencies, and the Marketplace would not have been authorized to terminate enrollment of those who had made a good-faith effort to resolve their inconsistencies. According to the official, the decision to apply the good-faith effort regulation in a way that waived certain document submission requirements recognized that applicants required a better understanding of the eligibility process and that many consumers faced frustrating technical problems with seeking to resolve inconsistencies.

CMS officials told us that the agency was generally enforcing the full submission requirement for 2015, and that good-faith extensions granted in 2015 were decided on a case-by-case basis and were of limited length. All consumers, regardless of whether they benefitted from the good-faith effort extension in 2014, will still be subject to deadlines for filing sufficient documentation, they said. In particular, according to the officials, those who made a good-faith effort by submitting documentation, but failed to clear their inconsistencies in 2014, were among the first terminations in 2015, which they said took place in February and early March. In addition, according to HHS, CMS expects to issue guidance outlining how the Marketplace will determine whether an applicant has demonstrated a good-faith effort to obtain the required documentation, and expects good-faith extensions for applications for 2016 coverage to be very limited.

CMS also provided some information on other terminations and adjustments. Officials told us that from April through June of 2015, enrollment in coverage through the federal Marketplace was terminated for about 306,000 consumers with citizenship or immigration status data-matching issues who failed to produce sufficient documentation. In addition, according to the officials, about 735,000 households with income inconsistencies had their APTC or CSR subsidies adjusted for coverage year 2015. By comparison, HHS reported that more than 8.84 million people selected or were automatically reenrolled in 2015 plans through

the federal Marketplace as of the end of the second open-enrollment period on February 15, 2015. While the information CMS provided reflected gross terminations and adjustment activity, it did not include details on fiscal impact of the actions.

Conclusions

Implementation of the new PPACA eligibility and enrollment provisions for the act's first year was a broad, complex, and costly undertaking. In light of that, standards for achieving efficiency and transparency, and assessing risk and fraud potential, are especially relevant. CMS effectively waived a significant portion of the Marketplace eligibility determination procedures for the 2014 coverage year. However, as our review demonstrated, the enrollment process is vulnerable to fraud. Our work indicates a number of areas where CMS should act to enhance program integrity and management and better assess potential fraud risk.

The data hub plays a pivotal role in the application process, supporting the electronic data matching used to assess applicant eligibility, which in turn determines billions of dollars in federal spending. As such, CMS program management would benefit from the ability to monitor and analyze the extent to which data hub queries provide requested or relevant applicant verification information. CMS officials stressed to us that, by design, the hub itself is not equipped to perform analysis, but agreed that any such analysis need not take place within the data hub itself. Data hub inquiries are important not only as a front-end control measure, but also because what happens at the front end affects back-end controls as well: The more applicant inconsistencies that arise following data hub queries—because the data hub process cannot successfully confirm applicant information—the more emphasis accrues to back-end controls. These back-end controls involve efforts first by applicants to submit required documentation and then by the Marketplace to resolve the inconsistencies. But as our work showed, the process is vulnerable to fraud. A greater understanding of the effectiveness of the data hub process could inform assessments about effectiveness of enrollment and eligibility controls, while still incorporating procedures that seek to safeguard applicant information. Underscoring the need for comprehensive data collection and analysis is that the agencies responding to data hub inquiries themselves have limited and inconsistent information available on query outcomes. CMS could conclude, upon making a comprehensive review of data hub inquiry outcomes, that current procedures are adequate. But without such a review, CMS cannot make a best-informed judgment.

In the case of not seeking to resolve Social Security number and incarceration inconsistencies, CMS officials effectively further waived program eligibility controls. In the case of incarceration inconsistencies, incarceration status is one of three initial eligibility criteria specified by PPACA. In the case of Social Security inconsistencies, regulations specify a resolution process that CMS did not follow, and the CMS decision also undermines IRS tax compliance efforts—a key control for ensuring that APTC subsidies, a significant federal cost under the program, are properly received.

Similarly, the inability of Marketplace call center representatives to have current information on the status of applicant document submissions can create consumer frustration and impair timely and accurate filing of eligibility information.

CMS has assumed a passive approach to identifying and preventing fraud. CMS relies on a contractor charged with document processing to report possible instances of fraud, even though CMS does not require the contractor to have fraud detection capabilities. Adopting a more strategic, risk-based approach could help identify fraud vulnerabilities before they could be exploited in the enrollment process. A comprehensive risk assessment identifying the potential for fraud in the enrollment process—which thus far has not been performed—could inform evaluations of program integrity and the effectiveness of enrollment and eligibility controls. In particular, as part of that, determining the value of terminated or adjusted subsidy payments—both APTC and CSR—could provide insight into financial risk the federal government faces when eligibility requirements are not met or it is determined application fraud may have occurred. In the specific case of CSR subsidies, it could be reasonable, depending on amounts determined to be at stake, to seek a method, and additional legislative authority, as necessary, for recovering benefits received, as there currently is for the APTC subsidy.

CMS's effective waiving of certain document filing requirements for applicant inconsistencies, through its application of the good-faith effort regulation, was a significant policy and financial decision—it allowed an unknown number of applicants to retain coverage, including subsidies, they might otherwise have lost, thus producing higher costs for the federal government. Similarly, we found CMS's decision on the reliability of PUPS data for resolving incarceration inconsistencies to be only partially documented. By failing to fully document its actions, including factors such as factual basis, scope, and cost, CMS undermines transparency

and ability to communicate effectively with both internal and external stakeholders, and also may undermine confidence in the program.

Recommendations for Executive Action

To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, we recommend that the Secretary of Health and Human Services direct the Acting Administrator of CMS to take the following eight actions:

1. Conduct a comprehensive feasibility study on actions that CMS can take to monitor and analyze, both quantitatively and qualitatively, the extent to which data hub queries provide requested or relevant applicant verification information, for the purpose of improving the data-matching process and reducing the number of applicant inconsistencies; and for those actions identified as feasible, create a written plan and schedule for implementing them.
2. Track the value of APTC and CSR subsidies that are terminated or adjusted for failure to resolve application inconsistencies, and use this information to inform assessments of program risk and performance. (See related recommendation 7.)
3. In the case of CSR subsidies that are terminated or adjusted for failure to resolve application inconsistencies, consider and document, in conjunction with other agencies as relevant, whether it would be feasible to create a mechanism to recapture those costs, including whether additional statutory authority would be required to do so; and for actions determined to be feasible and reasonable, create a written plan and schedule for implementing them.
4. Identify and implement procedures to resolve Social Security number inconsistencies where the Marketplace is unable to verify Social Security numbers or applicants do not provide them.
5. Reevaluate CMS's use of PUPS incarceration data and make a determination to either
    a. use the PUPS data, among other things, as an indicator of further research required in individual cases, and to develop an effective process to clear incarceration inconsistencies or terminate coverage, or

b. if no suitable process can be identified to verify incarceration status, accept applicant attestation on status in all cases, unless the attestation is not reasonably compatible with other information that may indicate incarceration, and forego the inconsistency process.

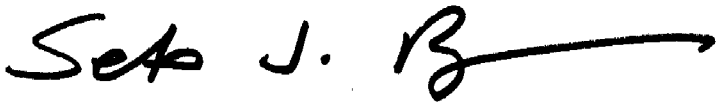
6. Create a written plan and schedule for providing Marketplace call center representatives with access to information on the current status of eligibility documents submitted to CMS's documents processing contractor.
7. Conduct a fraud risk assessment, consistent with best practices provided in GAO's framework for managing fraud risks in federal programs, of the potential for fraud in the process of applying for qualified health plans through the federal Marketplace.
8. Fully document prior to implementation, and have readily available for inspection thereafter, any significant decision on qualified health plan enrollment and eligibility matters, with such documentation to include details such as policy objectives, supporting analysis, scope, and expected costs and effects.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS, SSA, IRS, and DHS for their review and comment. HHS provided written comments, reproduced in appendix IV, in which the agency concurred with our recommendations. HHS said it is committed to verifying consumer eligibility for Marketplace plans and subsidies provided to qualifying applicants. HHS outlined several actions it plans to take, or is considering, to strengthen its oversight of the federal Marketplace. However, while concurring with our recommendations, HHS did not elaborate on particular actions it would take to implement them. For example, while saying HHS is working to provide call center representatives with current status of eligibility documentation, there is no indication how and when this will be done. Similarly, while agreeing to reevaluate use of PUPS incarceration data, HHS said it continues to use PUPS data as a "trusted data source" while also questioning its utility. Because actions in response to our recommendations have yet to be implemented, and it is not yet clear when and how such steps will be taken, it is too early to determine whether they will fully address the issues we identified. All four agencies provided us with technical comments, which we have incorporated, as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Acting Administrator of CMS, the Acting Commissioner of Social Security, the Commissioner of Internal Revenue, the Secretary of Homeland Security, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.



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Director of Audits
Forensic Audits and Investigative Service

List of Requesters

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Rob Portman
Chairman
Permanent Subcommittee on Investigations
Committee on Homeland Security & Governmental Affairs
United States Senate

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Fred Upton
Chairman
Committee on Energy & Commerce
House of Representatives

The Honorable Peter Roskam
Chairman
Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The Honorable Charles Boustany, Jr.
Chairman
Subcommittee on Tax Policy
Committee on Ways and Means
House of Representatives

Appendix I: Objectives, Scope, and Methodology

The objectives of this review are to (1) examine the extent to which information submitted by applicants under the Patient Protection and Affordable Care Act (PPACA) is verified through the federal "data services hub" (data hub)—the primary means for verifying eligibility—and the extent to which the federal Health Insurance Marketplace (Marketplace) resolved "inconsistencies" where applicant information does not match information from federal data sources available through the data hub; and (2) describe, by means of undercover testing and related work, potential vulnerabilities to fraud in the federal Marketplace's application, enrollment, and eligibility verification processes, for the act's first open-enrollment period, for 2014 coverage.

To examine outcomes of the data hub applicant verification process, we obtained information from key federal agencies involved in the process—the Social Security Administration, the Internal Revenue Service, and the Department of Homeland Security—on the nature and extent of their responses to electronic inquiries made through the data hub, for the 2014 and 2015 coverage years. We also interviewed agency officials and reviewed statutes, regulations, and other policy and related information. To assess the reliability of the agency summary data on data hub responses, we interviewed officials responsible for their respective data and reviewed relevant documentation. We concluded the data were sufficiently reliable for our purposes. In addition, we obtained applicant data on inconsistencies, subsidies awarded, and submission of required verification documentation, from the Centers for Medicare & Medicaid Services' (CMS) Multidimensional Insurance Data Analytics System. These data include subsidies provided and submission status of required verification documents as of April 2015, for coverage received for the act's first open-enrollment period, including for our undercover applications. Specifically, the enrollment period included was October 1, 2013, to March 31, 2014, and also included a special enrollment extension into April 2014. These data included

- application information, such as application version, date of creation, date of submission, and total application-level subsidies for coverage year 2014; and
- inconsistency information, such as type of inconsistency and resolution status as of April 2015.

For our analysis, we excluded applications modified from their original version, as well as applications with submission and creation dates after the special enrollment period ending in April 2014. To examine inconsistency resolution, we grouped inconsistencies into CMS-identified

categories and determined, at the application level, subsidy amounts associated with them. As provided to us by CMS, subsidy information is at the application level, while inconsistencies occur at the individual level. As a result, subsidy amounts are not mutually exclusive by resolution status. For example, a single application may have an open inconsistency in one category, but a resolved inconsistency in another. Thus, subsidy amounts associated with the application would be reflected in subsidy totals for each resolution status. This limitation, however, does not affect our overall calculation of subsidies associated with applications with one or more unresolved inconsistencies. To identify applications with Social Security number inconsistencies and no associated citizenship/immigration or income inconsistency, we first identified applications with Social Security number inconsistencies. We used those applications' unique identifiers to match them to applications with citizenship/immigration or income inconsistencies, and then removed those applications appearing in both categories. Additionally, we interviewed CMS officials to obtain an understanding of the application data that CMS maintains and reports. To assess the reliability of the CMS applicant data on inconsistencies, we performed electronic testing to determine the validity of specific data elements we used to perform our work. We also interviewed CMS officials and reviewed relevant documentation. On the basis of our discussions with agency officials and our own testing, we concluded the data were sufficiently reliable for our purposes.

To perform our undercover testing of the Marketplace application, enrollment, and eligibility verification processes, we created 12 fictitious identities for the purpose of making applications for individual health-care coverage by telephone or online.[1] Because the federal government, at the time of our review, operated a marketplace on behalf of the state in about two-thirds of the states, we focused our work on those states.[2] We selected three of these states for our undercover applications, and further

[1]For all our applicant scenarios, we sought to act as an ordinary consumer would in attempting to make a successful application. For example, if, during online applications, we were directed to make phone calls to complete the process, we acted as instructed.

[2]By focusing on federal Marketplace states, we also avoided introducing into our analysis any differences that might be present in how state-based marketplaces operate.

selected target areas within each state.[3] To maintain independence in our testing, we created our applicant scenarios without knowledge of specific control procedures, if any, that CMS or other federal agencies may use in accepting or processing applications. We thus did not create the scenarios with intent to focus on a particular control or procedure.[4] The results obtained using our limited number of fictional applicants are illustrative and represent our experience with applications in the three states we selected. They cannot, however, be generalized to the overall population of all applicants or enrollees. In particular, our tests were intended to identify potential control issues and inform possible further work. We began our undercover testing in January 2014 and concluded it in April 2015. We shared details of our work with CMS during the course of our testing, to seek agency responses to the issues we raised.

For these 12 applicant scenarios, we chose to test controls for verifications related to the identity or citizenship/immigration status of the applicant.[5] This approach allowed us to test similar scenarios across different states. We made half of these applications online and half by phone. In these tests, we also stated income at a level eligible to obtain both types of income-based subsidies available under PPACA—a premium tax credit and cost-sharing reduction (CSR).[6] Our tests included

[3]We based the state selections on factors including range of population size, mixture of population living in rural versus urban areas, and number of people qualifying for income-based subsidies under the act. We selected target areas within each state based on factors including community size. To preserve confidentiality of our applications, we do not disclose here the number or locations of our target areas. We generally selected our states and target areas to reflect a range of characteristics.

[4]We were aware of general eligibility requirements, however, from public sources such as websites.

[5]To be eligible to enroll in a qualified health plan offered through a marketplace, an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges). Marketplaces, in turn, are required by law to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies.

[6]To qualify for these income-based subsidies, an individual must be eligible to enroll in marketplace coverage; meet income requirements; and not be eligible for coverage under a qualifying plan or program, such as affordable employer-sponsored coverage, Medicaid, or the Children's Health Insurance Program. CSR is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments. Because the benefit realized through the CSR subsidy can vary according to medical services used, the value to consumers of such subsidies can likewise vary.

fictitious applicants who provided invalid Social Security identities, noncitizens incorrectly claiming to be lawfully present in the United States, and applicants who did not provide Social Security numbers. As appropriate, in our applications for coverage and subsidies, we used publicly available information to construct our scenarios. We also used publicly available hardware, software, and materials to produce counterfeit or fictitious documents, which we submitted, as appropriate for our testing, when instructed to do so. We then observed the outcomes of the document submissions, such as any approvals received or requests to provide additional supporting documentation.[7]

Overall, our review covered the act's first open-enrollment period, for 2014 coverage, as well as follow-on work through 2014 and into 2015 after close of the open-enrollment period.

For both objectives, we reviewed statutes, regulations, and other policy and related information. We also used federal internal control standards and GAO's fraud risk management framework to evaluate CMS's controls.[8]

We conducted this performance audit from January 2014 to February 2016 in accordance with 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 based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

[7]In addition to these 12 scenarios, we also created an additional 6 undercover applicant scenarios to examine enrollment through the Marketplace. We sought to determine the extent to which, if any, in-person assisters might encourage our undercover applicants to misstate income in order to qualify for either of the income-based PPACA subsidies. These scenarios and their outcomes are not presented in this report, but are fully described in GAO, *Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health-Care Coverage and Consumer Subsidies Provided under the Act*, GAO-15-702T (Washington, D.C.: July 16, 2015).

[8]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999) and *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 28, 2015), respectively.

Appendix II: Inconsistencies by Number of Applications and Category of Inconsistency

Figure 2 presents details of our analysis of inconsistency data from the Centers for Medicare & Medicaid Services (CMS), by number of applications, in the population identified for our analysis of CMS data, with associated subsidies. The population was applications made during the 2014 open-enrollment period—October 1, 2013, to March 31, 2014—plus a special enrollment period extension into April 2014; and, in addition, only applications that were not subsequently modified. These applications had associated with them a total of about $3.6 billion in advance premium tax credit subsidies and about $781 million in cost-sharing reduction subsidies.

Figure 2: Number of Applications, by Category and Resolution Status, for Federal Health Insurance Marketplace Unmodified Applications, with Associated Subsidies, First Enrollment Period, as of April 2015

Inconsistency Category	Applications			Associated Advance Premium Tax Credits (dollars in millions)			Associated Cost-Sharing Reductions (dollars in millions)		
Income	459,309	287,433	64,249	1,573.0	857.4	158.2	313.6	189.9	34.8
Citizenship/ Immigration	326,563	140,742	64,806	1,313.0	513.8	138.3	297.3	119.5	33.3
Incarceration	6,956	21,704	0	21.0	53.1	0	5.4	14.5	0
Social Security Number	29,318	35,414	0	114.0	126.1	0	25.1	28.0	0
Other[a]	4,927	24,135	0	18.5	87.2	0	6.9	21.4	0

Resolved[b]
Open[c]
Terminated[d]

Sources: GAO (analysis); Centers for Medicare & Medicaid Services (CMS) (data). | GAO-16-29

Notes: A single application may represent more than one person, and different people on an application may have different number or types of inconsistencies. Because subsidy information is at the application level, subsidy amounts are not mutually exclusive by category.

[a]Other inconsistency types are American Indian status, and presence of qualifying employer-sponsored coverage or other minimum essential coverage.

[b]Resolved status indicates inconsistencies resolved by consumer action, such as document submission, or removed due to events such as life change, application deletion, or consumer cancellation.

[c]Open status indicates applications with inconsistencies that had no reported resolution as of April 2015. Figures by category of inconsistency do not sum to total because the categories are not mutually exclusive.

[d]Terminated/adjusted status indicates the federal Health Insurance Marketplace has terminated policies or adjusted subsidies based on failure to submit documentation to resolve inconsistencies.

- **Income:** Approximately 27 percent (287,000) of applications in our review had an unresolved income inconsistency, and these were associated with more than $1 billion in combined APTC and CSR subsidies. By comparison, CMS adjusted applicant subsidies for about 6 percent (64,000) of applications with income inconsistencies, which were associated with $193 million in total subsidies.

- **Citizenship/immigration status:** About 13 percent (141,000) of applications had an unresolved citizenship or immigration inconsistency and were associated with more than $633 million in combined subsidies. CMS terminated coverage of relevant individuals for about 6 percent (65,000) of applications with citizenship or immigration status inconsistencies, which were associated with almost $172 million in total subsidies.[1]

- **Incarceration:** About 2 percent (22,000) of applications had an unresolved incarceration inconsistency and were associated with about $68 million in total subsidies. CMS did not terminate any coverage for incarceration inconsistencies.

- **Social Security number:** More than 3 percent (35,000) of applications had an unresolved Social Security inconsistency and were associated with about $154 million in combined subsidies. CMS

[1]According to CMS, coverage is generally terminated for inconsistencies involving citizenship and immigration status, while subsidies are generally adjusted for income inconsistencies. The CMS data we obtained did not distinguish between those inconsistencies for which coverage was terminated and those for which subsidies were adjusted.

did not terminate any coverage or adjust subsidies for Social Security inconsistencies.[2]

Table 2 presents a breakout, by number of inconsistencies, of all inconsistency types in the population identified for our analysis of CMS data. Our analysis examined about 1.1 million unmodified applications with at least one inconsistency.

Table 2: Number of Inconsistencies by Category and Resolution Status, for Federal Health Insurance Marketplace Unmodified Applications, First Enrollment Period, as of April 2015

Inconsistency category	Resolved[a]	Open[b]	Terminated[c]	Total
Income	694,799	414,599	81,038	**1,190,436**
Citizenship/immigration	421,407	179,489	78,149	**679,045**
Incarceration	6,983	21,921	0	**28,904**
Social Security number	31,577	36,585	0	**68,162**
Other[d]	5,586	26,626	0	**32,212**
Total	**1,160,352**	**679,220**	**159,187**	**1,998,759**

Source: GAO (analysis); Centers for Medicare & Medicaid Services (CMS) (data). | GAO-16-29

[a]Resolved status indicates inconsistencies resolved by consumer action, such as document submission, or removed due to events such as life change, application deletion, or consumer cancellation.

[b]Open status indicates applications with inconsistencies that had with no reported resolution as of April 2015. Figures by category of inconsistency do not sum to total because the categories are not mutually exclusive.

[c]Terminated/adjusted status indicates the Health Insurance Marketplace has terminated policies or adjusted subsidies based on failure to submit documentation to resolve inconsistencies.

[d]Other inconsistency types are American Indian status, and presence of qualifying employer-sponsored coverage or other minimum essential coverage.

[2]CMS officials maintained that a missing or invalid Social Security number is not a stand-alone inconsistency, but rather is a cause of other inconsistencies. They also told us CMS does not take any adverse actions based on Social Security number inconsistencies. However, CMS data we obtained separately identified Social Security number inconsistencies. See further discussion of such inconsistencies earlier in this report.

Appendix III: GAO Applicant Scenarios

Figure 3 summarizes outcomes for all 12 of our phone and online applications, and shows the fictitious applicant scenarios we used to attempt the applications.[1]

[1]This figure is excerpted from GAO, *Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health-Care Coverage and Consumer Subsidies Provided under the Act*, GAO-15-702T (Washington, D.C.: July 16, 2015). GAO-15-702T provides full results of our undercover testing for the 2014 coverage year, including the 12 cases shown here.

Figure 3: Summary of Outcomes for Applications for Coverage

Case number	Applicant scenario	Initial type of application	Outcome
1	**Lawfully present**	Phone	The Health Insurance Marketplace (Marketplace) approved health-care insurance enrollment, with advance premium tax credit (APTC) and cost-sharing reduction (CSR) subsidies.
2	**No Social Security number provided**	Phone	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
3	**Invalid Social Security identity**	Online	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
4	**Invalid Social Security identity**	Online	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
5	**Lawfully present**	Phone	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
6	**No Social Security number provided**	Phone	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
7	**Invalid Social Security identity**	Online	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
8	**Invalid Social Security identity**	Online	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
9	**Lawfully present**	Phone	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
10	**No Social Security number provided**	Phone	Marketplace did not allow application to proceed without Social Security number; applicant had declined to provide number, citing privacy concerns.
11	**Invalid Social Security identity**	Online	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.
12	**Invalid Social Security identity**	Online	Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies.

Source: GAO. | GAO-16-29

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

FEB 0 2 2016

Seto Bagdoyan
Director, Forensic Audits and Investigative Service
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Federal Health Care Exchange Internal Controls For Eligibility Verification and Enrollment*" (GAO-16-29).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: FEDERAL HEALTH CARE EXCHANGE INTERNAL CONTROLS FOR ELIGIBILITY VERIFICATION AND ENROLLMENT (GAO-16-29)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to verifying the eligibility of consumers who apply for enrollment in qualified health plans (QHPs) through the Marketplace or for insurance affordability programs. HHS takes seriously its responsibilities to protect taxpayer funds, while providing coverage to eligible individuals.

Moving forward, HHS is eager to build on the progress in reducing the number of uninsured Americans – an estimated 17.6 million Americans gained coverage since the Affordable Care Act's (ACA) coverage provisions have taken effect, and the Nation's uninsured rate is below 10 percent for the first time since data collection began over five decades ago. Through January 16, more than 11.6 million Americans have already used the Marketplace to select a plan or have continued coverage for 2016.

HHS has improved the Marketplace during the first three years of operation with a conscious focus on program integrity. HHS has expertise in preventing and detecting fraud, waste, and abuse from its other programs and is applying program integrity best practices to the Marketplace. HHS is expanding its proactive data analytics activity and real-time monitoring to identify and address vulnerabilities in the eligibility and enrollment system.

The Marketplace uses recent technological advancements to verify application information efficiently and without undue burden on individuals or families. As part of that effort, HHS created an innovative, multi-layered approach to verifying eligibility that protects the integrity of the Marketplace. To start, when applying online through HeathCare.gov, where millions of consumers completed their applications, consumers' identities must first be verified before they can apply - safeguards that blocked the GAO investigators' initial attempts to enroll. Next, HHS uses technology that allows the federal government to provide individuals with real-time, electronic eligibility verification via the Federal Data Services Hub (Hub). The Hub provides a secure electronic connection between the Marketplace and already-existing federal, state, and private databases. These databases verify the eligibility information in each application by matching it against trusted records, maintained by the Social Security Administration (SSA), the Internal Revenue Service (IRS), the Department of Homeland Security (DHS), Equifax, the Department of Veterans Affairs, Medicare, and TRICARE. Additionally, the Peace Corps and the Office of Personnel Management (OPM) use a secure electronic file transfer process to conduct monthly transmissions of Peace Corps and OPM data to verify application information about employer-sponsored coverage. The Hub supported tens of millions of data verifications during the first and second open enrollment periods.

Sometimes an applicants' eligibility cannot be verified in real time by the trusted data source. These situations often involve people who have gained or lost a job, divorced, or changed their name. The verification process relies on the data contained within the trusted data sources, which may be out of date when a consumer submits an application. For example, IRS data is the primary source of income verification as required by the ACA, and it is up to two years old

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: FEDERAL HEALTH CARE EXCHANGE INTERNAL CONTROLS FOR ELIGIBILITY VERIFICATION AND ENROLLMENT (GAO-16-29)

because data from the prior tax filing year is being used to verify projected income for the coming year. The statute accounts for these situations. If an applicant provides information that cannot be verified by the trusted data sources, then the statute requires the Marketplace to make a reasonable effort to identify and address the cause of the data inconsistency.

Consistent with the law and regulations, when such an inconsistency is identified, the Marketplace contacts the applicant to confirm the information, and if this does not resolve the issue, provides the applicant the opportunity to present satisfactory documentary evidence to resolve the inconsistency within 90 or 95 days (as applicable, depending on the inconsistency type). Contracted staff review the supporting documentation submitted by applicants to check that it is valid and sufficient to verify the application information before resolving the inconsistency. Contracted reviewers are given examples of valid documents and are trained to escalate possibly invalid or fraudulent documents. Under our operating procedures, if HHS suspects that someone made a fraudulent representation, HHS will report the issue to our law enforcement partners in the HHS OIG and Department of Justice.

During this inconsistency resolution period, the ACA provides the applicant with eligibility for coverage through the Marketplace or for an insurance affordability program based on the information they attested to in their applications. When submitting the application information required by the ACA, individuals attest, under penalty of perjury, that the information they submit is accurate. Knowingly and willfully providing false information is a violation of federal law and subject to a fine of up to $250,000.

It is important to HHS that eligible applicants receive subsidies. If an applicant does not provide satisfactory documentation within the required time, the Marketplace will determine their eligibility based on the information contained within the trusted data sources, as required by the law. The Marketplace ended coverage for approximately 471,000 consumers with 2015 coverage who failed to produce sufficient documentation on their citizenship or immigration status as requested and required. In addition, about 1,152,000 households had their advanced premium tax credit or cost sharing reduction for 2015 coverage adjusted.

To further protect the integrity of the Marketplace and in accordance with the eligibility process created by the ACA, at the end of the tax year, every tax filer on whose behalf advance payments of the premium tax credit (APTC) were paid must file a federal income tax return to reconcile the premium tax credit. The IRS, through the tax filing process, reconciles the difference between the APTC paid to the QHP issuer on the tax filer's behalf and the actual amount of the premium tax credit that the tax filer was entitled to claim for the enrollee. If Marketplace consumers do not file their taxes then they are not eligible to continue receiving tax credits. The IRS provides information to HHS on consumers who are blocked from receiving financial assistance to purchase coverage through the Marketplace because they received advance premium tax credits in prior coverage years but have not taken the necessary steps as part of this year's tax filing season to receive premium tax credits in future years.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: FEDERAL HEALTH CARE EXCHANGE INTERNAL CONTROLS FOR ELIGIBILITY VERIFICATION AND ENROLLMENT (GAO-16-29)

HHS's responses to GAO's recommendations are below.

GAO Recommendation 1
Conduct a comprehensive feasibility study on action(s) that HHS can take to monitor and analyze, both quantitatively and qualitatively, the extent to which data hub queries provide requested or relevant applicant verification information, for the purpose of improving the data-matching process and reducing the number of applicant inconsistencies; and for those action(s) identified as feasible, create a written plan and schedule for implementing them.

HHS Response
HHS concurs with this recommendation. HHS is currently reviewing options for conducting a feasibility study to monitor and analyze information received from the Hub as recommended by GAO. HHS plans to examine the Hub process in delivering usable information for applicant verification and analyzing data to identify trends or patterns that could suggest improvements in verification or actions that could reduce the number of inconsistencies that require further attention.

GAO Recommendation 2
Track the value of APTC and CSR subsidies that are eliminated or reduced for failure to resolve application inconsistencies, and use this information to inform assessments of program risk and performance.

HHS Response
HHS concurs with this recommendation. In 2015, HHS expanded the use of analytics to analyze the value of PTC and CSR subsidies that are eliminated or adjusted for 2015 actions at the policy level.

GAO Recommendation 3
In the case of CSR subsidies that are eliminated or reduced for failure to resolve application inconsistencies, consider and document, in conjunction with other agencies as relevant, whether it would be feasible to create a mechanism to recapture those costs, including whether additional statutory authority would be required to do so; and for action(s) determined to be feasible and reasonable, create a written plan and schedule for implementing them.

HHS Response
HHS concurs with this recommendation. HHS plans to reconcile 2014 benefit year CSR advance payments and 2015 benefit year CSR advance payments beginning with data submission for each benefit year in the Spring of 2016. This is a reconciliation between HHS and issuers, not individual tax-payers, and ensures that HHS recoups any advance payments for cost-sharing reductions to issuers for enrollees after the date which enrollees were terminated or had their financial assistance adjusted because of unresolved inconsistencies.

It is important to understand that during an inconsistency resolution period, the ACA provides the applicant with eligibility for coverage through the Marketplace or for an insurance affordability

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: FEDERAL HEALTH CARE EXCHANGE INTERNAL CONTROLS FOR ELIGIBILITY VERIFICATION AND ENROLLMENT (GAO-16-29)

program based on the information they attested to in their applications. When a consumer's eligibility is ended or adjusted, it does not mean that they are ineligible. Having eligibility ended or adjusted indicates that the consumer did not submit sufficient supporting documentation within the time allotted, which could be a result for a variety of reasons, including confusion or resource constraints.

Further, under the statute, during an inconsistency period, individuals who pay their monthly premium are eligible for CSRs for up to 90 days, regardless of the outcome of the inconsistency process.

GAO Recommendation 4
Identify and implement procedures to resolve Social Security number inconsistencies where the Marketplace is unable to verify Social Security numbers or applicants do not provide them.

HHS Response
HHS concurs with this recommendation. HHS has an extensive resolution process in place to resolve data matching issues and is continuously improving and refining those processes. For example, even when a consumer is not legally required to provide a Social Security number (SSN), HHS highly recommends to consumers that they provide a SSN for everyone on the application who has one as part of the application process, since providing a SSN enables the Federally-facilitated Marketplace to use more efficient electronic verification processes. To further encourage consumers to input a SSN, the Healthcare.gov application now features a new "pop-up" reminder message.

HHS estimates that less than 1 percent of consumers' SSN could not be matched to our trusted data sources (TDS) and did not result in a citizenship/immigration inconsistency flag. The remaining consumers were flagged for citizenship/immigration inconstancies if their SSN did not match our TDS. HHS is working on implementing functionality for updating consumers SSNs and their eligibility based on the correct SSN in 2016.

GAO Recommendation 5
Reevaluate HHS's use of PUPS incarceration data and make a determination to either

a. use the PUPS data, among other things, as an indicator of further research required in individual cases, and to develop an effective process to clear incarceration inconsistencies or terminate coverage, or

b. if no suitable process can be identified to verify incarceration status, accept applicant attestation on status in all cases, unless the attestation is not reasonably compatible with other information that may indicate incarceration, and forego the inconsistency process.

HHS Response

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: FEDERAL HEALTH CARE EXCHANGE INTERNAL CONTROLS FOR ELIGIBILITY VERIFICATION AND ENROLLMENT (GAO-16-29)

HHS concurs with this recommendation. HHS continues to use PUPS as a trusted data source to verify applicants' incarceration status, but does not rely solely on PUPS. The Marketplace also accepts the application filer's incarceration attestation and does not terminate an applicant's enrollment in coverage through the Marketplace based only on information in PUPS about incarceration status. This is because HHS has determined that the PUPS database, as presently available, is not sufficiently current or accurate for use for this purpose. HHS made this determination in 2015 and as a result of this determination, HHS no longer requires application filers to submit documentation regarding incarceration status.

GAO Recommendation 6
Create a written plan and schedule for providing Marketplace call center representatives with access to information on the current status of eligibility documents submitted to HHS's documents processing contractor.

HHS Response
HHS concurs with this recommendation. The call center representatives currently receive daily updates on the status of eligibility documentation. HHS is working to provide call center representatives with real-time data.

GAO Recommendation 7
Conduct a fraud risk assessment, consistent with best practices provided in GAO's framework for managing fraud risks in federal programs, of the potential for fraud in the process of applying for qualified health plans through the federal Marketplace.

HHS Response
HHS concurs with this recommendation. HHS plans to conduct a fraud risk assessment for the Marketplace. HHS greatly appreciates the foundation that GAO's framework for managing fraud risks provides. The framework provides controls to prevent, detect, and respond to fraud that HHS will consider when conducting the fraud risk assessment for the Marketplace. HHS's program integrity (PI) infrastructure continues to mature and adapt including through experience with the Marketplace. HHS already has in place solid internal financial controls to protect consumers enrolled in the Marketplace and safeguard federal dollars, and we are committed to strengthening our Marketplace program integrity efforts.

GAO Recommendation 8
Fully document prior to implementation, and have readily available for inspection thereafter, any significant decision on qualified health plan enrollment and eligibility matters, with such documentation to include details such as policy objectives, supporting analysis, scope, and expected costs and effects.

HHS Response
HHS concurs with this recommendation. HHS is committed to documenting significant decisions on qualified health plan enrollment and eligibility matters.

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Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Seto J. Bagdoyan, (202) 512-6722 or BagdoyanS@gao.gov

Staff Acknowledgments

In addition to the contact name above, Matthew Valenta and Gary Bianchi, Assistant Directors; Maurice Belding; Mariana Calderón; Marcus Corbin; Carrie Davidson; Paul Desaulniers; Colin Fallon; Suellen Foth; Sandra George; Robert Graves; Barbara Lewis; Maria McMullen; James Murphy; George Ogilvie; Shelley Rao; Ramon Rodriguez; Christopher H. Schmitt; Julie Spetz; Helina Wong; and Elizabeth Wood made key contributions to this report.

Congressional Budget Office

MARCH 2016

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026

Provided as a convenience, this "screen-friendly" version is identical in content to the principal ("printer-friendly") version of the report. Any tables, figures, and boxes appear at the end of this document; click the hyperlinked references in the text to view them.

Summary

The federal government subsidizes health insurance for most Americans through a variety of federal programs and tax preferences. In 2016, those subsidies for people under age 65 will total more than $600 billion, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate. (The government also bears significant costs for health insurance for people 65 or older, mostly through Medicare and Medicaid.)

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.

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

Unless otherwise indicated, all years referred to in describing estimates of mandatory spending and revenues are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Estimates of health insurance coverage reflect average enrollment in any given month of a calendar year and include spouses and dependents covered under family policies. Those estimates are for the noninstitutionalized civilian population under age 65.

Supplemental data for this report are available on CBO's website (www.cbo.gov/publication/51385).

In preparing the March 2016 baseline budget projections, CBO and JCT updated their estimates of the number of people under age 65 who have health insurance from various sources as well as their projections of the federal subsidies associated with that coverage. Those projections encompass a broad set of budgetary effects that operate under current law, including the effects of providing preferential tax treatment for employment-based coverage, costs for providing Medicaid coverage to people under age 65, and payments stemming directly from the Affordable Care Act (ACA). In this report, CBO and JCT also present estimates that focus only on those changes in coverage and federal deficits that stem from the ACA's major provisions related to health insurance coverage.

How Many People Under Age 65 Are Projected to Have Health Insurance?

By CBO and JCT's estimates, an average of about 244 million noninstitutionalized residents of the United States under age 65 will have health insurance in any given month in 2016. Almost two-thirds of them will obtain coverage through an employer, and about a quarter will be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). A smaller number will have nongroup coverage that they purchase either through or outside one of the health insurance marketplaces (previously referred to as exchanges in CBO's publications) established under the ACA or coverage that is provided by Medicare or through various other sources. On average, about 27 million people under age 65—10 percent of that population—will be uninsured in 2016, CBO and JCT estimate (see Figure 1).

From 2017 through 2026, the number of people with coverage is expected to grow from 246 million to 253 million; the number of people obtaining coverage through some sources will increase slightly, and for other sources that number will decrease slightly. The number of uninsured people is also expected to rise, from 26 million to 28 million, but the portion of the under-65 population without insurance is projected to remain at about 10 percent.

How Much Are the Federal Subsidies, Taxes, and Penalties Associated With Health Insurance?

CBO and JCT currently estimate that in 2016 the federal subsidies, taxes, and penalties associated with health insurance coverage will result in a net subsidy from the federal government of $660 billion, or 3.6 percent of gross domestic product (GDP). That amount is projected to rise at an average annual rate of 5.4 percent, reaching $1.1 trillion (or 4.1 percent of GDP) in 2026. For the entire 2017–2026 period, the projected net subsidy is $8.9 trillion. Two types of costs account for most of that amount:

- Federal spending for Medicaid and CHIP benefits provided to people under age 65 (excluding those who reside in a nursing home or other institution) is projected to

amount to $3.8 trillion—or 43 percent of the total net subsidy. That amount includes $1.0 trillion in subsidies for people whom the ACA made eligible for Medicaid.

- Federal subsidies associated with employment-based coverage for people under age 65, which stem almost entirely from the exclusion of most premiums for such coverage from income and payroll taxes, are projected to be $3.6 trillion—or 41 percent of the total net subsidy.

Other subsidy costs are much smaller:

- Medicare benefits (net of premium payments and other offsetting receipts) for noninstitutionalized beneficiaries under age 65 are projected to amount to $1.0 trillion—or 11 percent of the total net subsidy. Such spending is primarily for people who are disabled.

- Subsidies for coverage obtained in the nongroup market, including the health insurance marketplaces, and through the Basic Health Program are estimated to total $0.9 trillion—or 10 percent of the total net subsidy.

The costs of those subsidies are offset to a small extent—$0.4 trillion (or 5 percent)—by taxes and penalties collected from health insurance providers, uninsured people, and employers.

How Much Do the ACA's Insurance Coverage Provisions Cost?

The effects of the health insurance coverage provisions of the ACA are incorporated into the estimates of overall health insurance coverage and are a subset of the estimates of the net federal subsidies associated with such coverage that are discussed above. To separate the effects of the ACA's coverage provisions from those broader estimates, CBO and JCT compared their current projections with estimates of what would have occurred if the ACA had never been enacted. In 2016, those provisions are estimated to reduce the number of uninsured people by 22 million and to result in a net cost to the federal government of $110 billion. For the 2017–2026 period, the projected net cost of those provisions is $1.4 trillion. Those estimates address only the insurance coverage provisions of the ACA, which do not generate all of the law's budgetary effects. Many other provisions—such as various tax provisions that increase revenues and reductions in Medicare payments to hospitals, to other providers of care, and to private insurance plans delivering Medicare's benefits—are, on net, expected to reduce budget deficits.

How Have Estimates of the Cost of the ACA's Insurance Coverage Provisions Changed?

For the 2016–2025 period, CBO and JCT's projection of the net cost of the ACA's insurance coverage provisions is now $136 billion higher than their March 2015

estimate (from the last detailed projections that the agencies published).[1] The largest difference from the March 2015 projection stems from an increase in projected spending for Medicaid because more people whom the ACA made eligible for Medicaid are expected to enroll than were anticipated when that projection was made. Compared with the projection made by CBO and JCT in March 2010, just before the ACA was enacted, the current estimate of the net cost of the insurance coverage provisions over the 2016–2019 period (the final years of the 10-year budget window used in the original report) is lower by $157 billion, or 25 percent.[2]

How Will Future Reports Present Baseline Projections Related to Insurance Coverage?

Although CBO and JCT have included in this report estimates that separately identify the effects of the ACA's insurance coverage provisions on the federal budget, generating such estimates is becoming more difficult and less meaningful. As a result, CBO and JCT will no longer make separate projections of all of the incremental effects of the ACA's insurance coverage provisions; instead, they will present their projections of overall insurance coverage levels and related subsidies, taxes, and penalties under current law. In future years, the agencies will update and publish those broader estimates annually. Consistent with their statutory responsibilities, CBO and JCT will continue to estimate the effects of proposed legislation related to the ACA, including proposals to modify certain provisions of the law or to repeal it entirely.

Health Insurance Coverage for People Under Age 65

CBO and JCT project that, on average, 90 percent of the noninstitutionalized civilian population under 65 will have health insurance coverage during 2016. The primary sources of such coverage are employment-based plans, Medicaid, nongroup policies, and Medicare.

Employment-Based Coverage

The most common source of health insurance coverage for the noninstitutionalized civilian population under age 65 is coverage obtained through an individual or family member's employer. CBO and JCT estimate that in 2016 an average of about 155 million people (or about 57 percent of the population under age 65) will have such employment-based coverage in any given month (see Table 1). This number is projected to decline to 152 million in 2019 and to stay at that level through 2026, when about 54 percent of the population under age 65 is expected to be enrolled in employment-based coverage.

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

2. See Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 [final health care legislation] (March 20, 2010), www.cbo.gov/publication/21351.

Most of the projected reduction in employment-based coverage is attributable to the ACA: CBO and JCT expect that as a result of the ACA, some employers will decline to offer coverage and that some employees will elect to forgo offers of coverage that are made in favor of another source of coverage, such as Medicaid (see "Effects on Employment-Based Coverage" on page 20). Another factor contributing to the reduction is the continuation of a gradual decline in enrollment in employment-based coverage that started well before the ACA took effect, caused in part by health insurance premiums growing faster than wages over the long term.[3] That historical decline can be seen in the decreasing share of the population under age 65 with employment-based coverage over the past three decades.[4] Finally, projected changes in the size and composition of the labor force, due in part to the ACA and in part to the aging of the population, also factor into the projected decline in employment-based coverage.

Medicaid and CHIP

The next largest source of coverage among people under age 65 is Medicaid. CBO estimates that an average of 62 million noninstitutionalized people who receive full benefits will be covered by Medicaid in any given month in 2016.[5] In 2026, that number is projected to grow to 69 million people (15 million made eligible through the ACA's optional state expansion of Medicaid coverage and 54 million otherwise eligible).

CBO estimates that 6 million people, mostly children, will be enrolled in CHIP, on average, in 2016. That number falls to about 2 million in 2026, as funding projected in the baseline declines sharply.[6] Taken together, Medicaid and CHIP are projected to provide insurance coverage for about one-quarter of the population under age 65 in 2026.

Medicaid enrollment has been boosted by implementation of the ACA. Under that law, states are permitted but not required to expand eligibility for Medicaid to adults under

3. 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.

4. Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2014: With Special Feature on Adults Aged 55–64*, DHHS Publication 2015-1232 (May 2015), Table 112, www.cdc.gov/nchs/data/hus/hus14.pdf (15 MB).

5. Some enrollees receive only partial benefits from Medicaid. They include Medicare enrollees who receive only assistance with Medicare cost sharing and premiums, individuals who receive only family planning services, and unauthorized immigrants who receive only emergency services.

6. Annual spending for CHIP reaches $13 billion in 2017 in CBO's current projections, but federal funding for the program expires at the end of fiscal year 2017. Under the rules governing baseline projections for expiring programs, CBO projects funding for CHIP after 2017 at an annualized amount of about $6 billion; the estimates of enrollment shown here are based on that projected amount of funding. However, CBO anticipates that if lawmakers did not provide additional funding for subsequent years, all state programs would terminate at some point during fiscal year 2018.

age 65 whose income is equal to or less than 138 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL). The federal government pays a larger share of the costs for those individuals than it pays for those who would have been eligible otherwise.

By the end of 2015, 30 states and the District of Columbia had expanded their programs under the ACA; about half of the people who meet the new eligibility criteria reside in those states. CBO anticipates that more states will expand coverage during the next decade and that by 2026, about 80 percent of the people who meet the new eligibility criteria will live in states that have expanded Medicaid coverage. According to CBO's estimates, on average, about 7 million people made eligible for Medicaid by the ACA were enrolled in the program in 2014. That number rose to about 10 million in 2015. The agency's estimates of enrollment over the next decade reflect the expectations that additional states will expand their Medicaid coverage and that more people will enroll in the program in those states that have already done so; the number of people made eligible for Medicaid by the ACA who are enrolled in the program is projected to reach 11 million in 2016 and 15 million in 2026 (for additional details, see "Effects on Medicaid and CHIP" on page 19).

Nongroup Coverage and the Basic Health Program

Insurance purchased individually (known as a nongroup policy) covers a much smaller share of the population under age 65 than does either employment-based group coverage or Medicaid. In 2016, about 22 million people under age 65, on average, are expected to have such coverage, most of whom will have purchased it through the marketplaces established under the ACA. (Nongroup policies can be purchased either in the marketplaces—with or without government subsidies—or outside them.) An additional 1 million people are estimated to participate in the Basic Health Program, which offers subsidies to certain low-income people that are based on the subsidies available through the marketplaces.

Health Insurance Marketplaces. Under the ACA, individuals and families can purchase health insurance through the marketplaces operated by the federal government, state governments, or partnerships between the federal and state governments; those meeting certain criteria may receive federal subsidies for that coverage.

About 13 million people selected plans through the marketplaces in 2016 by the close of the open-enrollment period; however, CBO and JCT estimate that, in any given month, an average of about 12 million people will be covered by insurance

purchased through the marketplaces.[7] The agencies estimate that 10 million of those people will receive subsidies to purchase their coverage.

CBO and JCT expect average enrollment to continue to increase to 15 million people in 2017 and then to between 18 million and 19 million people each year from 2018 to 2026. Between 80 percent and 85 percent of those enrollees—or about 14 million to 16 million people—are expected to receive subsidies for purchasing that insurance each year after 2017.

Subsidized Coverage. The number of people enrolled in subsidized coverage through the marketplaces is projected to change over the course of the 2017–2026 period for several reasons. First, CBO and JCT expect enrollment to grow from 2016 to 2018 as more people gain experience with the marketplaces and subsidies and as the penalties for not having insurance coverage are phased up to their permanent levels. Additionally, enrollment through the marketplaces depends substantially on the availability of other insurance options. Over the next few years, more employers are expected to respond to the availability of coverage through the marketplaces by declining to offer insurance to their employees. As employers change their insurance offerings, some of their employees are expected to enroll in coverage through the marketplaces.

Projected changes to eligibility for Medicaid and CHIP will also affect who is eligible to enroll in subsidized coverage through the marketplaces. If someone is eligible for Medicaid or CHIP, he or she is not eligible to receive subsidies for coverage through a marketplace. Under current law, funding for CHIP will expire at the end of 2017. In accordance with the rules governing baseline projections, CBO therefore projects funding for CHIP after 2017 at an annualized amount of about $6 billion. With funding at that level, significantly fewer people would be able to enroll in CHIP, and those who could not do so would instead obtain coverage through the marketplaces, Medicaid, or an employer, or they would become uninsured. CBO and JCT anticipate that about 1 million additional people would enroll in coverage through the marketplaces after CHIP's funding dropped, increasing the agencies' estimate of subsidized enrollment through the marketplaces for years after 2017.

Countering those developments—that is, decreasing the estimate of subsidized enrollment through the marketplaces—is CBO's expectation that additional states will expand eligibility for Medicaid over the 2017–2026 period. Some of the people who

7. CBO and JCT estimate that average enrollment in any given month during the year will be lower than the number of people who selected a plan by the end of the open-enrollment period and lower than the total number of people who will have coverage at some point during the year. Some people are covered for only part of the year, and enrollment varies over the course of a year because people who experience a qualifying life event (such as a change in income or family size or the loss of employment-based insurance) are allowed to purchase coverage later in the year and because some people stop paying the premiums or leave their marketplace-based coverage as they become eligible for insurance through other sources.

would become eligible for Medicaid through those expansions would have otherwise been eligible to enroll in subsidized coverage through the marketplaces. CBO and JCT therefore expect that as more people become eligible for Medicaid coverage, enrollment in coverage through the marketplaces will decline. That trend continues over the 2017–2026 period in CBO's baseline. Hence, by 2026, about 14 million people are projected to obtain subsidized coverage through the marketplaces, down from a projected peak of 16 million in 2019.

Unsubsidized Coverage. Over the 2016–2019 period, the number of people enrolled in unsubsidized coverage through the marketplaces is projected to grow from 2 million to 4 million. In the next few years, as experience with the marketplaces continues to grow—and as additional people shift out of plans purchased directly from insurers that do not comply with the ACA's requirements but that are temporarily still available—more people who currently purchase unsubsidized coverage are expected to purchase their insurance through the marketplaces. After 2019, CBO and JCT expect unsubsidized coverage obtained through the marketplaces to stay relatively stable at around 4 million people; the expansion of Medicaid in additional states, discussed above, would probably not affect the unsubsidized population.

Other Nongroup Coverage. Outside the marketplaces, 9 million people are expected to purchase nongroup coverage in 2016, and 7 million people are expected to purchase such coverage in 2026. CBO and JCT believe that a number of people who are not eligible for subsidies for coverage through the marketplaces will continue to purchase nongroup coverage outside the marketplaces, in some cases through a broker or online. That number is projected to decline as experience with and enrollment through the marketplaces increases. Whether people who purchase unsubsidized nongroup coverage do so through a marketplace or directly from an insurer does not affect the federal budget.[8]

Basic Health Program. Under the ACA, states also have the option to establish a Basic Health Program, which is primarily for people whose income is between 138 and 200 percent of the FPL. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace. States can use those funds, in addition to funds from other sources, to offer health insurance to eligible people that covers a broader set of benefits or requires smaller out-of-pocket payments than is available through the marketplaces.[9] So far, only Minnesota and New York have created a Basic Health Program. CBO and JCT anticipate that other states will

8. Nongroup plans are generally subject to the same requirements whether they are offered through the marketplaces or directly from insurers. Insurers are also required to consider all enrollees in nongroup plans that comply with the ACA's requirements as members of a single risk pool.

9. For more information about the Basic Health Program, see Centers for Medicare & Medicaid Services, "Basic Health Program" (accessed March 23, 2016), http://go.usa.gov/cAa7A.

probably pursue this option in the future but that enrollment from those states will not be large. In total, about 1 million people are projected to be enrolled in such a plan in each year from 2016 through 2026.

Medicare and Other Coverage

Although Medicare is best known for providing coverage for people age 65 or older, it also covers some people who are under age 65. Many of those younger enrollees receive that coverage because they have qualified for Social Security Disability Insurance benefits. (In general, people are eligible for Medicare two years after they qualify for Disability Insurance.) An average of about 9 million people under age 65 are projected to be covered by Medicare in 2016, and that number is projected to remain stable over the 2017–2026 period.

Other miscellaneous sources of coverage account for 5 million to 6 million people each year from 2016 to 2026. Those sources include student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

Uninsured

An average of 27 million people under age 65 are projected to be uninsured in 2016. Over the next decade, roughly 1 out of every 10 residents under age 65 is projected to be uninsured each year, and the number of people who are uninsured is estimated to reach 28 million in 2026 (see Table 1).[10] In that year, according to CBO and JCT's estimates, about 35 percent of those uninsured people would be unauthorized immigrants and thus ineligible for subsidies through a marketplace or for most Medicaid benefits; about 10 percent would be ineligible for Medicaid because they lived in a state that had not expanded coverage; about 20 percent would be eligible for Medicaid but would not enroll; and the remaining 35 percent would not purchase insurance to which they had access through an employer, through the marketplaces, or directly from insurers.

10. The sum of the estimates of the number of people enrolled in health insurance plans through the different sources of coverage and the number of people who are uninsured exceed CBO and JCT's estimate of the total population under age 65 by 12 million to 14 million people, depending on the year, because some people will have multiple sources of coverage. People who report having both employment-based coverage and Medicaid constitute one of the most common examples of multiple sources of coverage. To arrive at the estimates shown here, CBO and JCT have not assigned a primary source of coverage to individuals who report multiple sources of coverage. Those amounts better align with estimates of spending as well as with information on the levels and sources of health insurance coverage from household surveys. (By contrast, CBO and JCT's estimates showing changes in sources of insurance coverage stemming from the ACA have counted individuals using only their primary source of coverage because that approach has generally proven more useful for reporting incremental effects of the ACA on coverage.)

Subsidies for Health Insurance Coverage for People Under Age 65

The federal government encourages people to obtain health insurance from one of several sources by making it less expensive than it would be otherwise. Under current law, the federal government subsidizes health insurance coverage for people under age 65 in four main ways:

- Excluding from federal income and payroll taxes nearly all premiums for employment-based coverage,
- Providing roughly two-thirds of all funding for Medicaid (the states participating in the program are required to provide the remainder),
- Offering tax credits and other subsidies to people who meet various criteria and purchase coverage through the health insurance marketplaces, and
- Providing coverage through the Medicare program to people under age 65 who receive Disability Insurance or who meet certain other criteria.

If current laws remained in place, the federal government would also collect taxes and penalties related to health insurance coverage, including excise taxes on high-premium insurance plans, penalty payments from people who do not obtain coverage, excise taxes on providers of health insurance, and penalty payments from large employers who do not offer health insurance that meets certain standards.

Under current law, the federal subsidy for health insurance coverage for people under age 65—net of taxes and penalties—is estimated to be about $660 billion in 2016 and to total $8.9 trillion over the 2017–2026 period (see Table 2). That sum reflects projections by CBO and JCT about choices that people would make about obtaining health insurance if current laws remained in place.

Those subsidy estimates differ in concept from estimates of the effects of *changes in law* that would remove those subsidies. Such cost estimates would incorporate changes in individual decisions and other behavioral responses that would be expected to occur under a proposed change in law. For instance, if the Medicaid program was altered, not only would estimates of outlays for that program change, but estimates of other outlays and revenues would probably change as well to reflect people's responses to changes in Medicaid. Such responses are not included in the subsidy estimates in this report but would be included in estimates of the budgetary effects of legislative proposals.

Employment-Based Coverage

One of the largest subsidies for health insurance coverage is for employment-based coverage. The federal tax system provides preferential treatment for health care coverage that people receive from their employer—the most common source of

coverage for people under age 65. Employers' payments for health coverage are a form of compensation, but unlike cash compensation, those payments are excluded from income and payroll taxes. In most cases, the amounts paid by workers themselves for their share of the cost of employment-based coverage are also excluded from income and payroll taxes.

Owners of noncorporate businesses generally are not considered employees and therefore are not eligible for the exclusion of health insurance benefits purchased by their businesses. They are, however, allowed to deduct that cost from their taxable income. The deduction for self-employed individuals who participate in their company's group health plan is included in this estimate of subsidies conveyed through the tax system for employment-based coverage. The deduction for self-employed individuals who purchase nongroup insurance is discussed below.

In all, JCT estimates that subsidies for employment-based coverage will total about $266 billion in 2016. That amount is estimated to grow to roughly $460 billion in 2026 and to total $3.6 trillion over the 2017–2026 period. The amount of the tax subsidy for employment-based coverage is very large because the number of people with such coverage is large. It is important to note that the estimate of the subsidy is not equal to the tax revenues that would be collected if the tax exclusion was eliminated because people would adjust their behavior to reduce the tax liability created by such a change.

Other budgetary effects related to employment-based coverage result from tax credits for certain small employers that provide health insurance to their employees; they are eligible to receive a tax credit of up to 50 percent of the cost of that insurance. CBO and JCT project that, under current law, those tax credits would amount to about $1 billion a year, totaling $9 billion over the 2017–2026 period.

Medicaid and CHIP

Outlays for all noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits are estimated to amount to $279 billion in 2016.[11] Over the 2017–2026 period, estimated outlays total $3.8 trillion—$1.0 trillion (26 percent) for people whom the ACA made eligible for Medicaid and $2.8 trillion (74 percent) for people who would have been eligible for Medicaid or CHIP otherwise. Medicaid spending for the noninstitutionalized population under age 65 accounts for roughly 75 percent of total projected Medicaid spending over the 2017–2026 period.

Nongroup Coverage and the Basic Health Program

In 2016, premium tax credits, cost-sharing subsidies, Basic Health Program payments, net spending and revenues for risk adjustment and reinsurance, and grants to states will total $43 billion, CBO and JCT estimate (see Table 2). Over the 2017–2026 period,

11. Spending for enrollees who receive partial assistance is excluded from those totals.

subsidies for coverage through the marketplaces and related spending and revenues are projected to total $866 billion, as follows:

- Outlays of $568 billion and a reduction in revenues of $104 billion for premium tax credits (to cover a portion of eligible individuals' and families' health insurance premiums), which together total $672 billion;
- Outlays of $130 billion for cost-sharing subsidies (which reduce out-of-pocket payments for low-income enrollees);
- Outlays of $63 billion for the Basic Health Program;
- Outlays of $92 billion and revenues of $91 billion related to payments and collections for risk adjustment and reinsurance (the projected outlays and revenues are exactly offsetting over the life of the programs, meaning they will ultimately have no net budgetary effect); and
- Outlays of less than $1 billion for grants to states for establishing health insurance marketplaces.

Combined, the subsidies for coverage through the marketplaces and the Basic Health Program are projected to average $4,240 per subsidized enrollee in calendar year 2016 and to rise to about $7,100 in 2026.

Subsidies for insurance obtained through the health insurance marketplaces depend on the number of people who purchase such coverage, the reference premiums for the policies, and certain characteristics of enrollees, such as family size and income. (See Box 1 for more on reference premiums.) Those subsidies fall into two categories: subsidies to cover a portion of participants' health insurance premiums and subsidies to reduce their cost-sharing amounts (out-of-pocket payments required under insurance policies). The first category of subsidies is primarily available to people with income between 100 percent and 400 percent of the FPL who meet certain other conditions, and the second is available to those who are eligible for premium subsidies, have a household income below 250 percent of the FPL, and enroll in an eligible plan.

The risk adjustment and reinsurance programs were established under the ACA to stabilize premiums in the nongroup and small-group insurance markets by reducing the likelihood that particular health insurers would bear especially high costs for having a disproportionate share of less healthy enrollees.[12] The programs, which were implemented in 2014, make payments to insurers that reflect differences in the health

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

status of each insurer's enrollees and in the resulting costs to insurers; those payments are financed by corresponding collections from insurers with healthier enrollees in the case of risk adjustment and by an assessment on a broad range of insurers in the case of reinsurance. Payments under the risk adjustment and reinsurance programs are recorded in the budget as mandatory outlays, and collections are recorded as revenues. In CBO's projections for the 2017–2026 period, risk-adjustment payments and collections each total about $86 billion, and reinsurance payments and collections each total $5 billion.[13] Collections and payments ultimately offset exactly, but because of differences in the timing of collections and payments, slight discrepancies between the two will occur in any given period.

Nongroup coverage is also subsidized in part by the income tax deduction for self-employed health insurance. JCT estimates the cost of the tax preference for self-employed people who purchase nongroup insurance to be $53 billion over the 2017–2026 period.

Medicare

Net outlays associated with Medicare coverage for noninstitutionalized people under age 65 are projected to be $80 billion in 2016 and to total $979 billion over the 2017–2026 period. That amount is about one-eighth of total projected net spending for the Medicare program.

Taxes and Penalties

Taxes and penalties related to health insurance coverage are expected to reduce the total amount of federal subsidies for such coverage by $15 billion in 2016. Under current law, those taxes and penalties would total $441 billion over the 2017–2026 period, CBO and JCT estimate.

Excise Tax on High-Premium Insurance Plans. The ACA established an excise tax on certain high-cost employment-based coverage, which is scheduled to be imposed beginning in 2020. The tax was originally supposed to take effect in 2018, but the Consolidated Appropriations Act, 2016 (Public Law 114-113), delayed its implementation by two years. In CBO and JCT's current projections, federal collections of those excise taxes on high-cost group health plans total $18 billion over the 2017–2026 period (see Table 2).

The excise tax is expected to cause employers and workers to shift to health plans with lower premiums to avoid paying the tax entirely or to reduce their tax liability. Those shifts will generally result in higher taxable income for affected workers, CBO and JCT

13. The ACA also established a risk corridors program designed in part to protect insurers from particularly large losses. Risk corridors are treated differently from risk adjustment and reinsurance: The payments to insurers are recorded as discretionary spending, and the government's collections from insurers are recorded as offsets to discretionary spending. Collections and spending for that program in 2016, related to plans purchased in 2014, each total $362 million.

estimate, because those workers will receive less of their income in nontaxable health benefits and more in taxable wages.[14]

The net increase in revenues from the excise tax collections and from related shifts in taxable compensation combined is projected to be $79 billion over the 2017–2026 period (see Table 3).

Penalty Payments by Uninsured People. Under a provision of the ACA known as the individual mandate, most U.S. citizens and noncitizens who lawfully reside in the country must either obtain health insurance or pay a penalty for not doing so. 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: either a fixed dollar amount assessed for each uninsured person in a household or a share of the difference between the household's adjusted gross income and its income threshold for tax filing. The fixed dollar amount per uninsured adult rises from $325 in 2015 to $695 in 2016 and at the rate of general inflation thereafter; the penalty per child is half as large. The income-based penalty rises from 2 percent in 2015 to 2.5 percent in 2016 and later. Both penalties are subject to a cap, and people who are uninsured for only part of the year face a reduced penalty.

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 is 8.13 percent in 2016 and is indexed for inflation thereafter. Other exemptions include those for having income below the tax-filing threshold, experiencing certain hardships, and being a member of certain religious groups. CBO and JCT expect that a substantial majority of the roughly 27 million people estimated to be uninsured in 2016 will receive an exemption. All told, the agencies expect that, on average, about 3 million people will pay the penalty for being uninsured in any given month in 2016 (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 than the monthly average.

According to the Internal Revenue Service, as of October 2015, roughly $2 billion in penalty payments had been collected from people who were uninsured during 2014.[15] In CBO and JCT's projections, penalty payments by uninsured people amount to $3 billion in 2016 and total $38 billion over the 2017–2026 period.

14. Under the opposite assumption—that workers' total compensation would be reduced by the amount of the premium reduction—their employers would have smaller deductions for compensation costs, and hence more taxable income. The resulting revenues would be similar to the amounts projected in the baseline.

15. John Koskinen, Internal Revenue Service, letter to Members of Congress (January 8, 2016), http://go.usa.gov/cGh5j (PDF, 196 KB).

Tax on Health Insurance Providers. Health insurers are subject to an excise tax established by the ACA. The law specifies the total amount of tax to be assessed, and that total is divided among insurers according to their share of total applicable premiums charged in the prior year. Several categories of health insurers—such as self-insured plans and certain state government entities and tax-exempt providers—are fully or partially exempt from the tax. Fiscal year revenues from the tax, which began to be collected in 2014, are projected to total $11 billion in 2016 but to fall to about $1 billion in 2017 as a result of recent legislation that placed a moratorium on that tax for calendar year 2017. Receipts from the tax, under current law, would reach about $13 billion in 2018 and rise steadily thereafter to about $21 billion by 2026, for a total of $156 billion over the decade, CBO and JCT estimate.

Employer Penalties. Some large employers who do not offer health insurance coverage that meets certain standards under the ACA will owe a penalty if they have any full-time employees who receive a subsidy through a health insurance marketplace. The standards specify income-related thresholds regarding the costs of that coverage and the share of the cost of covered health benefits paid by the employer's insurance plan.[16] The requirement generally applies to employers with at least 50 full-time-equivalent employees. In CBO and JCT's projections, payments of those penalties total $228 billion over the 2017–2026 period. However, the increased costs for employers who pay the penalties are projected to reduce other revenues by about $50 billion because employers will generally shift the costs of the penalties to workers by lowering taxable wages, yielding a net reduction in the deficit of $178 billion (see Table 3). The associated effects of changes in taxable compensation on tax revenues are included in JCT's estimate of the effects of the tax exclusion for employment-based coverage (in Table 2).

Effects of the Insurance Coverage Provisions of the ACA

The estimates of health insurance coverage and of the net federal subsidies associated with such coverage presented and discussed in the previous two sections of this report incorporate the effects of the insurance coverage provisions of the ACA. CBO and JCT also isolated the effects of those provisions for this report by comparing, as they have done in previous reports, their current projections with estimates of what would have occurred if the ACA had never been enacted. In 2026, 24 million more people are projected to have coverage than would have had it if the ACA had never been enacted. Two of the ACA's provisions in particular—those governing the health insurance marketplaces and allowing states to expand Medicaid coverage—are responsible for most of that increase. The number of people with employment-based coverage

16. To meet the standards, the cost to employees for self-only coverage must not exceed a specified share of their income (which is 9.66 percent in 2016 and is indexed for inflation over time), and the plan must pay at least 60 percent of the cost of covered benefits.

and the number of people with nongroup or other coverage outside the marketplaces are projected to decrease because of the ACA, but to a lesser degree.

The health insurance coverage provisions of the ACA will result in net costs to the federal government of $110 billion in 2016, according to CBO and JCT's estimates (see Table 3). Those costs are expected to grow each year over the next decade, but such growth would slow after 2026. For the 2017–2026 period, the projected net cost of those provisions is $1.4 trillion, consisting of the following amounts:

- Gross costs of $1.9 trillion for subsidies for coverage obtained through the health insurance marketplaces or provided through the Basic Health Program, Medicaid and CHIP, and tax credits for small employers; and
- An offsetting amount of $0.5 trillion in net receipts from penalty payments, revenues resulting from the excise tax on certain high-premium insurance plans, and the effects on income and payroll tax revenues and associated outlays arising from projected changes in employment-based coverage.

The agencies have separately identified those effects on coverage and net costs in this report but will not do so in the future because estimating what would have occurred if the ACA had never been enacted is becoming more difficult. (See Box 2 for more information.) The estimates address only the insurance coverage provisions of the ACA, which do not generate all of the law's budgetary effects.[17] Many other provisions—such as various tax provisions that increase revenues and reductions in Medicare payments to hospitals, to other providers of care, and to private insurance plans delivering Medicare's benefits—are, on net, expected to reduce budget deficits.

The estimates of the effects of the insurance coverage provisions of the ACA incorporate CBO's updated economic projections, data on enrollment through the marketplaces through the end of January 2016, administrative data on Medicaid enrollment, new data on premiums for both employment-based coverage and plans purchased through the marketplaces, and recent decisions by states about expanding Medicaid coverage. The updated estimates also incorporate several technical improvements to modeling, including a decrease in the share of future wage growth projected to go to lower-income people.

Insurance Coverage Provisions

Among the many insurance coverage provisions of the ACA are the following key elements:

17. For more information, see Congressional Budget Office, "Estimating the Budgetary Effects of the Affordable Care Act," *CBO Blog* (June 17, 2014), www.cbo.gov/publication/45447.

- Many individuals and families are eligible for subsidized health insurance through the health insurance marketplaces or through the Basic Health Program that states have the option of establishing.
- States are permitted but not required to expand eligibility for Medicaid to 138 percent of the FPL, and the federal government pays a larger share of the costs for individuals whom the ACA made eligible than for those who would have been eligible otherwise.
- Beginning in 2016, the federal government pays a larger share of the costs for CHIP.[18]
- Under the individual mandate, most citizens of the United States and noncitizens who are lawfully present in the country must either obtain health insurance or pay a penalty for not doing so.
- Certain employers that decline to offer their employees health insurance coverage that meets specified standards are assessed penalties.
- Beginning in 2020, a federal excise tax will be imposed on some health insurance plans with high premiums. Although that tax was originally scheduled to take effect in 2018, the Consolidated Appropriations Act, 2016, delayed the start by two years.
- Plans sold through the marketplaces along with most sold directly to consumers must accept all applicants regardless of their health status, and premiums for those plans may vary only by age (for adults age 21 or older, such variation is limited to a ratio of 3 to 1), smoking status, and geographic location.
- Children are generally permitted to stay on a parent's insurance plan until age 26.
- Certain small employers that provide health insurance to their employees are eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

The ACA also made changes to other rules governing health insurance coverage that are not listed above. Most of those rules address coverage in the nongroup, small-group, and large-group markets, including in some cases self-insured plans

18. CHIP, which was funded through the end of 2013 before the enactment of the ACA, received funding under the ACA for 2014 and 2015. Funding was subsequently provided through 2017 by the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10). As a result, CBO no longer counts its funding for additional years as an effect of the ACA.

(employment-based plans for which the risk is borne not by insurers but by employers).[19]

Several of the ACA's insurance coverage provisions have been modified by subsequent legislation, judicial decisions, or administrative actions. CBO and JCT's estimates are for the provisions as they currently exist and are being implemented; as a result, those estimates differ from what would have happened under the law as originally enacted.

Effects on the Uninsured

By CBO and JCT's estimates, an average of about 35 million residents of the United States under age 65 were uninsured during any given month in 2015; that is about 17 million less than the number of people under 65 that the agencies estimate would have been uninsured if the ACA had never been enacted.[20]

Those estimates of the effects of the ACA on insurance coverage are the net result of several changes in the extent and types of coverage. In 2026, 18 million people are projected to have coverage through the health insurance marketplaces, 1 million people are projected to have coverage through the Basic Health Program, and 19 million more people, on net, are projected to have coverage through Medicaid and CHIP than would have had it if the ACA had not been enacted. Partly offsetting those increases, however, are projected net decreases of 9 million in the number of people with employment-based coverage and 4 million in the number of people with coverage in the nongroup market outside the marketplaces or with coverage through other sources.

19. For more information on regulations governing health insurance, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), www.cbo.gov/publication/51130.

20. CBO and JCT's estimate of the number of people who would have been uninsured if the ACA had never been enacted is different from the result of subtracting the number of people who were uninsured in 2013 or 2014 from the number who were uninsured in 2015. The agencies' estimate accounts only for the effects of the coverage provisions since the law's enactment, whereas tallies in any given year after the enactment would also incorporate the incremental changes in that year from any underlying trends that would have occurred if the law had never been enacted. This estimate cannot be directly compared with estimates of the reduction in the number of uninsured people made by the Department of Health and Human Services, although it is broadly consistent with those estimates. CBO and JCT's estimate differs from the Administration's partly because of a difference in timing; the Administration's most recent estimate goes through the first quarter of 2016, whereas CBO and JCT's estimate covers only calendar year 2015. Additionally, the two estimates use a different population; CBO and JCT include children in their estimates, whereas the Administration does not. See Namrata Uberoi, Kenneth Finegold, and Emily Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016*, ASPE Issue Brief (Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 2016), http://go.usa.gov/cGzjw (PDF, 732 KB); and Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage and the Affordable Care Act," ASPE Data Point (September 2015), http://go.usa.gov/cGzkj (PDF, 536 KB).

Some people will pay penalties for being uninsured. CBO and JCT estimate those penalties to amount to $3 billion in 2016 and $5 billion in 2026. For the 2017–2026 period as a whole, those amounts are projected to total $38 billion.

Effects on Medicaid and CHIP

According to CBO's estimates, the total increase in Medicaid enrollment stemming from the ACA will average 13 million in any given month in 2016; that number is projected to continue to grow over the coming years as more states expand their Medicaid programs to people whose income is at or below 138 percent of the FPL. By 2026, the number of people enrolled in Medicaid as a result of the ACA is estimated to average 19 million (see Table 4).

In its estimates, CBO can identify people whom the ACA made eligible for Medicaid because the federal government pays a higher share of costs for those enrollees (and as a result, they are tracked separately). The agency estimates that those enrollees constitute the majority of people enrolling in Medicaid as a result of the ACA. (In addition, CBO expects that some people who would have been eligible for Medicaid but who would not have enrolled if the ACA had never been enacted will now enroll in the program.) The number of people enrolled in Medicaid who were made eligible by the ACA was about 10 million in 2015. The agency's estimates of enrollment over the next decade reflect the expectation that additional states will expand Medicaid coverage and that more people will enroll in the program in states that have already expanded Medicaid; the number of people enrolled in Medicaid who were made eligible by the ACA is projected to reach 11 million in 2016 and 15 million in 2026.

In addition, CBO and JCT expect that the ACA's individual mandate, increased outreach efforts under that law, and new opportunities for eligible people to apply for coverage through the health insurance marketplaces will increase enrollment of people who would have been eligible for Medicaid if the ACA had not been enacted. CBO estimates that in 2015, Medicaid enrollment increased by about 2 million people who would have been eligible without the ACA but who chose to enroll as a result of the ACA's enactment. (That estimate cannot be verified because there is no way to know whether new enrollees who would have been eligible without the ACA would have signed up if the ACA had never been enacted.)

As with projections of enrollment through the health insurance marketplaces, the numbers that CBO projects for Medicaid enrollment represent averages over the course of a year and differ from counts of enrollment at any particular point during a year. Unlike the rules governing plans offered through the marketplaces, which limit enrollment opportunities to an annual open-enrollment period and to other specified circumstances, the rules governing Medicaid allow people who are eligible to enroll at any time during a year. People move into and out of Medicaid for many reasons, including changes in their need for health care and changes in their financial circumstances.

Although several provisions of the ACA probably affect enrollment in CHIP, CBO estimates that, on net, CHIP enrollment will be largely unchanged by the ACA. The agency estimates that the ACA nevertheless affects federal spending for CHIP. In particular, it increased the share of CHIP's costs covered by the federal government, and that cost is included in the estimated budgetary effects of the ACA presented in this report.

In CBO and JCT's projections, the additional cost to the federal government for Medicaid and CHIP resulting from the ACA is $74 billion in 2016 and grows to $144 billion in 2026. For the 2017–2026 period as a whole, that cost is projected to total $1,063 billion (see Table 3). Federal spending for people whom the ACA made eligible for Medicaid is projected to be $64 billion in 2016 and to total $969 billion over the 2017–2026 period.

Effects on the Marketplaces and the Basic Health Program

Because the ACA established subsidies for health insurance purchased through the marketplaces and the Basic Health Program, the incremental effects of the ACA associated with those sources of insurance are the same as the overall effects discussed earlier in this report.

About 13 million people selected health insurance plans for 2016 through the marketplaces by the close of the open-enrollment period; however, CBO and JCT estimate that the average number of people who are covered by insurance purchased through the marketplaces during the year will be 12 million. The agencies estimate that 10 million of those people, on average, will receive subsidies to purchase their coverage.

CBO and JCT project average enrollment to continue to increase to 15 million people in 2017 and then to be between 18 million and 19 million people each year from 2018 to 2026. Between 80 percent and 85 percent of those enrollees—or about 14 million to 16 million people—are expected to receive subsidies for purchasing that insurance each year after 2017.

In 2016, premium tax credits, cost-sharing subsidies, Basic Health Program payments, net spending and revenues for risk adjustment and reinsurance, and grants to states will total $43 billion, CBO and JCT estimate (see Table 3). That amount is projected to rise to $106 billion in 2026 and to total $866 billion over the 2017–2026 period.

Effects on Employment-Based Coverage

Changes in employment-based coverage under the ACA affect federal tax revenues and outlays. In particular, if fewer people have employment-based health insurance, CBO and JCT expect that more of their income will take the form of taxable wages and thus increase revenues. As a result of the ACA, between 4 million and 9 million fewer people are projected to have employment-based coverage each year from 2017

through 2026 than would have had such coverage if the ACA had never been enacted. That net difference is the result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by active workers, retirees under age 65, and their families.

Those projected changes in coverage can be illustrated for a particular year. In 2026, for example, CBO and JCT estimate that 9 million fewer people would have employment-based coverage under current law than would have had it if the ACA had not been enacted. About 11 million people who would have enrolled in employment-based coverage had the ACA never been enacted are projected, under current law, to no longer have an offer of such coverage. An additional 4 million people who would have enrolled in employment-based coverage in the absence of the ACA and who will still have such an offer under the ACA are projected to nevertheless choose not to enroll in that coverage. Some of those 15 million people are expected to obtain coverage from some other source, such as Medicaid, for which they were made eligible by the ACA.

Those decreases in employment-based coverage in 2026 are, however, projected to be partially offset. About 6 million people who would not have had employment-based coverage if the ACA had never been enacted are expected to obtain such coverage under current law; they will either receive and accept a new offer of coverage or take up an offer that they would have received anyway. Some of those enrollees would have been uninsured if the ACA had never been enacted.

Because of the net reduction in employment-based coverage, the share of workers' pay that takes the form of nontaxable benefits (such as payments toward health insurance premiums) will be smaller—and the share that takes the form of taxable wages will be larger—than would otherwise have been the case. That shift in compensation is projected to reduce deficits by $5 billion in 2016 and by a total of $248 billion over the 2017–2026 period, primarily by boosting federal tax receipts, but also by reducing outlays from certain refundable tax credits. Partially offsetting the additional receipts during that period is an estimated $9 billion increase in Social Security benefits that will be paid because of the higher wages paid to workers. All told, CBO and JCT project, those changes would reduce federal budget deficits by $239 billion over the 2017–2026 period.

Effects on Nongroup and Other Coverage

According to CBO and JCT's estimates, 2 million fewer people will be enrolled in nongroup insurance plans offered outside the marketplaces or in other types of coverage, such as student health plans, in 2016 than if the ACA had not been enacted. That number stems almost entirely from changes in enrollment in nongroup plans and is expected to continue to grow over the coming years as more people switch to nongroup coverage offered through the marketplaces. By 2026, an average of 4 million fewer people are projected to enroll in nongroup plans outside the marketplaces and other types of coverage as a result of the ACA. The budgetary

effects caused by people switching out of nongroup plans—to enroll in Medicaid or subsidized coverage through the marketplaces, for example—are embedded in the estimates discussed above.

Trends in Net Costs of the Insurance Coverage Provisions of the ACA Beyond 2026

The projected costs of the insurance coverage provisions of the ACA continue to grow toward the end of the 2017–2026 period; however, CBO and JCT expect that growth to slow after 2026—possibly to such an extent that those net costs eventually decline—for two main reasons. First, the agencies anticipate that growth in the gross costs of coverage will begin to slow after 2026. In particular, additional states are projected to expand Medicaid coverage to people below 138 percent of the FPL in each year between 2017 and 2026. Hence, projected growth over the next decade in spending for Medicaid and CHIP that is attributable to the ACA reflects both additional enrollment and underlying trends in health costs. However, CBO and JCT estimate that additional states are unlikely to expand Medicaid coverage after 2026; growth in spending for Medicaid and CHIP attributable to the ACA would therefore probably be slower after 2026 than it is projected to be towards the end of the 2017–2026 period.

Second, CBO and JCT project that the revenues resulting from the excise tax on high-premium insurance plans will offset more of the gross costs of the ACA's insurance coverage provisions over time. The tax is expected to affect an increasing share of coverage offered through employers because premiums for health insurance are projected to increase more rapidly than the threshold for determining liability for the tax, thus generating rising revenues.

Changes in the Estimates of the Effects of the Insurance Coverage Provisions of the ACA Since March 2015

In CBO and JCT's current projections, in 2025 an average of 24 million people who would otherwise have been uninsured have health insurance because of the ACA. That estimate is 1 million less than the agencies' estimate from the most recent detailed projections of the effects of the ACA's insurance coverage provisions, which were published in March 2015.[21] For the 2016–2025 period covered by both last year's and the current projections, the agencies have increased their estimate of the net cost

21. CBO and JCT last published detailed projections of the effects of the ACA's insurance coverage provisions as part of CBO's March 2015 baseline update. This report compares the current baseline projections with those projections. See Congressional Budget Office, *Updated Budget Projections: 2015 to 2025* (March 2015), Appendix, www.cbo.gov/publication/49973. Some of the revisions described in this report, such as those stemming from changes in law and the higher-than-expected enrollment in Medicaid among people whom the ACA made eligible for the program, were previously incorporated into CBO's August 2015 or January 2016 baselines. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2015 to 2025* (August 2015), Appendix A, www.cbo.gov/publication/50724, and *The Budget and Economic Outlook: 2016 to 2026* (January 2016), Appendix A, www.cbo.gov/publication/51129.

of those provisions from $1,207 billion to $1,344 billion (see Table 5).[22]

Key Factors Contributing to Changes in the Estimates

The increase in the net cost of the coverage provisions results primarily from incorporating new data about enrollment and employer behavior and updates to CBO's projections of income.

The number of people estimated to have been enrolled in Medicaid in 2015 who were made eligible for the program by the ACA was significantly higher than CBO had previously projected, leading the agency to boost its projections of enrollment in the program in the first few years of the projection period. Conversely, CBO and JCT have lowered their projections of subsidized and unsubsidized coverage purchased through the marketplaces on the basis of information available about such enrollment in 2016. In addition, on the basis of available information from surveys, it appears that more employers are continuing to offer coverage to their employees than CBO and JCT had previously anticipated.

Over the next decade, earnings from wages and salaries are now expected to increase more slowly for lower-income people and more quickly for higher-income people than they were in the March 2015 projections.[23] Furthermore, average household wages in the current forecast are projected to be 1 percent to 2 percent lower overall through most of the next decade than they were previously projected to be during those years. Those revisions result in an increased share of the population with income below 200 percent of the FPL in the current projections, particularly in the latter years of the projection period. That increase expanded CBO's estimate of the share of the population eligible for Medicaid and thus further boosted projected enrollment in that program. One other result of the projected changes in income is that CBO and JCT have increased their projections of the per-person cost of subsidized coverage through the marketplaces and the Basic Health Program.

Several pieces of legislation enacted since March 2015 also affected projected enrollment and costs for Medicaid, the marketplaces, and employment-based coverage as well as projected revenues stemming from the excise tax on certain high-premium insurance plans. The net budgetary effect of those new laws on the ACA's insurance coverage provisions was small, however.

22. For changes since January 2016 in estimates for individual budget accounts affected by the ACA, see *Updated Budget Projections: 2016 to 2026* (March 2016), www.cbo.gov/publication/51384.

23. That technical change was implemented in CBO's January 2016 revenue projections and was incorporated into the estimates of the ACA's insurance coverage provisions presented in this report.

Changes in the ACA's Projected Effects on Health Insurance Coverage

Primarily as a result of those factors discussed above, CBO and JCT raised their projections for Medicaid enrollment, lowered their projections for coverage through the marketplaces, and revised their estimates of employment-based coverage.

Medicaid and CHIP. For most years, CBO has increased last year's projection of new enrollment in Medicaid resulting from the ACA by 2 million to 4 million people because the average number of people estimated to have been enrolled in 2015 who were made eligible by the ACA exceeded CBO's prior estimates by 2 million. In addition, the agency's projections of income growth and wages result in a larger share of the population having income below 138 percent of the FPL than was previously projected. The higher projected enrollment in each year over the next decade is the result of increases in CBO's estimates of both the share of the population that is eligible for Medicaid and the share of the eligible population that enrolls in the program.

Partially offsetting those increases in Medicaid enrollment, CBO has slowed the rate at which states are projected to expand Medicaid coverage. Previously, the agency estimated that by 2020, about 80 percent of the people who met the new eligibility criteria for Medicaid under the ACA would live in states that had expanded Medicaid coverage. CBO now projects that share would be reached in 2026.

All told, in CBO's current projection, an average of 18 million people are enrolled in Medicaid or CHIP in any given month in 2025 as a result of the ACA; in its March 2015 projection, that number was about 14 million (see Table 5).

Health Insurance Marketplaces and the Basic Health Program. The agencies have decreased their estimate of enrollment in coverage through the health insurance marketplaces and the Basic Health Program in each year. In CBO and JCT's current projections, in 2025 an average of 19 million people are enrolled in coverage through marketplaces or the Basic Health Program in any given month, whereas in last year's projections that number was 22 million. As part of that change, CBO and JCT have lowered their estimate of the number of people who will receive subsidies for enrolling in health insurance plans through the marketplaces. In March 2015, the agencies estimated that an average of 15 million people would receive subsidized coverage through the marketplaces in any given month in 2016 and that between 16 million and 18 million people, on average, would receive such coverage in later years. In the current projection, those estimates have fallen to 10 million people with subsidized

coverage in 2016 and between 12 million and 16 million people with such coverage in later years.[24]

The reduction in the number of people who are projected to receive subsidies for coverage through the marketplaces, particularly in the near term, partly stems from the lower estimate of the number of people projected to lose their offer of employment-based coverage as a result of the ACA (as discussed below), which in turn reduced the number of people who are eligible to receive a subsidy through the marketplaces. (CBO and JCT expect employers to respond to the availability of new insurance coverage options under the ACA—by not offering insurance coverage for their employees—more slowly than the agencies had anticipated.) In addition, part of the reduction reflects a technical reclassification of about 1 million people who are estimated to obtain subsidized coverage through the Basic Health Program.[25]

CBO and JCT have also revised downward their projection of unsubsidized enrollment in nongroup coverage through health insurance marketplaces because such enrollment has been smaller than they anticipated in the first two years that the marketplaces have been in operation. In the March 2015 projection, the agencies estimated that in each of the next 10 years, an average of 6 million people would be enrolled in unsubsidized plans purchased through the marketplaces in any given month; they now estimate that number will be 2 million in 2016, and it is projected to grow to 4 million by 2019. Some of the unsubsidized people who are no longer expected to purchase insurance through a marketplace are expected to purchase insurance directly from an insurer instead, particularly over the next two years.

Employer-Based Coverage. In CBO and JCT's current projections, the net reduction in employment-based coverage stemming from the ACA starts out 4 million smaller in 2016 (a reduction of 2 million in that year rather than the 6 million previously estimated), but grows to be about 2 million larger in 2025 (a reduction of 9 million in that year rather than the 7 million previously estimated). That net change reflects two offsetting factors. First, CBO and JCT still project that some employers will stop offering health insurance coverage to their workers, but they now estimate that those changes

24. In January, CBO and JCT projected that an average of 11 million people in any given month would receive subsidized coverage through health insurance marketplaces in 2016. On the basis of new information on enrollment through the close of the open-enrollment period for the year, the agencies now project that in any given month in 2016, the average subsidized enrollment will be around 10 million people. See Congressional Budget Office, *The Budget and Economic Outlook: 2016 to 2026* (January 2016), p. 17, www.cbo.gov/publication/51129.

25. In previous projections, CBO and JCT had not identified those enrollees separately and instead included them in their estimate of the number of people who purchased subsidized coverage through the marketplaces. Because those enrollees do not sign up for coverage through the marketplaces and therefore are not included in data on total enrollment through the marketplaces, the agencies now provide separate estimates of the number of people who receive a subsidy through the marketplaces and the number of people who receive a subsidy through the Basic Health Program.

will, for the most part, occur a few years later and to a lesser extent than previously anticipated because there is little evidence that a substantial number of employers have changed their decision to offer health insurance coverage.[26] Second, CBO and JCT now project that fewer people will choose to enroll in employment-based coverage that is available to them than previously estimated. That reduction stems from an increase in the number of people whom the ACA made eligible for Medicaid who are expected to enroll in that program instead of remaining enrolled in employment-based coverage, as well as from legislation enacted that repealed the automatic enrollment requirement for certain large employers.[27]

Changes in the Budgetary Effects of the ACA's Insurance Coverage Provisions

In CBO and JCT's current projections, the net cost of the ACA's insurance coverage provisions is $136 billion (or 11 percent) higher over the 2016–2025 period than it was in their March 2015 projections. That net increase results mainly from the following changes:

- A $146 billion increase in projections of federal spending for Medicaid and CHIP, mostly attributable to higher estimated enrollment among people whom the ACA made eligible for Medicaid.

- A $46 billion reduction in the estimated net cost of subsidies for coverage through the marketplaces and in related spending and revenues. That net reduction results from a downward revision of projected subsidized enrollment through the marketplaces, which was partially offset by an increase in the estimated per-person cost of subsidized coverage through the marketplaces and the Basic Health Program.

- A $28 billion reduction in projections of federal revenues—and thus a $28 billion increase in the net cost of the coverage provisions—related to the excise tax on certain high-premium insurance plans. That reduction stems mainly from legislation enacted in 2015 that delayed the implementation of that tax and made it deductible to employers; a small decrease in the projected growth of premiums for employment-based coverage also contributed to that reduction.

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26. For example, the Employee Benefit Research Institute found no change in the percentage of people under the age of 65 with employment-based coverage between 2013 and 2014. See Paul Fronstin, *Sources of Health Insurance Coverage: A Look at Changes Between 2013 and 2014 From the March 2014 and 2015 Current Population Survey*, Issue Brief 419 (Employee Benefit Research Institute, 2015), http://tinyurl.com/hdz2bc4. In addition, the *Employer Health Benefits Survey* reported that the percentage of firms that offered coverage to at least some of their employees in 2015 was statistically unchanged from 2014. See Gary Claxton and others, *Employer Health Benefits: 2015 Annual Survey* (Kaiser Family Foundation and Health Research and Educational Trust, 2015), http://tinyurl.com/h5xnpno.

27. Section 604 of the Bipartisan Budget Act of 2015 (P.L. 114-74) repealed the requirement under the ACA that certain large employers automatically enroll new employees in a health insurance plan and continue the enrollment of current employees.

Various other small revisions account for the remaining $8 billion net increase in the projected net cost of the ACA's insurance coverage provisions over the 2016–2025 period.

Changes in the Estimates Since the Enactment of the ACA

Although CBO and JCT's current projection of the net cost of the ACA's insurance coverage provisions is higher than the March 2015 projection for the period spanned by both estimates, the current projection is lower than the agencies' original estimate, made when the law passed in March 2010, for the four years covered by the two estimates (see Figure 2). In 2010, CBO and JCT projected that the provisions of the ACA that were related to health insurance coverage would cost the federal government $623 billion from 2016 through 2019. In the agencies' current projections, those provisions are estimated to cost $466 billion over that same period, a reduction of 25 percent. For 2019, for example, CBO and JCT projected in March 2010 that the ACA's insurance coverage provisions would have a net federal cost of $172 billion; the current projections show a cost of $123 billion—a reduction of $49 billion, or 28 percent.

Technical revisions and updates to CBO's economic projections account for part of the downward revision since March 2010 to CBO and JCT's estimates (when measured on a year-by-year basis). For example, in light of new data showing slower-than-expected growth in enrollment through the health insurance marketplaces, CBO and JCT have revised downward their estimates of subsidies for coverage through the marketplaces, particularly those for the 2016–2019 period. Another revision that reduced projected federal costs was the slowdown in the overall growth of health care costs covered by private insurance and by the Medicare and Medicaid programs. Although it is unclear how much of that slowdown is attributable to the recession and its aftermath and how much reflects other factors, the slower growth has been sufficiently broad and persistent to persuade the agencies to significantly lower their projections of federal costs for health care.

Judicial decisions, new legislation, and administrative actions also help explain the significant changes in the projected net costs of those provisions. For example, the Supreme Court decision that made the expansion of eligibility for Medicaid optional for states significantly reduced projected net costs. As a result of such developments, assessing the accuracy of CBO and JCT's March 2010 estimate has become more difficult over time.

About This Document

Each year, the Congressional Budget Office issues a series of reports about the federal budget. This study provides background information that helps to explain some of the projections included in the most recent report, *Updated Budget Projections: 2016 to 2026*. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

Kate Fritzsche and Sarah Masi prepared the report with contributions from Jessica Banthin and Philip Ellis. Susan Beyer, Daniel Hoople, Sean Lyons, Alexandra Minicozzi, Eamon Molloy, Romain Parsad, Allison Percy, Kyle Redfield, Robert Stewart, and the staff of the Joint Committee on Taxation contributed to the analysis. Linda Bilheimer, Chad Chirico, Theresa Gullo, and Holly Harvey provided guidance and helpful comments.

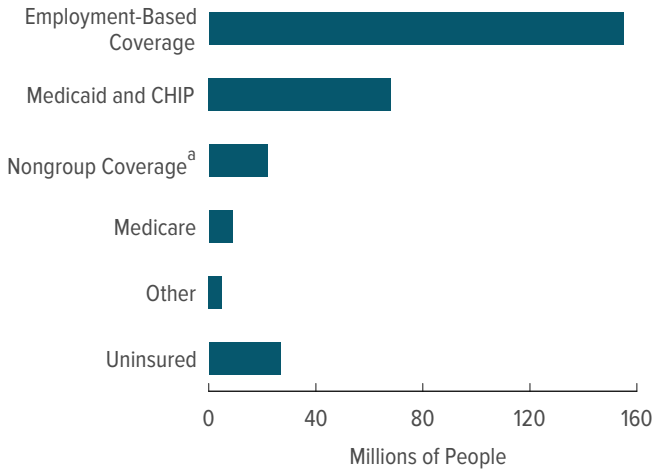
Jeffrey Kling and Robert Sunshine reviewed the report, Bo Peery edited it, and Maureen Costantino and Jeanine Rees prepared it for publication. The report is available on the agency's website (www.cbo.gov/publication/51385).

Keith Hall Director

March 2016

Figure 1. Return to Reference

Health Insurance Coverage in 2016 for People Under Age 65



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

CHIP = Children's Health Insurance Program.

a. Includes the Basic Health Program.

Table 1. Return to Reference 1, 2

Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	272	273	274	275	276	276	277	278	279	279	280
Employment-Based Coverage	155	155	153	152	152	152	152	152	152	152	152
Medicaid and CHIP[a]											
Made eligible for Medicaid by the ACA	11	11	12	12	13	13	14	14	14	15	15
Otherwise eligible for Medicaid	51	51	51	53	52	53	53	53	53	53	54
CHIP	6	6	4	3	3	3	3	3	3	3	2
Subtotal	68	67	67	67	68	69	69	70	70	71	71
Nongroup Coverage and the Basic Health Program											
Purchased through marketplaces[b]											
Subsidized	10	12	15	16	15	15	15	15	15	14	14
Unsubsidized	2	3	3	4	4	4	4	4	4	4	4
Subtotal	12	15	18	19	19	19	19	18	18	18	18
Purchased outside marketplaces	9	9	8	8	8	7	7	7	7	7	7
Subtotal, nongroup coverage	22	24	26	27	27	26	26	26	26	25	25
Coverage through the Basic Health Program[c]	1	1	1	1	1	1	1	1	1	1	1
Medicare[d]	9	9	9	9	9	9	9	9	9	9	9
Other Coverage[e]	5	5	5	5	5	5	5	5	6	6	6
Uninsured[f]	27	26	26	27	27	27	27	27	28	28	28
Memorandum:											
Number of Insured People	244	246	247	247	248	249	250	251	251	252	253
Insured as a Percentage of the Population											
Including all U.S. residents	90	90	90	90	90	90	90	90	90	90	90
Excluding unauthorized immigrants	92	93	93	93	93	93	93	93	93	93	93

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

Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that 12 million to 14 million people (or 5 percent to 6 percent of insured people) have multiple sources of coverage, such as both employment-based coverage and Medicaid.

Estimates reflect average enrollment in any given month over the course of a year and include spouses and dependents covered under family policies.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

a. Includes noninstitutionalized enrollees with full Medicaid benefits. Figures are adjusted to account for individuals enrolled in more than one state.

b. Under the ACA, many people can purchase subsidized health insurance coverage through marketplaces (sometimes called exchanges), which are operated by the federal government, state governments, or partnerships between federal and state governments.

c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

e. Includes people with insurance from other categories, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

f. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

Table 2. Return to Reference 1, 2, 3, 4

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017-2026
Subsidies												
Employment-based coverage												
Tax exclusion for employment-based coverage[a,b]	266	281	296	311	326	345	366	388	411	436	460	3,620
Small-employer tax credits[b]	1	1	1	1	1	1	1	1	1	1	1	9
Subtotal	**268**	**282**	**297**	**312**	**327**	**346**	**367**	**389**	**412**	**437**	**461**	**3,629**
Medicaid and CHIP[c]												
Made eligible for Medicaid by the ACA	64	67	71	77	83	91	99	107	116	125	134	969
Otherwise eligible for Medicaid	203	212	223	236	250	264	279	295	312	330	349	2,751
CHIP	13	13	12	6	6	6	6	6	6	6	6	70
Subtotal	**279**	**292**	**306**	**319**	**338**	**361**	**384**	**408**	**434**	**460**	**489**	**3,790**
Nongroup coverage and the Basic Health Program												
Premium tax credit outlays	27	35	45	51	54	57	60	62	65	68	70	568
Premium tax credit revenue reductions	5	8	8	9	10	11	11	11	12	12	13	104
Subtotal, premium tax credits	32	43	53	60	64	68	71	74	77	80	83	672
Cost-sharing outlays	7	9	11	12	13	13	13	14	14	15	16	130
Outlays for the Basic Health Program	3	4	5	5	6	6	7	7	7	8	8	63
Collections for risk adjustment and reinsurance	-10	-11	-7	-8	-9	-9	-10	-10	-10	-9	-9	-91
Payments for risk adjustment and reinsurance	12	10	8	8	9	9	10	10	10	9	9	92
Marketplace grants to states	1	*	*	0	0	0	0	0	0	0	0	*
Subtotal, subsidies through marketplaces and related spending and revenues	43	56	70	78	83	87	91	95	99	102	106	866
Income tax deduction for self-employed health insurance[b,d]	4	4	5	5	5	5	5	6	6	6	6	53
Subtotal	**48**	**60**	**75**	**83**	**88**	**92**	**96**	**100**	**105**	**108**	**113**	**919**
Medicare[e]	**80**	**81**	**83**	**86**	**91**	**95**	**99**	**104**	**109**	**112**	**118**	**979**

Continued

Table 2. Continued

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017-2026
Taxes and Penalties Related to Coverage												
Gross collections of excise tax on high-premium insurance plans[f]	0	0	0	0	-1	-2	-2	-3	-3	-3	-4	-18
Penalty payments by uninsured people	-3	-3	-3	-3	-3	-4	-4	-4	-4	-4	-5	-38
Tax on health insurance providers	-11	-1	-13	-15	-15	-16	-17	-18	-19	-20	-21	-156
Gross collections of employer penalties[f]	0	-11	-21	-25	-20	-21	-23	-24	-26	-28	-29	-228
Subtotal	**-15**	**-16**	**-36**	**-43**	**-39**	**-43**	**-46**	**-49**	**-53**	**-56**	**-59**	**-441**
Net Subsidies	**660**	**699**	**724**	**757**	**804**	**851**	**899**	**952**	**1,006**	**1,062**	**1,122**	**8,877**

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

Positive numbers indicate an increase in outlays or a decrease in revenues, and negative numbers indicate a decrease in outlays or an increase in revenues.

Excludes outlays made by the federal government as an employer.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; * = between zero and $500 million.

a. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and employer penalties. JCT made this projection; it differs from JCT's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from people over age 65 with employment-based insurance are excluded here and the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

b. Includes increases in outlays and reductions in revenues.

c. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. The federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; thus, the government tracks those groups separately.

d. JCT made this projection; it does not include effects stemming from people over age 65.

e. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

f. Excludes the associated effects of changes in taxable compensation on revenues, which are included in the estimate of the tax exclusion for employment-based insurance. If those effects were included, net revenues stemming from the excise tax would total $79 billion over the 2017–2026 period and revenues from penalty payments by employers would total $178 billion over that 10-year period.

Box 1. Return to Reference

Premiums for Coverage Purchased Through the Health Insurance Marketplaces

The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) project future premiums for private insurance plans on the basis of past trends in premium growth and of projected growth in personal income, which affects people's ability to buy health insurance. The projections factor in both the slow growth in premiums of recent years and the faster growth of earlier years. The agencies also adjust those projections to account for the effects of the Affordable Care Act (ACA), which is anticipated to increase nongroup premiums over the next few years but to reduce employment-based premiums in the longer term.[28] Over the 2017–2026 period, private health insurers' spending per beneficiary, which is the basis for premiums, will increase by an average of 5.5 percent per year, CBO and JCT estimate.

A key determinant of the subsidy that an eligible person receives for purchasing insurance through one of the marketplaces established under the ACA is the so-called reference premium—that is, the premium of the second-lowest-cost "silver" plan offered through the marketplace in which that person participates.[29] CBO and JCT currently estimate that the average reference premium for a 21- to 24-year-old who purchases health insurance coverage through the marketplaces is about $2,800 in calendar year 2016. (Analysts often focus on premiums for 21- to 24-year-olds because they are used as the basis for calculating premiums for other ages.) That estimate represents a national average, reflecting the agencies' projections of the geographic distribution of those who currently have coverage through the marketplaces.

Over the 2017–2026 period, the average reference premium for a 21- to 24-year-old is projected to grow by an average of 6.0 percent per year, about 0.5 percentage points faster than overall spending for private health insurance. That premium is expected to reach about $5,100 in calendar year 2026.

The agencies expect premiums for plans in the marketplaces to rise more rapidly over the 2017–2021 period than insurers' spending per beneficiary for all types of private coverage—6.5 percent per year versus 5.4 percent per year—for several reasons. One factor, for example, is that the reinsurance payments that the government makes to insurers whose enrollees incur particularly high costs for medical care will be phased out over the next two years, pushing up premiums for plans in the marketplaces. Another such factor is that, in general, plans offered through the marketplaces appear to have lower payment rates for providers, narrower networks of providers, and tighter

28. For more detail on how the agencies project premiums, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), pp. 9–11, www.cbo.gov/publication/51130.

29. 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.

management of their subscribers' use of health care than employment-based plans. CBO and JCT anticipate that some insurers offering plans in the marketplaces will decide to increase provider payment rates or broaden their networks over the next few years and to raise their premiums accordingly. From 2022 to 2026, the agencies expect premiums for marketplace plans and for other private insurance to grow by 5.5 percent per year, on average.

To assess changes in their projections over time, CBO and JCT compared their estimates of spending growth for the 2016–2025 period presented in this report with those published in March 2015. The agencies now estimate that health insurers' spending per beneficiary for all types of private coverage will increase by an average of 5.3 percent per year over that period; in the March 2015 projection, they had estimated that spending would increase by an average of 5.6 percent per year. That downward revision occurred in part because personal income is now estimated to grow more slowly than had previously been projected. CBO and JCT also revised their projections to incorporate recent data indicating that insurers' costs rose even more slowly in 2012 and 2013 than in preceding years. Those changes did not substantially affect the estimates of subsidies for health insurance coverage shown in this report.

Table 3. Return to Reference 1, 2, 3, 4, 5

Direct Spending and Revenue Effects of the Insurance Coverage Provisions of the Affordable Care Act

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017-2026
Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a]	43	56	70	78	83	87	91	95	99	102	106	866
Medicaid and CHIP Outlays	74	78	81	85	91	100	108	116	125	134	144	1,063
Small-Employer Tax Credits[b]	1	1	1	1	1	1	1	1	1	1	1	9
Gross Cost of Coverage Provisions	119	134	152	164	174	187	199	212	225	238	252	1,938
Penalty Payments by Uninsured People	-3	-3	-3	-3	-3	-4	-4	-4	-4	-4	-5	-38
Penalty Payments by Employers[b]	0	-9	-16	-20	-15	-16	-18	-19	-20	-22	-23	-178
Excise Tax on High-Premium Insurance Plans[b]	0	0	0	0	-3	-7	-9	-11	-13	-16	-20	-79
Other Effects on Revenues and Outlays[c]	-5	-9	-13	-18	-22	-24	-27	-29	-31	-33	-34	-239
Net Cost of Coverage Provisions	**110**	**113**	**119**	**123**	**130**	**136**	**142**	**150**	**157**	**163**	**170**	**1,403**
Memorandum:												
Increases in Mandatory Spending	123	137	150	162	172	186	198	210	223	235	248	1,920
Increases in Revenues	13	24	31	39	42	50	55	60	66	72	78	517

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

Estimates exclude effects on the deficit of provisions of the Affordable Care Act that are not related to insurance coverage and effects on discretionary spending of the coverage provisions.

Except in the memorandum lines, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

CHIP = Children's Health Insurance Program.

a. Includes subsidies for coverage through the Basic Health Program, grants to states for establishing health insurance marketplaces, and net spending and revenues for risk adjustment and reinsurance. The risk corridors program is recorded in the budget as a discretionary program; CBO estimates that payments and collections will offset each other in each year, resulting in no net budgetary effect.

b. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.

c. Consists mainly of the effects of changes in taxable compensation on revenues. CBO estimates that outlays for Social Security benefits will increase by about $9 billion over the 2017–2026 period and that the coverage provisions will have negligible effects on outlays for other federal programs.

Box 2. Return to Reference

Future Projections Related to the Insurance Coverage Provisions of the Affordable Care Act

Although the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have included in this report estimates that separately identify the effects of the insurance coverage provisions of the Affordable Care Act (ACA) on the federal budget, generating such estimates is becoming more challenging and less meaningful. The question of what would have occurred if the ACA had never been enacted is difficult to answer for two reasons. First, the available data on coverage and spending increasingly reflect the effects of the ACA's coverage provisions—only some of which are tracked separately. Second, legislative changes, judicial decisions, and administrative actions continue to alter the nature of the law's provisions, making it increasingly difficult to define which aspects of current law constitute the ACA's insurance coverage provisions and to ascertain how those provisions affect health insurance coverage and federal programs.[30] Moreover, such a counterfactual scenario is becoming less and less relevant for understanding the effects of future changes to law.

As a result, CBO and JCT will no longer make separate projections of all of the incremental effects of the ACA's insurance coverage provisions; instead, they will present their projections of overall insurance coverage levels and related subsidies, taxes, and penalties under current law. Those projections will incorporate—but not separately identify—the changes stemming from enacting the ACA's coverage provisions. In some cases, as with outlays for the subsidies conveyed through the health insurance marketplaces, those changes will be readily identifiable. In other cases, as with subsidies associated with employment-based coverage, the effects of those provisions will be embedded in the agencies' baseline estimates of federal spending and revenues. In preparation for that transition, CBO and JCT have included in this report both the narrower estimates of the effects of only the coverage provisions of the ACA and broader estimates about coverage obtained through various sources for people under age 65 and the federal subsidies, taxes, and penalties associated with that coverage. In future years, the agencies will update and publish those broader estimates annually and will no longer publish estimates that focus only on the coverage and budgetary effects of the ACA.

30. CBO and JCT have previously noted those challenges, first in August 2010, shortly after the ACA was enacted, and in greater detail in June 2014. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), Box 1-1, p. 6, www.cbo.gov/publication/21670, and "Estimating the Budgetary Effects of the Affordable Care Act," *CBO Blog* (June 17, 2014), www.cbo.gov/publication/45447.

Consistent with their statutory responsibilities, CBO and JCT will continue to estimate the effects of proposed legislation related to the ACA, including proposals to modify certain provisions of the law or to repeal it entirely.[31] Because of the complexities involved in implementing a repeal of the ACA, the budgetary effects of repealing the act would not simply be the opposite of the estimates of the budgetary effects of enacting the ACA that are presented here.

31. For example, see Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 2015), www.cbo.gov/publication/50252.

Table 4. Return to Reference

Effects of the Affordable Care Act on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Change in Insurance Coverage Under the ACA											
Health insurance marketplaces	12	15	18	19	19	19	19	18	18	18	18
Basic Health Program[a]	1	1	1	1	1	1	1	1	1	1	1
Medicaid and CHIP[b]	13	14	14	14	16	17	17	18	18	18	19
Employment-based coverage[c]	-2	-4	-6	-8	-9	-9	-9	-9	-9	-9	-9
Nongroup and other coverage[d]	-2	-2	-3	-3	-3	-4	-4	-4	-4	-4	-4
Uninsured[e]	-22	-24	-23	-23	-23	-23	-24	-24	-24	-24	-24
Insurance Coverage Under Current Law											
Number of uninsured people[e]	27	26	26	27	27	27	27	27	28	28	28
Insured as a percentage of the population											
Including all U.S. residents	90	90	90	90	90	90	90	90	90	90	90
Excluding unauthorized immigrants	92	93	93	93	93	93	93	93	93	93	93
Memorandum:											
Number of Subsidized Enrollees Through Marketplaces	10	12	15	16	15	15	15	15	15	14	14
Number of Unsubsidized Enrollees Through Marketplaces[f]	2	3	3	4	4	4	4	4	4	4	4
Average Subsidy per Enrollee Receiving a Subsidy Through a Marketplace or the Basic Health Program	4,240	4,550	4,670	4,870	5,200	5,470	5,750	6,090	6,430	6,730	7,110

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

Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65.

Estimates reflect average enrollment in any given month over the course of a year and include spouses and dependents covered under family policies; people reporting multiple sources of coverage are assigned a primary source.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

a. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

b. The changes under the ACA are almost entirely for Medicaid.

c. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.

d. "Other coverage" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage. Nongroup coverage here refers to coverage purchased directly from an insurer outside the health insurance marketplaces.

e. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

f. Excludes coverage purchased directly from insurers outside of a marketplace.

Table 5. Return to Reference 1, 2

Comparison of CBO and JCT's Current and Previous Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act

	March 2015 Baseline	March 2016 Baseline	Difference
	Change in Insurance Coverage Under the ACA in 2025 (Millions of people under age 65, by calendar year)[a]		
Health Insurance Marketplaces and the Basic Health Program	22	19	-3
Medicaid and CHIP[b]	14	18	4
Employment-Based Coverage[c]	-7	-9	-2
Nongroup and Other Coverage[d]	-4	-4	*
Uninsured[e]	-25	-24	1
	Effects on the Cumulative Federal Deficit, 2016 to 2025[f] (Billions of dollars)		
Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[g]	849	803	-46
Medicaid and CHIP Outlays	847	993	146
Small-Employer Tax Credits[h]	11	9	-2
Gross Cost of Coverage Provisions	1,707	1,805	98
Penalty Payments by Uninsured People	-43	-37	6
Penalty Payments by Employers[h]	-167	-155	12
Excise Tax on High-Premium Insurance Plans[h]	-87	-59	28
Other Effects on Revenues and Outlays[i]	-202	-210	-8
Net Cost of Coverage Provisions	**1,207**	**1,344**	**136**
Memorandum:			
Increases in Mandatory Spending	1,747	1,795	48
Increases in Revenues	540	452	-88

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

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; * = between zero and 500,000.

a. Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65.

b. The changes under the ACA are almost entirely for Medicaid.

c. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.

d. "Other Coverage" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage. Nongroup coverage here refers to coverage purchased directly from an insurer outside the health insurance marketplaces.

e. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

f. Except in the memorandum lines, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit. Estimates exclude effects on the deficit of provisions of the ACA that are not related to insurance coverage and effects on discretionary spending of the coverage provisions.

g. Includes subsidies for coverage through the Basic Health Program, grants to states for establishing health insurance marketplaces, and net spending and revenues for risk adjustment and reinsurance. The risk corridors program is recorded in the budget as a discretionary program; CBO estimates that payments and collections will offset each other in each year, resulting in no net budgetary effect.

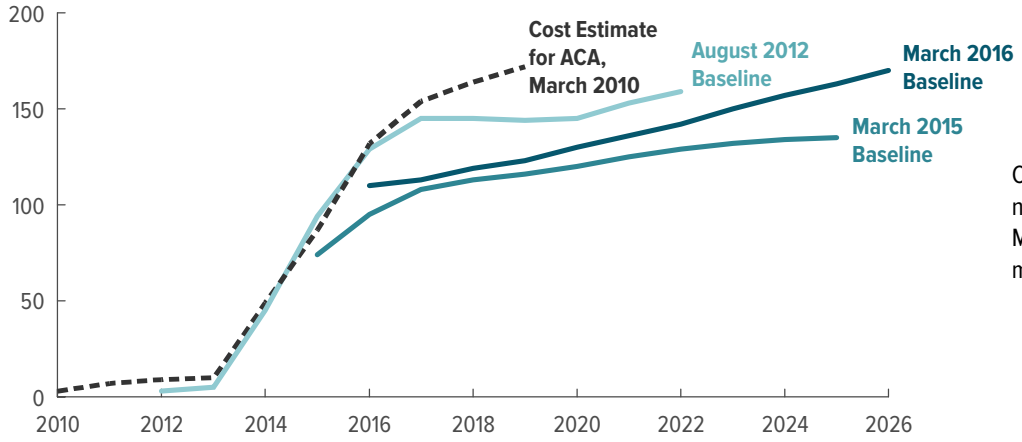
h. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.

i. Consists mainly of the effects of changes in taxable compensation on revenues.

Figure 2. Return to Reference

CBO and JCT's Estimates of the Net Budgetary Effects of the Insurance Coverage Provisions of the Affordable Care Act

Billions of Dollars, by Fiscal Year



CBO and JCT's projections are now higher than those issued in March 2015 but lower than those made when the law was enacted.

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

Effects on the deficit of provisions of the Affordable Care Act (ACA) that are not related to insurance coverage and effects on discretionary spending of the coverage provisions are not shown.

United States Government Accountability Office

Report to Congressional Requesters

March 2016

HEALTHCARE.GOV

Actions Needed to Enhance Information Security and Privacy Controls

GAO-16-265

March 2016

HEALTHCARE.GOV

Actions Needed to Enhance Information Security and Privacy Controls

GAO Highlights

Highlights of GAO-16-265, a report to congressional requesters

Why GAO Did This Study

The Patient Protection and Affordable Care Act required the establishment of health insurance marketplaces in each state to allow consumers to compare, select, and purchase health insurance plans. States establishing their own marketplaces are responsible for securing the supporting information systems to protect sensitive personal information they contain. CMS is responsible for overseeing states' efforts, as well as securing federal systems to which marketplaces connect, including its data hub.

GAO was asked to review security issues related to the data hub, and CMS oversight of state-based marketplaces. Its objectives were to (1) describe security and privacy incidents reported for Healthcare.gov and related systems, (2) assess the effectiveness of security controls for the data hub, and (3) assess CMS oversight of state-based marketplaces and the security of selected state-based marketplaces. GAO reviewed incident data, analyzed networks and controls, reviewed policies and procedures, and interviewed CMS and marketplace officials. This is a public version of a limited official use only report that GAO issued in March 2016. Sensitive information on technical issues has been omitted from this version.

What GAO Recommends

GAO is recommending that CMS define procedures for overseeing the security of state-based marketplaces and require continuous monitoring of state marketplace security controls. HHS concurred with GAO's recommendations.

View GAO-16-265. For more information, contact Gregory C. Wilshusen at (202) 512-6244 or wilshuseng@gao.gov or Dr. Nabajyoti Barkakati at (202) 512-4499 or barkakatin@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) reported 316 security-related incidents, between October 2013 and March 2015, affecting Healthcare.gov—the web portal for the federal health insurance marketplace—and its supporting systems. According to GAO's review of CMS records for this period, the majority of these incidents involved such things as electronic probing of CMS systems by potential attackers, which did not lead to compromise of any systems, or the physical or electronic mailing of sensitive information to an incorrect recipient. None of the incidents included evidence that an outside attacker had successfully compromised sensitive data, such as personally identifiable information.

Consistent with federal guidance, CMS has taken steps to protect the security and privacy of data processed and maintained by the systems and connections supporting Healthcare.gov, including the Federal Data Services Hub (data hub). The data hub is a portal for exchanging information between the federal marketplace and CMS's external partners. To protect these systems, CMS assigned responsibilities to appropriate officials and documented information security policies and procedures.

However, GAO identified weaknesses in technical controls protecting the data flowing through the data hub. These included

- insufficiently restricted administrator privileges for data hub systems,
- inconsistent application of security patches, and
- insecure configuration of an administrative network.

GAO also identified additional weaknesses in technical controls that could place sensitive information at risk of unauthorized disclosure, modification, or loss. In a separate report, with limited distribution, GAO recommended 27 actions to mitigate the identified weaknesses.

In addition, while CMS has taken steps to oversee the security and privacy of data processed and maintained by state-based marketplaces, improvements are needed. For example, CMS assigned roles and responsibilities to various oversight entities, met regularly with state officials, and developed a reporting tool to monitor performance. However, it has not defined specific oversight procedures, such as the timing for when each activity should occur, or what follow-up corrective actions should be performed if deficiencies are identified. Further, CMS does not require sufficiently frequent monitoring of the effectiveness of security controls for state-based marketplaces, only requiring testing once every 3 years.

GAO identified significant weaknesses in the controls at three selected state-based marketplaces. These included insufficient encryption and inadequately configured firewalls, among others. In September 2015, GAO reported these results to the three states, which generally agreed and have plans in place to address the weaknesses. Without well-defined oversight procedures and more frequent monitoring of security controls, CMS has less assurance that state-based marketplaces are adequately protected against risks to the sensitive data they collect, process, and maintain.

Contents

Abbreviations

CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
data hub	Federal Data Services Hub
FISMA	Federal Information Security Modernization Act of 2014
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
IT	information technology
MARS-E	Minimum Acceptable Risk Standards for Exchanges
NIST	National Institute of Standards and Technology
OMB	Office of Management and Budget
OTS	Office of Technology Solutions
PII	personally identifiable information
PPACA	Patient Protection and Affordable Care Act
SMART	State Based Marketplace Annual Reporting Tool
URL	uniform resource locator

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Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA),[1] signed into law on March 23, 2010, includes provisions to reform aspects of the private health insurance market and expand the availability and affordability of health care coverage. It required the establishment of health insurance exchanges, now commonly referred to as "marketplaces,"[2] in each state[3] by January 1, 2014. These marketplaces are required to allow consumers and small employers to compare, select, and purchase health insurance offered by participating private issuers of qualified health plans.[4]

The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing the establishment and operation of these marketplaces, including creating a federally facilitated marketplace in states not establishing their own. States choosing to implement their own marketplaces are responsible for securing the information systems that support the marketplace and their connections to the federal marketplace and for protecting the data collected and processed by the marketplace.

Given the high degree of congressional interest in the development and launch of the marketplaces, GAO has conducted a body of work in this area in order to assist Congress with its oversight responsibilities, of which this is the final report. This report examines the privacy and

[1]Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 119, 173, 186 (Mar. 23, 2010) (hereafter, "PPACA"), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-52, 124 Stat. 1029 (Mar. 30, 2010). PPACA requires the establishment of health insurance exchanges, now known as marketplaces.

[2]In this report, we use the term "marketplace."

[3]In this report, the term "state" includes the District of Columbia.

[4]PPACA requires the insurance plans offered under an exchange, known as qualified health plans, to provide a package of essential health benefits—including coverage for specific service categories, such as ambulatory care, prescription drugs, and hospitalization.

security issues related to the implementation of the Federal Services Data Hub (data hub)—a portal for exchanging information between the federal marketplace and CMS's external partners—and CMS's oversight of the state-based marketplaces. Our specific objectives were to (1) describe the extent to which security and privacy incidents were reported for Healthcare.gov or key supporting systems; (2) assess the effectiveness of the controls implemented by CMS to protect the data hub and the information it transmits; and (3) assess the effectiveness of CMS's oversight of key program elements and controls implemented by state-based marketplaces and the effectiveness of those elements at selected state-based marketplaces to protect the information they contain.

This is a public version of a limited official use only report we issued in March 2016. Sensitive information, such as detailed descriptions of information security weaknesses, has been omitted. Nevertheless, it addresses the same objectives and scope as the limited official use only report. Also, the overall methodology used for both reports is the same.

To address our first objective, we reviewed and analyzed data on information security and privacy incidents reported by CMS affecting Healthcare.gov and its supporting systems. Specifically, we reviewed a list of reported incidents and the information in CMS records associated with each incident, such as the incident reports and documentation of actions taken to mitigate the incidents. We analyzed this information to identify relevant statistics on the reported incidents.

To address our second objective, we analyzed the overall network control environment, identified interconnectivity and control points, and reviewed controls for the network and servers supporting the data hub. Specifically, we reviewed controls over the data hub and its supporting software, as well as the operating systems, network, and computing infrastructure provided by the contractor. In order to evaluate CMS's controls over its information systems supporting Healthcare.gov, we used our *Federal Information System Controls Audit Manual*, which contains guidance for reviewing information system controls that affect the confidentiality, integrity, and availability of computerized information; National Institute of Standards and Technology (NIST) standards and guidelines; and CMS policies, procedures, practices, and standards. We performed our work at CMS contractor facilities in Columbia, Maryland, and Chantilly, Virginia.

To address our third objective, we selected three states for review by concentrating on states that received a high amount of PPACA grant funding through 2014, while ensuring a mix of both population size and

contractors used. To assess the effectiveness of the three selected states' key management controls, we compared their documented policies, procedures, and practices to the provisions and requirements contained in CMS security and privacy standards for state-based marketplaces. To evaluate the technical controls implemented for their marketplaces, we analyzed the overall network control environment, identified control points, and reviewed controls for the supporting network and servers and compared these controls to those specified in our *Federal Information System Controls Audit Manual*, NIST guidance, and CMS guidance for state-based marketplaces. Lastly, to determine the effectiveness of CMS oversight of the states' program elements and controls, we reviewed and analyzed CMS policies and procedures regarding oversight of the state-based marketplaces and compared them to federal guidance on security controls testing and GAO's *Standards for Internal Control in the Federal Government*. We also obtained and reviewed oversight-related documentation that CMS provided to the three selected states.

We conducted this performance audit from December 2014 to March 2016 in accordance with 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 based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. A full description of our objectives, scope, and methodology can be found in appendix I.

Background

PPACA directed each state to establish and operate a state-based health insurance marketplace by January 1, 2014.[5] These marketplaces were intended to provide a seamless, single point-of-access for individuals to enroll in private health plans, apply for income-based financial assistance established under the law, and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid or the Children's Health Insurance Program (CHIP).[6]

[5]PPACA, § 1311(b)(1), 124 Stat. at 173.

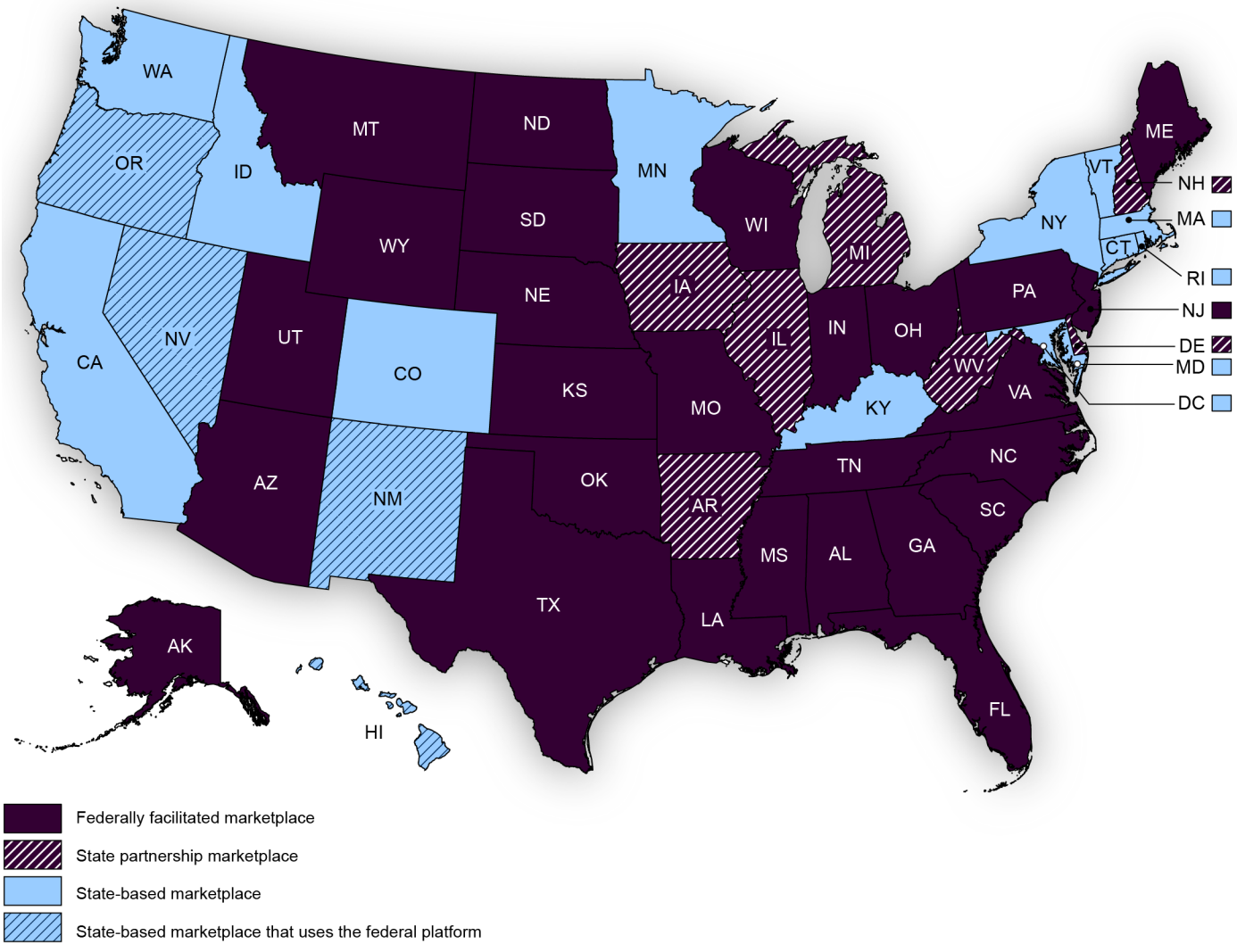
[6]Medicaid is a joint federal-state program that finances health care coverage for certain low-income individuals. CHIP is a federal-state program that provides health care coverage to children 19 years of age and younger living in low-income families whose incomes exceed the eligibility requirements for Medicaid.

In states electing not to establish and operate a marketplace, PPACA required the federal government to establish and operate a marketplace in that state, referred to as a federally facilitated marketplace. Thus, the federal government's role with respect to a marketplace for any given state—in particular whether it established a marketplace or oversees a state-based marketplace—was dependent on a state decision. For plan year 2016,[7] 13 states had a state-based marketplace, 4 had a state-based marketplace using the federal marketplace platform, 27 had a federally facilitated marketplace, and 7 had a state partnership marketplace.[8] Figure 1 shows the states and the types of marketplaces they use.

[7]Open enrollment period for plan year 2016 was the third enrollment period for the state marketplaces, which began on November 1, 2015, and ended on January 31, 2016.

[8]HHS specified options for states to partner with HHS when HHS establishes and operates a marketplace. Under this model, states may assist HHS in carrying out certain functions, such as plan management and consumer assistance. In addition, a state that operates its own marketplace can request that CMS perform eligibility and enrollment functions using federal IT systems. We refer to this as a state-based marketplace using the federal platform.

Figure 1: Type of Health Insurance Marketplace Used by States for Plan Year 2016

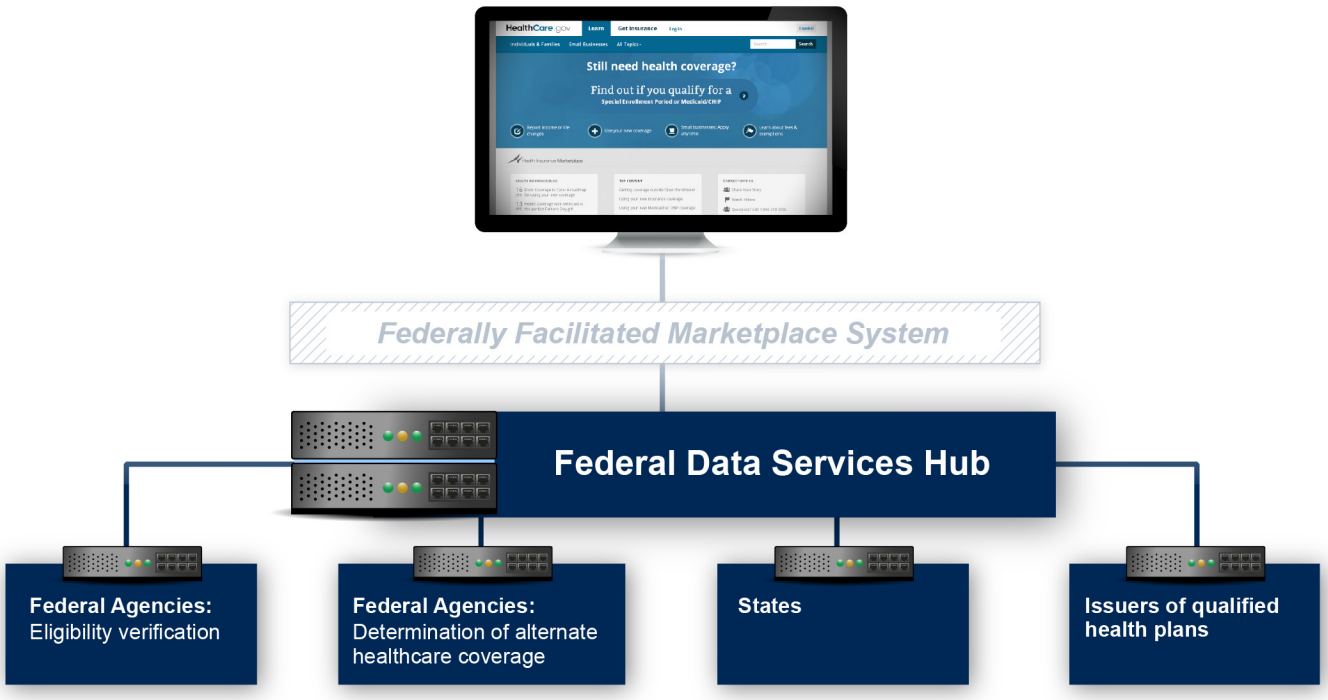


Sources: GAO analysis of Centers for Medicare & Medicaid Services data; Map Resources (map). | GAO-16-265

CMS and State-Based Marketplaces Exchange Data with Many Interconnected Systems and External Partners to Facilitate Enrollment

PPACA requires that CMS and the states establish automated systems to facilitate the enrollment of eligible individuals in appropriate health care coverage. Many systems and entities exchange information to carry out this requirement. The CMS Center for Consumer Information and Insurance Oversight (CCIIO) has overall responsibility for the federal systems supporting Healthcare.gov and for overseeing state-based marketplaces, which vary in the extent to which they exchange information with CMS. Other entities also connect to the network of systems that support enrollment in Healthcare.gov. Figure 2 shows the major entities that exchange data in support of marketplace enrollment and how they are connected.

Figure 2: Overview of Healthcare.gov and Its Supporting Systems



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-265

Regardless of whether a state established and operated its own marketplace or used the federally facilitated marketplace, PPACA and HHS regulations and guidance require every marketplace to have capabilities that enable them to carry out four key functions, among others:

- **Eligibility and enrollment.** The marketplace must enable individuals to assess and determine their eligibility for enrollment in health care coverage. In addition, the marketplace must provide individuals the ability to obtain an eligibility determination for other federal health care coverage programs, such as Medicaid and CHIP. Once eligibility is determined, individuals must be able to apply for and enroll in applicable coverage options.

- **Plan management.** The marketplace is to provide a suite of services for state agencies and health plan issuers to facilitate activities such as submitting, monitoring, and renewing qualified health plans.

- **Financial management.** The marketplace is to facilitate payments of advanced premium tax credits to health plan issuers and also provide additional services such as payment calculation for risk adjustment analysis and cost-sharing reductions for individual enrollments.

- **Consumer assistance.** The marketplace must be designed to provide support to consumers in completing an application, obtaining eligibility determinations, comparing coverage options, and enrolling in health care coverage.

Federal Data Services Hub

The data hub is a CMS system that acts as a single portal for exchanging information between the federally facilitated marketplace and CMS's external partners, including other federal agencies, state-based marketplaces, other state agencies, other CMS systems, and issuers of qualified health plans. The data hub was designed as a "private cloud" service[9] supporting the following primary functions:

- **Real-time eligibility queries.** The federally facilitated marketplace, state-based marketplaces, and Medicaid/CHIP agencies transmit queries to various external entities, including other federal agencies, state agencies, and commercial verification services, to verify information provided by applicants, such as immigration and citizenship data, income data, individual coverage data, and incarceration data.

[9]Although exact definitions vary, cloud computing can, at a high level, be described as a form of computing where users have access to scalable, on-demand IT capabilities that are provided through Internet-based technologies. A private cloud is operated solely for a single organization and the technologies may be on or off the premises.

- **Transfer of application and taxpayer information.** The federally facilitated marketplace or a state-based marketplace transfers application information to state Medicaid/CHIP agencies. Conversely, state agencies also use the data hub to transfer application information to the federally facilitated marketplace. In addition, the Internal Revenue Service (IRS) transmits taxpayer information to the federally facilitated marketplace or a state-based marketplace to support the verification of household income and family size when determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.[10]

- **Exchange and monitoring of enrollment information with issuers of qualified health plans.** The federally facilitated marketplace sends enrollment information to appropriate issuers of qualified health plans, which respond with confirmation messages back to CMS when they have effectuated enrollment. State-based marketplaces also send enrollment confirmations, which CMS uses to administer the advance premium tax credit and cost-sharing reductions and to track overall marketplace enrollment. Further, CMS, issuers of qualified health plans, and state-based marketplaces exchange enrollment information on a monthly basis to reconcile enrollment records.

- **Submission of health plan applications.** Issuers of qualified health plans submit "bids" for health plan offerings for validation by CMS.

Connections between external entities and the data hub are made through an Internet protocol that establishes an encrypted system-to-system web browser connection. Encryption of the data transfer between the two entities is designed to meet NIST standards, including Federal

[10]PPACA offers insurance affordability programs including the advance premium tax credit and cost-sharing reductions. The advance premium tax credit is available on an advance basis, and advance payments of the premium tax credit are reconciled on a tax filer's tax return. The credit is generally available to eligible tax filers and their dependents that are (1) enrolled in a qualified health plan through a marketplace, (2) meet income requirements and (3) not eligible for other health insurance coverage that meets certain standards. Cost sharing generally refers to costs that an individual must pay when using services that are covered under the health plan that the person is enrolled in. Common forms of cost sharing include copayments and deductibles.

Information Processing Standard 140-2.[11] This type of connection is intended to ensure that only authorized systems can access the data being exchanged, thus safeguarding against cyber attacks attempting to intercept the data.

The data hub is designed to not retain any of the data that it transmits in permanent storage devices, such as hard disks. According to CMS officials, data are stored only momentarily in the data hub's active memory. The entities that transmit the data are responsible for maintaining copies of their transmissions in case the data need to be re-transmitted. As a result, CMS does not consider the data hub to be a repository of personally identifiable information.[12]

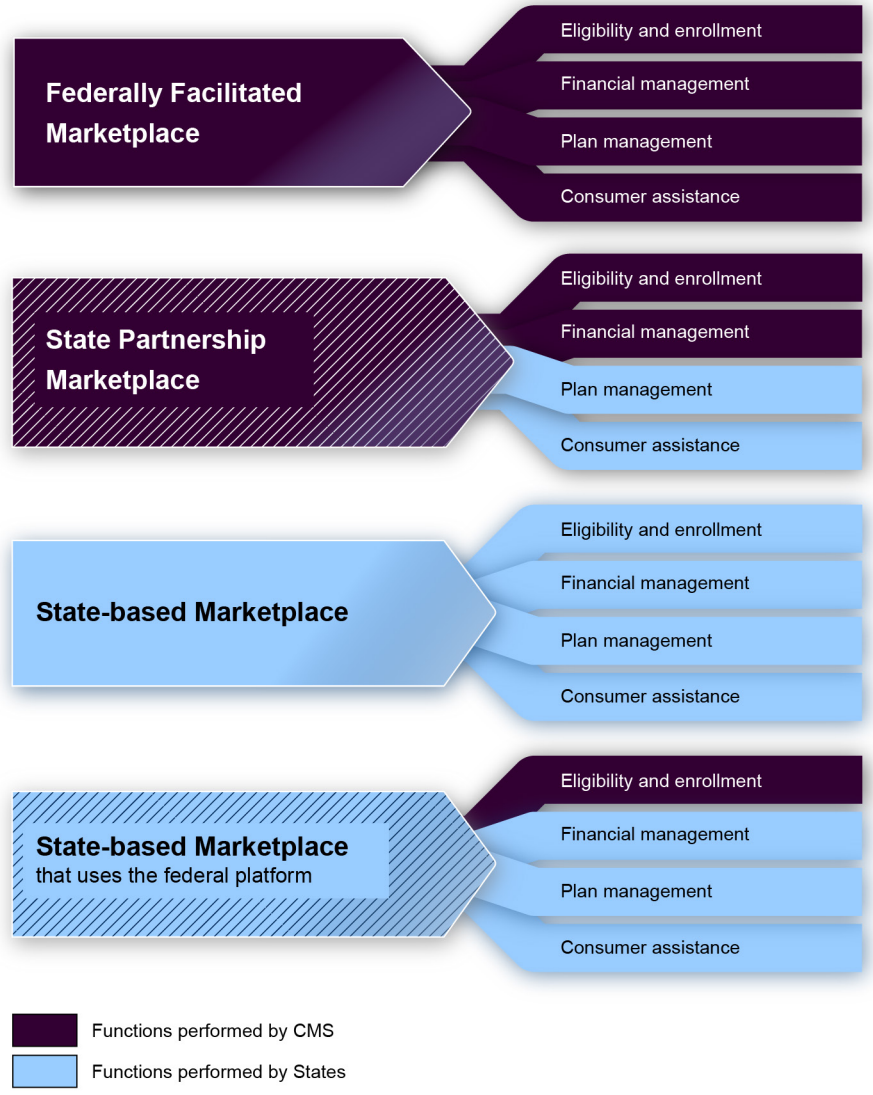
State-Based Marketplaces

State-based marketplaces generally perform the same functions that the federally facilitated marketplace performs for states that do not maintain their own marketplace. However, in certain cases, known as state partnership marketplaces, states may elect to perform one or both of the plan management and consumer assistance functions while the federally facilitated marketplace performs the rest. The specific functions performed by each partner vary from state to state. Figure 3 shows what functions are performed by each type of marketplace.

[11]Agencies are required to encrypt agency data, where appropriate, using NIST-certified cryptographic modules. FIPS 140-2 specifies the security requirements for a cryptographic module used within a security system protecting sensitive information in computer and telecommunication systems (including voice systems) and provides four increasing, qualitative levels of security intended to cover a wide range of potential applications and environments. NIST, *Security Requirements for Cryptographic Modules*, FIPS 140-2 (Gaithersburg, Md.: May 2001).

[12]In terms of the Privacy Act of 1974, CMS has determined that the data hub is not a system of records subject to the act's provisions.

Figure 3: Functions Performed by the Various Types of Marketplaces



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-265

Regardless of whether a state operates its own marketplace, most states need to connect their state Medicaid and CHIP agencies to either their state-based marketplace or the federally facilitated marketplace to exchange data about enrollment in these programs. Such data exchanges are generally routed through the CMS data hub. In addition, states may need to connect with the IRS (also through the data hub) in order to verify an applicant's income and family size for the purpose of determining eligibility for or the amount of the advance payment of the

premium tax credit and cost-sharing reductions. Finally, state-based marketplaces are to send enrollment confirmations to the federally facilitated marketplace so that CMS can administer advance payments of the premium tax credit and cost-sharing payments and track overall marketplace enrollment.

Laws and Regulations Set Requirements for Ensuring the Security and Privacy of Personally Identifiable Information

Federal laws and guidance specify requirements for protecting federal systems and data. This includes systems used or operated by a contractor or other organization on behalf of a federal agency. The Federal Information Security Modernization Act of 2014 (FISMA) requires each agency to develop, document, and implement an agency-wide information security program to provide security for the information and information systems that support operations and assets of the agency, including those provided or managed by another agency, contractor, or another organization on behalf of an agency.[13]

FISMA assigns certain responsibilities to NIST, which is tasked with developing, for systems other than national security systems, standards and guidelines that must include, at a minimum, (1) standards to be used by all agencies to categorize all of their information and information systems based on the objectives of providing appropriate levels of information security, according to a range of risk levels; (2) guidelines recommending the types of information and information systems to be included in each category; and (3) minimum information security requirements for information and information systems in each category.

Accordingly, NIST has developed a risk management framework of standards and guidelines for agencies to follow in developing information security programs. Relevant publications include:

- Federal Information Processing Standard 199, *Standards for Security Categorization of Federal Information and Information Systems*,[14]

[13]The Federal Information Security Modernization Act of 2014 (FISMA 2014) (Pub. L. No. 113-283, Dec. 18, 2014) partially superseded the Federal Information Security Management Act of 2002 (FISMA 2002), enacted as title III, E-Government Act of 2002, Pub. L. No. 107-347, 116 Stat. 2899, 2946 (Dec. 17, 2002). As used in this report, FISMA refers both to FISMA 2002 requirements relevant here that were incorporated and continued in FISMA 2014 and to other relevant FISMA 2002 requirements that were unchanged by FISMA 2014 and continue in full force and effect.

[14]NIST, *Standards for Security Categorization of Federal Information and Information Systems*, FIPS Publication 199 (Gaithersburg, Md.: February 2004).

requires agencies to categorize their information systems as low-impact, moderate-impact, or high-impact for the security objectives of confidentiality, integrity, and availability. The potential impact values assigned to the respective security objectives are the highest values from among the security categories that the agency identifies for each type of information resident on those information systems.

- Federal Information Processing Standard 200, *Minimum Security Requirements for Federal Information and Information Systems*,[15] specifies minimum security requirements for federal agency information and information systems and a risk-based process for selecting the security controls necessary to satisfy these minimum security requirements.

- Federal Information Processing Standard 140-2, *Security Requirements for Cryptographic Modules*,[16] requires agencies to encrypt agency data, where appropriate, using NIST-certified cryptographic modules. This standard specifies the security requirements for a cryptographic module used within a security system protecting sensitive information in computer and telecommunication systems (including voice systems) and provides four increasing, qualitative levels of security intended to cover a wide range of potential applications and environments.

- NIST Special Publication 800-53, *Security and Privacy Controls for Federal Information Systems and Organizations*,[17] provides a catalog of security and privacy controls for federal information systems and organizations and a process for selecting controls to protect organizational operations, assets, individuals, other organizations, and the nation from a diverse set of threats including hostile cyber attacks, natural disasters, structural failures, and human errors. The guidance includes privacy controls to be used in conjunction with the specified security controls to achieve comprehensive security and privacy protection.

[15]NIST, *Minimum Security Requirements for Federal Information and Information Systems,* FIPS Publication 200 (Gaithersburg, Md.: March 2006).

[16]NIST, *Security Requirements for Cryptographic Modules*, FIPS 140-2 (Gaithersburg, Md.: May 2001).

[17]NIST, *Security and Privacy Controls for Federal Information Systems and Organizations*, SP 800-53 Revision 4 (Gaithersburg, Md.: April 2013).

- NIST Special Publication 800-37, *Guide for Applying the Risk Management Framework to Federal Information Systems: A Security Life Cycle Approach*,[18] explains how to apply a risk management framework to federal information systems, including security categorization, security control selection and implementation, security control assessment, information system authorization, and security control monitoring.

- NIST Special Publication 800-160, *Systems Security Engineering: An Integrated Approach to Building Trustworthy Resilient Systems (draft)*,[19] recommends steps to help develop a more defensible and survivable IT infrastructure—including the component products, systems, and services that compose the infrastructure. While agencies are not yet required to follow these draft guidelines, they establish a benchmark for effectively coordinating security efforts across complex interconnected systems, such as those that support Healthcare.gov and state-based marketplaces.

While agencies are required to use a risk-based approach to ensure that all of their IT systems and information are appropriately secured, they also must adopt specific measures to protect personally identifiable information (PII)[20] and must establish programs to protect the privacy of individuals whose PII they collect and maintain. Agencies that collect or maintain health information also must comply with additional

[18]NIST, *Guide for Applying the Risk Management Framework to Federal Information Systems: A Security Life Cycle Approach*, SP 800-37 Revision 1 (Gaithersburg, Md.: February 2010).

[19]NIST, *Systems Security Engineering: An Integrated Approach to Building Trustworthy Resilient Systems*, SP 800-160, draft (Gaithersburg, Md.: May 2014).

[20]PII is any information that can be used to distinguish or trace an individual's identity, such as name, date and place of birth, Social Security number, or other types of personal information that can be linked to an individual, such as medical, educational, financial, and employment information.

requirements. In addition to FISMA, major laws and regulations[21] establishing requirements for information security and privacy in the federal government include the following:

- **The Privacy Act of 1974**[22] places limitations on agencies' collection, access, use, and disclosure of personal information maintained in systems of records. The act defines a "record" as any item, collection, or grouping of information about an individual that is maintained by an agency and contains his or her name or another individual identifier. It defines a "system of records" as a group of records under the control of any agency from which information is retrieved by the name of the individual or other individual identifier. The Privacy Act requires that when agencies establish or make changes to a system of records, they must notify the public through a system of records notice in the *Federal Register* that identifies, among other things, the categories of data collected, the categories of individuals about whom information is collected, the intended "routine" uses of data, and procedures that individuals can use to review and contest its content.[23]

- **The E-Government Act of 2002**[24] strives to enhance protection for personal information in government information systems by requiring that agencies conduct, where applicable, a privacy impact assessment for each system. This assessment is an analysis of how personal information is collected, stored, shared, and managed in a federal system. More specifically, according to Office of Management

[21]Regulations also establish security and privacy requirements that are applicable to the marketplaces or Healthcare.gov-related contracts. For example, in March 2012, CMS issued a final rule regarding implementation of the exchanges (marketplaces) under PPACA and it promulgated a regulation regarding privacy and security standards that marketplaces must establish and follow. See 77 Fed. Reg. 18310, 18444 (March 27, 2012), 45 C.F.R. § 155.260. To ensure that federal contractor-operated systems meet federal information security and privacy requirements, the Federal Acquisition Regulation requires that agency acquisition planning for IT comply with the information technology security requirements in FISMA and addresses application of the Privacy Act to contractors. 48 C.F.R. § 7.103(w), and Subpart 24.1.

[22]5 U.S.C. 552a.

[23]Under the Privacy Act, the term "routine use" means (with respect to the disclosure of a record) the use of such a record for a purpose that is compatible with the purpose for which it was collected. 5 U.S.C. § 552a(a)(7).

[24]Pub. L. No. 107-347, § 208, 116 Stat. 2899, 2921 (Dec. 17, 2002).

and Budget (OMB) guidance,[25] a privacy impact assessment is an analysis of how information is handled to (1) ensure handling conforms to applicable legal, regulatory, and policy requirements regarding privacy; (2) determine the risks and effects of collecting, maintaining, and disseminating information in identifiable form in an electronic information system; and (3) examine and evaluate protections and alternative processes for handling information to mitigate potential privacy risks. Agencies must conduct a privacy impact assessment before developing or procuring IT that collects, maintains, or disseminates information that is in an identifiable form or before initiating any new data collections involving identifiable information that will be collected, maintained, or disseminated using IT if the same questions or reporting requirements are imposed on 10 or more people.

- **The Health Insurance Portability and Accountability Act of 1996**[26] establishes national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers, and provides for the establishment of privacy and security standards for handling health information. The act calls for the Secretary of HHS to adopt standards for the electronic exchange, privacy, and security of health information, which were codified in the Security and Privacy Rules.[27] The Security Rule specifies a series of administrative, technical, and physical security practices for "covered entities"[28] and their business associates to implement to ensure the confidentiality of electronic health information. The Privacy Rule

[25]OMB, *OMB Guidance for Implementing the Privacy Provisions of the E-Government Act of 2002*, M-03-22 (Washington, D.C.: Sept. 26, 2003).

[26]Pub. L. No. 104-191, Title II, Subtitle F, 110 Stat. 1936, 2021 (Aug. 21, 1996) (codified at 42 U.S.C. §§ 1320d–1320d-9). Additional privacy and security protections, and amendments to the HIPAA Privacy and Security Rules, were established by the Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, Div. A, Title XIII, 123 Stat. 115, 226-279 and Div. B, Title IV, 123 Stat. 467-496 (Feb. 17, 2009).

[27]The Health Insurance Portability and Accountability Act of 1996 Privacy and Security Rules were promulgated at 45 C.F.R. Parts 160 and 164 and were updated at 78 Fed. Reg. 5566 (Jan. 25, 2013) and 79 Fed. Reg. 7290 (Feb. 6, 2014).

[28]"Covered entities" are defined in regulations implementing the Health Insurance Portability and Accountability Act of 1996 as health plans that provide or pay for the medical care of individuals, a health care clearinghouse, and a health care provider who transmits any health information in electronic form in connection with a transaction covered by the regulations. 45 C.F.R. § 160.103.

reflects basic privacy principles for ensuring the protection of personal health information, such as limiting uses and disclosures to intended purposes, notification of privacy practices, allowing individuals to access their protected health information, securing information from improper use or disclosure, and allowing individuals to request changes to inaccurate or incomplete information. The Privacy Rule establishes a category of health information, called "protected health information," which may be used or disclosed to other parties by "covered entities" or their business associates only under specified circumstances or conditions, and generally requires that a covered entity or business associate make reasonable efforts to use, disclose, or request only the minimum necessary protected health information to accomplish the intended purpose.

HHS Has Established Responsibilities for Ensuring the Security and Privacy of Health Insurance Marketplaces

CMS's CCIIO has overall responsibility for developing and implementing policies and rules governing state-based marketplaces, overseeing the implementation and operations of state-based marketplaces, and administering federally facilitated marketplaces for states that elect not to establish their own.

State-based marketplaces and the federal government must share data and otherwise integrate IT systems for the implementation and operation of the marketplaces. According to federal regulations, state-based marketplaces are responsible for protecting and ensuring the confidentiality, integrity, and availability of marketplace enrollment information, and must also establish and implement certain privacy and security standards. CMS oversees state-based marketplaces and compliance with those standards. Additionally, federal statutes, guidance, and standards require the federal government to protect its IT systems and the information contained within these systems.

As part of its oversight responsibilities, CMS developed a suite of documents—known as the Minimum Acceptable Risk Standards for Exchanges (MARS-E)—that addresses security and privacy standards for the state-based marketplaces. The documents define a risk-based security and privacy framework for state-based marketplaces and their contractors to use in the design and implementation of their IT systems and provide guidance regarding the minimum level of security controls that must be implemented to protect information and information systems. The MARS-E is designed to facilitate marketplaces' compliance with FISMA, the Health Insurance Portability and Accountability Act of 1996, and the Privacy Act of 1974, among other relevant laws.

Prior GAO Reports Highlighted Concerns Regarding the Implementation of the Health Insurance Marketplaces

Over the past 2 years, we have issued a number of reports highlighting challenges that CMS has faced in implementing and operating the health insurance marketplaces' IT systems. In September 2014, we reported that while CMS had taken steps to protect the security and privacy of data processed and maintained by the complex set of systems and interconnections that support Healthcare.gov, weaknesses remained in both the processes used for managing information security and privacy as well as the technical implementation of IT security controls.[29] Specifically, we noted that Healthcare.gov and the related systems had been deployed despite incomplete security plans and privacy documentation, incomplete security tests, and the lack of an alternate processing site to avoid major service disruptions.

We recommended that CMS implement 6 management controls and 22 information security controls to help ensure that the systems and information related to Healthcare.gov are protected. The management recommendations were aimed at ensuring system security plans were complete, privacy risks were analyzed and documented, computer matching agreements were developed with the Office of Personnel Management and the Peace Corps, a comprehensive security assessment of the federally facilitated marketplace was performed, the planned alternate processing site made operational in a timely fashion, and detailed security roles and responsibilities for contractors were established. HHS concurred fully or partially concurred with our information security program-related recommendations and all 22 of the recommendations to improve the effectiveness of its information security controls. As of December 2015, CMS had taken steps to address all 6 information security program-related recommendations and was in the process of addressing the security control-related recommendations.

In March 2015, we reported that several problems with the initial development and deployment of Healthcare.gov and its supporting systems had led to consumers encountering widespread performance issues when trying to create accounts and enroll in health plans.[30] We

[29]GAO, *Healthcare.gov: Actions Needed to Address Weaknesses in Information Security and Privacy Controls,* GAO-14-730 (Washington, D.C.: Sept. 16, 2014).

[30]GAO*, Healthcare.gov: CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices*, GAO-15-238 (Washington, D.C.: Mar. 4, 2015).

noted, for example, that CMS had not adequately conducted capacity planning, adequately corrected software coding errors, or implemented all planned functionality. In addition, the agency did not consistently apply recognized best practices for system development, which contributed to the problems with the initial launch of Healthcare.gov and its supporting systems. In this regard, weaknesses existed in the application of requirements, testing, and oversight practices. Further, we noted that HHS had not provided adequate oversight of the Healthcare.gov initiative through its Office of the Chief Information Officer.

We made recommendations aimed at improving requirements management, system testing processes, and oversight of development activities for systems supporting Healthcare.gov. HHS concurred with all of our recommendations and subsequently took or planned steps to address the weaknesses, including instituting a process to ensure functional and technical requirements are approved, developing and implementing a unified standard set of approved system testing documents and policies, and providing oversight for Healthcare.gov and its supporting systems through the department-wide investment review board.

In September 2015, we reported that CMS established a framework for oversight of IT projects within state-based marketplaces, but the oversight was not always effectively executed.[31] For example, CMS tasked various offices with responsibilities for overseeing states' marketplace IT projects, but the agency did not always clearly document, define, or communicate its oversight roles and responsibilities to states as called for by best practices for project management. In addition, CMS did not involve all relevant senior executives in decisions to approve federal funding for states' IT marketplace projects. Lastly, CMS established a process that required the testing of state marketplace systems to determine whether they were ready to be made operational, but the systems were not always fully tested, increasing the risk that they would not operate as intended.

We recommended that CMS define and communicate its oversight roles and responsibilities, ensure senior executives are involved in funding decisions for state IT projects, and ensure that states complete testing of

[31]GAO, *State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects*, GAO-15-527 (Washington, D.C.: Sept. 16, 2015).

their systems before they are put into operation. HHS concurred with all of our recommendations and stated it had taken various actions that were focused on improving its oversight and accountability for states' marketplace efforts.

Most recently, in February 2016, we reported that CMS should take actions to strengthen enrollment controls and manage fraud risk. We noted, for example, CMS does not, according to agency officials, track or analyze aggregate outcomes of data hub eligibility and enrollment queries—either the extent to which a responding agency delivers information responsive to a request, or whether an agency reports that information was not available. In addition, CMS did not have an effective process for resolving inconsistencies for individual applicants for the federal Health Insurance Marketplace. Lastly, CMS approved subsidized coverage for 11 of 12 fictitious GAO phone or online applicants for 2014 and the applicants obtained a total of about $30,000 in annual advance premium tax credits, plus eligibility for lower costs at time of service.

We made 8 recommendations aimed at strengthening enrollment controls and managing fraud risk, including that CMS consider analyzing outcomes of the verification system, take steps to resolve inconsistencies, and conduct a risk assessment of the potential for fraud in Marketplace applications. HHS concurred with all of GAO's recommendations.

Healthcare.gov and Key Supporting Systems Have Experienced Information Security Incidents

NIST defines an information security incident as a violation or imminent threat of violation of computer security policies, acceptable use policies, or standard security practices. A security incident can occur under many circumstances and for many reasons. It can be inadvertent, such as from the loss of an electronic device, or deliberate, such as from the theft of a device, or a cyber-based attack by a malicious individual or group, agency insider, foreign nation, terrorist, or other adversary. Protecting federal systems and the information on them is essential because the loss or unauthorized disclosure or alteration of the information can lead to serious consequences and can result in substantial harm to individuals and the federal government.

FISMA requires the establishment of a federal information security incident center to, among other things, provide timely technical assistance to agencies regarding cyber incidents. The United States Computer Emergency Readiness Team (US-CERT), established in 2003, is the federal information security incident center that fulfills the FISMA mandate. US-CERT consults with agencies on cyber incidents, provides technical information about threats and incidents, compiles the

information, and publishes it on its website, https://www.us-cert.gov/. US-CERT also issues guidelines for agencies to use when reporting incidents. For the time period under our review, US-CERT defined seven categories of incidents for federal agencies to use in reporting incidents, and CMS added two categories of its own, which are described below in table 1.

Table 1: United States Computer Emergency Readiness Team (US-CERT) and Centers for Medicare & Medicaid Services (CMS) Information Security Incident Categories

Category	Name	Description
CAT 0	Exercise/Network Defense Testing	Used during state, federal, national, and international exercises and approved activity testing of internal/external network defenses or responses.
CAT 1	Unauthorized Access	An individual gains logical or physical access without permission to a federal agency's network, system, application, data, or other resource.
CAT 2	Denial of Service	An attack that successfully prevents or impairs the normal authorized functionality of a network, system, or application by exhausting resources. Includes being the victim or participating in the denial of service.
CAT 3	Malicious Code	Successful installation of malicious software (e.g., virus, worm, Trojan horse, or other code-based malicious entity) that infects an operating system or application. Agencies are not required to report malicious logic that has been successfully quarantined by antivirus software.
CAT 4	Inappropriate Usage	A person violates acceptable computing use policies.
CAT 5	Probes and Reconnaissance Scans	Any activity that seeks to access or identify a federal agency computer, open ports, protocols, service, or any combination for later exploit. This activity does not directly result in a compromise or denial of service.
CAT 6	Investigation	Unconfirmed incident that is potentially malicious or anomalous activity deemed by the reporting entity to warrant further review.
CAT 7[a]	Other	Cases where the incident may fall outside the other defined categories.
CAT 8[a]	Lost, Stolen, Damaged Equipment	Incidents involving lost equipment such as mobile devices, laptops, and thumb drives.

Sources: US-CERT and CMS documentation. | GAO-16-265

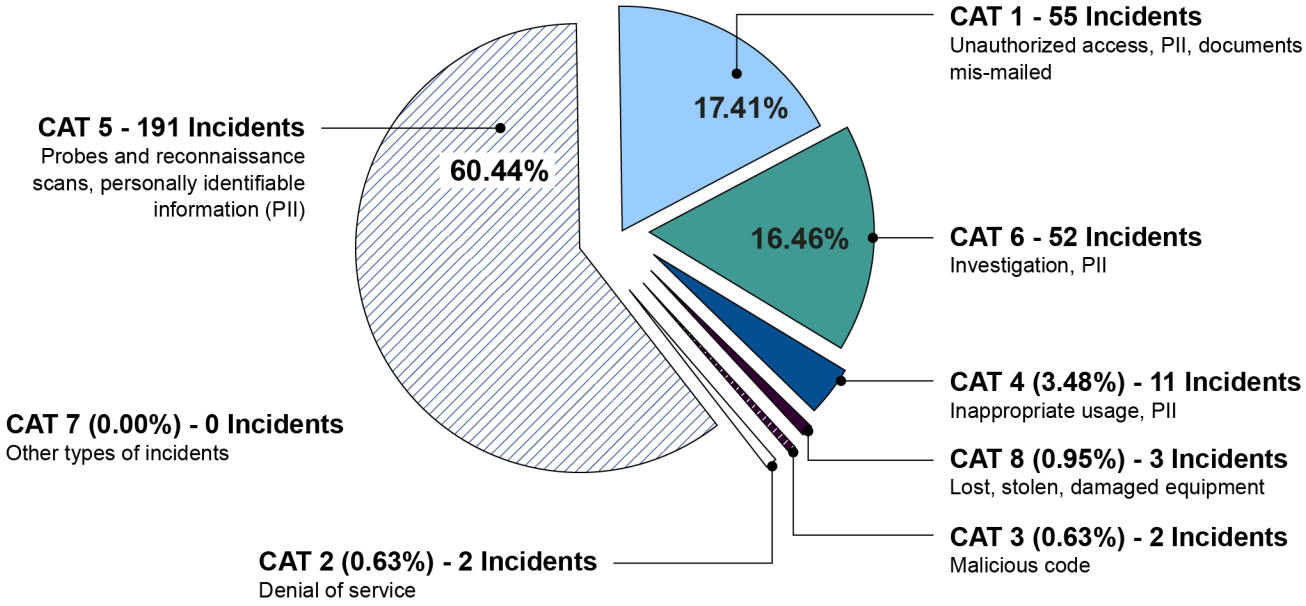
[a]This is a CMS-defined category not found in US-CERT guidance.

Between October 6, 2013, and March 8, 2015, CMS reported 316 incidents[32] affecting Healthcare.gov or key supporting systems.[33] These included—among others—incidents which involved PII and attempts by attackers to compromise part of the Healthcare.gov system. None of the incidents described in the data included any evidence that an attacker had compromised sensitive data, including PII, from Healthcare.gov. Figure 4 shows the 316 reported incidents grouped according to the US-CERT and CMS-defined incident categories.

[32]CMS defines a security incident as a reportable event that meets one or more of the following criteria: (1) the successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in any information system processing information on behalf of CMS. It also means the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents and misrouting of mail, all of which may have the potential to put CMS data at risk of unauthorized access, use, disclosure, modification, or destruction; (2) an occurrence that actually or potentially jeopardizes the confidentiality, integrity, or availability of an information system or the information the system processes, stores, or transmits; and (3) a violation or imminent threat of violation of computer security policies, acceptable use policies, or standard security practices.

[33]Healthcare.gov and key supporting systems include the Healthcare.gov website, the Enterprise Identity Management System, the Federally Facilitated Marketplace System, and the Federal Data Services Hub.

Figure 4: Healthcare.gov and Key Supporting Systems Reported Security Incidents by United States Computer Emergency Readiness Team and Centers for Medicare & Medicaid Services Incident Categories

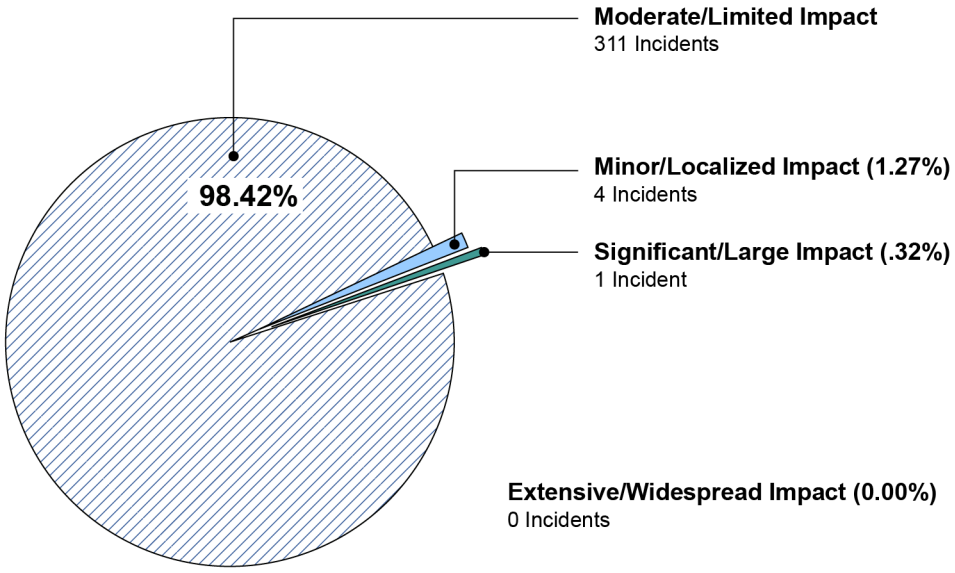


Source: GAO Analysis of Centers for Medicare & Medicaid Services data. | GAO-16-265

CAT 1 unauthorized access incidents made up 17 percent of the incidents logged during the time period under review. Of those, only one incident—which CMS publicly disclosed last year—involved a confirmed instance of an attacker gaining access to a Healthcare.gov-related server. In that incident, the attacker installed malware on a test server that held no PII. The rest of the CAT 1 incidents involved occurrences such as PII being disclosed because of physical mail being sent to an incorrect recipient or unencrypted PII being transmitted via e-mail to a limited number of individuals.

CMS also assessed incidents' impact, categorizing incidents as having an impact of "Extensive/Widespread," "Significant/Large," "Moderate/Limited," or "Minor/Localized." More than 98 percent of the reported incidents were assessed as "Moderate/Limited" impact, and the remainder, less than 2 percent, as "Minor/Localized" impact. See figure 5 for a breakdown of incidents by CMS-assigned level of impact.

Figure 5: Healthcare.gov and Key Supporting Systems Reported Security Incidents by Level of Impact



Source: GAO Analysis of Centers for Medicare & Medicaid Services data. | GAO-16-265

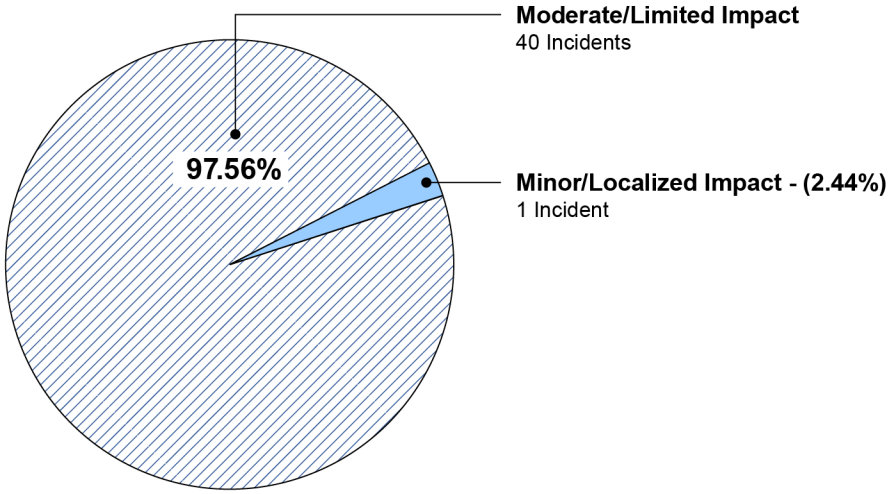
CMS did not classify any of the incidents we reviewed as having "Extensive/Widespread" impact, and classified only one incident as having "Significant/Large" impact. In that incident, a list of CMS employee account IDs, including passwords that had not yet been assigned to employees and phone numbers, was transmitted to CMS staff via an unencrypted e-mail message. In order to mitigate the incident, CMS created new passwords for the affected employees and advised the employees to log on and change their passwords.

A privacy incident generally refers to the unauthorized or unintentional exposure, disclosure, or loss of sensitive information, including PII.[34] According to CMS, 41 of the 316 incidents were reported to involve PII either not being secured properly or being exposed to an unauthorized

[34]CMS defines a privacy incident as a security incident that involves PII or protected health information where there is a loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users, and for an other than authorized purpose, have access or potential access to PII or protected health information in usable form, whether physical or electronic.

individual, as opposed to other security issues affecting Healthcare.gov and key supporting systems. Of the 41 PII incidents in the CMS data, the agency classified 40 as being of “Moderate/Limited” impact, and one as being of “Minor/Localized” impact. The number of individuals affected by these incidents was not fully documented. While CMS, as of October 2014, began including an estimate of the number of affected individuals in incident reports, several of the reports we reviewed were from earlier incidents and did not contain estimates of the number of affected individuals. See figure 6 for a breakdown of the privacy incidents by CMS-assigned level of impact.

Figure 6: Healthcare.gov and Key Supporting System Reported Privacy Incidents by Level of Impact



Source: GAO Analysis of Centers for Medicare & Medicaid Services data. | GAO-16-265

As noted above, none of these incidents were the result of an attacker compromising data, but were rather the result of errors such as information being sent to the incorrect recipient, PII being transmitted in an unencrypted format, or system configuration errors causing PII to be recorded to system logs or displayed in places it should not have been.

Information Security Weaknesses Associated with the Federal Data Services Hub Place Healthcare.gov Data at Risk

A basic management objective for any organization is to protect the confidentiality, integrity, and availability of the information and systems that support its critical operations and assets. Organizations accomplish this by designing and implementing access and other controls that are intended to protect information and systems from unauthorized disclosure, modification, and loss. Specific controls include, among other things, those related to identification and authentication of users, authorization restrictions, and configuration management. As required by FISMA, NIST has issued guidance for agencies on how to select and implement controls over their information systems. Additionally, in June 2015, OMB directed agencies to take steps to strengthen their controls in the areas of scanning and monitoring for attackers, patching vulnerabilities in a timely manner, limiting the use of administrative accounts, and requiring the use of two-factor authentication,[35] especially for administrators.[36]

As we previously reported, CMS took steps to protect the security and privacy of data processed and maintained by the complex set of systems and interconnections that support Healthcare.gov, including the data hub.[37] The steps included developing required security program policies and procedures, establishing interconnection security agreements with its federal and commercial partners, and instituting required privacy protections. For example, it assigned overall responsibility for securing the agency's information and systems to appropriate officials, including the agency Chief Information Officer and Chief Information Security Officer, and designated information system security officers to assist in certifying information systems of particular CMS components. Additionally, CMS documented information security policies and

[35]Authentication systems typically rely on one or more of the following factors: something you know (for example, a password); something you have (for example, an ID badge or a cryptographic key); and something you are (for example, a fingerprint or other biometric data). Two-factor authentication refers to the use of more than one of these factors. The strength of authentication systems is largely determined by the number of factors it uses. Implementations that use two factors are considered to be stronger than those that use only one factor, while systems that incorporate all three factors are stronger than systems that incorporate only two.

[36]OMB, *Fact Sheet: Enhancing and Strengthening the Federal Government's Cybersecurity*, (Washington, D.C.: June 12, 2015).

[37]GAO-14-730.

procedures to safeguard the agency's information and systems and to reduce the risk of and minimize the effects of security incidents.

While CMS has taken steps to secure the data hub, we identified weaknesses in the technical controls protecting the data flowing through the system. Specifically, CMS did not effectively implement or securely configure key security tools and devices to sufficiently protect the users and information on the data hub system from threats to confidentiality, integrity, and availability. For example:

- CMS did not appropriately restrict the use of administrative privileges for data hub systems. NIST Special Publication 800-53 recommends that agencies follow the concept of "least privilege," giving users and administrators only the privileges and access necessary to perform their assigned duties. OMB has also instructed agencies to tighten policies and procedures for privileged users, including limiting the functions privileged users can perform with their administrative accounts. However, CMS did not consistently restrict administrator accounts to perform only the functions necessary to perform their assigned duties. CMS officials stated they are working to further restrict administrative privileges and are reviewing accounts to ensure permissions and roles are appropriate. By not enforcing least privilege, CMS faces an increased risk that a malicious insider or an attacker using a compromised administrator account could access sensitive data flowing through the data hub.

- CMS did not consistently implement patches for several data hub systems. NIST Special Publication 800-53 recommends that organizations test and install newly released security patches, service packs, and hot fixes, and OMB has instructed agencies to patch critical vulnerabilities without delay. However, CMS did not consistently apply patches to critical systems or applications supporting the data hub in a timely manner. CMS officials stated they are reviewing the patch histories on all servers and are directing staff to bring them up-to-date or provide a business rationale for not applying specific patches. By not keeping current with security patches, CMS faces an increased risk that servers supporting the data hub could be compromised through exploitation of known vulnerabilities.

- CMS did not securely configure the data hub's administrative network. NIST Special Publication 800-53 recommends how such a network should be configured. CMS officials stated that they are reviewing the network's configurations to identify a plan for remediation. Without

adhering to NIST recommendations, CMS may face an increased risk of unauthorized access to the data hub network.

In addition to the above weaknesses, we identified other security weaknesses in controls related to boundary protection, identification and authentication, authorization, encryption, audit and monitoring, and software updates that limit the effectiveness of the security controls on the data hub and unnecessarily place sensitive information at risk of unauthorized disclosure, modification, or exfiltration. According to CMS officials, in response to the identified weaknesses, they have formed a task force, comprised of the Deputy Chief Information Security Officer, system maintainers and administrators, database administrators, and security personnel, to work with the stakeholders responsible for the data hub applications and the underlying platform and infrastructure. The same officials stated that meetings will be held on at least a weekly basis to monitor milestone dates, discuss activities, and identify potential barriers to resolution of any given weakness. The control weaknesses we identified during this review are described in greater detail in a separate report with limited distribution.

CMS Has Not Fully Implemented Security and Privacy Oversight of State-Based Marketplaces, Three of Which Had Significant Weaknesses

CMS has taken various actions to oversee the security and privacy controls implemented at the state-based marketplaces, including assigning roles and responsibilities for oversight entities, conducting regular meetings with state officials to discuss pending issues, and establishing a new reporting tool to monitor marketplace performance. However, CMS has not fully documented procedures that define its oversight responsibilities. Further, while CMS has set requirements for annual testing of a subset of security controls implemented within the state-based marketplaces, it does not require continuous monitoring or annual comprehensive testing. Until CMS documents its oversight procedures and requires continuous monitoring of security controls, it does not have reasonable assurance that the states are promptly identifying and remediating weaknesses and therefore faces a higher risk that attackers could compromise the confidentiality, integrity, and availability of the data contained in state-based marketplaces. The need for better assurance that controls are working was highlighted by the results of the reviews we conducted of security and privacy controls at three state-based marketplaces. For those three marketplaces, we identified significant weaknesses that placed the data they contained at risk of compromise.

CMS Has Established Policies to Oversee the Effectiveness of Security and Privacy Controls but Has Not Defined Specific Procedures, Time Frames, or Follow-up Actions

Effective organizational policies and procedures define key management activities in detail, establish time frames for their completion, and specify follow-up actions that must be taken to correct deficiencies. According to GAO's *Standards for Internal Control in the Federal Government*,[38] an organization's policies should identify internal control responsibilities and each unit's responsibility for designing and implementing those controls. Moreover, each policy should specify the appropriate level of detail to allow management to effectively monitor the control activities and define day-to-day procedures, which may include the timing of when an activity is to occur and any follow-up corrective actions to be performed if deficiencies are identified.

While CMS has developed policies for overseeing security and privacy controls at the state-based marketplaces, it has not defined specific oversight procedures, the timing for when each activity should occur, or what follow-up corrective actions should be performed if deficiencies are identified.

CMS has assigned roles and responsibilities for oversight entities, conducted regular meetings with state officials to discuss pending issues, and established a new reporting tool to monitor marketplace performance. For example, as we reported in September 2015,[39] CMS outlined oversight roles and responsibilities. Three key offices—CCIIO, Office of Technology Solutions (OTS), and Center for Medicaid and CHIP Services (CMCS)—were identified as having responsibility for overseeing states' efforts in establishing the marketplaces. Their primary roles and duties included the following:

- CCIIO led the marketplace implementation, and within that office, State Officers were assigned to be accountable for day-to-day communications with state marketplace officials.
- OTS was responsible for systems integration and software development efforts to ensure that the functions of the marketplaces were carried out. A primary participant within OTS was the IT project

[38]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

[39]GAO-15-527.

manager, who was the individual responsible for monitoring, among other things, state-based marketplaces' IT development activities.

- CMCS was the office responsible for coordinating and approving implementation of Medicaid activities related to the health insurance marketplaces. The office carried out these responsibilities in conjunction with CCIIO.

While CMS outlined general oversight roles, it did not define or document the specific day-to-day activities of these offices and staff that are responsible for the oversight. For example, according to CCIIO officials, the state officers conduct oversight through weekly meetings with state-based marketplace officials. The same officials stated that the meetings do not have a defined agenda or procedures, but that identified control weaknesses or other security issues are discussed. Further, there are no documented procedures that outline the specific responsibilities of the IT project manager, who was the individual responsible for monitoring state-based marketplaces' IT development activities.

In 2015, CMS began using a new reporting tool to monitor state performance. The State Based Marketplace Annual Reporting Tool (SMART) is intended to collect information to be used as the basis for evaluating a state-based marketplace's compliance with regulations and CMS standards. Information collected through SMART includes performance metrics, summaries from independent programmatic audits, and an attestation to the submission of the most recent required security and privacy documentation.[40] The first submissions from the states were due on April 1, 2015. According to CMS officials, they received the submissions and, as of December 2015, were still reviewing them.

While SMART is intended to collect information on compliance with regulations and CMS standards, including security and privacy controls, CMS has not defined specific follow-up procedures or time frames, including identifying corrective actions to be performed if deficiencies are identified. CMS officials stated SMART is a reporting mechanism used to provide a comprehensive picture of state-based marketplaces and that

[40]The required security and privacy documentation includes: a system security plan, interconnection security agreement, computer matching agreement, information exchange agreement, privacy impact assessment, security assessment report, plan of action & milestones, annual security attestation, and change reports.

CMS does not use it to identify corrective actions to be performed if deficiencies are identified. However, until CMS defines and documents its specific day-to-day procedures, the timing of when control activities are to occur, and what follow-up corrective actions are to be performed if deficiencies are identified, the agency does not have reasonable assurance that it is providing effective oversight of security and privacy at state-based marketplaces.

CMS Requires Testing of State-Based Marketplaces Only Every Three Years

FISMA requires that an agency develop, document, and implement an agency-wide information security program. The program should provide security for the information and information systems that support the operations of the agency, including those provided or managed by a contractor or other source. As part of the information security program, the agency should require periodic testing and evaluation of the effectiveness of information security policies, procedures, and practices, to be performed with a frequency depending on risk, but no less than annually. FISMA requires this testing to be comprehensive, including testing of management, operational, and technical controls of every information system identified in the inventory.

Further, in November 2013 OMB issued guidance to federal agencies on managing information security risk on a continuous basis, which includes the requirement to continually monitor the security controls in information systems and the environments in which they operate.[41] OMB noted that managing information risk on a continuous basis allows agencies to maintain awareness of information security vulnerabilities and threats to support risk management decisions and improve the effectiveness of safeguards and countermeasures. Rather than enforcing a static, point-in-time reauthorization process, agencies were encouraged by OMB to conduct ongoing authorizations of their information systems and the environments in which they operated, including common controls, through the implementation of their risk management programs.

Although CMS has set requirements for periodic testing of the security controls at the state-based marketplaces, it requires neither continuous monitoring nor comprehensive annual testing. Any state seeking to gain an “authority to connect” to the data hub is required to submit

[41]OMB, *Enhancing the Security of Federal Information and Information Systems*, M-14-03 (Washington, D.C.: Nov. 18, 2013).

documentation that it has properly secured its planned connection.[42] The standard "authority to connect" to the data hub is issued for a 3-year period. Following the approval of the initial "authority to connect," every state is required to conduct reviews of the documentation on a yearly basis, submit quarterly plan of action and milestone reports, and re-sign the interconnection security agreement every 3 years or whenever a significant change has occurred to the interconnected systems. As part of the signed agreement, each state must specify the security controls it has implemented and attest that the state IT system is designed, managed, and operated in compliance with CMS standards. According to the MARS-E, all security controls are required to be assessed over a 3-year period and to meet this requirement a subset is to be tested each year so that all security controls are tested during a 3-year period. However, according to CMS officials, during the time of our review, the states were not required to submit evidence that they had tested subsets of controls each year.

CMS officials stated that they monitor the effectiveness of security controls on an ongoing basis by reviewing documents that contain information on reported weaknesses. The same officials stated that they perform quarterly reviews of state marketplaces' plan of action and milestone reports, and changes to the system boundaries, hardware, software, and data centers. These officials added that if serious deficiencies are noted in their review, such as a large number of open high or moderate findings, or findings that have been open for a long time, they have the ability to terminate a state's connection to the data hub if the deficiencies are not remediated or sufficient progress is not made in a timely manner. However, according to CMS officials, they have not yet terminated any state's connection to the data hub because states have remediated deficiencies to their satisfaction in a timely manner.

[42]The documentation required by CMS included: (1) a system security plan describing the design of the system and the process for identifying and mitigating security risks, (2) a report documenting an assessment of the security risks for the system conducted either internally or through a third party, (3) a plan of action and milestones and corrective action plan for mitigating any risks identified by the security risk assessment, (4) a signed information exchange agreement documenting roles and responsibilities for protecting data, and (5) an interconnection security agreement specifying the interconnection arrangements and responsibilities for all parties, the security controls implemented by the state, the technical and operational security requirements that the state follows, and attesting that the state IT system is designed, managed, and operated in compliance with the CMS standards.

Numerous significant security weaknesses have been identified in state-based marketplaces. For example, in the second quarter of fiscal year 2015, the 14 states[43] that maintained their own state-based marketplaces reported a total of 27 high open findings, 288 moderate open findings, and 259 low open findings from their own internal assessments. One state reported 20 of the 27 high open findings during that time period.

According to CMS officials, while they do not require comprehensive annual testing or continuous monitoring of security controls, they perform annual reviews of the system security plans for the state-based marketplaces and require the states to submit new security assessments anytime they make significant changes to the systems. CMS officials also stated that they monitor various state-generated documents on a weekly, monthly, or yearly basis depending on when the reports are being required. States are advised to include any new assessment, audit, or weakness discovered during normal day-to-day operations in those documents. However, for the plan of action and milestones reports and state-based marketplaces we reviewed, the CMS oversight process has not resulted in timely identification and mitigation of security weaknesses. Without more frequently monitoring of the full set of security controls in the state-based marketplaces and the environments in which they operate, CMS does not have reasonable assurance that the states are promptly identifying and remediating weaknesses and therefore faces a higher risk that attackers could compromise the confidentiality, integrity, and availability of the data contained in state-based marketplaces.

Security and Privacy Weaknesses Place Selected State-Based Marketplaces' Data at Risk

The need for better assurance that security and privacy controls are working properly was highlighted by the results of our reviews of technical controls at three state-based marketplaces, which identified significant weaknesses in those systems. In September 2015, we reported on our reviews of three state-based marketplaces that assessed the effectiveness of key program elements and controls implemented to protect the information they contain.[44] We identified weaknesses in key

[43]For plan year 2015, Hawaii operated and maintained a state-based marketplace. However in plan year 2016, Hawaii now operates a state-based marketplace using the federal platform.

[44]We selected the three states by concentrating on states who received a high amount of PPACA grant funding through 2014, while ensuring a mix of both population size (i.e., large, medium, and small) and contractors used to ensure we reviewed a variety of approaches to system development and operation.

elements of each state's information security and privacy controls, such as security management, privacy policies and procedures, security awareness training, background checks, contingency planning, incident response, and configuration management. Further, we identified security weaknesses in technical controls related to access controls, cryptography, and configuration management that limit the effectiveness of the security controls on the systems. For example:

- One state did not encrypt connections to the authentication servers supporting its system. The MARS-E requires passwords to be encrypted when they are being transmitted across the network. However, the authentication servers we reviewed were configured to accept unencrypted connections. As a result, an attacker on the network could observe the unencrypted transmission to gather usernames and password hashes, which could then be used to compromise those accounts.

- One state did not filter uniform resource locator (URL) requests from the Internet through a web application firewall to prevent hostile requests from reaching the marketplace website. NIST Special Publication 800-53 requires the enforcement of access controls through the use of firewalls. However, the state did not fully configure its filtering to block hostile URL requests from the Internet. As a result, hostile URL requests could potentially scan and exploit vulnerabilities of the portal and potentially gain access to remaining systems and databases of the marketplace.

- One state did not enforce the use of high-level encryption on its Windows servers. NIST Special Publication 800-53 and MARS-E require that if an agency uses encryption, it must use, at a minimum, a Federal Information Processing Standards 140-2–compliant cryptographic module. However, the state did not configure its Windows Active Directory and Domain Name System servers to require the use of Federal Information Processing Standards–compliant algorithms. As a result, the servers may employ weak encryption for protecting authentication and communication, increasing the risk that an attacker could compromise the confidentiality or integrity of the system.

For each of the security and privacy weaknesses we identified, we also identified potential activities to mitigate those weaknesses. In total, we identified 24 potential mitigation activities to address weaknesses in the three states' security and privacy programs and 66 potential mitigation activities to improve the effectiveness of their information security

controls. The results of our work were reported separately in "limited official use only" correspondences.[45] The three states generally agreed with the potential mitigation activities and have plans to address them.

Conclusions

Healthcare.gov and its key supporting systems have experienced information security incidents which involved both PII not being secured properly and attempts by attackers to compromise the Healthcare.gov system. However, for the incidents we reviewed, we did not find evidence that an outside attacker with malicious intent had compromised sensitive data.

Although CMS continues to make progress in correcting or mitigating previously reported weaknesses within Healthcare.gov and its key supporting systems, the information security weaknesses found in the data hub will likely continue to jeopardize the confidentiality, integrity, and availability of Healthcare.gov. The information that is transferred through the data hub will likely remain vulnerable until the agency addresses weaknesses pertaining to boundary protection, identification and authentication, authorization, encryption, audit and monitoring, software updates, and configuration management.

While CMS has taken steps to ensure that the information processed and maintained by stated-based marketplaces is protected from unauthorized access or misuse, it lacks a documented oversight program to ensure that each state is implementing security and privacy controls properly. Given the significant number of control weaknesses found during our review of selected states, CMS not requiring continuous monitoring of security controls at the state level may pose unnecessary and increased security risks to the data hub and other Healthcare.gov systems.

Recommendations for Executive Action

To improve the oversight of privacy and security controls over the state-based marketplaces, we recommend that the Secretary of Health and Human Services direct the Administrator of the Centers for Medicare & Medicaid Services to take the following three actions:

[45]GAO, *Information Security: GAO Review of State-Based Marketplace Security and Privacy – 1*, GAO15-804RSU (Washington, D.C.: Sept. 22, 2015); *Information Security: GAO Review of State-Based Marketplace Security and Privacy – 2*, GAO15-805RSU (Washington, D.C.: Sept. 22, 2015); and *Information Security: GAO Review of State-Based Marketplace Security and Privacy – 3*, GAO15-806RSU (Washington, D.C.: Sept. 22, 2015).

- define procedures for overseeing state-based marketplaces, to include day-to-day activities of the relevant offices and staff;
- develop and document procedures for reviewing the SMART tool, including specific follow-up timelines and identifying corrective actions to be performed if deficiencies are identified; and
- require continuous monitoring of the privacy and security controls over state-based marketplaces and the environments in which those systems operate to more quickly identify and remediate vulnerabilities.

In a separate report with limited distribution, we are also making 27 recommendations to resolve technical information security weaknesses within the data hub related to boundary protection, identification and authentication, authorization, encryption, audit and monitoring, and software updates.

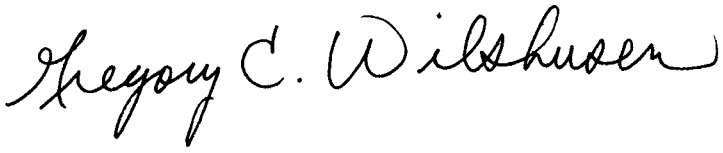
Agency Comments and Our Evaluation

We sent draft copies of this report to the Department of Health and Human Services (HHS) and received written comments in return. These comments are reprinted in appendix II. HHS concurred with all of GAO's recommendations. Further, it also provided information regarding specific actions the agency has taken or plans on taking to address these recommendations. We also received technical comments from HHS, which have been incorporated into the final report as appropriate.

In its written comments, HHS noted that the department and its federal partners comply with relevant laws and use processes, controls, and standards to secure consumer data maintained within Healthcare.gov and its supporting systems. Further, it described the process it uses to mitigate information security risks associated with the data hub, manage security incidents, and oversee the security and privacy of data transmitted by the state-based marketplaces.

We are sending copies of this report to the Department of Health and Human Services. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have questions about this report, please contact Gregory C. Wilshusen at (202) 512-6244 or Dr. Nabajyoti Barkakati at (202) 512-4499. We can also be reached by e-mail at wilshuseng@gao.gov and barkakatin@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



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List of Congressional Requesters

The Honorable Orrin Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Lamar Alexander
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Committee on Health, Education, Labor and Pensions
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United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Jason Chaffetz
Chairman
The Honorable Elijah E. Cummings
Ranking Member
Committee on Oversight and Government Reform
House of Representatives

The Honorable Kevin Brady
Chairman
The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

The Honorable Greg Walden
Chairman
Subcommittee on Communications and Technology
Committee on Energy and Commerce
House of Representatives

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

The Honorable Mark Meadows
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Subcommittee on Government Operations
Committee on Oversight and Government Reform
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The Honorable Jim Jordan
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Subcommittee on Health Care, Benefits, and Administrative Rules
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Honorable Charles Boustany, Jr.
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Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The Honorable Michael Bennet
United States Senate

The Honorable Richard Blumenthal
United States Senate

The Honorable Robert P. Casey, Jr.
United States Senate

The Honorable Al Franken
United States Senate

The Honorable Tim Kaine
United States Senate

The Honorable Amy Klobuchar
United States Senate

The Honorable Joe Manchin III
United States Senate

The Honorable Jeffrey A. Merkley
United States Senate

The Honorable Bill Nelson
United States Senate

The Honorable Jeanne Shaheen
United States Senate

The Honorable Jon Tester
United States Senate

The Honorable John Thune
United States Senate

The Honorable Mark R. Warner
United States Senate

The Honorable Ron Barber
House of Representatives

The Honorable Tulsi Gabbard
House of Representatives

The Honorable Duncan Hunter
House of Representatives

The Honorable Darrell Issa
House of Representatives

The Honorable Mike Kelly
House of Representatives

The Honorable Ann McLane Kuster
House of Representatives

The Honorable Daniel W. Lipinski
House of Representatives

The Honorable Patrick E. Murphy
House of Representatives

The Honorable Scott Peters
House of Representatives

The Honorable Kyrsten Sinema
House of Representatives

The Honorable Filemon Vela
House of Representatives

Appendix I: Objectives, Scope, and Methodology

Our objectives were to (1) describe the extent to which security and privacy incidents were reported for Healthcare.gov or key supporting systems; (2) assess the effectiveness of the controls implemented by the Centers for Medicare & Medicaid Services (CMS) to protect the Federal Data Services Hub (data hub) and the information it transmits; (3) assess the effectiveness of CMS's oversight of key program elements and controls implemented by state-based marketplaces and the effectiveness of those elements at selected state-based marketplaces to protect the information they contain.

To address our first objective, we reviewed and analyzed data on information security and privacy incidents reported by CMS that occurred between October 6, 2013, and March 8, 2015, affecting Healthcare.gov and its supporting systems. Specifically, we reviewed a list of reported incidents and the information associated with each incident, such as the incident reports and actions taken to mitigate the incidents. We also reviewed the reported impact of each incident. In order to ensure the reliability of the data, we reviewed related documentation, interviewed knowledgeable agency officials, and performed manual data testing for obvious errors. We then analyzed the information to identify statistics on the reported incidents. Lastly, we interviewed knowledgeable officials and reviewed CMS policies and procedures for incident handling.

