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Health Policy Brief

MAY 23, 2016

Uninsurance Rates and the Affordable Care Act. What does recent research show about changes in uninsurance rates since 2010?

WHAT'S THE ISSUE?

The uninsurance rate for nonelderly adults increased in the decade before the passage of the Affordable Care Act (ACA), driven by declining rates of employer-based coverage, especially during the recession at the end of the decade. The ACA was intended to decrease the percentage of the population without health insurance and to provide "quality, affordable health care for all." The purpose of this brief is to consider how uninsurance rates are changing under the ACA.

WHAT'S THE BACKGROUND?

While reducing the number of uninsured people is just one measure of the ACA's effect, it is arguably the most important metric. Several government surveys can be used to study the number uninsured in the US population, including the Current Population Survey, the National Health Interview Survey, the American Community Survey, and the Medical Expenditure Panel Survey. The various surveys have different survey designs, field periods, health insurance coverage questions, reference periods, and survey modes, making the uninsurance estimates slightly different among each of the sources (see Exhibit 1).

Current Population Survey (CPS). The CPS's Annual Social and Economic Supplement (ASEC) is conducted by the Census Bureau between February and April each year. Health insurance information has been collected for all household members since 1988, and the sample design makes it possible to produce state-level estimates. Initially, the CPS asked respondents whether members of the household had different types of insurance at any time in the previous calendar year—including employer-based coverage, privately purchased nongroup coverage, Medicare, Medicaid, and so forth. If respondents answered no to each question about coverage, they were assumed to be uninsured. Beginning in 2000, respondents who did not answer positively to any of the insurance coverage questions were asked explicitly if they or the members of their household were uninsured.

Prior to 2014, the CPS was designed to count only the number of people who were uninsured during the entire previous calendar year instead of those who were uninsured at the point the survey was conducted. Because CPS estimates of the share of full-year uninsured individuals were similar to other surveys' point-in-time uninsurance estimates, many analysts questioned whether respondents were forgetting about coverage they had the previous year, were actually answering questions about the coverage they currently had, or both. Beginning in 2014, a redesigned set of health insurance questions was introduced to address these recall errors and provide information on point-in-time coverage. The questions now start by asking about current health insurance coverage, when that cover-

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age began, and which months they have had that coverage. In light of the redesigned instrument, the uninsurance estimates for calendar year 2013 are not directly comparable to estimates in previous years.

National Health Interview Survey (NHIS). The NHIS is sponsored by the National Center for Health Statistics, part of the Centers for Disease Control and Prevention. Data collection for the NHIS began in 1957, with health insurance questions added in 1959, and significant revisions were made in 1997. The NHIS is fielded continuously throughout the year. In addition to questions about health insurance coverage, the NHIS asks a variety of questions on health status, health conditions, and use of services. It asks about a person's health insurance coverage at the point of the survey but also asks whether he or she did not have coverage at any point in the twelve months prior to the survey and how many months he or she went without coverage. Those who are uninsured at the time of the survey are asked how long it has been since they last had coverage. NHIS questions have a different format than the CPS. Respondents are first asked whether they are covered by any kind of health insurance or health care plan and then asked about the type(s) of coverage. The NHIS incorporates several verification questions as part of the instrument, including whether individuals have Medicaid if they do not initially report coverage. Health insurance estimates are available quarterly through the NHIS Early Release Program.

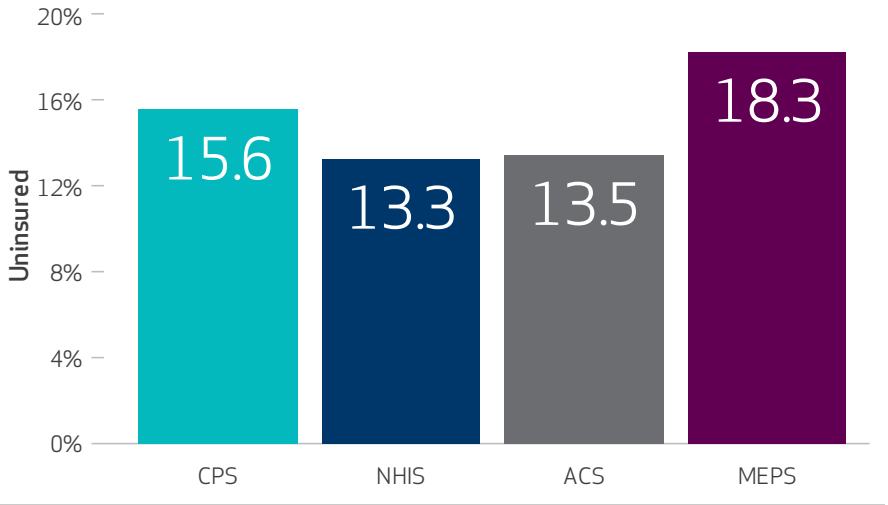
American Community Survey (ACS). The ACS, the newest of these government surveys, has been used to collect information on health insurance coverage since 2008. The ACS is conducted by the Census Bureau. Unlike the CPS, it collects data continually throughout the year. Respondents are asked if they are covered by any of several types of health insurance at the time of the interview. Unlike the CPS and the NHIS, the ACS does not include a verification question to follow up with people who do not report any insurance coverage to confirm that they are uninsured, nor does it include state-specific names for Medicaid or the Children's Health Insurance Program or a separate category for Marketplace coverage under the ACA. The ACS public use file is fifteen times larger than the CPS and about thirty times larger than the NHIS, with a sample of more than three million individuals. Because of its size and its sample design, both state-level and local-level estimates are available from the ACS.

Medical Expenditure Panel Survey (MEPS). Launched in 1996 and conducted by the Agency for Healthcare Research and Quality, MEPS collects information from households, medical providers, and employers on health insurance coverage, use of health care services, the cost of these services, and how they are paid for. The previous year's respondents to the NHIS constitute the sampling frame for the MEPS Household Component. Although MEPS has a smaller sample size than the other federal surveys, its longitudinal design (households are surveyed five times over two and a half years) provides unique information on transitions between different types of health insurance coverage and uninsurance.

Because of the time lag between data collection and release of estimates from federal surveys, several nonfederal surveys have been used to monitor trends in health insurance coverage following implementation of the ACA's key coverage provisions. These include the Gallup-Healthways Well-Being Index, which collects daily information, and the Health Reform Monitoring Survey, which pro-

EXHIBIT 1

Nonelderly population without health insurance, by survey, 2014



SOURCES National Center for Health Statistics, "Comparison of the Prevalence of Uninsured Persons from the National Health Interview Survey and the Current Population Survey, 2014 and 2015," Hyattsville (MD): NCHS, September 2015; Martinez ME, Cohen RA, Zammitti EP, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2015," Hyattsville (MD): National Center for Health Statistics, February 2016; Author's tabulations using American FactFinder, "Health Insurance Coverage Status: American Community Survey 1-Year Estimates," Washington (DC): Census Bureau, 2014; Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey Household Component Summary Tables, 2014," Rockville (MD): AHRQ, 2014. **NOTES** All data are point-in-time measurements. The Current Population Survey (CPS) is from February to April 2014. The National Health Interview Survey (NHIS) and the American Community Survey (ACS) are for the full year. The Medical Expenditure Panel Survey (MEPS) is for the first half of 2014.

vided quarterly data between early 2013 and March 2015 and semiannual data since then. Two additional private surveys providing less frequent estimates of the change in uninsurance are conducted by the Commonwealth Fund and the RAND Corporation.

Gallup-Healthways Well-Being Index. Conducted as part of daily Gallup Poll phone interviews of adults ages eighteen and older, the Gallup-Healthways Well-Being Index has collected information on health insurance since 2008. The large sample size (500 interviews per day since 2013; 1,000 interviews per day previously) and the frequency with which data are collected make it possible to provide quarterly estimates of uninsurance for the national population of adults and semiannual estimates of uninsurance by state. According to the most recent Gallup data, the share of nonelderly adults who were uninsured fell to a low of 12.9 percent in the first quarter of 2016, down 7.9 percentage points since the fourth quarter of 2013.

Health Reform Monitoring Survey (HRMS). The HRMS, which receives its major funding from the Robert Wood Johnson Foundation, was designed by the Urban Institute to provide timely information on the ACA before data from federal surveys become available. Samples include approximately 7,500 nonelderly adults (ages 18–64) and approximately 2,400 children younger than age 18 each round. The HRMS does not provide state-level estimates, although some funders have supported state oversamples to obtain state-specific estimates. Questions on health insurance, access to care, health care affordability, and health status are based on those questions used in government surveys, including the CPS, the NHIS, and the ACS. A unique feature of the HRMS is that each round includes a changing set of topical questions focused on timely ACA policy and implementation issues.

"There are several provisions in the ACA aimed at reducing the percentage of people without insurance."

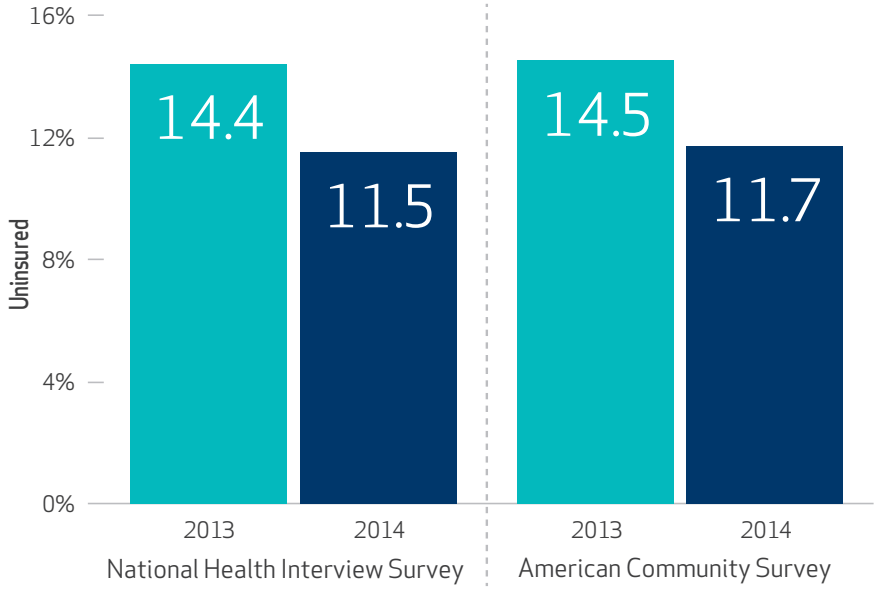
WHAT'S IN THE LAW?

There are several provisions in the ACA aimed at reducing the percentage of people without insurance. For plan years effective after September 23, 2010, the ACA allows young adults to stay on their parents' health plan as dependents until age twenty-six. The law applies to both dependent children as well as children who are no longer considered a dependent for tax filing purposes; married children (although their spouse and any children would not be eligible); and both employer-based insurance plans and individually purchased plans, including Marketplace plans. Prior to this change in law, coverage for young adults on their parents' policies usually ended once they turned nineteen unless they were a full-time student. Full-time students were often allowed to remain on their parents' insurance policies until they graduated or turned twenty-two, whichever came first. At the time the law was passed, young adults had the highest rates of uninsurance and the lowest rates of employer-based coverage.

When the ACA was passed in March 2010, the law required states that had not already done so to expand their Medicaid programs in January 2014 to cover nearly all people with incomes below 138 percent of the federal poverty level (FPL) (currently about $16,400 for an individual and $27,800 for a family of three). However, in 2012 the US Supreme Court struck down that part of the ACA and made the Medicaid expansion optional for states. As of May 2016, thirty-one states and the District of Columbia have expanded their Medicaid programs, although a few states did not expand their programs until mid-2014 or later. Prior to the ACA, most states did not allow nondisabled childless adults to enroll in

EXHIBIT 2

US population without insurance, 2013 versus 2014



SOURCES Ward BR, Clarke TC, Freeman G, Schiller JS, "Early Release of Selected Estimates Based on Data from the 2014 National Health Interview Survey," Hyattsville (MD): National Center for Health Statistics, June 2015; Smith JC, Medalia C, "Health Insurance Coverage in the United States: 2014," Washington (DC): Census Bureau, September 2015.

19%

The uninsurance rate for young adults ages 19–25 declined from more than 30 percent in 2009 to 19 percent in 2014.

Medicaid, while other states covered parents only at very low income levels. In states that did not expand Medicaid, coverage for adults remains minimal. According to the Kaiser Commission on Medicaid and the Uninsured, the median income limit for parents' eligibility in states that did not expand Medicaid is just 44 percent of the FPL, or about $8,870 for a family of three.

Along with states having the option of expanding Medicaid, the ACA created state Marketplaces for people to shop for and enroll in private health plans. Individuals and families with incomes between 100 percent and 400 percent of the FPL (currently up to $47,520 for an individual and $80,640 for a family of three) who are not eligible for Medicaid and do not have an affordable offer of employer-based coverage are eligible for federal tax credits to offset their health insurance premiums. Additional cost-sharing subsidies are available to those with family incomes below 250 percent of the FPL. Because the Medicaid expansion was intended to be mandatory, there is a gap in eligibility in states that did not expand their programs. People with incomes between their states' Medicaid eligibility thresholds and 100 percent of the FPL are not eligible for subsidized Marketplace coverage. As of early 2015, more than three million uninsured adults with incomes below 138 percent of the FPL were estimated to fall into a so-called coverage or assistance gap—living in states that had not expanded Medicaid and not qualifying for either Medicaid or tax credits for Marketplace coverage.

In addition to the health insurance coverage expansions in the ACA, the law made significant changes to private insurance markets. Among the most significant changes are the elimination of preexisting condition exclusions and the ability to charge higher premiums based on medical history. Finally, the law requires people to have health insurance or pay a fine for remaining uninsured. For those who do not have coverage in 2016, the fine is the greater of $695 per adult and $347.50 per child (maximum of $2,085 per family) or 2.5 percent of household income (maximum of the national average annual premium for a bronze level plan).

WHAT'S THE DEBATE?

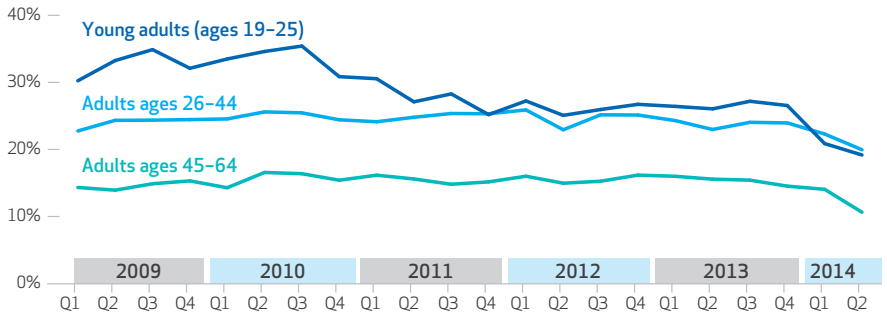
Measuring the number of people without insurance. There have long been debates about how best to measure the number of uninsured people. In addition to some of the issues discussed above, there is a fairly high number of people in a sample who do not respond or respond to only some portion of a survey. In the most recent CPS, for example, the nonresponse rate was 13.4 percent for the core survey and an additional 14.2 percent for the ASEC, meaning more than a quarter of the people surveyed did not answer questions on health insurance. Nonresponse might produce a downward bias in CPS uninsurance estimates—meaning the reported number uninsured on the survey is lower than in reality. Another source of error is the underreporting of Medicaid, which has been shown to produce a small upward bias to uninsurance estimates, resulting in people who are actually on Medicaid being counted as uninsured.

Although concerns about the reliability of the different estimates are warranted, both the ACS and the NHIS show very similar estimates of how the uninsurance rate changed between 2013 and 2014, the period when the subsidized Marketplace plans became available and Medicaid was expanded in close to half the states (see Exhibit 2). In the ACS and the NHIS, the decline was nearly 3 percentage points, the largest one-year decline in uninsurance rates since 1997, based on prior NHIS data.

Young adult coverage. One of the least controversial components of the law was the requirement to allow young adults to remain on their parents' policies up until age twenty-six.

EXHIBIT 3

Uninsurance rates by age group, 2009–14



SOURCES McMorrow S, Kenney GM, Long SK, Anderson N, "Uninsurance among Young Adults Continues to Decline, Particularly in Medicaid Expansion States," *Health Affairs* 34, no. 4 (2015):616–20. Authors' analysis of 2009–14 data from the National Health Interview Survey. **NOTES** Uninsurance is at the time of the survey. Coverage definitions reflect those used in the early release file for the 2014 survey, see Martinez ME, Cohen RA, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2014," Hyattsville (MD): National Center for Health Statistics, December 2014. The figure reflects point estimates for the available calendar quarters (Q1–Q4) in each year. Linear interpolation is used between quarters.

"With states opting out of the Medicaid expansion, state variations in uninsurance rates are more prominent than ever."

Since this part of the law went into effect in the later part of 2010, the uninsurance rate for young adults has dropped significantly (see Exhibit 3). Although some of the decrease in uninsurance rates in this population can be attributed to Medicaid expansion or subsidized coverage through the Marketplaces and improvements in the economy, the dramatic drop in uninsurance rates between 2010 and 2013 appears to be driven in large part by the extension of dependent insurance coverage to young adults.

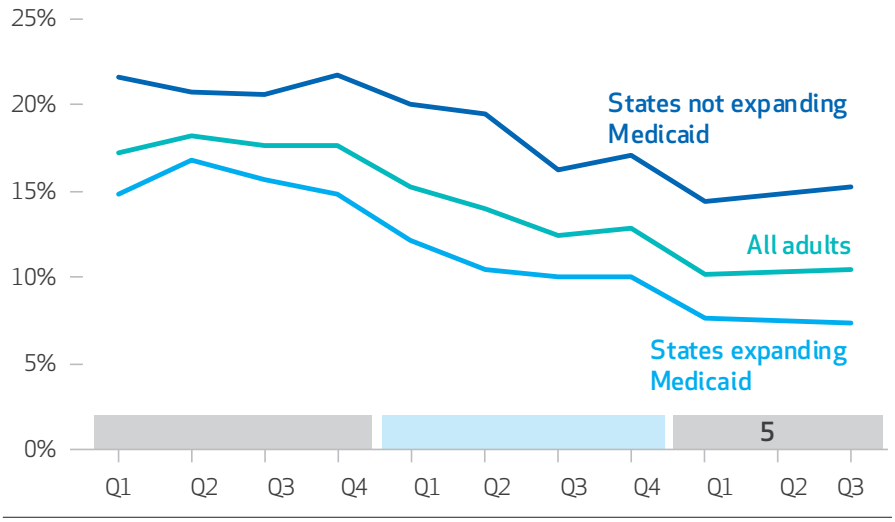
According to a recent *Health Affairs* article, the uninsurance rate for young adults ages 19–25 declined from more than 30 percent in 2009 to 19 percent in 2014. The authors found a significant decline in the percentage of young adults without insurance from the last quarter of 2010 through late 2011 and a corresponding increase in the number with private coverage mirroring the time when the dependent coverage expansion first took effect. Other age groups had relatively stable insurance rates during that time period. Young adults experienced another significant drop in uninsurance rates in 2014, when the Medicaid expansion and subsidized Marketplace coverage became available.