To address our second objective, we reviewed relevant information security laws and National Institute of Standards and Technology (NIST) standards and guidance to identify federal security and privacy control requirements. Further, we analyzed the overall network control environment, identified interconnectivity and control points, and reviewed controls for the network and servers supporting the data hub. Specifically, we reviewed controls over the data hub and its supporting software, the operating systems, network, and computing infrastructure provided by the supporting platform-as-a-service.

In order to evaluate CMS's controls over its information systems supporting Healthcare.gov, we used our *Federal Information System Controls Audit Manual*, which contains guidance for reviewing information system controls that affect the confidentiality, integrity, and availability of computerized information; Office of Management and Budget (OMB) guidance; NIST standards and guidelines; and CMS policies, procedures, practices, and standards.

Specifically, we

- reviewed network access paths to determine if boundaries had been adequately protected;
- analyzed system access controls to determine whether users had more permissions than necessary to perform their assigned functions;
- observed configurations for providing secure data transmissions across the network to determine whether sensitive data were being encrypted;
- reviewed software security settings to determine if modifications of sensitive or critical system resources had been monitored and logged; and
- inspected the operating system and application software on key servers and workstations to determine if critical patches had been installed and/or were up-to-date.

We performed our work at CMS contractor facilities in Columbia, Maryland, and Chantilly, Virginia.

To address our third objective, we selected three states by concentrating on states who received a high amount of federal grant funding through 2014, while ensuring a mix of both population size (I.e., large, medium, and small) and contractors used to ensure we reviewed a variety of approaches to system development and operation. To assess the effectiveness of the three selected states' key program elements and management controls, we compared their documented policies, procedures, and practices to the provisions and requirements contained in CMS security and privacy standards for state-based marketplaces. We also reviewed the results of testing of security controls; analyzed system and security documentation, including information exchange agreements; and interviewed state officials.

To determine the effectiveness of the information security controls the three states implemented for information systems supporting their marketplaces, we reviewed risk assessments, security plans, system control assessments, contingency plans, and remedial action plans. To evaluate the technical controls for the marketplaces, we analyzed the overall network control environment, identified control points, and reviewed controls for the supporting network and servers. We compared the aforementioned items to our *Federal Information System Controls Audit Manual*; NIST standards and guidelines; CMS security and privacy guidance for state-based marketplaces; and Center for Internet Security guidance.

To determine the effectiveness of CMS oversight of the states' program elements and controls, we reviewed CMS policies and procedures regarding oversight of the state-based marketplaces and compared them to Federal Information Security Modernization Act of 2014[1] requirements, OMB guidance on security controls testing, and *GAO's Standards for Internal Control in the Federal Government*. We also obtained and reviewed oversight-related information that CMS provided to the three selected states. Lastly, we interviewed officials from the relevant CMS offices that had oversight responsibilities.

We conducted this performance audit from December 2014 to March 2016 in accordance with 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 based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[1]The Federal Information Security Modernization Act of 2014 (FISMA 2014) (Pub. L. No. 113-283, Dec. 18, 2014) partially superseded the Federal Information Security Management Act of 2002 (FISMA 2002), enacted as title III, E-Government Act of 2002, Pub. L. No. 107-347, 116 Stat. 2899, 2946 (Dec. 17, 2002). As used in this report, FISMA refers both to FISMA 2002 requirements relevant here that were incorporated and continued in FISMA 2014 and to other relevant FISMA 2002 requirements that were unchanged by FISMA 2014 and continue in full force and effect.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 0 9 2016

Gregory C. Wilshusen
Director, Information Security Issues
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Wilshusen:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"Healthcare.gov: Actions Needed to Enhance Information Security and Privacy Controls" (GAO-16-264SU and GAO-16-265).*

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTHCARE.GOV: ACTIONS NEEDED TO ENHANCE INFORMATION SECURITY AND PRIVACY CONTROLS (GAO-16-265)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on the security and privacy of the HealthCare.gov systems and State-based Marketplaces (SBM). As the GAO reported, they did not find evidence that an outside attacker had successfully compromised sensitive data, such as personally identifiable information (PII).

The security and privacy of consumer data is a top priority for HHS and other federal and state agencies. HHS and our federal partners comply with relevant laws and use processes, controls, and standards to secure consumer data. As the GAO reported, consistent with federal guidance, HHS has taken steps to protect the security and privacy of data processed and maintained by the systems and connections supporting HealthCare.gov, including the Federal Data Services Hub (Hub). Consumers entrust HHS and states to protect their data, and HHS is committed to continuously improving privacy and security in the HealthCare.gov systems, including the Hub, and in overseeing privacy and security controls for SBMs.

HealthCare.gov uses recent technological advancements, including the Hub, to verify application information efficiently and without undue burden on individuals or families. As part of that effort, HHS created a multi-layered approach to verifying eligibility that protects the integrity of HealthCare.gov. The Hub provides a secure electronic connection between the Marketplaces and existing federal, state, and private databases. These databases verify the eligibility information in each application by matching it against trusted records, maintained by the Social Security Administration (SSA), the Internal Revenue Service (IRS), the Department of Homeland Security (DHS), Equifax, the Department of Veterans Affairs, Medicare, and TRICARE. Additionally, the Peace Corps and the Office of Personnel Management (OPM) use a secure electronic file transfer process to conduct regular transmissions of Peace Corps and OPM data to verify application information about employer-sponsored coverage. The Hub supported tens of millions of data verifications during the first three open enrollment periods.

HHS has taken significant steps and implemented robust security controls to protect the security and privacy of the systems and connections supporting HealthCare.gov, including the Hub. HHS developed these systems consistent with federal statutes, guidelines, and industry standards that help safeguard the security, privacy, and integrity of the systems and the data that flow through them. HealthCare.gov and the Hub have been determined to be compliant with the Federal Information Security Management Act (FISMA), based on standards promulgated by the National Institute of Standards and Technology (NIST). Marketplace systems are also in compliance with all the relevant privacy and security statutes, including the Privacy Act of 1974.

The Hub and its associated systems have several layers of protection in place to mitigate information security risk, including penetration testing, which happens on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. As part of the ongoing testing process, and in line with federal and industry standards, any open risk findings are appropriately addressed with risk mitigation strategies and compensating controls. The security of the system is also monitored by sensors and other tools to deter and prevent unauthorized access. HHS conducts continuous monitoring using a 24/7, multi-layer IT professional security team, added penetration

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTHCARE.GOV: ACTIONS NEEDED TO ENHANCE INFORMATION SECURITY AND PRIVACY CONTROLS (GAO-16-265)

testing, and a change management process that includes ongoing testing and mitigation strategies implemented in real time.

If HHS identifies a potential security incident, it has procedures and processes in place to quickly report the incident and mitigate any issues, in accordance with FISMA requirements and guidelines issued by the United States Computer Emergency Readiness Team (US-CERT). A dedicated operations center handles all HealthCare.gov and Hub incident response actions and has 24/7 monitoring and response capabilities. All potential incidents are investigated within 24 hours of being reported. Most potential incidents reported pose limited threat to the security and privacy of consumer data. As the GAO noted, more than 98 percent of the reported incidents affecting HealthCare.gov were assessed as "Moderate/Limited" impact. None of the incidents included evidence that an attacker had compromised sensitive data, including PII. As part of its continuous monitoring, HHS investigates all incidents to confirm containment, eradication, and remediation are achieved.

In addition to HHS' responsibilities to protect consumer data on the HealthCare.gov systems, HHS also is responsible for overseeing the security and privacy of data transmitted via the Hub by SBMs. The Affordable Care Act provides states with significant flexibility in the design and operation of their Marketplaces to best meet the unique needs of their citizens and their health insurance issuers. As part of HHS' oversight of SBMs, HHS established strong security controls and standards for each SBM to meet in order to connect to the Hub. These controls and standards are based on federal security and privacy guidelines, including FISMA and the Privacy Act.

Prior to connecting to the Hub, each state had to sign a Computer Matching Agreement, an Interconnection Security Agreement and an Information Exchange Agreement, all of which bind the state to rules and operating procedures related to data security and privacy. Each state is required to complete additional documentation, including a privacy impact assessment, a system security plan, an internal or third party risk assessment, and an action plan to address weaknesses and risks. Every state that connects to the Hub adheres to these procedures. To maintain a connection to the Hub, states are required to submit quarterly action plans and conduct an annual security self-assessment of one-third of their security controls. States must also have an independent, third-party security audit of all of their security controls every three years or have one-third of their security controls reviewed via an independent, third-party security audit each year.

HHS assesses states' progress on all new or urgent security findings regularly and receives quarterly updates on all open findings through an action plan. When HHS receives updates, we work with the states to evaluate the findings and determine remediation plans. In the limited cases where HHS may determine a security finding could pose a risk to the Hub, HHS requires the state to comply with additional security requirements, including significantly reducing or mitigating the findings. Failure to comply with the terms required by HHS may result in a state's disconnection from the Hub.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTHCARE.GOV: ACTIONS NEEDED TO ENHANCE INFORMATION SECURITY AND PRIVACY CONTROLS (GAO-16-265)

HHS acknowledges that risks exist inherently for every IT system and that as technology progresses, additional safeguards will be needed. Through the enforcement of documented policies and procedures, as well as dedicated information security staff, HHS protects the security and privacy of the systems and interconnections that support HealthCare.gov, including the Hub. Through the enforcement of requirements, such as annual testing and continuous monitoring, HHS provides oversight of SBM privacy and security. HHS is committed to continued oversight and support of states' protection of consumer data. HHS appreciates the GAO's suggestion of controls and processes that could be improved to further reduce or mitigate risk.

GAO Recommendation
Define procedures for overseeing State-based Marketplaces, to include day-to-day activities of the relevant offices and staff.

HHS Response
HHS concurs with this recommendation. HHS already has oversight and monitoring guidance that it regularly shares with states. To enhance HHS' privacy and security oversight and monitoring, HHS will create an overarching oversight process, including identifying appropriate roles and responsibilities for HHS staff.

GAO Recommendation
Develop and document procedures for reviewing the State-based Marketplace Annual Reporting Tool (SMART), including specific follow-up timelines and identifying corrective actions to be performed if deficiencies are identified.

HHS Response
HHS concurs with this recommendation. HHS already has a process in place outside of SMART for states to submit the required documentation relating to privacy and security of their Marketplaces. As part of this outside process, states are required to submit the most recent system security plan, interconnection security agreement, computer matching agreement, information exchange agreement, privacy impact assessment, security assessment report, action plan, and annual security attestation. Upon submission of these documents, HHS works with the states to evaluate risks and determine remediation plans. HHS will update SMART procedures to clarify this distinct process.

GAO Recommendation
Require continuous monitoring of the privacy and security controls over State-based Marketplaces and the environments in which those systems operate to more quickly identify and remediate vulnerabilities.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTHCARE.GOV: ACTIONS NEEDED TO ENHANCE INFORMATION SECURITY AND PRIVACY CONTROLS (GAO-16-265)

HHS Response

HHS concurs with this recommendation. HHS requires continuous monitoring as detailed in its Minimum Acceptable Risk Standards for Exchanges (MARS-E). As part of this requirement, states must develop and implement a continuous monitoring program that includes establishing metrics, monitoring and reporting on security controls on an ongoing basis, and developing response actions to address results of analyses. As part of this process, states conduct an annual security self-assessment of one-third of their security controls. States must also have an independent third-party security audit of all of their security controls every three years or have one-third of their security controls reviewed via an independent, third-party security audit each year. States are required to report on continuous monitoring through updates to their action plans, annual security attestations, security impact analyses, and other reporting documents. HHS will, as part of developing an overarching oversight process, include specific oversight procedures to verify states are performing continuous monitoring and reporting the outcomes to HHS. HHS is committed to continued support of states as they work to strengthen their Marketplaces, including enhancements, maintenance, and operations of their IT systems.

Appendix III: GAO Contacts and Staff Acknowledgments

GAO Contacts

Dr. Nabajyoti Barkakati, (202) 512-4499, barkakatin@gao.gov

Gregory C. Wilshusen (202) 512-6244, wilshuseng@gao.gov

Staff Acknowledgments

In addition to the contacts named above, John de Ferrari, Edward Alexander Jr., Lon Chin, West Coile and Duc Ngo (assistant directors); Christopher Businsky; Mark Canter; Marisol Cruz; Lee McCracken; Monica Perez-Nelson; Justin Palk; Michael Stevens; and Brian Vasquez made key contributions to this report.

TREASURY INSPECTOR GENERAL FOR TAX ADMINISTRATION

Affordable Care Act: Controls Over Financial Accounting for the Premium Tax Credit Should Be Improved

March 2, 2016

Reference Number: 2016-13-021

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E-mail Address / TIGTACommunications@tigta.treas.gov
Website / http://www.treasury.gov/tigta

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Ben Franklin Station
Washington, D.C. 20044-0589

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AFFORDABLE CARE ACT: CONTROLS OVER FINANCIAL ACCOUNTING FOR THE PREMIUM TAX CREDIT SHOULD BE IMPROVED

Highlights

Final Report issued on March 2, 2016

Highlights of Reference Number: 2016-13-021 to the Internal Revenue Service Chief Financial Officer.

IMPACT ON TAXPAYERS

The Patient Protection and Affordable Care Act created a refundable tax credit referred to as the Premium Tax Credit (PTC) to assist eligible individuals with the cost of their health insurance premiums. Rather than wait to claim the credit on their Federal tax returns, individuals may elect to have the PTC paid directly to their health insurance issuers as partial payment for their monthly premiums (referred to as the Advance Premium Tax Credit or APTC). In addition, as a refundable credit, the PTC is fully payable to the taxpayer even if the tax credit exceeds the tax liability.

WHY TIGTA DID THE AUDIT

This audit was initiated as the result of a congressional request for a review of the administration of the PTC. This review was performed as part of a series of coordinated audits and evaluations by the Department of Health and Human Services Office of Inspector General and TIGTA. The objective of this review was to evaluate IRS financial accounting controls for the PTC.

WHAT TIGTA FOUND

TIGTA identified that controls over the financial accounting for fund outlays (disbursements) associated with the PTC should be improved. Specifically, TIGTA found errors in the IRS financial accounting and reporting of PTC-related fund outlays. To reconcile the PTC, the IRS must adjust the amounts initially recorded for APTC payments based on taxpayer-estimated income and family size to the actual PTC amount based on income and number of dependent deductions reported on the taxpayer's Federal tax return. The errors we identified were due to a programming miscalculation. The miscalculation was not caught due to insufficient testing of the financial system programming developed to account for the impact of the reconciliation of PTC fund outlays (disbursements).

Due to this programing error, the IRS understated the amount of PTC disbursements and overstated the balance in the IRS PTC account by $447 million. Further, the error TIGTA identified in the financial accounting records, if left uncorrected, would have resulted in a misstatement of the Fiscal Year 2015 IRS financial statements refundable credits in excess of tax liability account.

In addition, TIGTA determined that the key controls established over PTC accounting do not include the requirement for the periodic performance of a financial reconciliation of the IRS's records and the APTC payment information (by taxpayer) prepared and reported by the Health Insurance Marketplaces.

WHAT TIGTA RECOMMENDED

TIGTA recommended that the Chief Financial Officer, in coordination with the Chief Technology Officer, develop procedures requiring the timely and comprehensive review and testing of any changes to the financial system programming used to report outlays related to the PTC. In addition, the Chief Financial Officer, in coordination with the Affordable Care Act Office, should work with the Centers for Medicare and Medicaid Services to jointly develop procedures for the periodic financial reconciliation of APTC information.

In their response, IRS management agreed with our recommendations. The IRS plans to ensure that established test standards and guidelines are adhered to during financial systems testing. In addition, the IRS plans to perform periodic reconciliations of APTC payment information provided by the Health Insurance Marketplaces to its financial records.

TREASURY INSPECTOR GENERAL
FOR TAX ADMINISTRATION

DEPARTMENT OF THE TREASURY

WASHINGTON, D.C. 20220

March 2, 2016

MEMORANDUM FOR CHIEF FINANCIAL OFFICER

FROM: Michael E. McKenney
Deputy Inspector General for Audit

SUBJECT: Final Audit Report – Affordable Care Act: Controls Over Financial Accounting for the Premium Tax Credit Should Be Improved (Audit # 201510312)

This report presents the result of our review to evaluate the Internal Revenue Service (IRS) financial accounting controls for the Premium Tax Credit (PTC). This review was initiated as the result of a congressional request to review the administration of the PTC. This review is included in our Fiscal Year 2016 Annual Audit Plan and addresses the major management challenge of Implementing the Affordable Care Act and Other Tax Law Changes.

Management's complete response to the draft report is included as Appendix V.

Copies of this report are also being sent to the IRS managers affected by the report recommendations. If you have any questions, please contact me or Gregory D. Kutz, Assistant Inspector General for Audit (Management Services and Exempt Organizations).

Table of Contents

Abbreviations

ACA	Patient Protection and Affordable Care Act
APTC	Advance Premium Tax Credit
CFO	Chief Financial Officer
CMS	Centers for Medicare and Medicaid Services
EPD	Exchange Periodic Data
FY	Fiscal Year
IITC	Individual Income Tax Credits
IRS	Internal Revenue Service
OMB	Office of Management and Budget
PTC	Premium Tax Credit
RRACS	Redesigned Revenue and Accounting Control System
TIGTA	Treasury Inspector General for Tax Administration

Background

Refundable tax credit created by the Affordable Care Act

The Patient Protection and Affordable Care Act (hereafter referred to as the ACA)[1] created a new refundable[2] tax credit, the Premium Tax Credit (PTC), to assist eligible taxpayers with paying their health insurance premiums. Funding for the PTC is provided by a permanent indefinite appropriation to the Department of the Treasury.[3] The ACA also created the Health Insurance Marketplace (hereafter referred to as the Marketplace). The Marketplaces are where individuals (and their families) find information about health insurance options, purchase qualified health plans, and, if eligible, obtain help in paying premiums. According to the U.S. Department of Health and Human Services, as of February 2015, qualified health plans selections and automatic reenrollments were 11.7 million.

When enrolling in a qualified health plan[4] through the Marketplace, eligible individuals can choose to have some or all of the PTC paid in advance to their health insurance company as payment of their monthly premium (hereafter referred to as the Advance Premium Tax Credit or APTC). Alternatively, individuals can pay the premium and wait to claim all of the PTC on their Federal income tax return.

Implementation of the APTC payment

The Centers for Medicare and Medicaid Services (CMS)[5] oversees implementation of certain ACA provisions related to the Marketplace. The CMS operates the Federally Facilitated Marketplace and works with the States to establish State partnership Marketplaces, including overseeing their operations. The Marketplaces have responsibility for determining if an individual is eligible to purchase health insurance through the Marketplace as well as determining the amount of the APTC they are eligible to receive. Total APTC disbursements[6]

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the Internal Revenue Code and 42 U.S.C.), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.
[2] Refundable tax credits can be used to reduce a taxpayer's tax liability to zero. Any excess of the credit beyond the tax liability can be refunded to the taxpayer.
[3] The Internal Revenue Service has implemented the PTC program on behalf of the Department of the Treasury.
[4] A qualified health plan is an insurance plan that is certified by the Health Insurance Marketplace and provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.
[5] The CMS has implemented the PTC program on behalf of the Department of Health and Human Services.
[6] Disbursements are amounts paid by Federal agencies, by cash or cash equivalent, during the fiscal year to liquidate Government obligations.

for Fiscal Year (FY) 2014[7] were nearly $11 billion ($15.5 billion in Calendar Year 2014). These disbursements went to 291 health insurance issuers. The IRS reported that as of September 30, 2015, total credits claimed on 2014 tax returns totaled $9.8 billion.

Once a Marketplace determines the amount of the APTC an individual is eligible to receive, the individual then elects the amount to be sent to their health insurance issuer on a monthly basis. The CMS subsequently sends a request to the Department of the Treasury's Bureau of the Fiscal Service[8] to issue monthly APTC payments to the individual's health insurance issuer. These payments are certified by the CMS and paid from an allocation account[9] established for the use of the CMS.

Reconciliation of the PTCs

Ultimately, the Internal Revenue Service (IRS) is responsible for determining the amount of the PTC a taxpayer receives based on his or her tax return. All individuals who chose to have APTC payments sent to a health insurance issuer are required to file a Federal tax return to reconcile the APTC with the actual PTC they are eligible to receive.[10] This reconciliation is necessary because a Marketplace's computation of the APTC is based on estimates of an individual's anticipated income and family size for the upcoming calendar year. The amount of the PTC that taxpayers are entitled to receive is based on their actual income and family size (number of exemptions) as reported on their annual Federal tax return, which may be different from the estimates used by the Marketplace to determine the allowable APTC.

The ACA requires Marketplaces to provide the IRS with information regarding individuals enrolled in a Marketplace Exchange on a monthly basis (referred to as Exchange Periodic Data or EPD). This information includes monthly (and year-to-date cumulative) amounts of the APTC paid to health insurers on behalf of taxpayers. During the Calendar Year 2014 health insurance enrollment period, the District of Columbia and 14 States operated their own Exchanges, while the remaining 36 States partnered with the Federal Exchange which constitutes the Marketplace. In addition, the Marketplaces provide an annual summary to both the IRS and

[7] For FY 2014, APTC disbursements began in January 2014. A fiscal year is any yearly accounting period, regardless of its relationship to a calendar year. The Federal Government's fiscal year begins on October 1 and ends on September 30.

[8] A new bureau of the Department of the Treasury formed from the consolidation of the Financial Management Service and the Bureau of the Public Debt. Its mission is to promote the financial integrity and operational efficiency of the U.S. Government through exceptional accounting, financing, collections, payments, and shared services.

[9] Allocation accounts are authorized and appropriate when a law requires funds that are appropriated to one department to be transferred to pay for activities that are the statutory responsibility of a second department.

[10] Taxpayers who enrolled in a qualified health plan through the Marketplace in Calendar Year 2014 will receive a Form 1095-A, *Health Insurance Marketplace Statement*, from the Marketplace. Information from this form should be used to calculate the amount of the taxpayer's PTC and reconcile the APTCs made on the taxpayer's behalf to the health insurance issuer. To do this, the taxpayer will use Form 8962, *Premium Tax Credit (PTC)*, when filing his or her tax return.

the enrolled individuals detailing specific information. This summary is referred to as Form 1095-A, *Health Insurance Marketplace Statement*.

Funding the PTC

After significant planning and review, the IRS, Department of the Treasury, Department of Health and Human Services, the CMS, and the Office of Management and Budget (OMB) agreed that creating an allocation account for the CMS to use in obligating and disbursing funds for the APTC was the most logical and efficient approach to administering the PTC. As part of this approach, the CMS is responsible for certifying the availability of funds (via the allocation account) for APTC payments to health insurance issuers.

The CMS is also responsible for leading the Federal Marketplace, managing relationships with State Marketplaces, and providing oversight for the agents and brokers who enroll qualified individuals in qualified health plans and assist them in applying for the APTC. Under this approach, APTC payments will be captured in the "child" (allocation) account, and all reconciliation (refund) outlays will be captured in the "parent" account of the refund appropriation. The IRS is responsible for the unified reporting of all PTC appropriation activity on its annual financial statements.

Tracking PTC outlays with IRS financial systems

The financial accounting for refundable tax credits is a complex multistep process. The PTC, as a refundable tax credit, is fully payable to the taxpayer even if the tax credit exceeds the tax liability, thereby providing greater economic benefit. The Department of the Treasury permanent Indefinite Refund Appropriation provides funding for the PTC. The Department of the Treasury account 20x0949 is used to track PTC funds within the IRS general ledger. Accurately tracking the total outlays (disbursements) associated with the PTC involves two steps.

First, the IRS records monthly the summary amount of the fund outlay (APTC payments made by the CMS to health insurers) in its general ledger based on PTC reports provided by the CMS. Second, the IRS records an adjustment to these outlays to reflect information on filed tax returns claiming the PTC. The overall objective of this two-part process is to allow the IRS to accurately record and report on the total amount of funding outlays associated with instances in which the total PTC exceeded the taxpayer's liability.

Calculation of the PTC funds outlays adjustment

This calculation is performed within the Individual Income Tax Credits (IITC) Report programming using taxpayer data extracted from the IRS Master File.[11] The results of this

[11] The IRS database that stores various types of taxpayer account information. This database includes individual, business, and employee plans and exempt organizations data.

calculation are posted to the Redesigned Revenue and Accounting Control System (RRACS), which serves as the IRS's general ledger for custodial accounting.

This review was initiated as the result of a congressional request for a review of the administration of the PTC. This report addresses the IRS's controls over the financial accounting (hereafter referred to as accounting) of the PTCs. Our audit objective was limited to assessing the ability of the IRS to accurately calculate, record, and report the outlay (disbursement) amount associated with the PTC. We did not perform any detailed testing to evaluate the IRS's efforts to ensure the accuracy of the underlying source information in the taxpayer's record that the IITC Report programming used in calculating the FY 2015 PTC outlay (disbursement) amount. An evaluation of controls over the accuracy of this underlying support information is the subject of a separate Treasury Inspector General for Tax Administration (TIGTA) audit scheduled to be completed in FY 2016.

This review was performed at the IRS Headquarters office of the Chief Financial Officer (CFO) in Washington, D.C., during the period October 2014 through October 2015. We conducted this performance audit in accordance with 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 based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. Detailed information on our audit objective, scope, and methodology is presented in Appendix I. Major contributors to the report are listed in Appendix II.

Results of Review

The Internal Revenue Service Did Not Accurately Track and Report Premium Tax Credit Outlays

TIGTA identified that controls over the financial accounting for fund outlays (disbursements) associated with the PTC should be improved. Specifically, errors were identified in the IRS financial accounting and reporting of PTC-related fund outlays during our testing conducted in June 2015. To reconcile the PTC, the IRS must adjust the amounts initially recorded for APTC payments in the IRS financial records. These amounts were based on taxpayer-estimated income and family size. These amounts must be adjusted to reflect the actual PTC amount based on income and number of dependent deductions reported on the taxpayer's Federal tax return. The errors we identified were due to a programming miscalculation. This miscalculation was not caught because of insufficient testing of the financial system programming developed to account for the impact of this reconciliation of PTC fund outlays (disbursements).

Due to this programing error, the IRS understated the amount of PTC disbursements and overstated the balance in the IRS account used to track PTC funds in its financial records by $447 million.[12] This resulted in an inaccuracy in the IRS quarterly report to the OMB on the amount of PTC funds outlays. Further, the error we identified in the financial accounting records, if left uncorrected, would have resulted in a misstatement of the IRS FY 2015 financial statements account refundable credits in excess of tax liability.

In order to accurately track and report fund outlays associated with refundable credits such as the PTC, the IRS must calculate the amount of the tax credit(s), in total, that exceeded the tax liability that an individual taxpayer is claiming for the credit(s) on his or her Federal tax return. In performing this calculation, the IRS uses the IITC Report programming. Although the IRS updated the financial system programing for the IITC Report programming in February 2015 to include the PTC, our review of a random sample of 50 tax returns claiming the PTC found that in 14 (28 percent) cases, the PTC outlay amount was not calculated accurately. The IRS informed us that in all 14 cases, the IITC Report programing did not properly consider the impact of other

[12] We did not perform detailed testing of the accuracy of information reported to the OMB; however, when we advised the IRS of the programming error they informed us that the second quarter reporting to the OMB was inaccurate and it will be corrected in the third quarter and the year-to-date figure in the third quarter will be accurate.

credits[13] claimed by the taxpayer when calculating the PTC outlay amount. As a result, the calculation of the PTC adjustment was incorrect.

After the errors were identified, the IRS revised the programming it uses to calculate PTC funds outlays and adjusted its financial records. This adjustment increased the June 2015 year-to-date net PTC funds outlay amount by $447 million (3 percent) as illustrated in Figure 1. The revised programming was completed in time for the IRS to provide corrected third quarter FY 2015 IITC reporting to the OMB. We determined that the revised outlay calculation programing correctly processed all of the 50 cases we sampled including the 14 error cases.

Figure 1: Summary of Correction to the IRS's PTC Funds Outlay Records (Third Quarter FY 2015 Year to Date)

	Amounts Before Programming Correction (millions)	Amounts After Revised Programming (millions)	Difference (millions)
Total APTC Funds Outlay	$17,260[14]	$17,260	-
PTC Funds Outlay Adjustment	($3,065)	($2,618)	$447
Net PTC Funds Outlay	**$14,195**	**$14,642**	**$447**

Source: Information regarding amounts before programming correction was provided by the IRS CFO. Amounts after revised programming reflect information provided in the IRS IITC Report (third quarter FY 2015).

The accounting errors identified are primarily attributable to the lack of comprehensive testing by the CFO of the financial system programming for the IITC Report program update to track outlay transactions related to the PTC. Specifically, our review found that although the IRS CFO informed us that some limited testing of the programming was performed, this testing was insufficient to ensure that the results produced were correct for various accounting scenarios such as taxpayers claiming multiple credits. It is important to note that the accounting errors we identified affected only the way in which the IRS recorded PTC transactions in its records for financial reporting purposes and did not affect the actual processing of the tax return by the IRS.

Recommendation

Recommendation 1: The CFO, in coordination with the Chief Technology Officer, should develop procedures requiring the timely and comprehensive review and testing of any changes to the financial system programming used to report outlays related to the PTC.

[13] Other refundable credits include for example, the Earned Income Tax Credit and the Child Tax Credit. In determining the excess credit over tax liability amount related to the PTC, the IRS must identify all refundable credits and then apply the total excess credit amount based on a pre-established formula.
[14] This number did not require adjustment because it was not affected by the programming error.

Management's Response: The IRS agreed with this recommendation. The CFO and Chief Technology Officer will ensure that established test standards and guidelines are adhered to during financial systems testing, including testing of the IITC Report and validating APTC and PTC reconciliation reporting. The IRS Chief Technology Officer will ensure adherence to these standards and guidelines through increased monitoring and discussion during regular progress meetings and by employing more frequent written reminders. Any additional testing is contingent on additional resources or the reprioritization of current workload.

Additional Steps Are Needed to Ensure That Advance Premium Tax Credit Payment Financial Accounting Information Is Accurate

The key controls established by the IRS and the CMS over PTC accounting do not include the requirement for the periodic performance of a financial reconciliation of APTC total outlays per the IRS's records and the APTC payment information (by taxpayer) prepared and reported by the Marketplaces. A financial reconciliation of this information would provide enhanced assurance that the information received by the IRS from the Marketplaces is complete, and total funds outlays, as recorded in the IRS's accounting records, are supported in total by detailed information tracked and reported by the Marketplaces. This financial reconciliation is also critical because the IRS is responsible for reporting financial activity related to the APTC in its annual audited financial statements. In addition, this periodic reconciliation would support an evaluation of the annual summary information provided at year-end by the Marketplaces to taxpayers and the IRS. In Calendar Year 2014, the IRS recorded approximately $15.5 billion in APTC disbursements to health insurers based on information provided by the CMS, which is the basis for the IRS's recording of APTC outlays in its general ledger.

The ACA requires the Marketplaces to provide the IRS with information regarding individuals who are enrolled in qualifying health plans by the Exchange on a monthly basis. This information is referred to as the EPD. The monthly and year-to-date cumulative EPD stipulate the amount of the APTC paid to health insurers on behalf of taxpayers, which should reconcile to the outlay information received by the IRS from the CMS after accounting for timing differences and any adjustments, such as in process corrections of prior payment errors.

The Marketplaces are also required to provide an annual summary to both the IRS and the individual detailing specific information related to the individual's enrollment. This is referred to as Form 1095-A. The Form 1095-A includes the amount of the APTCs paid for under the qualified health plan.

However, Marketplace information reported to the IRS, in the EPD as of May 2015, was incomplete and did not include APTC disbursement data from two exchanges on data that TIGTA received from the IRS. Marketplace information separately reported to the IRS in the Form 1095-A as of May 2015 was similarly incomplete and did not include APTC disbursement data from two exchanges based on data that TIGTA received from the IRS. While this

incomplete information adversely affected the IRS's ability to reconcile total Calendar Year 2014 APTC outlays, requiring a financial reconciliation would still provide strong benefits to the overall financial accounting process going forward.

First, the performance of a periodic reconciliation would provide a baseline for determining the magnitude of the difference between total APTC outlays and the APTCs reported by the Marketplaces. Second, because the Department of Health and Human Services Office of Inspector General has previously reported that the CMS cannot reconcile payments made to health insurers to APTC payments made to taxpayers,[15] a financial reconciliation between total APTC outlays and APTC payments reported via the EPD would provide the IRS with significantly enhanced assurance regarding accuracy of the amount of APTC advances it reports in its financial records. Finally, we have communicated this accounting issue to the Department of Health and Human Services Office of Inspector General for follow-up.

Recommendation

Recommendation 2: The CFO, in coordination with the ACA Office, should work with the CMS to jointly develop procedures for the periodic financial reconciliation of APTC information.

> ***Management's Response:*** The IRS agreed with this recommendation. On a quarterly basis, the IRS will reconcile the EPD to the CMS disbursements paid to the Marketplace insurance companies. These reconciliations will be prepared at a summary level and the IRS will work with the CMS to evaluate any significant variances.

[15] In June 2015, the Department of Health and Human Services Office of Inspector General reported that the CMS is unable to verify the amounts requested through qualified health plan issuers' attestations on an enrollee-by-enrollee basis because it obtains APTC payment data from qualified health plan issuers on only an aggregate basis.

Appendix I

Detailed Objective, Scope, and Methodology

Our overall objective was to evaluate IRS financial accounting controls for the PTC. To accomplish this objective, we:

I. Evaluated the effectiveness of the process and controls developed for the financial accounting of the PTC.

A. Obtained and reviewed any policies, procedures, and guidelines applicable to the financial accounting for Federal tax credits and allocation account activity.

B. Reviewed controls over posting of APTC outlay information to the IRS's records.

1. Compared IRS postings to the RRACS to CMS monthly trial balance activity for Calendar Year 2014 and FY 2015 (through June 2015) and investigated any differences identified.

2. Compared summary RRACS APTC-related information for Calendar Year 2014 and FY 2015 (through June 2015) to Bureau of the Fiscal Service account activity records and investigated any differences identified.

C. Assessed the results of the IRS's review of monthly input received from the CMS and evaluated any actions taken as a result of significant variances identified.

D. Determined the status of the IRS's efforts to update its IITC Report programming to include PTC information.

E. Reviewed the methodology used to update the IITC Report programming to account for PTC outlays and evaluated the accounting scenarios developed in support of this process.

F. Evaluated controls over the process for posting outlay adjustments to the RRACS for taxpayers claiming the PTC on tax returns.

1. Evaluated the audit trail maintained for posting outlay adjustments to the RRACS and reviewed whether it contains sufficient detail to identify transaction-level (taxpayer) adjustment information.

2. Identified the population of all tax returns filed from January 1 to April 2, 2015, claiming the PTC using information from data stored at TIGTA's Data Center Warehouse[1] (extracted from the Individual Return Transaction File). To assess

[1] TIGTA's Data Center Warehouse is used to maintain data that have been extracted from the IRS's data storage.

the reliability of this information, we ensured the extract contained the specific data elements requested and compared selected data in the extract with information in the Integrated Data Retrieval System for items we sampled in Step I.F.3.

3. Using the population of tax returns identified in Step I.F.2., selected a random sample of 50 tax returns and for each tax return identified the associated adjustment to PTC outlay information contained in the IITC Report programming audit trail. We selected our sample randomly from 1,570,920 taxpayers who filed IRS Form 8962, *Premium Tax Credit (PTC)*, from January 1 to April 2, 2015. Our testing was limited to evaluating the programming for the various accounting scenarios identified in Step I.E. and we selected a sample of 50 tax returns in order to ensure that all scenarios identified were tested. We did not perform the testing necessary to validate whether the population we identified included all taxpayers that filed IRS Form 8962. We used the Statistical Analysis System random number generator to select a random sample of 50 tax returns. Our sampling methodology was reviewed by our contracted statistician.
4. Reviewed the adjustment amounts for the 50 sampled tax returns for consistency with the accounting scenarios analyzed in Step I.E. and investigated any differences.
5. Reviewed posting of IITC Report programming results for the PTC to the Bureau of the Fiscal Service account activity records for the period January through June 2015.
6. Reviewed any reconciliations performed between the Calendar Year 2014 APTC disbursements reported to the IRS by the CMS monthly and total Calendar Year 2014 APTC payments reported to the IRS by Health Insurance Marketplaces.

II. Evaluated the steps taken to timely and accurately report PTC information to stakeholders.

A. Reviewed any procedures developed regarding the reporting of PTC information on the IRS's FY 2015 annual financial statements.

B. Determined whether the IRS reports total PTC outlays to the OMB and other stakeholders.

Internal controls methodology

Internal controls relate to management's plans, methods, and procedures used to meet their mission, goals, and objectives. Internal controls include the processes and procedures for planning, organizing, directing, and controlling program operations. They include the systems for measuring, reporting, and monitoring program performance. We determined that the following internal controls were relevant to our audit objective: the IRS's policies and procedures for recording and validating financial information related to the PTC. We evaluated these controls by interviewing IRS management, reviewing documentation related to the recording of PTC financial information, and evaluating PTC financial information reconciliation procedures.

Appendix II

Major Contributors to This Report

Gregory D. Kutz, Assistant Inspector General for Audit (Management Services and Exempt Organizations)
Alicia P. Mrozowski, Director
Anthony Choma, Audit Manager
Kanika Kals, Lead Auditor
Brandon Crowder, Senior Auditor

Appendix III

Report Distribution List

Commissioner
Office of the Commissioner – Attn: Chief of Staff
Deputy Commissioner for Operations Support
Deputy Commissioner for Services and Enforcement
Chief Technology Officer
Director, Affordable Care Act Office
Director, Filing and Premium Tax Credit Strategy, Affordable Care Act Office
Director, Program Management Office, Affordable Care Act Office
Associate Chief Information Officer, Affordable Care Act (PMO)
Director, Office of Audit Coordination

Appendix IV

Outcome Measure

This appendix presents detailed information on the measurable impact that our recommended corrective action will have on tax administration. This benefit will be incorporated into our Semiannual Report to Congress.

Type and Value of Outcome Measure:

- Reliability of Information – Actual (correction reflected in third quarter FY 2015 reporting to the OMB on Refundable Credit Outlays); $447 million (see page 5).

Methodology Used to Measure the Reported Benefit:

Our review found that the IRS understated the amount of PTC disbursements and overstated the balance in the IRS account used to track PTC funds in its financial records by $447 million. The errors we identified were due to a programming miscalculation. This miscalculation was not caught because of insufficient testing of the financial system programming developed to account for the impact of this reconciliation of PTC fund outlays (disbursements). This resulted in an inaccurate IRS quarterly report to the OMB on the amount of PTC funds outlays. After the errors were identified, the IRS revised the programming it uses to calculate PTC funds outlays and adjusted its financial records. This adjustment increased the year-to-date net PTC funds outlay amount by $447 million (3 percent). The revised programming was completed in time for the IRS to provide corrected third quarter FY 2015 IITC reporting to the OMB.

Appendix V

Management's Response to the Draft Report

CHIEF FINANCIAL OFFICER

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

February 10, 2016

MEMORANDUM FOR MICHAEL E. MCKENNEY
DEPUTY INSPECTOR GENERAL FOR AUDIT

FROM: Jeffrey S. Wallbaum
Acting Chief Financial Officer

SUBJECT: Draft Audit Report – Affordable Care Act: Controls Over Financial Accounting for the Premium Tax Credit Should Be Improved (Audit # 201510312)

Thank you for the opportunity to respond to your draft audit report, "Affordable Care Act: Controls over Financial Accounting for the Premium Tax Credit Should Be Improved." We agree with your recommendations and have developed corrective actions to address them, as listed in the attachment.

If you have any questions, please contact me or a member of your staff may contact Howard Marcus, Deputy Associate CFO for Financial Management, at (202) 803-9688.

Attachment

ATTACHMENT

RECOMMENDATION 1
The CFO, in coordination with the Chief Technology Officer, should develop procedures requiring the timely and comprehensive review and testing of any changes to the financial system programming used to report outlays related to the PTC.

CORRECTIVE ACTION
The IRS agrees with this recommendation. The Chief Financial Officer (CFO) and Chief Technology Officer (CTO) will ensure established test standards and guidelines are adhered to during the conducting of financial systems test efforts, including testing of the Individual Income Tax Credits report and validating Advanced PTC (APTC) and PTC reconciliation reporting. The IRS CTO will ensure adherence to these standards and guidelines through increased monitoring and discussion during regular progress meetings and by employing more frequent written reminders. Any additional testing is contingent on additional resources or the re-prioritization of current workload.

IMPLEMENTATION DATE
January 31, 2017

RESPONSIBLE OFFICIAL
Associate Chief Information Officer for Enterprise Services

RECOMMENDATION 2
The CFO and ACA Project Management Office should work with the CMS to jointly develop procedures for the periodic financial reconciliation of APTC information.

CORRECTIVE ACTION
The IRS agrees with this recommendation. On a quarterly basis, the IRS will reconcile the Exchange Periodic Data (EPD) data to the CMS disbursements paid to the marketplace insurance companies. These reconciliations will be prepared at a summary level and IRS will work with CMS to evaluate any significant variances.

IMPLEMENTATION DATE
May 31, 2016

RESPONSIBLE OFFICIAL
Deputy Associate Chief Financial Officer for Financial Management

ASPE
ISSUE BRIEF

HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT, 2010–2016

March 3, 2016
By Namrata Uberoi, Kenneth Finegold, and Emily Gee

This issue brief reviews the most recent survey and administrative information available about gains in health insurance coverage since the enactment of the Affordable Care Act (ACA) in 2010. We estimate that the provisions of the ACA have resulted in gains in health insurance coverage for 20.0 million adults through early 2016 (through February 22, 2016), a 2.4 million increase since our previous estimate in September 2015.[1] These estimated health insurance coverage gains are shared broadly across population groups.

Our estimate of a net reduction of 20.0 million uninsured adults is based on data from the National Health Interview Survey (NHIS) and from the Gallup-Healthways Well-Being Index (WBI). Our estimates of changes in the uninsured rate are adjusted to account for changes in general economic conditions (via employment status), geographic location, demographics, and other secular trends, allowing us to estimate the effects of the ACA on the number of uninsured. The Gallup-Healthways WBI shows a dramatic and steady decline in the uninsured rate since the 2012–2013 baseline period before the ACA's major coverage provisions took effect. We rely on the Gallup-Healthways WBI survey for tracking the current rate of health insurance coverage because it provides the timeliest information. Other federal and non-governmental surveys of health insurance status show similar trends over this time period.

[1] In September 2015, we estimated that 17.6 million uninsured adults had gained health insurance coverage as several of the ACA's coverage provisions took effect. This estimate and the estimate of gains in insurance coverage in this brief reflect the change in the number of individuals with coverage at a point in time. This differs from a cumulative count of individuals who have been covered by Medicaid/CHIP or the Health Insurance Marketplace for some period over the past several years, which would be considerably larger.

Key Highlights

- This report estimates that 20.0 million uninsured adults have gained health insurance coverage because of the Affordable Care Act as of early 2016. This includes:
  - 17.7 million nonelderly adults (ages 18 to 64) who gained health insurance coverage from the start of Open Enrollment in October 2013 through early 2016.
  - 2.3 million young adults ages (ages 19 to 25) who gained health insurance coverage between the enactment of the Affordable Care Act in 2010 and the start of the initial Open Enrollment Period in October 2013 due to the ACA provision allowing young adults to remain on a parent's plan until age 26.

- The uninsured rate for non-elderly adults (ages 18 to 64) declined by 43 percent between October 2013 and early 2016 (from 20.3 percent to 11.5 percent).

- Overall, 6.1 million young adults (ages 19 to 25) gained health insurance coverage because of the Affordable Care Act. This includes
  - 2.3 million young adults who gained coverage from 2010 through the start of Open Enrollment in October 2013 due to the provision that allows people under age 26 to stay on a parents' plan.
  - 3.8 million young adults who gained health insurance coverage from the start of Open Enrollment in October 2013 through early 2016.

- Coverage gains for nonelderly adults (ages 18 to 64) were broadly shared among racial and ethnic groups.
  - The uninsured rate among Black non-Hispanics dropped by 11.8 percentage points (a 52.7 percent decline) from 22.4 to 10.6 percent; corresponding to about 3 million Black nonelderly adults gaining coverage.
  - The uninsured rate among Hispanics dropped by 11.3 percentage points (a 27.0 percent decline) from 41.8 to 30.5 percent, corresponding to about 4 million Hispanic nonelderly adults gaining coverage.
  - The uninsured rate among White non-Hispanics dropped by 7.3 percentage points (a 50.7 percent decline) from 14.3 to 7.0 percent, corresponding to about 8.9 million White nonelderly adults gaining coverage.

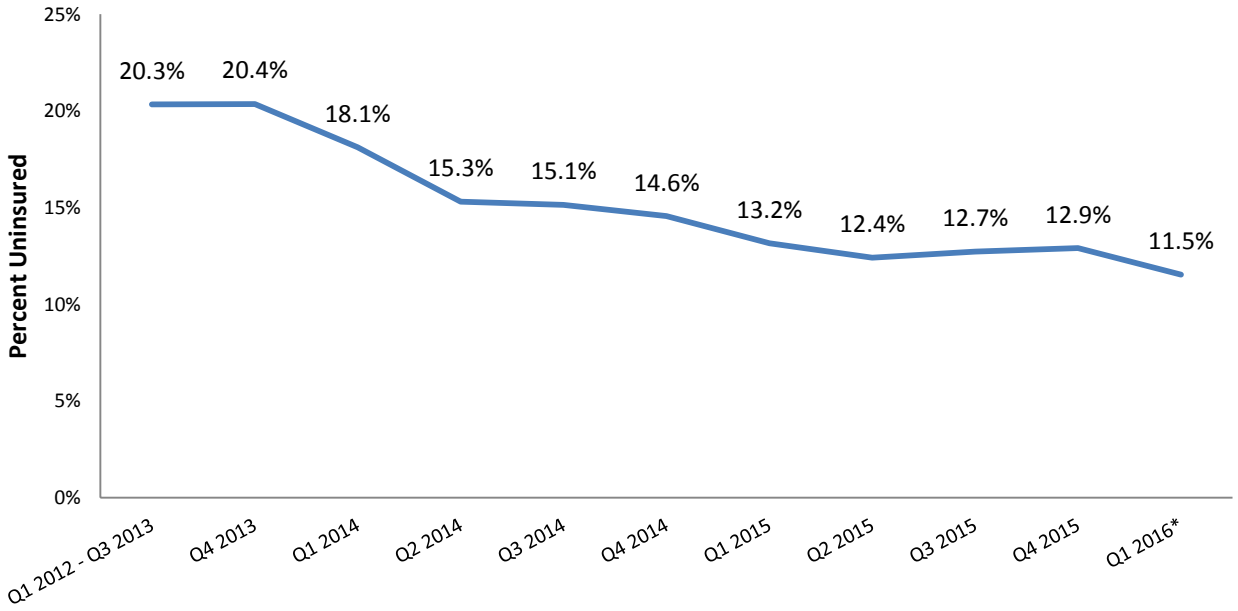
- There was a greater reduction in the uninsured rate among nonelderly adult (ages 18 to 64) women than among nonelderly adult men between October 2013 and early 2016. About 9.5 million women and 8.3 million men gained coverage.

Uninsured Rate for Nonelderly Adults Using the Gallup-Healthways Well-Being Index

The Gallup-Healthways WBI is a daily, nationwide poll of adults. Thanks to its large sample size and the timely availability of data, the Gallup-Healthways WBI can be used to produce timely, adjusted estimates of health insurance coverage. The Gallup-Healthways WBI shows a large decline in the uninsured rate since the third quarter of 2013.

Because the Affordable Care Act major coverage expansions began in the fourth quarter of 2013, we measured the law's impact on uninsured rates by measuring changes in the uninsured rate relative to a baseline period shortly before 2012 through the third quarter of 2013 (shortly before the coverage expansion was initiated). To estimate the effect of the ACA, we adjust the Gallup-Healthways WBI data to remove the contribution of general economic conditions (i.e., employment status), overall time trends, geographic location of respondents, and shifting demographics to the uninsured rate. The resulting adjusted estimates, in Figure 1, show the uninsured rate among nonelderly adults (ages 18 to 64) falling from 20.3 percent in the 2012–2013 baseline period to 11.5 percent as of early 2016.[2]

Figure 1: Quarterly Uninsured Rate Estimates for Nonelderly Adults (Ages 18 to 64) Using the Gallup-Healthways Well-Being Index, 2012 to 2016



Source: The Office of the Assistant Secretary for Planning and Evaluation's (ASPE) analysis of the Gallup-Healthways Well-Being Index survey data through February 22, 2016.

[2] Children (ages 0 to 17) and elderly (ages 65 and older) are not included in the estimates for Figure 1. The Gallup-Healthways WBI does not survey children (ages 0 to 17). The most recent available estimates from the National Health Interview Survey (NHIS) show the uninsured rate was 9.1 percent over the first nine months of 2015 for people of all ages, including the elderly and children. For children (ages 0 to 17), NHIS reports an uninsurance rate of 4.5 percent (corresponding to 3.3 million children) for the first nine months of 2015, a 31 percent drop from the rate in 2013 (6.5 percent, corresponding to 4.8 million children). (Accordingly, based on NHIS estimates, 1.5 million children gained coverage between 2013 and the first nine months of 2015.) The NHIS report is available at: http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf.

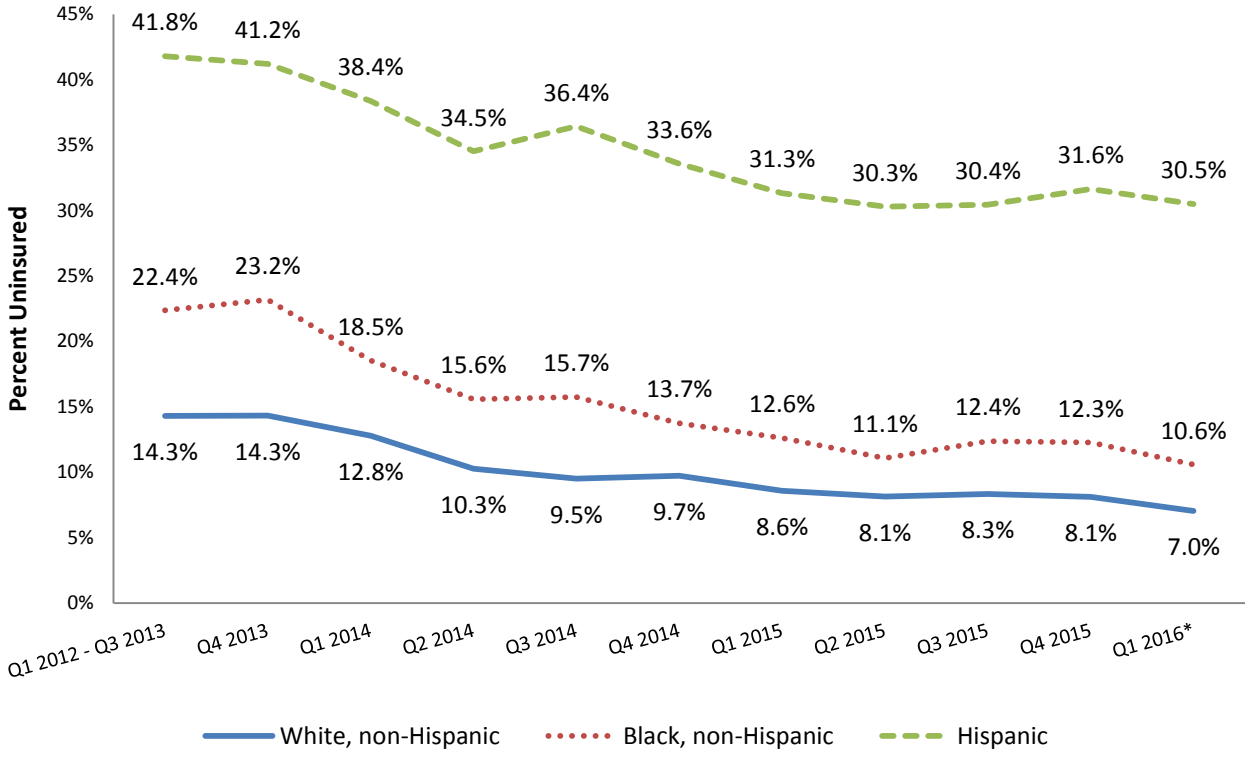
Uninsured Rates by Additional Categories Using the Gallup-Healthways Well-Being Index

Uninsured Rates by Race and Ethnicity

The uninsured rate declined for nonelderly adults (ages 18 to 64) across all race and ethnicity categories since the baseline period (see Figure 2). The reduction in the uninsured rate was greater among Black non-Hispanics (11.8 percentage point drop) and Hispanics (11.3 percentage point drop) than among White non-Hispanics (7.3 percentage point drop).

- Among Black non-Hispanics, the uninsured rate declined 11.8 percentage points (a 52.7 percent decline), from a baseline uninsured of 22.4 percent to 10.6 percent, resulting in 3.0 million adults gaining coverage.
- Among Hispanics, the uninsured rate declined 11.3 percentage points (a 27.0 percent decline), from a baseline uninsured of 41.8 percent to 30.5 percent, resulting in 4.0 million adults gaining coverage.
- Among White non-Hispanics, the uninsured rate declined by 7.3 percentage points (a 50.7 percent decline), from a baseline uninsured of 14.3 percent to 7.0 percent, resulting in 8.9 million adults gaining coverage.

Figure 2: Quarterly Uninsured Rate Estimates for Nonelderly Adults (Ages 18 to 64) by Race and Ethnicity Using the Gallup-Healthways Well-Being Index, 2012 to 2016



Source: The Office of the Assistant Secretary for Planning and Evaluation's (ASPE) analysis of the Gallup-Healthways Well-Being Index survey data through February 22, 2016.

Uninsured Rates among Young Adults

Coverage gains for young adults (ages 19 to 25) started in 2010 with the ACA's provision enabling them to stay on their parents' plans until age 26. From the 2010 baseline periods through the start of Open Enrollment in October 2013, the uninsured rate for young adults declined from 34.1 percent to 26.7 percent, which translates to 2.3 million more young adults with coverage.

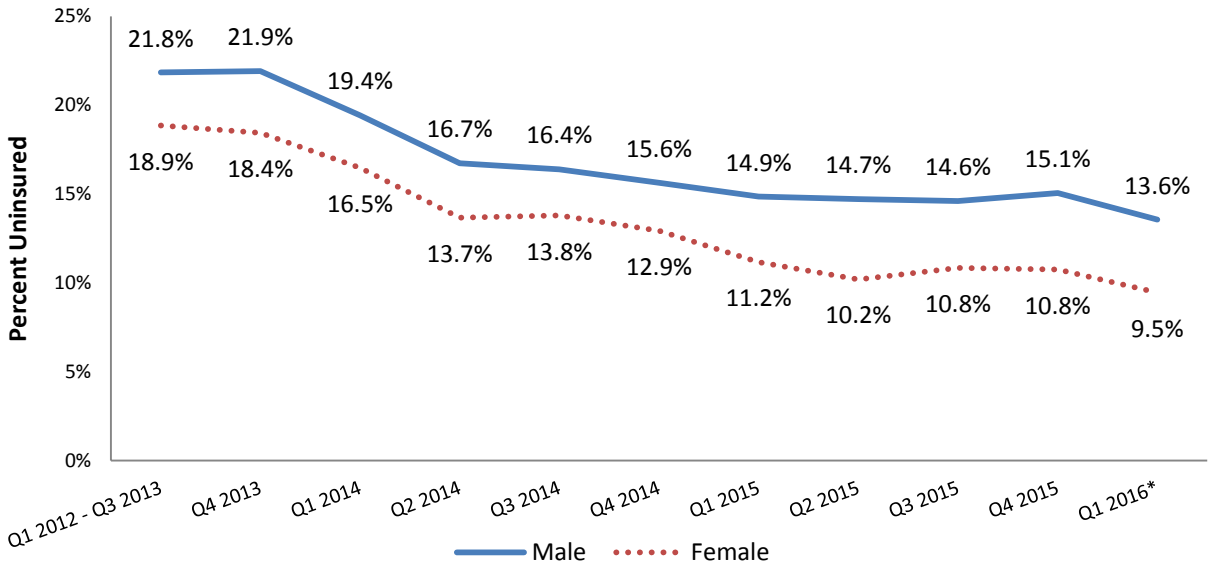
Our analysis of the Gallup-Healthways WBI shows that since October 2013, an additional 3.8 million young adults (ages 19 to 25) gained coverage, a 46.5 percent decrease in the number of uninsured young adults from that date. The adjusted Gallup-Healthways WBI uninsured rate for young adults fell by 12.1 percentage points, from 26.0 percent during the 2012-2013 baseline period to 13.9 percent as of early 2016. In total, an estimated 6.1 million young adults gained coverage from 2010 through early 2016.

Uninsured Rates by Gender

The uninsured rate declined for both males and females since the baseline periods (see Figure 3). There was a greater decline in the uninsured rate among females than among males.

- Males experienced a decline in their uninsured rate of 8.3 percentage points (a 37.9 percent decline), from a baseline of 21.8 percent to 13.6 percent, resulting in 8.3 million adult males gaining coverage.
- Females experienced a decline in their uninsured rate of 9.4 percentage points (a 49.9 percent decline), from a baseline of 18.9 percent to 9.5 percent, resulting in 9.5 million adult females gaining coverage.

Figure 3: Quarterly Uninsured Rate Estimates for Nonelderly Adults (Ages 18 to 64) by Gender Using the Gallup-Healthways Well-Being Index, 2012 to 2016



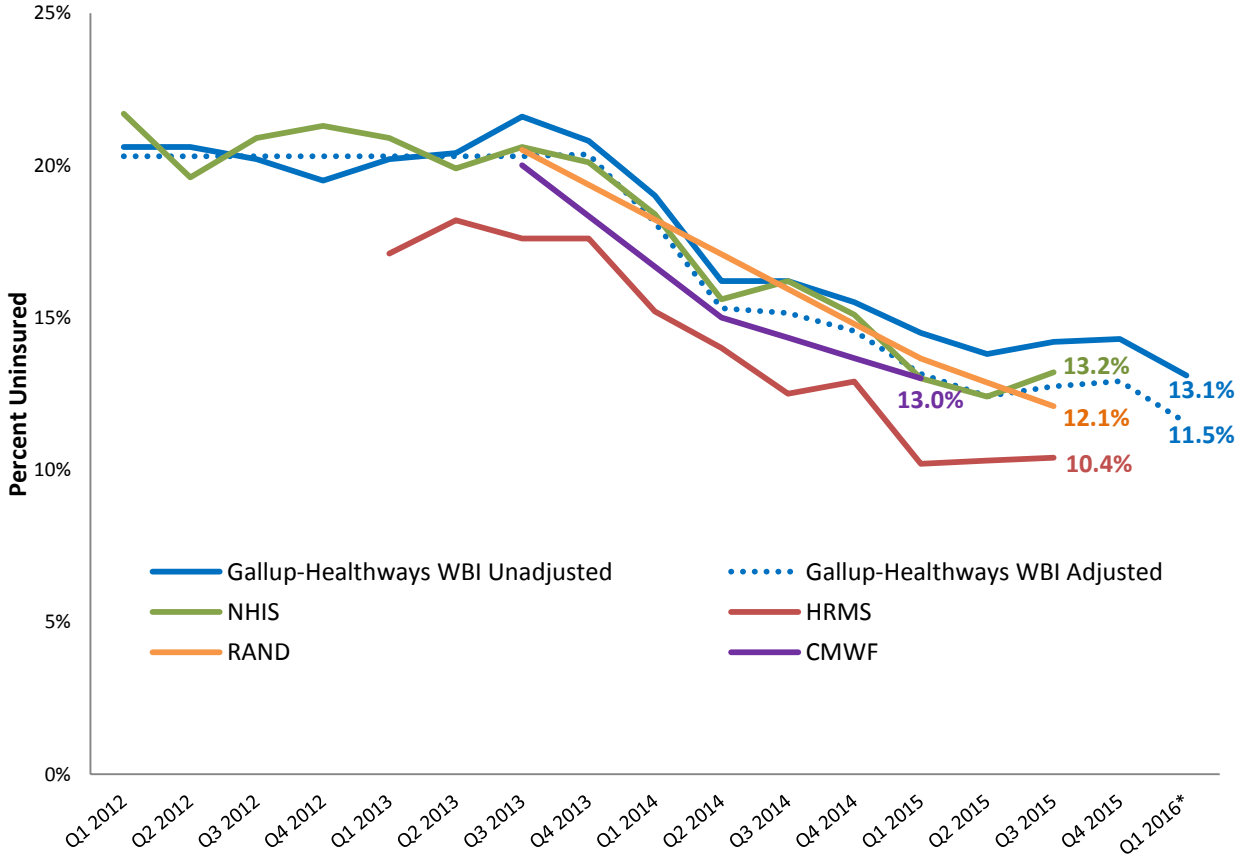
Source: The Office of the Assistant Secretary for Planning and Evaluation's (ASPE) analysis of the Gallup-Healthways Well-Being Index survey data through February 22, 2016.

Comparing Gallup-Healthways Well-Being Index Uninsured Rate to Other Public and Private Surveys

There are a number of estimates of the uninsured rate that are reported regularly. To put these new ASPE estimates in context, we report trends in the rate of uninsured from four other regularly reported survey efforts together with the Gallup-Healthways WBI (see Figure 4).

Despite differences in sample size, response rate, and question wording, estimates from these surveys—the Gallup-Healthways WBI, adjusted estimates from the Gallup-Healthways WBI, the National Health Interview Survey (NHIS), the Urban Institute's Health Reform Monitoring Survey (HRMS), the RAND Health Reform Opinion Survey (RAND), and the Commonwealth Fund Affordable Care Act Tracking Survey (CMWF)—all suggest large reductions in uninsured rates associated with the October 2013-March 2014 and November 2014-February 2015 Open Enrollment Periods. (Because HRMS, RAND, and CMWF do not sample in all quarters, some of the data points shown for these surveys are interpolated.) The unadjusted estimates, including those from Gallup Healthways WBI, are simply raw rates of being uninsured.

Figure 4: Quarterly Uninsured Rate Estimates for Nonelderly Adults (Ages 18 to 64) Using Multiple Surveys, 2012 to 2016



Source: The Gallup-Healthways Well-Being Index (including adjusted estimates from analysis by the Office of the Assistant Secretary for Planning and Evaluation), the National Health Interview Survey (NHIS), the Urban Institute's Health Reform Monitoring Survey (HRMS), the RAND Health Reform Opinion Survey (RAND), and the Commonwealth Fund Affordable Care Act Tracking Survey (CMWF).
Notes: Estimates for Q1 2016 using the Gallup-Healthways Well-Being Index include data through February 22, 2016.

ASPE regards the NHIS as the most reliable source of estimates of current coverage. NHIS's response rate (about 73 percent in 2014) is much higher than that reported for the other quarterly surveys, and the NHIS sample size is larger than any of the other quarterly polls except for the Gallup-Healthways WBI. The NHIS questionnaire collects information about coverage on the date of interview and contains detailed questions about type of coverage, including verification questions that have been shown to reduce the proportion of people who report being uninsured. The survey is also fielded continuously throughout the year. Gallup-Healthways WBI estimates of uninsured rates among the nonelderly tracked NHIS fairly well in 2012, 2013, and 2014, but began to suggest a higher uninsured rate than other surveys in 2015. Estimates from the RAND and Commonwealth Fund surveys are close to NHIS for the periods where all were fielded. Compared with the other surveys, the HRMS panel survey consistently produces lower estimates of the uninsured but suggests similar trends over time.

NHIS data are reported with a lag due to post-survey processing, and the most recent NHIS estimates available are through the third quarter of 2015. For this reason, ASPE uses the Gallup-Healthways WBI to track the current status of health care coverage rates in the U.S.[3]

Gallup Healthways WBI data for the first quarter of 2016 (through February 22) suggest the open enrollment period for Marketplace coverage in 2016 that ran from November 1, 2015 through January 31, 2016, produced another round of gains in health insurance coverage. Data for this most recent period are not yet available from the other surveys.

Conclusion

We estimate that the provisions of the ACA have resulted in gains in health insurance coverage for 20.0 million nonelderly adults (ages 18 to 64). This estimate comprises 17.7 million nonelderly adults who gained coverage due to the coverage expansions that began in the fourth quarter of 2013 and 2.3 million young adults (ages 19 to 25) who gained coverage between 2010 and 2013 due to the ACA's provision allowing young adults to stay on a parents' plan until the age of 26. In total, 6.1 million previously uninsured young adults have gained coverage due to the ACA. This is especially important because this population were particularly likely to be uninsured prior to the enactment of the ACA. The gains in coverage have been shared widely across racial and ethnic groups, with the rate of being uninsured decreasing by 11.8 percentage points among Black non-Hispanics, by 11.3 percentage points among Hispanics, and by 7.3 among White non-Hispanics.

[3] Previous studies have shown that estimates of uninsurance rates from the more timely Gallup-Healthways WBI tracks well compared with estimates from federal surveys, including the NHIS: Laura Skopec, Thomas Musco, Benjamin D. Sommers, "A potential new data source for assessing the impacts of health reform: Evaluating the Gallup-Healthways Well-Being Index," *Healthcare*, vol, 2, iss. 2, July 2014, p. 113-120.

Appendix: Administrative Enrollment Data

The estimated health insurance coverage gains represent estimates of coverage gains associated with provisions of the Affordable Care Act (ACA). That is, the coverage gains estimate reductions in the number of people who are uninsured after controlling for general economic conditions (via employment status), secular trends, geographic location and demographic changes. The sum of the enrollment gains in Medicaid and the Children's Health Insurance Program (CHIP) for individuals receiving comprehensive benefits (over 14 million) and the Health Insurance Marketplace (12.7 million) is greater than the net change in health insurance coverage (20 million) because people may move in and out of different sources of health insurance coverage, so the net change in coverage needs to measure more than these two sources of coverage. Our examination of administrative data shows that Medicaid/CHIP and Marketplace administrative data are in line with the health insurance gains seen in survey data and illustrates gains in enrollment for Medicaid/CHIP and the Marketplaces since 2014.

Medicaid Enrollment

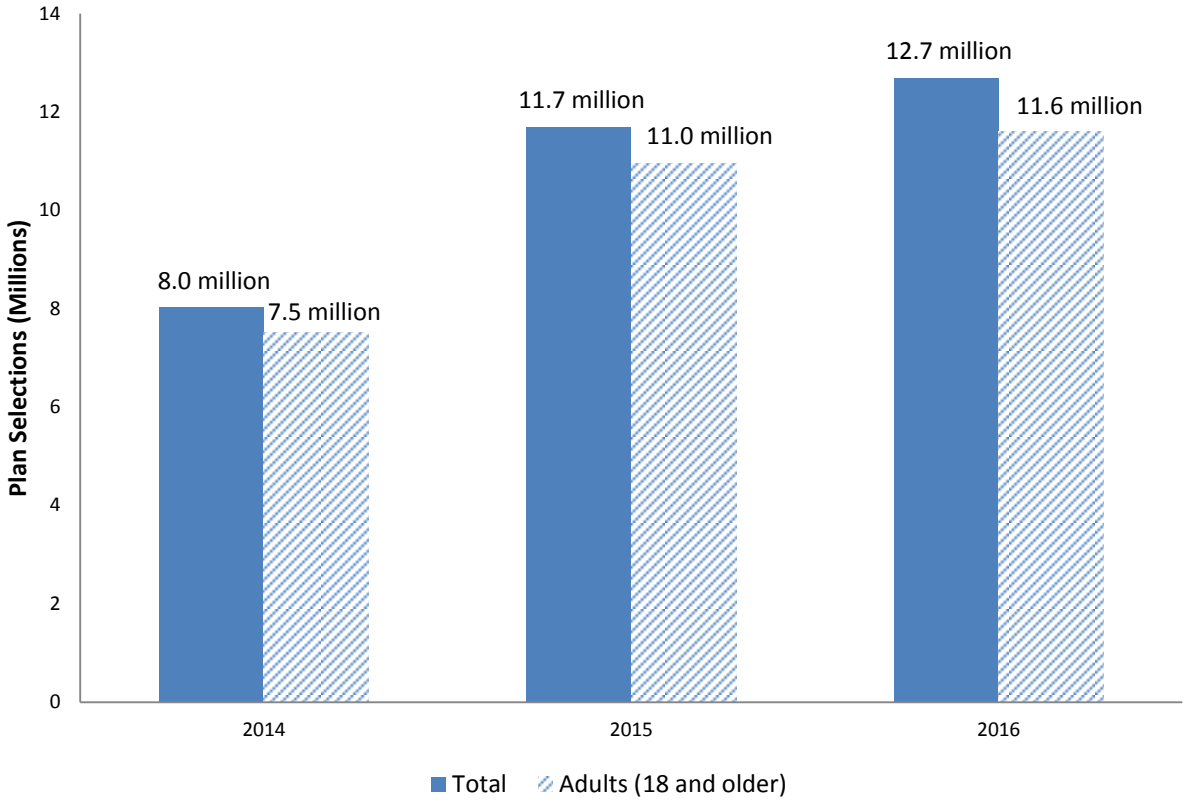
Enrollment of individuals receiving comprehensive benefits in Medicaid and CHIP has grown by 14.5 million since October 2013 in the 49 states reporting both December 2015 enrollment data and data for the July–September 2013 baseline period (the period before the initial Marketplace Open Enrollment Period).[4] Enrollment growth in Medicaid and CHIP has been fairly steady since October 2013; however, fluctuations in the data have occurred as states transitioned from their historic definitions of enrollment to CMS's standardized reporting specifications. As of December 2015, Medicaid and CHIP enrollment had increased by over 12 million since the baseline period among states that had implemented Medicaid expansion, and states that had not yet implemented Medicaid expansion reported enrollment growth of over 2 million.

Marketplace Enrollment

Plan selections in the Health Insurance Marketplaces during the annual Open Enrollment Periods (OEP) have increased over time (see Figure 5). On January 31, 2016, Open Enrollment for the 2016 coverage year ended, with the largest number of plan selections to date: approximately 12.7 million plan selections. The 2016 OEP had almost 60 percent more plans selections than the 2014 OEP, and an increase of 1 million plan selections over the 2015 OEP.

[4] Enrollment data were available for 48 states plus the District of Columbia for both the July–September 2013 baseline period and for December 2015. Connecticut and Maine are not included in the calculation of enrollment growth because those states did not submit enrollment data for the baseline period. The "Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations and Enrollment Report" is available at: https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html.

Figure 5: Open Enrollment Plan Selections in the Health Insurance Marketplaces, 2014 to 2016



Source: Centers for Medicare & Medicaid Services.

APPENDIX: SURVEY DATA AND METHODS

Survey Data

Estimate of impact of dependent coverage provision, measuring the change in young adult insurance coverage, 2010-2013

The National Health Interview Survey (NHIS) is a large national survey with robust sampling methods. It therefore produces the most reliable estimates of coverage. In March 2015, we were able to use NHIS data through the third quarter of 2013 to update our estimate of the impact of the Affordable Care Act (ACA) dependent coverage provision, which allowed young adults (ages 19 to 25) to stay on their parent's health insurance policy starting in September 2010.

Estimate of change in health insurance coverage for 18 to 64 population, Q3 2013-Q1 2016

To estimate the impact of the ACA health insurance coverage expansion through the Health Insurance Marketplaces and Medicaid, we cannot use the NHIS because data for the first quarter of 2016 are not yet available. Therefore, we use the most recent data available on health insurance coverage from the Gallup-Healthways Well-Being Index Survey, which are collected daily and become available soon after data collection. The data in this brief reflect interviews through February 22, 2016.

Methods

Estimate of impact of dependent coverage provision, measuring the change in young adult insurance coverage, 2010-2013

In March 2015, we used NHIS data to update our earlier estimates of the impact of the young adult dependent coverage provision of the ACA that took effect in September 2010. In this current brief, we use the same estimate of the impact of the dependent coverage provision as we reported in March. We used a baseline period stretching from Q4 2009 through Q3 2010 and compared it to the post period defined as Q4 2012 through Q3 2013. Because we had more data available in March, we updated our estimate published in June 2012 (which used a single quarter of data), using longer pre and post periods in order to smooth away random variation in the uninsured rate. This reduces the influence of random variation in the estimates of the number of uninsured on the exact start and end dates for the analysis, but could allow either more or less opportunity for confounding from other factors.

Our estimate showed an additional 2.3 million young adults gaining coverage. We also performed a sensitivity analysis in which we smoothed only the post period and used Q3 2010 as the baseline, yielding an estimate of 2.8 million additional insured young adults. Thus our core estimate, 2.3 million, is more conservative. We note that individuals move into and out of the 19-25 young adult age range as they age, so the 2.3 million is an estimate of the increased prevalence in coverage at a specific point in time. It is not a longitudinal estimate of all individuals who may have benefited from the provision at any point in time since 2010, which would be considerably larger.

ASPE Brief date	Young adult increase in insurance coverage estimate	Baseline period	End period
June 2012	3.1 million	Q3 2010	Q4 2011
March 2015	2.3 million	Q4 2009 – Q3 2010	Q4 2012 – Q3 2013
March 2015 Sensitivity Analysis	2.8 million	Q3 2010	Q4 2012 – Q3 2013

Estimate of change in health insurance coverage for 18-64 population, Q3 2013-Q1 2016

We used the Gallup Healthways WBI to estimate the change in the national uninsured rate from the baseline period of Q1 2012-Q3 2013 to Q1 2016 (January 1, 2016, through February 22, 2016). The 2016 Health Insurance Marketplace Open Enrollment Period ended on January 31, 2016 for a majority of states. Some states extended enrollment through a Special Enrollment Period, which spanned a few additional days.

We estimated the uninsured rates for the nation using the same methodology used in our previous analysis reported in "Health Insurance Coverage and the Affordable Care Act," published in September 2015.[5] To produce those estimates we used a statistical model that adjusted for age, race, ethnic group, sex, employment status, and state of residence. The current methodology also adjusts for marital status and rural residence. These covariates are aimed to control for changes in the economy, population composition, and non-policy factors affecting health insurance coverage. The statistical model also adjusts for time trends. Similar to the September 2015 Issue Brief, this methodology does not adjust for household income because on June 1, 2015, Gallup Healthways WBI changed the wording of its questionnaire to collect respondents' annual income instead of monthly income.

The brief includes nonelderly adults (ages 18 to 64). We excluded elderly adults (ages 65 and older) from this brief because a very high proportion are already enrolled in Medicare and thus not eligible for the coverage expansion under the ACA. Gallup Healthways WBI does not collect data on the 17 and under population.

Population estimates for the 18-64 population by race and ethnicity, young adults, and gender, Q3 2013-Q1 2016

For the national, race and ethnicity, young adult, and gender analyses, we used 2016 Census population projections to obtain population estimates for each subgroup. The population estimates we used are as follows:

[5] "Health Insurance and the Affordable Care Act," *ASPE Issue Brief*, Sept. 22, 2015, available at: https://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015.

Subgroups	2016 Census Population Projection
National (ages 18 to 64 years)	200.9 million
Race and ethnicity	
White non-Hispanic (ages 18 to 64 years)	122.5 million
Black non-Hispanic (ages 18 to 64 years)	25.7 million
Hispanic (ages 18 to 64 years)	35.8 million
Young adults (ages 19 to 25 years)	31.5 million
Gender	
Males (ages 18 to 64 years)	100.1 million
Females (ages 18 to 64 years)	100.7 million

Race and Ethnicity

For purposes of this brief, ASPE only analyzed gains in health coverage among White non-Hispanics, Black non-Hispanics, and Hispanics. Numbers do not sum to 17.7 million because other races are not included in the table. More detailed results with confidence intervals are below:

Quarter	Change in Percentage Points from Baseline Trend (95% CI)		
	White non-Hispanic	Black non-Hispanic	Hispanic
Baseline Uninsured Rate (Q1 2012–Q3 2013)	***14.3***	***22.4***	***41.8***
Q4 2013	0.0 (-0.7, 0.8)	0.9 (-1.5, 3.2)	-0.6 (-3.0, 1.8)
Q1 2014	-1.5 (-2.3, -0.7)	-3.7 (-6.2, -1.3)	-3.5 (-6.0, -0.9)
Q2 2014	-4.0 (-4.8, -3.2)	-6.7 (-9.3, -4.2)	-7.3 (-10.0, -4.6)
Q3 2014	-4.8 (-5.7, -3.9)	-6.5 (-9.3, -3.7)	-5.4 (-8.3, -2.5)
Q4 2014	-4.5 (-5.5, -3.6)	-8.5 (-11.5, -5.5)	-8.2 (-11.4, -5.1)
Q1 2015	-5.7 (-6.7, -4.6)	-9.6 (-12.9, -6.3)	-10.5 (-13.9, -7.1)
Q2 2015	-6.1 (-7.2, -5.0)	-11.1 (-14.7, -7.6)	-11.6 (-15.2, -7.9)
Q3 2015	-6.0 (-7.2, -4.8)	-10.0 (-13.8, -6.2)	-11.4 (-15.2, -7.5)
Q4 2015	-6.2 (-7.5, -4.9)	-10.1 (-14.1, -6.0)	-10.1 (-14.3, -6.0)
Q1 2016*	-7.3 (-8.7, -5.8)	-11.8 (-16.2, -7.4)	-11.3 (-15.9, -6.7)

Note: Estimates for Q1 2016 using the Gallup-Healthways Well-Being Index include data through February 22, 2016.

Young Adults

We analyzed how many young adults (ages 19 to 25) are included in the 15.8 million adults who have gained coverage since the baseline period of Q1 2012-Q3 2013. More detailed results with confidence intervals are below:

Quarter	Change in Percentage Points from Baseline Trend (95% CI)
	Young Adults (Ages 19 to 25)
Baseline Uninsured Rate (Q1 2012–Q3 2013)	***26.0***
Q4 2013	-0.6 (-2.7, 1.6)
Q1 2014	-2.6 (-4.8, -0.3)
Q2 2014	-6.3 (-8.7, -4.0)
Q3 2014	-6.4 (-9.0, -3.9)
Q4 2014	-7.9 (-10.6, -5.1)
Q1 2015	-9.0 (-11.9, -6.0)
Q2 2015	-10.0 (-13.1, -6.8)
Q3 2015	-9.9 (-13.3, -6.5)
Q4 2015	-10.4 (-14.0, -6.8)
Q1 2016*	-12.1 (-16.0, -8.1)

Note: Estimates for Q1 2016 using the Gallup-Healthways Well-Being Index include data through February 22, 2016.

Gender

We analyzed gains in health coverage by gender. More detailed results with confidence intervals are below:

Quarter	Change in Percentage Points from Baseline Trend (95% CI)	
	Male	**Female**
Baseline Uninsured Rate (Q1 2012–Q3 2013)	***21.8***	***18.9***
Q4 2013	0.4 (-0.6, 1.4)	-0.4 (-1.4, 0.6)
Q1 2014	-2.1 (-3.2, -1.0)	-2.3 (-3.4, -1.3)
Q2 2014	-4.9 (-6.0, -3.8)	-5.1 (-6.2, -4.0)
Q3 2014	-5.4 (-6.6, -4.2)	-5.0 (-6.2, -3.8)
Q4 2014	-5.7 (-7.0. -4.4)	-5.9 (-7.2, -4.6)
Q1 2015	-6.8	-7.6

Quarter	Change in Percentage Points from Baseline Trend (95% CI)	
	Male	Female
	(-8.2, -5.4)	(-9.0, -6.2)
Q2 2015	-7.4 (-8.9, -5.9)	-8.5 (-10.0, -7.0)
Q3 2015	-7.2 (-8.8, -5.6)	-8.0 (-9.6, -6.4)
Q4 2015	-6.8 (-8.5, -5.1)	-8.1 (-9.8, -6.4)
Q1 2016*	-8.3 (-10.2, -6.4)	-9.4 (-11.3, -7.5)

Note: Estimates for Q1 2016 using the Gallup-Healthways Well-Being Index include data through February 22, 2016.

United States Government Accountability Office

Report to Congressional Requesters

March 2016

PRIVATE HEALTH INSURANCE

Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015

GAO-16-326

March 2016

PRIVATE HEALTH INSURANCE

Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015

GAO Highlights

Highlights of GAO-16-326, a report to congressional requesters

Why GAO Did This Study

The Patient Protection and Affordable Care Act established the CO-OP program and provided loans that helped create 23 CO-OPs to offer qualified health plans to individuals and small employers. While the program seeks to increase competition and improve accountability to members, questions have arisen about their long-term sustainability and their effects on health insurance markets, particularly as 12 CO-OPs ceased operations on or before January 1, 2016.

In April 2015, GAO issued its first report examining the status of CO-OP premiums, enrollment, and program loans in 2014 (GAO-15-304). As one CO-OP ceased operations in early 2015, GAO was asked to review the CO-OP program again. This report examines (1) how CMS monitors the CO-OPs' performance and sustainability; (2) how CO-OP premiums changed from 2014 to 2015, and in 2015, how they compared to premiums for other health plans; and (3) how CO-OP enrollment changed from 2014 to 2015, and in 2015, how it compared to projections. GAO analyzed 2014 and 2015 premium and enrollment data from CMS, states, and the National Association of Insurance Commissioners; and reviewed applicable regulations, policies, procedures, and documentation of CMS monitoring activities. GAO also interviewed CMS officials.

In commenting on a draft of this report, the Department of Health and Human Services stated its commitment to CO-OP beneficiaries and taxpayers, and provided technical comments, which GAO incorporated as appropriate.

View GAO-16-326. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services' (CMS) monitoring of the consumer governed, nonprofit health insurance issuers—known as consumer operated and oriented plans (CO-OPs)—evolved as the CO-OP program matured, and as 12 of the 23 CO-OPs ceased operations on or before January 1, 2016. CMS's initial monitoring activities, starting when it began to award CO-OP program loans in early 2012, focused on the CO-OPs' progress as start-up issuers and their compliance with program requirements. Since then, CMS refined and expanded its monitoring to evaluate CO-OP performance and sustainability. CMS officials use enrollment and financial data to identify CO-OPs for which actual performance differed substantially from what was expected. CMS officials also perform routine assessments of each CO-OP's risk in various areas, such as working capital and management. To evaluate and respond to financial or operational issues identified at CO-OPs, CMS formalized a framework that it called an escalation plan. Under this plan, CMS may require that a CO-OP take corrective actions or the agency may implement an enhanced oversight plan based on its evaluation of the issue. As of November 2015, CMS used its escalation plan to evaluate and respond to issues at 18 CO-OPs, including 9 of the CO-OPs that have ceased operations. CMS officials told GAO that they plan to work with states' departments of insurance to continue monitoring CO-OPs that have ceased operations to the extent possible in order to minimize any negative impact on members and, if possible, recover loans made through the program.

GAO found that in 14 of the 20 states where CO-OPs offered health plans during both 2014 and 2015, the average CO-OP premiums for 30-year-old individuals purchasing silver health plans—the most commonly selected plan—were lower in 2015 than the average premiums for such plans in 2014. In the 23 states where CO-OPs offered health plans during 2015, the average premiums for all CO-OP health plans were lower than those for other issuers in more than 75 percent of rating areas—geographical areas established by states and used, in part, by issuers to set premium rates. Across the 23 states, average silver health plan premiums were lower for CO-OPs than other issuers in 31 percent to 100 percent of rating areas.

In addition, GAO found that the combined enrollment for the 22 CO-OPs that offered health plans in 2015 was over 1 million as of June 30, 2015, more than double the enrollment of a year earlier. More than half of these members were in CO-OPs that ceased operations. GAO also found that the combined enrollment for all 22 CO-OPs in 2015 exceeded their projections for 2015 by more than 6 percent. Of the 11 CO-OPs that have ceased operations, 6 did not meet their individual enrollment projections for 2015. Among the 11 CO-OPs that continue to operate in 2016, 4 CO-OPs had not yet reached a program benchmark of enrolling at least 25,000 members. CMS officials told GAO that exceeding this benchmark represents a level of enrollment that should better allow an issuer to cover its fixed costs; CMS officials told GAO that they are monitoring the CO-OPs' enrollment with attention to this benchmark.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
CO-OP	consumer operated and oriented plan
HHS	Department of Health and Human Services
LDI	Louisiana Department of Insurance
NAIC	National Association of Insurance Commissioners
OIG	Office of Inspector General
PPACA	Patient Protection and Affordable Care Act

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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March 10, 2016

Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA) established the consumer operated and oriented plan (CO-OP) program—a loan program intended to foster the creation of new, consumer-governed, nonprofit health insurance issuers, known as CO-OPs, to offer qualified health plans to individuals and small employers.[1] For this purpose, PPACA appropriated funding for the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers the CO-OP program, to award loans totaling more than $2.4 billion.[2] The funding disbursed under these loans helped establish 23 CO-OPs that began offering health insurance in 2014.[3] (See appendix I for a list of the 23 CO-OPs.)

The CO-OP program is intended to enhance competition in the states' markets for health insurance sold directly to individuals and small employers—which potentially could reduce health plan premiums—while improving choice for consumers and encouraging accountability to members.[4] However, 12 CO-OPs ceased operations on or before

[1]Pub. L. No. 111-148, § 1322, 124 Stat. 163, 187-192 (Mar. 23, 2010) (codified at 42 U.S.C. § 18042). Qualified health plans are health plans certified to be offered through a health insurance exchange established under PPACA. Small group market means the health insurance market under which individuals obtain health insurance coverage through a group health plan offered by a small employer. A small employer is defined as having employed an average of 1 to 50 employees during the preceding year; however, states may apply this definition based on an average of 1 to 100 employees. See 42 U.S.C. §§ 300gg-91(e), 18024(b).

[2]The amounts awarded represent the total funding that CMS agreed to provide the CO-OPs. The CO-OPs receive some or all of this funding when disbursements are made.

[3]One additional organization in Vermont received CO-OP program loan awards, but was subsequently denied a license as a health insurance issuer by the state. As a result, CMS terminated the organization from the CO-OP program. According to CMS officials, CMS did not recover any of the start-up loan funding disbursed to that CO-OP—about $4.5 million—but did recover all solvency loan funding that had been disbursed to the CO-OP—about $10 million.

[4]Members are individuals covered under policies issued by the CO-OP. PPACA requires that governance of a CO-OP be subject to a majority vote of its members.

January 1, 2016, renewing questions previously raised about the long-term sustainability of the CO-OPs and the effects that they will ultimately have on states' health insurance markets.[5] Such questions led to our first review of the CO-OP program. In April 2015, we reported that as of January 2015, CMS disbursed more than two-thirds of the $2.4 billion in CO-OP program loans awarded. We also reported that while the average premiums for CO-OP health plans were generally lower than those for other issuers, most CO-OPs did not meet their initial enrollment projections during the first enrollment period (October 1, 2013, through March 31, 2014).[6]

Given that questions about CO-OP sustainability and their ultimate impact continue, you asked us as the first CO-OP began to cease operations in early 2015 to conduct a follow-up review of the CO-OP program. In this report, we examine the following

1. How does CMS monitor the CO-OPs' performance and sustainability?
2. How did premiums for CO-OP health plans change from 2014 to 2015, and in 2015, how did they compare to premiums for other health plans?
3. How did enrollment in CO-OP health plans change from 2014 to 2015, and in 2015, how did it compare to projections?

To examine how CMS monitors the CO-OPs' performance and sustainability, we reviewed CMS policies and procedures regarding its monitoring activities, as well as documentation from CMS related to the implementation of those activities. In particular, we reviewed

[5]Specifically, the CO-OP that offered health plans in Iowa and Nebraska ceased operations early in 2015. The 10 CO-OPs that offered health plans in Arizona, Colorado, Kentucky, Louisiana, Michigan, Nevada, New York, South Carolina, Tennessee, and Utah, as well as 1 of the 2 CO-OPs that offered health plans in Oregon, ceased operations on or before January 1, 2016. In addition, the CO-OP that offers health plans in Illinois and the CO-OP that offers health plans in Maine and New Hampshire have both frozen enrollment for 2016.

[6]See GAO, *Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014*, GAO-15-304 (Washington, D.C.: April 2015). In addition, the HHS Office of Inspector General (OIG) reported in July 2015 that 2014 enrollment and profitability for the CO-OPs were below projections. See HHS OIG, *Actual Enrollment and Profitability Was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided under the Affordable Care Act*, A-05-14-00055 (Washington, D.C.: July 2015).

documentation regarding eight CO-OPs selected to reflect differences in the total amount of loan awards, the total amount of loan awards disbursed, actual enrollment in early 2015, geographic location, and the type of health insurance exchange (i.e., a federally facilitated or state-based exchange) operated in the state or states where the CO-OP offered health plans.[7] We also interviewed officials from CMS regarding the agency's oversight activities from 2013, prior to the first enrollment period, through the beginning of the open enrollment period in November 2015, including their monitoring of the 12 CO-OPs that ceased operations and other CO-OPs the agency considered at risk. We assessed CMS monitoring activities in the context of internal control standards.[8]

To examine how 2015 premiums for CO-OP health plans differed from 2014 premiums, we analyzed data regarding premiums on the health insurance exchanges of the 23 states where CO-OPs operated in 2015. This data included premium data that we obtained from CMS for the 16 states that either had a federally facilitated exchange or a federally supported state-based exchange where CO-OPs participated during the 2015 open enrollment period (November 15, 2014, through February 15, 2015). We also obtained comparable premium data from the 7 states that had state-based exchanges where CO-OPs participated. For the 20 states where CO-OPs offered health plans on an exchange during both the 2015 open enrollment period and the 2014 open enrollment period (October 1, 2013, through March 31, 2014), we calculated and compared the state-wide average CO-OP premium for silver tier health plans—the most commonly selected of the five levels of benefit coverage, including plans specified by metal level, as well as catastrophic plans—for 30-year-

[7]PPACA required the establishment in all states of health insurance exchanges—marketplaces where eligible individuals can compare and select among private insurance plans. In states electing not to establish and operate an exchange, PPACA required the federal government to establish and operate the exchange. Exchanges established and operated by the federal government are known as federally facilitated exchanges. The exchanges in states that chose to establish and operate their own exchange are known as state-based exchanges. The eight CO-OPs we selected were in Idaho and Montana, Illinois, Iowa and Nebraska, Kentucky, Maine and New Hampshire, Maryland, New Mexico, and Tennessee. We cannot generalize our observations from these eight CO-OPs to all CO-OPs.

[8]See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014); and *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 1, 1999). Internal control is a process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

old individuals in 2014 and 2015.[9] To examine how 2015 premiums for CO-OP health plans compared to the premiums for other health plans in the 23 states where CO-OPs operated in 2015, we calculated and compared the average CO-OP premium with the average premium for other health plans for each rating area (geographical areas established by states and used, in part, by issuers to set premium rates) and for each health plan tier. We did this for eight different categories of policyholder: 30, 40, and 60-year-old individuals and couples, and 30 and 50-year-old couples with two children.[10]

To examine how enrollment in CO-OP health plans changed from 2014 to 2015, we obtained data from the National Association of Insurance Commissioners (NAIC) on quarterly statements dated June 30, 2015, and annual statements dated December 31, 2014, filed by each of the CO-OPs that operated in 2015.[11] We then compared enrollment as of June 30, 2014, to enrollment as of June 30, 2015, for each CO-OP. To examine how CO-OP 2015 enrollments compared to projections, we obtained from CMS estimates of projected enrollment made by each

[9]PPACA required certain categories of benefits at standardized levels of coverage specified by metal level—bronze, silver, gold, and platinum—depending on the portion of health care costs expected to be paid by the health plan. Catastrophic plans, which are available to individuals meeting certain criteria, generally provide coverage for services only after a high deductible is met. In this report, we refer to each level of coverage—catastrophic, bronze, silver, gold, and platinum—as a "tier." We focused our analyses on 2015 premiums because they were the most recently available data at the beginning of our work. We also analyzed 2016 premiums for silver tier health plans in the 13 states where CO-OPs continued to operate as of January 4, 2016. Specifically, for each state we calculated and compared the 2016 state-wide average CO-OP premium for silver tier health plans for 30-year-old individuals to the 2015 state-wide average CO-OP premium. We focused on 30-year-old individuals to facilitate comparison to the results of our April 2015 report, for which we presented the average premiums for 30-year-old individuals in detail and also noted that results for those premiums were consistent with results for premiums involving other categories of policyholders.

[10]PPACA gave states the authority to establish geographic locations by which premiums may vary, known as rating areas.

[11]The NAIC is the standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. As health insurance issuers, CO-OPs are required to submit quarterly and annual filings to the NAIC.

CO-OP.[12] We compared actual 2015 enrollment as of June 30, 2015, to the CO-OPs' estimates of projected enrollment.

To assess the reliability of the data we obtained from CMS on CO-OP program loans, CO-OP and other issuer premiums, and CO-OP enrollment, we performed manual and electronic testing to identify missing data and other anomalies, and interviewed agency officials to confirm our understanding of the data. To assess the reliability of the data we obtained from states on CO-OP and other issuer premiums, we performed manual and electronic testing to identify missing data and other anomalies, and followed up with state officials and incorporated corrections as necessary. To assess the reliability of the CO-OP enrollment data we obtained from NAIC, we compared NAIC data to similar data obtained from CMS for consistency. Based on these procedures, we determined that the data were sufficiently reliable for our purposes.

We conducted this performance audit from June 2015 to March 2016, in accordance with 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 based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CO-OP Program Requirements, Loans, and Funding

PPACA established certain conditions governing participation in the CO-OP program. Specifically, PPACA defines a CO-OP as a health insurance issuer organized under state law as a nonprofit, member corporation of which the activities substantially consist of the issuance of qualified health plans in the individual and small group markets in the state where the CO-OP is licensed to issue such plans. PPACA prohibits organizations that were health insurance issuers on July 16, 2009, or sponsored by a state or local government, from participating in the

[12]Under the loan agreements, CMS requires annual enrollment projections as part of each CO-OP's business plan. CO-OPs may update business plans, including projected enrollment, on a semi-annual basis.

CO-OP program.[13] PPACA also requires that (1) governance of a CO-OP be subject to a majority vote of its members; (2) the governing documents of a CO-OP incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and (3) the operation of a CO-OP have a strong consumer focus, including timeliness, responsiveness, and accountability to its members.[14]

Consistent with PPACA, CMS established two types of CO-OP program loans: start-up loans and solvency loans.

- **Start-up loans** cover approved start-up costs including salaries and wages, fringe benefits, consultant costs, equipment, supplies, staff travel, and certain indirect costs. Disbursements were made according to a schedule established in the loan agreement between CMS and the loan recipient, and were contingent upon the loan recipient's achievement of program milestones. Milestones included obtaining health insurance licensure and submitting timely reporting information in the required format. Each disbursement for a start-up loan must be repaid within 5 years of the disbursement date.

- **Solvency loans** assist CO-OPs in meeting states' solvency and reserve requirements.[15] CO-OPs may request disbursements of solvency loans "as needed" to meet these requirements and obligations under their loan agreement with CMS. Reasons for a CO-OP's need for additional solvency disbursements could include enrollment growth or higher than anticipated claims from members. CO-OP requests are subject to CMS review of necessity and sufficiency. Each disbursement of a solvency loan must be repaid within 15 years of the disbursement date.

PPACA appropriated $6 billion for the CO-OP program; however, a series of subsequent laws reduced the appropriation by about 80 percent and

[13]A sponsor is an organization or individual that is involved in the development, creation, or organization of the CO-OP, or provides 40 percent or more in total funding to a CO-OP. 45 C.F.R. § 156.505. PPACA also prohibits organizations with a related entity that was a health insurance issuer on July 16, 2009, from participating in the CO-OP program.

[14]Federal regulations require the majority of a CO-OP's voting directors to be members—those covered under policies issued by the CO-OP—within a year of issuing health plans. 45 C.F.R. §§ 156.505, 156.515.

[15]PPACA prohibits the use of start-up and solvency loans for carrying on propaganda or otherwise attempting to influence legislation, or for marketing.

limited program participation. Specifically, in 2011, two separate appropriations acts rescinded $2.6 billion of the original CO-OP appropriation.[16] Additionally, in January 2013, the American Taxpayer Relief Act of 2012 rescinded $2.3 billion in unobligated CO-OP program appropriations, and as a result, about $1.1 billion of the original appropriation was available for the costs associated with the $2.4 billion in loans awarded and program administration.[17] The American Taxpayer Relief Act of 2012 transferred any remaining appropriations to a contingency fund for CMS to provide assistance and oversight to CO-OP loan awardees, which meant that no additional CO-OPs could be funded through the CO-OP program.

CO-OP Participation in States' Health Insurance Exchanges

The participation of CO-OPs in states' health insurance exchanges has varied since their establishment:

- For 2014, 22 CO-OPs offered health plans on the health insurance exchanges of 22 states.[18] One CO-OP participated in both the Iowa and the Nebraska exchanges, and two CO-OPs offered health plans on the exchange in Oregon. The CO-OP for Ohio offered plans off the exchange, but did not participate in the state's exchange.
- For 2015, 22 CO-OPs offered health plans on the exchanges of 23 states. While the Ohio CO-OP participated in the exchange for Ohio

[16]The Department of Defense and Full-Year Continuing Appropriations Act, 2011 rescinded $2.2 billion. Pub. L. No. 112-10, § 1857, 125 Stat. 38, 168 (Apr. 15, 2011). The Consolidated Appropriations Act, 2012 rescinded $400 million. Pub. L. No. 112-74, § 524,125 Stat. 786, 1115 (Dec. 23, 2011).

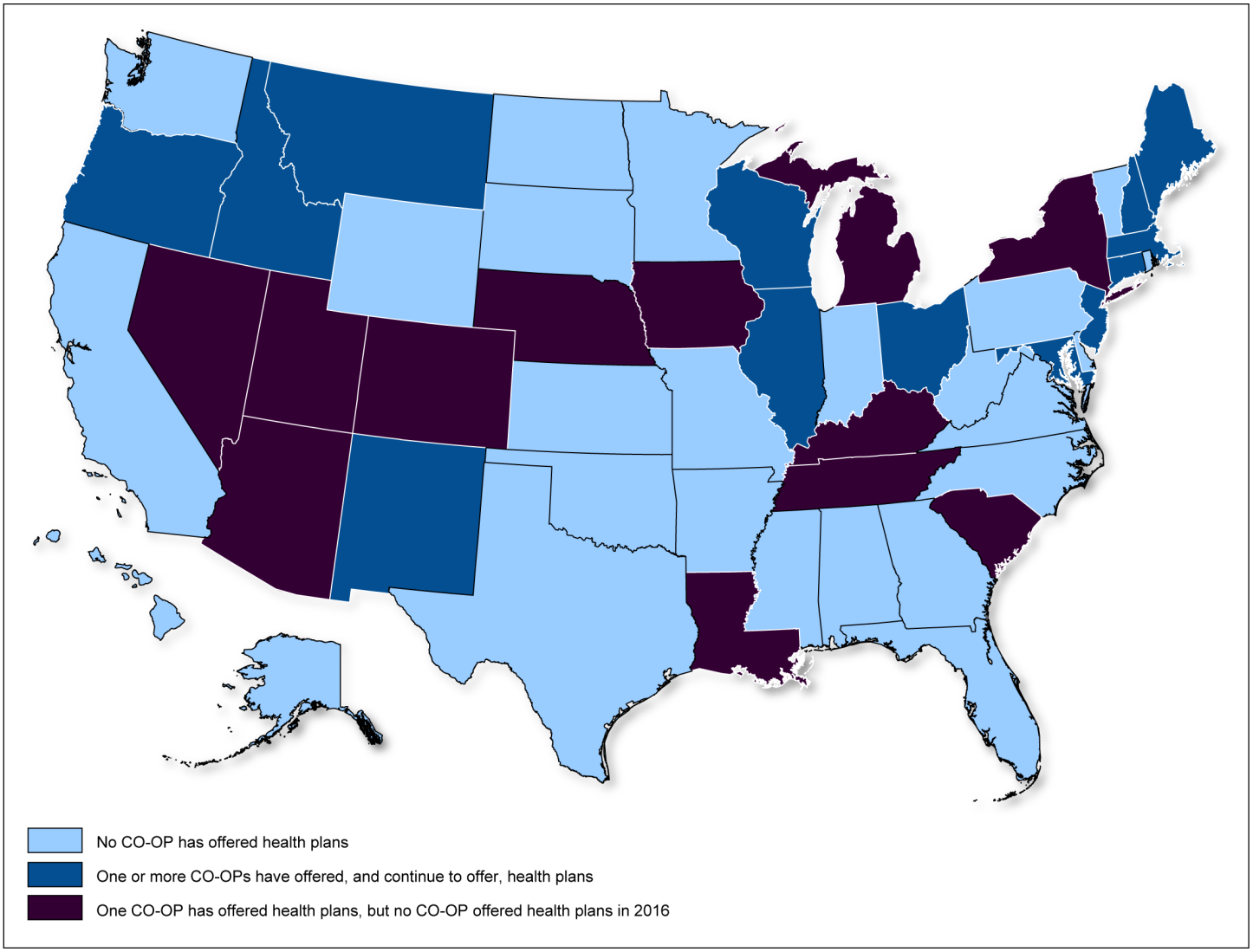
[17]Pub. L. No. 112-240, § 644, 126 Stat. 2313, 2362 (Jan. 2, 2013). The rescinded amount also reflects a $13 million reduction as part of the across-the-board cancellation of budget resources known as sequestration as ordered by the President on March 1, 2013. As a direct loan program, an appropriation is required to cover the estimated long term cost to the government—known as the credit subsidy cost—of the CO-OP program loans. Because this cost is calculated as the net present value of estimated cash flows over the life of each loan, the total amount of the CO-OP program loans awarded are greater than the appropriation amount. The difference between the appropriation and the loan awards is borrowed from the Department of Treasury and repaid with principal and interest payments by the loan recipients.

[18]CO-OP loan recipients are required to offer qualified health plans at the silver and gold metal levels in every individual market exchange that serves the geographic regions where the organization is licensed and intends to provide health care coverage. 42 C.F.R. § 156.515(c)(2).

for the first time, the CO-OP that offered plans on both the Iowa and the Nebraska exchanges withdrew from participation. In addition, the CO-OPs in Maine and Massachusetts both expanded to the New Hampshire exchange and the CO-OP from Montana expanded to the Idaho exchange.

- For 2016, 11 CO-OPs continued to offer health plans on the exchanges of 13 states as of January 4, 2016. The CO-OPs that offered health plans in Arizona, Colorado, Kentucky, Louisiana, Michigan, Nevada, New York, South Carolina, Tennessee, and Utah, and one of the CO-OPs that offered health plans in Oregon, ceased operations on or before January 1, 2016. (See fig. 1.)

Figure 1: States Where Consumer Operated and Oriented Plans (CO-OPs) Offered Health Plans in the Health Insurance Exchanges, 2014 through 2016, as of January 4, 2016



Source: GAO analysis of Centers for Medicare & Medicaid Services, CO-OP, and state data; Map Resources (map). | GAO-16-326

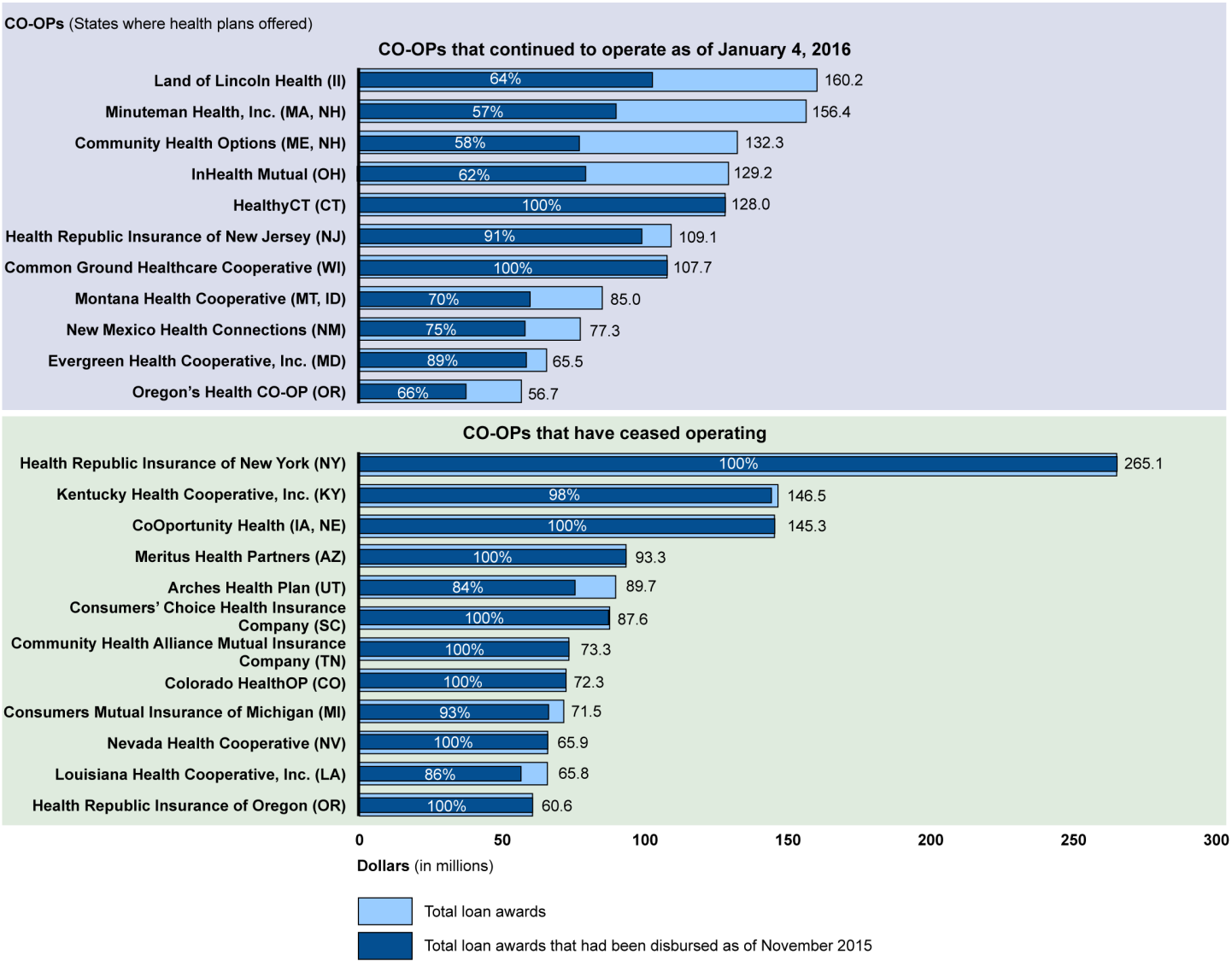
Notes: In 2014 and 2015, two CO-OPs offered health plans in Oregon. One of these CO-OPs ceased operations on January 1, 2016.

Disbursement of CO-OP Loan Awards

CMS awarded the 11 CO-OPs that continued to operate as of January 4, 2016, about $1.2 billion in combined start-up and solvency loans, and awarded about the same amount to the 12 CO-OPs that ceased operations. For the 11 CO-OPs that continued to operate, CMS disbursed, as of November 2015, about $897 million (74 percent) of the

CO-OP program loans awarded. Specifically, it disbursed 100 percent of the loans awarded to 2 CO-OPs, and from 57 percent to 91 percent of the loans awarded to the other 9 CO-OPs. This range primarily reflects differences in the percentage of solvency loan awards disbursed to each CO-OP, as disbursements of the start-up loan awards totaled nearly 100 percent. Disbursements of solvency loan awards to the 9 CO-OPs that received less than 100 percent of their awards ranged from 49 percent to 89 percent. For the 12 CO-OPs that ceased operations, CMS had disbursed 100 percent of the loan awards to 8 CO-OPs, while the percentage disbursed to the other 4 CO-OPs ranged from 84 percent to 98 percent. (See fig. 2.)

Figure 2: Total Consumer Operated and Oriented Plan (CO-OP) Loan Awards and the Percentage Disbursed, November 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Note: Oregon's Health CO-OP and Health Republic Insurance of Oregon both offered health plans in Oregon in 2014 and 2015. On January 1, 2016, the Health Republic Insurance of Oregon ceased operations.

Federal and State Roles Related to the CO-OP Program

CMS and state regulators have different, but complementary, roles for the CO-OP program. As the agency that administers the CO-OP program, CMS is responsible for

- interpreting statutory requirements and issuing regulations regarding CO-OP program eligibility, standards, and loan terms;
- soliciting and approving loan applications of qualified applicants;[19]
- determining loan award amounts and negotiating the related loan agreements;
- establishing and updating CO-OP program policy, procedures, and other guidance;
- approving the disbursement of loan funds to CO-OPs; and
- monitoring CO-OP financial controls and compliance with applicable statutory requirements and related regulations, loan agreements, and CO-OP program policy and guidance.

While CMS has oversight responsibilities for the CO-OP program, state regulators have primary oversight authority of the CO-OPs as health insurance issuers. This authority includes issuing and revoking licenses to offer health plans, monitoring issuers' financial solvency and market conduct, as well as reviewing and approving premium rates and policy and contract forms. CMS requires CO-OPs to report any requirements from and meetings with state regulators regarding their oversight to CMS. In addition, according to a CMS official, the agency has coordinated oversight activities with state regulators when appropriate.

[19]In July 2013, the HHS OIG reported that CMS awarded the initial start-up loans in accordance with federal requirements. See HHS OIG, *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight Is Needed*, A-05-12-00043 (Washington, D.C.: July 2013).

PPACA Provisions on Health Insurance Premiums, Benefits, and Risk Mitigation Programs

PPACA established rules governing how issuers, including CO-OPs, may set premium rates. For example, while issuers may not consider gender or health status in setting premiums, issuers may consider family size, age, and tobacco use.[20] Also, issuers may vary premiums based on areas of residence. States have the authority to use counties, Metropolitan Statistical Areas, zip codes, or any combination of the three in establishing geographic locations across which premiums may vary, known as rating areas.[21] The number of rating areas per state varies, ranging from a low of 1 to a high of 67. Most states have 10 or fewer rating areas.

PPACA also requires that coverage sold include certain categories of benefits at standardized levels of coverage specified by metal level—bronze, silver, gold, and platinum. Each metal level corresponds to an actuarial value—the proportion of allowable charges that a health plan, as opposed to the consumer, is expected to pay on average.[22] Health plans within a metal level have the same actuarial value, while plans from different metal levels have different actuarial values and pay a higher or lower proportion of allowable charges. For example, a gold health plan is more generous overall than a bronze health plan. Actuarial values for health plans under PPACA range from 60 to 90 percent by metal level as follows: bronze (60 percent), silver (70 percent), gold (80 percent), or platinum (90 percent).

[20]PPACA restricts the amount by which issuers can vary premiums based on age and tobacco use. Premiums for adults aged 64 or older may not be more than 3 times the premiums of adults aged 21. The premiums for tobacco users may not be more than 1.5 times the premiums of non-tobacco users. With regard to family size, issuers may only take into account the premium rates of three covered children under the age of 21 when determining the premium for a family with four or more children.

[21]A Metropolitan Statistical Area consists of one or more counties that contain at least one core urban area with a population of 50,000 or more, as well as adjacent counties that have a high degree of social and economic integration with the urban core, as measured by commuting ties.

[22]Actuarial value measures the relative generosity of benefits covered by a health insurance plan. Under PPACA, a health insurance plan's actuarial value indicates the average share of allowable medical spending that is paid by the plan, as opposed to being paid out of pocket by the consumer. Actuarial values are calculated on an average basis for a standard population and do not predict the actual out-of-pocket costs for any individual. Amounts paid in premiums are not considered part of a health plan's actuarial value.

Issuers may also offer "catastrophic" health plans to individuals under 30 and individuals exempt from the individual mandate.[23] Catastrophic plans have actuarial values that are less than what is required to meet any of the other metal levels. Although these plans are required to cover three primary care visits and preventive services at no cost, they generally do not cover costs for other health care services until a high deductible is met.

Some PPACA provisions, such as those that prohibit issuers from considering gender and health status in setting premiums and from denying coverage based on health status, reduced issuers' ability to mitigate the risk of high-cost enrollees. To limit the increased risk that issuers could face, PPACA also established three risk mitigation programs: a permanent "risk adjustment" program and two temporary programs, "reinsurance" and "risk corridors".[24] Each of these programs uses a different mechanism intended to both improve the functioning of the health insurance markets and stabilize the premiums that issuers charge for health coverage. For example, the risk adjustment program transfers funds from issuers with lower risk enrollees to those with higher risk enrollees, and the risk corridor program transfers funds from issuers with high profits to those with high losses.[25]

[23]PPACA mandates that individuals, subject to certain exceptions, obtain health insurance coverage beginning in 2014 or pay a financial penalty—the "individual mandate." Exemptions from paying the financial penalty are granted to people based on income or other factors that prevent them from getting coverage.

[24]See Pub. L. No. 111-148, §§ 1341, 1342, 1343, and 10104(r), 124 Stat. 208, 211, 212 and 906 (codified at 42 U.S.C. §§ 18061-18063).

[25]For information on CMS's implementation of the risk mitigation programs see GAO, *Patient Protection and Affordable Care Act: Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk*, GAO-15-447 (Washington, D.C.: April 30, 2015).

CMS Expanded and Refined CO-OP Monitoring Activities as the Program Matured

Since it began awarding CO-OP loans, CMS's oversight has evolved from monitoring the establishment of the CO-OPs to monitoring their performance and sustainability. CMS also refined its monitoring activities by formalizing a framework for responding to issues at specific CO-OPs, and it continues to adjust its monitoring as some CO-OPs have ceased operations.

Initial CMS Monitoring Focused on CO-OPs' Progress as Start-up Issuers

CMS's initial activities to monitor the CO-OPs, starting when it began awarding CO-OP loans in early 2012, tracked their progress in becoming health insurance issuers (for example, establishing provider networks, arranging appropriate office space, and filling key management positions) and their compliance with program requirements (for example, establishing governance subject to a majority vote of its members and incorporating ethics and conflict-of-interest standards). During this initial period, CMS established two core monitoring activities to be conducted by a CMS account manager—a primary point of contact at CMS who is responsible for the day-to-day monitoring of individual CO-OPs. These two core activities were

- **Routine teleconferences with CO-OPs**. The account manager participated in routine teleconferences with key stakeholders from each CO-OP. Key CO-OP stakeholders could have, for example, included the chief executive officer, chief financial officer, chief operating officer, or the chief information officer. CMS policy initially required that these meetings take place on at least a bi-weekly basis. According to CMS officials, the frequency of these meetings varied across CO-OPs depending on the progress demonstrated by the CO-OP. Items discussed during these meetings could have, for example, included the CO-OP's implementation of its business plan or progress in achieving the milestones of its disbursement schedule, as well as any challenges, issues, concerns, and questions the CO-OP had. CMS account managers maintained documentation of these teleconferences electronically.

- **Standard reporting.** CMS required each CO-OP to submit standard reports that provide financial and other performance related information. (See table 1.) CMS account managers tracked the timely submission and completeness of each report. Reports submitted by the CO-OP were maintained electronically for CMS officials to review, as needed.

Table 1: Standard Reports that Consumer Operated and Oriented Plans (CO-OPs) Were to Submit to CMS as of April 2013

Standard report	Frequency	Description
Project plan	Monthly	Demonstrates the CO-OP's approach to implementing its strategy for competing in the health insurance exchange(s) as well as meeting CO-OP program requirements.
Evidence of milestone completion	Quarterly	Documents the CO-OP's achievement of milestones that supported a particular loan disbursement.
Financial reports	Quarterly	Provides information on the CO-OP's financial position and results of operations, including cash flows.
Progress reports	Semi-annually	Provides the status of the CO-OP's progress in meeting its project plans and completing milestones.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) policies. | GAO-16-326

Note: CMS subsequently modified its standard reporting requirement to include enrollment data and more frequent reporting of certain financial data.

In addition, CMS hired an independent auditor to review each CO-OP's compliance with its loan agreement; key federal and state requirements, such as those related to governance of the CO-OP, the use of loan funding, types of investments; and the documentation that supported financial reporting. CMS officials stated that these reviews were completed in 2013 and 2014.

According to officials, CMS used the information obtained from these initial monitoring activities to assess loan recipients' progress in establishing start-up health insurance issuers and compliance with CO-OP program requirements. From the time loans were granted through November 2014, if there was a problem that presented a significant risk to a recipient's viability or a pattern of noncompliance with program requirements, CMS required an improvement plan. CMS policy states that an improvement plan could include (1) a corrective action plan to resolve noncompliance with program requirements or the terms and conditions of a loan agreement; (2) an enhanced oversight plan requiring stronger and more frequent CMS review of operations and financial status; (3) technical assistance to help improve performance, meet program requirements, or fulfill terms and conditions of the loan agreement; or (4) withholding of loan disbursements until milestones were achieved. According to CMS officials, the agency required improvement plans for five different CO-OPs during this time period. Officials stated that these plans generally focused on issues with meeting start-up milestones, including the CO-OP's capability to obtain licensure or comply with program requirements when establishing contractual relationships with providers or vendors for necessary services, such as information technology.

CMS Expanded and Refined CO-OP Monitoring Activities as the Program Matured

As CO-OPs began enrolling members, CMS supplemented its initial monitoring activities with additional tools to evaluate CO-OP performance and sustainability. CMS also formalized a framework for responding to financial or operational issues identified at specific CO-OPs and enhanced its reporting requirements to support the newly developed tools. CMS officials told us that they expect to monitor CO-OPs that have ceased operations to the extent possible.

CMS developed two tools that analyze enrollment and financial data, and other information collected from the CO-OPs:

Direct analysis. CMS officials developed a tool to analyze various aspects of performance, including enrollment, net income, premium revenues, claims and administrative expenses, and financial information related to risk mitigation programs and reserves. According to CMS officials, they conduct this analysis on a quarterly basis and compare the information with CO-OP projections and—when possible—to industry benchmarks. According to CMS officials, if direct analysis indicates that an individual CO-OP deviates appreciably from projections or otherwise signals a potential difficulty, then CMS officials perform additional review and analyses. CMS officials also noted that the direct analysis may, at times, be focused on particular areas of concerns. For example, during 2015, CMS looked closely at the CO-OPs' expectations related to risk mitigation programs: CMS officials monitored the extent to which each CO-OP's financial projections relied on estimated payments from risk mitigation programs. CMS officials told us that because of these analyses, they were able to identify CO-OPs that would likely face increased financial difficulties when the agency announced on October 1, 2015, that issuers eligible for payments through the risk corridor program would likely receive only a portion—12.6 percent—of the total amounts they claimed.[26] CMS officials told us that they worked with these CO-OPs to address concerns associated with these payments.

Risk assessment. CMS also developed a tool to assess risk based on data collected through its established monitoring activities. CMS officials

[26]In its announcement of 2014 risk corridor proration rates, CMS noted that issuers with high profits were expected to pay $362 million in risk corridor charges, and those with high losses had submitted claims for $2.87 billion in risk corridor payments, resulting in an anticipated 12.6 percent proration rate for the claims paid to those issuers with losses.

told us that they use this tool on a quarterly basis to assess risk across seven factors:

1. *Long-term sustainability.* CMS assesses risk based on whether a CO-OP expects to break even financially by 2017 and, if so, the extent to which a CO-OP expects to repay start-up loans while maintaining required reserve levels. CMS officials told us that although some viable CO-OPs might not expect to break even by 2017, they selected this date, in part, to provide a common basis for developing a risk score, because the first repayments of CO-OP loans are due in 2017.
2. *Working capital.* CMS assesses risk based on whether a CO-OP expects to generate net revenues from premiums, risk mitigation programs, or other funding sufficient to cover operating expenses over the next 12 months and, if not, the extent to which the CO-OP plans to rely on the disbursement of any remaining solvency loan funds.
3. *Profitability*. CMS assesses risk based on whether the CO-OP's performance is consistent with the projections in its business plan. This risk category does not measure current profitability.
4. *Compliance with state requirements.* CMS assesses risk based on whether a state department of insurance determined that a CO-OP was non-compliant with state requirements and, if so, the extent to which remedial action has been implemented. CMS also considers whether the CO-OP has had a history of non-compliance and the severity of any regulatory action taken by a department of insurance.
5. *Compliance with CO-OP program requirements.* CMS assesses risk based on whether the agency has determined that a CO-OP was non-compliant with CO-OP program loan terms and provisions and, if so, the extent to which the CO-OP has been responsive to CMS officials' requests. CMS also considers whether the CO-OP experienced any legal compliance issues that would affect participation in the program.
6. *CO-OP management.* CMS assesses risk based on whether the agency identified conflicts of interest with CO-OP management and performance concerns including high turnover, fraud, or a lack of appropriate internal controls.
7. *CO-OP infrastructure issues.* CMS assesses risk based on whether the agency identified concerns involving the CO-OP's key operating systems—including claims, enrollment and billing, customer service, and utilization management.

For quantitative factors included in the risk assessment, CMS officials told us they compare individual CO-OP data to benchmarks and assign a risk level (high, medium-high, medium, and low) based on the extent of deviation from the benchmarks. For qualitative factors, CMS officials told us they assign CO-OPs a risk level based on responses to a standard set of questions completed by account managers.

To help ensure the most current data are available to be used in the direct analysis and risk assessment tools, CMS enhanced certain reporting requirements associated with the core monitoring activities it previously established. While the agency continues to require routine teleconferences with CO-OPs and standard reporting, CMS enhanced its initial reporting requirements to include submission of enrollment and selected financial data on a monthly basis rather than on a quarterly basis. CMS also now requires CO-OPs to provide certain financial projections quarterly rather than annually.

To respond to issues identified at individual CO-OPs using the direct analysis and risk assessment tools, as well as its other monitoring activities, in November 2014, CMS formally established a framework, known as an escalation plan, for evaluating and responding to concerns. The identification of an issue at a CO-OP is the first of four steps described in the written guidance for establishing and implementing the escalation plan. (See fig. 3.)

Figure 3: Steps in the Centers for Medicare & Medicaid Services' Escalation Plan for Issues Identified at Consumer Operated and Oriented Plans (CO-OPs)

Source: GAO analysis of Centers for Medicare & Medicaid Services policy. | GAO-16-326

Issue identification. CMS initiates the escalation plan when the agency identifies an issue of potential concern at a CO-OP. Identification may be based on information obtained through a variety of sources, including internal channels (e.g., the core monitoring activities, direct analysis, and risk assessments described above) and external channels (e.g., communication with state regulators).

Issue assessment. A CMS account manager conducts a preliminary assessment of the severity, urgency, and nature of the identified issue. Using a standard set of questions, the account manager assesses the issue in light of five sets of considerations: (1) whether the issue was self-

reported by the CO-OP and the frequency with which the CO-OP experienced the same or other issues,[27] (2) the potential impact on the CO-OP's state licensure and exchange participation, (3) the potential impact on the CO-OP's approved business plan, (4) the potential impact on the CO-OP's compliance with program requirements, and (5) the potential impact on the CO-OP's members and markets where it participates. Answers to questions about these considerations result in a score that indicates whether the issue's severity and urgency is of minor, moderate, elevated, or greatest concern. The account manager then refers the preliminary assessment for review and approval by other CMS officials, including a team that has responsibility for evaluating CO-OP program integrity.

Enforcement action. CMS determines an enforcement action based on the final assessment of the issue as of minor, moderate, elevated, or greatest concern. Enforcement actions generally require a corresponding response from the CO-OP to resolve the issue. If the CO-OP's response to an enforcement action does not result in an acceptable resolution to an issue, the agency may elevate the assessment to a higher level and require additional responses from the CO-OP.

- *Minor.* CMS communicates with CO-OP officials to resolve the issue and prevent a recurrence. Examples of issues that might be assessed as minor—if no other issues were identified—would be challenges in submitting a required report or a divergence of less than 20 percent between the CO-OP's actual enrollment and its most recently projected enrollment.

- *Moderate.* CMS sends a formal written notice of the issue, known as a warning letter, to CO-OPs that have an issue assessed as a moderate concern. In response, CO-OP officials are required to submit evidence of the development and implementation of a plan to resolve the issue. As of November 9, 2015, CMS had issued warning letters to 11 CO-OPs, of which 7 continue to operate. According to CMS officials, issues for which CMS issued warning letters included the execution of a contract that is core to the CO-OP's business activity (e.g., a contract for a top executive) without the requisite prior CMS approval, and the submission of incomplete data for one of the risk mitigation

[27]All else being equal, CMS considers an unprompted self-reported issue to be a lower risk than an issue brought to CMS's attention by state regulators or other means.

programs.

- *Elevated.* CMS sends CO-OPs a formal written notice that a corrective action plan is required, an enhanced oversight plan will be implemented, or both. According to CMS officials, they generally require the CO-OP to develop a corrective action plan when they determine that the CO-OP can take action to address the issue and that the action and its effect can be documented; the corrective action plan is subject to CMS approval and monitoring. CMS officials implement an enhanced oversight plan when the issue is urgent or has the potential to become more severe. In response to an enhanced oversight plan, a CO-OP may be required to submit additional reports or may be subjected to additional audits. As of November 9, 2015, CMS had required corrective action plans or implemented enhanced oversight plans (or both) for 15 CO-OPs, of which 8 continue to operate in 2016.[28] Issues for which these were required include CO-OPs failing to comply with state laws and experiencing high enrollment and significant losses. CMS noted that some of the corrective action plans and enhanced oversight plans were the result of unresolved issues that required stronger enforcement actions.

- *Greatest.* CMS sends CO-OPs a formal written notice, and if a correction action plan and/or enhanced oversight plan cannot resolve the issue, CMS may consider terminating the CO-OP from the program or taking other enforcement measures, such as withholding loan disbursements. As of November 9, 2015, CMS officials had identified an issue of greatest concern at two CO-OPs.[29] For one CO-OP, it required a corrective action plan, and for the other CO-OP, it issued a termination letter. CMS officials noted that these two CO-OPs had issues involving serious and pervasive management problems or financial losses substantial enough to question the

[28]Among the 15 CO-OPs for which CMS required a corrective action plan and/or implemented an enhanced oversight plan, the agency also issued 8 CO-OPs warning letters for issues assessed as moderate concern.

[29]For the two CO-OPs that had issues CMS assessed as greatest concern, CMS issued warning letters for issues the agency assessed as moderate concern to one CO-OP and required corrective action plans for issues the agency assessed as elevated concern for the other CO-OP.

CO-OP's sustainability. Both CO-OPs ceased operations on, or before, January 1, 2016.[30]

Resolution. CMS monitors the CO-OP's progress for resolving an identified issue through status calls, additional reporting requirements, or other actions as appropriate. For some issues determined to be of elevated or greatest concern, CMS may conduct an on-site visit. If CMS determines that an issue has been resolved, CMS returns to a more routine level of monitoring, mindful of the history that the CO-OP had with the issue. If the problem is not resolved, or if the process of investigating an issue reveals other issues, CMS can re-assess the issue and take further actions, and it has done so with several CO-OPs. As already noted, CMS may ultimately determine that a satisfactory resolution is not likely and therefore pursue the option to terminate its loan agreement with the CO-OP. As of November 1, 2015, CMS had issued one termination letter following use of the escalation plan.[31]

[30]Of the 11 CO-OPs that provided coverage during 2015, but no longer operate, 9 had issues assessed as moderate, elevated, or greatest concern under the escalation plan. The CO-OP that offered health plans in Iowa and Nebraska ceased operations shortly after CMS implemented its escalation plan and as a result was not subject to it.

[31]According to CMS officials, 9 of 12 CO-OPs that ceased operations have received a termination letter as of late January 2016. The other 3 CO-OPs will receive a termination letter at a later date.

Escalation Plan Case Study: Louisiana Health Cooperative, Inc.

CMS officials learned in December 2014, through routine communication with the CO-OP and the Louisiana Department of Insurance (LDI), that LDI was preparing to notify the CO-OP that it had been found in a condition that would render continuance of its business hazardous to policyholders, creditors, or others. CMS had previously noted certain risks with the CO-OP's finances. CMS assessed the issue as an elevated concern and issued a letter in January 2015 requiring the CO-OP to provide information and a corrective action plan. The CO-OP responded in February 2015, citing problems with its third-party administrator—an entity with which the CO-OP had contracted to process claims—and describing its corrective action plan. CMS determined that the plan was not sufficient and issued a letter in March 2015 requesting revisions. The CO-OP submitted a revised corrective action plan, which CMS officials also found insufficient. Meanwhile, in response to LDI, the CO-OP submitted updated enrollment and financial data, which led CMS to question whether enrollment was sufficient for financial stability. CMS issued another letter in April 2015, asking for information and a corrective action plan to address these issues and stating that CMS would conduct a site visit. During that visit, CMS officials observed a number of serious and pervasive deficiencies. In response, CMS reassessed the issue as one of greatest concern and issued a letter in June 2015, summarizing its findings and stating that a complete and quick resolution was necessary to avoid termination of the loan agreement; the letter included specific milestones and dates. The CO-OP's board met in July and decided to cease operations by the end of 2015. According to CMS officials, the agency continues to monitor and oversee the CO-OP as the CO-OP and LDI work to cease operations with as few negative consequences as possible.

Source: GAO analysis of Centers for Medicare & Medicaid Services and state information. | GAO-16-326

In addition to developing the tools to evaluate performance and sustainability and the escalation plan, CMS formed a committee that, according to CMS officials, is to look at the CO-OP program as a whole—beyond individual issues or CO-OPs. The committee is to identify and address risks to, and concerns about, the program and make recommendations to address any risks or concerns identified. CMS officials told us that the committee consists of officials from across the agency with actuarial, health insurance, financial, legal, and health insurance exchange experience and expertise.

CMS is also using an independent auditor to conduct another review of CO-OPs, focusing on compliance and financial management. A preliminary audit phase was conducted to determine whether each CO-OP had established and documented controls and processes for five key areas, in accordance with the NAIC Market Conduct Examination Standards: (1) claims, (2) policyholder service, (3) complaint handling, (4)

provider credentialing, and (5) marketing and sales.[32] Based on the results of the preliminary phase, the auditor is to perform one of two types of reviews—a general review or a focused review—at each CO-OP; a more focused review is to be performed at CO-OPs that did not appear to have initially met the NAIC Market Conduct Examination Standards. CMS officials told us that the preliminary phase was completed in June 2015, and that the second phase is on-going and is expected to be completed by the middle of 2016 for the 11 CO-OPs that continued to operate as of January 4, 2016.

CMS officials told us that prior to the start of the 2016 open enrollment period, they assessed the CO-OPs with particular attention to their sustainability through 2016. According to CMS officials, they worked with CO-OPs and states' departments of insurance to address concerns relating to CO-OP sustainability. The goal of these efforts was to provide some assurance that CO-OPs with serious financial or operational difficulties (or both) took timely and effective action to address those difficulties or made plans to cease operations before the 2016 open enrollment period, which began on November 1, 2015. In addition, CMS officials told us that, to the extent possible, they plan to monitor CO-OPs that have ceased operations. When a CO-OP closes, the state's department of insurance takes the lead responsibility in winding down operations. CMS officials told us that their goal is to work with the CO-OPs and their states' departments of insurance to bring operations to an end in a way that minimizes negative effects on members, as well as to recover program loan funding to the extent possible.[33]

[32]In general, market conduct refers to the ways insurance companies distribute their products. Market conduct examinations are one form of oversight used by states' departments of insurance to help ensure insurance companies operate in ways that are legal and fair to consumers and customers have access to beneficial and compliant insurance products.

[33]According to CMS officials, it is too early to conclude whether, and to what extent, CO-OP program loan funding will be recovered. In general, member claims have first priority for payment followed by other liabilities and creditors, including CMS. State departments of insurance generally have responsibility for managing the liquidation process.

CO-OPs' 2015 Premiums Were Generally Lower than Their 2014 Premiums and Other Issuers' 2015 Premiums

Most CO-OPs' Premiums for 2015 Were Lower than Their 2014 Premiums

Our analysis showed that in most of the 20 states where CO-OPs offered health plans on the exchange during both the 2014 and 2015 open enrollment periods, the state-wide average monthly premium for a 30-year-old individual to purchase a CO-OP silver health plan was lower for 2015 than for the previous year. Specifically, there were 14 states where the state-wide average monthly premium for silver plans offered by CO-OPs decreased, with decreases ranging from $1.47 per month in Kentucky to $180.44 per month in Arizona. In 9 of these states, the decrease in the state-wide average premium was more than $30 per month. Of the 6 states where the state-wide average premium for silver plans offered by CO-OPs increased, the increases did not exceed $20 per month. As table 2 shows, the pattern of changes in average premiums for CO-OPs that continued to operate as of January 4, 2016, is similar to the pattern of change for CO-OPs that have ceased operations. Of the 11 states where CO-OPs no longer operate, 5 had decreases in the CO-OP's average monthly premium of more than $30, while the other 6 had increases or decreases less than $30. In the 10 states where CO-OPs continued to operate as of January 4, 2016, 4 had decreases in the CO-OP's average monthly premium of more than $30, while the other 6 had increases or decreases of less than $30.[34]

[34]The 11 states with CO-OPs that no longer operate and the 10 states with CO-OPs that continued to operate as of January 4, 2016, both included Oregon. Oregon initially had two CO-OPs, but one ceased operations on January 1, 2016.

Table 2: State-wide Average Premiums for 30-Year-Old Individuals for Silver Tier Health Plans for Consumer Operated and Oriented Plans (CO-OPs), 2014 and 2015

	Average CO-OP monthly premium		
State	**2014**	**2015**	**Increase (decrease)**
States where CO-OPs continued to operate (as of January 4, 2016)			
Connecticut	$346.07	$312.64	$(33.43)
Illinois	312.10	231.69	(80.41)
Maine	300.59	308.87	8.28
Maryland	251.06	217.97	(33.09)
Massachusetts	263.39	244.87	(18.52)
Montana	239.16	221.73	(17.43)
New Jersey	359.70	288.78	(70.92)
New Mexico	227.85	218.92	(8.93)
Oregon[a]	243.78	240.32	(3.46)
Wisconsin	281.36	300.69	19.33
States where a CO-OP has ceased to operate			
Arizona	$426.50	$246.06	($180.44)
Colorado	315.64	237.07	(78.57)
Kentucky	228.07	226.60	(1.47)
Louisiana	307.69	322.23	14.54
Michigan	367.76	320.62	(47.14)
Nevada	299.91	262.47	(37.44)
New York	313.68	325.43	11.75
Oregon[a]	243.78	240.32	(3.46)
South Carolina	263.91	266.52	2.61
Tennessee	272.67	213.55	(59.12)
Utah	235.53	238.53	3.00

Source: GAO analysis of Centers for Medicare & Medicaid Services and state data. | GAO-16-326

Note: This table includes states where CO-OPs offered health plans on the exchange in both 2014 and 2015. Ohio is not included because the CO-OP did not offer plans on the exchange in 2014.

[a]In 2014 and 2015, two CO-OPs offered health plans in Oregon. One of these CO-OPs ceased operations on January 1, 2016. Amounts for Oregon in this table represent the average premiums of these two CO-OPs.

For 2016, the state-wide average premiums for silver health plans increased from 2015 in 8 of 10 states where CO-OPs continue to operate. (See appendixes II through XIV for more details on the range of premiums in 2014, 2015, and 2016 for silver health plans in the states where CO-OPs continued operate as of January 4, 2016.)

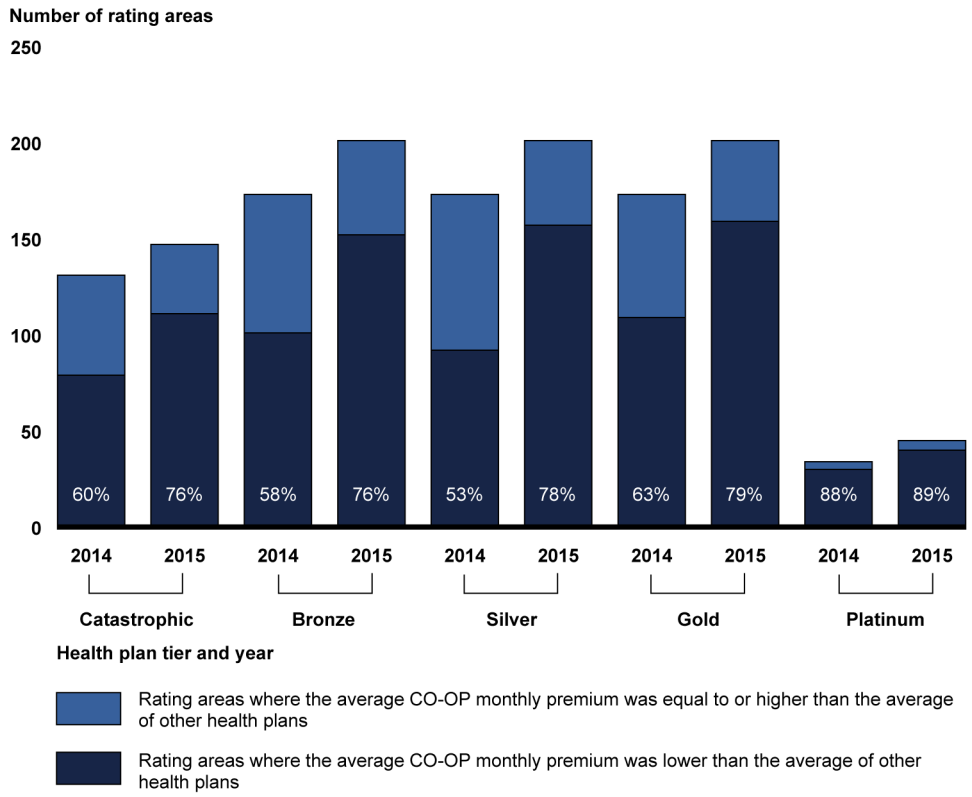
Average CO-OP Premiums in 2015 Were Generally Lower than those for Other Issuers

In the 23 states where CO-OPs offered health plans on the states' health insurance exchanges in 2015, our analysis showed that the average monthly premiums for CO-OP health plans in all tiers were lower than the average monthly premiums for other health plans for 30-year-old individuals in most rating areas.[35] CO-OPs offered bronze, silver, and gold tier health plans in 94 percent of the rating areas where they offered plans; they offered catastrophic and platinum tier health plans in fewer rating areas.[36] For all five tiers, the average premiums for CO-OP health plans were lower than the average premiums for other health plans in more than 75 percent of ratings areas where both a CO-OP and at least one other issuer offered health plans. (See fig. 4.)

[35]The relationship between the average premiums for CO-OPs and other health plans for 30-year-old individuals was similar to the relationship for the other categories of policyholders we analyzed: 40 and 60-year-old individuals; 30, 40, and 60-year-old couples; and 30 and 50-year-old couples with two children

[36]In total, there were 214 rating areas in the 23 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2015 open enrollment period. CO-OPs offered catastrophic health plans in 69 percent of rating areas and platinum health plans in 27 percent.

Figure 4: Rating Areas Where the Average Monthly Premium for Consumer Operated and Oriented Plans (CO-OPs) Was Lower than the Average of Other Health Plans, for 30-Year-Old Individuals, 2014 and 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services and state data. | GAO-16-326

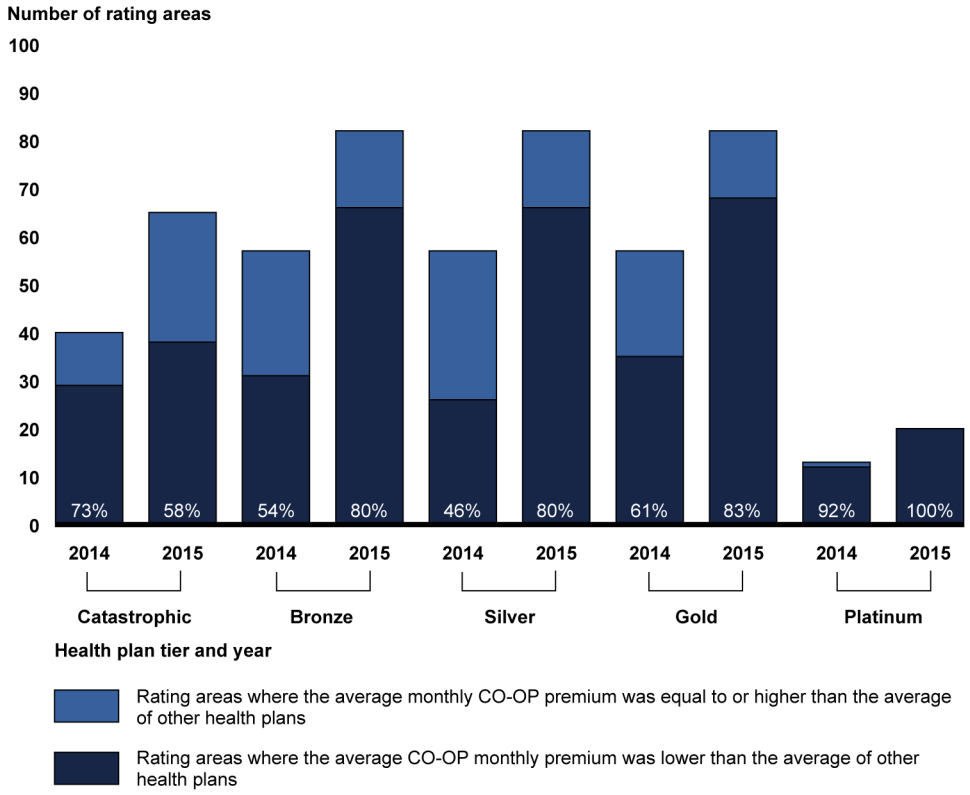
Notes: In total, there were 202 rating areas in the 22 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2014 open enrollment period. In total, there were 214 rating areas in the 23 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2015 open enrollment period.

Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Counts reflect rating areas where both a CO-OP and at least one other issuer offered health plans.

As shown in figure 4, the average monthly premiums for CO-OP health plans in all tiers were lower than for other issuers in a higher percentage of rating areas in 2015 than in 2014. Moreover, the number of ratings areas where a CO-OP and at least one other issuer offered health plans, and the number of rating areas where the average monthly CO-OP premium was lower than the average monthly premium from other issuers both increased from 2014 to 2015. As shown in figure 5, we found this same pattern of premiums when we restricted our analysis to the states where CO-OPs continued to operate as of January 4, 2016.

Figure 5: Rating Areas Where the Average Monthly Premium for Consumer Operated and Oriented Plans (CO-OPs) Operating in 2016 Was Lower than the Average of Other Health Plans, for 30-Year-Old Individuals, 2014 and 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services and state data. | GAO-16-326

Notes: In total, there were 69 rating areas in the 10 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2014 open enrollment period. In total, there were 94 rating areas in the 13 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2015 open enrollment period. Issuers did not always offer health plans in each tier.

Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Counts reflect rating areas where both a CO-OP and at least one other issuer offered health plans.

Although average CO-OP premiums for 30-year-old individuals were lower than those of other insurers in most rating areas, the percentage of rating areas where we found this difference varied substantially across states for silver health plans.

- In 10 states, the average monthly premium for CO-OP silver plans was lower than for other silver plans in 100 percent of the states' rating areas. Of these 10 states, CO-OPs continued to operate in 7 as

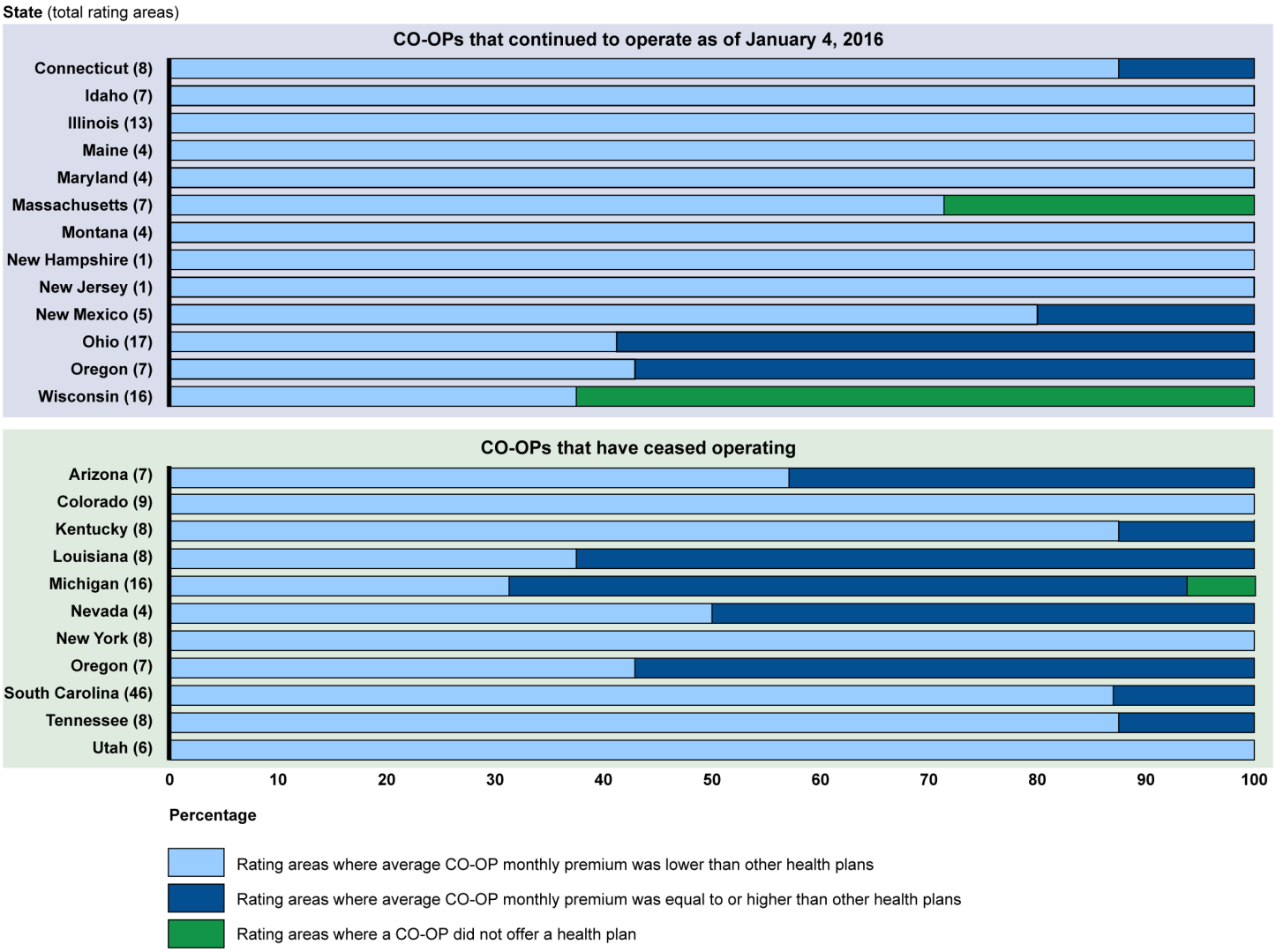
of January 4, 2016.

- In two states where the CO-OPs did not offer silver plans in each rating area, but continued to operate, the average premiums for CO-OPs were lower than for other issuers in all of the rating areas where the CO-OPs offered silver health plans.

- For five states, the average premium for CO-OP silver health plans was equal to or higher than for other silver plans in 50 percent of the rating areas or more.

The percentage of rating areas where the average premium for CO-OP silver plans was equal to or higher than for other silver plans tended to be higher in the 11 states where CO-OPs no longer operate than in those where CO-OPs continued to operate as of January 4, 2016. (See fig. 6 and appendixes II through XIV for more details on how the CO-OPs were priced in relation to other health plans in each of the states where CO-OPs continued to operate as of January 4, 2016.)

Figure 6: Percentage of Rating Areas Where the Average 2015 Monthly Premium for Consumer Operated and Oriented Plan (CO-OP) Silver Health Plans Was Lower than the Average for Other Silver Health Plans, for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services and state data. | GAO-16-326

Notes: In 2015, two CO-OPs offered health plans in Oregon. One of these CO-OPs ceased operations on January 1, 2016. The percentages for Oregon represent the average premiums of both CO-OPs.

CO-OP Enrollment Doubled from 2014 to 2015, but Less than Half Was in CO-OPs Continuing in 2016, and Enrollment for Most CO-OPs Differed from Projections

The 22 CO-OPs that participated in the 2015 open enrollment period together reported, as of June 30, 2015, enrollment of over 1 million—more than double the total enrollment reported at the same time the previous year. Specifically, the 22 CO-OPs gained 610,420 net new members, with all but one CO-OP experiencing an increase in enrollment.[37] The 11 CO-OPs that continued to operate as of January 4, 2016, reported about 391,855 in enrollment in 2015—representing about 38 percent of the combined CO-OP enrollment. Increases in enrollment for these 11 CO-OPs ranged from 11,139 to 56,889. The 3 CO-OPs that reported the largest enrollment as of June 30, 2015, are among those CO-OPs that no longer operate. (See table 3.)

Table 3: Enrollment in Consumer Operated and Oriented Plan (CO-OP) Health Plans, 2014 and 2015

	Enrollment as of June 30		
CO-OP (State(s) where health plans offered)	**2014**	**2015**	**Increase (decrease)**
CO-OPs that continued to operate (as of January 4, 2016)			
Community Health Options (Maine and New Hampshire)	38,226	70,454	32,228
Health Republic Insurance of New Jersey (New Jersey)	3,111	60,000[a]	56,889
Land of Lincoln Health (Illinois)	3,221	49,126	45,905
Montana Health Cooperative (Montana and Idaho)	12,052	42,302	30,250
Common Ground Healthcare Cooperative (Wisconsin)	25,421	36,560	11,139
New Mexico Health Connections (New Mexico)	9,412	32,812	23,400
HealthyCT (Connecticut)	2,558	31,212	28,654
InHealth Mutual (Ohio)	3,816	21,933	18,117
Evergreen Health Cooperative, Inc. (Maryland)	1,589	19,339	17,750
Minutemen Health, Inc. (Massachusetts and New Hampshire)	1,907	14,814	12,907
Oregon's Health CO-OP (Oregon)	1,055	13,303	12,248
Total	**102,368**	**391,855**	**289,487**
CO-OPs that have ceased to operate			
Health Republic Insurance of New York (New York)	126,738	209,136	82,398

[37]Enrollment in the CO-OP in Kentucky decreased from 56,680 to 51,665—a decline of 5,015 members.

CO-OP (State(s) where health plans offered)	Enrollment as of June 30 2014	2015	Increase (decrease)
Colorado HealthOP (Colorado)	13,466	80,282	66,816
Consumers' Choice Health Insurance Company (South Carolina)	50,155	71,594	21,439
Meritus Health Partners (Arizona)	3,601	56,019	52,418
Kentucky Health Care Cooperative, Inc. (Kentucky)	55,852	51,665	(4,187)
Arches Health Plan (Utah)	19,357	49,198	29,841
Community Health Alliance Mutual Insurance Company (Tennessee)	1,657	31,109	29,452
Consumers Mutual Insurance of Michigan (Michigan)	1,519	26,813	25,294
Nevada Health Cooperative (Nevada)	15,368	20,578	5,210
Louisiana Health Cooperative, Inc. (Louisiana)	13,022	17,176	4,154
Health Republic Insurance of Oregon (Oregon)	5,230	13,328	8,098
Total	**305,965**	**626,898**	**320,933**
Total overall enrollment	**408,333**	**1,018,753**	**610,420**

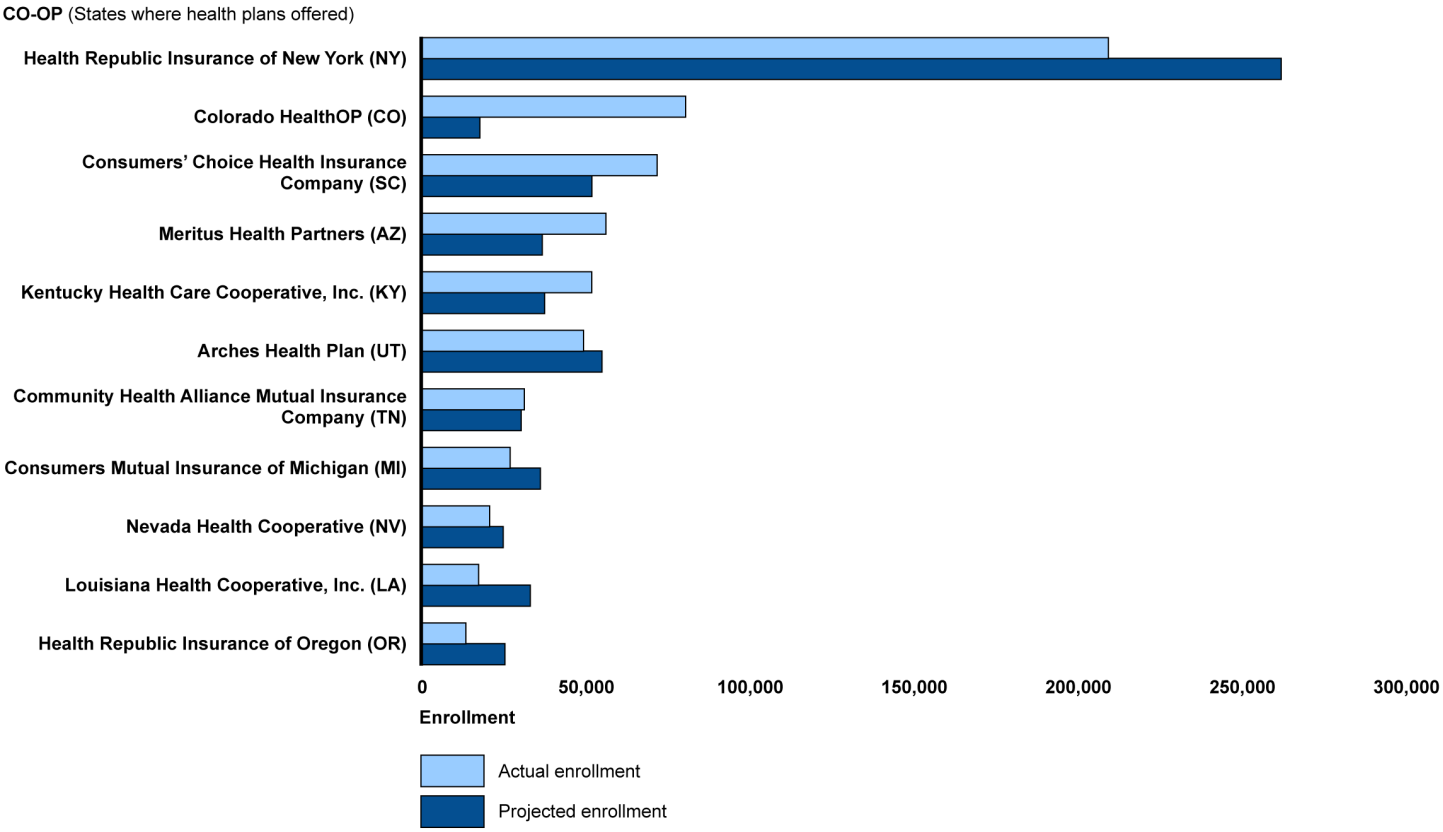
Source: GAO analysis of data from National Association of Insurance Commissioners. | GAO-16-326

Note: Oregon's Health CO-OP and Health Republic Insurance of Oregon both offered health plans in Oregon in 2014 and 2015. On January 1, 2016, the Health Republic Insurance of Oregon ceased operations.

[a]According to the National Association of Insurance Commissioners, enrollment as of June 30, 2015, for Health Republic Insurance of New Jersey was not available due to restrictions from New Jersey Department of Banking and Insurance. This amount is an estimate reported publicly by Health Republic Insurance of New Jersey.

Overall, our analysis showed that CO-OPs' combined enrollment for 2015 exceeded their projections by more than 6 percent, but half of the CO-OPs did not meet or exceed their individual projections. As figure 7 shows, of the 11 CO-OPs that have ceased operations, 6 did not meet their individual enrollment projections, while 5 CO-OPs exceeded their projections. (See fig. 7.)

Figure 7: Actual and Projected 2015 Enrollment for Consumer Operated and Oriented Plans (CO-OPs) that Have Ceased Operations



Source: GAO analysis of National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services data. | GAO-16-326

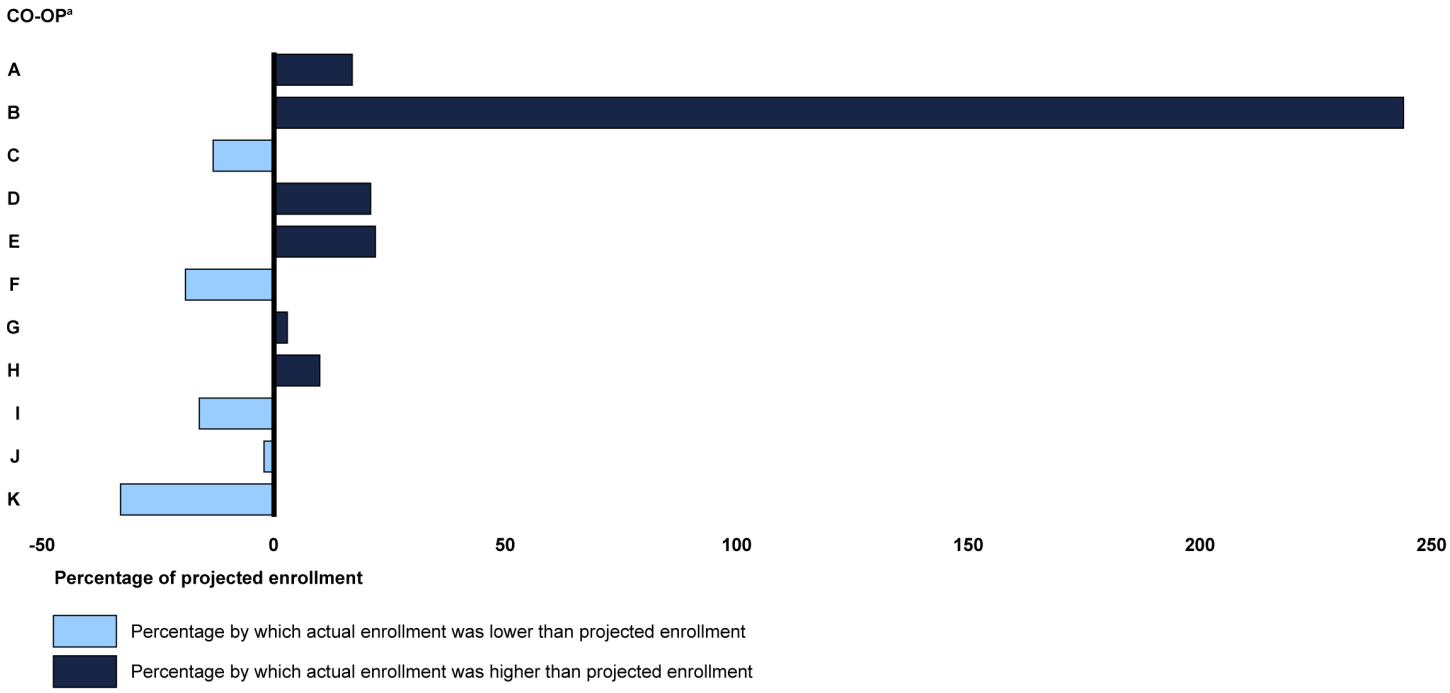
Further, of the 11 CO-OPs that continued to operate as of January 4, 2016, 6 exceeded their 2015 enrollment projections by June 30, 2015.[38] (See fig. 8.) Our analysis, however, also found that 4 CO-OPs had not yet reached a program benchmark of enrolling at least 25,000 members.[39]

[38]According to CMS officials, enrollment projections for the 11 CO-OPs that continued to operate as of January 4, 2016, are considered business-sensitive information. Accordingly, we are not reporting the names associated with specific results of our comparison of projected and actual enrollment.

[39]CMS officials told us that the minimum number of members that can normally be expected to permit a CO-OP to have financial solvency is in the range of 25,000 to 50,000.

According to CMS officials, exceeding this benchmark can be important for CO-OPs, because that number of enrollees should better allow a health insurance issuer to cover its fixed costs. CMS officials told us that they are monitoring the CO-OPs' enrollment with attention to this benchmark.

Figure 8: The Percentage by Which Actual Enrollment, as of June 30, 2015, Differed from Projected 2015 Enrollment for the Consumer Operated and Oriented Plans (CO-OPs) that Continued to Operate as of January 4, 2016



Source: GAO analysis of National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services data. | GAO-16-326

[a]According to officials from the Centers for Medicare & Medicaid Services, enrollment projections for the 11 CO-OPs that continued to operate as of January 4, 2016, are considered business-sensitive information. Accordingly, we are not reporting the names of specific CO-OPs.

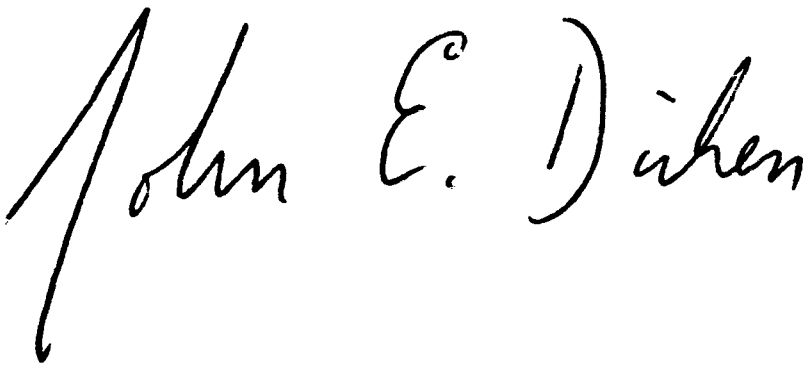
Agency Comments

We provided a draft of this report to HHS for comment. In its written comments, which appear in appendix XV, HHS stated its commitment to CO-OP beneficiaries and taxpayers in managing the CO-OP program, noted the achievements of the CO-OP program to date, and described developments in the department's oversight activities. In addition, HHS stated its goal to help facilitate the acquisition of additional capital or the development of other business relationships that could assist those

CO-OPs that continue to operate in achieving their goals and described its efforts to support them. HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix XVI.



John E. Dicken
Director, Health Care

List of Requesters

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Michael B. Enzi
Chairman
Subcommittee on Primary Health and Retirement Security
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Richard Burr
United States Senate

Appendix I: Consumer Operated and Oriented Plans and Loan Awards

The Centers for Medicare & Medicaid Services awarded consumer operated and oriented plan (CO-OP) program loans totaling more than $2.4 billion, of which about $358 million was awarded for start-up loans and about $2.1 billion was awarded for solvency loans. Table 4 provides the total amounts awarded to each of the 23 CO-OPs established with funds disbursed under the CO-OP program loans. As of January 4, 2016, 11 CO-OPs continued to operate while, 12 CO-OPs had ceased operations.

Table 4: Consumer Operated and Oriented Plans (CO-OPs) and CO-OP Program Loan Awards

CO-OP (State(s) where health plans were offered)	Total CO-OP program loan awards
CO-OPs that continued to operate as of January 4, 2016	
Land of Lincoln Health (Illinois)	$160,154,812
Minutemen Health, Inc. (Massachusetts and New Hampshire)	156,442,995
Community Health Options (Maine and New Hampshire)	132,316,124
InHealth Mutual (Ohio)	129,225,604
HealthyCT (Connecticut)	127,980,768
Health Republic Insurance of New Jersey (New Jersey)	109,074,550
Common Ground Healthcare Cooperative (Wisconsin)	107,739,354
Montana Health Cooperative (Montana and Idaho)	85,019,688
New Mexico Health Connections (New Mexico)	77,317,782
Evergreen Health Cooperative, Inc. (Maryland)	65,450,900
Oregon’s Health CO-OP (Oregon)	56,656,900
CO-OPs that ceased to operate	
Health Republic Insurance of New York (New York)	$265,133,000
Kentucky Health Care Cooperative, Inc. (Kentucky)	146,494,772
CoOportunity Health (Iowa and Nebraska)	145,312,100
Meritus Health Partners (Arizona)	93,313,233
Arches Health Plan (Utah)	89,650,303
Consumers’ Choice Health Insurance Company (South Carolina)	87,578,208
Community Health Alliance Mutual Insurance Company (Tennessee)	73,306,700
Colorado HealthOP (Colorado)	72,335,129

CO-OP (State(s) where health plans were offered)	Total CO-OP program loan awards
Consumers Mutual Insurance of Michigan (Michigan)	71,534,300
Nevada Health Cooperative (Nevada)	65,925,396
Louisiana Health Cooperative, Inc. (Louisiana)	65,790,660
Health Republic Insurance of Oregon (Oregon)	60,648,505
Total loan award amounts	$2,444,401,783

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-16-326

Notes: One additional organization in Vermont received loan awards totaling about $14.4 million. This organization was subsequently denied a license as a health insurance issuer by the state, and, as a result, CMS terminated the organization's participation in the CO-OP program.

Oregon's Health CO-OP and Health Republic Insurance of Oregon both offered health plans in Oregon in 2014 and 2015. On January 1, 2016, the Health Republic Insurance of Oregon ceased operations.

Appendix II: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Connecticut

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Connecticut decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $33, and the average increase from 2015 to 2016 was about $32. (See table 5.)

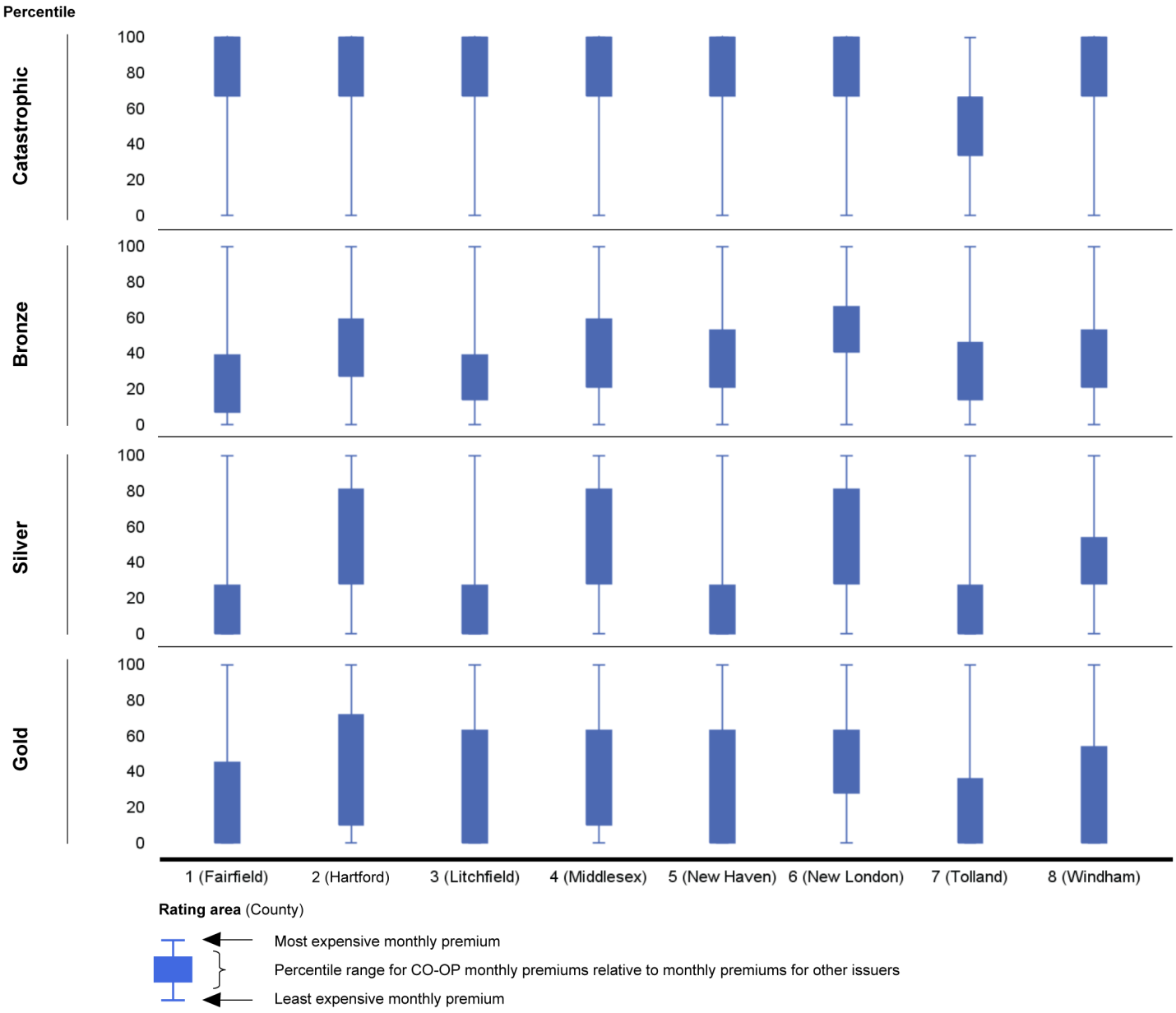
Table 5: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Connecticut for 30-Year-Old Individuals, 2014 though 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$311.76	$346.07	$387.41
	Other	280.79	309.02	375.27
2015	CO-OP	286.95	312.64	343.97
	Other	285.10	324.31	379.78
2016	CO-OP	309.62	344.38	383.21
	Other	281.00	324.77	386.59

Source: GAO analysis of state data. | GAO-16-326

For 2015, the CO-OP in Connecticut offered catastrophic, bronze, silver, and gold health plans in each of the state's eight rating areas, but did not offer a platinum health plan. Figure 9 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Connecticut were generally among the most expensive premiums for catastrophic health plans. For gold health plans, the CO-OP's premiums were among the least expensive or in the middle. The CO-OP's premiums for bronze and silver health plans were among the least expensive premiums in some rating areas, while ranging from the middle to among the most expensive premiums in others.

Figure 9: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Connecticut for 30-Year-Old Individuals



Source: GAO analysis of state data. | GAO-16-326

Notes: In total, there were eight rating areas in Connecticut. The CO-OP did not offer a platinum health plan. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Appendix III: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Idaho

The consumer operated and oriented plans (CO-OP) from Montana offered health plans on the Idaho health insurance exchange for the first time in 2015. The state-wide average monthly premium for CO-OP silver health plans for 30-year-old individuals increased from 2015 to 2016. Specifically, the average increase was about $57. (See table 6.)

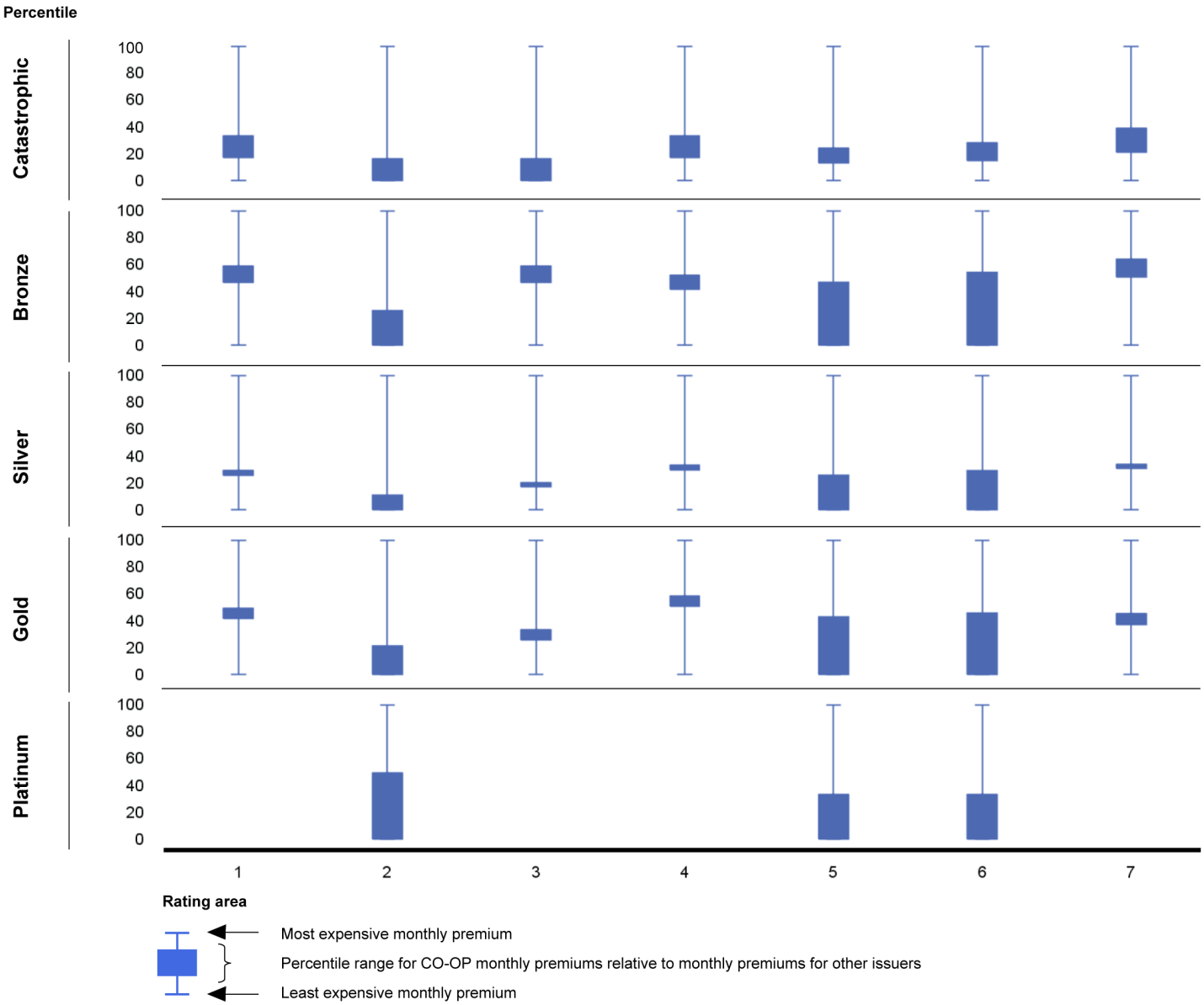
Table 6: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Idaho for 30-Year-Old Individuals, 2015 and 2016

		Monthly premiums		
Year	**Silver health plans**	**Minimum**	**Average**	**Maximum**
2015	CO-OP	$179.82	$206.61	$243.81
	Other	210.03	270.21	401.00
2016	CO-OP	235.01	263.59	300.91
	Other	242.69	324.88	381.00

Source: GAO analysis of state data. | GAO-16-326

For 2015, the CO-OP in Idaho offered catastrophic, bronze, silver, and gold health plans in each of the state's seven rating areas, but offered platinum health plans in only three. Figure 10 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Idaho were generally in the middle with premiums in some rating areas ranging from the least expensive to the middle.

Figure 10: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Idaho for 30-Year-Old Individuals



Source: GAO analysis of state data. | GAO-16-326

Notes: In total, there were seven rating areas in Idaho. The CO-OP offered platinum health plans only in rating areas 2, 5, and 6. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes zip codes that begin with 832.

Rating area 2 includes zip codes that begin with 833.

Rating area 3 includes zip codes that begin with 834.

Rating area 4 includes zip codes that begin with 835.

Rating area 5 includes zip codes that begin with 836.

Rating area 6 includes zip codes that begin with 837.

Rating area 7 includes zip codes that begin with 838.

Appendix IV: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Illinois

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Illinois decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $80, and the average increase from 2015 to 2016 was about $61. (See table 7.)

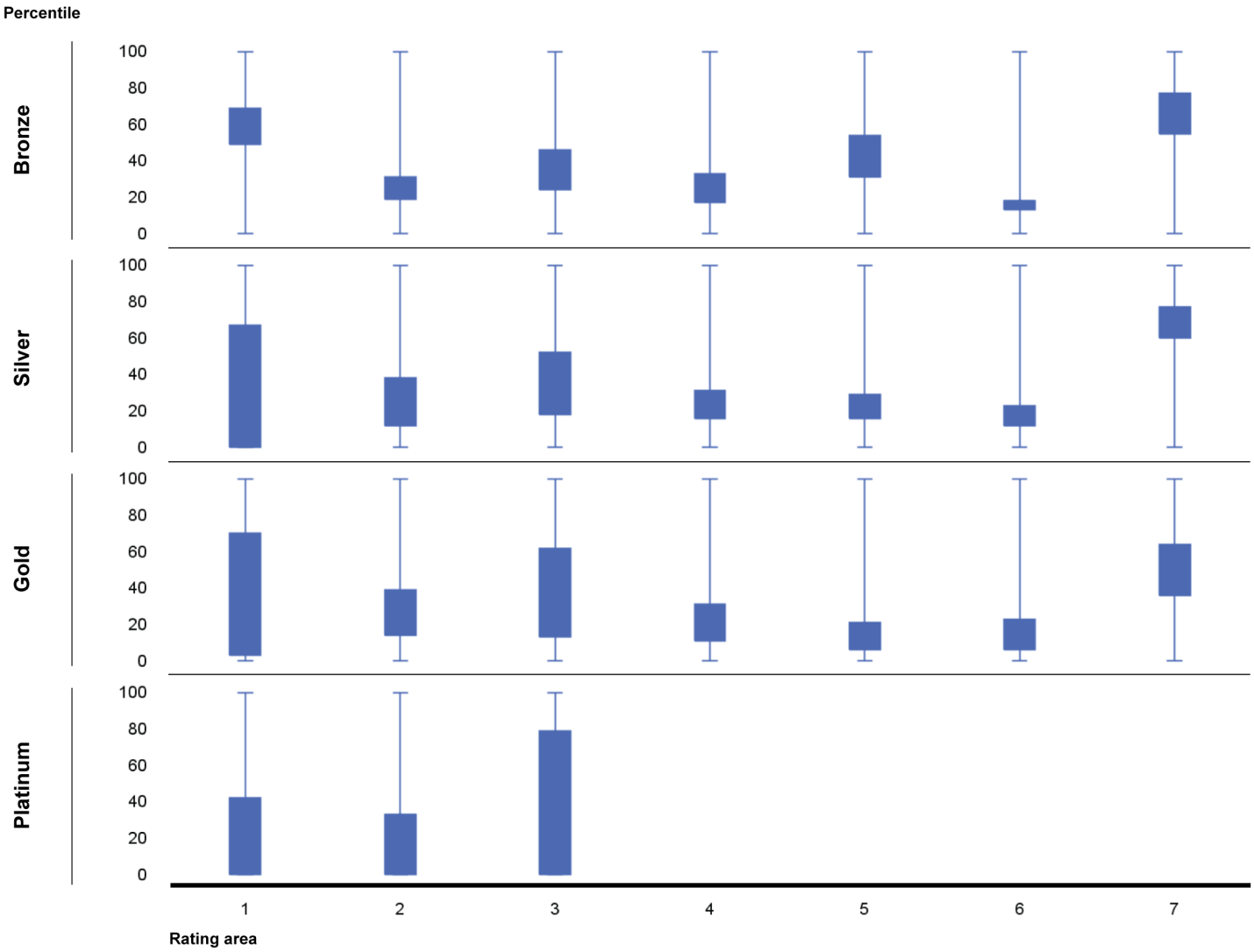
Table 7: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Illinois for 30-Year-Old Individuals, 2014 through 2016

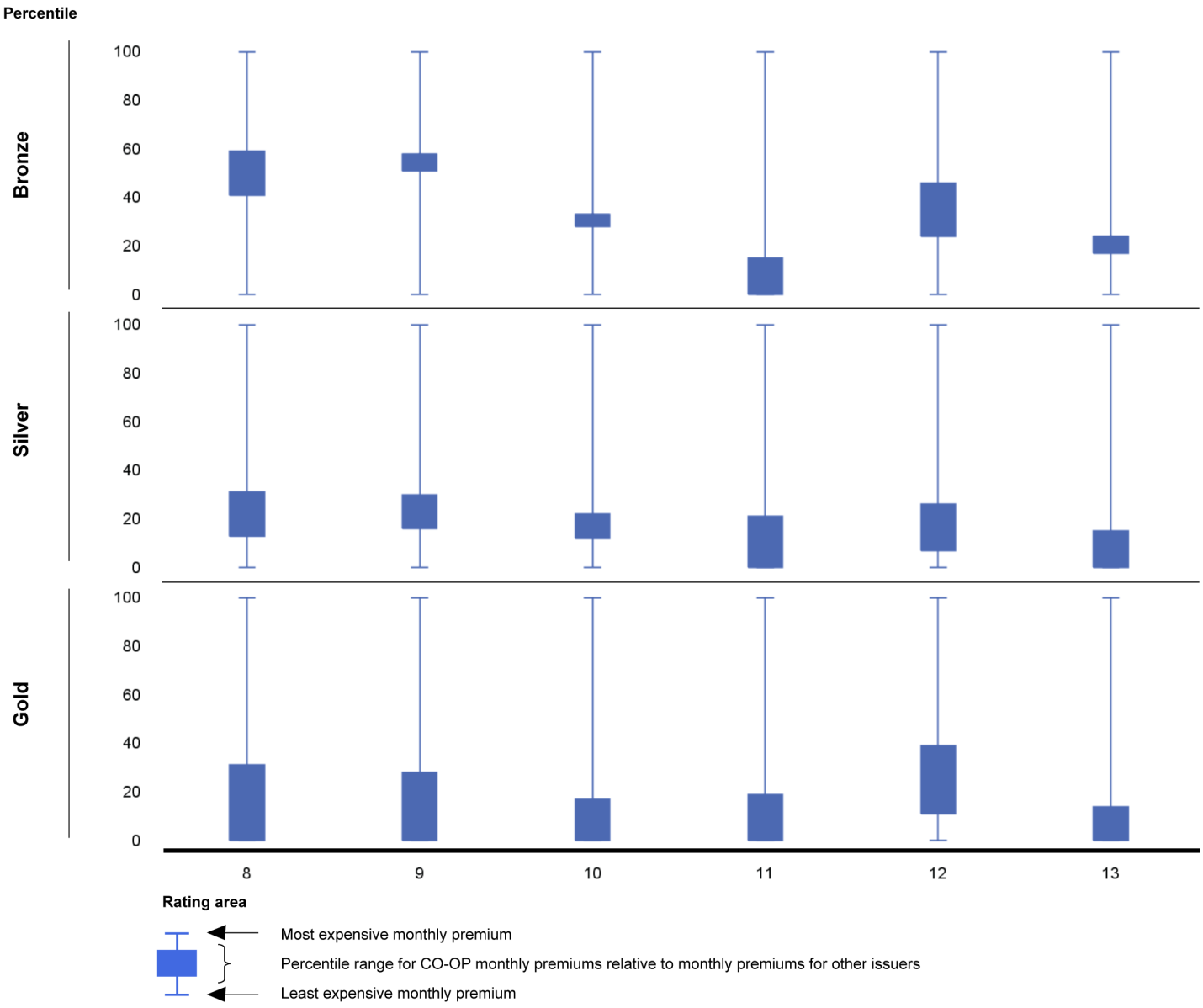
		Monthly premiums		
Year	**Silver health plans**	**Minimum**	**Average**	**Maximum**
2014	CO-OP	$258.47	$312.10	$355.58
	Other	170.07	260.86	362.00
2015	CO-OP	188.60	231.69	275.53
	Other	185.41	272.10	510.64
2016	CO-OP	225.75	292.33	359.78
	Other	172.99	290.72	446.41

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Illinois offered bronze, silver, and gold health plans in each of the state's 13 rating areas. The CO-OP offered platinum health plans in three rating areas, but did not offer any catastrophic health plans. Figure 11 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Illinois tended to be among the least expensive or in the middle.

Figure 11: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Illinois for 30-Year-Old Individuals





Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were 13 rating areas in Illinois. The CO-OP did not offer catastrophic health plans. The CO-OP offered platinum health plans only in rating areas 1, 2, and 3. Plans in the same metal level have the same actuarial value.

Rating area 1 includes Cook County.

Rating area 2 includes Lake and McHenry counties.

Rating area 3 includes Dupage and Kane counties.

Rating area 4 includes Grundy, Kankakee, Kendall, and Will counties.

Rating area 5 includes Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, and Winnebago counties.

Rating area 6 includes Bureau, Hancock, Henderson, Henry, Mercer, Rock Island, Warren, and Whiteside counties.

Rating area 7 includes Fulton, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, and Woodford counties.

Rating area 8 includes DeWitt, Livingston, and McLean counties.

Rating area 9 includes Champaign, Clark, Coles, Cumberland, Douglas, Edgar, Ford, Iroquois, Piatt, and Vermillion counties.

Rating area 10 includes Adams, Brown, Cass, Christian, Logan, Macon, Mason, Menard, Morgan, Moultrie, Pike, Sangamon, Schuyler, Scott, and Shelby counties.

Rating area 11 includes Bond, Calhoun, Clinton, Greene, Jersey, Macoupin, Montgomery, Randolph, and Washington counties.

Rating area 12 includes Madison, Monroe, and St. Clair counties.

Rating area 13 includes Alexander, Clay, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, and Williamson counties.

Appendix V: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Maine

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Maine increased from 2014 to 2015, but decreased slightly from 2015 to 2016. Specifically, the average increase from 2014 to 2015 was about $8, and the average decrease from 2015 to 2016 was about $1. (See table 8.)

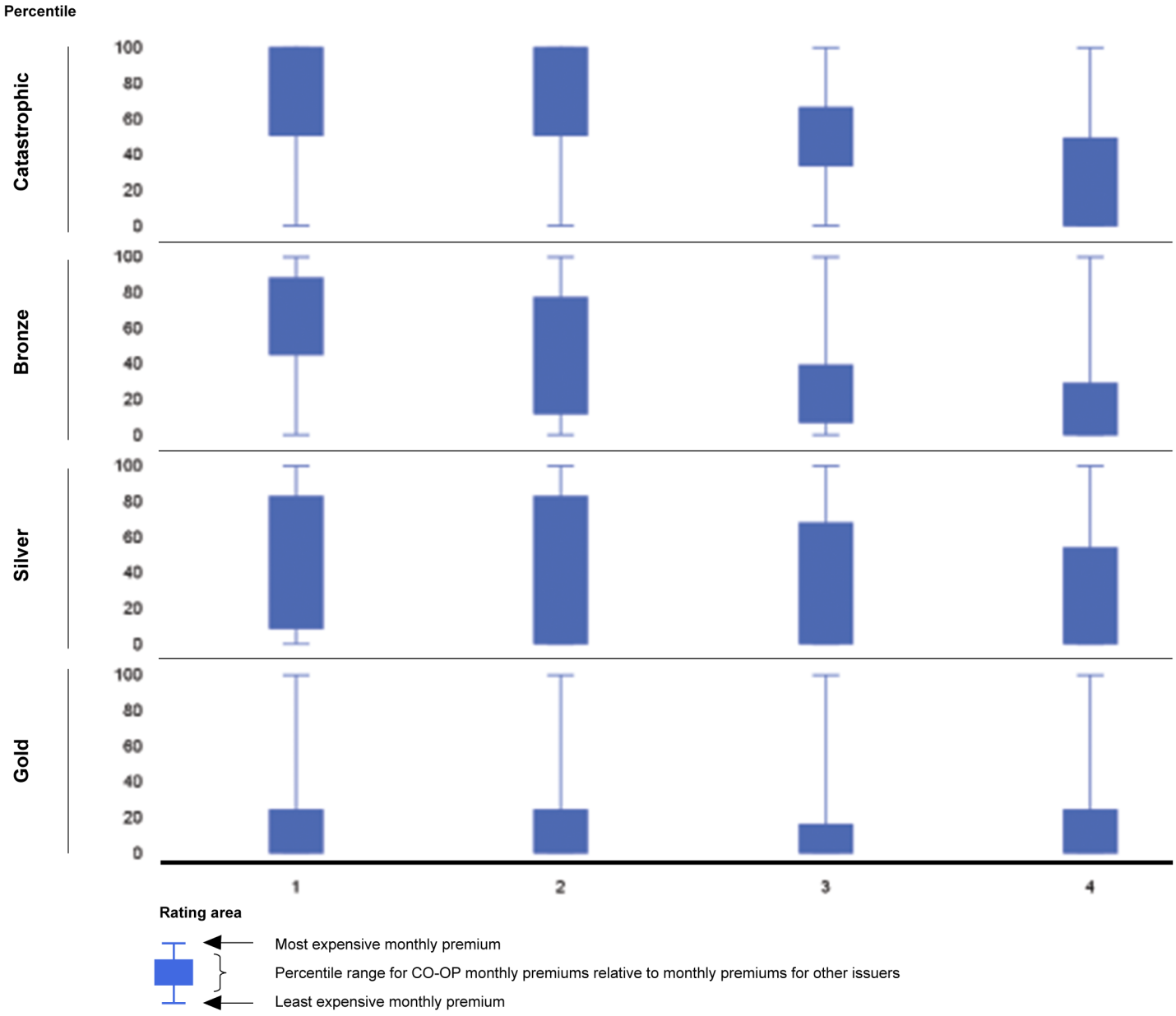
Table 8: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Maine for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$251.83	$300.59	$368.45
	Other	263.96	334.62	400.18
2015	CO-OP	250.38	308.87	393.12
	Other	244.06	341.73	471.55
2016	CO-OP	252.29	307.98	389.44
	Other	252.94	317.32	448.94

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Maine offered catastrophic, bronze, silver, and gold health plans in each of the state's four rating areas, but did not offer a platinum health plan. Figure 12 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for catastrophic, silver, and bronze health plans offered by the CO-OP in Maine were among the most expensive in some rating areas, the least expensive in some, and in the middle in others. Premiums for gold health plans were among the least expensive.

Figure 12: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Maine for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were four rating areas in Maine. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Cumberland, Sagadahoc, and York counties.

Rating area 2 includes Kennebec, Knox, Lincoln, and Oxford counties.

Rating area 3 includes Androscoggin, Franklin, Penobscot, Piscataquis, Somerset, and Waldo counties.

Rating area 4 includes Aroostook, Hancock, and Washington counties.

Appendix VI: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Maryland

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Maryland decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $33, and the average increase from 2015 to 2016 was about $18. (See table 9.)

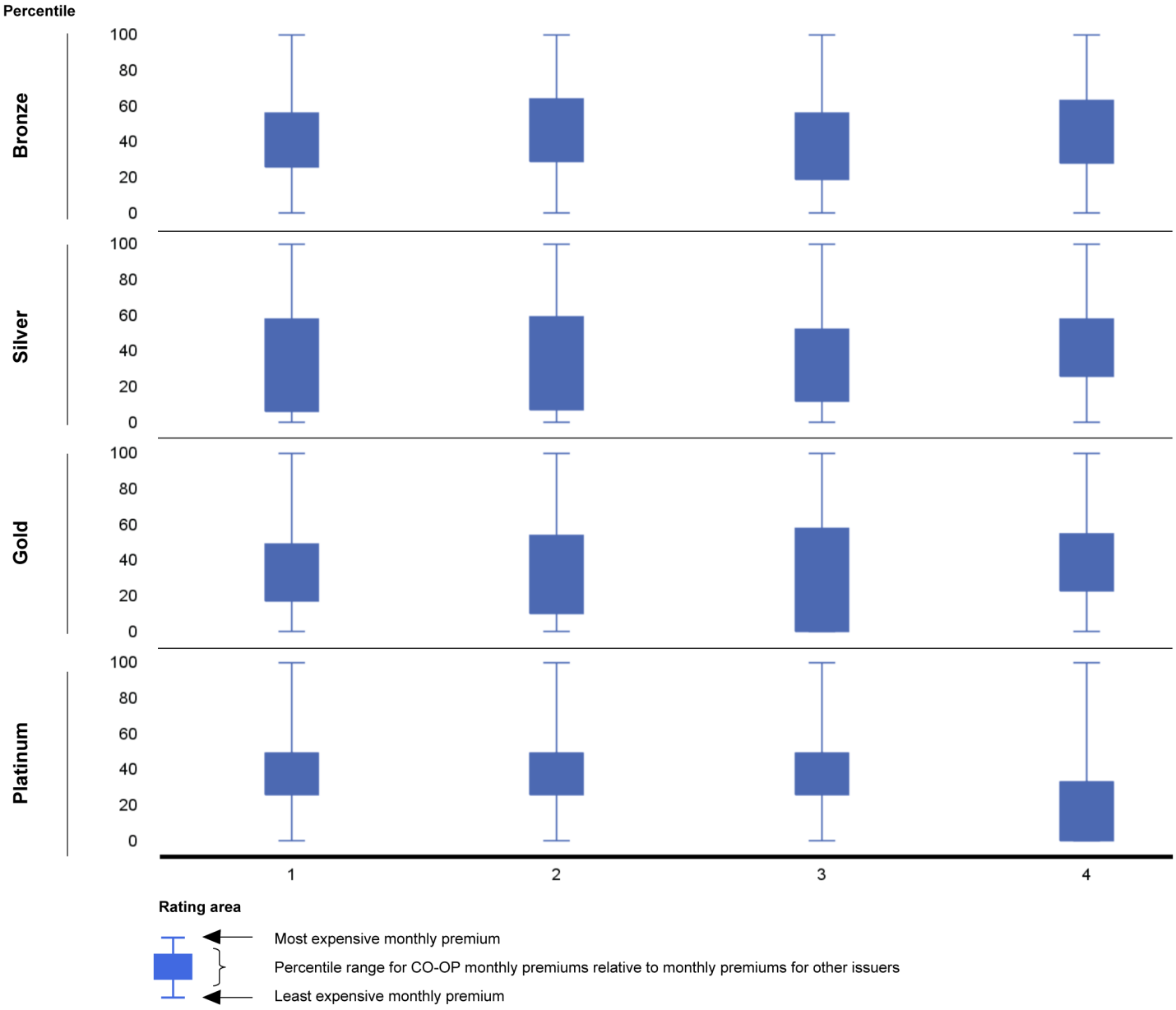
Table 9: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Maryland for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	**Silver health plans**	**Minimum**	**Average**	**Maximum**
2014	CO-OP	$213.00	$251.06	$282.00
	Other	187.00	248.07	305.00
2015	CO-OP	205.32	217.97	234.55
	Other	199.58	246.43	306.60
2016	CO-OP	224.03	235.66	246.36
	Other	216.15	272.10	313.61

Source: GAO analysis of state data. | GAO-16-326

For 2015, the CO-OP in Maryland offered bronze, silver, gold, and platinum health plans in each of the state's four rating areas, but did not offer catastrophic health plans. Figure 13 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Maryland were generally in the middle.

Figure 13: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Maryland for 30-Year-Old Individuals



Source: GAO analysis of state data. | GAO-16-326

Notes: In total, there were four rating areas in Maryland. The CO-OP did not offer catastrophic health plans. Plans in the same metal level have the same actuarial value.

Rating area 1 includes Anne Arundel, Baltimore, Baltimore City, Harford, and Howard counties.

Rating area 2 includes Calvert, Caroline, Cecil, Charles, Dorchester, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Wicomico, and Worcester counties.

Rating area 3 includes Montgomery and Prince George's counties.

Rating area 4 includes Allegany, Carroll, Frederick, Garrett, and Washington counties.

Appendix VII: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Massachusetts

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Massachusetts decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $19, and the average increase from 2015 to 2016 was about $7. (See table 10.)

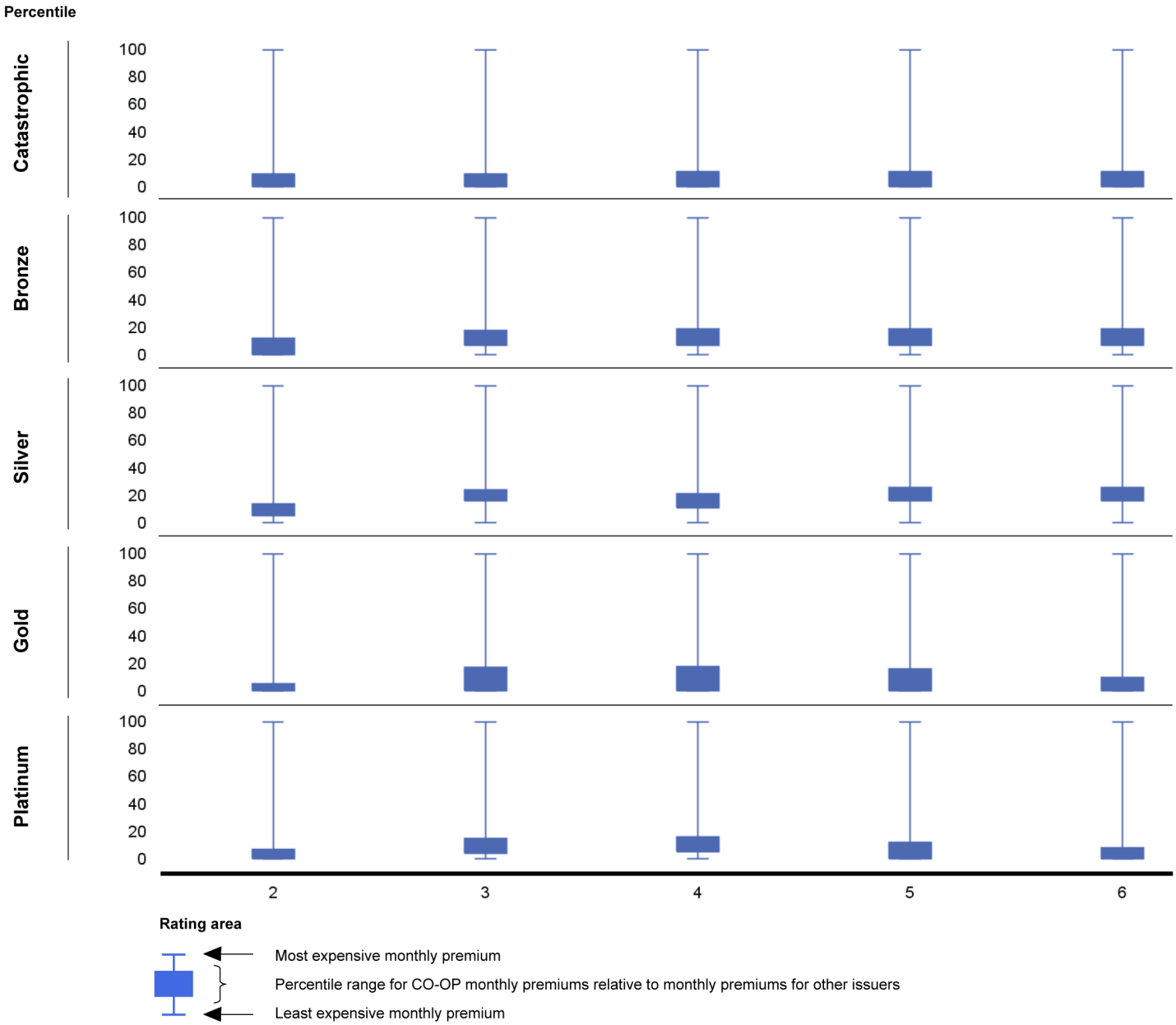
Table 10: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Massachusetts for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$233.44	$263.39	$291.44
	Other	216.31	309.42	423.58
2015	CO-OP	222.36	244.87	264.57
	Other	191.62	314.45	426.00
2016	CO-OP	234.81	251.50	264.31
	Other	221.27	322.16	468.73

Source: GAO analysis of state data. | GAO-16-326

For 2015, the CO-OP in Massachusetts offered plans in all tiers in five of the state's seven rating areas. Figure 14 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Massachusetts were among the least expensive across all tiers and rating areas.

Figure 14: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Massachusetts for 30-Year-Old Individuals



Source: GAO analysis of state data. | GAO-16-326

Notes: In total, there were seven rating areas in Massachusetts. The CO-OP did not offer health plans in rating areas 1 and 7. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes zip codes that begin with 010, 011, 012, and 013.

Rating area 2 includes zip codes that begin with 014, 015, and 016.

Rating area 3 includes zip codes that begin with 017 and 020.

Rating area 4 includes zip codes that begin with 018 and 019.

Rating area 5 includes zip codes that begin with 021, 022, and 024.

Rating area 6 includes zip codes that begin with 023 and 027.

Rating area 7 includes zip codes that begin with 025 and 026.

Appendix VIII: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Montana

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Montana decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $17, and the average increase from 2015 to 2016 was about $75. (See table 11.)

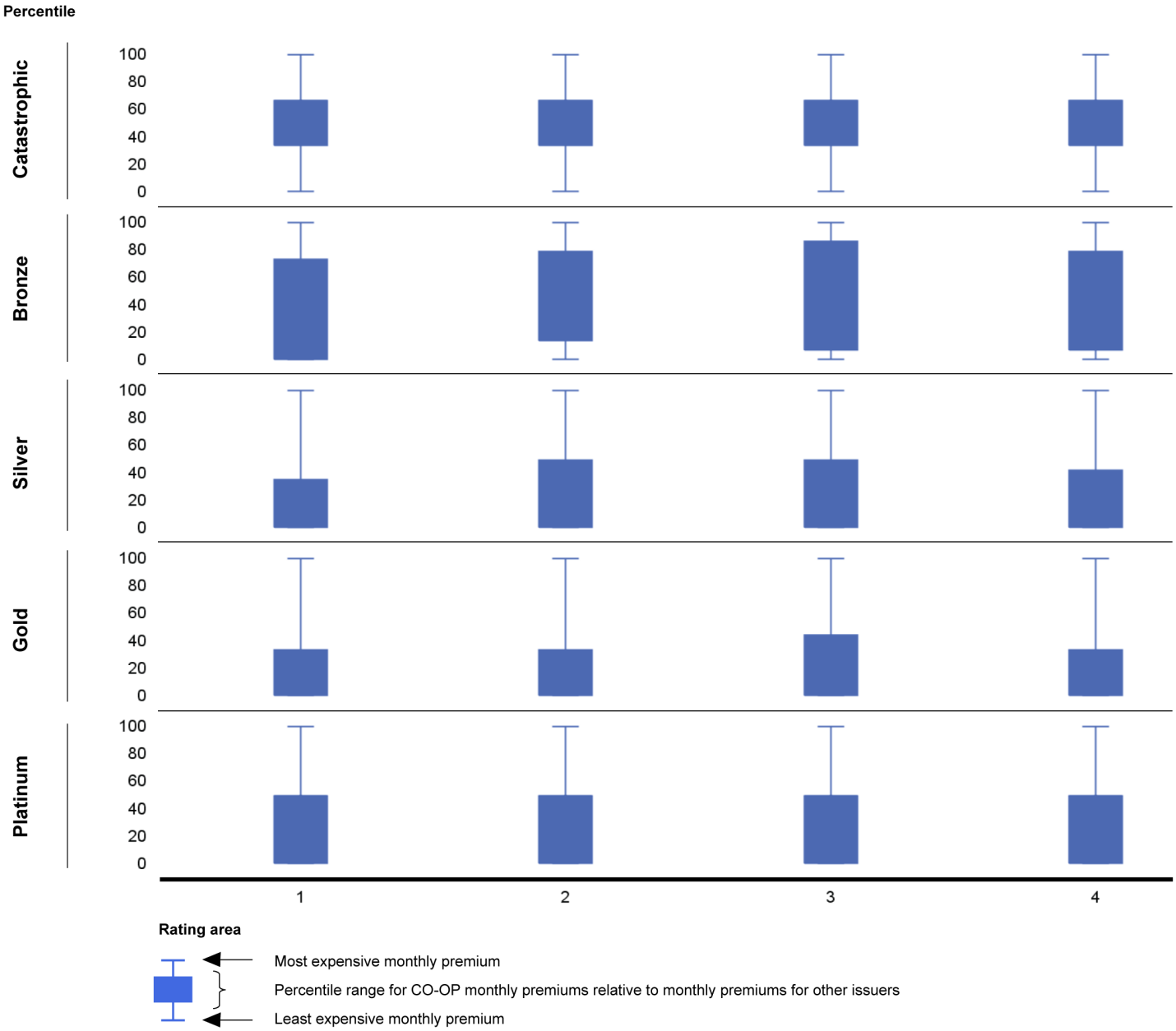
Table 11: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Montana for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$229.15	$239.16	$249.37
	Other	215.00	236.80	275.00
2015	CO-OP	208.96	221.73	243.69
	Other	218.00	251.60	297.19
2016	CO-OP	281.03	296.80	324.65
	Other	286.09	314.51	358.00

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Montana offered plans in all tiers in each of the state's four rating areas. Figure 15 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The CO-OP premiums for catastrophic health plans offered by the CO-OP in Montana were generally in the middle. The CO-OP premiums were among the least expensive premiums or in the middle for silver, gold, and platinum plans. CO-OP premiums for bronze plans ranged from among the least to most expensive.

Figure 15: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Montana for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were four rating areas in Montana. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Carbon, Musselshell, Stillwater, Sweet Grass and Yellowstone counties.

Rating area 2 includes Broadwater, Cascade, Chouteau, Clark, Deer Lodge, Gallatin, Judith Basin, Lewis and Jefferson, Silver Bow, and Teton counties.

Rating area 3 includes Flathead, Lake, and Missoula counties.

Rating area 4 includes Beaverhead, Big Horn, Blaine, Carter, Custer, Daniels, Dawson, Fallon, Fergus, Garfield, Glacier, Golden Valley, Granite, Hill, Liberty, Lincoln, Madison, McCone, Meagher, Mineral, Park, Petroleum, Phillips, Pondera, Powder River, Powell, Prairie, Ravalli, Richland, Roosevelt, Rosebud, Sanders, Sheridan, Toole, Treasure, Valley, Wheatland, and Wibaux counties.

Appendix IX: Premiums for the Consumer Operated and Oriented Plans Relative to Premiums for Other Health Plans in New Hampshire

The consumer operated and oriented plans (CO-OP) from Maine and Massachusetts both offered health plans on the New Hampshire health insurance exchange for the first time in 2015. The state-wide average premiums for CO-OP silver health plans for 30-year-old individuals increased from 2015 to 2016. Specifically, the average increase was about $33. (See table 12.)

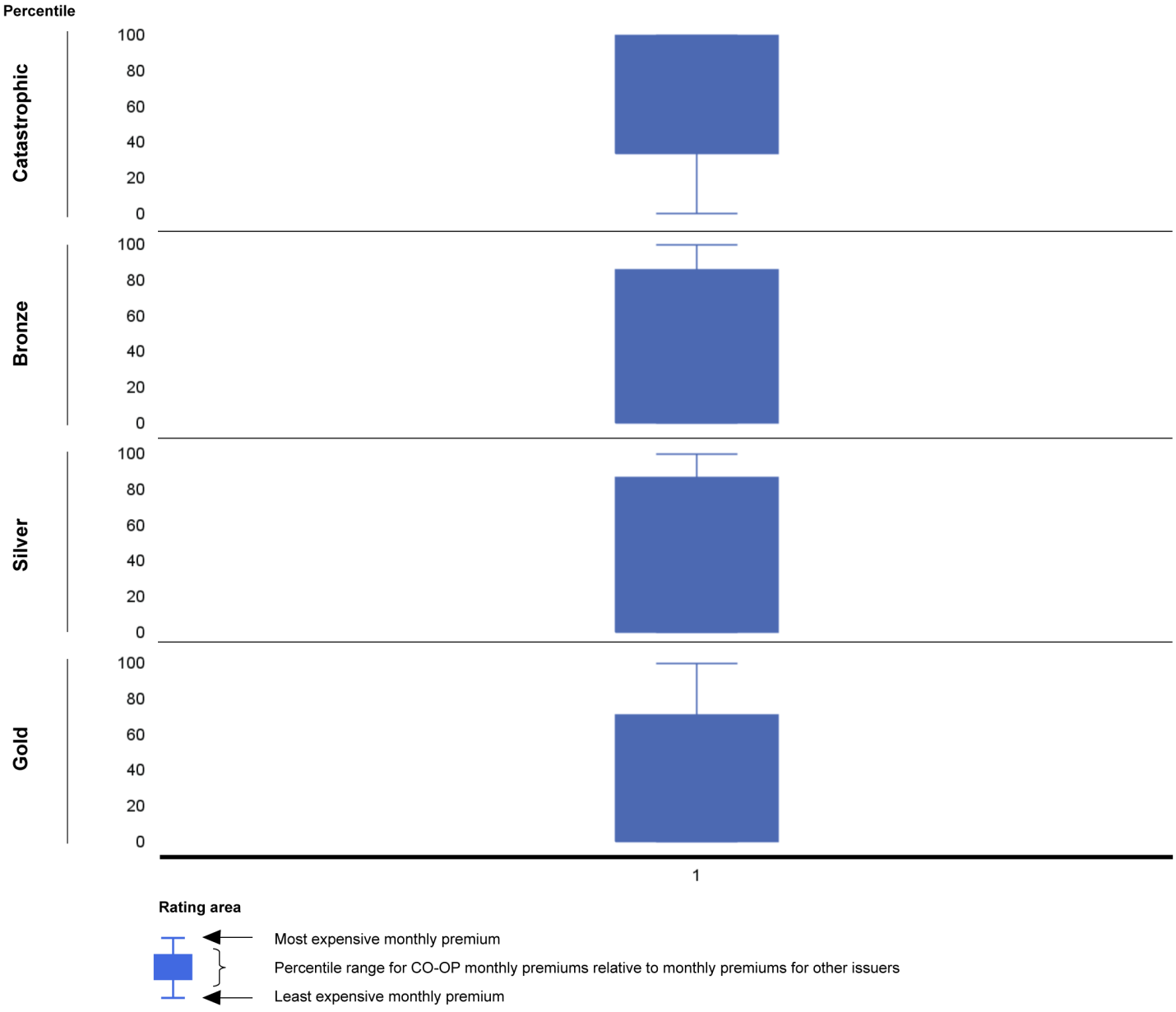
Table 12: Premiums for the Consumer Operated and Oriented Plans' (CO-OP) Silver Health Plans and Other Silver Health Plans in New Hampshire for 30-Year-Old Individuals, 2015 and 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2015	CO-OP	$211.18	$270.71	$319.39
	Other	251.86	308.94	429.18
2016	CO-OP	230.87	303.65	371.56
	Other	256.79	286.02	359.03

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, CO-OPs in New Hampshire offered health plans in all tiers except for platinum in the state's single rating area. Figure 16 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in the state's single rating area. The premiums for health plans offered by the two CO-OPs in New Hampshire varied widely. CO-OP premiums for bronze, silver, and gold health plans ranged from the least to the most expensive. Premiums for catastrophic plans ranged from the middle to the most expensive.

Figure 16: Relative Ranking (in Percentiles) of 2015 Premiums for the Two Consumer Operated and Oriented Plans (CO-OPs) Compared to Premiums for Other Health Plans by Rating Area and Tier in New Hampshire for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: There was one rating area in New Hampshire. The CO-OPs from Maine and Massachusetts both offered health plans in New Hampshire. The two CO-OPs did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Appendix IX: Premiums for the Consumer Operated and Oriented Plans Relative to Premiums for Other Health Plans in New Hampshire

Rating area 1 includes Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties.

Appendix X: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in New Jersey

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in New Jersey decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $71 and the average increase from 2015 to 2016 was about $54. (See table 13.)

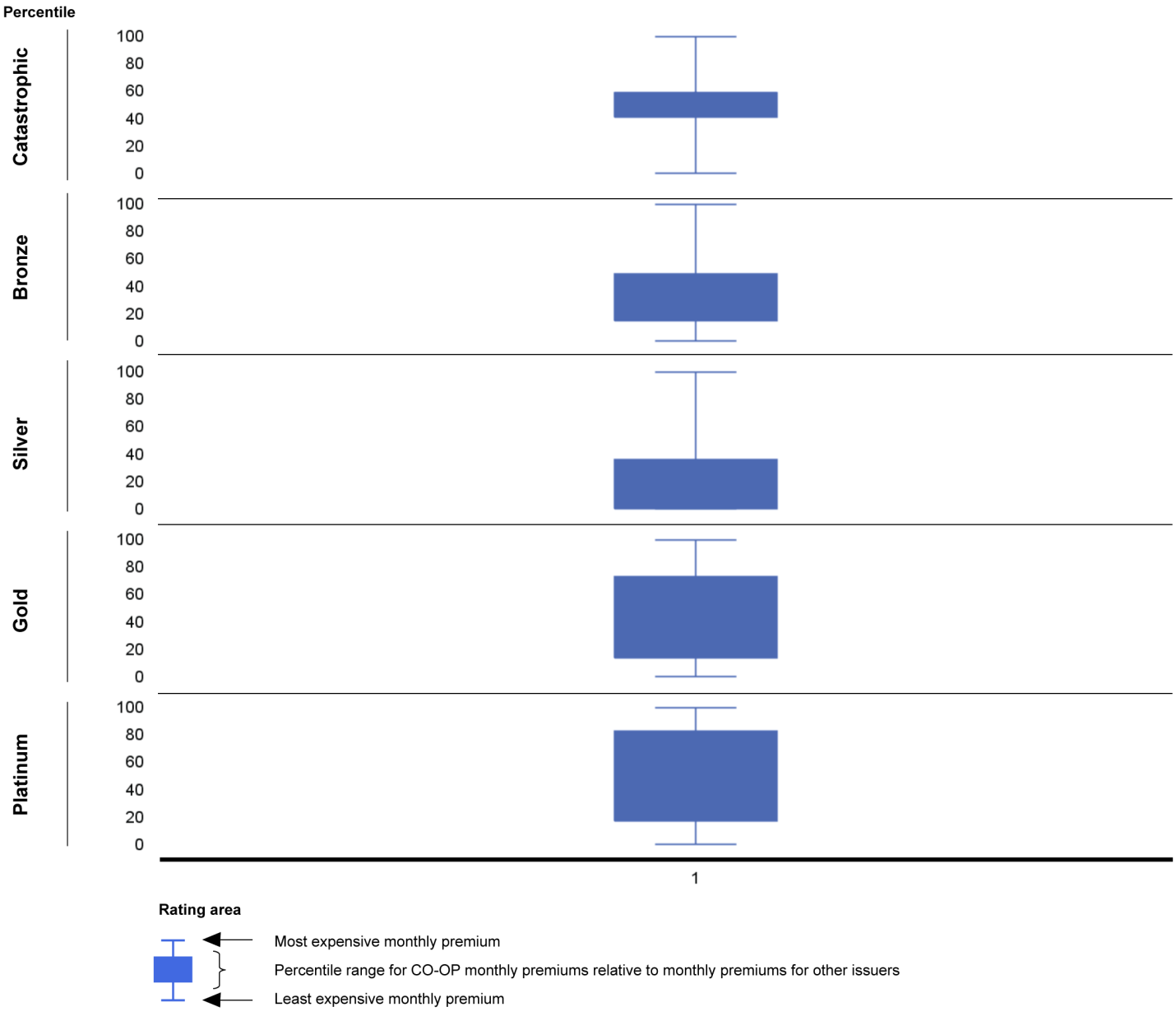
Table 13: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in New Jersey for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	**Silver health plans**	**Minimum**	**Average**	**Maximum**
2014	CO-OP	$356.01	$359.70	$365.50
	Other	273.48	321.43	390.00
2015	CO-OP	279.46	288.78	297.51
	Other	280.38	333.77	430.91
2016	CO-OP	329.75	342.48	351.06
	Other	287.56	334.76	458.49

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in New Jersey offered a health plan in all tiers in the state's single rating area. Figure 17 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in the state's single rating area. The premiums for the health plans offered by the CO-OP in New Jersey were among the less expensive premiums for bronze and silver health plans and in the middle for catastrophic plans. CO-OP premiums for gold and platinum health plans ranged from among the least to the most expensive.

Figure 17: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in New Jersey for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: There was one rating area in New Jersey. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Appendix X: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in New Jersey

Rating area 1 includes Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren counties.

Appendix XI: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in New Mexico

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in New Mexico decreased from 2014 to 2015 and decreased again from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $9 and the average decrease from 2015 to 2016 was about $7. (See table 14.)

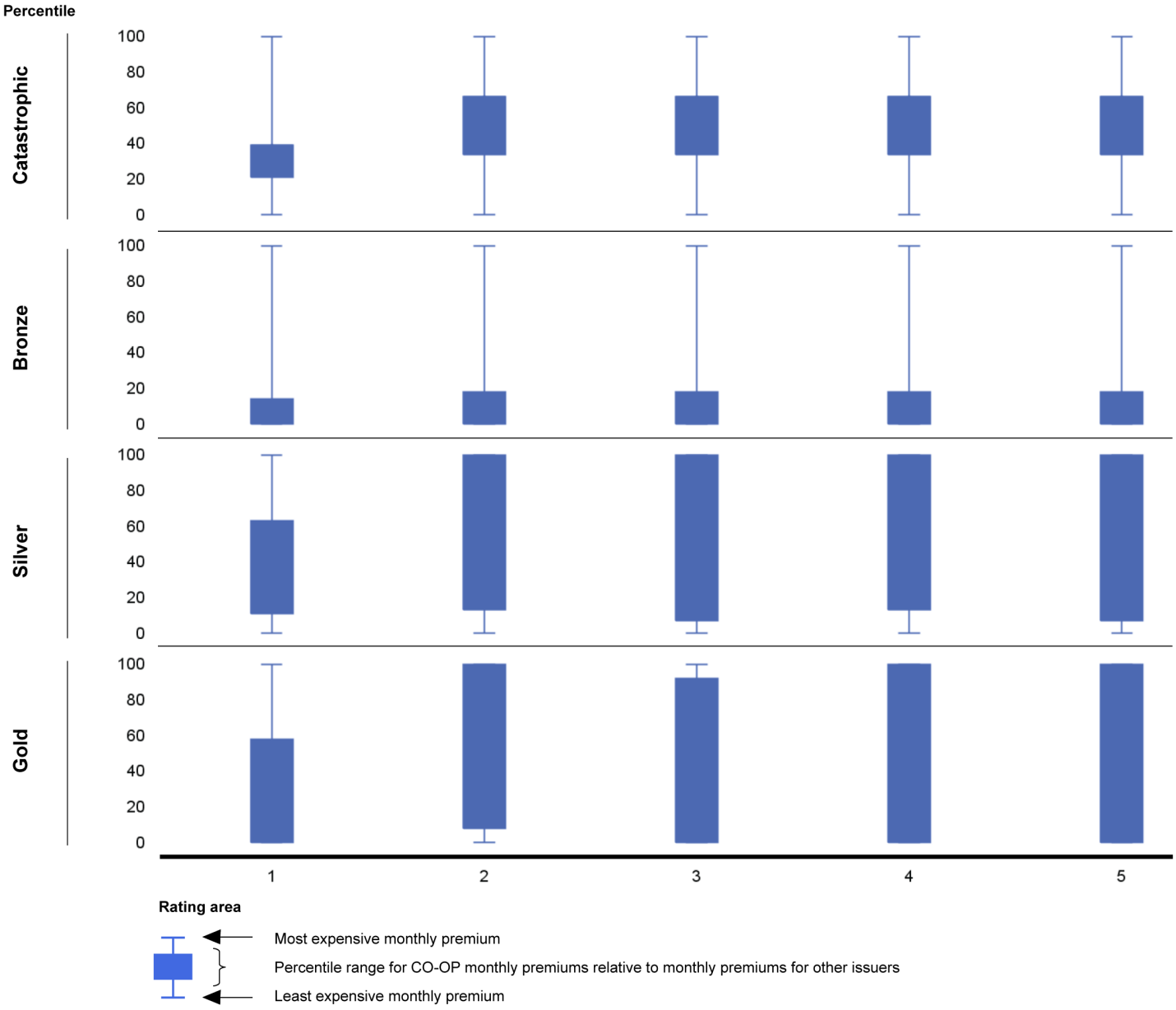
Table 14: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in New Mexico for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$193.64	227.85	276.33
	Other	167.43	235.68	282.18
2015	CO-OP	158.08	218.92	285.82
	Other	148.55	227.89	271.72
2016	CO-OP	165.42	212.17	248.13
	Other	160.57	241.58	307.37

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in New Mexico offered catastrophic, bronze, silver, and gold health plans in each of the state's five rating areas, but did not offer a platinum health plan. Figure 18 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for silver and gold health plans offered by the CO-OP in New Mexico varied widely, ranging from among the least to the most expensive premiums. CO-OP premiums were often among the less expensive premiums for bronze health plans, and were generally in the middle for catastrophic plans.

Figure 18: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in New Mexico for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were five rating areas in New Mexico. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Bernalillo, Sandoval, Torrance, and Valencia counties.

Rating area 2 includes San Juan County.

Rating area 3 includes Don Ana County.

Rating area 4 includes Santa Fe County.

Rating area 5 includes Catron, Chaves, Cibola, Colfax, Curry, DeBaca, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, Roosevelt, San Miguel, Sierra, Socorro, Taos, and Union counties.

Appendix XII: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Ohio

The consumer operated and oriented plan (CO-OP) in Ohio offered health plans on the state's exchange for the first time in 2015. The state-wide average monthly premium for CO-OP silver health plans for 30-year-old individuals increased from 2015 to 2016. Specifically, the average increase from 2015 to 2016 was about $43. (See table 15.)

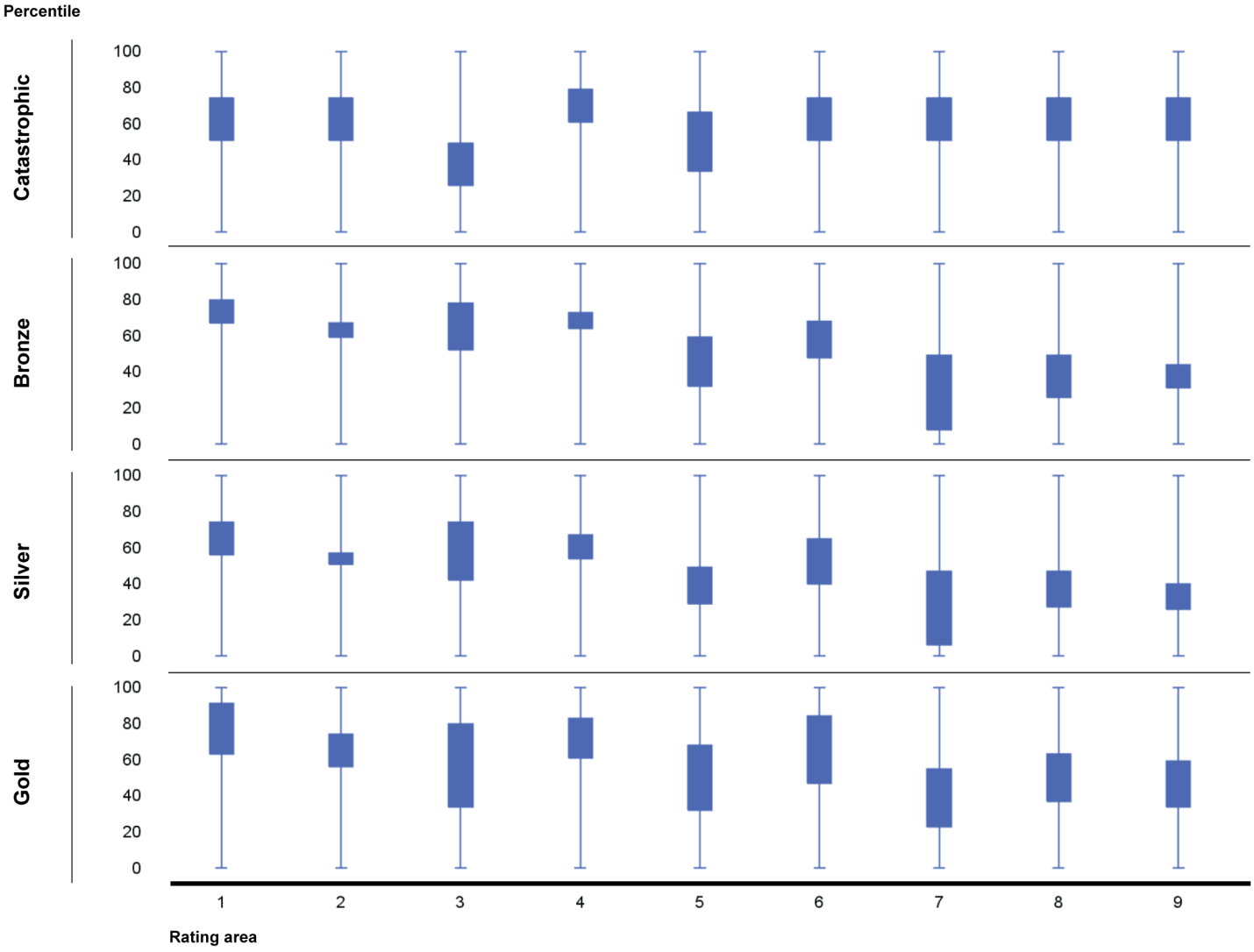
Table 15: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Ohio for 30-Year-Old Individuals, 2015 and 2016

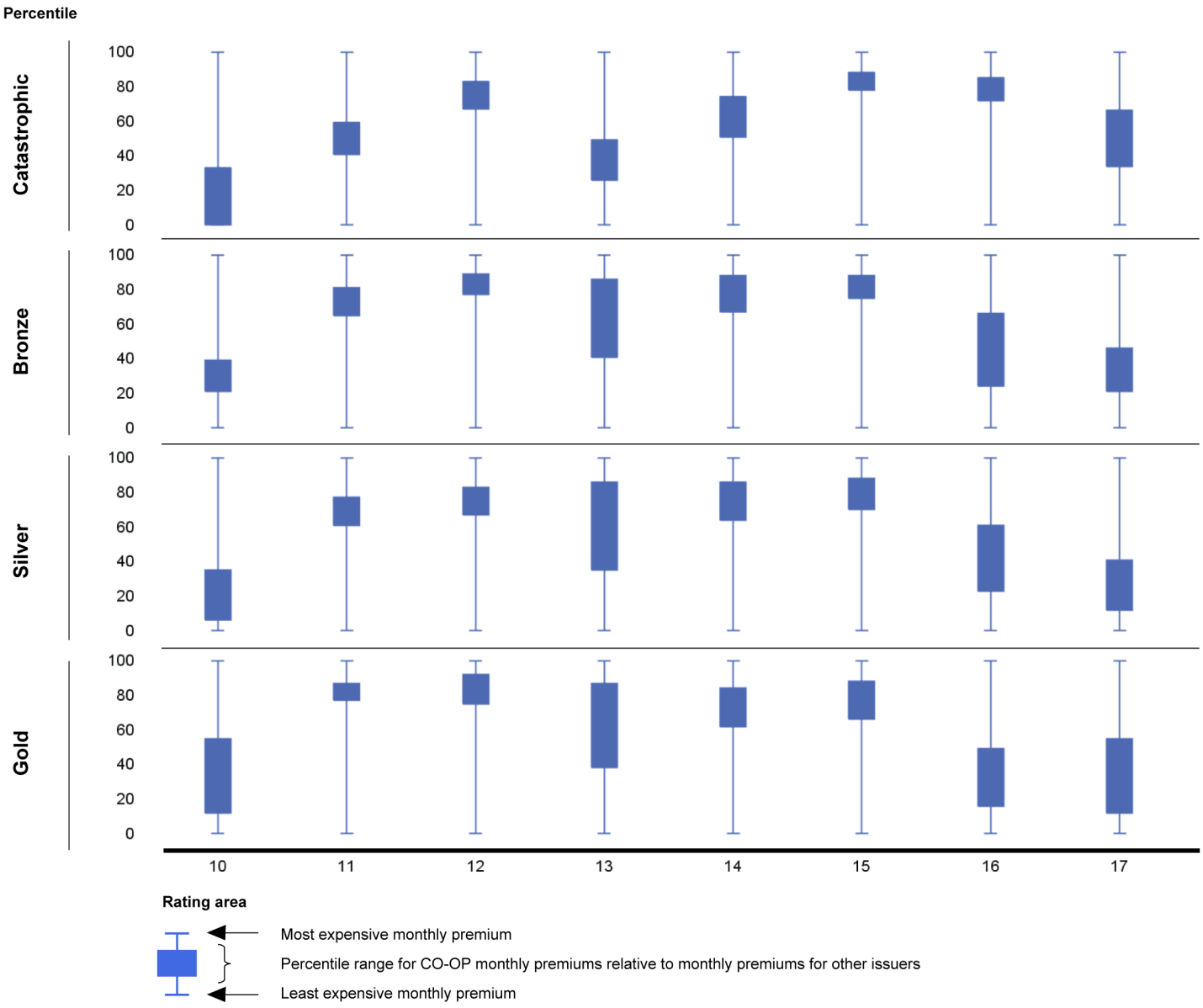
		Monthly premiums		
Year	**Silver health plans**	**Minimum**	**Average**	**Maximum**
2015	CO-OP	$266.87	$301.92	$345.73
	Other	206.27	290.76	443.39
2016	CO-OP	305.28	344.69	392.86
	Other	195.41	309.41	418.91

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Ohio offered catastrophic, bronze, silver, and gold health plans in each of the state's 17 rating areas, but did not offer a platinum health plan. Figure 19 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Ohio were often in the middle or among the most expensive premiums.

Figure 19: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Ohio for 30-Year-Old Individuals





Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were 17 rating areas in Ohio. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Defiance, Fulton, Henry, Lucas, Williams, and Wood counties.

Rating area 2 includes Allen, Auglaize, Hancock, Hardin, Mercer, Paulding, Putnam, and Van Wert counties.

Rating area 3 includes Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby counties.

Rating area 4 includes Butler, Hamilton, and Warren counties.

Rating area 5 includes Adams, Brown, Clermont, Clinton, and Highland counties.

Rating area 6 includes Erie, Huron, Ottawa, Sandusky, Seneca, and Wyandot counties.

Rating area 7 includes Crawford and Richland counties.

Rating area 8 includes Marion and Morrow counties.

Rating area 9 includes Delaware, Fairfield, Fayette, Franklin, Knox, Licking, Logan, Madison, Pickaway, and Union counties.

Rating area 10 includes Galia, Jackson, Lawrence, Pike, Ross, Scioto, and Vinton counties.

Rating area 11 includes Ashtabula, Cuyahoga, Geauga, Lake, and Lorain counties.

Rating area 12 includes Ashland, Medina, Portage, and Summit counties.

Rating area 13 includes Columbiana, Mahoning, and Trumbull counties.

Rating area 14 includes Holmes and Wayne counties.

Rating area 15 includes Carroll and Stark counties.

Rating area 16 includes Belmont, Coshocton, Guernsey, Harrison, Jefferson, Monroe, Morgan, Muskingum, Noble, Perry, and Tuscarawas counties.

Rating area 17 includes Athens, Hocking, Meigs, and Washington counties.

Appendix XIII: Premiums for the Consumer Operated and Oriented Plans Relative to Premiums for Other Health Plans in Oregon

The state-wide average monthly premium for the two consumer operated and oriented plans' (CO-OP) silver health plans for 30-year-old individuals in Oregon increased from 2014 to 2015 and, for the one CO-OP that continued to operate in 2016, increased again from 2015 to 2016.[1] Specifically, the average increase from 2014 to 2015 was about $1, and the average increase from 2015 to 2016 about $54. (See table 16.)

Table 16: Premiums for the Consumer Operated and Oriented Plans' (CO-OP) Silver Health Plans and Other Silver Health Plans in Oregon for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Issuer	Minimum	Average	Maximum
2014	CO-OP	$198.16	$243.78	$304.42
	Other	172.00	235.74	305.09
2015	CO-OP	199.00	245.00	270.00
	Other	188.00	238.25	302.00
2016	CO-OP	236.00	298.67	325.00
	Other	213.00	272.95	367.00

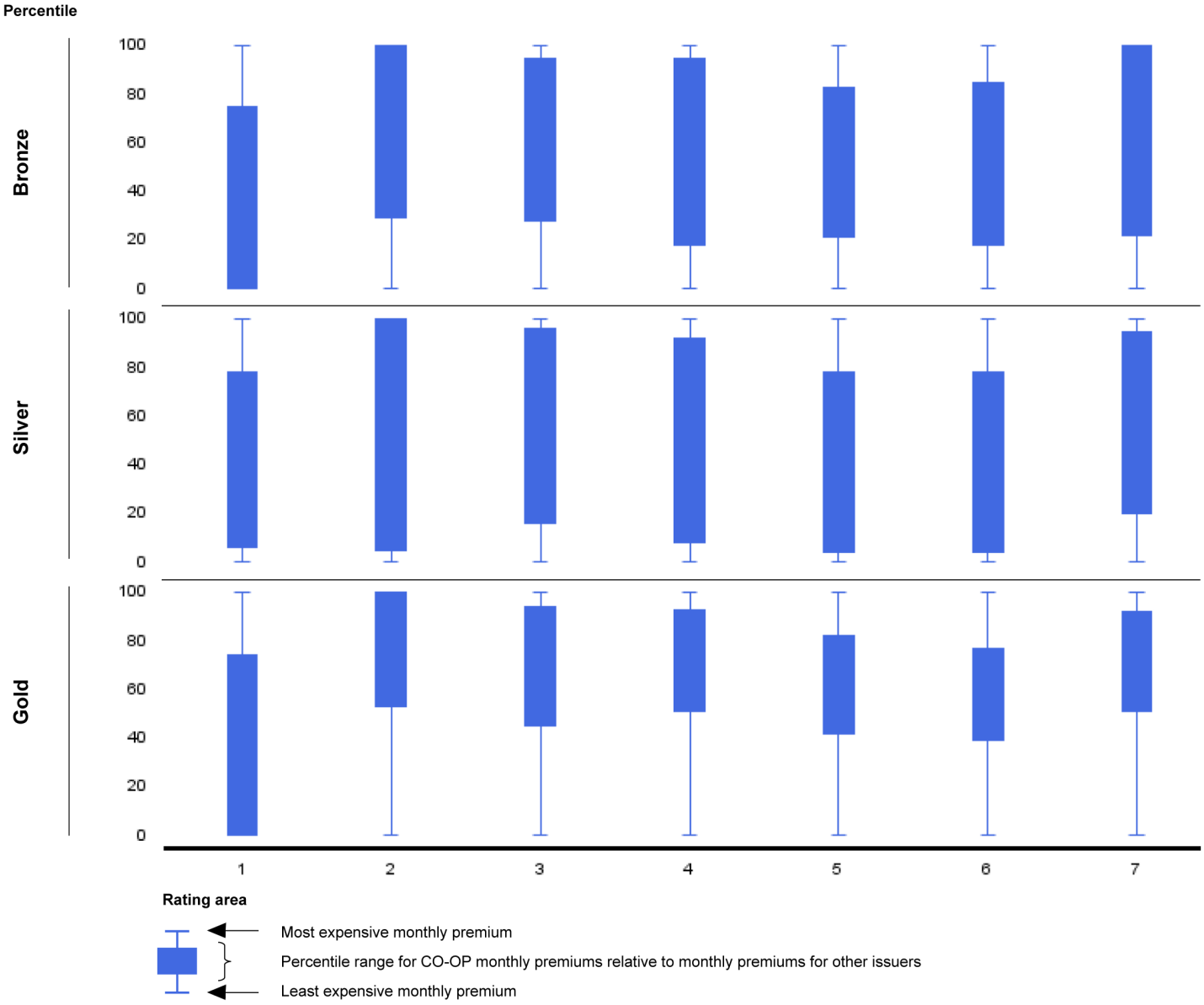
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: For 2014 and 2015, the CO-OP premiums include premiums for the two CO-OPs that offered health plans in Oregon during those two years. One of the two CO-OPs ceased operations on January 1, 2016.

For 2015, the CO-OP in Oregon that continued to operate as of January 4, 2016, offered catastrophic, bronze, silver, and gold health plans in each of the state's seven rating areas, but offered no platinum health plans. Figure 20 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for bronze and silver health plans offered by the CO-OP varied widely, ranging from among the least to the most expensive premiums. The premiums for gold health plans tended to be in the middle or among the most expensive premiums, except in rating area 1.

[1]CO-OP premiums in 2014 and 2015 include premiums for the two CO-OPs that offered health plans during those two years. One of the two CO-OPs ceased operations on January 1, 2016.

Figure 20: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Oregon for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were seven rating areas in Oregon. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value.

Rating area 1 includes Clackamas, Multnomah, Washington, and Yamhill counties.

Rating area 2 includes Benton, Lane, and Linn counties.

Rating area 3 includes Marion and Polk counties.

Rating area 4 includes Deschutes, Klamath, and Lake counties.

Rating area 5 includes Columbia, Coos, Curry, Lincoln, and Tillamook counties.

Rating area 6 includes Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler counties.

Rating area 7 includes Douglas, Jackson, and Josephine counties.

Appendix XIV: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Wisconsin

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Wisconsin increased from 2014 to 2015 and increased again from 2015 to 2016. Specifically, the average increase from 2014 to 2015 was about $19, and the average increase from 2015 to 2016 was about $25. (See table 17.)

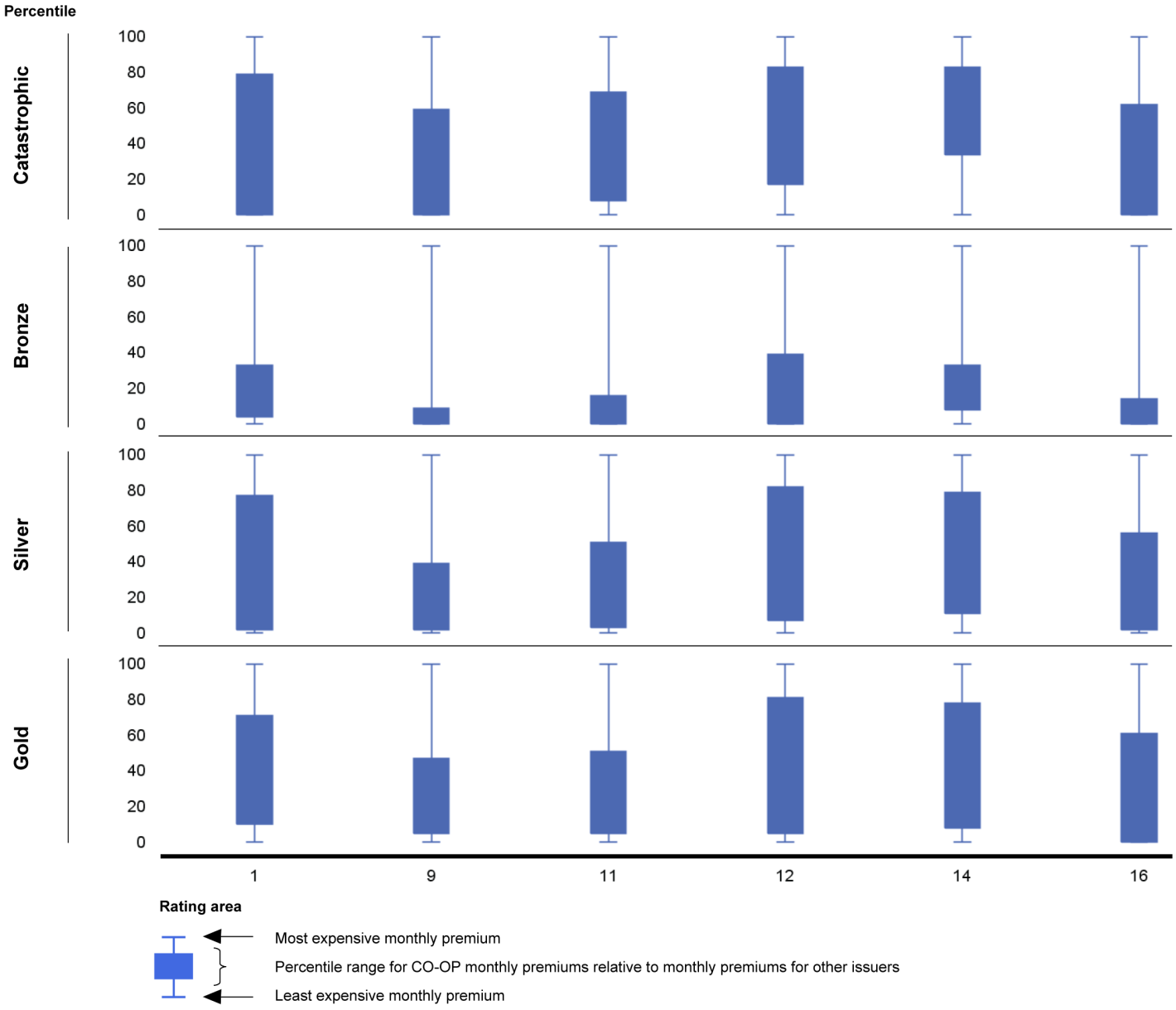
Table 17: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Wisconsin for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$225.47	$281.36	$343.93
	Other	213.72	299.58	463.90
2015	CO-OP	241.28	300.69	370.79
	Other	210.96	319.61	488.08
2016	CO-OP	284.04	325.59	372.07
	Other	200.84	341.22	523.83

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Wisconsin offered catastrophic, bronze, silver, and gold health plans in 6 of the state's 16 rating areas, but did not offer a platinum health plan. Figure 21 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for catastrophic, silver, and gold health plans offered by the CO-OP in Wisconsin varied widely, ranging from among the least to the most expensive. The premiums for bronze health plans tended to be among the least expensive premiums.

Figure 21: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Wisconsin for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were 16 rating areas in Wisconsin. The CO-OP did not offer health plans in rating areas 2 through 8, 10, 13, and 15. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Milwaukee County.

Rating area 2 includes Dane County.

Rating area 3 includes Polk, Pierce, and St. Croix counties.

Rating area 4 includes Chippewa, Dunn, Eau Claire, and Pepin counties.

Rating area 5 includes Ashland, Bayfield, Burnett, Douglas, Sawyer, and Washburn counties.

Rating area 6 includes Buffalo, Jackson La Crosse, Monroe, and Trempealeau counties.

Rating area 7 includes Crawford, Grand, Iowa, LaFayette, and Vernon counties.

Rating area 8 includes Clark, Price, Rusk, and Taylor counties.

Rating area 9 includes Racine and Kenosha counties.

Rating area 10 includes Lincoln, Marathon, Portage, and Rusk counties.

Rating area 11 includes Calumet, Dodge, Fond du Lac, Sheboygan, and Winnebago counties.

Rating area 12 includes Ozaukee, Washington, and Waukesha counties.

Rating area 13 includes Florence, Forest, Iron, Langlade, Oneida, and Vilas counties.

Rating area 14 includes Columbia, Green, Jefferson, Rock, and Walworth counties.

Rating area 15 includes Adams, Green Lake, Juneau, Marquette, Richland, and Sauk counties.

Rating area 16 includes Brown, Door, Kewaunee, Manitowoc, Menominee, Oconto, and Shawano counties.

Appendix XV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

FEB 2 6 2016

John E. Dicken
Director, Healthcare
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dickens:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Private Health Insurance: Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015*" (GAO-16-326).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PRIVATE HEALTH INSURANCE: FEDERAL OVERSIGHT, PREMIUMS, AND ENROLLMENT FOR CONSUMER OPERATED AND ORIENTED PLANS IN 2015 (GAO-16-326)

The Department of Health and Human Services (HHS) appreciates the opportunity to review GAO's draft report on Consumer Operated and Oriented Plans (CO-OPs). HHS takes its commitment to both the CO-OP beneficiaries and taxpayers seriously in managing the CO-OP program.

As of January 2016, CO-OPs have provided health insurance coverage to more than one million consumers, helping people access needed medical care. This program has increased competition and provided more consumer choices and control in choosing health insurance coverage. Overall, CO-OPs have added both choice and affordability to health insurance coverage options available to consumers. CO-OPs accomplished these goals by overcoming a variety of challenges, including building a provider network and customer support services, no previous claims experience on which to base pricing, and competing with larger, more experienced issuers. As the CO-OPs work has progressed, HHS's oversight of the CO-OP program has evolved and improved.

HHS closely monitors and evaluates the CO-OPs to assess performance and compliance, and has engaged regularly with state Departments of Insurance (DOIs), which are the primary regulators of insurance issuers in the states. HHS is committed to continuing its work with the current CO-OPs to facilitate progress and expand into new markets when appropriate. Working with state DOIs and the CO-OPs, HHS will continue its rigorous ongoing monitoring and oversight processes.

As part of that oversight process, HHS increased the data and financial reporting requirements for CO-OPs, requiring them to provide a statement on their semi-annual report that they comply with all relevant state licensure requirements or an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by state insurance regulators received by the CO-OP since the last-filed semi-annual report. During their first years of providing coverage, as more data became available, HHS learned more about the financial, management, operational, and compliance issues facing certain CO-OPs. As issues became apparent, HHS took action, including placing many CO-OPs on Corrective Action Plans (CAPs) or Enhanced Oversight Plans.

As the CO-OP program moves forward, HHS's goal is to make it easier for CO-OPs to attract outside capital or enter into new business relationships, if permitted by law, that could assist them in achieving their goals. In January 2016, HHS released general guidance concerning existing CO-OP statutory, regulatory, and contractual requirements and limitations that might affect such planning. CMS continues to explore measures to create an environment as accommodating as possible for CO-OPs and investors. CO-OPs are also introducing local innovation by implementing new programs, such as a harm reduction program launched by the CO-OP operating in New Jersey to help enrollees quit or reduce smoking. HHS will continue its work to support CO-OPs as they pursue innovative approaches to coverage.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PRIVATE HEALTH INSURANCE: FEDERAL OVERSIGHT, PREMIUMS, AND ENROLLMENT FOR CONSUMER OPERATED AND ORIENTED PLANS IN 2015 (GAO-16-326)

While the day-to-day oversight of insurance companies and review and approval of their products and rates is performed by state regulators, HHS continues to monitor each CO-OPs progress and remains committed to facilitating access to affordable, high-quality health insurance for all Americans. HHS appreciates the GAO's thorough analysis of the CO-OP program and their efforts in this program.

Appendix XVI: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Robert Copeland, Assistant Director; Kristen Joan Anderson; Sandra George; Giselle Hicks; Aaron Holling; and Drew Long made key contributions to this report.

ASPE
ISSUE BRIEF

HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: FINAL ENROLLMENT REPORT

For the period: November 1, 2015 – February 1, 2016 [1]

March 11, 2016

During the third open enrollment period, the Health Insurance Marketplaces ("the Marketplaces") continued to play an important role in fulfilling one of the Affordable Care Act's central goals: reducing the number of uninsured Americans by providing affordable, high-quality health insurance.

This report provides data summarizing enrollment-related activity in the individual market Marketplaces during the 2016 Open Enrollment Period (2016 OEP) for all 50 states and the District of Columbia (based on data for the period 11-1-15 to 2-1-16). The report indicates that about 12.7 million individuals selected or were automatically reenrolled in Marketplace plans during the 2016 OEP (see Table 1). This does not include data relating to individuals who have been enrolled in a Basic Health Plan.[2] The report also includes detailed state-level data on the characteristics of these individuals — including separate breakouts on new consumers and those who are reenrolling in coverage (including consumers who actively reenrolled, and consumers who were automatically reenrolled into Marketplace coverage). [3,4,5,6] The report includes data on

[1] For purposes of this Enrollment Report, an effort was made to align the reporting periods for the HealthCare.gov states and SBMs using their own Marketplace platforms with the reporting periods for the data that were included in the Week 13 CMS Marketplace Enrollment Snapshot (which can be accessed at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html). Most of the data in this report are for the 11-1-15 to 2-1-16 reporting period with the following exception: the data for 9 SBMs that are using their own Marketplace platforms (California, District of Columbia, Idaho, Kentucky, Maryland, New York, Rhode Island, Vermont, and Washington) are for the 11-1-15 to 1-31-16 reporting period.

[2] Minnesota and New York have begun enrolling individuals in a Basic Health Plan. These individuals are not included in reports of total Marketplace plan selections for these states.

[3] The data in this report reflect the total number of plan selections cumulatively from the beginning of Open Enrollment to the end of the reporting period, net of any cancellations from a consumer or cancellations from an insurer during that time. Because of further automation in communication with issuers, the number of net plan selections reported this year account for issuer-initiated plan cancellations that occur before the end of Open Enrollment for reasons such as non-payment of premiums. This change will result in a larger number of cancellations being accounted for during Open Enrollment than last year. Last year, these cancellations were reflected only in reports on effectuated enrollment (the number of people who have paid monthly premiums to the insurer) after the end of Open Enrollment.

[4] This report does not include data on effectuated enrollment. The Centers for Medicare & Medicaid Services (CMS) will be publishing data on effectuated enrollment for the 2016 coverage year separately. The most recent CMS quarterly snapshot on effectuated enrollment in the Marketplaces is available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html.

completed applications, eligibility determinations, website visitors, and call center activity; and data on the overall distribution of plan selections through the Marketplaces by gender, age, metal level, and financial assistance status (i.e., whether the consumer has been determined eligible for advance premium tax credits (APTC) and/or cost-sharing reductions). These data are available for the 38 states that are using the HealthCare.gov eligibility and enrollment platform (HealthCare.gov states) as well as for the 13 State-Based Marketplaces (SBMs) that are using their own Marketplace enrollment platforms for the 2016 coverage year.[7]

Additionally, for the 38 states that are using the HealthCare.gov eligibility and enrollment platform, the report includes: data on the distribution of plan selections by self-reported race/ethnicity, rural location, and household income; data on the number of reenrollees who actively reenrolled and/or changed plans, including average premium savings; and statistics that measure the impact of the advance premium tax credit and plan switching on net premium costs for these states.

[5] The 38 HealthCare.gov states include 37 states that used the HealthCare.gov eligibility and enrollment platform in 2015 and Hawaii, which is new to the HealthCare.gov eligibility and enrollment platform in 2016. For more information about data on plan selections through the Marketplaces for the 2015 coverage year, please see the Health Insurance Marketplaces 2015 Open Enrollment Period March Enrollment Report, which is available at https://aspe.hhs.gov/pdf-report/health-insurance-marketplace-2015-open-enrollment-period-march-enrollment-report.

[6] These data are consistent with the CMS Week 13 Health Insurance Marketplace Open Enrollment Snapshot, available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html.

[7] For the SBMs that are using their own Marketplace platforms, data availability for certain metrics varies by State. See the Addendum for a summary of the metrics that are available for each state. The Addendum of this report also includes some Basic Health Program enrollment data for New York. Under the Affordable Care Act, states have the option of using the Basic Health Program to provide affordable health coverage for low-income residents who would generally otherwise be eligible to purchase coverage through the Health Insurance Marketplace.

Key Highlights

For all the Marketplaces:

- About 12.7 million individuals selected, or were automatically reenrolled into, a 2016 Marketplace plan (including 4.9 million new consumers and 7.8 million that reenrolled) as of 2-1-16.[8]
- More than 3.5 million individuals who selected, or were automatically reenrolled in, a 2016 Marketplace plan are ages 18 - 34 (28 percent of total plan selections).
- Almost 10.5 million individuals who selected, or were automatically reenrolled in a 2016 Marketplace plan qualify for the advance premium tax credit (tax credit or APTC) to make coverage more affordable.

For the 38 states using the HealthCare.gov eligibility and enrollment platform:

- More than 8 in 10 individuals (more than 8.1 million, or 85 percent) who selected or were automatically enrolled in a 2016 Marketplace plan qualify for an advance premium tax credit[9] with an average value of $290 per person per month.[10]
- The average advance premium tax credit covers about 73 percent of the gross premium for individuals who qualify for an average advance premium tax credit.
- The average net premium after advance premium tax credit is $106 per month[11] among individuals with 2016 plan selections through the Marketplaces in the HealthCare.gov states who qualify for an advance premium tax credit.
- Nearly 7 in 10 of the consumers who selected, or were automatically enrolled into, a plan in the HealthCare.gov states had the option of selecting a 2016 Marketplace plan with a net premium of $75 or less per month after the advance premium tax credit.
- HealthCare.gov users are actively shopping and saving money. More than 3.9 million people (or 70 percent) who reenrolled actively selected a plan. Of those actively reenrolling, 61 percent switched to a different plan than they had in 2015.
- More consumers switched issuers than metal level. Specifically, 64 percent of the 5.6 million switchers changed issuers during the 2016 OEP (with or without changing their metal level), while only 31 percent of switchers changed metal level (with or without changing their issuer).

[8] This figure includes all individuals associated with these Marketplace plan selections, including subscribers and dependents.
[9] This represents the number of Marketplace plan selections by individuals eligible to receive an APTC. For purposes of this analysis, an individual qualifying for an advance premium tax credit was defined as any individual with an APTC amount >$0.
[10] Averages in this brief refer to plan-selection-weighted averages across individuals with plan selections with advance premium tax credits in the 37 states using the HealthCare.gov eligibility and enrollment platform (prior to the addition of Hawaii in 2016). For more information, see the ASPE Issue Brief "Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits Through January 30 in 37 States Using the HealthCare.gov Platform," which is available at http://www.aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/APTC/ib_APTC.pdf.
[11] This represents the difference between the $396 average monthly premium before advance premium tax credit and the $290 average monthly advance premium tax credit.

- Consumers who switched plans within the same metal level during the 2016 OEP saved $40 per month, or nearly $480 annually, relative to what they would have paid if they had remained in the same plan (or the crosswalked plan) as in 2015. Those who switched issuers as well as plans within the same metal level were able to save $45 per month, or nearly $540 annually.

National plan selection data show that as of 2-1-16, about 12.7 million[12] Americans selected or were automatically reenrolled[13] into a 2016 Marketplace plan, specifically:

- More than 9.6 million individuals selected or were automatically reenrolled in 2016 plans through the Marketplaces in the 38 states that are using the HealthCare.gov eligibility and enrollment platform (see Table 1).
- About 3.1 million individuals selected or were automatically reenrolled into 2016 plans through the Marketplaces in the 13 states (including DC) that are using their own Marketplace platforms.

Table 1

Plan Selections	Reporting Period: 11-1-15 to 2-2-16 (1)	
	Number	% of Total
Total 2016 Plan Selections in the Marketplaces	12,681,874	100%
2016 Plan Selections in the Marketplaces in the 38 States Using the HealthCare.gov Eligibility and Enrollment Platform	9,625,982	76%
2016 Plan Selections in the Marketplaces in the 13 State-Based Marketplaces Using Their Own Marketplace Platforms	3,055,892	24%

Note: (1) Most of the data in this table are for the 11-1-15 to 2-1-16 reporting period with the following exception: the data for 9 SBMs using their own Marketplace platforms are for the 11-1-15 to 1-31-16 reporting period. See Addendum for additional technical notes.

Source: Centers for Medicare & Medicaid Services, as of 3-8-16.

[12] It is important to note that these data generally represent the number of individuals who have selected, or been automatically reenrolled into a 2016 plan through the Marketplaces, with or without payment of premium. This is also known as pre-effectuated enrollment because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Data on effectuated enrollment are not yet available.

[13] It is important to note that the reenrollment data in this report may include some individuals who were reenrolled in coverage through the Marketplaces as of 2-1-16, but who may ultimately decide not to retain Marketplace coverage for the remainder of 2016 (for example, because they have obtained coverage through another source such as an employer or Medicaid/CHIP).

The Number of Marketplace Plan Selections in the HealthCare.gov States Has Been Higher, and Consumers Have Selected or Been Automatically Reenrolled into Marketplace Plans Earlier During the 2016 OEP Than in the 2015 OEP

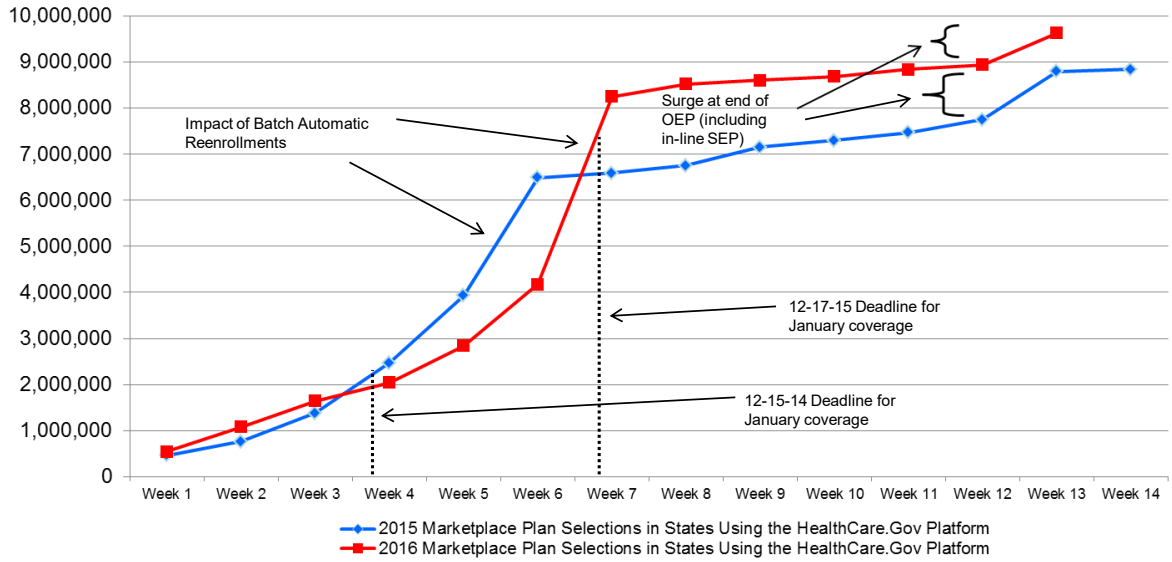
- The total number of consumers who selected or were automatically reenrolled into a Marketplace plan in the HealthCare.gov states during the 2016 OEP is 9 percent higher relative to the 2015 OEP (9.6 million vs. 8.8 million).[14]
    - The number of Marketplace plan selections in the HealthCare.gov states was generally higher during each week of the 2016 OEP, versus comparable weeks during the 2015 OEP (see Figure 1).[15]
- The proportion of consumers selecting or being automatically reenrolled into Marketplace plans during the early weeks of the OEP has continued to increase, and the proportion selecting a plan during the last few weeks of the OEP continued to decrease (see Table 2).
    - The proportion of consumers who selected or were automatically reenrolled in a Marketplace plan during the early part of the OEP was higher during the 2016 OEP (86 percent) when compared to the 2015 OEP (73 percent)[16] (see Figure 2).

[14] It is important to note that because of further automation in communication with issuers, the number of net plan selections reported for the 2016 OEP account for issuer-initiated plan cancellations that occur before the end of Open Enrollment for reasons such as non-payment of premiums. This change will result in a larger number of issuer-initiated cancellations being accounted for during the 2016 OEP than during the 2015 OEP. Last year, these cancellations were reflected only in reports on effectuated enrollment (the number of people who have paid monthly premiums to the insurer) after the end of Open Enrollment.
[15] This comparison is based on the weekly data that were reported in the 2015 and 2016 CMS Health Insurance Marketplace Open Enrollment Snapshots.
[16] For each coverage year, this analysis is based on publicly-reported data from the ASPE Marketplace Enrollment Report and/or CMS Enrollment Snapshot that included the deadline for January coverage during the applicable coverage year, and includes data for the following reporting periods: 2014 OEP (10-1-13 to 12-28-13), 2015 OEP (11-15-14 to 12-26-14), 2016 OEP (11-1-15 to 12-19-15).

Figure 1

Trends in the Cumulative Number of Individuals Who Selected a Marketplace Plan in States Using the HealthCare.gov Platform, 2015 and 2016 Open Enrollment Periods (OEPs)

During the 2016 OEP, the number of Marketplace plan selections in the HealthCare.gov states has been higher, and consumers selected plans earlier when compared with the 2015 OEP



Notes: Represents cumulative sums of weekly data on the number of unique individuals who have been determined eligible to enroll in a plan through the states using the HealthCare.gov platform, and have actively selected a plan (with or without the first premium payment having been received by the issuer), based on data published in the Weekly Enrollment Snapshots. Number of states using the HealthCare.gov platform: 37 states during the 2015 coverage year, and 38 states during the 2016 coverage year.

Source: Centers for Medicare & Medicaid Services, 2015 and 2016 Health Insurance Marketplace Weekly Enrollment Snapshots

Table 2

Comparison of the Timing of Marketplace Plan Selections in the States Using the HealthCare.gov Eligibility and Enrollment Platform During the 2014 , 2015 and 2016 Open Enrollment Periods	**2014 Open Enrollment Period** *(36 States)*		**2015 Open Enrollment Period** *(37 States)*		**2016 Open Enrollment Period** *(38 States)*	
	Number	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
Plan Selections at the Beginning of the Open Enrollment Period (1)	1,196,430	22%	6,490,492	73%	8,250,276	86%
Plan Selections in the Middle of the Open Enrollment Period (2)	1,424,656	26%	1,258,883	14%	688,998	7%
Plan Selections At the End of the Open Enrollment Period (3)	2,825,092	52%	1,088,916	12%	686,708	7%
Total Plan Selections in the HealthCare.gov States During the Open Enrollment Period	**5,446,178**	100%	**8,838,291**	100%	**9,625,982**	100%

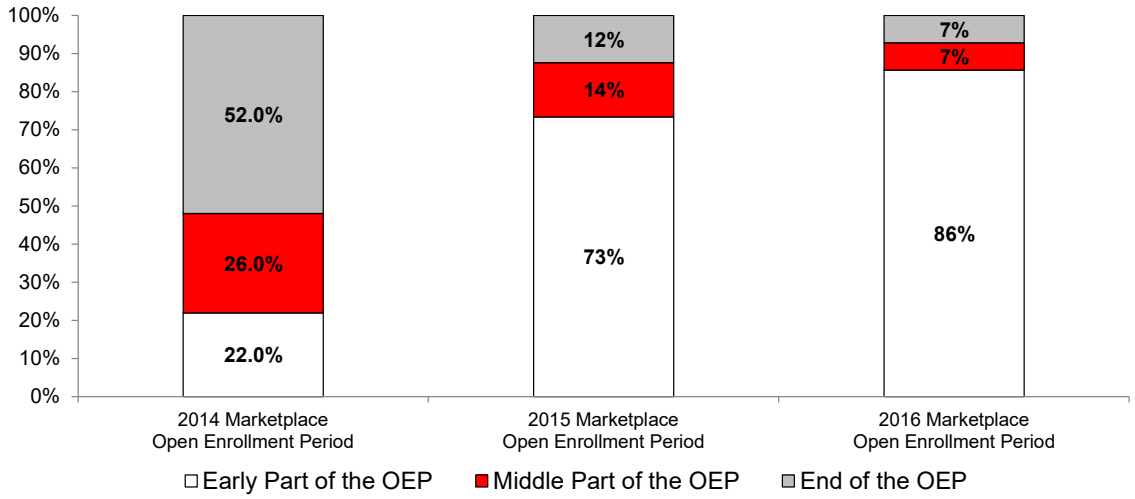
Notes: (1) Plan Selections at the Beginning of the Open Enrollment Period generally corresponds with publicly-reported data from the ASPE Enrollment Report and/or CMS Enrollment Snapshot that includes the deadline for January coverage during the applicable coverage year, and includes data for the following dates: 2014 OEP (10-1-13 to 12-28-13), 2015 OEP (11-15-14 to 12-26-14), 2016 OEP (11-1-15 to 12-19-15). (2) Plan Selections in the Middle of the Open Enrollment Period includes data for the following dates: 2014 OEP (12-29-13 to 3-1-14), 2015 OEP (12-27-14 to 2-6-15), 2016 OEP (12-20-15 to 1-23-16). (3) Plan Selections at the End of the Open Enrollment Period includes data for the following dates: 2014 OEP (3-2-14 to 3-31-14 including SEP Activity through 4-19-14), 2015 OEP (2-7-15 to 2-15-15 including SEP Activity through 2-22-15), 2016 OEP (1-24-16 to 2-1-16).

Source: ASPE calculations based on Centers for Medicare & Medicaid Services data that have been publicly reported in Marketplace Enrollment Reports and Marketplace Enrollment Snapshots for the applicable coverage years

Figure 2

Trends in the Timing of Marketplace Plan Selections in the HealthCare.gov States During the 2014, 2015 and 2016 Open Enrollment Periods (OEPs)

The proportion of consumers that who selected or were automatically reenrolled in a Marketplace plan during the early part of the OEP was higher during the 2016 OEP (86 percent) when compared to the 2015 OEP (73 percent)



Note: Data for the Early Part of the OEP corresponds with the Marketplace Enrollment Report or Snapshot that includes the deadline for coverage beginning on January 1st; data for the end of the OEP includes the week(s) OEP that correspond with the surge at the end of the applicable OEP.

Source: ASPE calculations based on Centers for Medicare & Medicaid Services data that have been publicly reported in Marketplace Enrollment Reports and Marketplace Enrollment Snapshots for the applicable coverage years.

More Than Half of those Who Reenrolled in the Marketplaces Actively Selected a Plan

- Within the Marketplaces as a whole for the 2016 OEP:
    - Nearly 4.9 million new consumers (39 percent of the 12.7 million total) and nearly 7.8 million (61 percent) who reenrolled (including 4.6 million who actively reenrolled, and 2.8 million automatically reenrolled)[17] had Marketplace plan selections as of 2-1-16) (see Table 3).[18]
    - More than half of those reenrolling actively reenrolled (59 percent, or 4.6 million out of 7.8 million), meaning that they returned to the Marketplaces and actively selected a 2016 Marketplace plan (see Table 3).

- Within the 38 states using the HealthCare.gov platform for eligibility and enrollment:
    - Over 4.0 million new consumers and over 5.6 million individuals who were actively or automatically reenrolled into coverage had 2016 Marketplace plan selections in the HealthCare.gov states as of 2-1-16) (see Table 3).
    - Nearly 2.4 million active reenrollees (61 percent of the 3.9 million who actively reenrolled) switched plans between the 2015 and 2016 coverage years (see Table 3). The remaining 1.5 million people that actively reenrolled (39 percent) remained in the same Marketplace plan (including those who remained in a crosswalked plan).

[17] The number of active reenrollees and automatic reenrollees may not add to the total number of reenrollees due to some SBM plan selections with missing data. For more details on reenrollment in the Marketplaces, see the Addendum.
[18] Additionally, approximately 3 percent of the 12.7 million plan selections had an unknown reenrollment type because 3 SBMs (MA, MN and NY) were unable to validate the number of active reenrollees vs. automatic reenrollees as of 2-1-16.

Table 3

2016 Marketplace Plan Selections By Enrollment Type and Switching Status (Reporting Period: 11-1-15 to 2-1-16) (1))	Cumulative (Reporting Period: 11-1-15 to 2-1-16)			
	Number	Plan Selection Data by Enrollment Type as a % of:		
		Total Plan Selections	All Consumers Reenrolling in Coverage	Active Reenrollees
Marketplace Total				
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2016 Marketplace Plan	12,681,874	100%	N/A	N/A
New Consumers (2)	4,887,026	39%	N/A	N/A
Consumers Reenrolling in 2016 Coverage through the Marketplaces (3)	7,794,848	61%	*100%*	N/A
Active Reenrollees	4,575,241	36%	*59%*	100%
Automatic Reenrollees	2,787,218	22%	*36%*	*N/A*
Unknown Reenrollment Type	432,389	3%	*6%*	*N/A*
States Using the HealthCare.Gov Eligibility and Enrollment Platform				
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2016 Marketplace Plan	9,625,982	100%	N/A	N/A
New Consumers (2)	4,025,637	42%	N/A	N/A
Consumers Reenrolling in 2016 Coverage through the Marketplaces	5,600,345	58%	*100%*	N/A
Active Reenrollees	3,918,452	41%	*70%*	100%
Active Reenrollees Who Remained in the Same (or the Crosswalked) Marketplace Plan	1,529,184	16%	*27%*	*39%*
Active Reenrollees Who Switched Marketplace Plans	2,389,268	25%	*43%*	*61%*
Automatic Reenrollees	1,681,893	17%	*30%*	*N/A*
Unknown Reenrollment Type	0	0%	*0%*	*N/A*
SBMs Using Their Own Marketplace Platforms				
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2016 Marketplace Plan	3,055,892	100%	N/A	N/A
New Consumers (2)	861,389	28%	N/A	N/A
Consumers Reenrolling in 2016 Coverage through the Marketplaces (3)	2,194,503	72%	*100%*	N/A
Active Reenrollees	656,789	21%	*30%*	100%
Automatic Reenrollees	1,105,325	36%	*50%*	*N/A*
Unknown Reenrollment Type	432,389	14%	*20%*	*N/A*

Note: (1) Most of the data in this table are for the 11-1-15 to 2-1-16 reporting period with the following exception: the data for 9 SBMs using their own Marketplace platforms are for the 11-1-15 to 1-31-16 reporting period. See Addendum for additional technical notes. (2) The number of New Consumers includes most of the 2016 plan selections for HI, which began using the HealthCare.gov platform for the 2016 coverage year. (3) For SBMs using their own Marketplace platforms, the number of active reenrollees and automatic reenrollees does not add to the total number of reenrollees due to some SBM plan selections with missing data. (4) Three SBMs (MA, MN and NY) were unable to validate the number of active reenrollees vs. automatic reenrollees as of 2-1-16.

Source: Centers for Medicare & Medicaid Services, as of 3-8-16.

Demographic Characteristics of Individuals Selecting Marketplace Plans

Table 4 summarizes the demographic characteristics of individuals selecting plans through the Marketplaces as a whole during the 2016 OEP. (Note that the totals and percentages reported in Table 4 reflect only those plan selections for which data are available on the relevant characteristic. The share of plan selections with unknown data has decreased between the 2015 OEP and the 2016 OEP, so care should be taken when comparing data for the 2015 and 2016 Open Enrollment periods).

- Approximately 36 percent of the individuals who selected, or were automatically reenrolled in, a 2016 Marketplace plan are younger than 35 (4.6 million out of 12.7 million).
- Approximately 28 percent of the individuals who selected, or were automatically reenrolled in, a 2016 Marketplace plan are ages 18 to 34 (3.5 million out of 12.7 million).

Table 4

Selected Characteristics of Plan Selections through the Marketplaces in All States (1)	2015 Open Enrollment Period (2) Total Plan Selections	2016 Open Enrollment Period 11-1-15 to 2-1-16(3) Total Plan Selections
Total Number of Individuals Who Have Selected a 2016 Plan Through the Marketplaces	11.69 million	12.68 million
Males who have selected a Marketplace plan	5.40 million	5.88 million
	46%	46%
Females who have selected a Marketplace plan	6.28 million	6.80 million
	54%	54%
0 to 34 year olds who have selected a Marketplace plan	3.53 million	4.59 million
	36%	36%
18 to 34 year olds who have selected a Marketplace plan	2.74 million	3.53 million
	28%	28%
Individuals who have selected a Silver Marketplace plan	7.80 million	8.52 million
	67%	68%
Individuals who have selected a Marketplace plan with Financial Assistance	9.94 million	10.49 million
	86%	83%

Note: (1) For each metric, the counts and percentages represent the percent of plan selections with known data for that category.
(2) Data for the 2015 Open Enrollment Period are for the following reporting period: 11-15-14 to 2-15-15 (including SEP activity through 2-22-15).
(3) Data for the 2016 Open Enrollment Period are for the following reporting period: 11-1-15 to 2-1-16.
Source: ASPE computation of CMS data as of 3-8-16.

Table 5 summarizes the demographic characteristics of consumers selecting plans through the Marketplaces in the 38 states using the HealthCare.gov eligibility and enrollment platform during the 2016 OEP, both in total and by reenrollment status. As noted in the 2014 summary enrollment report,[19] the data on race and ethnicity should be interpreted with great caution since more than one-third of enrollees do not self-report these data. It is also important to note that the proportion of 2016 plan selections with unknown data on self-reported race/ethnicity was slightly higher than in prior years (37 percent vs. 36 percent for the comparable period during the 2015 OEP).

[19] For more information about data on Marketplace plan selections for the 2014 coverage year, please see the Marketplace Summary Enrollment Report, which is available at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

Table 5

Selected Characteristics of Plan Selections through the Marketplaces in States Using the HealthCare.gov Eligibility and Enrollment Platform (1)	2015 Open Enrollment Period (2)	2016 Open Enrollment Period 11-1-15 to 2-1-16 (3)			
	Total Plan Selections	Total Plan Selections	By Reenrollment Status		
			New Consumers (%)	Active Reenrollees (%)	Automatic Reenrollees (%)
Total Number of Individuals Who Have Selected a 2016 Plan Through the Marketplaces in the HealthCare.gov States	8.84 million	9.63 million	4.03 million	3.92 million	1.68 million
Males who have selected a Marketplace plan	4.04 million	4.41 million	1.90 million	1.73 million	0.79 million
	46%	46%	47%	44%	47%
Females who have selected a Marketplace plan	4.80 million	5.21 million	2.13 million	2.19 million	0.90 million
	54%	54%	53%	56%	53%
0 to 34 year olds who have selected a Marketplace plan	3.20 million	3.56 million	1.72 million	1.22 million	0.62 million
	36%	37%	43%	31%	37%
18 to 34 year olds who have selected a Marketplace plan	2.48 million	2.68 million	1.33 million	0.87 million	0.47 million
	28%	28%	33%	22%	28%
Individuals who have selected a Silver Marketplace plan	6.09 million	6.82 million	2.77 million	2.89 million	1.16 million
	69%	71%	69%	74%	69%
Individuals who have selected a Marketplace plan with Financial Assistance	7.69 million	8.18 million	3.36 million	3.52 million	1.30 million
	87%	85%	84%	90%	77%
African-Americans who have selected a Marketplace plan (4)	0.79 million	0.71 million	0.34 million	0.24 million	0.13 million
	14%	12%	16%	8%	12%
Latinos who have selected a Marketplace plan (4)	0.61 million	0.92 million	0.37 million	0.40 million	0.14 million
	11%	15%	17%	14%	14%
Whites who have selected a Marketplace plan (4)	3.65 million	3.81 million	1.27 million	1.88 million	0.67 million
	62%	63%	57%	66%	65%
Individuals in ZIP Codes designated as rural who have selected a Marketplace plan	1.54 million	1.71 million	0.66 million	0.71 million	0.33 million
	17%	18%	17%	18%	20%

Note: (1) For each metric, the percentages represent the percent of plan selections with known data for that category.

(2) Data for the 2015 Open Enrollment Period are for the following reporting period: 11-15-14 to 2-15-15 (including SEP activity through 2-22-15). During the 2015 Marketplace coverage year, there were a total of 37 states using the HealthCare.gov platform, including 35 states that are states that used the HealthCare.gov platform in both 2014 and 2015, and two states which are new to the HealthCare.gov platform in 2015 (Oregon and Nevada).

(3) Data for the 2016 Open Enrollment Period are for the following reporting period: 11-1-15 to 2-1-16. During the 2016 Marketplace coverage year, there were a total of 38 states using the HealthCare.gov platform, including 37 states that are states that used the HealthCare.gov platform in both 2014 and 2015, and one state which is new to the HealthCare.gov platform in 2016 (Hawaii).

(4) The percentages by race/ethnicity are based on the total number of plan selections with known self-reported data on race/ethnicity. CMS has updated the methodology for identifying Latinos applying for 2016 coverage by incorporating the selection of "Other" ethnicity as Latino. Specifically, all consumers who selected "Other ethnicity" on their application are now counted as Latino. Latino ethnicity is indicated when Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban, and/or Other is selected. This has led to an increase in the number of reported Latinos compared to previous years. Please see the Addendum for additional information.

Source: ASPE computation of CMS data for 38 states using the HealthCare.gov Eligibility and Enrollment platform as of 3-8-16.

Advance Premium Tax Credits: Consumers Enrolling through the Marketplaces in the HealthCare.gov States are Saving Hundreds of Dollars on their Monthly Premiums[20]

Under the Affordable Care Act, advance premium tax credits (APTC) are available to reduce premium costs for eligible taxpayers.[21] In the 38 states using the HealthCare.gov eligibility and enrollment platform:

- More than 8.1 million (85 percent of 9.6 million) individuals that selected or were automatically reenrolled into a 2016 plan through the Marketplaces in the HealthCare.gov states qualify for an APTC[22] with an average value of $290 per person per month (see Table 6 and Appendix Table B1 on page 39).
- The average APTC covers about 73 percent[23] of the gross premium for individuals who qualify for an APTC (see Table 6 and Appendix Table B1 on page 39).
- The average net premium after APTC is $106 per month[24] among individuals with 2016 plan selections through the Marketplaces in the HealthCare.gov states who qualify for an APTC (see Table 6 and Appendix Table B1 on page 39).

Table 6

Reduction in Average Monthly Premiums from Advance Premium Tax Credits (APTC) in States Using the HealthCare.gov Eligibility and Enrollment Platform
11-1-15 to 2-1-16

Description	Total Number of Individuals With 2016 Plan Selections Through the Marketplaces	Percent of Plan Selections with APTC	Average Monthly Premium before APTC	Average Monthly APTC	Average Monthly Premium After APTC	Average Percent Reduction in Premium after APTC
TOTAL – States Using the HealthCare.gov Eligibility and Enrollment Platform	9.63 million	85%	$396	$290	$106	73%

Source: ASPE computation of CMS data for 38 states using the HealthCare.gov eligibility and enrollment platform as of 3-8-16.

[20] For additional information about these premium-related metrics, please see "Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits through January 30 in 37 States Using the HealthCare.gov Platform," ASPE Research Brief, U.S. Department of Health and Human Services, February 9, 2015. Available at: http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/APTC/ib_APTC.pdf.

[21] 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 (advance premium tax credit or "APTC") to an issuer of a qualified health plan in order to reduce the cost of monthly insurance premiums. APTCs are generally available for 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.

[22] For purposes of this analysis, an individual qualifying for an advance premium tax credit was defined as any policy with an APTC amount >$0.

[23] This represents the $106 average monthly premium after advance premium tax credit as a percentage of the $396 average monthly premium before advance premium tax credit.

[24] This represents the difference between the $396 average monthly premium before advance premium tax credit and the $290 average monthly advance premium tax credit.

Availability of Marketplace Plans with Premiums of $100, $75, $50 or Less in the HealthCare.gov States

- More than 7 in 10 consumers seeking coverage through the Marketplaces could select a plan with a monthly premium of $100 or less after applying the APTC. Through 1 2-1-16, more than 1 in 2 consumers (52 percent) selected or were automatically reenrolled into such a plan (see Table 7 and Appendix Table B2 on page 41).
- 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 2-1-16, more than 4 in 10 consumers (42 percent) selected such a plan (see Table 7 and Appendix Table B3 on page 43).

Table 7

Availability and Selection of Plans With Monthly Premiums of $100 or Less After the Advance Premium Tax Credit (APTC) through the Marketplaces in States Using the HealthCare.gov Eligibility and Enrollment Platform
11-1-15 to 2-1-16

Description	Number of Individuals With 2016 Plan Selections Through the Marketplaces (2)	Availability of Plans With Monthly Premiums of $100 or Less			Selection of Plans With Monthly Premiums of $100 or Less		
		Percent Who Could Have Selected a Plan with a Monthly Premium of:			*Percent Who Selected or Were Automatically Reenrolled into 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
Total Marketplace Plan Selections							
Total Number of Individuals With 2016 Plan Selections	9.63 million	61%	68%	74%	30%	42%	52%
Individuals With 2016 Plan Selections With APTC	8.15 million	72%	80%	86%	36%	49%	61%

Source: ASPE computation of CMS data for 38 states using the HealthCare.gov eligibility and enrollment platform as of 3-8-16.

Reenrolling Marketplace Consumers in the HealthCare.gov States Shop at a High Rate and Save on Premiums

- New consumers were more likely to purchase a plan for $100 or less after applying the APTC – 56 percent of new consumers selected coverage with a monthly premium of $100 or less, compared to 51 percent for people actively reenrolled, and 42 percent for those who automatically reenrolled (see Table 8).
- Individuals that actively reenrolled and returned to the Marketplaces to shop for coverage were more likely to have a monthly premium of $75 or less after applying the APTC than those who automatically reenrolled (41 percent vs. 33 percent, respectively).
- Savings from shopping: On average, those who actively reenrolled and changed plans selected plans for $132 per month after applying the APTC, compared to $174 per month if they had stayed in their 2015 plan (or the crosswalked plan), a savings of 24 percent or $42 per month on average, after applying the APTC (see Table 9).

Table 8

2016 Plan Selections Through the Marketplaces in States Using the HealthCare.gov Eligibility and Enrollment Platform By Monthly Premium After Tax Credit	Cumulative 11-1-15 to 2-1-16			
	Total Individuals With 2016 Marketplace Plan Selections	By Reenrollment Status		
		New Consumers	Active Reenrollees	Automatic Reenrollees
Total 2016 Plan Selections Through the Marketplaces in HealthCare.gov States	9.63 million	4.03 million	3.92 million	1.68 million
Plan Selections by Monthly Premium After the Advance Premium Tax Credit (APTC):				
Less Than or Equal to $100	52%	56%	51%	42%
≥$0 and ≤ $50	30%	35%	29%	22%
>$50 and ≤ $75	12%	11%	12%	11%
>$75 and ≤ $100	10%	9%	10%	9%
Greater Than $100	48%	44%	49%	58%

Source: ASPE computation of CMS data for 38 states using the HealthCare.gov eligibility and enrollment platform as of 3-8-16.

Table 9

Reduction in Average Monthly Premiums from Advance Premium Tax Credits (APTC) For All Shoppers in States Using the HealthCare.gov Eligibility and Enrollment Platform
11-1-15 to 2-1-16

Description	Active Reenrollees with 2015 Plan Selections		
	Total	Consumers Who Switched Plans	Consumers Who Remained in Same or Crosswalked Plan
Total Consumer Plan Selections	3.92 million	2.39 million	1.53 million
Percent of Active Reenrollees	100%	61%	39%
Percent of Plan Selections with APTC	89%	89%	91%
Average Monthly Premium After APTC if Remained in Same or Crosswalked Plan from 2015	$159	$174	$142
Average Monthly Premium After APTC After Shopping	$137	$132	N/A
Average Savings in Monthly Premium After APTC After Shopping	N/A	$42	N/A

Note: Average Savings in Monthly Premium After APTC was calculated for all consumers who switched plans, metal levels and/or issuers, including savings associated with consumers who decided to reduce their level of coverage.
Source: ASPE computation of CMS data for 38 states using the HealthCare.gov eligibility and enrollment platform as of 3-8-16.

Over One-Third of the Consumers Reenrolling in Marketplace Coverage in the HealthCare.gov States Switched Plans

- Among the 5.6 million consumers who reenrolled in Marketplace plans in the HealthCare.gov states, 43 percent switched to a new plan during the 2016 OEP (see Table 10). The proportion of consumers reenrolling in coverage who switched plans continues to be higher than the levels of switching seen in other programs, such as for Medicare Part D enrollees, active employees with Federal Employee Health Benefit Plan coverage, and individuals with employer-sponsored coverage.
- Among consumers who switched plans, more consumers switched issuers than metal levels (see Table 10). Specifically, 47 percent of switchers changed only their issuer during the 2016 OEP, while 15 percent of switchers changed only their metal level during the 2016 OEP, and 16 percent of switchers changed both issuers and metal levels.
    - A total of 64 percent of switchers changed their issuer, with or without also changing their metal level.
    - A total of 31 percent of switchers changed their metal level with or without also changing their issuer.

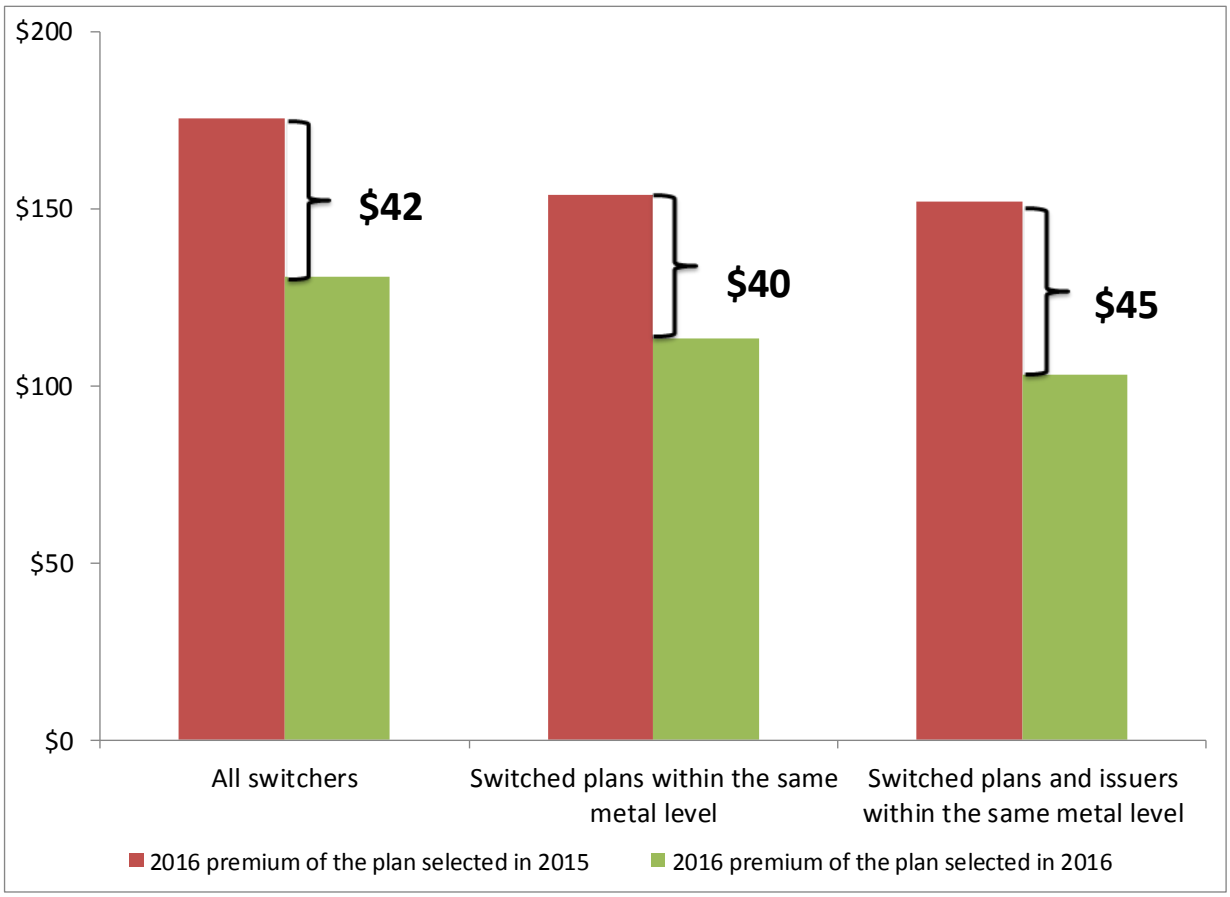
Table 10

2016 Issuer and Metal Level Choices of Switchers		
Description	**Percent of All Reenrollees** ***N = 5.6 million***	**Percent of All Switchers** ***N = 2.4 million***
Total Reenrollees in the HealthCare.gov States	100%	N/A
Switchers	43%	100%
Active Reenrollees Who Changed Plans but Not Metal Level or Issuer	9%	21%
Active Reenrollees Who Changed Issuer but Not Metal Level	20%	47%
Active Reenrollees Who Changed Metal Level but Not Issuer	6%	15%
Active Reenrollees Who Changed Metal Level and Issuer	7%	16%
Active Reenrollees Who Changed Metal Level (with or without changing issuer) (non-add)	*13%*	*31%*
Active Reenrollees Who Changed Issuer (with or without changing metal level) (non-add)	*27%*	*64%*
Active Reenrollees Who Switched Without Having a Valid 2015 Crosswalk Plan (non-add)	*0%*	*0%*
Non-Switchers	57%	N/A
Active Reenrollees Who Remained in The Same (or the Crosswalked) Marketplace Plan	27%	N/A
Automatic Reenrollees	30%	N/A

Source: ASPE computation of CMS data for 37 states using the HealthCare.gov eligibility and enrollment platform in 2015 and 2016 as of 3-8-16.

- Consumers who switched plans within the same metal level during the 2016 OEP saved $40 per month, or nearly $480 annually, relative to what they would have paid if they had remained in the same plan (or the crosswalked plan) as in 2015. Meanwhile, those who switched issuers as well as plans within the same metal level were able to save $45 per month, or nearly $540 annually (see Figure 3 and Appendix Table B5 on page 47).

Figure 3: Monthly Premium Savings for Switchers



Note: Savings are calculated as the difference between the 2016 premium of the 2016 selected plan and the 2015 selected plan. Numbers are rounded to the nearest dollar.
Source: ASPE computation of CMS data for 37 states using the HealthCare.gov eligibility and enrollment platform in 2015 and 2016 as of 3-8-16.

SECTION II. METHODOLOGICAL OVERVIEW

The data reported here have been obtained from the information systems of the Centers for Medicare & Medicaid Services (CMS), based on information collected for 38 states using the HealthCare.gov eligibility and enrollment platform. We also obtained more limited data reported to CMS by the 13 states (including DC) that are using their own Marketplace platforms. Data for the Small Business Health Options Program (SHOP) Marketplaces are not included in this report.

This report includes data that are currently available on enrollment-related activity for the 2016 Open Enrollment period – which generally corresponds with data from 11-1-15 to 2-1-16 for the 38 states using the HealthCare.gov eligibility and enrollment platform and for states that are using their own Marketplace platforms for the 2016 coverage year.

Table 11

Marketplace Type	Reporting Period (1)
States Using the HealthCare.gov Marketplace Eligibility and Enrollment Platform (38 states)	11-1-15 to 2-1-16
State Based Marketplaces (SBMs) Using Their Own Marketplace Platform (13 states)	
9 States: California, District of Columbia, Idaho, Kentucky, Maryland, New York, Rhode Island, Vermont, Washington	11-1-15 to 1-31-16
4 States: Colorado, Connecticut, Massachusetts, Minnesota	11-1-15 to 2-1-16

Note: (1) For purposes of the Final Enrollment Report, an effort was made to align the reporting periods for the HealthCare.gov states and SBMs using their own Marketplace platforms with the reporting periods for the data that were included in the Week 13 CMS Marketplace Enrollment Snapshot (which can be accessed at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html).

Data for certain metrics are not available for several of the states that are using their own Marketplace platforms.

It is important to note that some of the 13 states that are using their own Marketplace platforms are not reporting data separately for consumers who are actively reenrolling in coverage and consumers who have been automatically reenrolled into coverage through the Marketplaces. Please refer to the Addendum for additional technical notes.

This report also includes available data on the characteristics of individuals who have selected a plan through the Marketplaces for the 38 states that are using the HealthCare.gov eligibility and enrollment platform for 2016, and the 13 states that are using their own Marketplace platforms. In some cases, the data for certain characteristics of Marketplace plan selections are not yet available in selected states.

The information contained in this issue brief provides the most systematic summary of enrollment-related activity in the Marketplaces for the 2016 Open Enrollment period because the data for the various metrics are counted using comparable definitions for data elements across states and Marketplace types.

SECTION III: APPENDICES

	• C7 - Total Marketplace Plan Selections by Gender in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
	• C8 - Total Marketplace Plan Selections by Metal Level in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
	• C9 - Total Marketplace Plan Selections by Race/Ethnicity in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
	• C10 - Total Marketplace Plan Selections by Rural Status in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
	• C11 - Total Marketplace Plan Selections by Household Income in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
	• C12 - Total Marketplace Plan Selections by Gender and Age in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
	• C13 - Total Marketplace Plan Selections by Gender and Metal Level in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
	• C14 - Total Marketplace Plan Selections by Financial Assistance Status and Metal Level in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
	• C15 - Total Marketplace Plan Selections by Metal Level and Age in States Using the HealthCare.gov Eligibility and Enrollment Platform, By State	Addendum
Appendix D:	**State-Level Marketplace Plan Selection Tables – States Using Their Own Marketplace Platforms**	
	• D1 – Marketplace Plan Selection by Enrollment Type in States Using Their Own Marketplace Platforms, By State, By State	Addendum
	• D2 - Total Completed Applications and Individuals Who Completed Applications in States Using Their Own Marketplace Platforms, By State	Addendum
	• D3 - Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in States Using Their Own Marketplace Platforms, By State	Addendum
	• D4 - Total Marketplace Plan Selections by Financial Assistance Status in States Using Their Own Marketplace Platforms, By State	Addendum
	• D5 - Total Marketplace Plan Selections by Age in States Using Their Own Marketplace Platforms, By State	Addendum
	• D6 - Total Marketplace Plan Selections by Gender in States Using Their Own Marketplace Platforms, By State	Addendum
	• D7 - Total Marketplace Plan Selections by Metal Level in States Using Their Own Marketplace Platforms, By State	Addendum
Appendix E:	**Technical Notes**	Addendum

APPENDIX TABLE A1

Marketplace Plan Selections by Gender, Age, Metal Level, and Financial Assistance, All State Marketplaces *11-1-15 to 2-1-16 (1)*		
Characteristics	**Marketplaces Total** *(States Using the HealthCare.gov Eligibility and Enrollment Platform and States Using Their Own Marketplace Platforms)*	
	Number 11-1-15 to 2-1-16 (2)	**% of Available Data, Excluding Unknown (3)**
Total Who Have Selected a Marketplace Plan		
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2016 Marketplace Plan	12,681,874	100%
By Enrollment Status		
New Consumers	4,887,026	39%
Total Reenrollees (4)	7,794,848	61%
Active Reenrollees	*4,575,241*	*36%*
Automatic Reenrollees	*2,787,218*	*22%*
Unknown Reenrollment Type	*432,389*	*3%*
Subtotal: Plan Selections With Available Data on Enrollment Status	12,681,874	100%
Unknown Enrollment Status	0	N/A
By Gender		
Female	6,802,327	54%
Male	5,878,278	46%
Subtotal: Plan Selections With Available Data on Gender	12,680,605	100%
Unknown Gender	1,269	N/A
By Age		
Age < 18	1,068,631	8%
Age 18-25	1,370,048	11%
Age 26-34	2,155,493	17%
Age 35-44	2,043,932	16%
Age 45-54	2,682,762	21%

Marketplace Plan Selections by Gender, Age, Metal Level, and Financial Assistance, All State Marketplaces *11-1-15 to 2-1-16 (1)*		
Characteristics	**Marketplaces Total** *(States Using the HealthCare.gov Eligibility and Enrollment Platform and States Using Their Own Marketplace Platforms)*	
	Number 11-1-15 to 2-1-16 (2)	**% of Available Data, Excluding Unknown (3)**
Age 55-64	3,262,215	26%
Age ≥65	97,603	1%
Subtotal: Plan Selections With Available Data on Age (2)	12,680,684	100%
Unknown Age	1,190	N/A
Ages 18 to 34	3,525,541	28%
Ages 0 to 34	4,594,172	36%
By Metal Level		
Bronze	2,873,422	23%
Silver	8,520,787	68%
Gold	797,501	6%
Platinum	192,244	2%
Catastrophic	138,400	1%
Subtotal: Plan Selections With Available Data on Metal Level (5)	12,522,354	100%
Stand-alone Dental	1,710,112	N/A
Unknown Metal Level	159,520	N/A
By Financial Assistance Status		
With Financial Assistance	10,510,141	83%
Without Financial Assistance	2,088,385	17%
Subtotal: Plan Selections With Available Data on Financial Assistance (2)	12,598,526	100%
Unknown Financial Assistance Status	83,516	N/A
APTC	10,474,116	83%

Notes:

Percentages in this table have been rounded. Some numbers may not add to totals due to rounding.

(1) Unless otherwise noted, the data in this table represent cumulative data on the number of unique individuals who have been determined eligible to enroll in a Marketplace plan, and have selected or been automatically reenrolled into a Marketplace medical plan (with or without the first premium payment having been received by the issuer). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections for all but two states (Minnesota and DC). These data also do not include: stand-alone dental plan selections; or individuals who may have selected a 2015 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). For additional technical notes, please refer to the Addendum of this report.

(2) For each metric, the data represent the total number of "Individuals Applying for 2016 Coverage in Completed Applications" who have selected a 2016 medical Marketplace plan for enrollment through the Marketplace (with or without the first premium payment having been received directly by the issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Most of the data in this table are for the 11-1-15 to 2-1-16 reporting period with the following exception: the data for 9 SBMs using their own Marketplace platforms are for the 11-1-15 to 1-31-16 reporting period.

(3) In some cases, the data for certain characteristics of Marketplace plan selections are not yet available. For this reason, for each metric, we have calculated the comparable percentages based on the number of plan selections with known data for that metric.

(4) The number of active reenrollees and automatic reenrollees may not add to the total number of reenrollees due to some SBM plan selections with missing data.

(5) The subtotals for each metal tier type do not sum to the total number partially due to a small number of individuals who have multiple 2016 Marketplace plan selections in the system that will be resolved through data cleanup processes, but primarily due to Massachusetts counting 158,512 individuals enrolled in its Connector Care Program as unknowns. Connector Care plans are closest to Silver plans, but their actuarial value is higher than that of a Silver Plan. Data for stand-alone dental plan selections are shown in this section, but are not included in any of the other metrics in this report.

Source: Centers for Medicare & Medicaid Services, as of 3-8-16.

APPENDIX TABLE A2

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, Rural Status, and Household Income in States Using the HealthCare.gov Platform (1) *11-1-15 to 2-1-16*		
Characteristics	**Marketplaces Total States Using the HealthCare.gov Eligibility and Enrollment Platform for the 2016 Coverage Year** *(38 States)*	
	Number 11-1-15 to 2-1-16 (2)	**% of Available Data, Excluding Unknown (3)**
Total Who Have Selected a Marketplace Plan		
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2016 Marketplace Plan	9,625,982	100%
By Enrollment Status		
New Consumers	4,025,637	42%
Total Reenrollees	5,600,345	58%
Active Reenrollees	*3,918,452*	*41%*
Automatic Reenrollees	*1,681,893*	*17%*
Unknown Reenrollment Type	*0*	*0%*
Subtotal: Plan Selections With Available Data on Enrollment Status	9,625,982	100%
Unknown Enrollment Status	0	N/A
By Gender		
Female	5,213,706	54%
Male	4,412,276	46%
Subtotal: Plan Selections With Available Data on Gender	9,625,982	100%
Unknown Gender	0	N/A
By Age		
Age < 18	884,172	9%
Age 18-25	1,067,477	11%
Age 26-34	1,608,390	17%
Age 35-44	1,555,651	16%

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, Rural Status, and Household Income in States Using the HealthCare.gov Platform (1) *11-1-15 to 2-1-16*		
Characteristics	**Marketplaces Total States Using the HealthCare.gov Eligibility and Enrollment Platform for the 2016 Coverage Year** *(38 States)*	
	Number 11-1-15 to 2-1-16 (2)	**% of Available Data, Excluding Unknown (3)**
Age 45-54	2,010,657	21%
Age 55-64	2,431,625	25%
Age ≥65	67,957	1%
Subtotal: Plan Selections With Available Data on Age (2)	9,625,929	100%
Unknown Age	53	N/A
Ages 18 to 34	2,675,867	28%
Ages 0 to 34	3,560,039	37%
By Metal Level		
Bronze	2,060,447	21%
Silver	6,823,481	71%
Gold	571,327	6%
Platinum	71,701	1%
Catastrophic	99,026	1%
Subtotal: Plan Selections With Available Data on Metal Level (4)	9,625,982	100%
Stand-alone Dental	1,425,474	N/A
Unknown Metal Level	0	N/A
By Financial Assistance Status		
With Financial Assistance	8,183,059	85%
Without Financial Assistance	1,442,923	15%
Subtotal: Plan Selections With Available Data on Financial Assistance (2)	9,625,982	100%
Unknown Financial Assistance Status	0	N/A
APTC	8,147,034	85%

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, Rural Status, and Household Income in States Using the HealthCare.gov Platform (1) *11-1-15 to 2-1-16*		
Characteristics	**Marketplaces Total States Using the HealthCare.gov Eligibility and Enrollment Platform for the 2016 Coverage Year** *(38 States)*	
	Number 11-1-15 to 2-1-16 (2)	**% of Available Data, Excluding Unknown (3)**
By Self-Reported Race/Ethnicity (3)		
American Indian / Alaska Native	29,211	0%
Asian	530,180	9%
Native Hawaiian / Pacific Islander	7,089	0%
African-American	705,156	12%
Latino	916,970	15%
White	3,811,149	63%
Multiracial	82,984	1%
Subtotal: Plan Selections With Available Data on Self-Reported Race/Ethnicity	6,082,739	100%
Unknown Race/Ethnicity	3,543,243	N/A
By Rural Status		
In ZIP Codes Designated as Rural	1,710,082	18%
In ZIP Codes Designated as Urban	7,915,900	82%
Subtotal: Plan Selections With Available Data on Rural Status	9,625,982	100%
Unknown Rural Status	0	N/A
By Household Income		
<100% of FPL	259,768	3%
≥100% - ≤150% of FPL	3,413,650	38%
>150% - ≤200% of FPL	2,181,903	25%
>200% - ≤250% of FPL	1,324,281	15%
>250% - ≤300% of FPL	758,584	9%
>300%- ≤400% of FPL	736,322	8%

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, Rural Status, and Household Income in States Using the HealthCare.gov Platform (1) *11-1-15 to 2-1-16*		
Characteristics	**Marketplaces Total States Using the HealthCare.gov Eligibility and Enrollment Platform for the 2016 Coverage Year** *(38 States)*	
	Number 11-1-15 to 2-1-16 (2)	**% of Available Data, Excluding Unknown (3)**
> 400% of FPL	211,322	2%
Subtotal: Plan Selections With Available Data on Household Income	8,885,830	100%
Unknown Household Income	740,152	N/A

Notes:

Percentages in this table have been rounded. Some numbers may not add to totals due to rounding.

(1) Unless otherwise noted, the data in this table represent cumulative data on the number of unique individuals who have been determined eligible to enroll in a Marketplace plan, and have selected or been automatically reenrolled into a Marketplace medical plan (with or without the first premium payment having been received by the issuer). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: stand-alone dental plan selections; or individuals who may have selected a 2015 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). For additional technical notes, please refer to the Addendum of this report.

(2) For each metric, the data represent the total number of "Individuals Applying for 2016 Coverage in Completed Applications" who have selected a 2016 medical Marketplace plan for enrollment through the Marketplace (with or without the first premium payment having been received directly by the issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(3) The percentages by race/ethnicity are based on the total number of plan selections with known self-reported data on race/ethnicity. CMS has updated the methodology for identifying Latinos applying for 2016 coverage by incorporating the selection of "Other" ethnicity as Latino. Specifically, all consumers who selected "Other ethnicity" on their application are now counted as Latino. Latino ethnicity is indicated when Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban, and/or Other is selected. This has led to an increase in the number of reported Latinos compared to previous years. Please see the Addendum for additional information.

(4) In some cases, the data for certain characteristics of Marketplace plan selections are not yet available. For this reason, for each metric, we have calculated the comparable percentages based on the number of plan selections with known data for that metric.

(5) The subtotals for each metal tier type do not sum to the total number due to a small number of individuals (0.1%) who have multiple 2016 Marketplace plan selections in the system that will be resolved through data cleanup processes. Data for stand-alone dental plan selections are shown separately in this section, but are not included in any of the other metrics in this table.

Source: Centers for Medicare & Medicaid Services, as of 3-8-16.

APPENDIX TABLE A3

Marketplace Plan Selections by Gender and Age; Gender and Metal Level; Financial Assistance Status and Metal Level; and Metal Level and Age in States Using the HealthCare.gov Platform (1)
11-1-15 to 2-1-16

Description	HealthCare.gov States Total			Females – HealthCare.gov States			Males – HealthCare.gov States		
	Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan									
Number of Individuals Who Have Selected a Marketplace Plan	9,625,982	n/a	n/a	5,213,706	n/a	n/a	4,412,276	n/a	n/a
By Gender and Age	**Number**	**% of Gender Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Gender Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Gender Total (4)**	**% of Age Group Total (5)**
Age < 18	884,172	9%	100%	431,428	8%	49%	452,744	10%	51%
Age 18-25	1,067,477	11%	100%	569,274	11%	53%	498,203	11%	47%
Age 26-34	1,608,390	17%	100%	853,825	16%	53%	754,565	17%	47%
Age 35-44	1,555,651	16%	100%	834,664	16%	54%	720,987	16%	46%
Age 45-54	2,010,657	21%	100%	1,103,334	21%	55%	907,323	21%	45%
Age 55-64	2,431,625	25%	100%	1,383,421	27%	57%	1,048,204	24%	43%
Age ≥65	67,957	1%	100%	37,734	1%	56%	30,223	1%	44%
Subtotal: Plan Selections With Available Data on Age	9,625,929	100%	100%	5,213,680	100%	54%	4,412,249	100%	46%
Unknown Age	53	n/a	n/a	26	n/a	n/a	27	n/a	n/a
Ages 18 to34	2,675,867	28%	100%	1,423,099	27%	53%	1,252,768	28%	47%
Ages 0 to 34	3,560,039	37%	100%	1,854,527	36%	52%	1,705,512	39%	48%
By Gender and Metal Level	**Number**	**% of Gender Total (4)**	**% of Metal Level Total (5)**	**Number**	**% of Gender Total (4)**	**% of Metal Level Total (5)**	**Number**	**% of Gender Total (4)**	**% of Metal Level Total (5)**
Bronze	2,060,447	21%	100%	1,041,305	20%	51%	1,019,142	23%	49%
Silver	6,823,481	71%	100%	3,790,844	73%	56%	3,032,637	69%	44%
Gold	571,327	6%	100%	298,024	6%	52%	273,303	6%	48%
Platinum	71,701	1%	100%	36,642	1%	51%	35,059	1%	49%
Catastrophic	99,026	1%	100%	46,891	1%	47%	52,135	1%	53%
Subtotal: Plan Selections With Available Data on Metal Level	9,625,982	100%	100%	5,213,706	100%	54%	4,412,276	100%	46%
Stand-alone Dental	1,425,474	n/a	n/a	775,553	n/a	n/a	649,921	n/a	n/a
Unknown Metal Level	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Description	HealthCare.gov States Total			With Financial Assistance - HealthCare.gov States			Without Financial Assistance - HealthCare.gov States		
	Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan									
Number of Individuals Who Have Selected a Marketplace Plan	9,625,982	n/a	n/a	8,161,583	n/a	n/a	1,442,923	n/a	n/a
By Financial Assistance Status and Metal Level (6)	**Number**	**% of Financial Assistance Status Total (4)**	**% of Metal Level Total (5)**	**Number**	**% of Financial Assistance Status Total (4)**	**% of Metal Level Total (5)**	**Number**	**% of Financial Assistance Status Total (4)**	**% of Metal Level Total (5)**
Bronze	2,060,447	21%	100%	1,583,564	19%	77%	476,883	33%	23%
Silver	6,823,481	71%	100%	6,260,651	77%	92%	562,830	39%	8%
Gold	571,327	6%	100%	303,697	4%	53%	267,630	19%	47%
Platinum	71,701	1%	100%	35,147	0%	49%	36,554	3%	51%
Catastrophic	99,026	1%	100%	0	0%	0%	99,026	7%	100%
Subtotal: Plan Selections With Available Data on Metal Level	9,625,982	100%	100%	8,161,583	100%	85%	1,442,923	100%	15%
Stand-alone Dental	1,425,474	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Unknown Metal Level	0	n/a	n/a	0	n/a	n/a	0	n/a	n/a

Description	HealthCare.gov States Total			Bronze Plan Selections			Silver Plan Selections		
	Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan									
Number of Individuals Who Have Selected a Marketplace Plan	9,625,982	n/a	n/a	2,060,447	n/a	n/a	6,823,481	n/a	n/a
By Metal Level and Age (6)	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**
Age < 18	884,172	9%	100%	200,016	10%	23%	561,556	8%	64%
Age 18-25	1,067,477	11%	100%	208,711	10%	20%	775,885	11%	73%
Age 26-34	1,608,390	17%	100%	344,882	17%	21%	1,103,807	16%	69%
Age 35-44	1,555,651	16%	100%	308,439	15%	20%	1,131,782	17%	73%
Age 45-54	2,010,657	21%	100%	423,909	21%	21%	1,464,290	21%	73%
Age 55-64	2,431,625	25%	100%	561,949	27%	23%	1,733,388	25%	71%
Age ≥65	67,957	1%	100%	12,528	1%	18%	52,734	1%	78%
Subtotal: Plan Selections With Available Data on Age	9,625,929	100%	100%	2,060,434	100%	21%	6,823,442	100%	71%
Unknown Age	53	n/a	n/a	13	n/a	n/a	39	n/a	n/a
Ages 18 to34	2,675,867	28%	100%	553,593	27%	21%	1,879,692	28%	70%
Ages 0 to 34	3,560,039	37%	100%	753,609	37%	21%	2,441,248	36%	69%

Description	Gold Plan Selections			Platinum Plan Selections			Catastrophic Plan Selections		
	Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan									
Number of Individuals Who Have Selected a Marketplace Plan	571,327	n/a	n/a	71,701	n/a	n/a	99,026	n/a	n/a
By Metal Level and Age (6)	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**
Age < 18	104,497	18%	12%	11,986	17%	1%	6,117	6%	1%
Age 18-25	45,321	8%	4%	6,061	8%	1%	31,499	32%	3%
Age 26-34	95,497	17%	6%	14,239	20%	1%	49,965	50%	3%
Age 35-44	95,844	17%	6%	14,175	20%	1%	5,411	5%	0%
Age 45-54	105,421	18%	5%	13,233	18%	1%	3,804	4%	0%
Age 55-64	122,479	21%	5%	11,633	16%	0%	2,176	2%	0%
Age ≥65	2,267	0%	3%	374	1%	1%	54	0%	0%
Subtotal: Plan Selections With Available Data on Age	571,326	100%	6%	71,701	100%	1%	99,026	100%	1%
Unknown Age	0	n/a	n/a	0	n/a	n/a	0	n/a	n/a
Ages 18 to34	140,818	25%	5%	20,300	28%	1%	81,464	82%	3%
Ages 0 to 34	245,315	43%	7%	32,286	45%	1%	87,581	88%	2%

Description	Stand-alone Dental Plan Selections		
	Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan			
Number of Individuals Who Have Selected a Marketplace Plan	1,425,474	n/a	n/a
Number Who Have Selected a Stand-alone Dental Plan By Metal Level and Age	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**
Age < 18	115,304	8%	13%
Age 18-25	156,633	11%	15%
Age 26-34	321,245	23%	20%
Age 35-44	266,245	19%	17%
Age 45-54	275,523	19%	14%
Age 55-64	282,345	20%	12%
Age ≥65	8,166	1%	12%
Subtotal: Plan Selections With Available Data on Age	1,425,461	100%	15%
Unknown Age	13	n/a	n/a
Ages 18 to34	477,878	34%	18%
Ages 0 to 34	593,182	42%	17%

Notes:

Percentages in this table have been rounded. Some numbers may not add to totals due to rounding.

(1) Unless otherwise noted, the data in this table represent cumulative data on the number of unique individuals who have been determined eligible to enroll in a Marketplace plan, and have selected a Marketplace medical plan (with or without the first premium payment having been received by the issuer). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: stand-alone dental plan selections; or individuals who may have selected a 2015 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). For additional technical notes, please refer to the Addendum of this report.

(2) For each metric, the data represent the total number of "Individuals Applying for 2016 Coverage in Completed Applications" who have selected a 2016 medical Marketplace plan for enrollment through the Marketplace (with or without the first premium payment having been received directly by the issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(3) In some cases, the data for certain characteristics of Marketplace plan selections are not yet available. For this reason, for each metric, we have calculated the comparable percentages based on the number of plan selections with known data for that metric.

(4) Represents the vertical percentage for the data that are being shown based on a given set of metrics. For example, if the rows show Age Groups and the columns show Gender, then this percentage represents the data for a given Age Group / Gender combination as a percentage of the comparable Gender total for all Age Groups (e.g., Persons between the ages of 18 and 34 represent X percent of the all of the Female Marketplace Plan selections).

(5) Represents the horizontal percentage of the data that are being shown based on a given set of metrics. For example, if the rows show Age Groups and the columns show Gender, then this percentage represents the data for a given Age Group / Gender combination as a percentage of the comparable Age Group total for all Genders (e.g., Females represent X percent of the Marketplace Plan selections for persons between the ages of 18 and 34).

(6) The subtotals for each metal tier type do not sum to the total number due to a small number of individuals (0.1%) who have multiple 2016 Marketplace plan selections in the system that will be resolved through data cleanup processes. Data for stand-alone dental plan selections are shown separately in this section, but are not included in any of the other metrics in this table.

Source: Centers for Medicare & Medicaid Services, as of 3-8-16.

APPENDIX TABLE A4

Marketplace Plan Selections by Gender, Age, Metal Level, and Financial Assistance Status in State-Based Marketplaces Using Their Own Marketplace Platforms (1) *11-1-15 to 2-1-16*		
Characteristics	**Marketplaces Total State-Based Marketplaces Using Their Own Marketplace Platforms for the 2016 Coverage Year** *(13 States)*	
	Number 11-1-15 to 2-1-16 (2)	**% of Available Data, Excluding Unknown (3)**
Total Who Have Selected a Marketplace Plan *(13 States Reporting)*		
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2016 Marketplace Plan	3,055,892	100%
By Enrollment Status *(13 States Reporting New vs. Reenrollee; 10 States Reporting Active vs. Automatic Reenrollees)*		
New Consumers	861,389	28%
Total Reenrollees (4)	2,194,503	72%
Active Reenrollees	*656,789*	*21%*
Automatic Reenrollees	*1,105,325*	*36%*
Unknown Reenrollment Type	*432,389*	*14%*
Subtotal: Plan Selections With Available Data on Enrollment Status	3,055,892	100%
Unknown Enrollment Status	519	N/A
By Gender *(13 States Reporting)*		
Female	1,588,621	52%
Male	1,466,002	48%
Subtotal: Plan Selections With Available Data on Gender	3,054,623	100%
Unknown Gender	1,269	N/A
By Age *(13 States Reporting)*		
Age < 18	184,459	6%
Age 18-25	302,571	10%
Age 26-34	547,103	18%
Age 35-44	488,281	16%

Marketplace Plan Selections by Gender, Age, Metal Level, and Financial Assistance Status in State-Based Marketplaces Using Their Own Marketplace Platforms (1) *11-1-15 to 2-1-16*		
Characteristics	**Marketplaces Total State-Based Marketplaces Using Their Own Marketplace Platforms for the 2016 Coverage Year** *(13 States)*	
	Number 11-1-15 to 2-1-16 (2)	**% of Available Data, Excluding Unknown (3)**
Age 45-54	672,105	22%
Age 55-64	830,590	27%
Age ≥65	29,646	1%
Subtotal: Plan Selections With Available Data on Age (2)	3,054,755	100%
Unknown Age	1,137	N/A
Ages 18 to 34	849,674	28%
Ages 0 to 34	1,034,133	34%
By Metal Level *(13 States Reporting)*		
Bronze	812,975	28%
Silver	1,697,306	59%
Gold	226,174	8%
Platinum	120,543	4%
Catastrophic	39,374	1%
Subtotal: Plan Selections With Available Data on Metal Level (5)	2,896,372	100%
Stand-alone Dental	284,638	N/A
Unknown Metal Level	159,520	N/A
By Financial Assistance Status *(12 States Reporting)*		
With Financial Assistance	2,327,082	78%
Without Financial Assistance	645,462	22%
Subtotal: Plan Selections With Available Data on Financial Assistance (2)	2,972,544	100%
Unknown Financial Assistance Status	83,516	N/A
APTC	2,327,082	78%

Notes:

Percentages in this table have been rounded. Some numbers may not add to totals due to rounding.

(1) Unless otherwise noted, the data in this table represent cumulative data on the number of unique individuals who have been determined eligible to enroll in a Marketplace plan, and have selected or been automatically reenrolled into a Marketplace medical plan (with or without the first premium payment having been received by the issuer). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections for all but two states (Minnesota and DC). These data also do not include: stand-alone dental plan selections; or individuals who may have selected a 2015 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). For additional technical notes, please refer to the Addendum of this report.

(2) For each metric, the data represent the total number of "Individuals Applying for 2016 Coverage in Completed Applications" who have selected a 2016 medical Marketplace plan for enrollment through the Marketplace (with or without the first premium payment having been received directly by the issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Most of the data in this table are for the 11-1-15 to 2-1-16 reporting period with the following exception: the data for 9 SBMs using their own Marketplace platforms are for the 11-1-15 to 1-31-16 reporting period.

(3) In some cases, the data for certain characteristics of Marketplace plan selections are not yet available. For this reason, for each metric, we have calculated the comparable percentages based on the number of plan selections with known data for that metric.

(4) The number of active reenrollees and automatic reenrollees may not add to the total number of reenrollees due to some SBM plan selections with missing data.

(5) The subtotals for each metal tier type do not sum to the total number partially due to a small number of individuals who have multiple 2016 Marketplace plan selections in the system that will be resolved through data cleanup processes, but primarily due to Massachusetts counting 158,512 individuals enrolled in its Connector Care Program as unknowns. Connector Care plans are closest to Silver plans, but their actuarial value is higher than that of a Silver Plan. Data for stand-alone dental plan selections are shown in this section, but are not included in any of the other metrics in this report.

Source: Centers for Medicare & Medicaid Services, as of 3-8-16.

APPENDIX TABLE A5

Selected Enrollment-Related Information, 11-1-15 to 2-1-16 (1)			
Description	**Marketplace Total, All States**	**States Using the HealthCare.gov Eligibility and Enrollment Platform** *(38 States)*	**State-Based Marketplaces Using Their Own Marketplace Platforms** *(13 States)*
Visitors to the Marketplace Websites	43,827,138	31,128,448	12,698,690
Calls to the Marketplace Call Center	23,079,072	15,508,697	7,570,375
Number of Completed Applications	14,724,461	9,601,192	5,123,269
Number of Individuals Included in Completed Applications	23,235,614	13,036,519	10,199,095
Number of Individuals Determined Eligible to Enroll in a 2016 Plan Through the Marketplaces	16,164,261	11,639,701	4,524,560
Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2016 Marketplace Plan	12,681,874	9,625,982	3,055,892

Notes:

(1) Most of the data in this table are for the 11-1-15 to 2-1-16 reporting period with the following exception: the data for 9 SBMs using their own Marketplace platforms are for the 11-1-15 to 1-31-16 reporting period. See Addendum for additional technical notes.

(2) Within the HealthCare.gov states, visitors to the Marketplace Websites includes 29,422,294 unique visitors on HealthCare.gov and 1,706,154 unique visitors on CuidadoDeSalud.gov between 11-1-15 and 2-1-16.

(3) Total Calls to the Marketplace call centers includes 938,952 calls with Spanish-speaking representatives and 14,569,745 other calls between 11-1-15 and 2-1-16.

Source: Centers for Medicare & Medicaid Services, as of 3-8-16.

APPENDIX TABLE B1

Reduction in Average Monthly Premiums from Advance Premium Tax Credits in States Using the HealthCare.gov Platform (1) 11-1-15 to 2-1-16						
Description	**Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)**	**Percent of Plan Selections with APTC**	**Average Monthly Premium Before APTC**	**Average Monthly APTC**	**Average Monthly Premium After APTC**	**Average Percent Reduction in Premium After APTC**
States Using the HealthCare.gov Platform (4)						
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)						
Hawaii	14,564	81%	$389	$270	$118	70%
Nevada	88,145	87%	$372	$265	$107	71%
New Mexico	54,865	68%	$332	$205	$127	62%
Oregon	147,109	71%	$392	$250	$142	64%
Subtotal - SBMs Using the HealthCare.gov Platform	**304,683**	**76%**	**$371**	**$248**	**$124**	**67%**
Federally-Facilitated Marketplace (FFM) States						
Alabama	195,055	89%	$410	$308	$102	75%
Alaska	23,029	86%	$863	$737	$126	85%
Arizona	203,066	74%	$324	$204	$120	63%
Arkansas	73,648	87%	$409	$286	$122	70%
Delaware	28,256	82%	$477	$328	$150	69%
Florida	1,742,819	91%	$386	$302	$84	78%
Georgia	587,845	86%	$385	$287	$98	75%
Illinois	388,179	75%	$385	$233	$152	61%
Indiana	196,242	81%	$415	$259	$156	63%
Iowa	55,089	85%	$425	$303	$122	71%
Kansas	101,555	82%	$352	$246	$106	70%
Louisiana	214,148	89%	$448	$362	$86	81%
Maine	84,059	87%	$428	$325	$103	76%
Michigan	345,813	83%	$382	$239	$143	63%
Mississippi	108,672	90%	$388	$297	$91	76%
Missouri	290,201	87%	$407	$313	$94	77%
Montana	58,114	83%	$421	$306	$115	73%
Nebraska	87,835	88%	$400	$295	$105	74%
New Hampshire	55,183	66%	$396	$241	$155	61%
New Jersey	288,573	80%	$484	$323	$161	67%
North Carolina	613,487	89%	$497	$399	$98	80%
North Dakota	21,604	85%	$405	$262	$142	65%
Ohio	243,715	80%	$405	$240	$164	59%
Oklahoma	145,329	84%	$376	$296	$80	79%
Pennsylvania	439,238	76%	$396	$251	$145	63%
South Carolina	231,849	89%	$406	$309	$97	76%
South Dakota	25,999	88%	$416	$306	$110	74%
Tennessee	268,867	85%	$400	$296	$104	74%

Reduction in Average Monthly Premiums from Advance Premium Tax Credits in States Using the HealthCare.gov Platform (1) 11-1-15 to 2-1-16						
Description	**Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)**	**Percent of Plan Selections with APTC**	**Average Monthly Premium Before APTC**	**Average Monthly APTC**	**Average Monthly Premium After APTC**	**Average Percent Reduction in Premium After APTC**
Texas	1,306,208	84%	$344	$257	$87	75%
Utah	175,637	86%	$271	$187	$84	69%
Virginia	421,897	82%	$366	$273	$93	75%
West Virginia	37,284	85%	$542	$387	$155	71%
Wisconsin	239,034	84%	$455	$330	$125	73%
Wyoming	23,770	90%	$571	$454	$117	80%
TOTAL – States Using the HealthCare.gov Platform	**9,625,982**	**85%**	**$396**	**$290**	**$106**	**73%**

Source: ASPE computation of CMS data for 38 states using the HealthCare.gov platform as of 3-8-16.

APPENDIX TABLE B2

Availability and Selection of Marketplace Plans With Monthly Premiums of $100 or Less After the Advance Premium Tax Credit (APTC) For the Total Number of Individuals With 2016 Marketplace Plan Selections in States Using the HealthCare.gov Platform (1) 11-1-15 to 2-1-16							
Description	**Total Number of Individuals With 2016 Marketplace Plan Selections (2)**	**Availability of Plans With Monthly Premiums of $100 or Less**			**Selection of Plans With Monthly Premiums of $100 or Less**		
		Percent Who Could Have Selected a Plan with a Monthly Premium of:			***Percent Who Selected 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**
States Using the HealthCare.gov Platform (4)							
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)							
Hawaii	14,564	57%	63%	71%	30%	38%	46%
Nevada	88,145	58%	68%	74%	24%	40%	52%
New Mexico	54,865	39%	50%	59%	15%	25%	35%
Oregon	147,109	39%	47%	57%	13%	21%	31%
Subtotal - SBMs Using the HealthCare.gov Platform	**304,683**	**45%**	**54%**	**63%**	**17%**	**28%**	**38%**
Federally-Facilitated Marketplace (FFM) States							
Alabama	195,055	65%	72%	76%	32%	45%	55%
Alaska	23,029	62%	67%	71%	33%	41%	48%
Arizona	203,066	51%	59%	70%	19%	32%	43%
Arkansas	73,648	52%	62%	70%	16%	30%	44%
Delaware	28,256	54%	61%	67%	14%	24%	35%
Florida	1,742,819	72%	78%	82%	45%	57%	66%
Georgia	587,845	65%	72%	76%	32%	45%	55%
Illinois	388,179	44%	53%	61%	12%	20%	29%
Indiana	196,242	46%	55%	62%	12%	21%	31%
Iowa	55,089	55%	63%	70%	21%	32%	43%
Kansas	101,555	54%	62%	68%	28%	40%	49%
Louisiana	214,148	77%	81%	83%	45%	54%	61%
Maine	84,059	55%	63%	69%	31%	43%	53%
Michigan	345,813	54%	63%	72%	15%	26%	37%
Mississippi	108,672	69%	76%	80%	34%	50%	62%
Missouri	290,201	66%	71%	76%	35%	47%	57%
Montana	58,114	53%	61%	67%	22%	34%	45%
Nebraska	87,835	60%	69%	75%	29%	42%	53%
New Hampshire	55,183	38%	45%	57%	10%	17%	25%
New Jersey	288,573	42%	50%	57%	13%	22%	32%
North Carolina	613,487	70%	76%	80%	37%	48%	57%
North Dakota	21,604	50%	60%	68%	16%	27%	38%
Ohio	243,715	42%	53%	61%	10%	19%	29%
Oklahoma	145,329	72%	76%	82%	41%	51%	60%
Pennsylvania	439,238	44%	53%	60%	13%	24%	34%
South Carolina	231,849	52%	62%	69%	36%	48%	58%

Availability and Selection of Marketplace Plans With Monthly Premiums of $100 or Less After the Advance Premium Tax Credit (APTC) For the Total Number of Individuals With 2016 Marketplace Plan Selections in States Using the HealthCare.gov Platform (1) 11-1-15 to 2-1-16							
South Dakota	25,999	58%	67%	74%	26%	38%	49%
Tennessee	268,867	67%	72%	77%	30%	41%	51%
Texas	1,306,208	66%	72%	78%	36%	48%	58%
Utah	175,637	62%	72%	80%	35%	49%	61%
Virginia	421,897	61%	68%	72%	34%	45%	55%
West Virginia	37,284	51%	59%	65%	13%	25%	35%
Wisconsin	239,034	56%	63%	69%	25%	35%	43%
Wyoming	23,770	51%	60%	68%	29%	39%	49%
TOTAL – States Using the HealthCare.gov Platform	**9,625,982**	**61%**	**68%**	**74%**	**30%**	**42%**	**52%**

Source: ASPE computation of CMS data for 38 states using the HealthCare.gov platform as of 3-8-16.

APPENDIX TABLE B3

Availability and Selection of Marketplace Plans With Monthly Premiums of $100 or Less After the Advance Premium Tax Credit (APTC) For Individuals With 2016 Marketplace Plan Selections With APTC in States Using the HealthCare.gov Platform (1)
11-1-15 to 2-1-16

Description	Number of Individuals With 2016 Marketplace Plan Selections with APTC (2)	Data For Individuals Who Have 2016 Marketplace Plan Selections With APTC					
		Availability of Plans With Monthly Premiums of $100 or Less			Selection of Plans With Monthly Premiums of $100 or Less		
		Percent Who Could Have Selected a Plan with a Monthly Premium of:			*Percent Who Selected 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
States Using the HealthCare.gov Platform (4)							
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)							
Hawaii	11,852	71%	77%	83%	36%	46%	55%
Nevada	76,821	67%	78%	85%	28%	45%	60%
New Mexico	37,450	57%	69%	79%	22%	36%	49%
Oregon	104,728	55%	66%	75%	18%	30%	42%
Subtotal - SBMs Using the HealthCare.gov Platform	**230,851**	60%	71%	79%	23%	37%	50%
Federally-Facilitated Marketplace (FFM) States							
Alabama	173,078	74%	81%	86%	36%	50%	62%
Alaska	19,798	72%	78%	83%	38%	48%	56%
Arizona	150,256	69%	79%	86%	25%	41%	54%
Arkansas	64,179	60%	72%	80%	18%	35%	51%
Delaware	23,098	66%	75%	82%	17%	29%	42%
Florida	1,585,781	80%	86%	90%	49%	63%	72%
Georgia	507,619	76%	83%	88%	37%	52%	64%
Illinois	291,258	59%	70%	79%	16%	27%	39%
Indiana	159,229	56%	67%	76%	15%	26%	38%
Iowa	46,827	65%	74%	82%	25%	38%	50%
Kansas	83,193	66%	76%	83%	35%	48%	60%
Louisiana	191,042	86%	91%	94%	50%	60%	68%
Maine	73,012	63%	72%	80%	35%	50%	61%
Michigan	287,197	66%	76%	84%	18%	31%	44%
Mississippi	97,943	76%	84%	89%	38%	56%	68%
Missouri	251,295	76%	83%	88%	40%	54%	65%
Montana	47,974	65%	74%	81%	26%	41%	54%
Nebraska	77,185	69%	79%	85%	33%	47%	60%
New Hampshire	36,503	58%	68%	77%	14%	25%	37%
New Jersey	231,239	52%	63%	72%	16%	28%	39%
North Carolina	547,605	79%	85%	89%	41%	54%	64%
North Dakota	18,442	58%	70%	79%	19%	31%	43%
Ohio	196,048	52%	66%	76%	12%	23%	35%
Oklahoma	121,965	86%	91%	94%	49%	61%	70%

Availability and Selection of Marketplace Plans With Monthly Premiums of $100 or Less After the Advance Premium Tax Credit (APTC) For Individuals With 2016 Marketplace Plan Selections With APTC in States Using the HealthCare.gov Platform (1) 11-1-15 to 2-1-16							
Pennsylvania	334,760	58%	69%	77%	17%	31%	44%
South Carolina	205,740	59%	70%	78%	41%	54%	65%
South Dakota	22,869	66%	76%	84%	30%	43%	56%
Tennessee	227,386	79%	85%	90%	35%	48%	60%
Texas	1,093,573	79%	86%	91%	42%	57%	68%
Utah	151,593	71%	83%	90%	40%	57%	70%
Virginia	344,694	75%	83%	88%	41%	56%	67%
West Virginia	31,820	59%	69%	77%	16%	29%	41%
Wisconsin	200,571	67%	75%	82%	30%	41%	52%
Wyoming	21,411	57%	66%	75%	32%	44%	54%
TOTAL – States Using the HealthCare.gov Platform	**8,147,034**	72%	80%	86%	36%	49%	61%

Source: ASPE computation of CMS data for 38 states using the HealthCare.gov platform as of 3-8-16.

APPENDIX TABLE B4

2016 Plan Choice of Active Reenrollees by State in States using the HealthCare.gov Platform for the 2015 and 2016 Coverage Years				
State	Percent Who Chose the Same Plan or Crosswalked Plan in 2016			Percent Who Chose a New Plan in 2016
	All	Auto	Active	
All 37 States	57%	30%	27%	43%
AK	64%	36%	28%	36%
AL	57%	30%	26%	43%
AR	78%	46%	32%	22%
AZ	27%	15%	12%	73%
DE	70%	38%	32%	30%
FL	62%	26%	36%	38%
GA	56%	32%	24%	44%
IA	69%	35%	34%	31%
IL	47%	31%	16%	53%
IN	58%	38%	20%	42%
KS	37%	16%	20%	63%
LA	61%	36%	25%	39%
ME	81%	34%	46%	19%
MI	64%	37%	27%	36%
MO	59%	32%	28%	41%
MS	65%	48%	17%	35%
MT	69%	38%	30%	31%
NC	57%	29%	28%	43%
ND	76%	37%	39%	24%
NE	63%	24%	39%	37%
NH	71%	42%	29%	29%
NJ	58%	30%	29%	42%
NM	42%	29%	13%	58%
NV	48%	23%	24%	52%
OH	64%	35%	29%	36%
OK	68%	37%	30%	32%
OR	53%	22%	31%	47%
PA	48%	28%	21%	52%
SC	38%	20%	18%	62%
SD	49%	21%	28%	51%

2016 Plan Choice of Active Reenrollees by State in States using the HealthCare.gov Platform for the 2015 and 2016 Coverage Years				
State	**Percent Who Chose the Same Plan or Crosswalked Plan in 2016**			**Percent Who Chose a New Plan in 2016**
	All	**Auto**	**Active**	
TN	57%	26%	31%	43%
TX	52%	33%	19%	48%
UT	44%	21%	23%	56%
VA	72%	33%	39%	28%
WI	61%	32%	29%	39%
WV	74%	39%	34%	26%
WY	51%	22%	29%	49%

Notes: Information is for enrollees in the 37 states that used the HealthCare.gov platform for both 2015 and 2016. 2015 enrollees include those who selected plans during OEP2 and those who selected plans during a Special Enrollment Period but excludes those who had terminated their plan as of 11/1/2015. 2016 enrollees includes those who had an active Marketplace plan selection as of 2/1/2016, but excludes those whose plans were terminated prior to that date.

APPENDIX TABLE B5

Premium Savings from Switching Plans within Metal Levels by State in States using the HealthCare.gov Platform for the 2015 and 2016 Coverage Years			
State	**Average Monthly Premium Savings of Switchers**	**Average Annual Premium Savings of Switchers**	**Annual State-level Savings from Switching**
All 37 States	$40	$478	$600,468,962
AK	$46	$555	$1,689,418
AL	$53	$637	$20,638,622
AR	$22	$262	$1,665,915
AZ	$29	$348	$4,335,345
DE	$25	$295	$889,397
FL	$22	$260	$50,471,422
GA	$57	$686	$65,799,693
IA	$62	$745	$3,805,856
IL	$74	$887	$64,905,680
IN	$82	$984	$34,646,380
KS	$57	$690	$3,872,950
LA	$18	$211	$4,173,014
ME	$12	$149	$913,465
MI	$41	$491	$24,538,107
MO	$32	$383	$16,532,480
MS	$47	$560	$8,268,224
MT	$8	$94	$518,200
NC	$44	$533	$59,384,561
ND	$14	$169	$242,129
NE	$27	$329	$3,330,373
NH	$30	$365	$2,364,123
NJ	$53	$642	$30,978,485
NM	$56	$676	$3,490,799
NV	$14	$166	$1,243,487
OH	$61	$735	$20,387,001
OK	$13	$162	$2,580,505
OR	$37	$446	$10,197,001
PA	$15	$178	$5,974,076
SC	$25	$299	$6,750,468
SD	-$12	-$143	-$171,128
TN	$34	$411	$10,744,157

Premium Savings from Switching Plans within Metal Levels by State in States using the HealthCare.gov Platform for the 2015 and 2016 Coverage Years			
State	**Average Monthly Premium Savings of Switchers**	**Average Annual Premium Savings of Switchers**	**Annual State-level Savings from Switching**
TX	$37	$447	$96,118,396
UT	$18	$217	$3,297,115
VA	$23	$280	$11,779,482
WI	$54	$653	$22,553,952
WV	$29	$354	$1,128,814
WY	$10	$118	$135,694

Note: Information is from enrollees in the 37 states that used the HealthCare.gov platform for both 2015 and 2016. Savings is calculated as the difference between the 2016 premium of the 2016 selected plan and the 2016 premium of the 2015 selected plan and is calculated only on the enrollees who switched plans but not metal levels between 2015 and 2016, were in crosswalked plans as of 11-1-2015, and were non-tobacco users in both 2015 and 2016.

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 22, 2016

H.R. 4723
Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayments Act

As ordered reported by the House Committee on Ways and Means on March 16, 2016

H.R. 4723 would amend the Internal Revenue Code to provide for the recovery of overpayments resulting from certain federally subsidized health insurance. Under current law, qualified taxpayers are eligible to receive refundable tax credits to assist in the purchase of health insurance through the health insurance marketplaces established by the Affordable Care Act. The amount of those premium assistance credits are based on family size and income, and the advance payments of the credits is based on income estimated for the current year. If taxpayers' circumstances change and their advance payments exceed the premium assistance credits to which they are entitled, they may be required to repay some or all of the credits, subject to certain limits based on income. Enacting H.R. 4723 would eliminate existing limits on the amounts required to be repaid by taxpayers. Taxpayers would therefore be liable for the full amount of overpayments, beginning in tax year 2017.

The staff of the Joint Committee on Taxation (JCT) estimates that relative to CBO's January 2016 baseline, the legislation would decrease outlays by $45.8 billion and increase revenues by $15.8 billion over the 2016-2026 period. JCT therefore estimates that the legislation would reduce federal budget deficits by $61.6 billion over the 2016-2026 period. The change in revenues includes a reduction of about $718 million over the 2016-2026 period that would result from changes in off-budget revenues (from Social Security payroll taxes).

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending and revenues. The estimated net decrease in the deficit is shown in the following table. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

CBO Estimate of Pay-As-You-Go Effects for H.R. 4723, as ordered reported by the House Committee on Ways and Means on March 16, 2016

	By Fiscal Year, in Millions of Dollars												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016-2021	2016-2026
NET DECREASE (-) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	-3,015	-5,763	-5,992	-6,024	-6,204	-6,496	-6,778	-7,076	-7,344	-7,622	-27,000	-62,315
Memorandum:[a]													
Change in Outlays	0	-2,724	-4,156	-4,272	-4,306	-4,478	-4,719	-4,943	-5,176	-5,386	-5,603	-19,936	-45,763
Change in On-Budget Revenues	0	291	1,607	1,720	1,718	1,726	1,777	1,835	1,900	1,958	2,019	7,064	16,552
Change in Off-Budget Revenues	*0*	*0*	*-64*	*-69*	*-72*	*-76*	*-80*	*-84*	*-87*	*-91*	*-94*	*-282*	*-718*

Source: Staff of the Joint Committee on Taxation.

a. A negative sign for outlays indicates a reduction in outlays. A positive sign for revenues indicates an increase in revenues.

JCT estimates that enacting the bill would not increase net direct spending or on-budget deficits in any of the four 10-year periods beginning in 2027.

JCT has determined that the bill contains no intergovernmental mandates but would impose a private-sector mandate as defined in the Unfunded Mandates Reform Act (UMRA). Based on information provided by JCT, the cost of the provision's private-sector mandate would exceed the annual threshold established in UMRA for private-sector mandates ($157 million in 2017, adjusted annually for inflation) beginning in 2017.

The CBO staff contact for this estimate is Nathaniel Frentz. The estimate was approved by Mark Booth, Unit Chief, Revenue Estimating.

United States Government Accountability Office

Testimony

Before the Subcommittee on Economic Growth, Tax and Capital Access, Committee on Small Business, House of Representatives

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SMALL EMPLOYER HEALTH TAX CREDIT

Limited Use Continues Due to Multiple Reasons

Statement of James R. McTigue, Jr.
Director, Strategic Issues

March 2016

SMALL EMPLOYER HEALTH TAX CREDIT

Limited Use Continues Due to Multiple Reasons

GAO Highlights

Highlights of GAO-16-491T, a testimony before the Subcommittee on Economic Growth, Tax and Capital Access, Committee on Small Business, House of Representatives

Why GAO Did This Study

Many small employers do not offer health insurance. The Small Employer Health Insurance Tax Credit was established as part of the Patient Protection and Affordable Care Act to help eligible small employers—businesses or tax-exempt entities—provide health insurance for employees. The base of the credit is premiums paid or the average premium for an employer's state if premiums paid were higher. In 2016, for small businesses, the credit is 50 percent of the base unless the business had more than 10 FTE employees or paid average annual wages over $25,900.

This statement summarizes and updates GAO's prior work in May 2012, November 2014, and March 2015 on the extent to which the credit is claimed, any reasons that limit claims, and changes to the credit proposed by Congress and the administration. To conduct the updates, GAO reviewed 2013 and 2014 IRS data on credit claims and academic and government studies, and summarized proposed legislation related to the credit.

What GAO Recommends

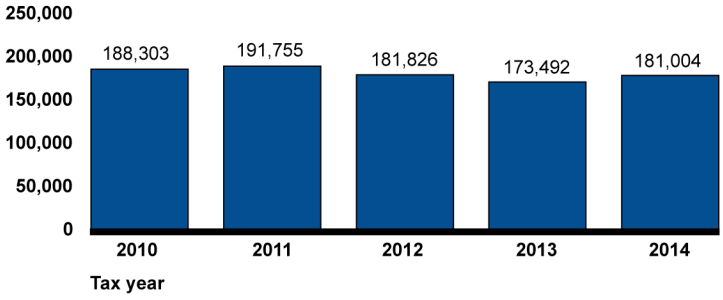
GAO is not making recommendations in this testimony statement.

View GAO-16-491T. For more information, contact James R. McTigue, Jr. at (202) 512-9110 or mctiguej@gao.gov.

What GAO Found

Claims of the small employer health tax credit have continued to be lower than thought eligible by government agency and small business group estimates, limiting the effect of the credit on expanding health insurance coverage through small employers. In 2014, about 181,000 employers claimed the credit, down somewhat from 2010 (see figure). These numbers are relatively low compared to the number of employers eligible for the credit. In 2012, GAO reported that selected estimates of the number of employers eligible ranged from about 1.4 million to 4 million. In 2010, claims totaled $468 million compared to initial estimates of $2 billion by the Congressional Budget Office and the Joint Committee on Taxation. Actual claims for the credit in 2013 and 2014 increased slightly to about $511 million and $541 million, respectively.

Number of Employers That Claimed Small Employer Health Tax Credit



Source: IRS. | GAO-16-491T

The small employer health tax credit has not been widely claimed for a variety of reasons, as GAO reported in May 2012. The maximum amount of the credit does not appear to be a large enough incentive for employers to offer or maintain insurance. Also, few small employers qualify for the maximum credit amount. For those employers who do claim the credit, the credit amount "phases out" to zero as employers employ up to 25 full time equivalent (FTE) employees at higher wages. The amount of the credit is also limited if premiums paid by an employer are more than the average premiums for the small group market in the employer's state. Furthermore, the credit can only be claimed for two consecutive years after 2013. GAO also found that the cost and complexity involved in claiming the tax credit was significant, deterring small employers from claiming it. Many small businesses have also reported that they were unaware of the credit. Even so, the Internal Revenue Service (IRS) had been taking steps since April 2010 to raise awareness about the credit and reduce the burden on taxpayers by offering tools to help taxpayers determine eligibility for the credit.

Congress and the administration have proposed a number of changes to the credit. These include expanding the size of eligible employers, altering the phase out rules, and allowing the credit to be claimed in more than two consecutive years. Amending the eligibility requirements or increasing the amount of the credit may allow more businesses to claim the credit. However, these changes would increase its cost to the federal government.

Chairman Huelskamp, Ranking Member Chu, and Members of the Subcommittee:

Thank you for the opportunity to discuss our work on small employers' use of the health tax credit.[1] The Small Employer Health Insurance Tax Credit was established as part of the Patient Protection and Affordable Care Act (PPACA) to help eligible small employers—businesses or tax-exempt entities—provide health insurance for employees. This testimony updates our work that showed seemingly low usage of the credit and some of the reasons for this low usage.

The Small Employer Health Insurance Tax Credit is generally available to eligible small employers and tax-exempt employers who have fewer than 25 full-time equivalent (FTE) employees with average annual wages that fall below a statutorily-specified cap.[2] For tax year 2016, the wage cap is $51,800.[3] These small employers must cover at least 50 percent of the cost of each of their employees' self-only health insurance coverage. The credit amount is a percentage of the employer's contributions to employees' health insurance premiums. The percentage varies according to the number of FTEs, average wage paid by the employer, and whether the employer is a for-profit or tax-exempt employer. The larger the average annual wage and the greater the number of FTEs, the lower the

[1]See GAO, *Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity*, GAO-12-549 (Washington, D.C.: May 14, 2012), GAO, *Small Business Health Insurance Exchanges: Low Initial Enrollment Likely due to Multiple, Evolving Factors*, GAO-15-58 (Washington, D.C.: Nov. 13, 2014), and GAO, *Private Health Insurance: Early Evidence Finds Premium Tax Credit Likely Contributed to Expanded Coverage, but Some Lack Access to Affordable Plans*, GAO-15-312 (Washington, D.C.: March 23, 2015).

[2]A tax-exempt eligible small employer is one that is exempt from federal income tax under section 501(a) and described in section 501(c) of the Internal Revenue Code. 26 C.F.R. §1.45R-1(a)(20). An eligible small employer can include businesses that are corporations in a controlled group of corporations, or members of an affiliated service group, as well as partnerships, sole proprietorships, cooperatives, and trusts. A sole proprietor is an individual who owns an unincorporated business but may employ others. Credit amounts claimed by partnerships and S corporations are to be passed through to their partners and shareholders, respectively, who may claim their portions of the credit on their individual income tax returns.

[3]To be eligible for the full credit, employers must have 10 or fewer FTEs with average wages below $25,900 in 2016. For 2010 to 2013, the wage cap to be an eligible employer was $50,000, with the full credit available for small employers with averages wages for FTEs at $25,000. Starting in 2014, the wage cap is adjusted for inflation each year using the Consumer Price Index–Urban.

credit percentage the small employer can claim, until the credit is entirely phased out. Beginning in 2014, small employers who qualify for the credit generally must purchase coverage through a Small Business Health Options Program (SHOP) exchange.[4] SHOP exchanges, as established under PPACA, are marketplaces where small employers can shop for and purchase health coverage for their employees. All health plans available through SHOP exchanges must meet certain federally required criteria, such as providing plans that offer minimum essential health benefits. Our 2014 report noted that a primary incentive for small employers to use SHOPs has been this tax credit.[5]

The vast majority of small employers do not offer health insurance to their employees. The Medical Expenditures Panel Survey (MEPS) estimates that 83 percent of employers who may be eligible for the full credit did not offer health insurance in 2010 and that 67 percent who could be eligible for a partial credit did not offer insurance.[6] As we discussed in our 2012 report, various factors have explained why small, low-wage employers historically tend not to offer health insurance. For example:

- For very low-wage employees, health insurance drives up total compensation costs.
- Low-wage employees generally prefer wages over insurance benefits. While employees pay income and employment taxes on wages, employees do not pay these taxes on premiums that employers pay for health insurance. However, the income tax exclusion is worth less to low-wage employees—being in a lower-income tax bracket—compared to those with higher wages.
- Insurers of small employers face higher-average fixed costs for billing and marketing and are less able to pool risk across many employees.

[4]IRS Notices 2014-6 and 2015-8 provide transition relief for certain small employers that cannot obtain coverage through a SHOP exchange because SHOP coverage is not available in their location. SHOP exchanges cover small employers with either 100 or fewer employees or 50 or fewer employees, as chosen by each state; this means that not all small employers as defined for SHOP purposes would be small enough to qualify for the credit.

[5]See GAO-15-58.

[6]MEPS is a set of large-scale surveys. MEPS is administered by the Agency for Healthcare Research and Quality in the Department of Health and Human Services. In a subsequent 2013 MEPS–Insurance Component, 34.8 percent of private-sector firms with fewer than 50 employees offered health insurance compared to 95.7 percent of firms with 50 or more employees in 2013.

As a result, plans for small employers are likely to have higher premiums, less coverage, and higher costs than plans for large employers.

This statement (1) describes the extent to which the credit is being claimed by smaller employers (2) describes the reasons, if any, limiting employer claims, and (3) summarizes legislative proposals on the credit. It is based on reports we issued from May 2012 through March 2015. Detailed information about the scope and methodology for this prior work can be found in each of these reports. Much of this statement discusses findings from our May 2012 report. For that report, we reviewed Internal Revenue Service (IRS) data on credit claims for tax year 2010. We interviewed IRS officials and subject-matter specialists from government, academia, research foundations, and think tanks. We also interviewed officials of groups representing employers, tax preparers, and insurance brokers, and worked with them to assemble discussion groups on the credit. Finally, we reviewed literature about the credit and health insurance as well as IRS documentation.

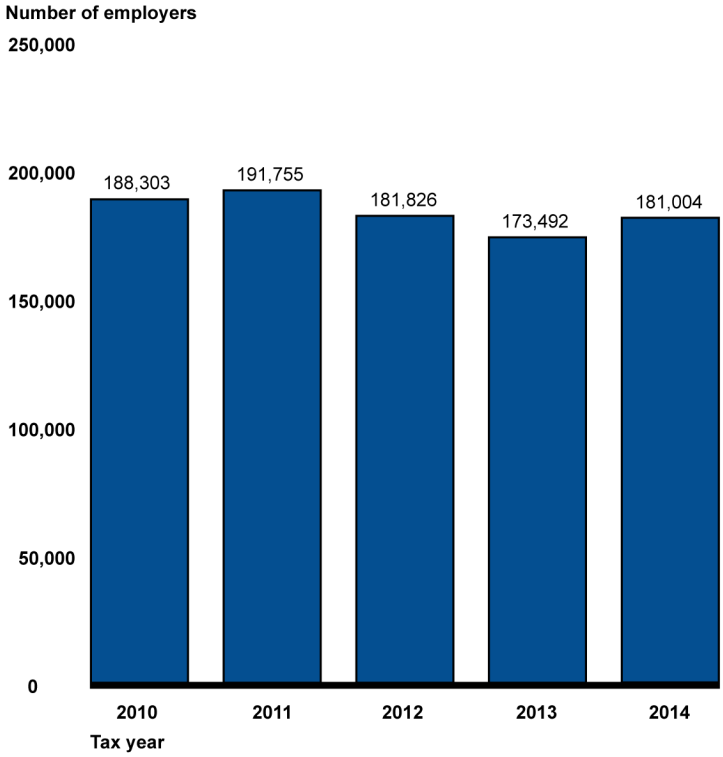
We updated selected data in this statement with 2013 and 2014 data from IRS on claims of the credit by small employers. To assess the reliability of the data, we reviewed the data and supporting documentation for obvious errors, reviewed our prior use of the data, and interviewed IRS officials about the data. We found the data to be sufficiently reliable for our purposes. We also reviewed academic and government studies about the tax credit, including reports from the Congressional Research Service and the Treasury Inspector General for Tax Administration, and a web page about the credit from the Taxpayer Advocate Service. We also summarized proposed legislation on the credit.

The work upon which this statement is based was conducted in accordance with 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 based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Fewer Small Employers Claimed the Credit Than Were Thought to Be Eligible

Claims of the small employer health tax credit have continued to be lower than thought eligible by government agency and small business group estimates, limiting the effect of the credit on expanding health insurance coverage through small employers. In 2014, about 181,000 employers claimed the credit, down somewhat from 2010 (see figure 1).

Figure 1: Number of Employers That Claimed Small Employer Health Tax Credit, Tax Years 2010 to 2014



Source: IRS. | GAO-16-491T

Note: Data for 2014 are reported on a calendar-year basis. These data differ from those we reported in GAO-12-549 and GAO-15-312 because additional returns were processed for a given tax year after the data were compiled by IRS.

These numbers are relatively low compared to the number of employers thought eligible for the credit. In 2012, we reported that selected estimates of the number of employers eligible ranged from about 1.4 million to 4 million.[7] The Council of Economic Advisors estimated 4 million

[7]See GAO-12-549.

and the Small Business Administration (SBA) estimated 2.6 million.[8] Estimates made by small business groups included the Small Business Majority and the National Federation of Independent Businesses. Their estimates were 4 million and 1.4 million, respectively.[9]

A similar outcome is seen when the dollar value of credits claimed is compared to initial estimates. In 2010, claims totaled $468 million compared to initial estimates of $2 billion by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT). In March 2012, CBO and JCT estimated that the credit would cost $1 billion in 2012 and $21 billion from 2012 to 2021, down considerably from the original estimate of $5 billion and $40 billion, respectively.[10] The revised estimates appear overstated as well given that actual claims for the credit in 2013 and 2014 were about $511 million and $541 million, respectively.[11]

Small Employers Have Been Unlikely to Claim the Health Tax Credit for Various Reasons

Based on our interviews, discussion groups, and literature review conducted for the 2012 report, we found the small employer health tax credit has not provided a strong enough incentive for employers to begin to offer health insurance for various reasons, as discussed below.

Maximum Small Employer Credit Amount is Too Small

The maximum amount of the credit does not appear to be a large enough incentive to get employers to offer or maintain insurance. For example, the maximum amount is available to small businesses with 10 or fewer FTE employees that pay an average of $25,900 or less in wages in tax

[8]The Council of Economic Advisors, within the Executive Office of the President, is charged with offering objective advice on forming domestic and international economic policy. SBA is a government agency that offers a variety of programs and support services to help small businesses.

[9]It is important to recognize data limitations make these estimates rough. It is not possible to combine data from available sources on three basic eligibility rules for the credit—wages, FTEs, and health insurance—to closely match the rules. Further, limited data are available on the distribution of claim amounts for business entities.

[10]See GAO-12-549.

[11]Data from 2013 are on a tax year basis and 2014 data are on a calendar basis because only partial tax year 2014 data were available at the time of this report.

year 2016 (adjusted for inflation in future years).[12] Such an employer could be eligible for a credit worth up to 50 percent of the premiums paid.[13] These employers did not consider the maximum credit amount to generally be high enough, and the amount tended to be less than the maximum, as discussed below.

Few Small Employers Qualify for Maximum Small Employer Credit Amount

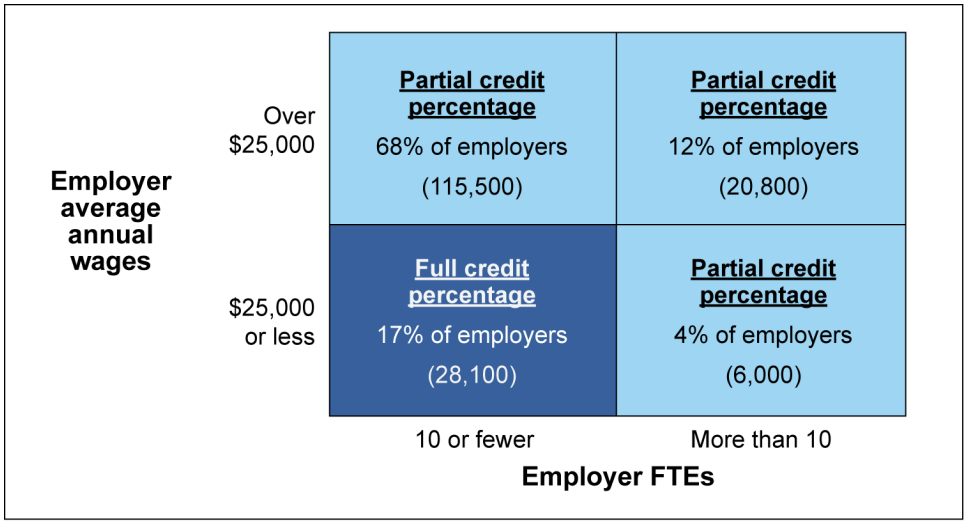
Most small employer credit claims are likely to be for less than the maximum credit percentage. To illustrate, our 2012 report analyzed how many of the approximately 170,300 small employers making claims for tax year 2010 could claim the full credit.[14] As figure 2 shows, only 28,100—17 percent—could use the full credit percentage. Usually, employers could not meet the average wage requirement to claim the full percentage, as 115,500—68 percent—did not qualify based on wages, but did meet the FTE requirement.

[12]Pursuant to the requirements of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, refund payments issued to certain small tax-exempt employers claiming the refundable portion of the Small Business Health Care Tax Credit under Internal Revenue Code Section 45R, are subject to sequestration. This means that refund payments processed on or after October 1, 2015, and on or before September 30, 2016, to a Section 45R applicant will be reduced by the fiscal year 2016 sequestration rate of 6.8 percent. The Congressional Budget Office estimates that a sequestration for fiscal year 2016 will not be required.

[13]Through 2013, small businesses received up to 35 percent and tax-exempt entities received up to 25 percent of their health insurance premium payments; these portions rose to 50 percent and 35 percent, respectively, in 2014.

[14]This amount differs from figure 1 because additional returns were processed for tax year 2010 since we initially reported this amount in GAO-12-549.

Figure 2: Percentage and Number of Small Employers Claiming the Full and Partial Credit Percentages, by FTE and Wage Requirements for the Credit, Tax Year 2010



Source: GAO analysis of IRS data on Form 8941. | GAO-16-491T

Note: This information is based on 170,300 small employer claims. This number has increased since our 2012 report because IRS later processed additional claims for tax year 2010. Numbers do not add to total because of rounding to the nearest hundred.

To the extent that a small employer qualifies to claim the credit, the employer may not be able to fully claim the credit amount for the tax year. For tax-exempt employers, the credit amount claimed cannot exceed the total amount of the employer's payroll taxes for the calendar year. For other small employers such as small businesses, the credit is not refundable but is limited to the actual income tax liability. If a small business had a year in which it ended up paying no taxes (i.e., it had no taxable income after accounting for all its other deductions and credits), then the small business tax credit could not be used for that year as there would be no income tax for the credit to reduce.[15]

[15]An unused credit amount can generally be carried back for 1 year and carried forward up to 20 years.

Certain Credit Design Features Reduce the Amount of Credit That Can Be Claimed

Credit Amount is "Phased Out"

The credit amount that can be claimed "phases out" to zero as employers employ up to 25 FTE employees at higher wages—up to an average of $51,800 for 2016. Table 1 shows the phasing out of the tax credit amount we calculated for a tax-exempt employer's contribution to health insurance in 2016. Table 2 shows the phasing out for other small employers in 2016.

Table 1: Phase out of the Credit as a Percentage of Employer Contributions to Premiums, Tax-Exempt Employers, 2016

Firm size (number of full-time equivalent employees)	Average wage					
	$25,900 and less	$30,000	$35,000	$40,000	$45,000	$51,800
10 and fewer	32.5%	27.3%	21.1%	14.8%	8.5%	0.0%
11	30.3%	25.2%	18.9%	12.6%	6.4%	0.0%
12	28.2%	23.0%	16.7%	10.5%	4.2%	0.0%
13	26.0%	20.8%	14.6%	8.3%	2.0%	0.0%
14	23.8%	18.7%	12.4%	6.1%	0.0%	0.0%
15	21.7%	16.5%	10.2%	4.0%	0.0%	0.0%
16	19.5%	14.4%	8.1%	1.8%	0.0%	0.0%
17	17.3%	12.2%	5.9%	0.0%	0.0%	0.0%
18	15.2%	10.0%	3.7%	0.0%	0.0%	0.0%
19	13.0%	7.9%	1.6%	0.0%	0.0%	0.0%
20	10.8%	5.7%	0.0%	0.0%	0.0%	0.0%
21	8.7%	3.5%	0.0%	0.0%	0.0%	0.0%
22	6.5%	1.4%	0.0%	0.0%	0.0%	0.0%
23	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%
24	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

GAO analysis of the Patient Protection and Affordable Care Act. | GAO-16-491T

Note: The maximum credit for tax-exempt employers in 2016 is 32.5 percent, which is calculated by using the 2015 and 2016 budget sequester rates in the following formula: [((0.35)(1-0.073)(9)) + ((0.35)(1-0.68)(3))] / 12 =32.5 percent.

Table 2: Phase out of the Credit as a Percentage of Employer Contributions to Premiums, For-Profit Employers, 2016

Firm size (number of full-time equivalent employees)	Average wage					
	$25,900 and less	$30,000	$35,000	$40,000	$45,000	$51,800
10 and fewer	50.0%	42.1%	32.4%	22.8%	13.1%	0.0%
11	46.7%	38.8%	29.1%	19.4%	9.8%	0.0%
12	43.3%	35.4%	25.8%	16.1%	6.5%	0.0%
13	40.0%	32.1%	22.4%	12.8%	3.1%	0.0%
14	36.7%	28.8%	19.1%	9.4%	0.0%	0.0%
15	33.3%	25.4%	15.8%	6.1%	0.0%	0.0%
16	30.0%	22.1%	12.4%	2.8%	0.0%	0.0%
17	26.7%	18.8%	9.1%	0.0%	0.0%	0.0%
18	23.3%	15.4%	5.8%	0.0%	0.0%	0.0%
19	20.0%	12.1%	2.4%	0.0%	0.0%	0.0%
20	16.7%	8.8%	0.0%	0.0%	0.0%	0.0%
21	13.3%	5.4%	0.0%	0.0%	0.0%	0.0%
22	10.0%	2.1%	0.0%	0.0%	0.0%	0.0%
23	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%
24	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

GAO analysis of the Patient Protection and Affordable Care Act. | GAO-16-491T

Notes: The maximum credit for for-profit employers is 50 percent in 2016.

Credit Amount is Reduced by State Average Premiums

The amount of the credit is also reduced if premiums paid by an employer are more than the average premiums for the small group market in the state in which the employer offers insurance. The credit percentage is multiplied by the allowable premium to calculate the dollar amount of credit claimed. For example, if the state average premium is $4,441 for a single employee, but a small employer in that state paid $5,000 for an employee's health premium, the credit would be calculated using the state average premium of $4,441 rather than the $5,000. According to IRS data, this cap reduced the credit for around 30 percent of employer claims as of 2012.

Credit is Temporary

Regardless of the allowable credit amount, small employers can claim the credit for just two consecutive years after 2013, which detracts from the incentive for small employers to begin offering coverage. Employers are

reluctant to provide a benefit to employees that would be at risk of being taken away later when the credit is no longer available. As of 2014, the two consecutive tax years for credit claims starts with the first year a qualified employer obtains coverage through a SHOP exchange. In other words, if a qualified employer first obtains coverage through a SHOP exchange in 2016, the credit would only be available to the employer in 2016 and in 2017. From 2010 through 2013, the credit was available to qualifying employers that purchased coverage in the small group market outside of SHOP exchanges, which were first established in 2014. Receipt of the credit for any years between 2010 and 2013 does not disqualify an employer from receiving the credit in 2014 and in subsequent years.

Costs and Complexity Deter Credit Claims

Small employers have not viewed the credit as a sufficient incentive to begin offering health insurance because the credit amount may not offset costs enough to justify the cost for health insurance premiums. In addition, our 2012 report described how small business owners generally do not want to spend the time or money to gather the necessary information to calculate the credit, given that the credit will likely be insubstantial. Tax preparers told us it could take 2 to 8 hours or possibly longer to gather the necessary information to calculate the credit and that the tax preparers spent, in general, 3 to 5 hours calculating the credit. To the extent that preparers did these tasks, small employers would generally incur additional cost for these services.

For example, a major complaint we heard in discussion groups with employers, tax preparers, and insurance brokers centered on gathering information on FTEs and the related health insurance premiums. Eligible employers reportedly did not have the number of hours worked for each employee readily available to calculate FTEs and their associated average annual wages nor did they have the required health insurance information for each employee readily available.

Our 2012 report also noted that the complexity involved in claiming the tax credit was significant, deterring small employers from claiming it. The complexity arises not only from the various data that must be recorded and collected (as just described), but also from the various eligibility requirements in the design of the credit and number of worksheets to be completed.

To determine eligibility requirements, exclusions from the definition of “employee” and from other rules make the calculations complex. For

calculating the number of FTEs and their wages, workers excluded from the definition of employee are seasonal workers (an employee who works no more than 120 days during the year), a self-employed individual, a 2 percent shareholder in an S-corporation, a 5 percent owner of an eligible small business, or someone who is related to or a dependent of these people. While seasonal workers are excluded from FTE counts, insurance premiums paid on their behalf count toward the tax credit. In determining premiums paid by the employer, the rules exclude employer contributions to health reimbursement arrangements, health flexible spending accounts, or health savings accounts. Similarly, an employer's premium payments exclude tobacco surcharges if an issuer charges higher premiums for tobacco users.

As for the complexity of the worksheets and paperwork to be completed to claim the credit, in 2012, tax preparers told us that they thought that IRS did the best it could with the Form 8941 given the credit's complexity.[16] IRS officials said they did not receive criticism about Form 8941 itself but did hear that the instructions and its seven worksheets were too long and cumbersome for some claimants and tax preparers. On its website, as of 2012, IRS tried to reduce the burden on taxpayers by offering "3 Simple Steps" as a screening tool to help taxpayers determine whether they might be eligible for the credit. However, to calculate the actual dollars that can be claimed, we found in 2012 that the three steps become 15 calculations, 11 of which are based on seven worksheets, some of which require multiple columns of information.

Given the effort involved to make a claim and the uncertainty about the credit amounts, our 2012 report discussed the view that having a way to quickly estimate employers' eligibility for the credit and the amount they might receive would help them decide whether the credit would be worth the effort. However, we also noted in 2012 that this would not reduce the complication of finding all the documentation needed to file Form 8941. Further, some employers may believe they are eligible based on a calculator, but then turn out to be ineligible, or find they are eligible for a smaller credit amount when they complete Form 8941 with all the required information.

[16]See IRS Form 8941, *Credit for Small Employer Health Insurance Premiums.*

IRS's Taxpayer Advocate Service developed a calculator in 2012 to quickly estimate an employer's eligibility, but this still requires gathering information such as wages, FTEs, and insurance plans. Our analysis showed that use of this tool peaked in March 2014 with 5,383 uses, and has declined since then, falling to less than 1,000 uses by February 2016.[17] The Centers for Medicare & Medicaid Services officials said they launched a SHOP Small Business Health Care Tax Credit Estimator on the federal exchange website in early 2014 to help employers determine if they qualify for the tax credit as well as the size of the credit they might receive.

Lack of Awareness May Contribute to Low Credit Claims, Although IRS Engaged in Significant Outreach

Many small businesses reported that they were unaware of the credit, as discussed in our 2012 report. The National Federation of Independent Businesses Research Foundation and the Kaiser Family Foundation both estimated that about half of small businesses were aware of the credit as of May 2011. The extent to which the lack of awareness prevented eligible employers from claiming the credit is unknown, particularly given other reasons for not claiming the credit. Further, a number of small business employers would not be eligible for the credit regardless of their awareness. Even if employers were unaware, their accountants or tax preparers may have been aware, but did not inform their clients because they did not believe their clients would qualify or because the credit amount would be very small.

To raise initial awareness of the credit, IRS conducted significant outreach, as discussed in our 2012 report. First, IRS developed a communication and outreach plan, written materials on the credit, a video, and a website. Second, IRS officials reached out to interest groups about the credit and developed a list of target audiences and presentation topics. IRS officials began speaking at events in April 2010 to discuss the credit and attended more than 1,500 in-person or web-based events from April 2010 to February 2012. Discussion of the credit at the events varied from being a portion of a presentation covering many topics to some events that focused on the credit.

[17]This number includes uses of a new tool, which started in May 2015. According to the Advocate's website, the tool helps to determine credit eligibility and estimate the amount, but does not determine whether the health insurance plan is eligible and which employees should be included in the credit estimation.

When we issued our 2012 report, IRS did not know whether its outreach efforts increased awareness of the credit or were otherwise cost effective. It would be challenging however to estimate the impact of IRS's outreach efforts on awareness with a rigorous methodology. As we reported in 2012, based on feedback they received, IRS officials told us they believe their efforts have been worthwhile and used this feedback to expand its outreach to include insurance brokers in 2012. IRS also issued a press release in 2014 to urge small employers to consider claiming the tax credit.

Addressing Factors and Expanding Credit Use Could Require Substantive Design Changes

Our 2012 report discussed ways that the design of the credit could be altered to spur use of the tax credit. Given that most small employers do not offer insurance and that the credit may be too small an incentive to convince employers to provide health insurance, we found that it may not be possible to significantly expand use of the credit without changing its design.

Amending the eligibility requirements or increasing the amount of the credit may allow more businesses to claim the credit, but as we noted in 2012, these changes would increase its cost to the federal government.[18] Options for changing the design of the credit include the following:

- increasing the amount of the full credit, the partial credit, or both;
- increasing the amount of the credit for some by eliminating state premium averages;
- expanding eligibility requirements by increasing the eligible number of FTEs and wage limit for employers to claim the partial credit, the full credit, or both; or
- simplifying the credit calculation by (1) using the number of employees and wage information already reported on the employer's tax return, which could reduce the amount of data gathering as well as credit calculations because eligibility would be based on the number of employees rather than FTEs; and (2) offering a flat credit amount per FTE (or per employee) rather than a percentage. A tradeoff inherent in these changes would be to reduce the precision in targeting the credit.

[18]The data limitations that made it difficult to estimate the number of businesses eligible for the current credit also make it difficult to estimate the impact of any design changes.

Administration and Legislative Proposals to Change the Design and Status of the Credit

The administration has offered proposals to alter the small employer health tax credit. The most recent proposal as of February 2016, would (1) expand eligible employers to include those with up to 50 FTEs; (2) begin the phase out at 20 FTEs; (3) provide for a more gradual phase-out based on average wage and number of employees; (4) eliminate the requirement that an employer make a uniform contribution for each employee (although nondiscrimination laws will still apply); and (5) eliminate the limit imposed by the area average premium.

Between 2011 and 2015, Congress has considered more than 20 bills on the small employer health tax credit. Many offered ways to expand usage of the credit. For example, the bills sought to increase the number of eligible small employers (e.g., allowing an employer to have 50 FTEs); changing the phase out formula; allowing the credit to be claimed in more than two consecutive years; increasing the average annual wage limitation; eliminating the requirement that employers contribute the same percentage of cost of each employee's health insurance; eliminating the cap limiting the credit amount to average premiums paid to a state health insurance exchange; and allowing a partial credit for health insurance purchased outside of SHOP exchanges. Some of these proposed bills restricted the use of the credit for abortion coverage. At least one would have eliminated the credit and a few offered alternatives to the credit.

In closing, the Small Employer Health Insurance Tax Credit was intended to offer an incentive for small, low-wage employers to provide health insurance. However, utilization of the credit has been lower than expected, with the available evidence suggesting that the design of the credit is a large part of the reason why. While the credit could be redesigned, such changes come with trade-offs. Changing the credit to expand eligibility or make it more generous would increase the revenue loss to the federal government.

Chairman Huelskamp, Ranking Member Chu, and members of the Subcommittee, this concludes my prepared remarks. I look forward to answering any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact James R. McTigue, Jr., Director, Tax Issues, Strategic Issues, (202) 512-9110 or mctiguej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this

testimony, or previous related work, are Tom Short, Assistant Director; Anna Bonelli, Amy Bowser, Leia Dickerson, Ed Nannenhorn, Robert Robinson, Cynthia Saunders, Lindsay Swenson, and Jason Vassilicos.

Adult Dental Benefits in Medicaid: Recent Experiences from Seven States

Andrew Snyder and Keerti Kanchinadam

The National Academy for State Health Policy (NASHP) conducted interviews with state administrative and legislative branch as well as dental stakeholders in California, Colorado, Illinois, Iowa, Massachusetts, Virginia, and Washington, all of which have recently taken action to add, reinstate, or enhance their Medicaid adult

This brief summarizes policy lessons and themes about why states decided to take up this coverage option and how they are implementing it. Accompanying case studies provide a more in-depth look at each state's adult

Key Findings

• There is growing recognition of the importance of oral health as it relates to overall health—including pregnancy, avoidable emergency room utilization, and chronic conditions such as diabetes and heart disease—as well as employability. These data points, as well as personal experiences with individuals who cannot access routine dental care, resonated with key state decision-makers.

• Policymakers generally support providing adult dental benefits to Medicaid enrollees, but prioritizing spending on the benefit can be challenging, given the need of states to balance limited resources with many competing priorities.

• Engagement by high-level state policymakers, including legislative leaders, governors' staff, and Medicaid agency leadership, along with active legislative outreach by dental associations and oral health coalitions is important to raise the profile of the issue.

• In many states, enhancements are progressing incrementally. In some states the benefit is being extended only to certain groups of enrollees such as pregnant women or the Medicaid expansion population. In other states the benefit is capped with a dollar limit.

• Many states expanding their adult dental benefit have done so by building on improvements made to their children's dental coverage programs over the last decade. This includes leveraging existing contractual relationships, provider networks, and care coordination efforts.

• States' decisions on adult dental coverage were affected by their broader work on implementing health reform. Enhanced federal funding through the Affordable Care Act's (ACA) Medicaid expansion motivated action in several states. Some states are also beginning to consider how dental services may fit into payment and delivery system reform efforts such as the State Innovation Models Initiative.

Introduction

Oral health is an important but often neglected part of overall health, particularly for adults. For children, states are required to cover dental services in Medicaid and the Children's Health Insurance Program (CHIP), also the ACA extended dental to more children through health insurance exchanges and Medicaid expansion. While implementation issues remain,

access to dental coverage and care over the last 10 years.[1]

Medicaid and the ACA does not address dental for adults.

across states. In 2015, only 15 offered extensive adult dental 17 states offered a more limited package, 15 states offered emergency-only dental and 4 states of [2]

Poor and near-poor adults ages 35-44 are more than twice as likely to experience gum disease and untreated tooth decay than non-poor adults, and almost twice as likely to have lost a tooth due to those conditions.

A 2012 survey found that 91 percent of adults aged 20-64 had dental caries and 27 percent had untreated tooth decay. [3] Poor and near-poor adults ages 35-44 are more than twice as likely to experience gum disease and untreated tooth decay than non-poor adults, and almost twice as likely to have lost a tooth due to those conditions. Poor seniors are more than twice as likely to have lost all of their natural teeth than non-poor seniors. [4]

Historically, states have cut back Medicaid adult dental due to state challenges, including in the wake of the 2007-2009 recession. In the past two years, however, a number of states have decided to enhance the dental provided to adult Medicaid enrollees.

NASHP examined recent experiences in seven states that acted to add, reinstate, or introduce adult dental in the last two years: California, Colorado, Illinois, Iowa, Massachusetts, Virginia, and Washington. These states took a

administrative vehicles for advancing the policy change. Across these states, however, some common themes emerged around:

- Key policymakers and advocates who were engaged in the decision, and the key data points that were important in making the case;
- States' adoption of incremental improvements in order to balance dental with other competing budgetary priorities;

Case Studies

For more on the actions taken on Adult Dental Benefits in the states listed in Table 1, see the Case Studies starting on page 13.

- Application of lessons learned from improvements to states'
- Desire among states to explore how dental might within their broader work on payment and delivery system reform in future.

leaders, legislators, and governors' health policy advisors—and state dental associations, oral health coalitions, and other key stakeholders conducted between February and May 2015. This brief summarizes the high-level themes that emerged from our interviews. More detailed descriptions of the approaches taken in each of the seven states are provided in case studies in Appendix II. Below is a chart that summarizes the actions taken in each of the seven states, the legislative or administrative fered.

Table 1. Actions Taken on

State	Legislative or Administrative Vehicle	Date Implemented	Benefits and Populations Covered
California	State budget, AB 82 (2013)	May 2014	Reinstated most benefits for all Medicaid-enrolled adults, with $1,800 annual "soft cap" that can be exceeded when medical necessity is proven. Additional services covered for pregnant women.
Colorado	SB 242 (2013)	April 2014	Introduced benefits for all Medicaid-enrolled adults, with $1,000 annual cap. Dentures are exempt from the cap.
Illinois	State budget, SB 741 (2014)	July 2014	Reinstated benefits for all Medicaid-enrolled adults. Additional preventive services covered for pregnant women. (Gov. Rauner's proposed FY2015 budget would cut the rates paid for adult dental services.)
Iowa	Section 1115 Medicaid waiver	May 2014	Introduced "earned benefit" to Medicaid expansion population; individuals who establish a regular source of care qualify for more expansive benefits.
Massachusetts	Annual state budgets	January 2013 March 2014 May 2015	Reinstated services for all adults incrementally – first fillings for front teeth, then all fillings, then dentures. Additional services covered for persons determined eligible through the Department of Developmental Services.
Virginia	Governor's Healthy Virginia plan (2014)	March 2015	Introduced dental benefit for adult pregnant women over age 21.
Washington	FY 2013-2015 biennial operating budget	January 2014	Reinstated extensive benefits for all Medicaid-enrolled adults.

Key Themes Among States

Partnerships and Gathering Support

Leadership

Involvement by legislative and administrative branch champions was critical in each state that NASHP interviewed. The champions in several states were people with particularly high authority—including Frank Chopp, Washington State Speaker of the House, Darrell Steinberg, California Senate President pro tempore, and Virginia Gov. Terry McAuliffe. Interviewees noted that the addition of adult dental

involvement of high-level champions was important to make and keep adult dental a priority in the midst of many other state concerns.

Oral health coalition members, stakeholders, and provider groups across states focused primarily on the message that oral health is part of overall health—and that there are linkages between oral health and health conditions such as diabetes, heart disease, and potentially, adverse birth outcomes.[5] Data on use of hospital emergency departments (EDs) for preventable dental conditions, and increases in such visits in states following elimination of adult dental was also noted as important. However, interviewees that it was particularly compelling for policymakers to personally meet individuals experiencing pain and tooth loss from untreated dental conditions. Attendance at dental association sponsored events in California and Virginia, where free dental care was provided to underserved communities, was noted as a key factor in policymakers' engagement in the issue.

Relationship building

In all states, efforts to advocate for, implement, and operationalize a new program required the collaboration of many different partners. The most frequently cited partners were oral health stakeholder groups such as state dental associations, dental hygiene associations, oral health coalitions, and oral health-focused philanthropies. The ability of these groups to lobby legislators was noted as an important factor in several states. Oral health stakeholders noted the importance of engaging a broader group of voices from outside of the dental community, like community health centers, anti-poverty groups, and advocates for seniors and individuals with disabilities.

In most states, strong partnership with the state's dental association was an important factor. Several state dental associations indicated that they decided to advocate for the addition of

even if the policy didn't fully address the concerns of their membership with program administration and provider reimbursement rates, as a way to demonstrate their support for improving oral health and access to care for Medicaid-enrolled individuals.

Good relations between dental associations, oral health coalitions, and Medicaid agencies within a state helped keep dental in front of key decision-makers, so that action could be taken on adult bene when a window of opportunity opened. All states NASHP spoke with said that the new bene came about as a result of years of effort and taking advantage of a ripe opportunity, for example opportunities presented by enhanced federal funding for Medicaid expansion under the ACA.

Approach and Implementation

Financing strategies

Most states their adult dental through state general funds, and the was often introduced in the context of a state's biennial budget process. One exception was Colorado, which redirected a portion of a trust fund that funded the state's high-risk pool, made obsolete through the ACA, to serve as the state

Interviewees across all seven states shared that an adult dental particularly one limited to certain services or populations, is a relatively minor budget item in the context of state Medicaid budgets. In 2013, the National Health Expenditure Accounts estimated that total state and local spending on dental services for children and adults in Medicaid was about $3.2 billion, equaling less than two percent of total state and local spending on Medicaid.[6] Washington's restoration of a dental for 874,000 Medicaid-enrolled adults required $23 million in state funding; Virginia's t for 45,000 pregnant women is projected to cost approximately $3 million in the two years.

in several states reported that the ACA presented a unique opportunity to expand dental coverage to many new enrollees at a reduced cost to the state. In particular, states that opted to expand Medicaid eligibility to individuals up to 133 percent were able to leverage the 100 percent federal match made available through the ACA to help mitigate the cost of a new adult dental bene-

The availability of new federal funding through Medicaid expansion was particularly important in Washington's consideration of an adult Although the state could have opted to only cover dental services for the expansion population, state felt it was important to offer coverage to all adults to ensure continuity and equity of coverage for all enrollees.[7]

Research on links between improvements in oral health and potential reductions in overall health care spending, while compelling to state - cials, generally didn't factor into states' budgeting for adult dental Interviewees in several states noted that demonstrating and booking short-term cost savings is challenging for states that are tied to short annual or biennial budgets and often lack proper systems to coordinate savings that cross medical and dental spheres—for example, reductions in ED usage from improved access to routine dental care. However there was general support for the idea that dental coverage could save money in the long-term, particularly as states move towards efforts to integrate dental and medical services within larger payment and delivery system reforms.

All seven states voiced concern about the perpetual vulnerability of the because it is categorized as "optional," it can be cut or scaled back during times of stress. Most states felt - dent that the they introduced are going to be sustainable for the foreseeable future, though Illinois is already considering a potential

budget negotiations.

Incremental Approaches

Most interviewees expressed a desire to extend full dental to all adults in Medicaid, allowing enrollees to obtain medically necessary care for tooth decay and gum disease. However, many

states pursued an incremental expansion of bene- limiting the to certain populations, covered services, or placing a dollar lim- it on the package. For example, Virginia extended comprehensive dental only to women enrolled in Medicaid during pregnancy and 60 days postpartum; non-pregnant adults in Medicaid are covered only for emergency dental services. Over the last three years Massachusetts has gradually added services including initially for front teeth only, later for all teeth, and dentures back into its adult package. In Colorado, the new dental is comprehen- sive and available to all adults enrolled in Medic- aid, however the is capped at $1,000 per enrollee per year. Dentures are exempt from the

In most cases, the state chose an incremental expansion because of concerns. There was wide acknowledgement among interviewees that an incremental is better than no and there was also a desire among states to limit within what their budget would bear, to reduce the possibility of future cutbacks. Multi- ple interviewees noted that a "pendulum swing" of repeated expansions and contractions had created challenges and confusion for enrollees, providers, and Medicaid agencies alike. During periods of reduced enrollees frequently forego care due to inability to pay. Providers— both dentists and safety net providers like com- munity health centers—reported feeling strain from multiple changes to states' packag- es, in regard to their ability to develop treatment plans for Medicaid-enrolled patients who may no longer have coverage for necessary services. State must manage the administrative challenge of stopping and restarting and face pent-up demand when are restored—particularly for expensive services like dentures, which might have been avoided with routine dental care.

Building on Existing Programs

States across the country have made great prog- ress in improving Medicaid-enrolled children's access to dental care over the last decade.[8]

Several states built on these successes in the policies they adopted for their adult dental Medicaid In particular, states focused on administrative n, including the use of specialized dental administrative vendors, and development of supports to help connect enrollees to dental care.