State variations in uninsurance rates. Historically, uninsurance rates varied from state to state, driven in part by differences in income, education, employment, age, race, and state policies. With states opting out of the Medicaid expansion, state variations in uninsurance rates are more prominent than ever. From the third quarter of 2013 to the third quarter of 2015, the national uninsurance rate for adults ages 18–64 declined by almost 41 percent (see Exhibit 4), according to the HRMS. Medicaid expansion states saw uninsurance rates for adults cut by more than half; states that did not expand Medicaid saw a decrease of only one-quarter.

Of the ten states with the highest uninsurance rates in 2013, five chose not to expand Medicaid (Texas, Florida, Georgia, Oklahoma, and Mississippi), four chose to expand in 2014 (Arizona, California, Nevada, and New Mexico), and one (Alaska) expanded Medicaid in 2015. One year later, two of the Medicaid expansion states (Arizona and California) dropped out of the top ten states with the highest uninsurance rates, replaced with two states that did not expand Medicaid (Montana and Louisiana, both of which are expanding Medicaid in 2016). Looking at the data another way, the states with the greatest percentage-point decline in the percentage uninsured from 2013 to 2014 all expanded their Medicaid programs (see Exhibit 5).

EXHIBIT 4

Trends in uninsurance for adults ages 18–64 from Q1 2013 to Q3 2015



SOURCES Based on the Health Reform Monitoring Survey. Karpman M, Long SK, "QuickTake: Taking Stock: Gains in Health Insurance Coverage under the ACA Continue as of September 2015, but Many Remain Uninsured," Washington (DC): Urban Institute Health Policy Center, November 4, 2015. **NOTES** Estimates are regression adjusted. States expanding Medicaid before September 2015 are Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. Estimates are not available for Q2 2015 because the Health Reform Monitoring Survey shifted from a quarterly fielding schedule to a semiannual schedule in March 2015. Beginning in Q1 2014, all quarters were significantly different from Q3 2013 ($p < 0.05$) except for Q1 2014 and Q2 2014 for states not expanding Medicaid.

WHAT'S NEXT?

The decline in the uninsurance rate from 2013 to 2014 when most coverage provisions went into effect is one measure of the ACA's effect on providing "quality, affordable health care for all." What remains to be seen is whether the uninsurance rate continues to decline in the coming years. Early release of NHIS data is promising. In 2015, 10.5 percent of the nonelderly population was uninsured. Overall, Gallup data indicate that an estimated twenty million adults have gained coverage since 2010, although not all of that decline can be attributed to the ACA and might be a result of the improving economy.

About 12.7 million people were enrolled in a Marketplace plan at the end of the third open enrollment period, up from 11.7 million at the end of the second enrollment period and 8.0 million at the end of the first open enrollment period. However, history has shown that

not all people who select plans will pay their premiums to keep them, so the number of enrollees is expected to decrease throughout the year because of attrition. While the rate of increase in enrollment has slowed, it is too early to determine whether Marketplace enrollment has leveled off.

Despite the increased penalty in 2016 for not having insurance, the remaining uninsured people might be hard to enroll. In addition, a significant number of the remaining nonelderly uninsured people (about thirty-three million as of March 2015, according to the CPS) are likely ineligible for either Medicaid or subsidized plans through the Marketplace because they are undocumented immigrants. Recent briefs by the Henry J. Kaiser Family Foundation and Urban Institute estimate that between 15 percent and 16 percent of currently uninsured people are ineligible for coverage because of immigration status. The board of Covered California just proposed allowing undocumented immigrants to purchase unsubsidized health insurance through the California Marketplace, a move that will require state and federal approval before taking effect.

Finally, many of the states with the largest number of uninsured people have publicly expressed no intention at this time to expand Medicaid, leaving many poor adults without access to financial assistance for purchasing coverage. While improved outreach is crucial to reaching uninsured people who are eligible for Medicaid or subsidized Marketplace insurance but have not yet taken up coverage, continued progress in reducing the ranks of the uninsured will also depend on federal and state policy changes that expand the number of people who are eligible for assistance and ensure that assistance is sufficient to make coverage affordable. ■

EXHIBIT 5

States with the greatest percentage-point change in uninsurance rates, all ages, 2013–14

Rank	State	2013 uninsurance rate	2014 uninsurance rate	Percentage-point difference
1	Kentucky	14.3%	8.5%	5.8
2	Nevada	20.7	15.2	5.5
3	West Virginia	14.0	8.6	5.4
4	Oregon	14.7	9.7	4.9
5	California	17.2	12.4	4.7
5 (tie)	Washington	14.0	9.2	4.7
7	Arkansas	16.0	11.8	4.2
7 (tie)	Rhode Island	11.6	7.4	4.2
9	New Mexico	18.6	14.5	4.1
10	Colorado	14.1	10.3	3.8

SOURCE Author's tabulations based on data from Smith JC, Medalia C, "Health Insurance Coverage in the United States: 2014," Washington (DC): Census Bureau, September 2015.

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ACA Implementation—Monitoring and Tracking

Increases in 2016 Marketplace Nongroup Premiums: There Is No Meaningful National Average

May 2016

Linda J Blumberg, John Holahan, 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.

INTRODUCTION

Several reports estimate that 2016 nongroup marketplace premium increases were considerably higher than in previous years. Depending on the source and the premium measure used, premium increases have been reported as 7.5 percent, 12.6 percent, and 11 percent.[1] Earlier this year, we published a national estimate that the lowest-cost silver plan premium available in 2016 was, on average, 4.3 percent higher than the lowest-cost silver plan premium available in 2015; that estimate is based on the largest population rating areas in the first states to have their rates approved, and the estimate weights premiums by rating area population size.[2] That analysis used data on 20 states plus the District of Columbia and included large and small states from a diverse geographic distribution. Now, with data available for all states, we find that the average change in premiums for the lowest-cost silver plan across all rating areas in all states increased a weighted average of 8.3 percent between 2015 and 2016. However, further exploration reveals that the rates of increase vary tremendously across states and across rating areas within states, with statewide averages as high as 41.8 percent in Oklahoma and as low as -12.1 percent in Indiana.

We conclude that a national average rate of premium increase is a fairly meaningless statistic since different markets are having very different experiences. The focus of attention should be on understanding the wide variability by identifying the characteristics of markets that have experienced high premiums or high growth in premiums and of markets with lower premiums or lower growth in premiums. Tables 1 and 2 summarize the considerable variation in the changes in lowest-cost silver plan premiums offered between 2015 and 2016, comparing statewide and regional averages as well as detailing the variation in experiences across rating areas within each state. We find the following:

- Across 499 rating areas nationally, 29.1 percent of the population lives in rating areas with reductions between 2015 and 2016 in lowest-cost silver plan premiums. Another 19.0 percent live in rating areas with increases between 0 and 5 percent, and 16.1 percent live in areas with increases between 5 and 10 percent. Finally, 9.6 percent of the population live in rating areas with increases between 10 and 15 percent, and 26.3 percent live in areas with increases greater than 15 percent (table 2).
- There is also considerable variation in premium changes by geographic area. In 19 states (including Michigan, Florida, Texas, Virginia, California, and Ohio), solid majorities of the population reside in areas where the lowest-cost silver plan marketplace premium either decreased any amount or increased less than 5 percent.
- On the other hand, 16 states (including North Carolina, Colorado, Arizona, Oklahoma, Tennessee, Minnesota, and West Virginia) had majorities of their populations living in areas in which the lowest-cost silver plan marketplace premium increased more than 15 percent between 2015 and 2016.
- In some states (such as New York), the large population centers (such as New York City, Long Island, and Buffalo) saw decreases or small increases in lowest-cost silver plan premiums, although the rest of the state saw larger increases.

Table 1. State Average Premium Price for Lowest-Cost Silver Plan Available, 2014–2016

State	Average 2014 premium	Average 2015 premium	2014-15 relative change	Average 2016 premium	2015-16 relative change	Year-to-year average
National Average	**$256**	**$264**	**2.9%**	**$283**	**8.3%**	**5.5%**
Northeast						
Regional Average	**$284**	**$288**	**1.8%**	**$307**	**6.7%**	**4.2%**
Connecticut	$346	$348	0.6%	$351	0.8%	0.7%
Delaware	$286	$297	4.0%	$354	19.0%	11.2%
District of Columbia	$238	$239	0.3%	$229	-4.2%	-2.0%
Maine	$311	$307	-1.5%	$309	0.8%	-0.4%
Maryland	$221	$228	3.2%	$245	7.5%	5.3%
Massachusetts	$247	$243	-1.5%	$247	1.5%	0.0%
New Hampshire	$288	$238	-17.5%	$260	9.3%	-5.1%
New Jersey	$308	$315	2.2%	$325	3.3%	2.7%
New York	$340	$344	1.0%	$372	8.1%	4.6%
Pennsylvania	$207	$222	7.1%	$245	10.5%	8.8%
Rhode Island	$274	$244	-10.9%	$259	6.1%	-2.8%
Vermont	$395	$428	8.3%	$465	8.6%	8.5%
Midwest						
Regional Average	**$239**	**$248**	**3.5%**	**$261**	**6.2%**	**4.8%**
Illinois	$222	$229	3.0%	$247	8.1%	5.5%
Indiana	$313	$300	-4.3%	$264	-12.1%	-8.3%
Iowa	$219	$231	5.7%	$273	18.2%	11.8%
Kansas	$208	$201	-3.3%	$241	19.6%	7.6%
Michigan	$218	$241	10.5%	$237	-1.9%	4.1%
Minnesota	$178	$199	11.8%	$250	25.8%	18.6%
Missouri	$257	$269	4.6%	$303	12.6%	8.5%
Nebraska	$239	$254	6.3%	$320	26.2%	15.8%
North Dakota	$281	$292	3.7%	$313	7.4%	5.6%
Ohio	$244	$252	3.2%	$249	-1.1%	1.0%
South Dakota	$274	$257	-6.4%	$318	23.8%	7.6%
Wisconsin	$277	$281	1.3%	$290	3.4%	2.3%

Table 1 Continued

State	Average 2014 premium	Average 2015 premium	2014-15 relative change	Average 2016 premium	2015-16 relative change	Year-to-year average
National Average	**$256**	**$264**	**2.9%**	**$283**	**8.3%**	**5.5%**
South						
Regional Average	**$248**	**$261**	**5.4%**	**$284**	**9.5%**	**7.4%**
Alabama	$244	$255	4.8%	$288	12.7%	8.7%
Arkansas	$282	$281	-0.6%	$293	4.5%	1.9%
Florida	$244	$276	12.8%	$283	2.6%	7.6%
Georgia	$255	$260	1.8%	$279	7.5%	4.6%
Kentucky	$203	$208	2.5%	$233	11.8%	7.0%
Louisiana	$294	$297	1.1%	$327	10.2%	5.5%
Mississippi	$324	$283	-12.5%	$264	-6.8%	-9.7%
North Carolina	$289	$307	6.2%	$371	20.6%	13.2%
Oklahoma	$206	$201	-2.2%	$285	41.8%	17.8%
South Carolina	$267	$266	-0.6%	$300	13.0%	6.0%
Tennessee	$189	$199	5.0%	$275	38.6%	20.7%
Texas	$231	$248	7.1%	$251	1.2%	4.1%
Virginia	$259	$273	5.3%	$280	2.7%	4.0%
West Virginia	$266	$290	9.0%	$352	21.6%	15.1%
West						
Regional Average	**$260**	**$261**	**0.4%**	**$281**	**8.8%**	**4.5%**
Alaska	$380	$488	28.4%	$684	40.2%	34.2%
Arizona	$200	$177	-11.3%	$221	24.4%	5.1%
California	$280	$293	4.5%	$297	1.4%	2.9%
Colorado	$258	$225	-12.5%	$281	24.8%	4.5%
Hawaii	$176	$195	10.4%	$260	33.6%	21.5%
Idaho	$223	$235	5.7%	$272	15.5%	10.5%
Montana	$249	$237	-4.8%	$320	35.2%	13.4%
Nevada	$276	$270	-2.1%	$284	5.2%	1.5%
New Mexico	$225	$204	-9.2%	$195	-4.7%	-7.0%
Oregon	$204	$216	5.9%	$254	17.6%	11.6%
Utah	$196	$211	8.0%	$231	9.1%	8.6%
Washington	$269	$237	-12.0%	$255	7.8%	-2.6%
Wyoming	$396	$429	8.6%	$454	5.6%	7.1%

Notes: Premium prices displayed are for a 40-year-old nonsmoking indiviudal and are weighted by rating area population.
Colorado's data for 2014 and 2014–15 change do not include rating areas 8 and 9 because they were adjusted after the first open enrollment period.

Table 2. Distribution of Changes in Lowest-Cost Silver Plan Premium

State	Number of rating areas	Percent of population with decrease	Percent of population with <5% increase	Percent of population with ≥5–9.99% increase	Percent of population with 10–14.99% increase	Percent of population with largest increases, ≥15%
National Average	**499**	**29.1%**	**19.0%**	**16.1%**	**9.6%**	**26.3%**
Northeast						
Regional Average	**46**	**23.7%**	**39.1%**	**17.2%**	**4.7%**	**15.4%**
Connecticut	8	29.6%	65.2%	5.2$	0.0%	0.0%
Delaware	1	0.0%	0.0%	0.0%	0.0%	100.0%
District of Columbia	1	100.0%	0.0%	0.0%	0.0%	0.0%
Maine	4	30.1%	69.9%	0.0%	0.0%	0.0%
Maryland	4	0.0%	13.6%	75.2%	11.2%	0.0%
Massachusetts	7	48.4%	27.2%	0.0%	12.1%	12.4%
New Hampshire	1	0.0%	0.0%	100.0%	0.0%	0.0%
New Jersey	1	0.0%	100.0%	0.0%	0.0%	0.0%
New York	8	49.3%	27.2%	0.0%	0.0%	23.4%
Pennsylvania	9	0.0%	36.2%	25.4%	11.6%	26.8%
Rhode Island	1	0.0%	0.0%	100.0%	0.0%	0.0%
Vermont	1	0.0%	0.0%	100.0%	0.0%	0.0%
Midwest						
Regional Average	**124**	**41.4%**	**7.4%**	**10.1%**	**9.5%**	**31.6%**
Illinois	13	40.7%	0.0%	5.4%	10.9%	43.1%
Indiana	17	100.0%	0.0%	0.0%	0.0%	0.0%
Iowa	7	0.0%	0.0%	0.0%	29.2%	70.8%
Kansas	7	0.0%	0.0%	0.0%	0.0%	100.0%
Michigan	16	74.9%	3.6%	18.8%	0.0%	2.6%
Minnesota	9	0.0%	0.0%	0.0%	0.0%	100.0%
Missouri	10	0.0%	0.0%	51.6%	9.8%	38.6%
Nebraska	4	0.0%	0.0%	0.0%	0.0%	100.0%
North Dakota	4	0.0%	0.0%	77.5%	22.5%	0.0%
Ohio	17	62.5%	15.1%	0.0%	22.3%	0.0%
South Dakota	4	0.0%	0.0%	0.0%	0.0%	100.0%
Wisconsin	16	26.1%	50.5%	10.5%	12.9%	0.0%

Table 2 Continued

States	Number of rating areas	Percent of population with decrease	Percent of population with <5% increase	Percent of population with ≥5–9.99% increase	Percent of population with 10–14.99% increase	Percent of population with largest increases, ≥15%
National Average	**499**	**29.1%**	**19.0%**	**16.1%**	**9.6%**	**26.3%**
South						
Regional Average	**249**	**23.6%**	**22.1%**	**13.9%**	**11.2%**	**29.2%**
Alabama	13	4.4%	0.0%	23.3%	55.9%	16.4%
Arkansas	7	0.0%	82.9%	17.1%	0.0%	0.0%
Florida	67	44.7%	19.0%	19.8%	1.5%	15.0%
Georgia	16	6.0%	50.1%	0.0%	22.1%	21.8%
Kentucky	8	20.5%	19.1%	0.0%	11.5%	48.9%
Louisiana	8	9.4%	0.0%	24.9%	65.6%	0.0%
Mississippi	6	93.4%	6.6%	0.0%	0.0%	0.0%
North Carolina	16	0.0%	0.0%	0.0%	12.7%	87.3%
Oklahoma	5	0.0%	0.0%	0.0%	0.0%	100.0%
South Carolina	46	0.0%	0.0%	42.8%	21.1%	36.0%
Tennessee	8	0.0%	0.0%	0.0%	0.0%	100.0%
Texas	26	32.7%	44.2%	11.5%	0.9%	10.7%
Virginia	12	48.6%	9.6%	41.8%	0.0%	0.0%
West Virginia	11	0.0%	0.0%	8.5%	36.7%	54.8%
West						
Regional Average	**80**	**30.5%**	**7.7%**	**23.9%**	**11.4%**	**26.4%**
Alaska	3	0.0%	0.0%	0.0%	0.0%	100.0%
Arizona	7	0.0%	0.0%	6.7%	0.0%	93.3%
California	19	47.1%	10.4%	31.8%	10.6%	0.0%
Colorado	9	0.0%	7.9%	0.0%	0.0%	92.1%
Hawaii	1	0.0%	0.0%	0.0%	0.0%	100.0%
Idaho	7	0.0%	0.0%	30.6%	21.5$	48.0%
Montana	4	0.0%	0.0%	0.0%	0.0%	100.0%
Nevada	4	13.5%	22.3%	64.2%	0.0%	0.0%
New Mexico	5	54.8%	7.1%	38.1%	0.0%	0.0%
Oregon	7	0.0%	0.0%	0.0%	28.0%	72.0%
Utah	6	19.0%	0.0%	63.0%	0.0%	18.0%
Washington	5	37.3%	0.0%	0.0%	42.1%	20.6%
Wyoming	3	0.0%	86.1%	0.0%	13.9%	0.0%

Notes: Population is determined at the rating area level

This analysis focuses on identifying the characteristics of local markets associated with higher and lower premiums and larger and smaller changes in premiums between 2015 and 2016. We estimate regression models as a way to summarize these associations. We find the following:

- There is some regression to the mean; rating areas that had high premiums in 2015 relative to the national average had lower premium growth in 2016 and vice versa.
- However, the most important factors associated with lowest-cost silver plan premiums and premium increases are those defining the contours of competition in the market. Rating areas with more competitors had significantly lower premiums and lower rates of increase than those that did not.
- Those rating areas with a Medicaid insurer competing in the marketplace also have lower premiums and lower rates of increase than those regions without a Medicaid insurer competing. The presence of a co-op insurer was associated with lower premium increases although a co-op was not significantly associated with a lower premium level in 2016.