- **Iowa's** unique Dental Wellness Plan in- corporates a tiered "earned" approach for the newly eligible Medicaid expansion population that conditions cer- tain on patients establishing a relationship with a dentist whom they see regu- larly. To help ensure that adults can build those relationships, Iowa is building on the network of Title V-funded county-based dental care coordinators that it has built over the last 10 years through its I-Smile children's dental program. Iowa also used the tiered structure to increase the capitation rate for the Dental Wellness Plan, enabling it to address some longstanding concerns about provider reimbursement rates.

- **Virginia** used its successful Smiles for Chil- dren program as the basis for its for pregnant women. Smiles for Children has built up strong dentist participation since its intro- duction in 2005 due to simpler administration and higher reimbursement rates.
- **Colorado** used its CHIP uses

a specialized dental vendor—as a model for its transition to a new Administrative Services Organization (ASO).

Other states NASHP interviewed reinstated the same administrative processes, and reimbursement rates that had been cut in previous years. Many of these states saw that as a step, and expressed a desire to continue improving program administration and provider participation in future years.

Officials in several states reported that the ACA presented a unique opportunity to expand dental coverage to many new enrollees at a reduced cost to the state.

Outreach and Education

States indicated that outreach and education to both newly eligible enrollees and providers will be crucial to the ongoing success of the new including ensuring that enrollees connect to regular and ongoing care. In addition to initiatives like Iowa's use of dental care coordinators, states are also working in partnership with stakeholders in the dental and medical communities to ensure that outreach and education efforts are successful. In Virginia, the state has partnered with OBGYNs and pediatricians to help communicate the availability of dental for pregnant women, and to spread information to patients and providers that receiving dental care during pregnancy is safe and appropriate. Colorado is working closely with its state dental association to recruit dentists to serve Medicaid-enrolled clients. Despite progress, provider recruitment and network adequacy remain a concern in many states.

Evaluating Success

NASHP spoke with state and stakeholders about how they would gauge whether they had achieved their policy goals from introduction or reinstatement of adult dental States are primarily looking to traditional measures to gauge their success, including utilization rates among enrollees, provider participation rates, and calls to customer service hotlines from enrollees seeking care.

NASHP spoke to many of these states very soon after their adult dental were implemented, so few were able to provide detailed gs. Some states, however, are reporting early successes in improving access to care and provider engagement.

- **In Iowa**, Delta Dental (the administrator of the Dental Wellness Program) reported that, as of February 2015, 36,500 of the program's 115,000 enrollees had received a dental service since the program began in May 2014.[9]
- **In Washington** State, more than 204,000 Medicaid-enrolled adults received a dental service in CY 2014, an increase from the roughly 136,000 adults who received services in CY 2010—the year before services were cut back. Howev-

er, this happened in the context of a doubling of the number of enrollees (from 410,000 to 874,000) due to Medicaid expansion, so the rate at which enrollees used services fell from 33 percent to 23 percent.[10]

- **Colorado** reported some success from their provider recruitment efforts, conducted in collaboration with the Colorado Dental Association (CDA). The CDA reported that the number of Medicaid-participating dentists had grown 17 percent between 2012 and 2014.[11]

Additionally, several states are setting concrete expectations around linkages between dental and overall health spending. Colorado has set yearly performance standards for its administrative services contractor. In year two, the state is focusing on decreased utilization of the emergency room for non-emergency dental care. In Iowa, because the Dental Wellness Plan is being implemented through a section 1115 demonstration waiver, the state, in partnership with the University of Iowa Public Policy Center, has developed a detailed evaluation plan that will attempt to track whether enrollment in the Dental Wellness Plan results in reduced ED utilization, and also measure whether enrollees receiving dental services experience better outcomes related to chronic conditions like diabetes.[12]

Looking Forward

and advocates in many states saw the addition or restoration of adult dental as the step in addressing oral health for Medicaid-enrolled adults, with more action being necessary to ensure that enrollees can effectively access care. In Colorado, the state legislature has followed up the initial introduction of a dental ben- with subsequent action to provide coverage for dentures (outside of the $1,000 annual cap) and to provide reimbursement rate increases for targeted services. State in Iowa are considering how the Dental Wellness Plan might into the state's shift toward managed care for all Medicaid-enrolled populations. In Washington, oral health stakeholders are working to partner with the Washington Health Care Authority to research the possibility of developing a targeted, enhanced for pregnant women and people with diabetes, modeled after the state's successful Access to Baby and Child Dentistry program. Other states like Illinois, however, are already facing the possibility of cutbacks to in the context of a changing state budget picture.

States are also looking for ways to expand their ability to provide dental services beyond the traditional dental California recently enacted legislation to permit Medicaid reimbursement to dentists who provide dental care via telehealth.[13] This supports programs such as the Virtual Dental Home, a model where dental hygienists and assistants provide preventive and limited restorative services in community settings like nursing homes, schools, and Head Start sites, with connection via telehealth to a supervising dentist. Colorado will soon begin a pilot project to replicate the Virtual Dental Home model, funded by the Caring for Colorado Foundation.[14]

Lastly, and advocates in several states are looking closely at ways to weave oral health into broader payment and delivery system reforms, to oral health's connection to overall health. Stakeholders from the Virginia Oral Health Coalition will be leading a workgroup through Virginia's State Innovation Model (SIM) design planning process. They will make recommendations on strategies that Accountable Communities for Health (ACH), regional multi-sector collaboratives that make decisions about allocation of health care resources, can use to address the oral health of their communities. In Washington, although oral health was not addressed in detail in the state's SIM Innovation Plan, state indicated that they expected several ACHs to identify oral health as a priority area for improvement. Colorado is considering ways to facilitate collaboration between its dental ASO and its Regional Care Coordination Organizations (the state's Medicaid-focused accountable care entities). Colorado is also examining ways to develop better linkages between dental claims data and its all-payer claims database.

Conclusion

Adult dental coverage'

that NASHP examined took a variety of approaches to adding, reinstating, or introducing adult dental

meaningful access for program enrollees. Many have also built on lessons learned from improvements to their Medicaid dental programs for children.

policymakers—who frequently cited the importance of oral health, high levels of unmet need among low-income populations, and links between oral health and overall health. However, prioritizing need to balance limited resources and many competing priorities. Important factors in these seven states included funding opportunities through the ACA, personal engagement by high-level state policymakers, and strong partnerships with dental

These seven states' experiences may be instructive for other states considering addressing adult dental coverage. The case studies in Appendix II of this brief provide much more detail on the strategies that each state pursued.

Endnotes

1. Andrew Snyder, Keerti Kanchinadam, et. al. Improving Integration of Dental Health Benefits in Health Insurance Marketplaces (Washington, DC: National Academy for State Health Policy, 2014).

2. The American Dental Association classifies Medicaid adult dental benefits into the following categories: Extensive benefits: A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the American Dental Association (ADA); per-person annual expenditure cap is at least $1,000. Limited: Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the ADA; per-person annual expenditure for care is $1,000 or less. Emergency Only: Relief of pain under defined emergency situations. (Center for Health Care Strategies, "Medicaid Adult Dental Benefits: An Overview." Retrieved May 21, 2015. http://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_21915.pdf.)

3. Bruce Dye, et. al. Dental Caries and Tooth Loss in Adults in the United States, 2011-2012. NHCS Data Brief no. 197 (Hyattsville, MD: National Center for Health Statistics, May 2015).

4. Bruce Dye and Gina Thornton-Evans, "Trends in oral health by poverty status as measured by Healthy People 2010 objectives," Public Health Reports 125: no. 6, 817-830 (May-June 2010). Poor is defined as income less than or equal to 100 percent of the Federal Poverty Level (FPL). Near-poor is defined as income between 100 and 199 percent FPL, and non-poor as income greater than or equal to 200 percent FPL.

5. Andrew Snyder, Oral Health And The Triple Aim: Evidence And Strategies To Improve Care And Reduce Costs (Washington, DC: National Academy for State Health Policy, 2015).

6. Centers for Medicare and Medicaid Services, "National Health Expenditures by type of service and source of funds, CY 1960-2013." Retrieved May 26, 2015. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

7. Interview with MaryAnne Lindeblad, Nathan Johnson, and Gail Krieger, Washington Health Care Authority, April 8, 2015.

8. Centers for Medicare and Medicaid Services, CMS Oral Health Initiative and Other Dental-Related Items (Baltimore, MD: U.S. Department of Health and Human Services, April 2013), CIB-04-18-13.

9. Interview with Beth Jones and Gretchen Hageman, Delta Dental of Iowa, February 25, 2015.

10. Personal communication with Nathan Johnson, Chief Policy Officer, Washington State Health Care Authority, April 8, 2015.
11. Interview with Colorado Dental Association, March 26, 2015.
12. Iowa Medicaid Enterprise and University of Iowa Public Policy Center, "Iowa Dental Wellness Plan Evaluation." (September 2014). Retrieved May 26, 2015. http://dhs.iowa.gov/sites/default/files/DentalWellnessPlanEvaluationDesign_Sept2014.pdf.
13. California Assembly Bill 1174. Approved by Governor September 27, 2014.
14. Caring for Colorado Foundation, "Caring for Colorado Announces New, Major Investments," news release, January 26, 2015, http://www.caringforcolorado.org/post/newsroom/caring-colorado-announces-new-major-investments.

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.
tisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP pro- vides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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Appendix I: Interviewee List

CALIFORNIA
Bob Isman
Former Dental Program Consultant
California Department of Health Care Services

Jenny Kattlove
Senior Director of Programs
The Children's Partnership

René Mollow
Deputy Director, Health Care Benefits and Eligibility
California Department of Health Care Services

Nik Ratliff
Section Chief, Contract Management and Administration
California Department of Health Care Services

Nicette Short
Director of Public Policy
California Dental Association

Darrell Steinberg
Shareholder
Greenberg Traurig, LLP
Former Senate President pro Tempore, California State Senate

Chris Wordlaw
Section Chief, Provider and Beneficiary Services
California Department of Health Care Services

COLORADO
Alyssa Aberle
President
Colorado Dental Hygienist Association

Deborah Foote
Executive Director
Oral Health Colorado

Bill Heller
Provider Relations and Dental Program Division Director
Department of Health Care Policy & Financing

Greg Hill
Executive Director
Colorado Dental Association

Jeff Kahl
Co-Chair of Council on Governmental Relations
Colorado Dental Association

Brett Kessler
President
Colorado Dental Association

Jennifer Miles
President, Miles Consulting, Inc.

Carol Morrow
Second Vice President and Secretary
Colorado Dental Association

Jeanne Nicholson
Former Senator
Colorado Senate

IOWA
Lawrence Carl
Executive Director
Iowa Dental Association

Peter Damiano
Director, Public Policy Center
Professor, Preventive and Community Dentistry, University of Iowa

Sabrina Johnson
Policy Specialist
Iowa Medicaid Enterprise

Beth Jones
Public Benefit Manager
Delta Dental of Iowa

Gretchen Hageman
Dental Wellness Plan Director
Delta Dental of Iowa

Sally Nadolsky
EPSDT Manager
Iowa Medicaid Enterprise

Bob Russell
Public Health Dental Director
Iowa Department of Public Health

Robert Schlueter
Bureau Chief of Adult & Children's Medical Programs
Iowa Medicaid Enterprise

Andria Seip
Affordable Care Act Project Manager
Iowa Medicaid Enterprise

Jennifer Vermeer
Assistant Vice President for Health Policy and Population Health
University of Iowa Health Care

ILLINOIS
Mona Van Kanegan
Co-founder and Co-director of Oral Health Forum
Heartland Alliance

Dave Marsh
Director of Government Relations
Illinois State Dental Society

Gina Swehla
Acting Bureau Chief
Illinois Department of Healthcare and Family Services

MASSACHUSETTS
Patricia Edraos
Health Resources/Policy Director
Mass League of Community Health Centers

Stacia Castro
Specialty Provider Network Manager
MassHealth

Ellen Factor
Director of Dental Practice
Massachusetts Dental Society

Brian Rosman
Research Director
Health Care for All

John Scibak
Representative
Massachusetts House of Representatives

Shannon Wells
Oral Health Affairs Manager
Mass League of Community Health Centers

Jane Willen
Dental Program Manager
MassHealth

VIRGINIA
Terry Dickinson
Executive Director
Virginia Dental Association

Pat Finnerty
President, Board of Directors, Virginia Dental Association Foundation
Senior Advisor, DentaQuest Foundation

Joseph Flores
Deputy Secretary of Health and Human Resources
Office of the Secretary of Health and Human Resources

Sarah Holland
Executive Director
Virginia Oral Health Coalition

Anna Healy James
Policy Director
Office of Governor McAuliffe

Cheryl Roberts
Deputy Director of Programs
Department of Medical Assistance Services

Myra Shook
Dental Program Manager
Department of Medical Assistance Services

Bryan Tomlinson
Division Director of Health Care Services
Department of Medical Assistance Services

WASHINGTON

Sarah Vander Beek
Chief Dental Officer
Neighborcare Health

Walt Bowen
President
Washington State Senior Citizens' Lobby

Eileen Cody
Representative
Washington State House of Representatives

Robert Crittenden
Senior Health Policy Advisor
Office of Governor Inslee

Colleen Gaylord
Chair, Regulation & Practice Committee
Washington State Dental Hygienist Association

Bracken Killpack
Executive Director
Washington State Dental Association

Tony Lee
Senior Fellow
Solid Ground

Nathan Johnson
Chief Policy Officer
Washington State Health Care Authority

Gail Krieger
Section Manager
Washington State Health Care Authority

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority

Kelly Richburg
Policy Advocate/Analyst
Washington Dental Service Foundation

Laura Smith
President and CEO
Washington Dental Service Foundation

Appendix II : State Case Studies

Medicaid Adult Dental Benefits: California Case Study

In 2014, California restored most

adults, following a cutback in the

2009. The state's implementation of the Affordable Care Act's (ACA) Medicaid expansion factored into the decision to restore dental bene- There are continuing concerns around access to care for the now 12 million state Medicaid enrollees with

History

In 2009, in the midst of a $42 billion budget stemming from the l crisis and recession, California cut back longstanding dental coverage for adults age 21 and older enrolled in Medi-Cal, the state's Medicaid program. Only very limited remained, covering emergency services, extractions, and some oral surgery services for all adults. Pregnant women and individuals in skilled nursing facilities or intermediate care facilities for individuals with developmental disabilities were not subject to the reduced As the state's picture improved, adult were partially restored through the 2013 state budget, Assembly Bill 82.[1] State estimate that the restored bene which went into effect in May 2014, cost approximately $70 million.

This partial restoration of adult happened in the context of the ACA's Medicaid expansion, which increased total Medi-Cal enrollment to approximately 12 million individuals. State noted that their goal around Medicaid expansion was to offer all adults the same package. They also noted that the availability of enhanced federal funding for the Medicaid expansion population was a positive factor with respect to the viability of bringing back adult dental

Approach and Implementation

The Medi-Cal dental program includes two delivery systems: dental managed care, and the Denti-Cal fee-for-service program. Dental managed care is available only in Sacramento County, where enrollment is mandatory, and Los Angeles County, where it is voluntary. Denti-Cal fee-for-service is available in all other counties of the state.[2]

The that were restored include exams, x-rays, root canals on front teeth, and full dentures.[3] Coverage for root canals on back teeth and treatment for gum disease were not returned. There is a yearly "soft cap" of $1,800 in although this limit can be exceeded if medical necessity can be proven.[4]

Though on utilization of dental services by Denti-Cal-enrolled adults since the restoration of will not be ready until later in 2015, state report that utilization has picked up, with some evidence of pent-up demand among adults for restorative and denture services

that had been eliminated. *Health Affairs* recently published an article noting an increase of 1,800 visits per year to hospital emergency departments for dental conditions following the cutback.[5]

Given the restored and enrollment expansion, state noted the need to closely monitor provider capacity and enrollees' access to dental care. Provider participation and program administration were noted by Denti-Cal as issues in a recent state auditor's report on children's access to dental care. Provider payments were reduced by 10 percent in September 2013[6] (for 10 common procedures, the auditor estimated that California's rates were 35 percent of the national average). The report also voiced concerns about whether adults that were newly eligible for dental services might crowd out children seeking care.[7] In response to the audit state must develop a corrective action plan to address recommendations. The state has met with stakeholder groups to establish additional measures of utilization and provider participation in the fee-for-service program. The state is also working on an active reprocurement of an administrative services contractor and intermediary contractor for the Medi-Cal dental program.[8]

Key Leadership and Partnerships

Senator Darrell Steinberg, former president pro tempore of the California Senate, was a key legislative champion keep restoration of adult a priority in the state budget. Sen. Steinberg became engaged in the issue after attending CDA Cares, a charity event organized by the California Dental Association (CDA), and being deeply affected by the event. He recalled seeing the health effects and human cost of unmet dental needs, including seeing the large number of people needing tooth extractions. After a state tax measure passed, there were state revenues to prioritize increased spending on a limited number of issues, and the senator advanced adult dental coverage with the support of his caucus. He noted that the measure wasn't controversial among his colleagues, but that high-level leadership was necessary to raise the of adult dental coverage and make it a priority.[9]

The CDA was a major supporter of the effort to restore and worked with legislative staff on developing several options for the Interviewees also noted the participation and support of the state oral health coalition, the state primary care association, and advocacy groups including The Children's Partnership, which has had longstanding involvement in oral health policy issues.

Looking Forward

Interviewees all indicated, while adult dental ben- are always vulnerable due to their optional status, they were that since the state was in a more sustainable situation they did not see future cuts on the horizon. State remain focused on ensuring access to dental care for Medi-Cal Budget discussions at the legislature have included a proposal to restore the remaining adult dental [10]

Following our interviews, stakeholders including the CDA successfully advocated for a reversal of the 2013 rate cut, effective July 1, 2015.[11] Stakeholders are continuing to consider strategies to enhance feeds for targeted services. Making adult coverage more available through Covered California, the state's health insurance marketplace, is also a priority for oral health stakeholders.

California is also examining ways to bring dental care closer to individuals who need it. The state recently enacted legislation to permit Medicaid reimbursement to dentists who provide dental care via telehealth.[12] This legislation supports programs such as the Virtual Dental Home, a model where dental hygienists and assistants provide preventive and limited restorative services in community settings like nursing homes, schools, and Head Start sites, with connection via telehealth to a supervising dentist. The Children's Partnership and CDA are partnering in support of legislation for $4 million in grants to support start-up costs of Virtual Dental Home projects in 20 communities for equipment, training, learning collaboratives, and technical assistance.[13]

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Medicaid Adult Dental Benefits: Colorado Case Study

In 2013, Colorado introduced a new law providing extensive dental bene- for all Medicaid-enrolled adults for - ed with funds that were freed up when the Affordable Care Act (ACA) eliminated the need for the state's

stakeholders are continuing to work to bolster provider participation and address reimbursement rates.

History

Prior to 2013, Colorado only covered emergency dental services for adult enrollees in Medicaid. In 2011, upon taking Gov. Hickenlooper 10 "winnable battles"—public health priorities with known and effective strategies to address them. Improving oral health was among those chosen. While the original focus was on children's oral health, it paved the way to address oral health issues for pregnant women, mothers, and the larger adult population.

In 2012, Colorado saw its major push towards expanding adult dental Senate Bill 12-108 proposed dental services for pregnant women under the state's Medicaid program. Advocacy organizations and the bill sponsor, Sen. Jeanne Nicholson, majority caucus chair and a public health nurse by training, spent years educating members of the state House and Senate on the importance of oral health for an adult's ability to maintain employment and their overall health. Interviewees credit these efforts for the success SB 12-108 initially saw. The bill passed the Senate but did not make it on the House's calendar for voting. Despite the initial bill being pulled back, it paved the way for a more comprehensive bill in the following year. With the Governor's leadership, Senate Bill 13-242 extended dental services to all adults over age 21 in the state's Medicaid program. This bill was signed in May 2013 with dental beginning in April 2014.

Approach and Implementation

Funding

Funding for the new adult dental came from a unique source. In 1990, the state established CoverColorado, a state-run high-risk pool to help individuals with pre-existing conditions enroll in coverage. Following the ACA's elimination of denials for pre-existing conditions and the establishment of health insurance exchanges, CoverColorado was made unnecessary. The state's Unclaimed Property Trust Fund (UPTF), which funded CoverColorado, was as a possible source of funding for the adult dental Due to Colorado's Taxpayer's Bill of Rights amendment—which requires that excess state revenue be refunded to taxpayers—there was a very limited window of availability for the freed UPTF funds. It was imperative that the state move quickly to redirect the funds. As a result, the Department of Health Care Policy and Financing

(DHCPF) had to implement the new pro-gram on a very compressed timeline of less than a year.

The new adult dental provides a fairly comprehensive set of for adults over age 21 in Medicaid. The main limitation on the is a $1,000 annual cap. The initial 2013 also did not include dentures, but in 2014, law-makers from both parties voted to add this cov-erage. Notably, this addition gained more support from Republican legislators than the initial 2013 legislation.

offered to adults in Colorado's Medicaid program include: basic preventive dental exams, diagnostic and restorative dental services, ex-tractions, root canals, crowns, partial and com-plete dentures (not subject to the $1,000 cap), and periodontal scaling and root planing. Other procedures requiring prior authorization are avail-able.[1]

Since July 2014, the bene has been adminis-tered by DentaQuest, a dental administrative ser-vices organization (ASO). Because of the short timeframe for implementation, DHCPF directly administered a more limited from April to July 2014. Colorado used its Children's Health In-surance Program (CHIP) uses a specialized dental vendor—as a model to develop the new ASO. Though the multiple changes cre-ated some disruptions for providers, state suggested that using a successful program such as CHIP

Reimbursement Rates and Provider Incentives

The Colorado General Assembly has continued to support Medicaid dental through appro-priations. The Joint Budget Committee approved a 4.5 percent increase in dental provider rates in FY 2013-2014[2] and a two percent across-the-board provider rate increase in FY 2014-2015.[3] Additional targeted rate increases for dental services are included in the Joint Budget Committee's budget for FY 2015-2016 as well,

4

The Legislature also approved $2.5 million in state funding (with a $2.5 million federal match) to provide incentives for dentists who treat Medicaid enrollees.[5] The state contribution comes from reinvesting a portion of the savings from the change in federal match rate for Med-icaid and CHP+, Colorado's CHIP program. As of March 2015, DHCPF was awaiting federal ap-proval of a State Plan Amendment to operational-ize the provider incentive program. Provider and stakeholder groups are concerned that the delay in implementing the incentives has taken some momentum out of provider recruitment efforts.

Key Leadership and Partnerships

Key policymakers in Colorado championed the is-sue of improved access to oral health for adults, ensuring that it was a legislative priority in the state. Engagement by Senator Nicholson, Gover-nor Hickenlooper's and the leadership of DHCPF were especially important.

From the stakeholder perspective, the Colorado Dental Association (CDA) and Oral Health Colo-rado (OHCO) led advocacy and lobbying efforts. OHCO convened a wide array of stakeholders, including community and safety net partners, to provide continued feedback on the development and implementation of the new The CDA was a strong supporter of the new and has been engaged in helping to communicate provid-ers' concerns and administrative challenges with the new The CDA has shown commit-ment to increasing provider participation, partic-ularly through a "Take 5" campaign to encourage dentists to begin seeing at least Medicaid patients. Colorado reported some success from their provider recruitment efforts, conducted in collaboration with the CDA. The CDA reported that the number of Medicaid-participating dentists had grown 17 percent between 2012 and 2014.[6]

Looking Forward

A major concern for the long-term sustainability of the new adult dental is provider partici-pation. Historically, perceived low reimbursement

rates and administrative barriers have made many dental providers reluctant to participate in the Medicaid program. DHCPF and DentaQuest are holding regular town hall meetings to gather provider and stakeholder feedback to address administrative issues. Also, the General Assembly has appropriated additional funds for reimbursement rate increases, though there is some concern that, without raising the $1,000 cap, enrollees may more quickly exhaust their annual

Although it is too early for Colorado to report utilization for the year of the DHCPF has laid out several benchmarks for evaluating their ASO vendor's performance. In year one, they looked to increase provider enrollment. In year two, they are focusing on decreased utilization of the emergency room for non-emergency dental care. Finally, the goal for year three will focus on better health outcomes, particularly by thinking of ways to coordinate their ASO with the state's Regional Care Collaborative Organizations.

Colorado is also exploring ways to expand their capacity to provide dental services beyond the traditional dental system. Colorado will soon pilot a 5-year, $1.65 million Virtual Dental Home initiative, funded by the Caring for Colorado Foundation, replicating legislation recently enacted in California. The Virtual Dental Home will allow licensed independent practice dental hygienists to provide preventive dental care and access to a dentist via telehealth technology.[7] In addition, Colorado is examining ways to develop better linkages between dental claims data and its all-payer claims database.

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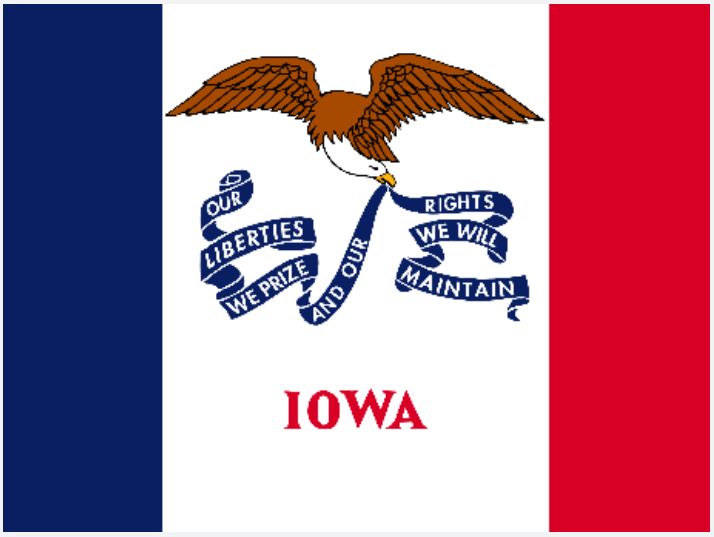
Medicaid Adult Dental Benefits: Iowa Case Study



In 2014, Iowa began offering a

to adults in the Medicaid expansion population. The Dental Wellness

where individuals who establish a regular source of care qualify for

-

ment rates, streamlined administration, and care coordinators, modeled after a successful Iowa program for

History

The Iowa Medicaid Enterprise (IME) has administered a fee-for-service dental for Medicaid-enrolled adults for many years without interruption. Advocates and stakeholders, however, report longstanding issues with inadequate access to care for enrollees and limited provider participation, driven in part by low provider reimbursement rates. IowaCare, a separate health coverage program for individuals under 200 percent of the Federal Poverty Level (FPL) who were not enrolled in Medicaid, included very limited dental services (mainly extractions).

The IowaCare program ended in December 2013, after the introduction of the Iowa Health and Wellness Plan, an alternative approach to the Affordable Care Act's (ACA) Medicaid expansion. The new program consists of two parts: the Iowa Wellness Plan, a program similar to traditional Medicaid, for adults ages 19-64 under 100 percent of the FPL, and the Iowa Marketplace Choice Plan, which helps individuals with income between 100 and 133 percent of the FPL purchase coverage on the ACA's health insurance marketplace.

The Iowa legislature included a dental in the legislation enabling the Health and Wellness Plan (Senate File 446, signed into law by Gov. Branstad in June 2013). IME implemented the Health and Wellness Plan through a section 1115 demonstration waiver, which received federal approval in December 2013.[1]

A 2013 evaluation of IowaCare found that dental services were the most frequently-cited unmet chronic health need among program enrollees, with 39 percent reporting dental, tooth, or mouth problems, and 47 percent reporting that they were unable to obtain needed dental care.[2] These evaluation s were important contributors to the approach to dental services in the Health and Wellness Plan. State wanted to address the high level of need among enrollees, and also take the opportunity presented by the waiver process to develop a program that addressed multiple barriers to dental access in the traditional Medicaid administration, reimbursement rates, and patient engagement—all at the same time. The availability of 100 percent federal funding for the ACA Medicaid expansion was also important in making the new program

Enrollment in the Dental Wellness Plan (DWP) started in May 2014, a few months following the January 2014 launch of the Iowa Wellness Plan. DWP is open to adults in both the Iowa Wellness Plan and the Iowa Marketplace Choice Plan.

Approach and Implementation

The DWP incorporates a tiered "earned" approach for the newly eligible Medicaid expansion population. It conditions certain on patients establishing a relationship with a dentist whom they see regularly. Nineteen- and 20-year olds enrolled in DWP can receive additional medically necessary dental services under the Medicaid Early Periodic Screening, Diagnostic, and T

- All enrollees are eligible for "Core" services upon enrollment, including exams, preventive services, x-rays, emergency services, and "stabilization" services intended to maintain basic functioning, including restorations for large cavities, crowns, dentures, and root canals and treatment for gum disease (periodontal disease) in limited circumstances.
- Enrollees who receive a second dental exam in 6-12 months become eligible for "Enhanced" services, including routine and expanded coverage for root canals and periodontal services.
- After a third recall exam, enrollees become eligible for "Enhanced Plus" services, including expanded coverage for crowns, bridges, dentures, and gum surgery.[3]

Enrollees must continue to make recall visits in order to keep these higher-level This approach is in keeping with the Iowa Wellness Plan's emphasis on personal responsibility, for example, premiums are waived for Wellness Plan enrollees who complete certain healthy behaviors.

To help ensure that adults can build those relationships, Iowa is building on the network of Title V-funded, county-based dental care coordinators that it has established over the last decade in its I-Smile children's dental program. Delta Dental, which administers the DWP, contracted with 19 regional coordinators, including many of the same agencies that provide I-Smile care coordination services, to connect DWP enrollees with dental providers. An eventual goal is for these coordinators to build relationships with hospital emergency rooms in order to divert patients seeking urgent care for oral conditions to a regular source of dental care. These contracts started in February 2015 and will be ramping up through June 2017.

Implementation of the has not been without challenges. Dentists cited confusion about which program their Medicaid-enrolled patients are in, what their current level of coverage is, and concern that the tiered design interferes with dentists' ability to provide appropriate care to their patients. Some issues were also reported with patients' ability to complete treatment plans that were begun prior to enrollment in the DWP. The state has tried to strike a balance between meeting enrollees' health needs and maintaining the earned structure. In response to stakeholder feedback, the state added additional stabilization and emergent services to the "Core" and has also allowed patients and providers to make arrangements for self-pay for services that go beyond a patient's current level.

Reimbursement Rates and Provider Incentives

An advantage of the tiered structure is that it has allowed the state to increase the capitation payment to Delta Dental to $22.66 per member per month. This translates into provider reimbursement rates that are approximately 60 percent higher than in fee-for-service Medicaid (though still below Delta's commercial fee schedule).

Delta also makes incentive payments to providers who complete annual oral health risk assessments for patients. Comprehensive risk assessments can form the basis of a treatment plan, help to measure changes in individuals' oral health status, and help the state to understand the oral

health status of the DWP population. The provider incentive payments were scheduled for April 2015. The state initially considered a tiered benstructure based on risk assessment, but shifted over time to its current focus on establishing a regular source of care.

Key Leadership and Partnerships

Multiple interviewees cited personal engagement by former Medicaid director Jennifer Vermeer in the design and development of the DWP as critical to the plan's success. Delta Dental (who had a history of administering the dental in hawk-i, the state's CHIP program) was also deeply engaged in the development of the plan. Several stakeholders, including Iowa's state dental director, Dr. Bob Russell, and representatives from the University of Iowa College of Dentistry were engaged in reviewing and adapting the plan.

Looking Forward

Delta Dental reports that 36,500 of the program's 115,000 enrollees had received a dental service between the start of the program and February 2015.[4] About half of those receiving services also received a risk assessment. Provider recruitment for the DWP has been robust; as of February, 721 dentists were participating in the program, exceeding Delta's goal of 500 providers.

Because the Dental Wellness Plan is being implemented through a section 1115 demonstration waiver, the state in partnership with the University of Iowa Public Policy Center has developed a detailed evaluation plan that will attempt to track over the next three years whether enrollment in the DWP results in reduced emergency department utilization, and also measure whether enrollees receiving dental services experience better outcomes related to chronic conditions like diabetes.[5] The state is also interested in measuring the program's success in actually improving the oral health of its target population—not just whether access improves, but whether the mix of services enrollees receive shifts away from and extractions and toward preventive services.

State are also considering how the DWP might into the state's shift toward managed care for all Medicaid-enrolled populations, and whether the approach might be adapted for other Medicaid-enrolled populations.

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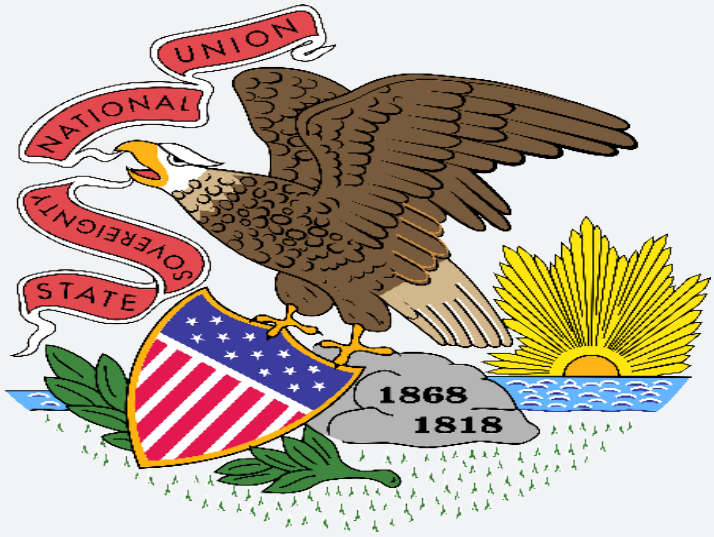
Medicaid Adult Dental Benefits: Illinois Case Study



In July 2014, Illinois passed legis-

Medicaid-enrolled adults. Just two

scaled back to emergency dental services only for adults. The Governor's 2015 budget proposes to cut

time.

History

Adult dental in Illinois' Medicaid program have had a turbulent history. The was cut and then quickly restored in the mid-1990's. Most recently, in 2012 Gov. Quinn passed the Save Medicaid Access and Resources Together (SMART) Act, which included $1.6 billion in spending reductions and cuts. Many optional services including most adult dental services were eliminated as a result. Coverage was retained for emergency extractions and for limited services for individuals receiving organ transplants or cancer treatment; later, limited coverage was restored for pregnant women.[1] In the years following the cut, lawmakers and advocates heard many complaints and stories from a variety of constituents regarding lack of access to dental care, particularly preventive care. In 2014, Gov. Quinn signed SB 741—omnibus legislation that included restoration of adult dental [2] In March 2015, NASHP spoke with stakeholders and state in Illinois to learn more about the 2014 restoration. However, at the time of our conversations, new Gov. Bruce Rauner had proposed $1.47 billion in Medicaid cuts including the reduction or elimination of adult dental coverage.[3] At the time of this writing, the Illinois General Assembly had not yet

Approach and Implementation

On July 1, 2014, adults in Illinois began receiving services through the new Illinois reinstated the same package and provider reimbursement rates that existed in 2011, prior to the elimination.[4] Covered services include diagnostic services, crowns, root canals, partial and complete dentures, and oral surgical procedures.[5] Pregnant women are eligible for additional preventive dental services.

Illinois saw a spike in utilization of dental services immediately after the bene was restored. There was a lot of media and publicity around the new which interviewees believe contributed to the high demand. The state also sent out notices informing clients of the new However, after the initial spike in July and August, the state

At the same time, as the state was implementing the new adult dental bene it was starting the resource-intensive undertaking of transitioning 1.5 million Medicaid recipients into managed care programs, including multiple subcontractors for

dental services. Interviewees suggested that the lower utilization in subsequent months of the ben- might have been a result of challenges during the transition period.

Key Leadership and Partnerships

The Illinois State Dental Society was a strong supporter of restoration of the adult dental and has consistently met with state and lawmakers to discuss the s future. Other advocates engaged in the policy discussion include the state primary care association, community health centers, the Illinois maternal and child health coalition EverThrive, and the Heartland Alliance, an anti-poverty organization. The state Medicaid agency also works with IFLOSS (the state oral health coalition) to get feedback on policy changes.

Stakeholders noted the importance of building and retaining strong dental advocates at the state level. In particular, interviewees noted that the absence of a state Dental Director since 2007 had made it more challenging to keep oral health as a policy priority.

Looking Forward

At the time of this writing, the immediate future of adult dental in Illinois is uncertain. Interviewees in the state feared that the by virtue of it being an optional would always be vulnerable to cuts. To help illustrate the need for adult dental researchers are working to show the impact of poor dental care on emergency room costs. In particular, researchers are collaborating with the American Dental Association and the Illinois Department of Public Health to collect and analyze data on emergency room utilization. Advocates hope that strong data demonstrating the impact of poor oral health on overall healthcare costs could help convince lawmakers in the future.

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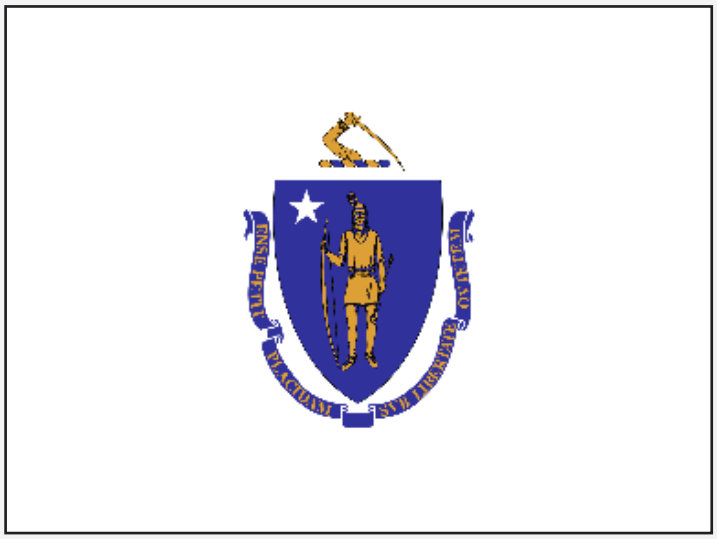
Medicaid Adult Dental Benefits: Massachusetts Case Study



Massachusetts has cut and restored Medicaid adult dental

last 13 years. In recent years, the state has adopted an incremental approach of restoring

and dentures. During periods of cutback, the state's Health Safety Net allows community health centers to continue providing restorative care.

History

Medicaid adult dental in Massachusetts have experienced what one advocate refers to as a "pendulum swing" of cuts and restorations for more than a decade. The state provided comprehensive dental to all adults enrolled in MassHealth, the state's Medicaid program, until 2002, when were cut back for most adults except for those in "special circumstances," including adults with developmental disabilities. These individuals were eligible for covering emergency services, x-rays, extractions, and a few other limited services. A supplemental cut to denture coverage happened in 2003. were restored in 2006, for pregnant women and mothers of children under age 3, then later for all adults as a result of the state's comprehensive health reform effort. were cut again in 2010 and were limited to cleanings, extractions, and oral surgery. were preserved for adults determined eligible through the Department of Developmental Services (DDS).

Since the 2010 cuts, the state has gradually added back coverage on a service-by-service basis through the state budget process. MassHealth has frequently put forward full restoration of the in its annual budget request, and oral health stakeholders and legislative champions, like those engaged in the state's Legislative Oral Health Caucus, have worked within the state's budget constraints to prioritize certain services. In January 2013, coverage was added for on front teeth, which are important for employability. In March 2014, coverage for all was restored. And in May 2015, coverage for dentures was restored.

During the periods of cutback, community health centers and hospital licensed health centers continued to provide services that were not covered by MassHealth, such as and dentures for adults. Funding for these services came from the state's Health Safety Net, formerly the Uncompensated Care Pool, which is funded through assessments on hospitals and ambulatory surgery centers. The Massachusetts League of Community Health Centers reports that the cuts resulted in increased demand at health center clinics from adult patients, and a more intensive case mix of individuals needing restorative and emergency care.[1]

Approach and Implementation

Massachusetts administers a fee-for-service dental through DentaQuest, a specialized dental administrative vendor. MassHealth currently provides coverage for the following services for adult enrollees: exams, x-rays, cleanings, -ings, extractions, anesthesia, emergency care, certain oral surgeries, and, as of May 2015, full dentures.[2] Adults that are determined eligible for services through the DDS receive more extensive coverage for root canals, crowns, and treatment for gum disease.

Approach and Implementation

Massachusetts has taken a very incremental approach to restoring adult dental over the past several years. Interviewees noted that their strategies included developing various options for legislators to consider for restoration of services, and working with the Ways and Means Committee to develop a target budget amount, then determining which services would inside that budget For example, MassHealth requested $8 million for the restoration of denture services in FY 2015, but $2 million was appropriated, which resulted in the starting in mid-May, close to the end of the state' .

Interviewees noted that an incremental approach allowed the state to bring back some in a sustainable way. They also noted some challenges, particularly confusion among providers and enrollees about which dental services are covered at any given time, and a continuing sense that the might be vulnerable to cutbacks in the future. While the state is currently experiencing a budget interviewees indicated that adult dental are not currently under consideration for cuts.

Key Leadership and Partnerships

Health Care for All Massachusetts (HCFA) was a key stakeholder in efforts to expand MassHealth adult dental HCFA founded the Oral Health Advocacy Taskforce, a broad coalition of approximately 40 community and provider groups. The coalition communicates with the budget-writing Ways and Means Committee and other policymakers. They formed a Legislative Oral Health Caucus to organize legislative support for Medicaid dental In years past, HCFA also ran the "Watch Your Mouth" public education campaign, which helped to raise the of oral health and its connection to overall health.

Rep. John Scibak, who chairs the Oral Health Caucus, introduced several of the measures to restore dental services. Rep. Scibak noted that his interest in the issue stemmed from his experiences as a clinical psychologist working with persons with developmental disabilities who needed dental care, as well as from legislative hearings where constituents talked about pain and infection, as well as barriers to employment caused by untreated oral health problems.[3]

Interviewees also noted the Mass League of Community Health Centers and Massachusetts Dental Society as important voices in the conversation.

Looking Forward

As the new are implemented, MassHealth will monitor utilization rates as well as process measures for quality improvement. The state is also in the process of hiring a new dental director who will help set oral health priorities in the state.

Interviewees indicated that they may continue to pursue their incremental strategy to obtain coverage for additional services like treatment for gum disease. They also indicated interest in exploring opportunities for better integration between dental and medical providers and delivery systems.

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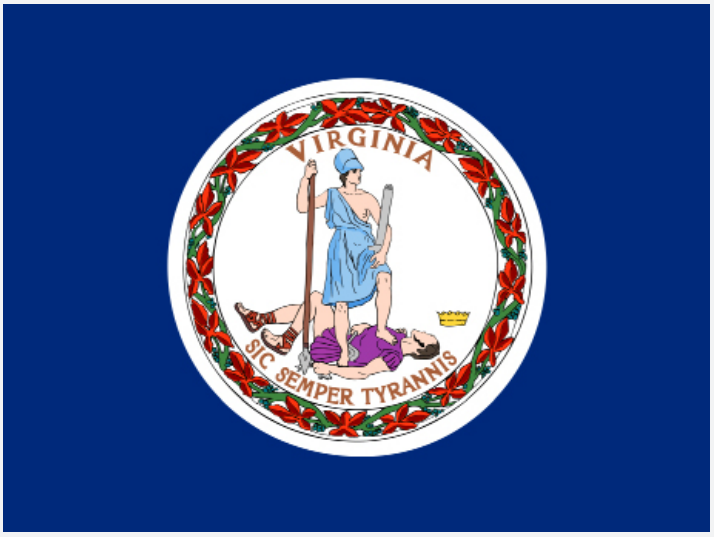
Medicaid Adult Dental Benefits: Virginia Case Study



In March 2015, Virginia began of - aid-enrolled pregnant women for the

in the governor's 10-point plan to expand access to care. It built on improvements to provider participation and program administration that the state made in its successful Smiles for Children program.

History

Prior to 2015, Virginia only offered emergency dental services to adults enrolled in Medicaid, although many actors in the state had been considering ways to expand coverage for years. The Virginia Department of Medical Assistance Services (DMAS), for example, had frequently included adult dental in its agency budget requests.

In 2013, the Virginia Joint Commission on Health Care was directed to study the impact of untreated dental disease, focusing on adult care. As a result of this study, the Commission voted to provide funding for preventive dental care for pregnant women.[1] A measure was introduced in the next legislative session to extend dental ben- not only to pregnant women but to all adults in Medicaid. This effort was ultimately unsuccessful because of declining 2013 state revenue estimates. In September 2014, in the wake of the legislature's decision not to adopt Medicaid expansion, Gov. McAuliffe introduced, by executive order, the Healthy Virginia Plan, a 10-point plan to expand access to care.[2] One of the provisions of the plan was a dental for pregnant women, which went into effect on March 1, 2015.

Approach and Implementation

The Healthy Virginia Plan extends comprehensive dental to approximately 45,000 pregnant women over age 21 enrolled in Medicaid and FAMIS MOMS, the state's Children's Health Insurance Program (CHIP). Targeting the to pregnant women was attractive in part because it limited the resources required—approximately $3 million of state general funds in the two years. Overall, interviewees agreed that the investment was worthwhile due to the positive effect on mothers' health and potential savings from avoided emergency room and medical costs.

DMAS enlisted a long-standing Dental Advisory Committee—comprised of members from the Virginia Dental Association, Virginia Primary Care Association, Virginia Commonwealth University School of Dentistry, and the Virginia Department of Health—to help design the new The new builds on a successful dental program for children in CHIP and Medicaid called Smiles for Children. Smiles for Children is a fee-for-service administered by DentaQuest ,a specialized dental administrative services vendor. The program been successful since its 2005 introduction, generating buy-in from both patients and dental providers.[3]

Services for pregnant women over age 21 are generally the same as those provided in Smiles for Children—a full range of dental services including diagnostic and preventive services, - ings, root canals, treatment for gum disease, and oral surgery. (Orthodontia and denture services are not covered.) Pregnant women above age 21 are eligible for until the end of the month following their 60th day postpartum.[4]

DMAS worked closely with partner organizations including the Virginia Oral Health Coalition, the Virginia Dental Association, VA Health Care Foundation, sister state agencies, and DentaQuest to ensure smooth rollout of the With input from the Dental Advisory Committee, DentaQuest developed materials to promote the new program and has led provider education efforts.

Key Leadership and Partnerships

In 2010, the Virginia Oral Health Coalition (VaOHC) was formed as an organization focused on improving access to oral health services for all Virginians. VaOHC was built off of an existing all-volunteer committee—Virginians for Increased Access to Dental Care—and had representation from the Virginia Dental Association, the Virginia Department of Health and DMAS, as well as other stakeholders. Since 2010, VaOHC has led the way in the lobbying effort as well as educating other stakeholders on the importance of adult dental coverage.

The Virginia Dental Association has been a strong partner in the Smiles for Children program, and has organized several annual "Missions of Mercy" events to deliver free dental care across the state. Gov. McAuliffe's attendance at one of these events was noted as an important factor in his engagement in the issue.

Stakeholders including VaOHC worked to engage physicians, pediatricians, community health centers and OBGYNs to help disseminate messages regarding the link between oral health and high blood pressure, preeclampsia, preterm birth, and other conditions. In addition, after the was established, they partnered with the Virginia Commonwealth University's School of Dentistry to develop continuing education to build dental providers' in treating women during pregnancy.

Looking Forward

Though it is too soon to evaluate success of the policy change, DMAS is closely monitoring provider and patient inquiries, and capturing data on utilization and provider participation.

Advocates in the state are also looking at options to expand dental to additional adult populations, either to targeted populations like elders or individuals with developmental disabilities, or to all Medicaid-enrolled adults. All interviewees agreed that in order to successfully expand to a full adult population, the state will likely need to address provider reimbursement rates, which have not been adjusted since the introduction of Smiles for Children in 2005, to ensure continued provider participation.

Finally, there are efforts ongoing in the state to integrate dental health care into larger health reform efforts. In particular, Virginia is considering creating Accountable Care Communities (ACCs) under a new State Innovation Model design grant. The ACCs will engage public and private stakeholders to work collectively to transform care delivery in their region. The state has engaged workgroups to develop strategies for ACCs on behavioral health, chronic care management, and other topics, including oral health. Two leaders from the VaOHC are chairing the Oral Health Workgroup to develop models on oral health integration for ACCs.[5]

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Medicaid Adult Dental Benefits: Washington Case Study

In 2013, Washington's legislature restored funding for full adult den-

cutback in 2010 due to the recession. The state's adoption of the Affordable Care Act's (ACA) Medicaid expansion—and the subsequent enhanced federal funding for newly-eligible individuals—was instrumental in the state's decision to bring back dental The restored

providers' efforts to ramp up dental services, but concerns remain about participation among private dental providers.

History

During times of pressure, Medicaid adult dental in Washington have periodically been cut back—either cut entirely, or limited to certain populations. Most recently, in 2010, services for all adults were limited to emergency services like tooth extractions. In July 2011, ben- for pregnant women, individuals with developmental disabilities, and individuals in long-term care were restored. Finally, in 2013, the Washington State Legislature's biennial operating budget included approximately $23 million in state funds (matched by federal funds) to restore full dental to all adults in Medicaid. The state's decision to expand Medicaid eligibility under the ACA was a strong motivating factor for the reinstatement of adult dental ts. Under the ACA, the state receives 100 percent federal for individuals newly eligible for Medicaid under the expansion (gradually declining to 90 percent by 2020). Enhancing the Medicaid to include dental services for all adults at the same time as Medicaid expansion under the ACA meant that the state could leverage newly available federal funds to make a large impact on access to coverage. Although the state could have opted to only cover dental services for the expansion population, state felt it was important to offer coverage to all adults to ensure continuity and equity of coverage for all enrollees.

Approach and Implementation

Adults in Washington began receiving services through the new on January 1, 2014. The state reinstated the same package, program administration (a fee-for-service directly administered by the Washington Health Care Authority), and provider reimbursement rates that existed prior to the elimination of the Covered services include diagnostic and preventive services, s, root canals on front teeth, treatment for gum disease, full and partial dentures, and oral surgery. Crowns, bridges, and root canals on back teeth are not covered.[1]

More than 204,000 Medicaid-enrolled adults received a dental service in CY 2014, an increase from the roughly 136,000 adults who received services in CY 2010. However, this happened in the context of rising Medicaid enrollment, so the rate at which enrollees used services fell from 33 percent to 23 percent.[2]

Community Health Centers (CHC) are a particularly important source of care for adult enrollees in Washington. Neighborcare Health, a Seattle CHC

that provides medical and dental care, reports that prior to the 2010 cut, adult patients were about 70 percent of its dental caseload. During the time when were eliminated, Neighborcare refocused on providing children's services and treatment for adults with dental emergencies, obstetric patients, and patients with diabetes. Now, the clinic is reintroducing adults into routine dental services, as well as dealing with four years of pent-up demand for services like dentures.[3] CHCs have been able to take on this caseload because adult dental services are again eligible to be reimbursed at the clinic's Medicaid encounter rate. During the period when were eliminated, adult dental patients were charged on the clinic's sliding fee scale, which many could not afford. with the Health Care Authority noted that, while CHCs are a welcome point of access, payment at the clinic's cost-based encounter rate can be higher than fee-for-service reimbursement rates, and often result in increased costs to the Medicaid program.

Interviewees acknowledged a need to attract dentists in private practice to treat Medicaid-enrolled adults. Reimbursement rates and program administration were noted as major barriers to participation. More than 1,530 dentists participated in the program in 2014, slightly fewer than the 1,608 who participated in 2010.[4] This is about 30 percent of Washington's 5,000 active licensed dentists.[5]

Services are reimbursed at the same rate that they were in 2007, and the Washington State Dental Association estimates that Medicaid reimbursements are approximately 25 percent of the prevailing rates charged by dentists.[6] Stakeholders noted that their initial focus was on bringing the back, but that they intend to continue advocating for further improvements in rates, outreach, and administration of the in future years.

Key Leadership and Partnerships

The Washington Dental Service Foundation (WDSF), a foundation funded by Delta Dental of Washington, organized and primarily led efforts to reinstate the adult dental The Foundation credits the success of advocacy efforts to three main factors:

1. **Data and messaging:** WDSF worked with partners such as the Washington State Hospital Association to conduct studies looking at the economic impact of dental including $36 million in charges from 54,000 visits to Washington emergency departments for preventable dental conditions.[7] Advocates were also able to leverage national data, such as a study by United Concordia that found that individuals with type 2 diabetes who received regular periodontal treatment had medical costs that averaged $2,840 less per year as a result of avoided hospitalizations and reduced utilization of medical services.[8]
2. **Relationship building:** WDSF was a leading partner in several coalitions, including the Coalition to Fund Dental Access, a group consisting mainly of dental stakeholders and led by an anti-poverty advocate and Oral Health Watch, a broader coalition of healthcare, business, and children's and seniors' advocacy groups. Coalition members met regularly with legislators. They created materials and worked persistently on sharing data and information with lawmakers, particularly highlighting the impact of oral health on overall health and its impact on health care costs. In addition, WDSF developed grassroots and social media outreach, and engaged media outlets through news coverage and letters to the editor.
3. **Important champions:** Washington State Speaker of the House, Frank Chopp, was a key champion for oral health. Multiple interviewees noted the Speaker's longtime engagement in the issue through his work with Seattle advocates for low-income individuals, and his work to ensure that oral health was a legislative priority for his caucus.

Looking Forward

Interviewees agreed that they had accomplished a major step—bringing the back—and now must focus on ensuring that the is meaningful and well utilized. State hope to show positive changes in emergency room

utilization and reduced medical costs for individuals with diabetes in coming years stemming from improved access to routine dental care, though they have not factored such savings into their budget projections. State are also considering options to bid out administration of the dental t, but noted that low dental fee-for-service reimbursement rates translate into per member per month capitation rates that might be too low to attract managed care bidders.

In the near term, stakeholders including WDSF are working to partner with the Health Care Authority to research the possibility of developing a targeted, enhanced for pregnant women and people with diabetes, modeled after the state's successful Access to Baby and Child Dentistry program.

Interviewees agreed that as long as adult dental is optional in Medicaid, the is always vulnerable to cuts. However, all interviewees felt that the latest dental reinstatement was relatively secure because it was made in the context of the state's broader decision to take up Medicaid expansion, thereby insulating it from being singled out for cuts.

There are a number of other care delivery reform opportunities to further integrate oral health into overall health care. For instance, Washington is undertaking broad-scale delivery system reform through its State Innovation Model grant. While the state's Innovation Plan does not explicitly address dental, it creates Accountable Communities for Health (ACH). ACHs are regionally based entities that will conduct community needs assessments and direct health care resources. Multiple interviewees said they anticipate that the community needs assessments would show a high need for dental services and are preparing to help ACHs meet that need.

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PATIENTS' PERSPECTIVES ON HEALTH CARE IN THE UNITED STATES

A LOOK AT SEVEN STATES & THE NATION

February 2016

npr

Robert Wood Johnson Foundation

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

INTRODUCTION

The landscape and experience of health care in the United States has changed dramatically in the last two years. January 2014 saw insurance purchased on state exchanges and the federal marketplace go into effect, the start of the Affordable Care Act's individual mandate and its accompanying subsidies and tax credits for qualifying Americans, discrimination protections, including pre-existing conditions, for those seeking to buy health insurance, and the implementation of essential health benefits for all plans sold through the insurance marketplace.

The Patients' Perspectives on Health Care survey series seeks to illuminate the self-reported experiences today of health care consumers across the country and in seven states: Florida, Kansas, New Jersey, Ohio, Oregon, Texas and Wisconsin. These locations were not picked at random; rather, they were selected to represent a geographically diverse group of states that *have* (NJ, OH, OR) and *have not* (FL, KS, TX) expanded Medicaid, as well as the only state in the nation that did not have to, since Wisconsin's pre-ACA eligibility criteria already matched those passed by national health reform.

All participants – both those sampled in the seven states and across the nation – were asked to share their personal experiences and opinions. Thus, comparisons between any state and the nation contrast the views of a representative sample of that state's residents to a representative sample of residents across the country asked about their perceptions of their own state. Although there are many differences among the views and experiences of people across states, this report only highlights such differences when they are statistically significant from the national sample. It summarizes the survey's state and national findings as they pertain to six main questions:

1. What is the overall picture in the United States – what has changed in the past two years, and how do adults in the U.S. rate their health care and costs at the state and personal levels?
2. How do adults in the U.S. rate the quality of their health care?
3. How do adults in the U.S. perceive the cost of their health care?
4. Do adults in the U.S. face barriers to accessing health care?
5. How do adults in the U.S. experience health care at different sites, including doctor's offices, hospitals, emergency rooms, urgent care centers and retail or drug store mini-clinics?
6. What do adults in the U.S. think of national health reform?

Only those adults who report having received care during a given type of health care visit were asked to rate the quality of their health care during their most recent visit. This prevents residents who have never used urgent care centers, for example, from weighing in on the quality or cost of those facilities.

EXECUTIVE SUMMARY

A new poll of adults across the U.S. and in seven states by National Public Radio, the Robert Wood Johnson Foundation, and the Harvard T.H. Chan School of Public Health shows that despite major shifts in the American health care system over the past two years, most U.S. residents report that the health care they personally receive has remained about the same. In terms of health care costs, most adults in the U.S. view these as reasonable, but getting less affordable over time. Survey results also indicate that Americans are more positive about the health care they personally receive than about the functioning of their state's overall health care system. Where most rate their own health care positively, far more Americans rate their state and the nation's overall health care system as fair or poor than rate it as excellent.

What is the overall picture in the United States?

Adults in the U.S. are much more positive in their feedback when it comes to the health care they personally receive as patients than they are about their state's or the nation's health care system. Far more adults rate the care they personally receive as excellent than rate the health care system in their state or the nation similarly. However, less than half of recent patients believe the health care they personally receive is excellent. When it comes to health care costs, most U.S. adults believe their personal costs are reasonable, if getting costlier over time. Most adults in the U.S. also say health care costs are a major problem in their state and more than half believe state costs have increased in the past two years. In terms of health insurance costs, more than a third of U.S. adults believe their health insurance co-pay, deductible and premium costs have increased in the past two years, while only about one in six say the same of their benefits.

How do adults in the U.S. rate the quality of their health care?

Adults in the U.S. have mixed feelings when it comes to the quality of their health care. Only one type of health care facility – hospitals – prompted nearly half of patients to say the quality of health care they received during their most recent overnight stay was excellent. In contrast, recent patients rate urgent care centers lowest among all surveyed health care facilities, with less than three in ten rating their care as excellent. Overall, most adults in the U.S. do not consider the health care they personally receive to be excellent, even though only a minority of adults says their care is fair or poor.

How do adults in the U.S. perceive the cost of their health care?

Most adults in the U.S. believe their health care costs are reasonable, although this varies substantially by facility. Patient cost ratings indicate emergency room visits are perceived to be the most unreasonable, while those who use mini-clinics are much more likely to say their health care costs are reasonable, even though overall use is low. Survey results also indicate that health care costs cause serious financial problems for more than a quarter of Americans, more than forty percent of whom report spending all or most of their personal savings on large medical bills. Notably, about one in five adults in the U.S. do not believe they get good value for what they pay toward the cost of their care, and about one in five say they struggle to afford prescription drugs.

Do adults in the U.S. face barriers to accessing health care?

Nearly three quarters of Americans say they have a regular doctor or health care professional that provides most of their care when they are sick or have a health concern. In the past two years, more than one in five adults say there has been at least one time when they couldn't see their regular doctor, but more than four in five of these patients were able to see a different provider – most commonly in the emergency room. About one in seven U.S. adults report they were not able to get the health care they needed at some point in the past two years. When asked whether they would be able to receive the best treatment available in the state where they live, if they became seriously ill; however, more than three quarters of Americans believe they would be able to access their state's best care.

How do adults in the U.S. experience health care at different sites?

More than forty percent of patients rate four out of six aspects of their most recent visit to a doctor as excellent, and more than three quarters of patients say the cost of their last visit was reasonable. Among those who have recently seen a doctor, patients in the U.S. rate their provider's sensitivity to their cultural background highest, and their ability to get in touch with their doctor by phone or email outside of appointments lowest. Survey participants also rated their overall experience, the quality of health care they received, the amount of time they spent with the doctor, and the doctor's concern with maintaining their long-term health and other factors that could affect their health and well-being. Overnight hospitalization performs best among all surveyed health care settings when it comes to perceived quality, but ranks second-to-last when it comes to the reasonableness of health care costs.

Among alternatives to doctor's offices and hospitals, emergency rooms are most commonly used by Americans for major health problems, while urgent care centers are mostly used for minor wounds and illnesses. Mini-clinics, on the other hand, are frequented for vaccines. Less than forty percent of recent patients say the quality of care at these sites is excellent – urgent care centers receive excellent ratings from less than three in ten recent patients – however, a strong majority of recent patients say health care costs at urgent care centers and mini-clinics are reasonable. Reported use of emergency rooms and urgent care centers is also increasing, as many patients say they use these facilities more now than they did two years ago. When asked why they prefer all three sites over doctor's offices or community health centers, many patients cite ease of being seen, rapidity of treatment and location as driving factors.

What do adults in the U.S. think of national health reform?

Americans have mixed feelings on the state- and personal-level effects of the Affordable Care Act. The proportion of U.S. adults who believe the law helped people in the state where they live approximately equals the proportion of people who believe national health reform hurt their fellow state residents. On a personal level, most Americans do not believe the law directly affected them. Among those who do, however, more believe the law directly hurt them than helped them.

OVERALL PICTURE

This section answers the question "What is the overall picture in the United States? What has or has not changed in the past two years, and how do adults in the U.S. rate their health care and costs at the state and personal levels?"

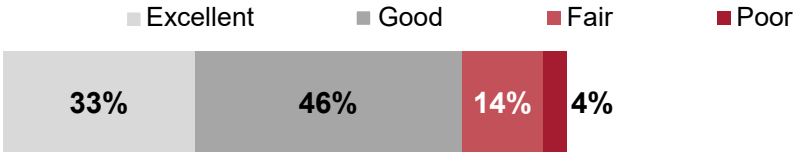
Adults in the U.S. are much more positive in their feedback when it comes to the health care they personally receive as patients than they are about their state's or the nation's health care system. Far more adults rate the care they personally receive as excellent than rate the health care system in their state or the nation similarly. However, less than half of recent patients believe the health care they personally receive is excellent. When it comes to health care costs, most U.S. adults believe their personal costs are reasonable, if getting costlier over time. Most adults in the U.S. also say health care costs are a major problem in their state and more than half believe state costs have increased in the past two years. In terms of health insurance costs, more than a third of U.S. adults believe their health insurance co-pay, deductible and premium costs have increased in the past two years, while only about one in six say the same of their benefits.

Assessment of Care Personally Received

Many adults in the U.S. are happy with the care they personally receive as patients; however, most do not rate their care as excellent (*Figure 1*) and a strong majority believes their care has stayed about the same in recent years (*Figure 2*). Three in five U.S. adults say the cost they personally pay for their care is reasonable (*Figure 3*), although many believe these costs – for health care services and prescription drugs – have become less affordable in recent years (*Figure 4*).

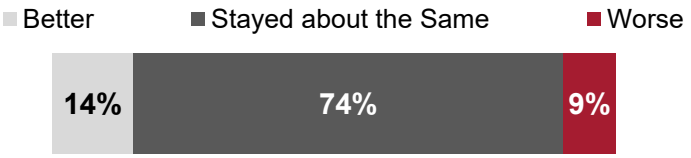
One-third (33%) of adults in the U.S. believe the health care they receive is excellent and just under half (46%) say their care is good, while just over one in six (18%) say it is fair or poor. Notably, adults in New Jersey (27%) are significantly less likely to report that their health care is excellent than adults nationwide (33%).

FIGURE 1. Percent of adults in the U.S. who rate the health care they personally receive as excellent, good, fair or poor (Q9).



Nearly three-fourths (74%) of adults in the U.S. believe the health care they receive has stayed about the same over the past two years, while less than a quarter (23%) believe it has gotten better or worse. Adults in Ohio (13%) and Oregon (13%) are significantly more likely than adults nationwide (9%) to report that the health care they receive has gotten worse in the past two years. Additionally, fewer adults in Florida (65%) believe their care has stayed about the same in recent years than adults across the country (74%). Among those who believe their care has changed, however, Floridians are divided. Sunshine State residents are both more likely to say their care has gotten better (18%) and more likely to say it has gotten worse (13%) over time compared to adults nationwide (14% and 9%, respectively).

FIGURE 2. Percent of adults in the U.S. who say the health care they personally receive has gotten better, worse, or stayed about the same over the past two years (Q10).



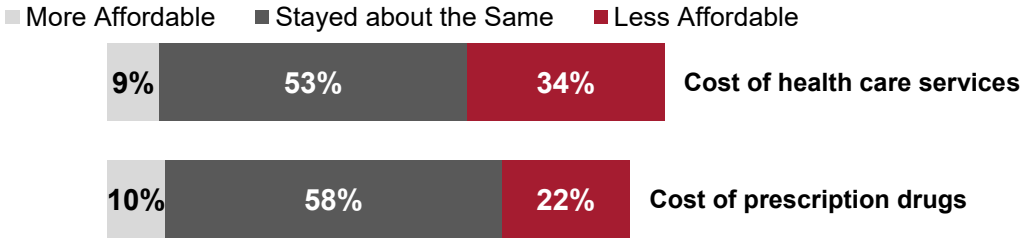
Most adults in the U.S. (60%) say the cost they personally pay for their health care is reasonable, while just under three in ten (29%) disagree, saying the amount they pay is unreasonable. However, adults in New Jersey (39%), Kansas (37%) and Ohio (36%) are significantly more likely than adults across the country (29%) to report that their health care costs are unreasonable.

FIGURE 3. Percent of adults in the U.S. who say the cost they personally pay for health care, including premiums, deductibles, copayments, and prescription drugs, is reasonable or unreasonable (Q15).

Most adults in the U.S. believe the cost of their health care services and prescription drugs have stayed about the same over the past two years. Among those who believe it has changed, more believe costs are getting worse over time. Thirty-four percent of U.S. adults believe their health care services are harder to afford now than they used to be, while just nine percent believe they are more affordable. When it comes to prescription drug costs, about one in five adults (22%) believes prescription drugs have become harder to afford in the past two years, while just 10 percent believe they have become more affordable.

Oregonians (14%) are significantly more likely than adults nationwide (9%) to report that the cost of their health care services have become more affordable in the past two years, while Kansans (43%) and Wisconsinites (41%) are significantly more likely than adults across the nation (34%) to say that these costs have become less affordable. In terms of prescription drug costs, Texans (15%) are significantly more likely than adults nationwide (10%) to report that theirs have become more affordable in recent years, whereas Kansans (28%) are more likely to say that theirs have become less affordable compared to U.S. adults (22%).

FIGURE 4. Percent of adults in the U.S. who say the cost of their health care services and prescription drugs has gotten more affordable, less affordable, or stayed about the same over the past two years (Q16 a-b).

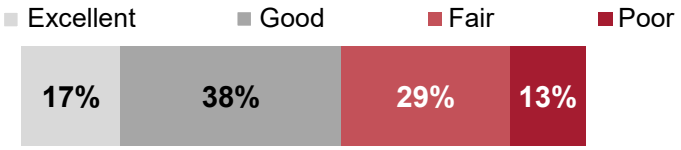


The State of the Nation

Adults in the U.S. tend to be less positive about their state's health care system than they are about the care they personally receive as patients, and reflect even less favorably on the nation's health care system than on that of their state. More than two in five U.S. adults rate the health care system in their state as fair or poor (*Figure 5*), whereas more than three in five say the same of the nation's health care system (*Figure 6*). Additionally, more than a quarter believes health of people in their state has gotten worse in the past two years (*Figure 8*). When it comes to health care costs, more than half of adults in the U.S. say health care costs are a major problem in their state (*Figure 9*), and most also say state costs have risen in recent years (*Figure 10*).

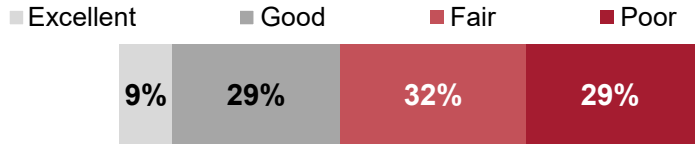
Even though most (55%) Americans reflect positively on their state's health care system, saying it is excellent or good, few give their state top marks. Just one in six (17%) say the health care system in their state is excellent, while more than two in five (42%) adults in the U.S. say it is fair or poor. Adults in Florida (10%) and Oregon (11%) are significantly less likely than adults across the country (17%) to say their state's system is excellent.

FIGURE 5. Percent of adults in the U.S. who rate the health care system in their state as excellent, good, fair or poor (Q2).



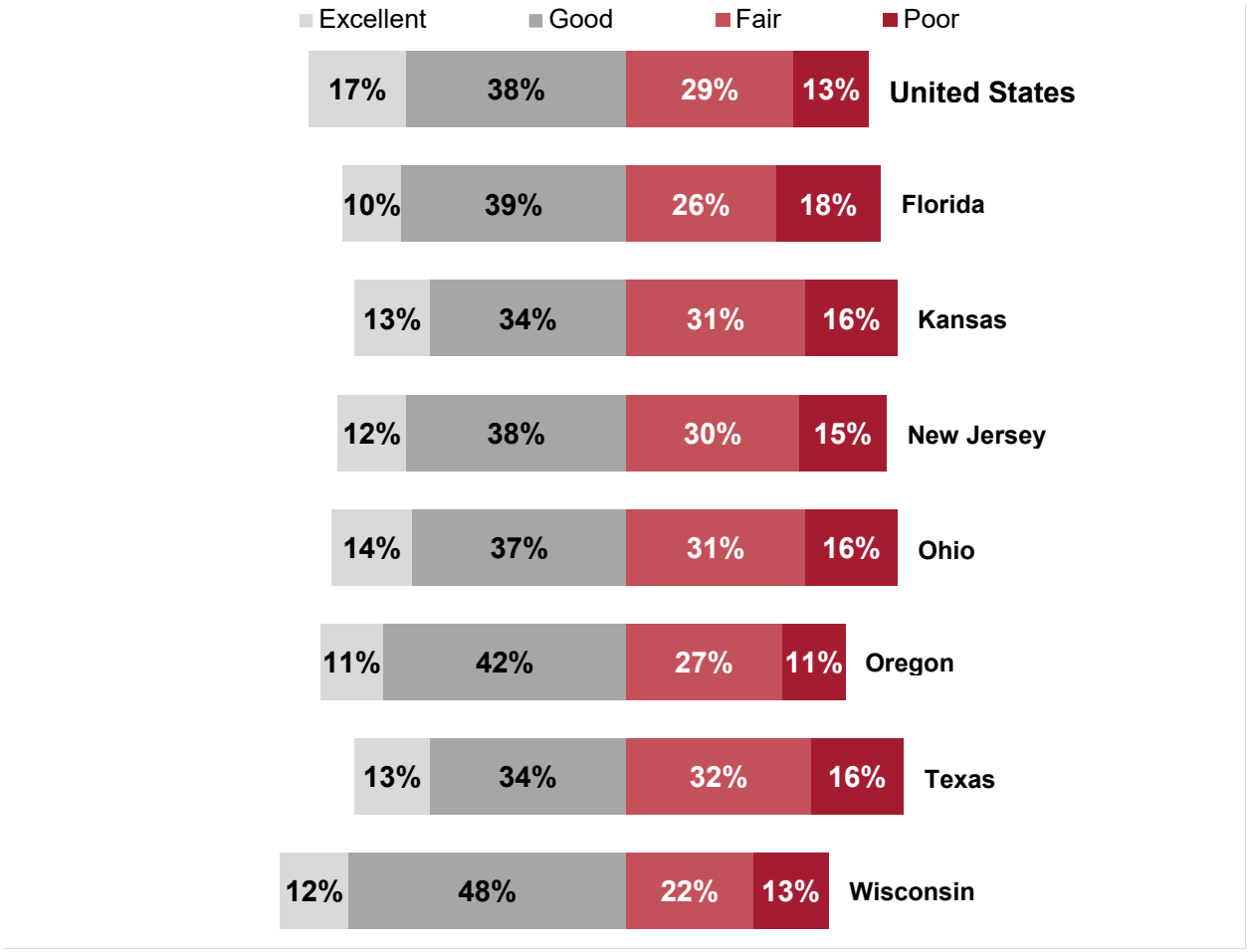
Americans are much more negative about the nation's health care system than they are about the health care system in the state where they live. Only 38 percent of adults in the U.S. had positive things to say about the country's health care system, and fewer than one in ten (9%) gave it top marks. In contrast, more than three in five (61%) U.S. adults say the nation's health care system is fair or poor.

FIGURE 6. Percent of adults in the U.S. who rate the nation's health care system as excellent, good, fair or poor (Q2a[1]).



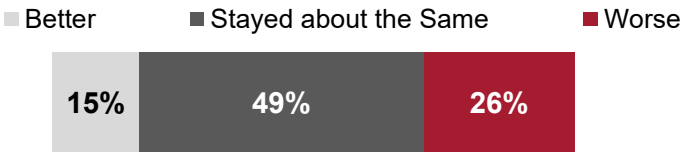
[1] This question was asked separately from the rest of the survey, by telephone of a representative national sample (n = 1,080) between October 14-19, 2015.

FIGURE 7. Percent of adults in the United States, Florida, Kansas, New Jersey, Ohio, Oregon, Texas and Wisconsin who rate the health care system in state where they live as excellent, good, fair or poor (Q2).



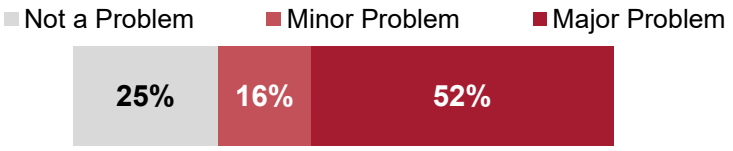
Nearly half (49%) of adults in the U.S. believe the health of people in the state where they live has stayed about the same over the past two years. Others note changes, with more adults believing that the health of people in their state has gotten worse (26%) than believing the health of residents has improved (15%).

FIGURE 8. Percent of adults in the U.S. who say the health of people in their state has gotten better, worse, or stayed about the same over the past two years (Q1).



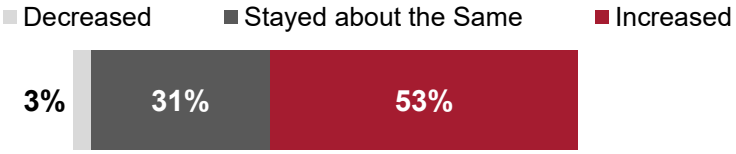
More than half of adults (52%) in the U.S. say health care costs are a major problem in the state where they live, and about one in six (16%) say costs are a minor problem. New Jersey residents (59%) are significantly more likely to say that health care costs are a major problem in their state, as compared to adults across the nation (52%). On the other hand, one quarter (25%) of Americans say health care costs are *not* a problem in the state where they live.

FIGURE 9. Percent of adults in the U.S. who say health care costs are or are not a problem in their state (Q66).



Most adults in the U.S. believe the cost of health care in the state where they live has increased in the past two years – a much greater proportion than those who believe health care costs have decreased or stayed about the same. Residents of New Jersey (63%), Kansas (62%), Wisconsin (62%) and Ohio (59%), however, are significantly more likely than adults nationwide (53%) to say that health care costs in their state have increased over the past two years.

FIGURE 10. Percent of adults in the U.S. who say the cost of health care in their state has increased, decreased, or stayed about the same over the past two years (Q4).

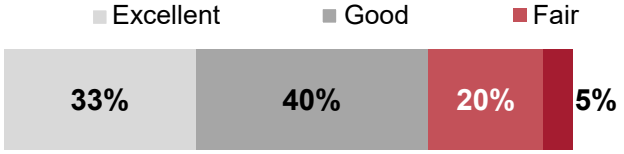


Changes in Health Insurance

Nationwide, one in seven (14%) American adults age 18 or older reports being currently without health insurance (Q57). Adults in Texas (20%) are significantly more likely to report being currently uninsured, while residents in New Jersey (9%), Ohio (8%), Oregon (10%), and Wisconsin (8%) are less likely to report lacking coverage. Additionally, nearly three in ten (29%) adults in the U.S. ages 18-64 say they have been uninsured at some point in the past two years (Q57/62a). Adults ages 18-64 living in Florida (37%) and Texas (36%) are significantly more likely than adults across the country (29%) to report that they are currently uninsured or have been at some point in the past two years, whereas adults living in Wisconsin (79%), New Jersey (76%) and Ohio (76%) are more likely to report having been continuously insured in recent years compared to adults nationwide (71%).

Only one-third (33%) of Americans who report being currently covered by health insurance say their coverage is excellent (*Figure 11*), while one quarter (25%) say their coverage is either fair (20%) or poor (5%). Two in five (40%) rate theirs as good.

FIGURE 11. Percent of adults in the U.S. who rate their health insurance as excellent, good, fair or poor (Q61).



Among those adults who report being currently insured, more say the cost of their coverage has gone up in recent years than those who say their benefits have increased. Whereas more than two in five (45%) insured U.S. adults say their premiums have gone up in the past two years and more than one-third (35%) say their co-pays or deductibles have risen, about one in six (16%) say their benefits have increased (*Figure 12*). However, the majority of adults in the U.S. say their benefits, co-pays, deductibles and benefits have stayed about the same over the past two years. Adults in Kansas (53%) are significantly more likely than adults nationwide (45%) to report that their premiums have increased in recent years.

FIGURE 12. Percent of adults in the U.S. who say their health insurance benefits, co-pays and deductibles, and premiums have increased, decreased, or stayed about the same over the past two years (Q63 a-b, 64).

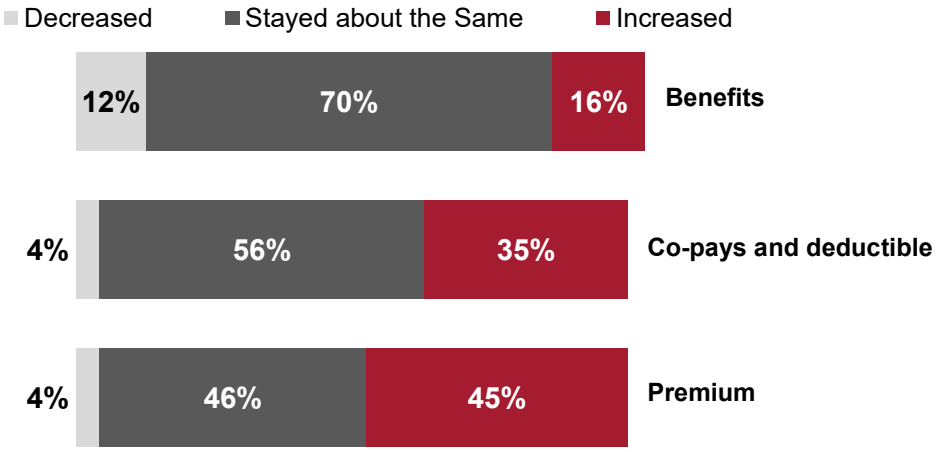
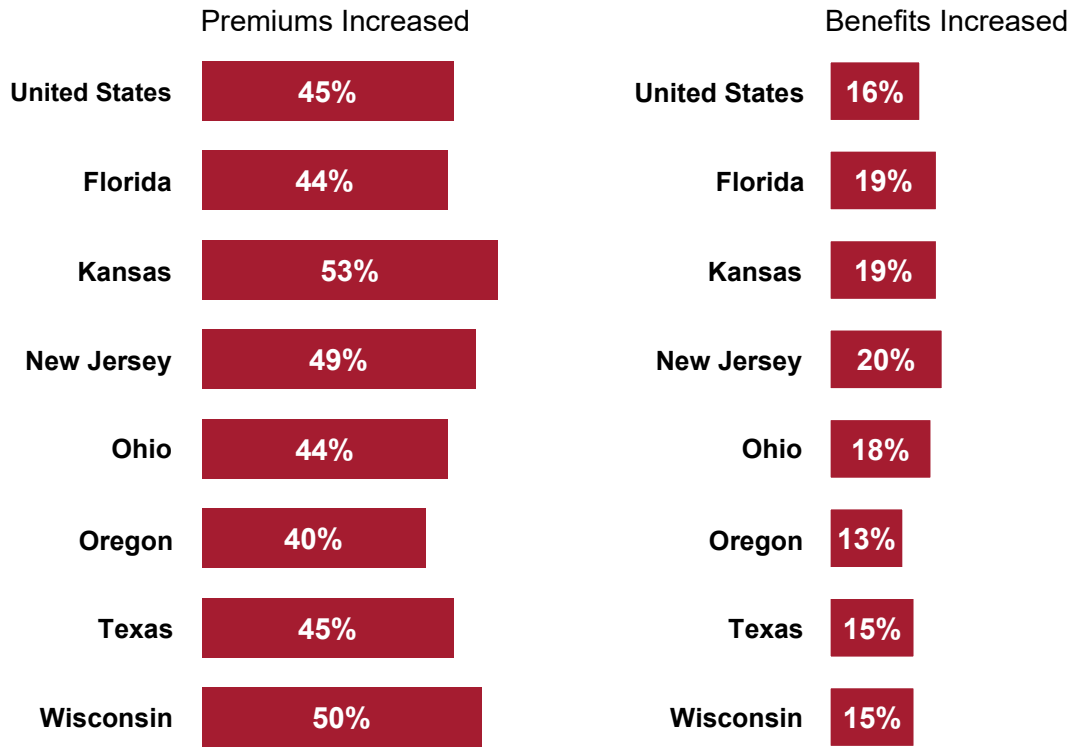


FIGURE 13. Percent of adults in the United States, Florida, Kansas, New Jersey, Ohio, Oregon, Texas and Wisconsin who say their premiums and benefits have *increased* in the past two years (Q63a, 64).

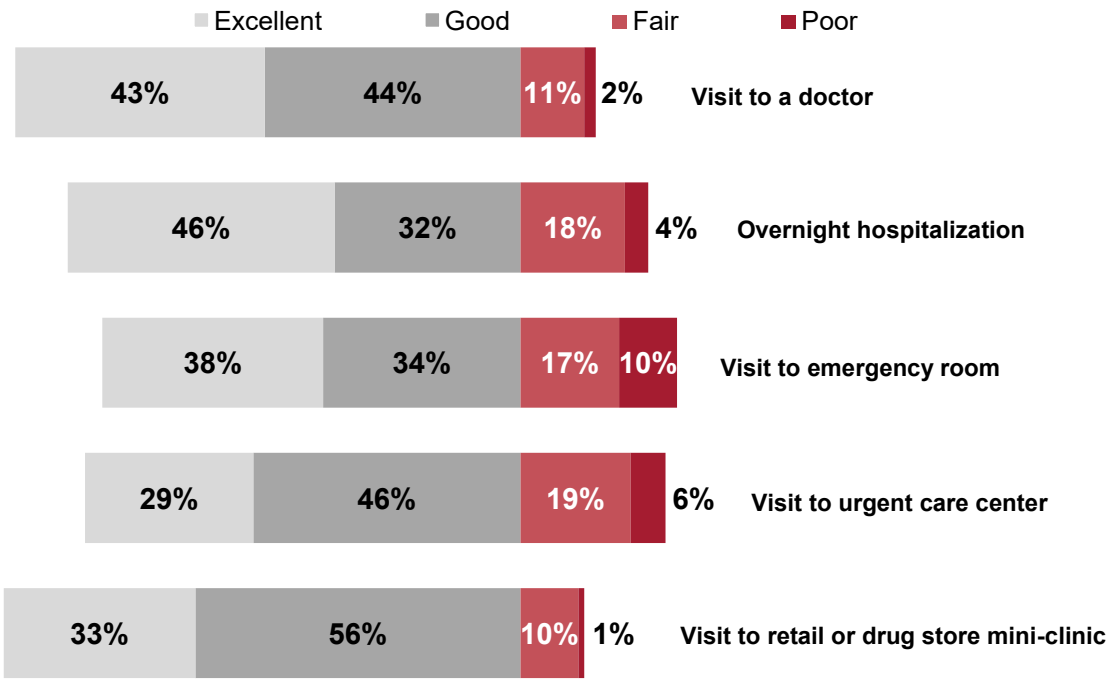


HEALTH CARE QUALITY

This section answers the question "How do adults in the U.S. rate the quality of their health care?" by examining how adults rate the care they have received during visits to five different health care facilities over the past two years.

Adults in the U.S. have mixed feelings when it comes to the quality of their health care. Only one type of health care facility – hospitals – prompted nearly half of patients to say the quality of health care they received during their most recent overnight stay was excellent (*Figure 14*). In contrast, recent patients rate urgent care centers lowest among all surveyed health care facilities, with less than three in ten rating their care as excellent. Overall, most adults in the U.S. do not consider the health care they personally receive to be excellent, even though only a minority of adults says their care is fair or poor.

FIGURE 14. Percent of adults in the U.S. who rate the quality of health care they received during visits to five different health care facilities in the past two years as excellent, good, fair or poor (Q12b, 33, 38, 45, 51).



On most measures of quality, the views of adults in the survey's seven states do not diverge substantially from the views of adults across the United States about their own state. Urgent care centers were the only type of health care facility that yielded different responses, as adults in New Jersey are significantly more positive when asked to reflect on their last visit to an urgent care center than adults nationwide. More than two in five (42%) of Garden State residents say the quality of the health care they received during their last urgent care visit was excellent, while 29% said the same across the nation.

HEALTH CARE COSTS

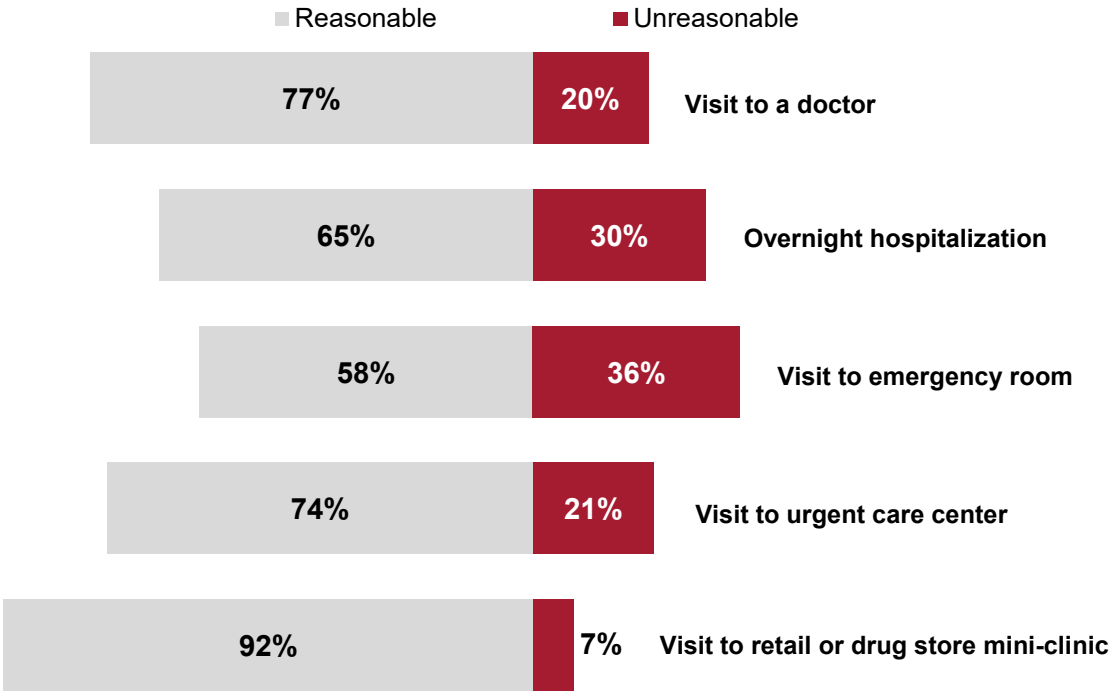
This section answers the question "How do adults in the U.S. perceive the cost of their health care?" by examining how adults characterize the cost of the care they have received during visits to five different health care facilities over the past two years.

Most adults in the U.S. believe their health care costs are reasonable, although this varies substantially by facility. Patient cost ratings indicate emergency room visits are perceived to be the most unreasonable, while those who use mini-clinics are much more likely to say their health care costs are reasonable, even though overall use is low. Survey results also indicate that health care costs cause serious financial problems for more than a quarter of Americans, more than forty percent of whom report spending all or most of their personal savings on large medical bills. Notably, about one in five adults in the U.S. do not believe they get good value for what they pay toward the cost of their care, and about one in five say they struggle to afford prescription drugs.

Cost of Care across Facilities

Most adults in the U.S. say the cost of health care they received during their most recent visit to five types of health care facilities in the past two years is reasonable (*Figure 15*); however, a notable portion of recent patients, in some cases, disagrees. The top cost performer among health care facilities included in this survey is retail or drug store mini-clinics; however, only about one in eight (12%) Americans use these sites of care. In contrast, more than a third (36%) of recent ER patients say the cost of their most recent visit was unreasonable, making it the worst cost performer in the group.

FIGURE 15. Percent of adults in the U.S. who characterize the cost of health care they received during visits to five different types of health care facilities in the past two years as reasonable or unreasonable (Q14, 34, 39, 46, 52).



On most facility cost measures, the views of adults in the survey's seven states do not diverge substantially from the views of adults across the United States about their own state. Doctor's offices were the only type of health care facility that yielded different responses, as adults in Wisconsin (25%) are significantly more likely than adults nationwide (20%) to say the cost of the health care they received during their last visit to a doctor's office, within the past two years, was unreasonable.

Health Care Value

When asked to think about the cost and quality of health care they receive, more than seven in ten (72%) adults in the U.S. say they get good value for what they pay toward the cost of their health care (Q65). In contrast, just over one in five (22%) disagrees, saying they do not believe they get good value for what they pay. Adults in New Jersey (28%) are significantly more likely than adults across the country (22%) to say they do not get good value for what they pay for their health care.

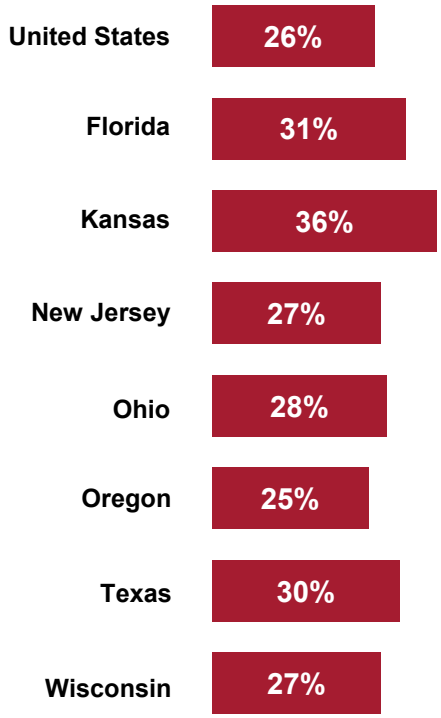
Serious Financial Problems

More than a quarter (26%) of adults in the U.S. says health care costs have caused a serious financial problem for them as individuals or for their family (*Table 1*). Setting up a payment plan with a hospital or health care professional was the most common consequence of these serious financial problems, experienced by more than two in five (44%) patients who struggle with health care costs. The second most common consequence of large medical bills in the U.S. was spending all or most of one's personal savings (42%). Adults in Kansas (36%) are significantly more likely than adults across the nation (26%) to report having serious financial problems resulting from health care costs.

TABLE 1. Percent of adults in the U.S. who say their health care costs over the past two years caused a very or somewhat serious problem for their personal or their family's overall financial situation and for whom the following happened because of large medical bills (Q20, 21 a-g).

Health care costs caused a serious financial problem	**26%**
Set up a payment plan with a hospital or health care professional	44%
Spent all or most of their personal savings	42%
Contacted by bill collectors	39%
Unable to pay for basic necessities like food, heat or housing	27%
Taken on credit card debt that may be difficult to pay off	23%
Taken out a loan that may be hard to pay back	19%
Declared bankruptcy	7%

FIGURE 16. Percent of adults in the United States, Florida, Kansas, New Jersey, Ohio, Oregon, Texas and Wisconsin who say their health care costs over the past two years caused a very or somewhat serious problem for their personal or their family's overall financial situation (Q20).



Prescription Drugs

The cost of prescription drugs has caused just under one in five (19%) U.S. residents to not fill a prescription, and about one in eight (12%) to cut pills in half or skip doses of medicine (*Table 2*). Adults in Kansas are significantly more likely to report difficulties with prescription drug costs, as Sunflower State residents report not filling prescriptions (24%) and cutting pills in half or skipping doses of medicine (16%) at higher rates than Americans nationwide (19% and 12%, respectively).

TABLE 2. Percent of adults in the U.S. who say they did the following at least once in the past two years because of the cost of prescription drugs (Q22 a-b).

Did not fill a prescription	19%
Cut pills in half or skipped doses of medicine	12%

HEALTH CARE ACCESS

This section answers the question "Do adults in the U.S. face barriers to accessing health care?" by examining whether or not adults report having a regular doctor, whether they have been unable to see their regular doctor during the past two years, and whether they have been able to consistently get health care when they needed it over the past two years.

Nearly three quarters of Americans say they have a regular doctor or health care professional that provides most of their care when they are sick or have a health concern. In the past two years, more than one in five adults say there has been at least one time when they couldn't see their regular doctor, but four in five of these patients were able to see a different provider – most commonly in the emergency room. About one in seven U.S. adults report they were not able to get the health care they needed at some point in the past two years. When asked whether they would be able to receive the best treatment available in the state where they live, if they became seriously ill; however, more than three quarters of Americans believe they would be able to access their state's best care.

Experiences with a Regular Doctor

One in four (25%) adults in the U.S. say they do not have a regular doctor or health care professional who provides most of their health care when they are sick or have a health concern, while nearly three-quarters (74%) say they do (Q27). Adults in Texas (31%) and Florida (30%) are significantly more likely than adults nationwide (25%) to not have a regular provider they can turn to when they have a health concern. On the other hand, adults in Wisconsin (82%), Ohio (82%), Kansas (81%) and New Jersey (81%) are significantly more likely than adults across the nation (74%) to report having a regular doctor whom they see when they are sick.

Even though a strong majority (74%) of Americans have regular doctors who provide most of their care, more than one in five (22%) say there has been at least one time in the last two years when they needed health care, but could not see their regular provider. Among those who could not see their regular doctor when they needed care, most say it was because either their doctor did not have any available appointment times or their doctor was away from the office (*Table 3*). Residents in Wisconsin (62%) and Oregon (56%) are significantly more likely than adults nationwide (42%) to say the reason they were unable to see their regular provider was because he or she was away from the office, while adults in Florida (26%) are more likely than adults across the nation (12%) to say it was because they lost their insurance coverage.

About one in six (17%) of those who were unable to see their regular provider when they needed health care say they were not able to receive health care from a different doctor. Four in five (80%), however, were able to get care elsewhere, most often in the emergency room. Texans (35%) and Floridians (30%) are significantly more likely than adults nationwide (17%) to report being unable to see another provider and having to go without care, while Wisconsinites (90%) are more likely to report being able to receive care from a different doctor compared to 80% of U.S. adults.

Overall, one in seven (14%) adults in the U.S. says it has gotten harder to see a doctor in the past two years, whereas nearly three-quarters (74%) say their ability to see a doctor has stayed about the same. In contrast, just one in ten (10%) say it has gotten easier to see a provider in recent years (Q26). Adults in

Florida (19%) and Texas (18%) are significantly more likely than adults nationwide (14%) to report that it has gotten harder to see a doctor in the past two years.

TABLE 3. Factors cited by adults in the U.S. that contributed to being unable to see their regular doctor when they needed care during the past two years and where they were ultimately able to receive treatment, among those who were able to see a different doctor (Q28, 29 a-g, 30, 31 a-e).

Could not see their regular doctor or health care professional at some point in the past two years when they needed health care	**22%**
Doctor did not have any available appointment times	52%
Needed care at night or on the weekend when doctor's office was not open	46%
Doctor was away from the office	42%
Could not afford the visit	24%
Doctor was too far away or difficult to get to	15%
Doctor stopped taking patient's insurance	14%
Lost insurance coverage	12%
Able to get health care from a different doctor	**80%**
In the emergency room	70%
At an urgent care center	60%
At regular doctor's office, but with a different doctor	56%
At a different doctor's office or clinic	37%
At a retail or drug store mini-clinic	27%
Unable to get health care from a different doctor	**17%**

Problems Getting Health Care When Needed

About one in seven (15%) adults in the U.S. says there has been a time in the past two years when they needed health care, but couldn't get it (*Table 4*). Being unable to afford it was the leading reason for not receiving needed health care – across the nation and in the survey's seven sample states. Adults in Florida (20%) are significantly more likely than adults nationwide (15%) to report being unable to receive the care they needed at least once in the past two years.

Notably, nearly a quarter (24%) of Americans who say they could not get the health care they needed at some point in the past two years also say they were turned away at least once by a doctor or hospital for financial or insurance reasons while trying to seek care.

TABLE 4. Factors cited by adults in the U.S. that contributed to being unable to receive the health care they needed sometime in the past two years (Q17, 18 a-d, 19).

Needed health care, but could not get it at least once in the past two years	**15%**
Could not afford the health care	58%
Could not find a doctor who would take their health insurance	35%
Could not get an appointment during the hours they needed	32%
Felt the health care center was too far or difficult to get to	26%
Tried to get medical care and were turned away for financial or insurance reasons	24%

Perceived Ability to Access Excellent Care

The survey asked, "If you became seriously ill, do you think you would or would not be able to get the best treatment available in your state?" About one in five (19%) adults in the U.S. says they do not think they would be able to access the state's best available treatment if they were seriously ill (Q3). In contrast, more than three-quarters (76%) of adults in the U.S. say they think they would be able to get the best treatment available. Adults in Florida (27%), Kansas (26%) and New Jersey (25%) are significantly more likely than adults nationwide (19%) to say they do not think they would be able to receive the best care available in the state where they live if they became seriously ill.

EXPERIENCES AT DIFFERENT SITES OF CARE

This section answers the question "How do adults in the U.S. experience health care at five different facilities, including doctor's offices, hospitals, emergency rooms, urgent care centers and retail or drug store mini-clinics?"

More than forty percent of patients rate four out of six aspects of their most recent visit to a doctor as excellent, and more than three quarters of patients say the cost of their last visit was reasonable. Among those who have recently seen a doctor, patients in the U.S. rate their provider's sensitivity to their cultural background highest, and their ability to get in touch with their doctor by phone or email outside of appointments lowest. Survey participants also rated their overall experience, the quality of health care they received, the amount of time they spent with the doctor, and the doctor's concern with maintaining their long-term health and other factors that could affect their health and well-being. Overnight hospitalization performs best among all surveyed health care settings when it comes to perceived quality, but ranks second-to-last when it comes to the reasonableness of health care costs.

Among alternatives to doctor's offices and hospitals, emergency rooms are most commonly used by Americans for major health problems, while urgent care centers are mostly used for minor wounds and illnesses. Mini-clinics, on the other hand, are frequented for vaccines. Less than forty percent of recent patients say the quality of care at these sites is excellent – urgent care centers receive excellent ratings from less than three in ten recent patients – however, a strong majority of recent patients say health care costs at urgent care centers and mini-clinics are reasonable. Reported use of emergency rooms and urgent care centers is also increasing, as many patients say they use these facilities more now than they did two years ago. When asked why they prefer all three sites over doctor's offices or community health centers, many patients cite ease of being seen, rapidity of treatment and location as driving factors.

DOCTOR'S OFFICES

The vast majority of adults in the U.S. say they have visited a doctor or other health professional in the past two years (*Table 5*). Of those, seven in ten (70%) say they were seen by a general practitioner such as a family physician or nurse practitioner during their most recent visit, while over a quarter (28%) report that they saw a medical specialist like a cardiologist or surgeon.

Adults in Texas (21%) are significantly more likely than adults across the country (16%) to report not having seen a doctor or other health professional in the past two years. Additionally, adults in Florida (37%) and New Jersey (36%) are significantly more likely than adults nationwide (28%) to report having last seen a medical specialist, rather than a general practitioner.

TABLE 5. Types of medical practitioners seen by adults in the U.S. during their most recent visit to a doctor or other health professional (Q11, 13).

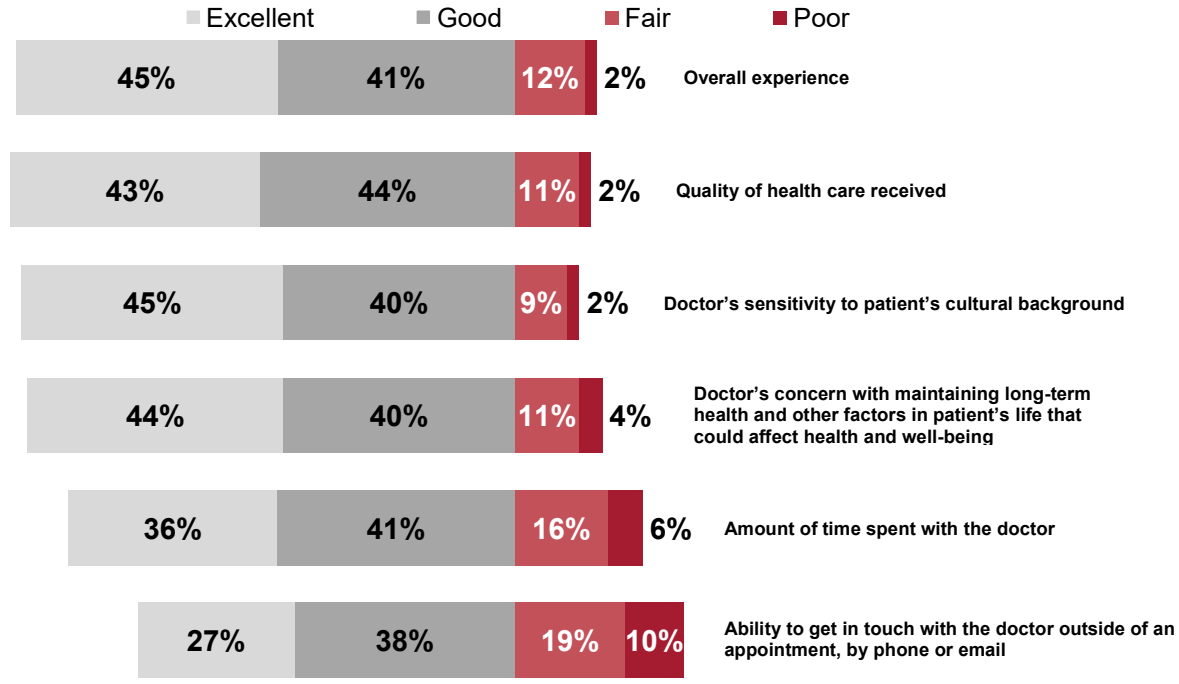
Visited a doctor or health care professional in the past two years	**84%**
General practitioner	70%
Medical specialist	28%

Most Recent Doctor's Visit

Adults who report having visited a doctor or other health care professional in the past two years were asked to rate their most recent visit on six different measures. More than two in five (45%) recent patients in the U.S. say their overall experience and also the doctor's sensitivity to their cultural background were excellent, making these the two top-rated elements of many Americans' last doctor's visit (*Figure 17*). In contrast, just over a quarter (27%) of recent patients say their ability to get in touch with the doctor outside of an appointment, by phone or email, was excellent, a slightly smaller proportion than those who rate this element of their care as fair or poor (29%).

Recent patients in Wisconsin are significantly more likely than adults nationwide to say the doctor's concern with maintaining their long-term health (55%), the doctor's sensitivity to their cultural background (52%), the amount of time they spent with the doctor (42%), and their ability to get in touch with the doctor outside of an appointment (33%) are excellent. In contrast, recent patients in Texas are more likely to say the doctor's sensitivity to their cultural background (15%), the doctor's concern with maintaining their long-term health (20%), and their ability to get in touch with a doctor outside of an appointment (35%) were fair or poor.

FIGURE 17. Percent of adults in the U.S. who rate six aspects of their most recent visit to a doctor or other health professional as excellent, good, fair or poor, among those have visited a doctor or other health professional in the past two years (Q12 a-f).



A strong majority of recent patients in the U.S. reflected positively when asked about cost. More than three-quarters (77%) say the cost of the health care they received during their last doctor's visit was reasonable, while one in five (20%) say it was unreasonable (Q14). Recent patients in Wisconsin (25%) are significantly more likely than adults across the country (20%) to say the cost of their last doctor's visit

was unreasonable, however, and recent patients in New Jersey (11%) are more likely than adults nationwide (7%) to say the cost of their visit was very unreasonable.

Sick Visits

Just under three in five (58%) adults in the U.S. say they have scheduled a visit with a doctor or other health care professional in the past two years because they were sick or had a health concern (*Table 6*). More than three in five (63%) of these patients report that three days or fewer elapsed between when they made the appointment and when they actually saw the doctor. On the other hand, about a quarter (24%) of patients says they had to wait more than a week to be seen by a doctor when they were sick or had a health concern. Oregonians (30%) are significantly more likely than adults across the country (24%) to report they had to wait a week or more between scheduling a sick visit and ultimately seeing their health care providers.

TABLE 6. Amount of time that passed between scheduling an appointment and actually seeing the doctor, among those adults in the U.S. who say they scheduled a doctor's appointment in the last two years because they were sick or had a health concern (Q23, 24).

Scheduled a sick visit in the past two years	**58%**
Less than 24 hours	30%
About one to three days	33%
About four to seven days	13%
More than one week	7%
More than two weeks	6%
More than three weeks	3%
More than one month	8%

Among those who report having scheduled a sick visit in the past two years, more than four in five (83%) say the length of time they had to wait between scheduling the appointment and seeing a doctor was reasonable (Q25). About one in six (17%) say the amount of time they had to wait for an appointment was unreasonable. Recent patients in Florida (23%) and New Jersey (23%) are significantly more likely than adults across the nation (17%) to report that the amount of time they had to wait for an appointment was unreasonable.

Overall, about one in seven (14%) adults in the U.S. say it has gotten harder to see a doctor in the past two years, while nearly three-quarters (74%) say their ability to see a doctor has stayed about the same. In contrast, just one in ten (10%) say it has gotten easier to see a provider in recent years (Q26). Adults in Florida (19%) and Texas (18%) are significantly more likely than adults nationwide (14%) to report that it has gotten harder to see a doctor in the past two years.

HOSPITALS

Just under one in five (18%) adults in the U.S. say they have been hospitalized overnight in the past two years (Q32).

Quality & Cost

Less than half (46%) of patients in the U.S. say the quality of health care they received during their most recent hospitalization was excellent and just under a third (32%) say their last overnight hospital stay was good. In contrast, more than one in six (18%) say their care was just fair, and four percent say it was poor (Q33). In terms of cost, just under two-thirds (65%) of patients in the U.S. say the cost of health care they received during their most recent hospitalization was reasonable, while three in ten (30%) say it was unreasonable (Q34).

Treatment by Doctors & Staff

More than four in five (81%) recently hospitalized patients in the U.S. say that during their last overnight stay, their views and preferences were taken into account by the doctors and other health care professionals who treated them, while about one in six (17%) say their views and preferences were not taken into account (Q35).

Less than two in five (37%) of recently hospitalized patients in the U.S. say that during their last overnight stay, staff did an excellent job of preparing them for the care they would need after leaving the hospital (Q36). More than forty percent (42%) rate their preparation as good, while one in seven (14%) say it was fair and seven percent say staff prepared them poorly. Recent patients in Kansas (50%) and Wisconsin (56%) are significantly more likely to say staff did an excellent job preparing them for the care they would need upon being discharged, as compared to adults nationwide (37%).

EMERGENCY ROOMS

A third (33%) of adults in the U.S. say they have received health care in the emergency room (ER) of a hospital in the past two years (Q37); however, adults in Ohio (39%) are significantly more likely to report having used the emergency room for health care in the past two years. Among recent ER patients nationally, nearly one quarter (23%) say their use of the emergency room has gone up in the last two years, whereas one in ten (10%) says they use the ER less now than they used to (Q42). Adults in Ohio (72%) are significantly more likely to say their use has stayed about the same in recent years compared to adults across the U.S. (63%).

Quality & Cost

Just under two in five (38%) patients in the U.S. say the quality of health care they received during their most recent visit to the ER was excellent, while about a third (34%) say it was good. In contrast, one in six (17%) say the care they received in the ER was only fair, while one in ten (10%) characterize their care as poor (Q38). Recent patients in Texas (18%) are significantly more likely to say the quality of care they received during their last visit to the ER was poor, as compared to recent patients nationwide (10%).

In terms of cost, 58 percent of patients in the U.S. say the cost of health care they received during their most recent ER visit was reasonable, while more than a third (36%) say it was unreasonable (Q39). Adults in New Jersey (32%) are significantly more likely to say the cost of their last visit to an ER was very unreasonable, compared to recent patients across the nation (20%).

Purpose of & Reason for Visit

Two in five (40%) of recent patients in the U.S. say they last went to the emergency room to get treatment for a major health problem like a broken bone, a cut, or a high fever (*Table 7*). Adults in New Jersey (52%) and Wisconsin (50%) are significantly more likely to use the ER for a major health problem.

When asked why they went to the ER instead of an urgent care center, doctor's office or community health center, two in five (40%) recent ER patients say it was because they thought they might need to be hospitalized, because they were brought by ambulance, or because they felt other facilities did not have the necessary staff or equipment to treat them. By comparison, 47 percent of patients say they received care in the ER because other facilities were not open or they could not get an appointment, they felt the ER was the only place that would treat them, or because other facilities were too far away.

TABLE 7. Main purpose for seeking treatment in the emergency room and main reasons for seeking care there, among recent ER patients in the U.S. (Q37, 40, 41).

Received health care in the emergency room of a hospital in the past two years	**33%**
Main *purpose* of most recent visit	
Treatment for major health problem	40%
Some other purpose	36%
Treatment for minor health problem	23%
Main *reason* for visiting the emergency room instead of other facilities	
Other facilities were not open or patient could not get an appointment	28%
Brought by ambulance	18%
Felt the ER was the only place that would treat them	16%
Some other reason	12%
Other facilities did not have the necessary staff or equipment	11%
Might need to be admitted to the hospital overnight	11%
Other facilities were far away too	3%

Treatment by Doctors & Staff

Just under two in five (38%) patients in the U.S. say that during their most recent visit to the ER, staff did an excellent job of preparing them for the care they would need after leaving the hospital, while one third (33%) say staff did a good job (Q43). On the other hand, one in five (20%) patients say ER staff prepared them only fairly and just under one in ten (9%) say staff prepared them poorly.

URGENT CARE CENTERS

Urgent care centers are a category of free-standing, walk-in healthcare facilities typically located in highly visible, easily accessible locations. They generally do not require appointments and have extended evening and weekend hours of service.[2] Centers are typically staffed by physicians, sometimes nurse practitioners or physician assistants,[3] and offer short-term medical care for a range of acute, non-life threatening illnesses and injuries, as well as a limited array of diagnostic services such as lab testing and imaging.[4] Urgent care centers began to appear in the early 1980s and as of 2015, there are nearly 7,000 locations nationwide.[5]

More than a quarter (27%) of adults in the U.S. says they have received health care at an urgent care center in the past two years (Q44). Adults in Oregon (33%) are significantly more likely than adults across the country (27%) to report having used an urgent care center in the past two years. Among urgent care users nationally, about one in six (17%) say their use of urgent care centers has gone up in the last two years, whereas about one in fifteen (7%) recent patients say they use urgent care centers less now than they used to (Q49). Recent patients in New Jersey (28%) are significantly more likely to say their use of urgent care centers has gone up in the last two years, compared to adults across the country (17%).

Quality & Cost

Less than three in ten (29%) patients in the U.S. say the quality of health care they received during their most recent visit to an urgent care center was excellent, while less than half (46%) say it was good. In contrast, just under one in five (19%) say their care was just fair and six percent say it was poor (Q45). Patients in New Jersey (42%) are significantly more likely to say the quality of care they received during their last urgent care visit was excellent, compared to adults nationwide (29%). In terms of cost, nearly three-quarters (74%) of patients in the U.S. say the cost of health care they received during their most recent visit to an urgent care center was reasonable, while about one in five (21%) say the cost was unreasonable (Q46).

Purpose of & Reason for Visit

When asked about the purpose of their last visit to an urgent care center, three in five (60%) recent patients in the U.S. say they went to get treatment for a minor wound or illness like a sprain or sore throat (*Table 8*). Recent patients in Florida (11%) are significantly more likely to say they use urgent care centers for routine screening, tests, exams and vaccinations, as compared to recent patients nationwide (4%).

About one in five (22%) patients say they went to an urgent care center because they thought it would take less time to be seen and treated, and a similar proportion (21%) say they considered the location to be more convenient, compared to other facilities like hospitals, doctor's offices and community health

[2] Urgent Care Association of America, "Industry FAQs," http://www.ucaoa.org/general/custom.asp?page=IndustryFAQs
[3] American College of Emergency Physicians, "Urgent Care Fact Sheet," http://newsroom.acep.org/index.php?s=20301&item=30033
[4] AMN Healthcare, "Will Healthcare Staffing Shortages Challenge Urgent Care Growth?," https://www.amnhealthcare.com/will_healthcare_staffing_shortages_challenge_urgent_care_growth/
[5] Urgent Care Association of America, "Industry FAQs," http://www.ucaoa.org/general/custom.asp?page=IndustryFAQs

centers, making these the top two reasons for receiving care at urgent care centers among Americans. Nearly three in ten recent patients in Kansas (28%), however, say they chose urgent care centers over other facilities because the hours were more convenient, compared to 17 percent of U.S. adults.

TABLE 8. Main purpose for seeking treatment at an urgent care center and main reasons for seeking care there, among recent urgent care center patients in the U.S. (Q44, 47, 48).

Received health care at an urgent care center in the past two years	**27%**
Main *purpose* of most recent visit	
Treatment for minor wound or illness	60%
Some other purpose	15%
Treatment for major wound or illness	15%
Routine screening, test, exam or vaccination	4%
Prescription or treatment for a long-term health condition	4%
Main *reason* for visiting urgent care instead of going to other facilities	
Thought it would take less time to be seen and treated	22%
Location was more convenient	21%
Some other reason	20%
Hours were more convenient	17%
Considered the cost to be more affordable	13%
Felt more comfortable with the staff	2%
Considered quality of health care to be better	2%

RETAIL OR DRUG STORE MINI-CLINICS

Retail and drug store mini-clinics, also referred to as convenient care clinics, are a category of walk-in healthcare facilities located in high traffic retail settings such as supermarkets and drug stores. Generally, these facilities do not require appointments and have extended evening and weekend hours of service. Mini-clinics are typically staffed by advanced practice nurses, such as nurse practitioners, or by physician assistants.[6] They offer routine care for a narrow range of common, low-severity, illnesses and conditions as well as preventive health care services such as physical exams and vaccinations.[7] Most locations accept private health insurance plans, though insurance is not necessary to receive treatment.[8] Nationally, these clinics first appeared in 2000,[9] and as of December 2015, the United States had several varieties, including more than 800 CVS Minute Clinic locations,[10] about 400 Walgreens Healthcare Clinics,[11] 80 clinics operated by health care affiliates in Walmart,[12] and 18 Walmart Care Clinics.[13]

[6] Association of State and Territorial Health Officials, "Defining the Safety Net: Retail Clinics," 2011, http://www.astho.org/Programs/Access/Primary-Care/Safety-Net-Fact-Sheets/Materials/Retail-Clinics-Fact-Sheet/
[7] Rheumatology Network, "The Impact of Mini-Clinics," 2011, http://www.rheumatologynetwork.com/pearls/impact-mini-clinics
[8] Association of State and Territorial Health Officials, "Defining the Safety Net: Retail Clinics," 2011, http://www.astho.org/Programs/Access/Primary-Care/Safety-Net-Fact-Sheets/Materials/Retail-Clinics-Fact-Sheet/
[9] Convenient Care Association, "History of the Industry," http://ccaclinics.org/about-us/history-of-the-industry
[10] CVS Minute Clinic, "Frequently Asked Questions," https://www.cvs.com/minuteclinic/info
[11] Walgreens, "Frequently Asked Questions," http://www.walgreens.com/topic/healthcare-clinic/frequently-asked-questions.jsp
[12] Walmart, "The Clinic at Walmart," 2014, http://i.walmartimages.com/i/if/hmp/fusion/Clinics_092414.pdf

About one in eight (12%) adults in the U.S. say they have received health care at a mini-clinic in the past two years (Q50). However, adults in Wisconsin (9%) are significantly less likely than adults across the country (12%) to report having used a mini-clinic in the past two years. Among mini-clinic users nationally, one in seven (14%) say their use of these facilities has gone up in the last two years, whereas one in ten (11%) recent patients say they use mini-clinics less now than they used to (Q55).

Quality & Cost

A third (33%) of recent mini-clinic patients in the U.S. say the quality of health care they received during their most recent visit was excellent, while less than three in five (56%) say it was good. In contrast, one in ten (10%) say their care was only fair and just one percent say it was poor (Q51). In terms of cost, more than nine in ten (92%) recent patients in the U.S. say the cost of health care they received during their most recent visit to a mini-clinic was reasonable; only about one in fifteen (7%), on the other hand, say the cost was unreasonable (Q52).

Purpose of & Reason for Visit

When asked about the purpose of their last visit to a mini-clinic, the top reason cited by a third (33%) of recent patients, was to get a vaccine (*Table 9*). More than a quarter (26%) of recent patients say they went to a mini-clinic instead of an urgent care center, doctor's office or hospital because they considered the location to be more convenient, making this the top reason for care at mini-clinics in the U.S. Twenty-one percent of recent patients say they chose mini-clinics over other facilities because they considered the hours to be more convenient, making this the second-most common reason for visiting a retail or drug store mini-clinic in America.

TABLE 9. Main purpose for seeking treatment at a retail or drug store mini-clinic and main reasons for seeking care there, among recent mini-clinic patients in the U.S. (Q50, 53, 54).

Received health care at a retail or drug store mini-clinic in the past two years	**12%**
Main *purpose* of most recent visit	
Vaccine	33%
Treatment for minor illness	21%
Prescription or treatment for long-term health condition	18%
Treatment for minor wound or skin condition	10%
Some other purpose	9%
Physical exam	5%
Health screening or test	3%
Main *reason* for visiting a mini-clinic	
Location was more convenient	26%
Hours were more convenient	21%
Considered cost to be more affordable	18%
Thought it would take less time to be seen and treated	18%
Some other reason	13%
More comfortable with staff	2%
Considered quality of health care to be better	1%

[13] Walmart, "Care Clinics," http://www.walmart.com/cp/Care-Clinics/1224932

OPINIONS ON NATIONAL HEALTH REFORM

This section answers the question "What do adults in the U.S. think of national health reform?"

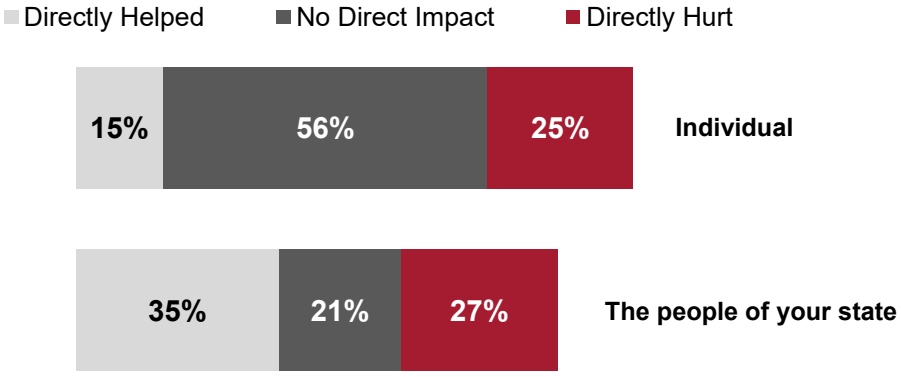
Americans have mixed feelings on the state- and personal-level effects of the Affordable Care Act. The proportion of U.S. adults who believe the law helped people in the state where they live approximately equals the proportion of people who believe national health reform hurt their fellow state residents. On a personal level, most Americans do not believe the law directly affected them. Among those who do, however, more believe the law directly hurt them than helped them.

National Health Reform

Views on the Affordable Care Act (ACA), also called Obamacare, are mixed among adults in the U.S (*Figure 18*). When asked about its effects on the people of their state, more than a third (35%) of adults say they believe national health reform has directly helped residents, while a similar proportion (27%) say they believe the law has directly harmed residents. On a more personal level, most (56%) Americans do not believe the ACA has directly impacted them. Among those who believe it had an impact, more say it has directly hurt them (25%), as individuals, than those who say national health reform has directly helped them (15%).

Adults in Kansas (39%) and Ohio (35%) are significantly more likely than adults across the country (27%) to say the law has hurt the people of their state; however, Ohioans (21%) are also more likely to say the law has directly helped them, as individuals, than adults nationwide (15%).

FIGURE 18. Perceptions of the Affordable Care Act's impact on survey participants or on people in the state where they live (Q5, 6).



METHODOLOGY

The polls in this study are part of an on-going series of surveys developed by researchers at the Harvard Opinion Research Program (HORP) at the Harvard T.H. Chan School of Public Health in partnership with the Robert Wood Johnson Foundation and National Public Radio. The research team consists of the following members at each institution.

Harvard T.H. Chan School of Public Health: Robert J. Blendon, Professor of Health Policy and Political Analysis and Executive Director of HORP; John M. Benson, Research Scientist and Managing Director of HORP; Caitlin L. McMurtry; Research Assistant; and Justin M. Sayde, Administrative and Research Manager.

Robert Wood Johnson Foundation: Fred Mann, Vice President, Communications; Carolyn Miller, Senior Program Officer, Research and Evaluation; and Joe Costello, Director, Marketing.

NPR: Anne Gudenkauf, Senior Supervising Editor, Science Desk; and Joe Neel, Deputy Senior Supervising Editor, Science Desk.

The "Patients' Perspectives on Health Care in the United States" project consisted of eight polls, conducted via telephone (including both landline and cell phone) by SSRS of Media (PA). Interviews were conducted in English and Spanish, using random-digit dialing, September 8 – November 9, 2015, among representative samples of adults age 18 or older nationally and in the seven states.

For the national poll, interviews were conducted with a nationally representative probability sample of 1,002 U.S. adults. The margin of error for total U.S. respondents is ± 3.8 percentage points at the 95% confidence level. For the state polls, sample sizes and margins of error are included in the table below:

State	Number of Interviews	Margin of Error (percentage points)
Florida	1,003	±3.9
Kansas	1,005	±3.8
New Jersey	1,003	±4.0
Ohio	1,000	±3.8
Oregon	1,009	±4.0
Texas	1,005	±3.9
Wisconsin	1,011	±3.9

Possible sources of non-sampling error include non-response bias, as well as question wording and ordering effects. Non-response in telephone surveys produces some known biases in survey-derived estimates because participation tends to vary for different subgroups of the population. To compensate for these known biases and for variations in probability of selection within and across households, sample data are weighted by cell phone/landline use and demographics (sex, age, race/ethnicity, education, and number of adults in household) to reflect the true population. Other techniques, including random-digit dialing, replicate subsamples, and systematic respondent selection within households, are used to ensure that the sample is representative.

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HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

Patients' Perspectives on Health Care in the United States: A Look at Seven States and the Nation

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Methodology

The survey was conducted for National Public Radio, the Robert Wood Johnson Foundation, and the Harvard T.H. Chan School of Public Health via telephone (landline and cell phone) by SSRS, an independent research company. Interviews were conducted in English and Spanish using random-digit dialing, September 8 – November 9, 2015, among representative probability samples of adults age 18 or older nationally and in seven states.

	Number of Interviews	**Margin of Error (percentage points)**
National (U.S.)	1002	+/-3.8
Florida	1003	+/-3.9
Kansas	1005	+/-3.8
New Jersey	1003	+/-4.0
Ohio	1000	+/-3.8
Oregon	1009	+/-4.0
Texas	1005	+/-3.9
Wisconsin	1011	+/-3.9

Significance Testing (indicated by letters next to the %s on the tables):

a = statistically higher proportion than in the U.S., p<0.05.
b = statistically higher proportion than in Florida, p<0.05.
c = statistically higher proportion than in Kansas, p<0.05.
d = statistically higher proportion than in New Jersey, p<0.05.
e = statistically higher proportion than in Ohio, p<0.05.
f = statistically higher proportion than in Oregon, p<0.05.
g = statistically higher proportion than in Texas, p<0.05.
h = statistically higher proportion than in Wisconsin, p<0.05.

I. Perceptions of Health Care in Their State

(Asked of half-sample A; Natl n = 501; FL n = 502; KS n = 512; NJ n = 545; OH n = 484; OR n = 493; TX n = 465; WI n = 505)

NP-1. In recent years, would you say the health of people in [INSERT STATE] has gotten better, gotten worse, or stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Better	15	17[ce]	11	13	10	19[cdeh]	16[e]	13
Worse	26	26	29	26	31[f]	24	26	31[f]
Stayed about the same	49	46	49	46	48	43	44	46
Don't know/ Refused	10	11	11	15	11	14	14	10

(Asked of half-sample B; Natl n = 501; FL n = 501; KS n = 493; NJ n = 458; OH n = 516; OR n = 516; TX n = 540; WI n = 506)

NP-2. In general, how would you rate the health care system in [INSERT STATE]? Would you say it is excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**55[cg]**	**49**	**47**	**50**	**51**	**53**	**47**	**60[bcdeg]**
Excellent	17[bf]	10	13	12	14	11	13	12
Good	38	39	34	38	37	42[cg]	34	48[abcdeg]
Fair/Poor	**42**	**44[h]**	**47[fh]**	**45[h]**	**47[fh]**	**38**	**48[fh]**	**35**
Fair	29	26	31[h]	30[h]	31[h]	27	32[h]	22
Poor	13	18[f]	16[f]	15	16[f]	11	16[f]	13
Don't know/ Refused	3	7	6	5	2	9	5[e]	5

NP-3. If you became seriously ill, do you think you would or would not be able to get the best treatment available in [INSERT STATE]?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, would be able to get the best treatment	76[bcd]	68	69	66	75[bcd]	74[bcd]	75[bcd]	78[bcd]
No, would NOT be able to get the best treatment	19	27[aefgh]	26[aefgh]	25[afh]	21	19	20	19
Don't know/ Refused	5	5	5	9	4	7	5	3

NP-4. In the past TWO years, has the cost of health care in [INSERT STATE] increased, decreased, or stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Increased	53	58	62[afg]	63[abfg]	59[af]	54	55	62[afg]
Decreased	3	3	2	3	4[c]	5[bcdgh]	3	3
Stayed about the same	31[cdef]	26	23	22	25	25	32[bcdefh]	26
Don't know/ Refused	13	13	13	12	12	16	10	9

(Asked of half-sample C; Natl n = 514; FL n = 467; KS n = 515; NJ n = 529; OH n = 472; OR n = 515; TX n = 484 WI n = 505)

NP-5. So far, would you say the Affordable Care Act, also called Obamacare, has directly helped the people of [INSERT STATE], directly hurt them, or has it not had a direct impact?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Directly helped	35[c]	35[c]	26	38[cg]	30	42[cegh]	28	32
Directly hurt	27	34	39[adfh]	27	35[ad]	30	32	31
No direct impact	21[f]	19	22[f]	17	18	13	25[def]	21[f]
Don't know/ Refused	17	12	13	18	17	15	15	16

(Asked of half-sample D; Natl n = 488; FL n = 536; KS n = 490; NJ n = 474; OH n = 528; OR n = 494; TX n = 521; WI n = 506)

NP-6. So far, would you say the Affordable Care Act, also called Obamacare, has directly helped you, directly hurt you, or has it not had a direct impact?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Directly helped	15	15	13	18	21[abcgh]	19[cgh]	13	13
Directly hurt	25	29[fh]	31[fh]	25	27	21	25	21
No direct impact	56	52	50	53	48	56[e]	57[ce]	61[bcde]
Don't know/ Refused	4	4	6	4	4	4	5	5

II. Experience with Doctors and Other Health Care Professionals

NP-9. Overall, how would you rate the health care you receive? Would you say it is excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**79**	**75**	**80**[b]	**77**	**82**[bdg]	**78**	**76**	**83**[abdfg]
Excellent	33[d]	30	34[d]	27	34[d]	34[d]	30	37[bdg]
Good	46	45	46	50[bf]	48	44	46	46
Fair/Poor	**18**	**21**[eh]	**18**	**20**[h]	**16**	**19**[h]	**21**[h]	**14**
Fair	14	16[h]	16[h]	16[h]	13	16[h]	15	11
Poor	4	5[c]	2	4	3	3	6[cdefh]	3
Don't know/ Refused	3	4	2	3	2	3	3	3

NP-10. Thinking about the past TWO years, would you say the health care you have received has gotten better or worse, or has it stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Better	14	18[acdeh]	12	13	14	15	15	13
Worse	9	13[ah]	10	12	13[ah]	13[a]	11	9
Stayed about the same	74[bf]	65	77[bdfg]	72[b]	72[b]	69	71[b]	76[bf]
Don't know/ Refused	3	4	1	3	1	3	3	2

For this next set of questions, I'm interested in learning more about your personal experiences with the health care system, and specifically your doctor. If you see a physician's assistant or nurse for medical care, instead of a doctor, please tell me about your experiences with that health professional. For the purposes of this survey, please focus only on medical care -- not dental care, eye exams, or hearing exams.

NP-11. Have you visited a doctor or other health professional in the last TWO years, or not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	84[g]	82	87[bg]	85[g]	88[bg]	86[bg]	79	85[g]
No	16	18[ce]	13	15	12	14	21[acdefh]	15
Don't know/ Refused	*	*	*	*	-	*	*	*

(Asked of those who visited a doctor/health professional in the last two years; Natl n = 869; FL n = 845; KS n = 886; NJ n = 863; OH n = 887; OR n = 884; TX n = 836; WI n =878)

NP-12. Thinking about your most recent visit to a doctor or other health professional, how would you rate the following? Would you say (INSERT FIRST ITEM) was excellent, good, fair, or poor?

a. The overall experience

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**86**	**83**	**85**	**86**	**87**[g]	**83**	**82**	**88**[bfg]
Excellent	45[d]	41	42	37	42	42	41	49[bcdefg]
Good	41	42	43	49[abfgh]	45[h]	41	41	39
Fair/Poor	**14**	**17**[eh]	**15**	**14**	**12**	**17**[eh]	**18**[eh]	**12**
Fair	12	12	12	11	9	13	12	9
Poor	2	5[a]	3	3	3	4	6[acdeh]	3
Don't know/ Refused	*	-	*	*	1	*	-	*

b. The quality of health care you received

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**87**	**83**	**85**	**84**	**88[bg]**	**84**	**83**	**88[bg]**
Excellent	43	40	43	39	42	42	40	47[bdg]
Good	44	43	42	45	46	42	43	41
Fair/Poor	**13**	**16[eh]**	**14**	**16[h]**	**12**	**15**	**17[eh]**	**12**
Fair	11	12[h]	12[h]	12	9	10	12[h]	9
Poor	2	4[ac]	2	4[ac]	3	5[ac]	5[ace]	3
Don't know/ Refused	-	1	1	*	-	1	*	*

c. The amount of time you spent with the doctor

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**77**	**75**	**77**	**78**	**80[bg]**	**79**	**74**	**82[abcg]**
Excellent	36	35	35	32	38[d]	36	34	42[abcdfg]
Good	41	40	42	46[bgh]	42	43	40	40
Fair/Poor	**22[h]**	**25[eh]**	**23[h]**	**21**	**20**	**21**	**26[eh]**	**17**
Fair	16	17	16	15	14	14	16	13
Poor	6	8[h]	7[h]	6	6	7[h]	10[adeh]	4
Don't know/ Refused	1	-	*	1	-	-	*	*

d. Your ability to get in touch with the doctor outside of an appointment, either by phone or email

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**65[g]**	**60**	**63**	**63**	**70[bcdg]**	**69[bcdg]**	**59**	**72[abcdg]**
Excellent	27	24	26	27	30[b]	29[b]	25	33[abcdg]
Good	38	36	37	36	41[g]	40[g]	34	39
Fair/Poor	**29[h]**	**32[efh]**	**32[efh]**	**31[eh]**	**25**	**26**	**35[aefh]**	**21**
Fair	19[fh]	17	19[fh]	18	15	13	22[efh]	14
Poor	10	15[aeh]	13[h]	13[h]	10	12[h]	13[h]	7
Don't know/ Refused	6	8	5	6	5	5	6	7

e. The doctor's sensitivity to your cultural background

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**85**	**81**	**84**	**82**	**87[bdg]**	**84**	**81**	**87[bdg]**
Excellent	45[d]	43	48[d]	39	50[bd]	47[d]	44	52[abdg]
Good	40	38	36	43[cgh]	37	37	37	35
Fair/Poor	**11**	**14[eh]**	**12[h]**	**11[h]**	**9**	**10**	**15[aefh]**	**8**
Fair	9[h]	10[eh]	9[h]	10[eh]	7	7	10[eh]	6
Poor	2	4[ad]	3[d]	1	2	3	5[adefh]	2
Don't know/ Refused	4	5	4	7	4	6	4	5

f. The doctor's concern with maintaining your long-term health and other factors in your life that could affect your health and well-being

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**84[g]**	**81**	**84**	**81**	**84[g]**	**83**	**80**	**87[bdfg]**
Excellent	44	41	45	41	47[bdg]	46	39	55[abcdefg]
Good	40[h]	40[h]	39[h]	40[h]	37	37	41[h]	33
Fair/Poor	**15**	**18[h]**	**16**	**18[h]**	**15**	**17**	**20[ah]**	**12**
Fair	11	11	11	13[h]	10	12	14[h]	8
Poor	4	7[a]	5	5	5	5	6[a]	4
Don't know/ Refused	1	1	*	1	1	*	*	*

(Asked of those who visited a doctor/health professional in the last two years; Natl n = 869; FL n = 845; KS n = 886; NJ n = 863; OH n = 887; OR n = 884; TX n = 836; WI n =878)

NP-13. Still thinking about this most recent visit, from what kind of doctor did you receive care? Was it a medical specialist like a cardiologist or surgeon, or did you see a general practitioner such as a family physician or a nurse practitioner?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Medical specialist	28	37[acefh]	24	36[acefh]	25	27	31[ceh]	26
General practitioner	70[bd]	62	74[bdg]	62	73[bdg]	72[bd]	67	73[bdg]
Don't know/ Refused	2	1	2	2	2	1	2	1

(Asked of those who visited a doctor/health professional in the last two years; Natl n = 869; FL n = 845; KS n = 886; NJ n = 863; OH n = 887; OR n = 884; TX n = 836; WI n =878)

NP-14. Do you think the cost of the health care you received during your most recent visit was reasonable or unreasonable?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Reasonable	**77[dh]**	**72[h]**	**74[h]**	**71**	**74[h]**	**74[h]**	**77[dh]**	**66**
Very reasonable	42[cdeh]	38[cdh]	32	33	36[h]	37[h]	38[ch]	30
Somewhat reasonable	35	34	42[abh]	38	38	37	39	36
Unreasonable	**20**	**20**	**21**	**22**	**20**	**18**	**19**	**25[afg]**
Somewhat unreasonable	13	10	11	11	11	11	9	14[bg]
Very unreasonable	7	10	10	11[a]	9	8	10	11
Don't know/ Refused	3	8	5	7	6	8	4	9

III. Health Care Cost Experiences

For this next set of questions, when I ask about your "premium," I mean the monthly, quarterly or yearly amount you have to pay for your insurance plan. When I ask about your "deductible," I mean the amount you personally have to pay before your insurance plan starts covering your services. And by "copayment," I mean the fixed fee you pay at the doctor's office when you receive a service.

NP-15. Overall, do you think the cost you personally pay for your health care, including premiums, deductibles, copayments and prescription drugs, is reasonable or unreasonable?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Reasonable	**60[d]**	**60[d]**	**57**	**52**	**59[d]**	**65[cdeg]**	**60[d]**	**63[cd]**
Very reasonable	30	31	28	26	29	36[acdegh]	27	29
Somewhat reasonable	30	29	29	26	30	29	33[d]	34[d]
Unreasonable	**29**	**32**	**37[af]**	**39[abfgh]**	**36[af]**	**27**	**32**	**32**
Somewhat unreasonable	15	13	18[bf]	17[f]	15	12	15	15
Very unreasonable	14	19[a]	19[a]	22[afgh]	21[af]	15	17	17
Don't know/ Refused	11	8	6	9	5	8	8	5

NP-16a. In the past TWO years, would you say the cost of your health care services has become more affordable, less affordable, or has it stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
More affordable	9	12[h]	9	11[h]	9	14[acegh]	10[h]	6
Less affordable	34	33	43[abfg]	39[bf]	38[f]	30	34	41[abfg]
Stayed about the same	53[cd]	51[c]	45	47	50	52[c]	52[c]	50
Don't know/ Refused	4	4	3	3	3	4	4	3

NP-16b. In the past TWO years, would you say the cost of your prescription drugs has become more affordable, less affordable, or has it stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
More affordable	10	12	12	11	13	12	15[ah]	10
Less affordable	22[f]	26[f]	28[afg]	26[f]	27[f]	17	23[f]	27[f]
Stayed about the same	58[bh]	52	53	54	54	58[bh]	55	52
Don't know/ Refused	10	10	7	9	6	13	7	11

NP-17. Was there any time in the past TWO years when you needed health care, but did not get it, OR did you get health care every time you needed it in the past TWO years?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Needed health care and DID NOT GET IT	15	20[adh]	16	14	17[h]	17	18[h]	13
Got health care EVERY TIME	81[b]	76	81[b]	82[b]	80	80	78	83[bg]
Don't know/ Refused	4	4	3	4	3	3	4	4

(Asked of those who needed health care in the past TWO years and did not get it; Natl n =139; FL n = 186; KS n = 156; NJ n = 148; OH n = 159; OR n = 165; TX n = 162; WI n =142)

NP-18. Please tell me if any of the following were or were not reasons you could not get the health care you needed. Was there a time in the past TWO years when you could not get health care because (INSERT ITEM)?

NP-18 Summary Table: % who said the following were reasons

RESULTS BASED <u>ONLY</u> ON THOSE WHO SAID THEY NEEDED HEALTH CARE IN THE PAST TWO YEARS AND DID NOT GET IT

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
a. You could not afford that health care	58	65	59	62	63	57	63	55
b. You could not find a doctor who would take your health insurance	35	34	27	32	23	23	35	23
c. You could not get an appointment during the hours you needed	32	26	27	35	24	38[e]	30	29
d. You felt the health care center was too far or difficult to get to	26[b]	14	18	25	20	17	27[b]	16

(Asked of those who needed health care in the past TWO years and did not get it; Natl n =139; FL n = 186; KS n = 156; NJ n = 148; OH n = 159; OR n = 165; TX n = 162; WI n =142)

RESULTS BASED <u>ONLY</u> ON THOSE WHO SAID THEY NEEDED HEALTH CARE IN THE PAST TWO YEARS AND DID NOT GET IT

NP-19. Was there any time during the past TWO years when you tried to get medical care and were **turned away** by a doctor or hospital for financial or insurance reasons, or not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	24	26	24	22	17	17	27[h]	15
No	76	74	76	76	83	83	73	85[g]
Don't know/ Refused	-	*	*	2	-	-	*	-

NP-20. Thinking about the cost of your health care over the past TWO years, how would you describe the overall impact of your health care costs on your or your family's financial situation? Would you say your health care costs caused a problem for you or your family's overall financial situation, or did they not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Very/somewhat serious problem (NET)	**26**	**31[f]**	**36[adefgh]**	**27**	**28**	**25**	**30**	**27**
Very serious problem	9	14[aefgh]	14[ah]	13[ah]	11	10	11	9
Somewhat serious problem	17[d]	17	22[bdef]	14	17	15	19[df]	18[d]
Not too serious/ Did not cause a problem (NET)	**70[c]**	**67**	**63**	**72[bc]**	**71[c]**	**73[bc]**	**68[c]**	**70[c]**
Not too serious problem	10[c]	7	6	9	8	8	9[c]	7
Did not cause a problem	60	60	57	63[c]	63[c]	65[cg]	59	63[c]
Don't know/ Refused	4	2	1	1	1	2	2	3

(Asked of those whose their health care costs have caused a very or somewhat serious problem for their overall financial situation; Natl n =259; FL n = 298; KS n = 321; NJ n = 260; OH n = 278; OR n = 243; TX n = 275; WI n =264)
NP-21. In the past TWO years, have any of the following happened to you? Have you (INSERT ITEM) because of large medical bills, or not?

NP-21 Summary Table: % who said the following happened to them

RESULTS BASED <u>ONLY</u> ON THOSE WHO SAID THEIR HEALTH CARE COSTS HAVE CAUSED A VERY OR SOMEWHAT SERIOUS PROBLEM FOR THEIR OVERALL FINANCIAL SITUATION

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
a. Spent all or most of your personal savings	42[d]	36	44[dg]	32	42[d]	45[dg]	33	40
b. Been unable to pay for basic necessities like food, heat or housing	27	30	24	27	27	30	29	25
c. Taken out a loan that may be hard to pay back	19[bcdh]	11	11	8	16[d]	14	16[d]	11
d. Taken on credit card debt that may be difficult to pay off	23	27	26	28	29	29	25	25
e. Been contacted by bill collectors	39	41	42	47	47	44	40	40
f. Declared bankruptcy	7[f]	3	3	3	4	2	5	5
g. Set up a payment plan with a hospital or health care professional	44	39	56[abdg]	44	53[bg]	53[bg]	41	53[bg]

NP-22. In the past TWO years, have you (INSERT ITEM) because of the cost of prescription drugs, or has this not happened?

BASED ON TOTAL RESPONDENTS

a. Not filled a prescription

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, have	19	22[h]	24[afh]	20[h]	21[h]	18	20[h]	15
No, have NOT	80[c]	78	76	80	79	82	80	85[bcdeg]
Don't know/ Refused	1	*	*	*	*	*	*	*

b. Cut pills in half or skipped doses of medicine

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, have	12	15[f]	16[af]	15[f]	15	11	15[f]	13
No, have NOT	87[c]	84	84	84	85	89[bc]	85	86
Don't know/ Refused	1	1	*	1	*	-	*	1

IV. Health Care Access Experiences

NP-23. In the past TWO years, have you scheduled a visit with a doctor or other health professional because you were sick or had a health concern, or have you not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, have scheduled a visit	58	58	67[abg]	66[abg]	67[abg]	66[abg]	57	62
No, have NOT scheduled a visit	41[cdef]	42[cdef]	33	34	32	34	43[cdef]	38[e]
Don't know/ Refused	1	-	*	*	1	*	*	*

(Asked of those who scheduled a visit with their doctor/health professional; Natl n =598; FL n = 595; KS n = 667; NJ n = 665; OH n = 662; OR n = 685; TX n = 599; WI n =645)

NP-24. Thinking about the last time you had to schedule a doctor's appointment because you were sick or had a health concern, how much time passed between when you made the appointment and when you actually saw a doctor? Would you say it was...?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Less than 24 hours	30[bef]	19	32[bdefh]	26[b]	23	21	28[bf]	24
About one to three days	33	30	36[f]	30	34	30	31	36
About four to seven days	13	20[a]	15	16	17	18[a]	15	16
More than one week	7	10	7	9	10	12[ac]	8	8
More than two weeks	6	7[c]	3	5	5	8[c]	5	4
More than three weeks	3	4	3	4	4	4	3	3
More than one month	8[c]	9[c]	4	9[c]	7[c]	6	9[c]	8[c]
Don't know/ Refused	*	1	*	1	*	1	1	1

(Asked of those who scheduled a visit with their doctor/health professional; Natl n =598; FL n = 595; KS n = 667; NJ n = 665; OH n = 662; OR n = 685; TX n = 599; WI n =645)

NP-25. Do you think the length of time you had to wait between scheduling the appointment and seeing a doctor was reasonable or unreasonable?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Reasonable	**83[d]**	**77**	**82[d]**	**75**	**78**	**77**	**78**	**81[d]**
Very reasonable	50	46	52	48	48	48	50	55[be]
Somewhat reasonable	33	31	30	27	30	29	28	26
Unreasonable	**17**	**23[ach]**	**17**	**23[ach]**	**21**	**22**	**21**	**17**
Somewhat unreasonable	10	10	10	10	12	12	9	8
Very unreasonable	7	13[ach]	7	13[ach]	9	10	12[ac]	9
Don't know/ Refused	*	*	1	2	1	1	1	2

NP-26. In the past TWO years, would you say it has gotten easier or gotten harder for you to see a doctor, or has it stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Easier	10[c]	9	6	8	8	8	12[cefh]	7
Harder	14	19[a]	17	16	17	17	18[a]	15
About the same	74[g]	70	75[bg]	74[g]	74[g]	73[g]	68	76[bg]
Don't know/ Refused	2	2	2	2	1	2	2	2

NP-27. Do you have a regular doctor or health care professional that provides most of your health care when you are sick or have a health concern, or do you not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, have a regular doctor	74[g]	70	81[abfg]	81[abfg]	82[abfg]	76[bg]	68	82[abfg]
No, do NOT have a regular doctor	25[cdeh]	30[acdefh]	18	19	18	23[ceh]	31[acdefh]	18
Don't know/ Refused	1	*	1	*	*	1	1	*

(Asked of those have a regular doctor/ health care professional; Natl n =793; FL n = 745; KS n = 846; NJ n = 809; OH n = 837; OR n = 805; TX n = 744; WI n =841)

NP-28. In the past TWO years, were there any times when you needed health care, but could not see your regular doctor or health care professional, or not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	22	19	24	22	22	27[bde]	23	26[b]
No	78[f]	80[fh]	76	78[f]	78[f]	72	76	73
Don't know/ Refused	*	1	*	*	*	1	1	1

(Asked of those who when needed health care, could not see their regular doctor/health care professional; Natl n =158; FL n = 146; KS n = 193; NJ n = 163; OH n = 182; OR n = 226; TX n = 158; WI n =208)

NP-29. Please tell me if each of the following was or was not a reason why you could not see your regular doctor or health care professional. How about (INSERT ITEM)? Was that a reason you could not see your regular doctor or health care professional, or not?

NP-29 Summary Table: % who said each of the following was a reason
Base: Those who when needed health care, could not see their regular doctor/health

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
a. You could not afford the visit	24[h]	24[h]	23[h]	24[h]	22	17	31[fh]	13
b. It was at night or on the weekend and the doctor's office was not open	46[f]	39	36	45[f]	46[fh]	32	43	33
c. The doctor did not have any available appointment times	52	55	64	58	57	55	58	61
d. The doctor was too far away or transportation was too difficult	15	16	14	17	14	12	22[fh]	11
e. You lost your insurance coverage	12	26[aceh]	13	18	14	15	18	11
f. The doctor stopped taking your insurance	14[f]	22[cfh]	9	17[f]	13[f]	6	21[cfh]	9
g. Your regular doctor was away from the office	42	44	54[dg]	38	43	56[adeg]	37	62[abdeg]

(Asked of those who when needed health care, could not see their regular doctor/health care professional; Natl n = 158; FL n = 146; KS n = 193 NJ n = 163; OH n = 182; OR n = 226; TX n = 158; WI n =208)

NP-30. At any time when you were not able to see your regular doctor, were you able to get health care from a different doctor or health professional, or not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, was able to get health care from a different doctor	80[g]	69	82[bdg]	71	87[bdg]	83[bdg]	64	90[abdg]
No, was NOT able to get health care from a different doctor	17	30[acefh]	18[h]	28[efh]	12	16	35[acefh]	9
Don't know/ Refused	3	1	*	1	1	1	1	1

(Asked of those who when needed health care, could not see their regular doctor/health care professional but were able to get care from a different doctor or health professional; Natl n = 119; FL n = 104; KS n = 157; NJ n = 119; OH n = 149; OR n = 193; TX n = 107; WI n =180)

NP-31. At any time when you were not able to see your regular doctor, were you able to get care at any of the following locations, or not?

NP-31 Summary Table: % who said they got care at the following locations
Base: Those who when needed health care, could not see their regular doctor/health but were able to get care from a different doctor or health professional

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
a. At your regular doctor's office, but with a different doctor	56	51	73[abde]	57	51	71[abde]	61	81[abdeg]
b. At a different doctor's office or clinic in the hospital	37	41	32	46[c]	32	40	47[ce]	45[c]
c. At an urgent care facility	60	46	56	62	65[b]	68[b]	65[b]	58
d. In the emergency room	70[bcdfh]	49	49	53	57	54	61	55
e, At a retail or drug-store mini-clinic	27[f]	28[f]	24[f]	20[f]	33[dfh]	9	27[f]	17

V. Hospitalization Experiences

NP-32. In the past TWO years, have you been hospitalized overnight, or has this not happened to you?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	18	22[f]	18	21[f]	21[f]	15	19	22[f]
No	81	78	81	79	78	85[bdeh]	81	78
Don't know/ Refused	1	*	1	*	1	-	*	*

(Asked of those who have been hospitalized overnight in the past two years; Natl n = 211; FL n = 216; KS n = 193; NJ n = 200; OH n = 236; OR n = 182; TX n = 217; WI n =211)

NP-33. Thinking about the most recent time you were hospitalized, how would you rate the quality of health care you received? Would you say it was excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**78**	**79**	**84[d]**	**69**	**80**	**82[d]**	**77**	**78**
Excellent	46	50[d]	50[d]	35	47	49[d]	44	51[d]
Good	32	29	34	34	33	33	33	27
Fair/Poor	**22**	**21**	**15**	**31[cf]**	**20**	**17**	**21**	**22**
Fair	18	14	10	21[cef]	11	10	14	16
Poor	4	7	5	10	9	7	7	6
Don't know/ Refused	*	*	1	-	-	1	2	-

(Asked of those who have been hospitalized overnight in the past two years; Natl n = 211; FL n = 216; KS n = 193; NJ n = 200; OH n = 236; OR n = 182; TX n = 217; WI n =211)

NP-34. What about the cost of the health care you received the most recent time you were hospitalized? Would you say it was reasonable or unreasonable?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Reasonable	**65**	**64**	**60**	**58**	**56**	**60**	**61**	**58**
Very reasonable	27	37	30	26	30	34	31	29
Somewhat reasonable	38[e]	27	30	32	26	26	29	29
Unreasonable	**30**	**31**	**36**	**33**	**39**	**28**	**36**	**33**
Somewhat unreasonable	10	7	13	8	13	11	17[bd]	15[b]
Very unreasonable	20	24	23	25	26	17	19	18
Don't know/ Refused	5	5	4	9	5	12	3	9

(Asked of those who have been hospitalized overnight in the past two years; Natl n = 211; FL n = 216; KS n = 193; NJ n = 200; OH n = 236; OR n = 182; TX n = 217; WI n =211)

NP-35. During your most recent hospital stay, did you feel your views and preferences were taken into account by the doctors and other health professionals treating you, or were they not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, views and preferences were taken into account by doctors	81	82	83	79	83	87	78	84
No, views and preferences were NOT taken into account by doctors	17	16	15	20[f]	15	10	19	16
Don't know/ Refused	2	2	2	1	2	3	3	*

(Asked of those who have been hospitalized overnight in the past two years; Natl n = 211; FL n = 216; KS n = 193; NJ n = 200; OH n = 236; OR n = 182; TX n = 217; WI n =211)

NP-36. Please rate how well you feel the staff prepared you for the care you would need after leaving the hospital. Would you say the preparation was excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**79**	**83**	**82**	**74**	**82**	**78**	**80**	**81**
Excellent	37	45	50[ad]	34	48[d]	40	48[d]	56[adf]
Good	42[h]	38[h]	32	40[h]	34	38[h]	32	25
Fair/Poor	**21**	**17**	**18**	**25**	**18**	**20**	**19**	**19**
Fair	14	9	14	16	13	10	11	8
Poor	7	8	4	9	5	10[c]	8	11[c]
Don't know/ Refused	*	*	-	1	-	2	*	-

VI. Emergency Room Experiences

NP-37. In the past TWO years, have you received health care in the **emergency room** of a hospital, or has this not happened to you?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, received health care in the emergency room	33	32	32	35[g]	39[abcfgh]	31	28	33
No, did not receive health care in the emergency room	66[e]	67[e]	67[e]	65	61	68[e]	71[deh]	66[e]
Don't know/ Refused	1	1	1	*	-	1	1	1

(Asked of those who received care in the emergency room in the past two years; Natl n =327; FL n = 308; KS n = 309; NJ n = 347; OH n = 378; OR n = 341; TX n = 287; WI n =332)

NP-38. Thinking about the most recent time you were a patient in the emergency room, how would you rate the quality of health care you received? Would you say it was excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**72**	**74**	**73**	**66**	**71**	**78[dg]**	**67**	**78[dg]**
Excellent	38	34	40	34	37	43[g]	33	44[g]
Good	34	40	33	32	34	35	34	34
Fair/Poor	**27**	**24**	**27**	**33[fh]**	**29**	**21**	**32[fh]**	**22**
Fair	17	14	14	19[f]	17	12	14	12
Poor	10	10	13	14	12	9	18[abfh]	10
Don't know/ Refused	1	2	*	1	*	1	1	-

(Asked of those who received care in the emergency room in the past two years; Natl n = 327; FL n = 308; KS n = 309; NJ n = 347; OH n = 378; OR n = 341; TX n = 287; WI n =332)

NP-39. What about the cost of the health care you received the most recent time you were a patient in the emergency room? Would you say it was reasonable or unreasonable?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Reasonable	**58**	**58**	**49**	**50**	**56**	**59[c]**	**54**	**62[cd]**
Very reasonable	29	27	24	23	30	32	27	23
Somewhat reasonable	29	31	25	27	26	27	27	39[acdefg]
Unreasonable	**36**	**38**	**43[fh]**	**43[fh]**	**38**	**32**	**37**	**32**
Somewhat unreasonable	16	10	18[bd]	11	17[b]	12	14	15
Very unreasonable	20	28[h]	25	32[aefh]	21	20	23	17
Don't know/ Refused	6	4	8	7	6	9	9	6

(Asked of those who received care in the emergency room in the past two years; Natl n = 327; FL n = 308; KS n = 309; NJ n = 347; OH n = 378; OR n = 341; TX n = 287; WI n =332)

NP-40. What was the MAIN purpose of your most recent visit to an emergency room? Was it…?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
To get treatment for a major health problem (like a broken bone, cut or high fever)	40	49[g]	49[g]	52[ag]	42	48[g]	38	50[ag]
To get treatment for a minor health problem (like a sprain or toothache)	23	19	25	20	23	23	27	23
Some other reason	36[ch]	30	26	27	35[c]	28	34	27
Don't know/ Refused	1	2	*	1	-	1	1	*

(Asked of those who received care in the emergency room in the past two years; Natl n = 327; FL n = 308; KS n = 309; NJ n = 347; OH n = 378; OR n = 341; TX n = 287; WI n =332)

NP-41. What is the MAIN reason you chose to receive health care in the emergency room instead of at an urgent care facility, doctor's office, or community health center? Was it mainly because…?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
You were brought to the emergency room by an ambulance	18[h]	16	11	18[h]	14	16	12	11
Other facilities were not open or you could not get an appointment	28[bdg]	16	35[bdeg]	18	23	27[bdg]	17	31[bdg]
You felt other facilities did not have the staff or equipment necessary to treat your health problem	11	9	11	11	8	9	8	6
You thought you might need to be admitted to the hospital overnight	11	12	10	14	9	11	11	10
You felt the emergency room was the only place that would treat you	16[c]	14	8	12	11	13	17[c]	13
Other facilities were too far away	3	8[a]	4	7[a]	8[a]	4	6	7[a]
Some other reason	12	22[a]	19	20[a]	24[a]	19	25[a]	21[a]
Don't know/ Refused	1	3	2	*	3	1	3	1

(Asked of those who received care in the emergency room in the past two years; Natl n = 327; FL n = 308; KS n = 309; NJ n = 347; OH n = 378; OR n = 341; TX n = 287; WI n =332)

NP-42. In the past TWO years has your use of the emergency room when you need health care gone up, gone down, or stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Gone up	23[ef]	19	25[ef]	23[ef]	13	13	20	21[ef]
Gone down	10	11	11	11	9	11	8	9
Stayed about the same	63	64	58	61	72[acdh]	68[c]	66	63
Don't know/ Refused	4	6	6	5	4	8	6	7

(Asked of those who received care in the emergency room in the past two years; Natl n = 327; FL n = 308; KS n = 309; NJ n = 347; OH n = 378; OR n = 341; TX n = 287; WI n =332)

NP-43. Please rate how well you feel the staff prepared you for the care you would need after leaving the emergency room. Would you say the preparation was excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**71**	**73**	**77**	**68**	**73**	**77**	**72**	**83[abdeg]**
Excellent	38	31	36	31	33	41	35	41[bd]
Good	33	42	41	37	40	36	37	42
Fair/Poor	**29[h]**	**25**	**22**	**30[h]**	**27[h]**	**21**	**27[h]**	**17**
Fair	20[f]	13	14	20[bfh]	19	12	19	12
Poor	9	12[h]	8	10	8	9	8	5
Don't know/ Refused	*	2	1	2	*	2	1	-

VII. Urgent Care Experiences

NP-44. An urgent care facility is a place that is not an emergency room, and that provides immediate medical care for illnesses and injuries which may be serious, but are not life-threatening and do not require hospitalization. In the past TWO years, have you received health care at an urgent care facility?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	27	24	23	28[c]	28[c]	33[abcg]	25	29[bc]
No	72[f]	75[f]	77[defh]	72	71	67	74[f]	70
Don't know/ Refused	1	1	*	*	1	*	1	1

(Asked of those who received care in an urgent care facility in the past two years; Natl n = 249; FL n = 235; KS n = 231; NJ n = 257; OH n = 261; OR n = 323; TX n = 236; WI n =293)

NP-45. Thinking about your most recent visit to an urgent care facility, how would you rate the quality of health care you received? Would you say it was excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**75**	**79**	**78**	**86[afg]**	**79**	**76**	**75**	**81**
Excellent	29	38	33	42[a]	38	36	34	39
Good	46	41	45	44	41	40	41	43
Fair/Poor	**25[d]**	**20**	**20**	**14**	**21**	**23[d]**	**25[d]**	**19**
Fair	19	15	15	12	13	15	18	14
Poor	6	5	5	2	8[d]	8[d]	7[d]	5
Don't know/ Refused	-	1	2	-	-	1	-	-

(Asked of those who received care in an urgent care facility in the past two years; Natl n = 249; FL n = 235; KS n = 231; NJ n = 257; OH n = 261; OR n = 323; TX n = 236; WI n =293)

NP-46. What about the cost of the health care you received during your most recent visit to an urgent care facility? Would you say it was reasonable or unreasonable?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Reasonable	**74**	**67**	**78[b]**	**77[b]**	**75**	**78[b]**	**76**	**70**
Very reasonable	33	32	37	35	43[bh]	37	37	30
Somewhat reasonable	41	35	41	42	32	41	39	40
Unreasonable	**21**	**29[cdf]**	**19**	**15**	**21**	**16**	**23**	**24[df]**
Somewhat unreasonable	11	15[d]	12	7	10	10	16[d]	16[d]
Very unreasonable	10	14[fg]	7	8	11	6	7	8
Don't know/ Refused	5	4	3	8	4	6	1	6

(Asked of those who received care in an urgent care facility in the past two years; Natl n = 249; FL n = 235; KS n = 231; NJ n = 257; OH n = 261; OR n = 323; TX n = 236; WI n =293)

NP-47. What was the MAIN purpose of your most recent visit to an urgent care facility? Was it mainly…?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
To get treatment for a minor wound or illness (like a sprain or sore throat)	60[b]	46	56	52	52	51	55	56
To get treatment for a major wound or illness (like a broken bone or high fever)	15	18	16	15	16	18	11	17
To get a routine screening, test, exam or vaccination	4	11[ah]	5	7	6	7	7	5
To get a prescription or treatment for a long-term health condition	4	3	6	5	6	6	9	4
Some other reason	15	22	16	19	20	17	18	17
Don't know/ Refused	2	-	1	2	*	1	*	1

(Asked of those who received care in an urgent care facility in the past two years; Natl n = 249; FL n = 235; KS n =231; NJ n = 257; OH n = 261; OR n = 323; TX n = 236; WI n =293)

NP-48. What is the MAIN reason you chose to receive health care at an urgent care facility instead of a hospital, doctor's office, or community health center? Was it mainly because…?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
You considered the hours to be more convenient	17	19	28[af]	22	19	18	20	25
You considered the location to be more convenient	21	20	19	21	20	23	28[h]	17
You felt more comfortable with the staff	2	1	2	2	2	2	4	5[b]
You considered the quality of health care to be better	2	3	1	4	1	4	2	3
You considered the cost to be more affordable	13	14[cgh]	7	8	9	12	7	7
You thought it would take less time to be seen and treated	22	24	16	23	25	17	22	17
Some other reason	20	19	26[g]	20	21	22	16	24
Don't know/ Refused	3	*	1	*	3	2	1	2

(Asked of those who received care in an urgent care facility in the past two years; Natl n = 249; FL n = 235; KS n = 231; NJ n = 257; OH n = 261; OR n = 323; TX n = 236; WI n =293)

NP-49. In the past TWO years has your use of urgent care facilities when you need health care gone up, gone down, or stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Gone up	17	17	22	28[abefh]	15	18	25[eh]	16
Gone down	7[d]	6[d]	5	2	8[d]	7[d]	9[d]	7[d]
Stayed about the same	72	73	70	65	75[dg]	70	64	72
Don't know/ Refused	4	4	3	5	2	5	1	5

VIII. Retail or Drug-Store Mini-Clinic Experiences

NP-50. In the past TWO years, have you received health care at a retail or **drug-store mini-clinic**?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	12[h]	15[h]	13[h]	13[h]	16[h]	NA	13[h]	9
No	87	85	86	86	84	NA	86	90[bcdeg]
Don't know/ Refused	1	*	1	1	*	NA	1	1

(Asked of those who received care at a mini-clinic in the past two years; Natl n = 123; FL n = 148; KS n = 153; NJ n = 138; OH n = 156; TX n = 134; WI n = 97)

NP-51. Thinking about your most recent visit to a retail or drug-store mini-clinic, how would you rate the quality of health care you received? Would you say it was excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**89**	**85**	**82**	**82**	**80**	**NA**	**84**	**89**
Excellent	33	44	34	37	40	NA	48	43
Good	56[eg]	41	48	45	40	NA	36	46
Fair/Poor	**11**	**15**	**18**	**18**	**19**	NA	**16**	**11**
Fair	10	12	15	18	16	NA	16	11
Poor	1	3	3	*	3	NA	*	-
Don't know/ Refused	-	-	-	*	1	NA	-	-

(Asked of those who received care at a mini-clinic in the past two years; Natl n = 123; FL n = 148; KS n = 153; NJ n = 138; OH n = 156; TX n = 134; WI n = 97)

NP-52.What about the cost of the health care you received during your most recent visit to a retail or drug-store mini-clinic? Would you say it was reasonable or unreasonable?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Reasonable	**92**	**85**	**88**	**85**	**86**	**NA**	**91**	**92**
Very reasonable	52	47	43	56	50	NA	46	66[bcg]
Somewhat reasonable	40	38	45[dh]	29	36	NA	46[dh]	26
Unreasonable	**7**	**13**	**10**	**13**	**11**	NA	**9**	**4**
Somewhat unreasonable	6	8	5	10	6	NA	7	4
Very unreasonable	1	5	5	3	5	NA	2	-
Don't know/ Refused	1	2	2	2	3	NA	*	4

NA = There are no listed mini-clinics in Oregon.

(Asked of those who received care at a mini-clinic in the past two years; Natl n = 123; FL n = 148; KS n = 153; NJ n = 138; OH n = 156; TX n = 134; WI n = 97)

NP-53. What was the MAIN purpose of your most recent visit to a retail or drug-store mini-clinic? Was it mainly…?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
To get a vaccine	33	35	37	46	39	NA	39	41
To get a physical exam	5	8	6	9	7	NA	8	6
To get a health screening or test	3	7	4	2	6	NA	5	8
To get treatment for a minor wound or skin condition	10	6	8	3	9	NA	8	4
To get treatment for a minor illness	21	16	29[b]	23	27	NA	21[f]	18[f]
To get a prescription or treatment for an long-term health condition	18[ce]	13[e]	5	12	5	NA	9	16[ce]
Some other reason	9	13[d]	10	3	6	NA	9	7
Don't know/ Refused	1	2	1	2	1	NA	1	*

NA = There are no listed mini-clinics in Oregon.

(Asked of those who received care at a mini-clinic in the past two years; Natl n = 123; FL n = 148; KS n = 153; NJ n = 138; OH n = 156; TX n = 134; WI n = 97)

NP-54. What is the MAIN reason you chose to receive health care at a retail or drug-store mini-clinic instead of a hospital, doctor's office, or urgent care facility? Was it mainly because…?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
You considered the hours to be more convenient	21[b]	9	17	20	25[b]	NA	16	17
You considered the location to be more convenient	26	32	24	34	30	NA	29	25
You felt more comfortable with the staff	2	3	2	2	3	NA	2	6
You considered the quality of health care to be better	1	*	3	2	*	NA	3	6[be]
You considered the cost to be more affordable	18[de]	9	14	8	8	NA	20[bde]	24[bde]
You thought it would take less time to be seen and treated	18	28[cdgh]	16	15	20	NA	15	12
Some other reason	13	14	24[h]	18	14	NA	14	10
Don't know/ Refused	1	5	*	2	-	NA	1	*

(Asked of those who received care at a mini-clinic in the past two years; Natl n = 123; FL n = 148; KS n = 153; NJ n = 138; OH n = 156; TX n = 134; WI n = 97)

NP-55. In the past TWO years has your use of retail or drug-store mini-clinics when you need health care gone up, gone down, or stayed about the same?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Gone up	14	20	13	25[c]	19	NA	23	13
Gone down	11[bcd]	2	3	3	7	NA	4	3
Stayed about the same	72	73	81[g]	71	73	NA	68	78
Don't know/ Refused	3	5	3	1	1	NA	5	6

NA = There are no listed mini-clinics in Oregon.

IX. Health Insurance

NP-57. Are you, yourself, currently covered by any form of health insurance or health plan or do you not have health insurance at this time?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, covered by insurance	86[g]	82	85[g]	91[abcg]	92[abcg]	90[abcg]	79	92[abcg]
No, NOT covered by insurance	14[defh]	17[defh]	15[defh]	9	8	10	20[acdefh]	8
Don't know/ Refused	*	1	*	*	*	*	1	*

(Asked of those who are uninsured; Natl n = 106; FL n = 143; KS n = 118; NJ n = 96; OH n = 65; OR n = 85; TX n = 167; WI n = 72)

NP-58. What is the MAIN reason you do not currently have health insurance? Is it mainly because…?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
It is too expensive or you can't afford it	45	39	52	39	65[abd]	51	61[abd]	63[bd]
You don't believe you need it or you don't want it	12	17[d]	13[d]	3	8	10	11	15[d]
You can't get it or you were rejected because of poor health, illness, or age	2	5	7	3	-	*	5	1
You do not know how to get it	12[eh]	10[eh]	7	11[eh]	-	11[eh]	5	*
Some other reason	28	25	21	43[bcgh]	24	27	18	20
Don't know/ Refused	1	4	*	1	3	1	2	1

(Asked of those who are insured; Natl n = 891; FL n = 856; KS n = 885; NJ n = 905; OH n = 933; OR n = 921; TX n = 835; WI n = 934)

NP-61. Overall, how would you rate your health insurance coverage? Would you say it is excellent, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent/Good	**73**	**71**	**77[b]**	**72**	**74**	**76[b]**	**76[b]**	**78[bd]**
Excellent	33	34	34	36	32	37	34	34
Good	40	37	43[bd]	36	42[bd]	39	43[bd]	44[bd]
Fair/Poor	**25**	**27[fh]**	**22**	**27[fh]**	**25**	**21**	**22**	**21**
Fair	20	20	18	19	19	16	16	17
Poor	5	7[ch]	4	8[ch]	6	5	6	4
Don't know/ Refused	2	2	1	1	1	3	2	1

(Asked of those who are currently insured)

NP-62a. During the last two years, did you have health insurance ALL the time, or was there any time during the last two years when you DID NOT have any health coverage?

NP-57/NP-62a combo table
Base = Respondents age 18-64

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Continuously insured (have had insurance coverage all the time in the past two years)	71[bg]	61	72[bg]	76[abg]	76 [abg]	75 [bg]	64	79 [abcg]
Uninsured currently or at any time during the past two years	29[deh]	37[acdefh]	28[h]	23	23	25	36[acdefh]	20
DK/Ref	*	2	*	1	1	*	*	1

(Asked of those who are insured; Natl n = 891; FL n = 856; KS n = 885; NJ n = 905; OH n = 933; OR n = 921; TX n = 835; WI n = 934)

NP-63a. Thinking about your health insurance premium -- that is, the monthly, quarterly or yearly amount you pay for your insurance plan -- would you say it has increased, decreased, or stayed about the same over the past TWO years?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Increased	**45**	**44**	**53[abefg]**	**49[f]**	**44**	**40**	**45**	**50[f]**
Increased a lot	18	23[af]	26[af]	27[af]	22[a]	18	22	24[af]
Increased a little	27[bef]	21	27[bef]	22	22	22	23	26
Decreased	**4**	**3**	**5[g]**	**3**	**3**	**7[bdeg]**	**3**	**5**
Decreased a lot	3[e]	2	1	2	1	4[bcdeg]	2	2
Decreased a little	1	1	4[abdg]	1	2	3	1	3[d]
Stayed about the same	**46[ch]**	**47[cdh]**	**36**	**41**	**47[ch]**	**47[ch]**	**45[c]**	**40**
Don't know/ Refused	5	6	6	7	6	6	7[a]	5

(Asked of those who are insured; Natl n = 891; FL n = 856; KS n = 885; NJ n = 905; OH n = 933; OR n = 921; TX n = 835; WI n = 934)

NP-63b. Thinking about your health insurance co-pays and deductibles-- that is, the fixed fees you pay when you receive a service and the amount you personally have to pay before your insurance plan starts covering your services -- would you say they have increased, decreased, or stayed about the same over the past TWO years?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Increased	**35**	**32**	**34**	**35**	**34**	**30**	**31**	**37[fg]**
Increased a lot	15	18	18	19	19	15	16	17
Increased a little	20[befg]	14	16	16	15	15	15	20[be]
Decreased	**4**	**3**	**4**	**3**	**3**	**6[bdeg]**	**3**	**4**
Decreased a lot	2	2	3	1	2	4[abdegh]	1	2
Decreased a little	2	1	1	2	1	2	2	2
Stayed about the same	**56**	**56**	**57**	**55**	**58**	**58**	**61[h]**	**55**
Don't know/ Refused	5	9	5	7	5	6	5	4

(Asked of those who are insured; Natl n = 891; FL n = 856; KS n = 885 NJ n = 905; OH n = 933; OR n = 921; TX n = 835; WI n = 934)

NP-64. Thinking about your health insurance benefits -- that is, the health care services that your insurance plan pays for -- would you say they have increased, decreased, or stayed about the same over the past TWO years?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Increased	**16**	**19[f]**	**19[f]**	**20[fgh]**	**18[f]**	**13**	**15**	**15**
Increased a lot	7	8	8	9	8	7	7	6
Increased a little	9	11[f]	11[f]	11[f]	10[f]	6	8	9
Decreased	**12**	**10**	**10**	**10**	**12**	**10**	**11**	**11**
Decreased a lot	6	4	4	3	6	5	5	5
Decreased a little	6	6	6	7	6	5	6	6
Stayed about the same	**70**	**66**	**67**	**66**	**68**	**71**	**69**	**71[d]**
Don't know/ Refused	2	5	4	4	2	6	5	3

Insurance status/Source of insurance

NP-57. Are you, yourself, currently covered by any form of health insurance or health plan or do you not have health insurance at this time? **(Asked of those who are insured)** NP-59. Which of the following is your MAIN source of health insurance coverage (READ LIST)? **(Asked of insured respondents who purchased an insurance plan themselves)** NP60. Did you buy your health insurance plan through a state or federal health insurance exchange like healthcare.gov, or not?

NP-57/NP-59/NP-60 Combo Table
Base: Total Respondents

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, covered by insurance	**86[g]**	**82**	**85[g]**	**91[abcg]**	**92[abcg]**	**90[abcg]**	**79**	**92[abcg]**
A plan through employer	30[b]	22	32[b]	31[b]	29[b]	28[b]	30[b]	34[bef]
A plan through spouse's employer	10	8	13[b]	14[bfg]	13[bg]	10	10	13[b]
A plan purchased yourself	**5**	**11[acdegh]**	**7**	**5**	**6**	**9[ade]**	**7**	**6**
Bought insurance through a state or federal insurance exchange	1	4[ade]	3	1	2	3	3	2
Did not through a state or federal insurance exchange	4	6[adegh]	4	4	4	6[h]	4	3
Don't know where bought it	*	1	*	-	*	*	*	1
Medicare	18	21[cfgh]	17	19[g]	20[g]	16	14	17
Medicaid	9[cg]	8[c]	5	9[cg]	10[cg]	17[abcdegh]	6	11[bcg]
Some other government program (VA or Tricare)	6[h]	7[cdfh]	4	4	5	4	6[h]	3
Some other form of insurance	7	5	7	9	9	6	6	7
Don't know/ Refused	1	*	*	*	*	*	*	1
No, NOT covered by insurance	14[defh]	17[defh]	15[defh]	9	8	10	20[acdefh]	8
Don't know/ Refused	*	1	*	*	*	*	1	*

X. Perceptions of Health Care Value

NP-65. Thinking about both the cost and quality of the health care that you receive, do you think that you get good value for what you pay toward the cost of your health care, or not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	72	70	72	67	73[d]	76[bdg]	70	77[bcdg]
No	22	24	25[fh]	28[aefh]	23	20	26[fh]	20
Don't know/ Refused	6	6	3	5	4	4	4	3

XI. Perceptions of the Reasons for Rising Health Care Costs

NP-66. Do you think health care costs are a problem in [INSERT STATE], or don't you think they are? (If a problem, ask:) Would you say they are a major problem or a minor problem?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Major problem	52	56[g]	55[g]	59[aeg]	53[g]	55[g]	47	54[g]
Minor problem	16	13	15	14	15	14	16	18[b]
NOT a problem	25[d]	24[d]	22	19	24[d]	21	29[bcdefh]	21
Don't know/ Refused	7	7	8	8	8	10	7	7

NP-67. A number of things have been suggested as possible reasons for rising health care costs in [INSERT STATE] today. For each thing I mention, please tell me whether you feel it is a reason or not a reason for rising health care costs in [INSERT STATE] today. If you do not know enough about some of these things to have an opinion, just let me know. (If a reason, ask:) Is it a major reason or a minor reason?

(Asked of one-third sample X; Natl n = 316; FL n = 334; KS n = 330; NJ n = 336; OH n = 317; OR n = 348; TX n = 317; WI n = 350)

a. Insurance companies charging too much money

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	57	61	59	68[afg]	68[afg]	58	57	63
MINOR reason	14	11	21[bdefg]	11	13	11	12	15
NOT a reason	13	12	12	9	11	14	17[d]	14
Don't know/ Refused	16	16	8	12	8	17	14	8

(Asked of one-third sample Y; Natl n = 329; FL n = 326; KS n = 329; NJ n = 336; OH n = 326; OR n = 335; TX n = 340; WI n = 334)

b. Doctors charging too much money

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	40	38	36	43	42	37	42	40
MINOR reason	18	12	20[b]	24[b]	22[b]	20[b]	16	25[bg]
NOT a reason	25	28	30	21	22	25	28	25
Don't know/ Refused	17	22	14	12	14	18	14	10

(Asked of one-third sample X; Natl n = 316; FL n = 334; KS n = 330; NJ n = 336; OH n = 317; OR n = 348; TX n = 317; WI n = 350)

c. It is too hard for patients to find out the cost of a recommended treatment

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	27	33[g]	27	32	25	25	24	30
MINOR reason	17	15	29[abdfg]	15	23[bd]	16	18	21
NOT a reason	29	33	30	30	37	32	32	35
Don't know/ Refused	27	19	14	23	15	27	26	14

(Asked of one-third sample Z; Natl n = 357; FL n = 343; KS n = 346; NJ n = 331; OH n = 357; OR n = 326; TX n = 348; WI n = 327)

d. Most people with health insurance having little incentive to look for lower-priced doctors and services

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	26	33[cefh]	23	27	22	24	28	23
MINOR reason	16	15	20	22	26[ab]	18	23[b]	18
NOT a reason	35	29	35	34	32	35	32	35
Don't know/ Refused	23	23	22	17	20	23	17	24

(Asked of one-third sample X; Natl n = 316; FL n = 334; KS n = 330; NJ n = 336; OH n = 317; OR n = 348; TX n = 317; WI n = 350)

e. People not taking good care of their health, so many need more medical treatment

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	51	55[g]	56[g]	53	50	57[g]	45	54
MINOR reason	20	15	19	18	25[bfg]	16	17	21
NOT a reason	13	17	16	16	14	13	23[aef]	16
Don't know/ Refused	16	13	9	13	11	14	15	9

(Asked of one-third sample Y; Natl n = 329; FL n = 326; KS n = 329; NJ n = 336; OH n = 326; OR n = 335; TX n = 340; WI n = 334)

f. Medicare and Medicaid not doing enough to keep their costs down

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	32	34	33	33	28	26	30	30
MINOR reason	15	15	15	13	15	18	16	19
NOT a reason	26[f]	23	22	21	28[f]	17	25[f]	22
Don't know/ Refused	27	28	30	33	29	39	29	29

(Asked of one-third sample X; Natl n = 316; FL n = 334; KS n = 330; NJ n = 336; OH n = 317; OR n = 348; TX n = 317; WI n = 350)

g. Some well-known or large hospitals or doctor groups using their influence to get higher payments from insurance companies

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	38	42[fh]	37	44[fh]	43[fh]	33	37	30
MINOR reason	12	12	14	12	15	13	12	20[abdg]
NOT a reason	18	21[d]	19	13	17	19	24[d]	19
Don't know/ Refused	32	25	30	31	25	35	27	31

(Asked of one-third sample X; Natl n = 316; FL n = 334; KS n = 330; NJ n = 336; OH n = 317; OR n = 348; TX n = 317; WI n = 350)

h. Too much government regulation

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	37	45	58[abdfgh]	43	54[adfh]	40	46[a]	44
MINOR reason	19[beg]	9	16[b]	13	11	13	10	17[bg]
NOT a reason	21	23	18	22	17	25[e]	23	23
Don't know/ Refused	23	23	8	22	18	22	21	16

(Asked of one-third sample Z; Natl n = 357; FL n = 343; KS n = 346; NJ n = 331; OH n = 357; OR n = 326; TX n = 348; WI n = 327)

i. The population as a whole is getting older and older people require more medical services

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	43	50[efh]	44	50[efh]	38	35	49[ef]	40
MINOR reason	27[b]	16	26[b]	20	28[bg]	25[b]	20	27[b]
NOT a reason	18	25	21	23	26[a]	27[a]	22	25
Don't know/ Refused	12	9	9	7	8	13	9	8

(Asked of one-third sample Y; Natl n = 329; FL n = 326; KS n = 329; NJ n = 336; OH n = 326; OR n = 335; TX n = 340; WI n = 334)

j. People having to pay for free care for people who don't have health insurance

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	41	51[f]	48[f]	47[f]	47[f]	37	43	45
MINOR reason	15	15	15	19	21	22	14	22
NOT a reason	21	21	21	21	17	19	21	17
Don't know/ Refused	23	13	16	13	15	22	22	16

(Asked of one-third sample X; Natl n = 316; FL n = 334; KS n = 330; NJ n = 336; OH n = 317; OR n = 348; TX n = 317; WI n = 350)

k. Too much spending on expensive medical treatment for patients who have virtually no hope of recovery

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	25	30[h]	25	32[fh]	25	23	26	21
MINOR reason	18	19	15	18	18	19	13	19
NOT a reason	28	31	40[ad]	26	35	31	34	41[abdf]
Don't know/ Refused	29	20	20	24	22	27	27	19

(Asked of one-third sample Y; Natl n = 329; FL n = 326; KS n = 329; NJ n = 336; OH n = 326; OR n = 335; TX n = 340; WI n = 334)

l. Drug companies charging too much money

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	67[g]	64[g]	63[g]	64[g]	71[g]	69[g]	54	71[g]
MINOR reason	15[h]	9	12	13	14	11	15[h]	8
NOT a reason	7	15[aef]	13[a]	13	8	8	18[aefh]	10
Don't know/ Refused	11	12	12	10	7	12	13	11

(Asked of one-third sample Z; Natl n = 357; FL n = 343; KS n = 346; NJ n = 331; OH n = 357; OR n = 326; TX n = 348; WI n = 327)

m. Hospitals charging too much money

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	64	63	65	71[f]	67	58	69[f]	63
MINOR reason	12	10	14[d]	8	12	15[d]	9	18[bdg]
NOT a reason	13	12	10	10	11	11	11	11
Don't know/ Refused	11	15	11	11	10	16	11	8

(Asked of one-third sample Y; Natl n = 329; FL n = 326; KS n = 329; NJ n = 336; OH n = 326; OR n = 335; TX n = 340; WI n = 334)

n. The number of medical malpractice lawsuits

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	33	40[fgh]	32	46[acefgh]	32	25	28	29
MINOR reason	18	17	17	12	22[dg]	20[d]	15	17
NOT a reason	16	18	22	16	19	18	23[a]	24[a]
Don't know/ Refused	33	25	29	26	27	37	34	30

(Asked of one-third sample X; Natl n = 316; FL n = 334; KS n = 330; NJ n = 336; OH n = 317; OR n = 348; TX n = 317; WI n = 350)

o. People not getting the right diagnosis or treatment

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	27	33[f]	33	36[af]	28	24	28	30
MINOR reason	27[d]	21	22	16	25[d]	32[bcdgh]	20	23
NOT a reason	25	24	29	28	27	21	27	32[f]
Don't know/ Refused	21	22	16	20	20	23	25	15

(Asked of one-third sample X; Natl n = 316; FL n = 334; KS n = 330; NJ n = 336; OH n = 317; OR n = 348; TX n = 317; WI n = 350)

p. Fraud and abuse by some hospitals, doctors and nursing homes

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	35[fh]	48[acefgh]	36[fh]	48[acefgh]	34[fh]	25	38[fh]	25
MINOR reason	21	16	23	19	28[bdg]	25[b]	19	32[abcdg]
NOT a reason	18	15	23[bd]	14	20	20	21	26[bd]
Don't know/ Refused	26	19	18	19	18	30	22	17

(Asked of one-third sample Y; Natl n = 329; FL n = 326; KS n = 329; NJ n = 336; OH n = 326; OR n = 335; TX n = 340; WI n = 334)

q. People getting more expensive tests and services than they really need

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	35	41	39	43	41	35	37	36
MINOR reason	24[g]	18	24[g]	19	21	23[g]	14	25[g]
NOT a reason	23	18	22	23	23	24	25	21
Don't know/ Refused	18	23	15	15	15	18	24	18

(Asked of one-third sample Z; Natl n = 357; FL n = 343; KS n = 346; NJ n = 331; OH n = 357; OR n = 326; TX n = 348; WI n = 327)

r. Too much paperwork in the health care system

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	35	39[f]	35	40[f]	33	27	37[f]	32
MINOR reason	22	16	26[b]	22	25[b]	27[b]	24[b]	26[b]
NOT a reason	28	29	26	25	31	27	26	32
Don't know/ Refused	15	16	13	13	11	19	13	10

(Asked of one-third sample Z; Natl n = 357; FL n = 343; KS n = 346; NJ n = 331; OH n = 357; OR n = 326; TX n = 348; WI n = 327)

s. Too little government regulation of prices charged in health care

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	32	47[acf]	38	39	39	33	38	38
MINOR reason	15	10	14	10	14	12	18[bd]	17[bd]
NOT a reason	26	22	29	26	30	23	23	24
Don't know/ Refused	27	21	19	25	17	32	21	21

(Asked of one-third sample Z; Natl n = 357; FL n = 343; KS n = 346; NJ n = 331; OH n = 357; OR n = 326; TX n = 348; WI n = 327)

t. Patients' medical care not being well-coordinated, leading to duplication of test and treatments or necessary tests or treatments not being ordered at all

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	33	37[f]	31	42[cfh]	36[f]	25	44[acfh]	30
MINOR reason	21	17	23	20	23	22	18	27[bg]
NOT a reason	22	20	25	19	25	31[abdg]	19	26
Don't know/ Refused	24	26	21	19	16	22	19	17

(Asked of one-third sample Y; Natl n = 329; FL n = 326; KS n = 329; NJ n = 336; OH n = 326; OR n = 335; TX n = 340; WI n = 334)

u. Patients are afraid to discuss cost when doctors outline treatment options

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	22	28[cefgh]	16	29[cefgh]	18	19	18	18
MINOR reason	21	20	20	23	24	19	18	24
NOT a reason	28	28	39[abd]	28	32	36	38[abd]	33
Don't know/ Refused	29	24	25	20	26	26	26	25

(Asked of one-third sample Z; Natl n = 357; FL n = 343; KS n = 346; NJ n = 331; OH n = 357; OR n = 326; TX n = 348; WI n = 327)

v. Doctors do not share cost information when outlining treatment options

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
MAJOR reason	26[f]	36[af]	27[f]	33[f]	28[f]	18	28[f]	27[f]
MINOR reason	19	14	19	20	22[b]	17	22[b]	18
NOT a reason	27	25	26	25	28	34[g]	24	32
Don't know/ Refused	28	25	28	22	22	31	26	23

XII. Health Demographics

NP-7. Do you currently take any prescription medicine on a regular basis, or do you not regularly take prescription medicine?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, take prescription medicine on a regular basis	48	50[g]	53[fg]	50	58[abdfgh]	48	44	51[g]
No, do NOT take prescription medicine regularly	51[e]	50[e]	47	50[e]	41	52[ce]	56[bceh]	49[e]
Don't know/ Refused	1	*	-	*	1	*	-	*

NP-8. In general, would you say your health is excellent, very good, good, fair, or poor?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Excellent	20	22[e]	19	20	17	21[e]	21[e]	18
Very good	26	26	28[g]	26	28[g]	29[g]	22	31[bg]
Good	29	29	28	34	30	31	32	33
Fair	19[dfh]	15	19[dfh]	14	18[h]	14	20[bdfh]	13
Poor	5	7	5	6	6	5	4	5
Don't know/ Refused	1	1	1	-	1	*	1	*

NP-68. In the past TWO years, have you had a serious medical condition, illness, injury, or disability that has required a lot of medical care, or not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	22	25[g]	24[g]	22	25[g]	27[adg]	19	26[g]
No	78[f]	74	75	77	74	73	80[bcefh]	74
Don't know/ Refused	*	1	1	1	1	*	1	*

NP-8/NP-68 Combo Table: "SICK" = Currently in fair or poor health OR have in the past two years had a serious medical condition, illness, injury, or disability that has required a lot of medical care, or not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Sick	36	36	38	33	37	35	34	33
Not sick	64	64	62	67	63	65	66	67

NP-56. Has a doctor or other health care professional ever told you that you have a chronic illness, such as heart disease, lung disease, cancer, diabetes, high blood pressure, asthma or a mental health condition, or haven't they?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	34	39[g]	39[g]	37	41[ag]	41[ag]	33	37
No	65[ef]	61	61	63	58	59	67[bcef]	62
Don't know/ Refused	1	*	*	*	1	*	*	1

XIII. Demographics

Gender

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Male	48	48	49	48	48	49	50	49
Female	52	52	51	52	52	51	50	51

NP-69. Have you been living in [STATE] for the past two years, or have you moved there more recently than that?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes, living for the past 2 years	90	90	94[ab]	95[ab]	96[abg]	94[ab]	93[ab]	95[ab]
No, move there more recently	10[cdefgh]	10[cdefgh]	6	5	4	6	6	5
Don't know/ Refused	*	-	-	*	-	-	1	*

Z-4. Currently, are you yourself employed full-time, part-time, or not at all?
(Asked of those who are not employed)
Z-5. Are you retired, a homemaker, a student, temporarily unemployed, or disabled or handicapped?

Z-4/Z-5 Combo Table
Base: Total Respondents

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Employed full-time	46	41	48[b]	48[b]	43	43	48[b]	47[b]
Employed part-time	12	14	16[ag]	13	17[ag]	16[ag]	12	15
Not employed	**41[c]**	**44[cdh]**	**35**	**38**	**40**	**40**	**40**	**37**
Retired	19	22[dg]	18	16	20[g]	20[g]	15	20[g]
A homemaker	6[h]	6[h]	5	6	8[h]	6[h]	8[h]	4
A student	4[ch]	4[ch]	2	5[ceh]	3	4[h]	4[h]	1
Temporarily unemployed	7[e]	6	5	7[e]	4	5	7[e]	6
Disabled/handicapped	5	6	5	4	5	5	5	5
Other	*	*	*	*	*	1	1[a]	1
Refused	1	1	1	*	-	*	*	1

Z-2. Martial status

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Single, that is never married	21	21	19	24[c]	21	21	23	23
Living with a partner	7	7	7	7	9[h]	7	7	6
Married	51	49	57[b]	52	52	51	53	54[b]
Separated	3[h]	3[h]	2	3[h]	2	2	3[h]	1
Widowed	5	7	6	5	6	7	5	6
Divorced	10	13[dg]	10	8	10	10	8	10
Refused	3	*	*	1	*	2	1	*

Z-11b Are you registered to vote at your present address, or not?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Yes	75[g]	71	76[g]	74[g]	82[abcdg]	78[bg]	67	79[bg]
No	24[e]	26[efh]	23[e]	24[e]	18	20	31[abcdefh]	21
Don't know/ Refused	1	3	1	2	*	2	2	*

Z-11a Generally speaking, do you usually think of yourself as a Republican, a Democrat, or an Independent?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Republican	21[d]	23[df]	29[abdfgh]	16	26[adfh]	19	24[df]	20[d]
Democrat	32[c]	31[c]	25	31[c]	28	31[c]	28	29
Independent	39	35	36	38	37	39	35	40
Other (vol)	*	2[ad]	2[ad]	1	1	2[a]	2[a]	1
Don't know/ Refused	8	9	8	14	8	9	11	10

(Asked of those who say they are independent, have no preference, other party, or Don't know/Refused)
D8a. Do you LEAN more towards the (Democratic Party) or the (Republican Party)?