We also provide detailed information on substate rating areas in seven states that had high statewide average increases in their 2016 lowest-cost silver plan premiums and seven states that had low statewide average increases in 2016. These examples allow us to ground the findings of the regressions in specific experiences.

DATA AND METHODS

We analyze nongroup marketplace premium and insurer participation data taken from the 2015 and 2016 Robert Wood Johnson Foundation Health Insurance Exchange Comparison (HIX Compare) datasets for every rating area in the country; we combine those data with several validity checks and edits based on Healthcare.gov and the relevant state marketplace websites. Our analyses use the premium for the lowest-cost silver plan offered in each rating area for a 40-year-old nonsmoker. We have focused on the lowest-cost silver plan as a premium measure because it represents the least expensive entry point into the most popular tier of coverage. All averages presented are weighted by rating area population. In addition to average changes in state premiums between 2015 and 2016, we also calculate changes in average state premiums between 2014 and 2015 and the average annual change between 2014 and 2016 (geometric mean) to provide a broader context for the premium changes seen thus far.

To summarize the market-level characteristics associated with higher or lower premiums and higher or lower growth in premiums, we estimate linear probability models. We estimate two regressions, each with premium rating area as the unit of observation. The first has a dependent variable equal to the lowest-cost monthly silver plan premium in the rating area in 2016, and the second has a dependent variable equal to the percentage difference between the lowest-cost silver plan premium in the rating area in 2015 and in 2016. Explanatory variables in each regression include state population; the number of insurers in the rating area in 2015; the change in the number of insurers between 2015 and 2016; and indicators for 2016 participation in the rating area for previously Medicaid-only insurers (hereafter referred to as Medicaid insurers), co-ops, national insurers, regional or local insurers (including new commercial entrants like Oscar), provider-sponsored insurers, and Blue Cross Blue Shield–affiliated insurers (including Anthem and subsidiaries such as Bridgespan).

Additionally, in the premium regression we included indicators for states with pure community rating (New York and Vermont) because premiums in those states for a 40-year-old are significantly higher than in other states because the former states' insurers are prohibited from varying premiums by age (relative to cases in which premium variation by age is permitted, pure community rating increases premiums for younger enrollees and reduces them for older enrollees).[3] In the premium change regression we add average lowest-cost silver plan premiums in the rating area relative to the national average in 2015 to test for regression to the mean as an explanation for variation in premium increases or decreases.

We define Blue Cross Blue Shield insurers as those that are members of the Blue Cross Blue Shield Association. Co-ops were established under the Affordable Care Act (ACA), and all operating members are listed on the National Alliance of State Health Co-ops website. Medicaid insurers are those that only offered public insurance (Medicaid with or without Medicare) plans before the 2014 nongroup open enrollment period. Provider-sponsored insurers are those directly affiliated with a provider group (usually a hospital system).

A limitation of our analysis is that some insurers participating in a given rating area do not serve the full population in that rating area, only a part of it. As a result, in some portions of some rating areas, individuals likely do not have access to the lowest cost silver premium we identify. However, we are unable to analyze sub-rating area service areas at this time.

FINDINGS

Characteristics of Markets Associated with High and Low Premium Levels and Growth Rates, 2016

The weighted means of each variable used in the regressions are shown in table 3. The regressions estimated to summarize the association of market characteristics with premium levels and relative premium growth are shown in table 4. In table 4, the dependent variables are the monthly premium of the lowest-cost silver plan in each rating area in 2016 and the percentage difference between the lowest-cost silver plan premium in the rating area in 2015 and the lowest-cost silver plan premium in the rating area in 2016.

Table 4 shows that the lowest-cost silver plan premium available is lower when more insurers participate in the nongroup marketplace in a given region in 2015. Although this is likely because of the effect of competition, it could also be because markets that begin with somewhat lower premiums have more competition; causation cannot be determined here. Markets with a Medicaid insurer or a provider-sponsored plan in 2016 had lowest-cost silver plan premiums that were statistically lower than those in rating areas in which these insurer types did not compete. Premiums in rating areas with a local or regional insurer or a Blue Cross Blue Shield–affiliated insurer participating tended to be higher, signaling that such insurers may be more likely to participate in higher-priced markets, were less likely to price aggressively, or were underpriced in 2015. The presence of a co-op insurer in a rating area in 2016 is negatively correlated with the lowest-cost silver plan premium in the rating area, but the relationship is not statistically significant. The presence of a national insurer is also not statistically significant.

Table 3. Table of Means for Premium Level and Percent Change Regression Models, at the Rating Area Level

Variable	Weighted mean[a]
Dependent variables	
Percentage change in lowest-cost silver plan premium, 2015-16	0.08
2016 lowest-cost silver plan monthly premium	283.12
Independent variables	
State population	14,003,000
Number of participating insurers, 2015	5.69
Change in number of insurers, 2015-16	- 0.38
Lowest-cost silver plan premium relative to the national average, 2015[b]	0.97
Medicaid insurer participating in 2016	0.48
Co-op insurer participating in 2016	0.20
National insurer participating in 2016	0.76
Regional or local insurer participating in 2016	0.52
Provider-sponsored insurer participating in 2016	0.55
Blue Cross Blue Shield insurer participating in 2016	0.95
Community rated nongroup market[c]	0.06

a. Weighted by rating region population
b. Only included in the premium percent change regression
c. Only included in the premium level regression; yes value for rating areas in New York and Vermont

Table 4 shows that rating areas with more insurers participating in the marketplace in 2015 tended to have smaller relative premium increases in 2016, and this relationship is highly significant. Each additional insurer participating in 2015 is associated with a 2016 premium increase that is 1.9 percentage points lower, all else constant. For example, a rating area that had eight marketplace insurers in 2015 had an expected premium increase of 3.8 percent in 2016; a rating area with average characteristics (including having two marketplace insurers in 2015) had an expected premium increase of 15.1 percent in 2016, measured at the mean for all other variables (table 5, scenario 1).

Whether a rating area experienced an increase or decrease in the number of marketplace insurers between 2015 and 2016 was also significantly correlated with its relative change in lowest-cost silver plan premium. Increases in the number of marketplace insurers are correlated with lower increases in the regions' lowest-cost silver plan premiums; the opposite holds true for decreases in the number of marketplace insurers. A 2016 increase (or decrease) of one in the number of insurers is associated with a 2.9 percentage point lower (or greater) increase in its lowest cost silver premium than an identical region that had the same number of insurers in each of 2015 and 2016 (table 5, scenario 2).

Rating areas with 2015 silver plan premiums that were high relative to the national average tended to have lower premium increases in 2016. For example, a rating area that was average in all other characteristics but that had a 2015 lowest-cost silver plan premium that was 10 percent above the national average had an expected premium increase in 2016 2.8 percentage points lower than an otherwise identical rating area in which the 2015 lowest-cost silver plan premium was equal to the national average (table 5, scenario 3). This finding suggests a possible regression to the mean over time; that is, markets in which early premiums were high are growing at a slower rate than markets in which early premiums were low.

Table 4. Lowest-Cost Silver Plan Monthly Premium and 2015-2016 Percentage Change Regression Models Coefficients

	2016 premium regression model	2015-16 relative change regression model
State population	-5.52E-08	-2.77E-09***
Number of participating insurers, 2015	-10.60***	-0.02***
Change in number of insurers, 2015-16	-4.50	-0.03***
Lowest-cost silver plan premium in 2015 relative to national average	N/A	-0.28***
Medicaid insurer participating in 2016	-21.07***	-0.07***
Co-op insurer participating in 2016	-10.72	-0.05***
National insurer participating in 2016	-4.59	-0.01
Regional or local insurer participating in 2016	26.13***	0.07***
Provider-sponsored insurer participating in 2016	-12.31**	-0.02
Blue Cross Blue Shield insurer participating in 2016	28.13***	0.06***
Community rated nongroup market	112.16***	N/A
Intercept	320.67	0.45
R^2	0.34	0.39
n	499	499

Source: Author's analysis of RWJF HIX Compare datasets combined with Healthcare.gov and state marketplace websites
Note: N/A = Variable not included in this regression.
* $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$.
R^2 : is a representation of the share of variation in the dependent variable explained by the independent variables.

Table 5. Effect of Market Characteristics on Relative Change in Lowest-Cost Silver Plan Premiums, 2015-2016

Scenarios		Percentage-point difference in estimated annual growth rates between scenarios
1	2 insurers competing in 2015	15.1%
	8 insurers competing in 2015	3.8%
	Difference	11.3%
2	No change in number of insurers in a rating region	9.4%
	1 insurer exits the region in 2016	12.3%
	Difference	2.9%
3	2015 lowest-cost silver premium at the national average	10.7%
	2015 lowest-cost silver premium 10 percent above the national average	7.8%
	Difference	-2.8%
4	Medicaid insurer competes in rating area	5.4%
	No medicaid insurer competes in rating area	12.8%
	Difference	-7.3%
5	Co-op insurer competes in rating area	6.9%
	No co-op insurer competes in rating area	11.4%
	Difference	-4.5%
6	Regional insurer competes in rating area	15.2%
	No regional insurer competes in rating area	8.1%
	Difference	7.1%
7	Blue Cross Blue Shield-affiliated insurer competes in rating area	11.1%
	No Blue Cross Blue Shield-affiliated insurer competes in rating area	5.2%
	Difference	5.9%
8*	National insurer competes in rating area	10.4%
	No national insurer competes in rating area	11.2%
	Difference	-0.8%
9*	Provider-sponsored insurer competes in rating area	9.6
	No provider-sponsored insurer competes in rating area	11.3%
	Difference	-1.7%
10	Rating area in state of average population size	10.7%
	Rating area in state of with population size 10 million above average	7.9%
	Difference	-2.8%

Note: Effects are evaluated at mean values for all other variables; unit of observation is the rating area.

* The variables indicating presence in the market of a national insurer or a provider sponsored insurer is not statistically significant in the regression (see table 4)

The regression results also indicate that a Medicaid insurer or a co-op participating in the marketplace in 2016 is associated with a significantly lower rate of increase in the lowest-cost silver plan premium in 2016. For example, competition from a Medicaid insurer in a rating area with otherwise average characteristics is associated with a relative premium increase 7.3 percentage points lower than that in an identical rating area that lacks a Medicaid insurer (table 5, scenario 4). The participation of a co-op in a rating area with otherwise average characteristics is associated with an increase in the lowest-cost silver plan premium that is 4.5 percentage points lower than that of an identical rating area that lacks a co-op (table 5, scenario 5). On the other hand, the presence of a regional insurer or a Blue Cross Blue Shield–affiliated insurer was associated with a higher rate of increase (7.1 percentage points and 5.9 percentage points, respectively; table 5, scenarios 6 and 7). The presence of a national insurer or a provider-sponsored insurer in the market did not have a statistically significant correlation with premium growth (table 5, scenarios 8 and 9).

Rating areas in states with larger populations had lower rates of premium growth than rating areas in states with smaller populations. For an otherwise average rating area, for example, being in a state with 10 million more people than average was associated with an increase in that region's lowest-cost silver plan premium that is 2.8 percentage points lower than that of an identical rating area in a state with the average population (table 5, scenario 10).

These results, which show smaller increases in lowest-cost silver plan premiums in rating areas with more marketplace participating insurers in 2015, combined with larger increases in the number of marketplace participating insurers in 2016, point to strong effects of competition in the marketplaces. That is, in markets with strong and growing competition, premium increases are held down. Markets with few insurers and those in which competition is diminishing are seeing much greater rates of increase. However, our findings also indicate that the presence of certain types of insurers in a market is associated with lower premium increases than the presence of other types. Medicaid insurers, co-ops, and to a lesser extent provider-sponsored insurers, seem to be associated with lower rates of premium growth than Blue Cross Blue Shield–affiliated insurers, regional or local insurers, and national insurers.

Examples of Market Experiences of Low Premium-Increase States, 2016

We ground the findings in the regression further by looking in detail at 2016 changes in lowest-cost silver plan premiums in seven states with low average rates of increase (California, Texas, Florida, Michigan, Virginia, Ohio, and New York) and seven states with high average rates of increase (Colorado, Minnesota, North Carolina, Arizona, Oklahoma, Tennessee, and West Virginia). Within each of these states, we analyze premium changes in the largest rating areas (including providing detail by insurer), show the average relative change in lowest-cost silver plan premiums across the state's remaining rating areas, and provide a statewide average percentage change in lowest-cost silver plan premiums. Table 6 (low average premium growth states) and table 7 (high average premium growth states) show the change in the lowest-cost silver plan premium between 2015 and 2016, the 2015 premium relative to the national average, and the number of insurers in each rating area. We also provide an average for the rest of the state and the state population. Detailed tables for each of the 14 states are provided as an appendix (tables A.1 through A.14). In each, we present additional detail on the lowest-cost silver plan premiums offered by each insurer participating in the marketplace in each rating area studied.

In general, large urban markets in larger states are experiencing lower rates of increase in their lowest-cost silver plan premiums, reflecting the higher level of competition in those markets. Smaller markets outside the large cities, even in low-growth states, are experiencing higher rates of growth. The data also show that states with higher average rates of growth have fewer competitors.

Table 6. Summary Table of Selected States with Decreases or Low Increases in Lowest-Cost Silver Plan Premium, 2015-16

State	Rating area	2015-16 relative change	Number of 2015 insurers	2015 lowest-cost silver premium relative to national average	State population
California	*State Average*	*1.4%*	*5*	*1.08*	38,333,000
	East Los Angeles	5.4%	6	0.85	
	West Los Angeles	-4.5%	6	0.91	
	San Francisco	-1.1%	5	1.31	
	San Diego	-3.3%	6	1.09	
	Rest of State	2.2%	4	1.16	
Texas	*State Average*	*1.2%*	*8*	*0.92*	26,448,000
	Dallas	-6.7%	7	1.03	
	Austin	15.7%	9	0.84	
	Houston	1.9%	9	0.92	
	San Antonio	0.3%	8	0.82	
	Rest of State	5.0%	7	0.87	
Florida	*State Average*	*2.6%*	*5*	*1.02*	19,553,000
	Miami	-5.6%	7	1.01	
	Ft Lauderdale	10.0%	8	0.89	
	Orlando	4.9%	5	1.06	
	Tampa	-10.4%	5	1.02	
	Rest of State	6.1%	5	1.02	
Michigan	*State Average*	*-1.9%*	*8*	*0.89*	9,896,000
	Detroit	-4.4%	11	0.81	
	North of Detroit	-4.4%	10	0.81	
	Grand Rapids	-5.6%	7	0.81	
	Rest of State	0.8%	6	0.99	
Virginia	*State Average*	*2.7%*	*4*	*1.01*	8,260,000
	Richmond	9.2%	5	0.89	
	DC Suburbs	-0.9%	5	1.01	
	Virginia Beach	5.4%	3	1.01	
	Rest of State	4.9%	3	1.05	

Table 6. Continued

State	Rating area	2015-16 relative change	Number of 2015 insurers	2015 lowest-cost silver premium relative to national average	State population
Ohio	*State Average*	*-1.1%*	*10*	*0.93*	11,571,000
	Cincinnati	3.2%	12	0.86	
	Columbus	10.7%	9	0.90	
	Cleveland	-4.7%	12	0.89	
	Rest of State	-4.5%	9	0.97	
New York	*State Average*	*8.1%*	*9*	*1.27*	19,651,000
	New York City	-1.5%	11	1.37	
	Long Island	0.8%	9	1.40	
	Buffalo	4.3%	6	0.97	
	Rest of State	29.4%	6	1.10	

Table 7. Summary Table of Selected States with Large Increases in Lowest-Cost Silver Plan Premium, 2015-16

State	Rating area	2015-16 relative change	Number of 2015 insurers	2015 lowest-cost silver premium relative to national average	State population
Colorado	*State Average*	*24.8%*	*8*	*0.82*	5,267,000
	Denver	29.0%	10	0.76	
	Colorado Springs	32.2%	7	0.72	
	West	0.0%	4	1.29	
	Rest of State	31.2%	6	0.84	
Minnesota	*State Average*	*25.8%*	*4*	*0.73*	5,420,000
	Rochester	16.8%	2	1.04	
	West of Minneapolis	31.8%	3	0.83	
	Minneapolis	25.5%	4	0.67	
	Rest of State	30.9%	3	0.78	
North Carolina	*State Average*	*20.6%*	*3*	*1.13*	9,848,000
	Charlotte	18.7%	3	1.19	
	Fayetteville	21.1%	3	0.99	
	Raleigh/Durham	25.5%	3	1.08	
	Rest of State	21.8%	3	1.15	
Arizona	*State Average*	*24.4%*	*10*	*0.65*	6,627,000
	Phoenix	23.1%	11	0.61	
	Tucson	20.2%	10	0.63	
	Flagstaff	26.8%	8	0.76	
	Rest of State	30.3%	8	0.79	
Oklahoma	*State Average*	*41.8%*	*3*	*0.74*	3,851,000
	Oklahoma City	40.9%	4	0.74	
	Tulsa	41.4%	4	0.75	
	Rest of State	42.8%	3	0.74	
Tennessee	*State Average*	*38.6%*	*3*	*0.73*	6,496,000
	Knoxville	49.0%	4	0.67	
	Nashville	35.4%	4	0.72	
	Memphis	47.0%	4	0.68	
	Rest of State	33.3%	2	0.80	
West Virginia	*State Average*	*20.5%*	*1*	*1.07*	1,854,000
	Charleston	21.1%	1	1.16	
	Huntington	2.8%	1	1.02	
	Rest of State	23.3%	1	1.07	

Table 6 and tables A.1 through A.7 provide data on seven states with low increases. California had an average rate of increase of 1.4 percent in its lowest-cost silver plan premiums between 2015 and 2016; this was quite low compared to the national average increase of 8.3 percent (table 6). Throughout the state, there was strong competition among Health Net (a regional insurer) Blue Shield, Anthem, and Kaiser (table A.1). A national Medicaid plan, Molina Healthcare, provided strong competition in several California markets. A large local Medicaid plan, L.A. Care, was important in the Los Angeles markets. On balance, 2015 lowest-cost silver plan premiums in California were higher than the national average, although this was not the case in the Los Angeles rating areas (table 6). The California experience is consistent with the regression analysis finding that 2015 premiums that are high relative to the national average are associated with a lower percent increase in premiums in 2016 as well as the finding that larger states tend to have lower rates of increase. The marketplace participation of multiple Medicaid insurers in several regions also likely contributed to low increases.