Z-11a/D8a Combo Table
Base: Total Respondents

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Republican (including leaners)	33[d]	35[d]	42[abdfgh]	26	37[d]	32[d]	35[d]	34[d]
Democrat (including leaners)	49[ceg]	45[c]	36	48[ceg]	42	46[c]	41	44[c]
Independent/Don't lean	15	14	17	18	17	17	17	18
Other (vol)	*	1	1[h]	1	1[h]	*	1	*
Don't know/ Refused	3	5[a]	4	7	3	5	6	4

Z-7. What is your age?
Z-7a. Could you please tell me if you are ...?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
18-29	21	19	21	19	19	19	23[bef]	19
30-49	33	31	33	35	33	34	36[b]	33
50-64	26	26	26	27	28	27	25	28
65+	19	24[acdg]	18	18	20[g]	20[g]	15	19
Refused	1	*	2	*	*	*	*	*

Z-8. What is the last grade of school you completed?

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
High School Graduate or less (NET)	**46[c]**	**45[c]**	**38**	**41**	**46[c]**	**46[c]**	**46[c]**	**44[c]**
Less than High school graduate	12[h]	12[h]	9	10	11	12	17[abcdefh]	9
High school graduate	32[cg]	29	26	29	34[cdg]	33[cg]	26	31[cg]
Business, tech/vocational school	1	3[aef]	3[e]	2[e]	1	1	3[e]	4[aef]
Some college or more (NET)	**54**	**54**	**61[abefgh]**	**58**	**54**	**53**	**54**	**56**
Some college (including associate's degree)	24	29[df]	32[adf]	23	29[df]	23	29[df]	29[df]
Graduated college	20	16	18	20[e]	16	19	17	18
Graduate school or more	10	10	11[g]	15[abcefgh]	9	11[g]	8	9
Refused	*	1	*	1	1	1	1	*

Z-10. Are you of Hispanic origin or background?
Z-11. Do you consider yourself white, black or African American, Asian, Native American, Pacific Islander, mixed race or some other race?

Race/Ethnicity Summary Table
Base: Total Respondents

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
White (non-Hispanic)	63[bg]	58[g]	79[abdg]	58[g]	81[abdg]	79[abdg]	48	85[abcdfg]
Black (non-Hispanic)	11[cfh]	13[cfh]	5[f]	12[cfh]	11[cfh]	1	11[cfh]	5[f]
Hispanic	15[cefh]	22[acdefh]	9[eh]	16[cefh]	3	10[eh]	34[abcdefh]	5
Asian	3[ceh]	1	1	5[abcefgh]	*	1	2[e]	1
American-Indian/ Alaska-Native	2[e]	1	2[eg]	1	*	2[bdegh]	1	1
Native Hawaiian/ Pacific Islander	*	*	-	*	-	*	*	*
Other/Mixed	3	2	3	4[bh]	2	3	3	2
Don't know/ Refused	2	3	1	3	2	2	1	2

Income Summary

	Natl (a)	FL (b)	KS (c)	NJ (d)	OH (e)	OR (f)	TX (g)	WI (h)
Less than $50,000	**47[d]**	**57[ad]**	**51[d]**	**41**	**54[ad]**	**57[acd]**	**54[ad]**	**52[ad]**
Less than $25,000 unspecified	-	*	*	1[a]	1[a]	1	1[a]	1[a]
Less than $15,000	14	15[d]	15	12	14	15	18[ade]	15
$15,000 but less than $25,000	9	14[a]	13[a]	13	15[a]	16[a]	13[a]	12
$25,000 but less than $30,000	7[d]	8[d]	7[d]	4	6	7	9[d]	7
$30,000 but less than $40,000	9[d]	10[d]	8	5	9[d]	10[d]	7	9[d]
$40,000 but less than $50,000	7	7[g]	7[g]	6	7[g]	7[g]	4	8[g]
Less than $50,000 (unspecified	-	2[a]	1[a]	1[a]	1[a]	2[a]	2[a]	1[a]
$50,000 but less than $100,000	**24**	**20**	**28[bdfg]**	**23**	**25[bfg]**	**19**	**20**	**26[bfg]**
$50,000 but less than $100,000 (unspecified)	1	*	1	1	*	*	*	*
$50,000 but less than $75,000	12	12	17[abdfg]	11	13	10	11	16[bdfg]
$75,000 but less than $100,000	11	8	11	11	11[b]	9	8	10
$100,000 and over	**16[e]**	**14**	**13**	**26[abcefgh]**	**11**	**16[e]**	**16[e]**	**14**
$100,000 and over (unspecified)	*	1	1	1	*	*	1	1
$100,000 but less than $150,000	10[e]	8	8	13[bcegh]	7	10[e]	8	9
$150,000 but less than $200,000	2	2	3	5[abefh]	3	2	4[abh]	2
$200,000 but less than $250,000	2	1	1	3[be]	1	2	2	1
$250,000 and over	1	2[e]	1	4[abcefgh]	1	1	2	1
Don't know	6	4	2	3	3	3	4	1
Refused	8	5	5	7	6	5	6	6

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February 2016 | Issue Brief

A Closer Look at the Remaining Uninsured Population Eligible for Medicaid and CHIP

Robin Rudowitz, Samantha Artiga, Anthony Damico, and Rachel Garfield

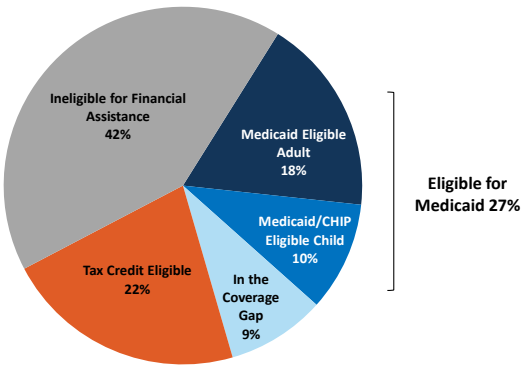
The Affordable Care Act (ACA) extends health insurance coverage to people who lack access to an affordable coverage option. Under the ACA, as of 2014, Medicaid coverage is extended to low-income adults up to 138% of the Federal Poverty Level (FPL) in states that have opted to expand eligibility, and 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. Recent analysis shows that 27% or 8.8 million of the 32.3 million non-elderly uninsured are eligible for Medicaid coverage. This issue brief provides a closer look at key characteristics of the uninsured who are eligible for Medicaid and where they live. Analysis is based on state Medicaid expansion decisions as of January 2016 which includes Louisiana's decision to adopt the expansion. These data may help inform outreach and enrollment efforts to increase coverage gains among the eligible but uninsured population.

How many uninsured are eligible for Medicaid or CHIP?

Of the total 32.3 million nonelderly people who remained uninsured as of 2015, an estimated 27% (8.8 million) are eligible for Medicaid or the Children's Health Insurance Program (CHIP). This 27% (8.8. million) includes 18% (5.7 million) who are Medicaid-eligible adults and 10% (3.2 million) who are Medicaid or CHIP-eligible children (Figure 1). The uninsured and eligible for Medicaid and CHIP (referred to as the uninsured and eligible for the rest of this brief) include both adults made newly eligible for the program by the expansion and individuals who were already eligible under pre-ACA rules but had not enrolled. Among the remaining uninsured, 9% fall into the "coverage gap" because they live in one of the 19 states that have not adopted the Medicaid expansion and the ACA does not provide financial assistance to people below poverty for other coverage options. Another 22% of the uninsured may be eligible for tax credits. This group includes individuals with incomes between 100 and 138% FPL in states that have not adopted the Medicaid expansion.

Figure 1

8.8 million or 27% of the uninsured are eligible for Medicaid or CHIP.

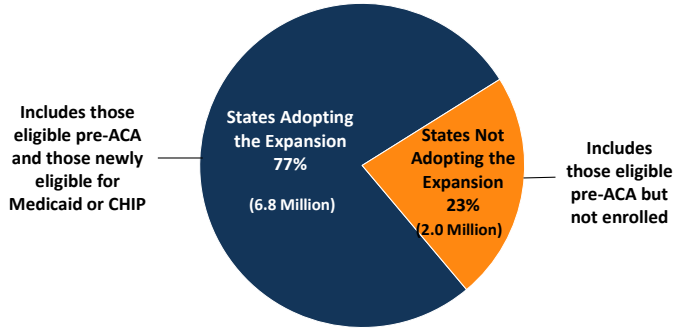


NOTES: Numbers may not sum to subtotals or 100% due to rounding. Tax Credit Eligible share includes adults in MN and NY who are eligible for coverage through the Basic Health Plan.
SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Most of the 8.8 million uninsured and eligible (77%, or 6.8 million people) reside in states that are expanding their Medicaid programs for adults, as these states have higher income eligibility for adults than non-expansion states (Figure 2). The other quarter (23%, or 2.0 million people) are in states that have not expanded Medicaid, but are eligible for Medicaid or CHIP under pathways in place before the ACA.

Figure 2

More than 3 out of 4 of the uninsured and eligible for Medicaid or CHIP live in states moving forward with the expansion.



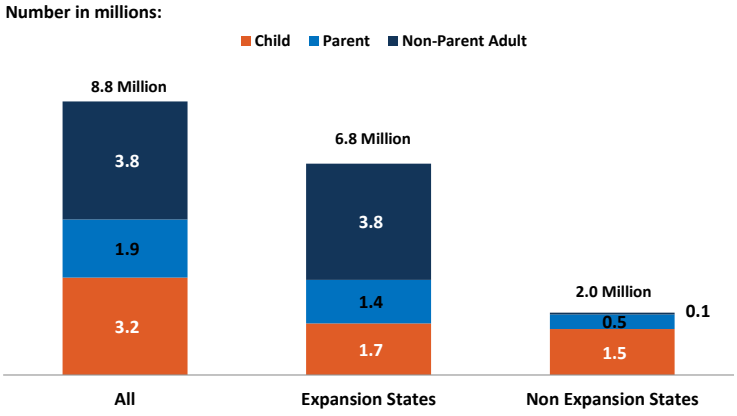
Total: 8.8 Million Uninsured Eligible for Medicaid or CHIP

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 for Medicaid among the uninsured differ between states that have and have not expanded Medicaid. Overall, about two-thirds of the uninsured and eligible are adults and one-third are children. However, in expansion states, most (5.2 million or 76%) of the uninsured and eligible are adults and over half (3.8 million or 55%) are non-parent adults. These non-parent adults were the primary group affected by the Medicaid expansion. In non-expansion states, three out of four of the uninsured and eligible are children and a very small share (0.1 million or 3%) are non-parent adults (Figure 3).

Figure 3

In expansion states, most of the uninsured and eligible for Medicaid or CHIP are non-parent adults.

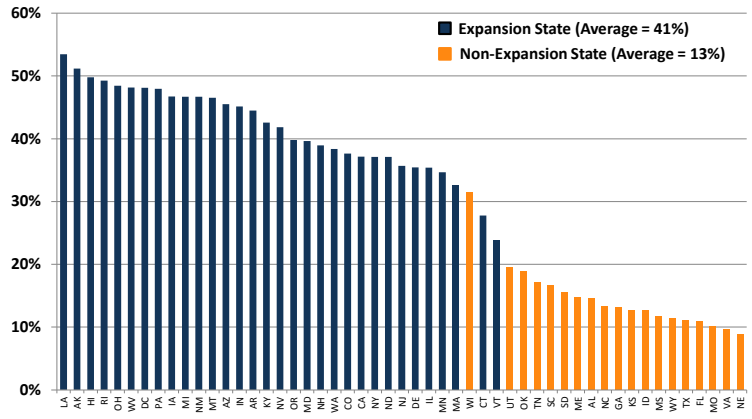


NOTES: Numbers may not sum to subtotals or 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

The share eligible for Medicaid varies across states. A greater share of the nonelderly uninsured is eligible for Medicaid in states that have expanded their programs under the ACA. In these states, 41% of the uninsured are eligible, versus just 13% in non-expansion states. Overall, the share of uninsured and eligible ranges from a high of 53% in Louisiana to a low of 9% in Nebraska (Figure 4). The share of uninsured and eligible is high in Louisiana relative to other states because the state has adopted the Medicaid expansion but not yet implemented it; coverage is set to begin in July 2016. Among non-expansion states, Wisconsin has the highest share of uninsured eligible at 32%. Although not an expansion state, Wisconsin covers parents and other adults up to 100% FPL largely tied to coverage expansions prior to the ACA. In other non-expansion states, parent eligibility levels generally remain very low and other non-disabled adults without dependent children are not eligible regardless of their income level. For adults, the share of the uninsured who are Medicaid eligible ranges from 50% in Louisiana, 44% in Rhode Island and 42% in West Virginia and DC to only 2% in Texas and 3% in Florida and Georgia; for uninsured children the range eligible is from a high of 17% in Minnesota and Utah to a low of 5% in Mississippi (Table 1).

Figure 4

The share of uninsured and eligible for Medicaid or CHIP varies across states, but is generally greater in expansion states.



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.

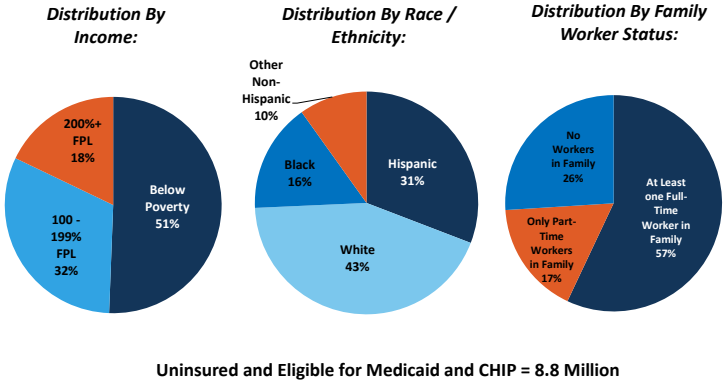
The uninsured eligible for Medicaid are concentrated in a small number of large states. California, New York, Texas and Pennsylvania account for about one-third of the total non-elderly uninsured who are eligible for Medicaid. Among non-elderly uninsured and eligible adults, five states (California, New York, Pennsylvania, Ohio and Illinois) account for more than four in ten; all of these states have adopted the Medicaid expansion. A combination of expansion and non-expansion states, including Texas, California, Florida and New York, account for 37% of uninsured and eligible children (Table 1).

What are the characteristics of the uninsured population eligible for Medicaid or CHIP?

Across all non-elderly uninsured and eligible, half have incomes below poverty, six in ten are people of color and three out of four live in working families (Figure 5). Hispanics account for 31% of those uninsured and eligible, and Blacks account for another 16%. Only one-quarter are in families with no worker. However, there are some key differences between the characteristics of adults who are uninsured and eligible in expansion versus non-expansion states, as discussed below. When examining the characteristics of uninsured and eligible adults it is important to remember that a much higher number of adults (5.2 million) are eligible in expansion states compared to 0.5 million in non-expansion states).

Figure 5

The uninsured and eligible for Medicaid or CHIP are likely to be poor, a person of color and working.



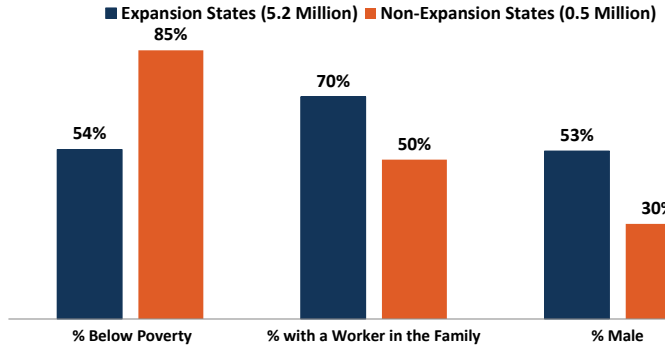
Uninsured and Eligible for Medicaid and CHIP = 8.8 Million

NOTES: Numbers may not sum to subtotals or 100% 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.

Uninsured and eligible for Medicaid adults in non-expansion states are significantly more likely to have incomes below poverty compared to those in expansion states (85% vs. 54%). This finding reflects the continued limited eligibility limits for adults in non-expansion states (Figure 6). Given the historically higher eligibility thresholds for children in Medicaid, the uninsured and eligible children are less likely than adults to have incomes below poverty, and there are small differences in income across expansion and non-expansion states for children. Because the Medicaid expansion effectively eliminated categorical eligibility requirements, more than half of the uninsured and eligible adults are male in expansion states, compared to non-expansion states where uninsured and eligible adults are mostly women due to historic eligibility criteria for Medicaid.

Figure 6

Uninsured and eligible for Medicaid adults are less likely to be poor, but more likely to be in a working family and male in expansion states.



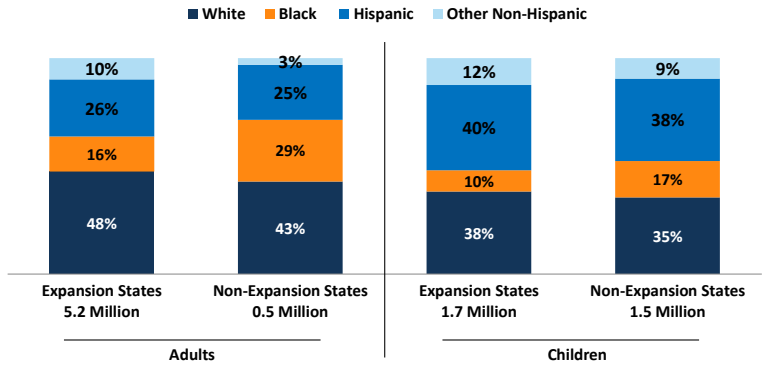
NOTE: Adults are non-elderly.
SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Consistent with these income findings, uninsured and eligible adults in expansion states are more likely to live in a family with a worker than those in non-expansion states. In expansion states, 70% of uninsured and eligible adults live in a family with a worker, compared to half of eligible but uninsured adults in non-expansion states (Figure 6). In contrast, the majority of uninsured and eligible children in both expansion and non-expansion states live in a working family, reflecting the more expansive eligibility limits for children across states.

Over half of the uninsured and eligible adults in expansion and non-expansion states are persons of color. Blacks make up a higher share of the uninsured and eligible adults in non-expansion states compared to expansion states (29% compared to 16%). In both expansion and non-expansion states, uninsured and eligible children are more likely to be Hispanic compared to adults (Figure 7). There are few differences in the health status of uninsured and eligible adults in Medicaid expansion and non-expansion states. However, children are more likely than adults to report very good or excellent health in both expansion and non-expansion states.

Figure 7

Over half of the uninsured and eligible for Medicaid or CHIP in expansion and non-expansion states are persons of color.



NOTES: Numbers may not sum to subtotals or 100% 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.

Policy Implications

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 more than one in four of the uninsured population appears to be eligible for Medicaid. As such, continued coverage gains may be achieved by reaching and enrolling these individuals into coverage. Better understanding who this group is and where they live can help support outreach and enrollment efforts. These findings show that as a result of the increased coverage potential for adults through the ACA, most of the uninsured and eligible live in states that have expanded Medicaid; however, two million (mostly children) reside in non-expansion states. In planning outreach and enrollment efforts, it is also important to recognize some key differences between the eligible but uninsured population in expansion versus non-expansion states:

- **In non-expansion states, the large majority of uninsured and eligible individuals are children, who are covered up to higher income levels than adults.** Roughly four in ten of these children are Hispanic, demonstrating the importance of outreach and enrollment efforts targeted to Hispanics to achieve coverage gains among this group. Just half a million uninsured adults are eligible for Medicaid in non-expansion states since adult eligibility remains limited. The majority of these adults have incomes below poverty and only half live in a family with a worker. Three in ten of these adults are Black, and seven in ten are women.

- **In expansion states, the majority of the uninsured and eligible population is adults, particularly non-parent adults.** Moreover, most live in working families and, as such, have higher incomes than adults traditionally covered by Medicaid. Further, over half are men, a group that historically has had limited connections to Medicaid. Given these characteristics, it will be important for states to explore new outreach and enrollment avenues to reach these individuals, who may not be touched through previous outreach and enrollment avenues designed to reach low-income families.

States that have achieved significant enrollment success have embraced a full array of outreach and enrollment strategies and approaches. These strategies include implementing broad marketing and outreach campaigns, promoting the expansion through strong leadership and collaboration, establishing a coordinated and diverse network of assisters, developing effective eligibility and enrollment systems that coordinate with Marketplace coverage, and planning ahead to translate coverage gains into improved access to care. While 100% participation in voluntary programs like Medicaid is not likely, sustained efforts over time have resulted in significantly higher rates of coverage for children and low uninsured rates. As many adults are newly eligible for coverage under the ACA, a focus on uninsured adults who are eligible for Medicaid is one of the next challenges in reducing overall uninsured rates.

Robin Rudowitz, Samantha Artiga and Rachel Garfield are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

Nonelderly People Eligible for Medicaid Coverage Among those Remaining Uninsured as of 2015							
State	Total Nonelderly Uninsured	Total Medicaid Eligible		Medicaid-Eligible Adults		Medicaid-Eligible Children	
		Number	As a % of Uninsured	Number	As a % of Uninsured	Number	As a % of Uninsured
US Total	**32,339,000**	**8,850,000**	**27%**	**5,675,000**	**18%**	**3,175,000**	**10%**
Alabama	513,000	75,000	15%	NR	NR	55,000	11%
Alaska	100,000	51,000	51%	37,000	37%	14,000	14%
Arizona	808,000	368,000	46%	280,000	35%	NR	NR
Arkansas	285,000	127,000	44%	112,000	39%	NR	NR
California	3,845,000	1,428,000	37%	1,060,000	28%	368,000	10%
Colorado	593,000	223,000	38%	150,000	25%	73,000	12%
Connecticut	247,000	69,000	28%	56,000	22%	NR	NR
Delaware	63,000	22,000	35%	15,000	24%	NR	NR
DC	42,000	20,000	48%	17,000	42%	NR	NR
Florida	2,788,000	306,000	11%	75,000	3%	231,000	8%
Georgia	1,524,000	201,000	13%	47,000	3%	154,000	10%
Hawaii	70,000	35,000	50%	26,000	37%	NR	NR
Idaho	166,000	21,000	13%	NR	NR	NR	NR
Illinois	1,122,000	397,000	35%	302,000	27%	95,000	9%
Indiana	686,000	310,000	45%	227,000	33%	82,000	12%
Iowa	188,000	88,000	47%	53,000	28%	NR	NR
Kansas	302,000	38,000	13%	NR	NR	NR	NR
Kentucky	285,000	121,000	43%	90,000	32%	NR	NR
Louisiana	582,000	311,000	53%	292,000	50%	NR	NR
Maine	121,000	18,000	15%	NR	NR	NR	NR
Maryland	336,000	133,000	40%	107,000	32%	NR	NR
Massachusetts	288,000	93,000	32%	57,000	20%	36,000	13%
Michigan	685,000	320,000	47%	279,000	41%	NR	NR
Minnesota	364,000	126,000	35%	65,000	18%	61,000	17%
Mississippi	359,000	42,000	12%	24,000	7%	18,000	5%
Missouri	516,000	52,000	10%	NR	NR	47,000	9%
Montana	126,000	59,000	47%	43,000	34%	15,000	12%
Nebraska	178,000	16,000	9%	NR	NR	NR	NR
Nevada	350,000	147,000	42%	110,000	31%	37,000	10%
New Hampshire	94,000	37,000	39%	30,000	32%	NR	NR
New Jersey	940,000	335,000	36%	264,000	28%	71,000	8%
New Mexico	233,000	109,000	47%	80,000	34%	29,000	12%
New York	1,476,000	548,000	37%	376,000	25%	172,000	12%
North Carolina	1,138,000	152,000	13%	NR	NR	120,000	11%
North Dakota	64,000	24,000	37%	15,000	23%	NR	NR
Ohio	834,000	404,000	48%	313,000	38%	91,000	11%
Oklahoma	581,000	109,000	19%	22,000	4%	87,000	15%
Oregon	307,000	122,000	40%	96,000	31%	26,000	9%
Pennsylvania	994,000	477,000	48%	357,000	36%	120,000	12%
Rhode Island	55,000	27,000	49%	24,000	44%	NR	NR
South Carolina	604,000	100,000	17%	36,000	6%	65,000	11%
South Dakota	77,000	12,000	16%	NR	NR	NR	NR
Tennessee	605,000	104,000	17%	NR	NR	71,000	12%
Texas	4,425,000	493,000	11%	80,000	2%	413,000	9%
Utah	337,000	66,000	20%	NR	NR	56,000	17%
Vermont	34,000	8,000	24%	7,000	21%	NR	NR
Virginia	804,000	77,000	10%	NR	NR	61,000	8%
Washington	621,000	238,000	38%	171,000	28%	67,000	11%
West Virginia	116,000	56,000	48%	49,000	42%	NR	NR
Wisconsin	410,000	129,000	32%	86,000	21%	43,000	10%
Wyoming	56,000	6,000	11%	NR	NR	5,000	9%

NOTES: Numbers may not sum to totals due to rounding. NR = 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.

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.[1,2] 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 implementation of the Medicaid expansion as of January 2016 and 2015 Federal Poverty Levels.[3] 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.[4]

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] 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

[2] Van Hook, J., Bachmeier, J., Coffman, D., and Harel, O. "Can We Spin Straw into Gold? An Evaluation of Immigrant Legal Status Imputation Approaches" *Demography*. Forthcoming.

[3] 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 January 2016 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.

[4] 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/.

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Contraceptive Coverage at the Supreme Court *Zubik v. Burwell*: Does the Law Accommodate or Burden Nonprofits' Religious Beliefs?

Laurie Sobel and Alina Salganicoff

Among the most contentious and litigated elements of the Affordable Care Act (ACA) is the requirement that most private health insurance plans provide coverage for a broad range of preventive services, including Food and Drug Administration (FDA) approved prescription contraceptives and services for women. Since the implementation of the ACA contraceptive coverage requirement in 2012, over 200 corporations have filed lawsuits claiming that their religious beliefs are violated by the inclusion of that coverage or the "accommodation" offered by the federal government. The legal challenges have fallen into two groups: those filed by for-profit corporations and those filed by nonprofit organizations and both have reached the Supreme Court.

In the *Burwell v. Hobby Lobby* decision, the Supreme Court ruled that "closely held" for-profit corporations may be exempted from the requirement. This ruling, however, only settled part of the legal questions raised by the contraceptive coverage requirement, as other legal challenges have been brought by nonprofit corporations. The nonprofits are seeking an "exemption" from the rule, meaning their workers would not have coverage for some or all contraceptives, rather than an "accommodation," which entitles their workers to full contraceptive coverage but releases the employer from paying for it.

The lawsuits brought by nonprofits have worked their way through the federal courts. On March 23, 2016, the Supreme Court will hear oral argument for *Zubik v. Burwell*, a consolidated case for seven legal challenges that involve nonprofit corporations. After the death of Justice Antonin Scalia, this already complicated case has taken on yet an additional question. Given that the Court will be operating with only 8 Justices, what would be the impact of a tie (4-4) decision? This brief explains the legal issues raised by the nonprofit litigation, discusses the influence of the *Hobby Lobby* decision on the current case before the Supreme Court, and the potential impact of a tie decision.

Who are the Petitioners in the Case Before the Supreme Court?

Since the contraceptive coverage regulations have been implemented, over 100 nonprofit corporations have challenged the contraceptive coverage requirement claiming that the accommodation for religiously affiliated nonprofits is insufficient and still burdens their religious rights. Multiple federal courts of appeals denied stays to all of the nonprofits involved in the litigation, finding that the accommodation is not a substantial burden. Only one federal Court of Appeals, the 8th Circuit, has ruled in favor of nonprofits, striking down the accommodation, but these nonprofits are not part of the case before the Supreme Court. Following these

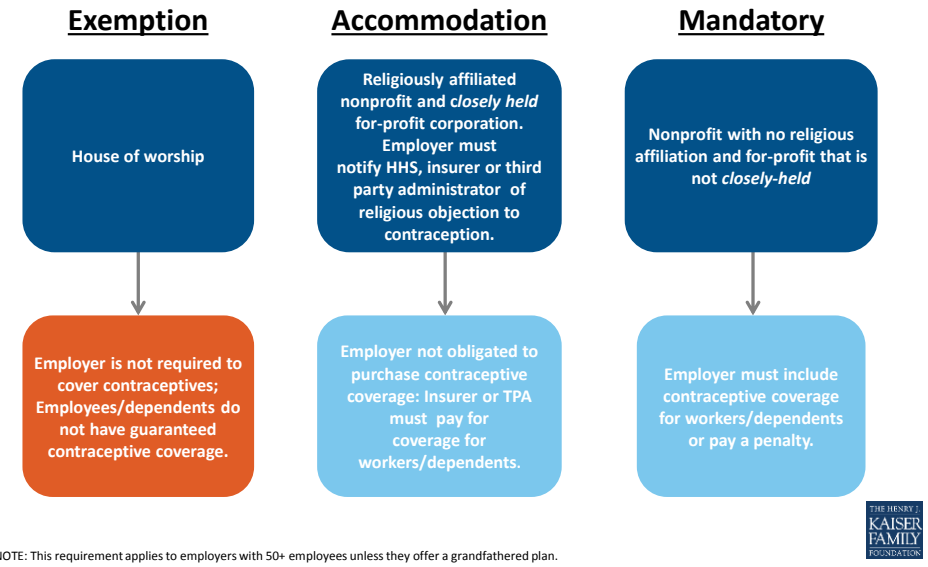
rulings, a number of the litigants petitioned the Supreme Court to review their cases, which the Court agreed to do on November 6, 2015. The named petitioners in the cases to be reviewed by the Court are: Zubik (the Bishop of the Roman Catholic Diocese of Pittsburgh), Priests for Life, Roman Catholic Archbishop, East Texas Baptist University, Little Sisters of the Poor, Southern Nazarene University, and Geneva College.[1] All of the petitioners contend that complying with the accommodation triggers the contraceptive coverage, but the petitioners outline different burdens for fully insured plans, self-insured plans, and church plans (**Appendix 1**).

What is the Basis for the Challenges Brought by the Religious Nonprofits?

As the contraceptive coverage rules have evolved through litigation and new regulations, there are three categories of employers with differing requirements. Most employers are required to include the coverage in their plans. Houses of worship can choose to be exempt from the requirement if they have religious objections (**Figure 1**). Workers and dependents of exempt employers do not have coverage for either some or all FDA approved contraceptive methods. Religiously-affiliated nonprofits and closely held for-profit corporations are not eligible for an exemption. They can opt out of providing contraceptive coverage by notifying their insurer, third party administrator or the federal government of their objection and receive an accommodation which assures that their workers and dependents have contraceptive coverage, and relieves the employers of the requirement to pay for it.

Figure 1

Employers Objecting to Contraceptive Coverage: Exemptions and Accommodations



NOTE: This requirement applies to employers with 50+ employees unless they offer a grandfathered plan.

The nonprofit corporations continuing to pursue legal challenges are seeking an "exemption" from the contraceptive coverage rule, not an "accommodation." They contend that they are unjustly burdened under the Religious Freedom Restoration Act (RFRA). RFRA was enacted in 1993 to protect "persons" from generally applicable laws that burden their free exercise of religion. The Government contends that it is federal law that requires the insurance issuer or the third party administrator to provide this coverage. In resolving these cases, the Court must consider a series of threshold questions in deciding whether the contraceptive coverage requirement is in violation of the RFRA (**Figure 2**). While RFRA was the basis for both the for-profit and nonprofit challenges, the questions raised by the Zubik consolidated cases differ somewhat. The nonprofit legal challenges involve a different question than the one raised by the for-profit challenges: Does the requirement to

notify the employer's insurer/TPA/government of their religious objection to contraceptive that results in an "accommodation" to the contraceptive coverage rule "substantially burden" the nonprofits' religious exercise?

DO THE NONPROFITS HAVE A SINCERELY HELD RELIGIOUS ?

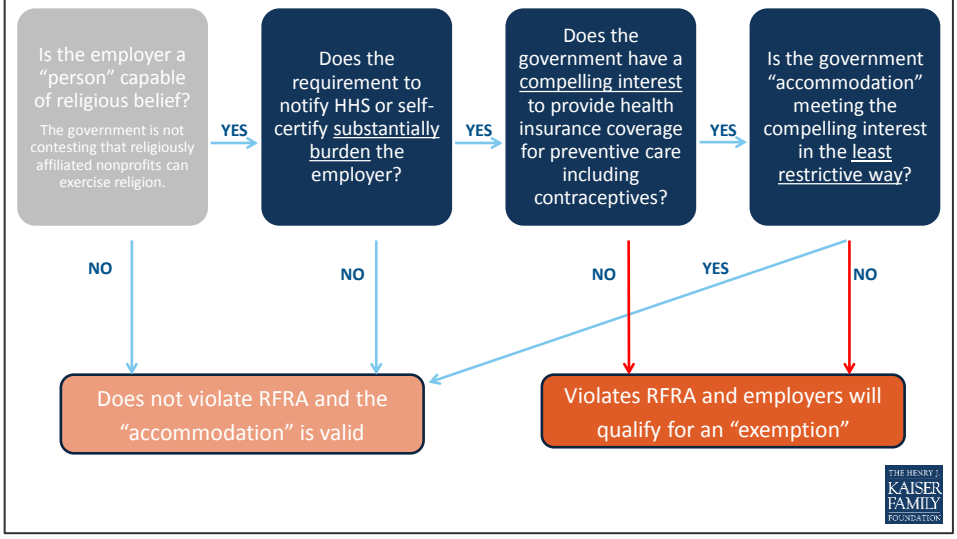
The government is not contesting that the religiously affiliated nonprofits are considered "persons" under RFRA and hold sincerely held religious beliefs opposed to contraceptives.

IS THE ACCOMMODATION A "?

The nonprofits must demonstrate the accommodation is a "substantial burden." In other words, does the notice requirement that results in an "accommodation" to the contraceptive coverage requirement "substantially burden" the nonprofits' religious exercise? Federal regulations require that religiously affiliated nonprofits with an objection to contraception either notify their insurer, third party administrator or Health and Human Services of their objection to including some or all contraceptives in their health insurance plan. This notice then qualifies them for an "accommodation" relieving them of the requirement to pay for the benefit, yet assuring that women workers and women dependents get the contraceptive coverage to which they are entitled under the ACA. The religiously-affiliated nonprofit organizations contend that when the insurer separately contracts with an employer's workers to cover contraception at no cost, it remains part of the employer's plan and is financed by the employer. By providing notice they contend they will "facilitate" or "trigger" the provision of insurance coverage for contraceptive services, enabling their insurance company or their third party administrator "to provide the morally objectionable coverage and allow their health plans to be used as a vehicle to bring about a morally objectionable wrong."[2] The Government contends that it is federal law that requires the insurance issuer or the third party administrator to provide this coverage, not the actual act of notification.

Figure 2

Legal Analysis of the Religious Freedom Restoration Act as It Applies to Religiously-Affiliated Nonprofits



Religiously affiliated nonprofit employers offering a health insurance plan to their workers may choose whether to offer a fully insured plan, self-insured plan, or a church plan. The nonprofit employers challenging the accommodation have selected different types of health insurance plans that address the accommodation in different ways (**Table 1**).

: Typology of Insurance Arrangements used by Litigants in the Zubik v. Burwell Consolidated Cases			
Type of plan	**How is the Accommodation is Handled**	**Payment for Coverage**	**Oversight**
Fully-Insured Plan Insurer collects premiums and assumes the risk of providing covered services	The insurer must exclude contraceptive coverage from the employer's plan[3] and not apply any of the employer's premium contributions to pay for the coverage.[4]	No payment – federal government determined this coverage is cost neutral.	State insurance regulators
Self-Insured ERISA plan Employer assumes the risk of providing covered services and usually contracts with a third party administrator (TPA) to manage the claims payment process.	The TPA must provide contraceptive coverage to employees and dependents. The employer does not pay for or control this benefit but it is considered part of the employer's plan.	The costs of the benefit are offset by reductions in the fees the TPA paid to participate in the federal exchange. The value is equal to the amount the TPA spent on contraceptive coverage plus a minimum 10% administrative fee.[5]	Department of Labor under the Employer Retirement Income Security Act (ERISA).
Self-Insured Church Plan "A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches" and may also include entities controlled by or associated with a religious denomination.[6]	A TPA for a church plan is not required to provide the coverage. It can voluntarily choose to provide contraceptive coverage for the workers and dependents of an employer that has filed notice for an accommodation.	The costs of the benefit are offset by reductions in the fees the TPA paid to participate in the federal exchange. The value is equal to the amount the TPA spent on contraceptive coverage plus a minimum 10% administrative fee.[7]	Unlike other fully-insured or self-insured plans, Church plans are not regulated by ERISA or state insurance agencies. There is effectively no enforcement authority for self-insured church plan TPAs to provide contraceptive coverage.

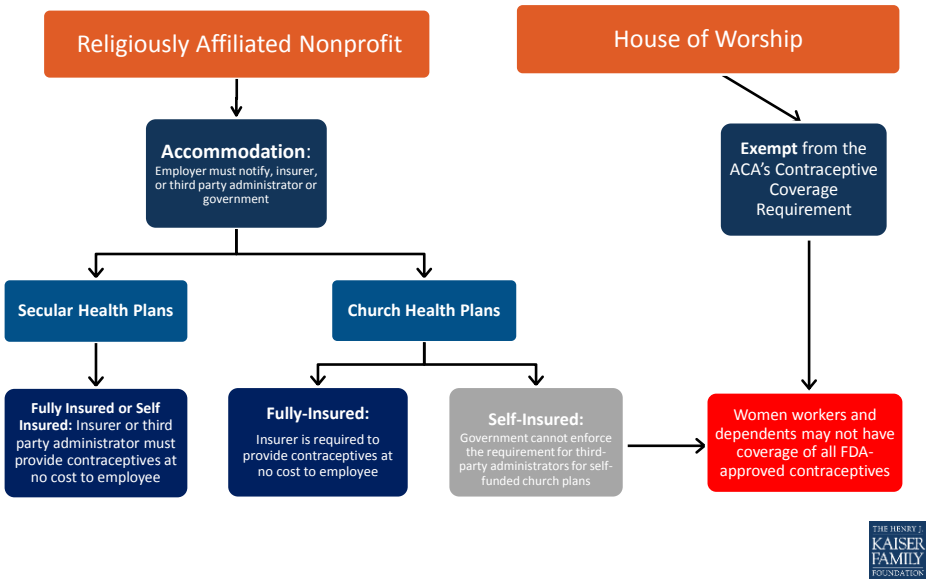
One of the more complicated aspects of the cases relates to *self-insured church plans* because there are regulatory gaps in oversight of these particular entities when it comes to contraceptive coverage. Eighteen petitioners, including Little Sisters of the Poor, have a self-insured church plan,[8] which is different than other types of employer self-insured plans in that it is explicitly not regulated by ERISA as are other self-insured plans. A church plan is a plan "established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches." Church plans are not limited to traditional church entities, but may include entities controlled by or associated with a religious denomination. For example, church-related hospitals, educational institutions and nonprofits that provide services to the aging, children, youth and family, may sponsor church plans. Because church plans are not governed under ERISA, they are not required to follow the ACA-related health reform mandates incorporated only into the ERISA law.[9] However, church plans are required to follow all the ACA provisions included in the Internal Revenue Code (IRC).[10] The IRS may impose penalty taxes on group health plans, including church plans for noncompliance with the contraceptive coverage provision.[11]

Employers with self-insured plans must designate entities to take on two different roles: plan administrator (who operates the plan) and third party administrator (who processes the claims).[12] These are typically two separate entities. However, when a religiously affiliated nonprofit employer with a self-insured plan provides notice of its objection to contraception, the contraceptive coverage regulations designate the plan TPA to function as the *plan administrator*, as defined in ERISA, but only for the contraceptive coverage benefit which effectively becomes a contraceptive plan.

Because the government's authority to require a TPA to provide contraceptive coverage derives from ERISA, the government cannot actually enforce these regulations for self-funded church plans.[13] While employers with self-funded church plans are required to provide notice of their objection, the TPAs for these plans have no enforceable obligation to provide the employees with contraceptive coverage. The litigants, however, contend that if a TPA voluntarily decides to offer the contraceptive services to the employees, the employer believes that they would be substantially burdened by the notice requirement (**Figure 3**).

Figure 3

How Health Insurance Arrangement Used by Religious Employers Affects Contraceptive Coverage for Workers



The parties' arguments on this point are a bit circular. The Little Sisters of the Poor and others contend the Government cannot have a "compelling" reason to require them to complete the notice when their TPA is not required to provide the contraceptive coverage. In response, the Government asserts that because the employees will only receive contraceptive coverage if the TPAs for self-insured church plans voluntarily choose to provide the coverage, these nonprofits have an even more attenuated burden than other nonprofits and cannot claim that the notification "triggers" the coverage.[14]

Does the Contraceptive Coverage Requirement Further a Compelling Interest?

If the nonprofit corporations can show that they are substantially burdened, then the government will then need to prove that the contraceptive coverage requirement is a "compelling interest" that is met in the "least restrictive means." The Government has articulated the same *compelling* reasons for the contraceptive coverage requirement in these cases as it did in Hobby Lobby. These reasons include: 1) safeguarding the public health, 2) promoting a woman's compelling interest in autonomy and 3) promoting gender equality.[15]

In the Hobby Lobby decision, the Supreme Court did not adjudicate this issue; for the purpose of the ruling, they assumed that the Government had a compelling interest, and skipped to their analysis on whether the

contraceptive mandate is the least restrictive means of furthering that compelling governmental interest."[16] The Court may have skipped this question because there was no clear agreement among the five Justices signing onto the Court's majority opinion on whether the Government had a compelling interest. In the decision, Justice Alito articulated that in order to demonstrate a compelling interest, the Government not only needs to show a compelling reason for the contraceptive coverage requirement generally, but the Government needs to specifically demonstrate "the marginal interest in enforcing the contraceptive mandate in these cases."[17] However, Justice Kennedy (who sided with the majority), and the four Justices that signed onto the dissent endorsed the position that providing contraceptive coverage to employees "serves the Government's compelling interest in providing insurance coverage that is necessary to protect the health of female employees, coverage that is significantly more costly than for a male employee."[18]

In these cases, the Government is also asserting a compelling interest in its ability to fill the gaps created by accommodations for religious objectors.[19] The contraceptive coverage regulations, including the religious accommodations, also advance the government's related compelling interest in assuring that women have equal access to recommended health care services.

In their briefs, the nonprofits contend that the government cannot have a compelling interest when it does not apply this requirement equally to all employers, effectively exempting those with less than fifty employees that do not provide health insurance, grandfathered plans, and houses of worship. Furthermore, grandfathered plans are required "to comply with a subset of the Affordable Care Act's health reform provisions" that provide what HHS has described as "particularly significant protections."[20] But the contraceptive mandate is expressly excluded from this subset. "Here, granting a religious exemption for Petitioners would not undercut any "compelling" interest because the mandate is already riddled with exemptions."[21] Citing examples of other laws including the Civil Rights Act which allow exceptions, the Government counters that the exceptions to the contraceptive coverage requirement do not negate the Government's compelling interest.[22]

IF THE GOVERNMENT DEMONSTRATES IT HAS A COMPELLING INTEREST, IS IT MEETING IT IN THE ?

Lastly, the government must show it is meeting the compelling interest in the *least restrictive means*. The nonprofits argue there are less restrictive ways to accomplish the same goals, including allowing employees to qualify for subsidies on the exchange so they can enroll in an entirely new plan or a contraceptive only plan, or using Title X, the federal family planning program, to provide contraceptives to employees and dependents who lack coverage. The Government contends that none of these alternatives would be as effective in achieving its compelling interest because they would place "financial, logistical, informational, and administrative burdens" on women seeking contraceptive services.[23]

In the Court's *Hobby Lobby* ruling, Justice Alito, wrote about the accommodation as a "less restrictive means," to provide contraceptive coverage. The Court, however, did not decide whether the accommodation is lawful: "We do not decide today whether an approach of this type complies with RFRA for purposes of all religious claims. At a minimum, however, it does not impinge on the plaintiffs' religious belief that providing insurance coverage for the contraceptives at issue here violates their religion, and it serves HHS's stated interests equally well."[24]

The majority opinion hints that the accommodation may not be least restrictive means: "The most straightforward way of doing this would be for the Government to assume the cost of providing the four contraceptives at issue to any women who are unable to obtain them under their health-insurance policies due to their employers' religious objections. This would certainly be less restrictive of the plaintiffs' religious liberty, and HHS has not shown … that this is not a viable alternative."[25] Justice Ginsburg disagrees with this position in her dissent citing evidence that Title X cannot absorb more people, and it would be burdensome for women to find out about and sign up for another health insurance plan for contraceptives.

Why Are Houses of Worship Suing if They Are "Exempt"?

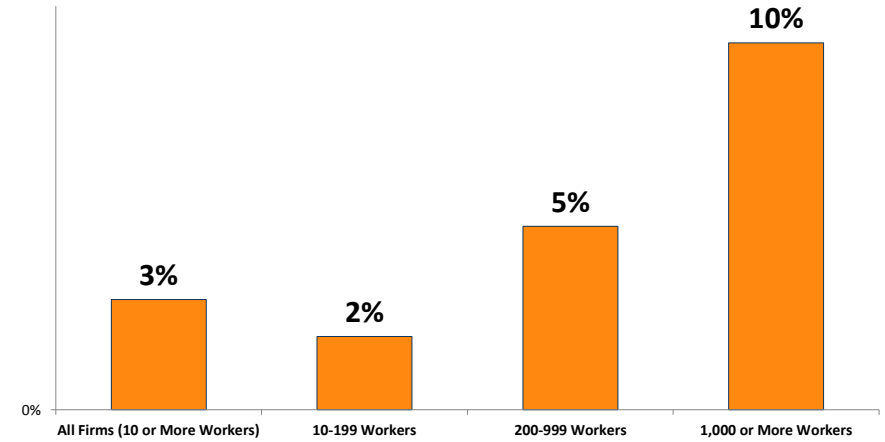
Three houses of worship that are exempt from the contraceptive coverage rule are also petitioners in the cases before the Supreme Court. The Archdiocese of Washington, the Diocese of Pittsburg, and the Diocese of Erie, each sponsor a self-insured church plan administered by a TPA, and have invited nonexempt nonprofit religiously affiliated organizations to participate in their plan. The Dioceses which sponsor these plans can choose to either drop coverage for their affiliates or complete the accommodation form for the other employers participating in the church plan. The Diocese objects to "facilitating" contraceptive coverage for the workers and dependents, employed by the other participating nonprofits.

What Are Potential Ramifications of the Decision?

There is much at stake in the Court's ruling on these cases. If the Court decides that the accommodation violates RFRA, then many workers and dependents may not receive contraceptive coverage because their employers will be exempt. Overall 3% of nonprofits offering health benefits (with 10 or more workers) have given notice for an accommodation, and a much larger share, 10% of nonprofits with 1,000 or more workers, have given notice for accommodation (**Figure 4**).[26] It is not known if the nonprofits that have already filed notice of their objection and have obtained an accommodation would continue or would seek an exemption if that became an option.

Figure 4

Percentage of Nonprofit Firms Offering Health Insurance Self-Certifying as a Religiously Affiliated Organization with Objection to Contraceptives, by Firm Size, 2015



Note: 76% of all nonprofits and 98% of nonprofits with 199 or more workers offered health insurance.
SOURCE: Data Note: Are Nonprofits Requesting an Accommodation for Contraceptive Coverage? based on Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

If the Supreme Court rules in favor of the religiously affiliated nonprofits, religious objectors in other contexts may be allowed to block the conduct of the government or third parties to fill in the gap left by the objector. The 10th Circuit court found that "Many religious objection schemes require an affirmative opt out before another person is required to step in and assume responsibility, and may require the objector to identify a replacement

in the process."[27] Lower courts have noted that if providing notice of an objection is a "substantial burden" then many other notifications resulting in opt outs could be affected including conscientious objector. "A religious conscientious objector to a military draft" could claim that being required to claim conscientious-objector status constitutes a substantial burden on his exercise of religion because it would "trigger the draft of a fellow selective service registrant in his place and thereby implicate the objector in facilitating war."[28]

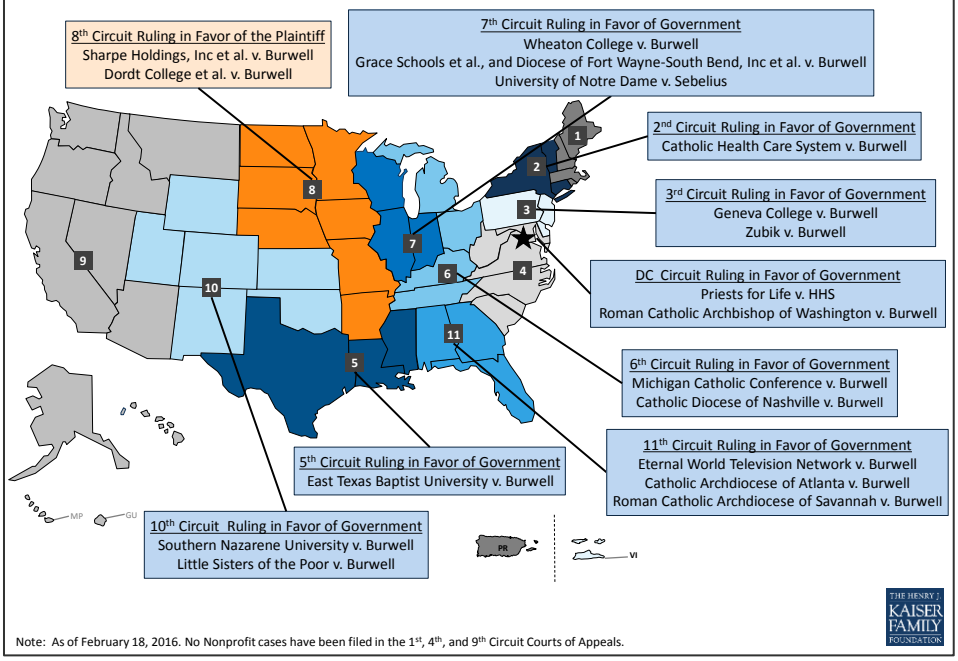
In his decision for the 10th Circuit Court of Appeals for Little Sisters v. Burwell,[29] Judge Matheson notes other examples of when a religious objector is required to identify another person to step in: requiring a county clerk with objections to same sex marriage to designate someone else to solemnize a legal marriage;[30] requiring pharmacists who object to providing contraception to refer patients to another pharmacist that will dispense the contraception;[31] requiring health care providers who object to implementing a do-not-resuscitate order to "turn over care of the patient without delay to another provider who will implement the DNR order;"[32] and requiring a church that opts out of paying Social Security and Medicare taxes for religious reasons to deduct those taxes from its employees' paychecks as though the employees were self-employed.[33]

What Happens if There is a Split Decision?

In reviewing the seven nonprofit cases, the Supreme Court will have to decide whether the notice and the resulting accommodation from the contraceptive coverage requirement substantially burdens the religious exercise of nonprofits, whether the government has a compelling interest, and whether there is a less restrictive way of achieving the same of goal of allowing women coverage for all FDA-approved contraceptive methods without cost-sharing.

Figure 5

US Appeals Court Rulings on Lawsuits by Nonprofits Objecting to Contraception



Note: As of February 18, 2016. No Nonprofit cases have been filed in the 1st, 4th, and 9th Circuit Courts of Appeals.

If the Court decision is a tie, 4-4, the rulings for each case heard by the lower courts of the U.S. District Courts of Appeals will stand. All of the Circuits that have heard the cases of the petitioners in the consolidated case have ruled in favor of the Government, finding that the accommodation is not a substantial burden. However, unlike the other Federal Courts of Appeals, the 8th Circuit ruled in two separate cases (*Sharpe Holdings Inc. et al. v. Burwell*, and *Dordt College et al. v. Burwell*) that the religiously affiliated nonprofits *are* substantially burdened by the accommodation to the contraceptive coverage requirement, and the accommodation is not the least restrictive means of furthering the government's interests **(Figure 5)**. These two cases, however, are not among the nonprofit employers petitioning the Supreme Court. So while a 4-4 decision by the Supreme Court would mean that all of the nonprofits before the court would need to abide by the accommodation, it would not be upheld and enforceable in the 8th Circuit (ND, SD,

NE, MN, IA, MO, AR), meaning that the religiously affiliated nonprofits that object to contraception in those states would effectively become exempt from the requirement and their employees and dependents would not get contraceptive coverage. Alternatively, if the Court determines that that the Justices are split evenly, the Court might defer a decision and order a re-argument in the next term when there are nine Justices. The possibility also exists, if the Court issues a 4-4 decision, that it may revisit this issue in a future term when there are nine Justices to review the case.

Are These Supreme Court Cases The Final Word?

In addition to the current nonprofit cases that are being considered by the Court, there is other litigation by both employers and employees of organizations that are challenging the contraception coverage provisions. On August 31, 2015, the DC District Court issued a decision in a case brought by March for Life, and two of its employees. March for Life was formed after the Roe v. Wade decision in 1973, and claims moral objections to many forms of contraceptives. As a secular nonprofit, however, it is not eligible for the exemption or accommodation available to religious organizations. This case represents a new legal approach and, for the first time, includes employees. The employer's claim is that that the government has violated equal protection under the 5th Amendment by treating secular organizations with moral objections differently from religious organizations with religious objections. In addition, two employees of March for Life are also challenging the contraceptive coverage requirement under RFRA claiming they *personally* have religious objections to contraceptives, and do not want contraceptive coverage included in their plan. U.S. District Court for the District of Columbia issued a decision favorable to both March for Life and the two employees. The Administration is likely to appeal this decision to the DC Court of Appeals.

More litigation may also emerge from for-profit employers like Hobby Lobby who also receive an accommodation from the requirements. Beginning in their new plan year,[34] Hobby Lobby and other similar corporations will be required to notify their insurer or HHS of their objection to contraceptive coverage so that the insurer can still provide the contraceptive coverage directly to the employees and their dependents. Depending on the outcome of the nonprofit cases before the Supreme Court, some closely held corporations may challenge the accommodation as applied to them, contending that the accommodation still substantially burdens the corporation, in much the same way that the religiously-affiliated nonprofits have done.

The outcome of all of these cases will determine if the employees and dependents of these corporations, and potentially other firms that are eligible for the accommodation, will have access to no cost contraceptive coverage as intended under the ACA. As with most cases before the Supreme Court, the ruling will also likely have implications that go far beyond the issue of contraceptive coverage.

Cases to be reviewed by Supreme Court in Zubik v Burwell		
	Case History	
Zubik et al. v. Burwell	On February 11, 2015, a unanimous 3rd Circuit panel issued a decision that the accommodation does not impose a substantial burden on plaintiffs' religious exercise. The 3rd Circuit denied plaintiffs' petition for a rehearing en banc and request for a stay. Zubik et al. filed an emergency petition with the Supreme Court asking for a stay.	temporary stay allowing the plaintiffs to not plaintiffs filed a brief requesting that the 2015, the Supreme Court denied the request for a stay, but allowed the plaintiffs to inform
Geneva College v. Burwell	On February 11, 2015, a unanimous 3rd Circuit panel issued a decision that the accommodation does not impose a substantial burden on plaintiffs' religious exercise. The 3rd Circuit denied plaintiffs' petition for a rehearing en banc and request for a stay.	brief requesting the Supreme Court to review
Priests for Life v. HHS; Roman Catholic Archbishop of Washington v. Burwell	The DC Circuit Court of Appeals panel ruled that the accommodation does not impose a substantial burden on plaintiffs' religious exercise, the regulations advance compelling government interests, and the regulations are the least restrictive means. Plaintiffs petitioned for a re-hearing *en banc* asking the full D.C. Circuit to rehear the case.	denied the request for an *en banc* hearing. In June 2015, the Priests for Life and Roman Catholic Archbishop of Washington filed briefs
East Texas Baptist University v. Burwell	The 5th Circuit Court of Appeals ruled that burden on plaintiff's religious exercise. RFRA does confer the right to challenge independent	plaintiffs appealed to the Supreme Court. On November 6, 2015 the Supreme Court granted

Cases to be reviewed by Supreme Court in Zubik v Burwell		
Lawsuit	Case History	Status
	conduct of third parties.	review.
Southern Nazarene University et al. v. Burwell	U.S. District Court for the Western District of Oklahoma, granted plaintiffs' motion for a preliminary injunction and then stayed proceedings until March 1, 2014. The government appealed to the 10th Circuit.	The 10th Circuit issued a decision on July 14, 2015, denying Southern Nazarene University a stay. On July 24, 2015 the plaintiffs submitted a brief requesting the Supreme Court to review the case. On November 6, 2015 the Supreme Court granted review.
Little Sisters of the Poor v. Burwell	The Supreme Court granted plaintiffs' emergency application for an injunction pending appeal on the condition that they file notice with HHS that they are organizations that hold themselves out as religious and have religious objection to contraceptive coverage. Following the government's issuance of interim final rules amending the accommodation for nonprofit, the parties filed supplemental briefs addressing the impact of those rules on the case	The 10th Circuit issued a decision on July 14, 2015, denying Little Sister of the Poor a stay. On July 28, 2015, the plaintiffs submitted a brief requesting the Supreme Court to review the case. On November 6, 2015 the Supreme Court granted review, but will not consider the question about whether RFRA is violated by treated houses of worship differently than religiously affiliated nonprofits.

ENDNOTES

[1] The briefing order consolidates three cases for one brief: *Zubik v. Burwell*, *Priests for Life v. Department of Health & Human Services*, and *Roman Catholic Archbishop of D.C. v. Burwell*. It consolidates the other four cases for the second brief: the *Little Sisters, East Texas Baptist University v. Burwell*, *Southern Nazarene University v. Burwell*, and *Geneva College v. Burwell*.

[2] *Zubik et al. v. Burwell et al.*, Emergency Application to Recall and Stay Mandate or Issue Injunction Pending Resolution of Certiorari Petition. April 15, 2015, at page 17.

[3] 45 C.F.R. 147.131(c)(2)(ii).

[4] Ibid.

[5] A participating issuer offering a plan through a Federally-facilitated Exchange may qualify for an adjustment in the Federally-facilitated Exchange user fee for payments made for contraceptive services for employers that self-certified for the accommodation. *Adjustments of Federally-Facilitated Exchange User Fees:* 45 CFR § 156.50(d) and 156.80(d).

[6] 26 C.F.R. § 1.414(e)-1.

[7] A participating issuer offering a plan through a Federally-facilitated Exchange may qualify for an adjustment in the Federally-facilitated Exchange user fee for payments made for contraceptive services for employers that self-certified for the accommodation. *Adjustments of Federally-Facilitated Exchange User Fees:* 45 CFR § 156.50(d) and 156.80(d).

[8] Lederman, M. Who is "Zubik" in *Zubik v. Burwell* . . . and why is he allegedly complicit in the use of contraception? [Updated with list and categorization of al 37 petitioners]. November 8, 2015.

[9] Church plans are exempt from regulation under the Employee Retirement Income Security Act of 1974 (ERISA) unless they affirmatively opt in. 29 U.S.C. 1003 (b)(2); 26 U.S.C. §410(d).

[10] 26 U.S.C. §5000, 26 U.S.C. §9832.

[11] 26 U.S.C. § 4980 (D).

[12] ERISA Glossary, Health Plan Law.

[13] Coverage of Recommended Preventive Services Under 26 CFR 54.9815-2713, 29 CFR 2590.715-2713, and 45 CFR 147.130 , July 14, 2015, footnote 22

[14] *Little Sisters of the Poor et al. v. Burwell et al.*, Supplemental Brief for Government filed in 10th Circuit, July 22, 2014, at page 7.

[15] Brief of Respondents, *Burwell, et al. v. Zubik*, Supreme Court of the United States February 10, 2016, at pages 54-61.

[16] *Burwell v. Hobby Lobby*, Supreme Court opinion, June 30 2014 at page 28.

[17] *Burwell v. Hobby Lobby*, Supreme Court opinion, June 30, 2014 at page 39.

[18] *Burwell v, Hobby Lobby*, Supreme Court opinion, June 30, 2014, at page 28 (Kennedy, J., concurring); accord id. at pages 40-41 & footnote 23 (Ginsburg, J., dissenting).

[19] *Little Sisters of the Poor et al. v. Burwell et al.*, Supplemental Brief for Government filed in 10th Circuit, July 22, 2014, at page 17.

[20] 75 Fed. Reg. 34540 (2010).

[21] Brief for Petitioners, *Zubik, et al, v. Burwell et al.*, Supreme Court of United States, January 4, 2016, at page 55.

[22] Brief of Respondents, *Zubik et al. v. Burwell et al.*, Supreme Court of United States, February 10, 2016, at page 62.

[23] Brief of Respondents in Opposition to Petition for Writ of Certiorari, Priests for Life et al., v, Department of Health and Human Services, at page 12 citing United State Court of Appeals for the DC Circuit, Priests for Life et al. v. HHS et al decision issued November 14, 2014.

[24] *Burwell v. Hobby Lobby*, Supreme Court opinion, June 30 2014 at page 44.

[25] *Burwell v. Hobby Lobby*, Supreme Court opinion, June 30 2014 at page 41.

[26] Sobel, L., Rae, M., & Salganicoff, A. Data Note: Are Nonprofits Requesting an Accommodation for Contraceptive Coverage?, Kaiser Family Foundation (Dec. 2015).

[27] Tenth Circuit Decision, *Little Sisters of the Poor et al. v. Burwell* et al. Published July 14, 2015, at page 51 footnote 31.

[28] United State Court of Appeals for the DC Circuit, Priests for Life et al. v. HHS et al decision issued November 14, 2014, at page 24 quoting in part United States Court of Appeals for the 7th Circuit, Univ. of Notre Dame v. Sebelius, decision issued February 21, 2014.

[29] Tenth Circuit Decision, *Little Sisters of the Poor et al. v. Burwell et al.* Published July 14, 2015, at page 51, footnote 31.

[30] 2015 Utah Laws Ch. 46.

[31] Stormans Inc. v. Selecky, 844 F. Supp. 2d 1172 (W.D. Wash. Feb. 22, 2012).

[32] Conn. Agencies Regs. § 19a-580d-9.

[33] Internal Revenue Service, Tax Guide for Churches & Religious Organizations 18 (2013), page 21.

[34] Hobby Lobby's plan year begins on July 1. In the midst of its lawsuit, Hobby Lobby changed the start of its plan year. "According to the plaintiffs, the corporations' deadline to comply with the contraceptive-coverage requirement is July 1, 2013" Hobby Lobby Stores, Inc. v. Sebelius, 723 F.3d 1114, 1125 (10th Cir. 2013).

Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

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Getting Enrollment Right for Immigrant Families:

Steps the Federally Facilitated Health Insurance Marketplace Can Take to Improve the Application Process for Eligible Lawfully Present Immigrants

By Sonya Schwartz and Tricia Brooks, Georgetown University Center for Children and Families

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The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve health coverage for America's children and families.

As part of the University's McCourt School of Public Policy, Georgetown CCF provides research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act.

Introduction

The Affordable Care Act (ACA) has yielded impressive progress in reducing the ranks of the uninsured, with more than 12 million people covered by the health insurance marketplaces alone.[1] However, meeting the goal of enrolling the remaining seven million people who are eligible for marketplace coverage but are still uninsured—even after the third open enrollment period—will be an *even bigger* challenge than getting the first 12 million people covered.[2] It will require not only targeted, effective outreach with groups that are eligible but unenrolled, but also improved systems to make the application process work better for individuals and families with more complex situations—like families with immigrants—who remain without coverage.

> ***"Open Enrollment is going to be tougher than last year. But while those remaining uninsured may be harder to reach, we're working smarter to reach them."***
>
> U.S. Department of Health & Human Services Secretary Burwell at the start of the third open enrollment period.[3]

This brief is the result of a yearlong effort to identify substantial action steps that the federally-facilitated health insurance marketplace (FFM or federal marketplace) can take to enhance the consumer experience and reduce the number of uninsured Americans, particularly those living in immigrant families. While conducting research and writing this brief, the federal marketplace made some significant improvements to the online application and enrollment processes. Importantly, federal marketplace staff began discussions with stakeholders about additional improvements needed to facilitate enrollment of immigrants and their families. Although many positive steps were taken or are underway, there is still more work to be done to smooth the path to enrollment for eligible lawfully present immigrants and their families.

The ACA offers an opportunity for lawfully present immigrants to access affordable health coverage in the health insurance marketplace. Before passage of the ACA, many lawfully present immigrants did not meet the limited definition of "qualified" immigrant to be eligible for Medicaid or CHIP.[4] Importantly, the ACA introduced a more inclusive eligibility standard for legal immigrants by allowing all "lawfully present" individuals to purchase insurance in the marketplace and, if income-eligible, receive premium subsidies and cost sharing reductions.[5] Health reform also clarified existing consumer protections like ensuring that mixed immigration status families did not have to disclose the immigration status of individuals in the household who were not applying for health insurance. The Department of Homeland Security supported inclusiveness by assuring potential enrollees that information collected through the application process for health coverage will not be used for immigration enforcement purposes.[6]

Despite the overarching goal of increasing coverage for immigrant families, many faced significant barriers to enrollment in the federally facilitated health insurance marketplace. These barriers were particularly acute in the first open enrollment period. Eligible lawfully present immigrants often confronted long waits to get coverage; were inaccurately denied coverage or gave up trying and remained uninsured; or lost coverage that they thought they had enrolled in successfully. Moreover, the applications of families with immigrants who were determined eligible took much longer to process than applications for families with all U.S. born citizens.[7] Many of the challenges immigrant families faced when applying for coverage in the FFM resulted from the way its eligibility and enrollment system (known as Healthcare.gov) was designed and built. The main focus of Healthcare.gov's design was to streamline eligibility and enrollment for most applicants, which left it unable to accommodate the needs of individuals and families with more complex situations. Many aspects of the application process—such as ID proofing based largely on credit history; electronic verification of citizenship and immigration status with federal databases; and ruling out Medicaid and CHIP before assessing eligibility for marketplace coverage—often broke down for immigrant families.

Although there were many improvements to Healthcare.gov in its first year, including abatement of a key problem that caused the system to freeze when

key immigration and citizenship status information was entered, many challenges persisted for immigrant families in the second open enrollment period, and some continued in the third open enrollment period.

These problems added a layer of frustration on top of barriers to enrollment that predated the ACA for immigrant families who applied for health coverage in Medicaid and the Children's Health Insurance Program (CHIP). Some immigrant families may have been (correctly) determined ineligible for Medicaid and CHIP in the past and may be discouraged from applying for health coverage again. Some fear that applying for government sponsored health programs will have negative consequences on their ability to change their immigration status. Others struggle to understand application forms and notices when adequate access to language services is unavailable. Immigrant families may also believe that the immigration status of a parent disqualifies a citizen child from enrollment or are unaware of the range of lawfully present immigration statuses that are eligible for financial assistance in the federal marketplace. These barriers are some of the key reasons why even citizen children in immigrant families are more likely to go without health coverage than children with US-born families.[8]

The recommended action steps included in this brief are based on an online survey and listening sessions with navigators and certified application counselors who assist immigrants in applying for coverage—conducted by the Georgetown University Center for Children and Families in the spring of 2015 after the close of the second open enrollment period. Additional input was obtained from key stakeholders and national experts in the summer and fall of 2015, in the third open enrollment period.

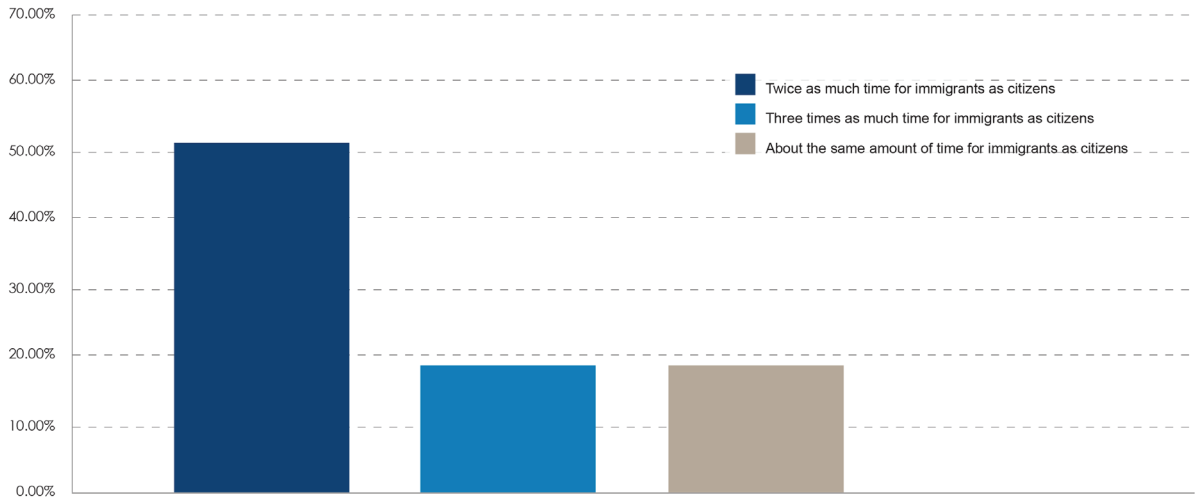
To better understand how the eligibility and enrollment process was working for immigrant families, the Georgetown University Center for Children and Families, in the spring of 2015, conducted an online survey and facilitated a series of small group listening sessions of navigators and certified application counselors (referred to collectively as consumer assisters) who provided application assistance to at least one immigrant or individual in an immigrant family applying to enroll in the FFM. At that time, 37 states relied on the federal marketplace for making determinations of marketplace eligibility. (For more information about the survey and focus groups, please see the Methodology section). Additional input was obtained from key stakeholders and national experts in the summer and fall of 2015 and in the third open enrollment period.

Assisters clearly indicated that the challenges immigrant families faced in the FFM continued despite overall advances in Healthcare.gov's application systems and processes in the second open enrollment period. Assisters generally reported improvements in the second open enrollment period related to setting up accounts online and by phone and fewer system errors, including the pernicious 'yellow screens' that froze the online application and blocked applicants from continuing. However, a majority of assisters reported that it took twice as much time for people in immigrant families to apply for coverage than families with only U.S.-born citizens [see Figure 1]. Assisters also had many ideas about what the federal marketplace could do to improve: topping the list were better coordination of eligibility with Medicaid and CHIP, providing other timely options for proving identity, and enhancing the system's ability to use document numbers to verify immigration status. [see Figure 2]

Consumer Assisters Have First Hand Knowledge About the Consumer Experience Using the Federal Marketplace

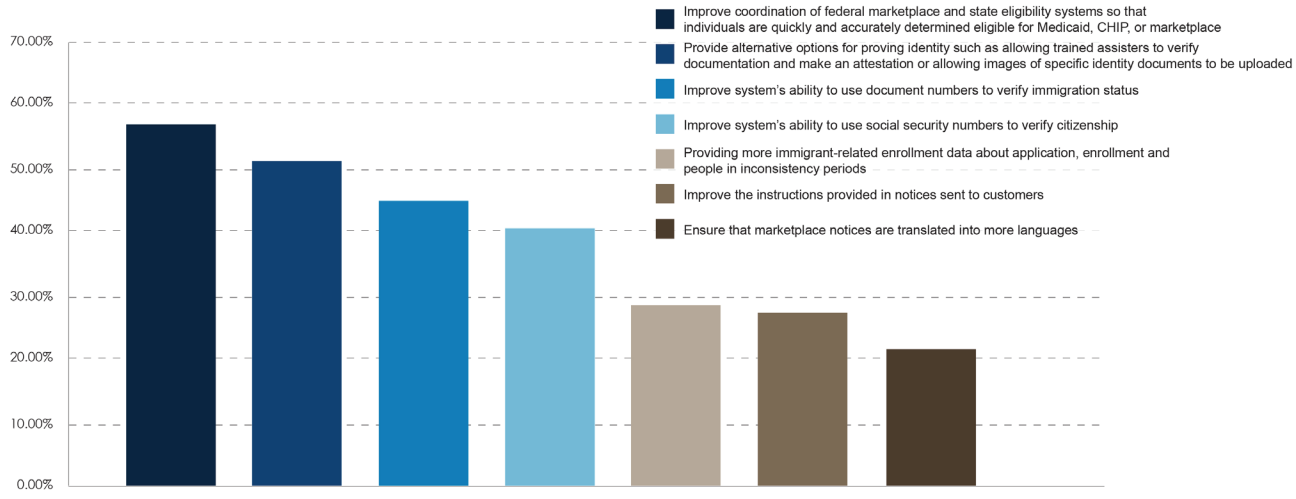
Consumer assisters, including navigators, in-person assisters, and certified application counselors, are trained to help people enroll in health coverage. In particular, they have been key in helping vulnerable people—including immigrants—overcome hurdles to enroll in health coverage. These assisters are located in or connected to trusted community organizations; are well equipped to meet the language and cultural needs of families in their service area; and are knowledgeable and skilled in navigating the eligibility and enrollment processes. Having accumulated first hand experience in helping families enroll in coverage, they understand the program rules and make excellent informants on how eligibility and enrollment systems and processes are working.

Figure 1: Survey Response: How Much Time Does the Application Take for Immigrants vs US-Born Citizens? (As of April 2015)



Question: Provide your best estimate of how much time, on average, it took to complete and submit an application for immigrants versus US-born citizens. The use below of "immigrants" means immigrant applicants and individuals in immigrant families and "citizens" means families with only US-born citizens. Time spent includes all time needed to set up an account, ID proof, and move the application forward, including time with the applicant, doing research, doing casework or whatever it takes to complete and submit the application.

Figure 2: Survey Response: What Could the Marketplace do to Improve the Application and Enrollment Process (As of April 2015)



Question: "Imagine that the federal marketplace could only do three things to improve the application and enrollment process for immigrant applicants and individuals in immigrant families. What would be on the top of your list? (Check up to three)"

Overview

The purpose of this paper is to identify priority areas where HHS and stakeholders can work together to improve enrollment in the FFM for immigrant families. We will describe five broad recommendations for improvement, providing assister feedback and action steps for each.

Immigrant Eligibility for Health Insurance Affordability Programs

The eligibility rules for immigrants in Medicaid and the Children's Health Insurance Program (CHIP) differ by program and by state, and are generally based on being a "qualified" immigrant who has reached the end of a five-year waiting period. States have the option to cover some additional lawfully residing immigrants without the five-year waiting period—particularly children and pregnant women—but not all states take advantage of the opportunity to use federal funds to cover these groups.[9] The eligibility rules include a broader group of "lawfully present" immigrants who are eligible to purchase a qualified health plan in the marketplace, and to receive premium tax credits (PTC) and cost sharing reductions (CSR) if income-eligible.

An additional complicating factor is that in a mixed-immigration status family, each family member may be eligible/ineligible for programs depending on whether the individual is a citizen, "lawfully present" under the marketplace definition, "qualified" based on the Medicaid and CHIP definition, or has an immigration status that is neither "lawfully present," nor "qualified." While this paper recognizes the complexity of layering complicated immigrant eligibility rules on top of income, family status, and other eligibility requirements, it does not attempt to cover immigrant eligibility for health care programs in depth. (See Appendix A for more information on the eligibility rules for health programs).

The Federal Marketplace Application and Enrollment Process

Individuals and families, with or without the help of a consumer assister, can apply for health coverage online using Healthcare.gov, by phone by calling the federal marketplace call center, or by mailing in a paper application. The online application comes with a significant advantage: applicants receive personalized information about premiums and out-of-pocket costs that include their PTC and CSR, which is essential to making an informed selection of health plans.

There are many steps involved in completing the online application on Healthcare.gov, from creating an online account to providing detailed information about household members, their income, and employment to plan comparison, selection, and enrollment. In Appendix B, we describe the key steps in the Healthcare.gov process that are particularly challenging for immigrant families to complete—creating an online account; clearing ID proofing; attesting to and verifying citizenship and immigration status; determining ineligibility for Medicaid and CHIP; and the 'inconsistency process' that is triggered when the system is unable to instantaneously verify citizenship or qualified immigration status through electronic data matching. However, it does not walk through every step in the entire application. (See Appendix B for additional details on the application process).

Priority Areas for Improvement

What follows are priority areas and specific action steps to improve the FFM application process for immigrant families, which have been developed through analysis of results from an online survey of consumer assisters and listening sessions, and in consultation with key stakeholders who work on these issues. The priority areas for improvement include refining immigration and citizenship status verification protocols (so that valid document numbers are more likely to be electronically verified and immigrants who are not eligible for Medicaid or CHIP are not routed unnecessarily to the state Medicaid agency); improving communications and expediting the resolution of inconsistencies; boosting resources in languages other than English and Spanish; and improving the customer experience for both assisters and applicants.

RECOMMENDATION #1: Refine the FFM's immigration status and citizenship status verification protocols and processes.

SUMMARY OF THE ISSUE

When applying for health coverage through Healthcare.gov, eligible individuals are encountering a series of problems with enrollment and eligibility that occur when the system is unable to immediately confirm their status as a lawfully present immigrant. These problems arise for U.S.-born, naturalized, and derived citizens alike if the system cannot generate a match based on a Social Security number (SSN) or other information.[10] Applicants who attest that they meet an eligible immigration status must provide a number from an immigration document type allowable under federal rules. This number is then electronically verified through the Systemic Alien Verification for Entitlements (SAVE) program. If the number cannot be immediately verified, SAVE instructs the marketplace to "institute additional verification." A similar action occurs for immigrants who have become citizens when their SSN cannot be verified through the Social Security Administration (SSA) or SAVE. These actions trigger what is referred to as 'an inconsistency period,' during which the applicant has 95 days to provide documents to prove their status. In the meantime, federal regulations allow these individuals to enroll in coverage with subsidies, based on which coverage option matches their financial eligibility.[11]

The inability to immediately verify immigration or citizenship status does not mean that the individual is ineligible or has provided false information.[12] It often results from a processing error, mistyping when entering document numbers, a slight mismatch between the exact name entered and the name in the online data set, or the use of hyphens and apostrophes. It will also occur if an applicant skips entering document numbers in an effort to move on in the application process. For citizenship status, verification might fail because SSA does not have complete citizenship records for some citizens, including many who were born outside the U.S. (For more details on how this works, see "How the Application and Enrollment Process Works" earlier in this paper or Appendix A for more detailed information).

When electronic verification of immigration status or citizenship fails, it results in unnecessary administrative work for Medicaid agencies and applicants and delays the enrollment of eligible immigrants in coverage provided through the FFM. Even though this was not the top concern for assisters, the inability to verify eligible status promptly causes additional problems and, therefore, should be refined.

Problem #1: Even when valid document numbers are entered for immigrants who are eligible, the electronic verification through SAVE may not be successful.

In the first year of open enrollment, problems with entering document numbers were particularly acute, resulting in the infamous 'yellow screen,' indicating the system had 'frozen' and preventing the applicant from continuing. During the second open enrollment period, this problem lingered although the frequency was reduced thanks to fixes implemented in Healthcare.gov. Even with fewer occurrences of this problem, some assisters reported they skip entering document numbers in an effort to move the application forward. While this may avoid the upfront difficulty, doing so can cause further delays in processing the application and create additional problems for applicants. This prompted the FFM to try different ways to communicate the importance of inputting these numbers during the third year of open enrollment.

WHAT CONSUMER ASSISTERS TOLD US ABOUT THE SECOND OPEN ENROLLMENT PERIOD

Even with new processes in place to alleviate barriers in the second open enrollment period, consumer assisters reported that the electronic verification process still needs significant improvement. Using document numbers to verify immigration status online and citizenship status were the third and fourth most pressing concerns respectively for assisters working with immigrant families in the second open enrollment period. When asked to name the top three improvements FFM could make, 45 percent of consumer assisters surveyed selected, "Improve [the] system's ability to use document numbers to verify immigration status, while 40 percent of consumer assisters said, "improve system's ability to use SSNs to verify citizenship status."

In the listening sessions, assisters described how the yellow screens interfered with the application process. One assister said that the yellow screen

happened when they chose "other" for the type of immigration documentation, and another assister said it happened even when entering immigration numbers from a green card or another common type of immigration document. In an effort to continue with the application, the assisters said that they would contact the federal marketplace call center, and in some cases, the call center representative resolved the problem. In other cases, the call center could not unlock the application, allowing the individual to upload documentation, so it was necessary to refer the case for further problem solving known as 'case work.'

In consumer assisters' own words:

"I could never get any of the ID numbers to go in and be accepted, [whether] citizenship certificates or green cards, for example."

"Almost every immigrant applicant I assisted was asked to submit documents online or by mail to verify their citizenship or immigration status, even when social security numbers and immigrant document numbers were provided on the application."

Recommended Action Steps

Conduct extensive technical testing with knowledgeable users to identify circumstances that lead to the inability to input or verify document numbers. Although there have been significant improvements to Healthcare.gov, problems continue, which may or may not be reported to the federal marketplace. A concerted effort to test multiple scenarios and document numbers, with system experts present, could hasten the identification of circumstances that create the problem and lead to quicker corrective action. While there has been a collaborative effort in the fall and winter of 2015 and 2016 to troubleshoot many immigration and citizenship status inconsistencies, a more structured process for user testing on an ongoing basis would be helpful in identifying both residual problems, as well as in pinpointing new issues as system changes are implemented. System developers can then implement technical solutions to the problem, including correcting glitches in the underlying system programming; providing additional online prompts for users (some of which has been done in November 2015); and developing training resources for assisters and FFM call center representatives about required data entry, highlighting common mistakes and how to avoid them.

Institute a second step to resolve a data-matching problem before triggering the inconsistency period even if applicants appear eligible for Medicaid or CHIP based on income and other factors. Sending an individual or family to Medicaid or CHIP may not be necessary if there are additional steps that can be taken to verify immigration status relatively quickly. While these steps may not be in "real-time"—meaning they cannot be executed on the spot—if verification can be expedited with a second check in the SAVE system or prompt review of uploaded documents by authorized FFM staff or contractors, then the process of being sent to Medicaid could be averted for individuals who are ineligible for the program. The FFM should consider implementing procedures whereby applications that fail the initial match with SAVE are routed for this second step before initiating an inconsistency period. While current regulations require the immediate triggering of an inconsistency, CMS should consider whether changes to this timeline (for example, a five-day delay rather than immediate action) would reduce both administrative barriers and costs while expediting access to coverage.

Continue to communicate the importance of inputting document numbers through assister trainings and communications, and online prompts. Some immigrant applicants rely on assisters to help them through the application process. Assisters who encountered problems entering document numbers may skip this process in order to complete the application process. This may lead to eligible immigrant families who have the needed document numbers, ending up in an inconsistency period and ultimately losing coverage if they are confused about the need to provide documentation or take other steps to correct the inconsistency.

(Authors' Note: When the third open enrollment period began, Healthcare.gov incorporated prompts to encourage individuals to provide SSNs and immigration document numbers online to avoid data matching issues.)

Ensure a path to affordable coverage for individuals who have an ongoing immigration status-related data matching issue. Individuals eligible for financial assistance to purchase marketplace coverage are not always offered immediate enrollment with subsidies, although federal rules allow it.[13] According

to marketplace rules, applicants who attest to an eligible immigration or citizenship status should be offered enrollment with subsidies if otherwise eligible while they await verification. However, this does not happen in two cases for individuals with immigration or citizenship status data matching issues:

1. If an individual whose immigration status cannot be confirmed appears to be ineligible for Medicaid based on income and other factors, the applicant is allowed to buy a marketplace plan but without financial assistance until they provide documentation proving their lawfully present status.

   (Authors' Note: In December 2015,Healthcare.gov implemented a new, more automated process to identify and inform applicants with incomes below 100 percent of FPL who have immigration status data matching issues that they may be eligible for PTC. If the applicant provides verification of immigration status and is indeed ineligible for Medicaid based on immigration status, the applicant is then enrolled in PTC.[14] More details about this process are provided in Appendix B).

2. If an individual looks eligible for Medicaid on factors other than unverified immigration status (i.e. income), the individual is routed to Medicaid. Although the Medicaid agency is required to enroll the individual during a reasonable opportunity period if the only outstanding verification is proof of immigration status, this is not happening consistently.[15]

Problem #2: Many immigrants who are not eligible for Medicaid or CHIP are being routed unnecessarily to the state Medicaid agency.

The wording of the application in Healthcare.gov does not allow the system to distinguish the differences between the definitions of 'qualified immigrant' for Medicaid eligibility and 'lawfully present' for marketplace eligibility. As a result, when the system is unable to immediately verify immigration status, applicants who attest to the broader definition of lawful presence are transferred to Medicaid if they otherwise appear eligible based on income and other factors, including eligibility category (e.g., child, parent, or newly eligible adult). Transferring individuals who are not eligible for Medicaid based on the narrower 'qualified immigrant' status often results in substantial enrollment delays for applicants. It also creates unnecessary administrative burden for state agencies in collecting documents from applicants and, at best, yields a denial from Medicaid and a transfer back to the FFM. However, it is not clear that these individuals are consistently transferred back to the FFM, and when they are, they are required to provide the same documentation again to prove their lawful presence status to the marketplace. In the meantime, the lowest income, most vulnerable lawfully present individuals have gone without coverage for weeks or months, even when they are eligible to enroll in the marketplace.

WHAT CONSUMER ASSISTERS TOLD US ABOUT THE SECOND OPEN ENROLLMENT PERIOD

Eliminating the transfer of individuals who are not eligible for Medicaid, and particularly for those with income below the federal poverty line, is the top priority for a majority of assisters (57 percent). Assisters also expressed a lingering concern about a lack of awareness by FFM call center representatives of PTC eligibility for immigrants with income below the poverty line.

In consumer assisters' own words:

"Still having issues with getting tax credits for immigrants with less than 5 years of LPR status"

"The most common problems have been… application being sent to Medicaid even though family did not meet the 5-year [waiting period] requirement."

"There was also inconsistency with some clients receiving proper premium tax credits and others being denied [LPRs for] under 5 years and under normal tax [credit income] limits."

A number of assisters noted that they sometimes work with their state agency to get an "expedited review" of Medicaid or CHIP eligibility, particularly if individuals are facing an urgent medical problem.[16] This step bypasses the sometimes-problematic account transfer process between the FFM and state Medicaid agencies and allows an ineligible individual to receive a faster Medicaid denial. Once an applicant attests to

receiving a Medicaid denial, the FFM is able to move forward with its determination of eligibility for PTC. Importantly, assisters viewed this type of "expedited denial" as a short-term fix for only applicants working with an assister who is savvy enough to navigate the issue. Moreover, assisters are anxious for a long-term solution that allows the FFM to accurately assess these individuals' ineligibility for Medicaid, and moves them through the FFM eligibility process without an unnecessary detour to Medicaid.

Recommended Action Steps

Improve Healthcare.gov's ability to discern differences between immigration statuses that qualify for Medicaid eligibility versus Marketplace eligibility. The immigration statuses that qualify for Medicaid are a subset of those that qualify for marketplace eligibility. Currently, applicants are shown the more inclusive marketplace list of 'lawfully present' immigration statuses and asked to respond yes or no to whether they have an eligible immigration status. As a result, when the system is unable to instantly verify immigration status, it is not able to differentiate between Medicaid and marketplace eligibility. Healthcare.gov should be enhanced to gather sufficient information to distinguish an attestation of qualified immigrant status for Medicaid eligibility so that ineligible immigrants are not unnecessarily transferred to the Medicaid agency.

Involve stakeholders in problem solving. In some cases, it may be challenging for the FFM to screen Medicaid eligibility if they lack immigration status or citizenship verification. A further discussion with immigrant stakeholders on developing the best protocols for these circumstances could help uncover better procedures and processes to verify immigration status. Is it best to continue processing such applications at the FFM and provide coverage through the marketplace in the interim? Should those applications be expedited for resolving the issues associated with immigration or citizenship status? These are the kind of questions that can be probed if stakeholders are engaged in the problem-solving process.

(Authors' Note: In December 2015, FFM staff began conversations with immigrant and consumer stakeholders on how to best develop these protocols. At the time of publication, next steps had not yet been decided.)[17]

RECOMMENDATION #2: Improve communications and expedite the resolution of inconsistencies.

SUMMARY OF THE PROBLEM

When immigration or citizenship status cannot be immediately verified, an inconsistency period is triggered. A key problem with the inconsistency process is difficulty in communicating effectively with affected applicants. Although the FFM sends email or paper notices to applicants several times during the 95-day inconsistency period, notices are provided in only two languages. Many immigrant families whose primary language is not English or Spanish do not understand that the notice requires them to take additional action or risk losing coverage. Some of these individuals are enrolled in coverage and are paying their premiums, so they may assume that no action is necessary. If they are unable to comprehend the notices and do not respond within the required time frames, some may eventually discover they have been disenrolled when they try to see a doctor, pick up a prescription, or are sent a bill for service that has been denied.

A tagline translated into 15 languages is embedded in the English notice.[18] However, in the first and second open enrollment periods, these taglines contained the same generic 'how to get help' messages, rather than conveying the urgency of action required, or even that an individual must take action at all. As a result, applicants often did not know whether or how to respond.[19] Additionally, the notices are not tailored to communicate individualized information – for example, an individual may have submitted "x" document, but needs to submit "y" document instead to prove immigration or citizenship status. In April 2015, the federal marketplace began including customized language in the inconsistency notices that is more specific about why previously submitted citizenship documentation did not clear up the data matching issue, and what documents are needed to resolve the problem.[20] The marketplace has indicated that it hopes to move to these more customized notices for immigration status inconsistencies as well, which will be a welcomed improvement but is not in place as of this brief's publication date.[21]

Initial problems in the first open enrollment period with matching documents uploaded to Healthcare.gov or submitted by mail to the right application

have largely been resolved, but delays in processing documents and a lack of clear communication when documentation is inadequate creates a void in the process. This problem is exacerbated by the fact that the federal marketplace does not automatically confirm the receipt of documents nor can federal call center representatives confirm if documentation has been received or processed. It is our understanding that in the third open enrollment period, a manual process was being used for call center representatives who receive consumer inquiries to request and share information confirming receipt of documents and the status of the review process. How well this process works and how timely it will be is unclear.

Following the first open enrollment period, more than 100,000 people with immigration and citizenship status inconsistencies ultimately lost coverage.[22] In September 2015, more than 400,000 individuals lost coverage due to unresolved immigration status and citizenship inconsistencies.[23] HHS has indicated that the majority of applicants in the first open enrollment period who lost marketplace coverage due to inconsistencies never submitted documentation, pointing to communication issues rather than document processing issues. Additionally, it is important to note that the majority of the 400,000 affected in the second open enrollment period had *citizenship status* inconsistencies rather than immigration status inconsistencies. The positive steps the federal marketplace has already undertaken to improve the inconsistency process, along with other action steps suggested in this brief, will go a long way in lowering the number of unresolved inconsistencies that may result in a loss of coverage.

WHAT CONSUMER ASSISTERS TOLD US ABOUT THE SECOND OPEN ENROLLMENT PERIOD

Assisters expressed concern that when they mailed documents to the mail-in center or uploaded documentation to HealthCare.gov to verify the applicant's immigration or citizenship status, verifications were not processed and resulted in erroneous terminations of coverage. The experience with mailing in documents was so frustrating, assisters determined that they could not rely on the process and stopped using the option. The alternative of uploading documentation to Healthcare.gov was also problematic. The FFM call center cannot see and confirm the receipt of documents in real time, and a notice is not sent when documentation is "received," electronically, so assisters expressed concerns that even uploaded documentation were getting lost. Assisters also noted that the FFM often required naturalized citizens who had already provided a SSN during the application process to provide additional documentation to prove their citizenship. While assisters perceived this as an additional requirement for naturalized citizens, this was likely a routine data matching issue that followed the standard protocol to clear up such an inconsistency.[24]

In consumer assisters' own words:

"Never mail in documents [to the FFM's mail-in processing site] because they go into a black hole."

"Almost every immigrant applicant I assisted was asked to submit documents online or by mail to verify their citizenship or immigration status, even when social security numbers and immigrant document numbers were provided on the application."

Recommended Action Steps

Improve communication with those in immigration and citizenship status inconsistency periods.

Importantly, notices should be provided in languages beyond English and Spanish according to language preference indicated in the application. Federal law requires the FFM to meet the language needs of applicants for health insurance (see language access section recommendations below). In the meantime, the FFM should continue work to improve the placement and content of taglines that direct non-English or non-Spanish readers to better understand how to take action, what additional action they need to take, and to receive language assistance. Immigrant stakeholders have a wealth of experience in communicating complex information to immigrants. Stakeholders should continue to be involved in content and message development in order to achieve the highest level of comprehension in written notices. Devising ways other than traditional mail to communicate notice content, through calls in languages other than English, translated text messages, or other means, could also be helpful. Ultimately, notices should be translated into the

most common languages spoken by FFM enrollees in addition to Spanish.

(Authors' Note: In the third open enrollment period, Healthcare.gov began providing "onscreen eligibility results" (instead of just a downloadable eligibility notice) that includes eligibility for each individual in the household, and a warning in red text of "temporary eligibility" for anyone in the household who needs to clear up a data matching issue to keep their coverage.)

Expedite the resolution of inconsistencies when adequate documentation is uploaded during the application process. The FFM should work to improve its timeliness in reviewing uploaded documentation and complete the verification process. The FFM should also implement system functionality that enables FFM call center representatives to see the status of documents received and inconsistency issues resolved in real time.

Continue to improve timeliness and overall performance of the mail-in document center. Although the federal marketplace has indicated that early problems matching documents to applications have been largely resolved, residual problems persist, particularly when an individual may have been locked out of their account and created a new one. Ongoing assessment of the mail-in document center performance to identify and resolve problems with lost documents and eliminate delays in processing inconsistency documents is needed. Common problems in matching documents with the correct applications should be identified and communicated to assisters and the stakeholder community.[25]

(Authors' Note: Since the time this assister survey was fielded and listening sessions were facilitated, new information has been shared by the federal marketplace (as noted above) that helps explain why there was a perception that the documentation process was flawed (i.e., a lack of clarity regarding inadequate vs. lost documents). This illustrates that timely sharing of information with assisters and the national experts who support them can lessen the tendency to make wrong assumptions and will promote more rapid problem-solving.)

RECOMMENDATION #3: Develop an alternative process to confirm identity.

SUMMARY OF THE ISSUE

The identity proofing process ("ID proofing") is one of the first steps in applying for health insurance online on HealthCare.gov. Although identity proofing is not an eligibility requirement, it has been put in place to assure that applicants are who they say they are and protect access to personal information that may be provided from electronic sources during the application process.[26] After setting up an online account in order to proceed with the application process, a household contact filing an application must correctly answer several questions derived from his or her credit history and other personal information gathered by Experian, the credit history company contracted by Healthcare.gov to verify identity.

This protocol can pose an immediate obstacle for immigrants and citizens alike.[27] When there is limited or no credit history or other demographic information available, Experian cannot generate the questions online and there is the perception that calling Experian, which is the next step in the process, does not solve the problem. This has led assisters to conclude that calling Experian in these cases is unnecessary and administratively inefficient, in addition to being frustrating for applicants. On the other hand, when the online application is able to generate the questions but the individual is not able to answer correctly, calling Experian may result in additional questions that can be answered satisfactorily so that the individual can continue with the application.

When ID proofing online and by phone does not work, HealthCare.gov applicants are instructed to submit identity documents but must wait a week or more for this documentation to be reviewed and approved. In the meantime, individuals who are unable to complete the online application or individuals who are unable to submit satisfactory documentation can apply by phone or mail in a paper application. However, it is unclear how or if they are notified of these options. Importantly, individuals who are unable to pass the online or phone ID proofing are not allowed to use key online account features like selecting a plan based on the individual's financial assistance, receiving electronic notices, updating their information, and renewing their coverage.

WHAT CONSUMER ASSISTERS TOLD US ABOUT THE SECOND OPEN ENROLLMENT PERIOD

Consumer assisters report that getting through ID proofing is one of the most common obstacles to enrolling in health insurance on Healthcare.gov. When asked to name the top three improvements the FFM

could make, offering "alternative options for proving identity" was the next to the top priority, with more than half (53 percent) of assisters ranking it in the top three. Moreover, four out of ten assisters surveyed indicated that proving identity online was almost always or often a problem.[28]

Assisters noted that many immigrant families cannot be helped when calling Experian to resolve ID proofing issues. This includes individuals for whom Experian cannot generate questions, as well as those who are unable to answer difficult questions such as confirming past addresses when they have frequently moved. In assister listening sessions, it was clear that this problem is so frustrating that some assisters circumvent Experian and directly contact the FFM call center to begin a phone application when online ID proofing fails, although this is not the most efficient path to eligibility and enrollment. Other assisters indicate they may bypass ID proofing screens, complete the whole application online, and then call the FFM call center and ask them to "submit the application" rather than follow the process Healthcare.gov provides. However, individuals determined eligible through this process are unable to compare plan features and costs based on the size of their premium tax credit or cost sharing reduction online as the system was designed.

In consumer assisters' own words:

"The most common and time consuming problem was verifying identity..."

"Many immigrant applicants I worked with could not complete the application online, and had to call the marketplace instead, because we could not get through the identify verification step online."

"An immigrant … was unable to get his identity verified because of lack of a credit history, even though he had all his documents."

Recommended Action Steps

Identify circumstances when calling Experian is not useful and bypass this step for those applicants. It is generally believed that when Experian is unable to generate online questions to confirm identity, it is also unable to help applicants over the phone although this is the required next step. The federal marketplace has not confirmed if this consistently happens in these cases but should test the theory and develop an alternative mechanism that bypasses the need to call Experian if doing so is not useful.

Expedite the review and approval of uploaded identity documents. Applicants who cannot get through online identity proofing should be able to submit documents electronically on Healthcare.gov and have them quickly reviewed. In an ideal world, the uploaded documentation would be reviewed in real-time. By the time the individual had completed the rest of the online application, their identity would be confirmed, and they would be able to get an immediate eligibility determination and continue with choosing a health plan. The immediacy of such action is particularly important when an applicant is being helped by an assister since a delay necessitates a subsequent appointment, which may or may not happen if the applicant is discouraged by the process.

Permit authorized assisters, with appropriate training, to attest to an applicant's identity and upload documentation for the case record. Under this approach, consumer assisters would be trained to review the appropriate type of documentation needed to verify an individual's identity, and upload the copies of documentation for the case record. In listening sessions, some assisters noted a willingness to take on this role to simplify the application process, but wanted to receive additional training to ensure they are prepared for this task. Similar practices are in place in several states that operate their own marketplaces.

Expand the list of documents that can be used to confirm identity. A more expansive list of acceptable documents would help more consumers confirm identify and take full advantage of the online tools available for enrollment. For example, for household contacts who are immigrants, acceptable documents could also include a combination of documents such as a foreign driver's license, official school or college transcripts that include the applicant's date of birth or a signed lease agreement that confirms to the address shown on a photo identification.[29]

Provide an alternative online application that retains the advantages of applying online but does not share protected personal information. As noted earlier, a significant disadvantage of not being able to submit an online application is the absence of an alternative

process for plan comparison showing individualized financial assistance. Individuals who are unable to complete the application online cannot see their *personalized costs* with respect to premiums and out of pocket charges *based on their premium tax credits and cost sharing reductions*. Cost is always a top, if not the top, factor when choosing a health plan. The individual's share of premiums and cost-sharing reductions are extremely difficult and impractical for an applicant and assisters to manually factor into comparison and selection of plans. And, even the most patient and skilled FFM call center representative cannot walk through all the plan options, given different metal levels and plan choices. Providing another path to accessing individualized cost information and plan options is a high priority, both as a short-term solution for those who await manual verification of identity, as well as those who lack sufficient documents to pass identity proofing.

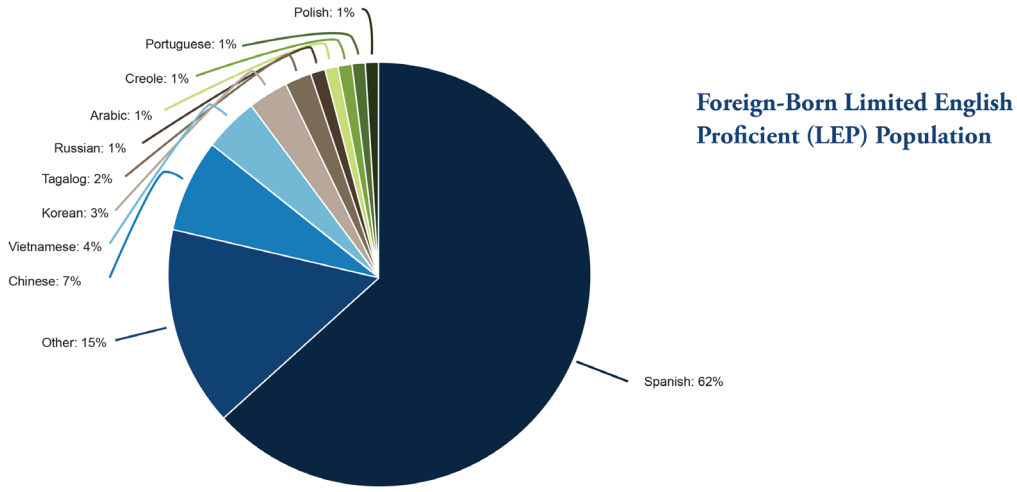
RECOMMENDATION #4: Boost resources for communication in languages other than English and Spanish.

SUMMARY OF THE PROBLEM

Language access is a common barrier when working to improve coverage rates for immigrant and mixed immigration status families.[30] An estimated 25 million people in the U.S. are limited English proficient (LEP), which for purposes of this paper means that they reported speaking English less than "very well" as classified by the Census Bureau.[31] The most prevalent languages spoken among foreign-born LEP individuals in the U.S. are Spanish, Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, Creole, Portuguese, and Polish with hundreds of thousands of LEP individuals speaking additional languages.[32] The FFM provides the bulk of its written and online information—including paper and web-based applications, marketing materials, notices, and more—only in English or in some cases Spanish.[33] As a result, LEP consumers are left with effectively two options to learn about their coverage options, make changes to their application, and enroll: use the contracted telephonic language service or seek the help of an application assister. And, when interacting with either the FFM call center to apply, inquire about their application, or make changes, or the FFM contractor (Experian) for matters related to ID proofing, people who do not speak English or Spanish proficiently must use a contracted telephonic language service.

Language barriers have become particularly evident in the notices provided to enrollees by the FFM. These notices often contain critical action steps the individual must take to gain or retain health coverage, and yet are provided only in English and, in some cases, Spanish. The notices do contain a tagline translated into 15 languages, embedded in the English notice.[34] However, in the first and second open enrollment periods, these taglines contained

Figure 3: Most Prevalent Languages Spoken Among Foreign-Born People in the United States Who are Limited English Proficient (2013)



Source: "The Limited English Proficient Population in the United States," Migration Policy Institute, (July 2015), available at http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states (Figure 3).

generic 'how to get help' messages, rather than content specific to each particular notice.[35] As a result, consumers often disregarded the notices or were unable to understand the urgency of taking action. On April 2015, these taglines were revised and are now more action oriented.[36] HHS staff also sought comment from stakeholders on notices, but yet it is not clear when or whether there will be additional translations of notices or revisions or customization of the translated taglines.

When more than 100,000 people who had bought coverage in the FFM during the first open enrollment period lost coverage due to immigration or citizenship status inconsistencies, the National Immigration Law Center filed two administrative complaints with the HHS Office for Civil rights asserting that the FFM violated longstanding civil rights laws and the ACA's anti-discrimination provisions by not having the notices translated into the primary languages of the consumers.[37]

Language Access is Required By Federal Law

Meeting the language needs of applicants for health insurance in the FFM is required both by Title VI of the Civil Rights Act of 1965 and Section 1557 of the ACA, which prohibit discrimination on the basis of race, color or national origin in any program or activity administered by an executive agency or receiving federal funds. With regard to oral communication, LEP individuals must be able to access bilingual staff or interpreters to assist with oral communication as part of the application process.[38]

WHAT CONSUMER ASSISTERS TOLD US ABOUT THE SECOND OPEN ENROLLMENT PERIOD

The highest priority language access problem identified by assisters in the online survey was the need for the FFM to translate notices. Although not among the top three improvements noted by assisters, "improv[ing] the instructions provided in notices sent to consumers" and "ensur[ing] that marketplace notices are translated into more languages" were the sixth and seventh most popular responses.

In terms of oral interpreting, consumer assisters generally noted that progress was made—like shorter wait times for interpreters—in the second open enrollment period when individuals sought language assistance by phone through the FFM call center or through Experian's ID proofing phone line.[39,40] However, in listening sessions, assisters identified confusion about protocols around the use of on-site interpreters when calling the language line with an LEP consumer. Specifically, some assister entities have their own bilingual staff who provide enrollment assistance directly to consumers in a non-English language or utilize in-person interpreters in their organizations. When calling the FFM call center, sometimes assisters were allowed to interpret for clients themselves or use their on-site interpreter, while in other cases, the FFM call center incorrectly required the assister to use an interpreter through the federally contracted language line only. Assisters in our listening sessions found that the process worked more smoothly when they interpreted themselves or used an on-site interpreter who could communicate with the consumer face to face.

In consumer assisters' own words:

"I was impressed that the marketplace got hold of an [interpreter] for …[an uncommon] African language… However the [interpreter] didn't have any background as to why we were placing the call and ultimately was not able to help the client answer the questions that were being asked in the marketplace phone call."

"Often… it was difficult to connect with the call center operators that were bilingual."

"Some of the phone help spoke very rapid Spanish… with different vocabulary. Choosing a plan over the phone is next to impossible."

"It should be better known that if consumer needs an uncommon language, a 'reservation' for an interpreter can be made in advance for a particular day and time."

Recommended Action Steps

Translate notices so that LEP applicants and enrollees know when and how to take action. Translating notices sent to applicants and enrollees in additional non-English languages should be the FFM's highest

translation priority. The FFM should work with stakeholders to develop a work plan and secure the resources to translate all notices into other languages based on the standard provided in the HHS Office for Civil Rights LEP Guidance.[41] The FFM should also analyze language data from applications to identify and prioritize languages for translation. As a first step, the FFM should customize all translated taglines to the particular type of notice so that applicants will know when and if they need to take action.

Provide in-language assistance through the FFM call center in more languages than Spanish. In recent meetings, HHS staff shared that the vast majority of FFM call center requests for language assistance were for ten specific languages, though they did not disclose which languages rose to the top. With more than two years of enrollment experience, HHS staff should analyze and share data with stakeholders about language assistance use, along with preferred language data from FFM applications. Stakeholders with expertise in assisting consumers with languages other than English and Spanish could provide useful input in regard to moving toward providing in-language assistance in additional top-tier languages. HHS should also recruit and hire bilingual call center staff and continuously monitor the quality of call center interpreting.

Allow assisters to provide interpreting directly or through onsite interpreters when calling the FFM call center. Organizations that receive navigator grants are required to accommodate the language needs of the communities they assist. Many do so by hiring bi- or multi-lingual staff to work with consumer assisters. Face-to-face interpreting can be much more effective than over the phone. However, some FFM call center representatives insist on using the FFM's contracted language line for interpreting, even though it is duplicative of the service that paid navigators are required to provide. HHS should provide clear guidance to both FFM call center staff and external assister entities that clearly permits assisters to provide interpreting directly or through onsite interpreters when calling the call center.

Permit assisters to pre-schedule appointments with interpreters. When helping the individuals who speak less common languages, assisters may face a long wait time to get the appropriate interpreter in addition to time spent waiting to talk with a FFM call center representative. Often, these waits exceed the appointment time, which is very frustrating for applicants. This problem could be rectified with advance planning. Assisters take note of LEP applicant language needs when scheduling appointments in order to match them with existing language resources or flag the need for external interpretation. In that latter case, prescheduling appointments with the FFM's call center representatives and interpreters would be more efficient and effective for all concerned.[42]

Target assister resources to organizations that work to enroll immigrant and LEP communities. A critical way to support applicant and enrollees language needs is to continue to target federal consumer resources to organizations that can work with consumers in languages other than English.[43] One strategy would be to require organizations applying for grants to identify specific strategies and languages they will use to reach out to and enroll people in immigrant families or people with limited English proficiency. These language access plans could then be evaluated and rated during the review process for future navigator and consumer assistance grants. In addition, HHS should continue to provide grants through the Office of Minority Health to consumer assisters who support and can competently assist immigrant and minority families.

Recommendation #5: Improve the customer experience for both assisters and applicants, including refining the process for resolving complex cases.

SUMMARY OF THE PROBLEM

The FFM was designed to operate in a highly sophisticated technology environment where online systems and electronic databases determine eligibility in real time. However, immigrant families, and the consumer assisters who help them apply for health coverage through the FFM, continue to face problems throughout the application process that often requires a human touch for troubleshooting or individual casework. When individuals and assisters run into these kinds of situations, they generally contact the FFM call center to ask for help in troubleshooting the problem or determining the next step. But call center representatives have limited access to individual case information. Attempts to request that the case be referred to casework, which was the next step when

the FFM call center is unable to resolve a problem, are often unsuccessful. As a result, cases may stall for weeks or months without action. While a formal appeals process is an option for some but not all cases, it is a prolonged and resource-intensive step that is not a substitute for casework.

(Authors' Note: In the third open enrollment period, the marketplace added a helpline for assisters that acts as a technical assistance resource to help assisters with complex issues. This helpline focuses on policy issues and helpline staff do not have access to the consumer's application information.[44]

WHAT CONSUMER ASSISTERS TOLD US ABOUT THE SECOND OPEN ENROLLMENT PERIOD

Assisters stressed that a key area where the FFM can improve is having a clear process for getting timely help on complex cases. When asked what the FFM could do to improve support for assisters in helping immigrant families, more than four-fifths responded (83 percent) "provide an easier way for assisters to get help on complex cases" and more than half (58 percent) said, "improve assisters access to the call center or other help."[45] In listening sessions, assisters reflected that the process for "escalating cases" through the FFM call center was unclear and inconsistent at best. Consumer assisters described contacting the FFM call center to check on a case, and having a call center representative tell them that there was no progress and to re-escalate the case for another 30-day period and then wait again for a resolution. Another assister described reaching an FFM call center representative who told her that a case had been resolved, but the applicant had not been notified. More than one assister said that it was easier to delete an application, and start the process again online or by phone—which could take hours—and hope for a better outcome than to try to escalate a case.

In listening sessions, consumer assisters also discussed general customer service problems they encountered during listening sessions. They noted that when contacting the FFM call center to check on the status of a case, FFM call center representatives cannot access case notes from the mail processing center in Kentucky (run by SERCO). Assisters noticed that some applicants were locked out of uploading documentation to their application during the inconsistency process and that some call center staff could "unlock" an application and others could not. Another issue is the lack of ability to train in a "live system" environment.

Assisters also frequently noted that many of the applicants they worked with had little to no computer literacy and limited literacy even in their own language. These individuals and families will continue to need to application assistance to apply online, and would not be able to apply online their own even if the entire application were translated.

In consumer assisters' own words:

"Almost everyone I helped had no email address, no computer at home, and no tech skills such as … typing. Literacy skills [were] very low as well, even in their native language."

"I've done escalations with 25 different clients and I didn't get a call back on a single one."

"The wait times [at the federal marketplace call center] can be long. I waited on hold with one family for 40 minutes only to be cut off. When we called back, it was another 35-minute wait. The family ended up leaving without being helped due to time constraints."

RECOMMENDED ACTION STEPS

Dedicate a specialized unit in the FFM call center to resolving complex cases for immigrant families. As noted in the immigrant eligibility section, the overlay of two complex sets of rules: general eligibility rules for marketplace financial assistance and Medicaid, and eligibility rules for immigrant families, makes it very difficult for FFM call center representatives to understand and troubleshoot complicated cases. Even with additional training and carefully written scripts, expecting all call center representatives to be experts on all aspects of marketplace and Medicaid eligibility would be a tall order. Having a customer service unit within the federal call center that specializes in resolving the complex application issues immigrant families face, including data matching issues, documentation needs, and eligibility scenarios, would be an enormous help.

Provide functionality for the FFM call center to access the application to better manage and resolve complex cases. FFM call center representatives do not appear to have the tools to manage casework or get updates on a case. A 'back end' to the application and enrollment system should be built that allows FFM call center staff to see and communicate case information in real time. This should include the status of documentation review, whether ID proofing or the inconsistency process had been cleared, next steps, and if any additional action is needed.

Create workflows for casework and share processes with stakeholders. Call center representatives refer to an "escalation" process when an application needs casework, but the process is unclear and action on cases is not always communicated to applicants. The FFM should map out suggested workflows for casework and share so that assisters and other stakeholders understand the process. The result would lead to a common understanding of steps and timelines, as well as expectations about how and when the FFM communicates with applicants with the potential to identify improvements and efficiencies.

Provide additional training tools to the assister community. Assisters suggested that they could expand their competence, increase their efficiency in helping applicants, and better train new consumer assisters if they had ready access to a training or testing environment that mirrors Healthcare.gov. This type of access would allow assisters to review the entire online application and show the possible answers in order to train additional assisters and better understand the online application when changes are introduced.

Continue to provide resources for application assistance. Assisters stressed that, with many immigrant families they helped, applicants or household contacts had no email address, no computer at home, no computer skills such as keyboarding, and low literacy. Individuals in these circumstances will continue to need personalized assistance to apply online and may even struggle to apply by phone, even with an interpreter, without in-person assistance.

Continue to promote an environment of transparency and problem solving with stakeholders. Agency staff have committed to regular conversations with stakeholders. These meetings and the work that needs to take place in between achieve the best results when there is transparency and timely sharing of information with stakeholders to help diagnose and fix problems quickly. Immigrant policy experts and other stakeholders have a deep understanding of the barriers that lawfully present immigrants face in accessing health coverage. Many have years of experience in public insurance programs, as well the eligibility and enrollment systems used to access coverage. They are knowledgeable about translating complex eligibility and health insurance concepts into comprehensible notices that meet legal and regulatory requirements. They interact frequently with assisters and others who work with the immigrant community, and can act as a conduit for sharing information from and with the field. Moreover, they are motivated and committed to ensuring that the promise of affordable health coverage is fulfilled for those who qualify. Routine sharing of key data can help stakeholders communicate with key communities and help to identify trends that may lead to quicker resolutions. Allowing stakeholders to test new systems and processes before they go live—when making changes to an application process—could also be a very helpful strategy and one that some state-based marketplaces have used. In working together, HHS and stakeholders can conduct case reviews to identify root causes of problems. Stakeholders can also continue to assist with additional training and communications with those who work directly with immigrants.

Conclusion

The Affordable Care Act has provided a significant opportunity to provide health coverage to many lawfully present immigrants who are not eligible for Medicaid and CHIP because of the restricted immigrant eligibility rules in those programs. With the third open enrollment now complete, enrolling the remaining eligible but uninsured is likely to become more challenging. It will require not only tailored communication to those who are eligible but unenrolled, but also improved systems that make the application and enrollment process work for individuals and families with more complicated

situations—like immigrants—who remain without coverage. The action steps provided in this paper are intended to provide a roadmap for those who oversee the FFM as they continue to work to get enrollment right for families with immigrants.

Methodology

The Center for Children and Families at Georgetown University's Health Policy Institute (CCF) conducted two types of qualitative research that informed this report: an online survey and telephone listening sessions. Both methods helped gather information from consumer assisters in states that rely on Healthcare.gov and the FFM call center.

Online Survey

The online survey, provided in Appendix D, was designed to gain a more comprehensive understanding of successes and challenges of providing assistance in applying for health coverage during the second open enrollment period (November 15, 2014 to February 15, 2015) to families that include immigrants. The survey was open from March 22, 2015 to April 23, 2015 on surveymonkey.com. The survey instructions invited anyone who "provide[d] application assistance to at least one immigrant or individual in an immigrant family during the second open enrollment period to respond."

In total, CCF received 281 complete responses to the online survey. However, 71 responses were removed from analysis because the individuals did not work in the 37 states that rely on Healthcare.gov for enrollment in the health insurance marketplace.[46] This left 210 survey responses remaining that were used for the analysis. CCF promoted the survey link through In the Loop, an online community for consumer assisters, the Asian Pacific Islander Health Forum's Network of assisters, and through navigator contacts in a number of Healthcare.gov states, including Arizona, Florida, Michigan, Ohio, Georgia, Virginia, Oklahoma and Texas. Responses to the survey were voluntary.

Of respondents, more than one-third (41 percent) were certified application counselors; more than one-third (38 percent) were Navigators, and a smaller share (14 percent) are in-person assisters in states that partner with the FFM to manage consumer assistance, known as partnership marketplace states. In these states, CMS contracted with one or two private vendors to provide in-person assistance to consumers seeking health coverage. More than half of the assisters who responded to the survey (54 percent) had a caseload in which more than 25 percent of the consumers they serve include immigrant applicants or families with immigrants.

Of those surveyed, more than half of assisters have the ability to assist individuals in Spanish and about half (51 percent) were funded through a federal navigator grant or contract during the second open enrollment period. Almost one in three assistance programs were funded through HHS grants to community health centers (30 percent). About one in five of assistance programs are funded through state contracts (19 percent).

[See Appendix D for the online survey]

Listening Sessions

The listening sessions were developed to enable more robust conversations with assisters on nuanced issues that arose from the online survey. In the online survey, responders were asked if they would be willing to participate in a follow up listening session. Those who responded affirmatively were invited by email to participate in one of three listening sessions. Participation in the listening sessions was voluntary. The three one-hour listening sessions were convened by phone between May 18 and May 21, 2015. Thirty immigrant health care coverage enrollment assisters from 14 states and the District of Columbia participated. However, the contributions from one of the participants was removed from analysis because the individual did not work in a state that relies on the federal marketplace.

Acknowledgements

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Appendix A: Immigrant Eligibility Rules for Federal Health Insurance Affordability Programs

The eligibility rules for immigrants in Medicaid and CHIP differ by program and by state, and are generally narrower for immigrants than rules in the marketplace. States have the option to cover some lawfully residing immigrants, particularly children and pregnant women, but not all states take advantage of the opportunity to use federal funds to cover eligible immigrants. Another complicating factor is that in a mixed-immigration status family, different rules may apply to different family members, depending on whether the individual is a citizen, lawfully present under the ACA definition, considered not lawfully present or undocumented, and/or in an immigration status considered "not-qualified." This paper does not attempt to cover immigrant eligibility for health care programs in depth, but to recognize the complexity of layering complicated immigrant eligibility rules on top of income, family status, and other health insurance program rules.

Immigrant Eligibility for Medicaid and CHIP

The current immigrant eligibility rules for non-emergency Medicaid and CHIP were not changed by the ACA and stem from the 1996 welfare reform law.[47,48] Since 1996, eligibility for these programs depends on having a "qualified" immigration status; and for many immigrants who entered the U.S. on or after August 22, 1996, meeting a five-year federal waiting period for coverage. However, some groups of qualified immigrants are eligible to enroll in Medicaid or CHIP right away (see below).[49]

Figure 4: "Qualified" Immigrants

- Lawful Permanent Residents (LPR, green card holders)
- Refugees
- Asylees
- Cuban/Haitian entrants
- Individuals who were paroled into the U.S. for more than a year
- Conditional entrants
- Certain domestic violence and trafficking survivors and their derivatives
- Persons granted withholding of deportation/removal
- Member of a federally recognized Indian tribe or American Indian Born in Canada

Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities

Figure 5: Five-Year Waiting Period for Medicaid & CHIP

- Many "qualified" immigrants are subject to a five-year waiting period (also know as "the five-year bar")
  - The five years begin when an immigrant obtains a "qualified" immigration status
- Some people with a "qualified" immigration status are not subject to the five-year bar:
  - Immigrants who physically entered the U.S. before 8/22/96 and remained in the U.S. continuously until obtaining a qualified status
  - Refugees, asylees, persons granted withholding of deportation/removal (even if they later become LPRs)
  - Cuban/Haitian entrants, certain Amerasian immigrants, individuals granted Iraqi or Afghan special immigrant status, trafficking survivors (even if they later become LPRs)
  - Qualified immigrants who are U.S. veterans or on active military duty and their spouses or children
  - Children (at state option)
  - Pregnant women (at state option)

Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities.

State Option to Provide Coverage of "Lawfully Residing" Children and/or Pregnant Women and Other State Options

As of 2009, states can opt to expand Medicaid or CHIP coverage to lawfully residing children and/or pregnant women with no five-year waiting period.[50] In this context, the term lawfully residing refers to lawfully present individuals who are also residents in a particular state.[51] As of the writing of this paper, 28 states and DC have opted to take advantage of federal funding to cover lawfully present children, and 22 states and DC provide coverage to lawfully present pregnant women under this option.[52] As of January 2015, 15 states had also taken up the option to provide coverage for the unborn through federal CHIP funding, effectively covering services to pregnant women regardless of immigration status.[53] It is important to note that there can be additional state variation in immigrant eligibility rules beyond the above-mentioned options. A few states do not cover qualified immigrants even after their first five

years of lawful present, but on the other end of the spectrum, some states use state-only funds to provide coverage to more categories of immigrants, such as undocumented immigrant children or adults in the five-year waiting period.[54]

Figure 6: State Flexibility to Vary from the General Eligibility Rules

- Federal Medicaid/ CHIP Options
  - CHIPRA 2009 gave states the option to cover children and/or pregnant women:
    - Who are lawfully present and otherwise eligible
    - Without a 5-year waiting period
    - Regardless of date of entry into the U.S.
  - Through CHIP, states can also opt to provide certain medical services to pregnant women (including prenatal care), regardless of immigration status, if they are not otherwise eligible for Medicaid
- State-Funded Options
  - States can cover additional immigrants with state-only funds

Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities.

Immigrant Eligibility for the Marketplace

To be eligible to enroll in health insurance in the marketplace, an individual must be a U.S. citizen or national or be "lawfully present" in the U.S.[55] Under the ACA, lawfully present individuals are eligible to purchase health insurance in a Qualified Health Plan (QHP), may qualify if income-eligible for help with costs in the form of premium tax credits (PTC) and cost-sharing reductions (CSR), and are required to have health insurance unless they are eligible for an exemption.

The definition of individuals considered to be "lawfully present" by the U.S. Department of Health and Human Services (HHS) is an extensive list (see the Figures below).[56] The definition includes qualified immigrants who meet eligibility requirements for Medicaid and CHIP, as well as many others.[57] It is important to note that, young people granted deferred action through the Deferred Action for Childhood Arrivals (DACA) program are not eligible for coverage or subsidies in the marketplace although other non-citizens granted deferred action for other reasons remain eligible.

Figure 7: "Lawfully Present" Immigration Categories - Part I

"Qualified" Immigrants:	Other "Lawfully Present" Immigrants:
• Lawful Permanent Resident (LPR/green card holder) • Refugee • Asylee • Cuban/Haitian Entrant • Paroled into the U.S. • Conditional Entrant • Battered Spouse, Child and Parent • Trafficking Survivor and his/her Spouse, Child, Sibling or Parent • Granted Withholding of Deportation or Withholding of Removal **Others:** • Member of a federally-recognized Indian tribe or American Indian Born in Canada	• Granted relief under the Convention Against Torture (CAT) • Temporary Protected Status (TPS) • Deferred Enforced Departure (DED) • Deferred Action (except DACA)* • Paroled into US for less than one year • Individual with Nonimmigrant Status (includes worker visas; student visas; U visas; citizens of Micronesia, the Marshall Islands, and Palau; and many others) • Administrative order staying removal issued by the Department of Homeland Security • Lawful Temporary Resident • Family Unity

***EXCEPTION:** *Individuals granted deferred action under the* **2012 Deferred Action for Childhood Arrivals (DACA)** *program are not eligible to enroll in coverage in the Marketplace.*

Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities.

Figure 8: "Lawfully Present" Immigration Categories – Part II

Applicant for Any of These Statuses:	With Employment Authorization:
• Lawful Permanent Resident (with an approved visa petition) • Special Immigrant Juvenile Status • Victim of Trafficking Visa • Asylum* • Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention Against Torture (CAT)*	• Applicant for Temporary Protected Status • Registry Applicants • Order of Supervision • Applicant for Cancellation of Removal or Suspension of Deportation • Applicant for Legalization under IRCA • Applicant for LPR under the LIFE Act

**Only those who have been granted employment authorization or are under the age of 14 and have had an application pending for at least 180 days are eligible*

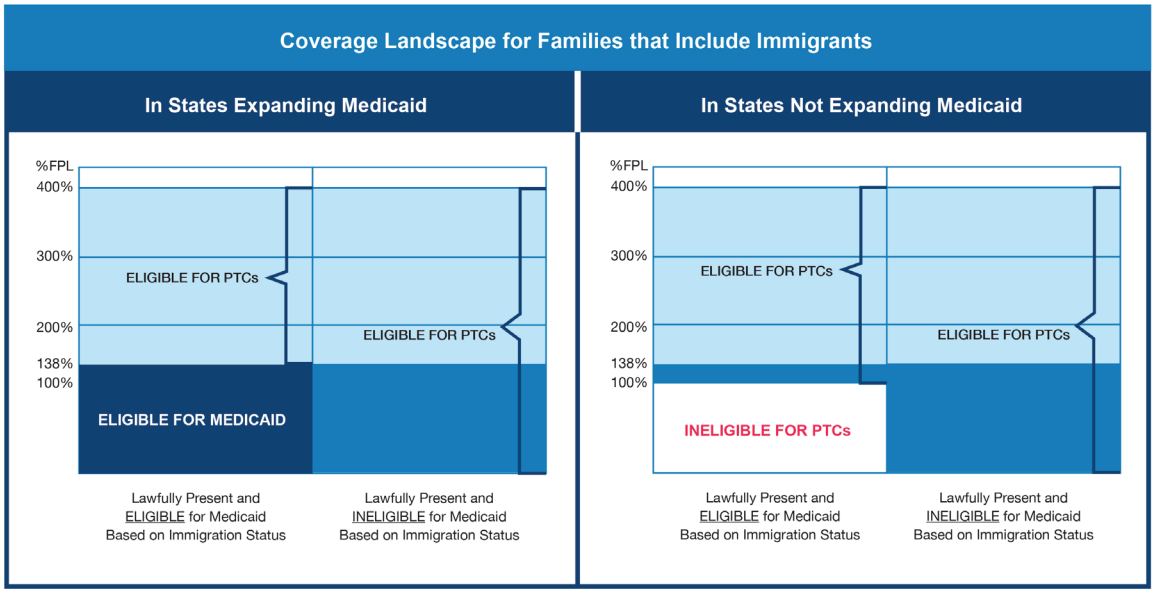
Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities.

Coverage for Lawfully Present Individuals with Incomes Below the Poverty Line

The ACA provides a pathway to federal health coverage programs for lawfully present immigrants whose *immigration status* makes them ineligible under the more restrictive immigrant eligibility rules for Medicaid or CHIP.[58] Lawfully present individuals are eligible for both PTC and CSR in the marketplace, and those with income below 100 percent of the federal poverty level (FPL) are eligible for marketplace financial assistance if they are ineligible for Medicaid because of immigration status.

However, in states that have not expanded Medicaid, there are lawfully present immigrants who qualify for neither Medicaid nor marketplace financial assistance. This group includes certain qualified immigrants who *would be* eligible for Medicaid based on immigration status but *are not* eligible Medicaid because their state has not taken up the Medicaid expansion. Examples include qualified immigrants who have income below the poverty line and who are either exempt from the five-year waiting period in Medicaid/CHIP or have reached the end of the five-year waiting period. These immigrants fall into the coverage gap and are not eligible for PTCs or CSRs unless their income is at or above 100 percent FPL.

Figure 9: General PTC Eligibility for Lawfully Present Adults



Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities.

Appendix B: How the Application and Enrollment Process Works for the FFM

Individuals and families, with or without the help of a consumer assister, can apply for health coverage through the FFM online, by phone, or by paper application. The online application comes with a significant advantage: applicants receive personalized information about premiums and out-of-pocket costs that include their premium tax credits (PTC) and cost sharing reductions (CSR). This information is essential to making an informed selection of health plans.

There are many steps involved in completing the online application on Healthcare.gov, ranging from creating an online account to providing detailed information about household members, their income, and employment to plan selection and enrollment. Below, we describe the key steps in the Healthcare.gov process that are particularly challenging for immigrant families to complete—creating an online account; ID proofing; attesting to and verifying citizenship and immigration status; determining ineligibility for Medicaid and CHIP; and the inconsistency process when the system is unable to instantaneously verify citizenship or qualified immigration status through electronic data matching. It does not walk through every step in the entire application.

CREATING AN ONLINE ACCOUNT

The application process starts with the applicant creating an online account. This entails the household contact entering his/her zip code followed by name, email address, password, and choosing from a list of security questions that must be answered correctly to retrieve a lost password. The applicant then must wait for an email confirmation with a verification link back to the online application and accept the terms and conditions before moving onto the next step in the process.

A Note About Language/ Translation

The online application is available in English and Spanish. In order to get to the Spanish online application, you click on "Español" on the top right hand corner of the site.

IDENTITY PROOFING

The second step in the online application on Healthcare.gov is identity proofing ("ID proofing"), which must be completed by the person designated as the household contact in an application. This process is used to verify an individual's identity; prevent an unauthorized person from applying for health coverage in another person's name without her/his knowledge and consent; and to protect against disclosure of information to the person completing the application since Healthcare.gov connects to a federal hub which accesses data from federal agencies.

ID proofing is similar to confirming your identity in order to access your credit history, and is managed by Experian, the credit rating service. The individual must correctly answer questions based on financial and personal information in Experian's database. For example, questions might be about current and past addresses, auto ownership, names of current and previous employers, and more. If an individual has limited or no credit history, and Experian does not have other demographic data about the individual, it cannot generate the questions necessary to complete ID proofing.[59] In these cases, the next required step—calling Experian—may also be unsuccessful.

When an individual's identity cannot be verified online, additional steps are required before an online application can be completed. As outlined in a CMS FAQ, these steps include:

- Calling the Experian Help Desk and providing a reference code generated on Healthcare.gov when ID proofing was not completed, so that that Experian can attempt to verify identity by phone with language assistance if needed.
- If Experian cannot complete the process by phone, an individual will be required to upload or mail in a copies of documents from an approved list to show identity. Processing of documentation is supposed to take 7-10 business days after it is received, if not sooner.
- After documentation is processed, the individual will receive a written notice that identity has been verified or that additional information is required.

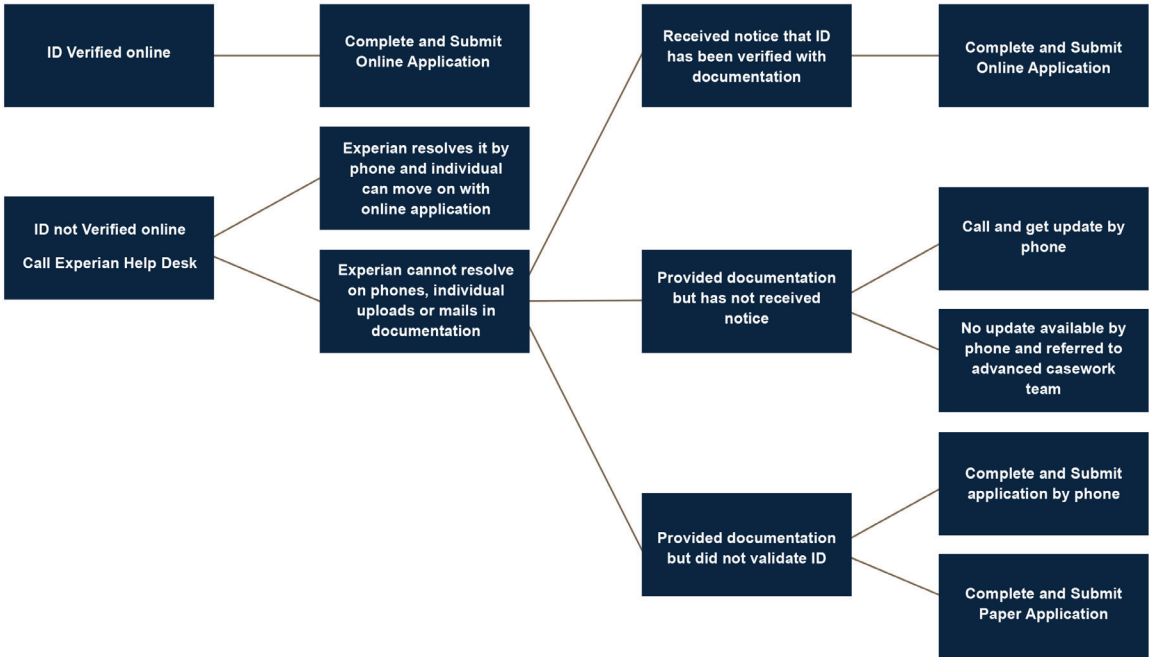
Once satisfactory documentation has been approved, an individual can return to Healthcare.gov to continue the application online.

Individuals who provide documents that are insufficient in verifying identity are instructed to contact the FFM call center. The call center representative will provide a status update, if possible, or contact an "advanced casework team" to look into the status of the case and contact the applicant "when it is reviewed."

Applicants who have difficulty verifying their identity online, and are not able to resolve it through Experian call center or by submitting documentation, may give up early in the process. Some applicants who are working with a determined consumer assister who understands the process or who receive instructions from the Experian call center, might call the FFM call center and apply for health insurance by phone right away to try to speed up the process.[61]

If the household does not have access to needed documents to complete the ID proofing process, they can complete an application by phone by contacting the FFM call center or mail in a completed paper application. They can also bypass ID proofing and continue the application process. However, they will not receive their eligibility results online and will not be able to compare, choose and enroll in a plan online.

Figure 10: Identity Proofing Process



ATTESTING TO AND VERIFYING CITIZENSHIP STATUS

In the FFM, when applicants attest to being U.S. citizens and provide an SSN, their information is checked against information the Social Security Administration's (SSA) records to verify citizenship.[62] SSA does not have citizenship records for some citizens, including many who were born outside the U.S. If citizenship cannot be immediately verified electronically through SSA, applicants will be asked if they are "naturalized or derived citizens." Individuals who respond "yes" will be asked to provide their Alien registration or USCIS number and either a naturalization certificate number or a certificate of citizenship number. Healthcare.gov will then try to verify citizenship through data matching with the Department of Homeland Security's Systematic Alien Verification for Entitlements system (SAVE) (see more about SAVE below). If these document numbers are unavailable, individuals can mail in or upload other proof of citizenship and identity such as a copy of their U.S. passport. While their citizenship is being verified, applicants who otherwise meet all eligibility requirements can enroll in Medicaid, CHIP or a

marketplace plan during a "reasonable opportunity period" or "inconsistency period."[63]

ATTESTING TO AND VERIFYING IMMIGRATION STATUS

When applying for coverage in the FFM on Healthcare.gov, immigrants attesting to not being a US citizen are shown a list of immigration statuses and are asked if they have an "eligible immigration status."[64] A "yes" response prompts the applicant to choose their document type and usually enter their alien number (referred to as the "A" or "USCIS" number) and the immigration document/ card receipt number.[65] If this number is not available, it is possible to use another document number, such as an I-94 number. Healthcare.gov then transmits the information electronically to SAVE (called SAVE step 1) to see if it can instantly verify the immigration status of the applicant, which should take three to five seconds.[66] If the process works smoothly and there is a match, SAVE then provides information about whether the individual has an eligible immigration status for purposes of the marketplace, Medicaid or CHIP. Otherwise, SAVE prompts the FFM to "institute additional verification," which triggers the inconsistency process describe below.[67]

An Introduction to SAVE

A critical part of the eligibility verification process for immigrant families is the Systematic Alien Verification for Entitlements, or SAVE, an inter-governmental information service that electronically verifies the immigration status of individuals applying for benefits, including Medicaid, CHIP, and eligibility to purchase insurance through the marketplace.[68] SAVE relies on document numbers such as the Arrival/Departure Record (Form I-94), the Permanent Resident Card (Form I-551), the Employment Authorization Document (Form I-766), or a foreign passport or visa to electronically match to records in the Department of Homeland Security database. SAVE does not provide the FFM or other programs with an *eligibility determination* for a specific program. Instead it provides key information the agency uses to determine if the applicant meets the applicable immigration-related eligibility standards for that program.

In the third open enrollment period, Healthcare.gov included some additional prompts to help encourage individuals to provide SSNs and immigration document numbers online and avoid inconsistencies. If an individual does not provide an SSN in the online application, a prompt pops up that reminds them why it is important to provide SSNs for applicants who have them in order to avoid a data matching inconsistency. A similar prompt reminds individuals to provide immigration document numbers. There is also an additional reminder that allows individuals to correct an SSN that was not instantly verified. Finally, the FFM now includes "onscreen eligibility results" (instead of just a downloadable eligibility notice) that provides coverage options for each individual in the household, which includes a red warning of "temporary eligibility" for anyone in the household that needs to clear up a data matching issue to keep their coverage.

DETERMINING INELIGIBILITY FOR MEDICAID OR CHIP BASED ON IMMIGRATION STATUS

As noted previously, lawfully present immigrants who have income within the Medicaid eligibility range, but are ineligible for Medicaid or CHIP based on their *immigration status* can qualify for premium tax credits and cost-sharing reductions even if their income falls below the poverty line. If the FFM can instantly verify that the consumer is lawfully present but ineligible for Medicaid based on immigration status through SAVE, the application proceeds smoothly, and a correct eligibility determination can be made immediately. However, if the FFM cannot instantly verify that an applicant is ineligible for Medicaid based on immigration status, the process is more complicated. Healthcare.gov has system limitations that prevent a correct eligibility determination for some of these individuals (see below).[69]

WHEN IMMIGRATION STATUS OR CITIZENSHIP STATUS IS NOT INSTANTLY VERIFIED

If Healthcare.gov cannot instantly verify if the applicant's immigration status is ineligible for Medicaid—even though the applicant indeed is ineligible for Medicaid based on immigration status—the applicant will receive an incorrect eligibility determination for subsidies.[70] This happens because Healthcare.gov will assume the consumer is eligible for Medicaid based on immigration status until the applicant provides proof of her immigration status (which then confirms ineligibility for Medicaid). One of two determinations occurs:[71]

- Group 1: If the consumer appears to be eligible for Medicaid based on income and other factors, Healthcare.gov incorrectly assesses or determines eligibility for Medicaid.[72]
- Group 2: If the consumer appears ineligible for Medicaid based on income below 100% of FPL and other factors, Healthcare.gov determines that the individual is temporarily eligible for a QHP at full cost. The FFM then provides notice that if proof of immigration status is provided and the individual is determined lawfully present but ineligible for Medicaid based on immigration status, the individual will get an eligibility determination for PTC and a special enrollment period.[73]

Figure 11: If Income is in the Medicaid Range or Below the Poverty Line

If Healthcare.gov can't electronically verify an individual's immigration status through DHS (i.e. individual has an immigration status data matching issue), immigration status must be verified by the Marketplace through a manual document review or by the Medicaid or CHIP agency.

As a result:	
When the individual appears eligible for Medicaid based on income and other factors:	**When the individuals income is below 100% FPL and is not otherwise eligible for Medicaid:**
• sent to Medicaid	• given the opportunity to enroll in a Marketplace plan with no PTC • notified of possible eligibility for PTC if provide proof of immigration status • if verified as lawfully present but ineligible for Medicaid, notified of eligibility determination for PTC/CSR and Special Enrollment Period

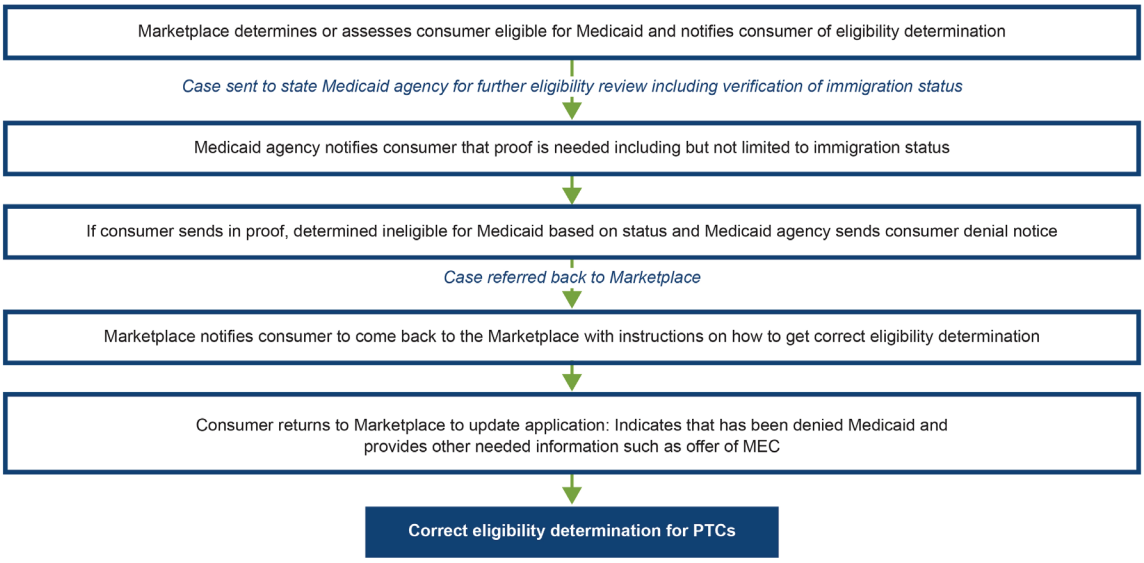
Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities.

Group 1: The Applicant Appears to Be Otherwise Eligible for Medicaid[74]

If the individual appears to be otherwise eligible for Medicaid based on income and other factors (e.g. a child or pregnant woman) and the immigration status cannot be instantly verified, the FFM will assess the individual as potentially eligible for Medicaid and notify the consumer.[75] The application is transferred electronically to the state Medicaid agency, which notifies the applicant that proof of immigration status is needed. (Note that some states continue to experience lengthy backlogs in Medicaid due to expansions of coverage and the welcome mat affect of health reform, and applications may take longer than the maximum 45 days allowed by law.)[76]

If the applicant sends in adequate immigration documentation and is determined ineligible for Medicaid based on immigration status, the agency sends the consumer a Medicaid denial notice and the account *should be* transferred back to the FFM. The FFM then notifies the consumer to return to the FFM, and with instructions on how to get a correct eligibility determination, which will likely include providing the same documentation to the FFM. The applicant must then return to the FFM to update his/her application, indicated that s/he has been denied eligibility for Medicaid, and provide other information (if needed), which then results in a correct eligibility determination for coverage through the marketplace and financial assistance.

Figure 12: Process When Appears Eligible for Medicaid (Based on Income and Other Factors)

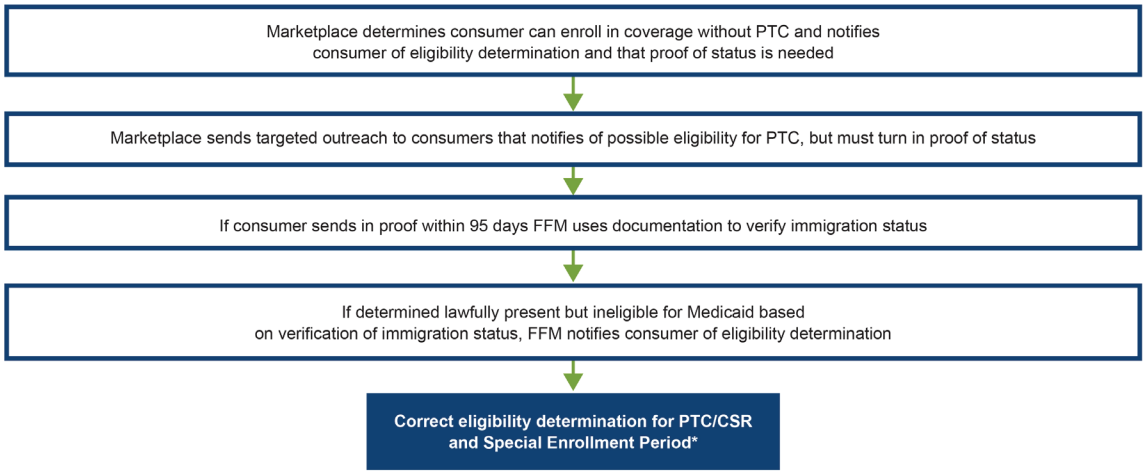


Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities.

Group 2: The Applicant Appears Not to Be Otherwise Eligible for Medicaid

Beginning in December 2015, the FFM launched a new automated process for individuals who have income below 100 percent of the federal poverty line and who appear to be otherwise ineligible for Medicaid, but whose immigration status cannot be instantly verified.[77] The marketplace now identifies these individuals and notifies them of them of the data matching issue and potential eligibility for PTC. If an individual then provides verification of immigration status within 95 days, and is indeed ineligible for Medicaid based on immigration status, the marketplace uses the documentation to verify the immigration status. It then notifies the individual that s/he is eligible for PTC/CSR and a special enrollment period. This new automated process replaced a manual process that required a consumer to take multiple steps in order to get PTC.[78]

Figure 13: Process When Appears ineligible for Medicaid (Based on Income Below 100% FPL and Not Otherwise Eligible for Medicaid)



*Special enrollment period is accessible through HealthCare.gov and FFM Call Center. Consumers can enroll in plan within 60 days of eligibility determination notice. No need to update application or answer additional questions.

Note: This figure was developed in partnership with the National Immigration Law Center and Center on Budget and Policy Priorities.

THE INCONSISTENCY PROCESS

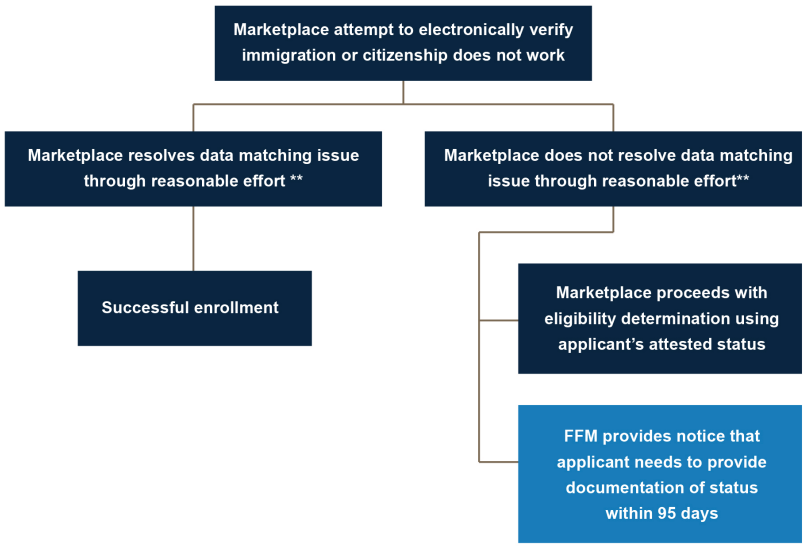
When the FFM is unable to electronically verify the immigration or citizenship information supplied by the applicant—including when the individual does not provide an SSN or immigration-related document numbers—the inconsistency process is triggered immediately. The applicant is instructed that additional documentation is needed but at the same time the FFM's contractor, SERCO, makes a reasonable effort to identify and address the cause of inconsistency, including correcting typographical or other clerical errors.[79]

It is important to emphasize that a data inconsistency does not mean that an individual has provided false information on their application.[80] Sometimes valid immigration document numbers or SSNs entered into HealthCare.gov or through the FFM call center do not return a match with SAVE or the SSA data. A data inconsistency can be the result of a processing error or indicate a need for additional documentation.

Even though the second step of SAVE may be initiated, the applicant may already be in the process of submitting documents. If the second step of SAVE is successful, the applicant is notified that the data matching issue has been resolved and is instructed on any additional steps needed.

As soon as the inconsistency is triggered, FFM provides specific notice to the applicant that documentation of citizenship or immigration status must be submitted electronically or via mail.[81] These notices are provided in English or in Spanish, and include taglines in 15 languages.[82] As of April 17, 2015 notices include a revised tagline that states, "This notice has important information about your application or coverage through the Health Insurance Marketplace. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-800-318-2596 and wait through the opening. When an agent answers, state the language you need and you'll be connected with an interpreter."[83]

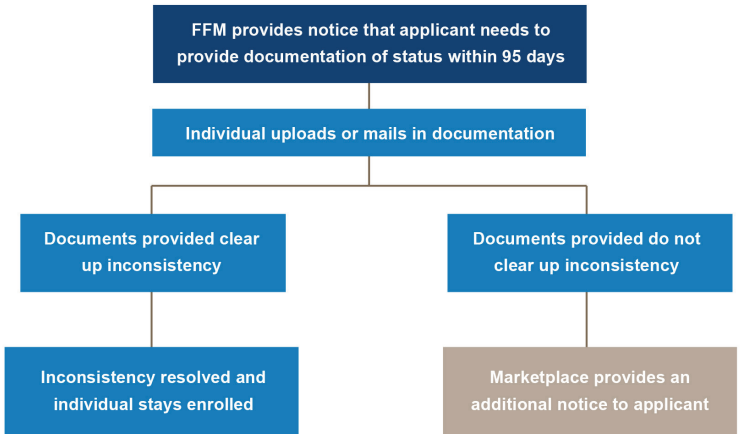
Figure 14: Immigration and Citizenship Status Inconsistency Process (Part 1 of 3)



*'**Reasonable effort to ID and address causes of inconsistency, including typographical or other clerical errors, and contacting filer to confirm accuracy of information submitted.*

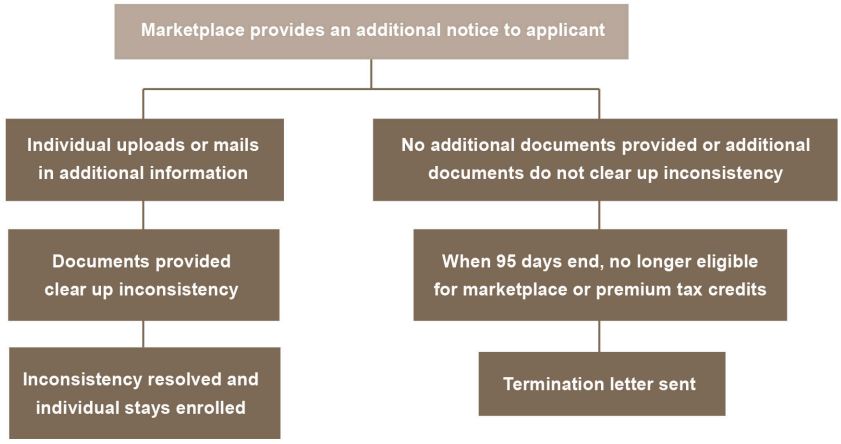
The "inconsistency period" for resolving citizenship or immigration issue is 95 days from the day the notice is sent. As noted previously, if income cannot be automatically verified, the FFM may transfer certain applications to Medicaid or provide a temporary eligibility determination for enrollment in coverage through the marketplace.[84]

Figure 15: Immigration and Citizenship Status Inconsistency Process (Part 2 of 3)



If the individual submits immigration documents within the 95-day period, the FFM or its contractor conducts a case review and if possible resolves the inconsistency, which results in eligibility for coverage through the marketplace. If documents are not provided, the FFM sends warning notices at specific intervals. If individuals provide documents that do not clear up the inconsistency, they continue to receive warning notices. If the documents provided do not resolve the inconsistency or are not submitted, the FFM notifies the applicant at the end of the 95-day period that the individual is no longer eligible for to enroll in coverage through the marketplace with or without PTC and terminates coverage.

Figure 16: Immigration and Citizenship Status Inconsistency Process (Part 3 of 3)



Appendix C: List of Recommended Action Steps

1. Refine the FFM's immigration status and citizenship status verification protocols and processes.

Even when valid document numbers are entered for immigrants who are eligible, the electronic verification through SAVE may not be successful. Recommended steps to improve the verification process:

- Conduct extensive technical testing with knowledgeable users to identify the circumstances that lead to the inability to input or verify document numbers.
- Institute a second step to resolve a data-matching problem before triggering the inconsistency period even if applicants appear eligible for Medicaid or CHIP based on income and other factors.
- Continue to communicate the importance of inputting document numbers through assister trainings and communications, and online prompts.
- Ensure a path to affordable coverage for individuals who have an ongoing immigration status-related data matching issue.

Many immigrants who are not eligible for Medicaid or CHIP are being routed unnecessarily to the state Medicaid agency. Recommended steps to smooth out the process:

- Improve Healthcare.gov's ability to discern differences between immigration statuses that qualify for Medicaid eligibility versus Marketplace eligibility.
- Involve stakeholders in problem solving.

2. Improve communications and expedite the resolution of inconsistencies.

When immigration or citizenship status cannot be immediately verified, an inconsistency period is triggered. A key problem with the inconsistency process is difficulty in communicating effectively with affected applicants. Recommended steps to expedite the resolution of inconsistencies:

- Improve communication with those in immigration and citizenship status inconsistency periods.
- Expedite the resolution of inconsistencies when adequate documentation is uploaded during the application process.
- Continue to improve timeliness and overall performance of the mail-in document center.

3. Develop an alternative process to confirm identity.

The ID proofing process is one of the first steps in applying for coverage on Healthcare.gov. Although not an eligibility requirement, in order to proceed with the online application process, a household contact filing the application must correctly answer personal questions derived from his or her credit history and other information. This protocol poses an immediate obstacle for immigrants and citizens alike when there is limited or no credit history or other demographic information available because the system cannot generate needed questions. Recommended steps to improve the ID proofing process:

- Identify circumstances when calling Experian is not useful and bypass this step for those applicants.
- Expedite the review and approval of uploaded identity documents.
- Permit authorized assisters, with appropriate training, to attest to an applicant's identity and upload documentation for the case record.
- Expand the list of documents that can be used to confirm identity.
- Provide an alternative online application that retains the advantages of applying online but does not share protected personal information.

4. Boost resources for communication in languages other than English and Spanish.

Language access is a common barrier in working to improve coverage rate for immigrant families.

Although an estimated 25 million people in the U.S. are limited English proficient (LEP), the FFM provides the bulk of its written and online information only in English or in some cases Spanish. Steps to improve communication:

- Translate notices so that LEP applications and enrollees know when and how to take action.
- Provide in-language assistance through the FFM call center in more languages than Spanish.
- Allow assisters to provide interpreting directly or through onsite interpreters when calling the FFM call center.
- Permit assisters to pre-schedule appointments with interpreters.
- Target assister resources to organizations that work to enroll immigrant and LEP communities.

5. Improve the customer experience for both assisters and applicants, including refining the process for resolving complex cases.

The FFM is intended to operate in a highly sophisticated technology environment where online systems connected to electronic databases determine eligibility in real time. However, immigrant families, and the consumer assisters who help them apply for health coverage through the FFM, continue to face problems throughout the application process that often requires a human touch. Promising action steps to improve the customer experience include:

- Dedicate a specialized unit in the FFM call center to resolving complex cases for immigrant families.
- Provide functionality for FFM call center to access the application to better manage and resolve complex cases.
- Create workflows for casework and share processes with stakeholders.
- Provide additional training tools to the assister community.
- Continue to provide resources for application assistance.
- Continue to promote an environment of transparency and problem solving with stakeholders.

Appendix D: Assister Survey

The Center for Children and Families at Georgetown University's Health Policy Institute is conducting a brief online survey of assisters who have helped immigrants and individuals in immigrant families apply for coverage in states that rely on healthcare.gov or the federal marketplace call center to provide access to coverage.

Our goal is to better understand what worked and what did not when immigrants and individuals in immigrant families applied for health coverage during the second open enrollment period (November 15, 2014 to February 15, 2015).

As an assister, you can provide valuable feedback on the successes and challenges of enrolling immigrant individuals and families. Your participation in this research is completely voluntary and confidential. Our project team will not use your name or the name of your organization in any reports we publish. Your survey responses will be combined with the replies from others to establish report findings and to describe where the process is working well and where problems exist.

The survey has 21 questions and should take about 15 minutes to complete.

Notes:

For purposes of this survey, "immigrant applicants and individuals in immigrant families" means:

- individuals applying for coverage who are immigrants or naturalized citizens themselves, and/or
- individuals living in the same household as immigrants or naturalized citizens, whether they are applying for coverage or not Also, for purposes of this survey, "a state that relies on healthcare.gov or the federal marketplace call center to provide access to coverage" means a federally-facilitated marketplace, a state-partnership marketplace, or a federally-supported State-based marketplace. If you have assisted someone who meets these definitions, we want to hear from you! Questions? Please contact Sonya Schwartz, Research Fellow, Georgetown University Center for Children and Families, ss3361@georgetown.edu or 202-784-4077.

1. What category of navigator/ assister best describes you?

a. Certified Application Counselor
b. Enrollment Counselor in Federally Qualified Health Center
c. Navigator
d. In-Person Assister in federal partnership state
e. CMS Enrollment contractor
f. I provide training, technical assistance or other support to a group of navigators or assisters
g. Other (Please specify)

2. What portion of the consumers you assisted included immigrant applicants and individuals in immigrant families?

a. Less than 10 percent of the consumers I assisted
b. More than 10 percent and less than 25 percent of the consumers I assisted
c. More than 25 percent and less than 50 percent of the consumers I assisted
d. More than 50 percent and less than 75 percent of the consumers I assisted
e. More than 75 percent of the consumers I assisted

3. What reasons did immigrant applicants and individuals in immigrant families most often give for seeking application assistance? (Please check your top four reasons)

a. Limited understanding of health coverage
b. Could not make it through identity proofing to start the application
c. Needed help completing the application
d. Needed language assistance
e. Feared discrimination
f. Could not get help they needed from another assister or organization
g. Could not get the help they needed through the federal marketplace call center
h. Had questions about how to resolve a data matching problem
i. Needed help understanding plan choices
j. Had online technical difficulties
k. Lacked internet access at home
l. Had a question about whether or not they were required to purchase coverage or pay a penalty
m. Needed help filling an exemption application
n. Questions related to paying the premium
o. Other (Please specify)

4. When applying for coverage on the federal marketplace ONLINE/ on healthcare.gov, have you experienced any of the following problems? Please indicate whether it was a problem and how often.

	Never a problem	Infrequent problem	Sometimes a problem	Often a problem	Almost always a problem	NA
Setting up an account online	○	○	○	○	○	○
Proving your identity online in order to begin the application	○	○	○	○	○	○
Using a social security number to verify citizenship status online	○	○	○	○	○	○
Using a document numbers to verify immigration status online	○	○	○	○	○	○
Uploading documentation to verify factors like citizenship or immigration status online	○	○	○	○	○	○
Getting help in the preferred language of applicant with an application assister	○	○	○	○	○	○
Receiving an improper denial of the premium tax credit, even though the individual meets eligibility requirements for the preium tax credit (ex. income below poverty line and lawfully present but ineligible for Medicaid based on immigration status)	○	○	○	○	○	○
Other (please specifiy)						

5. Please describe a problem you faced or a story you want to share that illustrates your experience in helping immigrant applicants and individuals in immigrant families for coverage on the federal marketplace ONLINE/on healthcare.gov.

6. When applying for coverage on the federal marketplace BY PHONE, have you experienced any of the following problems when assisting immigrant applicants and individuals in immigrant families? Please indicate whether it was a problem and how often.

	Never a problem	Infrequent problem	Sometimes a problem	Often a problem	Almost always a problem	NA
Setting up an account by phone	○	○	○	○	○	○
Long wait times by phone	○	○	○	○	○	○
Proving your identity by phone in order to begin the application	○	○	○	○	○	○
Getting help in preferred language of applicant through marketplace/ healthcare.gov call center	○	○	○	○	○	○
Getting help in preferred language of applicant through Experian/identity verification	○	○	○	○	○	○
Getting help in the preferred language of applicant with an application assister	○	○	○	○	○	○
Received an improper denial of the premium tax credit, even though the individual meets eligibility requirements for the preium tax credit (ex. income below poverty line and lawfully present but ineligible for Medicaid based on immigration status)	○	○	○	○	○	○
Call center operator provided inaccurate information	○	○	○	○	○	○
Other (please specifiy)						

7. Please describe a problem you faced or story you want to share that illustrates the experience in helping immigrant applicants and individuals in immigrant families apply for coverage on the federal marketplace by PHONE here.

8. When assisting immigrant applicants and individuals in immigrant families AFTER THE APPLICATION WAS SUBMITTED to the federal marketplace, have you experienced any of the following problems? Please indicate whether it was a problem and how often.

	Never a problem	Infrequent problem	Sometimes a problem	Often a problem	Almost always a problem	NA
Individual could not understand an initial eligibilty notice provided by marketplace	○	○	○	○	○	○
Individual could not understand a notice requiring further action to verify citizenship or immigration status	○	○	○	○	○	○
Individual provided social security number to verify citizenship status online but it was not used to verify status citizenship status	○	○	○	○	○	○
Individual provided a number from an immigration document to verify immigration status online but it was not used to verify immigration status	○	○	○	○	○	○
Individual uploaded documentation to verify eligibility information like citizenship or immigration status online but it was not used to verify citizenship or immigration status	○	○	○	○	○	○
Individual provided a document by mail but it was not used to verify citizenship or immigration status	○	○	○	○	○	○
Individual/family was not actually enrolled in a health plan	○	○	○	○	○	○
Individual did not understand his insurance plan, premiums, or out of pocket costs	○	○	○	○	○	○
Other (please specifiy)						

9. Please describe a problem you faced or story you want to share that illustrates the experience in helping immigrant applicants and individuals in immigrant families enroll in coverage AFTER THE APPLICATION WAS SUBMITTED to the federal marketplace here.

10. Provide your best estimate of how much time, on average, it took to complete and submit an application for immigrants versus US-born citizens. The use below of "immigrants" means immigrant applicants and individuals in immigrant families and "citizens" means families with only US-born citizens. Time spent includes all time needed to set up an account, ID proof, and move the application forward, including time with the applicant, doing research, doing casework or whatever it takes to complete and submit the application.

a. Less time for immigrants than for citizens

b. About the same amount of time for immigrants as citizens

c. Twice as much time for immigrants as citizens

d. Three times as much time for immigrants as citizens

e. Four times as much time for immigrants as citizens

f. Other (Please specify)

11. If you provided enrollment assistance in open enrollment one (Oct. 1, 2013 – March 31, 2014) as well as in open enrollment two (Nov. 15, 2014 – Feb. 15, 2015), have you noticed improvements in open enrollment two in the application or enrollment process for immigrant applicants and individuals in immigrant families? Please indicate whether and how much improvement in open enrollment two.

	no improvement in open enrollment two	some improvement in open enrollment two	major improvement in open enrollment two	NA
Setting up an account/proving identity online	○	○	○	○
Setting up an account/proving identity by phone	○	○	○	○
Using a social security number to verify citizenship status online	○	○	○	○

	no improvement in open enrollment two	some improvement in open enrollment two	major improvement in open enrollment two	NA
Using a social security number to verify citizenship status by phone	○	○	○	○
Using a document number to verify immigration status online	○	○	○	○
Using a document number to verify immigration status by phone	○	○	○	○
Uploading documentation to verify factors like citizenship or immigration status online when applying	○	○	○	○
Uploading documentation to verify factors like citizenship or immigration status online after applying	○	○	○	○
Providing a document by mail to verify citizenship or immigration status after applying	○	○	○	○
Getting help in preferred language of applicant through marketplace/ healthcare.gov call center	○	○	○	○
Getting help in the preferred language of applicant through Experian/identity verification	○	○	○	○
Finding in person help from an assister who speaks the applicant s preferred language	○	○	○	○
Eligibility determinations more accurate	○	○	○	○
Error screens (such as “yellow screen”)	○	○	○	○
Other (please specify)				

12. Have you developed any best practices or tips that would help ensure a smoother enrollment process for immigrant applicants and individuals in immigrant families that you’d like to share with other assisters? Please provide up to three here.

13. When individuals are correctly determined ineligible for coverage due to immigration status, do you provide information or materials about any of the following? (Check all that apply)

a. Emergency Medicaid

b. Safety net clinics

c. Local programs

d. Options for private coverage in the individual insurance market (outside of the marketplace and without subsidies)

e. Other (please specify)

14. What could the federal marketplace do to improve support for ASSISTERS that help immigrant applicants and individuals in immigrant families? (Check up to two)

a. Provide more federal funding for assisters

b. Provide more training for assisters

c. Improve assisters' access to call center or other help

d. Provide an easier way for assisters to get help on complex cases

e. Other (please specify)

15. Imagine that the federal marketplace could only do three things to improve the application and enrollment process for immigrant applicants and individuals in immigrant families. What would be on the top of your list? (Check up to three)

a. Improve system's ability to use social security numbers to verify citizenship

b. Improve system's ability to use document numbers to verify immigration status

c. Provide alternative options for proving identity such as allowing trained assisters to verify documentation and make an attestation or allowing images of specific identity documents to be uploaded

d. Improve the instructions provided in notices sent to consumers

e. Ensure that marketplace notices are translated into more languages

f. Improved coordination of federal marketplace and state eligibility systems so that individuals are quickly and accurately determined eligible for Medicaid, CHIP or marketplace

g. Provide higher quality interpretive services

h. Providing more immigrant-related enrollment data about application, enrollment and people in inconsistency periods

i. Other (Please specify)

16. Do you have the ability to assist individuals in languages other than English? If yes, please check all that apply. If no, check "I do not have the ability to assist individuals in languages other than English."

a. I do not have the ability to assist individuals in languages other than English
b. Spanish
c. Chinese
d. Vietnamese
e. Korean
f. Tagalog
g. Russian
h. French Creole
i. Arabic
j. Portuguese
k. African Languages
l. Other (Please specify)

17. How were your organization's assistance programs funded during open enrollment two (November 15, 2014 to February 15, 2015) (Check all that apply)

a. Federal marketplace grant or contract
b. Office of minority health grant
c. HRSA grant to community health centers
d. CHIPRA outreach grantee
e. State contract
f. Private foundation
g. Individual donors
h. Member dues
i. Volunteer
j. Other (Please specify)

18. How likely is your assister program to be available to help consumers during open enrollment three (November 1, 2015 – January 31, 2016)?

a. Very likely
b. Somewhat likely
c. Somewhat unlikely
d. Very unlikely
e. Not sure

19. In what state do you provide application and enrollment assistance?

20. Would you be willing to participate in a telephone listening session to tell us more about your experiences with enrollment? Note: Your name or that of your organization will not be shared in anything we publish.

a. Yes

b. No

21. Optional Contact info. Note: Your name or that of organization will not be shared in anything we publish.

Name:

Organization:

City/Town:

State:

ZIP:

Email Address:

Phone Number:

Endnotes

1. U.S. Department of Health & Human Services, "Fact Sheet: About 12.7 million people nationwide signed up for coverage during Open Enrollment," February 4, 2016.

2. R. Garfield, et al, "New Estimates of Eligibility for ACA Coverage Among the Uninsured," Kaiser Family Foundation, January 22, 2016. It is unclear how many eligible lawfully present immigrants who are eligible for marketplace coverage with PTC remain uninsured. The federal marketplace has not shared data on how many enrollees are immigrants or live in immigrant families. The fact that the uninsured rate for noncitizens dropped almost 8 percentage points from 38.7 percent in 2013 to 31.2 in 2014 is evidence that some immigrants are in fact gaining coverage. But the uninsured rate for immigrants (31.2 percent uninsured) is still more than three times the uninsured rate of native-born citizens (8.7 percent uninsured). The census data counts native-born citizens, naturalized citizens, and noncitizens, but does not separate lawfully present noncitizens for other noncitizens. So noncitizens include tho=se lawfully present immigrants eligible for marketplace coverage and those who are not. For more information, see The United States Census Bureau "Health Insurance Coverage in the United States: 2014," (September 2015), available at http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf (accessed October 4, 2015).

3. U.S. Department of Health & Human Services, "Secretary Burwell previews third Open Enrollment," October 22, 2015.

4. The Personal Responsibility and Work Opportunity Act of 1996 limited eligibility for Medicaid and CHIP to "qualified immigrants," many of who are required to wait five years to gain eligibility for Medicaid and CHIP. For more information on a list of "qualified immigrants", see T. Broder & J. Blazer J (accessed September 23, 2015).

5. For more information explaining the lawfully residing immigration statuses, see National Immigration Law Center, " 'Lawfully Residing' Children and Pregnant Women Eligible for Medicaid and CHIP," available at http://www.nilc.org/lawfullyresiding.html (accessed September 23, 2015).

6. Office of the Director U.S. Department of Homeland Security, Clarification of Existing Practices Related to Certain Health Care Information, Statement (October 25, 2013), available at https://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf (accessed September 23, 2015).

7. The majority of assisters surveyed said it still took twice (52 percent) or three times (18 percent) longer to complete and submit an application for families with immigrants versus families with all US-born citizens.

8. E. Seiber, "Which States Enroll Their Medicaid-Eligible, Citizen Children with Immigrant Parents?" Health Services Research, 48: 519-538 (2013).

9. T. Brooks, et al, "Modern Era Medicaid: A 50-State Survey of Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-sharing Policies," Kaiser Family Foundation, January 2015.

10. Derived citizens gain US citizenship through actions of their parents or other members of their family. Naturalized citizens gain US citizenship through a legal process where a non-citizen becomes a citizen.

11. 45 CFR 155.315 (2013).

12. SAVE's own verification process information page states, "If the SAVE Program does not verify an applicant's status on the Initial Verification, it does not necessarily imply that the applicant is not authorized to be in the United States. It may be the result of processing error or indicate the need for additional or corrected documentation." U.S. Citizenship and Immigration Services, "SAVE Verification Process,",available at http://www.uscis.gov/save/getting-started/save-verification-process (accessed June 24, 2015).

13. 45 CFR 155.305 (2015) and 45 CFR 155.315 (2015).

14. Centers for Medicare & Medicaid Services, "Update to FFM Functionality for Immigrants with Income Under 100% FPL" (December 2015), available at https://marketplace.cms.gov/technical-assistance-resources/immigrants-with-income-under-100-percent-fpl.pdf (accessed January 20, 2016).

15. This works a little differently in FFM determination states (of which there are 10) than FFM assessment states. In determination states, the applicant should be immediately enrolled in Medicaid and informed that he or she must send in proof of her immigration status to complete the eligibility process, though it does not always work this say, at least two of ten determination states are not providing Medicaid to individuals while their immigration status is being documented and verified. In FFM assessment states, the FFM treats applicants as though likely to be eligible for Medicaid, and the Medicaid applicants are told to provide the Medicaid agency with documents to prove their immigration status. In most cases, Medicaid benefits are not provided with the individual gathers and submits documents. Conversation with Shelby Gonzalez, Center on Budget and Policy Priorities, November 2, 2015.

16. In January 2015, Get Covered Illinois (GCI) provided guidance about a process where application assisters could call GCI to request a "Medicaid Expedite" for individuals facing medical emergencies. The guidance stated that for a "Marketplace eligible consumer who has been incorrectly referred to Medicaid but has a medical emergency and needs to get back on the marketplace, this procedure may also be followed to receive a Medicaid denial more quickly." The application assister would provide information about the applicant, the problem with individual's application to the FFM (including whether there was a data inconsistency, incorrect financial help, incorrect eligibility result or other issue), and the Emergency need (the state provided a list of emergencies acceptable for expediting the denial). Get Covered Illinois guidance on file with author.

17. Op. cit. (14).

18. This information is available in Arabic, Chinese, French, French Creole, German, Gujarati, Hindi, Korean, Polish, Portuguese, Russian, Spanish, Tagalog, Urdu, and Vietnamese.

19. The tagline states, "If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-318-2596."

20. Centers for Medicare Medicaid Services, "Assister newsletter," (April 2015), available at https://marketplace.cms.gov/technical-assistance-resources/assister-newsletter-april-21-2015.PDF (accessed November 17, 2015).

21. Data matching notices are posted on the federal marketplace website. As of November 17, 2015 there are no specific notices describing why immigration status documentation received did not clear up the data matching problem, and exactly which documents need to be submitted. For more information, see "Applications and Forms," Centers for Medicare & Medicaid Services, available at https://marketplace.cms.gov/applications-and-forms/notices.html (accessed November 17, 2015).

22. National Immigration Law Center, "Freedom of Information Act (FOIA) Requests," (September 2014), available at http://www.nilc.org/healthcarelitig.html#complaints (accessed September 23, 2015).

23. Centers for Medicare & Medicaid Services, "March 31, 2015 Effectuated Enrollment Snapshot," (March 2015), available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html (accessed September 23, 2015).

Endnotes

24. While assisters perceived this as an additional requirement for naturalized citizens, this was likely a routine data matching issue that followed the standard protocol to clear up such an inconsistency. There are two main reasons why SSNs entered into the healthcare.gov online application may not validate citizenship. The first reason is either because there was a name change or date of birth or other error in coding the number. The second reason is that the SSN itself could not be used to validate citizenship. As a result, the FFM needed to receive additional documentation, in accordance with the inconsistency rules to clear up the data matching error.

25. Assisters described this situation as one of documents getting lost. However, some stakeholders have suggested that the problem may occur when the individual has more than one Healthcare.gov online account (possibly as a result of an individual's attempt to work around system problems) and documents were matched to the duplicate account.

26. T. Shaw & S. Gonzales, "Remote Identity Proofing: Impacts on Access to Health Insurance," Social Interest Solutions and Center on Budget and Policy Solutions (Jan 2016).

27. The Consumer Financial Protection Bureau (CFPB) recently found that more than 26 million adults in America are "credit invisible," meaning that they have no credit records maintained by the three nationwide credit-reporting agencies. CFPB also found that Hispanics are more likely to be credit invisible than Whites, Asians or Blacks. For more information, see Consumer Financial Protection Bureau, "Data Point: Credit Invisibles," (May 2015), available at http://files.consumerfinance.gov/f/201505_cfpb_data-point-credit-invisibles.pdf (accessed September 23, 2015).

28. This question for assisters was worded, "When applying for coverage on the federal marketplace ONLINE/on healthcare.gov, have you experienced any of the following problems? Please indicate whether it was a problem and how often." While the overall survey was geared toward assisters who had helped families with immigrants, this question was not limited to immigrant families only.

29. Op. cit. (26).

30. Some people born in the United States are also limited English proficient. J. Zong, J. Batalova, "The Limited English Proficient Population in the United States," Migration Policy Institute, (July 2015), available at http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states (Figure 1) (accessed November 16, 2015).

31. Ibid.

32. Migration Policy Institute tabulation of data from the U.S. Census Bureau 2013 American Community Survey. See ibid. Analysis of data about LEP populations eligible for marketplace subsidies (based on income and immigration status) is beyond the scope of this paper, however it is known that LEP populations are more likely to be low income than English proficient individuals.

33. In the first open enrollment period, there were also "job aids," basically translated versions of the paper application in multiple languages, available as well.

34. This information is available in Arabic, Chinese, French, French Creole, German, Gujarati, Hindi, Korean, Polish, Portuguese, Russian, Spanish, Tagalog, Urdu, and Vietnamese.

35. The original tagline stated, "If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-318-2596.

36. The revised tagline states, "This notice has important information about your application or coverage through the Health Insurance Marketplace. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-800-318-2596 and wait through the opening. When an agent answers, state the language you need and you'll be connected with an interpreter." See Op. cit. (17).

37. S. Schwartz, "Advocates File Civil Rights Complaint with HHS on Coverage Termination Day," Center for Children and Families, available at http://ccf.georgetown.edu/all/advocates-file-civil-rights-complaint-with-hhs-on-coverage-termination-day/ (accessed September 23, 2015). The complaint is still pending at HHS OCR.

38. The HHS Office for Civil Rights LEP Guidance includes a "safe harbor" for recipients of federal funds who meet specific translation guidelines. The "safe harbor" means that recipients of federal funds will not be held in violation of federal civil rights laws when: 1) "vital" documents are translated for each LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered; or 2) if there are fewer than 50 people in a language group that reaches the five percent trigger and the recipient does not translate vital written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost. See "U.S. Department of Health and Human Services Office for Civil Rights, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/lepguidance.pdf (accessed October 6, 2015).

39. A small percent of assisters (three percent) said that getting language assistance through the FFM call center was almost always a problem, less than one in ten assisters said it was often a problem (seven percent).

40. Slightly more than one in ten (11 percent) assisters responded that it was almost always a problem getting help in the preferred language of the applicant when calling Experian, and one in ten (10 percent) assisters said this was often a problem.

41. HHS OCR's LEP guidance provides a safe harbor when "vital" documents should be translated for each LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered or if there are fewer than 50 people in a language group that reaches the five percent trigger or if the recipient does not translate vital written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost. Op. cit. (38).

42. HHS staff indicated that if a translator in a needed language is not available through the language line at a given time, the FFM call center will document the language and available times to call back, and return the call when the translator is available.

43. In the 2015 Navigator application FAQs, HHS says that applicants that demonstrate a focus on underserved populations or communities and a commitment to serve these populations or communities, while also being prepared to assist any consumer seeking assistance may receive a higher score in the application than those applicants that do not. HHS's definition of underserved included populations with limited English proficiency). Centers for Medicare & Medicaid Services, "External Frequently Asked Questions for Navigator FOA," available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-

Endnotes

Insurance-Marketplaces/Downloads/Navigator-FOA-External-FAQs-FINAL-508-MM.PDF (accessed November 8, 2015).

44. "Assister Help Resource Center Questions and Answers." Available at http://www.nationaldisabilitynavigator.org/wp-content/uploads/news-items/CMS_ahrc-questions-and-answers.pdf (accessed December 3, 2015).

45. In the online survey, these were much more popular answers than more "self-focused" options, like providing more federal funding to assisters (34 percent), or training for assisters (38 percent).

46. "State Health Insurance Marketplace Types, 2015," The Henry J. Kaiser Family Foundation, available at http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/ (accessed September 23, 2015).

47. Note that non-citizens who meet Medicaid's other eligibility criteria, but not the immigration status requirements are eligible for treatment of an emergency medical condition paid for by Medicaid, commonly known as "emergency Medicaid."

48. "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," Pub. L. 104-193, 110 Stat 2105 (1996); subsequently amended "Illegal Immigration Reform and Immigrant Responsibility Act of 1996," Pub. L. 104-208, 110 Stat 3009 (1996).

49. For more information, especially about authority for and eligibility of survivors of domestic violence, survivors of trafficking, individuals "lawfully residing" before 8/22/96, Amerasian LPRs, and Iraqi and Afghan special immigrants, see Op. cit. (5).

50. This option was enacted as Section 214 of the CHIP Reauthorization Act of 2009 (CHIPRA). "Children's Health Insurance Program Reauthorization Act of 2009," Pub. L. 111-3, 123 Stat 8 (2009).

51. For more information explaining the lawfully residing immigration statuses, see "'Lawfully Residing' Children and Pregnant Women Eligible for Medicaid and CHIP," National Immigration Law Center, http://www.nilc.org/lawfullyresiding.html (accessed September 23, 2015).

52. Note than on July 1, 2015, after "Modern Era Medicaid" was published, Colorado began coverage for lawfully residing children with no five-year waiting period. Center for Children and Families and the Henry J. Kaiser Family Foundation, "Modern Era Medicaid," (January 2015), available at http://ccf.georgetown.edu/wp-content/uploads/2015/01/Modern-Era-Medicaid-January-2015.pdf (accessed September 23, 2015). See also Center for Children and Families, "CHIP and Health Coverage for Lawfully Residing Children," available at http://ccf.georgetown.edu/wp-content/uploads/2015/06/CCF-ICHIA-KIDS-1-pagerFINAL-1.pdf (accessed September 23, 2015).

53. 67 Fed. Reg. 61955-74 (October 2, 2002); Department of Health and Human Services, Letter to State Health Officials, Statement (Nov. 12, 2002); and National Immigration Law Center, "Prenatal Coverage through the State Children's Health Insurance Program," (June 2003). For more information on the number of states that provide the CHIP unborn child option, see Ibid.

54. For more information on a list of states providing optional coverage, including prenatal care with CHIP funding, see "TABLE: Medical Assistance Programs for Immigrants in Various States," National Immigration Law Center, available at http://www.nilc.org/health.html (accessed September 23, 2015).

55. A person whose only connection to the U.S. is through birth in an outlying possession (currently limited to American Samoa and Swains Island), or through descent from a person so born acquires U.S. nationality but not U.S. citizenship. Nationals may reside and work in the U.S. without restrictions and apply for citizenship. Not all U.S. nationals are U.S. citizens; however, all U.S. citizens are U.S. nationals. See 8 U.S.C. §1408 (1986).

56. U.S. Department of Health and Human Services, "Immigration Status and the Marketplace," available at https://www.healthcare.gov/immigration-status-and-the-marketplace/ (accessed September 23, 2015).

57. For more information on the lawfully present immigration statuses, see "'Lawfully Present' Individuals Eligible under the Affordable Care Act," National Immigration Law Center, available at http://www.nilc.org/ACAfacts.html (accessed September 23, 2015).

58. 45 CFR § 155.305f(2) (2013); and 26 CFR § 1.36B-2b(5) (2013).

59. Experian states that it has data on more than 215 million consumers, including credit report data and demographic data from more than 400 data sources. See "Precise ID: An integrated approach to the world of identity risk management," Experian Information Solutions, (September 2006), available at https://www.experian.com/whitepapers/precise_id_whitepaper.pdf. Op. cit. (26).

60. Health Insurance Marketplace, "FAQ on Remote Identity Proofing, Remote Identity Proofing Failures and Application Inconsistencies (Federally-facilitated Marketplace)," (May 2014), available at https://marketplace.cms.gov/technical-assistance-resources/remote-identity-proofing-faqs.pdf (accessed September 23, 2015).

61. Recent testimony provided by the GAO said that when testing marketplace applications, a government contractor (likely Experian) could not resolve the identity verification, the contractor directed the individual to call the marketplace (either federal or state). Statement of Seto Bagdoyan, "Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015," United States Government Accountability Office (October 23, 2015) available at http://www.gao.gov/assets/680/673286.pdf (accessed January 21, 2016).

62. Center on Budget and Policy Priorities, "Key Facts: Helping Families That Include Immigrants Apply for Health Coverage," http://www.healthreformbeyondthebasics.org/key-facts-application-process-families-that-include-immigrants/ (accessed November 4, 2015).

63. Ibid.

64. Note, those who respond that they are a naturalized or U.S. citizen are then asked to choose a document type and verify citizenship status.

65. This is actually the same number, but the A number has an "A" in front of it.

66. U.S. Citizenship and Immigration Services, "SAVE Verification Process," available at http://www.uscis.gov/save/getting-started/save-verification-process (accessed June 24, 2015).

67. Ibid. SAVE provides up to four indicators about the applicant, depending on what is needed by the eligibility entity: 1) Is the individual a qualified immigrant? 2) Is the individual subject to the five-year bar? 3) If subject to five-year bar, has the individual met it? 4) Is the individual lawfully present ? (For more information on SAVE, see text box in Appendix B).

68. For more information about SAVE, see "What is SAVE?," U.S. Citizenship and Immigration Services, available at http://www.uscis.gov/save/what-save/what-save (accessed September 23, 2015).

69. Op. cit. (62).

70. Op. cit. (62).

71. Op. cit. (62)

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72. Op. cit. (62).

73. Op. cit. (14).

74. Details about this process are provided in Op. cit. (62).

75. Op. cit. (62).

76. The "Welcome Mat" effect is a term used to describe why expanding coverage to uninsured children results in many low-income families with already-eligible children securing coverage. For more information see Center for Children and Families, "Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children," (September 2008), available at http://ccf.georgetown.edu/wp-content/uploads/2012/03/Strategy%20center_putting%20out%20the%20welcome%20mat.pdf (accessed September 23, 2015). See also L. Coutré, "New Hanover DSS staff working overtime to clear Medicaid backlog," available at http://www.starnewsonline.com/article/20150622/ARTICLES/150629935/ (accessed September 23, 2015); and A. Seidman, "New Jersey Works to Fix Medicaid Backlog," available at http://www.govtech.com/state/New-Jersey-Works-to-Fix-Medicaid-Backlog.html (accessed September 23, 2015).

77. Op. cit. (14).

78. Prior to December 15, 2015, there was a multiple step, manual process for individuals in this group to get PTC. What follows is a summary of the prior manual process. The FFM notified the consumer periodically that s/he could enroll in coverage without PTC and that s/he need to provide proof of immigration status. If the consumer sent in proof, the case was sent to a special processing unit for verification of immigration status first, based on Medicaid rules. If determined ineligible for Medicaid based on verification of his/her immigration status, the FFM notified the consumer to return to the FFM and provides instructions on how to get an updated eligibility determination. The individual had to then return to the FFM to update the application, indicate that Medicaid has been denied, and provide any other needed information before the FFM could make a correct eligibility determination for PTCs. Details about this process are provided in Center on Budget and Policy Priorities, "Key Facts: Helping Families That Include Immigrants Apply for Health Coverage," http://www.healthreformbeyondthebasics.org/key-facts-application-process-families-that-include-immigrants/ (accessed November 4, 2015).

79. ACA § 1411(c)(2) (2010) and 45 CFR § 155.315(c) (2013).

80. Op. cit. (12).

81. For more information, see National Immigration Law Center, "ACA: Fact Sheets & Advocacy Materials," https://www.nilc.org/ACAfacts.html (November 18, 2015).

82. This information is available in Arabic, Chinese, French, French Creole, German, Gujarati, Hindi, Korean, Polish, Portuguese, Russian, Spanish, Tagalog, Urdu, and Vietnamese.

83. Op. cit. (18).

84. 42 CFR 155.315c(3) (2013)

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OLIVER WYMAN

SPECIAL ENROLLMENT PERIODS AND THE NON-GROUP, ACA-COMPLIANT MARKET

By: Chris Carlson, FSA, MAAA
Kurt Giesa, FSA, MAAA

February 24, 2016

Executive Summary

Oliver Wyman reviewed data from health insurance issuers to understand the impact that special enrollment periods (SEP) are having on the non-group, ACA-compliant market. We found that individuals enrolling during an SEP represent a significant and growing share of exchange enrollment. Moreover, we found that SEP enrollees have higher morbidity than those who enrolled during the open enrollment period (OEP) and were much more likely, on average, to lapse coverage than those that enrolled during the OEP. Specifically, we found:

- SEP enrollment represented 17% of total exchange enrollment during 2014, and represented almost 20% of active enrollees at December 31, 2014.
- The per member per month (PMPM) claim costs during 2014 for individuals that enrolled during an SEP were 10% higher than those that enrolled during the OEP.
- PMPM claim costs for SEP enrollees during 2014 were 24% higher on average during the first three months of enrollment than for OEP enrollees.
- In 2015, the difference in PMPM claims costs increased to 41% for the first three months of enrollment.
- SEP enrollees are more than 40% more likely, on average, to lapse coverage than those that enroll during the OEP (lapse rates were 3.5% per month for OEP enrollees as compared to 5.0% per month for SEP enrollees).
- SEP enrollees that chose plans with the highest actuarial values showed especially high costs during the first month of enrollment.
- Newborns who are born to a mother who enrolled during the OEP are considered SEP enrollees in our analysis, but we estimate that they contributed only 2.5% of the increased cost for all SEP enrollees during 2014.

Introduction

The Affordable Care Act (ACA) allows all individuals to enroll in a health plan on a guaranteed basis regardless of pre-existing conditions. To help manage selection, the ACA allows individuals to enroll only during a time-limited OEP, so individuals cannot wait until they become ill or require medical care before enrolling in a health plan. However, recognizing that a person's circumstances may change, the ACA makes allowances for an individual to enroll in non-group coverage outside of the OEP. Periods during which this is allowed are referred to as SEPs and are triggered when an individual meets certain criteria, such as when an individual loses their

employer-sponsored health coverage. Through regulation and guidance, the eligibility categories allowing an individual to qualify for an SEP have expanded to include over 30 different criteria and there is considerable concern among issuers that individuals are using SEPs to delay purchasing health insurance until a need arises. The resulting adverse selection results in individuals enrolling through SEPs costing far more than those enrolling during the OEP. This, in turn, increases the cost to provide health care for all enrollees. Eventually, this higher cost will be passed down to consumers in the form of higher premiums.

We were engaged by America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA) to collect and analyze data from issuers to quantify the impact of SEPs on the non-group market. This report provides the results of our analysis and compares the cost of individuals enrolling through an SEP to individuals enrolling during the OEP.

Data and Methodology

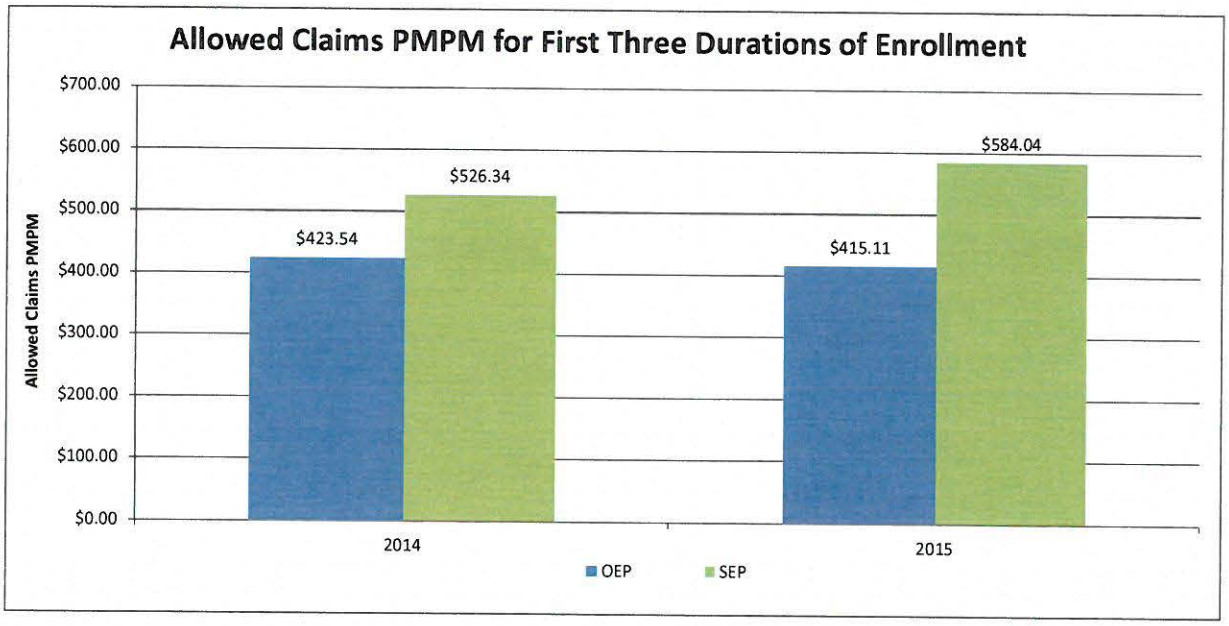
AHIP and BCBSA solicited their member plans to provide data to Oliver Wyman to support our work. Thirteen health insurance issuers responded to the data request and the results provided in this report reflect the collective data for these health plans. In total, the data represent 82 million member months, $27 billion of premium from January 2014 through June 2015, and over $26 billion in allowed claims (using claims incurred from January 2014 through June 2015 and paid through October 2015). We have $15 billion of the premium in 2014, which we estimate represents more than 40% of the total premium for the non-group, ACA-compliant market.

The data provided by each issuer is aggregated data (earned premium, members, allowed claims, etc.) for each month and is split by the original effective date of the enrollee. For the purposes of this analysis, we have defined individuals that have an effective date from June through December 2014, and April through June 2015 as having enrolled though an SEP. In the event of a newborn, the data associated with the mother and other family members is identified based on their initial effective date, typically during the OEP. However, the newborn is assigned a new effective date which would be considered an SEP if enrolled during the months described above. We show below the impact that newborns have on the results of our analysis.

For lapse and durational studies, we excluded any lapses that occurred at calendar year-end to avoid counting members who changed plans during open enrollment as having lapsed.
The data represent a cross-section of issuers that cover many states. The results we provide represent a weighted average for all of the issuers and are not necessarily representative of any specific issuer or market. Our analysis of claim costs focuses on allowed claims before the application of any cost-sharing.

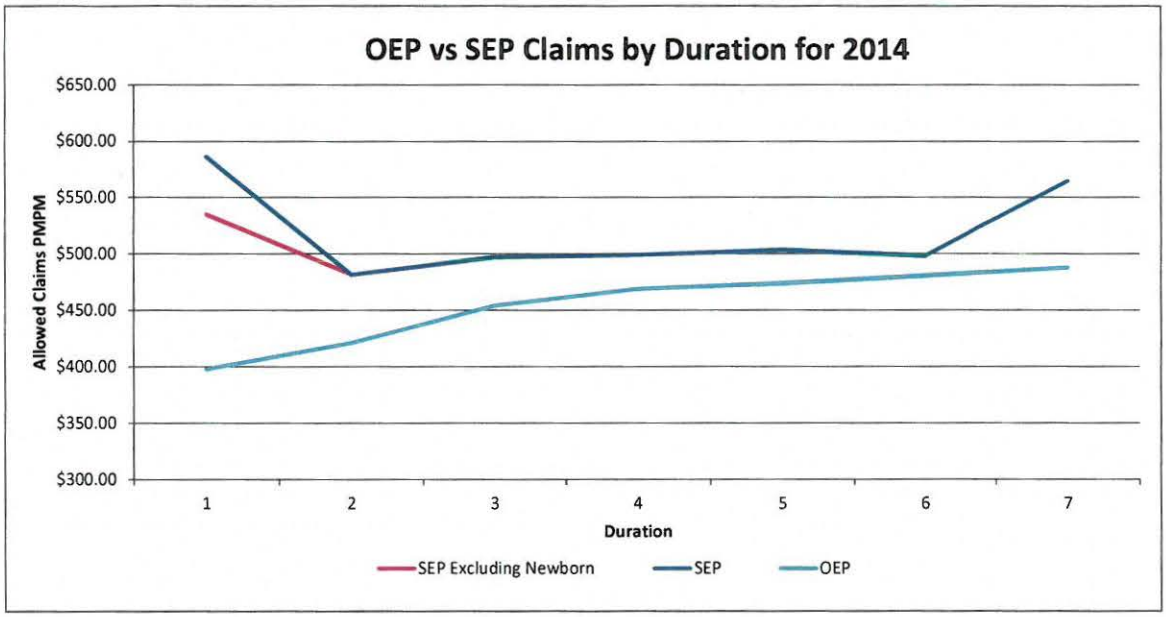
Detailed Results

Issuers' primary concern is that a portion of individuals who are enrolling through an SEP are doing so because of an immediate or imminent need for health care. Therefore, we compared PMPM claim costs for SEP and OEP enrollees during the first three months of coverage. In total, the average cost PMPM for the SEP enrollees was 24% higher over this period in 2014, and 41% higher in 2015. The chart below shows the average allowed claims PMPM during the first three months of enrollment.



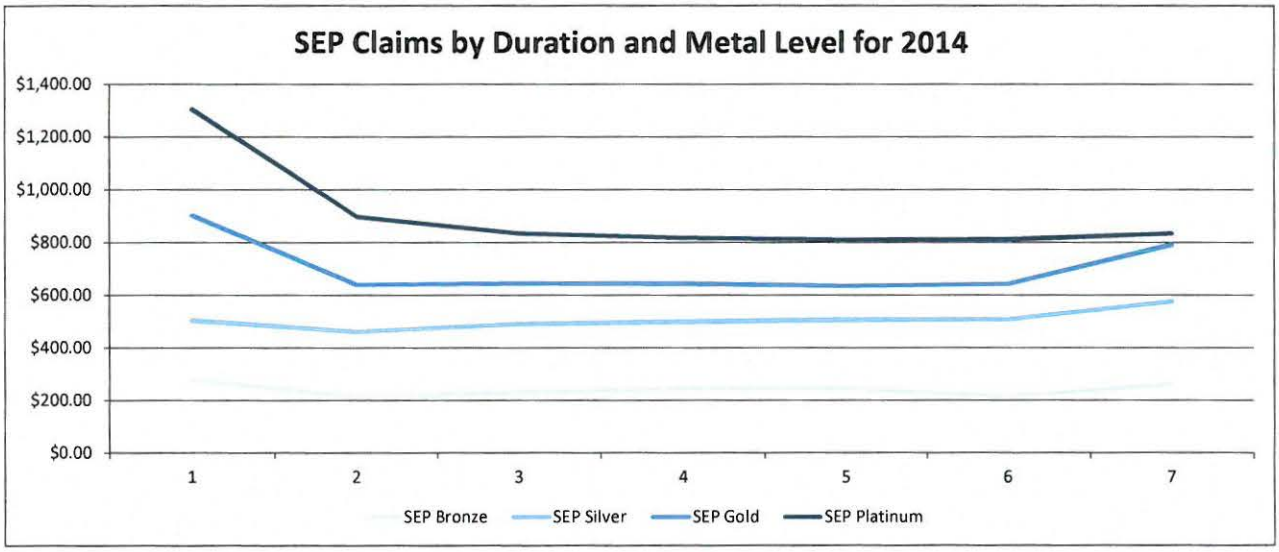
Beyond the first three months of enrollment, the claim costs for those that enrolled through an SEP remained higher than for OEP enrollees. As discussed previously, newborns that are born to mothers who enrolled during the OEP are identified as SEP in our data, even though their family unit previously was covered. While these newborns enrolled because of an SEP, it is more appropriate to include their costs as OEP for this analysis, since their parents were previously enrolled during the OEP. However, data limitations prevent us from using the issuer-provided data to remove the cost of these newborns from our analysis. Therefore, we reviewed a different claims database that accumulated data from a group of nationally representative issuers to assess the impact of the newborns. We found that the allowed claim costs for the newborns that are born to mothers who enrolled during the OEP represented 2.5% of the total allowed claim costs during 2014 for the individuals enrolling through an SEP.

The chart below shows claim costs by duration throughout 2014. Note that the duration only goes to seven months, which is the maximum duration for an individual that enrolled through an SEP in 2014. To understand how the newborn SEP issue affects our analysis, we reallocated 2.5% of the 2014 SEP claim costs to OEP to reflect the newborn costs. Note that in this chart we assumed that all of the newborn costs are incurred during the first month of enrollment.

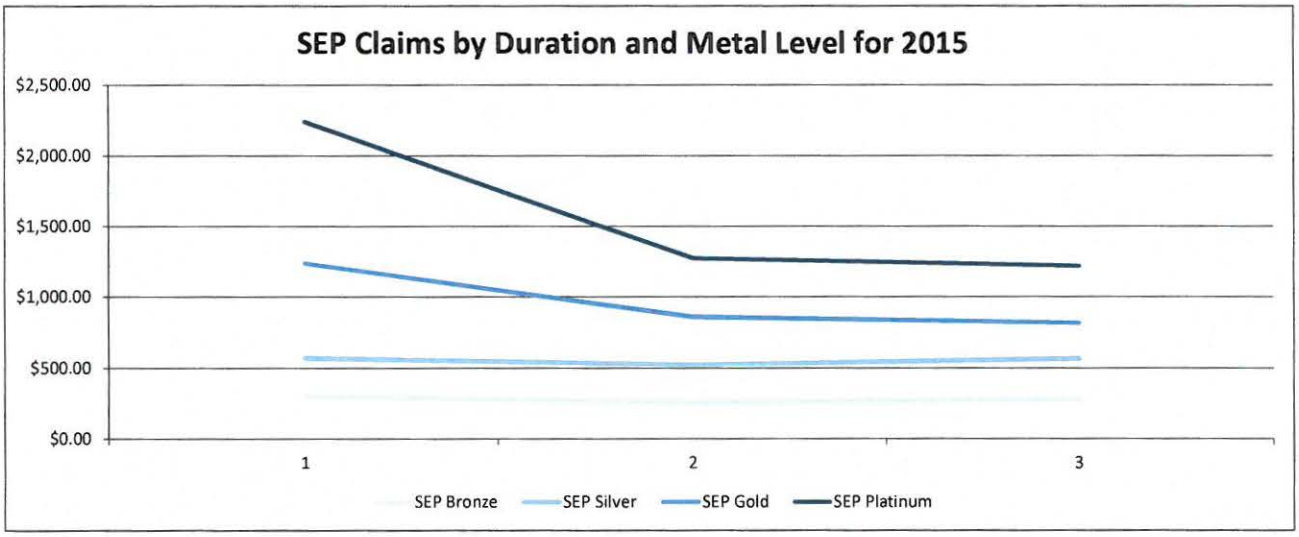


This chart illustrates that even after adjusting for the newborn costs, the data indicate that individuals with other health care needs are enrolling through SEPs and using health care services at higher rates shortly after enrollment.

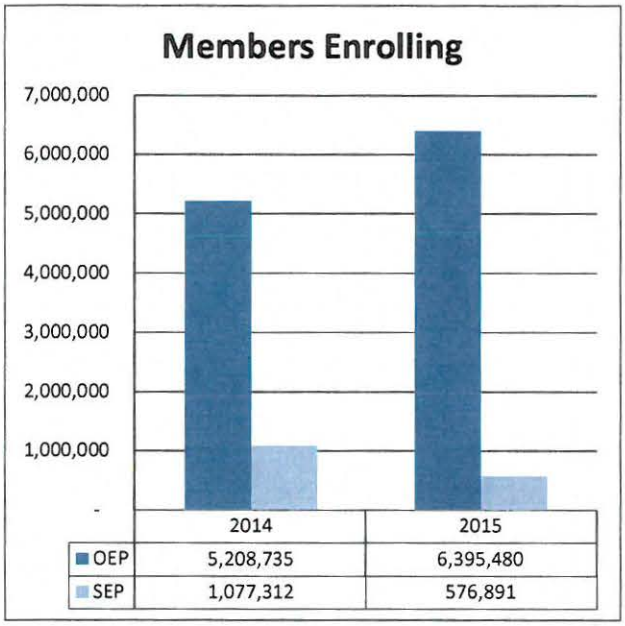
Individuals enrolling through an SEP have no limitations on the plans that they may choose to enroll in. Therefore, it is likely that enrollees that anticipate a greater need for health care services will enroll in a richer benefit plan. To illustrate this point, we split the SEP data from the prior chart based on the metal level of the health plan that was selected. As shown in the chart below, SEP enrollees choosing the richest benefit plans are also those with the highest costs during the first month of enrollment. Specifically, the claim costs for platinum enrollees in the first month are 56% higher than the average of all other months, but for gold and bronze enrollees, the first month is only 35% and 18% higher, respectively. There is almost no spike for silver plan enrollees.



Although we have only three months of data for the SEP enrollees during 2015, the claim costs by metal level follow a similar pattern, as shown below.

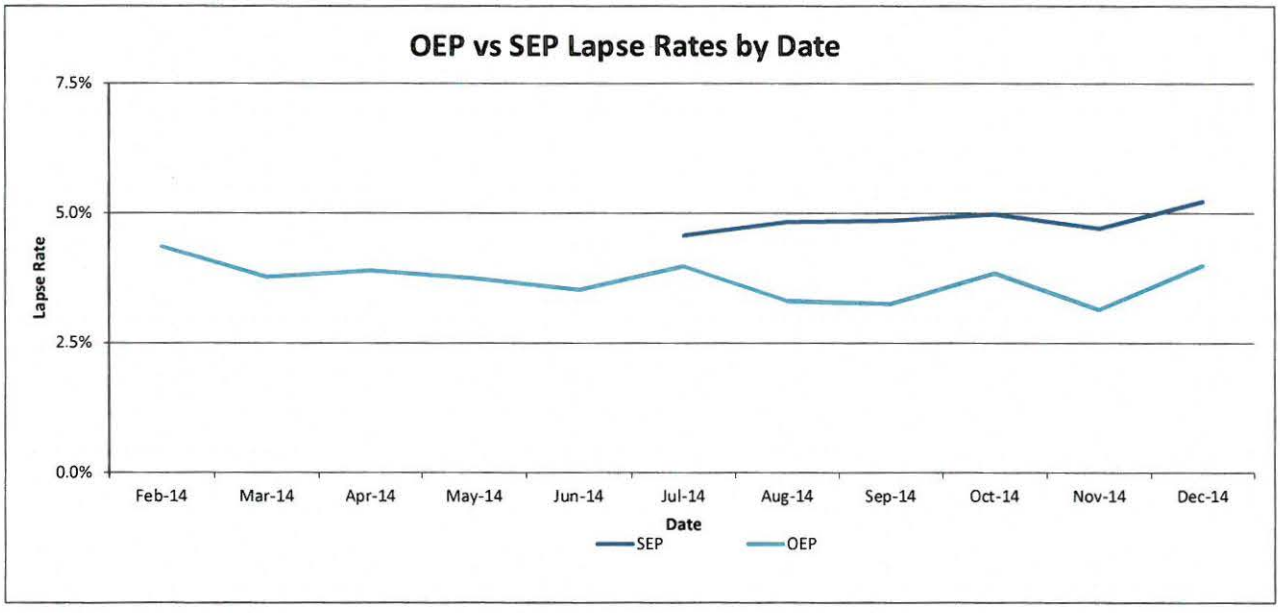


SEP enrollment represents a significant and growing portion of the total membership. In the chart below we show the total enrollees during 2014 and 2015 based on whether they enrolled in the OEP or through an SEP. We also show the membership at the end of the period.



During 2014, 17% of enrollment was through an SEP. With only three months of SEP enrollees during 2015, this amount already exceeded 8% of total enrollment. Furthermore, at the end of 2014, SEP enrollees represented almost 20% of total enrollees. As of June 2015, the SEP enrollees represent 17% but this amount will grow throughout the year.

Finally, in addition to higher claim costs, SEP enrollees lapse at a higher rate than the OEP enrollees. The table below shows the monthly lapse rates during 2014.



Limitations

This report does not constitute advice by Oliver Wyman to any third parties and is solely for informational purposes and not for purposes of reliance by any third parties. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein. This report should not replace the due diligence on behalf of any third party.

For our analysis, we relied on data and information provided by health insurance issuers without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Building a More Efficient Marketplace: Lessons from DC Health Link's Experience with Open Source Code

Corinne Alberts

Every open enrollment affords State-based Marketplaces (SBMs) new opportunities to introduce innovative ways to continually improve their systems while also lowering costs to achieve sustainability of their marketplaces. During the 2015-2016 open enrollment season DC Health Link, the District of Columbia's health insurance marketplace, began using open source code, an Agile development approach, a commercially hosted government cloud, and a re-architected solution.

This change comes on the heels of several years of costly issues. Launched in 2013 with two commercial off-the-shelf (COTS) products DC Health Link faced millions of dollars in annual licensing fees for COTS products. Change requests ranged from hundreds of thousands to millions of dollars due to the complexity of changing hard-coded software. Product development cycles were long, averaging six to eight months for updates. Deployment of changes required the marketplace to be taken off-line for maintenance, which meant customers could not use the marketplace while the system was down.

Following the major overhaul to its health insurance marketplace, DC Health Link reports from these changes including: documented savings, a reduction in consumer complaints, and greater agility to address and improve technical functions.

DC's success with open source code presents an interesting opportunity for states exploring their marketplace models and technology. Using the experience of DC Health Link, this brief explores the use of open source technology to improve customer experience, reduce technical failures and cost savings.

What is Open Source Code?

"Open source" refers to publicly accessible code or technology that can be shared or by any developer, giving users the ability to choose and customize at will without incurring extra costs.[1] Source code, or the underlying code that runs a program or application, is made publicly available to networks of developers that can then review or modify the code.[2] Using open source code is a way organizations can reduce costs while taking advantage of a vast network of technical innovation.

The open source community is a thriving network of tens of thousands of developers who collaborate on data and the creation of new software.[3] Unlike a website like Wikipedia ®, where changes can be made by anyone and are immediately displayed, open source patches are subject to a system of review.[4] Usually, open source networks are highly watched and reviewed communities, regarded by technology professionals as extremely reliable and secure. In fact, some open source software is more secure than closed source code.[5] Developers submit patches or updates to the source code, usually to address security issues or other glitches. After review and testing, the patch can either be accepted or the original builders of the program can work on developing their own patch. This network is not all volunteer-based; there are companies that sell support and training services for open source technology.

Flexibility is a large part of the appeal of open source code. Unlike commercial products, open source coding is a constantly evolving technology that often produces solutions more quickly than private companies. There is also a wealth of existing code that can be pieced together to form a unique program. To use the Linux example (**see box on right**) different applications and functions can build off the "kernel" to suit individual requirements.[9]

Popular Uses of Open Source Code

The most well-known and popular example of open source sharing is Linux, an operating system originally developed in 1991 by Linus Torvalds.[6] The in- customizability and low associated costs of the Linux "kernel" has caused it to be taken up by businesses the world over; Google, IBM, and Amazon all use Linux code in major IT functions. Linux is the operating software for 98 percent of supercomputers, and powers most of the worlds Internet servers.[7]

Thousands of developers use and have access to the Linux code everyday. Patches and changes are subject to a higher rate of review then most private companies are capable of. The code itself can be acquired and by anyone. anywhere, for free.[8]

Why Open Source for Health Insurance Marketplaces?

Use of open source code can insurance marketplaces because it can be freely acquired and adapted to suit the needs of each state. Unlike commercial products, open source enables a marketplace to have greater ability to bring the technology "in-house," allowing greater autonomy to marketplaces to innovate as well as to be proactive about identifying and solutions for technical problems. Industry experts would say, this is notable, as, by nature, code is not perfect or static. Bugs, such as website crashes or security breaches are almost inevitable.[10]

Open source technology gives those that use it access to the resources of thousands of developers across the world increasing cost-effectiveness. This large and supportive community is the centerpiece of open source software, and what makes it so distinct from off-the-shelf products. Developers work with open source software daily and have the ability to identify and offer solutions to emerging issues quicker than most commercial systems. Moreover, the rewards of open source software multiply as more people use it, so, if several marketplaces were to adopt the same open source code, they could become part of their own network of innovation and support.[11]

Making the Switch at DC Health Link

In late 2014, DC Health Link decided to make the switch from COTS products to an open source solution. The switch, it determined, would lead to better prospects for long-term sustainability and improved customer experiences. DC Health Link the open source initiative in grant work submitted to the Center for Medicare and Medicaid Services (CMS), and staff kept in regular contact with CMS throughout the development and implementation of the new software.

DC's local tech corridor was key to the development and launch of the new open source system. Building on an already existing internal IT team of consultants to lead development, the transition was - cient, with minimum down time of the website. In fact, when initiating the switch, DC Health Link was able to make a full migration to the new system without needing to run a parallel platform before the site went live. DC also received input from customers, brokers, and internal business staff to build their new system. Since making the switch, DC Health Link has witnessed many improvements.

Cost-Savings

After an initial investment in developing the open source solution, DC has seen reductions in costs. Eliminating annual licensing fees from their previous commercial products translated into an immediate $2.9 million in savings. Furthermore, by bringing technical systems in-house, DC Health Link eliminated spending resources on time consuming and costly change orders; previously, even simple changes to text required full code deployment and expensive end-to-end testing. Under the new system, if DC Health Link's call center notices a pattern of consumer issues arising because of a technical glitch, then its team can make immediate changes (e.g., changing language on website after hearing that consumers are wording). This also applies to functional and user interface (UI) code changes. There is a cost for developer time, quality assurance testing of new modular functions (modular meaning it requires testing of the functions that would be affected by the changes -- which is different from end-to-end testing of the entire code replacement), and deployment by the internal operations and maintenance team.

More Agile and Responsive Systems

An immediate effect of open source code is that DC Health Link gained more ownership over their system. This enables DC Health Link to move swiftly to correct defects and address software bugs as soon as they are changes can be made every day without down time. Moreover, when customers or brokers offer suggestions for improvements; those can be developed and implemented quickly. Business and operations teams can work in tandem with IT teams to address changing priorities without the constraint of an eight-month development cycle common for many private-sector vendors.

Code is a constantly evolving organism, requiring constant maintenance and new IT deployments. The agile approach and open source code means when technical issues arise, the issues are constrained and do not impact other functionality.

DC Health Link's previous system required that the system be during major IT deployments, resulting in productivity loss and impacting consumers. Now, updates can be made continually and without taking the system This is enormously important for DC Health Link's growing small business marketplace. Long system outages during deployments can be especially disruptive for the Small Business Health Options Programs (SHOP) enrollment since small business can enroll at any time during the year.

DC Health Link staf
policies and demands of marketplace consumers. For example, DC Health Link anticipates that 2016 will be a big year for the small group marketplace. A 2013 law that merges the individual and small group markets into the marketplace and requires all carriers to sell all products on the marketplace is [12] DC's SHOP--which already covers nearly 800 small busi-

the improvements to agility, usability, and website performance (1.45 second average page load time and commercially hosted government cloud with automated virtual server capacity) means that their new platform is equipped to handle a high volume of users.

, is that because most of their website and enrollment functions are run by in-house teams, DC Health Link has immediate access to data they are generating. This gives staf
consumers. This data is an invaluable resource for the marketplace as accurate and timely knowledge of who is using the marketplace and how they are using it is essential for making technical improvements to website usability as well as for creating marketing strategies, policies, and goals for the marketplace.

Improved Consumer Usability

with customer and broker feedback.

to complete enrollment. The employer application was reduced from 22 screens to six, while employ- A progress bar, similar to those seen on commercial websites, was added to help consumers track their enrollment process. Every step in the enrollment process can be completed in less than 3 minutes. On average, users spend 6.33 minutes on the site at a time.

Website improvements have also impacted the demand for assistance through DC Health Link's call centers. During the 2015-16 open enrollment season, average wait times were reduced from 8.7 minutes during the previous open enrollment to 1.5 minutes. Abandonment rates improved from 23 to six percent. DC Health Link staff directly attributes these reductions in contact center use to the vast improvements in usability made possible by the improved website. Inter-team collaboration ensures that the front-line consumer input that call centers receive goes directly to the IT staff. The current routine regression testing of new IT deployments means that buggy functions never see the light of day. All of this adds up to an easier consumer experience, meaning fewer questions and problems and a lighter volume of calls.

Challenges and Opportunities

DC Health Link has been able to use its open source code to make steps towards securing the sustainability of the marketplace by reducing its overhead and administrative costs. The of open source code and the autonomy it affords states makes it an attractive solution for other SBMs looking to make sustainability improvements of their own. None of this is to say that there are not challenges in moving to open source for those interested in exploring that option.

While a bene of open source code is that it can be tailored, there are inevitable costs and challenges associated with that process. Marketplaces would need to dedicate resources to conduct a full inventory of their current systems and determine how to migrate over to the new code. There are inevitable start-up costs. Bringing additional IT functions in-house means that internal IT capabilities will need to be strengthened, either through additional staff or increased resources. DC Health Link has found there is some trade-off in this area. While they did add some open source consultants for this new system, they were able to reduce the consultants needed to support the two COTS products.

The full capabilities of open source software have not been fully examined. While DC Health Link uses open source code to run all aspects of their SHOP marketplace and for full pay individual marketplace customers, some COTS software is still used for Advance Premium Tax Credit (APTC) calculations because of DC's shared rules engine with Medicaid. While DC Health Link is developing an open source, cloud-based back-up for APTC to use when the COTS product is off-line, this is an area of future growth. DC Health Link plans to deploy their new code before the next open enrollment, but this would be uncharted territory for other marketplaces.

Challenges aside, open source code is an intriguing possibility for SBMs looking to reduce expenses, improve their web systems and consumer experiences. Low costs, and the potential of open source software for customization are particularly important As SBMs work towards a more sustainable future, we may see more states take up an open source solution of their own. DC Health Link stands ready to work in partnership with any SBMs that would like to move to an open source code solution.

The open source code from DC Health Link is available to all SBMs at the following links:

- https://github.com/dchbx/enroll (enrollment application)
- https://github.com/dchbx/cv (ACApi canonical vocabulary)
- https://github.com/dchbx/gluedb (enrollment database)

End Notes

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About the National Academy for State Health Policy:
The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.

dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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The State Health Exchange Leadership Network is a project of the National Academy for State Health Policy (NASHP),

and staff working on the operation and implementation of health insurance exchanges.

November 2015

Express Scripts **2015 Drug Trend Report**

THE EXPRESS SCRIPTS LAB

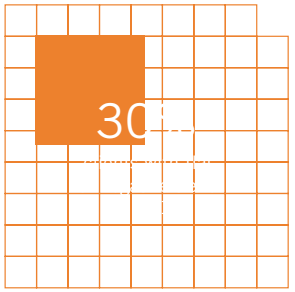
Content

Introduction

Drug trend year in review

2015 drug trend reduction reflects bold actions

Payers faced a seismic shift in the pharmacy landscape in 2014, which led to the highest annual increase in drug spending in more than a decade. As they have for the past 30 years, our clients worked with us in 2015 to implement effective new solutions to address the biggest drivers of that increased spend. Our collective actions helped slow the country's year-over-year increase in drug spending to only 5.2%, roughly half of what it was in 2014. Meanwhile, our members' average out-of-pocket spending on prescription drugs fell 3.2% in 2015, while their overall health outcomes improved.



One thing is clear: taking action works. **Clients who adopted more solutions had an even lower trend.** Our clients who tightly managed their pharmacy benefit held their 2015 increase in drug spending to 3.3% – nearly two percentage points lower than the national average.

Our legacy of client-driven innovation, action and alignment is seen throughout our company's 30 years. Our continued success relies on our commitment to always do what's right for our clients and patients and to always keep patients at the center of everything we do. To all of us at Express Scripts, and to our clients, patients matter most.

In this, the 20th edition of our Drug Trend Report, the impacts of that commitment, and our latest innovations and actions, are clear:

- **Together, we're curing patients with hepatitis C.** In 2015, nearly 50,000 Express Scripts and Accredo® patients with hepatitis C received curative treatment. Payers saved more than $1 billion on costly therapies through our Hepatitis Cure Value Program® (HCV). Marketplace competition – ignited by Express Scripts – made these medications more affordable across the U.S., and for many of our plans, accessible to all patients, not just the sickest. Our Accredo specialty pharmacy delivered industry-leading persistency rates for Viekira Pak® (ombitasvir/paritaprevir/ritonavir with dasabuvir) and Harvoni®

To all of us at Express Scripts, and to our clients, **patients matter most**.

(ledipasvir/sofosbuvir) of 93 to 94%, compared to 83 to 92% at retail and specialty pharmacies. New hepatitis C medications coming to market in 2016 will continue to bring down prices.

- **Together, we're eliminating cost and waste.** Payers effectively mitigated the dramatic increases in spending on compounded medications in 2014. They achieved a 97% drop in total plan costs for the class in 2015 through the Express Scripts compound management solution.
- **Together, we're addressing persistent brand price inflation.** Clients who implemented the National Preferred Formulary (NPF) in 2014 will achieve cumulative savings of $3 billion. Fostering competition in existing therapies significantly drives down the cost of care and creates room for payers to cover new, breakthrough therapies.
- **Together, we're innovating.** The Express Scripts Lab is a workshop where we collaborate with clients to create programs that improve patient care and outcomes and tackle unique pharmacy benefit challenges. More than 300 clients participate in pilot programs with Express Scripts, such as our award-winning remote diabetes monitoring program.
- **Together, we're taking on egregious price hikes.** When Turing Pharmacueticals' massive price increase put Daraprim® (pyrimethamine) out of reach for many of those suffering from toxoplasmosis, including many patients with HIV and other conditions that compromise the immune system, Express Scripts partnered with Imprimis Pharmaceuticals to give patients access to a low-cost alternative. Imprimis is offering a compounded oral formulation of pyrimethamine (the active ingredient in Daraprim) and leucovorin (a form of folic acid) for $1 per capsule patients whose pharmacy benefit is managed by Express Scripts.

Still, we have more work to do. A record number of U.S. Food and Drug Administration (FDA) approvals in 2015 and the current pipeline of research and pending approvals will bring promising new therapies to patients, particularly for cancer. This will require new clinical programs and creative approaches to managing spend.

In addition, U.S. drug prices are still on the rise, and the increases are occurring with greater magnitude and frequency than in recent years. In 2015, nearly one-third of branded drugs experienced annual price increases of 20%. Drug maker consolidation and price gouging from a select few pharmaceutical companies are diluting the value of generic medications and lower-cost therapies.

As we've proven over the past three decades, and will continue to prove in the years ahead, our history of alignment and action demonstrates that no test is too great for Express Scripts. We believe there's always a better way to make pharmacy smarter, more accessible and more affordable. We'll continue innovating and taking bold actions, in partnership with our clients, to always keep medicine within reach.

Sincerely,

Glen Stettin, MD
Senior Vice President, Clinical Research & New Solutions and Chief Innovation Officer

Rochelle Henderson, PhD
Senior Director, Research & Clinical Services

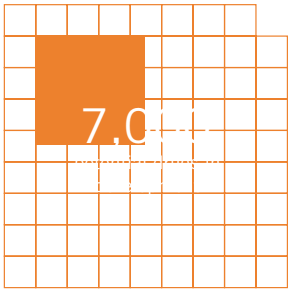
Pharmacy landscape overview

The dynamics underlying anticipated drug cost increases reflect advances in biotechnology, vast improvements in drug development and the superior marketing power of the pharmaceutical industry. Coupled with greater understanding of human genetics, biotechnology promises unique therapies not even imagined when Express Scripts was founded three decades ago. Breakthroughs in the treatment of certain cancers are among the many contributions research brings to the medical marketplace. As a result of pharmaceutical innovation, a record 50 new drugs were approved by the FDA in 2015. Yet, not all increases in spend can be attributed to breakthrough science.

Here's a look at the main factors driving spend in 2015.

High prices for new products

The allocation of pharmacy spend has changed significantly over the last 30 years as more and more dollars are spent on specialty, rather than traditional, medications. In the late '80s and early '90s, most drug development and spend was on traditional, mostly oral, small-molecule solid drugs used to treat conditions such as heartburn/ulcer, depression and diabetes. Today, 37.7% of drug spend is for specialty medications, with the number expected to increase to 50% by 2018 and continue to grow from there. There are 7,000 potential drugs in development, with most aimed at treating the high-use categories of oncology, neurologic disorders and infectious diseases.



High-cost therapies for nonorphan conditions, particularly for cancer, high cholesterol and Alzheimer's disease, will continue to increase the population of patients with high annual drug expenditures.

Oncology therapies

The last decade ushered in an unprecedented number of FDA approvals for oncology medications, with 19 in 2015 alone. These new medications offer oncologists and patients more treatment options and can add months or years of life. Some of these newer medications leverage the body's own immune system to fight cancer. In addition to newer products, medications like Xtandi® (enzalutamide) are used to help patients delay the need to start chemotherapy. These therapies have positive impacts on patient care but come with a hefty price tag – averaging more than $8,000 per prescription.

Increasingly, cancer is becoming a chronic disease that could require more complex, costly and long-term treatment. The average cost for a full-treatment regimen is roughly $150,000 per patient.[1] The cost trend for oncology medications in 2015 was 23.7%, due to growth in both utilization (9.3%) and cost (14.4%). The costs of these medications continue to represent a significant challenge to patients and the overall healthcare system. Some drugs, like Gleevec® (imatinib), are approved to treat multiple types of cancer. However, efficacy may vary for these different indications. The annual cost of Gleevec was $92,000 in 2012, and the economic burden is substantial, due to its multiple indications, wide use and effectiveness.[2]

The future does offer some financial solace for patients who are taking Gleevec, as it lost patent protection in February 2016. Although only one generic manufacturer has 180-day exclusivity, generics from multiple manufacturers are expected to be released in late summer 2016, a competition that should bring lower prices.

High cholesterol therapies

Repatha™ (evolocumab) and Praluent® (alirocumab), new cholesterol-lowering drugs known as PCSK9 inhibitors, entered the market in the second half of 2015. The self-injectable medications block a protein that interferes with the liver's ability to clear "bad" cholesterol from the bloodstream. These new medications are appropriate for only a small number of patients dealing with very specific and

rare forms of high cholesterol that are unresponsive to available statin therapies. The challenge, of course, is that these drugs are priced at more than $14,000 per year, before discounts – far greater than the cost for statin therapies. Although the clinical trials for Praluent and Repatha have been successful in getting these drugs approved for lowering LDL cholesterol, little has been proven about the long-term effects on heart attack and stroke prevention, the main reason people are treated for high cholesterol. For both patient safety and payer affordability, it's important to ensure this class of drugs is appropriately managed.

While we effectively mitigated the expected impact of cholesterol-lowering drugs Repatha and Praluent, we need to prepare for 2017-2018, when the results of outcome trials regarding the effects of these drugs on myocardial infarction and cerebrovascular incidents are anticipated, as those may drive more use.

Price inflation is persistent and costly

Our exclusive Prescription Price Index (page 59) reveals brand price inflation nearly doubled between 2011 and 2015, with the greatest impact seen in more recent years. Compared to 2014, brand prices in 2015 were 16% higher. Brand medications have increased in price by 164% between 2008 and 2015.

Consider the case of Gleevec: In 2015, Novartis, the exclusive manufacturer, engaged in the prevalent practice of increasing the price of a medication in the year prior to patent expiration, and raised the price of Gleevec by 32% to $112.37 per 100mg tablet. Between 2005 and 2015, the price of Gleevec increased three-fold, from $25.50 to $112.37.

On the whole, generic prices continue to decline and deliver significant cost savings to payers and patients. Of greater concern, however, are the increases seen among prices for specific generic drugs, including drugs for diabetes and skin conditions.

Several industry factors are influencing the increase in generic drug pricing. The first is consolidation among pharmaceutical manufacturers that's driving down marketplace competition. For example, Horizon Pharma purchased the product Vimovo® (naproxen/esomeprazole magnesium), then increased the price by 175% in 2015, far exceeding the healthcare value.[3] Other high-profile examples include the greater than 5,000% increase in the price of Daraprim by Turing pharmaceuticals, and the 800% price increase by Valeant Pharmaceuticals on Glumetza®, a branded form of the drug metformin for the treatment of diabetes.

Captive pharmacies circumvent effective cost management

In 2015, we observed the emergence of "captive pharmacies," or pharmacies that enter arrangements to be owned or operated by pharmaceutical manufacturers. Captive pharmacies typically promote the manufacturer's products instead of other lower-cost, equally effective medications. The intent is to circumvent formulary management programs designed to protect the patient and the plan sponsor from unnecessarily filling high-cost medications. The most high-profile captive pharmacy arrangements were between Valeant Pharmaceuticals International and Philidor Rx Services, and Horizon Pharma PLC and Linden Care Pharmacy.

Solutions

How we can deliver better health at a lower cost

Only patient-centric solutions deliver better outcomes and true overall value. Building upon our previous bold actions, we created Express Scripts SafeGuardRx℠, a collection of novel solutions designed to mediate the high cost of new medications through a combination of clinical programs and strategic reimbursement solutions.

SafeGuardRx leverages the clinical specialization at our Therapeutic Resource Centers℠ to target and manage the medication classes that will pose the largest budgetary threats to payers.

In addition to our groundbreaking Hepatitis Cure Value Program (HCV), SafeGuardRx includes our Cholesterol Care Value Program℠ (CCV), Oncology Care Value Program℠ (OCV) and our industry-first Inflation Protection Program.

SafeGuardRx is a **collection of novel solutions** designed to mediate the high cost of new medications through a combination of clinical programs and strategic reimbursement solutions.

Cholesterol Care Value Program

We're already seeing the impact of the Cholesterol Care Value Program, which combines discounts and rigorous utilization management for both Praluent and Repatha, and which offers additional protection by capping plan cost in 2016 for PCSK9 inhibitors. Created to ensure coverage of these medications for patients with rare familial hypercholesterolemia, the program is holding down current spending on this new class of therapy for high cholesterol.

Oncology Care Value Program

Introduced in 2016, this program is designed to ensure cancer patients obtain the treatment they need while helping to protect payers from the high cost of their medications. The approach addresses inefficiencies in the market, whereby some cancer treatments produce a wide range of outcomes across different indications and treatment scenarios, yet prices charged remain the same.

As the country's first program to factor these differences into value-based prescription drug payments, the Express Scripts Oncology Care Value Program takes a multifaceted approach to align cost of treatment with outcomes. The program will focus in 2016 on prostate cancer, lung cancer and renal cell carcinoma.

Inflation Protection program

New for 2016, the Express Scripts Inflation Protection program shields participating plans from the full impact of year-over-year price increases on brand drugs by offering inflation guarantees. All payers fear the unknown costs associated with future brand-drug price inflation. By being creative in our contracting with drug manufacturers, and by taking on our own financial risk, Express Scripts is delivering more value and budget predictability to the payers and patients we serve.

SafeGuardRx programs leverage the specialization of our Therapeutic Resource Centers (TRCs). Our TRC teams are extensively trained in specific medical conditions and provide patients with specialized support from patient-care advocates, specialist pharmacists and nurses.

Championing access and affordability

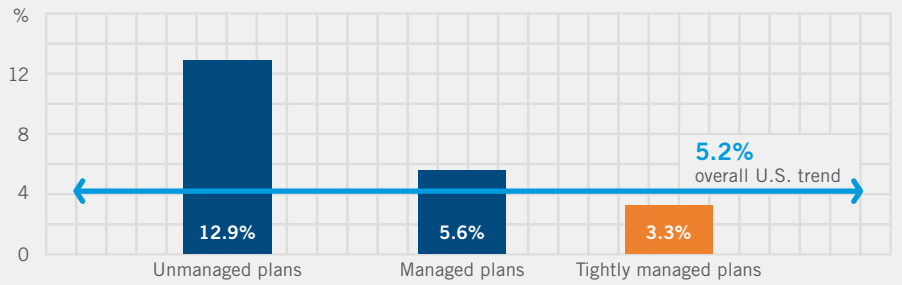
Some drug price increases dominated the industry – and the news – in 2015. Yet those cases are not the only factors driving spend. Guided by an independent panel of clinical experts, our 2016 NPF continues to help payers mitigate rising drug costs. By opening up access to all clinically necessary medications and excluding a handful of "me-too" and other products that have no clinical benefit beyond what's provided by more affordable alternatives, we have leverage to more effectively negotiate with manufacturers and ultimately achieve lower drug prices for the clients and patients we serve.

The 2016 NPF excludes just 80 medications – out of more than 4,000 drugs available on the market – that have clinically equivalent, lower-cost options available. With the NPF, our plan sponsors will save approximately $1.3 billion in 2016, creating more than $3 billion in total savings for those plans that have implemented the NPF since 2014.

Equally important is ensuring that patients receive the most clinically appropriate and cost-effective medications, every time. By using a combination of drug cost management and clinical programs, clients can eliminate waste and maximize the value of every dollar spent.

In our examination of multiple utilization-management and cost-management strategies on traditional drug spend in 2015, we found that "unmanaged" plans experienced an annual average increase in per-member-per-year (PMPY) spend of 12.9% in 2015, compared to 3.3% trend for "tightly managed" plans.

UNMANAGED VS TIGHTLY MANAGED TREND



Therapy class review

A look at drug trend for 2015

Total plan sponsor drug trend for the commercially insured population, including health plans and self-insured plans, increased by 6.4% in 2015. This is roughly half the increase reported in the 2014 Drug Trend Report, noting the change to include rebates in the calculation of trend numbers. Including the impact of member cost share of -1.2%, overall trend was 5.2% in 2015. The largest contributors to rising trend were increased unit cost and utilization for specialty medications. The largest contributors to mitigating trend were the reduction in compounded therapies and cost-saving initiatives for hepatitis C drugs.

Overall drug trend reflects two factors: utilization and unit cost. In 2015, overall trend for traditional medications was almost flat, at 0.6%. Utilization of traditional medications increased by just less than 2%, while unit cost declined 2.1%, the result of programs that drive better discounts and shift share to more cost-effective generics and plan-preferred medications. Overall specialty spend increased 17.8% in 2015. Utilization of specialty medications rose almost 7% for 2015, while unit cost increased by 11.0%. At 37.7%, specialty medications contributed to overall spend more than ever – 5.7% more than in 2014.

COMPONENTS OF TREND

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$708.09		-2.1%	**-0.1%**
Specialty	$352.66	6.8%	11.0%	**17.8%**
TOTAL TREND	**$1,060.75**	**2.0%**	**3.2%**	**5.2%**

January-December 2015 compared to same period in 2014, commercially insured.
Reflects total cost for both payers and patients.

Traditional therapy classes and insights: commercially insured

The top 10 traditional therapy classes have shifted compared to last year, yet diabetes remains the most expensive traditional therapy class when ranked by PMPY spend for the fifth consecutive year. Total trend was negative for four of these top classes (high blood cholesterol, high blood pressure/heart disease, asthma and compounded drugs). These decreases in total spend were due to unit cost decreases, with the exception of compounded drugs, which declined in spend due to the sharp decrease in utilization of 55.7%. This decrease reflects commercially insured clients adopting multiple strategies. Utilization increased for all but three of the top 10 therapy classes (high blood cholesterol, heartburn/ulcer disease and compounded drugs).

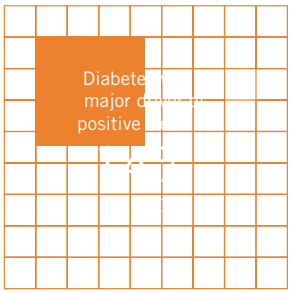
The top three classes by spend (diabetes, pain/inflammation and high blood cholesterol) contributed more than 25% of total traditional drug spend in 2015. High blood cholesterol medications dropped to number three, while pain/inflammation rose to second in spend. Attention disorder medications is number four for 2015, and mental/neurological disorders is number seven. The depression therapy class fell from this top list, replaced by skin conditions at number 10.

COMPONENTS OF TREND FOR THE TOP 10 TRADITIONAL THERAPY CLASSES

RANKED BY 2015 PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Diabetes	$77.50	6.7%	7.4%	**14.0%**
2	Pain/inflammation	$40.65	0.8%	2.1%	**2.9%**
3	High blood cholesterol	$32.66	-0.3%	-8.8%	**-9.2%**
4	Attention disorders	$29.44	5.9%	2.5%	**8.5%**
5	High blood pressure/heart disease	$25.70	2.4%	-14.9%	**-12.5%**
6	Heartburn/ulcer disease	$23.95	-0.7%	36.3%	**35.6%**
7	Mental/neurological disorders	$23.28	2.4%	-2.2%	**0.2%**
8	Asthma	$22.72	5.8%	-7.5%	**-1.6%**
9	Compounded drugs	$20.62	-55.7%	1.8%	**-53.9%**
10	Skin conditions	$20.18	1.4%	26.4%	**27.8%**
	TOTAL TRADITIONAL	**$565.00**	**1.9%**	**-1.4%**	**0.6%**

Highlights



- Diabetes remains a major driver of positive trend within the traditional therapy classes. Trend for this category was 14.0%, reflecting increases in both utilization and unit cost. New cases of diabetes continue to occur, and approximately 27.8% of adults with diabetes are currently undiagnosed.[4] Since diabetes is a chronic condition, utilization will undoubtedly continue to increase, especially as patients increasingly use multidrug regimens. Brand inflation continues to drive the rising unit cost of diabetes medications, which is affected by the lack of generics available in this class. Additionally, new therapies, such as Invokana® (canagliflozin) and Janumet® (sitagliptin/metformin), drove trend through increases in both utilization and unit cost.

- Drugs to treat heartburn and ulcer disease had the largest total trend this year, 35.6%, heavily influenced by a 36.3% increase in unit cost. Although generic medications account for most of the medications filled in this class, the price-per-unit trend was heavily influenced by the increase in branded products such as Nexium® (esomeprazole), Dexilant® (dexlansoprazole) and Prevacid® (lansoprazole). The availability of generic Nexium in February 2015 should result in lower overall unit cost increases for the class in the future.

- At 27.8%, medications used to treat skin conditions, such as psoriasis, had the second largest overall trend of the top 10 therapy classes. This trend was largely due to a 26.4% increase in unit cost of medications in the class, which occurred among both brand and generic therapies. Mergers and acquisitions of manufacturers of drugs in this class have led to a less-competitive market. Of the top 10 drugs in spend for this class, six are generics. Eight of the top 10 drugs in this class by spend increased in unit cost, five of them by more than 40%.

- Medications used to treat high blood cholesterol declined in spend by 9.2% in 2015, moving it down to the third therapy class in spend after over a decade in the top two. Most of the top drugs in this class are generic therapies that continue to decrease in unit cost. Utilization for this class remained almost stable, with a decline of only 0.3%. Despite a decline of conventional generic therapies, such as statins, a 78.2% increase in utilization was noted for omega-3 acid ethyl esters, which are prescription-strength formulations of fish oil. This increase put fish oils as the number four drug in spend for this therapy class. The increase in utilization could reflect patients processing these therapies through the pharmacy benefit.

- Compounded medications had a -53.9% trend in 2015, reflecting the bold actions taken by Express Scripts to ease the staggering increase in spend during 2014. The negative trend reflects the 55.7% decline in utilization of compounded drugs for 2015.

TRADITIONAL SPEND RANK 1

Diabetes

Diabetes medications were the most expensive among traditional therapies, with an overall trend of 14.0%, influenced equally by utilization and unit cost increases. Three of the top five drugs in spend across all traditional therapy classes were diabetes medications: Lantus® (insulin glargine), Januvia® (sitagliptin) and Humalog® (insulin lispro).

Four of the top 10 diabetes drugs by spend were insulins – three dispensed as pre-filled insulin pens. Unit cost for the top insulin, Lantus, decreased 13.7%. However, unit cost trend reflects the increased price for most pre-filled insulin pens and the availability of newer and more expensive treatments – Trulicity® (dulaglutide) and Synjardy® (empagliflozin/metformin) – which launched in 2015. Another pre-filled insulin pen, Levemir® FlexTouch® (insulin detemir), approved in late 2014, rose to seventh place for diabetes drug spend in 2015.

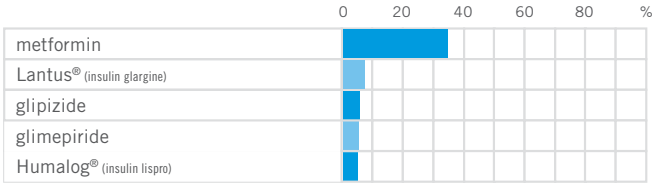
Currently, no generic insulins are available, but Basaglar® (insulin glargine) – the first "follow-on" insulin to Lantus – will launch in December 2016. Four of the most commonly used diabetes treatments – metformin, glipizide, glimepiride and pioglitazone – have been generic for years. Approximately 53% of diabetes prescriptions were generic in 2015.

Spend increased by **14.0%** influenced equally by utilization and unit cost.

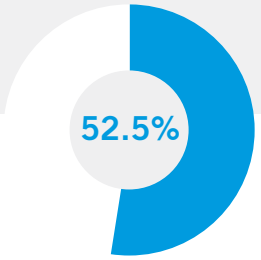
3	High blood cholesterol	$32.66
5	High blood pressure/heart disease	$25.70
7	Mental/neurological disorders	$23.28
9	Compounded drugs	$20.62

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

0.82 number of prescriptions PMPY

5.1% prevalence of use

$94.21 average cost per prescription

42.8% of patients are nonadherent

TRADITIONAL SPEND RANK 2

Pain/inflammation

Medications used to treat pain and inflammation became the second-highest cost therapy class in 2015, reflecting the consolidation of opioids, nonsteroidal anti-inflammatory drugs (NSAIDS) and gamma-aminobutyric acid (GABA) analogs into a combined pain and inflammation class. Small increases in utilization (0.8%) and unit cost (2.1%) contributed to an overall increase of only 2.9% in PMPY spend.

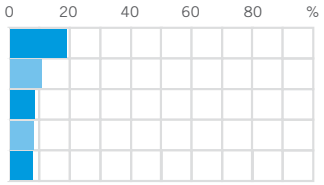
Trend in this class reflects both the reclassification of some controlled substances and the increasing availability of generics. In October 2014, hydrocodone combination products (HCPs) were reclassified as Schedule II controlled substances, making them harder to obtain since fewer prescribers are allowed to write prescriptions for them. In 2015, hydrocodone/acetaminophen (a generic combination) increased in plan cost by 18.3% but decreased in utilization by 14.7%. This utilization decline could be a response to tighter regulations, with unit cost increasing by manufacturers in an attempt to recoup revenue from decreased sales. Generic introductions for Celebrex® (celecoxib) in December 2014 prompted a switch of almost all prescriptions to the generic form throughout 2015, influencing the lower 2.1% unit cost trend.

Despite the additional generic availability in the class, two branded drugs led spend this year: Lyrica® (pregabalin) and the reformulated tamper-resistant, extended-release form of oxycodone, OxyContin® (oxycodone extended release). Although Lyrica increased in spend by 19.8%, OxyContin decreased by 4.4%, mostly due to a utilization decline.

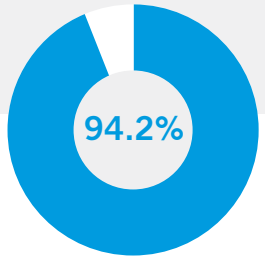
1	Diabetes	$77.50
3	High blood cholesterol	$32.66
5	High blood pressure/heart disease	$25.70
7	Mental/neurological disorders	$23.28
9	Compounded drugs	$20.62

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

1.06 number of prescriptions PMPY

22.1% prevalence of use

$38.36 average cost per prescription

TRADITIONAL SPEND RANK 3

High blood cholesterol

A decrease in both utilization and unit cost resulted in a downward trend of 9.2% in spend for high blood cholesterol treatments in 2015. The class moved down to the third most costly traditional therapy class.

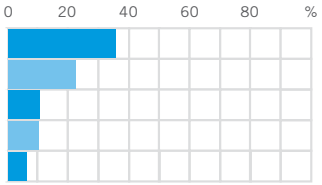
Overall trend is heavily influenced by the availability of generic medications, which represent 83.1% of the market share in this class. Four of the top 10 drugs in this class are statins. Most are available as generics and had negative unit cost increases. Omega-3 acid ethyl esters, prescription-only formulations of fish oil, have increased in plan cost by 57.8%, influenced by a 78.2% utilization trend and a -20.4% unit cost trend. This increase may be the result of patients filling through the pharmacy benefit.

1	Diabetes	$77.50
5	High blood pressure/heart disease	$25.70
7	Mental/neurological disorders	$23.28
9	Compounded drugs	$20.62

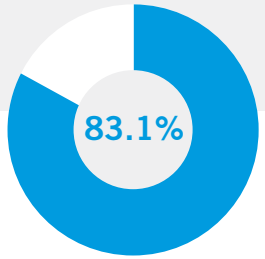
A decrease in both utilization and unit cost **decreased trend by 9.2%**.

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

1.1	number of prescriptions PMPY
10.6%	prevalence of use
$29.78	average cost per prescription
28.0%	of patients are nonadherent

TRADITIONAL SPEND RANK 4

Attention disorders

PMPY spend for medications used to treat attention disorders increased 8.5% in 2015, driven by a 5.9% increase in utilization and a 2.5% increase in unit cost.

Vyvanse® (lisdexamfetamine), one of the leading brands in this class, increased in both utilization and unit cost. Spend for Vyvanse won't decrease soon, as its manufacturer has secured patent protection until at least 2023, and in January 2015 received an additional indication for treating adults with binge eating disorder (BED).

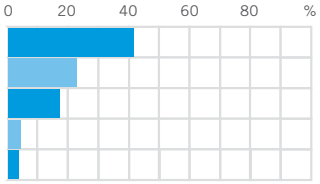
The first generic of Intuniv™ (guanfacine), a nonstimulant attention disorder medication, became available in December 2014, followed by several others in June 2015. Guanfacine became the sixth most utilized attention disorder drug in 2015. Most of the top 10 drugs in spend and utilization are stimulants, and five are branded formulations. Increased utilization for this therapy class reflects increased prevalence of use by adults, including in the elderly population.

The **8.5%** trend was influenced by increased utilization by adults.

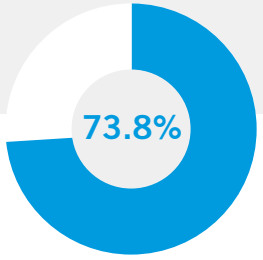
1	Diabetes	$77.50
3	High blood cholesterol	$32.66
5	High blood pressure/heart disease	$25.70
7	Mental/neurological disorders	$23.28
9	Compounded drugs	$20.62

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

- 0.23 number of prescriptions PMPY
- 2.8% prevalence of use
- $125.96 average cost per prescription

TRADITIONAL SPEND RANK 5

High blood pressure/ heart disease

Spend for medications used to treat high blood pressure/heart disease decreased for a second year, this year by 12.5%. The decrease was driven mostly by a 14.9% decline in unit cost. Generic medications made up 95.7% of total 2015 market share. The number of PMPY prescriptions for high blood pressure/heart disease medications was the highest among the traditional therapy classes in the top 10.

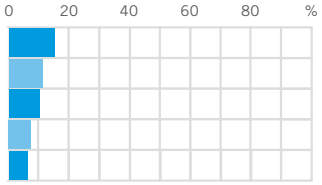
Although overall cost in this class is stable and some branded drugs have increased in unit cost, patent expirations have decreased the unit costs of specific therapies. The first U.S. generic for Diovan® (valsartan) was launched in mid-June 2014 with multiple generic options available by early 2015, thus further decreasing spend for generic valsartan in 2015. Overall, in this therapy class there was a small increase in utilization of 2.4%, possibly due to affordability within the class.

The **12.5%** decrease in trend was driven mostly by the decline in unit cost.

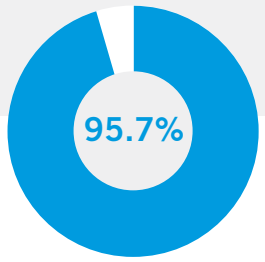
1	Diabetes	$77.50
3	High blood cholesterol	$32.66
7	Mental/neurological disorders	$23.28
9	Compounded drugs	$20.62

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

2.46 number of prescriptions PMPY

16.7% prevalence of use

$10.45 average cost per prescription

33.3% of patients are nonadherent

TRADITIONAL SPEND RANK 6

Heartburn/ulcer disease

In 2015, PMPY spend for medications used to treat heartburn, ulcer disease and gastroesophageal reflux disease (GERD) increased 35.6%.

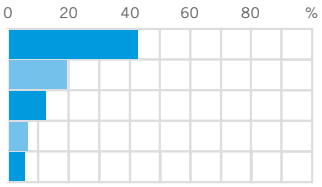
Drugs to treat heartburn and ulcer disease had the largest total trend this year, heavily influenced by a 36.3% increase in unit cost. All of the top five ulcer drugs by market share are generic medications, which now make up 92.3% of total market share in the class. Although dominated by generics, the price per unit trend for heartburn and ulcer medications was heavily influenced by the increase in branded products like Nexium, Dexilant and Prevacid. The availability of generic Nexium in February 2015, and some shift to over-the-counter Nexium, should result in lower overall unit cost increases for the class.

1	Diabetes	$77.50
3	High blood cholesterol	$32.66
5	High blood pressure/heart disease	$25.70
7	Mental/neurological disorders	$23.28
9	Compounded drugs	$20.62

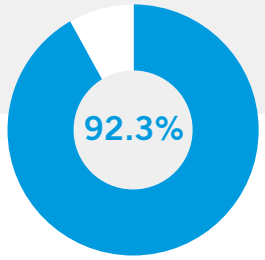
Generic medications represent **92.3%** of medications filled in this class.

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

- 0.56 number of prescriptions PMPY
- 7.8% prevalence of use
- $43.14 average cost per prescription

TRADITIONAL SPEND RANK 7

Mental and neurological disorders

Overall trend in this class was relatively flat (0.2%), influenced by a small increase in utilization offset by a small decrease in unit cost. The negative cost trend is heavily influenced by the availability of generic medications, including aripiprazole, the generic version of Abilify® (aripiprazole), an antipsychotic that lost patent protection in April 2015. Conversely, the branded products in this class, including Namenda® (memantine), Abilify and Seroquel® (quetiapine), had moderate increases in unit costs of 5.7%, 4.9% and 6.7%, respectively.

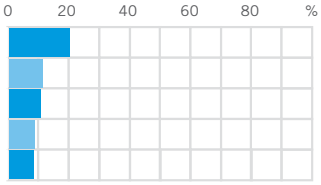
Modest decreases in utilization were observed across the majority of medications in this class. The largest utilization increases influencing the 2.4% increase in trend were observed for mood stabilizers and bipolar disorder therapies.

1	Diabetes	$77.50
3	High blood cholesterol	$32.66
5	High blood pressure/heart disease	$25.70
9	Compounded drugs	$20.62

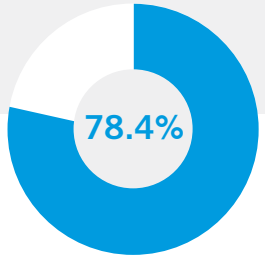
Overall trend in this class was **0.2%**, influenced by a small increase in utilization offset by a small decrease in unit cost.

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

0.12 number of prescriptions PMPY

1.5% prevalence of use

$199.62 average cost per prescription

TRADITIONAL SPEND RANK 8

Asthma

Spend for asthma medications decreased 1.6%. A 5.8% increase in utilization was more than offset by a 7.5% decrease in unit cost, moving asthma down to the eighth most expensive traditional therapy class. Montelukast, the generic of Singulair®, is the most commonly prescribed asthma therapy. However, it has decreased in spend by 37.4% due to a sharp decline of 45.4% in unit cost, despite an 8.0% increase in utilization. This oral tablet holds 33.6% of market share for this therapy class. The next four asthma drugs by utilization are all branded inhalers.

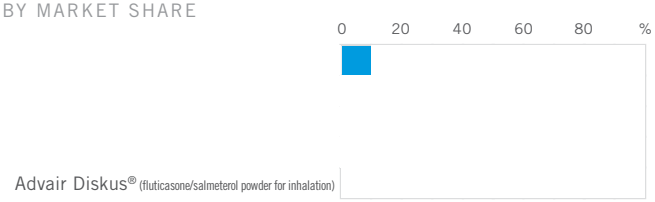
Advair Diskus® (fluticasone/salmeterol powder for inhalation), an inhaler therapy, declined sharply in unit cost – by 29.6%. Utilization increased, possibly due to this decrease in cost. Of the top 10 most utilized asthma drugs, only Flovent® HFA (fluticasone inhalation aerosol) decreased in utilization, by 10.7%, among commercial members. As asthma prevalence continues to rise, spend for branded inhalers will increase.

With **-1.6%** trend, asthma moved down to the **eighth** most expensive traditional therapy class.

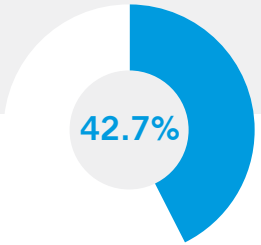
1	Diabetes	$77.50
3	High blood cholesterol	$32.66
5	High blood pressure/heart disease	$25.70
7	Mental/neurological disorders	$23.28
9	Compounded drugs	$20.62

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

- 0.44 number of prescriptions PMPY
- 9.0% prevalence of use
- $51.37 average cost per prescription
- 55.2% of patients are nonadherent

TRADITIONAL SPEND RANK 9

Compounded drugs

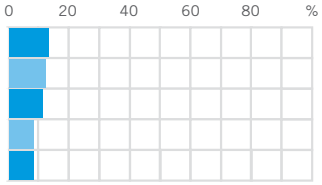
For the first time last year, compounded drugs appeared in the top 10 traditional therapy classes by spend, ranking third in overall spend. Due to various compound management solutions, utilization dropped 55.7% in 2015. Regulations that were implemented in 2012 required that all components of compounded drugs be specified and billed at the ingredient level. Previously, they were billed by the cost of the most expensive ingredient. Consequently, bulk manufacturers and compounding pharmacies raised prices substantially for many components of compounded medications, resulting in much higher drug spend in 2014. Uptake of compound management solutions within the commercial sector yielded a 53.9% decrease in PMPY spend for compounded drugs in 2015. The most common ingredients within compounded drugs were muscle relaxants, hormones and pain medications.

1	Diabetes	$77.50
3	High blood cholesterol	$32.66
5	High blood pressure/heart disease	$25.70
7	Mental/neurological disorders	$23.28

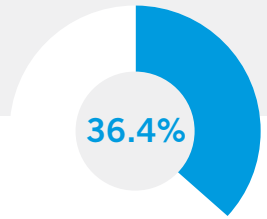
Uptake of compound management solutions within the commercial sector yielded a **53.9% decrease** in PMPY spend.

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

0.02 number of prescriptions PMPY

0.6% prevalence of use

$1,182.83 average cost per prescription

TRADITIONAL SPEND RANK 10

Skin conditions

The skin conditions therapy class had a large increase in overall trend of 27.8%. This trend was largely due to a nearly 26.4% increase in unit cost of medications in the class, which occurred with both brand and generic therapies. Mergers and acquisitions of manufacturers of drugs in this class have led to a less competitive market. Of the top 10 drugs in spend for this class, six are generics. Eight of the top 10 drugs in this class by spend increased in unit cost, five of them by more than 40%.

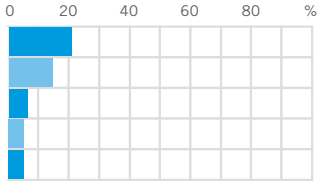
Nine of the 10 most utilized drugs were generics, and many had sharp cost increases. For example, the two most utilized drugs, clobetasol and triamcinolone – both generic corticosteroids – increased in unit cost by 96.2% and 28.0%, respectively.

1	Diabetes	$77.50			
3	High blood cholesterol	$32.66			
5	High blood pressure/heart disease	$25.70			
7	Mental/neurological disorders	$23.28			
9	Compounded drugs	$20.62	-55.7%	1.8%	**-53.9%**
	TOTAL TRADITIONAL	**$565.00**	**1.9%**	**-1.4%**	

The **27.8%** trend was largely due to a nearly **26.4%** increase in unit cost.

TOP DRUGS

BY MARKET SHARE



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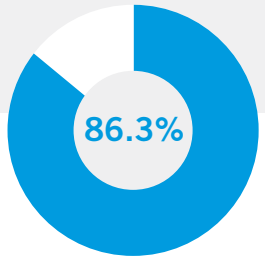


By the numbers

0.15 number of prescriptions PMPY

7.2% prevalence of use

$136.61 average cost per prescription

Top 10 traditional drugs

Only six of the top 10 drugs in 2015 were branded medications when ranked by PMPY spend, compared to nine branded medications on the list in 2014. Two of the 2014 top 10 traditional drugs, Nexium and Abilify, became available as generics in 2015. Their equivalents, esomeprazole and aripiprazole, both appear in the top 10. Esomeprazole ranks second and encompasses 2.3% of traditional drug spend. The two other generic therapies on the list are for attention disorders: amphetamine/dextroamphetamine, the generic form of Adderall®, and methylphenidate, the generic for Ritalin®. Lantus, a branded insulin, now takes the top place, with more than 2.5% of total traditional drug spend, despite a double-digit decrease in unit cost. The sharp 46.9% decline in utilization of Abilify is due to brand-to-generic shift, but the branded therapy remained in the top 10 traditional drugs in spend for 2015, since generic formulations weren't available until the end of April.

Two of the 2014 top 10 traditional drugs, Nexium and Abilify, became **available as generics** in 2015.

TOP 10 TRADITIONAL THERAPY DRUGS

RANKED BY 2015 PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL TRADITIONAL SPEND	UTILIZATION	UNIT COST	TOTAL
1	Lantus® (insulin glargine)	Diabetes	$14.24	2.5%	2.3%	-13.7%	**-11.4%**
2	esomeprazole	Heartburn/ulcer disease	$13.28	2.3%	–	–	–
3	Crestor® (rosuvastatin)	High blood cholesterol	$10.20	1.8%	-7.1%	12.4%	**5.3%**
4	Lialda® (mesalamine)	Inflammatory conditions	$8.29	1.5%	0.8%	10.3%	**11.1%**
5	Humalog® (insulin lispro injection)	Diabetes	$8.18	1.4%	8.2%	9.0%	**17.2%**
6	amphetamine/dextroamphetamine	Attention disorders	$7.71	1.4%	9.7%	-12.2%	**-2.5%**
7	Januvia® (sitagliptin)	Diabetes	$7.54	1.3%	5.5%	14.3%	**19.8%**
8	aripiprazole	Mental/neurological disorders	$7.23	1.3%	–	–	–
9	methylphenidate extended release	Attention disorders	$7.01	1.2%	0.0%	16.2%	**16.3%**
10	Vyvanse® (lisdexamfetamine)	Attention disorders	$6.70	1.2%	7.4%	11.5%	**18.9%**

Specialty therapy classes and insights: commercially insured

Specialty medications contributed 37.7% of total drug spend in 2015, with an overall trend of 17.8%. All of the top 10 therapy classes increased in spend, and all had increases in unit cost of medications. Together, spend for the top three specialty therapy classes when ranked by PMPY spend – inflammatory conditions, multiple sclerosis and oncology – contributed 56.3% of the spend for all specialty medications billed through the pharmacy benefit in 2015. Therapies for inflammatory conditions (such as rheumatoid disease and psoriasis) remained at the top, while transplant disappeared from the top 10. This year, we further sub-categorized the miscellaneous specialty conditions, resulting in cystic fibrosis and sleep disorders making the top 10 list, ranked at 7 and 10, respectively.

The **top three** specialty therapy classes accounted for **56.3%** of all specialty spend.

COMPONENTS OF TREND FOR THE TOP 10 SPECIALTY THERAPY CLASSES

RANKED BY 2015 PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Inflammatory conditions	$89.10	10.3%	14.7%	**25.0%**
2	Multiple sclerosis	$53.31	3.5%	6.2%	**9.7%**
3	Oncology	$49.62	9.3%	14.4%	**23.7%**
4	Hepatitis C	$38.44	-2.2%	9.2%	**7.0%**
5	HIV	$31.53	4.6%	12.0%	**16.6%**
6	Growth deficiency	$7.12	2.8%	2.8%	**5.6%**
7	Cystic fibrosis	$6.64	12.5%	40.9%	**53.4%**
8	Pulmonary hypertension	$5.85	13.4%	4.8%	**18.1%**
9	Hemophilia	$5.79	4.9%	15.4%	**20.4%**
10	Sleep disorders	$4.57	5.5%	18.5%	**24.1%**
	TOTAL SPECIALTY	**$341.21**	**6.8%**	**11.0%**	**17.8%**

Highlights

- Trend for cystic fibrosis (CF) medications reached 53.4% in 2015. The entire therapy class contains only 10 drugs, with an average cost per prescription of $6,441.27. Many of the therapies in this class are different dose forms of tobramycin, several of which are now either inhaled solutions or powder form. Orkambi® (lumacaftor/ivacaftor), one of the two most costly drugs in this class, was approved in mid-2015, driving trend.

- Inflammatory conditions, trending at 25.0%, remained at the top of the specialty therapy classes when ranked by PMPY spend, as the top two drugs, Humira® Pen (adalimumab) and Enbrel® (etanercept), had double-digit unit cost increases. Brand innovation is driving some of this increased spend, with newer drugs like Otezla® (apremilast) and Entyvio® (vedolizumab), both approved in 2014, showing triple-digit utilization increases.

- There were 19 new FDA approvals in 2015 for oncology therapies, contributing greatly to the 23.7% increase in spend for this class. Both increased utilization and unit cost of the drugs in this class drove trend. Gleevec, the oncology treatment with the largest market share, increased in unit cost by 19.3%, a common practice by pharmaceutical manufacturers before an expected patent expiration.

- Hemophilia drugs continued to rise in spend for 2015, driven by a 15.4% increase in unit cost of medications. Brand inflation occurred for clotting and antihemophilic factor drugs such as Eloctate® (antihemophilic factor [recombinant], Fc fusion protein), which had triple-digit utilization and unit cost increases. Trends for expensive medications to treat rare conditions such as hemophilia are susceptible to small changes in a plan sponsor's patient populations.

- Trend for HIV medications was driven by brand inflation and utilization, as all of the top 10 HIV therapies are brand medications. Six of these top drugs increased in spend in 2015 by double and triple digits. The top two drugs in utilization, Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate) and Truvada® (emtricitabine/tenofovir disoproxil fumarate), were also the top two drugs in spend; both had unit cost increases in 2015, and utilization of Truvada increased by 29.3%.

There were **19 new FDA approvals** in 2015 for oncology therapies, contributing to the **23.7%** increase in spend for this class.

SPECIALTY SPEND RANK 1

Inflammatory conditions

Inflammatory conditions topped spend in specialty drugs for the seventh year in a row, trending upward by a total of 25.0%, driven by 14.7% trend in unit cost and 10.3% increase in utilization. Most of the top drugs in this category are disease modifying anti-rheumatic drugs (DMARDs), which treat rheumatoid arthritis, inflammatory bowel diseases, psoriasis and several other conditions.

Spend for all of the leading inflammatory condition drugs increased in 2015, with an average cost per prescription of $3035.95. Together, the top two, Humira Pen and Enbrel, captured more than 66% of market share for the class and almost 15% of overall specialty market share. Unit costs for each increased more than 17% in 2015, proving these are major trend drivers.

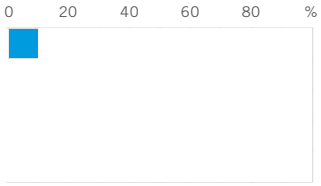
Overall utilization trend was influenced by positive utilization trend of Humira Pen, Xeljanz® (tofacitinib) and Stelara® (ustekinumab). Two medications approved in 2014 – Otezla, for plaque psoriasis and psoriatic arthritis, and Entyvio, for ulcerative colitis and Crohn's disease – affected utilization.

Inflammatory conditions topped spend in specialty drugs for the **seventh year in a row**.

3	Oncology	$49.62
5	HIV	$31.53
7	Cystic fibrosis	$6.64
9	Hemophilia	$5.79

TOP DRUGS

BY MARKET SHARE



By the numbers

0.03 number of prescriptions PMPY

0.3% prevalence of use

$3,035.95 average cost per prescription

43.7% of patients are nonadherent

SPECIALTY SPEND RANK 2

Multiple sclerosis

Total trend for multiple sclerosis (MS) medications was 9.7%, due to increases in unit cost (6.2%) and utilization (3.5%). Overall trend was influenced by the unit price increase of the top five most-prescribed medications in the class, which accounted for 84% of the spend. Unit cost increases for these medications ranged from 3.8% to 9.4%. Copaxone® (glatiramer) is the most widely used and had the highest spend in this class. Glatopa™ (glatiramer), a generic alternative for Copaxone's 20mg/mL dosage form, was launched in June 2015.

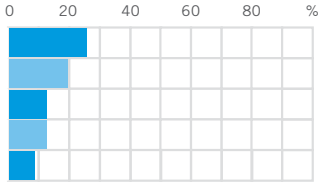
Several injected interferon beta-1 drugs had decreases in utilization: Avonex® (-16.8%), Betaseron® (-21.0%) and Rebif® (-13.9%). Tecfidera® (dimethyl fumarate) and Gilenya® (fingolimod), oral medications introduced in the last few years, have similar outcomes but fewer side effects than the interferons, making them preferable to patients.

1	Inflammatory conditions	$89.10
3	Oncology	$49.62
5	HIV	$31.53
7	Cystic fibrosis	$6.64
9	Hemophilia	$5.79

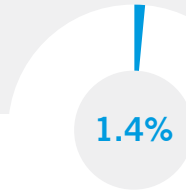
The **9.7%** trend was due to increases in unit cost and utilization.

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

0.01 number of prescriptions PMPY

0.1% prevalence of use

$4,549.22 average cost per prescription

25.1% of patients are nonadherent

SPECIALTY SPEND RANK 3

Oncology

For 2015, trend for the oncology therapy class increased by 23.7%, due to growth in both utilization (9.3%) and unit cost (14.4%). Together, the two drugs that captured the most spend, Gleevec and Revlimid® (lenalidomide), accounted for more than 22% of market share for oncology drugs.

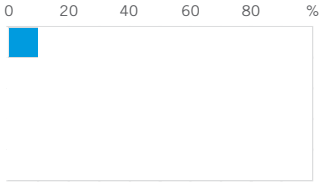
Gleevec, the oncology treatment with the largest market share, increased in unit cost by 19.3%, a common practice by pharmaceutical manufacturers before an expected patent expiration. Utilization trend for Gleevec was relatively flat at 1.1%.

Several oncology drugs had substantial increases in utilization. Imbruvica® (ibrutinib), now approved for multiple types of cancer, is the only FDA-approved Bruton's tyrosine kinase (BTK) inhibitor; its effectiveness for hard-to-treat cancers, oral dosing and relatively mild side effects resulted in a 2015 utilization surge of 78.1%. Utilization for capecitabine, a generic to Genentech's chemotherapy drug Xeloda®, rose 39.3%, following its launch in April 2014. Xtandi, an oral hormone modifier for prostate cancer, increased in utilization by 39.0%.

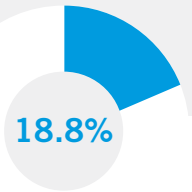
1	Inflammatory conditions	$89.10
5	HIV	$31.53
7	Cystic fibrosis	$6.64
9	Hemophilia	$5.79

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



The two drugs that captured the most spend accounted for more than **22%** of market share for oncology drugs.

By the numbers

- 0.01 number of prescriptions PMPY
- 0.1% prevalence of use
- $7,158.53 average cost per prescription
- 38.4% of patients are nonadherent

SPECIALTY SPEND RANK 4

Hepatitis C

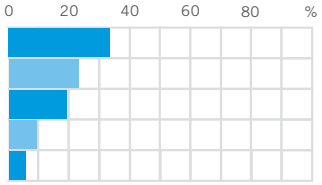
Hepatitis C drug spend increased 7.0% in 2015. After the 2014 record increase in spend due to a few new and effective, but expensive, oral antiviral therapies, 2015 trend was lower. While utilization decreased 2.2%, a 9.2% increase in unit cost drove most of the change in spend. Viekira Pak and Harvoni, two of the therapies approved in 2014, together captured more than 57% of market share for this therapy class. Many of the other therapies concurrently fell in utilization, with several dropping in use by more than 75%.

1	Inflammatory conditions	$89.10
3	Oncology	$49.62
5	HIV	$31.53
7	Cystic fibrosis	$6.64
9	Hemophilia	$5.79

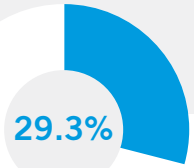
Increase in unit cost drove most of the **7.0%** change in spend.

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

0.002 number of prescriptions PMPY

0.05% prevalence of use

$17,090.18 average cost per prescription

8.9% of patients are nonadherent

SPECIALTY SPEND RANK 5

HIV

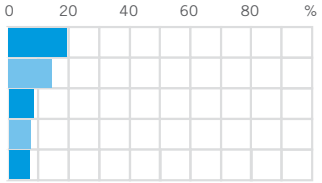
A 4.6% increase in utilization and a 12.0% unit cost increase resulted in an overall 2015 trend increase of 16.6% in PMPY spend for HIV treatments, moving them up to the fifth most costly specialty therapy class.

The average unit cost increase for the top 10 most commonly prescribed medications was 4.8%. In addition, for the most prescribed medications, unit cost was influenced by large price increases in medications with smaller market share. At 48.7% and 997.8%, respectively, two of the largest spend increases were for Stribild® (cobicistat/elvitegravir/emtricitabine/tenofovir disoproxil fumarate), and Triumeq® (abacavir/dolutegravir/lamivudine). These are attributable to large upticks in utilization trend, as more patients move to combination therapies. All but one of the drugs in the top 10 for HIV had only small unit cost increases. Three new combination treatments for HIV hit the U.S. market in 2015: Evotaz™ (atazanavir/cobicistat), Prezcobix® (darunavir/cobicistat), and Genvoya® (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide).

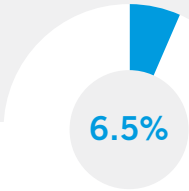
1	Inflammatory conditions	$89.10
3	Oncology	$49.62
7	Cystic fibrosis	$6.64
9	Hemophilia	$5.79

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



The **16.6%** increase in PMPY spend moved HIV up to the **fifth** most costly specialty therapy class.

By the numbers

- 0.02 number of prescriptions PMPY
- 0.20% prevalence of use
- $1,272.01 average cost per prescription
- 24.9% of patients are nonadherent

SPECIALTY SPEND RANK 6

Growth deficiency

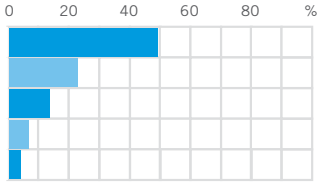
In 2015, growth deficiency medications trended 5.6%, from equal trends in utilization (2.8%) and unit cost (2.8%). Norditropin® FlexPro® (somatropin) continued to dominate this class for the fourth year in a row, capturing 49.1% of market share. It's also the drug with the highest spend in this therapy class, increasing in both utilization and unit cost by approximately 11%. For Genotropin® (somatropin), the second drug in spend for 2015, trend decreased 12.0%, due mostly to a 11.2% decrease in unit cost. Increlex® (mecasermin) had the highest trend this year, with an overall increase in spend of 140.6%, mostly due to a 126.8% increase in utilization. Increlex treats a rare condition, primary insulin-like growth factor deficiency (IGFD), which affects approximately 6,000 children in the United States. Trends for expensive medications to treat rare conditions, such as growth deficiency, are susceptible to small changes in a plan sponsor's patient population.

1	Inflammatory conditions	$89.10
3	Oncology	$49.62
5	HIV	$31.53
7	Cystic fibrosis	$6.64
9	Hemophilia	$5.79

Growth deficiency medications trended **5.6%** from equal trends in utilization and unit cost.

TOP DRUGS

BY MARKET SHARE



By the numbers

0.003 number of prescriptions PMPY

0.03% prevalence of use

$2,735.29 average cost per prescription

39.9% of patients are nonadherent

SPECIALTY SPEND RANK 7

Cystic fibrosis

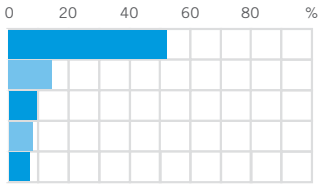
In 2015, drugs that treat cystic fibrosis broke into the top 10 therapy classes in spend for the first time. Currently, the therapy class contains only 10 drugs. Of those 10, only one is available as a generic and many therapies have been recently approved. CF drugs trended 53.4% in 2015, largely from a 40.9% increase in unit cost that was mostly due to use of Orkambi, one of the new branded therapies that hit the market in mid-2015. Orkambi is an oral combination therapy, which is clinically effective for CF, but costs more than $20,000 per month. Utilization in the class increased by 12.5%. Together, all the therapies derived from tobramycin, an antibiotic that has been available in generic inhaled form since late 2013, captured 26.4% of market share for this class. Some of the newer, brand-name forms of tobramycin include the TOBI® Podhaler™ (tobramycin inhalation powder), Bethkis® (tobramycin inhalation solution) and the Kitabis™ Pak (tobramycin), averaging approximately $3,500 to $4,700 for a 30-day supply.

1	Inflammatory conditions	$89.10
3	Oncology	$49.62
5	HIV	$31.53
9	Hemophilia	$5.79

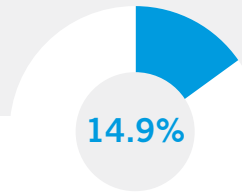
Currently, the therapy class contains only 10 drugs; **only one is available as a generic**.

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

- 0.001 number of prescriptions PMPY
- 0.01% prevalence of use
- $6,441.27 average cost per prescription

SPECIALTY SPEND RANK 8

Pulmonary hypertension

Spend for pulmonary hypertension increased by 18.1% in 2015. A 13.4% utilization increase and a 4.8% unit cost increase were responsible for the trend. For the top 10 drugs in spend for this class, utilization increased for all but three older drugs. Sildenafil, a generic oral tablet therapy for World Health Organization (WHO) Group 1 pulmonary arterial hypertension, remains the most prescribed drug in this class, with 36.4% of the market share. However, Orenitram® (treprostinil), Opsumit® (macitentan) and Adempas® (rociguat) increased greatly in utilization – by 315.8%, 111.2% and 72.3%, respectively. All three are relatively new drugs, approved in the fourth quarter of 2013 and launched in late 2013 or early 2014, explaining some of their 2015 utilization increases. As oral therapies, they're more convenient than some other PH therapies requiring inhalation or infusion.

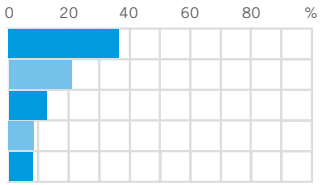
In 2015, Orenitram decreased in unit cost by 53.2%, which likely contributed to its utilization increase. Sildenafil's unit cost decreased by 25.1% in 2015. Uptravi® (selexipag), expected to hit the U.S. market early in 2016, is predicted to compete with Orenitram.

For the top 10 drugs in spend for this class, utilization increased for all but **two** older drugs.

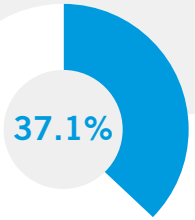
1	Inflammatory conditions	$89.10
3	Oncology	$49.62
5	HIV	$31.53
7	Cystic fibrosis	$6.64
9	Hemophilia	$5.79

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

0.002 number of prescriptions PMPY

0.02% prevalence of use

$3,892.31 average cost per prescription

31.3% of patients are nonadherent

SPECIALTY SPEND RANK 9

Hemophilia

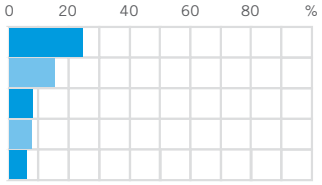
Of the top 10 classes, hemophilia drugs have the lowest market share. In 2015, trend of 20.4% was driven by a 15.4% increase in unit cost and a 4.9% increase in utilization. Eloctate and Alprolix® (coagulation factor IX [recombinant], Fc fusion protein), two long-acting therapies that were approved in 2014, are now in the top 10 in spend for this class. In 2015, each had large increases in utilization of more than 400%, in 2015. Eloctate also had a unit cost trend of 141.0%. Because this class has such small market share and high average cost of therapy, even a small increase in utilization can have a large impact on overall spend. The average 2015 cost per 30-day adjusted prescription for the top 10 utilized hemophilia drugs was $22,857.79.

1	Inflammatory conditions	$89.10
3	Oncology	$49.62
5	HIV	$31.53
7	Cystic fibrosis	$6.64

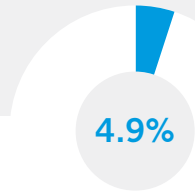
Because this class has such **small market share** and **high average cost of therapy**, even a small increase in utilization can have a **large impact** on overall spend.

TOP DRUGS

BY MARKET SHARE



GENERIC FILL RATE (GFR)



By the numbers

0.0002 number of prescriptions PMPY

0.005% prevalence of use

$25,668.55 average cost per prescription

SPECIALTY SPEND RANK 10

Sleep disorders

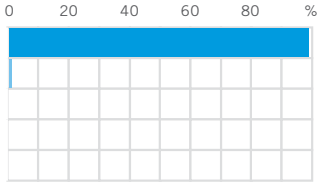
In the 2014 Express Scripts Drug Trend Report, sleep disorders were included in the miscellaneous specialty conditions therapy class. With an average cost of approximately $9,000 per prescription, sleep disorders medications easily made the top 10 specialty medications ranked by PMPY spend, despite low market share. In 2015, the PMPY spend for medications to treat sleep disorders increased by 24.1%, influenced by an 18.5% increase in cost and a 5.5% increase in utilization. Xyrem® (sodium oxybate) and Hetlioz® (tasimelteon) account for 100% of the market share in the sleep disorder therapy class.

1	Inflammatory conditions	$89.10			
3	Oncology	$49.62			
5	HIV	$31.53			
7	Cystic fibrosis	$6.64			
9	Hemophilia	$5.79	4.9%	15.4%	**20.4%**
	TOTAL SPECIALTY	**$341.21**	**6.8%**	**11.0%**	

Xyrem and Hetlioz account for **100%** of the specialty market share in the sleep disorder class.

TOP DRUGS

BY MARKET SHARE



By the numbers

0.0005 number of prescriptions PMPY

0.01% prevalence of use

$8,928.96 average cost per prescription

Top 10 specialty drugs

In 2015, all but two of the top 10 specialty drugs increased in PMPY spend, and all but one with increased in unit cost. Seven of the top 10 therapies had increases in utilization. Humira Pen remained the drug with the highest spend, with 9.8% of total specialty drug spend. Harvoni and Viekira Pak moved into the top 10 specialty drugs, leading in the highest trends for utilization and unit cost. Enbrel moved down to the second most expensive drug, capturing 7% of total specialty drug spend. Two oncology drugs, Gleevec and Revlimid, remained among the most expensive specialty drugs, with increases in both utilization and unit cost. Three drugs for multiple sclerosis and one HIV drug, Atripla, comprise the remainder of this list. Atripla and Copaxone were the only top specialty drugs with a decrease in overall spend in 2015. Atripla decreased in spend despite a 6.3% increase in unit cost. The decline was due to downward utilization trend by 8.9%, which was the result of new, competing HIV therapies rising in popularity. Decrease in Copaxone spend was due to a decline in utilization, a result of the availability of a generic alternative.

TOP 10 SPECIALTY THERAPY DRUGS

RANKED BY 2015 PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL SPECIALTY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Humira® Pen (adalimumab)	Inflammatory conditions	$33.54	9.8%	10.5%	18.1%	**28.6%**
2	Enbrel® (etanercept)	Inflammatory conditions	$23.85	7.0%	-5.2%	17.7%	**12.5%**
3	Harvoni® (ledipasvir/sofosbuvir)	Hepatitis C	$21.35	6.3%	293.6%	-16.7%	**276.9%**
4	Copaxone® (glatiramer)	Multiple sclerosis	$13.76	4.0%	-5.4%	3.8%	**-1.6%**
5	Tecfidera® (dimethyl fumarate)	Multiple sclerosis	$11.81	3.5%	9.8%	9.2%	**19.0%**
6	Viekira Pak® (dasabuvir/ombitasvir/ paritaprevir/ritonavir)	Hepatitis C	$9.85	2.9%	–	–	–
7	Gleevec® (imatinib)	Oncology	$7.85	2.3%	1.1%	19.3%	**20.4%**
8	Revlimid® (lenalidomide)	Oncology	$7.74	2.3%	6.4%	8.3%	**14.7%**
9	Gilenya® (fingolimod)	Multiple sclerosis	$7.30	2.1%	20.3%	7.5%	**27.8%**
10	Atripla® (efavirenz/emtricitabine/tenofovir)	HIV	$7.23	2.1%	-8.9%	6.3%	**-2.6%**

2016 – 2018 trend forecast

Traditional trend forecast

Traditional trend will continue with modest increases over the next few years. Diabetes will continue to be a significant contributor to trend, driven by increases in both utilization and unit cost. The trend forecast is negative for several of the top 10 classes over the next three years, primarily due to decreases in unit cost. It's important to note that unit cost reflects the price change across the class, including both the brand and generics within that class. These forecasted numbers include the anticipated effects of SafeGuardRx inflation protection to ensure that drug price increases will be mitigated. The significant increase in trend in 2015 for heartburn/ulcer disease medications is not likely to be sustained. High 2015 trend for the skin conditions class should moderate as well. Although compounded drugs remained in the top 10 therapy classes in 2015, they're expected to continue to decrease in trend over the next three years, as more clients adopt the Express Scripts trend management solutions. The compounded medication class may drop out of the top 10 in the near future.

Diabetes

PMPY drug spend for diabetes medications is projected to increase slightly, then stabilize in the upper teens for 2016 through 2018. Positive utilization trend is a result of increasing disease prevalence. As type 2 diabetes progresses, patients may require more than one therapy to adequately control the disease. Many of these therapies have been merged into new combination products that entered the market in 2014 and 2015. As patients switch from older regimens that require multiple pills per day to the new combination products, increased spend is anticipated, since these combination therapies are branded. Additional continuing unit cost increases are likely due to steady price increases for branded drugs, especially insulin. The first follow-on insulin product, Basaglar, which will compete with Lantus and other basal insulins, will be launched in the U.S. in December 2016. A number of Lantus biosimilars are in development, which will lead to additional competition.

2016 – 2018 TREND FORECAST

	2016	2017	2018
TOTAL OVERALL	**6.8%**	**7.3%**	**8.4%**

TREND FORECAST FOR KEY TRADITIONAL THERAPY CLASSES

2016 – 2018

	TREND FORECAST		
THERAPY CLASS	**2016**	**2017**	**2018**
Diabetes	18.0%	17.7%	16.6%
Pain/inflammation	2.9%	10.2%	12.1%
High blood cholesterol	-11.5%	-14.1%	-13.3%
Attention disorders	9.2%	6.5%	5.5%
High blood pressure/heart disease	-4.6%	-9.1%	-7.6%
Heartburn/ulcer disease	-11.8%	-9.8%	-10.7%
Mental/neurological disorders	-4.0%	-7.0%	-3.0%
Asthma	4.0%	6.1%	0.0%
Compounded drugs	-7.7%	-6.4%	-5.1%
Skin conditions	21.2%	16.2%	11.1%
Other traditional classes	-3.6%	-4.5%	-4.5%
TOTAL TRADITIONAL	**0.4%**	**0.7%**	**1.3%**

Pain/inflammation

The pain/inflammation therapy class is the second highest cost therapy class for 2015. PMPY spend for pain and inflammation drugs is forecast to go up modestly in 2016 and then by double digits in 2017 and 2018, driven almost entirely by increases in unit cost. The October 2014 reclassification of hydrocodone combination products as schedule II controlled substances limits ease of refill on the most utilized drugs in the class. Although the class is dominated by generics, three brand-name drugs are in the top five pain/inflammation drugs according to 2015 PMPY spend and are expected to continue to dominate the class. Generics for the leading brand, Lyrica, are not due until 2019. Additionally, reformulated tamper-resistant or abuse-deterrent opioids, such as the number two drug, OxyContin, are only available as branded therapies. Abuse-deterrent formulations (ADF) of opioids are typically much more expensive than non-ADF alternatives. Additionally, the new formulations give years of extra patent protection to the brand manufacturer.

High blood cholesterol

Although expensive injectable treatments known as proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors were approved in 2015, statins remain the standard of therapy for most patients with high blood cholesterol. PCSK9s are currently indicated for a small and specific subset of patients. Thus they're examined within a separate specialty therapy class. Negative trends for traditional high blood cholesterol therapies are forecast for the next several years, mostly as a result of decreases in drug costs. In May 2016, Generic competition for the last popular brand statin, Crestor® (rosuvastatin) will be followed by generics for Zetia® (ezetimibe) in December 2016 and Vytorin® (ezetimibe/simvastatin) in April 2017. New guidelines for treating high blood cholesterol and the introduction of PCSK9s have not yet caused significant changes in utilization, but statins are prescribed widely for preventative use and for patients who have had a cardiovascular event. Any potential increases in utilization will be more than offset by overall generic cost savings and savings from the uptake of the Express Scripts Cholesterol Care Value Program as a part of SafeGuardRx.

Attention disorders

We expect trend for drugs used to treat attention disorders to increase at progressively smaller rates from 2016 through 2018. There's a shift in the population that utilizes attention disorder medications, as pediatric patients who utilized medications in this therapy class grow into adulthood and continue therapy. Positive utilization trend is likely as this patient population continues to age. Unit cost for medications used to treat attention disorders also is forecast to increase in each of the next three years. Generics for the nonstimulant Intuniv, which launched in December 2014, and scheduled patent expiration for Strattera® (atomoxetine) in May 2017 should slightly alleviate cost increases. However, brand loyalty is high in the class, with patients, physicians and caregivers reluctant to switch therapies. The top brand in the class, Vyvanse, was recently approved for binge eating disorder, which may increase its utilization in coming years. Most products in the pipeline are new formulations of currently available amphetamines.

High blood pressure/heart disease

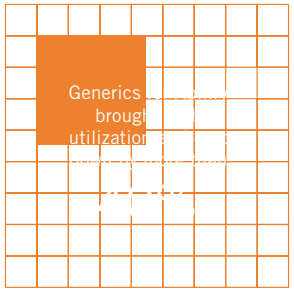
With current market saturation levels and the dominance of generic therapies, the predicted trend decreases for the high blood pressure/heart disease class stem from flat utilization and falling unit costs. Valsartan, the generic for Diovan, was first released in July of 2014, with several manufacturers following with their own generics in January of 2015. All the main subclasses used to treat high blood pressure and heart disease are predominantly generic, resulting in falling unit cost as reflected in the forecasted trend for this class.

Increases in utilization for PCSK9s will be more than offset by overall generic cost savings and savings from the uptake of the Express Scripts Cholesterol Care Value Program as a part of SafeGuardRx.

Heartburn/ulcer disease

No new drugs are in development for heartburn/ulcer disease. The two remaining principal brands aren't among the most commonly used drugs in the class, indicating Nexium had high cost increases leading up to the introduction of a generic in February 2015. Negative trends are forecast for 2016 through 2018, since patients will continue using less expensive generic and over-the-counter (OTC) versions of the most common medications in the class. Over the next three years, the anticipated generic competition for Nexium should drive unit cost down, resulting in decreased overall trend.

Mental/neurological disorders



Trend for medications used to treat mental/neurological disorders is forecast to decrease for each of the next three years. Utilization may increase marginally, as atypical antipsychotics are used more for treatment-resistant depression and other difficult-to-manage psychiatric conditions. Generics for Abilify, which launched in May 2015, brought both utilization and cost down by more than 40% for what had been the top drug in the class. Several other brands are in the top 10 drugs by spend, contributing to expected brand inflation for the class. Unit cost trend for multiple popular generics was down significantly in 2015, helping to mitigate some brand cost increases. This effect is expected to continue over the next three years and is reflected in the forecast.

Asthma

PMPY spend for asthma medications will increase slightly in 2016 and 2017 from anticipated brand inflation. For 2018, however, trend is forecasted to drop to zero after the first generic for Advair Diskus is approved by the FDA, which is expected in late 2017. Another popular inhaler, ProAir® HFA (albuterol), could face generic competition in December 2016. However, a settlement agreement will only allow limited supplies of the generic to become available, which will decrease competition in the market and result in reduced cost savings.

Compounded medications

Continued decreases in utilization for compounded medications will be seen, as more clients adopt the Express Scripts compound utilization management program. However, the drops in trend will not be as significant over the next three years, as some of the utilization in this class has been already been affected. The lower, more moderate trend is likely to be driven exclusively by this decrease in utilization, as there is no expectation that the prices for these medications will decrease over the next few years, given their continued rise in 2015. The forecast in this category is dependent upon client adoption of utilization management strategies, rather than events within the compounded medications market itself.

Skin conditions

This year's skin condition therapy class incurred a 34.9% increase in unit cost, with both brand and generic therapies showing substantially higher costs. Consolidations among drug manufacturers have led to a less competitive market, allowing some companies to increase prices drastically. For the next three years we foresee trends decreasing from 21.0% in 2016 to 11.0% in 2018 as plans continue to reap benefits of the' trend management strategies implemented by Express Scripts in 2015.

Specialty trend forecast

Specialty trend is forecast to increase around 17% annually between 2016 and 2018. Existing specialty drugs will gain approval for other indications and will be prescribed more often, and new therapies will receive approval from the FDA. All of these factors will increase utilization trend. However, the major contributors to rising PMPY spend for specialty medications will continue to be both brand inflation and high starting costs for new, highly targeted therapies.

Inflammatory conditions

Trend for the class is forecast to remain above 25.0% due to increases in utilization and unit cost. Cosentyx® (secukinumab), approved in January 2015 for psoriasis, received expanded approvals for ankylosing spondylitis and psoriatic arthritis in January 2016. It's anticipated to be a major driver of increased utilization trend for this class. However, two competitors for Cosentyx are expected to enter the market in 2016: ixekizumab in March and brodalumab in November, which may drive unit cost down as they compete for marketshare.

Beginning in 2017, potential launches of biosimilars to the top two therapies in the class – Remicade® and Humira – may lower the unit cost of therapy. Several biosimilar-related regulatory issues remain unanswered. Once these are resolved, biosimilars may either be expedited or delayed to the market. Several competitors to Xeljanz, the first FDA-approved Janus kinase (JAK) inhibitor, should reach the market in 2017.

Multiple sclerosis

Brand inflation continues to be the primary driver of the trend predicted for medications used to treat MS over the next three years. Launched in June 2015, Glatopa – an A-rated generic to Copaxone 20mg/mL – was expected to lessen the previous predicted cost increases for the class. However, many patients were switched to Copaxone's newer 40mg/mL strength before Glatopa was marketed, which may limit uptake. Generics for Copaxone's higher strength are not expected until February 2017. Older, injectable medications with adverse side effects continue to lose ground to newer, more convenient oral MS drugs.

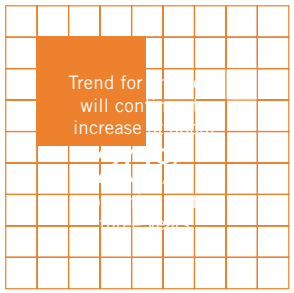
TREND FORECAST FOR KEY SPECIALTY THERAPY CLASSES

2016 – 2018

	TREND FORECAST*		
THERAPY CLASS	2016	2017	2018
Inflammatory conditions	25.5%	25.5%	26.7%
Multiple sclerosis	11.2%	10.2%	7.2%
Oncology	21.1%	20.0%	20.0%
Hepatitis C	10.2%	8.1%	8.0%
HIV	17.7%	17.8%	18.9%
Growth deficiency	9.1%	9.1%	9.0%
Cystic fibrosis	58.2%	36.2%	28.8%
Pulmonary hypertension	16.6%	5.8%	5.9%
Hemophilia	17.3%	18.3%	22.4%
Sleep disorders	22.6%	21.5%	20.5%
Other specialty classes	6.7%	6.4%	6.4%
TOTAL SPECIALTY	**17.4%**	**16.8%**	**17.2%**

*Trend is forecast only for specialty medications billed through the pharmacy benefit.

Oncology



Over the next three years, trend for the oncology class will continue to increase at approximately 20% annually. As more patients survive initial cancer treatment, utilization will increase as these patients may need maintenance therapy or treatment for recurring disease. Additionally, with more oral and self-administered drugs available, coverage shifts from medical benefits to pharmacy benefits continue, causing increases in utilization and cost on the pharmacy side. Cost also will continue to escalate as more expensive, targeted drugs are introduced. The first generic to Gleevec launched in February 2016, and is expected to result in cost savings. A generic for the prostate cancer drug Zytiga® (abiraterone) is expected in October 2018. However, the lower cost of available generics won't offset high prices for branded oncology drugs.

Hepatitis C

In the next three years, moderate increases in trend are likely for drugs to treat hepatitis C. Two new drugs were approved in July 2015. Daklinza™ (daclatasvir) was approved for use with Sovaldi® (sofosbuvir) to treat genotype 3 hepatitis C, and Technivie® (ombitasvir/paritaprevir/ritonavir) was approved to treat genotype 4 for patients without cirrhosis. In January 2016, the approval of Zepatier™ (elbasvir/grazoprevir) introduced another option for genotypes 1 and 4. Multiple regimens that treat more than one genotype are expected to be approved through 2018. As a result, more competition and more affordable pricing may increase utilization and help to alleviate costs. The implementation of the Hepatitis Cure Value Program as a part of SafeGuardRx is reflected in these trend forecasts.

The first generic to Gleevec launched on Feb. 1, 2016, and is expected to result in cost savings.

HIV

Medications used to treat HIV are expected to trend upward with continued use of branded products. Utilization continues to increase modestly, partially because screening for HIV is more accessible and a greater number of patients are surviving longer after diagnosis. Double-digit increases in unit cost are the major driver of trend in 2016. The convenience and improvement of newer drugs that combine several different drugs in a once-daily dose will increase utilization in this class. Additionally, Genvoya, which contains a new version of tenofovir, abbreviated as TAF, is less likely to cause bone and kidney side effects than tenofovir disoproxil fumarate (TDF) and was approved in November 2015. The manufacturer plans to replace several other combinations that contain TDF with new TAF-containing brands, effectively making drugs containing TDF obsolete. As these new, more expensive, branded TAF formulations replace existing TDF brand formulations, unit cost is expected to increase. Patent protection for brands in the market will also lengthen.

Growth deficiency

In 2015, trend for growth hormone products was influenced equally by utilization and unit cost increases. In each of the next few years, positive trend is expected to be roughly 9%. Brand inflation will drive trend in all three years. Utilization is expected to remain flat as utilization management programs ensure that patients requiring the therapy receive appropriate and affordable care. In 2017, some market share may go to new, expensive and long-acting products that are currently in development.

Cystic fibrosis

At 53.4%, 2015 trend for CF was the greatest increase among the top 10 specialty classes. It was driven primarily by drug costs associated with the July 2015 FDA approval of the very expensive combination drug Orkambi, which treats the underlying disease in some patients. Originally, Orkambi was approved only for patients 12 years of age and older. However, approval for use in children ages 6 to 11 could come in 2017. Additional new medications to treat CF are in development for possible approval in 2018. In the meantime, trend for CF should remain high for 2016, and then begin to moderate as these new products reach a saturation point among this population.

Pulmonary hypertension

Steady utilization and a slight increase in drug cost are projected for pulmonary hypertension drugs in 2016. However, with generic formulations of Tracleer® (bosentan) tablets expected to be marketed in 2016, cost trend could be lower in 2017 and 2018. Several generic medications are expected in 2018 that should increase competition and reduce total trend considerably in 2017 and 2018. Generics are expected for Adcirca® (tadalafil) tablets in May, Remodulin® (treprostinil) injection in June, Letairis® (ambrisentan) tablets in July and Tyvaso® (treprostinil) inhalation solution in November.

Hemophilia

Through 2018, double-digit increases are anticipated in PMPY spend for medications used to treat hemophilia and other bleeding disorders. Utilization should be fairly steady as patients use maintenance drugs regularly to prevent bleeds, rather than occasionally to control bleeding episodes. Although utilization is expected to remain steady, unit cost – and therefore overall trend – will rise, due to increasing use of longer-acting products that were launched in 2014 and 2015.

Sleep disorders

PMPY spend for medications used to treat sleep disorders is expected to increase by double digits for the next three years resulting from unit cost increases. Utilization is expected to remain relatively flat over the next three years.

Through 2018, **double-digit increases** are anticipated in PMPY spend for medications used to treat hemophilia and other bleeding disorders.

Looking to the future

Express Scripts is constantly monitoring and anticipating indications with potential for high-cost and high-use drugs, and preemptively developing strategies to counter widespread drug spend problems before they occur. Nonalcoholic steatohepatitis and Alzheimer's disease (AD) are two such disease states.

Nonalcoholic steatohepatitis

According to the National Institutes of Health (NIH), 2% to 5% (approximately 6 million to 16 million) of Americans are affected by nonalcoholic steatohepatitis (NASH). NASH is inflammation and damage of the liver due to fatty buildup in people who drink little or no alcohol. Most prevalent in middle-age individuals who are overweight or obese, NASH affects more than 25% of obese Americans. Although NASH may be asymptomatic, it can lead to cirrhosis or permanent liver damage. Currently, the best treatment options are weight reduction or a balanced diet and physical activity, as well as avoidance of alcohol and substances that cause liver damage. While no true pharmacologic treatments are currently specific for NASH, several products are in various stages of development, with the first approvals expected in 2016. The prevalence of NASH, coupled with a PCSK9-like price tag, could dramatically affect drug spend.

Alzheimer's disease

As the baby boomer generation reaches the age of 65, the potential financial and clinical impact of pharmacotherapy to prevent, delay or treat AD looms large. It's estimated that each of the 5.4 million Americans who suffers from AD incurs an annual cost of $35,000 in treatment. Currently, fewer than 10 pharmacologic treatments are available. With no cure and no drugs to prevent AD progression, treatments provide only symptomatic relief, temporarily improving brain function in patients with mild to moderate disease. Despite the large potential population, these patients accounted for only $1.92 PMPY in 2015. Many of these medications are generic, with Namenda being the latest to go generic in July 2015. However, newer agents with potential disease-modifying characteristics are entering into clinical Phase III trials. If the pricing for new hepatitis C therapies was any indication of how manufacturers set prices for drugs that demonstrate substantial improvement in clinical outcomes, it's likely that AD medications will come to market with hefty price tags.

It's estimated that each of the 5.4 million Americans who suffers from AD incurs an **annual cost of $35,000** in treatment.

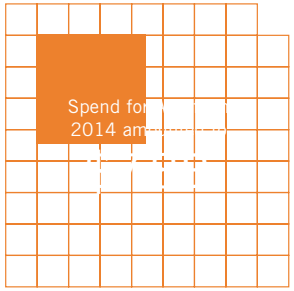
Trend drivers

2015 patent expirations

PATENT EXPIRATION DATE	BRAND (GENERIC) NAME	PRIMARY INDICATION	ESTIMATED ANNUAL SALES (MILLIONS)
Dec. 7, 2015	Patanol® (olopatadine) ophthalmic solution	Eye allergy	$223
Nov. 30, 2015	Viramune XR® (nevirapine extended release)	HIV	$60
Nov. 19, 2015	Jalyn® (dutasteride/tamsulosin)	Benign prostatic hyperplasia	$91
Nov. 5, 2015	Naprelan® (naproxen sodium)	Pain	$58
Oct. 9, 2015	Avodart® (dutasteride)	Benign prostatic hyperplasia	$499
Sep. 28, 2015	Invega® (paliperidone extended release)	Schizophrenia	$612
Sep. 21, 2015	Testred® (methyltestosterone)	Hypogonadism	$15
Sep. 18, 2015	Lescol® XL (fluvastatin extended release)	High cholesterol	$38
Sep. 9, 2015	Exelon® Patch (rivastigmine transdermal system)	Alzheimer's disease	$611
Aug. 24, 2015	hydroxyprogesterone	Female hormone-related conditions	N/A
Aug. 17, 2015	Xenazine® (tetrabenazine)	Huntington's disease	$242
Aug. 12, 2015	Mirapex ER® (pramipexole extended release)	Parkinson's disease	$45
Jul. 28, 2015	Megace® ES (megestrol oral suspension)	Cachexia of AIDS	$44
Jul. 13, 2015	Namenda® (memantine)	Alzheimer's disease	$1,588
Jul. 9, 2015	Targretin® (bexarotene) capsules	Lymphoma	$156
Jul. 9, 2015	Angiomax® (bivalirudin)	Blood clot prevention	$485
Jul. 7, 2015	Axert® (almotriptan)	Migraine	$32
Jul. 1, 2015	Aggrenox® (aspirin/dipyridamole extended release)	Blood modifying	$460
Jun. 29, 2015	Pristiq® (desvenlafaxine)	Depression	$719
Jun. 23, 2015	Zyvox® (linezolid) tablets	Bacterial infections	$470
Jun. 19, 2015	Copaxone® (glatiramer) 20mg	Multiple sclerosis	$2,493
Jun. 1, 2015	Actonel® (risedronate) 5mg, 30mg, 35mg tablets	Osteoporosis	$158
May 28, 2015	Lotronex® (alosetron)	Irritable bowel syndrome with diarrhea	$80
May 18, 2015	Atelvia® (risedronate)	Osteoporosis	$74
Apr. 28, 2015	Abilify® (aripiprazole)	Schizophrenia/bipolar disorder	$7,838
Apr. 24, 2015	Fusilev® (levoleucovorin injection)	Colorectal cancer/methotrexate toxicity	$185
Apr. 15, 2015	Suprax® (cefixime) oral suspension	Bacterial infections	$120
Mar. 10, 2015	Temovate® (clobetasol 0.05%) cream	Skin conditions	$185
Feb. 26, 2015	Tarka® (trandolapril/verapamil)	High blood pressure/heart disease	$24
Jan. 26, 2015	Nexium® (esomeprazole magnesium)	Gastroesophageal reflux	$5,931

Jan. 26, 2015	Lamictal® ODT™ (lamotrigine) orally disintegrating tablets	Seizures	$51
Jan. 12, 2015	AndroGel® (testosterone gel) 1%	Hypogonadism	$1,267
Jan. 12, 2015	Clobex® (clobetasol) Spray	Psoriasis	$100
Jan. 9, 2015	Zyvox® (linezolid) injection	Bacterial infections	$260

Highlights



- At the end of April, the FDA approved the first AB-rated generics for Abilify tablets. An atypical antipsychotic, aripiprazole is indicated to treat mental and neurological disorders, including autism, bipolar disorder, depression, mania, schizophrenia and Tourette's syndrome. Generics from four manufacturers were approved and at least one launched immediately, despite continuing litigation concerning three patents that might have covered Abilify for several more years. According to the IMS Institute for Healthcare Informatics, nondiscounted spend for Abilify in the United States amounted to $7.8 billion in 2014, making it second only to the hepatitis C drug Sovaldi among the country's top-selling drugs. Other atypical antipsychotics are available – many in generic versions – and two new brands, Rexulti® (brexpiprazole) and Vraylar™ (cariprazine), were approved in 2015.

- In December 2015, the FDA announced the approval of Basaglar, a long-acting human insulin analog to improve glycemic control in patients with diabetes. Although it's a new branded insulin, it has the same amino acid sequence as Sanofi's Lantus. The FDA designated it as a "follow-on," not a biosimilar, because insulins are FDA approved under provisions of the Food, Drug, and Cosmetic Act while biologic products are granted approval under a different law, the Public Health Service Act. Following terms of a settlement agreement, Basaglar will launch in December 2016. It will be dispensed in 3mL cartridges, 100 units/mL for KwikPen® delivery devices. Dosing is once daily.

- The first FDA-approved generic to Targretin® (bexarotene) capsules was introduced to the U.S. market on July 9, 2015. Originally approved by the FDA in December 1999, it's used for the treatment of cutaneous (skin) manifestations of cutaneous t-cell lymphoma for patients who are refractory to at least one prior systemic therapy. Generics to topical Targretin gel 1% aren't expected until October 2016 at the earliest.

- Glatopa, an A-rated generic to Copaxone, launched in mid-June 2015. Glatiramer is a disease-modifying drug administered by subcutaneous (SC) injection to treat relapsing forms of MS. It's not a biological drug, but it's more complex and difficult to replicate than most traditional drugs. Copaxone has been available for nearly 20 years as a 20mg/mL formulation that's injected once daily. Several patents on the original formulation expired in 2014, but litigation over a later patent delayed the release of a generic. In addition, Copaxone 40mg/mL – a strength that's needed only three times a week – was FDA approved in January 2014. It will have protection from direct generic competition until at least May 2017, but likely longer following the issuance of additional patents. Up to 70% of patients shifted to the higher strength before Glatopa launched.

- In August 2015, the FDA approved a generic for Delalutin® (hydroxyprogesterone) injection, 250 mg/mL, even though the brand was discontinued in 1999. Hydroxyprogesterone treats a wide variety of female hormone-related conditions, including advanced uterine cancer and abnormal uterine bleeding. Since the original brand product was withdrawn from the market for business, not safety or effectiveness reasons, the FDA approved the generic. Launch isn't expected until mid-2016. Hydroxyprogesterone in the same strength is in the branded drug Makena®, which is indicated only to prevent premature births.

- Generics for the $1 billion seller Namenda tablets were released in July 2015. Namenda is indicated twice a day for treating moderate to severe dementia of Alzheimer's type. A settlement agreement allowed several other generics after a secondary Namenda patent expired in October. A once-daily follow-on product, Namenda XR® (memantine extended release), was marketed in June 2013, and the brand manufacturer intended to discontinue Namenda before the patent expired. However, in December 2014, a district court ruled that Namenda tablets were required to remain on the market. In this instance, the "hard switch" strategy, in which a manufacturer discontinues one formulation of a product in favor of another, was prevented. Still, a majority of Namenda patients have transitioned to the longer-acting form.

- The FDA approved the first AB-rated generics to Janssen's Invega® (paliperidone) extended-release tablets. Invega is indicated to treat schizophrenia in adults and adolescents 12 years of age and older. It's also approved for the treatment of schizoaffective disorder as monotherapy and as an adjunct to mood stabilizing and/or antidepressant therapy in adults. Since Invega was first approved, longer-lasting injectable versions have also received FDA approval. Invega Sustenna® is injected once a month for treating bipolar disorder and schizophrenia. More recently, Invega Trinza™ won FDA approval in May 2015, for treating adult patients with schizophrenia. Each intramuscular (IM) Invega Trinza injection, which must be given by a healthcare provider, lasts for three months. Before starting on Invega Trinza, patients have to be treated with monthly Invega Sustenna injections for at least four months.

- In August 2015, the first A-rated generic to Xenazine® (tetrabenazine) tablets was launched in the U.S. Tetrabenazine is the only FDA-approved drug that treats chorea (involuntary, unpredictable movements) associated with Huntington's disease. Its individualized dosing requires careful weekly titration. The first week's starting dose is 12.5mg daily with a maximum recommended dose of no more than 100mg per day for most adults. Although Xenazine is only available through a limited network of specialty pharmacies, tetrabenazine is marketed through open distribution.

In the instance of Namenda, the **"hard switch" strategy**, in which a manufacturer discontinues one formulation of a product in favor of another, **was prevented**.

2015 brand approvals

APPROVAL DATE	BRAND (GENERIC) NAME	PRIMARY INDICATION	PRODUCT UNIQUENESS
Dec. 22 2015	Zurampic® (lesinurad)	Gout	New mechanism of action
Dec. 21, 2015	Uptravi® (selexipag)	Pulmonary arterial hypertension	Similar to existing products
Dec. 15, 2015	Bridion® (sugammadex)	Neuromuscular blockade reversal	New mechanism of action
Dec. 11, 2015	Alecensa® (alectinib)	ALK-positive lung cancer	Similar to existing products
Dec. 11, 2015	Vistogard® (uridine triacetate)	Fluorouracil toxicity	New mechanism of action
Dec. 10, 2015	Otiprio™ (ciprofloxacin) otic suspension	Otitis media	Refinement of an existing product
Dec. 8, 2015	Kanuma™ (sebelipase alfa)	Lysosomal acid lipase deficiency	New mechanism of action
Dec. 7, 2015	Bendeka™ (bendamustine)	Chronic lymphocytic leukemia/non-Hodgkin lymphoma	Refinement of an existing product
Dec. 4, 2015	QuilliChew ER™ (methylphenidate) extended release	Attention deficit hyperactivity disorder	Existing product with new dosing form
Nov. 30, 2015	Empliciti™ (elotuzumab)	Multiple myeloma	New mechanism of action
Nov. 24, 2015	Portrazza™ (necitumumab)	Non-small cell lung cancer	Similar to existing products
Nov. 20, 2015	Ninlaro® (ixazomib)	Multiple myeloma	New mechanism of action
Nov. 18, 2015	Narcan® (naloxone) Nasal Spray	Opioid overdose	Existing product with new dosing form
Nov. 16, 2015	Darzalex™ (daratumumab)	Multiple myeloma	New mechanism of action
Nov. 13, 2015	Targrisso™ (osimertinib)	Non-small cell lung cancer	New mechanism of action
Nov. 13, 2015	Adynovate [antihemophilic factor (recombinant)],	Hemophilia A	Refinement of an existing product
Nov. 10, 2015	Cotellic™ (cobimetinib)	Melanoma	New mechanism of action
Nov. 5, 2015	Genvoya® (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	HIV	Refinement of an existing product
Nov. 4, 2015	Nucala® (mepolizumab)	Asthma	New mechanism of action
Oct. 29, 2015	Seebri™ Neohaler® (glycopyrrolate/indacaterol)	Chronic obstructive pulmonary disease	New combination of existing products
Oct. 29, 2015	Ultibron™ Neohaler® (glycopyrrolate)	Chronic obstructive pulmonary disease	New mechanism of action
Oct. 27, 2015	Imlygic™ (talimogene laherparepvec)	Melanoma	New mechanism of action
Oct. 23, 2015	Belbuca™ (buprenorphine) buccal film	Pain	Existing product with new dosing form
Oct. 23, 2015	Strensiq™ (asfotase alfa)	Hypophosphatasia	New mechanism of action
Oct. 23, 2015	Yondelis® (trabectedin)	Soft tissue sarcomas	Similar to existing products
Oct. 22, 2015	Vivlodex™ (meloxicam) capsules	Osteoarthritis	Existing product with new dosing form
Oct. 22, 2015	Onivyde™ (irinotecan) liposomal injection	Pancreatic cancer	Existing product with new dosing form
Oct. 21, 2015	Veltassa™ (patiromer)	Hyperkalemia	Similar to existing products
Oct. 20, 2015	Coagadex® (coagulation factor X, human)	Hereditary Factor X Deficiency	New mechanism of action

Oct. 19, 2015	Dynavel™ XR (amphetamine) oral suspension, extended release	Attention deficit hyperactivity disorder	Existing product with new dosing form
Oct. 16, 2015	Praxbind® (idarucizumab)	Pradaxa® (dabigatran) anticoagulant reversal	New mechanism of action
Oct. 16, 2015	Enstilar® (calcipotriene/betamethasone dipropionate) Foam	Psoriasis	Existing product with new dosing form
Oct. 6, 2015	Aristada™ (aripiprazole lauroxil)	Schizophrenia	Refinement of an existing product
Oct. 2, 2015	MorphaBond™ (morphine) extended-release tablets	Pain	Existing product with new dosing form
Sep. 25, 2015	Tresiba® (insulin degludec)	Diabetes	Similar to existing products
Sep. 25, 2015	Ryzodeg®70/30 (insulin aspart/insulin degludec)	Diabetes	New combination of existing products
Sep. 22, 2015	Lonsurf® (trifluridine/tipiracil)	Colorectal cancer	New mechanism of action
Sep. 17, 2015	Vraylar™ (cariprazine)	Schizophrenia/Bipolar disorder	Similar to existing products
Sep. 15, 2015	Nuwiq® (human coagulation factor VIII (rDNA), simoctocog alfa)	Hemophilia A	Similar to existing products
Sep. 4, 2015	Xuriden™ (uridine triacetate)	Hereditary orotic aciduria	New mechanism of action
Sep. 4, 2015	Durlaza™ (aspirin) extended-release capsules	Heart attack/stroke prevention	Existing product with new dosing form
Sep. 2, 2015	Varubi™ (rolapitant)	Chemotherapy-induced nausea and vomiting	Similar to existing products
Aug. 27, 2015	Repatha™ (evolocumab)	Familial hypercholesterolemia	Similar to existing products
Aug. 26, 2015	Synjardy® (empagliflozin/metformin),	Diabetes	New combination of existing products
Aug. 18, 2015	Addyi™ (flibanserin)	Female hypoactive sexual desire disorder	New mechanism of action
Aug. 13, 2015	Ximino® (minocycline) extended-release capsules	Acne	Existing product with new dosing form
Jul. 31, 2015	Spritam® (levetiracetam)	Seizures	Existing product with new dosing form
Jul. 29, 2015	Finacea® (azelaic acid) Foam 15%	Rosacea	Existing product with new dosing form
Jul. 24, 2015	Technivie® (ombitasvir/paritaprevir/ritonavir)	Hepatitis C	New combination of existing products
Jul. 24, 2015	Daklinza™ (daclatasvir)	Hepatitis C	New mechanism of action
Jul. 24, 2015	Odomzo® (sonidegib)	Basal cell carcinoma	Similar to existing products
Jul. 24, 2015	Praluent® (alirocumab)	Familial hypercholesterolemia	New mechanism of action
Jul. 15, 2015	Epiduo® Forte (adapalene/benzoyl peroxide) Gel	Acne	Refinement of an existing product
Jul. 10, 2015	Envarsus® XR (tacrolimus extended-release)	Transplant rejection	Existing product with new dosing form
Jul. 10, 2015	Rexulti® (brexpiprazole)	Schizophrenia/Depression	Similar to existing products
Jul. 7, 2015	Entresto™ (sacubitril/valsartan)	Heart failure	New mechanism of action
Jul. 2, 2015	Orkambi® (lumacaftor/ivacaftor)	Cystic fibrosis	New mechanism of action
Jun. 22, 2015	Kengreal™ (cangrelor)	Blood clot prevention	New mechanism of action
Jun. 22, 2015	Tuxarin ER® (codeine/chlorpheniramine)	Cough and cold	New combination of existing products
May 27, 2015	Viberzi® (eluxadoline)	Irritable bowel syndrome with diarrhea	New mechanism of action
May 21, 2015	Stiolto™ Respimat® (tiotropium/olodaterol)	Chronic obstructive pulmonary disease	New combination of existing products

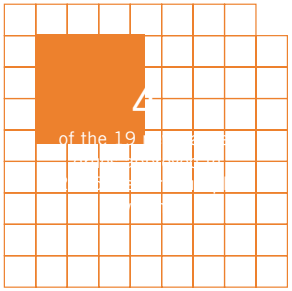
May 19, 2015	Invega Trinza™ (paliperidone) extended-release injectable suspension	Schizophrenia	Refinement of an existing product
Apr. 30, 2015	Tuzistra™ XR (codeine polistirex/chlorpheniramine polistirex)	Cough and cold	New combination of existing products
Apr. 29, 2015	Ixinity® (coagulation factor IX [recombinant])	Hemophilia B	Similar to existing products
Apr. 29, 2015	Kybella® (deoxycholic acid)	Submental fat	New mechanism of action
Apr. 17, 2015	Aptensio XR™ (methylphenidate)	Attention deficit hyperactivity disorder	Refinement of an existing product
Apr. 15, 2015	Corlanor® (ivabradine)	Heart failure	New mechanism of action
Mar. 31, 2015	ProAir® RespiClick (albuterol) dry-powder inhaler	Reversible obstructive airway disease	Refinement of an existing product
Mar. 30, 2015	Jadenu™ (deferasirox)	Chronic iron overload	Refinement of an existing product
Mar. 17, 2015	Cholbam® (cholic acid)	Bile acid synthesis disorders	New mechanism of action
Mar. 10, 2015	Unituxin™ (dinutuximab)	Neuroblastoma	Similar to existing products
Mar. 6, 2015	Cresemba™ (isavuconazonium)	Invasive aspergillosis/Invasive mucormycosis	New mechanism of action
Feb. 26, 2015	Liletta® (levonorgestrel-releasing intrauterine system)	Contraception	Refinement of an existing product
Feb. 25, 2015	Toujeo® (insulin glargine)	Diabetes	Similar to existing products
Feb. 25, 2015	Avycaz™ (ceftazidime/avibactam)	Complicated intra-abdominal infections/Complicated urinary tract infections	New mechanism of action
Feb. 23, 2015	Farydak (panobinostat)	Multiple myeloma	New mechanism of action
Feb. 13, 2015	Lenvima™ (lenvatinib)	Thyroid cancer	Similar to existing products
Feb. 6, 2015	Dutrebis™ (lamivudine/raltegravir)	HIV	New combination of existing products
Feb. 3, 2015	Ibrance® (palbociclib)	Breast cancer	New mechanism of action
Jan. 30, 2015	Pazeo® (olopatadine ophthalmic solution) 0.7%	Eye allergy	Refinement of an existing product
Jan. 30, 2015	Glyxambi® (empagliflozin/linagliptin)	Diabetes	New combination of existing products
Jan. 30, 2015	Zohydro® ER (hydrocodone) with abuse deterrents	Pain	Refinement of an existing product
Jan. 29, 2015	Evotaz™ (atazanavir/cobicistat)	HIV	New combination of existing products
Jan. 29, 2015	Prezcobix® (darunavir/cobicistat)	HIV	New combination of existing products
Jan. 23, 2015	Natpara® (parathyroid hormone)	Hypocalcemia of hypoparathyroidism	New mechanism of action
Jan. 23, 2015	Triferic® (ferric pyrophosphate citrate)	Chronic kidney disease	New mechanism of action
Jan. 21, 2015	Cosentyx™ (secukinumab)	Psoriasis	New mechanism of action
Jan. 21, 2015	Prestalia® (amlodipine/perindopril)	High blood pressure	New combination of existing products
Jan. 9, 2015	Duopa™ (carbidopa/levodopa) enteral suspension	Parkinson's disease	Existing product with new dosing form
Jan. 8, 2015	Savaysa® (edoxaban)	Blood clot prevention	Similar to existing products
Jan. 7, 2015	Rytary™ (carbidopa/levodopa)	Parkinson's disease	Refinement of an existing product

Highlights

Approvals

- Addyi™ (flibanserin) was approved by the FDA in August 2015 as the first drug to treat female sexual dysfunction. Specifically, it's indicated for acquired, generalized hypoactive sexual desire disorder (HSDD) among premenopausal women. Unlike drugs for male erectile dysfunction, which influence muscle tone, blood supply or testosterone levels, Addyi affects neurotransmitter levels in the brain, increasing the desire for sex. It must be taken daily. Prescribers of Addyi are trained and certified, each potential patient is assessed using a Patient-Provider Agreement Form and the drug is dispensed only through certified pharmacies.

- Four of the 19 new cancer drugs that were FDA approved in 2015 are for treating multiple myeloma. A relatively uncommon, but frequently aggressive cancer of the blood-forming cells in bone marrow, multiple myeloma has an overall five-year survival rate under 50%. Currently, it can't be cured and the incidence of recurrence is high. Additionally, most drug treatments for multiple myeloma lose effectiveness after they've been used repeatedly, so other drugs are needed – usually in combinations.



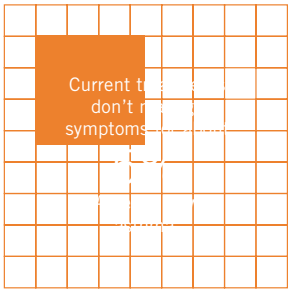
- A new cardiovascular drug, Entresto™ (sacubitril/valsartan), was approved in July 2015. Containing a well-established angiotensin receptor blocker, it also includes the first drug in a new class called neprilysin inhibitors. Entresto is indicated to reduce the risk of cardiovascular death and hospitalization for patients with chronic heart failure and reduced ejection fraction – around 2.2 million Americans. In clinical trials, Entresto outperformed the previous standard of care, angiotensin converting enzyme (ACE) inhibitors. However, it's significantly more expensive than most other cardiovascular drugs.

- In November 2015, the FDA approved the combination drug Genvoya for the once-daily treatment of specific patients who have HIV-1. In addition to three drugs already approved for treating HIV, Genvoya includes a new nucleotide reverse transcriptase inhibitor (NRTI), tenofovir alafenamide (TAF). Although it's similar to Viread® (tenofovir disoproxil fumarate or TDF), TAF is effective in much smaller doses, so it has less risk of causing kidney damage and bone mineral density problems than TDF. Two other combination products that contain TAF are being reviewed by the FDA with action dates in the first half of 2016. They're expected to replace the older TDF-containing combinations.

- Five specialty products were approved in 2015 to treat hemophilia and related conditions. Among them is Coagadex® (Coagulation Factor X [human]), the first drug FDA approved to treat hereditary Factor X deficiency. A rare blood-clotting disorder, Factor X deficiency is estimated to affect between 300 and 600 patients in the United States. Coagadex is used to manage bleeding before, during and after surgical procedures, as well as to treat and control acute bleeding episodes.

- Narcan® Nasal Spray, the first noninjected form of naloxone, was approved by the FDA in November 2015. To treat opioid overdoses in emergency situations, the first spray (4mg) should be administered immediately. One spray is given every two to three minutes until the patient recovers consciousness or emergency medical help arrives. Narcan nasal spray can be used for both adults and children. It will be available by prescription at retail pharmacies across the United States, but in some states a prescription won't be required.

- The FDA approved Nucala® (mepolizumab) injection for use as an add-on maintenance treatment for severe eosinophilic asthma. The first humanized interleukin-5 (IL-5) antagonist monoclonal antibody to be approved, it's injected subcutaneously by a healthcare professional once every four weeks. Current treatments don't manage symptoms for about 5% of the estimated 25.7 million people in the U.S. who have asthma. For many of these resistant cases, Nucala could be added to inhaled corticosteroids and other current asthma treatments. Nucala reduces severe asthma attacks by sticking to IL-5 receptors. Blocking the action of IL-5 decreases eosinophils, white blood cells that contribute to increased sensitivity of the airways among asthma patients.



- Several orphan drugs, intended to treat patient populations of 200,000 or less, were approved during 2015. Considered specialty drugs, many are the first approved treatments for rare but severe conditions. These drugs include:
    - Cholbam® (cholic acid) – indicated for treating rare disorders of bile acid synthesis caused by an enzyme defect. It's also approved for a group of very serious inherited conditions that result from missing or malfunctioning peroxisomes – parts of cells that produce enzymes to break down fatty acids. Around one person in 50,000 has a condition that Cholbam might treat.
    - Kanuma™ (sebelipase alfa) – for the treatment of patients with lysosomal acid lipase (LAL) deficiency. Individuals with LAL deficiency have defective genes that prevent the proper metabolism and storage of fats, causing damage to the blood vessels, heart, liver and other organs. In the general population, fewer than 20 patients in one million have LAL deficiency.
    - Keveyis™ (dichlorphenamide) – an oral carbonic anhydrase inhibitor. It's indicated for the treatment of primary hyperkalemic and hypokalemic periodic paralysis, inherited disorders that cause episodes of muscle weakness or paralysis for approximately 5,000 patients in the U.S.
    - Xuriden™ (uridine) – oral granules that treat hereditary orotic aciduria (HOA). It's the first approved treatment for this rare metabolic disorder that's been reported in only about 20 patients in the world.
- In the summer of 2015, two specialty drugs were approved for specific types of hard-to-treat high cholesterol. Praluent and Repatha are the first in a new class, proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors. Praluent was approved to be used once every two weeks for treating patients with heterozygous familial hypercholesterolemia (HeFH) and patients with clinical atherosclerotic cardiovascular disease (ASCVD) who require additional lowering of low-density lipoprotein cholesterol (LDL-C). Repatha is indicated once or twice a month for the same two conditions and also for homozygous familial hypercholesterolemia (HoFH). Both drugs are available in self-injectors and each is used in tandem with dietary and statin therapies. About 11 million Americans have one of the three indicated conditions, but the use of PCSK9 inhibitors may expand if results from ongoing clinical trials show they reduce heart disease risks. PCSK9 inhibitors are included on our specialty formulary.
- Pradaxa® (dabigatran) is an oral direct thrombin inhibitor anticoagulant that was approved in 2010 to reduce the risk of stroke and blood clots for patients with nonvalvular atrial fibrillation. It's also approved to treat and prevent deep venous thrombosis (DVT) and pulmonary embolism (PE). Although it's less complicated to use than earlier anticoagulants, its effects couldn't be counteracted when needed. In 2015, the first reversal agent for it, Praxbind® (idarucizumab), was approved for emergency surgery/urgent procedures and in life-threatening or uncontrolled bleeding episodes. Praxbind is a humanized monoclonal antibody fragment that's administered as a single intravenous (IV) infusion.
- In 2015, the FDA approved a number of older drugs redesigned as new dosage forms, developed in new strengths, combined in new ways or repurposed for different indications. They include a new form and dose of aspirin; a topical acne cream remade into a foam for rosacea; a new combination of blood pressure medications; a former glaucoma treatment now approved as the first treatment for a rare condition. Even though many of the drugs have been generic for years, the newly approved versions are all branded. As new technologies become available, more older drugs will probably be repurposed in similar ways.
- In August 2015, the FDA approved Spritam®, a new version of the anti-seizure drug levetiracetam. Spritam is the first FDA-approved drug to be manufactured by a 3-D printing process. Using proprietary technology, the unique process allows layers of powdered medication to be formed into spongy, mint-flavored tablets that disintegrate very quickly when taken.

Among FDA approvals in 2015 are a number of older drugs that have been redesigned as new dosage forms, developed in new strengths, combined in new ways or repurposed for different indications.

New indications

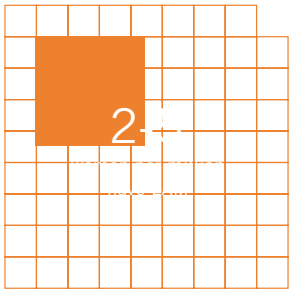
- In April 2015, the FDA granted Breo® Ellipta® a new indication for treating adults with asthma. Initially approved in May 2013 for the treatment of chronic obstructive pulmonary disease (COPD), it includes a corticosteroid (fluticasone furoate) to reduce inflammation and a bronchodilating long-acting beta blocker (LABA), vilanterol. Breo Ellipta isn't indicated for treating asthma patients under the age of 18 and it's not a rescue medicine for acute bronchospasms. For asthma, adult patients use one inhalation daily.

- Clozapine, an oral drug for treating schizophrenia, is used when other antipsychotic medications don't adequately manage symptoms. However, severe and possibly fatal neutropenia – very low numbers of a white blood cell type known as neutrophils – can be caused by taking clozapine. Its prescribing information has been changed to better describe monitoring for and treating neutropenia if needed. Additionally, beginning in October 2015, the registries previously kept separately by manufacturers of clozapine were replaced by a single risk evaluation and mitigation strategy (REMS) program for all patients. Prescribers and dispensing pharmacies now have to be certified, and clozapine is available only through the REMS. Clozapine is available as generic tablets and orally disintegrating tablets, as well as under the brand names Clozaril® tablets, FazaClo® Orally Disintegrating Tablets and Versacloz™ Oral Suspension.

- In March 2015, Kalydeco® (ivacaftor) was FDA approved for use in children age two to five who have CF and who have one of 10 mutations in the CF transmembrane conductance regulator (CFTR) gene. Approximately 300 children in the U.S. age two to five have these mutations. Previously, Kalydeco was indicated only for appropriate patients six years of age and older. The FDA also approved a new oral granule formulation of Kalydeco, which can be mixed in soft foods and liquids.

- Opdivo® (nivolumab) injection is a human programmed death receptor-1 (PD-1) immune checkpoint inhibitor first approved by the FDA in December 2014. It enhances immune response by blocking specific receptors that deactivate immune cells. Originally, it was indicated for treating progressed and malignant melanoma, as well as for second-line, single-agent therapy for advanced squamous and nonsquamous-cell nonsmall cell lung cancer (NSCLC). In 2015, Opdivo also was approved for metastatic renal cell carcinoma (RCC) and as first-line monotherapy for treating patients with inoperable or metastatic BRAF V600 wild-type melanoma.

- After priority review and with orphan and breakthrough designations, the FDA approved Rapamune® (sirolimus) in May 2015 to treat lymphangioleiomyomatosis (LAM). A very rare disease of the lungs, LAM almost exclusively affects women; about two to five women per million have it. In LAM, smooth muscle tissue that grows in the lungs clogs airways, blood vessels and lymph channels, restricting breathing and eventually destroying lung function. Current treatment includes symptom relief with bronchodilators, fluid removal from the lungs and lung transplants. Initially approved more than 15 years ago to help prevent rejection of transplanted kidneys, Rapamune is the first treatment to slow the progression of LAM.



- The FDA approved the over-the-counter (OTC) use of Rhinocort® (budesonide) nasal spray for the temporary relief of symptoms of hay fever or other upper respiratory allergies (nasal congestion, runny nose, itchy nose and sneezing) in adults and children age six and older. An estimated 50 million Americans have nasal allergies. Most treat their symptoms with OTC products. Rhinocort Allergy Spray will compete in the nonprescription market with Flonase® Allergy Relief (fluticasone propionate) and Nasacort® Allergy 24HR (triamcinolone acetonide).

- A new indication for Saphris® (asenapine) was approved in March 2015, under an FDA priority review. An atypical antipsychotic medication that's been on the U.S. market for nearly six years, Saphris is already indicated for both acute and maintenance treatment of adults with schizophrenia and/or bipolar disorder. Now, it's also approved for treating bipolar I disorder for children as young as 10 years. For pediatric patients, it will be used alone to manage acute episodes of mania or mixed manic-depressive behaviors resulting from bipolar I disorder. Saphris is manufactured as sublingual, black-cherry-flavored tablets that may be easier for children to take than other oral dose forms.

- The FDA released a Drug Safety Communication in December 2015 about possible adverse effects from sodium-glucose cotransporter-2 (SGLT2) inhibitors. Following up on a warning issued in May, the FDA found more than 70 reports of ketoacidosis, which is a dangerous accumulation of ketones (a type of fatty acid) in the blood, due to lack of insulin among patients taking an SGLT2 inhibitor. Additionally, the FDA identified cases of urosepsis

(blood infections caused by infections in the urinary tract) and pyelonephritis (kidney infections) associated with SGLT2 inhibitor use. Labeling for all SGLT2 inhibitors will now have warnings about the potential side effects and how to monitor for them. Manufacturers of SGLT2 inhibitors are required to investigate reported incidences of ketoacidosis for the next five years. SGLT2 inhibitors that have been approved in the U.S. include Farxiga™ (dapagliflozin), Glyxambi® (linagliptin/empagliflozin), Invokamet® (canagliflozin/metformin), Invokana, Jardiance® (empagliflozin), Synjardy and Xigduo® XR (dapagliflozin/metformin extended release).

- In January 2015, an expanded indication for the treatment of moderate to severe binge eating disorder (BED) in adults was granted for Vyvanse capsules. Vyvanse is the first drug approved for BED, which results in patients overeating when not feeling hungry. BED patients often eat to the point of being uncomfortably full. Vyvanse, a central nervous system (CNS) stimulant, was already approved as a maintenance treatment for adults and children six years of age and older with attention deficit hyperactivity disorder (ADHD).

Vyvanse is the **first drug** approved for BED, which results in patients overeating when not feeling hungry.

Express Scripts Prescription Price Index

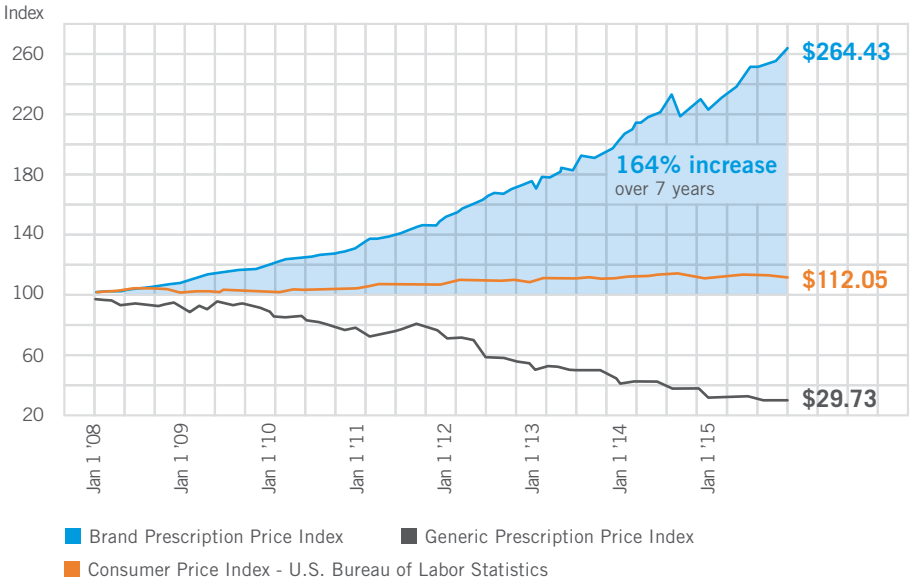
Roughly half of Americans take prescription medications. Generic products comprise 84% of filled prescriptions. By achieving higher generic fill rates, there's still opportunity for employers, state governments, unions and members to ensure cost savings. According to the Express Scripts Prescription Price Index, the average price for the most commonly used brand-name drugs has increased 164% since 2008, whereas generic drug prices have continued to decline. Between 2014 and 2015, the price of generic products, on average, decreased 19.9%, while the price of brand name products increased, on average, 16.2%.

Express Scripts mitigates the risk of drug price inflation for our clients and members by utilizing our task force of clinical experts who assess and recommend additional potential savings measures as they arise.

While news reports focus on a few outliers, payers should remain confident that, on the whole, generic medications continue to deliver significant cost savings. Encouraging use of generics over more expensive brand alternatives, when clinically appropriate, keeps costs down and helps patients adhere to their prescribed therapy.

The gap between brand inflation and generic deflation increased slightly, from 35.5 percentage points in December 2014 to 36.1 percentage points in December 2015. From the base price of $100.00 set in January 2008, in December 2015 prices for the most commonly used generic medications decreased to $29.73 (in 2008 dollars), and prices for the most commonly used brand medications increased to $264.33 (in 2008 dollars). In contrast, a market basket of commonly used household goods costing $100.00 in 2008, as measured by the Bureau of Labor Statistics consumer price index, grew to only $112.05 (in 2008 dollars) by December 2015.

THE EXPRESS SCRIPTS PRESCRIPTION PRICE INDEX



Medicare

Medicare overview

The Centers for Medicare and Medicaid Services (CMS) celebrated the 50th year of Medicare in 2015. The Medicare prescription drug benefit through Part D also reached its 10-year milestone in 2015. In that time, the Medicare Part D Program has saved Medicare beneficiaries more than $7 billion on their prescription drugs, and 94% of members reported being satisfied with their Medicare prescription drug benefit.[5]

Approximately two million new members became eligible for Medicare in 2015. In terms of Medicare plan spread, more than 24 million members were enrolled in Medicare prescription drug plans (PDPs), nearly 17 million members were enrolled in Medicare Advantage plans (MAPD) and approximately 8.1 million Medicare beneficiaries were enrolled in Employer Group Waiver Plans (EGWP).[6]In the past year, MAPD enrollment has shown the most growth, with an increase of nearly one million members.[6]

Approximately **two million new members** became eligible for Medicare in 2015.

The Medicare-eligible population will only continue to grow over the next decade. As CMS requirements and strategies change, the future of the Medicare prescription drug benefit will continue to be dynamic.

Future trend drivers introduced in 2015 will further shape the Medicare landscape:

- **New 2017/2018 Star Measures:** CMS-proposed changes to Star Ratings will continue to affect Medicare trend if finalized,[7] including Part C measures focusing on asthma and depression and a Part D measure addressing the use of antipsychotic medications in elderly dementia patients.
- **New 2017 Formulary Tiering Structure:** The recommended introduction of a nonpreferred drug tier is an additional opportunity to influence trend by allowing plans to place their highest cost generics alongside their nonpreferred brand drugs within the same copayment tier.[8] As the costs of some generics drastically rise, management through strategic tier placement will be critical to continued success for plans.
- **Increased Competition:** As the market changes and Medicare enrollment maintains its rapid growth, competition among plans continues to increase. In 2016, 53 net new Medicare plans will enter the marketplace, providing an additional layer of competition.[9] More plans are utilizing aggressive benefit designs, closed formularies and preferred pharmacy networks to differentiate themselves from and stay ahead of the competition.

Ten years into the program, Medicare is now leading the change as to how healthcare is delivered. Clearly, plans respond to risk (enforcement actions) and reward (quality bonus payments). This is exactly what CMS hoped to accomplish. We're seeing innovative programs taking the risk and reward concept to new frontiers.

What's driving Medicare trend?

In 2015, total per-member-per-year (PMPY) spend for Medicare plans rose 10.9%, to $2,914.20, as the result of a modest increase in PMPY utilization (2.2%), combined with a significant increase in unit cost (8.7%). Traditional drug spend increased 4.8%, driven by an almost equal increase in PMPY utilization (2.2%) and unit cost (2.6%).

Specialty

Specialty drug spend increased 27.9% in 2015, following a much larger 2014 trend increase of 45.9% which was attributed to newly introduced hepatitis C medications. Oncology, hepatitis C, multiple sclerosis and inflammatory conditions classes each accounted for at least $100 of PMPY spend in 2015. Express Scripts continues to maintain an unwavering focus on doing what's right to keep specialty medications affordable and accessible. Unlike commercial health plans, Medicare plans have additional challenges with managing expensive drug classes. Medicare formulary placement and utilization management must be approved by CMS and can only be implemented at certain times in the plan year.

The handful of biosimilars approved in 2015 and expected to launch in 2016 won't radically mitigate the marked increases in specialty trend. But significant discounts of 20-30% are anticipated when biosimilar costs are compared to their reference products, potentially saving the United States more than $250 billion over the next decade.[10]

Compounded drugs

Overall, Medicare trend for compounded drugs increased by 32.7% from 2014, moving it from the 19th therapy class to the 13th, based on PMPY spend. Although MAPDs saw an increase in compounded drug trend of 5.1% and EGWPs of 78.1%, PDP trend decreased by 35.3%. This overall trend decline was influenced by a 31.5% drop in compounded drug utilization among PDPs.

Star Ratings

Quality Star Ratings remain a key factor in determining which plans remain in the Medicare marketplace and which ones receive top reimbursements. Medicare Star Ratings and The Healthcare Effectiveness Data and Information Set (HEDIS) measures affect Medicare trend directly and indirectly. Medicare plans have earned higher Star Ratings than ever before, with the average increasing from 4.0 for 2015 to 4.5 stars for 2016. Currently, 71% of Medicare enrollment is in 4-star-or-better-performing plans.[11]

Star Rating measures that focus on adherence to medications commonly used to treat diabetes, high cholesterol and hypertension play a key role in driving trend. These therapy classes remain in Medicare's top-five traditional therapy classes by PMPY spend. All three have average adherence rates that increased for MAPDs and PDPs between 2013 and 2015.[12] Express Scripts plan sponsors had an average of 4% higher adherence rates in 2015 compared to industry adherence rates.[13] As CMS continues to develop new quality ratings, quality measures will play a major role in Medicare trend.

STAR RATINGS ADHERENCE MEASURES

2015

	TRADITIONAL THERAPY CLASS RANK (BY OVERALL MEDICARE PMPY SPEND 2015)	2015 MAPD INDUSTRY ADHERENCE	2015 PDP INDUSTRY ADHERENCE
Diabetes	1	78.21%	78.93%
High Cholesterol*	4	80.31%	78.20%
High Blood Pressure**	5	76.91%	80.50%

*CMS measures statin adherence specifically for Star Ratings
**High blood pressure grouped with heart disease for drug trend report

A look at Medicare overall drug trend for 2015

PMPY spend for Medicare plans rose 10.9% to $2,914.20 from 2014 to 2015. Increased trend resulted primarily from an increase in unit cost (8.7%), complemented by a small increase in utilization (2.2%). Medicare continues to be a rapidly expanding market. By 2035, one in five Americans will be over the age of 65.[14] These numbers place a substantial burden on the Medicare system, driving the CMS to continue focusing on both cost containment and quality performance.

Trend by plan type

We examined Medicare trend in 2015 by Medicare plan type: MAPD, PDP and EGWP. Overall, we saw the impact of benefit and formulary design driving significant trend differences among the three plan types.

MAPD

Traditional spend for MAPDs decreased 3.2%, with a PMPY spend of $1,479.10, stemming from a 4.3% decline in unit cost combined with a 1.0% increase in PMPY utilization. This decrease could be a reflection of a higher (87.5%) generic fill rate (GFR) for MAPDs compared to the other two types. MAPD plans at Express Scripts have achieved success in driving down traditional drug spend with the highest percentage of closed formularies and the use of five tiers in their formulary structures. Specialty PMPY spend for MAPDs increased to $621.22 in 2015, a 24.3% increase over 2014.

COMPONENTS OF MEDICARE TREND

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$2,025.67	2.2%	2.6%	**4.8%**
Specialty	$888.53	10.7%	17.2%	**27.9%**
TOTAL OVERALL	**$2,914.20**	**2.2%**	**8.7%**	**10.9%**

January-December 2015 compared to same period in 2014

COMPONENTS OF MAPD TREND

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$1,479.10	1.0%	-4.3%	**-3.2%**
Specialty	$621.22	9.9%	14.3%	**24.3%**
TOTAL OVERALL	**$2,100.33**	**1.1%**	**2.5%**	**3.5%**

January-December 2015 compared to same period in 2014

PDP

Medicare traditional drug spend increased 9.8%, to $2,236.77, for PDP plans, driven by a 5.2% increase in unit cost and a 4.6% increase in PMPY utilization. In addition, PDP plans had a higher specialty spend increase (36.3%) than the two other types of Medicare plans. Data suggest that richer benefits typically associated with PDPs (which still generally follow a five-tier formulary design and utilize open formularies in their prescription drug benefit) may be driving higher PMPY spend.

EGWP

EGWPs, which consist of plan sponsors that continue to offer benefits to their retirees, tend to have broader formularies, lower copayments and fewer member restrictions. In 2015, EGWP plans had the highest PMPY spend ($2,452.31) for traditional drugs among the three Medicare plan types. However, they had a somewhat lower increase in utilization for traditional drugs than PDP plans. For specialty drugs, EGWPs had a 27.2% increase, to $925.94 PMPY spend. They also had the lowest GFR (82.4%) among the three plan types.

Generic fill rate by plan type

In 2015, GFR differed by plan type, with MAPD and PDP plans with similar GFRs (87.5% and 87.2%, respectively), and EGWP with the lowest GFR (82.4%).

Components of Medicare trend by brand generic classification

As expected, our analysis of Medicare trend by brand and generic medications found that utilization of brand medications decreased (-6.6%) in alignment with an increase in unit cost (21.9%). Utilization of generic medications increased 3.8%, with a 3.4% decrease in unit costs.

COMPONENTS OF PDP TREND

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$2,236.77	4.6%	5.2%	**9.8%**
Specialty	$1,141.27	15.6%	20.7%	**36.3%**
TOTAL OVERALL	**$3,378.04**	**4.7%**	**12.9%**	**17.5%**

January-December 2015 compared to same period in 2014

COMPONENTS OF EGWP TREND

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$2,452.31	1.4%	6.5%	**7.9%**
Specialty	$925.94	11.4%	15.7%	**27.2%**
TOTAL OVERALL	**$3,378.25**	**1.5%**	**11.1%**	**12.6%**

January-December 2015 compared to same period in 2014

COMPONENTS OF MEDICARE TREND BY BRAND GENERIC CLASSIFICATION

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
		-6.6%	21.9%	**15.4%**
Generic	$788.06	3.8%	-3.4%	
TOTAL OVERALL	**$2,914.20**	**2.2%**	**8.7%**	**10.9%**

January-December 2015 compared to same period in 2014

Trend by plan type and brand generic classification

MAPD

Significant decrease in unit costs for generic medications (-11.1%) offset the 2.2% increase in utilization for MAPD plans, resulting in a trend of -9.0% for generics. The decrease in generic unit costs can be attributed to formulary tiering and placing high-cost generics on a higher tier, thus increasing utilization of lower-cost generic medications. However, the 16.4% increase in unit cost far outweighed the 6.3% decrease in utilization for brand medications, contributing to a brand trend of 10.1% for MAPDs.

PDP

For PDP plans, generic unit cost remained nearly unchanged from 2014 to 2015, but a 25.9% increase in brand drug unit cost resulted in an overall increase in unit costs of 12.9% for PDPs. Concurrently, PMPY utilization also increased for PDPs (4.7%), primarily from a 6.0% increase in utilization of generic medications. Brand utilization fell 3.8%.

EGWP

Unit costs for generic medications changed minimally by 0.6%, but brand medication costs jumped by 25.8% for EGWPs. Although utilization of brand medications decreased by 10.3%, most of the utilization for EGWPs was from generics, increasing overall PMPY utilization by 1.5%.

COMPONENTS OF MAPD TREND BY BRAND GENERIC CLASSIFICATION

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Brand	$1,463.46	-6.3%	16.4%	**10.1%**
Generic	$636.87	2.2%	-11.1%	**-9.0%**
TOTAL OVERALL	**$2,100.33**	**1.1%**	**2.5%**	**3.5%**

January-December 2015 compared to same period in 2014

COMPONENTS OF PDP TREND BY BRAND GENERIC CLASSIFICATION

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Brand	$2,515.59	-3.8%	25.9%	**22.1%**
Generic	$862.45	6.0%	-0.1%	**5.9%**
TOTAL OVERALL	**$3,378.04**	**4.7%**	**12.9%**	**17.5%**

January-December 2015 compared to same period in 2014

COMPONENTS OF EGWP TREND BY BRAND GENERIC CLASSIFICATION

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
	$2,490.49	-10.3%	25.8%	**15.5%**
Generic	$887.76	4.4%	0.6%	
TOTAL OVERALL	**$3,378.25**	**1.5%**	**11.1%**	**12.6%**

January-December 2015 compared to same period in 2014

Trend by plan type and low-income subsidy classification

Focusing on quality ratings for Medicare plans, CMS has taken significant steps to better understand the impact of dual-eligible members (Medicare-Medicaid Plans [MMP]) and Low-Income Cost-Sharing Subsidy (LICS) members on Star Ratings. Acknowledging that MMP and LICS status of beneficiaries impacts quality ratings, CMS is working to devise an appropriate adjustment to Star Ratings for these members.

In light of CMS findings, this year's report breaks down plan type trend by the LICS status of beneficiaries. The differences between LICS and non-LICS members utilization and unit cost trends for traditional drugs varied between each plan type. However, the utilization trend was significantly lower (4.5%) for LICS members compared with non-LICS members (14.1%), and unit cost trend was higher for LICS members (18.5%) compared with non-LICS members (16.0%) for specialty medications. The overall trend of lower utilization and higher unit cost for LICS members when compared with non-LICS members can be seen in MAPD and PDP plan types, and EGWPs showed lower utilization trend and unit cost trend in the LICS population. This trend analysis confirms that disparities existing between LICS and non-LICS members are not always consistent based on plan type. Express Scripts continues to closely monitor and track the impact of low-income status on trend and quality measures.

COMPONENTS OF MEDICARE TREND BY PLAN TYPE AND LOW-INCOME SUBSIDY CLASSIFICATION

2015

	OVERALL MEDICARE		MAPD		PDP		EGWP	
	LICS	NON-LICS	LICS	NON-LICS	LICS	NON-LICS	LICS	NON-LICS
TRADITIONAL								
Utilization	2.3%	2.1%	0.8%	0.5%	2.8%	4.5%	0.3%	1.4%
Unit cost	1.5%	3.0%	-0.8%	-7.7%	4.4%	-1.2%	1.8%	6.6%
TOTAL	3.8%	5.1%	-0.1%	-7.2%	7.2%	3.3%	2.1%	8.1%
SPECIALTY								
Utilization	4.5%	14.1%	5.0%	10.8%	6.9%	19.9%	7.9%	11.5%
Unit cost	18.5%	16.0%	14.9%	13.8%	20.5%	19.7%	4.7%	15.9%
TOTAL	23.0%	30.1%	19.9%	24.6%	27.3%	39.6%	12.6%	27.4%

January-December 2015 compared to same period in 2014

Traditional therapy classes and insights: Medicare

Total traditional trend for Medicare plans in 2015 was 4.8%, the result of small increases in both unit costs (2.6%) and PMPY utilization (2.2%). Together, spend for the top three Medicare traditional therapy classes when ranked by PMPY spend contributed 32.1% of the total for all traditional medications used by Medicare beneficiaries in 2015. Total trend was negative in three of the top 10 traditional therapy classes, with the sharpest decline for medications used to treat high blood pressure/heart disease.

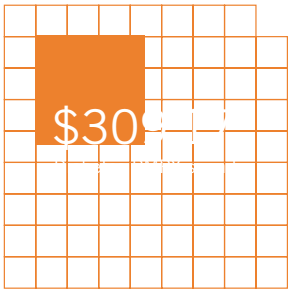
Spend for the **top three** Medicare traditional therapy classes when ranked by PMPY contributed **32.1%** of total Medicare traditional spend.

COMPONENTS OF TREND FOR THE TOP 10 OVERALL MEDICARE TRADITIONAL THERAPY CLASSES

RANKED BY 2015 OVERALL MEDICARE PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Diabetes	$309.17	4.5%	15.0%	**19.5%**
2	Pain/inflammation	$183.48	-0.4%	-0.7%	**-1.2%**
3	Mental/neurological disorders	$157.14	1.4%	-0.9%	**0.5%**
4	High blood cholesterol	$154.94	2.3%	-10.3%	**-8.0%**
5	High blood pressure/heart disease	$141.79	1.2%	-16.9%	**-15.7%**
6	Asthma	$110.76	7.1%	-5.3%	**1.8%**
7	Heartburn/ulcer disease	$90.67	2.7%	24.4%	**27.2%**
8	Anticoagulants	$72.65	4.6%	40.3%	**44.8%**
9	Urinary disorders	$64.84	5.2%	1.0%	**6.3%**
10	Chronic obstructive pulmonary disease	$52.39	2.1%	6.8%	**9.0%**
	TOTAL TRADITIONAL	**$2,025.67**	**2.2%**	**2.6%**	**4.8%**

Highlights



- Diabetes saw a higher PMPY spend ($309.17) than any other traditional therapy class among Medicare beneficiaries. Trend for diabetes medications was 19.5%, driven by an increase in utilization (4.5%) and an even greater increase in unit cost (15.0%). Highly utilized oral medications, including metformin, glipizide, glimepiride, and Januvia® (sitagliptin), are driving the utilization increase. Insulins, such as Lantus® (insulin glargine) and some commonly used diabetes-testing supplies, such as pen needles and OneTouch® Delica® lancets, had unit cost increases.

- Total PMPY spend for medications used to treat pain/inflammation decreased 1.2%, due to slight decreases in both unit costs (-0.7%) and utilization (-0.4%). PMPY spend declined (compared to 9.1% increase in 2014) in accordance with availability of generic medications that continue to dominate this class. Together, the five most commonly used pain/inflammation drugs captured 57.8% of market share for this therapy class.

- Unit costs for medications used to treat high blood pressure/heart disease decreased 16.9%, resulting in the largest drop (-15.7%) in PMPY spend among the top 10 traditional therapy classes. Even with an increase in utilization, total trends were negative for both high blood pressure/heart disease medications and high blood cholesterol medications in 2015. Declines in unit costs can be attributed to the availability of generics in these classes, and increase in utilization may reflect greater adherence to medications by beneficiaries. In addition, the GFRs for the high blood pressure/heart disease and high blood cholesterol classes increased to 97.4% and 85.5%, respectively, in 2015.

- The 40.3% increase in unit cost for traditional anticoagulant medications was primarily driven by unit cost increases for the newer oral products Xarelto® (rivaroxaban) and Eliquis® (apixaban). Both drugs also experienced significant increases in utilization, likely as a result of patients switching from less-convenient warfarin and specialty injectable anticoagulants. The overall trend for the class was 44.8%.

Unit costs for medications used to treat high blood pressure/heart disease decreased **16.9%**, resulting in the largest fall **(-15.7%)** in PMPY spend.

Top traditional classes by Medicare plan type

When analyzing therapy class details by Medicare plan types, the top 10 traditional therapy classes by PMPY spend in MAPD, PDP and EGWP plan types mostly remained the same as overall Medicare classes. However, the ranking by PMPY spend within the top 10 classes varied.

MAPD

The only plan type to see a negative traditional trend was MAPD (-3.2%). Among MAPD plans, trend for seven of the top 10 traditional classes was negative in 2015, mostly due to decreased unit costs. With the exception of chronic obstructive pulmonary disease (COPD), which was almost flat (-0.3%), all other classes among the top 10 saw a slight to moderate increase in utilization. Asthma had the highest utilization increase at 6.2%.

MAPD was the only plan type to see negative traditional trend **(-3.2%)**.

COMPONENTS OF TREND FOR THE TOP 10 MAPD TRADITIONAL THERAPY CLASSES

RANKED BY 2015 MAPD PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Diabetes	$258.62	2.3%	4.6%	**6.9%**
2	Pain/inflammation	$136.74	0.8%	-5.2%	**-4.4%**
3	High blood pressure/heart disease	$108.00	0.4%	-20.8%	**-20.4%**
4	High blood cholesterol	$104.04	0.5%	-18.7%	**-18.1%**
5	Mental/neurological disorders	$103.47	0.7%	-1.4%	**-0.8%**
6	Asthma	$97.66	6.2%	-9.1%	**-2.9%**
7	Anticoagulants	$57.57	2.5%	37.2%	**39.6%**
8	Urinary disorders	$50.93	2.5%	-2.9%	**-0.4%**
9	Chronic obstructive pulmonary disease	$48.57	-0.3%	7.0%	**6.8%**
10	Heartburn/ulcer disease	$43.95	2.0%	-7.4%	**-5.3%**
	TOTAL TRADITIONAL	**$1,479.10**	**1.0%**	**-4.3%**	**-3.2%**

PDP

Medicare traditional drug spend increased 9.8%, to $2,236.77, for PDP plans, driven by a 5.2% increase in unit costs and a 4.6% increase in utilization. Five of the top 10 traditional therapy classes saw double-digit increases in trend. The top five classes alone accounted for nearly 50% of the total PMPY spend for traditional classes. Compared to overall Medicare, the seizures class replaced urinary disorders in the top 10 by PMPY spend among PDP plans. PMPY spend for seizures increased 20.6%, driven by substantial increases in both unit costs (11.5%) and utilization (9.0%).

Five of the top 10 traditional therapy classes saw **double-digit increases** in trend.

COMPONENTS OF TREND FOR THE TOP 10 PDP TRADITIONAL THERAPY CLASSES

RANKED BY 2015 PDP PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Diabetes	$322.88	7.5%	21.3%	**28.8%**
2	Mental/neurological disorders	$255.37	9.0%	3.0%	**12.0%**
3	Pain/inflammation	$234.13	2.0%	5.8%	**7.8%**
4	High blood cholesterol	$149.22	3.8%	-4.1%	**-0.3%**
5	High blood pressure/heart disease	$144.57	2.2%	-10.0%	**-7.8%**
6	Asthma	$124.60	10.6%	-2.5%	**8.1%**
7	Heartburn/ulcer disease	$84.88	4.8%	-3.3%	**1.5%**
8	Anticoagulants	$63.20	5.9%	42.8%	**48.6%**
9	Chronic obstructive pulmonary disease	$58.56	8.5%	9.8%	**18.3%**
10	Seizures	$56.54	9.0%	11.5%	**20.6%**
	TOTAL TRADITIONAL	**$2,236.77**	**4.6%**	**5.2%**	**9.8%**

EGWP

In 2015, EGWP plans had the highest PMPY spend ($2,452.31) for traditional drugs among the three Medicare plan types. The trend for EGWPs (7.9%) resulted mainly from a 6.5% increase in unit costs. Remarkably, compounded drugs replaced chronic obstructive pulmonary disease in the top 10 classes for EGWPs. Trend for compound drugs increased by 78.1% due to increase in unit cost trend (77.8%). In 2015, Express Scripts made additional compound drug coverage options available to plans. Another class of medications that saw a significant increase in EGWP trend compared to other plan types is heartburn/ulcer disease (84.2%). While at 2.4% PMPY utilization increased very little, unit costs of these medications increased dramatically (81.8%).

Compounded drugs replaced chronic obstructive pulmonary disease in the top 10 classes for EGWPs.

COMPONENTS OF TREND FOR THE TOP 10 EGWP TRADITIONAL THERAPY CLASSES

RANKED BY 2015 EGWP PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Diabetes	$355.30	2.3%	20.1%	**22.4%**
2	High blood cholesterol	$223.74	1.2%	-9.8%	**-8.6%**
3	Pain/inflammation	$182.62	0.3%	-5.5%	**-5.2%**
4	High blood pressure/heart disease	$179.93	0.9%	-20.3%	**-19.4%**
5	Heartburn/ulcer disease	$154.42	2.4%	81.8%	**84.2%**
6	Asthma	$110.93	6.2%	-4.9%	**1.3%**
7	Mental/neurological disorders	$110.25	-0.7%	-5.6%	**-6.2%**
8	Anticoagulants	$101.90	4.6%	37.4%	**42.0%**
9	Urinary disorders	$94.10	3.1%	8.4%	**11.6%**
10	Compounded drugs	$88.01	0.3%	77.8%	**78.1%**
	TOTAL TRADITIONAL	**$2,452.31**	**1.4%**	**6.5%**	**7.9%**

Top 10 Medicare traditional drugs

Together, the nine brand drugs in the top 10 accounted for 18.5% of PMPY spend for all of Medicare's traditional therapy drugs. Esomeprazole magnesium, the generic formulation of the brand Nexium® (esomeprazole magnesium), was approved by the FDA in January 2015 and brought to market in mid-February. It was the only generic medication to rank in the top 10 overall Medicare traditional therapy drugs.

Three diabetes treatments – Lantus, Januvia and Levemir® FlexTouch® (insulin detemir) – were among the 10 most-expensive traditional therapies for Medicare beneficiaries when ranked by PMPY spend. All three medications had double-digit increases in PMPY spend, and together they captured 6.9% of PMPY spend for all traditional therapy drugs used by Medicare beneficiaries in 2015.

The highest trend for a brand medication in the top 10 was for the oral anticoagulant Xarelto (40.4%). Its trend was driven largely by a 26.5% increase in PMPY utilization, likely as a result of patients switching from less-convenient traditional oral and specialty injectable anticoagulants.

The only top 10 brand drug that decreased in unit cost trend (-5.5%) was Advair Diskus® (fluticasone/salmeterol), a dry-powder inhaler for asthma and COPD. Utilization of Advair Diskus increased 10.2%, possibly due to its decrease in cost. Utilization declined significantly for some of the top 10 brands. Lantus, a diabetes medication, was down by 0.7%; Crestor® (rosuvastatin), a high blood cholesterol treatment, by 2.0%; and Namenda XR® (memantine extended release), a treatment for dementia and Alzheimer's disease, by 21.3%.

TOP 10 OVERALL MEDICARE TRADITIONAL THERAPY DRUGS

RANKED BY 2015 OVERALL MEDICARE PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL TRADITIONAL SPEND	UTILIZATION	UNIT COST	TOTAL
1	Lantus® (insulin glargine)	Diabetes	$73.50	3.6%	-0.7%	11.2%	**10.5%**
2	Spiriva® (tiotropium)	Chronic obstructive pulmonary disease	$45.92	2.3%	2.9%	6.0%	**8.8%**
3	Advair Diskus® (fluticasone/salmeterol)	Asthma	$44.50	2.2%	10.2%	-5.5%	**4.7%**
4	Crestor® (rosuvastatin)	High blood cholesterol	$41.93	2.1%	-2.0%	11.2%	**9.3%**
5	esomeprazole magnesium	Heartburn/ulcer disease	$38.90	1.9%	–	–	–
6	Januvia® (sitagliptin)	Diabetes	$37.16	1.8%	16.6%	9.1%	**25.7%**
7	Xarelto® (rivaroxaban)	Anticoagulants	$35.34	1.7%	26.5%	13.9%	**40.4%**
8	Lyrica® (pregabalin)	Pain/inflammation	$34.25	1.7%	5.0%	22.1%	**27.1%**
9	Namenda® extended release (memantine)	Mental/neurological disorders	$32.80	1.6%	-21.3%	5.7%	**-15.6%**
10	Levemir® FlexTouch® (insulin detemir)	Diabetes	$28.98	1.4%	16.3%	16.9%	**33.2%**

Top 10 traditional drugs by Medicare plan type

MAPD

By PMPY spend, three of the top 10 drugs for MAPD plans were for diabetes. PMPY utilization for the top insulin, Lantus, decreased 13.5% in 2015. After another pre-filled insulin pen, Levemir FlexTouch, was approved in late 2013, it rose to sixth place for MAPD drug spend, with a 51.8% utilization increase in 2015. Currently, no generic insulin pens are available. Another medication that made the top 10 for MAPD was OneTouch Ultra® Test Strips, a diagnostic aid. A significant decrease in unit cost (16.6%) was partially offset by an increase in utilization (7.8%), resulting in a MAPD trend of -8.9% for OneTouch Ultra Test Strips.

Three of the top 10 drugs for MAPD plans were for **diabetes**.

TOP 10 MAPD TRADITIONAL THERAPY DRUGS

RANKED BY 2015 MAPD PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL TRADITIONAL SPEND	UTILIZATION	UNIT COST	TOTAL
1	Lantus® (insulin glargine)	Diabetes	$68.95	4.7%	-13.5%	11.2%	**-2.3%**
2	Spiriva® (tiotropium)	Chronic obstructive pulmonary disease	$43.24	2.9%	0.2%	6.7%	**6.9%**
3	Advair Diskus® (fluticasone/salmeterol)	Asthma	$39.61	2.7%	-1.4%	-3.8%	**-5.2%**
4	Xarelto® (rivaroxaban)	Anticoagulants	$30.24	2.0%	25.6%	13.8%	**39.4%**
5	Januvia® (sitagliptin)	Diabetes	$30.15	2.0%	7.6%	8.5%	**16.2%**
6	Levemir® FlexTouch® (insulin detemir)	Diabetes	$27.30	1.8%	51.8%	4.1%	**55.8%**
7	Namenda® extended release (memantine)	Mental/neurological disorders	$23.93	1.6%	-23.1%	5.3%	**-17.8%**
8	Crestor® (rosuvastatin)	High blood cholesterol	$22.77	1.5%	-5.0%	13.5%	**8.5%**
9	OneTouch Ultra® Test Strips	Diagnostic aid	$22.39	1.5%	7.8%	-16.6%	**-8.9%**
10	Lyrica® (pregabalin)	Pain/inflammation	$21.40	1.4%	2.3%	23.2%	**25.4%**

PDP

Among PDP plans, brand Nexium remained in the top 10 by spend rankings even though its generic, esomeprazole magnesium, was launched in February 2015. However, as a result of generic availability, PMPY utilization for Nexium decreased 54.1%. Its unit cost rise of 29.2% resulted in a total PDP trend of -24.9% for Nexium. Another new drug in the top 10 was Renvela® (sevelamer carbonate), used to treat kidney patients receiving dialysis. For 2015, Renvela captured 56.8% market share in its class among PDPs. With increases in both PMPY utilization (39.9%) and unit cost (40.7%), total trend for Renvela was 80.5%.

Brand **Nexium remained in the top 10** by spend rankings even though its generic was launched in February 2015.

TOP 10 PDP TRADITIONAL THERAPY DRUGS

RANKED BY 2015 PDP PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL TRADITIONAL SPEND	UTILIZATION	UNIT COST	TOTAL
1	Lantus® (insulin glargine)	Diabetes	$81.36	3.6%	10.5%	16.2%	**26.7%**
2	Spiriva® (tiotropium)	Chronic obstructive pulmonary disease	$50.58	2.3%	8.9%	10.0%	**18.9%**
3	Crestor® (rosuvastatin)	High blood cholesterol	$49.71	2.2%	-4.2%	18.8%	**14.6%**
4	Advair Diskus® (fluticasone/salmeterol)	Asthma	$48.58	2.2%	40.8%	-19.8%	**20.9%**
5	Abilify® (aripiprazole)	Mental/neurological disorders	$41.56	1.9%	-51.8%	8.1%	**-43.6%**
6	Lyrica® (pregabalin)	Pain/inflammation	$41.34	1.8%	14.5%	23.1%	**37.6%**
7	Namenda® extended release (memantine)	Mental/neurological disorders	$39.03	1.7%	-15.9%	9.7%	**-6.2%**
8	Nexium® (esomeprazole magnesium)	Heartburn/ulcer disease	$38.11	1.7%	-54.1%	29.2%	**-24.9%**
9	Januvia® (sitagliptin)	Diabetes	$37.95	1.7%	38.0%	3.0%	**41.0%**
10	Renvela® (sevelamer)	Kidney disease	$36.31	1.6%	39.9%	40.7%	**80.5%**

EGWP

In 2015, EGWP plans had the highest PMPY spend ($2,452.31) for traditional drugs among the three Medicare plan types. The top 10 medications accounted for 21.4% of the total traditional spend for EGWPs. At $96.19, esomeprazole magnesium, the generic for Nexium, ranked number one by PMPY spend for EGWPs. Higher PMPY for esomeprazole in EGWP could be driven by multiple factors, such as composition of plan design, beneficiaries, formulary decisions and negotiated discounts. Unit cost increased for all of the top 10 medications. The only two top 10 medications that decreased in total PMPY spend for EGWPs were Advair Diskus and Namenda extended release, both due primarily to decreases in utilization.

The **top 10** medications accounted for **21.4%** of the total traditional spend for EGWPs.

TOP 10 EGWP TRADITIONAL THERAPY DRUGS

RANKED BY 2015 EGWP PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL TRADITIONAL SPEND	UTILIZATION	UNIT COST	TOTAL
1	esomeprazole magnesium	Heartburn/ulcer disease	$96.19	3.9%	–	–	–
2	Lantus® (insulin glargine)	Diabetes	$70.07	2.9%	1.9%	6.1%	**8.0%**
3	Crestor® (rosuvastatin)	High blood cholesterol	$56.47	2.3%	2.4%	5.6%	**8.1%**
4	Advair Diskus® (fluticasone/salmeterol)	Asthma	$45.81	1.9%	-5.8%	3.8%	**-2.0%**
5	Xarelto® (rivaroxaban)*	Anticoagulants	$44.86	1.8%	17.6%	13.9%	**31.5%**
6	Januvia® (sitagliptin)	Diabetes	$44.83	1.8%	5.7%	13.2%	**18.9%**
7	Spiriva® (tiotropium)	Chronic obstructive pulmonary disease	$43.86	1.8%	-1.0%	1.1%	**0.0%**
8	Zetia® (ezetimibe)	High blood cholesterol	$43.20	1.8%	-0.2%	20.5%	**20.2%**
9	Lyrica® (pregabalin)	Pain/inflammation	$41.84	1.7%	0.1%	21.3%	**21.4%**
10	Namenda® extended release (memantine)	Mental/neurological disorders	$36.53	1.5%	-23.8%	2.0%	**-21.9%**

Specialty therapy classes and insights: Medicare

PMPY spend on specialty medications for Medicare beneficiaries increased 27.9% in 2015, driven by a 17.2% increase in unit costs and 10.7% increase in PMPY utilization. Ranked by PMPY spend, the top three therapy classes – oncology, hepatitis C and multiple sclerosis – together contributed nearly 60% of total specialty PMPY spend. Each of these therapy classes had double-digit increases in 2015 PMPY spend. All but three – immune deficiency, osteoporosis and central nervous system CNS/autonomic disorders – had unit cost increases, and only two therapy classes – HIV and blood cell deficiency – had decreases in PMPY utilization. Therapies for immune deficiency, osteoporosis, CNS/autonomic disorder and blood cell deficiency (the seventh, eighth, ninth and 10th specialty classes, respectively, when ranked by PMPY spend) were unique to the top 10 list for Medicare beneficiaries when compared to the commercially insured and Medicaid populations. Primarily, the medications in these four classes are used to treat conditions that more commonly affect older populations. Specialty medications treating rare conditions are sensitive to changes in population composition, which may affect their trend. By far, the key drivers of trend were drugs to treat cancer, hepatitis C and multiple sclerosis.

COMPONENTS OF TREND FOR THE TOP 10 OVERALL MEDICARE SPECIALTY THERAPY CLASSES

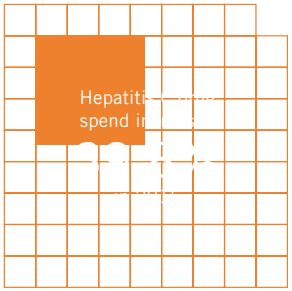
RANKED BY 2015 OVERALL MEDICARE PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Oncology	$275.73	17.1%	14.7%	**31.8%**
2	Hepatitis C	$133.77	12.3%	27.5%	**39.8%**
3	Multiple sclerosis	$119.82	9.5%	10.5%	**20.0%**
4	Inflammatory conditions	$104.11	8.4%	18.0%	**26.3%**
5	HIV	$65.37	-0.5%	11.0%	**10.5%**
6	Pulmonary hypertension	$38.55	14.6%	6.8%	**21.4%**
7	Immune deficiency	$15.66	29.8%	-5.4%	**24.4%**
8	Osteoporosis	$15.33	52.8%	-26.6%	**26.2%**
9	Central nervous system (CNS)/autonomic disorders	$15.25	20.1%	-2.2%	**17.8%**
10	Blood cell deficiency	$14.15	-1.9%	13.1%	**11.1%**
	TOTAL SPECIALTY	**$888.53**	**10.7%**	**17.2%**	**27.9%**

Highlights

- At 31.8%, the increase in PMPY spend for oncology treatments continued to top that of other specialty medications in 2015. It was driven almost equally by a 14.7% increase in cost and a 17.1% increase in utilization. The utilization increase likely results from several factors, including the expansion of indications for several drugs; the continued development of newer, more targeted therapies; and an increase in the survival rates of patients living with cancer but continuing medication therapy. Moreover, a CMS proposal suggested that manufacturers are keeping the cost of certain "protected classes of drugs" (PCDs) high because of coverage requirement and, moreover, that plan sponsors are limited in their ability to implement restrictions on patients who currently use these medications.[15] As a result, the status of cancer therapies as PCDs also may be contributing to high unit cost trend for this class.

- Hepatitis C drug spend increased 39.8% in 2015. After the 2014 record 1,000+% increase in hepatitis C spend due to a few new and effective, but expensive, oral antiviral therapies, 2015 trend was much slower; while utilization increased 12.3%, a 27.5% increase in unit cost drove most of the change in spend. Viekira Pak® (ombitasvir/paritaprevir/ritonavir with dasabuvir) and Harvoni® (ledipasvir/sofosbuvir), two of the therapies approved at the end of 2014, together captured over 67% of market share for this therapy class, while Sovaldi® (sofosbuvir) accounted for an additional 11.9%.



- Total trend for multiple sclerosis medications was 20.0%, due to increases in both PMPY utilization and unit cost. More than one in four multiple sclerosis patients is covered by Medicare.[16] In addition, two of the most expensive and highly utilized drugs in the class – Tecfidera® (dimethyl fumarate), released in April 2013, and Aubagio® (teriflunomide), released in September 2012 – are oral medications. Their convenience, compared to the mainstay injectables, is appealing. Glatopa™, a generic alternative for the 20mg/mL strength of Copaxone® (glatiramer), was launched in the United States in June 2015. However, the brand manufacturer is hoping to continue the shift of existing Copaxone users to a new, longer-acting formulation that has patent protection until 2030.

- Spend for inflammatory conditions increased 26.3%. PMPY utilization increased substantially (8.4%), but the main driving factor for the increased trend was the 18.0% increase in unit cost. One of the key treatments in this class is Xeljanz® (tofacitinib), the most recent oral disease-modifying anti-rheumatic drug approved. At the time of U.S. Food and Drug Administration (FDA) approval in 2012, its place in therapy was unclear due to questions concerning its safety profile. Now that longer-term safety and effectiveness data is available, Xeljanz has begun to capture Medicare market share (nearly 5% in 2015) from some more-established injectable treatments in the same class.

- Trend for medications used to treat blood cell deficiencies, a potential temporary result of taking powerful chemotherapy agents, increased 11.1% in 2015, the unit-cost trend dampened somewhat by a 1.9% decrease in utilization.

Top specialty classes by Medicare plan type

The top 10 specialty therapy classes by PMPY spend in MAPD, PDP and EGWP plan types mostly remained the same, as with overall Medicare classes. However, rankings by PMPY spend within the top 10 classes varied.

MAPD

Among all three plan types, MAPD plans had the least overall PMPY trend increase (24.3%). Idiopathic pulmonary fibrosis and anticoagulants replaced immune deficiency and osteoporosis in the top 10 rankings compared to overall Medicare rankings. Anticoagulants were the only specialty class to see a decrease in unit cost, resulting in a total trend of -20.1%. This could be a result of the availability of traditional medications to treat the same condition. With the exception of blood cell deficiency and CNS/autonomic disorders, all other classes among the top 10 saw small-to-significant utilization increases, with hepatitis C having the highest at 15.8%.

MAPD plans had the least overall PMPY specialty trend increase (**24.3%**) among all three plan types.

COMPONENTS OF TREND FOR THE TOP 10 MAPD SPECIALTY THERAPY CLASSES

RANKED BY 2015 MAPD PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Oncology	$199.82	15.5%	14.6%	**30.1%**
2	Hepatitis C	$102.59	15.8%	16.0%	**31.7%**
3	Multiple sclerosis	$98.70	10.4%	9.5%	**19.9%**
4	Inflammatory conditions	$59.81	1.8%	16.1%	**17.9%**
5	HIV	$33.58	2.5%	12.5%	**15.0%**
6	Pulmonary hypertension	$26.94	9.6%	3.0%	**12.7%**
7	Idiopathic pulmonary fibrosis	$11.37	–	–	–
8	Anticoagulants	$10.00	0.1%	-20.2%	**-20.1%**
9	Blood cell deficiency	$9.40	-5.5%	8.8%	**3.3%**
10	Central nervous system (CNS)/autonomic disorders	$8.41	-0.3%	5.6%	**5.3%**
	TOTAL SPECIALTY	**$621.22**	**9.9%**	**14.3%**	**24.3%**

PDP

Medicare specialty drug spend increased 36.3%, to $1,141.27, for PDP plans due to increases in both utilization (15.6%) and unit cost (20.7%). All of the top 10 specialty therapy classes showed double-digit increases in trend. The top four classes accounted for 71.0% of the total PMPY spend for specialty classes.

All of the top 10 specialty therapy classes showed **double-digit increases** in trend.

COMPONENTS OF TREND FOR THE TOP 10 PDP SPECIALTY THERAPY CLASSES

RANKED BY 2015 PDP PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Oncology	$300.12	23.8%	14.4%	**38.2%**
2	Hepatitis C	$214.01	18.8%	38.2%	**57.0%**
3	Multiple sclerosis	$161.73	15.1%	11.9%	**27.0%**
4	HIV	$134.90	9.2%	11.8%	**21.0%**
5	Inflammatory conditions	$95.50	10.7%	17.2%	**27.9%**
6	Pulmonary hypertension	$46.27	28.3%	4.0%	**32.3%**
7	Central nervous system (CNS)/autonomic disorders	$25.44	28.6%	-3.0%	**25.6%**
8	Immune deficiency	$20.75	29.1%	-5.7%	**23.4%**
9	Idiopathic pulmonary fibrosis	$13.77	–	–	–
10	Blood cell deficiency	$13.41	5.5%	12.2%	**17.7%**
	TOTAL SPECIALTY	**$1,141.27**	**15.6%**	**20.7%**	**36.3%**

EGWP

In 2015, the PMPY specialty spend for EGWP plans was $925.94. The trend for EGWPs (27.2%) resulted mostly from a 15.7% increase in unit cost. Two of the top 10 specialty classes – osteoporosis and immune deficiency – saw unit cost decreases of 19.0% and 1.3% respectively. Even with a 19.0% decrease in unit cost, spend for osteoporosis still increased 23.2%, driven by a drastic 42.2% rise in PMPY utilization. Blood cell deficiency was the only class that decreased in utilization (-6.9%).

The trend for EGWPs resulted mostly from a **15.7% increase** in unit cost.

COMPONENTS OF TREND FOR THE TOP 10 EGWP SPECIALTY THERAPY CLASSES

RANKED BY 2015 EGWP PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Oncology	$340.62	12.8%	15.8%	**28.6%**
2	Inflammatory conditions	$168.16	8.3%	19.4%	**27.7%**
3	Multiple sclerosis	$97.65	8.0%	10.9%	**19.0%**
4	Hepatitis C	$79.97	12.2%	22.2%	**34.4%**
5	Pulmonary hypertension	$43.92	6.8%	12.8%	**19.7%**
6	Osteoporosis	$26.29	42.2%	-19.0%	**23.2%**
7	HIV	$24.60	4.2%	12.4%	**16.6%**
8	Blood cell deficiency	$20.81	-6.9%	16.3%	**9.5%**
9	Immune deficiency	$18.72	44.5%	-1.3%	**43.2%**
10	Idiopathic pulmonary fibrosis	$17.47	–	–	–
	TOTAL SPECIALTY	**$925.94**	**11.4%**	**15.7%**	**27.2%**

Top 10 Medicare specialty drugs

The top 10 specialty drugs accounted for 43.3% of PMPY spend for all Medicare specialty drugs in 2015. They represented only four therapy classes – four drugs for treating cancer, two for hepatitis C, two for inflammatory conditions and two for multiple sclerosis. Together, the four oncology medications in the top 10 contributed 15.9% of Medicare specialty drug spend: Revlimid® (lenalidomide), Gleevec® (imatinib), Xtandi® (enzalutamide) and Zytiga® (abiraterone). PMPY spend among the top 10 drugs ranged from a low of $18.45 for Sovaldi to a high of $99.99 for Harvoni. Sovaldi was the only specialty drug in the top 10 that decreased in PMPY utilization (-64.7%), unit cost (-4.0%) and PMPY spend (-68.8%) in 2015. After its launch in late 2014, Harvoni alone contributed 11.3% of all Medicare specialty drug spend in 2015. Aside from the hepatitis C medications, the largest increases in utilization (62.8%) and total spend (72.5%) were observed for Xtandi, an oral hormone modifier for prostate cancer. The incidence of prostate cancer rises substantially with age.[17]

The **top 10** drugs represented only **four therapy classes** – cancer, hepatitis C, inflammatory conditions and multiple sclerosis.

TOP 10 OVERALL MEDICARE SPECIALTY THERAPY DRUGS

RANKED BY 2015 OVERALL MEDICARE PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL SPECIALTY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Harvoni® (ledipasvir/sofosbuvir)	Hepatitis C	$99.99	11.3%	641.0%	-114.4%	**526.6%**
2	Revlimid® (lenalidomide)	Oncology	$58.72	6.6%	10.0%	9.2%	**19.2%**
3	Gleevec® (imatinib)	Oncology	$37.84	4.3%	6.0%	20.4%	**26.4%**
4	Enbrel® (etanercept)	Inflammatory conditions	$36.99	4.2%	-5.1%	24.2%	**19.1%**
5	Copaxone® (glatiramer)	Multiple sclerosis	$36.11	4.1%	-4.4%	10.8%	**6.4%**
6	Humira® Pen (adalimumab)	Inflammatory conditions	$28.75	3.2%	9.7%	17.0%	**26.7%**
7	Xtandi® (enzalutamide)	Oncology	$23.07	2.6%	62.8%	9.7%	**72.5%**
8	Tecfidera® (dimethyl fumarate)	Multiple sclerosis	$22.92	2.6%	27.5%	11.6%	**39.2%**
9	Zytiga® (abiraterone)	Oncology	$21.60	2.4%	-7.4%	8.9%	**1.5%**
10	Sovaldi® (sofosbuvir)	Hepatitis C	$18.45	2.1%	-64.7%	-4.0%	**-68.8%**

Top 10 specialty drugs by Medicare plan type

MAPD

The top 10 drugs for MAPD plans were the same as those for Medicare overall. A decrease in utilization (-59.8%) and unit cost (-5.6%) for Sovaldi resulted in the only negative trend (-65.5%) for a specialty medication in the top drugs for MAPD. Utilization of prostate cancer medications is higher in MAPD beneficiaries, as observed from the high utilization trend for Xtandi (83.9%). Harvoni was the only drug among the top 10 to have a triple-digit trend increase (508.4%), because it entered the market in the last quarter of 2014.

A **decrease in utilization** and **unit cost** for Sovaldi resulted in the **only negative trend** for specialty medication in the top drugs for MAPD.

TOP 10 MAPD SPECIALTY THERAPY DRUGS

RANKED BY 2015 MAPD PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL SPECIALTY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Harvoni® (ledipasvir/sofosbuvir)	Hepatitis C	$78.79	12.7%	703.2%	-194.8%	**508.4%**
2	Revlimid® (lenalidomide)	Oncology	$39.19	6.3%	5.5%	9.2%	**14.8%**
3	Gleevec® (imatinib)	Oncology	$28.36	4.6%	7.1%	22.6%	**29.6%**
4	Copaxone® (glatiramer)	Multiple sclerosis	$27.14	4.4%	1.3%	8.7%	**10.0%**
5	Enbrel® (etanercept)	Inflammatory conditions	$20.28	3.3%	-8.8%	20.7%	**11.9%**
6	Tecfidera® (dimethyl fumarate)	Multiple sclerosis	$20.18	3.2%	25.1%	11.0%	**36.1%**
7	Humira® Pen (adalimumab)	Inflammatory conditions	$18.31	2.9%	10.1%	15.6%	**25.7%**
8	Xtandi® (enzalutamide)	Oncology	$17.88	2.9%	83.9%	11.5%	**95.4%**
9	Zytiga® (abiraterone)	Oncology	$16.64	2.7%	-7.1%	9.7%	**2.6%**
10	Sovaldi® (sofosbuvir)	Hepatitis C	$16.47	2.7%	-59.8%	-5.6%	**-65.5%**

PDP

Among PDPs, H.P.Acthar® (repository corticotropin) replaced Zytiga in the top 10 rankings by PMPY spend. H.P.Acthar decreased in unit costs by 3.0%. However, due to a 28.6% increase in PMPY utilization, it had a 25.6% total trend. Similar to MAPD plans, with the exception of Harvoni, Xtandi had the highest increase in PMPY utilization (64.9%) for PDPs. The next highest increase in utilization was for Tecfidera – an oral multiple sclerosis medication. Going forward, Tecfidera is expected to continue taking market share from older injectable medications.