Texas's statewide average increase in its lowest-cost silver plan premiums was only 1.2 percent between 2015 and 2016 (table 6). All its major urban areas except Austin had very low increases or decreases. The rest of the state, which includes midsize cities and rural areas, had a premium increase of 5.0 percent on average. Texas has several insurance competitors; the average number of insurers per rating area is eight. The state has strong competition from Medicaid plans, both national plans such as Molina and local Medicaid insurers (table A.2). Texas also had active competition from Blue Cross Blue Shield, Scott & White Health Plan (a provider-sponsored insurer) and Oscar (a startup insurer that initially offered coverage only in New York and New Jersey but offers coverage in Oregon, Dallas–Fort Worth and San Antonio starting in 2016). Although most large cities and the rural rating area had small increases or decreases in the number of marketplace insurers and the price of their lowest-cost options, Austin lost three of the nine insurers participating in their 2015 marketplace and had an increase of 15.7 percent in its lowest-cost silver plan premium in 2016.

Florida had a statewide average increase in lowest-cost silver plan premiums of 2.6 percent in 2016 (table 6). The state had many insurers in 2015, particularly in large urban areas. The largest rating area in the state, Miami, had a reduction of 5.6 percent in its lowest-cost silver plan premium, and Tampa had a reduction of 10.4 percent. Coventry Health Care (part of Aetna); Florida Blue, part of the Blue Cross and Blue Shield Association and which offered an HMO product in much of the state; and United Healthcare all participated in several markets (table A.3). Ambetter and Molina, both national Medicaid chains, were also important players in Florida. The state has a large population and had average lowest-cost silver plan premiums slightly above the national average in 2015 ($276 per month versus $264 per month, table 1).

Michigan had many insurers in 2015 and an almost 2 percent decrease in its average lowest-cost silver plan premium in 2016 (table 6). Michigan has strong competition from Humana (a national insurer), a Blue Cross HMO product, Priority Health and Health Alliance Plan (both provider-sponsored insurers), and Molina, a national Medicaid chain (table A.4). Although Michigan's average 2015 lowest-cost silver plan premium was below the national average, a circumstance correlated with higher 2016 premium growth in our data, the large number of competitors in the marketplace and the presence of Medicaid and provider sponsored insurers are associated with the state's relatively low premiums and its average lowest cost silver premium decrease in 2016.

In **Virginia**, the average rate of increase in lowest-cost silver plan premiums across the state was 2.7 percent in 2016 (table 6). In 2015, there were five competitors in the major urban markets (excluding Virginia Beach, which had three) and fewer in the rest of the state. Anthem is the largest insurer in the state and offers an HMO product throughout the state, HealthKeepers, as well as a multistate plan option (table A.5). Innovation, a provider-sponsored insurer operated by the Inova Hospital System, is highly competitive in the Washington, DC, suburbs. Optima, an insurer operated by the Sentara Hospital System, is a low-cost insurer in Virginia Beach and is priced almost the same as Anthem's HealthKeepers lowest-cost silver plan there. Both Anthem HealthKeepers and Coventry are the most price-competitive insurers in Richmond. Kaiser, a provider-sponsored insurer, is very competitive in Richmond and the Washington, DC, markets. The state's premiums were roughly equivalent to the national average in 2015, a correlate of low premium increases in our model as is its relatively large population.

Ohio had a statewide average decrease in lowest-cost silver plan premium in 2016, seemingly associated with its large number of insurers; the state averaged 10 insurers per rating area (table 6). Cincinnati and Cleveland each had 12 insurers and Columbus had nine. CareSource, a regional Medicaid insurer, and national Medicaid chains Molina and Ambetter are strong price competitors in the state and were primarily responsible for keeping rates low (table A.6). Anthem, Aetna, and Humana also competed but are not among the lowest-cost insurers. Premier Health Plan, a provider-sponsored insurer, is price competitive in Cincinnati in 2016.

New York had a statewide average increase of 8.1 percent in its lowest-cost silver plan premiums between 2015 and 2016 (table 6). But the interesting feature of New York is that New York City experienced a drop in its lowest cost silver option (-1.5 percent), there was almost no change in Long Island (0.8 percent), and there was a small increase in Buffalo (4.3 percent), all rating areas where there are a large number of competitors. The participating insurers include several Medicaid insurers in both New York City and Long Island as well as one in Buffalo. Many of those Medicaid insurers had lower rates of premium increase than their competitors (table A.7). New York also has participation by Empire Blue Cross Blue Shield and several national and regional insurers, but those are generally not among the lowest-cost insurers. Northshore LIJ, a provider-sponsored insurer, became the lowest-cost silver plan for 2016 in New York City and Long Island. Oscar, a startup commercial insurer, was also reasonably price competitive in both years in the same rating areas. Outside of the New York City, Long Island, and Buffalo regions, there were fewer insurers (including fewer Medicaid insurer participants), and lowest-cost silver plan premium increases were substantially higher at 29.4 percent on average. Competition from Fidelis, a Medicaid plan, was still associated with modest premium increases in some markets. Health Republic, the state's co-op, had premiums in 2015 priced significantly below the remainder of the market. The subsequent exit of Health Republic significantly contributed to these large increases.

Examples of Market Experiences in High Premium Increase States, 2016

Table 7 provides data on seven states with larger relative premium increases in their lowest-cost silver plans between 2015 and 2016, averaging across rating areas. Some had low 2015 premiums relative to the national average, some lost a low-cost insurer from 2015, and others simply had little competition. All of these market characteristics are associated with higher relative premium increases in our summary regression.

Colorado had a 24.8 percent statewide average increase in its lowest-cost silver plan premiums in 2016 (table 7). Before 2016, Colorado had significant marketplace competition and participation among insurers, with an average of eight insurers participating in the state's marketplace and 10 insurers offering coverage in Denver. However, several insurers left the marketplace for 2016, including the co-op, which left Colorado in its entirety and was the lowest-premium insurer in Denver and Colorado Springs in 2015 (table A.8). In 2016, eight of the state's nine rating areas saw a reduction in the number of insurers offering marketplace nongroup coverage. Plus, in 2015, the average lowest-cost silver plan premiums on the state's marketplace were significantly below the national average (0.82 relative to the national average), with the exception of the western counties (1.29 relative to the national average). The large increases can likely be attributed to the exit of its lowest-cost insurer, the co-op, and possibly to premium re-adjustments to account for setting premium rates too low in the first two years of reform.

Minnesota had a statewide average increase of 25.8 percent from 2015 to 2016 for its lowest-cost silver plan premiums (table 7). In 2014, Minnesota had the lowest premiums in the country, attributable to incredibly low premiums set by PreferredOne, a provider-sponsored insurer (data not shown). After taking substantial losses because of inadequate premiums, PreferredOne left the market in 2015, immediately increasing the lowest-cost silver plan premium for 2015. But Minnesota premiums were still very low in 2015, reflected by the 0.73 index relative to the national average. Blue Cross Blue Shield increased its lowest-cost silver plan premium more than 50 percent, possibly because of disproportionate enrollment of high-risk individuals for which they were not compensated adequately (table A.9). Despite double-digit rate increases themselves, local Medicaid insurers Ucare and Medica have become the lowest-cost insurers in the state's largest markets.

North Carolina had a 2015–16 statewide average increase in the lowest-cost silver plan premium available of 20.6 percent (table 7). North Carolina's marketplace has been a relatively stable insurance market with little change in the number of insurers offering marketplace coverage in the state. However, the number of participating insurers is low compared to states with lower premium growth. North Carolina has no Medicaid insurers participating, nor do they have a co-op or a provider-sponsored insurer (table A.10). The state's Blue Cross Blue Shield plan had relatively high premiums in both 2015 and 2016 compared with the national average, and its lowest-cost silver plan premiums increased over 30 percent in 2016. Its lowest-cost insurers are national carriers (Aetna or United, depending upon the rating area), and they are typically not aggressive marketplace competitors.

Arizona has had an experience somewhat similar to Colorado's in terms of 2015 insurer participation. Of the focal states with high premium growth, Arizona had the largest number of insurers participating in the marketplace in 2015 (table 7). Arizona also had an average lowest-cost silver plan premium substantially below the 2015 national average, 0.65 relative to the national average. These below-average premium prices were present in all the rating areas studied here: Phoenix, Tucson, Flagstaff, and the rest of the state (0.61, 0.63, 0.76, and 0.79 relative to the national average, respectively). Many of the 2015 insurers left the Arizona marketplace in 2016, however, with an average of five insurers leaving the marketplace across

the states' seven rating areas (table A.11). Meritus Health, the state's co-op, was the lowest-cost insurer in much of the state in 2015 and left the state altogether in 2016. The exit of so many insurers combined with the substantially below-average 2015 premiums likely led to the high rate of premium growth in the state from 2015 to 2016.

Oklahoma had the highest state average increase in the lowest-cost silver plan of any state in the country in 2016, 41.8 percent. Few insurers participated in the Oklahoma marketplace in 2015, with four participating in Oklahoma City and Tulsa and only three in the rest of the state (table 7). Blue Cross Blue Shield of Oklahoma was the only insurer to offer coverage statewide. In 2016, three of the insurers, Global Health, CommunityCare, and Assurant, left the market, but United Healthcare entered statewide, though it had significantly higher premiums than Blue Cross Blue Shield (table A.12). Thus, Blue Cross Blue Shield has little price competition statewide in 2016. Similar to the other states with large premium increases, Oklahoma had 2015 lowest-cost silver plan premiums well below the national average, with a statewide average premium index of 0.73. In 2016 only a Blue Cross Blue Shield–affiliated insurer and a national insurer participate in the Oklahoma nongroup marketplace; both types of insurers are correlated with higher premium increases in our regression.

Tennessee had an experience very similar to Oklahoma's, with a statewide average increase in the lowest-cost silver plan premium of 38.6 percent in 2016 (table 7). Insurer marketplace participation was low during plan year 2015; only four insurers participated in the major cities in the state and only two participated statewide following the collapse of the state's co-op earlier in the year. Consistent with expectations based on the regression analysis, Tennessee's premium prices in 2015 were low relative to the national average, with a statewide average index value of 0.73; those low 2015 premiums may have contributed to relatively large premium increases in 2016. Community Health Alliance was the lowest-cost insurer in the state in 2015, but it left the marketplace in 2016 as did Assurant, although the latter was high priced (table A.13). Blue Cross Blue Shield of Tennessee was the second-lowest-priced insurer in 2015, and it increased the premium of its lowest-cost option by 27 to 37 percent in 2016, depending upon the rating area. United Healthcare entered the Tennessee marketplace in 2016 with fairly competitive premiums relative to Blue Cross Blue Shield and Cigna. Thus, Tennessee's marketplace, like Oklahoma's, now relies on Blue Cross Blue Shield–affiliated and national insurers.

West Virginia, unlike many of the states with large 2016 premium increases, had a statewide average lowest-cost silver plan premium slightly above the national average in 2015, with an index value of 1.07 (table 7). West Virginia had only one insurer participating in its marketplace in 2015, Highmark Blue Cross Blue Shield. As shown by the regression analysis, the number of insurers is inversely correlated with premium increases and the price of the lowest-cost option available. In addition, Blue Cross Blue Shield–affiliated insurers are associated with larger premium increases in 2016 than Medicaid insurers and co-ops. It has been difficult for other insurers to enter the state because of Highmark's dominance, and it is difficult for Highmark to negotiate rates in most of the state because of the limited number of providers. In 2016, CareSource, a regional Medicaid insurer, entered some regions in West Virginia. CareSource, although high priced compared with insurers in nearby states, is price competitive with Highmark in the regions it entered.

CONCLUSION

We find that although the national average increase in lowest-cost silver plan premiums between 2015 and 2016 was 8.3 percent, the rates of increase in premiums across the country vary tremendously. Average increases range from -12.1 percent in Indiana to 41.8 percent in Oklahoma. Across the country, about 29.1 percent of the population lives in rating areas that experienced reductions in the lowest-cost silver premium available to them; at the other extreme, 26.3 percent of the population lives in rating areas that experienced increases of more than 15 percent. In large states, such as Michigan, Ohio, Florida, Texas, Virginia, and California, a majority of people live in areas in which the lowest-cost silver plan premiums either fell or increased less than 5 percent in 2016. At the other extreme, 16 states, including North Carolina, Colorado, Arizona, Oklahoma, Tennessee, Minnesota, and West Virginia, have most of their population in areas in which the lowest-cost silver plan premiums increased more than 15 percent between 2015 and 2016.

We show that several factors are associated with these differences. Both large and small increases in lowest-cost silver plan premiums in a rating area sometimes reflect regression to the mean. Rating areas with relatively high 2015 lowest-cost silver plan premiums tended to see smaller increases on average; states with low lowest-cost silver plan premiums in 2015 tended to see larger increases. We find that one of the

most important factors associated with premium levels for the lowest cost silver plan and premium increases between 2015 and 2016 is the amount of competition in the market as measured by the number of insurers. Rating areas with more competitors tend to have lower premiums for their lowest-cost silver plans and lower premium growth; having fewer insurers competing is associated with higher premiums and premium growth. Competition from Medicaid insurers is also correlated with lower premiums and lower rates of premium increase than seen in rating areas without a Medicaid insurer competing; the same is true of co-ops. The presence of provider-sponsored insurers is correlated with lower premiums but is not significantly correlated with lower growth. However, having a national insurer (such as United Healthcare, Aetna, or Cigna) competing in a rating area is not significantly associated with premiums or premium growth. On average, the presence of insurers affiliated with Blue Cross Blue Shield in a market is associated with higher premiums and higher premium growth. In many instances, however, a Blue Cross Blue Shield insurer offers an HMO product that is price competitive.

These findings also support our earlier work indicating that United Healthcare was not driving price competition in most marketplaces, and that therefore the insurers' announcement that it intends to leave several marketplace nongroup markets should not cause substantial disruption.[4] United Healthcare does participate in some markets in which there are few other insurers, and its departure from these markets could be problematic.

The results of this analysis indicate that, where markets are competitive, premium levels and premium increases tend to be lower. This most often occurs in large states and in urban markets. Such markets typically have several insurers, and they also often have intense competition from insurers that provided coverage only through Medicaid (or Medicaid and Medicare) before 2014, Blue Cross Blue Shield–affiliated insurers offering health maintenance organization products, or provider-sponsored insurers. One consequence of this successful price competition is the growth in insurers using more-limited provider networks. Limited networks could create barriers to access to needed care, particularly for specialists, and the adequacy of these networks bear monitoring and evaluation.

But many markets in the nation are not seeing significant insurer competition, and premium increases are higher in those areas. Such areas have too few insurers or new insurers who have entered the area are having a difficult time competing with an established insurer, such as one affiliated with Blue Cross Blue Shield, that dominates the market. In some markets, even dominant insurers have a difficult time negotiating rates with a limited supply of providers. Thus, the managed competition approach, an essential feature of the ACA, is having success in many but not all markets. If the degree of insurer competition does not increase naturally or if provider consolidation or limited supply means insurers have little ability to negotiate payment rates, other options can be considered to control premium increases. These could include the adoption of a public option in less-competitive markets or public regulation of both insurer and provider payment rates. However, such interventions could focus on the rating areas where premium levels and premium growth rates are problematic; the many areas where the ACA's design has already engendered market price competition can be left alone.

Meanwhile, as has happened in the first three open enrollment periods, some have begun to predict widespread, large premium increases for marketplace plans in 2017.[5] These predictions are being fed by insurer reports of adverse selection into the nongroup insurance market, concerns that the current risk-adjustment methodology may be inadequate, and the planned end of the federal reinsurance and risk corridor programs. Insurers that are still priced too low in 2016 may increase premiums in 2017 to avoid losses. However, several factors will soon arise that should contribute to improved risk pools and hence lower premium increases. First, the size of the individual mandate penalties increased to their permanent and highest level for 2016, and the penalty's full effect will be felt by those remaining uninsured in early 2017 when they file their 2016 tax returns. This could increase marketplace enrollment with individuals who are healthier on average and who have been more resistant to purchasing coverage in the early years of reform. Second, "grandmothered" and "grandfathered" plans, which have kept some healthier nongroup insurance enrollees out of ACA-compliant markets and risk pools in some areas, will continue to decrease in size, and the grandmothered plans will be eliminated by the end of 2017.[6] Many enrollees currently in these plans will enroll in ACA-compliant coverage once their current coverage options are gone, a shift that should improve the average health care risk of those in the ACA-compliant plans. Finally, as the first few years of the reforms have demonstrated, the incentives for insurers to offer lower-cost plans in the marketplaces are strong, and large premium increases will tend to decrease enrollment in a given plan as many consumers are willing to change plans to save money. These competitive pressures, present in many markets and for large swaths of the population, tend to keep premium increases in check. So although increases will undoubtedly be substantial in some areas with weaker competition, the experience will vary considerably across the country with no overall average able to meaningfully describe the dynamics of marketplace premiums.