With the exception of Harvoni, Xtandi had the **highest increase** in PMPY utilization (**64.9%**) for PDPs.

TOP 10 PDP SPECIALTY THERAPY DRUGS

RANKED BY 2015 PDP PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL SPECIALTY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Harvoni® (ledipasvir/sofosbuvir)	Hepatitis C	$160.89	14.1%	765.7%	-117.5%	**648.3%**
2	Revlimid® (lenalidomide)	Oncology	$66.62	5.8%	17.0%	8.2%	**25.2%**
3	Copaxone® (glatiramer)	Multiple sclerosis	$50.91	4.5%	-2.6%	12.2%	**9.6%**
4	Gleevec® (imatinib)	Oncology	$41.14	3.6%	11.5%	21.4%	**32.8%**
5	Enbrel® (etanercept)	Inflammatory conditions	$32.98	2.9%	-7.7%	30.1%	**22.4%**
6	Tecfidera® (dimethyl fumarate)	Multiple sclerosis	$31.91	2.8%	40.5%	12.9%	**53.3%**
7	Sovaldi® (sofosbuvir)	Hepatitis C	$31.06	2.7%	-61.1%	-3.3%	**-64.5%**
8	H.P.Acthar® (repository corticotropin)	Central nervous system (CNS)/ autonomic disorders	$25.44	2.2%	28.6%	-3.0%	**25.6%**
9	Humira® Pen (adalimumab)	Inflammatory conditions	$25.03	2.2%	11.9%	10.5%	**22.4%**
10	Xtandi® (enzalutamide)	Oncology	$23.89	2.1%	64.9%	9.5%	**74.4%**

EGWP

The top 10 medications accounted for 44.8% of the total specialty spend for EGWPs. Imbruvica® (ibrutinib) and Forteo® (teriparatide) replaced Tecfidera and Sovaldi among the top 10 rankings for EGWP. Imbruvica, first approved for mantle cell lymphoma in November 2013, now has indications for chronic lymphocytic leukemia (CLL) and Waldenstrom's macroglobulinemia (a type of lymphoma). As the only FDA-approved Bruton's tyrosine kinase (BTK) inhibitor, Imbruvica's effectiveness with hard-to-treat cancers, oral dosing and relatively mild side effects resulted in a 2015 utilization surge of 98.7% in EGWPs. Although utilization trend was the highest for Imbruvica (with the exception of Harvoni), its unit cost increase (2.0%) was the lowest among the top 10 drugs for EGWPs. At a PMPY spend of $21.78 in 2015, Forteo, an injection used for the treatment of osteoporosis, ranked last among the top 10 drugs for EGWPs.

The top 10 medications accounted for **44.8%** of the total specialty spend for EGWPs.

TOP 10 EGWP SPECIALTY THERAPY DRUGS

RANKED BY 2015 EGWP PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL SPECIALTY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Revlimid® (lenalidomide)	Oncology	$73.55	7.9%	8.7%	10.2%	**18.9%**
2	Enbrel® (etanercept)	Inflammatory conditions	$62.01	6.7%	-3.4%	21.6%	**18.2%**
3	Harvoni® (ledipasvir/sofosbuvir)	Hepatitis C	$56.15	6.1%	386.2%	-7.2%	**379.0%**
4	Humira® Pen (adalimumab)	Inflammatory conditions	$45.80	4.9%	5.9%	22.4%	**28.3%**
5	Gleevec® (imatinib)	Oncology	$45.67	4.9%	1.1%	18.4%	**19.5%**
6	Copaxone® (glatiramer)	Multiple sclerosis	$30.14	3.3%	-1.1%	11.0%	**9.9%**
7	Xtandi® (enzalutamide)	Oncology	$28.49	3.1%	49.2%	9.0%	**58.2%**
8	Zytiga® (abiraterone)	Oncology	$27.95	3.0%	-10.9%	8.0%	**-3.0%**
9	Imbruvica® (ibrutinib)	Oncology	$22.85	2.5%	98.7%	2.0%	**100.6%**
10	Forteo® (teriparatide)	Osteoporosis	$21.78	2.4%	-0.6%	21.6%	**21.0%**

Comparison of Medicare and commercial trend

Comparison of traditional therapy classes

Overall, trend for traditional therapy classes experienced by Medicare clients (4.8%) was higher than trend for commercial clients (0.6%). With the exception of medications used to treat pain/inflammation and asthma, trend for each of the top 10 classes moved in the same direction for both groups of clients. Pain/inflammation trend for Medicare decreased by 1.2%, but increased 2.9% in commercial plans. Asthma trend for Medicare increased by 1.8%, but decreased 1.6% in commercial plans. Medicare trend was moderately lower than the commercial trend for four classes – pain/inflammation, high blood pressure/heart disease, heartburn/ulcer disease and urinary disorders. The biggest differences in trend for the two client groups were seen for anticoagulants (a 44.8% increase for Medicare vs. 36.3% for commercial), heartburn/ulcer disease (27.2% vs. 35.6%) and COPD (9.0% vs. 1.6%).

The magnitude of trend for the diabetes therapy class was greater for Medicare clients than for commercial clients because the prevalence of diabetes is higher in older individuals, and diabetes worsens even with treatment. Because these medications are more highly utilized by older populations, the decline in spend for high blood cholesterol medications was less for Medicare clients than for commercial clients. Conversely, the increase in spend for asthma medications observed among Medicare beneficiaries (as opposed to the decline in spend seen for the commercially insured) likely is related to the utilization of some treatments classified as asthma medications to treat COPD, a condition that usually affects older populations. Interesting to note is that both asthma and COPD are in the top 10 rankings by PMPY spend for Medicare, which indicates a high prevalence of pulmonary diseases among older adults compared to commercially insured populations.

MEDICARE TREND VS. COMMERCIAL TREND FOR THE TOP 10 MEDICARE TRADITIONAL THERAPY CLASSES

RANKED BY 2015 OVERALL MEDICARE PMPY SPEND

		TREND				
RANK	THERAPY CLASS	OVERALL MEDICARE	MAPD	PDP	EGWP	COMMERCIAL
1	Diabetes	19.5%	6.9%	28.8%	22.4%	14.0%
2	Pain/inflammation	-1.2%	-4.4%	7.8%	-5.2%	2.9%
3	Mental/neurological disorders	0.5%	-0.8%	12.0%	-6.2%	0.2%
4	High blood cholesterol	-8.0%	-18.1%	-0.3%	-8.6%	-9.2%
5	High blood pressure/heart disease	-15.7%	-20.4%	-7.8%	-19.4%	-12.5%
6	Asthma	1.8%	-2.9%	8.1%	1.3%	-1.6%
7	Heartburn/ulcer disease	27.2%	-5.3%	1.5%	84.2%	35.6%
8	Anticoagulants	44.8%	39.6%	48.6%	42.0%	36.3%
9	Urinary disorders	6.3%	-0.4%	2.2%	11.6%	9.4%
10	Chronic obstructive pulmonary disease	9.0%	6.8%	18.3%	1.6%	1.6%
	TOTAL TRADITIONAL	**4.8%**	**-3.2%**	**9.8%**	**7.9%**	**0.6%**

Comparison of specialty therapy classes

In general, the trends for specialty therapy classes that were experienced by Medicare clients were consistent with those for commercial clients.

Both Medicare and commercial clients experienced double-digit trend for all of the top 10 specialty classes except for hepatitis C, multiple sclerosis and CNS/autonomic disorders in the commercial population. For all of the top 10 specialty conditions except HIV, the magnitude of trend was higher for Medicare, potentially related to higher prevalence of the conditions those medications treat among older populations.

For **all** of the top 10 specialty conditions except HIV, the magnitude of trend was **higher** for Medicare.

MEDICARE TREND VS. COMMERCIAL TREND FOR THE TOP 10 MEDICARE SPECIALTY THERAPY CLASSES

RANKED BY 2015 OVERALL MEDICARE PMPY SPEND

		TREND				
RANK	THERAPY CLASS	OVERALL MEDICARE	MAPD	PDP	EGWP	COMMERCIAL
1	Oncology	31.8%	30.1%	38.2%	28.6%	23.7%
2	Hepatitis C	39.8%	31.7%	57.0%	34.4%	7.0%
3	Multiple sclerosis	20.0%	19.9%	27.0%	19.0%	9.7%
4	Inflammatory conditions	26.3%	17.9%	27.9%	27.7%	25.0%
5	HIV	10.5%	15.0%	21.0%	16.6%	16.6%
6	Pulmonary hypertension	21.4%	12.7%	32.3%	19.7%	18.1%
7	Immune deficiency	24.4%	16.3%	23.4%	43.2%	24.2%
8	Osteoporosis	26.2%	18.5%	32.4%	23.2%	23.6%
9	Central nervous system (CNS)/autonomic disorders	17.8%	5.3%	25.6%	39.5%	0.9%
10	Blood cell deficiency	11.1%	3.3%	17.7%	9.5%	10.4%
	TOTAL SPECIALTY	**27.9%**	**24.3%**	**36.3%**	**27.2%**	**17.8%**

2016 – 2018 Medicare trend forecast

Trend for Medicare is expected to increase an average of 13.3% over the next three years.

Forecast for key traditional therapy classes

Medicare traditional trend was 4.8% in 2015, after accounting for rebates. The PMPY traditional spend for Medicare overall was $2,025.67 – lower than the traditional spend in 2014 and mainly due to the inclusion of rebates in estimating drug spend in 2015. Traditional drug trend is anticipated to increase by an average of 8.9% over the next three years. Four of the top 10 traditional therapy classes – mental/neurological disorders, high blood cholesterol, high blood pressure/heart disease and heartburn/ulcer disease – are forecast to continue with negative trends all three years, due to declines in unit cost resulting from patent expirations and greater generic dispensing. The largest increases in the next three years are expected in the anticoagulants and diabetes classes. Insulins will continue to drive the diabetes trend in Medicare. However, the availability of biosimilar insulin therapies may mitigate the trend in 2018. The continued shift from warfarin to the newer oral anticoagulant therapies will continue to fuel trends of more than 50% during the next three years.

2016 – 2018 TREND FORECAST

	2016	2017	2018
TOTAL OVERALL	**12.4%**	**13.3%**	**14.3%**

TREND FORECAST FOR KEY TRADITIONAL THERAPY CLASSES

2016 – 2018

	TREND FORECAST		
THERAPY CLASS	**2016**	**2017**	**2018**
Diabetes	16.5%	16.6%	14.4%
Pain/inflammation	6.0%	9.1%	8.1%
Mental/neurological disorders	-3.0%	-5.1%	-2.0%
High blood cholesterol	-9.1%	-10.2%	-11.1%
High blood pressure/heart disease	-3.1%	-7.1%	-5.1%
Asthma	4.0%	6.1%	0.0%
Heartburn/ulcer disease	-6.1%	-4.1%	-3.0%
Anticoagulants	53.7%	51.6%	53.7%
Urinary disorders	6.1%	5.0%	16.6%
COPD	11.2%	11.2%	11.2%
Other traditional classes	10.4%	9.6%	9.6%
TOTAL TRADITIONAL	**7.8%**	**8.7%**	**10.2%**

Forecast for key specialty therapy classes

Medicare specialty drug trend was 27.9% in 2015 and the PMPY spend in Medicare of $888.53 was about $164 higher, compared to specialty drug spend in 2014. Medicare specialty trend is expected to decline over the next three years, although the average trend may still be more than 22%. However, increased adoption, brand inflation and rise in costs of newer therapies may continue to fuel utilization trends as well as total specialty drug spending. It's anticipated that oncology will see the largest trends (more than 30%) due to several factors, including approval of newer targeted therapies as well as expanded indications for existing therapies and increased survival of cancer patients on chemotherapy. The projected launch of the generic imatinib is predicted to have a small impact on trend due to high utilization and brand inflation in this therapy class. Market saturation will lead to stabilization of hepatitis C trend in Medicare over the next three years. Medications used to treat inflammatory conditions are expected to continue to trend in double digits, the result of newer, more convenient oral therapies as well as expanded indications for existing therapies. Similar factors may contribute to large trends in immune deficiency and CNS/autonomic disorders drugs over the next three years.

TREND FORECAST FOR KEY SPECIALTY THERAPY CLASSES

2016 – 2018

	TREND FORECAST*		
THERAPY CLASS	2016	2017	2018
Oncology	33.3%	33.3%	31.0%
Hepatitis C	12.2%	14.2%	10.0%
Multiple sclerosis	16.6%	15.6%	12.9%
Inflammatory conditions	26.5%	26.5%	27.7%
HIV	15.3%	15.3%	16.3%
Pulmonary hypertension	18.8%	7.9%	8.0%
Immune deficiency	26.0%	22.8%	20.8%
Osteoporosis	17.0%	8.0%	-1.0%
Central nervous system (CNS)/ autonomic disorders	17.6%	17.6%	17.6%
Blood cell deficiency	9.9%	4.0%	4.0%
Other specialty classes	21.1%	18.6%	18.6%
TOTAL SPECIALTY	**22.8%**	**22.5%**	**21.5%**

*Trend is forecast only for specialty medications billed through the pharmacy benefit

Solutions

Solutions for Medicare challenges

To address plans' challenges in today's competitive Medicare landscape, Express Scripts offers a range of innovative solutions. Our Medicare formularies, compound management, and star ratings solutions deliver better outcomes and true overall value for our Medicare clients and members.

Express Scripts continues to be at the forefront of addressing challenges facing Medicare health plans.

Formulary solutions

Express Scripts strategic Medicare formulary options allow plans to be at the forefront of offering the most competitive benefit designs in the marketplace. **Express Scripts formularies drive significant savings through formulary coverage, tier placement and utilization management** (with specialty-specific utilization management programs to drive down costs for these expensive drug classes), yielding more than $100 million in savings in 2015.[18]

Compound management

In 2015, all Express Scripts Medicare plans adopted our compound management solution, which includes forecasting analysis and compound coverage options. As a result, compounded drugs dropped out of the top 10 traditional therapy classes by spend. Express Scripts Medicare plans experienced, on average, a decrease of nearly 40% in compound claims year over year (comparing December 2014 to December 2015), with some showing nearly a 50% decrease in compound claims and an 80% decrease in compound spend from 2014 to 2015.[19]

Star Ratings solutions

Constellation

Recognizing the importance of predictive analytics in helping plans project Star Ratings performance, Express Scripts revamped its industry-leading Constellation® ratings advisor tool. The new web-enabled version builds upon the tool's established foundation of providing plans with a customized model that identifies areas where they can boost Star Ratings performance and maximize reimbursements from the CMS. **Using Constellation to analyze and project improvements across all Part C and Part D measures, plans can evaluate which seemingly minor changes can have a major impact on CMS ratings and reimbursements.**

Pay-for-Performance Pharmacy Network

Express Scripts developed one of the first and the largest pharmacy-quality network pay-for-performance programs. Pharmacies in this program achieved higher performance ratings for high-risk medications and diabetes treatment of 60% and 23%, respectively, compared to a national sample of retail pharmacies. This program also achieved statistically significant favorable differences for hypertension and diabetes adherence rates.[20] Offering incentives to pharmacies to be more accountable through a financial risk-and-reward arrangement and involved in Medicare quality can improve member health outcomes and plan Star Ratings. **As new Star Rating measures are introduced, Express Scripts will continue to evolve the quality pay-for-performance pharmacy network program.**

Throughout the year, Express Scripts Medicare experts will report on Medicare trends in greater detail.

Offering **incentives** to pharmacies through a financial risk-and-reward arrangement to be **more accountable** and involved in **Medicare quality** can improve member health outcomes and plan Star Ratings.

Medicaid

Medicaid overview

Medicaid at 50

Enacted in 1965 through Title XIX of the Social Security Act, Medicaid covers 72 million beneficiaries. It's now the largest health insurance program for Americans with limited incomes, including the elderly and the disabled.

Here are some of the most notable changes to the program over the last 50 years:[21]

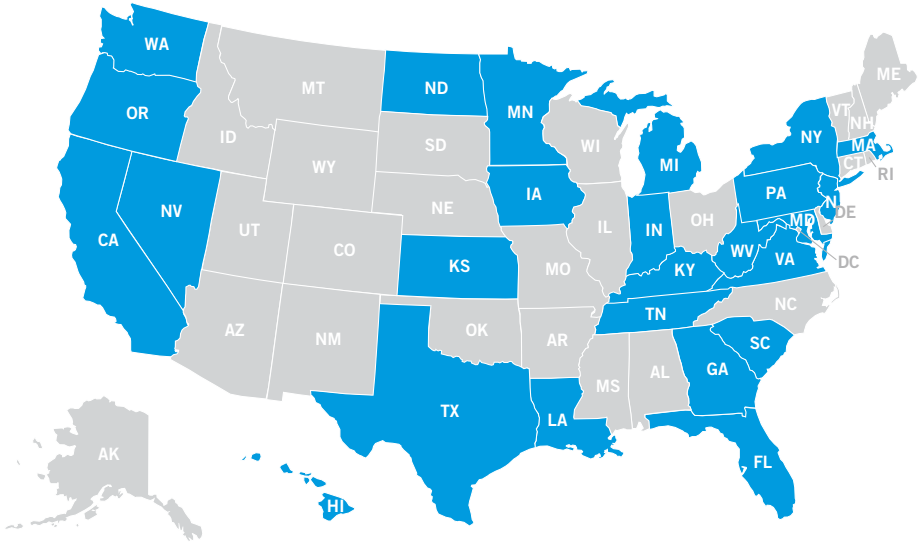
- The Medicaid Drug Rebate Program, implemented in 1991, required drug manufacturers to return part of Medicaid drug spending to the states and the federal government in exchange for having drugs covered under Medicaid. When the rebate program was amended as part of the Patient Protection and Affordable Care Act (ACA) in 2010, federal rebates were extended to managed care claims. Many states were prompted to shift the management of their prescription drug benefit to managed care organizations (MCOs) which were already administering the medical benefit for Medicaid members.
- In 1996, the replacement of Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF) prevented employed Medicaid members from losing their medical benefits.
- The creation of the State Children's Health Insurance Program (CHIP) in 1997 as part of the Balanced Budget Act extended benefits to low-income children who didn't meet their state's Medicaid eligibility criteria. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided states with significant new funding and additional incentives for covering children through Medicaid and CHIP.
- Finally, the expansion of Medicaid eligibility under the ACA has resulted in 15 million new beneficiaries gaining Medicaid coverage since January 2014.

The expansion of Medicaid eligibility has resulted in **15 million new beneficiaries** gaining coverage since January 2014.

Federal legislative proposals

Beyond 2015, Medicaid is poised for numerous potential changes proposed by the Centers for Medicare and Medicaid Services (CMS). Specifically, CMS seeks to align requirements among Medicaid, CHIP, Medicare Advantage and Health Insurance Exchange programs when possible in an attempt to simplify administrative processes. Additionally, CMS has proposed changes to encounter data and formulary reporting, addressed quality ratings and standard performance measures and a minimum medical loss ratio. With more than 800 comments, including those made by Express Scripts, the proposed legislation received an extensive and thorough reaction, with publishing of the final rule delayed until the end of June 2016.

In an effort to improve the 340B program, the Health Resources Services Administration (HRSA) also released new and extensive proposed guidance in August 2015, including proposals to modify the definition of an eligible patient, registration protocols for Covered Entities and the manner in which Covered Entities identify if they will dispense 340B drugs to Medicaid beneficiaries. Given the number of changes recommended and the amount of feedback received on the proposed rule, it's clear that a desire to modify the 340B program exists.



Express Scripts and Medicaid

Since partnering with our first Medicaid client in 1995, Express Scripts has served the Medicaid population. The number of low-income and underserved populations served by Express Scripts continues to grow as states move more of their enrollees to Medicaid managed care (MMC). Our commitment to the Medicaid population remains steadfast while continuing to evolve, as patients with more complex pharmacy needs are covered by MMC. With Medicaid-specific pharmacy solutions and strategic support available to all of our health plans, our Medicaid line of business has expanded to more than 35 health plans in 25 states (highlighted in blue in the map at right). Our passion for serving Medicaid and CHIP beneficiaries is evident in our ongoing advocacy for MMC and our focus on Medicaid innovation. Additionally, we have a strong record of compliance in meeting constantly evolving Medicaid regulations.

Our Medicaid line of business has expanded to more than **35 health plans in 25 states**.

What's driving Medicaid trend?

Specialty medications

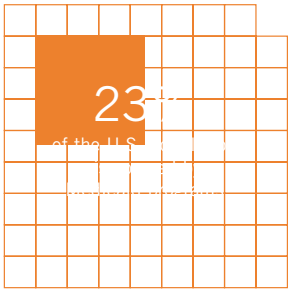
Medicaid spending on specialty drugs continues to grow. Total per-member-per-year (PMPY) specialty drug spend accounted for nearly 36.5% of the total Medicaid drug spend in 2015, despite the small proportion of the Medicaid population utilizing specialty medications.

In 2015, the HIV and hepatitis C therapy classes continued to lead Medicaid specialty drug trend, with eight of the top 10 specialty medications as ranked by PMPY spend belonging to one of these two therapy classes. Medicaid is estimated to be the largest source of coverage for HIV care, covering half of all HIV patients in the U.S.[22] The approval of newer combination therapies, which have convenient once-daily dosing, means that spending on HIV will maintain its large impact on specialty drug spending in Medicaid. Second only to HIV's $131.80, the 2015 PMPY spend on hepatitis C medications ($62.96) accounted for 17.7% of specialty spend. Faced with severe financial concerns over the price of specialty medications, state Medicaid agencies and Medicaid health plans continue to implement a diverse set of benefit design, utilization management and formulary administration techniques to contain utilization and costs for specialty drugs, particularly hepatitis C drugs.

In addition to HIV and hepatitis C, the approvals of newer specialty medications for traditional disease conditions, several new therapies and approval of expanded indications for existing therapies are influencing upward trend in specialty drug spending in Medicaid for the near future.

Medicaid is estimated to be the largest source of coverage for HIV care, covering half of all HIV patients in the U.S.

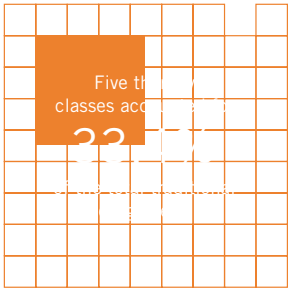
Continuing expansion of state Medicaid programs and Medicaid managed care



About 23% of the U.S. population is covered by Medicaid programs, including 15 million new beneficiaries who gained Medicaid coverage since the beginning of 2014.[23] Currently, approximately 51 million Americans, or 70% of all Medicaid beneficiaries, receive their health benefits from MMC. This growth has been propelled by changes in the Medicaid Drug Rebate Program as part of the ACA and the use of MMC for new ACA Medicaid expansion enrollees in states that haven't historically enrolled their beneficiaries in managed care. CMS data shows that newly enrolled Medicaid beneficiaries had higher benefit costs than previously estimated, mostly due to a surge in the number of newly enrolled patients who lacked health insurance and had previously unmet healthcare needs and untreated conditions, such as diabetes.[24, 25]

In 2015, Alaska, Indiana and Pennsylvania expanded their Medicaid programs under the ACA. Montana's state legislature approved Medicaid expansion for implementation in 2016. In February 2016, through an executive order by the state's governor, Louisiana also approved Medicaid expansion. Given the impending decrease in federal funding for Medicaid expansion, the federal government continues to look for ways to provide incentives for states to expand their programs. States such as South Dakota, Tennessee, Utah, Virginia and Wyoming continue to have active discussions on Medicaid expansion.[26] The use of Alternative Benefit Plans (ABPs) continues to influence state decisions on expanding Medicaid, with many ABP proposals now encouraging the use of benefit designs that promote personal responsibility and engage participants in making healthcare decisions based on cost and quality. States use MMC not only to help new members receive needed care, but also to effectively limit costs. Given these challenges, Medicaid health plans must implement advanced clinical and utilization management solutions to ensure appropriate access to care while reigning in spiraling healthcare costs.

Mental health and controlled substances



Medicaid beneficiaries are disproportionately affected by mental and behavioral health issues, making Medicaid the single largest payer for mental health services in the U.S.[27] Among Medicaid beneficiaries, medications for treating mental/neurological disorders, attention disorders, pain/inflammation, depression and chemical dependence were among the top 10 traditional therapy classes ranked by PMPY spend in 2015. These five therapy classes accounted for 33.4% of the total traditional drug spend in Medicaid. The increase in utilization of antipsychotics, antidepressants, mood stabilizers, attention disorder drugs and anti-anxiety drugs – collectively referred to as psychotropic medications – among children in Medicaid is also of growing concern. Findings from a study done at Express Scripts showed that pediatric use of psychotropic drugs accounted for 16.0% of total Medicaid drug costs in 2012.[28]

Prescription painkiller abuse, overdose and associated deaths have reached epidemic proportions nationally.[29] In addition, a recent report from the Centers for Disease Control and Prevention (CDC) highlighted the increased prevalence of hepatitis C and HIV due to injectable opioid abuse.[30] Previous research by Express Scripts found troubling trends:

- **Nearly 60%** of patients taking opioid pain treatments were prescribed potentially dangerous combinations of medications.
- **Two-thirds of patients** using these medication combinations were prescribed the drugs by two or more physicians and **nearly 40%** filled their prescriptions at more than one pharmacy.[31]

Moreover, medical fraud and abuse that includes but isn't limited to billing for unnecessary or unfurnished services or items, upcoding, unbundling and taking kickbacks and using other tactics, can divert significant resources away from necessary care for Medicaid recipients. Such practices signal the need for bold strategies as being essential to ensure appropriate management of psychotropic and pain medications for this vulnerable population.

edicaid's PMPY total spend in 2015 was $969.56, which was up 5.7% from 2014. Still, our Medicaid health plans had the lowest overall 2015 drug trend

The increase in utilization of **psychotropic medications** among children in Medicaid is of growing concern.

A look at Medicaid overall drug trend for 2015

Medicaid trend is typically higher when compared to our commercial insurance, Medicare and health insurance exchange lines of business. The overall Medicaid trend increase in 2015 was driven by a 2.0% increase in utilization and a 3.7% increase in unit cost trend.

Overall drug trend for traditional medications rose 3.3%, reflecting a 1.3% increase in unit cost and a 2.1% bump in utilization. For specialty medications, drug trend increased by 10.1%, driven by a 12.3% increase in unit cost and lessened somewhat by a 2.2% decline in utilization. Faced with financial pressures, state Medicaid programs aggressively countered rising drug costs in 2015 by implementing various programs or policies, including decisions to carve out coverage of certain therapy classes, like hepatitis C, from the health plan's managed pharmacy benefit. Although these decisions had an impact on the reduced drug trend, they had only a modest effect on unit cost trend.

In 2015, we updated our Medicaid section to provide expanded insights into drug trend observed for different populations within our Medicaid book of business:

- **Temporary Assistance for Needy Families (TANF) –** includes all TANF members and similar populations including but not limited to pregnant women, foster children, the homeless and ACA Medicaid Expansion members
- **Children's Health Insurance Program (CHIP) –** includes separate CHIP plans, as well as Medicaid extension CHIP programs
- **Aged, Blind and Disabled (ABD) –** includes all ABD members or members classified as long-term care (LTC) members

Dual-eligible beneficiaries were excluded, since the majority of their drug benefits are managed by Medicare Part D drug plans.

Components of Medicaid trend

When looking at Medicaid trend by different populations, we made note of a few initial observations:

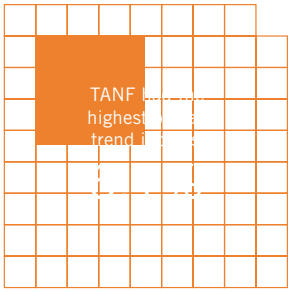
- The TANF population had the highest total trend (6.1%) despite a nominally lower PMPY drug spend ($1,029.28) compared to the ABD population
- The CHIP population had the highest overall specialty trend (20.6%) despite the majority of their $287.75 PMPY spend being attributed to traditional drugs ($228.13)
- The ABD population had the lowest total trend (2.9%) but the highest PMPY drug spend ($1,170.71)

COMPONENTS OF MEDICAID TREND

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$615.36	2.1%	1.3%	**3.3%**
Specialty	$354.20	-2.2%	12.3%	**10.1%**
TOTAL OVERALL	**$969.56**	**2.0%**	**3.7%**	**5.7%**

January-December 2015 compared to same period in 2014



The TANF population had the highest overall trend increase (6.1%) and the second highest PMPY spend ($1,029.28) among the three populations. The overall trend was driven by a unit cost trend of 4.0% and a 2.1% trend in utilization – the greatest utilization trend increase among the three Medicaid population groups. The overall trend was affected primarily by specialty drug spending, which accounted for 38.0% of the total spend for this population, despite a 3.0% decrease in specialty drug utilization. Additionally, the 13.9% jump in unit cost trend for specialty drugs drove the overall 4.0% increase in unit cost.

When looking at the trend in the CHIP population, we observed the highest overall specialty trend at 20.6%, driven by significant increases in both utilization (8.3%) and unit cost trend (12.3%). The significant rise in specialty trend was the main contributor to the 4.3% overall trend and 5.3% total unit cost trend for the CHIP population. Despite significant trend increases in specialty utilization and unit cost, over 79% of the total PMPY spend for CHIP members came from traditional drug spend ($228.13). Specialty drug utilization among children has been found to be increasing as well, as reflected in the 8.3% CHIP specialty trend.[32]

The overall drug trend for ABD members was the lowest of the three populations analyzed; however, their overall PMPY spend was the highest of the three groups at $1,170.71. The ABD population's higher PMPY drug spend reflects the fact that these beneficiaries have some of the highest health care needs. This is due to a higher number of comorbidities and, consequently, a higher number of PMPY prescription claims filled (16.0 PMPY) when compared to TANF (14.6 PMPY) and CHIP (4.9 PMPY). Of the ABD population's total PMPY spend, 72% was spent on traditional drugs ($845.96), a result attributable to a high number of comorbidities that can be treated with traditional drugs. When looking more closely at the PMPY spend for traditional drugs, we note that the total traditional trend of 6.3% resulted primarily from a 4.5% increase in traditional unit cost trend. Conversely, total specialty trend for ABD members declined by 4.8%, in large part due to a 6.3% decline in specialty drug utilization for this population.

TANF

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$638.10	2.2%	1.3%	**3.4%**
Specialty	$391.18	-3.0%	13.9%	**10.8%**
TOTAL OVERALL	**$1,029.28**	**2.1%**	**4.0%**	**6.1%**

January-December 2015 compared to same period in 2014

CHIP

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$228.13	-1.0%	1.8%	**0.8%**
Specialty	$59.61			
TOTAL OVERALL	**$287.75**	**-1.0%**	**5.3%**	**4.3%**

January-December 2015 compared to same period in 2014

ABD

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$845.96	1.8%	4.5%	**6.3%**
Specialty	$324.74	-6.3%	1.5%	**-4.8%**
TOTAL OVERALL	**$1,170.71**	**1.7%**	**1.2%**	**2.9%**

January-December 2015 compared to same period in 2014

Traditional therapy classes and insights: Medicaid

For Medicaid plans, trend for traditional medications was 3.3% in 2015, resulting from a 2.1% increase in utilization and a 1.3% upswing in unit cost. When ranked by PMPY spend, the top three traditional therapy classes – diabetes, mental/neurological disorders and asthma – contributed to 37.7% of the total traditional drug spend among Medicaid beneficiaries. Diabetes medications alone accounted for 15.8% of the total traditional drug spend. Five of the top 10 traditional therapy classes had negative total trend, with medications used to treat depression having the largest drop in trend for the second year in a row.

When ranked by PMPY spend, the **top three** traditional therapy classes contributed **37.7%** of the total traditional drug spend.

COMPONENTS OF TREND FOR THE TOP 10 MEDICAID TRADITIONAL THERAPY CLASSES

RANKED BY 2015 PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Diabetes	$97.03	4.1%	17.6%	**21.7%**
2	Mental/neurological disorders	$71.97	-1.5%	-4.8%	**-6.4%**
3	Asthma	$62.73	-2.0%	4.6%	**2.6%**
4	Attention disorders	$52.00	1.1%	7.0%	**8.0%**
5	Pain/inflammation	$51.18	-0.1%	0.1%	**0.0%**
6	Seizures	$20.57	-0.1%	-0.6%	**-0.7%**
7	Infections	$20.47	-1.9%	-2.2%	**-4.1%**
8	Depression	$15.38	7.3%	-31.3%	**-24.0%**
9	Chemical dependence	$15.21	10.7%	-6.2%	**4.5%**
10	High blood pressure/heart disease	$14.19	3.5%	-6.9%	**-3.4%**
	TOTAL TRADITIONAL	**$615.36**	**2.1%**	**1.3%**	**3.3%**

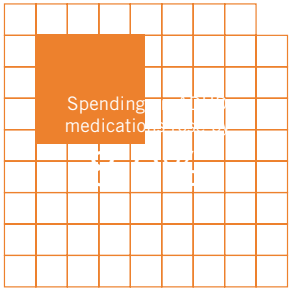
Highlights

- Diabetes had the highest PMPY spend ($97.03) of all traditional therapy classes among Medicaid beneficiaries for the third consecutive year. Among the top 10 Medicaid traditional therapy classes, trend for diabetes medications was highest, at 21.7%. It was driven by a unit cost trend of 17.6%, and a smaller rise in utilization (4.1%). Brand inflation for Lantus® (insulin glargine) and Humalog® (insulin lispro) was the key driver. An interplay of several factors is responsible for the trends observed in diabetes drug spending. These include the current unavailability of any generic insulins, the 2015 approvals for newer therapies such as Tresiba® (insulin degludec), Ryzodeg® 70/30 (insulin degludec/insulin aspart), and Toujeo® (insulin glargine) and the anticipated approvals of brand and follow-on insulin therapies beginning in 2016.

- Mental illnesses are highly prevalent among the Medicaid-eligible population; an estimated 35% of low-income, nonelderly, adult Medicaid enrollees have some form of mental illness.[33] Although mental/neurological disorder therapies had the second highest PMPY spend at $71.97, their total trend declined by 6.4%, resulting from negative utilization (-1.5%) and unit cost trends (-4.8%). Multiple generic versions of the antipsychotic drug Abilify® (aripiprazole) were launched after patent expiration in April 2015. Combined, Abilify and generic aripiprazole contributed to 49.8% of the total PMPY spend for the mental/neurological disorders therapy class, with generic aripiprazole accounting for 24.0%.

- Asthma drugs continue to be among the top three traditional therapy classes. Medicaid enrollees have a high prevalence of asthma, with Medicaid being the largest payer for asthma-related hospitalizations among children and adults.[34] PMPY drug spend was up by 2.6% to $62.73, fueled by an uptick in unit cost (4.6%) and a drop in utilization (-2.0%). While Symbicort® (budesonide/formoterol) had the highest PMPY drug spend in Medicaid ($10.74), Ventolin® HFA (albuterol sulfate) had the highest asthma market share in Medicaid.

Brand inflation for insulin products was a key driver in spend growth for diabetes medications.



- PMPY spend on attention disorders medications rose by 8.0% in 2015 to $52.00, mostly influenced by a unit cost trend of 7.0%. Despite concerns regarding use of attention disorders drugs among children in Medicaid,[35] spending on these drugs continued to rise from last year. Although the generic drugs methylphenidate and dextroamphetamine/amphetamine dominate this class in the Medicaid population, utilization and unit cost for the brand drug Vyvanse® (lisdexamfetamine) have shown continued increases in 2015. Use of Vyvanse is up among adults aged 18 or older who are treating attention disorders or binge eating disorder, for which it gained FDA approval in January 2015.[36]

- Pain/inflammation medications had a PMPY spend of $51.18, but trend balanced between a 0.1% increase in unit cost and a 0.1% decline in utilization. Although generics continue to dominate this class in Medicaid, the brand drug Lyrica® (pregabalin) had the highest PMPY spend, at $7.96. In fact, brand inflation for Lyrica and the tamper-resistant formulation OxyContin® (oxycodone) elevated unit cost for the class.

- Depression medications had the largest negative total trend (-24.0%), driven mainly by a 31.3% drop in unit cost. This therapy class has one of the highest generic penetrations with a generic fill rate (GFR) of 98.5% in 2015. Decreased unit cost trend in 2015 may be due in part to no new therapies approved and no new drugs in the pipeline for treating depression.

- Along with mental illnesses, substance abuse disorders are also prevalent in the Medicaid population. Drugs used to treat chemical dependence had a total trend of 4.5%, mainly due to a 10.7% increase in utilization, but offset by a 6.2% reduction in unit cost. Suboxone® (buprenorphine/naloxone), which had the highest drug spend, was the most commonly used drug in this class among the Medicaid patients, followed by its generic version buprenorphine/naloxone. Combined, the brand and generic versions captured more than 94% of chemical dependence market share in 2015 among the Medicaid population.

Top 10 Medicaid traditional drugs

Together, the six brand drugs in the top 10 accounted for 15.8% of PMPY spend for all traditional therapy drugs. Three of the top 10 traditional drugs used by Medicaid beneficiaries in 2015 were generics, up from only one in 2014. An amphetamine salt combination used to treat attention disorders and the atypical antipsychotic aripiprazole joined methylphenidate on this list. Aripiprazole, the generic version of Abilify approved in April 2015, won significant marketshare. The drop in utilization for Abilify (-60.3%) was offset only slightly by a sustained increase in unit cost (7.2%), leading to a total trend of -53.1%, which was the lowest among the top 10 traditional therapies. Lantus overtook Abilify to have the highest PMPY traditional drug spend ($28.88) for Medicaid in 2015. Humalog had the highest trend among the top 10 traditional therapies (17.7%), mainly from 20.4% unit cost inflation. Trends for several brand drugs, such as Symbicort, Lantus and Humalog, were found to stabilize despite rising in 2015.

Three of the top 10 traditional drugs were generics, up from only **one** in 2014.

TOP 10 MEDICAID TRADITIONAL THERAPY PRODUCTS

RANKED BY 2015 PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL TRADITIONAL SPEND	UTILIZATION	UNIT COST	TOTAL
1	Lantus® (insulin glargine)	Diabetes	$28.88	4.7%	3.4%	10.7%	**14.1%**
2	Abilify® (aripiprazole)	Mental/neurological disorders	$18.56	3.0%	-60.3%	7.2%	**-53.1%**
3	Humalog® (insulin lispro)	Diabetes	$17.97	2.9%	-2.7%	20.4%	**17.7%**
4	aripiprazole	Mental/neurological disorders	$17.28	2.8%	–	–	–
5	methylphenidate extended release	Attention disorders	$14.24	2.3%	-5.9%	12.2%	**6.2%**
6	Symbicort® (budesonide/formoterol)	Asthma	$10.74	1.7%	5.7%	7.6%	**13.3%**
7	Suboxone® (buprenorphine/naloxone)	Chemical dependence	$10.62	1.7%	5.1%	-1.2%	**3.9%**
8	Ventolin® HFA (albuterol sulfate)	Asthma	$10.30	1.7%	-2.3%	6.9%	**4.6%**
9	dextroamphetamine/amphetamine	Attention disorders	$10.00	1.6%	-6.6%	-10.2%	**-16.8%**
10	OneTouch Ultra® Test Strips	Diagnostic aids	$9.93	1.6%	12.3%	-6.1%	**6.2%**

Specialty therapy classes and insights: Medicaid

Specialty medications accounted for 36.5% of total Medicaid pharmacy spend in 2015. PMPY spend for specialty medications for Medicaid ($354.20) rose by 10.1%, primarily boosted by a unit cost trend of 12.3%, but tempered slightly by a 2.2% decline in utilization. Ranked by PMPY spend, the top three specialty therapy classes – HIV, hepatitis C and inflammatory conditions – together contributed almost 67.0% of total specialty PMPY spend. At $131.80, medications used to treat HIV displaced hepatitis C as the specialty therapy class having the highest PMPY drug spend in 2015. This change was propelled by a negative utilization trend (-39.9%) for hepatitis C drugs, which more than offset a 30.2% unit cost trend. Anticoagulants along with hepatitis C were the only two of the top 10 specialty therapy classes with negative total trends, while both anticoagulants and pulmonary hypertension had declining unit cost trends.

Ranked by PMPY spend, the **top three** specialty therapy classes contributed **almost 67.0%** of total specialty PMPY spend.

COMPONENTS OF TREND FOR THE TOP 10 MEDICAID SPECIALTY THERAPY CLASSES

RANKED BY 2015 PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	HIV	$131.80	-5.9%	10.8%	**4.9%**
2	Hepatitis C	$62.96	-39.9%	30.2%	**-9.7%**
3	Inflammatory conditions	$41.30	24.5%	21.1%	**45.6%**
4	Oncology	$27.50	12.1%	17.3%	**29.4%**
5	Multiple sclerosis	$24.36	6.4%	9.7%	**16.0%**
6	Growth deficiency	$9.55	9.1%	14.7%	**23.7%**
7	Cystic fibrosis	$7.89	-2.1%	21.3%	**19.2%**
8	Pulmonary hypertension	$5.32	11.4%	-1.7%	**9.8%**
9	Anticoagulants	$4.78	0.7%	-6.8%	**-6.1%**
10	Hemophilia	$4.12	54.8%	40.0%	**94.8%**
	TOTAL SPECIALTY	**$354.20**	**-2.2%**	**12.3%**	**10.1%**

Highlights

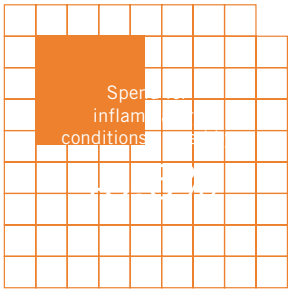
- The PMPY spend for HIV treatments topped that of other specialty medications, with a unit cost trend of 10.8% and a decline in utilization by 5.9%. Despite the wave of patent expirations, brand drugs continue to dominate this class due to pipeline replenishment with newer and more potent drugs that tackle the continually mutating virus strains. Additionally, the one-a-day dosage regimens offered by some newer combination brand drugs such as Complera® (emtricitabine/tenofovir disoproxil fumarate), Stribild® (cobicistat/elvitegravir/emtricitabine/tenofovir disoproxil fumarate) and Triumeq® (abacavir/dolutegravir/lamivudine) have led to large increases in the utilization. Truvada® (emtricitabine/tenofovir disoproxil fumarate) had the highest PMPY spend ($24.64) and the highest market share (17%) in Medicaid. Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate) had the next highest drug spend in Medicaid ($17.08).

- Hepatitis C spending declined by 9.7% in 2015, heavily influenced by a 39.9% fall in utilization. Harvoni® (ledipasvir/sofosbuvir), which was approved in October 2014, still captured more than half (51.0%) of the hepatitis C Medicaid marketshare in 2015, with Sovaldi® (sofosbuvir) a distant second (14.3%). Viekira Pak™ (ombitasvir/paritaprevir/ritonavir; with dasabuvir), which was also approved at the end of 2014, took only 10.8% of the marketshare for Medicaid users in 2015. As mentioned earlier, state Medicaid programs implemented a variety of strategies to address the substantial strain on their budgets due to expensive hepatitis C therapies. Such strategies include:

    - Managing utilization through limiting drug treatments to the sickest patients or those with comorbid HIV or liver damage.
    - Imposition of various restrictions on the use of these drugs, such as assessing patients for drug and alcohol use or monitoring adherence to the drug regimen.
    - Carving out coverage for these drugs from the health plan managed pharmacy benefit to fee-for-service Medicaid.

  Medicaid health plans also implemented utilization management controls, including more thorough reviews of prior-authorization requests and quantity management protocols for hepatitis C drugs. Health plans were careful to develop these with thoughtful attention to the FDA-approved indications, as well as drawing on input from their hepatitis specialists.

- Spend for inflammatory conditions, the number-three specialty therapy class, surged by 45.6%, influenced by increases in utilization (24.5%) and unit cost (21.1%). Positive utilization trends for Humira Pen® (adalimumab), Enbrel® (etanercept), Stelara® (ustekinumab) and Xeljanz® (tofacitinib) contributed considerably to overall class trend. Costs continued to rise among the Medicaid population due to brand inflation. Humira Pen had the highest unit cost trend of 27.3% among the top 10 specialty drugs, followed by Enbrel with 21.7%. Otezla® (apremilast), the newest oral prescription drug to treat psoriatic arthritis, had a total trend of 989.5%, caused largely by a utilization trend increase of 855.2%. This may have resulted, in part, from an additional indication for psoriasis in September 2014 – after Otezla's initial approval in April 2014 for the much smaller pool of patients with psoriatic arthritis.



- In 2015, PMPY spend for oncology medications increased by 29.4% for the Medicaid population. Trend was driven by large rises in unit cost (17.3%) and utilization (12.1%). The utilization increase was likely the result of several factors, including the expansion of indications for several drugs such as Imbruvica® (ibrutinib), the continued development of newer, more targeted therapies and lengthening survival rates for patients living with cancer but continuing medication therapy. Utilization of a generic, capecitabine, went up by 37.4% in 2015, gaining the top marketshare spot in the Medicaid oncology drug class. On the other hand, utilization for the brand version of the same drug, Xeloda®, which lost patent in April 2014, plummeted by more than 96% in 2015. Nonetheless, brands still dominate this class, with eight of the top 10 oncology medications among Medicaid beneficiaries being brands. The leader was Gleevec® (imatinib), which had the highest PMPY spend in the class, due to a 17.8% unit cost trend. Going forward, generic versions of Gleevec, which were introduced in February 2016, should have a positive impact on oncology trend.

Among Medicaid specialty medications, drug spend for HIV treatments was highest in 2015.

- Total trend for multiple sclerosis (MS) medications was 16.0%, due to growth in both PMPY utilization (6.4%) and unit cost (9.7%). Copaxone® (glatiramer) is the most widely used MS drug in Medicaid, and also had the highest PMPY spend ($6.84), followed by the oral medication Tecfidera® (dimethyl fumarate) with a PMPY spend of $5.63. Glatopa™, a generic alternative for Copaxone's 20mg/mL dosage form, was launched in the U.S. in June 2015. However, the brand manufacturer is hoping to continue the shift of existing users to a new, longer-acting 40mg/mL formulation with patent protection until 2030.

- In 2015, trend for growth deficiency medications rose by 23.7%. Double-digit inflation (of 14.7%) in unit cost trend was the main factor. Norditropin® FlexPro® (somatropin) and Omnitrope® (somatropin) continue to dominate growth deficiency Medicaid marketshare and both had high unit cost trends (19.6% and 18.9%, respectively) in 2015. For cystic fibrosis (CF) medications, trend also rose significantly; by 19.2% relative to 2014's 8.5%. A unit cost increase of 21.3% greatly overshadowed the 2.1% utilization decrease for the class. Pulmozyme® (dornase alfa), which went up 10.0% in unit cost, continues to dominate the CF Medicaid market, followed by generic tobramycin inhalation. Orkambi® (lumacaftor/ivacaftor), which was approved in July 2015, quickly gained more than 4% of the Medicaid CF marketshare. At $1.34, it ranked second behind Pulmozyme's $3.10 in PMPY drug spend. We note that trends for expensive medications to treat rare conditions, such as growth deficiency, cystic fibrosis and hemophilia, are more susceptible to small changes in a plan sponsor's patient population.

Trends for expensive medications to treat rare conditions are **more susceptible to small changes** in a plan sponsor's patient population.

Top 10 Medicaid specialty drugs

Six of the top 10 specialty drugs were HIV medications, four of which are combination products with two or more different drugs in one tablet. Collectively, these six drugs contributed 25.0% of the total Medicaid specialty drug spend. Stribild and Complera were the only two HIV drugs with positive total trends. Stribild's total trend of 40.3% was driven by a 36.3% lift in utilization; the uptick was likely from the convenience offered by the combination of several drugs. Harvoni had a utilization increase of more than 1,100%, capturing the top Medicaid hepatitis C marketshare from Sovaldi, which dropped in utilization by 78.1%. The utilization increase for Harvoni may be attributed to a variety of influences, including significant cure rates, and consequently greater formulary preference over competing therapies. Humira Pen had the second highest total trend after Harvoni, with substantial rises in utilization (22.5%) and unit cost (27.3%) contributing to an overall trend of 49.8%. The other anti-inflammatory drug in the top 10, Enbrel, also had an uptick in drug spending (34.4%) driven by increases in utilization (12.7%) and unit cost (21.7%).

TOP 10 MEDICAID SPECIALTY THERAPY PRODUCTS

RANKED BY 2015 PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL SPECIALTY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Harvoni® (ledipasvir/sofosbuvir)	Hepatitis C	$44.56	12.6%	1,101.2%	-188.1%	**913.0%**
2	Truvada® (emtricitabine/tenofovir disoproxil fumarate)	HIV	$24.64	7.0%	-6.1%	3.9%	**-2.1%**
3	Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)	HIV	$17.08	4.8%	-18.2%	5.6%	**-12.6%**
4	Humira® Pen (adalimumab)	Inflammatory conditions	$15.53	4.4%	22.5%	27.3%	**49.8%**
5	Stribild® (elvitegravir/cobicistat/ emtricitabine/tenofovir disoproxil fumarate)	HIV	$14.42	4.1%	36.3%	4.0%	**40.3%**
6	Complera® (emtricitabine/rilpivirine/ tenofovir disoproxil fumarate)	HIV	$12.68	3.6%	9.0%	4.8%	**13.8%**
7	Sovaldi® (sofosbuvir)	Hepatitis C	$11.49	3.2%	-78.1%	-1.1%	**-79.1%**
8	Prezista® (darunavir)	HIV	$11.38	3.2%	-8.5%	6.1%	**-2.4%**
9	Enbrel® (etanercept)	Inflammatory conditions	$10.65	3.0%	12.7%	21.7%	**34.4%**
10	Reyataz® (atazanavir)	HIV	$8.21	2.3%	-25.0%	5.0%	**-20.0%**

2016 – 2018 Medicaid trend forecast

The Medicaid traditional drug trend for 2015 was 3.3%, with a PMPY traditional spend of $615.36. We anticipate that over the next three years, the traditional drug trend will rise by an average of 5.7%. Smaller utilization increases due to stabilization of the influx of new Medicaid beneficiaries, coupled with modest unit cost changes for traditional therapies, will lead to a moderate trend upturn in 2016. This will be followed by only small trend increases thereafter. Trend is forecast to be negative for three of the top 10 traditional therapy classes (mental/neurological disorders, depression and high blood pressure/heart disease) for all three years, due to unit cost declines resulting from patent expirations and greater generic dispensing. The largest average traditional class increases in the next three years are expected for the diabetes and attention disorder therapy classes. Despite small increases in utilization of diabetes drugs, unit cost trend will plateau due to the availability of follow-on insulin therapies beginning in December 2016. In the attention disorders therapy class over the next three years, multiple factors including market saturation, generic availability and utilization management will lead to smaller trends among Medicaid beneficiaries.

In addition to the benefit and utilization management strategies employed by health plans, state and federal legislative actions will also play a role in impacting Medicaid prescription drug trend.

In Medicaid, PMPY specialty drug spend was $354.20 in 2015. The total trend was 10.1%. Due to a large drop in utilization, Hepatitis C, the main trend driver in 2014, reversed trend in 2015. The decrease was fueled by state regulations such as therapy class carve-outs, coupled with appropriate utilization management strategies by health plans. Moving forward, specialty

2016 - 2018 TREND FORECAST

	2016	2017	2018
TOTAL OVERALL	7.5%	8.8%	9.9%

TREND FORECAST FOR KEY TRADITIONAL THERAPY CLASSES

2016 - 2018

	TREND FORECAST		
THERAPY CLASS	2016	2017	2018
Diabetes	23.9%	22.4%	21.8%
Mental/neurological disorders	-2.0%	-3.6%	-2.6%
Asthma	2.0%	2.0%	2.0%
Attention disorders	7.1%	6.1%	4.0%
Pain/inflammation	1.5%	6.1%	5.0%
Seizures	3.0%	3.0%	3.0%
Infections	-1.1%	0.9%	0.9%
Depression	-14.2%	-8.1%	-4.8%
Chemical dependence	4.5%	1.3%	1.3%
High blood pressure/heart disease	-5.2%	-4.2%	-5.1%
Other traditional classes	3.3%	2.4%	2.4%
TOTAL TRADITIONAL	5.1%	5.8%	6.3%

trend is expected to increase steadily by an average of 13.6% over the next three years. Several factors, such as expanded indications for existing drugs, newer therapies in the pipeline, higher prescribing rates and wider adoption of these therapies, will lead to rising utilization from 2016 through 2018. However, double-digit growth in unit costs will also fuel trends. Pipeline replenishment with newer drugs that attack mutating HIV strains, along with the convenience of once-daily dosage regimens offered by some combination brand drugs, will continue to drive the HIV trend in Medicaid. In the inflammatory conditions therapy class, newer, more convenient oral drugs, along with expanded indications for existing drugs, will lead to sustained double-digit increases in both utilization and unit cost. Despite the launch of generic imatinib, oncology trends will continue to escalate at high levels due to targeted-drug approvals, increased utilization and brand inflation. Similar factors will contribute large trends in CF and hemophilia drugs over the next three years.

Specialty trend is expected to **increase steadily by an average of 13.6%** over the next three years.

TREND FORECAST FOR KEY SPECIALTY THERAPY CLASSES

2016 - 2018

	TREND FORECAST*		
THERAPY CLASS	**2016**	**2017**	**2018**
HIV	7.7%	7.8%	10.0%
Hepatitis C	-5.0%	0.0%	0.0%
Inflammatory conditions	40.0%	36.2%	32.7%
Oncology	27.8%	25.7%	26.6%
Multiple sclerosis	12.3%	10.2%	10.2%
Growth deficiency	15.5%	15.5%	13.0%
Cystic fibrosis	30.0%	27.8%	26.6%
Pulmonary hypertension	16.6%	6.9%	6.9%
Anticoagulants	-3.0%	-1.0%	1.0%
Hemophilia	30.0%	24.4%	27.5%
Other specialty classes	3.3%	3.4%	3.4%
TOTAL SPECIALTY	**11.8%**	**13.7%**	**15.4%**

*Trend is forecast only for specialty medications billed through the pharmacy benefit

Solutions

Solutions for Medicaid challenges

Express Scripts works tirelessly to address the issues facing Medicaid plan sponsors, such as high drug prices, through negotiations with pharmaceutical manufacturers and through benefit management solutions. Although we will continue to advocate for more sustainable and fair drug pricing along with our client and industry partners, we encourage Medicaid health plans to take advantage of our benefit and utilization management strategies, clinical solutions and innovative tools and unique services to ensure the most appropriate use of these medications.

Superior specialty care management

The rising number of Medicaid beneficiaries with chronic and complex disease states requires new strategies to manage healthcare needs. Express Scripts offers beneficiaries with chronic and complex conditions several industry-leading clinical solutions utilizing our Specialized Care group at our clinically specialized Therapeutic Resource Centers℠ (TRCs). **At our 20-plus TRCs, more than 1,000 advanced clinicians – pharmacists, nurses and patient advocates – receive clinically specialized training in one disease state, allowing them to focus almost exclusively on these specific clinical conditions.** This commitment to specialized expertise ensures an optimal patient experience and assures the highest performance in pharmacy safety, improved medication adherence and overall medical care. With their highly specialized knowledge of these complex disease states and complicated treatment protocols, our advanced clinicians are experts at identifying gaps in care – such as failure to prescribe an essential therapy, inappropriate dosing, dangerous drug interactions or patient nonadherence. They can also identify opportunities to reduce waste and out-of-pocket costs by moving patients to a different medication or pharmacy.

Express Scripts offers beneficiaries with chronic and complex conditions several **industry-leading clinical solutions** utilizing our Specialized Care group at our clinically specialized Therapeutic Resource Centers.

Our specialty pharmacy, Accredo®, currently treats approximately 600,000 active specialty patients, with patient satisfaction levels well above 90%. Accredo's delivery of specialty pharmacy services results in better health and financial

outcomes for Medicaid health plans, providers and, most importantly, patients. A recent study of patients with rheumatoid arthritis underscores the importance of the pharmacy services and care Accredo provides through our specialty pharmacists, who conduct outreach to and serve as resources for patients: Accredo's clinical care resulted in 16% higher adherence over other pharmacies, 23% fewer doctors' office visits, 9% fewer annual ER visits and $1,797 in annual medical cost savings per patient.[37]

Specialty drug management

Specialty medications contribute significantly to rising prescription drug spending, which continues to strain state Medicaid agency and MMC plan budgets.[38] Controlling this trend will require an integrated approach that involves the active management of specialty drugs and the use of best pharmacy practices to achieve improved patient outcomes along with better savings. One such best practice is the use of medical benefit management services, such as those available through Accredo, to enhance patient care and reduce wasteful expenses associated with specialty drugs. With Accredo, medications are billed through the medical benefit using the industry's most comprehensive range of utilization, trend and claims management tools for medically billed drugs. Additionally, Accredo's Site of Care Management Program utilizes 600 Accredo-employed nurses across the country to deliver and infuse specialty medications in patients' homes rather than in expensive infusion suites and outpatient surgery centers. **No other PBM has this many employed nurses – nurses who receive the same training to provide consistent care according to clinical guidelines.**

Express Scripts innovative specialty care programs such as the Cholesterol Care Value Program℠ (CCV) and Oncology Care Value Program℠ (OCV) use rigorous clinical review processes to provide cost-effective and value-based prescription drug purchase and management solutions. We encourage Medicaid health plans to evaluate marketplace best practices and consider our solutions as they create their own guidelines.

Innovative clinical solutions

Among Medicaid enrollees, medication adherence is imperative to medication effectiveness. Increases in prescription drug use have been associated with decreases in nondrug costs, such as inpatient and outpatient spending.[39] Medicaid health plans can benefit tremendously from our proprietary ScreenRx® predictive modeling platform that identifies potential future nonadherence among Medicaid beneficiaries and can be extremely useful in designing tailored interventions that drive adherence among patients. Additionally, our RationalMed® platform uses proprietary clinical analyses of prescription, medical and lab data to identify trends and safety risks, thus providing plan sponsors greater precision in directing resources to address important patient issues.

In addition to using data to identify adherence or intervention opportunities, Express Scripts uses claims data at the pharmacy counter to identify excessive dosing of opiates. At the point of sale, at a member level, Express Scripts can calculate the analgesic effectiveness of all opiate medications prescribed for an equivalent dose of morphine, which can then be compared to a designated threshold to ensure that patients receive only a clinically appropriate amount of opiates. Using sensitivity in the design, we can ensure that patients with conditions requiring higher doses of pain relief, such as cancer, have access to higher doses of needed opiates.

Smart formulary management

To preserve patient access and choice while helping payers obtain fair and affordable pricing, Express Scripts effectively uses smart management techniques in a transparent manner to build effective formularies for our Medicaid health plans, while complying with state Medicaid agency regulations. These techniques ensure that plan formularies cover essential medications that are both superior to other products and clinically effective, while excluding costly drugs providing no additional clinical benefit. **Our Medicaid health plans benefit from formulary management decisions and recommendations that provide additional leverage to more effectively negotiate lower drug prices and compel manufacturers to charge fair and reasonable prices for their drugs.** Without a well-managed formulary, Medicaid health plans may end up paying significantly more for medications.

Fraud, waste and abuse prevention

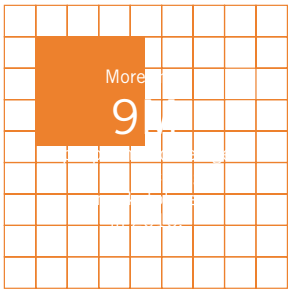
Express Scripts Fraud, Waste and Abuse program uses industry-leading, proprietary data analytics and reporting tools to help uncover and flag potential fraud or abuse committed by providers, pharmacists or members. Using these advanced analytic insights, Express Scripts launched a proactive opioid education pilot program to identify members at higher risk for prescription drug abuse, at the time of their first fill. In addition, our data analytics solutions help identify physicians prescribing many more opioids than their practice would warrant and "pill mill" pharmacies filling opioids excessively. With this data, Express Scripts can make additional recommendations for members who should be evaluated for a lock-in, an effective program that state Medicaid agencies and Medicaid health plans use to restrict members to one prescriber or pharmacy, for one or more classes of medications. Express Scripts' advanced diagnostic and data-mining platform, MediCUBE®, integrates medical and pharmacy claims data, giving real-time access to more than 15 billion records for nearly 180 million patients. Express Scripts continually works to develop solutions that can be leveraged for any fraud, waste and abuse interventions that Medicaid health plans may need.

MediCUBE integrates medical and pharmacy claims data, giving real-time access to more than **15 billion records** for nearly **180 million patients**.

Health insurance exchange

Exchange overview

Since 2015 was just the second year of health insurance exchanges ("exchanges") – a major tenet of the Patient Protection and Affordable Care Act (ACA) – it's the first year for which Express Scripts can analyze this population's year-over-year trends. The Centers for Medicare and Medicaid Services (CMS) reported that more than nine million people had coverage in the exchange marketplace in 2015.[40] With access to approximately one third of the nation's state and federal health exchange pharmacy claims, Express Scripts is uniquely positioned to provide insights and identify emerging trends.



Prescription medication utilization and spending patterns provide valuable insights into the health status of exchange members. Our knowledge helps health insurers anticipate potential risks and take advantage of proactive prescription medication solutions that address the needs of their populations. Working with our clients, we can help implement strategies that deliver safe, affordable prescription care while helping them remain competitive in the exchange marketplace.

The exchange market is still young and subject to a high degree of change and uncertainty. These factors are evident in the trends we see. In the near term, we expect market growth projections, population health indicators and government regulations to remain volatile. Despite these variables, we believe this early analysis offers helpful insights and highlights a substantial opportunity to make pharmacy care more affordable and accessible to the exchange population.

In 2014, Express Scripts introduced the Exchange Pulse™ reports, which examined in depth the behavior and medication usage of exchange members. This, our first Health Insurance Exchange Drug Trend Report, continues our effort to share cutting-edge data and insights drawn from the exchange population. We're pleased to offer this detailed look at drug trend in this unique group.

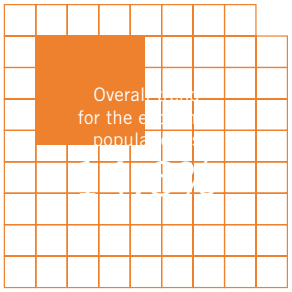
With access to approximately **one third** of the nation's state and federal health exchange pharmacy claims, Express Scripts is **uniquely positioned** to provide insights and identify emerging trends.

A look at exchange overall drug trend for 2015

The exchange market has grown, albeit slower than previously projected by the Congressional Budget Office (CBO).[41] Even so, exchange enrollment was volatile in 2015. According to the U.S. Department of Health and Human Services (HHS), just over half of the enrollees who selected a plan through HealthCare.gov in 2015 didn't have coverage in the previous year. Additionally, of those who re-enrolled using HealthCare.gov, 29% selected a new plan.[42] In comparison, studies show that approximately 13% of Medicare Part D enrollees change plans in a given year and only about 7.5% of those with employer-sponsored coverage switch plans for reasons other than a job change.[42] As we examine exchange membership, we expect drug trend to reflect the changing nature of this still developing marketplace, as well as general industry trends.

Components of exchange trend

Overall trend for the exchange population is 14.6%, which is notably higher than the trends among our commercial, Medicare and Medicaid populations. Trend in the exchanges was driven by increases in utilization (8.6%) and drug costs (6.0%). Although unit costs remained relatively flat (0.7%) for traditional medications, they increased significantly (15.8%) for specialty medications, similar to the commercially insured population. However, utilization increases for traditional medications outpaced those for specialty drugs (8.7% vs. 4.7%), a trend that may be due to patients in this population filling a previously unmet need. Overall per-member-per-year (PMPY) spend was nearly the same for traditional and specialty drugs.



As noted in the Express Scripts Exchange Pulse reports, specialty medications remain a significant contributor to overall exchange cost trend – a common theme throughout the industry. In the exchanges, specialty trend may also be attributed to an overall increase in drug utilization, as newly insured and existing exchange members fully utilize their prescription drug benefit. Many of the individuals enrolled in exchange plans were persistently uninsured prior to 2014. Prior to the ACA, many individuals with chronic and high-cost diseases such as HIV/AIDS did not qualify for insurance coverage due to pre-existing conditions. As outlined in the April 2014 edition of the Exchange Pulse Report, exchange plan members were four times more likely to have a prescription for at least one HIV medication than members in our commercial book of business. Over time, we expect utilization patterns to reflect general market characteristics, as fewer newly insured members with pent-up demand enter the market.

COMPONENTS OF EXCHANGE TREND

2015

		TREND		
	PMPY* SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$391.13	8.7%	0.7%	**9.4%**
Specialty	$386.14	4.7%	15.8%	**20.4%**
TOTAL OVERALL	**$777.27**	**8.6%**	**6.0%**	**14.6%**

*Per member per year

Specialty medications remain a significant contributor to overall exchange cost trend. However, traditional medication usage – compared to our other lines of business – indicates this is a new market whose members are just beginning to fully use their benefits.

Exchange trends by age groups and metal levels

Components of exchange trend by age group

As expected, total trend increased with older age groups. Beneficiaries aged 0 to 19 had the lowest trend (8.6%) and the 45 to 64 age groups had the highest at 19.5%. With the exception of unit cost trend for traditional medications, which remained relatively stable across all adult age groups, cost and utilization trend components increased for most age groups.

Total overall trend for the youngest exchange beneficiaries was much lower than the total aggregate trend across all exchange beneficiaries (8.6% vs. 14.6%). Primary drivers of 2015 trend were a big jump (18.8%) in unit costs and a smaller increase (3.9%) in utilization of specialty medications. A moderate 3.1% increase in unit costs of traditional medications also contributed. The youngest group also had the lowest percentage of total spend (about 30%) attributed to specialty drugs.

As anticipated, we saw low unit cost trend for traditional therapies in the 20 to 34 age bracket, but the group's utilization trend (9.9%) was particularly high. Total trend for this group was 12.7%, due to increased utilization of traditional medications (9.9%) and increases in both utilization and costs for specialty medications (4.5% and 11.3% respectively). Among beneficiaries 20 to 34, per member per year (PMPY) spending for specialty was actually $1.44 higher than spend for traditional drugs.

The 14.9% overall trend for exchange beneficiaries in the 35 to 44 age group slightly outpaced the 14.6% total overall trend across all exchange beneficiaries. A 10.3% increase in utilization for traditional drugs and a 17.2% unit cost increase for specialty medications were the main contributing factors. For beneficiaries in the 35 to 44 cohort, PMPY spend for specialty drugs ($374.80) was 12.7% more than spend for traditional drugs ($332.54).

Among beneficiaries aged 45 to 54, total trend increased by 19.5%, largely resulting from increased unit cost for specialty (18.4%) and increased utilization for traditional medications (13.2%). Specialty spend accounted for 54% of total PMPY spend by the group.

AGES 0 TO 19

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$130.26	0.4%	3.1%	**3.5%**
Specialty	$55.64	3.9%	18.8%	**22.8%**
TOTAL OVERALL	**$185.90**	**0.4%**	**8.2%**	**8.6%**

January-December 2015 compared to same period in 2014

AGES 20 TO 34

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$242.86	9.9%	-0.2%	**9.7%**
Specialty	$244.30	4.5%	11.3%	**15.8%**
TOTAL OVERALL	**$487.17**	**9.8%**	**2.9%**	**12.7%**

January-December 2015 compared to same period in 2014

AGES 35 TO 44

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$332.54	10.3%	0.7%	**11.0%**
Specialty	$374.80	1.5%	17.2%	**18.7%**
TOTAL OVERALL	**$707.34**	**10.2%**	**4.8%**	**14.9%**

January-December 2015 compared to same period in 2014

PMPY spend and total trend were higher for exchange beneficiaries aged 55 to 64 years than most other age groups included in the exchanges. Spend increased 19.5%, driven by high utilization growth for both traditional and specialty medications. Despite an almost flat traditional cost trend, a 13.6% increase in costs for specialty medications pushed total overall unit cost trend to 6.9%. PMPY utilization trend of 54.4% for osteoporosis was the highest among the top 10 specialty classes in this group. In this age bracket, PMPY spend for specialty medications was the highest among all age groups, but PMPY spend for traditional and specialty drugs differed by less than $71.00 due to significant growth in traditional medication spend.

Components of exchange trend by metal level

Exchanges give individuals a choice by offering a selection of qualified health plans at varying metal-level coverage values labeled platinum, gold, silver or bronze. In general, platinum plans have the highest monthly premiums, but also offer the highest coverage value. Individuals in bronze plans typically have the lowest premiums, but have the lowest coverage value. Correspondingly, premiums and coverage values for gold and silver plans fall between those for platinum and bronze. To understand how costs and utilization trends varied by metal-level plan selection, we examined a sample of exchange beneficiaries by the type of plan they chose. Similar to the distribution presented by CMS,[40] most members selected a silver-level plan, followed by bronze, gold and platinum plans respectively. Not surprisingly, the ratio of enrollees to benefit users increased with higher-level benefit plans. Bronze plans had the lowest ratio of utilizers to enrolled beneficiaries.

At 20.5%, silver benefit plans had the highest overall trend, driven by increases in utilization (12.0%) and unit costs (8.5%). However, the platinum benefit plans – with the lowest overall trend – had more than twice the annual PMPY spend of the silver plans and 10 times the spend for bronze plan members. This strongly indicates that those who selected platinum plans, which carry the highest coverage value, began utilizing their benefit for known, costly conditions upon plan enrollment in 2014.

AGES 45 TO 54

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$439.50	13.2%	0.5%	**13.7%**
Specialty	$516.53	6.4%	18.4%	**24.9%**
TOTAL OVERALL	**$956.03**	**13.1%**	**6.4%**	**19.5%**

January-December 2015 compared to same period in 2014

AGES 55 TO 64

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
		12.5%	0.1%	**12.6%**
Specialty	$522.59			
TOTAL OVERALL	**$1,115.62**	**12.5%**	**6.9%**	**19.5%**

January-December 2015 compared to same period in 2014

COMPONENTS OF EXCHANGE TREND BY METAL LEVEL

2015

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Platinum	$2,191.16	-0.1%	4.4%	**4.4%**
Gold	$1,543.80	-3.4%	9.4%	**6.0%**
Silver	$1,086.08	12.0%	8.5%	**20.5%**
Bronze	$208.09	10.2%	-5.8%	**4.5%**

January-December 2015 compared to same period in 2014

Traditional therapy classes and insights: exchanges

Total traditional trend for exchange plans in 2015 was 9.4%, almost entirely the result of an 8.7% increase in PMPY utilization. When ranked by PMPY spend, the top three traditional therapy classes – diabetes, pain/inflammation and mental/neurological disorders – contributed 32.7% of total spend for all traditional medications used by exchange beneficiaries in 2015. Although total trend was negative in just one of the top 10 traditional therapy classes (depression), unit costs decreased for five classes – high blood pressure/heart disease (-5.8%), asthma (-8.1%), high blood cholesterol (-4.3%), depression (-33.4%), and infections (-1.2%). Interestingly, PMPY utilization for all of the top 10 traditional therapy classes increased, ranging from 4.8% to 17.8%. This suggests general coverage fulfillment for previously unmet needs.

PMPY utilization for all of the top 10 traditional therapy classes increased. This suggests general coverage fulfillment for **previously unmet needs**.

COMPONENTS OF TREND FOR THE TOP 10 OVERALL EXCHANGE TRADITIONAL THERAPY CLASSES

RANKED BY 2015 OVERALL EXCHANGE PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Diabetes	$67.22	8.2%	3.6%	**11.8%**
2	Pain/Inflammation	$40.74	4.8%	12.1%	**16.9%**
3	Mental/Neurological Disorders	$19.78	9.4%	5.5%	**15.0%**
4	Attention Disorders	$17.81	17.8%	3.8%	**21.6%**
5	High Blood Pressure/Heart Disease	$16.67	9.1%	-5.8%	**3.3%**
6	Asthma	$16.31	12.9%	-8.1%	**4.8%**
7	High Blood Cholesterol	$16.02	7.3%	-4.3%	**2.9%**
8	Depression	$15.54	12.0%	-33.4%	**-21.4%**
9	Contraceptives	$14.46	17.2%	7.2%	**24.4%**
10	Infections	$12.59	8.0%	-1.2%	**6.9%**
	TOTAL TRADITIONAL	**$391.13**	**8.7%**	**0.7%**	**9.4%**

Highlights

- Diabetes saw a higher PMPY spend ($67.22) than any other traditional therapy class among exchange beneficiaries. Trend for diabetes medications was 11.8%, driven by an increase in PMPY utilization (8.2%) and a smaller increase in unit cost (3.6%). Highly utilized medications, including metformin, glimepiride, and Januvia® (sitagliptin) drove the utilization and cost increases.

- Total PMPY spend for medications used to treat pain/inflammation grew 16.9%, the result of an increase in PMPY utilization (4.8%) and an even greater rise in unit costs (12.1%). Although generic medications continue to dominate the class, PMPY spend has not declined accordingly. Together, the five most commonly used pain/inflammation drugs – hydrocodone/acetaminophen, gabapentin, meloxicam, tramadol and oxycodone/acetaminophen – all generic medications, captured 58.9% of market share for this therapy class.

- PMPY spend for medications used to treat attention disorders increased 21.6% in 2015, mostly from a 17.8% increase in PMPY utilization, but also from a 3.8% increase in unit cost. Vyvanse® (lisdexamfetamine), one of the leading brand medications in this class, increased in both PMPY utilization (19.3%) and unit cost (12.7%). Spend for Vyvanse is not likely to decrease in the near future, as the product has patent protection until at least 2023. In January 2015, Vyvanse was approved by the U.S. Food and Drug Administration (FDA) to treat patients aged 18 and older who have binge eating disorder. By June, over half of Vyvanse patients were adults.[43] Increased utilization for this therapy class is likely due to coverage provided by the ACA and the new criteria for diagnosing attention disorders in adults.[44]

- In 2015, the unit cost trends for both the high blood pressure/heart disease and high blood cholesterol classes were negative. Declines in unit costs can be attributed to the availability of generics in each class. In 2015, the generic fill rate (GFR) for the high blood pressure/heart disease class increased to 98.6%, while the GFR for high blood cholesterol medications went up to 94.4%.

- Unit costs for medications used to treat depression decreased 33.4%, resulting in the only decrease (-21.4%) in PMPY spend among the top 10 traditional therapy classes. Four of the top five most-utilized antidepressants were generics, representing almost 72% of all utilization in this class. These four drugs had double-digit decreases in unit cost trends: sertraline (-34.8%), citalopram (-36.3%), bupropion extended release (-21.1%) and escitalopram oxalate (-84.2%).

- The highest increase (24.4%) in PMPY spend among the top 10 traditional therapy classes was for contraceptives, driven by increases in PMPY utilization (17.2%) and unit costs (7.2%). The ACA mandate requiring exchange plans to offer access to at least one contraceptive medication in each of the 18 categories of contraceptives without a copayment[45] is largely responsible for the increases in this category.

Four of the top five most-utilized antidepressants were generics, representing **almost 72%** of all utilization in this class.

Top 10 exchange traditional drugs

Together, seven of the top 10 brand name drugs ranked by PMPY spend accounted for 12.3% of PMPY spend for all traditional therapy drugs. Five injectable diabetes treatments were among the top 10 traditional therapies for exchange beneficiaries based on PMPY spend: Lantus® (insulin glargine), Levemir® FlexTouch® (insulin detemir), NovoLog® FlexPen® (insulin aspart), Victoza® 3-Pak (liraglutide) and Humalog® U-100 KwikPen® (insulin lispro). They captured 9.6% of PMPY spend for all traditional therapy drugs used by exchange beneficiaries in 2015. Two of them (NovoLog FlexPen and Victoza 3-Pak) had double-digit increases in PMPY spend.

Five injectable diabetes treatments captured **9.6%** of PMPY spend for all traditional therapy drugs used by exchange beneficiaries in 2015.

TOP 10 OVERALL EXCHANGE TRADITIONAL THERAPY DRUGS

RANKED BY 2015 OVERALL EXCHANGE PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL TRADITIONAL SPEND	UTILIZATION	UNIT COST	TOTAL
1	Lantus® (insulin glargine)	Diabetes	$11.34	2.9%	-7.2%	-8.2%	**-15.4%**
2	Levemir® FlexTouch® (insulin detemir)	Diabetes	$9.06	2.3%	19.2%	-18.2%	**1.0%**
3	dextroamphetamine/amphetamine	Attention disorders	$7.93	2.0%	20.1%	-7.6%	**12.5%**
4	aripiprazole	Mental/neurological disorders	$6.70	1.7%	-	-	**-**
5	NovoLog® FlexPen® (insulin aspart)	Diabetes	$6.14	1.6%	-2.9%	16.5%	**13.6%**
6	Victoza® 3-Pak (liraglutide)	Diabetes	$5.94	1.5%	20.1%	21.9%	**42.1%**
7	duloxetine	Depression	$5.92	1.5%	23.2%	-61.8%	**-38.6%**
8	Lyrica® (pregabalin)	Pain/inflammation	$5.23	1.3%	10.2%	26.2%	**36.5%**
9	Humalog® U-100 KwikPen® (insulin lispro)	Diabetes	$5.23	1.3%	12.6%	-21.7%	**-9.0%**
10	APRISO® (mesalamine)	Inflammatory conditions	$5.23	1.3%	5.3%	12.1%	**17.4%**

The highest trend for a brand medication in the top 10 (42.1%) was for Victoza 3-Pak, a type 2 diabetes treatment which, as the brand-name Saxenda®, is also approved to treat obesity. The trend was driven by large increases in both PMPY utilization (20.1%) and unit costs (21.9%) and represents Victoza 3-Pak alone (excluding Saxenda).

The only three brand name drugs that saw unit cost trend decreases were insulin therapies (Lantus, Levemir FlexTouch and Humalog U-100 KwikPen) that are sold in pre-filled pens. Unit cost for the top insulin, Lantus, decreased 8.2% in 2015. After Levemir FlexTouch was approved in late 2013, it rose to second place for all traditional drug spend for exchange members in 2015. Currently, no generic insulins are available in the U.S. Basaglar® (insulin glargine) – the first "follow-on" insulin to Lantus – is expected to reach the market by December 2016.[46]

Utilization declined for only two of the top 10 drugs. Both were insulins: Lantus (-7.2%) and NovoLog FlexPen (-2.9%).

Abilify® (aripiprazole), an antipsychotic, lost patent protection in April 2015. By the end of 2015, the generic medication aripiprazole already ranked fourth among traditional medications. At PMPY spend of $6.70, aripiprazole alone accounted for 1.7% of total traditional spend.

In 2015, the generic drug duloxetine, an antidepressant, had the largest decrease (-61.8%) in unit costs and the highest increase (23.2%) in PMPY utilization among the top 10 traditional drugs. Prior evidence suggests antidepressants are the most common drug class utilized by patients aged 18 to 44[47], who constitute the largest part of the exchange population.

By the end of 2015, the generic version of Abilify ranked fourth among traditional medications and accounted for 1.7% of the total traditional spend.

Lyrica® (pregabalin), a drug to treat pain/inflammation, ranked eighth in traditional therapy drugs among the exchange population. Its trend (36.5%) was driven by double-digit increases in unit cost (26.2%) as well as utilization (10.2%). The unit cost is expected to remain high, as generic pregabalin is not likely to enter the U.S. market until December 2018.[48]

Specialty therapy classes and insights: exchanges

Specialty medications account for nearly 50% of total pharmacy spend in the exchanges. PMPY spend for specialty medications among exchange beneficiaries increased 20.4% in 2015, fueled by a 15.8% increase in unit cost and a 4.7% increase in PMPY utilization. Ranked by PMPY spend, the top three therapy classes – HIV, hepatitis C and inflammatory conditions – contributed almost 65% of total specialty PMPY spend. Two of the three – HIV and inflammatory conditions – had double-digit PMPY spend increases in 2015. All of the top 10 therapy classes increased in unit cost, but four of them – HIV, hepatitis C, hereditary angioedema and hemophilia – decreased in PMPY utilization. Specialty medications which treat rare conditions are sensitive to changes in population composition which may affect their trends. By far, the key drivers of trend were drugs to treat HIV, hepatitis C and inflammatory conditions.

Specialty medications which treat rare conditions are **sensitive** to changes in **population composition** which may affect their trends.

COMPONENTS OF TREND FOR THE TOP 10 OVERALL EXCHANGE SPECIALTY THERAPY CLASSES

RANKED BY 2015 OVERALL EXCHANGE PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	HIV	$99.96	-3.1%	13.8%	**10.7%**
2	Hepatitis C	$86.81	-1.0%	7.1%	**6.1%**
3	Inflammatory conditions	$63.94	33.5%	19.1%	**52.6%**
4	Oncology	$47.45	21.3%	15.8%	**37.2%**
5	Multiple sclerosis	$41.94	10.1%	11.4%	**21.4%**
6	Pulmonary hypertension	$5.41	48.1%	25.7%	**73.8%**
7	Hereditary angioedema	$5.21	-6.5%	9.2%	**2.8%**
8	Hemophilia	$4.66	-7.6%	13.3%	**5.7%**
9	Sleep disorders	$4.13	2.4%	15.8%	**18.2%**
10	Cystic fibrosis	$3.63	23.6%	25.5%	**49.2%**
	TOTAL SPECIALTY	**$386.14**	**4.7%**	**15.8%**	**20.4%**

Highlights

- The increase in PMPY spend for HIV treatments topped that of other specialty medications. Despite a 3.1% PMPY utilization decrease, a 13.8% unit cost increase led to an overall 2015 trend increase of 10.7% in PMPY spend for HIV treatments, moving them up to the most costly specialty therapy class. Our third Exchange Pulse Report, released in July 2015, found that exchange members have a higher prevalence of use for HIV medications: "more than 1 out of every 2 specialty claims are for HIV – making it the #1 specialty condition impacting 18 to 64 year olds in the exchanges."[49]

- Hepatitis C drug spend increased 6.1% in 2015 after a few effective but expensive oral antiviral therapies were introduced to the market. While utilization decreased 1.0%, a 7.1% increase in unit cost caused most of the change in spend. Harvoni® (ledipasvir/sofosbuvir) and Sovaldi® (sofosbuvir) together captured nearly 75% of market share for this therapy class. Viekira Pak® (ombitasvir/paritaprevir/ritonavir with dasabuvir), which was approved at the end of 2014, only took 2.5% of market share among exchange users in 2015.

- Spend for the number three therapy class, inflammatory conditions, jumped 52.6%. Unit cost increased substantially (19.1%), but an even bigger component of the PMPY spend trend was a 33.5% increase in PMPY utilization. Together, the top two drugs (both injected), Humira® Pen (adalimumab) and Enbrel® (etanercept), accounted for about two-thirds of market share for the inflammatory conditions class and more than 9% of overall specialty market share. Unit costs for each increased more than 21% in 2015, contributing a major portion of the escalation in overall class spend. One of the key treatments in this class is Xeljanz® (tofacitinib), a relatively new oral disease-modifying antirheumatic drug. With longer-term safety and effectiveness data now available, Xeljanz has begun capturing exchange market share (nearly 2% in 2015) from some of the more established, but less convenient, injectable treatments in the class.

The top five specialty therapy classes by PMPY spend contributed 88% of total specialty PMPY spend for health insurance exchanges.

- In 2015, PMPY spend for oncology drugs increased 37.2% among exchange beneficiaries. This trend was due to large increases in both PMPY utilization (21.3%) and unit cost (15.8%). The utilization increase was likely the result of several factors, including the expansion of indications for several drugs, the continued development of newer, more targeted therapies and an increase in the survival rates of patients living with cancer, but continuing medication therapy. For instance, Imbruvica® (ibrutinib) is the only currently FDA-approved Bruton's tyrosine kinase (BTK) inhibitor. Its effectiveness for hard-to-treat cancers, additional indications, oral dosing and relatively mild side effects contributed to a 2015 utilization surge of 80.5%.

- Total trend for multiple sclerosis medications was 21.4%, due to increases in both PMPY utilization (10.1%) and unit cost (11.4%). Copaxone® (glatiramer) has the highest PMPY spend and is the most widely used medication in the class. Glatopa™, a generic alternative for Copaxone's 20mg/mL dosage form was launched in the U.S. in June 2015. However, the brand manufacturer is hoping to continue the shift of existing users to a new, longer-acting 40mg/mL formulation that has patent protection until 2030. In addition, another drug with a high PMPY spend in the class – Tecfidera® (dimethyl fumarate), released in April 2013, is an oral medication. Its convenience compared to injectables is appealing to many patients.

Top 10 exchange specialty drugs

The top 10 specialty drugs accounted for 53.2% of PMPY spend for all specialty drugs used by exchange participants in 2015. The top 10 specialty medications for exchanges represented four therapy classes – four drugs for HIV, two drugs each for hepatitis C, multiple sclerosis and inflammatory conditions.

The top four HIV medications are all combination products with two or more different drugs in one tablet: Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate), Stribild® (cobicistat/elvitegravir/emtricitabine/tenofovir disoproxil fumarate), Truvada® (emtricitabine/tenofovir disoproxil fumarate) and Complera® (emtricitabine/rilpivirine/tenofovir disoproxil fumarate). Together they contributed 16.2% of exchange specialty trend. Although trend for Stribild, Truvada and Complera increased, a utilization drop for Atripla more than offset its increased unit cost to result in a negative 5.8% trend for the year.

PMPY spend among the top 10 specialty drugs ranged from a low of $7.87 for Complera, an HIV medication, to a high of $62.27 for Harvoni, a hepatitis C drug. Even though it didn't launch until late 2014, Harvoni alone contributed 16.1% of all exchange specialty drug spend in 2015. Another hepatitis C medication, Sovaldi, was the only specialty drug in the top 10 to see decreases in PMPY utilization (-59.0%), unit cost (-4.9%) and PMPY spend (-64.0%) in 2015.

TOP 10 OVERALL EXCHANGE SPECIALTY THERAPY DRUGS

RANKED BY 2015 OVERALL EXCHANGE PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL SPECIALTY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Harvoni® (ledipasvir/sofosbuvir)	Hepatitis C	$62.27	16.1%	511.1%	-178.8%	**332.3%**
2	Humira® Pen (adalimumab)	Inflammatory conditions	$23.76	6.2%	35.5%	25.1%	**60.6%**
3	Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)	HIV	$21.97	5.7%	-14.4%	8.6%	**-5.8%**
4	Sovaldi® (sofosbuvir)	Hepatitis C	$19.67	5.1%	-59.0%	-4.9%	**-64.0%**
5	Stribild® (cobicistat/elvitegravir/ emtricitabine/tenofovir disoproxil fumarate)	HIV	$17.21	4.5%	28.1%	6.8%	**34.9%**
6	Enbrel® (etanercept)	Inflammatory conditions	$16.03	4.2%	6.8%	21.2%	**28.0%**
7	Truvada® (emtricitabine/tenofovir disoproxil fumarate)	HIV	$15.33	4.0%	-0.8%	6.3%	**5.6%**
8	Copaxone® (glatiramer)	Multiple sclerosis	$12.14	3.1%	11.0%	12.1%	**23.0%**
9	Tecfidera® (dimethyl fumarate)	Multiple sclerosis	$9.29	2.4%	10.2%	11.5%	**21.6%**
10	Complera® (emtricitabine/rilpivirine/ tenofovir disoproxil fumarate)	HIV	$7.87	2.0%	15.5%	9.0%	**24.5%**

With the exception of Harvoni, the largest increases in utilization (35.5%), unit cost (25.1%) and total spend (60.6%) were observed for Humira Pen, a drug to manage inflammatory conditions. These findings are consistent with those from the third Exchange Pulse Report, released in June 2015, which states that use of medications to treat inflammatory conditions is on the rise among exchange members older than age 55.

With a biosimilar alternative for Humira expected in the near future, plans will eventually be able to offer lower-cost versions of these complex drugs.

The newer, 40 mg/mL, three-times-a-week formulation of Copaxone continued to lead the multiple sclerosis class in spend, with double-digit increases in both PMPY utilization (11.0%) and unit cost (12.1%). However, Glatopa, a generic alternative for Copaxone's 20mg/mL dosage form, launched in the U.S. in June 2015. It may capture some of the higher-strength brand market share in the next few years. Tecfidera, another medication used in the treatment of multiple sclerosis, also had high increases in both PMPY utilization (10.2%) and unit cost (11.5%). The 2014 Commercial Drug Trend Report forecasted Tecfidera, an oral medication approved by the FDA in March 2013, would capture market share from older injectables. More recent data indicates that this forecast held true for the exchange population.

Comparison of exchange, Medicaid and commercial trend

In examining therapy class trends, we identified areas of difference between the exchange population and other lines of business – specifically Medicaid and commercial plans. Among traditional therapy classes, pain/inflammation, mental/neurological disorders, attention disorders, asthma and infections all had much higher 2015 trends within the exchange population than Medicaid or commercial members. Contraceptives, which the ACA requires be provided at zero cost sharing, also had a markedly higher trend within the exchange. The increase was most likely caused by exchange members continuing to take advantage of their new benefits.

Among specialty classes, trends were considerably higher for the inflammatory conditions, oncology, multiple sclerosis and pulmonary hypertension classes in the exchange population than in Medicaid or commercial plans. Hepatitis C trend in the exchange population was comparable to the commercial line of business. Pulmonary hypertension trend was markedly greater than both Medicaid and commercial populations.

Whether these therapy class trends represent a continuing departure from other lines of business, or reflect a new exchange population that is just beginning to use their benefits, remains to be determined. As the exchanges continue to evolve, we'll continue to monitor, report and assist in managing trends.

EXCHANGE TREND VS. MEDICAID AND COMMERCIAL TREND FOR THE TOP 10 EXCHANGE TRADITIONAL THERAPY CLASSES

RANKED BY 2015 OVERALL EXCHANGE PMPY SPEND

		TREND		
RANK	THERAPY CLASS	EXCHANGE	MEDICAID	COMMERCIAL
1	Diabetes	11.8%	21.7%	14.0%
2	Pain/inflammation	16.9%	0.0%	2.9%
3	Mental/neurological disorders	15.0%	-6.4%	0.2%
4	Attention disorders	21.6%	8.0%	8.5%
5	High blood pressure/heart disease	3.3%	-3.4%	-12.5%
6	Asthma	4.8%	2.6%	-1.6%
7	High blood cholesterol	2.9%	-3.9%	-9.2%
8	Depression	-21.4%	-24.0%	-30.1%
9	Contraceptives	24.4%	6.8%	1.5%
10	Infections	6.9%	-4.1%	-5.4%
	TOTAL TRADITIONAL	**9.4%**	**3.3%**	**0.6%**

EXCHANGE TREND VS. MEDICAID AND COMMERCIAL TRENDS FOR THE TOP 10 EXCHANGE SPECIALTY THERAPY CLASSES

RANKED BY 2015 OVERALL EXCHANGE PMPY SPEND

		TREND		
RANK	THERAPY CLASS	EXCHANGE	MEDICAID	COMMERCIAL
1	HIV	10.7%	4.9%	16.6%
2	Hepatitis C	6.1%	-9.7%	7.0%
3	Inflammatory conditions	52.6%	45.6%	25.0%
4	Oncology	37.2%	29.4%	23.7%
5	Multiple sclerosis	21.4%	16.0%	9.7%
6	Pulmonary hypertension	73.8%	9.8%	18.1%
7	Hereditary angioedema	2.8%	8.7%	29.6%
8	Hemophilia	5.7%	94.8%	20.4%
9	Sleep disorders	18.2%	40.9%	24.1%
10	Cystic fibrosis	49.2%	19.2%	53.4%
	TOTAL SPECIALTY	**20.4%**	**10.1%**	**17.8%**

Solutions

Solutions for exchange challenges

Balancing regulatory requirements and consumer needs with optimal pharmacy benefit designs will remain challenging in the near term. As the health insurance exchanges mature, health plans will increasingly look at managing both cost and patient risk within their health insurance exchange portfolios.

Managing cost to lower premiums

Cost management will remain a critical challenge. Cost also will continue to be a key element in consumer decision making. Offering a regulatory compliant, competitively priced benefit that attracts and retains members is essential to a plan's positioning in the consumer market. Express Scripts is uniquely positioned to help exchange plans lower premium costs through the use of pharmacy benefit designs. **Our formularies, channel management solutions and disease-specific utilization management tools can meet the needs of the exchange populations.** In fact, nearly half of our exchange clients have taken advantage of additional savings though our home delivery programs.

The exchange market is still **new and volatile**. Quickly understanding and managing patient risk is crucial for exchange sponsors and patient health.

Understanding patient risk

The exchange market is still new and volatile. In addition, the exchange population is currently using high-cost specialty medications at a higher rate than any other line of business. Quickly understanding and managing patient risk is crucial for exchange sponsors and patient health. **Leveraging pharmacy data and Knowledge Solution resources from Express Scripts not only identifies patients most at risk, but also helps predict and mitigate potentially costly gaps in care.**

Member retention

Member churn among plans makes providing cohesive patient management difficult. Thus, plans may not readily see quantifiable returns on their population heath initiatives. To help members with high-cost, complex and chronic conditions achieve optimal outcomes and to coordinate with the health plan's member retention strategies, Express Scripts offers specialized care through our Therapeutic Resource Centers℠ (TRC). Because TRC specialist pharmacists, field nurses and support teams are extensively trained in the drugs used to treat specific conditions, they provide a personal approach to healthcare management. They actively elicit member participation in managing healthcare needs. Clinical specialization is a fundamental component of the way Express Scripts practices pharmacy. **The expertise of our TRC specialists impacts our patients in many ways.** For example, our TRC specialist pharmacists have advanced training to understand what patients with complex, chronic conditions like hepatitis C, multiple sclerosis and HIV experience on a daily basis. They're able to provide the in-depth information that members need in order to understand how taking their medications appropriately affects their overall health. All members have access to our TRCs and staff of specialists at no additional charge, regardless of where their prescriptions are filled.

With more than 20 years experience in supporting regulated market clients and their members, Express Scripts is well positioned to handle the ever-changing complexities of the exchange market.

Specialty trend management

Specialty medications continue to drive up plan and individual costs in the exchange population – most notably within oncology, hepatitis C, HIV and pulmonary hypertension therapy classes. Accredo Specialty Benefit Services are available for our clients who are looking for better ways to manage their specialty trend. Specialty Benefit Services improve care for patients through our specialized behavioral and clinical care approach to pharmacy. **By coordinating Specialty Benefit Services with specific network, utilization and medical benefit management strategies, Express Scripts is better able to manage costly specialty trends for plan sponsors.**

The Health Insurance Exchange Marketplace will continue to present the industry with unprecedented opportunities and unique challenges. Health plans require partners with recognized expertise, proven capabilities and innovative solutions to navigate through complex uncertainties. Express Scripts offers all of this and provides dedication and personal support to help plans take advantage of opportunities, while minimizing risks.

Appendix

The Drug Trend Report methodology

Our research team analyzes prescription drug use data for members with drug coverage provided by Express Scripts plan sponsors[50] for this report. The plan sponsors providing the pharmacy benefit paid at least some portion of the cost for the prescriptions dispensed to their members, providing what is known as a funded benefit.

Both traditional and specialty drugs are included in the data. Specialty medications include injectable and noninjectable drugs that are typically used to treat chronic, complex conditions and may have one or more of the following qualities: frequent dosing adjustments or intensive clinical monitoring; intensive patient training and compliance assistance; limited distribution; and specialized handling or administration. Nonprescription medications (with the exception of diabetic supplies billed under the pharmacy benefit) and prescriptions that were dispensed in hospitals, long-term care facilities and other institutional settings or billed under the medical benefit aren't included.

Trend and other measures are calculated separately for those members with commercial insurance coverage, for Medicaid recipients and for Medicare beneficiaries receiving prescription benefits through Employer Group Waiver Plans (EGWPs), managed Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MAPDs). Members used Express Scripts for retail and home delivery pharmacy services; they used Accredo®, the Express Scripts specialty pharmacy, for specialty drug prescriptions.

Gross drug trend measures the rate of change in plan costs, which include ingredient costs, taxes, dispensing fees, administrative fees, rebates and member cost share.

Total trend measures the rate of change in plan costs, which include ingredient costs, taxes, dispensing fees and administrative fees. Rebates are included as a component of cost, reflecting more managed trends as noted in this report. Total trend comprises utilization trend and unit cost trend. Utilization trend is defined as the rate of change in total days' supply of medication per member, across prescriptions. Unit cost trend is defined as the rate of change in costs due to inflation, discounts, drug mix and member cost share. Utilization and cost are determined on a PMPY basis. Metrics are calculated by dividing totals by the total number of member-months, which is determined by adding the number of months of eligibility for all members in the sample.

The Express Scripts Prescription Price Index measures inflation in prescription drug prices by monitoring changes in consumer prices for a fixed market basket of commonly used prescription drugs. Separate market baskets are defined for brand drugs and for generic drugs and are based on the top 80% of utilized drugs.

Please note: Although up to nine decimal places were allowed in making all calculations, in most cases the results were rounded down to one or two decimals for easier reading. Therefore, dollar and percentage calculations may vary slightly.

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Download the complete 2015 Drug Trend Report
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THE HEALTH OF AMERICA REPORT

NEWLY ENROLLED MEMBERS IN THE INDIVIDUAL HEALTH INSURANCE MARKET AFTER HEALTH CARE REFORM:

THE EXPERIENCE FROM 2014 AND 2015

EXECUTIVE SUMMARY

The Affordable Care Act (ACA) expanded access to health insurance for millions of Americans and broadened medical benefits. Under the health reform law, anyone can obtain coverage regardless of age and health status. The law also applied the ACA's insurance reforms and expanded benefits to individual policies sold outside of government marketplaces.

Major reforms took effect in 2014, prompting many individuals who lacked coverage, and needed immediate health care services, to enroll for coverage. In addition, many individuals with significant medical conditions had previously been covered through state-based "high-risk" pools, and these people also transitioned into individual coverage. Overall, individual policies before reform offered less generous benefits. The ACA broadened benefits made available to everyone, including, for example, preventive services and screenings, maternity care, disease management, mental health and substance abuse services.

For more than 80 years, Blue Cross and Blue Shield (BCBS) companies have provided secure and stable health coverage to people in communities across the country. As part of this continuing commitment, BCBS companies have participated in the new ACA marketplaces more broadly than any other insurance carrier. As a result, millions of newly enrolled BCBS members are the largest single group of individuals whose health status and use of medical services can be examined for key insights into the medical needs and costs associated with providing care for the new individual market enrollees.

This report is a comprehensive, in-depth study of medical claims among those enrolled in BCBS individual coverage before and after the ACA took effect. In addition, the report also compares the newly enrolled ACA members to those who receive insurance through their employers.

Because the ACA guarantees coverage for pre-existing conditions and broadens benefits available to everyone, individual policies that comply with the law now resemble those offered by employer groups. Thus, comparing the health status, use of medical services and costs of caring for members receiving coverage through the employer market with those covered through ACA-compliant[1] individual policies is important to understanding the dynamics now at work in the health care system.

1. "ACA-compliant" coverage describes health insurance purchased on or off the ACA marketplaces that meets all of the requirements of the ACA for individual coverage. Compared with individual insurance purchased prior to 2014, ACA-compliant coverage has richer benefits on average and may be subsidized for individuals depending on their incomes.

Comparing the health status and use of medical services among those who enrolled in individual coverage before and after the ACA took effect, as well as those with employer-based health insurance, the study finds that:

- Members who newly enrolled in BCBS individual health plans in 2014 and 2015 have higher rates of certain diseases such as hypertension, diabetes, depression, coronary artery disease, human immunodeficiency virus (HIV) and Hepatitis C than individuals who already had BCBS individual coverage.
- Consumers who newly enrolled in BCBS individual health plans in 2014 and 2015 received significantly more medical services in their first year of coverage, on average, than those with BCBS individual plans prior to 2014 who maintained BCBS individual health coverage into 2015, as well as those with BCBS employer-based group health coverage.
- The new enrollees used more medical services across all sites of care—including inpatient hospital admissions, outpatient visits, medical professional services, prescriptions filled and emergency room visits.
- Medical costs associated with caring for the new individual market enrollees were, on average, 19 percent higher than employer-based group members in 2014 and 22 percent higher in 2015. For example, the average monthly medical spending was $559 for individual enrollees versus $457 for employer-based group members in 2015.

STUDY FINDS...

Newly enrolled in BCBS individual health plans in 2014 and 2015 appear to:

have higher rates of certain diseases

used more medical services across all sites of care

have higher medical costs associated with care

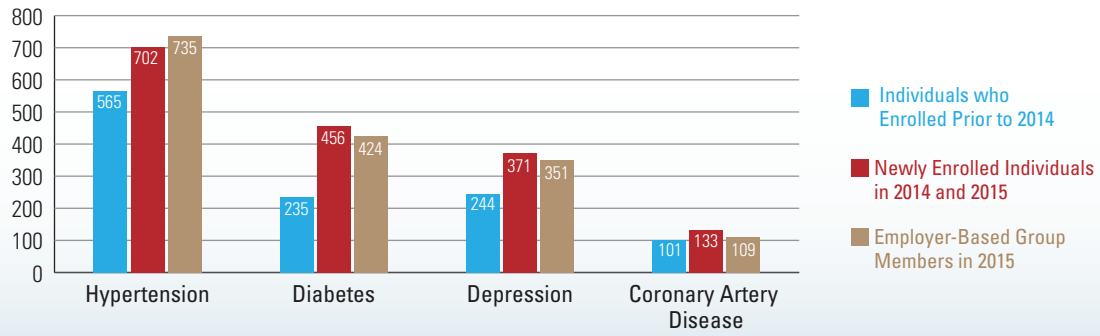
The data underscores the need for health insurers, medical professionals and newly insured consumers to work together to ensure that individuals understand their benefits, and use them to improve their health and well-being. BCBS companies are changing their individual health plan products to enhance care management programs to address the unique needs of this population. In addition, patient-focused care programs that emphasize prevention, wellness and coordinated care—programs that are offered across the country by Blue Cross and Blue Shield companies—can support individuals in getting healthy faster and staying healthy longer.

DISEASE PREVALENCE AND USE OF MEDICAL SERVICES

Consumers who newly enrolled in BCBS individual health plans in 2014 and 2015 received significantly more medical services in 2015, on average, than those with BCBS individual plans prior to 2014 who maintained BCBS individual health coverage into 2015.

During the first nine months of 2015, data show that those who enrolled for coverage after the ACA had higher rates of hypertension, diabetes, coronary artery disease and depression than individuals who enrolled prior to 2014. Due to the shorter period of time for which claims data on this group is available, it is possible that the rate of disease among individuals newly enrolled in 2014 and 2015 is underestimated in this report.

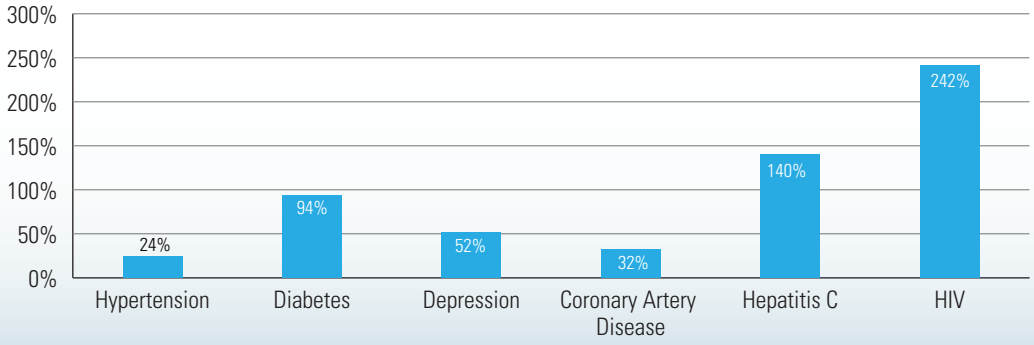
2015 PREVALENCE OF SELECT CONDITIONS (PER 10,000)



Based on the first nine months of 2015 medical claims data.
The blue bar represents individuals who enrolled prior to 2014 and continued BCBS individual coverage into 2015.

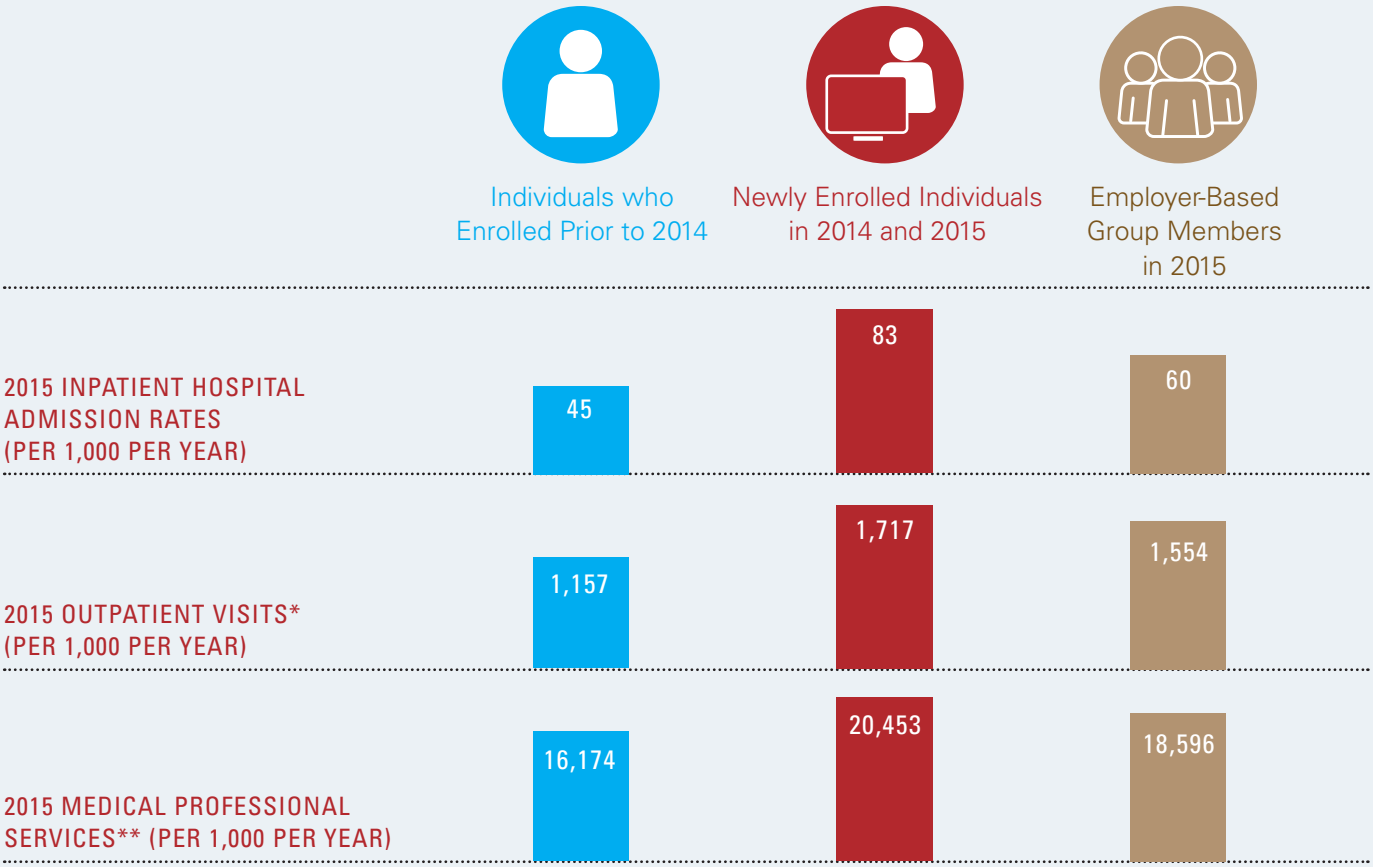
Those enrolling after health-care reform took effect also had higher rates of HIV and Hepatitis C in 2015. New enrollees have rates of HIV and Hepatitis C of 41 and 24 per 10,000 respectively, compared to 12 and 10 respectively among those with individual policies prior to health care reform. Rates of HIV and Hepatitis C for those who receive insurance through their employers were 11 per 10,000 for both conditions.

PERCENTAGE DIFFERENCE IN 2015 PREVALENCE OF SELECT CONDITIONS BETWEEN INDIVIDUALS WHO ENROLLED PRIOR TO 2014 VERSUS NEWLY ENROLLED IN 2014 AND 2015



Based on the first nine months of 2015 medical claims data.

New enrollees also utilized more medical services across all sites of care in 2015 compared to enrollees who first purchased their coverage prior to 2014. Inpatient admissions were higher by 84 percent; outpatient visits by 48 percent and medical professional services by 26 percent. New enrollees also utilized more medical services compared to members who received their coverage through an employer, with inpatient admissions higher by 38 percent; outpatient visits by 10 percent and medical professional services by 10 percent.

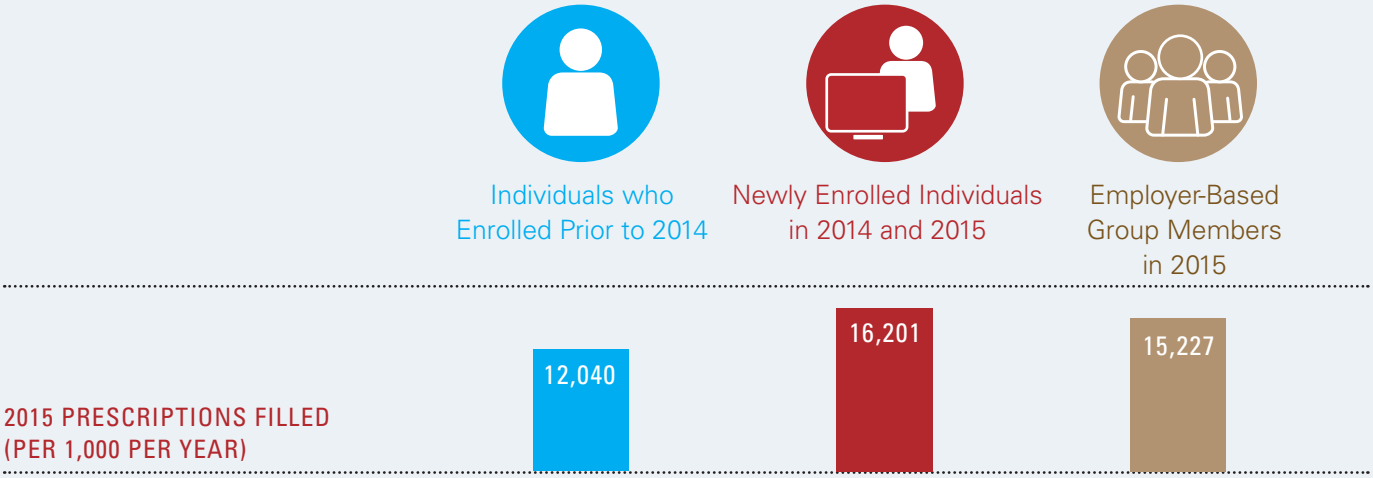


Charts based on the first nine months of 2015 medical claims data. The blue bar represents individuals who enrolled prior to 2014 and continued BCBS individual coverage into 2015.

* Outpatient encompasses medical bills submitted by hospitals and health care centers for reimbursement. Patients visit and leave the medical facility on the same day.

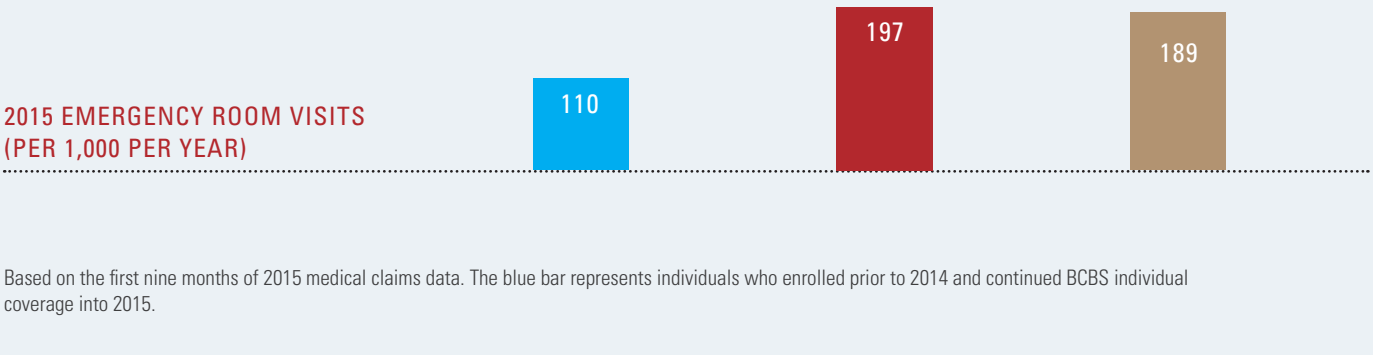
** Medical Professional Service encompasses medical bills submitted by physicians and other medical professionals for reimbursement.

New enrollees filled 35 percent more prescriptions in 2015 compared to enrollees who first purchased their coverage prior to 2014 and six percent more prescriptions compared to those who received their coverage through an employer.



Based on the first nine months of 2015 medical claims data. The blue bar represents individuals who enrolled prior to 2014 and continued BCBS individual coverage into 2015.

Another clear difference between the previously enrolled individual members and the newly enrolled population is their use of hospital emergency rooms (ER). ER use among the newly enrolled population was 79 percent higher than that of the previously enrolled during the first nine months of 2015 and slightly higher than those who receive their coverage through an employer.

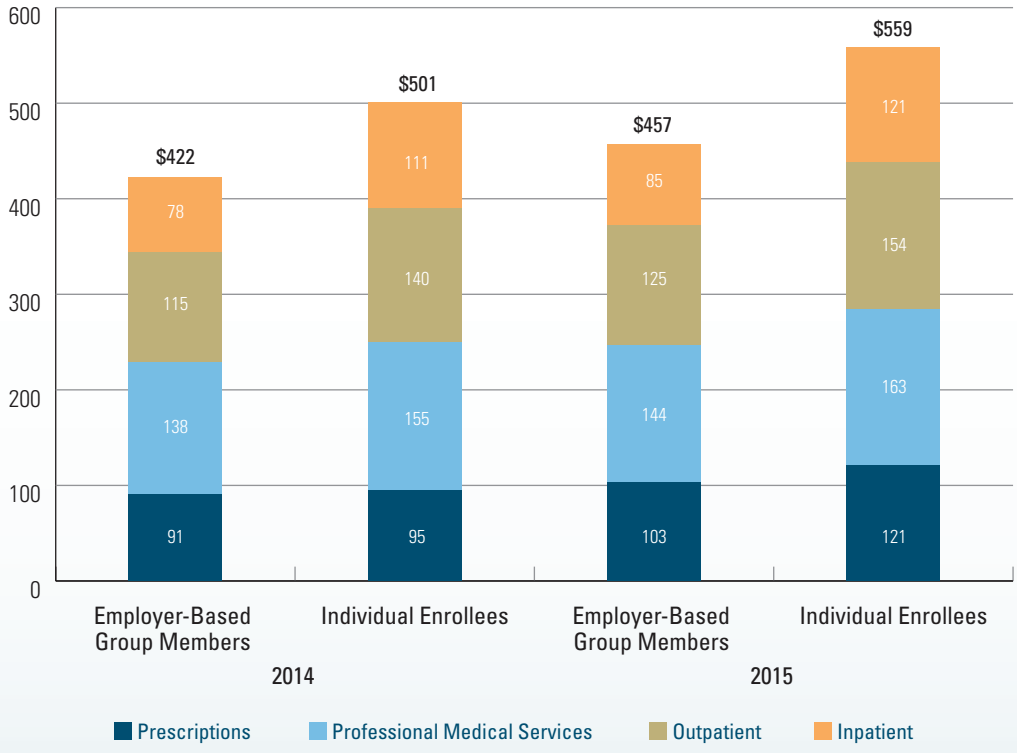


Based on the first nine months of 2015 medical claims data. The blue bar represents individuals who enrolled prior to 2014 and continued BCBS individual coverage into 2015.

MEDICAL SPENDING IN 2014 AND 2015

Average monthly medical spending per member for consumers who newly enrolled in BCBS individual coverage after health-care reform took effect increased 12 percent—from $501 to $559—from the first nine months of 2014 to the first nine months of 2015. This increase is due to several factors, including an increased use of medical services and underlying medical-cost inflation. All types of medical services saw increases. By comparison, spending on BCBS members with employer-based group coverage rose eight percent—from $422 to $457—during the first nine months of 2014 compared to the same period in 2015. Medical costs of caring for individual members were, on average, 19 percent higher than employer-based group members in 2014 and 22 percent higher in 2015.

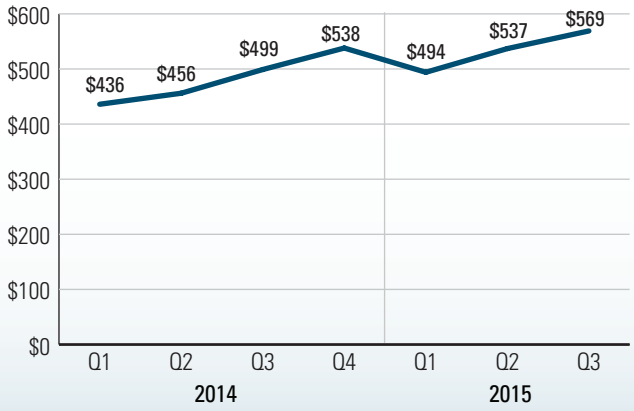
AVERAGE MONTHLY SPENDING FOR INDIVIDUAL ENROLLEES AND GROUP MEMBERS IN 2014 AND 2015 BY TYPE OF SERVICE



Note: Based on medical claims data for the first nine months of 2014 and the first nine months of 2015. 2014 includes all new individual members who enrolled in 2014 through September 2014. 2015 includes all individual members who enrolled in 2014 and remained covered by a BCBS policy in 2015 and those who enrolled through September 2015. Exchange members age 21 through 64 who enrolled in 2015 were younger than those who enrolled in 2014 by a half year, with an average age of 45.1 in 2015 compared to 45.6 in 2014. Employer-based group members age 21 through 64 who enrolled in 2015 were slightly younger than those who enrolled in 2014, with an average age of 42.6 in 2015 compared to 42.7 in 2014.

Throughout the first 21 months of health-care reform, the average medical spending for new BCBS individual members increased steadily, consistent with seasonal patterns and how members typically utilize health benefits throughout the year. More time and data will be needed to understand the long-term health status and costs associated with caring for this new population. In addition, underlying medical-cost inflation and continued demand for medical services will continue to be factors.

AVERAGE MONTHLY SPENDING PER MEMBER BY CLAIM QUARTER



Includes medical claims between Jan. 1, 2014 through Sept. 30, 2015.
Includes BCBS individual members age 21 through 64.

CONCLUSION

This is the first comprehensive, in-depth look at the medical needs and costs of caring for individuals enrolled in health insurance coverage with the expanded access and broader benefits called for under the ACA. The findings underscore the need for health insurers, medical professionals and newly insured consumers to work together and assure the most effective use of health care services in every community across the country.

To manage this transition to a new system in which everyone can obtain coverage, BCBS companies are advising consumers on the importance of primary care and medication adherence. It is important that newly insured consumers understand their benefits and are able to access preventive services in the right care setting, at the right time, to improve their health and avoid unnecessary emergency room visits. It is also important for members to be continually enrolled in order to maintain access to primary and preventive care, and fill prescriptions in a timely manner. Importantly, those with chronic conditions need quality, well-coordinated care to ensure the appropriate management of these diseases and improve patients' long-term health.

BCBS companies are expanding patient-focused care programs that emphasize prevention, wellness and coordinated care so that individuals get healthy faster and stay healthy longer. BCBS companies have engaged with more than 327,000 physicians and 2,000 hospitals that now serve 42 million members through these innovative care models. Through these programs, BCBS companies around the country have documented reductions in emergency room visits, fewer hospital admissions and readmissions and reduced hospital infection rates. At the same time, there have been measurable improvements in prevention, including improved cholesterol control, better adherence to best practices for treating diabetes and higher rates of screenings and immunizations.

Currently, BCBS companies serve millions of members through the ACA marketplaces in 46 states and the District of Columbia, with coverage in 89 percent of counties in both urban and rural areas. In addition to offering products on the federal and state-run marketplaces, all BCBS companies sell individual and employer-based group health insurance products throughout the country. BCBS companies insured more than 8.6 million individual members through Dec. 31, 2015.

METHODOLOGY NOTES

This report examines the medical claims of people enrolled in BCBS plans to compare the health status, use of medical services and cost of caring for three distinct populations:

- Individuals across the country who purchased BCBS coverage that became effective on or after January 1, 2014, through both state-based and federally-facilitated marketplaces, as well as individual, ACA-compliant policies sold outside of the government marketplaces;

- People who obtained BCBS coverage in the individual market prior to 2014 and continued to be enrolled in some type of BCBS individual market coverage into 2014 for 2014 statistics and 2015 for 2015 statistics; and

- People with BCBS employer-based group coverage.

The data in this report include approximately 4.7 million individual members and approximately 25 million employer-based group members and focuses on members ages 21 through 64. The impact of the federal risk adjustment program for the individual market is not reflected in this report. The charts report statistics calculated with the first nine months of claims data for each year because the medical claims for the fourth quarter of 2015 were not available at the time of publication. Using only the first nine months of data for both years ensures comparability. Data on medical spending are reported in terms of "allowed" medical costs—an insurance term that describes the total dollar amount paid to the provider and which includes both the insurer payment and member cost-sharing. By using allowed medical spending, claims data can be more easily compared across plans with different member cost-sharing, such as individual market plans with different metal levels.

The analysis relied on data from BCBS companies in many different parts of the country. The statistics discussed in the report represent collective results across many regions, and are not intended to represent the experience of any particular BCBS company. Each company's circumstances are different; they face different state laws, are exposed to different market dynamics, have adopted varying strategies, and may have experienced divergent results in the individual market since 2014.

This is the sixth study of the Blue Cross Blue Shield, The Health of America Report series, a collaboration between the Blue Cross Blue Shield Association and Blue Health Intelligence, which uses a market-leading claims database to uncover key trends and insights into health care affordability and access to care.

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HCCI HEALTH CARE COST INSTITUTE

Issue Brief #11

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Spending on Shoppable Services in Health Care

In the United States, the price of health care services is often not known to patients prior to receiving care. This is generally true regardless of whether the patient is covered by health insurance. Over the last several years a movement to introduce price transparency—information about the price before the service is rendered—has emerged.

As consumers are asked to pay more for health care services, understanding and anticipating those costs may be increasingly important to them. At the same time, consumers must be able to consume value through shopping, by choosing lower-priced high-quality providers. Insurers, employers, and governments also have an interest in greater price transparency as they hope it will lead to lower spending on health care. In general, two main arguments have been advanced for how price transparency may lower spending on health care.[1] First, consumers will be able to know the full cost of services before receiving them, and will be able to choose lower-cost services or providers, while holding quality constant. Second, when pricing information is publicly available, health care providers will be incentivized to lower their prices to be more competitive (for more information about the difficulties with this, see CBO 2008[2]). This issue brief focuses on the first of these: the potential for consumer activity to lower overall health care spending.

One study has estimated that price transparency efforts could save $100 billion dollars over a decade.[3] Of this amount, $18 billion could come from greater consumer access to pricing information. In theory, consumers would use pricing information to comparison shop for their health care services and providers. However, not all health care services are shoppable. It should not be expected that someone pull out his or her Smartphone and research the lowest price emergency room before dialing 911. For a health care service to be "shoppable," it must be a common health care service that can be researched ("shopped") in advance; multiple providers of that service must be available in a market (i.e., competition); and sufficient data about the prices and quality of services must be available. Another study has estimated that only about one third of total health care spending in a given year is on services that are shoppable.[4] Also notable is that consumer shopping does not have to be limited to comparisons across providers for Service X. Consumers may also choose to compare the cost of Service X with the cost of Service Y or even choose not to receive Service X at all.

KEY FINDINGS

At most, **43%** of the $524.2 billion spent on health care by individuals with ESI in 2011 was spent on shoppable services.

About **15%** of total spending in 2011 was spent by consumers out-of-pocket.

$37.7 billion (7% of total spending) of the out-of-pocket spending in 2011 was on shoppable services.

Overall, the potential gains from the consumer price shopping aspect of price transparency efforts are modest.

Analysis

This analysis replicated the White and Eguchi methodology as closely as possible using the HCCI dataset weighted to be nationally representative. The HCCI study population comprised individuals younger than age 65 and covered by employer-sponsored insurance (ESI). The analysis was conducted using 2011 data comparable to those of White and Eguchi. Using their definition of "shoppable" health care services, we examined the total spending on these services. As defined by White and Eguchi, shoppable services are those that are both the highest-spending and could be scheduled in advance of receiving the service. That is not to say that shopping for each of these services would be practical for an individual, only that he or she could shop for the service. Health care services are divided into six general categories, as shown in Table 1.[5] (See Data and Methods for more information about the categories of services and the meth-

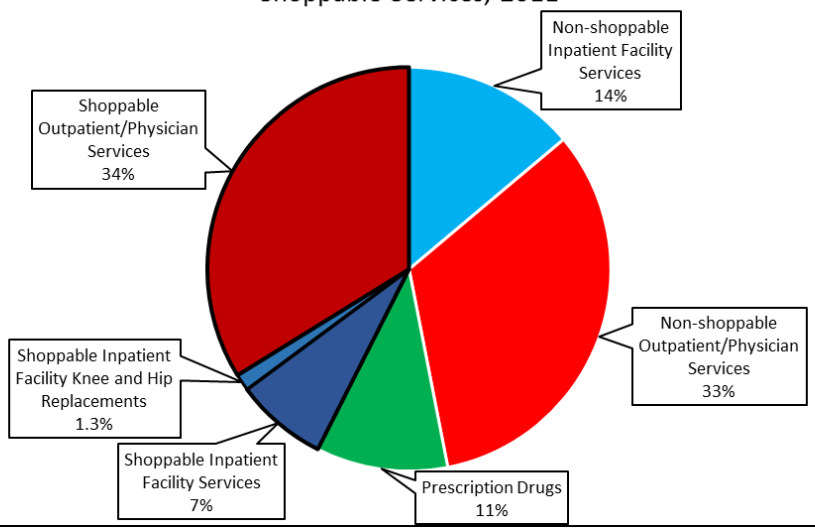
odology used in the analysis.) The numbers presented in this issue brief should be viewed as estimated upper-bound maximums for the amount of money that could be spent on shoppable and non-shoppable services. It is important to note that this analysis did not incorporate market features (e.g., number of providers in a market, insurer concentration), geographic location (e.g., rural, urban, population), or health status (e.g., percentage of population with serious health problems).

Total health care spending

In 2011, total spending on all health care services for the national ESI population was estimated at $524.2 billion. Of this amount, we found that at most, 43% of total spending was on services that can be considered shoppable. This is in contrast to, and higher than, the one-third of spending on shoppable services found by White and Eguchi. One reason for this difference could be the study populations, as the White and Eguchi study population included mainly urban autoworkers and their families, whereas the HCCI population was weighted to be nationally representative.

As seen in Figure 1, the largest piece of the spending "pie" was for shoppable outpatient/physician services (34% of total spending), followed by non-shoppable outpatient/physician services (33% of total spending). This suggests that in 2011, more dollars were spent on shoppable outpatient/physician services than on non-shoppable outpatient/physician services. In contrast, more was spent on non-shoppable inpatient services than on shoppable inpatient services. And hip and knee replacements, which are considered shoppable, add only an additional 1.3% to the shoppable inpatient services category. These disparate findings may reflect differences in the mix and use of services between the two categories: inpatient services and outpatient/physician services. For example, there are more services that are considered shoppable among the shoppable outpatient/physician services than among the shoppable inpatient services category, and far more outpatient/physician services than inpatient admissions are used in a given year. Overall, however, more than half of the spending in 2011 was on services not considered shoppable.

Figure 1: Distribution of Total ESI Spending by Shoppable/Non-Shoppable Services, 2011



Source: HCCI, 2016. Claims data from employer-sponsored insurance (ESI) population younger than age 65 for the year 2011, data weighted to be nationally representative.

Out-of-pocket spending for health care

For consumers—those potentially actually shopping—out-of-pocket spending should be more important than total

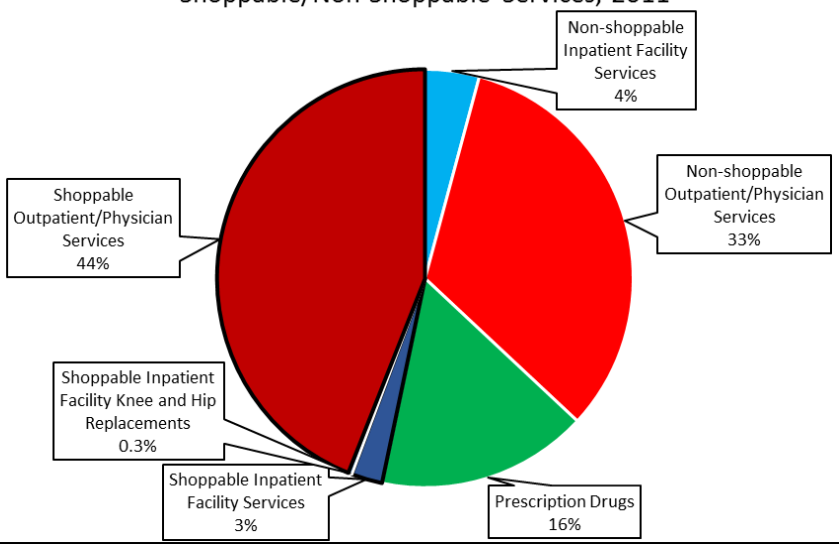
Table 1: Description of Categories of Services

Shoppable Inpatient Admissions	Shoppable Knee and Hip Replacement Admissions	Shoppable Outpatient/Physician Services	Non Shoppable Inpatient Admissions	Non Shoppable Outpatient/ Physician Services	Prescription Drugs
68 DRG-based admissions	5 DRG-based admissions	277 CPT or HCPCS codes	Other hospital admissions not considered shoppable	Other outpatient/ physician claims not considered shoppable	Prescription drug and device claims filled through a pharmacy

Source: HCCI, 20156
Note: Categories of services used in the analysis are based on the schema designed by Chapin and White..

spending. Out-of-pocket spending in the HCCI dataset is calculated as the total of copayments, coinsurance payments, and deductible payments made by consumers to providers for health care services. According to HCCI's *2012 Health Care Cost and Utilization Report* (using 2011 data), about 16% of spending on health care services are payments made out of pocket by consumers in the form of copayments, coinsurance, and deductibles. In this analysis, of the $524.2 billion spent on health care in 2011, about 15%[6]—or $80.8 billion—was spent out of pocket. Of this amount, about 7%—or $37.7 billion—was spent out of pocket on shoppable services (Figure 2).

Figure 2: Distribution of Out-of-Pocket ESI Spending by Shoppable/Non-Shoppable Services, 2011



Source: HCCI, 2016. Claims data from employer-sponsored insurance (ESI) population younger than age 65 for the year 2011, data weighted to be nationally representative.

Of the out-of-pocket spending, the most dollars were spent on shoppable outpatient/physician services: around 44%. Out-of-pocket spending on inpatient services, both shoppable and non-shoppable, makes up a very small piece of total out-of-pocket spending, as most consumers spend far more money on outpatient/physician services than on inpatient services.

Total out-of-pocket spending, however, is not the complete story. The amount of money consumers spend out of pocket on any given health service is determined in part by their health insurance benefit design. Out-of-pocket payments can be one of three types: coinsurance, deductibles, or copayments. Though copayments tend to be specifically defined dollar amounts, coinsurance and deductible payments can be highly variable, depending on the insurance plan, the provider, and the health care services.

For consumers hoping to save money through price shopping, a (relatively) straightforward method might be to choose lower-priced providers when shopping for services that require coinsurance payments, as coinsurance payments often vary with the price of the health care service. In this analysis, about 27% of the out-of-pocket spending for shoppable services was for coinsurance payments. These coinsurance dollars represent around 12% of all dollars spent out of pocket. The vast majority of the coinsurance payments were on outpatient/physician services; consumers spent about six times more for coinsurance payments for these shoppable services than for coinsurance for shoppable inpatient services.

We also might assume that consumers would be more likely to price-shop for procedures that cost more (i.e., "high-dollar" procedures) than for procedures that cost less (i.e., "low-dollar" procedures), as the potential savings to the consumer would be greater. Coinsurance payments by consumers on high-dollar outpatient/physician services[7] accounted for about 9% of total out-of-pocket spending for all health care services. In other words, if we were to assume that consumers have the highest incentive to alter their behavior and price-shop for high-dollar outpatient/physician services, they could alter only 9% of their total out-of-pocket spending, on average, through coinsurance payments.

Deductible payments, as opposed to coinsurance payments, may provide a different set of incentives for consumers. Consumers may want to choose low priced providers while in their health plan's deductible. Conversely, they may care less about price if they believe they will reach their deductible. In this analysis, payments for deductibles accounted for nearly 50% of the dollars spent out of pocket on shoppable services. However, deductible payments make up a larger portion of the out-of-pocket spending on low-dollar outpatient/physician services (51% of out-of-pocket spending) as compared to out of pocket spending on high-dollar outpatient/physician services (41% of out-of-pocket spending).

After coinsurance and the deductible, the balance of the out-of-pocket spending is copayments. For consumers who want to

Table 2: Price Variation in Inpatient Services

Services	Coefficient of Variation (lower numbers indicate less price variation)
Inpatient Facility Shoppable (excludes hip/knee replacements)	2.07
Inpatient Facility Hip/Knee	0.61
Inpatient Facility Non-Shoppable	2.45

Source: HCCI, 2016
Notes: Data represents the weighted national population of insureds 0-64 covered by ESI, for the year 2011

save money on their health care services, price-shopping services that are mainly paid for by copayments (rather than through coinsurance or deductible payments) may not be a very effective way to save money. Copayments are generally a fixed price for a service and are set by the health plan: for example, a $20 flat fee to see an in-network primary care provider. One fourth of the dollars spent out of pocket on shoppable services were for copayments in 2011. Copayments seem to have the largest effect on low-dollar shoppable outpatient/physician services, where 30% of out-of-pocket spending on this category of services was through copayments. In contrast, copayments on shoppable high-dollar outpatient/physician services accounted for only 2% of the out-of-pocket spending.

Price variation

For consumers to be able to influence their out-of-pocket payments by price-shopping, price variation must exist in the market. If prices do not vary in a market, the availability of perfect pricing information will not lead to lower spending, as consumers would find no lower-priced services from which to choose. This section describes the amount of variation observed in the weighted data; the higher the coefficient of variation, the larger the price variation.

We find that nationally, knee and hip replacement admissions had a coefficient of variation much lower than either inpatient shoppable (excluding knee and hip replacements) or inpatient non-shoppable (Table 2). In other words, nationally there seems to be less price variation in the categories of shoppable services then non-shoppable services. While we understand that people cannot shop nationally for most services, Table 1 illustrates general price variation across broad categories of services. However, this result is not to suggest that shopping for knee and hip replacements never makes sense. In Palm Bay, Florida, for example, a knee replacement costs $16,822 more than the same surgery 180 miles away in Miami.

Analysis of price variation by state reveals that the three states with the highest variation across all three categories of inpatient services were Kentucky, Texas, and Georgia (Table 3). These states had much more variation than the national average across all three categories. Two states near the bottom for variation in all three categories were Montana and Hawaii. These states had far less price variation that the national averages, and less than almost all other states. In general, the more populous states had greater price variation, while the less populous states had the least variation.

The top five most frequently utilized services were analyzed for both the shoppable and non-shoppable outpatient/professional services categories (Table 4). Of all ten frequently used services identified, the most price variation was observed for venipunctures—a shoppable service with a coefficient of variation five

Table 3: Price Variation in Inpatient Services for States with Most and Least Variation

State	Inpatient Shoppable Coefficient of Variation	Inpatient Hip/Knee Coefficient of Variation	Inpatient Non Shoppable Coefficient of Variation
Kentucky	2.99	1.03	3.14
Texas	2.98	0.84	3.28
Georgia	2.51	0.97	3.17
Montana	0.83	0.23	1.15
Hawaii	0.41	0.29	0.37

Source: HCCI, 2016
Notes: Data represents the weighted population of insureds 0-64 covered by ESI, for the year 2011

times larger than that for urinalysis, the service with the second-most observed price variation. Overall, the level of variation is fairly similar across categories and is possibly a bit higher for the shoppable identified services as compared to the non-shoppable services.

Another frequently discussed shoppable procedure is colonoscopies (CPT code 45378). The national price variation for colonoscopies (coefficient of variation = 0.95) is relatively similar to that of the procedures displayed in Table 4. However, as noted above, price variation also varies across geographies. The greatest price variation for colonoscopies was observed for Arizona (coefficient of variation = 1.36); Florida (coefficient of variation = 1.35); and Kentucky (coefficient of variation = 1.32). At the other end of the spectrum, the states with the least variation were South Dakota (coefficient of variation = 0.30); Alaska (coefficient of variation = 0.29); and Hawaii (coefficient of variation = 0.15).

Discussion

One barrier to consumer shopping is the presence and/or perception of transaction costs, whereby the costs of shopping appear to be higher than the perceived benefits. This may apply especially to lower-cost services, and services with consumer payments mandated by the benefit design (e.g., pre-set copayments for doctor visits). In terms of a simple calculus: the benefits of shopping must exceed the individual's costs associated with shopping, in order to achieve the desired outcome of price shopping. This provides two possible ways whereby interventions could encourage consumers to price-shop for the health care services: lowering costs and/or increasing benefits.

Lowering the costs associated with shopping is possible and there are many private and public efforts made at this. For example, HCCI's Guroo.com, pricing tools available to the members of many health insurers, and state efforts at building all-payer claims databases (APCDs)—in states such as Vermont—and creating pricing Websites as in New Hampshire and Maine. However, even in a world with perfect pricing information, consumers must perceive benefits to want to gather and then apply the information.

While raising benefits may seem more difficult than lowering the costs associated with shopping, early efforts at these types of efforts are ongoing and may prove fruitful at saving money. One notable example of this is the reference-based pricing program implemented by California Public Employees' Retirement System (CalPERS) for knee and hip replacements. Based on the implementation of this program, procedures at lower-cost facilities increased while procedures at higher-cost facilities decreased. This reference price program was estimated to save the state of California $2.8 million and saved CalPERS members an additional $300,000 in out-of-pocket costs.[8]

Another idea would be a modification of the reference price model into a benefits-sharing model. Once the reference price is set, if consumers chose providers with prices above the reference price, they would pay the difference, whereas if they chose a provider under the reference price—holding quality constant—they would share in the savings. An important note is that this type of incentive structure would require information about provider quality, so consumers were not forced to choose lower-quality care to save money. And, at the same time, standardizing quality across the health care system would remove quality from this process. Additionally, this type of

Table 4: Price Variation in the Most Frequently Utilized Procedures for Shoppable and Non-Shoppable Outpatient/Professional Services

Outpatient Shoppable CPT Code	Coefficient of Variation	Outpatient Non Shoppable CPT Code	Coefficient of Variation
Established patient office visit, level 3: 99213	0.54	Immunization administration: 90460	0.86
Established patient office visit, level 4: 99214	0.51	Chiropractic manipulative therapy: 98940	0.51
Collection of venous blood through venipuncture: 36415	10.89	Urinalysis: 81001	2.02
Therapeutic exercises: 97110	1.05	E&M emergency room visit, moderate severity: 99283	0.88
Manual therapy techniques: 97140	1.08	Rapid strep test: 87880	0.80

Source: HCCI, 2016
Notes: Data represents the weighted national population of insureds 0-64 covered by ESI., for the year 2011

incentive structure could work only for specific health services that are shoppable; if prices are high; where consumer payments are not set ahead of time (i.e., copayments); pricing and quality information is available; there are a sufficient number of providers in market from which to choose; and where there is a wide variation in the distribution of prices for that service within the geography.

The limits of price transparency and shopping

Some evidence suggests that greater price transparency and emphasis on price shopping by consumers might lower spending on health care—for states, insurers, employers, and consumers.[3] At the same time, however, logistical and incentive roadblocks prevent full realization of the goals of price transparency efforts.

Patient limits: Some of the biggest limitations in price-shopping by consumers are from the patients themselves. Most important, if an individual is very sick, he or she might not be able or willing to shop for services, even if the needed services can be defined—or utilized by others—as shoppable. Additionally, though some services might be considered shoppable, such as a venipuncture, shopping for that service might not be convenient, practical, or advisable. Many such services often take place at a patient's usual care source (i.e., their primary care physician's office) and, as such, shopping for a different provider to provide small routine services may present difficulties, or even hardships, to many. There is also a sizable segment of the ESI-covered population that is largely unengaged from the health care system. In any given year, roughly 25% of HCCI's ESI population does not have a health care claim (see "The percentage of HCCI's ESI population that has no health insurance claim (2010–2014)"). Engaging these individuals as consumer price shoppers may be difficult and not immediately productive.

Integrated care: An important theme within the Affordable Care Act was the development of a comprehensive and integrated medical records system across the health care system. However, nearly 4 years out from the ACA implementation, this worthy goal has yet to be wholly realized. Shopping for low priced health care services seems likely to lead to consumers accessing care and services from a variety of providers. Without an integrated records system, health care providers will have a difficult time providing quality care. This shopping for providers also may be at odds with other ACA initiatives, such as Accountable Care Organizations (ACOs), whose goal is to coordinate patient care across providers.

Prescription drugs: In this analysis, prescription drugs are not considered shoppable services. This is not because it is impossible for consumers to shop for lower drug prices; rather, it is an open question as to how consumers should be incentivized to shop for their prescriptions. Without an integrated data system, shopping could increase the risk of drug interactions.

Benefit design: As noted above, consumer payments made out of pocket on health care services are often largely determined by the specific benefit design of their insurance plan. Some basic benefit design features may make consumers either more or less likely to price-shop, absent any other cost or benefit calculations. On one hand, for example, benefit designs that are heavily dominated by copayments may deter consumers from price shopping. On the other hand, shopping may make the most sense for people in high-deductible health plans (HDHPs), as these consumers tend to face the highest (and perhaps the most variable) deductible and coinsurance costs.

Conclusions

The analysis presented here suggests that a large portion of health care spending every year is on services for which consumers could price-shop ahead of receiving them. As much as 43% of the dollars spent on health care services in 2011

The percentage of HCCI's ESI population that has no health insurance claim (2010-2014)

In any given year, about 25% of the population of individuals younger than age 65 and covered by ESI in HCCI's dataset (unweighted) have no health care claim filed with their insurer. Though this percentage of non-utilizers has increased slightly over time, it has remained at around a quarter of the population in all years.

Year	Percentage of Non Utilizers
2010	25.3%
2011	24.3%
2012	24.6%
2013	25.1%
2014	26.9%

Source: HCCI, 2016
Notes: Data represents the population of insureds 0-64 covered by ESI..

were for such shoppable services. For consumers, shoppable services totaled about 47% of their portion of the health care bill. This is an interesting finding—that consumers might be able to effect, on average, up to nearly half of their yearly out-of-pocket payments by price-shopping. Given the limits of benefit design, however, altering some of this total may be difficult for consumers.

The parts of out-of-pocket spending that might be variable, and therefore have the potential to be lowered through price-shopping, are coinsurance and deductible payments. Coinsurance and deductible payments made up 75% of the out-of-pocket spending on shoppable services in 2011. This totaled 35% of all of the out-of-pocket spending in that year. One take-away from this might be that on average, consumers may be able to alter a third of their out-of-pocket health care spending in a given year. This could mean important savings for people with serious health conditions or people with high deductible plans. At the same time, this also suggests that on average, consumers will have difficulty altering 65% of the out-of-pocket spending. While 46% of total out-of-pocket spending was on shoppable services, 53% of out-of-pocket spending was on non-shoppable services.

Overall, we come to the conclusion that the potential gains from the consumer price shopping aspect of price transparency efforts are modest. There are those arguing that we need to design health care systems and price transparency tools with consumer price shopping as central goals. Though one important feature of properly functioning markets is the availability of both price and quality information, consumer activity driven by this information should not be the focus. Rather, we believe that delivery systems should be designed without consumer shopping at the fore and view any benefits from shopping as a positive outcome.

Limitations

Our study has several limitations that can affect the interpretation of the findings. For this reason, HCCI considers its work a starting point for analysis and research on the cost of shoppable services for individuals younger than age 65 covered by ESI.

Our findings are estimates for the United States ESI population based on a sample of approximately 25% of ESI insureds younger than age 65. The estimates for numbers of insured individuals by each plan type were weighted to account for any demographic differences between the analytic sample and population estimates based on the United States Census, making the dataset representative of the national, ESI population younger than age 65. The tables and figures presented are limited to descriptive statistics for they study population. Finally, the numbers presented here represent an outer-upper bounds for potential totals of spending and shoppable services. Follow up analyses that include finer precision and more potential factors, such as place of service, could further refine these numbers.

Data and Methods

This issue brief utilized the Health Care Cost Institutes' dataset of private insurance health care claims. The final analytic dataset consisted of individuals who were covered by ESI for calendar year 2011. To be included in the study population individuals must have been younger than age 65 in 2011, had an identifiable age and gender, and a valid state, zip code, or core-based statistical area (CBSA) of residence. If an individual had multiple states of residence listed in 2011, the state from the first month of insurance in 2011 was used. The final study population was weighted by age-gender-state to be representative of the national population.

Emergency room visits: The original methodology designed by White and Eguchi classified otherwise shoppable services (inpatient and outpatient/physician) as non-shoppable if there was evidence of an emergency room (ER) visit within the 3 days prior to the service utilization. ER visits were identified as outpatient claims with a 23 point of service (POS) claim or a 450, 451, 452, 456, or 459 revenue code.

Outpatient/physician services: Outpatient and physician claims were combined and then divided into shoppable and non-shoppable services by the CPT or HCPCS code on the claim (see outpatient/physician shoppable CPT and HCPCS codes). Claim lines were removed from the sample if there were null vales for the procedure code, and all three diagnosis codes.

Inpatient admissions: To create an inpatient admission, all inpatient claim lines with the same patient identification number, admit identification number, and first admission date were combined. The three categories of inpatient admissions (shoppable inpatient admissions – excluding knee and hip replacements; shoppable knee and hip replacements; non-shoppable inpatient admissions) were classified by the diagnosis-related group (DRG) for each admission (see all shoppable inpatient admissions DRGs). If any claim line in an admission had a DRG from the list of shoppable DRGs, admission was considered shoppable. If an admission had DRGs from both the shoppable inpatient and shoppable knee and hip replacement lists then the following rules were applied. 1) If the DRG was 945, 462,

494, or 491, then the admission was considered a shoppable knee and hip replacement. 2) If the DRG was any other from the shoppable admissions list, than the admission was classified by the DRG with the earliest claim date. If the total allowed amount of an admission summed to less than $50, the average allowed amount for the whole category was substituted for the less than $50 amount. Several rules were also applied to limit outlier admissions. Admissions were removed from the sample if:

- The length of stay was greater than 180 days or less than 1 day;
- The allowed amount on the admission summed to less than or equal to zero dollars;
- All claim lines for the admission had a null DRG or null major diagnostic category (MDC).

Endnotes

1. Muir MA, Alessi SA, King JS. "Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?" William & Mary Policy Review 4 (2013): 319—366. Web.
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4. White C, Eguchi M. Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. *National Institute for Health Care Reform* Research Brief Number 18. Web. October 2014.
5. For a full list of DRG and CPT/HCPCS used to categorize services, see the online appendix of White and Eguchi.
6. Differences between these two numbers are likely due to small differences in study populations and population weighting techniques.
7. High dollar outpatient/physician services are defined here as services whose average price is two standard deviations above the mean price for the whole category. For shoppable outpatient/physician services this is an average price of about $1,000.
8. Robinson JC, Brown TT. "Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery." Health Affairs 32.8 (2013): 1392-1397

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By Fredric Blavin, Michael Karpman, and Stephen Zuckerman

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DATAWATCH

Understanding Characteristics Of Likely Marketplace Enrollees And How They Choose Plans

In 2015, adults likely to have enrolled in the Affordable Care Act Marketplace were predominantly non-Hispanic whites and, on average, older and more aware of the availability of Marketplace subsidies than adults who remained uninsured. Enrollees were also significantly more likely than adults who remained uninsured to rely on some type of application assistance instead of exclusively looking for information through the Marketplace website.

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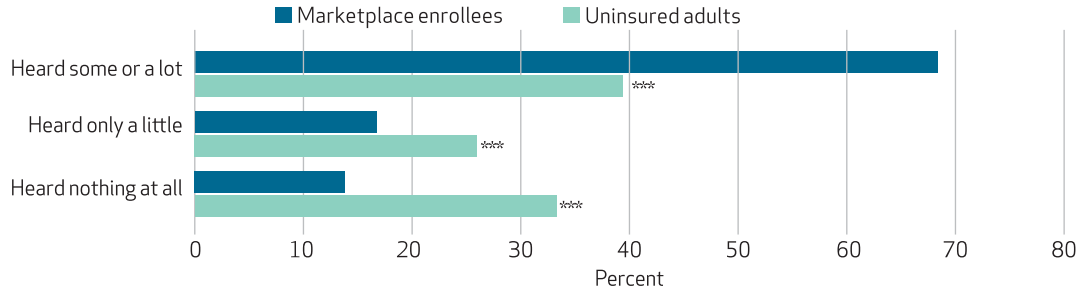
The Affordable Care Act (ACA) introduced government-run Marketplaces, a new way to purchase nongroup coverage. To understand who is enrolling in the plans offered in the Marketplaces and to better direct outreach to people who may be eligible for subsidized coverage, policy makers need to know how Marketplace enrollees differ from those with other types of coverage and those who remain uninsured. Surveys have historically provided the richest set of demographic and socioeconomic data but have had difficulty identifying the types of health insurance people have.[1] Adding Marketplace coverage to the range of insurance options only exacerbates this problem.

To overcome these survey data limitations, we developed a process for identifying likely Marketplace enrollees using the Urban Institute's Health Reform Monitoring Survey (HRMS), an Internet-based survey, discussed below, that was designed to provide timely assessments related to the ACA. We found that people who remained uninsured were less likely to have heard "some or a lot" about premium and cost-sharing subsidies and more likely to have heard "only a little" or "nothing at all" about them, compared to likely Marketplace enrollees (Exhibit 1).

Government reports do not describe how enrollees navigated the enrollment process, nor do they allow for comparisons between Marketplace enrollees, other insured individuals, and the uninsured. This article fills both of these gaps.

EXHIBIT 1

Awareness of premium and cost-sharing subsidies among likely Marketplace enrollees and uninsured adults



SOURCE Authors' analysis of data from the Health Reform Monitoring Survey, first quarter of 2015 (see Note 5 in text). **NOTES** Adults are those ages 18–64; sample consists of those with family incomes below 400 percent of the federal poverty level. Estimates are not shown for the 1.1 percent of likely Marketplace enrollees and the 1.3 percent of uninsured adults who did not report whether they had heard about subsidies. Significance refers to differences from likely Marketplace enrollees as measured by two-tailed tests. ***$p < 0.01$

Study Data And Methods

IDENTIFYING LIKELY MARKETPLACE ENROLLEES We limited the pool of likely Marketplace enrollees to adults who reported that they were enrolled in a plan through the Marketplace and did not report coverage through an employer-sponsored plan or the military.[2] This group contained substantially more individuals (20.0 million) than administrative data showed were enrolled (11.7 million), in part because it included likely enrollees in the Marketplace, Medicaid, and other public programs.[3] We used information on coverage type, health plan or carrier name, state of residence, and family income as a percentage of the federal poverty level to differentiate these coverage types and refine our definition of *likely Marketplace enrollees*. Exhibit 2 shows the results for respondents to the HRMS in the first quarter of 2015.

DATA We used data from the March 2015 HRMS, which every quarter samples approximately 7,500 adults ages 18–64 drawn from the KnowledgePanel, a nationally representative, probability-based online panel maintained by GfK Custom Research.[4] Respondents complete self-administered online surveys to provide information on health insurance, access to health care, affordability of care, and health status. The HRMS also includes questions that change each quarter to address timely ACA policy and implementation issues. Detailed information about the HRMS methodology can be found elsewhere.[5,6]

We assessed differences in several demographic and socioeconomic characteristics between likely Marketplace enrollees, other insured adults, and uninsured adults. We also explored the sources that likely Marketplace enrollees used when looking for information about and enrolling in health plans. We compared these sources with the ones used by adults who looked for information on Marketplace plans but remained uninsured at the time of the survey.

We also assessed awareness of the premium and cost-sharing subsidies for Marketplace plans among respondents whose family incomes were below 400 percent of the federal poverty level. Full details of our approach and comparisons with other surveys are available in the online Appendix.[7]

LIMITATIONS Our study had several limitations. First, the HRMS's cumulative response rate in March 2015—a combination of the GfK panel recruitment rate, the rate at which recruited households completed a demographic profile, and the rate at which they completed the HRMS—was 5 percent. This is comparable to response rates of 7 percent for the well-being

EXHIBIT 2

Coverage for respondents who reported enrolling in a health plan through the Marketplace

Reported coverage type	Plan name associated with Marketplace plan?	Likely Marketplace enrollee	Number of respondents
ESI or military[a]	—[b]	No	186
Nongroup[c]	Yes	Yes	79
	No	No	3
	Ambiguous	Yes	310
Public	Yes	Yes	0
	No	No	109
	Ambiguous	No	67
Public and nongroup[d]	Yes	Yes	1
	No	No	90
	Ambiguous:		
	Income below Medicaid eligibility threshold[e]	No	84
	Income above Medicaid eligibility threshold	Yes	80

SOURCE Authors' analysis of data from the Health Reform Monitoring Survey, first quarter of 2015 (see Note 5 in text). **NOTES** Of the 8,039 respondents, 1,009 reported that they enrolled through the Marketplace, and 470 were identified as likely Marketplace enrollees. Public coverage includes Medicare, Medicaid, Medical Assistance, Children's Health Insurance Program, and other state or government-sponsored assistance plans based on income or disability. [a]Editing rules for people with employer-sponsored insurance (ESI) or military coverage also apply to those reporting ESI or military coverage and any additional coverage type. [b]Not applicable. Plan name information not used. [c]Editing rules for people with nongroup coverage also apply to those reporting both nongroup and other nonspecified coverage. [d]Editing rules for those reporting both public and nongroup coverage also apply to those reporting both public and other nonspecified coverage and to those reporting only other nonspecified coverage. [e]If it was ambiguous as to whether a plan name for those reporting public and nongroup coverage was associated with a Marketplace plan, we checked whether the reported family income was above 138 percent of the federal poverty level if the person lived in a Medicaid expansion state or above 100 percent of poverty if the person did not live in an expansion state.

track of the Gallup-Healthways Well-Being Index[8] and 9 percent for a typical survey conducted by the Pew Research Center,[9] both of which are random-digit-dialed telephone surveys.

Second, although we were able to use the HRMS to identify likely Marketplace enrollees as of March 2015, there may have been some error in our identification process because of problems in reporting income, plan names, and type of coverage (public or private). The Appendix describes these limitations in more detail.[7]

Study Results

WHO ARE THE LIKELY MARKETPLACE ENROLLEES?

In March 2015, 5.3 percent of adults ages 18–64 were likely to have had Marketplace coverage, while 67.6 percent had other private insurance, 17.1 percent had public insurance, and 10.0 percent were uninsured (Exhibit 3). Just over one-third of Marketplace enrollees reported having been uninsured at some point in the past twelve months (data not shown).

There were four key differences in demographic and socioeconomic characteristics across these insurance groups. First, likely Marketplace enrollees tended to be older than uninsured and other insured adults (Exhibit 3). About two in five Marketplace enrollees were ages 50–64, compared to only about one in five uninsured adults. In contrast, 48.6 percent of uninsured adults, but only 37.5 percent of Marketplace enrollees, were ages 18–34.

Second, likely Marketplace enrollees had higher family incomes than adults who were uninsured or had public insurance, but lower incomes than other privately insured adults (Exhibit 3). Given our approach to identifying Marketplace enrollees, it was not surprising that they were more likely than adults in all other insurance groups to report having family incomes of 139–399 percent of poverty, as this is the premium subsidy target range.

Third, there were some significant differences in the racial and ethnic compositions of the groups. Likely Marketplace enrollees were more likely to be white and non-Hispanic (60.0 percent) than uninsured adults (45.4 percent) and those with public insurance (49.9 percent). Mar-

EXHIBIT 3

Characteristics of respondents by insurance status

Characteristic	Likely Marketplace enrollees (n = 470)	Other privately insured adults (n = 5,650)	Publicly insured adults (n = 1,288)	Uninsured adults (n = 631)
Percent of sample (weighted)	5.3%	67.6%	17.1%	10.0%
Estimated population (millions)	10.6	135.1	34.2	20.0
Age (years)				
18–34	37.5%	34.8%	38.6%	48.6%***
35–49	21.8	31.6***	26.4*	30.6***
50–64	40.7	33.6**	35.0**	20.8***
Income (percent of federal poverty level)				
≤138	25.5	10.8***	75.9***	63.2***
≤100	11.5	6.4***	52.5***	39.6***
100–138	14.0	4.4***	23.4***	23.6***
139–399	56.4	40.4***	21.4***	30.2***
≥400	18.0	48.8***	2.7***	6.6***
Race/ethnicity				
White, not Hispanic	60.0	68.7**	49.9**	45.4***
Nonwhite, not Hispanic	21.6	19.2	25.0	19.8
Hispanic	18.5	12.1*	25.1	34.8***
Health status				
Excellent or very good	47.8	57.7***	28.8***	39.5***
Good	34.8	33.4	38.3	43.9***
Fair or poor	17.0	8.8***	32.7***	16.5
Citizenship status				
Citizen	91.1	94.2	87.6	74.8***
Not a citizen	8.7	4.8**	11.1	24.2***

SOURCE Authors' analysis of data from the Health Reform Monitoring Survey, first quarter of 2015 (see Note 5 in text). **NOTES** Adults are those ages 18–64. "Other privately insured adults" includes the 3.1 percent of adults with nonspecified coverage who do not have Marketplace coverage. Estimates are not shown for people who did not report health or citizenship status. Significance refers to differences from likely Marketplace enrollees as measured by two-tailed tests. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

ketplace enrollees were also more likely to be US citizens (91.1 percent) than uninsured adults (74.8 percent), as only US citizens and immigrants who are legally present in the United States are eligible for Marketplace coverage.

Finally, despite being older, on average, likely Marketplace enrollees were more likely to report being in excellent or very good health (47.8 percent), compared to adults who remained uninsured (39.5 percent) and those who had public coverage (28.8 percent). However, we found no statistically significant differences in the shares of likely Marketplace enrollees and the uninsured who reported being in excellent or very good health after we controlled for age, sex, race or ethnicity, marital status, income, home ownership status, and residence in a Metropolitan Statistical Area.

HOW DO LIKELY MARKETPLACE ENROLLEES CHOOSE A HEALTH PLAN? Adults with Marketplace coverage relied on a variety of sources, including in-person assistance, to learn about and enroll in health plans. Likely Marketplace enrollees were significantly less likely to use only a website to search for a plan, compared to people who looked for information but remained uninsured (32.7 percent versus 57.4 percent; Exhibit 4). Marketplace enrollees were also significantly more likely to use other sources of information or assistance, either on their own or in conjunction with a website, than the people who remained uninsured. The other sources of information included call centers; navigators, application assisters, certified application counselors, and community health workers; Medicaid and other public programs; insurance agents and brokers; and family members, friends, employers, tax preparers, and health care providers who gave indirect or informal assistance.

Before the rollout of the ACA Marketplaces in 2014, most adults had heard little about the availability of premium and cost-sharing subsidies, with knowledge levels particularly low among people with the most to gain from the subsidies—low-income uninsured adults.[10] Many uninsured adults with family incomes below 400 percent of poverty continued to be unaware of the availability of subsidies in March 2015, just after the second open enrollment period ended (Exhibit 1). Slightly more than one-third of these adults reported that they had heard "nothing at all" about the subsidies.[11] Somewhat surprisingly, 13.8 percent of likely Marketplace enrollees in the same income group had also heard "nothing at all" about the subsidies.

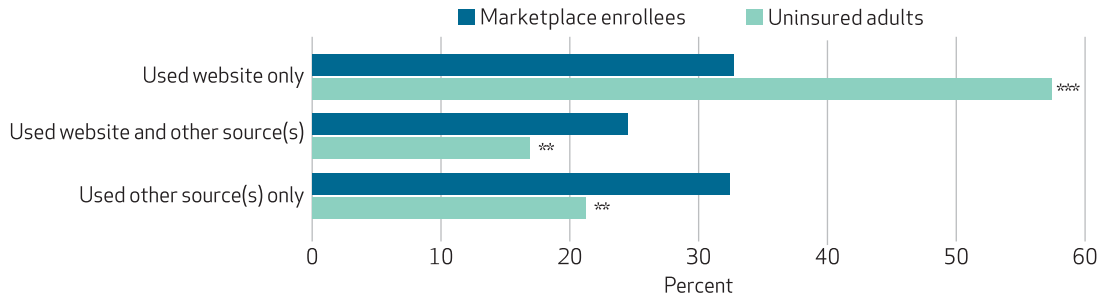
Discussion

Using the HRMS data allowed us to contrast likely Marketplace enrollees with other insured individuals and those who remained uninsured. We found that Marketplace enrollees were more likely to be ages 50–64 and non-Hispanic white, compared to adults who remained uninsured. This finding is not inconsistent with studies that show the ACA reduced coverage disparities for black and Hispanic adults relative to whites.[12] Our analysis focused on the population of likely Marketplace enrollees, whereas other studies focused on changes in coverage related to both the Marketplace and Medicaid expansion.[12]

The data presented here suggest that many people who could benefit from subsidized Marketplace coverage are still unaware of its existence, despite extensive media coverage (in particular, of the US Supreme Court ruling in *King v. Burwell*). This is consistent with previous HRMS findings that the Marketplace target population

EXHIBIT 4

Sources of information used by likely Marketplace enrollees and uninsured adults who looked for health plan information through the Marketplace



SOURCE Authors' analysis of data from the Health Reform Monitoring Survey, first quarter of 2015 (see Note 5 in text). **NOTES** Adults are those ages 18–64. Estimates are not shown for the 10.4 percent of likely Marketplace enrollees and the 4.4 percent of uninsured adults who did not report using one of the sources of information listed in the survey question. Significance refers to differences from likely Marketplace enrollees as measured by two-tailed tests. $^{**}p < 0.05$ $^{***}p < 0.01$

struggled to understand key health insurance concepts before implementation of the ACA.[5] Our findings suggest that there is still a great deal of confusion about the subsidies available through the ACA.

We also found that people who gained coverage were significantly more likely to have received some type of application assistance beyond the Marketplace website, compared to people who remained uninsured. Being able to continue the progress made in expanding coverage during the first two open enrollment periods will require that potential enrollees have access to the broad range of application assistance that has been used by Marketplace enrollees thus far.

Conclusion

The extent to which the ACA will lead to further Marketplace enrollment depends on how successful targeted outreach efforts are at reaching people who remain uninsured. Many of these people are ineligible for Marketplace coverage because of their immigration status. Nonetheless, our results suggest that further outreach and public education may need to be geared toward young adults and those with moderate incomes who can potentially benefit from subsidized Marketplace coverage. ■

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NOTES

1 Call KT, Davern ME, Klerman JA, Lynch V. Comparing errors in Medicaid reporting across surveys: evidence to date. Health Serv Res. 2013;48(2 Pt 1):652–64.

2 This restriction is based on findings that most people with employer-sponsored insurance accurately report their coverage type. See Davern M, Call KT, Ziegenfuss J, Davidson G, Beebe TJ, Blewett L. Validating health insurance coverage survey estimates: a comparison between self-reported coverage and administrative data records. Public Opin Q. 2008;72(2):241–59.

3 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health insurance Marketplaces 2015 open enrollment period: March enrollment report [Internet]. Washington (DC): HHS; 2015 Mar 10 [cited 2016 Jan 19]. (ASPE Issue Brief). Available from: http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf

4 The Health Reform Monitoring Survey shifted to a semiannual fielding schedule after March 2015.

5 Long SK, Kenney GM, Zuckerman S, Goin DE, Wissoker D, Blavin F, et al. The Health Reform Monitoring Survey: addressing data gaps to provide timely insights into the Affordable Care Act. Health Aff (Millwood). 2014;33(1):161–7.

6 Health Reform Monitoring Survey. HRMS frequently asked questions [Internet]. Washington (DC): Urban Institute; c 2015 [cited 2016 Jan 19]. Available from: http://hrms.urban.org/faq.html

7 To access the Appendix, click on the Appendix link in the box to the right of the article online.

8 Karpman M, Long SK, Huntress M. Nonfederal surveys fill a gap in data on ACA [Internet]. Washington (DC): Urban Institute; 2015 Mar 13 [cited 2016 Jan 19]. Available for download from: http://www.urban.org/research/publication/nonfederal-surveys-fill-gap-data-aca

9 Pew Research Center. Assessing the representativeness of public opinion surveys: overview [Internet]. Washington (DC): The Center; 2012 May 15 [cited 2016 Jan 19]. Available from: http://www.people-press.org/2012/05/15/assessing-the-representativeness-of-public-opinion-surveys/

10 Long SK, Goin D. Most adults are not aware of health reform's coverage provisions [Internet]. Washington (DC): Urban Institute; 2014 Feb 6 [cited 2016 Jan 19]. Available from: http://hrms.urban.org/briefs/awareness-of-provision.html

11 Low awareness of subsidies among the uninsured was also reported in a survey conducted by the Commonwealth Fund. See Collins SR, Rasmussen PW, Doty MM, Beutel S. Americans' experiences with Marketplace and Medicaid coverage: findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015 [Internet]. New York (NY): Commonwealth Fund; 2015 Jun 12 [cited 2016 Jan 19]. Available from: http://www.commonwealthfund.org/publications/issue-briefs/2015/jun/experiences-marketplace-and-medicaid

12 For example, see McMorrow S, Long SK, Kenney GM, Anderson N. Uninsurance disparities have narrowed for black and Hispanic adults under the Affordable Care Act. Health Aff (Millwood). 2015;34(10):1774–8.

2016 Obamacare Deductible Increase Tracker

After enduring double-digit premium increases and cancelled plans under the Affordable Care Act, surging out of pocket costs—specifically deductibles—are making it difficult for Americans across the country to access the health care plans they were mandated to purchase.

This year, Americans in 41 states face higher health care deductibles under the Affordable Care Act. Seventeen of those states are experiencing deductible increases in the double digits.

In many states consumers face deductibles of $3,000 or more.

Want to know where your state ranks? Type your state into the search bar below to view the average deductible increase per plan offered on the Affordable Care Act exchange, along with the weighted average deductible increase. You can also sort or export the data.

2016 Exchange Deductible Increases by State

Search:

State	Bronze ($)	Silver ($)	Gold ($)	Average ($)
Alabama	835	116	-86	158
Alaska	-9	42	-83	18
Arizona	505	836	-208	664
Arkansas	-392	411	-366	184
California	533	297	0	362
Colorado	168	54	-433	48
Connecticut	539	151	74	233
DC	287	-286	-168	-49
Delaware	594	39	12	129
Florida	472	1,129	94	990
Georgia	415	121	48	156
Hawaii	1,350	43	-194	207

Idaho	1,079	362	-453	436
Illinois	609	-535	-126	-188
Indiana	597	245	42	355
Iowa	577	-36	-443	105
Kansas	71	443	-83	305
Kentucky	467	265	-210	232
Louisiana	727	676	458	673
Maine+	366	104	132	160
Maryland	580	-42	-31	101
Massachusetts	1,219	-8	-109	58
Michigan	755	457	-8	492
Minnesota	973	13	-310	317
Mississippi	1,146	1,473	131	1,395
Missouri	474	298	-162	305
Montana	743	-327	-133	15
Nebraska	996	341	-19	539
Nevada	408	201	507	268
New Hampshire	395	367	100	345
New Jersey	433	207	-36	209
New Mexico	637	-526	-359	-228
New York	300	205	71	206
North Carolina	764	579	317	602
North Dakota	886	233	-18	325
Ohio+	583	375	-175	379
Oklahoma	935	-915	-804	-436

Oregon	630	-333	-184	-79
Pennsylvania	718	222	57	254
Rhode Island	167	568	414	470
South Carolina	608	834	87	735
South Dakota	311	123	125	153
Tennessee	561	164	204	250
Texas	764	-710	-272	-323
US Average	609	195	-38	265
Utah	823	-62	88	107
Vermont	1,443	46	608	433
Virginia	655	186	88	285
Washington	527	1,091	69	809
West Virginia	1,156	-185	-87	11
Wisconsin	482	510	-73	477
Wyoming	375	104	-17	168

Showing 1 to 52 of 52 entries

Deductible data are sourced through the Robert Wood Johnson Foundation. Enrollment data is sourced through publicly-available information on cms.gov. Deductible averages are weighted by total enrollment for each metallic level for plans offered on the marketplace.

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March 2016 | Issue Brief

Assessing ACA Marketplace Enrollment

Larry Levitt, Gary Claxton, Anthony Damico, and Cynthia Cox

As of the end of the third open enrollment under the Affordable Care Act (ACA), 12.7 million people had signed up for coverage in the health insurance marketplaces, up from 11.7 million last year and 8.0 million in 2014.

Actual enrollment will end up somewhat lower than this because some people will not pay their premiums or will have their coverage terminated due to inconsistencies on their applications, and there is typically additional attrition as the year progresses (e.g., as some enrollees get jobs with health benefits). For example, in 2015 paid enrollees totaled 10.2 million as of end of March and 9.3 million as of the end of September. If a similar pattern holds, actual enrollment should end 2016 over 10 million, which was the target established by the Department of Health and Human Services (HHS). (There are reasons to believe that attrition may be lower this year, including the fact that terminations occurring during open enrollment have already been subtracted from official signup figures, which was not the case previously.)

While enrollment is in line with the HHS target announced in advance of this year's open enrollment, it is short of earlier projections by the Congressional Budget Office (CBO), which became an implicit yardstick for judging the law. In March 2015, CBO projected average monthly marketplace enrollment of 21 million in calendar year 2016, though recently lowered that forecast to 13 million.

In this analysis, we look at why enrollment may be lower than projected by CBO and discuss the potential for future enrollment growth.

Why Is Enrollment Lower Than Projected?

There are several reasons why marketplace enrollment may be lower than what CBO projected:

The availability of employer coverage has not declined. People with access to affordable employer coverage are not eligible for marketplace premium subsidies, so there was an expectation that some employers might drop coverage to allow their employees to take advantage of those subsidies.

CBO projected a decline in employer coverage relative to what would have happened in the absence of the ACA of 1 million people in 2015 and 6 million in 2016. So far, there are no signs of such a decline due to the ACA. A federal survey of employers found that fewer private sector employees were in establishments that offered health insurance coverage in 2014 as the ACA took effect, but that was consistent with a longer term trend that predated the ACA. The Kaiser-HRET Employer Health Benefits Survey showed 57% of firms offering health benefits in 2015, statistically unchanged from 55% in 2014.

It may be that the incentives for employers to maintain health benefits are more powerful than expected, at least so far. Employers with 50 or more full-time employees face penalties under the ACA if they do not offer affordable coverage to their full-time workers, and employer-based insurance benefits are provided tax-free to employees.

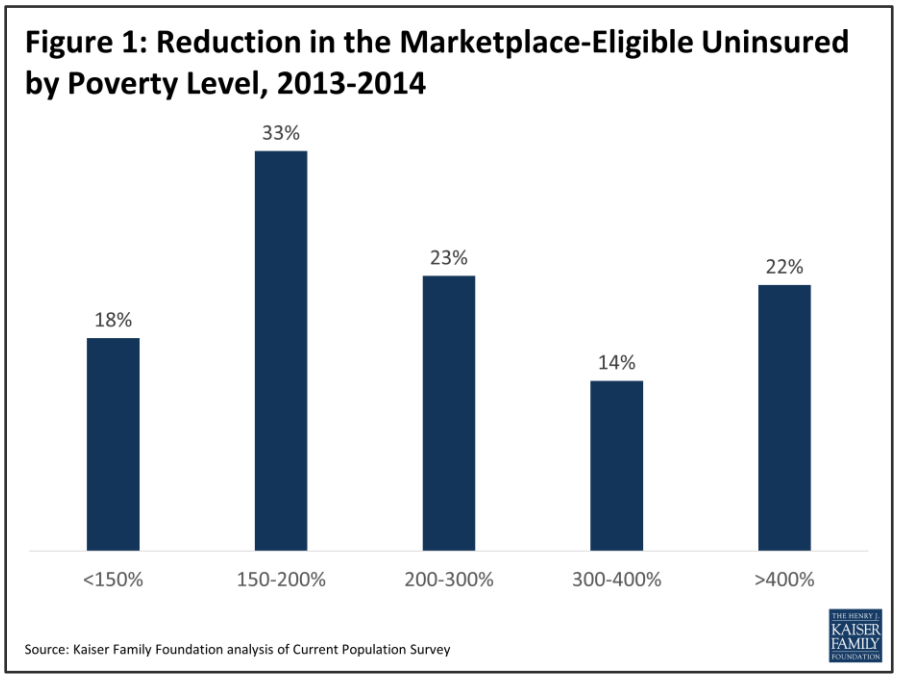
Many people are still buying their own insurance outside of the marketplaces. There are three types of individual coverage outside of the marketplaces:

- **ACA-compliant plans.** Anyone buying individual coverage effective starting January 1, 2014 had to purchase an ACA-compliant plan, whether it was offered inside a marketplace or on the outside market. These plans must follow virtually all of the same rules as marketplace plans – including no discrimination against people with pre-existing conditions and inclusion of essential health benefits – and their premiums are set as part of one insurance risk pool. The main distinguishing feature is that premium subsidies for low and middle-income enrollees are only available inside a marketplace. For people not eligible for premium subsidies, there is little advantage to buying through the marketplace. Insurers and brokers may also prefer the application process outside of the marketplaces when enrolling people not eligible for premium subsidies.
- **"Grandfathered" plans.** These are plans that were purchased prior to the enactment of the ACA in March 2010, and can exist in perpetuity largely under pre-ACA insurance rules. Given substantial turnover in the individual insurance market, the prevalence of these plans will diminish over time.
- **"Transitional" plans.** These plans – also referred to as "grandmothered" coverage – include coverage that was purchased after the enactment of the ACA but before the beginning of the first open enrollment period in October 2013. Following controversy over these plans being cancelled because they did not comply with new insurance market rules taking effect in 2014 under the ACA, the Obama Administration issued guidance that permits these plans to remain in effect until December 31, 2017). The federal rules granted discretion to states and individual insurers, so transitional plans have not been allowed to continue in all cases.

Current data regarding how many people are purchasing individual coverage outside of the marketplaces is difficult to come by. As of the end of 2014, we estimated that 57% of all individual market coverage was purchased outside of the marketplaces (including ACA-compliant, grandfathered, and transitional plans). That share may have fallen since then as market churn lowers the number of grandfathered and grandmothered policies. However, it is still quite common for people not eligible for subsidies to buy in the outside market, evidenced by the fact that 82% of marketplace enrollees are receiving subsidies. There is, in some sense, an artificial distinction between ACA-compliant plans purchased on or off the marketplaces, since they offer equivalent coverage and are part of the same insurance risk pool.

Affordability remains a challenge. A recent Kaiser poll found that the overwhelming reason why people who are uninsured say they are uncovered is cost – 46% of uninsured, non-elderly adults say they tried to get coverage but found that it was too expensive. However, it is difficult to separate lack of affordability from lack of awareness of financial help that may be available, which could be addressed through more intensive outreach. For example, going into this last open enrollment period, another poll found that 82% of uninsured adults had not been contacted in the previous 6 months about the health law.

One way to gauge where affordability or outreach challenges may exists is to look at how the number of people uninsured has changed by income group. Figure 1 shows the change in the number of uninsured in the first year of the ACA among those who are potential purchasers of marketplace coverage (i.e., those who are ineligible for Medicaid or employer coverage and are not undocumented immigrants, excluding people below poverty in states that have not expanded Medicaid).



The two groups that saw the least gains in coverage were those who were very low income (below 150% of the poverty level) and those with incomes 300-400% of the poverty level.

The lowest income group qualifies for the biggest premium subsidies, but they still generally have to pay something towards the premium (up to about 4% of income for those at 150% of poverty to enroll in a benchmark Silver plan). And, while cost-sharing subsidies are available to enrollees with incomes up to 250% of the poverty level, the deductibles and copays may still feel high for a family struggling with a very low income. These low-income households – who would mostly qualify for Medicaid if their states chose to expand eligibility up to the ACA standard of 138% of the poverty level – may also be hard to reach given their often unstable financial and employment circumstances.

Those with incomes 300-400% of the poverty level had the smallest gains in coverage. Premium subsidies phase out quickly in that income range, and may provide insufficient incentive for them to purchase insurance.

Surprisingly, there was a 22% decline in the number of marketplace-eligible uninsured with incomes above 400% of the poverty level, given that they are not eligible for any premium subsidies. It may be that the so-called “individual mandate” had an effect on this group. Some people were also likely excluded from insurance previously because they had pre-existing health conditions.

What Is A Reasonable Expectation for Future Marketplace Enrollment Growth?

While marketplace enrollment has continued to grow in the third year of operation, that growth is slower than it was in year two – an increase of 1 million plan selections during 2016 open enrollment versus 3.7 million in 2015.

A key question for the future of the marketplace is whether enrollment will continue to grow and by how much. Enrollment growth is important for several reasons, including:

- Higher enrollment among those who would otherwise be uninsured would increase the number of people with insurance, which is a primary aim of the ACA.
- Since it is likely the case that many people who are sick already obtained coverage once pre-existing condition exclusions were prohibited starting in 2014, increasing enrollment would bring healthier people into the risk pool and help to stabilize premiums.
- A growing market would be more attractive to insurers, whose participation is central to the success of the marketplaces.

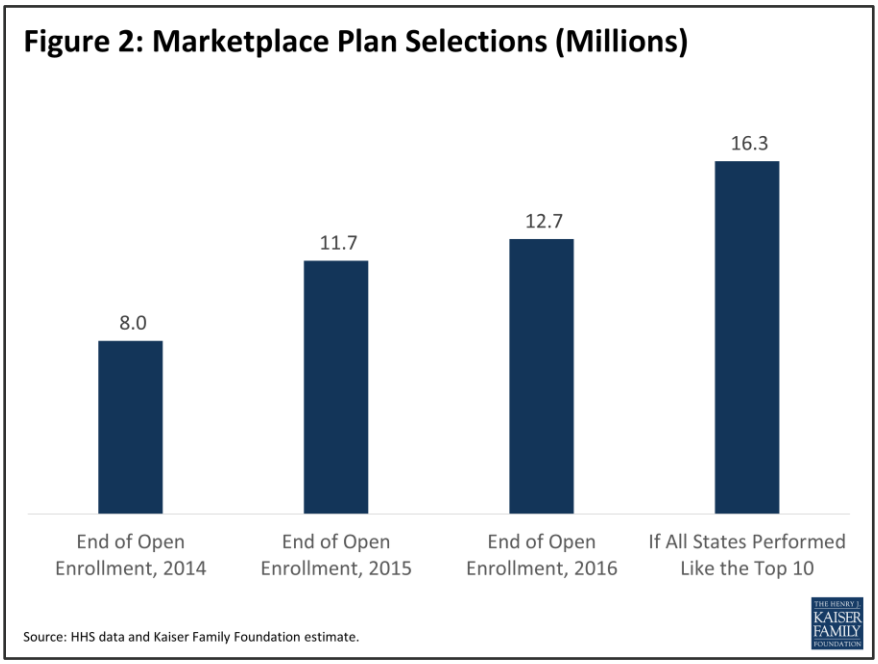
Any effort to forecast marketplace enrollment is subject to substantial uncertainty, as illustrated by the wide gap between what CBO has projected and actual enrollment so far. One way to estimate potential growth is to look at the experience of the top-performing states.

We estimate that the 12.7 million signups so far represent 46% of the "potential market" for the marketplaces. The potential market includes people who are uninsured or purchasing their own coverage. It excludes those who have an employer offer of insurance, are eligible for Medicaid, are undocumented immigrants, or who have incomes below the poverty level and live in states that have not expanded Medicaid (the methodology for this calculation can be found here.)

The 10 best-performing states – which include several large states such as Florida, North Carolina, and California -- have collectively signed up 59% of the potential market. While that might appear to leave room for substantial further growth, there are reasons to believe that enrollment has close to plateaued in those states. The potential market includes people who are buying their own coverage outside the marketplaces, many of whom do not qualify for subsidies. The experience so far is that the vast majority (82%) of marketplaces enrollees are receiving premium subsidies, while people who are ineligible for subsidies typically buy coverage on the outside market. In fact, we estimate that in the top-performing states the number of people who have selected a plan and qualified for a subsidy represents more than 90% of subsidy-eligible people. This is a very high take-up rate for a public program, suggesting there is very little potential for growth in these states. The only way enrollment could grow substantially is to attract people not eligible for subsidies who are already buying their own coverage directly.

However, there is still considerable room for enrollment growth among states that have enrolled a lower share of the potential market. If all states improved to at least the average of the 10 best-performing states, we estimate that total marketplace signups would reach 16.3 million. Assuming that around 10% of these people would not pay their first month's premium, this would translate into an "effectuated" enrollment total of 14.7

million. This may provide a reasonable estimate of a ceiling on what marketplace enrollment could grow to over the next several years, assuming current levels of premium subsidies and outreach.



Discussion

Marketplace enrollment under the ACA is lower than projected, though signups continue to grow and the program appears sustainable overall. It is important that enrollment continue to grow to fulfill expectations for reducing the number of people uninsured, to keep premiums stable, and to remain attractive to insurers. Since insurance risk is pooled at the state level, problems in certain states could develop if enrollment stagnates and skews towards sicker-than-average individuals.

Judging by the experience of the top performing states, there is considerable room for enrollment growth over the next several years. However, even if all states signed people up at the rate of the top 10 states, enrollment would still fall well short of projections by CBO, suggesting that those forecasts may have been unrealistic.

There are a number of areas of uncertainty that will affect marketplace enrollment. Enrollment could grow if larger numbers of employers drop health benefits for their workers, or if the buying experience in the marketplaces continues to improve and attracts people now buying their own insurance in the outside market. The pool of purchasers could also grow as transitional policies get terminated over the next year and a half. On the other hand, enrollment could shrink if more states expand Medicaid, pulling people with incomes between 100% and 138% of the poverty level out of the marketplace. There are also concerns that some existing enrollees may drop coverage if premiums become unaffordable or the cost-sharing is too high to offer sufficient value.

There are signs that marketplace coverage could continue to grow modestly in the years ahead. But, absent a substantial boost in outreach or changes to the subsidies to make insurance more affordable, substantial increases in marketplace enrollment are unlikely.

McKinsey Center for U.S. Health System Reform

healthcare.mckinsey.com/reform

Hospital networks: Perspective from three years of exchanges

As of 03.05.2016

Hospital networks: Perspective from three years of exchanges

We analyzed every hospital network across the country and uncovered the following insights:

1. Proportion of narrowed networks has remained relatively constant, yet the overall number of networks has declined
2. Median premiums for narrowed-network plans have declined even further compared to broad-network plans
3. Consumers' choice of networks has declined, with more consumers only having access to narrowed networks in 2016
4. Margins are higher for exchange carriers with narrowed networks than those with broad networks
5. Co-branded provider/carrier relationships have become increasingly common

SOURCE: McKinsey Center for U.S. Health System Reform

DEFINITIONS

Network types vary in their hospital participation:

Broad network: More than 70% of hospitals in a rating area participate in this network.

Narrow network: More than 30% and no more than 70% of hospitals participate.

Ultra narrow network: No more than 30% of hospitals participate.

Tiered network: Any network with multiple levels of in network cost sharing for hospital services.

Narrowed network: Narrow, ultra narrow, and tiered network, unless otherwise noted.

Note: Only hospital networks are considered in these analyses. Physician networks are not covered.

Plan types typically vary in their gatekeeping arrangements and out of network cost sharing:

HMO (health maintenance organization): a plan that typically offers a primary care physician who acts as gatekeeper to other services and referrals; it usually provides no coverage for out of network services, except in emergency or urgent care situations.

EPO (exclusive provider organization): a plan similar to an HMO that usually provides no coverage for any services delivered by out of network providers or facilities except in emergency or urgent care situations; however, it generally does not require members to use a primary care physician for in network referrals.

PPO (preferred provider organization): a plan that typically allows members to see physicians and get services that are not part of a network, but out of network services often require a higher co payment.

POS (point of service plan): a hybrid of an HMO and a PPO; offering an open access model that may assign members to a primary care physician and usually provides partial coverage for out of network services.

Other terms:

Competitively priced plan: Any plan within 10% of the lowest price plan within the relevant market and on the relevant metal tier.

Co branded plan: Any insurance plan offered by a carrier that includes the brand name of or refers to the brand of a healthcare provider.

SOURCE: McKinsey Center for U.S. Health System Reform

Distribution of individual exchange hospital networks by breadth

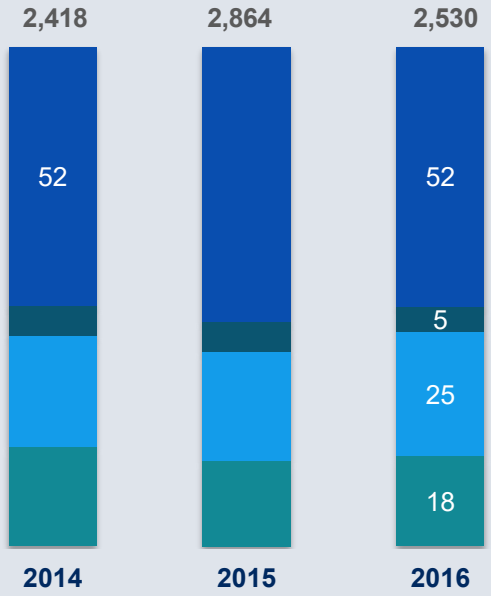
- The proportion of narrowed networks has remained relatively flat.
- Yet, total number of networks decreased over 10% from 2015 to 2016, primarily driven by carrier exits[1]. 66% of terminated networks were broad, while 45% of newly added networks were broad.[2]

Across the U.S.

% of hospital networks across all metal tiers

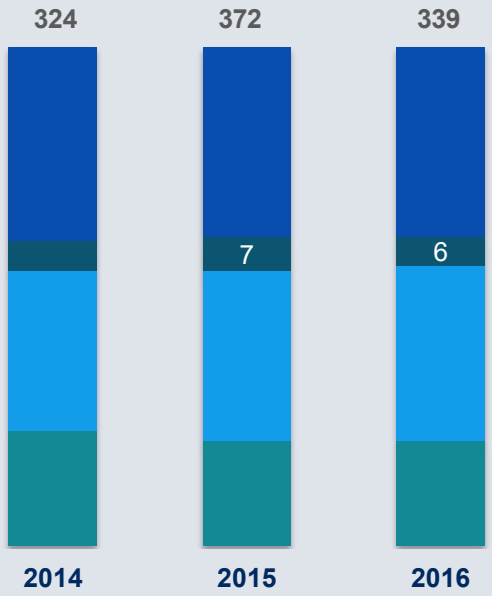
100% = Number of network-rating area combinations[1]

KEY:
- Broad
- Tiered
- Narrow
- Ultra narrow



In the largest city of each U.S. state

% of hospital networks across all metal tiers



1 Network calculations are based on the number of networks offered in each rating area (the same network offered in four different rating areas would be considered four different networks, potentially with different network breadths).

2 437 networks were lost in 2016 due to carrier exits; of these, 73% were broad.

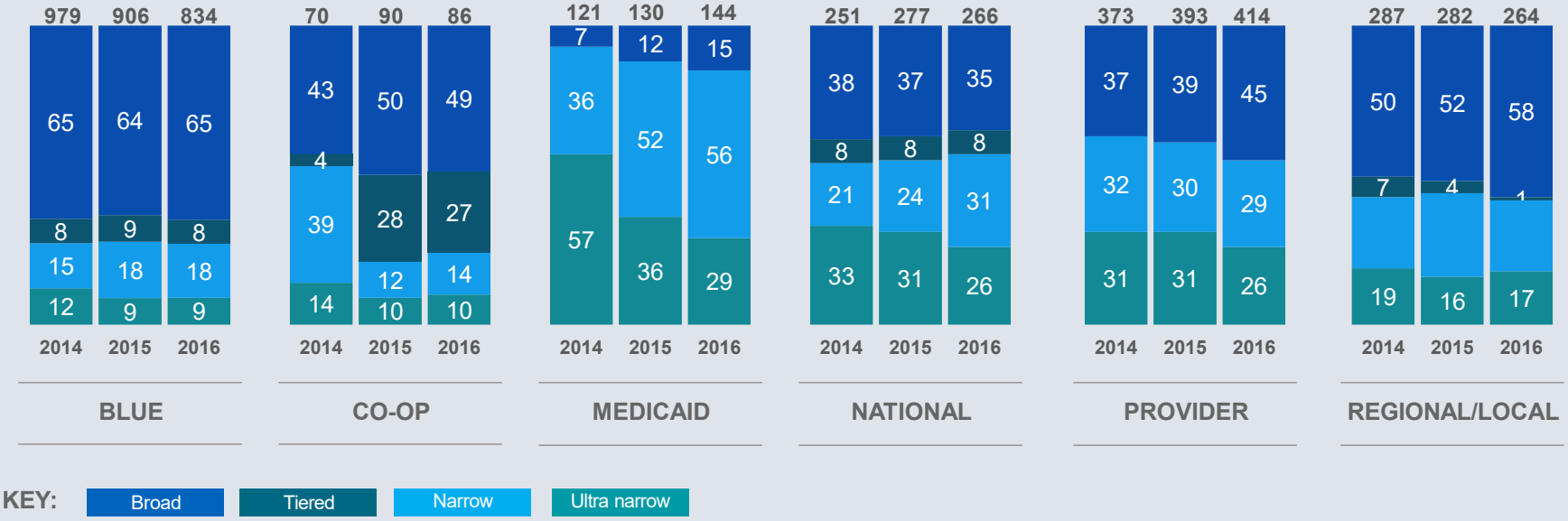
SOURCE: McKinsey Center for U.S. Health System Reform

Network breadth by carrier type

- While most carrier types offered fewer networks this year than in 2015, many Medicaid carriers and providers increased the number of networks they offered.
- Medicaid and national carriers, in aggregate, have increased their proportion of narrow networks (from 52% to 56% and 24% to 31%, respectively).
- Blues continue to offer the highest proportion of broad networks about two thirds.