APPENDIX

Table A.1: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], California

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 15: East Los Angeles				
Anthem	Blue	$257	$274	6.5%
Blue Shield	Blue	$270	$245	-9.3%
Health Net	Regional	$230	$243	5.4%
Kaiser Permanente	Provider	$287	$298	3.9%
L.A. Care	Regional	$265	$254	-4.3%
Molina Healthcare	Medicaid	$259	$253	-2.3%
Percentage change in region's lowest-premium option				**5.4%**
Rating Area 16: West Los Angeles				
Anthem	Blue	$270	$278	2.9%
Blue Shield	Blue	$308	$318	3.4%
Health Net	Regional	$247	$255	3.4%
Kaiser Permanente	Provider	$300	$312	3.9%
L.A. Care	Regional	$278	$266	-4.3%
Molina Healthcare	Medicaid	$259	$236	-9.2%
Oscar	Regional	N/A	$298	N/A
Percentage change in region's lowest-premium option				**-4.5%**
Rating Area 4: San Francisco				
Anthem	Blue	$414	$455	9.9%
Blue Shield	Blue	$401	$388	-3.2%
CCHP	Regional	$356	$352	-1.1%
Health Net	Regional	$449	$438	-2.4%
Kaiser Permanente	Provider	$393	$413	5.0%
Percentage change in region's lowest-premium option				**-1.1%**

Table A.1: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 19: San Diego				
Anthem	Blue	$333	$361	8.5%
Blue Shield	Blue	$343	$342	-0.2%
Health Net	Regional	$295	$296	0.2%
Kaiser Permanente	Provider	$314	$329	4.8%
Sharp	Provider	$329	$344	4.7%
Molina Healthcare	Medicaid	$314	$286	-9.1%
Percentage change in region's lowest-premium option				**-3.3%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***2.2%***
Percentage change in lowest-cost premium state average[b]				***1.4%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.2: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Texas

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 8: Dallas/Fortworth				
Molina Healthcare of Texas	Medicaid	$280	$260	-7.1%
Oscar Insurance Company of Texas	Regional	N/A	$320	N/A
Blue Cross Blue Shield of Texas	Blue	$279	$334	19.6%
Insurance Company of Scott & White	Provider	$292	$340	16.4%
Aetna Life Insurance Company	National	$361	$362	0.1%
Cigna Health and Life Insurance Company	National	$364	$368	1.1%
Assurant Health	National	$475	N/A	N/A
United Healthcare	National	$290	N/A	N/A
Percentage change in region's lowest-premium option				**-6.7%**
Rating Area 3: Austin				
Humana Health Plan of Texas, Inc.	National	$229	$280	22.4%
Ambetter	Medicaid	$260	$264	N/A
Assurant Health	National	$388	N/A	N/A
Cigna HealthCare of Texas, Inc.	National	$338	N/A	N/A
Insurance Company of Scott & White	Provider	$250	$290	16.1%
Blue Cross Blue Shield of Texas	Blue	$261	$309	18.3%
Sendero Health Plans	Medicaid	$241	N/A	N/A
United Healthcare	National	$258	$291	12.7%
Aetna Life Insurance Company	National	$296	$338	14.0%
Percentage change in region's lowest-premium option				**15.7%**
Rating Area 10: Houston				
Molina Healthcare of Texas	Medicaid	$268	$253	-5.6%
Community Health Choice, Inc.	Medicaid	$248	$261	5.1%
Insurance Company of Scott & White	Provider	$250	$290	16.1%
Blue Cross Blue Shield of Texas	Blue	$250	$292	16.8%
Cigna HealthCare of Texas, Inc.	National	$339	$311	-8.3%
Aetna Life Insurance Company	National	$327	$328	0.1%
Assurant Health	National	$432	N/A	N/A
United Healthcare	National	$264	N/A	N/A
Humana Health Plan of Texas, Inc.	National	$294	$375	27.6%
Percentage change in region's lowest-premium option				**1.9%**

Table A.2: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 19: San Antonio				
Oscar Insurance Company of Texas	Regional	N/A	$224	N/A
Celtic Insurance Company	Medicaid	$233	$236	1.6%
Community First Health Plans, Inc.	Medicaid	$239	$245	2.5%
All Savers Insurance Company	National	$244	$260	6.5%
Humana Health Plan of Texas, Inc.	National	$223	$280	25.3%
Allegian Insurance Company	Regional	$271	$281	3.7%
Blue Cross Blue Shield of Texas	Blue	$254	$301	18.2%
Assurant Health	National	$307	N/A	N/A
Aetna Life Insurance Company	National	$273	$316	16.0%
Percentage change in region's lowest-premium option				**0.3%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***5.0%***
Percentage change in lowest-cost premium state average[b]				***1.2%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.3: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Florida

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 43: Miami				
Ambetter	Medicaid	$274	$258	-5.6%
Coventry	National	$309	$301	-2.6%
Florida Blue (BCBS of Florida)	Blue	$362	$347	-4.1%
Florida Blue HMO	Blue	$430	$307	-28.6%
Humana	National	$301	$362	20.3%
Molina	Medicaid	$274	$274	0.0%
United Healthcare Assurant	National	N/A	$366	N/A
	National	$397	N/A	N/A
Cigna	National	$419	N/A	N/A
Percentage change in region's lowest-premium option				**-5.6%**
Rating Area 6: Ft. Lauderdale				
Coventry	National	$241	$265	10.0%
Ambetter	Medicaid	$293	$277	-5.5%
Florida Blue	Blue	$363	$342	-5.8%
Florida Blue HMO	Blue	$388	$279	-28.1%
Molina	Medicaid	$287	$288	0.3%
Humana	National	$272	$299	9.9%
Assurant	National	$397	N/A	N/A
Cigna	National	$377	N/A	N/A
United Healthcare	National	$308	$338	9.7%
Percentage change in region's lowest-premium option				**10.0%**
Rating Area 48: Orlando				
Florida Blue (BCBS of Florida)	Blue	$312	$312	0.0%
Florida Blue HMO	Blue	$374	$302	-19.3%
Humana	National	$288	$336	16.7%
Cigna	National	$374	N/A	N/A
Assurant	National	$348	N/A	N/A
United Healthcare	National	$298	$355	19.1%
Percentage change in region's lowest-premium option				**4.9%**

Table A.3: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 28: Tampa				
Ambetter	Medicaid	N/A	$247	N/A
Florida Blue (BCBS of Florida)	Blue	$275	$275	0.0%
Florida Blue HMO	Blue	$345	$287	-16.8%
Humana	National	$275	$306	11.1%
Assurant	National	$327	N/A	N/A
United Healthcare	National	$292	$348	19.2%
Cigna	National	$369	N/A	N/A
Percentage change in region's lowest-premium option				**-10.4%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***6.1%***
Percentage change in lowest-cost premium state average[b]				***2.6%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.4: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Michigan

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 1: Detroit				
Humana Medical Plan of Michigan, Inc.	National	$219	$209	-4.4%
Total Health Care USA, Inc.	Regional	$243	$250	2.8%
Blue Care Network of Michigan	Blue	$234	$236	0.6%
McLaren Health Plan, Inc.	Provider	$309	$324	4.9%
Health Alliance Plan (HAP)	Provider	$266	$260	-2.3%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$301	$332	10.2%
Priority Health	Provider	$285	$246	-13.8%
Molina	Medicaid	$252	$229	-8.8%
Alliance Health and Life	Provider	$338	$335	-0.9%
Consumers Mutual Insurance of Michigan	Co-op	$348	N/A	N/A
Assurant	National	$334	N/A	N/A
UnitedHealthcare	National	$230	$262	14.1%
Percentage change in region's lowest-premium option				**-4.4%**
Rating Area 2: North of Detroit				
Blue Care Network of Michigan	Blue	$244	$236	-3.3%
McLaren Health Plan, Inc.	Provider	$309	$324	4.9%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$301	$331	10.1%
Priority Health	Provider	$286	$246	-14.0%
Alliance Life and Health	Provider	N/A	$334	N/A
Health Alliance Plan	Provider	$264	$258	-2.3%
Humana Insurance Company	National	$221	$211	-4.4%
Molina	Medicaid	$252	$229	-8.8%
Total Health Care	Regional	$243	$250	2.8%
United Health Care	National	$248	$253	1.7%
Assurant	National	$347	N/A	N/A
Consumers Mutual Insurance of Michigan	Co-op	$348	N/A	N/A
Percentage change in region's lowest-premium option				**-4.4%**

Table A.4: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 12: Grand Rapids				
Blue Care Network of Michigan	Blue	$219	$226	3.6%
McLaren Health Plan, Inc.	Provider	$274	$287	4.9%
Priority Health	Provider	$273	$235	-14.0%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$326	$378	15.9%
Consumers Mutual Insurance of Michigan	Co-op	$274	N/A	N/A
Humana Insurance Company	National	$232	$206	-10.9%
Assurant	National	$328	N/A	N/A
Physician's Health Plan	Provider	$356	$348	-2.3%
Percentage change in region's lowest-premium option				**-5.6**
Percentage change in lowest-cost premium, rest-of-state average[b]				***0.8%***
Percentage change in lowest-cost premium state average[b]				***-1.9%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.5: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Virginia

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 7: Richmond				
Aetna	National	$312	$335	7.4%
Anthem (MSP)	Blue	$280	$295	5.4%
Anthem HealthKeepers	Blue	$264	$276	4.7%
CoventryOne	National	$241	$264	9.2%
Kaiser Permanente	Provider	$273	$384	3.9%
Optima Health	Provider	$372	$382	2.5%
United Healthcare	National	N/A	$280	N/A
Piedmont Community Health Care	Provider	$324	$305	-5.6%
Percentage change in region's lowest-premium option				**9.2%**
Rating Area 10: Washington D.C. suburbs				
Anthem (MSP)	Blue	$309	$323	4.4%
Anthem HealthKeepers	Blue	$292	$303	3.8%
CareFirst BlueChoice, Inc.	Blue	$323	$356	10.1%
CareFirst (MSP)	Blue	N/A	$413	N/A
Innovation Health Insurance Company	Provider	$282	$270	-4.1%
Kaiser Permanente	Provider	$273	$284	3.9%
United Healthcare	National	N/A	$288	N/A
Optima Health	Provider	$355	$389	9.4%
Percentage change in region's lowest-premium option				**-0.9%**
Rating Area 9: Virginia Beach, Norfolk				
Aetna	National	$305	$333	9.3%
Anthem (MSP)	Blue	$304	$321	5.4%
Anthem Health Keepers	Blue	$287	$301	4.8%
Optima Health	Provider	$285	$308	7.9%
Percentage change in region's lowest-premium option				**5.4%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***4.9%***
Percentage change in lowest-cost premium state average[b]				***2.7%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.6: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Ohio

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 4: Cincinnati				
CareSource	Medicaid	$232	$243	4.6%
Ambetter from Buckeye Health Plan	Medicaid	$236	$240	1.5%
Humana, Inc.	National	$253	$295	16.9%
Premier Health Plan	Provider	$257	$247	-3.6%
HealthSpan	Regional	$268	$343	28.0%
Molina Marketplace	Medicaid	$281	$244	-12.9%
Aetna	National	$298	$340	14.0%
InHealth Mutual	Co-op	$300	$344	14.4%
Anthem Blue Cross and Blue Shield	Blue	$319	$304	-4.7%
UnitedHealthcare	National	$326	$330	1.1%
MedMutual	Regional	$353	$367	4.1%
Assurant Health	National	$478	N/A	N/A
Percentage change in region's lowest-premium option				**3.2%**
Rating Area 9: Columbus				
CareSource	Medicaid	$244	$270	10.7%
Molina Marketplace	Medicaid	$281	$274	-2.3%
Paramount Insurance Company	Medicaid	$282	$312	10.7%
Aetna	National	$303	$337	11.0%
InHealth Mutual	Co-op	$307	$351	14.4%
Anthem Blue Cross and Blue Shield	Blue	$342	$317	-7.3%
MedMutual	Regional	$352	$396	12.6%
UnitedHealthcare	National	$366	$304	-17.1%
Assurant Health	National	$435	N/A	N/A
HealthSpan	Regional	N/A	$421	N/A
Percentage change in region's lowest-premium option				**10.7%**

Table A.6: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 11: Cleveland				
Ambetter from Buckeye Health Plan	Medicaid	$242	$230	-4.7%
CareSource	Medicaid	$252	$252	-0.2%
HealthSpan Integrated Care	Regional	$268	$319	19.4%
Molina Marketplace	Medicaid	$278	$265	-4.7%
Aetna	National	$283	$333	17.9%
MedMutual	Regional	$301	$339	12.6%
Paramount Insurance Company	Medicaid	$302	$334	10.7%
UnitedHealthcare	National	$322	$314	-2.5%
InHealth Mutual	Co-op	$326	$372	14.3%
Anthem Blue Cross and Blue Shield	Blue	$346	$317	-8.2%
SummaCare Inc	Provider	$373	$372	-0.3%
Assurant Health	National	$488	N/A	N/A
Humana, Inc.	National	N/A	$315	N/A
Percentage change in region's lowest-premium option				**-4.7%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***-4.5%***
Percentage change in lowest-cost premium state average[b]				***-1.1%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.7: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], New York

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 4: New York City				
Metro Plus	Medicaid	$383	$422	10.3%
Health Republic Insurance	Co-op	$380	N/A	N/A
Oscar	Regional	$394	$430	9.0%
Emblem	Regional	$407	$463	13.7%
New York Fidelis	Medicaid	$384	$408	6.4%
Empire BCBS	Blue	$448	$513	14.5%
Northshore LIJ	Provider	$394	$366	-7.1%
Healthfirst	Medicaid	$387	$435	12.3%
Affinity - All Standard Benefits	Medicaid	$372	$395	6.3%
United Healthcare of NY	National	$545	$667	22.4%
Wellcare HMO	Medicaid	$472	$486	3.0%
Percentage change in region's lowest-premium option				**-1.5%**
Rating Area 8: Long Island				
Health Republic Insurance	Co-op	$380	N/A	N/A
Affinity	Medicaid	$380	$403	6.1%
Emblem HIP	Regional	$407	$527	29.4%
Empire HMO	Blue	$448	$472	5.3%
Fidelis	Medicaid	$384	$395	3.0%
Health First	Medicaid	$387	$435	12.3%
North Shore LIJ	Provider	$394	$383	-2.8%
Oscar	Regional	$394	$430	9.0%
United Healthcare of NY	National	$545	$667	22.4%
Percentage change in region's lowest-premium option				**0.8%**
Rating Area 2: Buffalo				
New York Fidelis	Medicaid	$337	$353	4.7%
Univera (An Excellus Company)	Blue	$474	$514	8.3%
Health Republic Insurance	Co-op	$342	N/A	N/A
IHBC	Provider	$428	$374	-12.7%
MVP Health	Regional	$365	$389	6.5%
Blue Cross Blue Shield of Western NY	Blue	$342	$352	2.9%
Percentage change in region's lowest-premium option				**4.3%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***29.4%***
Percentage change in lowest-cost premium state average[b]				***8.1%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.8: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Colorado

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 3: Denver				
Kaiser Permanente	Provider	$240	$266	17.8%
Humana	National	$244	$278	13.7%
Colorado Health OP	Co-op	$207	N/A	N/A
Denver Health Medical Plan	Provider	$318	$363	13.8%
Colorado Choice Health Plan	Regional	$308	$287	-6.8%
Rocky Mountain Health Plans	Regional	$345	$459	33.2%
Cigna	National	$339	$296	-12.4%
HMO Colorado (Anthem)	Blue	$316	$402	27.0%
All Savers	National	$349	$331	-5.1%
New Health Ventures (Access Health Colorado)	Regional	$274	N/A	N/A
United Healthcare of CO	National	N/A	$319	N/A
Percentage change in region's lowest-premium option				**29.0%**
Rating Area 2: Colorado Springs				
Humana	National	$233	$267	15.0%
Colorado Choice Health Plan	Regional	$276	$257	-7.0%
Kaiser Permanente	Provider	$257	$259	1.0%
Rocky Mountain Health Plans	Regional	$312	$451	45.0%
HMO Colorado (Anthem)	Blue	$296	$320	8.0%
Colorado Health Op	Co-op	$194	N/A	N/A
New Health Ventures (Access Health Colorado)	Regional	$251	N/A	N/A
Percentage change in region's lowest-premium option				**32.2%**
Rating Area 9: Western Counties				
HMO Colorado (Anthem)	Blue	N/A	$446	N/A
United Healthcare of CO	National	N/A	$529	N/A
Rocky Mountain Health Plans	Regional	N/A	$452	N/A
Cigna	National	N/A	$446	N/A
Kaiser Permanente	Provider	N/A	$346	N/A
Percentage change in region's lowest-premium option				**0.0%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***31.2%***
Percentage change in lowest-cost premium state average[b]				***24.8%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

N/A: Data not Available

Table A.9: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Minnesota

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 1: Rochester				
Medica	Medicaid	$282	$329	16.8%
BCBS Minnesota	Blue	$283	$445	57.5%
BCBS Minnesota (MSP)	Blue	$351	$502	42.9%
Blue Plus	Blue	N/A	$422	N/A
Percentage change in region's lowest-premium option				**16.8%**
Rating Area 8: Minneapolis, St. Paul, Bloomington				
HealthPartners	Regional	$181	$235	29.8%
BCBS Minnesota	Blue	$201	$321	59.8%
Ucare	Medicaid	$183	$228	24.4%
Medica	Medicaid	$222	$254	14.2%
BCBS Minnesota (MSP)	Blue	$249	$361	45.1%
Blue Plus	Blue	$205	$300	46.4%
Percentage change in region's lowest-premium option				**25.5%**
Rating Area 7: West of Minneapolis				
HealthPartners	Regional	N/A	$260	N/A
BCBS Minnesota	Blue	N/A	$358	N/A
Ucare	Medicaid	N/A	$252	N/A
Medica	Medicaid	N/A	$270	N/A
BCBS Minnesota (MSP)	Blue	N/A	$403	N/A
Blue Plus	Blue	N/A	$286	N/A
Percentage change in region's lowest-premium option				**31.8%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***30.9%***
Percentage change in lowest-cost premium state average[b]				***25.8%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

N/A: Data not Available

Table A.10: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], North Carolina

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 4: Charlotte				
Aetna Health Inc.	National	$317	$376	18.7%
Blue Cross and Blue Shield of NC	Blue	$328	$452	37.7%
UnitedHealthcare of North Carolina, Inc	National	$340	$409	20.3%
Percentage change in region's lowest-premium option				**18.7%**
Rating Area 9: Fayetteville				
Aetna Health Inc.	National	$339	$446	31.7%
Blue Cross and Blue Shield of NC	Blue	$362	$472	30.4%
UnitedHealthcare of North Carolina, Inc	National	$267	$324	21.1%
Percentage change in region's lowest-premium option				**21.1%**
Rating Area 13: Raleigh/Durham				
Aetna Health Inc.	National	$282	$358	27.0%
Blue Cross and Blue Shield of NC	Blue	$293	$392	33.9%
UnitedHealthcare of North Carolina, Inc	National	$305	$354	15.8%
Percentage change in region's lowest-premium option				**25.5%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***21.8%***
Percentage change in lowest-cost premium state average[b]				***20.6%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.11: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Arizona

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 4: Phoenix				
Aetna	National	$257	$277	7.6%
All Savers	National	$262	$249	-5.0%
Blue Cross Blue Shield of Arizona, Inc.	Blue	$240	$269	11.8%
Health Choice Insurance Co.	Medicaid	$195	$207	6.2%
Health Net of Arizona, Inc.	Regional	$222	$276	24.3%
Humana Health Plan, Inc.	National	$265	$269	1.4%
Cigna	National	$350	$259	-25.9%
Meritus	Co-op	$166	N/A	N/A
University of Arizona	Provider	$202	N/A	N/A
Assurant	National	$314	N/A	N/A
Phoenix Health Plans, Inc.	Medicaid	$252	$204	-19.0%
Percentage change in region's lowest-premium option				**23.1%**
Rating Area 6: Tucson				
All Savers	National	$217	$208	-4.1%
Blue Cross Blue Shield of Arizona, Inc.	Blue	$200	$229	14.6%
Meritus	Co-op	$170	$204	20.2%
University of Arizona	Provider	$189	N/A	N/A
Aetna	National	$221	N/A	N/A
Health Choice Insurance Co.	Medicaid	$232	$256	10.5%
Health Net of Arizona, Inc.	Regional	$191	$237	24.3%
Cigna	National	$290	N/A	N/A
Assurant	National	$313	N/A	N/A
Humana Health Plan, Inc.	National	$238	$247	3.7%
Percentage change in region's lowest-premium option				**20.2%**

Table A.11: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 1: Flagstaff				
All Savers Insurance Company	National	$424	$409	-3.4%
Blue Cross Blue Shield of Arizona, Inc.	Blue	$334	$380	14.0%
Health Choice Insurance Co.	Medicaid	$309	$325	5.2%
Meritus	Co-op	$206	$262	26.8%
Health Net of Arizona, Inc.	Regional	$295	N/A	N/A
Assurant	National	$399	N/A	N/A
Cigna	National	$470	N/A	N/A
Aetna	National	$355	N/A	N/A
Percentage change in region's lowest-premium option				**26.8%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***30.3%***
Percentage change in lowest-cost premium state average[b]				***24.4%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.12: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Oklahoma