% of networks across tiers by network breadth, for carriers participating across 2014–2016[1]

100% = Number of network-rating area combinations



KEY: Broad | Tiered | Narrow | Ultra narrow

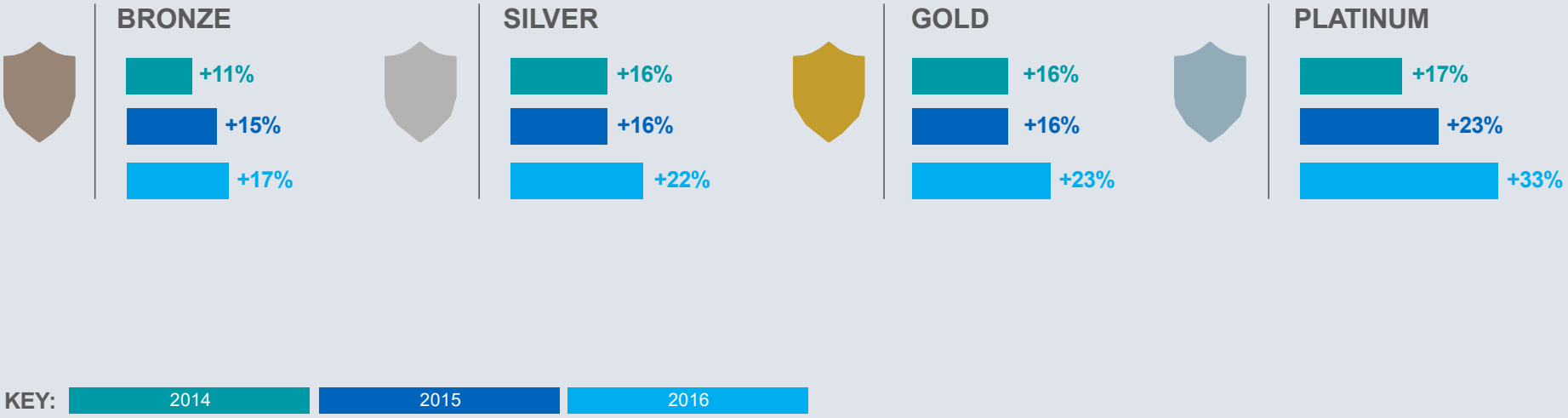
1 Only carriers who participated in their state for all 3 years are shown, in order to exclude effects of carrier exits and entrances.

SOURCE: McKinsey Center for U.S. Health System Reform

Premium difference between broad and narrowed networks

- In 2016, premium differences between narrowed and broad networks have widened across all metal tiers, although factors beyond hospital network breadth may have played a part.
- On the silver tier, the most commonly purchased, broad networks are now 22% higher priced than narrowed ones, compared to 16% in 2014 and 2015.

% difference between median premium for broad and narrowed networks from the same carrier and plan type[1,2,3]



1 Narrowed networks comprise ultra-narrow and narrow networks in this analysis, i.e., any with network breadth less than or equal to 70%. Tiered networks are excluded from the analysis.

2 Plan types include PPO, HMO, EPO, and POS.

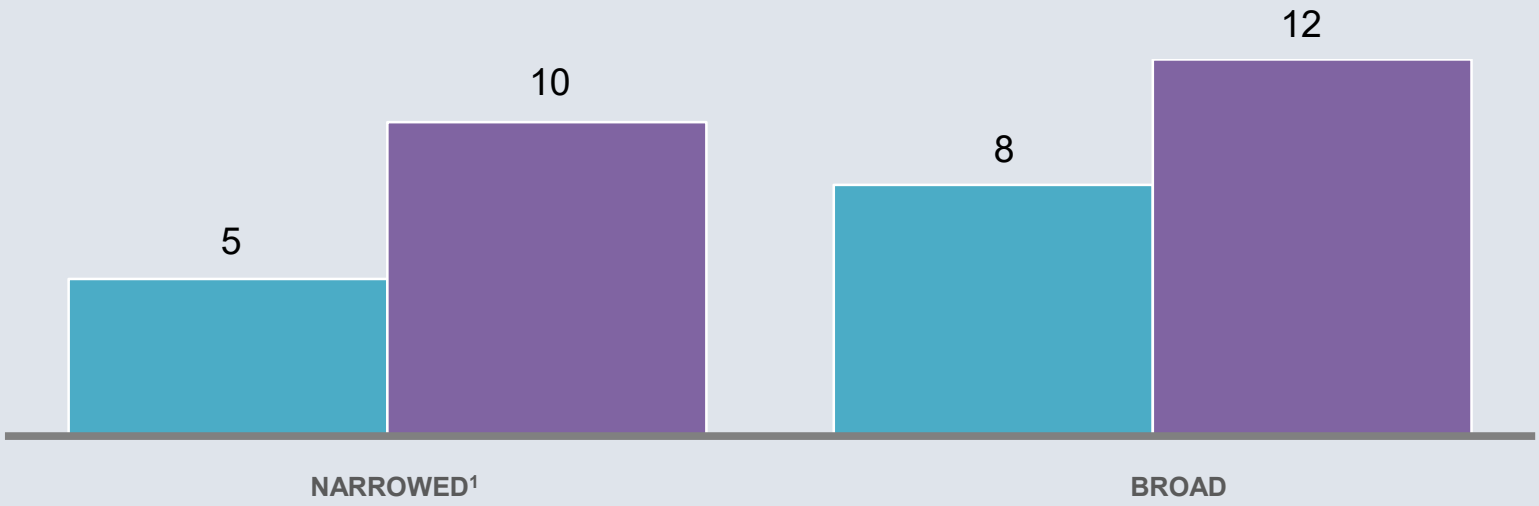
3 Median prices are based on premiums for a 40–year-old single non-smoker. When a network has multiple plans, the lowest-price plan is used as price of the network. If there are multiple networks available for selection as "narrowed," the narrowest is selected. If there are multiple networks available for selection as broad, the broadest is selected.

SOURCE: McKinsey Center for U.S. Health System Reform

Premium increases for broad and narrowed networks

Narrowed network plans had lower premium increases than broad network plans for the past two years.

% median silver premium increases among re-filed 2014 and 2015 plans



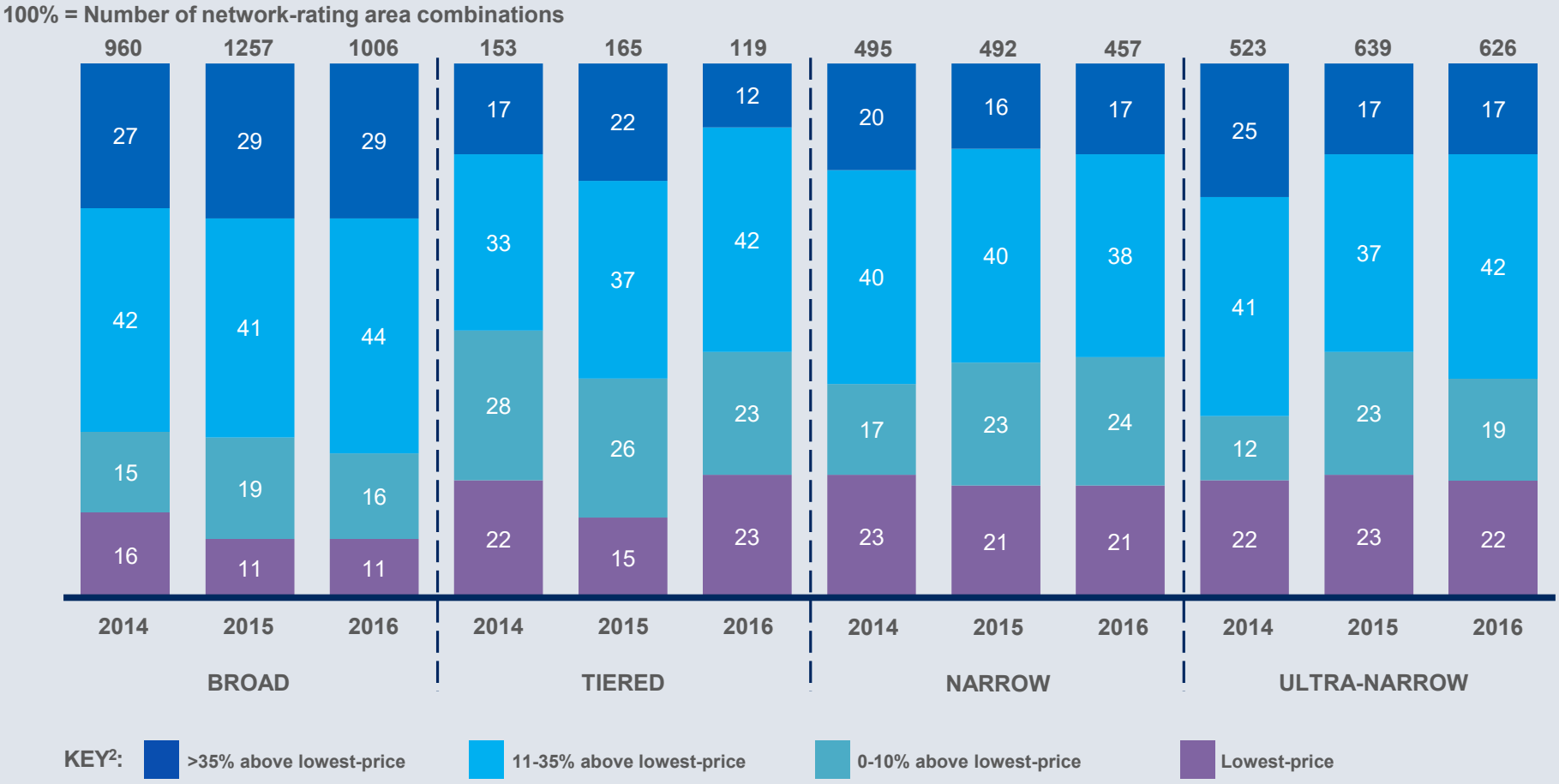
1 Includes ultra-narrow, narrow and tiered networks.

SOURCE: McKinsey Center for U.S. Health System Reform

Price gap to lowest-price plan by network breadth

- Close to half of narrow and ultra narrow networks are priced competitively (within 10% of lowest price) in 2016, compared with less than a third of broad networks.
- Price competitiveness of narrowed networks is increasing, while price competitiveness of broad is declining.

% of networks by price category[1] in regions with at least one narrowed network



1 Price category is the difference between a network's lowest-priced plan and the lowest-priced plan within the same metal tier in the same rating area. For networks with multiple tiers, the tier used for the network price is chosen in priority order: silver, bronze, gold, platinum, catastrophic. For networks with multiple plans at different prices within the same tier and rating area, the lowest-price plan is used.

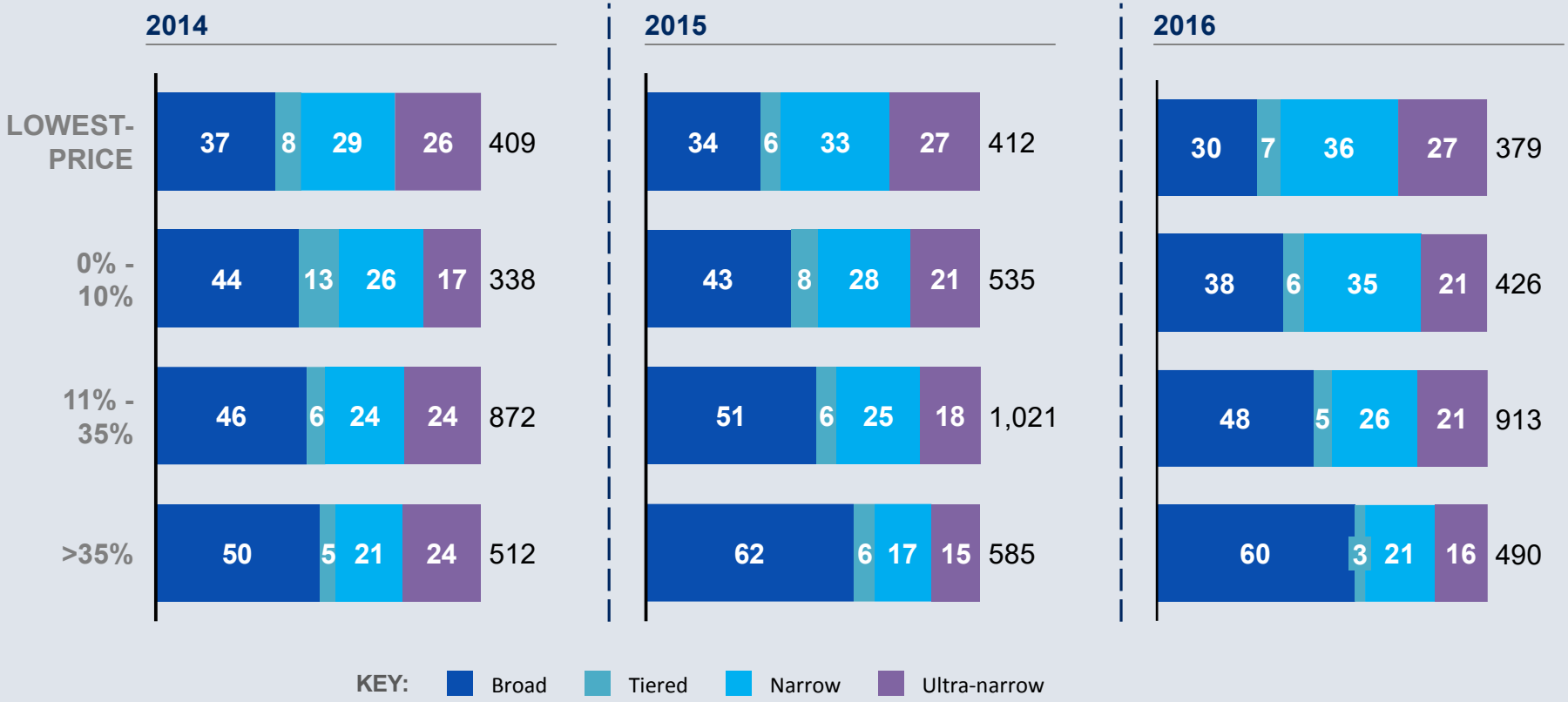
SOURCE: McKinsey Center for U.S. Health System Reform

Price category by network breadth

Narrowed networks continue to be more common among lower price plans; the proportion of narrowed networks among price leaders increased from 66% to 70% in 2016.

% of networks in each price category[1] by breadth in rating areas with at least one narrowed network

100% = Number of network-rating area combinations



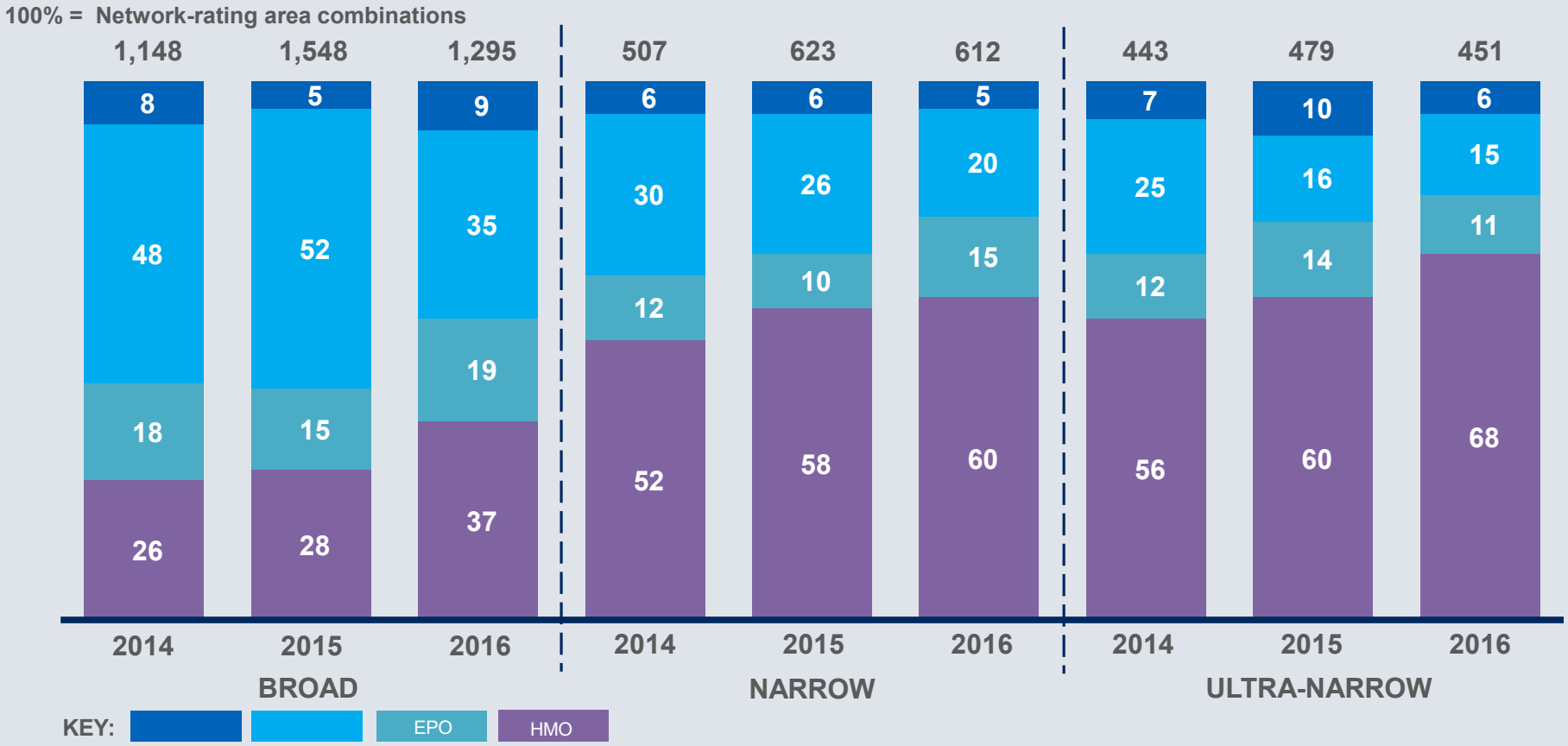
1 Price category is defined as the premium gap to the lowest-price product. This is the difference between a network's lowest-priced plan and the lowest-priced plan within the same metal tier in the same rating area. For networks with multiple tiers, the tier used for the network price is chosen in priority order: silver, bronze, gold, platinum, catastrophic. For networks with multiple plans at different prices within the same tier and rating area, the lowest-price plan is used.

SOURCE: McKinsey Center for U.S. Health System Reform

Trends across network breadth and plan type

Plans are becoming more managed (i.e., HMO's, EPO's) across all network breadth types, which can lead to less consumer choice at the point of care.

% of silver network offerings by plan type[1,2]



1 Plan types reported were taken directly from exchange websites and Summary of Benefits and Coverage (SBC) documents.

2 When multiple silver plans are available on a single network we use the plan type associated with the lowest-price silver plan in that network.

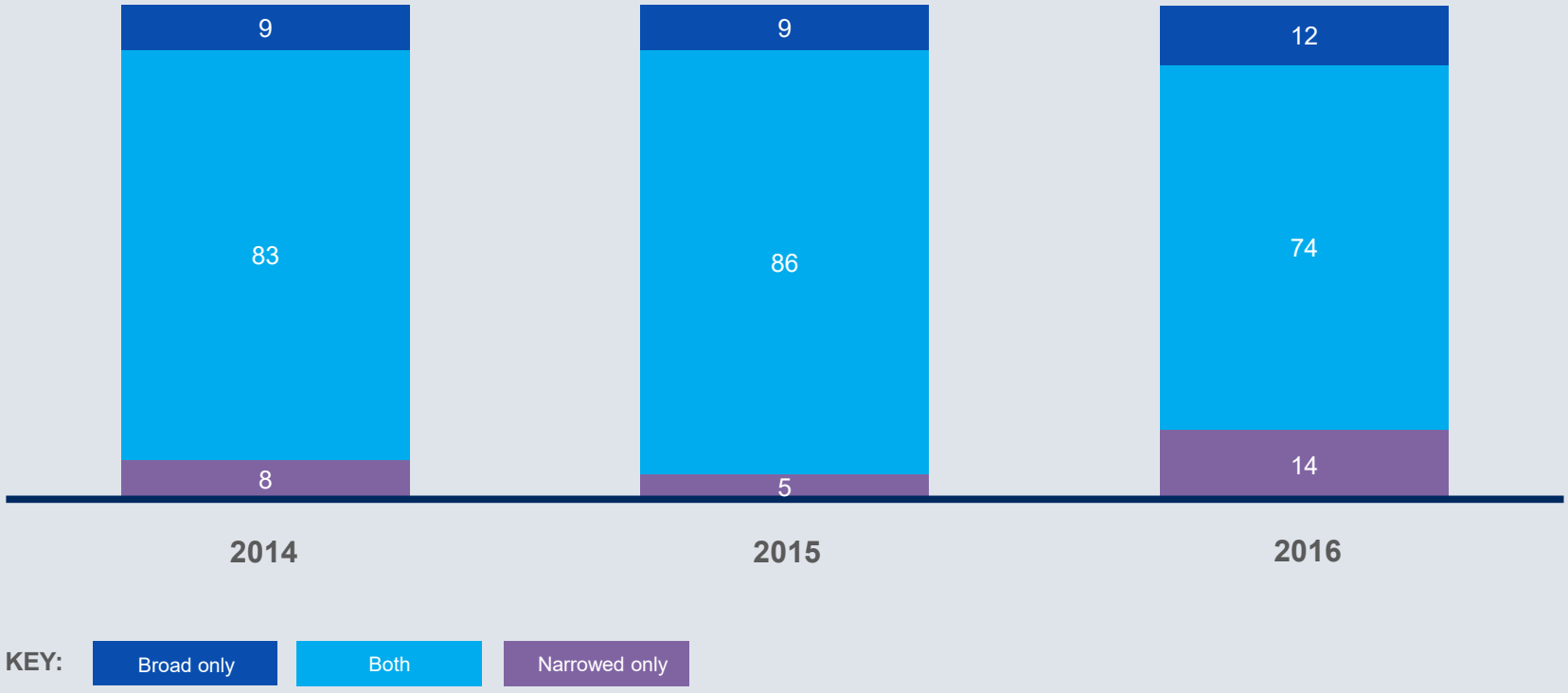
SOURCE: McKinsey Center for U.S. Health System Reform

Consumer access to network types

- Consumer choice of network breadth at the point of purchase is declining in some places.
- There is a nearly three fold increase in the percentage of consumers who have access to only narrowed networks.
- Access to both broad and narrowed networks declined for most urban consumers (89% to 74% from 2015 16) but increased for rural consumers (45% to 69%).

% of QHP-eligible consumers with access to various network types[1]

100% = 39M QHP-eligible consumers



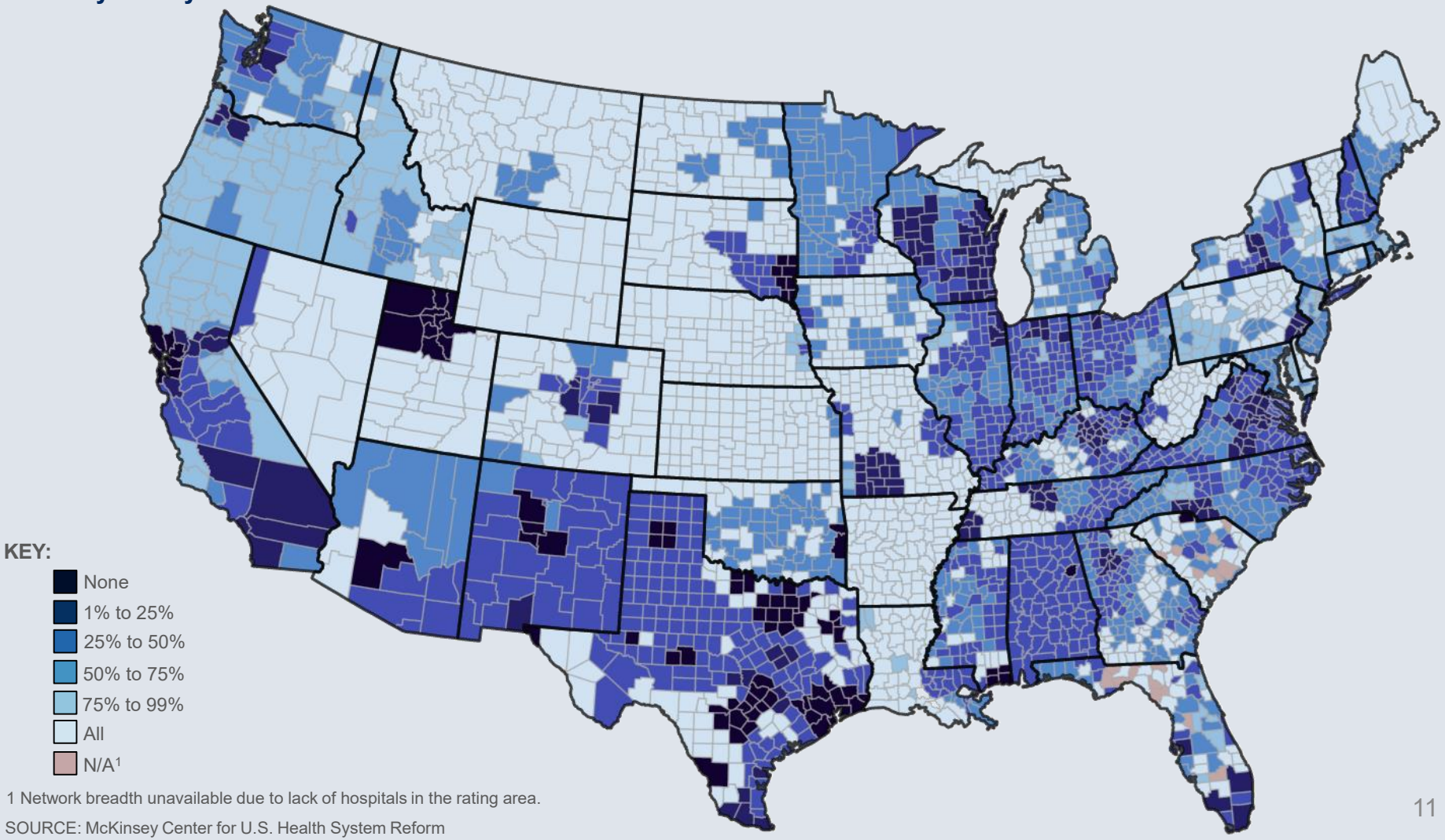
1 Whether broad, narrowed, or both breadth types were available was determined on a county level, and QHP-eligible consumers residing in county were counted toward given category.

SOURCE: McKinsey Center for U.S. Health System Reform

Geographic distribution of network composition in 2016

- Between 2015 and 2016, median network breadth stayed relatively constant in urban counties, but increased in rural counties.
- Carriers in markets with higher carrier and provider fragmentation are more likely to offer narrowed networks.

% of hospital networks classified as broad by county



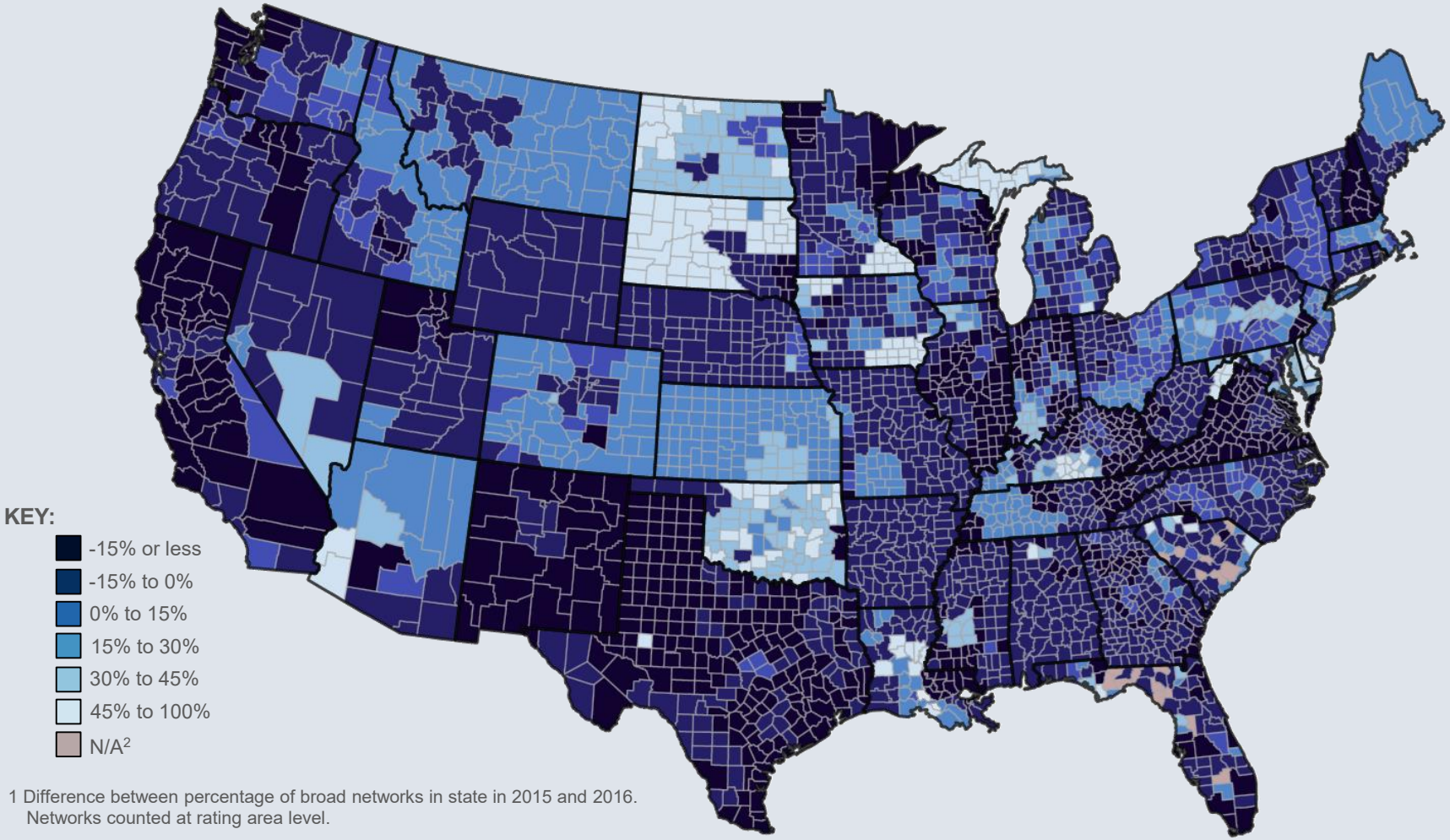
1 Network breadth unavailable due to lack of hospitals in the rating area.

SOURCE: McKinsey Center for U.S. Health System Reform

Difference in distribution of exchange networks between 2015 and 2016

- The largest increases between 2015 and 2016 in the proportion of broad networks were seen in Delaware (50%) and Iowa (31%).
- The largest decreases in the proportion of broad networks were seen in Texas (25%) and Utah (25%).

Change in the % of hospital networks classified as broad[1]



1 Difference between percentage of broad networks in state in 2015 and 2016. Networks counted at rating area level.

2 Network breadth unavailable due to lack of hospitals in the rating area.

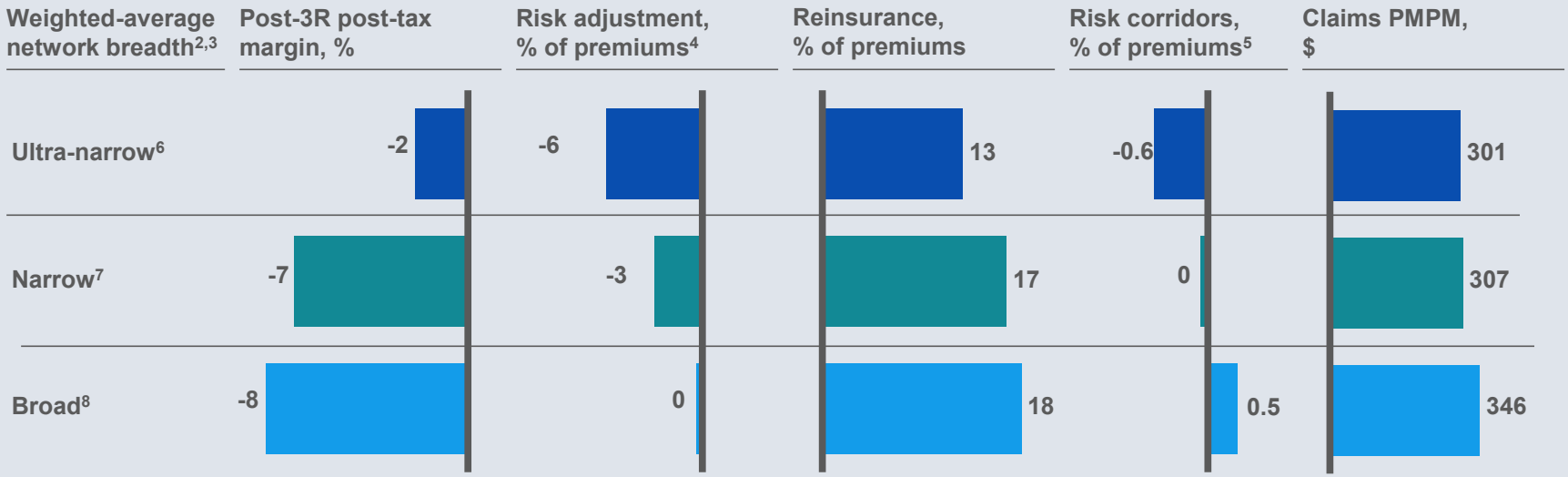
SOURCE: McKinsey Center for U.S. Health System Reform

2014 post-3R financial performance and network breadth

- In 2014, while overall, only 30% of carriers were profitable, exchange carriers[1] with narrowed networks [2,3] fared better: of these, 39% were profitable vs. 26% with broad networks[3].
- Exchange carriers with narrowed networks had better margins and lower claims, in aggregate, than those offering broad.
- Carriers[1] with narrowed networks also received less in reinsurance than other carriers did, and may be less affected by the program's termination in 2017.

Select 2014 post-3R, post-tax individual market financial metrics across exchange carriers[1]

QHP-members weighted-average



1 Carrier performance was determined at the NAIC/HIOS state-level entity level. Analysis only includes entities HIOS ID's associated with on-exchange plans in 2014, with >1K 2014 QHP members.

2 In this analysis, tiered networks are assigned to the ultra-narrow, narrow, or broad category based on the breadth of the first tier.

3 Network breadth for each entity is rolled-up to a state-level (from county) using QHP-eligible population and the network associated with the lowest-price silver plan. Each state-level entity is then associated with their respective breadth category (broad, narrow, ultra-narrow). The financial metrics for all entities in each breadth category are weighted by their 2014 QHP lives, obtained from CMS MLR reports.

4 Risk adjustment does not total to 0 as data reflects only those entities with on-exchange presence in 2014. Negative values indicate payment into the program. In aggregate, risk adjustment for all exchange entities amounted to –1% of premiums.

5 Net risk corridor payments across these carriers amount to -$17M.

6 The ultra-narrow category includes 38 entities (17 with positive margins), 12% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -51% to 15%).

7 The narrow category includes 104 entities (39 with positive margins), 50% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -77% to 17%).

8 The broad category includes 92 entities (24 with positive margins), 38% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -146% to 26%).

SOURCE: McKinsey Center for U.S. Health System Reform

Offering and price competitiveness of co-branded and provider-led plans

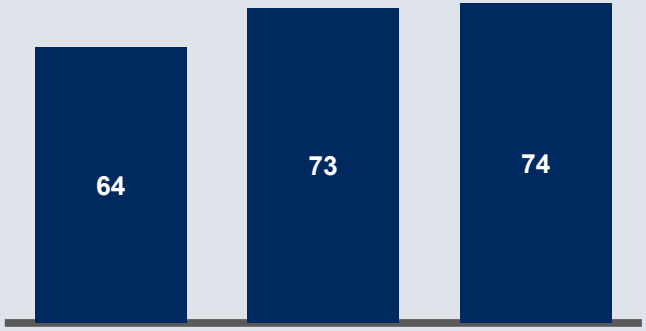
- In 2016, the number of co branded relationships increased 13%, while the net number of provider led carriers remained relatively flat.
- Yet, in 2016 only 18% of consumers have access[1] to a co branded plan, compared to 60% who have access to a provider led plan.
- Provider led plans are the lowest price option for more consumers this year and, when compared to co branded plans.

Co-branded relationships

Number of co-branded relationships[2]

Provider-led carriers

Number of carriers[2]



	2014	2015	2016
% of QHP-eligible with access[1]:	9%	18%	18%
% of QHP-eligible in a market where respective carrier is lowest-price:	28%	26%	24%

	2014	2015	2016
% of QHP-eligible with access[1]:	55%	59%	60%
% of QHP-eligible in a market where respective carrier is lowest-price:	18%	23%	31%

1 Access to plan type defined as the co-branded or provider-led plan being available in the given county.

2 Counted at state level.

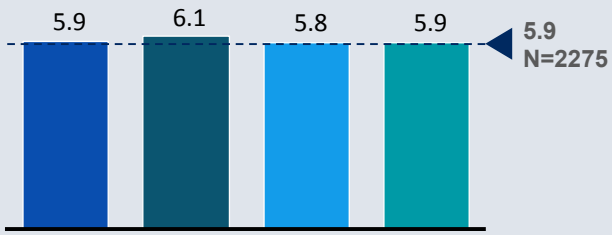
SOURCE: McKinsey Center for U.S. Health System Reform

2015 CMS hospital performance metrics and 2016 network breadth

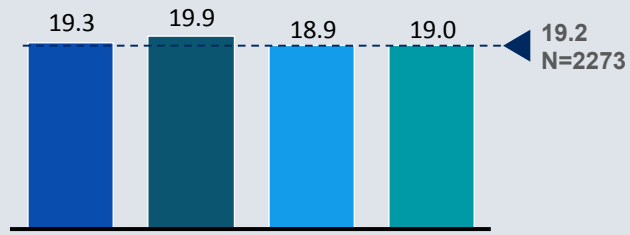
We continue to observe no signifcant difference in CMS hospital performance scores for narrowed vs. broad networks.

Weighted-average scores for all exchange hospital networks by breadth across four domains of total performance score[1,2]

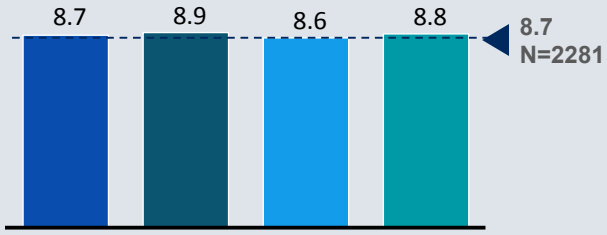
Clinical process domain score



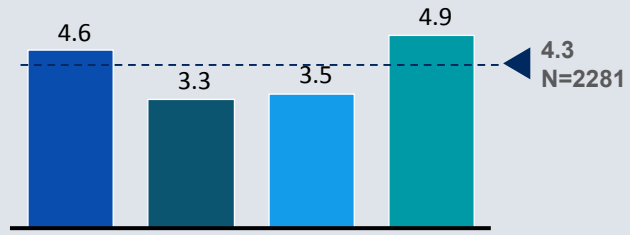
Outcome domain score



Patient experience domain score



Efficiency domain score



KEY: Broad | Tiered | Narrow | Ultra Narrow

1 Across all hospital networks. N refers to the number of networks and varies across metrics because CMS does not publish all metrics across all hospitals.

2 Scores reflect the weighted average of all scores for given network breadths, weighted by the number of inpatient admissions for each in-network hospital in a given network.

SOURCE: McKinsey Center for U.S. Health System Reform

METHODOLOGY AND SOURCES

The above findings are based on publicly available data.

Other relevant publications can be found at these sites:

http://healthcare.mckinsey.com/2015-hospital-networks

http://healthcare.mckinsey.com/2014-individual-market-post-3r-financial-performance

http://healthcare.mckinsey.com/2016-exchange-market-remains-flux-plan-type-trends

Pricing: Individual exchange premiums were obtained from state based exchange websites and CMS / healthcare.gov public use files. For analyses involving comparison of network premiums, unless otherwise noted, if a network is associated with multiple plans we consider only the lowest price plan in each metal tier when comparing that network with other networks.

Hospitals: All hospital data was obtained, as is, from carrier website provider search tools available to consumers. Hospital network data over 2014 2016 was collected from carrier websites. Our analysis focuses only on acute care facilities that are defined by the American Hospital Association (AHA) as general medical and surgical; surgical; cancer; heart; eye, ear, nose, and throat; orthopedic; or children's general hospitals. In order to effectively compare hospital inclusion in networks, we also identified each hospital s unique AHA ID through a combination of geospatial distance matching, approximate string matching, and manual verification.

Networks: Network breadth is calculated for each CMS rating area, where available, by taking the number of hospitals that are in network for the lowest AV cost sharing network tier (only applicable for Tiered networks) in a given rating area divided by the total number of hospitals that are in the rating area. Network breadth definitions are outlined in the front of the document. Adjustments were made to CMS rating area definitions for AK, ID, MA, and NE to convert their 3 digit zip rating area definitions to a county based definition. These rating area adjustments are made to be as close as possible to (for MA), or identical to (for AK, ID and NE) the adjustments made in the healthcare.gov exchange database files. In general, counties were assigned to the rating area in which a plurality of the county s population reside.

Financials: All our financial findings are based on publicly available sources. Individual performance and financials were obtained from MLR reports, SHCE filings, DMHC filings, and CMS 2014 3R reports. We analyzed all available data for 2014 carriers with more than 1,000 individual lives. Profitability is based on reported post tax, post 3R (reinsurance, risk corridor, and risk adjustment) operating margin. Risk adjustment and reinsurance were obtained directly from the CMS September 17, 2015, report titled Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year. Risk corridor details were obtained from carrier reports. Carrier level risk corridor information in the quarterly reports was occasionally found to be outdated with regard to CMS s most recent risk corridor announcement. We independently calculated to verify and update the amounts at the carrier level.

Plan types: Plan types reported were taken directly from exchange websites and Summary of Benefits and Coverage (SBC) documents. Plan type definitions are outlined in the front of the document.

SOURCE: McKinsey Center for U.S. Health System Reform

The COMMONWEALTH FUND

Realizing Health Reform's Potential

MARCH 2016

How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services

Munira Gunja, Sara R. Collins, and Sophie Beutel

Abstract Only by knowing which health care services are excluded from their insurance plan's deductible can consumers take full advantage of their coverage and ensure timely access to needed care. This is particularly important for people with higher incomes who do not qualify for the Affordable Care Act's cost-sharing reductions and individuals who do not use a lot of health care services and are therefore unlikely to reach their annual deductible. This analysis of silver-tier plans offered in the largest markets in states using HealthCare.gov as well as generic drugs, from the deductible. In 24 of these plans, specialist visits and prescriptions for preferred brand-name drugs are excluded as well. The number of excluded services varies considerably by market.

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

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BACKGROUND

When evaluating a health insurance plan for the cost protections it provides, consumers must look beyond the size of the deductible to determine how much they can expect to pay out-of-pocket for health care services. For example, the Affordable Care Act requires all health plans, including those provided by employers, to fully cover preventive services like cholesterol screenings and mammograms. That means when someone goes to the doctor for one of these screenings, he or she is not required to first meet a deductible before the coverage kicks in.

Often other services, such as doctor visits or prescription drugs, are excluded from deductible requirements as well. For these services, patients must pay any required copayments or coinsurance but not the full cost of the service, even if they have not yet reached their deductible. To take full advantage of a health plan's coverage, it is essential to know which services are omitted from the deductible.

In this Commonwealth Fund brief, a companion to *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket*

Costs in 2016?, we explore how deductible exclusions vary across health plans sold in the marketplaces in states using the federal HealthCare.gov website for 2016 enrollment. We look at the 22 adult services that are listed on HealthCare.gov's website, excluding dental services. We focus on a hypothetical 40-year-old, nonsmoking man who earns $35,000 a year and chooses the second-lowest-cost silver plan in each of these states' largest city.[1] We limit our analysis to the 37 markets whose silver plans have a deductible for people at this income level.

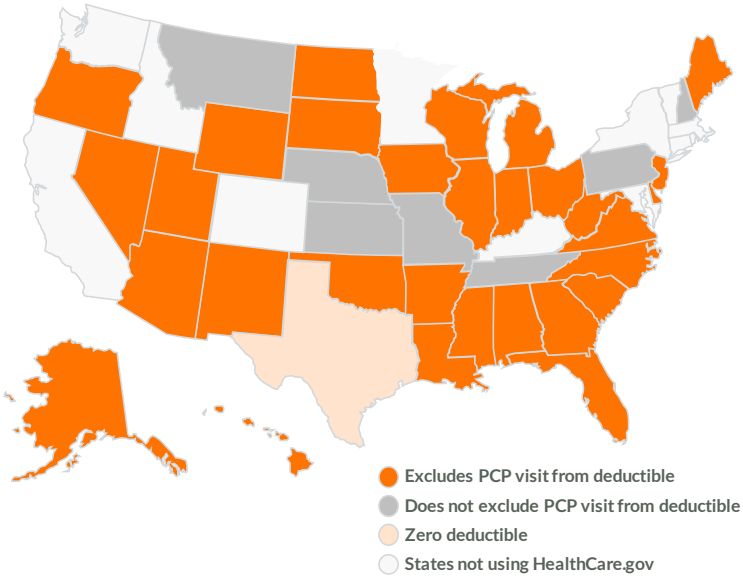
HOW MUCH DO DEDUCTIBLE EXCLUSIONS VARY FROM MARKET TO MARKET?

The results of our analysis show that 30 of 37 silver-tier plans exclude primary care visits, as well as generic drugs, from the plan's deductible (Exhibit 1, Table 1). In 24 plans, specialist visits and prescriptions for preferred brand-name drugs (those included on the plan's formulary) are excluded as well. Twenty-three plans exclude mental or behavioral health outpatient visits, 16 exclude chiropractor visits, and nine exclude specialty drugs.

The number of excluded services varies considerably by market. In the markets we analyzed in New Mexico, Hawaii, Ohio, Nevada, South Dakota, and North Carolina, second-lowest-cost silver plans exclude 10 or more services. In 17 markets, silver plans exclude six to nine services; in nine markets, plans excluded two to four services. Silver plans in the largest markets in Montana, Kansas, Nebraska, Missouri, and Pennsylvania do not exclude any services.

Exhibit 1

In 30 of 37 Silver Plans, Primary Care Physician Visits Are Excluded from the Deductible



Other services excluded from plan deductibles	Number of states
Generic drugs	30
Specialist visit	24
Preferred drugs	24
Mental/behavioral health—outpatient	23
Chiropractic care	16
Nonpreferred drugs	12
ER visit	11
Outpatient rehabilitation	9
Specialty drugs	9
Habilitation	7
Lab outpatient & professional services	7
X-ray & diagnostic imaging	5
Acupuncture	3
Hearing aids	3
Private duty nursing	2
Infertility treatment	2
Mental/behavioral health—inpatient	1
Inpatient physician & surgical	1
Inpatient hospital	1

Notes: PCP = primary care physician. Second-lowest-cost silver plans for 2016 plans with positive deductibles; 40-year old male nonsmoker; largest city in state. Deductible exclusions are based on an adult with an annual income of $35,000. Analysis does not include Houston, Texas, which has a plan with a zero-dollar deductible.

Source: HealthCare.gov.

While patients do not have to meet a deductible for a service that's excluded, most plans require a copayment or coinsurance. Differences in the amount of these charges will, of course, affect patients' overall out-of-pocket costs. For example, someone earning $35,000 who is enrolled in the silver plans we analyzed in Newark, New Jersey, and Oklahoma City, Oklahoma, would have free generic drugs (Appendix Table 5). But in the Houston, Texas, plan, that person would face a $35 generic copayment.

CONCLUSION

By understanding which health care services are excluded from the plan deductible, consumers can ensure they are taking maximum advantage of their coverage and have timely access to needed care. This is particularly important for people with higher incomes who do not qualify for cost-sharing reductions and may have higher deductibles, as well as for individuals who do not use a lot of health care services and are therefore unlikely to reach their annual deductible.

California, which runs its own marketplace (and so was not included in this analysis), requires health plans to exclude all physician visits and outpatient services from the deductible for all silver, gold, and platinum plans.[2] The federal government also is striving to make it easier for consumers to understand their health plans. In its new rule for health plans offered in the 2017 federal marketplaces, the Department of Health and Human Services gives insurers the option to offer standard health plans with fixed deductibles and other cost-sharing. These standard plans also exclude eight services from the deductible at the silver and gold level, including primary and specialty care visits, urgent care visits, mental health and substance-use disorder outpatient visits, and all prescription drugs.[3] Consistency in plan design will simplify plan choice for consumers and also create greater certainty about the cost of services when they use their plans to get care.

Notes

1 Someone earning $35,000 would not be eligible for cost-sharing reductions.

2 E. S. Fisher and P. V. Lee, "Toward Lower Costs and Better Care—Averting a Collision Between Consumer and Provider-Focused Reforms," *New England Journal of Medicine,* March 10, 2016 374(10):903–6; and J. C. Robinson, P. Lee, and Z. Goldman, "Whither Health Insurance Exchanges Under the Affordable Care Act? Active Purchasing Versus Passive Marketplaces," *Health Affairs Blog,* Oct. 2, 2015.

3 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule, *Federal Register,* March, 8, 2016 81(45):12204–352.

Table 1. Services Excluded from a Plan's Deductible, Second-Lowest-Cost Silver Plan in HealthCare.gov States, 40-Year-Old Male Nonsmoker, Largest City in Each State, 2016

State	Total number of services excluded from deductible in each state	Generic drugs	Primary care visit	Specialist visit	Preferred drugs	Mental/ behaviorial health outpatient	Chiro-practic care	Non-preferred drugs	ER visit	Out-patient rehabil-itation	Specialty drugs	Habili-tation	Lab outpatient and professional services	X-ray and diagnostic imaging	Acupunc-ture	Hearing aids	Private duty nursing	Infertility treatment	Mental/ behaviorial health inpatient	Inpatient physician and surgical	Inpatient hospital
New Mexico	14	*	*	*	*	*	*	*	*	*		*	*	*	*					*	
Hawaii	13	*	*	*	*	*		*		*	*	*	*	*		*		*			
Ohio	12	*	*	*	*	*	*		*	*		*	*	*			*				
Nevada	12	*	*	*		*	*		*	*			*	*		*	*	*			
South Dakota	10	*	*	*	*	*	*	*		*	*	*									
North Carolina	10	*	*	*	*	*	*	*		*	*	*									
Alaska	9	*	*	*	*	*	*						*	*	*						
Oklahoma	9	*	*	*	*	*		*	*										*		*
Arkansas	9	*	*		*	*	*	*		*		*				*					
West Virginia	8	*	*	*	*	*		*	*		*										
Oregon	8	*	*	*	*	*	*			*					*						
Michigan	7	*	*	*	*	*			*				*								
Delaware	7	*	*		*			*	*		*		*								
Utah	7	*	*	*	*			*	*		*										
Alabama	7	*	*	*	*			*	*		*										
Louisiana	7		*	*		*	*		*	*		*									
Georgia	6	*	*	*	*	*	*														
Wisconsin	6	*	*	*	*	*	*														
Illinois	6	*	*	*	*	*	*														
Florida	6	*	*	*	*	*	*														
Indiana	6	*	*	*	*	*	*														
South Carolina	6	*	*	*	*			*	*												
Mississippi	6	*	*	*	*	*	*														
Tennessee	4	*			*			*			*										
North Dakota	4	*	*	*			*														
Iowa	4	*	*	*		*															
Wyoming	3	*	*								*										
Arizona	3	*	*			*															
Maine	3	*	*		*																
Virginia	3		*	*		*															
New Jersey	3	*	*			*															
New Hampshire	2	*			*																
Montana	0																				
Kansas	0																				
Nebraska	0																				
Missouri	0																				
Pennsylvania	0																				
Total number of states with service excluded from deductible		**30**	**30**	**24**	**24**	**23**	**16**	**12**	**11**	**9**	**9**	**7**	**7**	**5**	**3**	**3**	**2**	**2**	**1**	**1**	**1**

Notes: Data are for the second-lowest-cost silver plan in 2016 plans for a 40-year old male nonsmoker in the largest city in each of the 38 states that use HealthCare.gov as its enrollment platform for the 2016 open enrollment season. We analyze plans that have positive deductibles for a total of 37 states; Texas has a zero deductible for all income levels and is therefore excluded from the analysis. No plans exclude skilling nursing and bariatric surgery from their deductibles, although these two services are part of the 22 services we analyzed.
* Indicates that state excludes the service from the deductible.
Source: HealthCare.gov.

About the Authors

Munira Gunja, M.P.H., is senior research associate in the Health Care Coverage and Access program at The Commonwealth Fund. Ms. Gunja joined the Fund from the U.S. Department of Health and Human Services in the office of the Assistant Secretary for Planning and Evaluation (ASPE), Division of Health Care Access and Coverage, where she received the Secretary's Award for Distinguished Service. Before joining ASPE, Ms. Gunja worked for the National Cancer Institute where she conducted data analysis for numerous studies featured in scientific journals. She graduated from Tulane University with a B.S. in public health and international development and an M.P.H. in epidemiology.

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MARCH 2016

How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?

Sara R. Collins, Munira Gunja, and Sophie Beutel

Abstract Health insurers selling plans in the Affordable Care Act's marketplaces are required to reduce cost-sharing in silver plans for low- and moderate-income people earning between 100 percent and 250 percent of the federal poverty level. In 2016, as many as 7 million Americans may have plans with these cost-sharing reductions. In the largest markets in the 38 states using the federal website for marketplace enrollment, the cost-sharing reductions substantially lower projected out-of-pocket costs for people who qualify for them. However, the degree to which consumers' out-of-pocket spending will fall varies by plan and how much health care they use. This is because insurers use deductibles, out-of-pocket limits, and copayments in different combinations to lower cost-sharing for eligible enrollees. In 2017, marketplace insurers will have the option of offering standard plans, which may help simplify consumers' choices and lead to more equal cost-sharing.

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

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Vol. 6

BACKGROUND

Since the Affordable Care Act (ACA) was passed in 2010, the number of uninsured people in the United States has fallen by about 20 million.[1] As a result, the amount Americans collectively spend out-of-pocket for health care has declined.

According to the Centers for Medicare and Medicare Services, growth in household out-of-pocket health care spending slowed from 2.1 percent in 2013 to 1.3 percent in 2014.[2] Out-of-pocket spending on hospital services, a big-ticket item for the uninsured prior to the ACA, actually fell by more than 4 percent. Moreover, federal and private consumer surveys show nationwide declines in reports of medical bill problems and cost-related delays in getting health care.[3]

Out-of-pocket spending growth has moderated not only because millions more people have full protection against catastrophic health care costs, but also because the ACA both requires private health insurance plans

(and Medicaid plans) to cover a comprehensive set of services and places limits on annual out-of-pocket costs. Whether consumers purchase insurance inside or outside the marketplaces, they can choose among plans offering varying levels of cost protection, ranging from bronze to platinum (see box). Those who have gained coverage through the Medicaid expansion face little cost-sharing.

COST EXPOSURE IN MARKETPLACE PLANS

Insurance companies that sell plans inside or outside the marketplaces must offer plans at four different levels of cost exposure, also known as actuarial values:

- **Bronze**, covering an average 60% of medical costs
- **Silver**, covering 70%
- **Gold**, covering 80%
- **Platinum**, covering 90%.

The law also stipulates out-of-pocket limits that increase as income rises. The limit cannot exceed $6,850 for a single policy or $13,700 for a family policy (Appendix Table 1).

Insurers also are required to provide silver-level marketplace plans with reduced cost-sharing for people who have incomes between 100 percent and 250 percent of the federal poverty level. The lower one's income, the higher the proportion of health care costs covered:

- 100%–<150% of poverty: eligible for plans with 94% actuarial value
- 150%–<200% of poverty: eligible for plans with 87% actuarial value
- 200%–<250% of poverty: eligible for plans with 73% actuarial value.

The U.S. Treasury Department reimburses health plans directly for these cost-sharing reductions.

In 2016, 57 percent of people who selected plans in the largest city in the 38 states using HealthCare.gov had silver plans with reduced cost-sharing. Assuming that a similar share of people had such plans in states running their own marketplaces, as many as 7 million people may benefit from the reductions this year.[4]

For people with low or moderate incomes who are purchasing marketplace plans, the law expands financial protection in two ways: by lowering out-of-pocket limits and by reducing the amount of cost-sharing required. Cost-sharing reductions, which are available to people enrolled in silver plans who earn between 100 percent and 250 percent of the federal poverty level ($11,770 to $29,425 for an individual; $24,250 to $60,625 for a family of four), effectively increase the actuarial value of the coverage—the average percentage of costs covered—to that of a gold or platinum plan. Insurers provide these silver plan variants through a combination of lower deductibles, out-of-pocket limits, copayments, and coinsurance. The federal government reimburses insurance companies directly for these cost-sharing reductions, though Congress is currently disputing how the Obama administration is carrying this out.

In this brief, we look at the effects of cost-sharing reductions on projected 2016 out-of-pocket costs for the people who qualify for them. To do this, we compare hypothetical 40-year-old, nonsmoking males with annual income of $17,000, $20,000, and $25,000, making them eligible for the reductions, with a similar adult earning $35,000, which is above the qualifying threshold. In our study, each person purchases the second-lowest-cost silver plan available in the largest city in each of the 38 states that use the federal website HealthCare.gov to enroll residents in marketplace plans. We use the website's consumer cost comparison tool to provide a rough estimate of out-of-pocket costs for people at these different income levels and for low, medium, and high users of care, as defined by HealthCare.gov. (For further detail, see How We Conducted This Study.)

STUDY FINDINGS

Cost-Sharing Reductions Lower Plan Deductibles

People with low or moderate incomes who selected a silver plan this year will experience lower deductibles in the 38 markets we studied.[5] For our hypothetical consumer, the median deductible for the second-lowest-cost silver plan is $2,500 if his income is $25,000, $600 if his income is $20,000, and $125 if he is earning $17,000 (Exhibit 1, Table 1).[6] In contrast, the median deductible for someone earning $35,000 or more, and thus ineligible for a reduction, is $3,500.[7]

The effects of the cost-sharing reductions on deductibles vary widely across the plans we analyzed (Exhibit 2). For example, for people with a $17,000 annual income, deductibles range from zero in 12 plans to a high of $700 in Newark, New Jersey. For someone with $20,000 in income, deductibles range from zero in the largest cities in Hawaii, Nevada, Oregon, Tennessee, and Texas to $1,750 in the Indiana and Wisconsin plans (Table 1).

In six states, the second-lowest-cost silver plans required a separate deductible for prescription drugs (Appendix Table 2), but the cost-sharing reductions lowered these deductibles as well. In Wyoming, for example, the prescription drug deductible falls from $750 for those not eligible for reductions to $50 for enrollees earning $17,000.

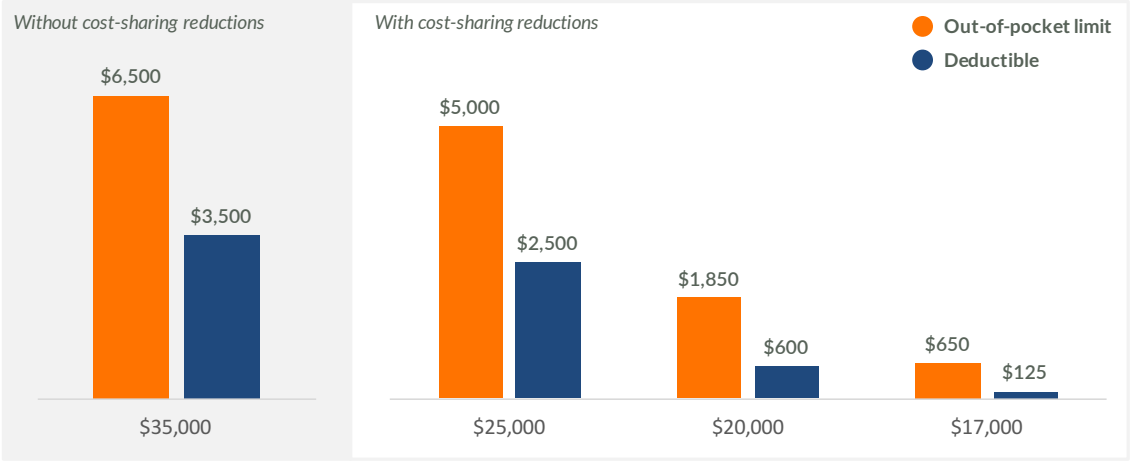
Cost-Sharing Reductions Lower Out-of-Pocket Limits

A health plan's deductible is only one of many factors that determine enrollee costs over the year. Another is the plan's out-of-pocket spending limit: the maximum amount someone would have to pay for their care in a given year. These limits are particularly important for people who need a lot of health care.

Exhibit 1

At lower incomes, enrollees have lower out-of-pocket limits and deductibles

Median out-of-pocket (OOP) limits and median deductible in states that use HealthCare.gov



Notes: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker; largest city in state. The median includes 36 states that use the HealthCare.gov platform, excluding Alaska and Hawaii for the $17,000 category; 37 states that use the HealthCare.gov platform for the $20,000 category; and the 38 states that use the HealthCare.gov platform for the $25,000 and $35,000 categories.

Data: HealthCare.gov. Source: S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016.

Exhibit 2

There is wide variation in deductibles across markets for silver plans

Highest, median, and lowest in-network deductible amounts in states that use HealthCare.gov

Notes: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker; largest city in state. The highest, median, and lowest amounts include 36 states that use the HealthCare.gov platform, excluding Alaska and Hawaii for the $17,000 category; 37 states that use the HealthCare.gov platform for the $20,000 category; and the 38 states that use the HealthCare.gov platform for the $25,000 and $35,000 categories.

* Minimum values are not displayed because the benchmark plan for Texas has a zero dollar deductible across all income levels.

Data: HealthCare.gov. Source: S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016.

The ACA's cost-sharing reductions help lower enrollees' out-of-pocket limits. In the 38 markets we examined, the median out-of-pocket limit in the second-lowest-cost silver plans for people with incomes too high for the reductions is $6,500, which is just under the legal maximum set by the health reform law (see box) (Exhibit 1, Table 1). But for people with incomes low enough to qualify for the reductions, out-of-pocket limits are lower: $5,000 for someone earning $25,000; $1,850 for someone earning $20,000; and $650 for someone earning $17,000. This is in part because the ACA lowers the out-of-pocket maximum as incomes fall (some insurers set their out-of-pocket limits at the legal maximum, while others set lower limits to meet the actuarial value thresholds for plans).

Out-of-pocket limits vary across the 38 plans we analyzed (Exhibit 3, Table 1). For example, at the $17,000 income level, out-of-pocket limits range from $500 in eight states to $2,250—the maximum amount allowed for this income level in 2016—in three states. For someone with a $20,000 income, limits ranged from $1,000 in the New Mexico plan to $2,250 in 13 plans.

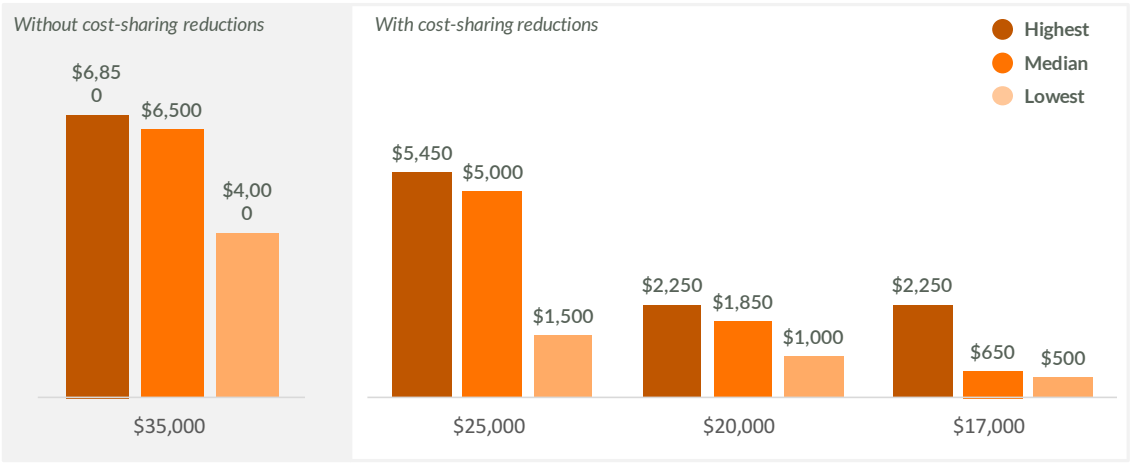
Cost-Sharing Reductions Lower Copayments and Coinsurance

Under most health insurance, people must make a copayment or pay coinsurance whenever they use their plan to get health care. We find that the cost-sharing reductions in many health plans lower these costs for many services. For example, in about three-quarters of plans, copayments for primary care visits are lower for adults earning $17,000 or $20,000 compared to adults earning $35,000 (Appendix Tables 3–7). In 18 plans, people with income of $25,000 had copayments for primary care visits that were lower than those who earned $35,000.

Exhibit 3

There is wide variation in out-of-pocket limits across markets for silver plans

Highest, median, and lowest out-of-pocket limits in states that use HealthCare.gov



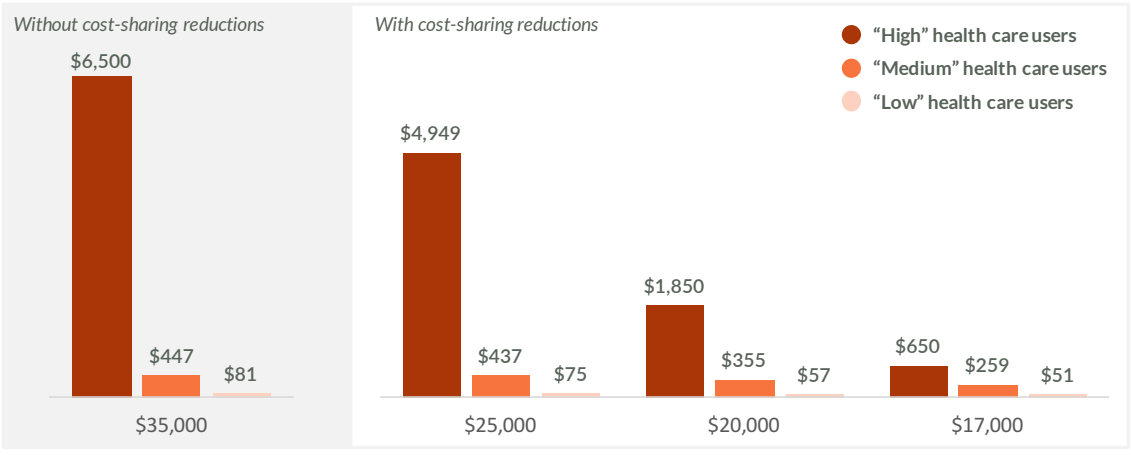
Notes: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker; largest city in state; The highest, median, and lowest amounts include 36 states that use the HealthCare.gov platform, excluding Alaska and Hawaii for the $17,000 category; 37 states that use the HealthCare.gov platform for the $20,000 category; and the 38 states that use the HealthCare.gov platform for the $25,000 and $35,000 categories.

Data: HealthCare.gov. Source: S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016.

Exhibit 4

Cost-sharing reductions lower peoples' projected out-of-pocket costs, especially for those who use health care the most

Median projected out-of-pocket costs



Notes: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker; largest city in state. The median includes 36 states that use the HealthCare.gov platform, excluding Alaska and Hawaii for the $17,000 category; 37 states that use the HealthCare.gov platform for the $20,000 category; and the 38 states that use the HealthCare.gov platform for the $25,000 and $35,000 categories. OOP costs is either the difference between total expected costs and the annual premium cost to the enrollee, or the plan's out-of-pocket limit, whichever is lower.

Data: HealthCare.gov. Source: S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016.

In addition, most plans offered in the 38 marketplaces provide full coverage for many key services. This means that even if they have not yet met their deductible, enrollees can go to the doctor or fill a prescription while making only the required copayment. (See our companion brief, *How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services.*)

Cost-Sharing Reductions Lower Projected Out-of-Pocket Costs for 2016

What do these reductions in deductibles, out-of-pocket limits, and copayments mean for someone's out-of-pocket costs? To get a rough estimate, we used the HealthCare.gov out-of-pocket cost comparison tool, designed to help consumers shop for a marketplace plan. We determined costs for low, medium, and high users of care, as defined by the government for a 40-year-old nonsmoking male. Men use somewhat fewer services than women in this age group, so women's costs will be higher than those presented here. (For further detail, see How We Conducted This Study.)

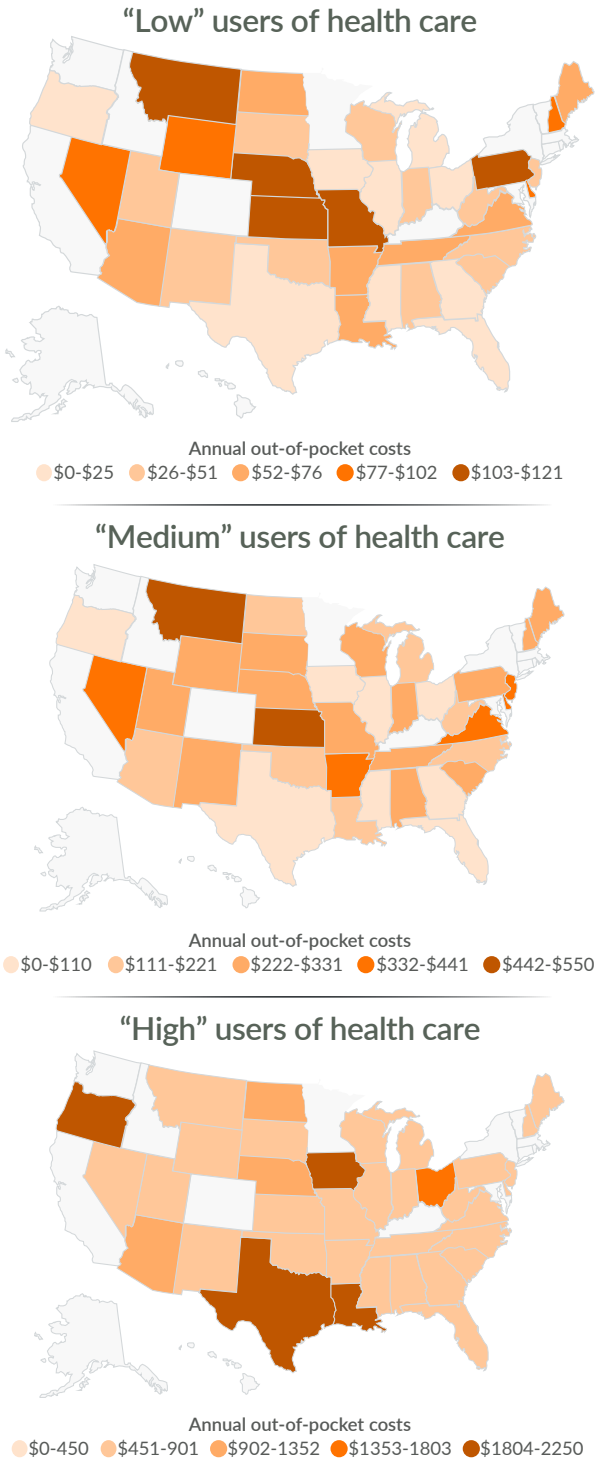
We find that the combination of the cost-sharing reductions and maximum out-of-pocket limits will lower out-of-pocket costs for people eligible for them (Exhibit 4, Table 2). People who use the most health care will see the largest reductions. For a 40-year-old-man who is a high user of care and has a $35,000 income (and therefore is not eligible for cost-sharing reductions), the projected median out-of-pocket expense for the plans we analyzed is $6,500. But projected median costs are much lower for high users with lower incomes: $4,949 for someone earning $25,000, $1,850 for someone earning $20,000, and $650 for someone earning $17,000.

How Much Consumers Pay Depends on Their Health Plan

While the cost-sharing reductions lower people's out-of-pocket costs, the degree to which they

Exhibit 5

Variation in projected out-of-pocket costs across markets, for enrollees with incomes of $17,000



Notes: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker; largest city in state. The amounts include 36 states that use the HealthCare.gov platform, excluding Alaska and Hawaii. OOP costs is either the difference between total expected costs and the annual premium cost to the enrollee, or the plan's out-of-pocket limit.

Data: HealthCare.gov. Source: S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016.

fall depends on their health and their health plan. This is because insurance companies use different combinations of deductibles, out-of-pocket limits, copayments, and coinsurance to arrive at the same average actuarial value for enrollees in a plan. And these different combinations mean very different costs for people, depending on how much health care they use in a given year.

For a 40-year-old man earning $17,000 and using very little care during the year, projected out-of-pocket costs for the second-lowest-cost silver plan range from $7 in the Mississippi plan to $121 in the Pennsylvania plan (Exhibit 5, Table 2). For a medium care user at that same income level, out-of-pocket costs range from $59 in the Ohio plan to $550 in the Montana plan (Exhibit 5, Table 2). And for a high user, costs in the silver plan range from $500 in eight plans to $2,250 in three plans (Exhibit 5, Table 2).[8]

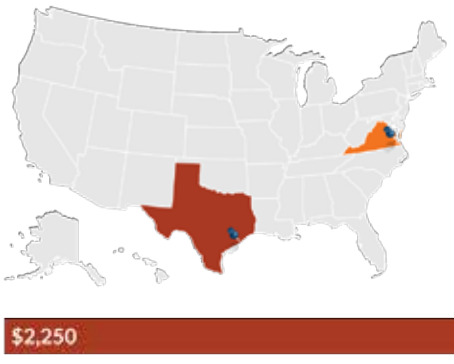
Explaining the Wide Range in Plan Costs

To understand what's behind the wide variation in potential out-of-pocket costs in the 38 state markets, we compare the experiences of a 40-year-old man earning $17,000, and thus eligible for the greatest cost-sharing reduction, in the second-lowest-cost silver plan in four markets: Houston, Texas; Virginia Beach, Virginia; Newark, New Jersey; and Columbus, Ohio.

Differences between the silver plans in Houston and Virginia Beach demonstrate why it is important to look beyond the deductible when projecting enrollees' potential cost exposure (Exhibit 6). Virginia's second-lowest-cost silver plan for someone earning $17,000 has a $150 medical deductible but also a $250 prescription drug deductible. The plan also comes with a low $600 out-of-pocket limit. It provides coverage for primary care visits and specialist visits before the medical deductible and charges $15 and $30 copayments, respectively. But for both generic and preferred prescription

Exhibit 6

Silver plans in Houston, Texas, and Virginia Beach, Virginia, for enrollees with incomes of $17,000



Notes: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker with an annual income of $17,000; largest city in state. OOP costs is either the difference between total expected costs and the annual premium cost to the enrollee, or the plan's out-of-pocket limit, whichever is lower.

* Copayments/Coinsurance are compared for only 5 of the services displayed on HealthCare.gov.

Data: HealthCare.gov. Source: S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016.

	Cost breakdown	
$0	In-network deductible	$150
$0	Prescription drug deductible	$250
$2,250	Out-of-pocket limit	$600
	Copayments/Coinsurance*	
$0	*Primary care visit*	*$15*
$10	*Specialist visit*	*$30*
$3	*Generic drugs*	*$15 copayment after deductible*
$8	*Preferred drugs*	*50% coinsurance after deductible*
$100	*Emergency room visit*	*20% coinsurance after deductible*

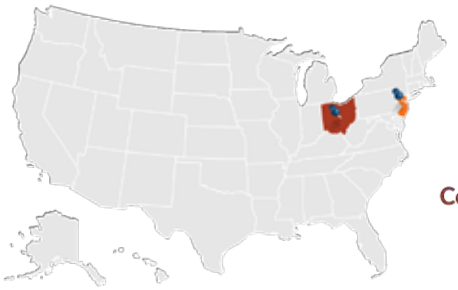
medications, the enrollee must first meet the drug deductible, after which a $15 copayment is charged for generic drugs and 50 percent coinsurance is charged for preferred drugs. Low users of care are projected to spend $72 for the year, medium users, $403, and high users, $600.

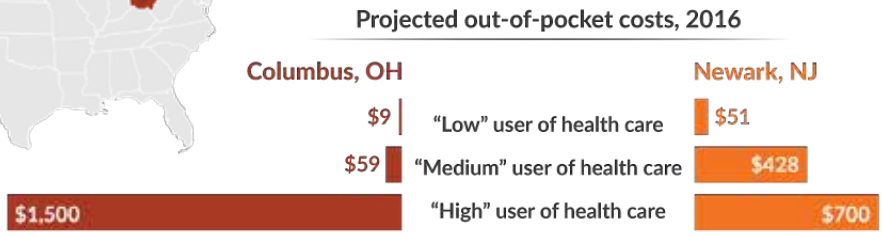
The Texas plan is quite different. It has no deductible for either medical or prescription drugs but a high $2,250 out-of-pocket limit. People have free primary care visits and pay $10 for specialist visits. Prescription drug costs are substantially lower compared to those in the Virginia plan: $3 copayments for generic drugs and $8 for preferred drugs. These low copayments mean that low and medium users of care spend significantly less in the Texas plan ($15 and $69 vs. $72 and $403). But because out-of-pocket limits are so much higher, someone enrolled in the second-lowest-cost silver plan in Texas who uses a lot of health care will have out-of-pocket costs more than three-and-a-half times those incurred by a high user in Virginia ($2,250 vs. $600).

There are similar differences in estimated out-of-pocket costs in the silver plans in Columbus, Ohio and Newark, New Jersey (Exhibit 7). Low and medium users of care are projected to spend significantly less in Ohio than in New Jersey ($9 and $59 vs. $51 and $428), but high users in Ohio are projected to spend more than twice what they would spend in New Jersey ($1,500 vs. $700). In this case, the higher out-of pocket-costs for low and medium users in New Jersey are driven in part by what's included in the plan deductible. While the New Jersey plan excludes primary care visits and generic drugs from the deductible, plan enrollees have to pay the full price of specialist visits and preferred drugs until they have met their deductible. By contrast, there is no deductible in Ohio; people just pay $10 for specialist visits and $15 for preferred drugs.

Exhibit 7

Silver plans in Columbus, Ohio, and Newark, New Jersey, for enrollees with incomes of $17,000





	Cost breakdown	
$0	In-network deductible	$700
$0	Prescription drug deductible	$0
$1,500	Out-of-pocket limit	$700
	Copayments/Coinsurance*	
$0	*Primary care visit*	*$0*
$10	*Specialist visit*	*$0 after deductible*
$2	*Generic drugs*	*$0*
$15	*Preferred drugs*	*$0 after deductible*
$100	*Emergency room visit*	*$0 after deductible*

Notes: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker with an annual income of $17,000; largest city in state. OOP costs is either the difference between total expected costs and the annual premium cost to the enrollee, or the plan's out-of-pocket limit, whichever is lower.

* Copayments/Coinsurance are compared for only 5 of the services displayed on HealthCare.gov.

Data: HealthCare.gov. Source: S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016.

CONCLUSION

The Affordable Care Act's cost-sharing reductions are playing a critical role in limiting out-of-pocket cost exposure for low- and moderate-income people enrolled in marketplace plans. If the House of Representatives prevails in its suit against the Obama administration challenging the financing of these reductions, up to 7 million people will have higher out-of-pocket costs than before (see box). This may lead many people, especially those in good health, to disenroll from their plans, an event that could destabilize the marketplaces.

A CHALLENGE TO THE COST-SHARING REDUCTIONS: *HOUSE V. BURWELL*

The Affordable Care Act requires the U.S. Treasury to reimburse insurers on a monthly basis for the cost-sharing reductions they provide to consumers. But last year, the House of Representatives filed a lawsuit against the Obama administration challenging the legality of how it is financing these payments to insurers.

The House argues that the payments are illegal, since Congress never appropriated specific funding to pay for them.[9] The administration counters that no specific appropriation is necessary to pay for the cost-sharing reductions, because these payments and the law's premium tax credits are linked and thus covered under the same appropriation.[10]

If the House prevails in the case and Congress fails to pass an appropriation, insurers would still be required under the ACA to provide the cost-sharing reductions–but now could not be reimbursed by the federal government. Insurers could sue the federal government for the money they are owed, or insurers could argue that, without reimbursement, they cannot be required to continue providing the reductions.[11]

Facing substantial revenue shortfalls, many insurers would likely leave the marketplaces or sharply increase premiums to cover their costs. With higher premiums and cost-sharing protections eliminated, many consumers–particularly those in better health–might give up their coverage. A decision on the merits of the case, *House of Representatives v. Burwell,* is expected this spring.[12]

We also found that the considerable variation in the design of the second-lowest-cost silver plans creates variation in estimated out-of-pocket costs in the 38 markets. In its final rule for 2017, the federal government will give insurers the option of offering a set of standard plans in the federal marketplaces.[13] These plans would have fixed deductibles, out-of-pocket limits, and copayments or coinsurance for health care services. In addition, they would provide pre-deductible coverage for eight services and prescription drugs. If insurers offer the plans, it will be easier for consumers to compare their potential out-of-pocket costs under different health plans. The standard options also could lead to more equal consumer cost-sharing across across the country, at least for some plans.

How We Conducted This Study

For this analysis, we looked at the second-lowest-cost silver plan in the largest city in the 38 states that used the federal website HealthCare.gov to enroll consumers in marketplace plans for 2016. We pulled information for a 40-year-old, nonsmoking male.

State	ZIP code	Largest city (by population)	Second-lowest-cost silver plan
Alabama	35203	Birmingham	Humana *Humana Silver 3800/Birmingham PPOx*
Alaska	99501	Anchorage	Premera Blue Cross Blue Shield of Alaska *Blue Cross Blue Shield Plus 3000, a Multi-State Plan*
Arizona	85018	Phoenix	Health Choice Insurance Co. *Health Choice Total Wellness Silver*
Arkansas	72201	Little Rock	Arkansas Blue Cross and Blue Shield *Silver 2500 with PCP/Rx Copayments*
Delaware	19802	Wilmington	Highmark Blue Cross Blue Shield Delaware *Shared Cost Blue EPO 4000*
Florida	32207	Jacksonville	Ambetter from Sunshine Health *Ambetter Balanced Care 1 (2016)*
Georgia	30303	Atlanta	Ambetter from Peach State Health Plan *Ambetter Balanced Care 1 (2016)*
Hawaii	96812	Honolulu	Kaiser Permanente *KP Silver III $30–Fit*
Illinois	60601	Chicago	Ambetter Insured by Celtic *Ambetter Balanced Care 1 (2016): Sinai/IlliniCare Health Network*
Indiana	46201	Indianapolis	Ambetter from MHS *Ambetter Balanced Care 2 (2016)*
Iowa	50301	Des Moines	Coventry *Coventry Silver $10 Copayment UnityPoint Health Des Moines*
Kansas	67209	Wichita	BlueCross BlueShield Kansas Solutions, Inc. *BlueCare Solutions Simple Silver*
Louisiana	70130	New Orleans	HMO Louisiana *Blue Connect Copayment 70/50 $3,500*
Maine	04101	Portland	Anthem Blue Cross and Blue Shield *Anthem Silver X HMO 3500 20*
Michigan	48201	Detroit	Harbor Health Plan, Inc. *Harbor Choice Silver*
Mississippi	39202	Jackson	Ambetter from Magnolia Health *Ambetter Balanced Care 1 (2016)*
Missouri	64101	Kansas City	Blue Cross and Blue Shield of Kansas City *Saver Select Silver*
Montana	59102	Billings	Montana Health CO-OP *Connected Care Silver Plus*
Nebraska	68102	Omaha	UnitedHealthcare *Silver Compass HSA 3000*
Nevada	89112	Las Vegas	Health Plan of Nevada, Inc. *MyHPN Silver 3.1*
New Hampshire	03105	Manchester	Minuteman Health, Inc. *MyDoc HMO Silver Basic*

State	ZIP code	Largest city (by population)	Second-lowest-cost silver plan
New Jersey	07102	Newark	Oscar *Oscar Classic Silver*
New Mexico	87107	Albuquerque	New Mexico Health Connections *Care Connect Silver HMO*
North Carolina	28263	Charlotte	UnitedHealthcare *Silver Compass 5000*
North Dakota	58103	Fargo	Medica *Medica Applause Silver Copayment*
Ohio	43215	Columbus	Molina Marketplace *Molina Marketplace Silver Plan*
Oklahoma	73101	Oklahoma City	Blue Cross and Blue Shield of Oklahoma *Blue Advantage Silver PPO℠ 102*
Oregon	97207	Portland	Kaiser Permanente *KP OR Silver 3000/30*
Pennsylvania	19147	Philadelphia	UnitedHealthcare *Silver Compass HSA 2000-1*
South Carolina	29201	Columbia	BlueCross BlueShield of South Carolina *BlueEssentials Silver 7*
South Dakota	57104	Sioux Falls	Avera Health Plans *Avera MyPlan $2,500/$6,350 Out-of-Pocket*
Tennessee	38103	Memphis	BlueCross BlueShield of Tennessee *Silver S02E, Network E*
Texas	77002	Houston	Molina Marketplace *Molina Marketplace Silver Plan*
Utah	84101	Salt Lake City	Humana *Humana Silver 3800/Salt Lake City HMOx*
Virginia	23451	Virginia Beach	Optima Health *OptimaFit Silver 4000 20*
West Virginia	25301	Charleston	Highmark Blue Cross Blue Shield West Virginia *Shared Cost Blue PPO 4750*
Wisconsin	53233	Milwaukee	Ambetter from MHS Health Wisconsin *Ambetter Balanced Care 2 (2016)*
Wyoming	82001	Cheyenne	Blue Cross Blue Shield of Wyoming *BlueSelect Silver ValueTwo with Kid's Dental*

For the analysis presented in this brief, we then focused on adults at four annual income levels: $17,000, $20,000, $25,000, and $35,000. People with incomes between 100 percent and 250 percent of poverty who purchase silver-level plans through the marketplaces are eligible for cost-sharing reductions that increase the actuarial value—that is, the cost protection—of their plans through lower deductibles and copayments. People with incomes of $17,000 are between 100 percent and less than 150 percent of poverty and are eligible for cost-sharing reductions that increase the actuarial value of their plans to 94 percent; for those with income of $20,000 and between 150 percent and less than 200 percent of poverty, it increases to 87 percent; and for those with income of $25,000 and between 200 percent and less than 250 percent of poverty, it increases to 73 percent. Our comparison group is adults making $35,000, as this income exceeds 250 percent of poverty and therefore exceeds the cost-sharing reduction range.

Under each income category, we include only states for which plan information is available. This is because states that have expanded Medicaid enroll low-income adults in that program rather than in a marketplace plan. For adults earning $17,000, we include 36 states, since Alaska and Hawaii would enroll people at this income level in Medicaid; for those earning $20,000, we include 37 states, since Alaska would enroll them in Medicaid; and for those earning $25,000 and $35,000, we include all 38 HealthCare.gov states.

For our analyses of deductible exclusions, we included only the second-lowest-cost silver plans that have deductibles. At the $35,000 annual income level, Texas is the only state that has no deductible and is therefore not included in the analysis.

Our estimates for out-of-pocket costs come from HealthCare.gov. To enable consumers to more accurately estimate their total costs for the year under different health plans, this year HealthCare.gov added an out-of-pocket cost comparison tool that allows consumers to compare plans based on their potential out-of-pocket costs.[14] Consumers can choose whether they are "low," "medium," or "high" users of health care, categories that will affect their projected costs (see examples below). We calculated a 40-year-old male's out-of-pocket costs by taking the difference between his total estimated costs and his annual premium contribution, data that are available through HealthCare.gov. If the estimated out-of-pocket costs exceed a consumer's out-of-pocket limit, then we report the out-of-pocket limit, rather than the out-of-pocket costs. Health care use is somewhat higher for women of the same age and older adults, and somewhat lower for younger people. The cost comparison tool is based on national average cost estimates for services. This means that the estimates presented in the analysis do not reflect regional differences in health care costs. Differences in out-of-pocket costs reflect differences in plan design only.

Assumed Health Care Service Use Among 40-Year-Old Nonsmoking Males and Females

	Low user		Medium user		High user	
	Male	Female	Male	Female	Male	Female
Doctor visits	1	3	4	7	13	18
Lab or diagnostic tests	0	1	1	3	6	11
Prescription drugs	2	5	6	11	28	32
Days in hospital	0	0	0	0	1	2
Other medical expenses	Minimal	Minimal	$100	$300	$10,300	$13,800

Source: HealthCare.gov.

Notes

[1] S. R. Collins and D. Blumenthal, "New Federal Survey Shows Gains in Private Health Coverage and Fewer Cost-Related Problems Getting Care," *The Commonwealth Fund Blog*, Feb. 24, 2016.

[2] S. R. Collins and D. Blumenthal, "New U.S. Health Care Spending Estimates Reflect ACA Coverage Expansions and Higher Drug Costs," *The Commonwealth Fund Blog,* Dec. 4, 2015.

[3] R. A. Cohen and J. S. Schiller, *Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates from the National Health Interview Survey, 2011–June 2015* (Washington, D.C.: National Center for Health Statistics, Dec. 2015); S. L. Hayes, S. R. Collins, D. C. Radley, D. McCarthy, S. Beutel, and J. Kiszla, *The Changing Landscape of Health Care Coverage and Access: Comparing States' Progress in the ACA's First Year* (New York: The Commonwealth Fund, Dec. 2015); *Early Release of Selected Estimates Based on Data From the National Health Interview Survey, January–March 2015, Failure to Obtain Needed Medical Care* (Washington, D.C.: National Center for Health Statistics, Sept. 2015); and S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect* (New York: The Commonwealth Fund, Jan. 2015).

[4] By the end of the third open enrollment period on January 31, 2016, 12.7 million people nationwide had selected a plan through the health insurance marketplaces. Fifty-seven percent of people enrolled through HealthCare.gov had cost-sharing subsidies, and we applied this percentage to the overall number, yielding approximately 7.2 million people. See Centers for Medicare and Medicaid Services, *Health Insurance Marketplace Open Enrollment Snapshot—Week 13* (Washington, D.C.: CMS, Feb. 4, 2016); U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Addendum to the Health Insurance Marketplace 2016 Open Enrollment Period: January Enrollment Report* (Washington, D.C.: ASPE, Jan. 7, 2016), Appendix Table B5.

[5] The cost-sharing medians are for the largest city in the state and may not apply for every 40-year-old male nonsmoker in the market.

[6] We analyzed plans in 36 markets for adults earning $17,000 annually, as adults in Alaska and Hawaii would qualify for Medicaid at this income level, and in 37 markets for adults earning $20,000, as at this income level, adults in Alaska would qualify for Medicaid.

[7] For adults earning $17,000, we include 36 markets, since they would be eligible for Medicaid in Alaska and Hawaii; for those earning $20,000, we include 37 markets, since they would be eligible for Medicaid in Alaska; and for those earning $25,000 and $35,000, we include the markets in all 38 HealthCare.gov states.

[8] The out-of-pocket cost comparison tool at HealthCare.gov estimates high users of health care with annual incomes of $17,000 to spend $2,250 on out-of-pocket costs in the Texas and Oregon plans. We also include the Louisiana plan in this definition since the second-lowest-cost silver plan's out-of-pocket limit is $2,250.

[9] S. Rosenbaum, "House of Representatives Sues Secretary Burwell, Round 1," *The Commonwealth Fund Blog,* Sept. 24, 2015.

[10] N. Bagley, "Legal Limits and the Implementation of the Affordable Care Act," *University of Pennsylvania Law Review* (forthcoming 2016).

[11] The case is being heard by Judge Rosemary Collyer of the United States District Court for the District of Columbia. T. Jost, "Implementing Health Reform: House Can Sue Administration Over ACA Cost-Sharing Reduction Payments (Sept. 10 Individual Market Update)," *Health Affairs Blog,* Sept. 10, 2015.

[12] Both the House and the Obama administration have filed final briefs in the case and the administration has requested oral arguments. T. S. Jost, "Perspective: The House and the ACA—A Lawsuit over Cost-Sharing Reductions," *New England Journal of Medicine,* Jan. 7, 2016, 374(1):5–7.

[13] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule, *Federal Register,* March, 8, 2016 81(45):12204–352.

[14] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "CMS Final Bulletin on Out-of-Pocket (OOP) Cost Comparison Tool for the Federally-Facilitated Marketplaces (FFMs)," Oct. 29, 2015.

Table 1. Deductible and Out-of-Pocket Limit for the 2016 Second-Lowest-Cost Silver Plan in the Largest City in HealthCare.gov States for a 40-Year-Old Nonsmoking Male, by State and Income

	$17,000		$20,000		$25,000		$35,000	
State	Deductible	Out-of-pocket limit	Deductible	Out-of-pocket limit	Deductible	Out-of-pocket limit	Deductible	Out-of-pocket limit
Median	**$125**	**$650**	**$600**	**$1,850**	**$2,500**	**$5,000**	**$3,500**	**$6,500**
Alabama	$500	$750	$900	$1,500	$3,250	$4,750	$3,800	$6,300
Alaska					$1,000	$1,500	$3,000	$5,400
Arizona	$100	$1,100	$600	$2,200	$2,450	$5,450	$3,100	$6,850
Arkansas	$200	$500	$500	$1,700	$2,400	$5,100	$2,500	$6,850
Delaware	$250	$500	$750	$1,500	$4,000	$4,500	$4,000	$6,850
Florida	$0	$650	$350	$2,250	$3,500	$5,000	$5,500	$6,500
Georgia	$0	$650	$350	$2,250	$3,500	$5,000	$5,500	$6,500
Hawaii			$0	$2,250	$0	$2,250	$2,500	$6,850
Illinois	$0	$650	$350	$2,250	$3,500	$5,000	$5,500	$6,500
Indiana	$550	$550	$1,750	$1,750	$4,500	$4,500	$6,500	$6,500
Iowa	$0	$2,100	$1,000	$2,150	$3,000	$4,900	$3,500	$6,250
Kansas	$500	$500	$1,250	$1,250	$3,250	$3,250	$4,000	$4,000
Louisiana	$25	$2,250	$500	$2,250	$2,750	$5,400	$3,500	$6,850
Maine	$200	$600	$750	$1,450	$2,500	$4,750	$3,500	$6,850
Michigan	$100	$630	$600	$2,250	$2,300	$5,450	$3,500	$6,500
Mississippi	$0	$650	$350	$2,250	$3,500	$5,000	$5,500	$6,500
Missouri	$250	$500	$850	$1,200	$2,300	$3,300	$3,000	$4,750
Montana	$550	$550	$1,250	$1,250	$3,300	$3,300	$4,100	$4,100
Nebraska	$250	$1,000	$800	$2,250	$2,500	$5,200	$3,000	$6,500
Nevada	$0	$500	$0	$1,250	$3,000	$4,500	$4,000	$6,250
New Hampshire	$175	$650	$800	$1,500	$1,800	$5,000	$2,000	$6,000
New Jersey	$700	$700	$1,600	$1,600	$2,500	$4,500	$2,500	$6,600
New Mexico	$100	$500	$500	$1,000	$2,500	$5,000	$4,000	$6,850
North Carolina	$0	$500	$800	$1,600	$3,600	$5,000	$5,000	$6,600
North Dakota	$50	$1,000	$400	$1,850	$2,400	$4,800	$2,600	$5,750
Ohio	$0	$1,500	$450	$2,250	$2,000	$5,450	$2,000	$6,850
Oklahoma	$0	$700	$200	$2,000	$2,000	$5,400	$2,000	$6,850
Oregon	$0	$2,250	$0	$2,250	$1,500	$5,350	$3,000	$6,850
Pennsylvania	$200	$700	$550	$2,250	$1,800	$4,900	$2,000	$6,500
South Carolina	$200	$700	$1,000	$2,250	$4,500	$5,450	$6,200	$6,850
South Dakota	$350	$700	$1,000	$2,000	$2,250	$5,300	$2,500	$6,350
Tennessee	$0	$600	$0	$1,500	$1,000	$4,400	$1,000	$6,250
Texas	$0	$2,250	$0	$2,250	$0	$5,450	$0	$6,850
Utah	$500	$750	$900	$1,500	$3,250	$4,750	$3,800	$6,300
Virginia	$150	$600	$500	$1,300	$2,500	$5,450	$4,000	$6,850
West Virginia	$100	$500	$500	$2,000	$4,000	$5,200	$4,750	$6,850
Wisconsin	$550	$550	$1,750	$1,750	$4,500	$4,500	$6,500	$6,500
Wyoming	$150	$700	$1,250	$1,500	$3,000	$3,750	$3,000	$6,600

Notes: Data are for the second-lowest-cost silver plan for a 40-year-old male nonsmoker in the largest city in each of the 38 states that use HealthCare.gov as its enrollment platform for the 2016 open enrollment season. Blank cells represent states that have expanded Medicaid making people in that income range eligible for Medicaid. We analyze plans in 36 states for adults with incomes of $17,000, as adults in Alaska and Hawaii would qualify for Medicaid at this income level; 37 plans for adults with incomes of $20,000, as adults in Alaska would qualify for Medicaid at this income level.
Source: HealthCare.gov.

Table 2. Annual Out-of-Pocket Costs for the 2016 Second-Lowest-Cost Silver Plan in the Largest City in HealthCare.gov States for a 40-Year-Old Nonsmoking Male, by State and Income

	$17,000			$20,000			$25,000			$35,000		
	Out-of-pocket costs*			Out-of-pocket costs*			Out-of-pocket costs*			Out-of-pocket costs*		
State	Low user	Medium user	High user	Low user	Medium user	High user	Low user	Medium user	High user	Low user	Medium user	High user
Median	**$51**	**$259**	**$650**	**$57**	**$355**	**$1,850**	**$75**	**$437**	**$4,949**	**$81**	**$447**	**$6,500**
Alabama	$49	$329	$750	$51	$355	$1,500	$64	$391	$4,750	$72	$434	$6,300
Alaska							$59	$314	$1,500	$60	$351	$5,400
Arizona	$66	$219	$1,100	$72	$476	$2,200	$74	$501	$5,450	$77	$503	$6,850
Arkansas	$76	$332	$500	$70	$430	$1,695	$84	$474	$5,099	$81	$472	$6,846
Delaware	$80	$397	$500	$73	$413	$1,497	$77	$416	$4,500	$78	$424	$6,848
Florida	$18	$87	$650	$38	$290	$2,250	$59	$363	$5,000	$79	$441	$6,500
Georgia	$16	$85	$650	$36	$288	$2,250	$57	$361	$5,000	$81	$443	$6,500
Hawaii				$28	$108	$2,250	$39	$179	$2,250	$80	$371	$6,850
Illinois	$10	$80	$650	$42	$294	$2,250	$51	$356	$5,000	$73	$435	$6,500
Indiana	$27	$259	$550	$33	$264	$1,750	$85	$453	$4,500	$88	$469	$6,500
Iowa	$23	$94	$2,100	$58	$354	$2,150	$63	$437	$4,900	$86	$501	$6,250
Kansas	$118	$500	$500	$123	$686	$1,250	$115	$678	$3,250	$119	$681	$4,000
Louisiana	$61	$209	$2,250	$74	$441	$2,250	$86	$512	$5,400	$96	$521	$6,850
Maine	$65	$290	$600	$81	$476	$1,450	$85	$510	$4,750	$97	$530	$6,850
Michigan	$22	$141	$630	$29	$171	$2,250	$49	$282	$5,450	$81	$431	$6,500
Mississippi	$7	$76	$650	$39	$291	$2,250	$60	$364	$5,000	$74	$436	$6,500
Missouri	$118	$306	$500	$123	$686	$1,200	$115	$678	$3,300	$125	$687	$4,750
Montana	$118	$550	$550	$123	$686	$1,250	$115	$678	$3,300	$125	$687	$4,100
Nebraska	$118	$292	$1,000	$123	$686	$2,250	$115	$678	$4,136	$125	$687	$4,615
Nevada	$81	$380	$500	$86	$385	$1,250	$84	$444	$4,500	$87	$447	$6,250
New Hampshire	$98	$289	$649	$111	$574	$1,500	$110	$617	$4,997	$110	$625	$5,996
New Jersey	$51	$428	$700	$57	$434	$1,600	$61	$437	$4,500	$58	$435	$6,600
New Mexico	$48	$258	$500	$73	$341	$1,000	$95	$418	$5,000	$93	$416	$6,850
North Carolina	$50	$212	$500	$61	$366	$1,595	$64	$370	$4,999	$62	$368	$6,596
North Dakota	$69	$211	$1,000	$74	$444	$1,850	$66	$436	$4,800	$76	$446	$5,750
Ohio	$9	$59	$1,500	$42	$197	$2,250	$74	$328	$5,450	$74	$336	$6,850
Oklahoma	$26	$150	$700	$50	$299	$2,000	$64	$392	$5,400	$73	$401	$6,850
Oregon	$22	$91	$2,250	$48	$234	$2,250	$83	$451	$5,350	$83	$450	$6,850
Pennsylvania	$121	$307	$700	$114	$584	$2,250	$118	$681	$4,900	$122	$684	$5,502
South Carolina	$46	$289	$700	$39	$308	$2,250	$43	$312	$5,450	$66	$400	$6,850
South Dakota	$30	$235	$700	$49	$293	$2,000	$68	$392	$5,300	$88	$452	$6,350
Tennessee	$52	$297	$600	$57	$303	$1,500	$95	$546	$4,400	$98	$550	$6,250
Texas	$15	$69	$2,250	$56	$236	$2,250	$76	$422	$5,450	$84	$439	$6,850
Utah	$51	$331	$750	$54	$357	$1,500	$66	$393	$4,750	$72	$434	$6,300
Virginia	$72	$403	$600	$76	$507	$1,297	$80	$511	$5,450	$77	$508	$6,848
West Virginia	$46	$203	$500	$47	$314	$1,995	$62	$362	$5,198	$59	$360	$6,846
Wisconsin	$30	$262	$550	$36	$267	$1,750	$77	$445	$4,500	$91	$472	$6,500
Wyoming	$99	$224	$700	$109	$600	$1,500	$101	$592	$3,750	$110	$601	$6,600

Notes: Data are for the second-lowest-cost silver plan for a 40-year-old male nonsmoker who is a "low" user of health care in the largest city in each of the 38 states that use HealthCare.gov as its enrollment platform for the 2016 open enrollment season. Blank cells represent states that have expanded Medicaid making people in that income range eligible for Medicaid. We analyze plans in 36 states for adults with incomes of $17,000, as adults in Alaska and Hawaii would qualify for Medicaid at this income level; 37 plans for adults with incomes of $20,000, as adults in Alaska would qualify for Medicaid at this income level. Out-of-pocket costs are calculated by taking the difference between an adult's total expected costs as a low user of health care and their annual premium.

* Out-of-pocket costs is either the difference between total expected costs and the annual premium cost to the enrollee, or the plan's out-of-pocket limit.

Source: HealthCare.gov.

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March 2016 | Issue Brief

Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014

Michelle Long, Matthew Rae, Gary Claxton, and Anthony Damico

The majority of nonelderly people get their health coverage through an employer-based plan. This issue brief uses data from the National Health Interview Survey (NHIS) to examine trends in employer-sponsored health insurance (ESI) for different types of people and households.[1] While ESI remains the leading source of coverage for nonelderly people (those under age 65), the percentage covered by an employer plan has declined over the last fifteen years. A similar pattern exists with firm offer rates; fewer workers were offered health insurance from their employer in 2014 than in 1999. The decrease in offer and coverage rates has not been universal; families with low and modest incomes have been most affected by the decline. While coverage rates have declined over time, the percentage of the nonelderly population covered by ESI is similar between 2013 and 2014.

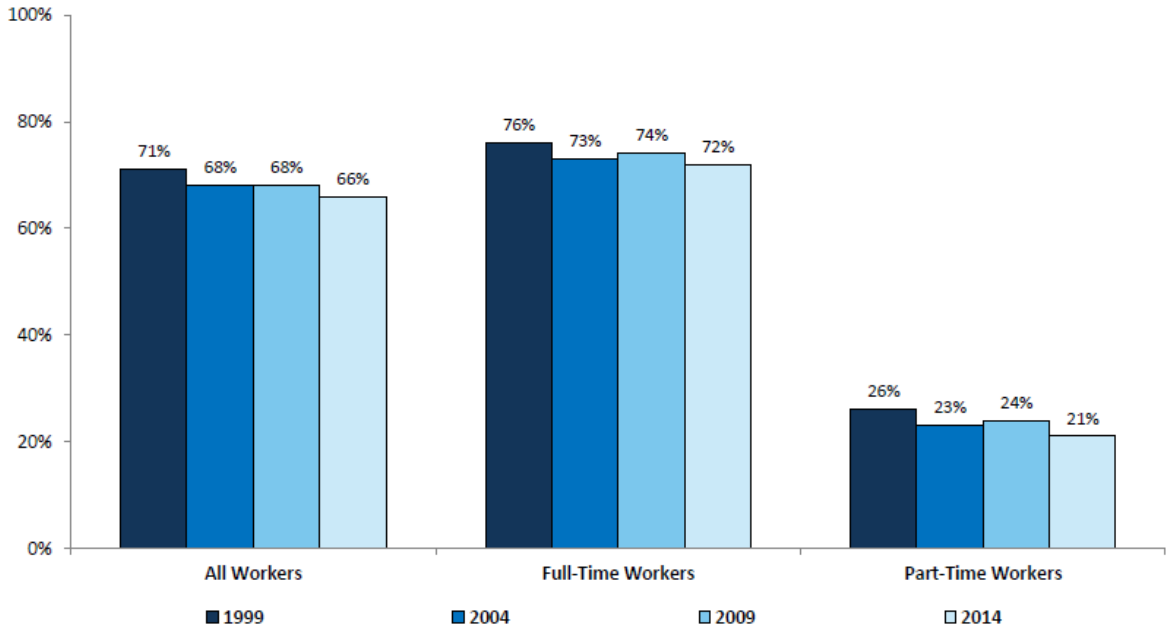
Both the percentage of employers who offer insurance and the percentage of people covered will be important to watch as the changes brought about by the Affordable Care Act (ACA) continue to unfold. New coverage provisions and financial assistance provided in the ACA affect employers' decision to offer coverage and employees' decisions to take up any coverage they are offered at work. The employer shared responsibility provision, for example, requires employers with 50 or more full-time equivalent employees to offer coverage to full-time employees and their dependent children or face a financial penalty. This provision should tend to expand the number of workers offered coverage in these firms, and, because most individuals are required to have health insurance or pay a penalty (the individual responsibility provision), more workers may take up the coverage offered at work. At the same time, new coverage options and financial assistance available through health insurance marketplaces may encourage some small employers (who are exempt from the employer shared responsibility provisions) to stop offering health benefits if they feel that their employees would be better off getting coverage through the marketplaces.[2] Larger employers may also reconsider who they offer coverage to; some may stop offering coverage to part-time workers so those workers are eligible to receive a subsidy on the marketplaces. The percentage of people who received coverage through an employer sponsored plan in 2014 remained similar to the coverage rates in 2010, the year of the ACA's passage.

Trends in Offer Rates

In 2014, 66% of nonelderly workers received an offer of coverage from their employer; less than the 71% offer rate in 1999 (Figure 1). ESI offer rates vary by workers' full-time status. Employees who worked part time (less than 30 hours a week at all their jobs) were less likely to be offered coverage from their employer than were employees who worked full time (30 or more hours a week) (21% vs. 72%).

Figure 1

Percent of Nonelderly Workers Offered Employer-Sponsored Coverage, by Full-Time Status, 1999-2014



NOTES: Full-time workers are those who work, on average, 30 or more hours per week. NHIS, and this brief, sum the total number of hours worked by each worker at any/all jobs. All workers under the age of 65 are included.

SOURCE: Kaiser Family Foundation analysis of the National Health Interview Survey, 1999-2014.

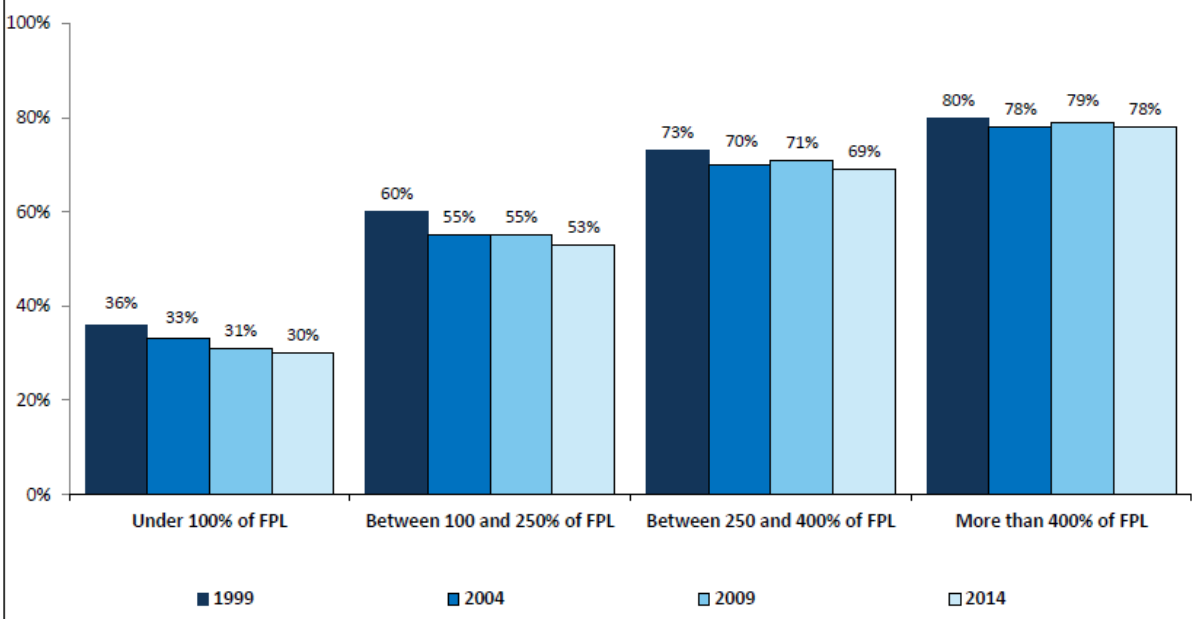
OFFER RATE DIFFERENCES BY INCOME

There are differences in ESI offer rates based on household income (Figure 2). Workers in higher income households, (those that earn more than four times the federal poverty level (FPL)) are most likely to receive an offer of ESI (78%), whereas workers in households with lower incomes (those that earn less than the FPL) are least likely to receive an offer of ESI (30%).

Since 2004, offer rates have remained stable for workers in households over 400% of the FPL, but have decreased for households below the poverty line (Figure 2). The percentage of workers offered employer sponsored coverage has decreased from 1999 to 2014 for all income groups.

Figure 2

Percent of Workers Offered Employer-Sponsored Coverage by Household Poverty Level, 1999-2014



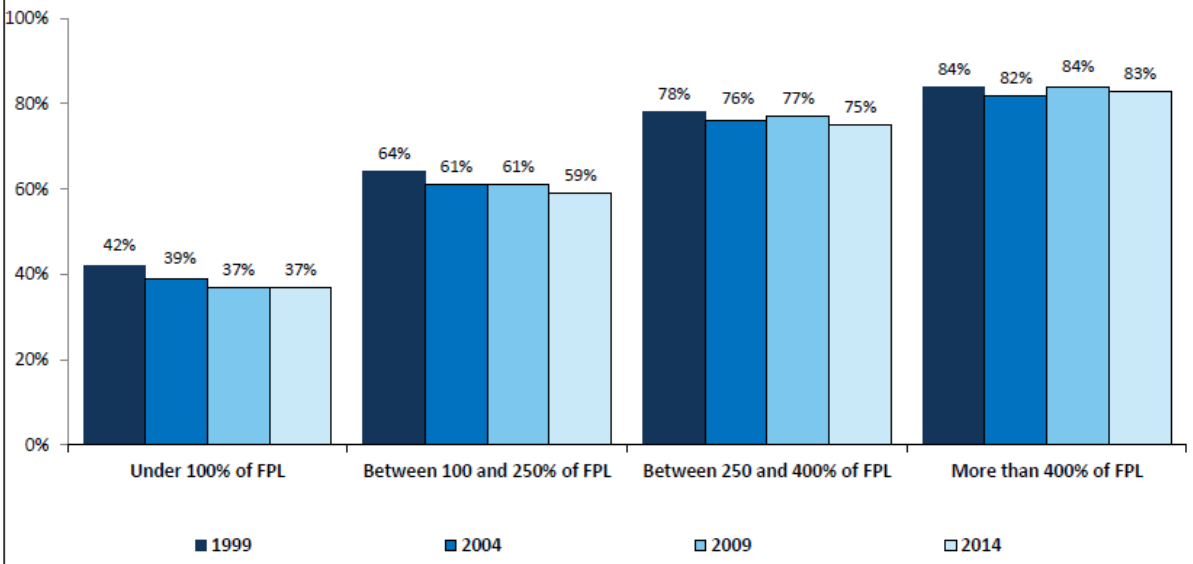
NOTE: FPL stands for the Federal Poverty Level.

SOURCE: Kaiser Family Foundation analysis of the National Health Interview Survey, 1999-2014.

A similar pattern exists for both full-time workers and part-time workers; workers in higher income households are more likely to have an offer of employer coverage than workers in a household earning less than 100% of the FPL (Figures 3 and 4).

Figure 3

Percent of Nonelderly Full-Time Workers Offered Employer-Sponsored Coverage by Household Poverty Level, 1999-2014

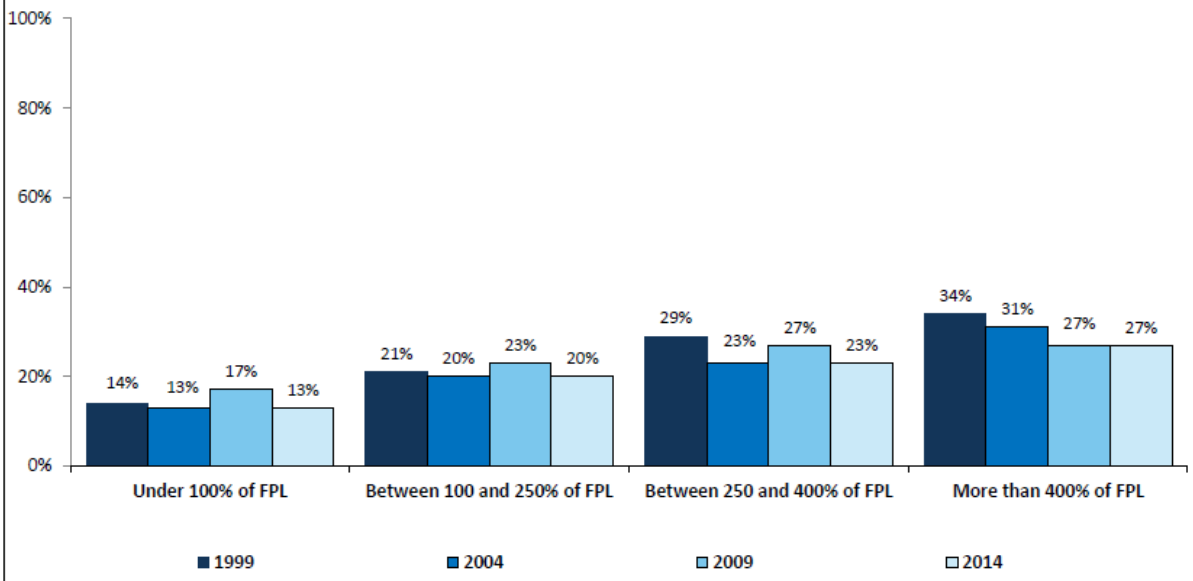


NOTE: FPL stands for the Federal Poverty Level. Full-time workers are those who work, on average, 30 or more hours per week. NHIS, and this brief, sum the total number of hours worked by each worker at any/all jobs. All workers under the age of 65 are included.

SOURCE: Kaiser Family Foundation analysis of the National Health Interview Survey, 1999-2014.

Figure 4

Percent of Nonelderly Part-Time Workers Offered Employer-Sponsored Coverage by Household Poverty Level, 1999-2014



NOTE: FPL stands for the Federal Poverty Level. Full-time workers are those who work, on average, 30 or more hours per week. NHIS, and this brief, sum the total number of hours worked by each worker at any/all jobs. All workers under the age of 65 are included.

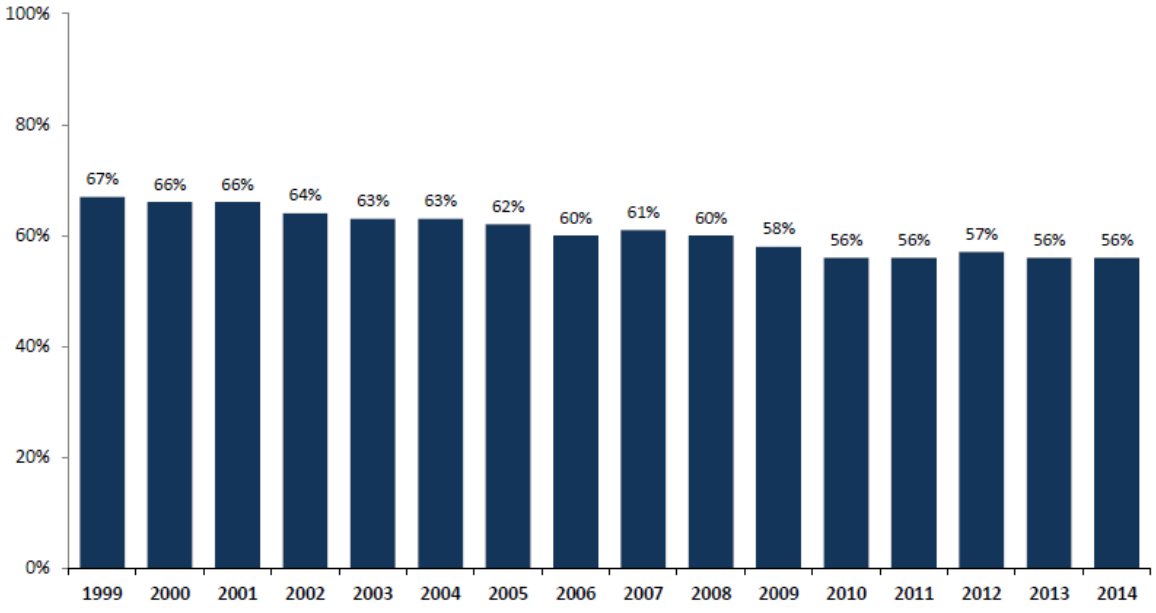
SOURCE: Kaiser Family Foundation analysis of the National Health Interview Survey, 1999-2014.

TRENDS IN COVERAGE RATES

In addition to looking at the percentage of workers who are offered benefits, we can look at the percentage of the nonelderly population that is covered by ESI (Figure 5).[3] Not all workers who are offered coverage accept their employer's benefits, and many nonelderly people (with or without a job) receive coverage as a dependent on a family member's plan. In 2014, 56% of nonelderly people were covered by ESI, similar to recent years, but a decline from the 67% covered by ESI in 1999. A variety of factors may contribute to this decline. First, changes in the economy and labor market; for example, a decrease in the percentage of people employed, known as the labor market participation rate, will decrease the percentage of individuals eligible for employer coverage.[4,5] In 2014, people in families with a full-time worker were more likely to be covered by ESI (63%) than those in a family without a full-time worker (26%). In addition to changes in the labor market, employer coverage may also be less prevalent because fewer employers are offering coverage; in 2014, a smaller percentage of firms offered coverage than in 1999 (55% vs. 66%),[6] and a smaller percentage of workers at firms offering benefits were covered by those benefits (62% vs. 66%).[7]

Figure 5

Percent of the Nonelderly Population Enrolled in Employer-Sponsored Coverage, 1999–2014



SOURCE: Kaiser Family Foundation analysis of the National Health Interview Survey, 1999-2014.

There is considerable interest in how employers and individuals alike will respond to changes brought on by the ACA. Beginning in 2014, millions of individuals enrolled in private health insurance subsidized with premium tax credits. As of yet, the NHIS data do not show that employer coverage is diminishing in its importance. The same percentage of the nonelderly households were covered by ESI in 2014 as in 2010 (56%).

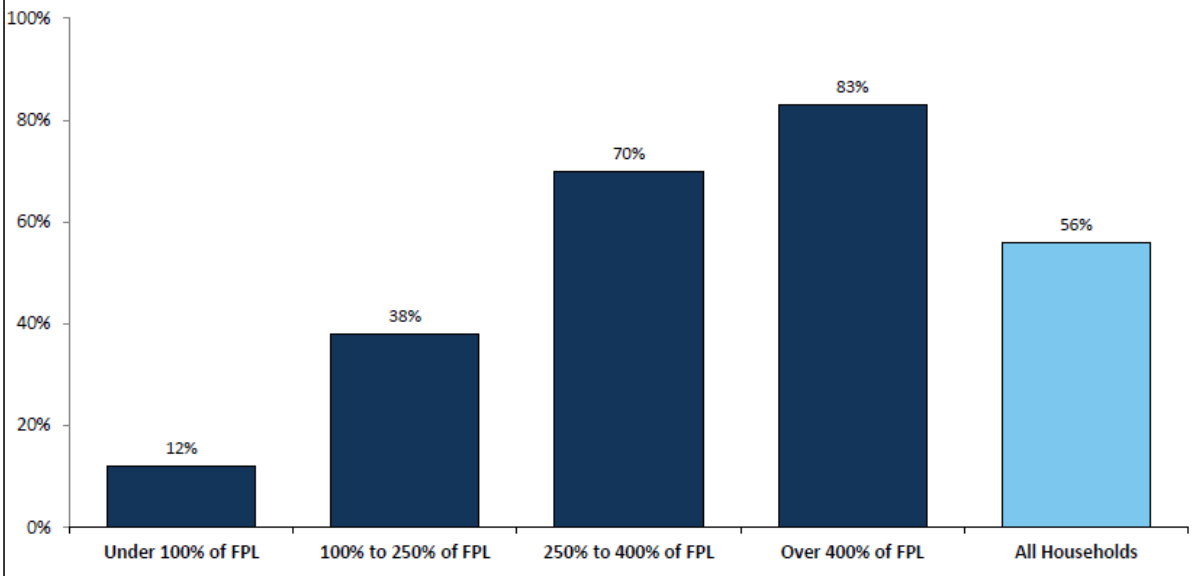
COVERAGE DIFFERENCES BY INCOME

There are important differences in who is covered by ESI based on a household's income. Employer-sponsored coverage remains the main source of coverage for people in higher-income households while substantially fewer people in lower-income families are covered by an employer (Figure 6). Eighty-three percent of nonelderly people in families that earn more than four times the FPL are enrolled in employer coverage.[8] Households at more than four times the FPL earn different incomes depending on a family's composition; for example, in 2014, a single nonelderly adult would earn about $49,000 and a family of four including two children would earn about $96,000.[9]

People in families with lower incomes are less likely to be covered by an employer. The ACA aims to provide alternate health coverage options for this population. For example, people who are not offered affordable coverage options and are in families earning between 100 and 400% of the FPL can qualify for premium subsidies through the ACA's health insurance exchanges.[10] Households between 100 and 250% of the FPL are eligible for additional cost-sharing subsidies. Only 38% of people in families earning between 100 and 250% of the FPL are covered by ESI. However, 70% of individuals in families earning between 250 and 400% of the FPL are covered through ESI. Overall, people in families whose income qualifies them for subsidies on the health insurance exchanges are less likely to be covered through an employer plan than those in households whose income does not qualify them for subsidies.[11] Among households that earn too little to qualify for any subsides (those making less than 100% of the FPL), 12% of individuals are covered by ESI.[12]

Figure 6

Percent of the Nonelderly Population Enrolled in Employer-Sponsored Coverage by Household Poverty Level, 2014



NOTE: FPL stands for the Federal Poverty Level.

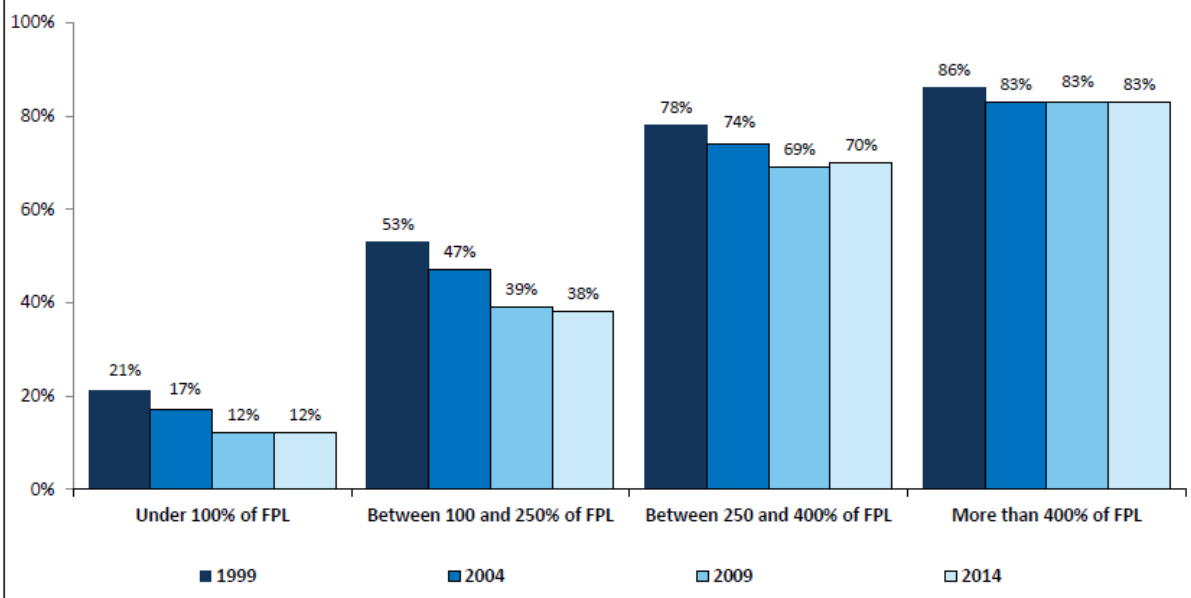
SOURCE: Kaiser Family Foundation analysis of the National Health Interview Survey, 2014

While the percentage of individuals covered by ESI has decreased, the decline has been more precipitous among lower income families (Figure 7). Comparing 2004 to 2014, there has been no change in the percentage of individuals covered by ESI in families earning more than 400% of the FPL. Alternatively, the percentage of individuals covered by ESI in households earning 100 to 250% of the FPL has decreased from 47% in 2004 to 38% in 2014. Similarly, for those in families between 250 and 400% of the FPL, the percentage covered by ESI has decreased from 74% in 2004 to 70% 2014. These trends indicate that there has been relative stability in ESI enrollment for higher-income households. Since 1999, the decrease in the percentage of nonelderly people covered by ESI has been slower for households above 400% of the FPL than households earning between 100 and 250% or between 250 and 400% of the FPL.

There have not been significant changes recently in the percentage of people covered by ESI based on income; a similar percentage of people have been covered by ESI for households in each of the income groups between 2009 and 2014. Since 2013, there has not been a significant change in the percentage of people covered by ESI within any of the household income groups.

Figure 7

Percent of the Nonelderly Population Enrolled in Employer-Sponsored Coverage by Household Poverty Level, 1999-2014



NOTE: FPL stands for the Federal Poverty Level. Vertical markers indicate a 95% confidence interval.
SOURCE: Kaiser Family Foundation analysis of the National Health Interview Survey, 1999-2014.

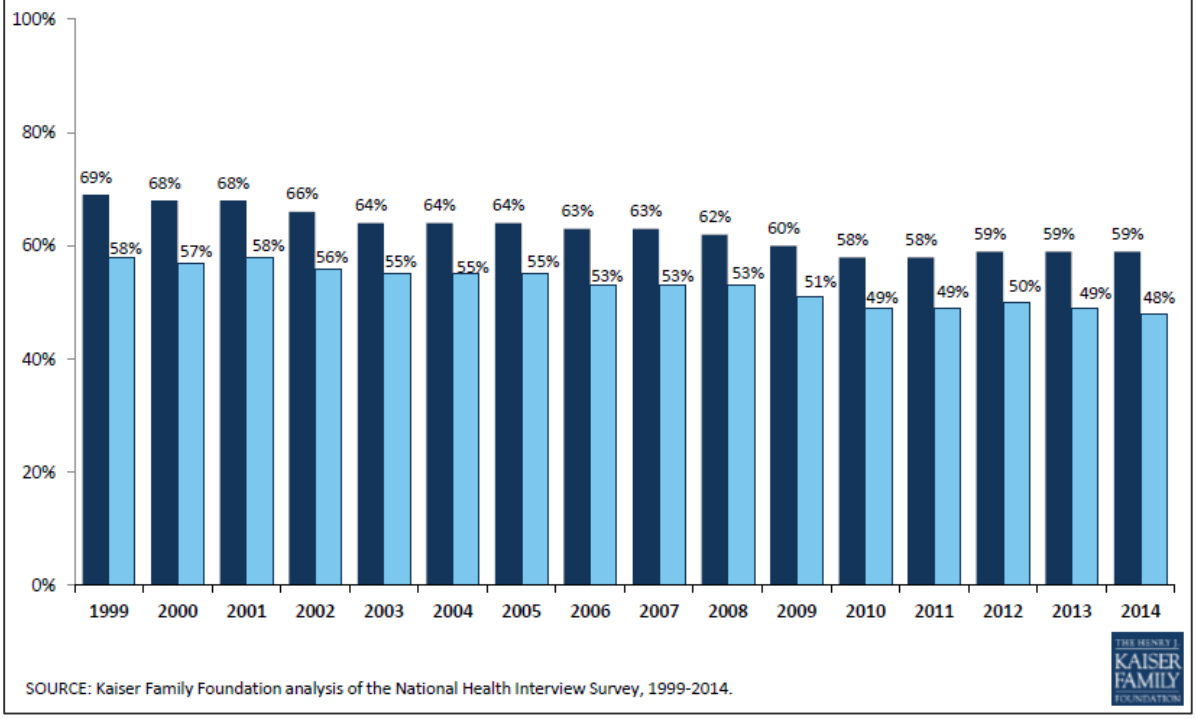
Coverage Differences by Age

ESI is a more prevalent source of coverage for adults than children (Figure 8). In 2014, 59% of nonelderly adults (ages 19 to 64) were covered by ESI compared to half of children under 19. The percentage of both nonelderly adults and children covered by ESI has decreased since 1999. There are important differences by income; 86% of children in households above 400% of the FPL are covered by employer coverage compared to 6% of children in households under 100% of the FPL and 35% of children between 100 and 250% of the FPL.

The percentage of both nonelderly adults and children covered by ESI has decreased since 1999. The growth in public programs, namely State Children's Health Insurance Program (SCHIP), plays an important role in coverage for children.

Figure 8

Percent of Nonelderly Adults and Children Enrolled in Employer-Sponsored Coverage, 1999–2014



SOURCE: Kaiser Family Foundation analysis of the National Health Interview Survey, 1999-2014.

Conclusion

Employer-sponsored coverage became the central component of the American health insurance system for a variety of reasons, including the tax preference of employer's spending on health benefits over wages, as well as the advantages of purchasing coverage as a group rather than as individuals. Many employers and employees continue to believe that offering health benefits is an important way for firms to recruit, retain and value talent. With employers facing rising costs, many commentators are speculating about the long-term stability of the employer-sponsored insurance system.

While employer-sponsored coverage remains the most common source of healthcare coverage, a smaller proportion of people are covered by employers than a decade ago. Estimates from the non-partisan Congressional Budget Office (CBO) suggest that employer coverage will remain the leading source of insurance coverage for nonelderly Americans even after the ACA is fully implemented.[13] At the same time, changes in the American workforce and economy will continue to impact employer coverage. Health reform has expanded coverage to the uninsured while providing incentives for employers to continue to offer benefits (such as tax credits for small employers who offer coverage and penalties for large employers who do not). How employers

respond to increasing costs and regulatory changes will, in part, determine how people receive coverage in the years to come.

Gary Claxton, Matthew Rae, and Michelle Long are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

Endnotes

[1] The National Health Interview Survey (NHIS) is a national probability survey of American Households sponsored annually by the U.S. Census Bureau and the Center for Disease Control and Prevention (CDC). Although NHIS was started in 1957, the survey was redesigned in 1997; therefore, in most cases, this analysis uses the years 1999 through 2014. For more information on NHIS, please see http://www.cdc.gov/nchs/nhis.htm.

[2] While individuals who are offered coverage that meets minimum value and affordability requirements may purchase coverage on the health insurance exchanges, they are not eligible for advanced premium tax credits or cost-sharing subsidies.

[3] Individuals covered by Tricare are included among those with ESI. Some individuals have multiple types of coverage; individuals who are covered by a Medicaid or Medicare Part B in addition to an employer plan are not included. Individuals who are covered by Medicare Part A and an employer plan are assumed to have ESI as their primary coverage (less than 1% in 2014). Regardless of secondary coverage source, 57% of non-elderly people are covered by ESI.

[4] Reschovsky, James, Strunk, Bradley, and Ginsburg, Paul. "Why Employer-Sponsored Insurance Coverage Changed, 1997–2003." *Health Affairs*. May 2006 vol. 25 no. 3774-782.

[5] According to the Bureau of Labor Statistics, the civilian labor force participation rate decreased from 67.2% in January 1999 to 62.9% in January 2014. http://data.bls.gov/timeseries/LNS11300000. During the same periods, the percentage of workers who usually work part-time increased. See the Bureau of Labor Statistics at http://www.frbsf.org/economic-research/publications/economic-letter/2013/august/part-time-work-employment-increase-recession/.

[6] Kaiser Family Foundation, Health Research and Educational Trust. 2014 Employer Health Benefits Survey [Internet]. Menlo Park (CA): KFF; 2014 Sep [cited 2016 Jan 15]. Available from http://kff.org/report-section/ehbs-2014-section-two-health-benefits-offer-rates/.

[7] Kaiser Family Foundation, Health Research and Educational Trust. 2014 Employer Health Benefits Survey [Internet]. Menlo Park (CA): KFF; 2014 Sep [cited 2016 Jan 15]. Available from http://kff.org/report-section/ehbs-2014-section-three-employee-coverage-eligibility-and-participation/.

[8] This analysis uses the U.S. Census Bureau's definition of families and poverty thresholds. In 2014, the federal poverty threshold was $24,008 for a family of four including two children. "Poverty Thresholds 2014." U.S. Census Bureau. Social, Economic, and Housing Statistics Division. https://www.census.gov/hhes/www/poverty/data/threshld/.

[9] It is important to note that NHIS uses the Census Bureau's federal poverty thresholds, while HHS and this portion of the brief use federal poverty guidelines to determine eligibility for some public assistance programs.

[10] Health Insurance Marketplace Calculator. http://www.kff.org/interactive/subsidy-calculator/.

[11] A person's family poverty threshold is often, but not always, the same as his or her exchange marketplace eligibility level, which is based on the federal poverty guidelines.

[12] In states that elected to expand Medicaid to the federal maximum, households up to 138% of the FPL will be eligible for Medicaid. Only households between 100 and 400% of the FPL are eligible for exchange subsidies. For more information on premium subsidies please see "Explaining Health Care Reform: Questions About Health Insurance Subsidies." Kaiser Family Foundation, October 2014. http://kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/.

[13] Effects of the Affordable Care Act on Health Insurance Coverage: CBO's March 2015 Baseline, Congressional Budget Office. https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.

By Marc L. Berk and Zhengyi Fang

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DATAWATCH

Young Adult Insurance Coverage And Out-Of-Pocket Spending: Long-Term Patterns

The Affordable Care Act appears to have improved health insurance coverage for young adults (ages 18–30). But data from twenty national surveys conducted between 1977 and 2013 paint a more complex picture, showing coverage rates lower in 2013 than they were thirty-six years earlier. Racial and ethnic disparities in coverage have declined recently, while out-of-pocket expenditures remain low for most young adults.

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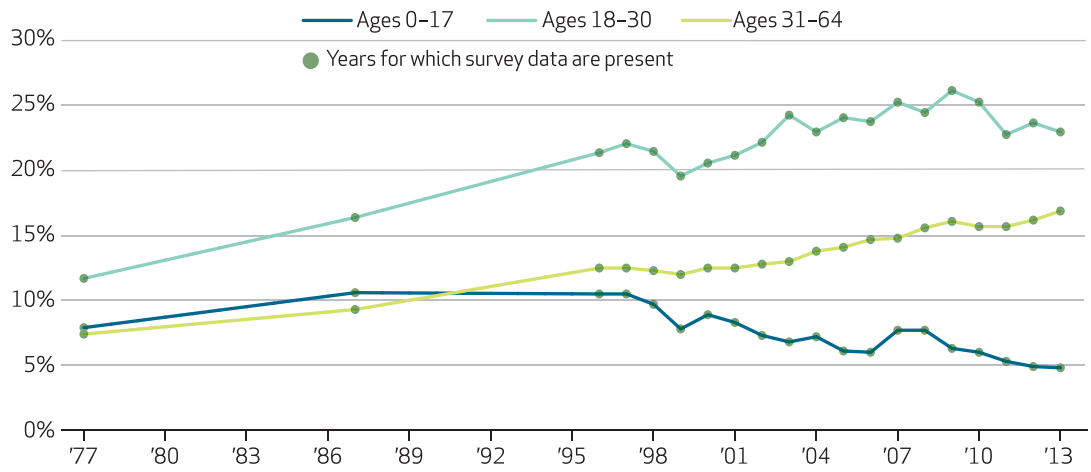
One of the first provisions of the Affordable Care Act (ACA) to take effect was a dependent coverage provision, which allows young adults to remain covered under their parents' policies until age twenty-six. Previous studies comparing the period just before the September 2010 implementation of this provision with the period just after it have found an increase in coverage among young adults.[1–3] Taking a longer historical perspective, we examined long-term patterns of insurance coverage and out-of-pocket spending among young adults, finding that young adults have always been more likely than older adults to lack coverage.

In 1977, for example, 11.7 percent of young adults (those ages 18–30) lacked coverage, compared to only 7.4 percent of adults ages 31–64 (Exhibit 1). The size of the difference had increased substantially by 1987, when 16.4 percent of young adults lacked coverage, compared to 9.3 percent of older adults (ages 31–64). By 1996, 21.4 percent of young adults did not have insurance, compared to 12.5 percent of older adults. The percentage of young adults without coverage peaked in 2009, at 26.2 percent. After the dependent coverage provision of the ACA was implemented, the proportion of young adults

EXHIBIT 1

All-year uninsurance rates for people in three age groups in the United States



SOURCE Authors' analysis of data from the 1977 National Medical Care Expenditure Survey, the 1987 National Medical Expenditure Survey, and the 1996–2013 Medical Expenditure Panel Surveys. NOTES Linear interpolation was used to fill in values for 1978–86 and 1988–95. An expanded version of this figure, including discrete numbers and standard errors, can be found in the Appendix (see Note 10 in text).

without coverage reached a low of 22.8 percent in 2011. No significant reductions were seen in 2012 or 2013.

Study Data And Methods

Our estimates are derived from our analyses of data from twenty surveys conducted by the Agency for Healthcare Research and Quality (AHRQ) and its predecessor agencies that collectively cover a thirty-six-year period. The first of these surveys was the 1977 National Medical Care Expenditure Survey. Ten years later AHRQ conducted the National Medical Expenditure Survey, which had a similar structure. In 1996 AHRQ began conducting the Medical Expenditure Panel Survey (MEPS), which the agency has fielded annually since then. Details about MEPS and its predecessor surveys are available on the MEPS website.[4] For all years in this study, we defined *the uninsured* as people who lacked coverage for the entire year. All discussed differences are significant ($p < 0.05$).

We focused on the bivariate relationships between age cohort and coverage, ethnicity and coverage, and coverage and out-of-pocket spending. Our analysis is descriptive, and we hope it will encourage others to conduct multivariate analyses of these and related issues. Our primary goal was to give the historical context for viewing recent changes in young adult coverage and out-of-pocket spending.

In addition to studies of coverage rates, other outcomes of the dependent care provision have been examined. One evaluation of the ACA has reported reductions in high out-of-pocket spending.[5] The ACA's dependent coverage provision has not been in place long enough to permit researchers to make definitive conclusions about its effect on health outcomes. A number of studies have each looked at specific possible measures both before and just after the provision took effect. When comparisons were made between the two periods, differences in mortality were not found,[6] but differences were observed in overall ability to obtain care[7] as well as access to specific services, including provision of the human papillomavirus (HPV) vaccine[8] and mental health care services.[9]

Study Results

The definition of *uninsured young adults* varies across studies. However, the most common approach has been to define *young adults* as people ages 18 or 19 to age 25 and to compare them to control groups of people ages 26 to 30 or 34[1,5,7,8] or even older.[3]

We used the following three cohorts of young adults: people ages 18–22, ages 23–26, and ages 27–30. The first cohort includes most college students, the second cohort contains people most likely to benefit from the ACA's dependent care provision, and the third cohort contains young adults who would not benefit from the provision. Our findings suggest that insurance patterns among these three cohorts have changed both before and after implementation of the dependent coverage provision.

Data from 1977, 1987, and 1996–2013 do not show any statistically significant differences between the cohort of people ages 18–22 and that of people ages 23–26 except in 2005, 2010, and 2013, when the cohort ages 23–26 had a higher uninsurance rate than the younger one (Exhibit 2). In 1977 about 13 percent of both cohorts were uninsured, increasing to about 18 percent in 1987. Similar increases were observed in 1997, with 22.5 percent of people ages 18–22 lacking coverage, compared to 24.4 percent of those ages 23–26.

While the long-term pattern was generally stable, some fluctuations occurred in the period 1997–99. In 1997, 22.5 percent of people ages 18–22 lacked coverage, closely mirroring the 23.3 percent in 1999. No significant increase in coverage was observed in the cohort of people ages 23–26 between 1997 and 1999. However, we did observe a significant increase in coverage in the cohort of people ages 27–30, with the uninsurance rate dropping from 19.5 percent in 1997 to 14.5 percent in 1999 (Exhibit 2).

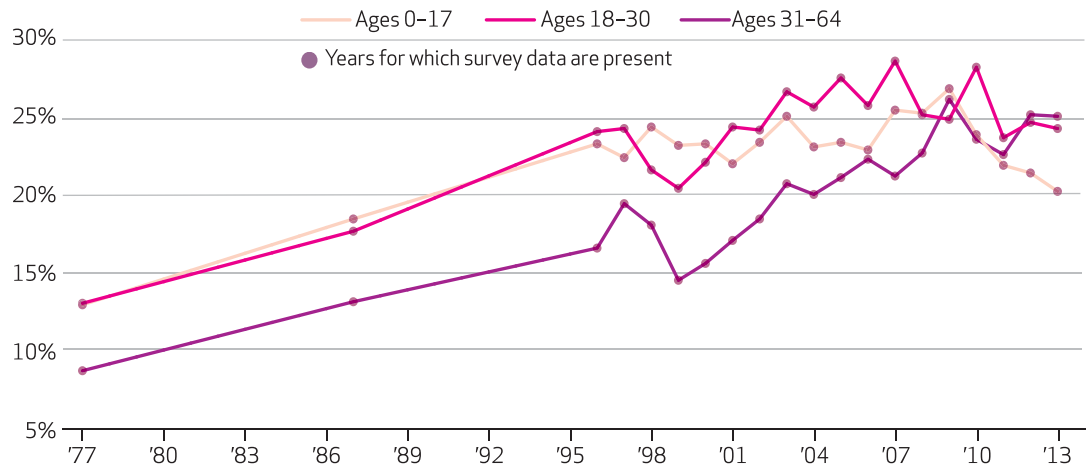
The difference in coverage between the older and younger cohorts peaked in 1999, with 23.3 percent of people ages 18–22 lacking coverage, compared to only 14.5 percent of those ages 27–30. The likelihood of being uninsured began to steadily increase in the latter cohort, and by 2013 its barriers to coverage were at least equal to those of the other cohorts.

We explored fluctuations in employment rates as a possible explanation for the decreased differential between age cohorts. When we examined the proportion of each cohort employed for thirty or more hours a week during the entire year, we observed a somewhat similar decline among the three age cohorts over the past decade. Employment among people ages 27–30 declined from 67.0 percent in 2004 to 59.6 percent in 2013, while the employment rate for those ages 23–26 declined from 57.5 percent to 50.0 percent during the same period (for employment rates for young adults reported in MEPS, see the online Appendix).[10] It is unlikely that difference in employment is the primary driver of difference in coverage.

While it comes as no surprise that coverage among young adults is associated with race or

EXHIBIT 2

All-year uninsurance rates for three cohorts of children and young adults in the United States

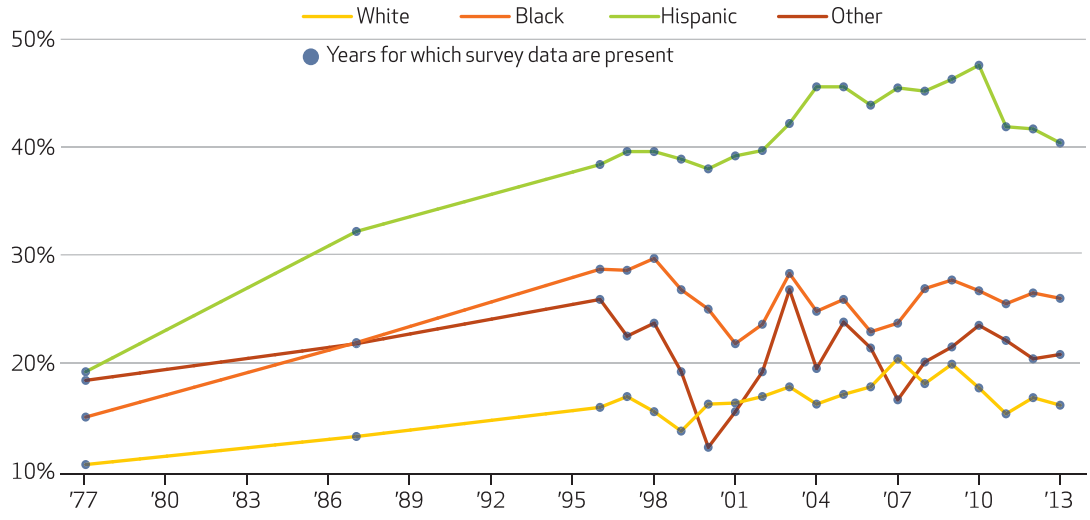


SOURCE Authors' analysis of data from the 1977 National Medical Care Expenditure Survey, the 1987 National Medical Expenditure Survey, and the 1996–2013 Medical Expenditure Panel Surveys. **NOTES** Linear interpolation was used to fill in values for 1978–86 and 1988–95. An expanded version of this figure, including discrete numbers and standard errors, can be found in the Appendix (see Note 10 in text).

ethnicity, the magnitude of change over the years is striking. In 1977, 10.6 percent of white young adults (ages 18–30) lacked coverage, compared to 15.0 percent of blacks and 19.2 percent of Hispanics (Exhibit 3). The percentage of uninsured white young adults rose slowly and relatively steadily, eventually peaking at 20.4 percent in 2007 and then decreasing to 16.1 percent in 2013. Lack of insurance among black young adults peaked at 29.7 percent in 1998, fell to 21.8 percent in 2001, and rose to 26.0 percent in 2013. The probability of lacking insurance rose dramatically among Hispanic young adults, reaching 39.6 percent in 1997 and 1998, and peaking at 47.6 percent in 2010. Between 2010 and 2013, however, there was a significant drop

EXHIBIT 3

All-year uninsurance rates for people in the United States ages 18–30, by race or ethnicity



SOURCE Authors' analysis of data from the 1977 National Medical Care Expenditure Survey, the 1987 National Medical Expenditure Survey, and the 1996–2013 Medical Expenditure Panel Surveys. **NOTES** Linear interpolation was used to fill in values for 1978–86 and 1988–95. An expanded version of this figure, including discrete numbers and standard errors, can be found in the Appendix (see Note 10 in text).

in the uninsurance rate among young Hispanics, to 40.4 percent.

We also found that historically most people ages 18–30 have not incurred high out-of-pocket expenses regardless of coverage status. The percentage of people in this age group with annual out-of-pocket expenses exceeding $1,000 decreased for both the insured and the uninsured from the levels observed in 1977 and 1987 (Exhibit 4). While some year-to-year fluctuations can be observed, the long-term pattern has been quite stable. Since 2006 the share of uninsured young adults who incurred high annual out-of-pocket expenses was 5.6–8.0 percent.

Discussion

We examined insurance coverage and out-of-pocket spending among young adults using data from twenty nationally representative surveys that collectively covered the period 1977–2013. There are distinct advantages to using such a long-term perspective. The ACA, after all, is not a controlled experiment: Other factors, such as changes in the demographics of the US population and in the economy and an evolving system of health care delivery, may also affect rates of coverage and spending levels. The potential impact of the ACA's dependent coverage provision can be better illuminated by looking at data that extend further back than just before its implementation in September 2010.

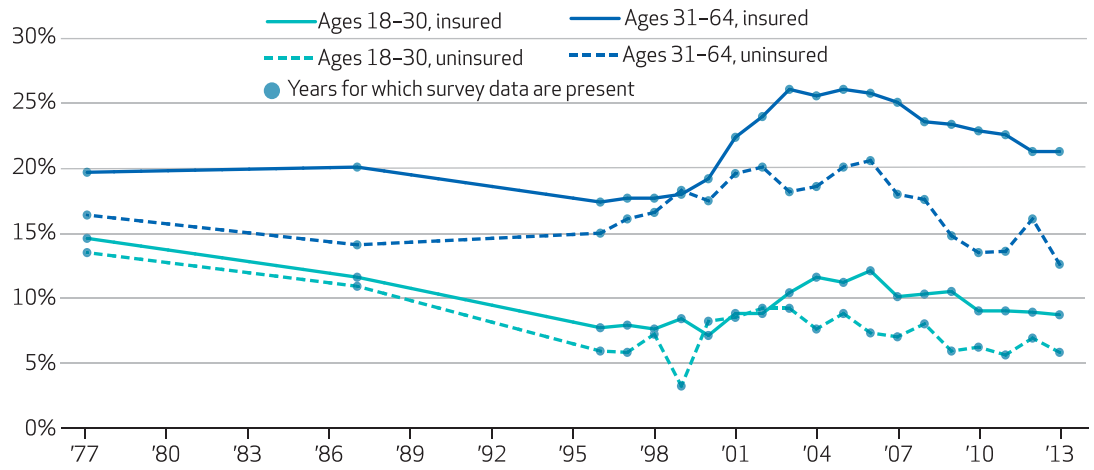
We found, for example, that the share of adults ages 18–30 without coverage declined from 26.2 percent in 2009 to 22.8 percent in 2011. When this decline is viewed in historical perspective, it is unclear whether it was meaningful. We also found that 23.0 percent of these adults lacked coverage in 2013. There is no significant difference between this and the rates observed in any of the years between 1996 and 2012 except for 1999 and 2009, when the rates were 19.6 and 26.2 percent, respectively (Exhibit 1). This long-term perspective provides a somewhat different picture of the magnitude of changes that occurred, compared to looking only at the periods just before and after the dependent coverage provision took effect.

While overall improvements in coverage among young adults appear small, our analysis of racial and ethnic disparities (Exhibit 3) suggested a significant improvement in the coverage of Hispanic young adults: Between 2010 and 2011 the share without coverage dropped from 47.6 percent to 41.9 percent. This gain in coverage was unprecedented and represents the first significant annual improvement for this group of young adults since 1996.

While our analysis suggests that the dependent coverage provision of the ACA may have had a relatively modest impact on overall coverage of young adults, other important provisions of the ACA did not go in effect until 2014, one year after the end of our study period. It is likely that Marketplace premium subsidies, Medicaid expansions in selected states, and other provisions will have much greater effects on coverage for young people than did the dependent coverage provi-

EXHIBIT 4

People in the United States with annual out-of-pocket health care expenses over $1,000, by age group and insurance status



SOURCE Authors' analysis of data from the 1977 National Medical Care Expenditure Survey, the 1987 National Medical Expenditure Survey, and the 1996–2013 Medical Expenditure Panel Surveys. **NOTES** Linear interpolation was used to fill in values for 1978–86 and 1988–95. Dollar amounts for all years were converted to 2013 dollars. An expanded version of this figure, including discrete numbers and standard errors, can be found in the Appendix (see Note 10 in text).

sion. Indeed, estimates from the National Health Interview Survey show a large increase in coverage for people ages 19–25 during 2014 and the first three months of 2015.[11]

Conclusion

In a dynamic health care system, short-term changes in coverage and expenditures are not unusual. National surveys will play an important role in evaluating the effect of the ACA and other potential new initiatives. Our findings suggest that a consideration of long-term patterns will help distinguish the aspects of cost and insurance that have fundamentally changed from those that are subject to mere short-term fluctuations. ■

[*Published online March 23, 2016.*]

NOTES

1 Sommers BD, Kronick R. The Affordable Care Act and insurance coverage for young adults. JAMA. 2012;307(9):913–4.

2 Cantor JC, Monheit AC, DeLia D, Lloyd K. Early impact of the Affordable Care Act on health insurance coverage of young adults. Health Serv Res. 2012;47(5):1773–90.

3 McMorrow S, Kenney GM, Long SK, Anderson N. Uninsurance among young adults continues to decline, particularly In Medicaid expansion states. Health Aff (Millwood). 2015; 34(4):616–20.

4 Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey: survey background [Internet]. Rockville (MD): AHRQ; [last revised 2009 Aug 21; cited 2016 Feb 1]. Available from: http://meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp

5 Busch SH, Golberstein E, Meara E. ACA dependent coverage provision reduced high out-of-pocket health care spending for young adults. Health Aff (Millwood). 2014;33(8): 1361–6.

6 Scott JW, Sommers BD, Tsai TC, Scott KW, Schwartz AL, Song Z. Dependent coverage provision led to uneven insurance gains and unchanged mortality rates in young adult trauma patients. Health Aff (Millwood). 2015;34(1):125–33.

7 Sommers BD, Buchmueller T, Decker SL, Carey C, Kronick R. The Affordable Care Act has led to significant gains in health insurance and access to care for young adults. Health Aff (Millwood). 2013;32(1): 165–74.

8 Lipton BJ, Decker SL. ACA provisions associated with increase in percentage of young adult women initiating and completing the HPV vaccine. Health Aff (Millwood). 2015;34(5):757–64.

9 Saloner B, Lê Cook B. An ACA provision increased treatment for young adults with possible mental illnesses relative to comparison group. Health Aff (Millwood). 2014;33(8):1425–34.

10 To access the Appendix, click on the Appendix link in the box to the right of the article online.

11 Cohen RA, Martinez ME. Health insurance coverage: early release of estimates from the National Health Interview Survey, January–March 2015 [Internet]. Hyattsville (MD): National Center for Health Statistics; 2015 Aug [cited 2016 Feb 1]. Available from: http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf

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Agency of Human Services

Vermont's Proposal to Waive Affordable Care Act Requirement to Establish an Internet Portal for the Small Business Health Options Program (SHOP) Per Section 1332, Waivers for State Innovation

Table of Contents

Executive Summary

Vermont has long been at the forefront of health care reform. It has set up its health benefits exchange to ensure sustainability and full consumer protection and choice. As a result, it had the highest total small group enrollment out of all of the state-based exchanges in 2014. This success occurred in part because employers could enroll directly with health insurance issuers instead of through an Internet portal. As a result, Vermont is seeking to maintain its current system and requesting a waiver of the federal requirement that employers enroll through an internet portal. Under a 1332 Waiver for State Innovation:

- The only plans available for purchase are qualified health plans with VHC certification
- Enrollment takes place through the issuer instead of through a VHC website
- There is no minimum participation requirement
- Full employer choice of QHPs is available
- Insurance carriers administer premium processing
- Insurance carriers provide required employer and employee notices
- Vermont provides an appeal process as needed for eligibility concerns as well as certification of eligibility for purposes of the small business tax credit
- Health insurance issuers report enrollment data to the federal government

Vermont will meet the all of the 1332 waiver parameters:

- Equivalent or greater scope of coverage: Vermont's proposal will maintain seamless coverage for all small employers currently covered while allowing streamlined access for large employers in 2018.
- Equivalent or greater affordability of coverage: Vermont's proposal will provide coverage that is as affordable as current plans by requiring enrollment in QHPs subject to rigorous rate review oversight.
- Equivalent comprehensiveness of coverage: Vermont's proposal will maintain coverage with the same essential health benefits as provided today.
- Deficit neutral: Vermont's proposal will not increase the federal deficit because it will maintain its current enrollment system and funding mechanism.
- No impact on federally-facilitated marketplace: Because Vermont maintains a state-based marketplace, this proposal will not impact the federally-facilitated marketplace.
- No impact on other public programs: Vermont's proposal will not impact public coverage programs, such as Medicaid and the Children's Health Insurance Program.
- Meaningful public input: Vermont provided and will continue to provide opportunities for public input prior to and after submission of its 1332 application.

Characteristics of Vermont's Health Insurance Market

Vermont is a rural state with a population of approximately 625,000 people.[1] It consistently ranks near the top of the list for healthiest state in the nation[2] and lowest uninsured rate in the country.[3] It has a long history of health care innovation and had such consumer protections as guaranteed issue and community rating in the individual and small group market well before the ACA put them into place.[4]

For these and other reasons, Vermont's insurance market is unique. It currently has only two health insurance issuers offering individual and small group coverage to a total of approximately 75,000 lives: Blue Cross Blue Shield of Vermont[5] (BCBSVT) and MVP Health Care[6] (MVP). Furthermore, Vermont merged its small group and individual markets and limited the purchase of individual or small group plans outside of its health benefits exchange, Vermont Health Connect (VHC).[7] Merging the pools and limiting outside enrollment helps to ensure that

[1] http://quickfacts.census.gov/qfd/states/50000.html
[2] Vermont ranked second behind Hawaii for healthiest state. http://www.americashealthrankings.org/reports/annual
[3] Vermont ranked second or the same as Massachusetts for lowest uninsured rate at 3.7 percent. http://www.leg.state.vt.us/jfo/healthcare/Uninsured_Rate_in_Vermont_and_Massachusetts.pdf
[4] These protections were established in 1992.
[5] As of January 2016, BCBSVT has a total small employer and individual count of 69,794 lives.
[6] As of January 2016, MVP has a total small employer and individual count of 5,816 lives
[7] Vermonters may purchase QHPs off the exchange but these are the only products available in the individual market. 33 V.S.A. § 1803(b)(4).

plan costs remain low and that VHC continues to be sustainable despite Vermont's small population.

Vermont also has rigorous oversight of its small group and individual market. As mentioned above, all plans offered must be qualified health plans that are chosen by VHC. Vermont Health Connect has 8 standard plan designs to assist with direct comparison between health insurance issuers, including 2 standard catastrophic insurance plans offered to those under 30. The insurance carriers are also encouraged to submit a limited number of their own innovative plan designs, with a focus on quality and wellness. Any new plan designs or plan benefits are presented to Vermont's independent health care oversight entity, the Green Mountain Care Board (GMCB), where they go through a public process before board approval. Once plan design and benefits are established, the plans are subject to the rate review process. The health insurance issuers file their rates with the GMCB and the GMCB posts the filed rate requests on its website. Vermont's nonprofit health care advocacy organization, the Health Care Advocate, is automatically named a party to the rate review on behalf of Vermont's consumers. All Vermonters may submit public comments on the proposed rates. Next, the GMCB posts on its website an opinion of its actuary of the impact of the rates as well as an opinion from Vermont's Department of Financial Regulation regarding the solvency of the health insurance carrier. Within 30 days, the GMCB holds a public hearing on the filing and will decide to approve, modify, or disapprove the rate. [8]

After the plans are approved through the GMCB, they then must go through a selection process with Vermont's health program agency, the Department of Vermont Health Access (DVHA)[9] before they are offered through VHC. Here, DVHA will certify that the plans meet all state access requirements and promote quality and wellness. [10]

Vermont's past and current focus on consumer protections and public input ensures coverage in the small group and individual market remain affordable while emphasizing access to providers, quality health care outcomes, and wellness.

Implementation of a State-Based Marketplace and Lessons Learned

The Affordable Care Act mandated the establishment of a health benefits exchange in all states by 2014. Since October 1, 2013, Vermont Health Connect has been operational as Vermont's health benefits exchange. Prior to this federally mandated launch date, the State executed contracts and took internal steps to implement all required exchange functions, including qualified health plan (QHP) certification, customer support, and streamlined eligibility and enrollment. Vermont designed its state-based exchange to determine Medicaid eligibility, provide additional state subsidies, process premium payments and provide small employers with full choice of QHPs.

[8] Green Mountain Care Board, "How Rates Are Reviewed," http://ratereview.vermont.gov/how_reviewed
[9] Vermont Health Connect is located within the Department of Vermont Health Access (DVHA).
[10] 33 V.S.A. § 1806.

With respect to the development of the information technology (IT) system, in December 2012, the state entered into a contract with CGI Technologies and Solutions, Inc. (CGI), to perform software integration and hosting services for the exchange. While VHC provided open enrollment for 2014 coverage as required, it was limited by deficiencies in functionality of the VHC IT platform, inhibiting several operations for individual plans and group market enrollment altogether. In particular, functionality to allow employers and their employees to enroll in VHC plans (the VHC SHOP) was not deployed successfully in time for employers to enroll employees into coverage for January 1. 2014. As a result, after consultation with CCIIO, employers in the small group market were encouraged to enroll directly in QHPs through Vermont's insurance carriers. Due in part to this direct enrollment with the insurance carriers, Vermont had the highest total small group enrollment out of all of the state-based exchanges in 2014.[11]

For 2015 and 2016, Vermont took advantage of CCIIO's transitional flexibilities for State-based SHOP direct enrollment[12] and continued to encourage small employers to directly enroll with health insurance issuers in order to concentrate its resources on developing a fully functional marketplace for the individual market. During this time, VHC, in partnership with health insurance issuers:

- made full choice of VHC's QHP plans available to employers to offer to their employees, regardless of metal level or insurer[13]
- ensured seamless transition between small group plans and individual plans, so that any cost sharing paid under one plan would be credited to the same plan if that individual's employer status changed.

With federal flexibility for state-based SHOP direct enrollment ending in 2017, Vermont now faces the choice of: (1) building a SHOP Internet portal with uncertain IT outcomes and likely disruption of the small group market; or (2) waiving the requirement for an Internet portal and continuing small business direct enrollment into VHC QHP plans while maintaining all of the ACA's market reforms as well as Vermont's merged risk pool, full employer choice, and seamless transition between plans.

[11] In 2014, Vermont had 33,696 individuals enrolled in its SHOP QHPs. The next highest state was Utah with over 20,000 fewer people at 10,900. GAO, "Small Business Health Insurance Exchanges: Low Initial Enrollment Likely Due to Multiple Evolving Factors, Nov.2014, http://gao.gov/assets/670/666873.pdf

[12] Flexibilities for State-based SHOP Direct Enrollment—Frequently-Asked Questions (FAQs) https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/SBM-SHOP-Transitional-Flexibility-FAQ-Rev-5-29-2015.pdf

[13] Under Vermont rules, QHP health insurance issuers must allow employers to offer the full range of their QHPs to employees. HBEE 34.00. However, if an employer wishes to offer plans from both QHP health insurance issuers, it must administer that plan selection internally.

Proposed Waiver: Direct Purchase of Vermont Health Connect Plans from Health Insurance Carriers

Under a 1332 waiver, the state would seek to maintain the current configuration of its small group market by eliminating the requirement to have a small business exchange website for enrollment and premium processing. Specifically:

- The only plans available for purchase are qualified health plans with VHC certification
- Enrollment takes place through the issuer instead of through a VHC website
- There is no minimum participation requirement
- Full employer choice of QHPs is available
- Insurance carriers administer premium processing
- Insurance carriers provide required employer and employee notices
- Vermont provides an appeal process as needed for eligibility concerns as well as certification of eligibility for purposes of the small business tax credit
- Health insurance issuers report enrollment data to the federal government

Waiving each of the items listed above would not compromise the comprehensiveness or affordability of coverage, total number of Vermonters covered, or the federal deficit. Instead, the waiver would streamline access to a small group market that is already robust and save costs and market disruption associated with implementation of other ACA small business exchange requirements.

The specific sections[14] for which Vermont requests a waiver and the reason for each request are outlined below:

Section	Summary	Explanation
§ 1311(b)	Requires establishment of an American Health Benefit Exchange, including a Small Business Health Options Program (SHOP) that is designed to assist qualified employers in facilitating the enrollment of their employees in QHPs and details responsibilities of the exchange	Vermont proposes to waive the requirement that it design a SHOP Internet portal to enroll employers and employees for small group QHPs. Instead, it will avoid disruption to its market through maintaining its current process of direct enrollment through insurance carriers while maintaining full employer choice.
§ 1311(c)(3)	Rating system based on quality and price of plan	This provision will continue to apply to QHPs for individuals.

[14] For an overview of all waivable provisions, see Appendix B.

		Small employer plans will be rated because they must be the same QHPs as offered to individuals. Vermont is requesting to waive the requirement that the ratings be available through a separate SHOP Internet portal.
§ 1311(c)(4)	Enrollee satisfaction system	This provision will continue to apply to QHPs for individuals. Vermont is requesting to waive the requirement that the satisfaction system be available through a separate SHOP Internet portal.
§ 1311(c)(5)	Internet portals may be used to direct qualified individuals and qualified employers to QHPs	This provision will continue to apply to QHPs for individuals. Vermont is requesting to waive the requirement that small employer plans be available through a separate SHOP Internet portal.
§ 1311(d)(1)	Specifies which entities are eligible to carry out responsibilities of the Exchange	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(2)	Exchange shall make QHPs available to qualified individuals and qualified employers and offer stand-alone dental plans.	This provision will continue to apply to QHPs for individuals and small employers. All small employers will have access to QHPs and standalone dental plans, but Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(A)	Requirement that Exchange shall implement procedures for certification of plans	Vermont proposes to retain these provisions. Because QHPs will remain the same for individuals and small employers, these provisions will also apply to small employer plans.
§ 1311(d)(4)(B)	Requirement that Exchange shall	This provision will continue to

	provide for the operation of a toll-free telephone hotline	apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(C)	Requirement that Exchange shall maintain an Internet website	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(D)	Requirement that Exchange shall assign a quality rating to each QHP	This provision will continue to apply to QHPs for individuals. To the extent the quality ratings must be posted on a website, Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(E)	Requirement that Exchange shall utilize a standardized format for presentation of plans	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(G)	Requirement that Exchange shall post to the website a calculator to determine premium tax credits and cost sharing reductions	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(k)	Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary of Human Services	To the extent the rules are not waived, Vermont proposes to retain these provisions.
§ 1312(a)	Provisions for employer choice among QHPs through an exchange, including requirement that employer may specify metal level and employee may choose a plan within metal level	Vermont proposes maintaining current consumer total choice through direct enrollment with insurance carriers of employer and employee's choosing without use of a SHOP Internet portal.
§ 1312(f)(2)(A)	Definition of qualified employer	Vermont does not propose to waive this provision but notes that this (and the incorporated definition of small employer at § 1304(b)) will be determined through employer self-

attestation to the QHP issuer.

In waiving the above provisions, Vermont also requests waiver of the corresponding implementing regulations.[15] Under the proposed Vermont model, QHP health insurance issuers will handle small business enrollment processes according to existing market practice. This includes application, noticing, enrollment periods, effective dates, and termination. QHP health insurance issuers will also perform all premium functions.

At the same time, the State will continue to provide the essential consumer protections within the SHOP regulations including:

- Employer choice
- QHP certification
- Rate review
- Customer assistance tools including a "small business toolkit" for employers and in person assistance, educational materials, an affordability estimator, and an online plan comparison tool for employees
- Eligibility appeals

The Vermont small group rules generally exceed the federal minimum standards for SHOP. Full choice is available to employers. Vermont actively selects the QHPs that are available across the merged market and approves rates that must be maintained for the full plan year.

Eligibility for coverage will be determined by the QHP issuer based on employer attestation.[16] Employers may request an eligibility determination directly from VHC on a voluntary basis. This would generally be for the purpose of claiming the small business tax credit. In that case, VHC will review the employer's application, issue an eligibility determination, and maintain a record thereof for records requests by the IRS. This procedure is currently operational at VHC.

Finally, data sharing is inherently limited in the direct enrollment model as the State does not have access to issuer enrollment records. Therefore, Vermont requests waiver of the following:

1. Coordination with individual market. 45 CFR 155.330(d)(2)(iii), 155.705(c).
    - VHC will not have small group enrollment data for use in eligibility determinations or verification related to employer-sponsored coverage.
2. Reporting for tax administration. 45 CFR 155.720(i).
    - While the State can request aggregate enrollment figures from the QHP health insurance issuers, it cannot provide the level of detail currently required in the IRS monthly schema. Moreover, health insurance issuers report enrollment data to the IRS via the 1095B process as of tax year 2015.

[15] Appendix C lists the related SHOP regulations.
[16] If an employer receives an adverse eligibility determination from the QHP issuer, it can appeal to VHC. The State has found this scenario to be exceedingly rare.

3. Other federal reporting requests.
    - Vermont receives periodic "SHOP" reporting requests from CMS that it is unable to fulfill because it does not have access to the level of detail requested. To the extent that CMS requires other than aggregate (lump sum) small group enrollment data, such a request would be most efficiently made directly to Vermont's QHP health insurance issuers.

Description of Post-Waiver Marketplace

With implementation of the waiver, Vermont's small group marketplace will remain exactly the same as it is today. Vermont will also continue to have plan comparison tools of all available QHPs on its website for employers[17] and will direct employers to health insurance issuers as appropriate. It will continue to meet all other ACA requirements as well as a merged risk pool, full employer choice, and seamless transition between plans.

Coverage: Number of Employers Offering Coverage Before and After Waiver Remains the Same or Increases

As of January 2016, 4,025 Vermont small businesses offer qualified health plans to their employees, representing 44,347 covered lives. This number is expected to increase over the course of 2016 as a result of the small group expansion to 100 employees. By 2018, large employers may also elect to offer qualified health plans to their employees.[18] The number of employers offering coverage before and after the waiver is anticipated to remain the same or increase, since the waiver would maintain Vermont's current process for enrollment with insurance carriers. Without a waiver, Vermont's small employers would have to enroll through an Internet portal, which would likely result in fewer employers offering coverage due to disruption and potential IT difficulties. Therefore, the waiver will provide coverage to at least a comparable number of Vermonters as would be provided coverage absent the waiver.

Moreover, under the waiver, VHC assisters would still work with small businesses to facilitate enrollment. Maintaining the current market structure instead of building SHOP website would allow VHC to focus on outreach and education in the small business community as well as continued work with registered agents and brokers to encourage participation.

Affordability of Coverage Remains the Same or Is More Affordable

Affordability of coverage will not change under the waiver. By maintaining the current enrollment process for small business, the waiver will help ensure that Vermont's merged market remains robust and affordable. Furthermore, Vermont's intensive and transparent rate review process will remain in place to maintain affordability.

[17] See http://info.healthconnect.vermont.gov/healthplans.

[18] 33 V.S.A. § 1804.

Comprehensiveness: No Impact on Covered Services

There is no anticipated impact on small employer insurance coverage after the waiver because the waiver would maintain Vermont's current process for enrollment with insurance carriers and would maintain QHPs with VHC certification. Every health plan available to small businesses would continue to include all essential health benefits and ACA consumer protections.[19] Therefore, the waiver would provide coverage that is inherently as comprehensive as the coverage offered through VHC.

10-Year Waiver Budget Projection: Maintaining Deficit Neutrality

The proposed waiver will maintain Vermont's current enrollment process for small businesses. As a result, the infrastructure for enrollment is already in place and will require no additional funds from the federal government. Furthermore, unlike the federal Exchange, Vermont does not tie its state funding source for VHC to QHP plans. Vermont will continue to fund VHC through its Health Care Resources Fund and no additional state funding will be required.

No Impact on Other Sections of the ACA or Other Public Coverage Programs

Vermont's only request is to waive the Internet portal requirement of the ACA and any attendant reporting requirements in order to maintain Vermont's current enrollment process for small employers. Accordingly, Vermont can identify no other sections of the ACA that would be affected by the proposed waiver.

No Impact on Federally-Facilitated Marketplace

Vermont marketplace is a state-based marketplace. As a result, waiver of the Internet portal requirement will not impact the federally-facilitated marketplace.

No Request for Federal Pass-Through Funding

Vermont is not requesting federal pass-through funding with its request to waive the Internet portal for SHOP.

No Impact on Administrative Burden

Implementation of the waiver would likely reduce administrative burden compared to building a new IT infrastructure for a SHOP Internet portal. With a waiver, employers will continue to enroll as they do now. Health insurance issuers will maintain the same infrastructure they use now without having to adapt to a new Internet portal. Federal agencies would provide the same oversight that they currently provide.

Data and Analysis, Actuarial Certifications, Assumptions, Targets

The attached certification shows that under a waiver of an Internet portal for small employer enrollment, Vermont's coverage, affordability, and comprehensive benefits will remain the same as it is today. [20] In addition, such a waiver will not increase the federal deficit.

[19] See Appendix D for more details.
[20] See Appendix E.

Ensuring Compliance, Reducing Waste and Fraud

As previously mentioned, Vermont has a robust regulatory framework overseeing all individual and small employer QHPs. Not only are the QHP benefits and plan designs put through a public process overseen by an independent health care oversight entity, the GMCB, but all rates are rigorously reviewed by the GMCB with input from Vermont's Department of Financial Regulation, the Office of the Health Care Advocate, and the public.[21] Once these plans are approved, DVHA selects the plans to offer through VHC based on wellness, access, and quality.[22]

In addition to the QHP rate review and selection process, Vermont's Department of Financial Regulation has strong investigatory and regulatory authority, including subpoena powers and the ability to issue penalties and fines for violations of Vermont's consumer protections and provisions of the ACA where applicable.[23] This oversight would continue after the waiver, ensuring compliance and reducing waste and fraud.

Implementation Timeline and Process

Vermont is currently using direct enrollment for SHOP and proposes to waive the SHOP Internet portal, which will result in continued direct enrollment in health plans for small employers. As a result, Vermont will implement the waiver immediately upon notification that it has been granted. The process will include providing public information about the waiver and the expectation of continuing to enroll directly with health insurance issuers.

Meaningful Public Input Prior to and After Waiver Application

Prior to submission of its 1332 waiver, Vermont passed legislation[24] providing authority to pursue a 1332 waiver and held a 30-day public comment and notice period.[25]

As required, Vermont will hold public forums six months after the proposed waiver is granted and annually thereafter. The date, time, and location of each forum will be posted in the newspaper and on the VHC and DVHA websites and shared with consumer and business advocacy organizations.

While Vermont is amenable to providing quarterly reports to the Secretary, the proposed waiver does not seem to warrant such scrutiny. Alternatively, Vermont proposes to report upon the completion of the first six months of the waiver and annually thereafter 90 days after the anniversary of the date on which the waiver was granted. Vermont will cooperate fully with any independent evaluation conducted by the Secretary or the Secretary of the Treasury.

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[21] 8 V.S.A. § 4062.
[22] 33 V.S.A. § 1806.
[23] See 8 V.S.A. § 13.
[24] For more details, see Appendix A.
[25] For more details, see Appendix F. Tribal government notification of the public process was unnecessary because Vermont has no federally recognized Indian tribes or groups.

In its reports, Vermont proposes to include:

- Evidence of compliance with public forum requirements, including date, time, place, description of attendees, and the substance of the public comment and Vermont's response, if any.
- Information about any challenges Vermont may face in implementing and sustaining the waiver program and its plan challenges.
- Any other information consistent with the terms and conditions in the State's approved waiver.

Appendix A. Vermont's Enabling Waiver Legislation

Place final language of H.524 here

http://legislature.vermont.gov/bill/status/2016/H.524

Appendix B. Section by Section Consideration of Waivable Provisions

Part I of Subtitle D: Establishment of Qualified Health Plans		
Section 1301: Definition of QHPs		
§ 1301(a)(1)	The definition of "Qualified Health Plan" including providing EHB, and offering plans conforming to metal levels (bronze, silver, gold, and platinum)	Vermont proposes to retain these provisions.
§ 1301(a)(2)	Inclusion of Co-Op and Multi- State Plans	Vermont proposes to retain these provisions.
§ 1301(a)(3)	Treatment of Qualified Direct Primary Care Medical Home Plans	Vermont proposes to retain these provisions.
§ 1301(a)(4)	Variation based on rating area	Vermont proposes to retain these provisions. It will continue to have community rating throughout the state.
§ 1301(b)	Exceptions for Self-Insured Plans and MEWAS (multiple employer welfare arrangements)	Vermont proposes to retain these provisions.
Section 1302: Essential Health Benefit requirements		
§ 1302(a) & (b)	Defines Essential Health Benefits	Vermont proposes to retain these provisions.
§ 1302(c)	Annual limitations on cost- sharing	Vermont proposes to retain these provisions.
§ 1302(c)(2)	Annual limitations on deductibles for employer- sponsored plans	Vermont proposes to retain these provisions.
§ 1302(d)	Definition of metal levels by actuarial value	Vermont proposes to retain these provisions.
§ 1302(e)	Availability of catastrophic plans	Vermont proposes to retain these provisions.
§ 1302(f)	Availability of child-only plans	Vermont proposes to retain these provisions.
§ 1302(g)	Defines payment to federally- qualified health centers	Vermont proposes to retain these provisions.

Section 1303: Special rules related to abortion services		
§ 1303	Details special rules related to abortion services	Vermont proposes to retain these provisions.
Section 1304: Definitions related to: group and individual markets; large and small employers; and rules related to determining the size of an employer		
§ 1304(a)	Defines small and large group markets	Vermont proposes to retain these provisions.
§ 1304(b)	Defines large and small employers. Specifies rules for aggregation treatment of employers, employers not in existence in preceding year, and predecessor employers. Defines when a "growing" small employer that purchased employee coverage through SHOP may continue to do	Vermont proposes to retain these provisions.
Part II of Subtitle D: Employer choices and Insurance Competition through Health Benefit Exchanges		
Section 1311: Affordable health plan choices via establishing exchanges		
§ 1311(b)	Requires establishment of an American Health Benefit Exchange, including a Small Business Health Options Program (SHOP) that is designed to assist qualified employers in facilitating the enrollment of their employees in QHPs and details responsibilities of the exchange	Vermont proposes to waive the requirement that it design a SHOP Internet portal to enroll employers and employees for small group QHPs. Instead, it will retain its current process of direct enrollment through insurance carriers while maintaining full employer choice.
§ 1311(c)(1)	Responsibilities of the Secretary of HHS to establish criteria around certification of plans, including: marketing requirements, sufficient choice, ensuring networks with essential community providers, accreditation, quality improvement, uniform enrollment forms, standardized health benefit plan options, information on quality measures, reporting on pediatric quality measures	Vermont proposes to retain these provisions. All health insurance issuers offering small group plans will be required to offer certified QHPs.
§ 1311(c)(3)	Rating system based on quality and	This provision will continue to

	price of plan	apply to QHPs for individuals. Small employer plans will be rated because they must be the same QHPs as offered to individuals. Vermont is requesting to waive the requirement that the ratings be available through a separate SHOP Internet portal.
§ 1311(c)(4)	Enrollee satisfaction system	This provision will continue to apply to QHPs for individuals. Vermont is requesting to waive the requirement that the satisfaction system be available through a separate SHOP Internet portal.
§ 1311(c)(5)	Internet portals may be used to direct qualified individuals and qualified employers to QHPs	This provision will continue to apply to QHPs for individuals. Vermont is requesting to waive the requirement that small employer plans be available through a separate SHOP Internet portal.
§ 1311(c)(6)	Enrollment periods	Vermont proposes to retain these provisions.
§ 1311(d)(1)	Specifies which entities are eligible to carry out responsibilities of the Exchange	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(2)	Exchange shall make QHPs available to qualified individuals and qualified employers and offer stand-alone dental plans.	This provision will continue to apply to QHPs for individuals and small employers. All small employers will have access to QHPs and standalone dental plans, but Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(3)	States must assume cost for additional benefits	Vermont proposes to retain these provisions.
§ 1311(d)(4)(A)	Requirement that Exchange shall implement procedures for certification of plans	Vermont proposes to retain these provisions. Because QHPs will remain the same for

		individuals and small employers, these provisions will also apply to small employer plans.
§ 1311(d)(4)(B)	Requirement that Exchange shall provide for the operation of a toll-free telephone hotline	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(C)	Requirement that Exchange shall maintain an Internet website	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(D)	Requirement that Exchange shall assign a quality rating to each QHP	This provision will continue to apply to QHPs for individuals. To the extent the quality ratings must be posted on a website, Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(E)	Requirement that Exchange shall utilize a standardized format for presentation of plans	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(F)	Requirement that Exchange shall inform individuals of eligibility requirements for Medicaid	Vermont proposes to retain these provisions.
§ 1311(d)(4)(G)	Requirement that Exchange shall post to the website a calculator to determine premium tax credits and cost sharing reductions	This provision will continue to apply to QHPs for individuals. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(d)(4)(H)	Requirement that Exchange shall provide certification for individuals exempt from shared responsibility payment	Vermont proposes to retain these provisions.
§ 1311(d)(4)(I)	Requirement that Exchange shall transfer to the Secretary of the Treasury a: (i) list of individuals who are issued an exemption certificate; (ii) the name and taxpayer identification	Vermont proposes to retain these provisions, noting that (i) is not applicable to VHC which has elected to adopt HHS exemption eligibility

	number of each individual who was an employee of an employer but who determined to be eligible for the premium tax credit due to lack of affordable or adequate minimum essential coverage; (iii) the name and taxpayer identification number of each individual who does not have affordable or adequate minimum essential coverage from her employer and notifies the Exchange that they have changed employers and each individual who ceases coverage under a QHP during a plan year and the effective date of cessation	determinations under 45 CFR § 155.625.
§ 1311(d)(4)(J)	Requirement that Exchange shall provide to each employer the names of employees who ceases coverage under a QHP during a plan year and effective date of cessation	Vermont proposes to retain these provisions.
§ 1311(d)(4)(K)	Requirement that Exchange shall establish a Navigator program	Vermont proposes to retain these provisions.
§ 1311(e)	Exchange certification of QHPs	This provision will continue to apply to QHPs for individuals and small employers because both groups will have access to the same QHPs. Vermont proposes to waive the SHOP Internet portal requirement.
§ 1311(f)	Flexibility in regional or other interstate exchanges, subsidiary exchanges, and authority to contract	Vermont proposes to retain these provisions.
§ 1311(g)	Rewarding quality through market-based incentives—providing increased reimbursement or other incentives for improving health outcomes	Vermont proposes to retain these provisions.
§ 1311(h)	Quality improvement through enhancing patient safety—requiring QHPs to contract with hospitals that uses certain safety standards	Vermont proposes to retain these provisions.
§ 1311(i)	Requirements for Navigators	Vermont proposes to retain these provisions.
§ 1311(j)	Applicability of mental health parity	Vermont proposes to retain

		these provisions.
§ 1311(k)	Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary of Human Services	To the extent the rules are not waived, Vermont proposes to retain these provisions.
Section 1312: Employer choice		
§ 1312(a)	Provisions for employer choice among QHPs through an exchange, including requirement that employer may specify metal level and employee may choose a plan within metal level	Vermont proposes maintaining current consumer total choice through direct enrollment with insurance carriers of employer and employee's choosing without use of a SHOP Internet portal.
§ 1312(c)	Establishes that: all enrollees in the individual market are in a single risk pool; all enrollees in the small group market are in a single risk pool; allows states to merge individual and small group insurance in a single risk pool if the state deems it appropriate; and prevents state law from requiring grandfathered plans to be in the individual or small group risk pool	Vermont proposes to retain these provisions, and will continue its merged individual and small group market risk pool.
§ 1312(d)(1)	Allows health insurance issuers to offer coverage outside an exchange, and allows individuals and qualified employers to purchase coverage outside an exchange	Vermont proposes to retain these provisions.
§ 1312(d)(2)	Maintains state control of plans outside of the exchange	Vermont proposes to retain these provisions.
§ 1312(d)(3)	Provides choice to qualified individuals as to whether or not to enroll via an exchange and which plan to choose and describes health plan choices for members of Congress and Congressional staff	Vermont proposes to retain these provisions.
§ 1312(d)(4)	Ensures that individuals who cancel enrollment on the exchange in favor of employer coverage will not be penalized	Vermont proposes to retain these provisions.
§ 1312(e)	Allows enrollment through agents and brokers	Vermont proposes to retain these provisions.
§ 1312(f)(1)(A)	Limits enrollment through an exchange to citizens and lawful residents	Vermont proposes to retain these provisions.

§ 1312(f)(1)(B)	Excludes incarcerated individuals	Vermont proposes to retain these provisions.
§ 1312(f)(2)(A)	Definition of qualified employer	Vermont does not propose to waive this provision but notes that this (and the incorporated definition of small employer at § 1304(b)) will be determined through employer self-attestation to the QHP issuer.
§ 1312(f)(2)(B)	Allows coverage via the exchange for the large group market	Vermont proposes to retain these provisions.
§ 1312(f)(3)	Provides that access to coverage through an exchange may be denied to those who are not lawful residents for the entire enrollment period	Vermont proposes to retain these provisions.
	Section 1313: Financial integrity	
§ 1313	Details financial management and protections against fraud and abuse for an exchange	Vermont proposes to retain these provisions as they pertain to VHC.
Premium tax credits and reduced cost-sharing		
	Section 1402: Cost-sharing reductions via enrollment in QHPs	
§ 1402	Details provisions and eligibility for reductions in cost-sharing and out-of-pocket costs for qualified individuals who enroll in a QHP	Vermont proposes to retain these provisions.
	Section 36B of the IRS Code: Refundable credits/premium assistance for coverage in a QHP	
I.R.C. § 36B	Details provisions and eligibility for a premium tax credit for qualified individuals who enroll in a QHP	Vermont proposes to retain these provisions.
Individual and employer responsibility requirements		
	Section 4980H of the IRS Code: Shared responsibility for employee health insurance	
I.R.C. § 4980H	Defines and details requirements for offering health insurance coverage by applicable large employers	Vermont proposes to retain these provisions.
	Section 5000A of the IRS Code	
I.R.C. § 5000A	Requirement to maintain minimum coverage (Section 1501), definition of minimum essential coverage, penalties,	Vermont proposes to retain these provisions.

	exemptions	

Appendix C. Relevant Implementing Regulations

Regulation	Requested Action
§155.700 Standards for the establishment of a SHOP.	Vermont requests to waive this provision.
§155.705 Functions of a SHOP.	
(a) Exchange functions that apply to SHOP.	Vermont requests to waive this provision.
(b) Unique functions of a SHOP.	
(1) Enrollment and eligibility functions.	Vermont requests to waive this provision.
(2) Employer choice requirements.	Vermont proposes to retain these provisions. Full employer choice is available under state law.
(3) SHOP options with respect to employer choice requirements.	Full employer choice is available under state law.
(4)(i) Premium aggregation.	Issuer would perform all premium processing
(5) QHP Certification.	Vermont will certify QHPs
(6) Rates and rate changes.	QHP rates are approved for the entire plan year
(7) QHP availability in merged markets.	QHPs are available throughout the merged market
(8) QHP availability in unmerged markets. If a State does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.	n/a
(9) SHOP expansion to large group market.	Vermont law allows for large group expansion in 2018
(10) Participation rules.	n/a
(11) Premium calculator.	Vermont provides plan comparison tools including an affordability calculator on its informational website
(c) Coordination with individual market Exchange for eligibility determinations.	Vermont requests to waive this provision.
(d) Duties of Navigators in the SHOP.	n/a

§155.710 Eligibility standards for SHOP.	Eligibility will be established through employer self-attestation; Employers may request an eligibility determination from VHC on a voluntary basis for purposes of claiming the small business tax credit
§155.715 Eligibility determination process for SHOP.	Vermont requests to waive this provision. Eligibility will be established through employer self-attestation; QHP health insurance issuers will follow current market practice
§155.720 Enrollment of employees into QHPs under SHOP.	Vermont requests to waive this provision. QHP health insurance issuers will follow current market practice
(i) Reporting requirement for tax administration purposes. The SHOP must report to the IRS employer participation, employer contribution, and employee enrollment information in a time and format to be determined by HHS.	Vermont requests to waive this provision. QHP health insurance issuers will submit enrollment data to IRS through 1095B reporting process
§155.725 Enrollment periods under SHOP.	Vermont requests to waive this provision. QHP health insurance issuers will follow current market practice; all plans are calendar year due to merged market
§155.730 Application standards for SHOP.	Vermont requests to waive this provision. QHP issuer will use its own application; however, Vermont will establish eligibility if requested for purposes of the small business tax credit using HHS approved application
§155.735 Termination of coverage.	Vermont requests to waive this provision. QHP health insurance issuers will follow current market practice
§155.740 SHOP employer and employee eligibility appeals requirements.	Vermont will hear eligibility appeals

Appendix D. Vermont's Essential Health Benefits

Merge with pdf from https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/vermont-ehb-benchmark-plan.pdf

Appendix E. Data and Analysis, Actuarial Certifications, Assumptions, Targets

To be added by Wakely Consulting Group

Appendix F. Information on Vermont's Public Notice and Comment Period

To be added after notice and comment period