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 3: Oklahoma City				
Blue Cross Blue Shield of Oklahoma	Blue	$201	$283	40.9%
UntiedHealthcare of Oklahoma, Inc.	National	N/A	$334	N/A
GobalHealth	Regional	$270	N/A	N/A
Assurant	National	$276	N/A	N/A
ComunityCare	Regional	$269	N/A	N/A
Percentage change in region's lowest-premium option				**40.9%**
Rating Area 4: Tulsa				
Blue Cross Blue Shield of Oklahoma	Blue	$204	$289	41.4%
UnitedHealthcare of Oklahoma, Inc.	National	N/A	$334	N/A
GlobalHealth	Regional	$265	N/A	N/A
Assurant	National	$340	N/A	N/A
ComunityCare	Regional	$269	N/A	N/A
Percentage change in region's lowest-premium option				**41.4%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***42.8%***
Percentage change in lowest-cost premium state average[b]				***41.8%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.13: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Tennessee

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 2: Knoxville				
Blue Cross Blue Shield of Tennessee	Blue	$210	$288	37.3%
Humana Insurance Company	National	$241	$292	21.2%
Assurant Health	National	$355	N/A	N/A
Community Health Alliance	Co-op	$181	N/A	N/A
United	National	N/A	$270	N/A
Percentage change in region's lowest-premium option				**49.0%**
Rating Area 4: Nashville, Clarksville				
Blue Cross Blue Shield of Tennessee	Blue	$220	$288	30.7%
Humana Insurance Company	National	$292	$350	20.2%
Cigna Health and Life Insurance Company	National	$301	$262	-12.9%
Community Health Alliance	Co-op	$194	N/A	N/A
United	National	N/A	$303	N/A
Percentage change in region's lowest-premium option				**35.4%**
Rating Area 6: Memphis				
Blue Cross Blue Shield of Tennessee	Blue	$214	$271	26.8%
Humana Insurance Company	National	$240	$288	20.2%
Cigna Health and Life Insurance Company	National	$298	$324	8.8%
Community Health Alliance	Co-op	$184	N/A	N/A
United	National	N/A	$291	N/A
Percentage change in region's lowest-premium option				**47.0%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***33.3%***
Percentage change in lowest-cost premium state average[b]				***38.6%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.14: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], West Virginia

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 2: Charleston				
Highmark Blue Cross Blue Shield (MSP)[2]	Blue	$314	N/A	N/A
Highmakr Blue Cross Blue Shield West Virginia	Blue	$314	$388	23.5%
CareSource	Medicaid	N/A	$381	N/A
Percentage change in region's lowest-premium option				**21.1%**
Rating Area 5: Huntington				
Highmark Blue Cross Blue Shield (MSP)[2]	Blue	$277	N/A	N/A
Highmakr Blue Cross Blue Shield West Virginia	Blue	$277	$342	23.5%
CareSource	Medicaid	N/A	$284	N?A
Percentage change in region's lowest-premium option				**2.8%**
Percentage change in lowest-cost premium, rest-of-state average[b]				***23.3%***
Percentage change in lowest-cost premium state average[b]				***20.5%***

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

ENDNOTES

1. Hilgemann L. Obamacare premiums are on the rise, but don't blame insurers. *Forbes*. December 8, 2015. http://www.forbes.com/sites/realspin/2015/12/08/obamacare-premiums-are-on-the-rise-but-dont-blame-insurers/#3bf2ad028d5e. Accessed May 12, 2016. Brinkley-Badgett C. Obamacare premiums will increase in 2016, but by how much? *Fox Business*. December 22, 2015. http://www.foxbusiness.com/features/2015/12/22/obamacare-premiums-will-increase-in-2016-but-by-how-much.html. Accessed May 12, 2016.
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Strengthening the Marketplace – Actions to Improve the Risk Pool

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Strengthening the Marketplace – Actions to Improve the Risk Pool

With millions of Americans insured through the Health Insurance Marketplaces, it's clear that Marketplace coverage is a product consumers want and need and an important business for insurers, with several major issuers expanding their Marketplace presence. At the Department of Health and Human Services (HHS), we are constantly monitoring the health of the Marketplace and are always looking to make improvements that benefit both consumers and issuers. Over the past several months, HHS has taken a series of actions to strengthen the Marketplace risk pool, limit upward pressure on rates, and ensure a strong Marketplace for the long term. We believe those actions are bringing positive results. As part of our continued commitment to the long-term strength of the Marketplace, we are announcing new measures to ensure that the Marketplace continues to provide affordable coverage for millions of Americans.

During the month of June, HHS will make three announcements regarding our ongoing efforts to: strengthen the risk pool by spreading the costs of care over a diverse mix of enrollees, work with issuers and state Departments of Insurance to improve coverage options, and step up Marketplace outreach, especially to young adults and uninsured families in advance of Open Enrollment 4.

Today, HHS is announcing a series of actions to strengthen the Marketplace risk pool. These actions include:

- Curbing abuses of short-term plans that exploit gaps in current rules to use medical underwriting to keep some of the healthiest consumers out of the Affordable Care Act's single risk pool.
- Improving the risk adjustment program to more accurately reflect the cost of partial-year enrollees and to incorporate prescription drug utilization data that provide a more complete picture of enrollees' health status. These improvements will ensure that the program continues to work as intended to compensate issuers with higher-risk enrollees and thereby help issuers sustainably serve all types of consumers.
- Helping consumers who turn 65 make the transition to Medicare, so that older consumers are served by the program designed for them and their health needs.
- Beginning full implementation of the Special Enrollment Confirmation Process, which ensures that eligible individuals continue to have access to coverage through Special Enrollment Periods (SEPs), but prevents people from misusing the system to enroll in coverage only if they get sick.
- Continuing our efforts to reduce data-matching issues (DMIs). CMS outreach, education, and operational improvements have contributed to a sharp reduction in total data matching issues generated and an almost 40 percent year-over-year increase in documents submitted to help resolve income and citizenship and immigration data matching issues. Improving the resolution of DMIs benefits the risk pool because it keeps eligible consumers, often younger and healthier consumers less motivated to overcome obstacles such as extra paperwork, from losing coverage mid-year.

Risk Pool Actions

Curbing Abuse of Short-Term Limited Duration Plans

Short-term limited duration coverage is health care coverage issued for a short period of time. Because short-term limited duration plans are designed to fill only very short coverage gaps, this coverage is not subject to any of the key rules governing the ACA's single risk pool: they can be priced based on health status (medically underwritten), can discriminate against consumers with pre-existing conditions, and do not have to cover essential health benefits. Some issuers are now offering short-term limited duration plans to consumers as their primary form of health coverage for periods that last nearly 12 months, allowing them to target only the healthiest consumers while avoiding consumer protections. As highlighted in recent press accounts, by keeping these consumers out of the ACA single risk pool, such abuses of limited duration coverage increase costs for everyone else, and they could have a greater impact over time if allowed to become more widespread.

Today, the Department of Labor, Department of Treasury, and Department of Health and Human Services (HHS) issued a proposed rule to revise the definition of short-term, limited duration coverage. Under the new rules, short-term policies may be offered only for less than three months, and coverage cannot be renewed at the end of the three month period. The proposed rule also improves transparency for consumers by requiring issuers to provide notice to

consumers that the coverage is not minimum essential coverage, does not satisfy the health coverage requirement of the ACA, and will not prevent the consumer from owing a tax penalty. The proposed changes will help strengthen the risk pool by ensuring that short term limited duration plans are used only as intended, to fill truly temporary gaps in coverage.

Maturing the Risk Adjustment Program

By reducing incentives for issuers to try to design products that attract a disproportionately healthy risk pool, risk adjustment lets them design products that meet the needs of all consumers, protecting consumers' access to a range of robust options. Updating risk adjustment to more accurately assess every enrollee's risk makes it more effective in achieving this goal. Earlier this year, CMS made a number of changes to improve the stability, predictability, and accuracy of the risk adjustment program for issuers. These changes include better modeling of costs for preventive services, changes to the data update schedule, and earlier reporting of preliminary risk adjustment data where available. We also published a Risk Adjustment White Paper and hosted a conference on March 31, 2016 to solicit feedback from issuers, consumers, and other stakeholders on additional areas for improvement.

Building off the Risk Adjustment White Paper and stakeholder feedback, today we are announcing two additional important changes to risk adjustment that we intend to propose in future rulemaking. First, we intend to propose that, beginning for the 2017 benefit year, the risk adjustment model include an adjustment factor for partial-year enrollees. By more accurately accounting for the costs of short term enrollees in ACA-compliant risk pool, this change will support the Marketplace's important role as a source of coverage for people who are between jobs, experiencing life transitions, or otherwise need coverage for part of the year. Second, we intend to propose that, beginning for the 2018 benefit year, prescription drug utilization data be incorporated in risk adjustment, as a source of information about individuals' health status and the severity of their conditions. We are also considering proposing additional changes to the model for 2018 and beyond.

Transitioning Consumers to Medicare

The Marketplace serves as an essential backstop for consumers as they transition between different types of coverage over their lifetime. For example, many early retirees access Marketplace coverage until they become eligible for Medicare when they turn 65. But once individuals turn 65, most people should end their Marketplace coverage and switch to Medicare. In fact, if consumers do not enroll in Medicare Part B when they turn 65, they could face financial consequences for years into the future, because they could owe higher Medicare premiums. Meanwhile, the Marketplace is intended to serve consumers who are not Medicare eligible, and continued enrollment by individuals who are eligible for Medicare can raise costs for other consumers.

To make sure consumers understand the steps they need to take to move to Medicare, this summer the Marketplace will start contacting enrollees as they near their 65th birthday. This outreach will provide consumers with the information they need to enroll in Medicare if they are eligible and end their Marketplace coverage if they choose to. This builds off the changes we made to the HealthCare.gov application this year which included new pop ups with reminders for consumers who are about to turn 65 that they may be eligible for Medicare.

Implementing the Special Enrollment Confirmation Process

Over the last several months, the Marketplace has taken a number of steps to ensure that Special Enrollment Periods (SEPs) are there for consumers when they need them while avoiding misuse or abuse. We've strengthened our rules and clarified our processes for SEPs, so that the people who need to can still easily get coverage, while making it hard for anyone thinking about taking advantage. We also eliminated 7 SEPs, including the SEP for individuals who paid the tax penalty for not having health insurance, contributing to an almost 30 percent year-over-year drop in the number of SEP enrollments during the three months after Open Enrollment.

Continuing that work, today we are announcing that, consistent with the process we announced in February, starting June 17 individuals enrolling in coverage through Special Enrollment Periods will be asked to provide certain documents. We are also providing models of the eligibility notices that consumers will receive with the list of documents that people enrolling through a Special Enrollment Period will need to prove their eligibility for their SEP. Consumers should provide the appropriate documents by the deadline listed in their notice to confirm eligibility for a Special Enrollment Period to avoid any disruptions to their coverage.

Reducing the Impact of Data Matching Issues

CMS takes very seriously its obligation to ensure that access to coverage and financial assistance are limited to those individuals who are indeed eligible. The Marketplace verifies eligibility for most consumers through electronic trusted data sources, but if consumers' data cannot be matched electronically we generate a data matching issue to request additional information from enrollees. Consumers who do not provide the necessary information will have their coverage or financial assistance ended or modified.

Unfortunately, eligible individuals sometimes lose coverage or financial assistance through the Marketplace during the year because they have trouble finding documents or navigating the data matching process. In addition to the direct impact on consumers, avoidable terminations due to data-matching issues also negatively impact the risk pool, since younger, healthier individuals appear to be less likely to persevere through the data matching process. In fact, in 2015, younger open enrollment consumers who experienced a data matching issue were about a quarter less likely to resolve their problem than older consumers.

This year, CMS made a range of improvements to the data matching process to help consumers avoid generating data matching issues in the first place and to help them resolve these issues once generated. More recently, we have also

intensified our outreach, and partnered with issuers so that they are reaching out to consumers about data-matching issues as well. These efforts are beginning to pay off, with a sharp reduction in total data-matching issues generated and an almost 40 percent year-over-year increase in the number of documents consumers have submitted to resolve these issues. Continued progress in this area should benefit both directly affected consumers and other consumers who will benefit from a stronger risk pool.

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The Oversight Series
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Misleading Congress: CMS Acting Administrator Offers False Testimony to Congress on State Exchanges

Prepared by the Energy and Commerce Committee, Majority Staff

Table of Contents

I. Executive Summary

The Centers for Medicare and Medicaid Services (CMS) is the federal agency charged with overseeing the state-based exchanges (SBE) established under the Patient Protection and Affordable Care Act (PPACA). The exchanges offer health care insurance plans to individuals through websites established and maintained by the state. As part of its oversight of the exchanges, CMS must ensure federal grant dollars awarded to SBEs are legally and appropriately spent. Only 16 states and the District of Columbia set up SBEs. Of those, four have already failed to date. When asked under oath about the status of American taxpayer dollars invested in the exchanges, Acting Administrator Andy Slavitt testified before the House Energy and Commerce Committee's Subcommittee on Oversight and Investigations in December 2015 that SBEs returned over $200 million in grant dollars to the federal government. But information and documents CMS recently provided to the committee fail to corroborate Mr. Slavitt's testimony and raise significant questions regarding the truthfulness of his statements.

The purpose of the December 8, 2015, hearing entitled, "An Overdue Checkup Part II: Examining the ACA's State Insurance Marketplaces" was to examine how state-based exchanges spent grant dollars, and better understand the sustainability challenges facing the exchanges, and CMS' role in overseeing the SBEs. In his opening remarks before the committee, Mr. Slavitt testified that "over $200 million of the original grant awards have already been returned to the federal government, and we're in the process of collecting and returning more." After the hearing, it was widely reported by the media that CMS recouped over $200 million from failed state exchanges.

Following the hearing, the committee requested CMS provide documents and information supporting Mr. Slavitt's $200 million figure. After repeated requests for this information, on March 18, 2016, CMS finally produced a chart to the committee outlining the grants awarded to 49 states and the District of Columbia, the amount of each grant, and the amount that CMS de-obligated. This chart is included in Appendix B to this report. CMS did not provide any primary source documents or other materials supporting the figures in the chart. According to the chart, CMS only recovered $21.5 million in unspent federal grant dollars from the SBEs out of the approximately $4.6 billion originally awarded by the agency. The chart also reflects that states that did not establish SBEs returned nearly $300 million in unspent grant dollars to the federal government. This sum, however, was returned only because these states never established a SBE, and therefore had no use for the funds they were granted. This $300 million was not part of the $4.6 billion disbursed for the purposes of establishing the 17 SBEs, but was part of a larger pool of money that went to 49 states and the District of Columbia.

Mr. Slavitt's testimony misled the committee in two ways: he misstated the amount of grant money returned to the Treasury, and he wrongfully implied that the funds were returned because of improper spending and CMS' oversight efforts. According to CMS' chart, CMS recovered a small fraction of the $200 million Mr. Slavitt declared at the committee's December

8 hearing. In fact, the federal government has only reclaimed $21.5 million from the 17 SBEs. Further, CMS did not "recoup" these dollars. These funds were de-obligated, because the time for the grant had expired or the funds were no longer needed. None of the funds reflect grant dollars recouped by CMS due to improper spending. CMS, however, never corrected or revised Mr. Slavitt's testimony before the committee. Further, CMS does not appear to have corrected the record with the numerous news outlets that reported CMS recouped $200 million from failed SBEs.

CMS is charged with an important task to oversee the SBEs to ensure taxpayer dollars are spent appropriately. If CMS is satisfactorily accomplishing its mission, the agency should be at the ready to provide timely and accurate information to Congress, especially with regard to how taxpayer dollars are spent and recovered. If CMS is incapable of providing this information, it calls into question whether CMS is effectively overseeing the SBEs and lawfully implementing the Affordable Care Act.

II. Findings

- Mr. Slavitt's testimony that "over $200 million" has been returned to the federal government is not supported by any CMS documents, including a chart created by the CMS staff and produced to the committee.

- Mr. Slavitt's testimony greatly overstated the sum returned to the Treasury from state-based exchanges—by nearly $180 million. CMS only recouped $21.5 million from the 16 states and the District of Columbia that actually established state-based exchanges.

- CMS does not appear to have made an effort to correct the record when it was widely reported that "over $200 million" was returned to the Treasury because of improper spending and CMS' oversight efforts. Despite Mr. Slavitt's implication otherwise, CMS did not recover any of the funds due to improper spending. Instead of recouping funds from the exchanges, CMS simply "de-obligated" these funds because the time for the grant had expired or the funds were no longer needed.

III. State-Based Exchanges

The Patient Protection and Affordable Care Act authorized the Secretary of the Department of Health and Human Services (HHS) to establish health insurance exchanges to sell private insurance policies in all 50 States and the District of Columbia.[1] These exchanges were intended to provide individuals with an online portal to compare plans and purchase health insurance.

CMS awarded billions of dollars to states to help them establish their own state-based exchanges. Ultimately, only 16 states and the District of Columbia decided to establish exchanges. Several of these SBEs have struggled to become self-sustaining. For those states that did not establish SBEs, HHS created a federally facilitated marketplace (FFM) and an IT platform instead.[2]

A. Background on Establishment Grants

HHS charged CMS with awarding grants to the states to help them plan and establish the exchanges. These grants are known as "establishment" grants. CMS is also responsible for overseeing how these grant dollars are spent. When the law was passed, lawmakers assumed that most states would establish their own state-based exchanges.[3] Accordingly, CMS awarded over $5 billion in federal grants to 49 states and the District of Columbia.[4]

Only 16 states and the District of Columbia, however, established SBEs.[5] As shown in the table on the next page, HHS awarded approximately $4.6 billion to these 17 SBEs to plan and establish their exchanges.[6] The 17 SBEs spent the majority of the grant money on IT costs for setting up websites to enroll individuals into health insurance plans. Grant funds were also spent on outreach strategies, such as in-person consumer assistance, training programs, development of call centers, and staff salaries.[7]

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[1] 42 U.S.C. § 18031.
[2] 42 U.S.C. § 18041(c).
[3] Robert Pear, *Four Words That Imperil Health Care Law Were All a Mistake, Writers Now Say*, N.Y. TIMES, May 25, 2015 ("[S]enators and staff lawyers came to believe that some states — 'five or 10 at the most' — would choose not to set up exchanges, said Christopher E. Condeluci, who was a staff lawyer for Republicans on the Finance Committee.").
[4] Alaska was the only state that did not apply or receive a grant from CMS to establish a state-based exchange. *See* Centers for Medicare & Medicaid Serv., *Health Insurance Exchange Establishment Grants*, *available at* www.cms.gov/cciio/resources/marketplace-grants/ (last visited April 28, 2016).
[5] For the 34 states that declined to establish a SBE, the law directs HHS to establish a "federally facilitated" exchange, also known as "Federally-Facilitated Marketplace" within that State. *See* 42 U.S. Code § 18041(c).
[6] Centers for Medicare & Medicaid Serv., *Health Insurance Exchange Establishment Grants*, *available at* www.cms.gov/cciio/resources/marketplace-grants/ (last visited April 28, 2016).
[7] *Id*.

State-Based Exchange	Grant Award
California	1,065,683,056
New York	575,079,804
Washington	302,333,280
Kentucky	289,303,526
Massachusetts	233,803,787
Vermont	199,718,542
District of Columbia	195,141,151
Maryland	190,130,143
Minnesota	189,363,527
Colorado	184,986,696
Connecticut	175,870,421
Rhode Island	152,574,494
Idaho	105,290,745
Oregon	305,206,587
New Mexico	123,281,600
Nevada	101,001,068
Hawaii	205,342,270
Total	**$4,594,110,697**

CMS awarded nearly $1 billion to the 34 states that never established SBEs and elected to use the FMM established by HHS and/or its IT platform.[8] When these 34 states declined to establish a SBE, CMS de-obligated the unspent grant money because it would not be used for the intended purpose of the grant. As a result, the remaining balance returned to the Treasury by these states was not a result of CMS' oversight actions, but rather the state's own decision to forgo establishing a SBE, thus forfeiting the grants. These 34 states have never been part of the conversation about the success or failure of the SBE model because SBEs in these states never existed. Appendix A provides a breakdown of the spending for each exchange model.

B. State-Based Exchanges Encounter Difficulties

By law, SBEs were supposed to be self-sustaining—that is, have a funding source other than federal grant dollars—by January 1, 2015.[9] But SBEs are struggling to find additional sources of funding to support expensive operations and sophisticated IT systems to support enrollment.

In an attempt to help the struggling SBEs, CMS has been awarding "No-Cost Extensions" to SBEs so they can continue to spend federal grants on "establishment" activities in

[8] *Health Insurance Exchange Establishment Grants supra* note 6.
[9] 42 U.S. Code § 18031(a)(4)(B).

2015 and 2016.[10] Currently, every SBE has utilized these No-Cost Extensions and thus, continues to spend federal grant money to support itself.[11] Nevertheless, of the 17 SBEs, four—Oregon, Hawaii, Nevada, and New Mexico—have already closed their doors. Those four SBEs joined the rest of the 34 states that use the federal IT platform, Healthcare.gov, to enroll individuals into health insurance plans. Meanwhile, many of the 13 remaining SBEs continue to face low enrollment numbers coupled with high operational costs, raising concerns that more SBEs will choose to shut down.[12]

In April 2015, the HHS Office of Inspector General (OIG) alerted CMS that these faltering SBEs may be improperly using establishment grants to cover operational costs.[13] For example, HHS OIG found that CMS failed to notice that the SBE in the state of Washington used federal establishment grant dollars on "operational costs," such as postage, in violation of federal law.[14] The OIG noted in its alert that SBEs are facing uncertain financial futures, based both on media reports and its review of state exchanges' budget information. Because of this uncertainty, the OIG highlighted the risk that state exchanges might use establishment grant funds to cover operational costs.

IV. The Committee's Investigation

After the HHS OIG alert and several high-profile SBE closures, the committee heightened its scrutiny of the establishment and sustainability of the state-based exchanges.

The committee's oversight has primarily focused on the expenditure of federal funds on SBE activities and the long-term sustainability challenges SBEs face. The committee seeks to determine whether federal funds have been spent in accordance with the law, and whether CMS has conducted proper oversight to safeguard the taxpayers' billion dollar investment in these SBEs. If SBEs spent federal grant dollars unlawfully, it is CMS' responsibility to recoup these dollars on behalf of the taxpayers. Recoupment is distinct from de-obligation, which occurs when the grantee has not spent the full amount of the grant award. When the end date of the grant arrives, or all the work associated with the grant is completed, funds that have not been spent are "de-obligated," meaning the grantee is no longer allowed to spend those funds.

[10] Centers for Medicare and Medicaid Services, *FAQs on the Use of 1311 Funds and No Cost Extensions*, *available at* www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/no-cost-extension-faqs-3-14-14.pdf (Mar. 14, 2014).
[11] Centers for Medicare & Medicaid Serv., *1311 Deobligations and Spending* (on file with Committee) (hereinafter "CMS Chart").
[12] Memorandum from Majority Staff to Members of the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *An Overdue Checkup: Examining the ACA's State Insurance Marketplaces* (Sept. 25, 2015).
[13] Dept. of Health & Human Serv., Office of the Inspector Gen., *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law* (A-01-14-02509) (Apr. 27, 2015).
[14] *Id*.

The committee convened two hearings before its Subcommittee on Oversight and Investigations to examine issues surrounding the struggling SBEs. The first hearing was held on September 29, 2015, featuring testimony from the leaders of six state exchanges—California, Connecticut, Hawaii, Massachusetts, Minnesota, and Oregon.[15] Witnesses testified about the challenges of running an exchange, including growing maintenance costs and lower than expected enrollment numbers, as well as interactions with CMS on federal funding for the SBEs. To expand upon the discussion at the hearing, the committee wrote letters to all 17 SBEs in October 2015, requesting information and documents about each SBE's financial viability and expenditure of federal dollars.[16]

The committee held its second hearing on December 8, 2015, where Acting Administrator Andrew Slavitt was the sole witness.[17] The committee requested Mr. Slavitt's testimony to understand CMS' oversight protocols to ensure the 17 SBEs were not spending federal dollars improperly and assess the long-term sustainability of SBEs still in operation.

V. Acting Administrator Slavitt's Testimony

At the December 2015 subcommittee hearing, Members sought an opportunity to hear from CMS' leader about the struggling SBEs. According to the hearing's published memorandum, the subcommittee specifically convened the hearing to "understand the sustainability challenges state exchanges are facing" and "examine how federal establishment grant dollars were spent."[18]

In his opening oral statement, Mr. Slavitt focused solely on the 17 SBEs established under PPACA, and elaborated on CMS' oversight priorities for the SBEs (as indicated by the bolded language):

> Setting up and managing **State marketplaces** is a significant task, and I would like to talk now about how we provide oversight and assistance to the marketplaces but also watch over the American taxpayers' dollars.
>
> In considering our oversight role, it is important to understand all the responsibilities of a **State-based marketplace.** States must establish the infrastructure to review and qualify health plan offerings, develop online and call center capabilities to provide eligibility and enrollment services,

[15] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *An Overdue Checkup: Examining the ACA's State Insurance Marketplaces*, 114th Cong. (Sept. 29, 2015).
[16] *See, e.g.*, Letter from Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Jeffrey Kissel, Executive Director, Hawaii Health Connector, (Oct. 14, 2015).
[17] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *An Overdue Checkup Part II: Examining the ACA's State Insurance Marketplaces*, 114th Cong. (Dec. 8, 2015) (hereinafter "Part II").
[18] Memorandum from Majority Staff to Members of the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *An Overdue Checkup Part II: Examining the ACA's State Insurance Marketplaces* (Dec. 4, 2015).

interface with State Medicaid systems, develop cybersecurity capabilities, outreach and education functions, and dozens of other activities.

* * *

In discussing now our three key oversight priorities, I want to focus in particular on those situations where States have had more significant challenges. Our first priority is to be good stewards of the Federal taxpayers' dollars. This means returning unspent dollars to the Treasury and closing grants, collecting improperly spent dollars, and preventing more from going out the door. **Over $200 million of the original grant awards have already been returned to the Federal Government, and we're now in the process of collecting and returning more.** This also means no new money to fix IT problems was given or will be given to any of the five States or any other State that ran into difficulties. We should not pay twice for the same result.

Second, our job is to manage every dollar tightly. I have always been a big believer in preventing problems so we can spend less time recovering from them. Every **State-based marketplace** has external funding sufficient to run their operations. Federal money may not be used for regular operations. We do a line-item review of the expenditures a State proposes to ensure compliance with the law and conduct audits to make sure there's a full accounting of all Federal dollars. Important to our approach, we maintain control of the purse strings, and 69 times this year we've denied use of Federal funds. We also make adjustments through readiness reviews, detailed reporting, regular audits, and site visits.

Third, and perhaps most important, we assist the State in getting a return on their investment, as measured by the value they provide to their State. . . . As of June 30, **State-based marketplaces** provided coverage to approximately 2.9 million people, and private health plans have helped millions access Medicaid, and the uninsured rates in these States have declined an average of 47 percent since 2013 to under 10 percent.[19]

Mr. Slavitt's opening statement clearly and distinctly focused on issues facing the state-based exchanges.

[19] Part II, *supra* note 17 (emphasis added).

Mr. Slavitt's testimony that "over $200 million" had been returned to the federal government came as a surprise to committee members and staff. CMS did not include the $200 million figure in Mr. Slavitt's prepared written remarks submitted for the record the day before the hearing. The $200 million declaration became a major focus of the news coverage of the hearing:

- The *Wall Street Journal* reported that "[t]he Obama administration on Tuesday said it has recouped more than $200 million in funding given to states that faltered in setting up their own health-insurance exchanges."[20]

- *Bloomberg* reported that "[t]he federal government recouped more than $200 million from Affordable Care Act state-run health insurance marketplaces that wasn't spent in accordance with federal guidelines, and it is in discussions with Maryland and two other states to collect more, a federal official told a House panel Dec. 8."[21]

- *The Hill* reported that Mr. Slavitt "said $200 million in federal funds had already been returned from states, and that CMS emphasizes prevention of federal funds being granted improperly in the first place."[22]

- The *Washington Examiner* reported that "[i]n a charged oversight hearing focused on the new Obamacare marketplaces, Centers for Medicare and Medicaid Services Acting Administrator Andy Slavitt said his agency is requiring Maryland to pay back dollars it either misspent or no longer needs and is working on collecting money from three other states spent on their failed exchanges. And CMS has recovered $200 million from states so far, he said."[23]

To the committee's knowledge, CMS has made no effort to correct the record with those news outlets. Following the hearing, the committee promptly requested that CMS provide documents and information supporting the $200 million figure, and to explain how it recovered $200 million from the state exchanges, including from which states and for what reasons the money was recovered.[24] Despite numerous follow-up emails and phone calls from committee staff requesting the information, and an in-person briefing with CMS Chief of Staff Mandy Cohen, CMS did not provide documents or information regarding the $200 million figure until March 18, 2016, over three months later.

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[20] Stephanie Armour, U*.S. Recoups Funds from States That Faltered on Health Exchanges*, WALL STREET J., Dec. 8, 2015.
[21] Sara Hansard, *More Than $200M Recouped From State ACA Exchanges, Official Says*, BLOOMBERG, Dec. 9, 2015.
[22] Peter Sullivan, *Lawmakers Press Obamacare Chief on State Money Troubles*, THE HILL, December 8, 2015.
[23] Paige Winfield Cunningham, *Official Under Fire for Oversight of Obamacare Funds,* THE WASH. EXAMINER, Dec. 8, 2015.
[24] Email from committee staff to CMS staff (Dec. 9, 2015) (on file with Committee).

In the briefing with committee staff, Ms. Cohen was unprepared to answer questions regarding the $200 million figure on the questions that committee staff had sent CMS ahead of the briefing. Ms. Cohen did not tell committee staff from which states CMS recovered grant money from, or for what reason the money was recovered. Appendix C contains a detailed timeline of the committee's efforts to obtain this information.

Over three months after the hearing, Mr. Slavitt and Oversight and Investigations Committee Chairman Tim Murphy (R-PA) spoke on the phone about the committee's request for information regarding Mr. Slavitt's testimony and the documentation for the $200 million figure. Mr. Slavitt informed Congressman Murphy that the reason for the delay in providing information supporting his testimony was that CMS was "still checking the numbers."[25]

VI. CMS Documents Contradict Acting Administrator Slavitt's Testimony

FINDING: Mr. Slavitt's testimony that "over $200 million" has been returned to the federal government is not supported by any CMS documents, including a chart created by CMS staff and produced to the committee.

On March 18, 2016, three months after the committee's request, CMS provided the committee with a chart, created by CMS staff, that outlines the grants awarded to 49 states and the District of Columbia, the amount of the grant, and the amount de-obligated. CMS did not provide any primary source documents, such as the grant applications, the grant awards, or other materials supporting the de-obligation of these funds. CMS did provide a narrative response, explaining that all of the grants on CMS' chart represent funds that were de-obligated or never disbursed to the states because the grant had closed before the grantee used the funds. The narrative explains that the numbers in the chart do not include "unallowable costs" CMS is working to recover from states that spent federal money improperly.[26] The chart CMS produced to the committee is included in Appendix B.

After a thorough review of the materials provided by CMS, the committee has found that Mr. Slavitt's testimony before the Oversight and Investigations Subcommittee on December 8, 2015, is not supported by any documents produced by CMS and is misleading in two areas. First, it misstates the amount of the grants returned to the Treasury, and second, the testimony wrongfully implies the funds were returned because of improper spending and CMS' oversight efforts.

[25] Phone call between Hon. Tim Murphy, Chairman, Subcomm. on Oversight & Investigations, H. Comm. on Energy & Commerce, and Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Serv. (March 15, 2016).
[26] CMS Chart, *supra* note 11.

A. Mr. Slavitt's testimony incorrectly states the amount of federal funds returned to the Treasury

FINDING:	**Mr. Slavitt's testimony greatly overstated the sum returned to the Treasury from state-based exchanges—by nearly $180 million. CMS only recouped $21.5 million from the 16 states and the District of Columbia that actually established state-based exchanges.**

Mr. Slavitt testified that "[o]ver $200 million of the original grant awards have already been returned to the federal government."[27] CMS documents, however, show that of the $4.6 billion awarded to the 17 states that established SBEs, only $21.5 million was returned to the Treasury—or less than half of one percent of the total awards.[28]

Early in his opening testimony, Mr. Slavitt clearly addressed the issue of the struggling SBEs:

> In discussing now our three key oversight priorities, **I want to focus in particular on those situations where States have had more significant challenges**. Our first priority is to be good stewards of the Federal taxpayers' dollars. This means returning unspent dollars to the Treasury and closing grants, collecting improperly spent dollars, and preventing more from going out the door. **Over $200 million of the original grant awards have already been returned to the Federal Government, and we're now in the process of collecting and returning more.** This also means no new money to fix IT problems was given or will be given to any of the five States or any other State that ran into difficulties. We should not pay twice for the same result.[29]

Mr. Slavitt announced the $200 million figure during his discussion of oversight priorities for SBEs with "more significant challenges," not a discussion about the 34 states without a state exchange.[30] Furthermore, Mr. Slavitt implied that the $200 million was returned because of improper expenditures, stating that "we're now in the process of collecting and returning more."[31]

Even interpreted in a light most favorable to CMS, the documents do not support Mr. Slavitt's testimony. As discussed in Section III, soon after the law was passed, CMS awarded grants to 49 states and D.C. to establish SBEs, but 34 states declined to do so. Documents provided to the committee show that of the $5.5 billion awarded to 49 states and D.C., approximately $319 million in unspent grant money was returned to the Treasury. The vast

[27] Part II, *supra* note 17.
[28] CMS Chart, *supra* note 11.
[29] Part II, *supra* note 17 (emphasis added).
[30] *Id*.
[31] *Id*.

majority of these funds—nearly $300 million—was returned because CMS awarded the funds to states that never established a SBE. As a result, those grants were necessarily closed.[32]

B. Mr. Slavitt's testimony wrongfully implied the funds were returned because of improper spending and CMS' oversight efforts

FINDING:	**CMS does not appear to have made an effort to correct the record when it was widely reported that "over $200 million" was returned to the Treasury because of improper spending and CMS' oversight efforts. Despite Mr. Slavitt's implication otherwise, CMS did not recover any of the funds due to improper spending. Instead of recouping funds from the exchanges, CMS simply "de-obligated" these funds because the time for the grant had expired or the funds were no longer needed.**

Mr. Slavitt's testimony wrongfully implied the funds were recouped because of improper spending, rather than simply de-obligated because the grant was closed. According to CMS, the funds Mr. Slavitt referenced during the hearing were "de-obligated" because the grantee had completed all the work associated with the grant agreement, or the end date for the grant had arrived. In other words, these numbers simply represent that amount of money leftover in the grant that CMS did not authorize because the grant had closed. In fact, CMS acknowledged that the grant information provided to the committee supporting Mr. Slavitt's testimony "does not contain the unallowable costs that we are working with states to recover."[33]

Because Mr. Slavitt made his remarks in the context of recouping misspent funds from the 17 SBEs, it was widely assumed–and reported in the media–that the $200 million figure represented funds recouped because CMS found SBEs spent them improperly.

VII. Conclusion

After a thorough review, the committee has found that the documents provided by CMS do not support Mr. Slavitt's testimony before the committee. It appears Mr. Slavitt misled Congress and the American people by providing false information under oath. Mr. Slavitt testified that over $200 million of original state exchange grant awards had been returned to the Treasury. In reality, CMS de-obligated $21.5 million intended for the 17 SBEs. Mr. Slavitt's testimony is still inaccurate when the committee takes into account grants returned from 34 states that did not even establish SBEs.

[32] Even if Mr. Slavitt intended to include all 49 states and the District of Columbia in his calculation, including those that did not establish a SBE, his testimony would have stated over $300 million, not over $200 million, had been returned. Furthermore, the increase in CMS' figures, from $200 million to $300 million, cannot be justified by the passage of time. CMS' chart provided to the Committee reflects the grant numbers as of November 30, 2015, about a week before Mr. Slavitt's testimony.

[33] CMS Chart, *supra* note 11.

Mr. Slavitt led both the committee and the press to believe that the money was returned to the Treasury because of improper spending and CMS' oversight efforts. Instead, the funds were returned because the grants had closed—because either the end date for the grant arrived or all the work had been completed. In the case of the 34 FFM states, the vast majority was returned because they declined to set up SBEs. No part of Mr. Slavitt's $200 million figure included federal funds that had been returned because of improper spending.

CMS did not provide the committee with information regarding Mr. Slavitt's testimony in a timely manner. The committee expects that testimony before the committee be truthful and based on fact, and CMS should be willing and able to immediately provide information supporting testimony from its officials.

Based on Mr. Slavitt's false and misleading testimony, CMS' ability to determine whether a state exchange spent federal dollars in accordance with the law and its ability to properly implement the law is called into question. As a result, it appears that Mr. Slavitt's testimony before the committee was based on estimates and conjecture, not facts. Mr. Slavitt's original source for the "over $200 million" figure he testified to has still not been provided to the committee.

CMS officials must make tough decisions, and implementing a law as broad and unwieldy as PPACA is a daunting task. However, it is never acceptable for administration officials to distort the truth to avoid Congressional and public scrutiny.

Appendix A

This chart reflects the amounts CMS awarded to the 50 states and the District of Columbia to establish state-based exchanges. 34 states did not set up state-based exchanges, although seven accepted funds to perform consumer assistance functions. Only 16 states and the District of Columbia established state based exchanges. The overwhelming majority of the de-obligated grant funds come from states that declined to set up exchanges.

States	Amount CMS Awarded	Amount CMS De-Obligated
17 State-Based Exchanges California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington, Oregon, Nevada, New Mexico, Hawaii. Four of the above state-based exchanges failed and now use the federal IT platform, healthcare.gov.	$4.6 Billion	$21.5 Million
7 State-Partnership Exchanges Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, West Virginia. These states only control in-person consumer assistance; HHS controls the rest of the	$483 Million	$12.8 Million

Appendix A

functions, and these states use healthcare.gov.		
<u>27 Remaining States</u> The majority of the states did not establish state-based exchanges, and are covered by the Federally-Facilitated Exchange, solely controlled by HHS.	$481 Million	$285 Million

Appendix B

The following pages in "Appendix B" are copies of documents produced by CMS to the Committee on March 18, 2016.

The chart was created by CMS staff. CMS did not provide any primary source documents or other materials supporting the figures in the chart.

Request #1: State exchanges (follow up questions from hearing Dec. 8, and briefing Jan. 12):

- **A breakdown of the $200 million recouped by CMS from state exchanges – by state, amount, date and why the funds were returned.**

Section 1311 Grants - Obligations and Deobligations as of 11/30/15			
State	**Marketplace grant funding awarded**	**Deobligated**	
State-Based Marketplace			
California	1,065,683,056.00	(470,105.63)	02/29/2012
New York	575,079,804.00	(4,544,589.81)	02/10/15; 05/01/15
Washington	302,333,280.00		
Kentucky	289,303,526.00	(530,911.65)	02/29/2012
Massachusetts	233,803,787.00		
Vermont	199,718,542.00		
District of Columbia	195,141,151.00	(634.50)	05/01/2015
Maryland	190,130,143.00	(192.84)	05/21/15; 05/27/15; 09/11/15
Minnesota	189,363,527.00	(100,119.84)	09/11/2015
Colorado	184,986,696.00		
Connecticut	175,870,421.00	(43,332.99)	12/19/12; 05/21/2015
Rhode Island	152,574,494.00	(29,019.36)	05/22/2013
Idaho	105,290,745.00		02/29/2012
Subtotal	**3,859,279,172.00**	**(5,718,906.62)**	
State-Based Marketplace using the Federal Platform			
Oregon	305,206,587.00		
New Mexico	123,281,600.00	(15,720,604.81)	05/01/15; 09/03/15
Nevada	101,001,068.00	(12,000.00)	10/16/14

Hawaii	205,342,270.00		01/19/2016
Subtotal	**734,831,525.00**	**(15,732,604.81)**	
Federally-facilitated Partnership			
Illinois	164,902,306.00	(71,411.68)	02/08/2013
Arkansas	158,039,122.00	(44,928.17)	01/23/2013
Iowa	59,683,889.00	(1,838,473.61)	05/24/13; 08/27/13; 05/29/14
Michigan	41,517,021.00	(9,915,298.03)	06/11/13; 08/01/13
Delaware	22,236,059.00		
West Virginia	20,832,828.00	(17,028.76)	05/20/2015
New Hampshire	15,919,960.00	(999,080.73)	05/01/2015
Subtotal	**483,131,185.00**	**(12,886,220.98)**	
Federally-facilitated Marketplace			
North Carolina	87,357,314.00	(73,520,471.03)	09/09/13; 04/30/15
Oklahoma	55,608,456.00	(54,710,475.69)	11/25/11; 11/16/12
Mississippi	42,712,661.00	(329,874.63)	04/13/2012
Wisconsin	39,057,947.00	(34,371,180.79)	05/28/15; 09/25/15
Pennsylvania	34,832,212.00	(33,778,843.01)	10/16/13; 10/16/14; 06/10/15
Kansas	32,537,465.00	(31,527,074.98)	02/10/2012
Arizona	30,877,097.00	(6,595.24)	06/30/14; 09/30/2015
Missouri	21,865,716.00	(19,586,468.42)	08/21/2013
Virginia	15,862,889.00		
Alabama	9,772,451.00	(6,284,785.38)	08/15/13; 05/1/15
Tennessee	9,110,165.00	(6,557,668.47)	05/24/13; 10/17/13; 05/29/15; 9/30/2010
New Jersey	8,897,316.00	(7,713,826.08)	05/29/14; 05/1/15

Indiana	7,895,126.00	(978,071.48)	02/29/12; 10/16/13; 06/17/15
South Dakota	6,879,569.00	(4,962,486.88)	05/16/14; 05/01/15; 09/03/15
Maine	6,877,676.00	(5,877,834.79)	06/29/12; 11/01/12
Nebraska	6,481,838.00	(949,914.31)	2/28/12; 10/16/13; 5/27/12
Utah	6,407,987.00	(26,326.62)	05/13/13; 06/17/15
Florida	1,000,000.00	(1,000,000.00)	02/29/2012
Georgia	1,000,000.00	(10,270.21)	08/01/2013
Montana	1,000,000.00		
North Dakota	1,000,000.00	(3,984.00)	12/12/12; 09/11/15; 09/18/15
Ohio	1,000,000.00	(81,905.39)	06/30/2014
South Carolina	1,000,000.00	(695,003.54)	05/23/2012
Texas	1,000,000.00	(903,574.59)	02/29/2012
Louisiana	998,416.00	(969,025.00)	12/14/2011
Wyoming	800,000.00	(267,792.19)	10/01/10; 6/10/15
Subtotal	**431,832,301.00**	**(285,113,452.72)**	
Total	**5,509,074,183.00**	**319,451,185.13**	

As previously reported by CMS as well as by the GAO, CMS has awarded approximately $5.5 billion in section 1311 grant awards for the planning and establishment of State-based Marketplaces. As of November 30, 2015, over $300 million of the $5.5 billion has been deobligated and returned to the federal government.

As Mr. Slavitt previously testified, CMS is in the process of collecting and returning more of the grant funds to the federal government through the grant closeout process, as well as through audits that identify any unallowable costs. As Dr. Cohen described during her briefing, section 1311 grants are closed out once the grantee has completed all the work associated with a grant agreement or the end date for the grant has arrived, or both.

Note, the chart above does not include the $32.5 million that Maryland has agreed to return to the federal government due to their legal settlement with their contractor. It also does not contain the unallowable costs that we are working with states to recover that Dr. Cohen spoke about at her briefing.

- **How many federal funds have been used to transition states like Hawaii and Oregon away from the state exchange model to the federal IT platform?**

As Dr. Cohen explained at her briefing, HealthCare.gov is a scalable platform, meaning that the cost to provide eligibility and enrollment functionality for additional states is marginal. CMS obligated $7.3 million in Fiscal Year (FY) 2014 to complete the federal IT and system changes related to the transition for Oregon, Nevada, and New Mexico to the HealthCare.gov platform. CMS is currently finalizing the amount obligated to transition Hawaii to HealthCare.gov.

Oregon, Nevada, New Mexico, and Hawaii did not receive new 1311 grant awards to transition to HealthCare.gov. These states were required to re-budget any remaining funds in existing 1311 grants for allowable activities only. For example, Hawaii submitted a budget request for about $7.2 million for activities that Hawaii is required to continue to provide as a SBM-FP (such as establishment activities related to SBM responsibilities like plan management). CMS reviewed the request and approved approximately $6.9 million as allowable activities. For these states, CMS is currently going through the closeout process for their grants and remaining funds will be deobligated and returned to the federal government.

- **What were the federal funds used for?**

Section 1311 grants may only be used for allowable activities as determined by the HHS grant policy and the Affordable Care Act. After January 1, 2015, 1311 grant funds may only be used for establishment activities and may not be used to support ongoing operations. HHS grants policy also allows grant funds to be used for associated grant close out procedures.

As such, any state transitioning to a SBM-FP can request funds for establishment activities for which it remains responsible and for activities required to close out its grant. A state transitioning from a SBM to SBM-FP could not use 1311 funds for IT system costs that are associated with a transition to the FFM platform.

- **How did CMS approve the use of those funds?**

CMS reviews each budget requests from section 1311 grantees for allowability and reasonableness per the HHS grants policy and the Affordable Care Act, and makes a determination for the approved amount that may be drawn down according to the grantee's budget request.

- **How many state exchanges have No-Cost Extensions approved for 2016?**

1. Connecticut
2. DC
3. Idaho
4. Massachusetts
5. Minnesota
6. Rhode Island
7. Vermont
8. Washington
9. California

10. Colorado
11. Hawaii
12. Kentucky
13. Maryland
14. Nevada
15. New York
16. New Mexico

Appendix C

Timeline for $200 million documents re: state exchanges

Dec. 8, 2015: CMS Acting Administrator Andrew Slavitt testified before the Oversight and Investigations Subcommittee on struggling state exchanges. Mr. Slavitt testified that "[o]ver $200 million of the original grant awards have already been returned to the Federal Government, and we're now in the process of collecting and returning more."

Dec. 9, 2015: Committee staff emailed CMS staff to request a staff level briefing concerning Mr. Slavitt's testimony. Specifically, committee staff asked CMS staff to answer "how did CMS take back the $200 million from the state exchanges?" and "[f]rom which states and for what?"

Dec. 11, 2015: Committee staff and CMS staff discussed the committee's request for a briefing.

Dec. 16, 2015: Committee staff emailed CMS staff to reiterate the committee's request for a briefing, after hearing no response.

Dec. 17, 2015: Committee staff and CMS staff discussed the committee's request for a briefing. CMS staff is reluctant to provide the requested briefing.

Dec. 28, 2015: CMS staff offers dates to schedule a briefing.

Jan. 12, 2016: CMS staff briefed committee staff on follow-up questions to the state exchange hearing. CMS staff clarified that the $200 million figure referred to grant money that had originally been allocated but not disbursed, and that CMS simply chose not to disburse the money in some of the grants. CMS did not provide the Committee with any documentation or information supporting the $200 million number, such as which states the funds came from, why CMS decided not to allocate the money, when the decision was made, etc. Committee staff again requested that information.

Jan. 13, 2016: Committee staff emailed CMS staff with a list of follow-up questions from the briefing, including the initial underlying question that had not been answered: "a breakdown of the $200 million recouped by CMS from state exchanges – by state, amount, date and why the funds were returned."

Jan. 21, 2016: Committee staff emailed CMS staff about the outstanding request, after hearing no response.

Jan. 27, 2016: Committee staff emailed CMS staff again about the request, after hearing no response. CMS staff responds, "we're working on those Qs and should get you something shortly."

Feb. 11, 2016: Chairman Murphy called Mr. Slavitt to ask about the status of the follow-up information on the $200 million from state exchanges. Mr. Slavitt

responded that CMS staff was working quickly to response to committee requests.

Feb. 12, 2016: Committee staff calls CMS staff to follow-up on Chairman Murphy's call, and CMS staff promised to prioritize the $200 million state exchange grant information, and hoped to send it to the committee the week of February 15.

Feb. 17, 2016: CMS staff emailed Committee staff that the information would not arrive this week.

Mar. 3, 2016: Committee staff emailed CMS staff for an update on the requested information – no response from CMS.

Mar. 15, 2016: Chairman Murphy and Mr. Slavitt have a phone conversation about outstanding committee document and information requests, including about the request regarding the $200 million from state exchanges. Mr. Slavitt reports to Chairman Murphy that CMS is still "checking the numbers," but CMS should be able to provide that information to the committee by the end of the week.

Mar. 18, 2016: CMS staff provided the Committee with information and a chart regarding the $200 million figure.

TREASURY INSPECTOR GENERAL FOR TAX ADMINISTRATION

Affordable Care Act: Internal Revenue Service Verification of Premium Tax Credit Claims During the 2015 Filing Season

March 31, 2016

Reference Number: 2016-43-033

This report has cleared the Treasury Inspector General for Tax Administration disclosure review process and information determined to be restricted from public release has been redacted from this document.

Redaction Legend:
2 = Risk Circumvention of Agency Regulation or Statute

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AFFORDABLE CARE ACT: INTERNAL REVENUE SERVICE VERIFICATION OF PREMIUM TAX CREDIT CLAIMS DURING THE 2015 FILING SEASON

Highlights

Final Report issued on March 31, 2016

Highlights of Reference Number: 2016-43-033 to the Internal Revenue Service Commissioner for the Wage and Investment Division.

IMPACT ON TAXPAYERS

The Affordable Care Act created the refundable Premium Tax Credit (PTC) to help offset the cost of health care insurance for those with low or moderate income. Individuals can receive the PTC in advance or can claim the PTC on their tax return. Individuals who received the PTC in advance are required to reconcile the amount paid on their behalf to the allowable amount of the PTC on their tax return. According to the IRS, almost $11 billion in Advance PTCs (APTC) was paid to insurers in Fiscal Year 2014.

WHY TIGTA DID THE AUDIT

The House Committee on Appropriations requested that TIGTA evaluate the IRS processes to ensure that unauthorized payments or overpayments of the PTC are fully recouped. The objective of this review was to evaluate the effectiveness of the IRS's verification of PTC claims during the 2015 Filing Season.

WHAT TIGTA FOUND

As of June 11, 2015, the IRS processed more than 2.9 million tax returns involving the PTC, and taxpayers received approximately $9.8 billion in PTCs that was either received in advance or claimed at filing.

TIGTA's analysis of more than 2.6 million tax returns with a PTC claim that were filed between January 20, 2015, and May 28, 2015, for which the IRS had Exchange Periodic Data (EPD), found that the IRS accurately determined the allowable PTC on more than 2.4 million (93 percent) returns. TIGTA is continuing to work with the IRS to determine the cause for calculation differences in 150,385 of the remaining 182,884 tax returns. Computer programming errors resulted in an incorrect computation of the allowable PTC for 27,827 tax returns. For 4,672 tax returns, the IRS did not have authority to correct the PTC claim during processing.

In addition, Exchanges did not provide the EPD to the IRS prior to the start of the 2015 Filing Season, and IRS system problems prevented the IRS from being able to use the EPD received between January 20, 2015, and March 29, 2015. Without the required EPD, the IRS was unable to perform computer matches to verify filed claims or that individuals who received the APTC filed a tax return as required.

TIGTA verified that the IRS processes to identify potentially fraudulent PTC claims are operating as intended. In addition, the IRS corrected programming errors identified by TIGTA that resulted in tax returns not being identified for further review during processing.

Finally, the IRS sent letters to individuals who received the APTC but did not file a tax return to remind them of the requirement to reconcile APTCs. However, the IRS processes to identify these taxpayers did not use the most current tax filing data.

WHAT TIGTA RECOMMENDED

TIGTA recommended that the IRS review the 27,827 tax returns identified by TIGTA to ensure that these individuals receive the correct PTC. Also, the IRS should modify the Income and Family Size Verification processes to use the most current information available when determining if a taxpayer has reconciled APTCs received in the prior calendar year.

The IRS agreed with both of TIGTA's recommendations. The IRS stated that it will review the 27,827 tax returns to prioritize them against existing workload demands and resource constraints so that they may be addressed accordingly. In addition the IRS stated that implementation of agreed changes to the Income and Family Size Verification process are subject to budgetary constraints, limited resources, and competing priorities.

TREASURY INSPECTOR GENERAL
FOR TAX ADMINISTRATION

DEPARTMENT OF THE TREASURY

WASHINGTON, D.C. 20220

March 31, 2016

MEMORANDUM FOR COMMISSIONER, WAGE AND INVESTMENT DIVISION

FROM: Michael E. McKenney
Deputy Inspector General for Audit

SUBJECT: Final Audit Report – Affordable Care Act: Internal Revenue Service Verification of Premium Tax Credit Claims During the 2015 Filing Season (Audit #201540317)

This report presents the results of our review to evaluate the effectiveness of the Internal Revenue Service's (IRS) verification of Premium Tax Credit claims during the 2015 Filing Season. This audit was conducted in response to a June 2014 request from the House Committee on Appropriations. The Committee requested, among other things, that the Treasury Inspector General for Tax Administration evaluate the processes the IRS uses to ensure that unauthorized payments or overpayments of the Premium Tax Credit are fully recouped. This audit 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 in 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 Russell Martin, Assistant Inspector General for Audit (Returns Processing and Account Services).

Table of Contents

Abbreviations

ACA	Affordable Care Act
APTC	Advance Premium Tax Credit
CMS	Centers for Medicare and Medicaid Services
e-file(d)	Electronically file(d)
EPD	Exchange Periodic Data
FPL	Federal Poverty Level
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
OIG	Office of Inspector General
PTC	Premium Tax Credit
QHP	Qualified Health Plan
SLCSP	Second Lowest Cost Silver Plan
TIGTA	Treasury Inspector General for Tax Administration

Background

The Affordable Care Act (ACA)[1] created the Health Insurance Marketplace, also known as the Exchange. The Exchange is where taxpayers find information about health insurance options, purchase qualified health plans, and, if eligible, obtain help paying premiums and out-of-pocket costs. The ACA also created a new refundable tax credit,[2] the Premium Tax Credit (PTC), to assist eligible taxpayers with paying their health insurance premiums. The PTC helps to offset the cost of health care insurance for those with low or moderate income. Because the PTC is a refundable credit, individuals who have little or no income tax liability can still benefit. Figure 1 lists eligibility requirements to purchase insurance through an Exchange and qualify for the PTC.

Figure 1: Eligibility Requirements to Purchase Health Insurance Through an Exchange and Qualify for the PTC

Exchange Eligibility Requirements	PTC Eligibility Requirements
Individuals must: • Live in the United States. • Be a U.S. citizen or national or be lawfully present. • Not be currently incarcerated.	**Individuals must:** • Buy health insurance through the Exchange. • Be ineligible for Minimum Essential Coverage[3] through an employer or Government plan. • Be within certain income limits.[4] • File an income tax return (joint tax return, if married). • Not be claimed as a dependent on another tax return.

Source: IRS.gov and Healthcare.gov.

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code), 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] Minimum Essential Coverage is health insurance coverage that contains essential health benefits including emergency services, maternity and newborn care, and preventive and wellness services. Minimum Essential Coverage also includes doctor visits, hospitalization, mental health services, and prescription drugs.

[4] The taxpayer's income must generally be at least 100 percent but not more than 400 percent of the Federal poverty level (FPL) for the taxpayer's family size. For example, in Calendar Year 2013, this equated to $23,550 to $94,200 for a family of four. The FPL is a measure of income level issued annually by the Department of Health and Human Services and is used to determine eligibility for certain programs and benefits. More information on the FPL can be found at https://www.healthcare.gov/glossary/federal-poverty-level-FPL.

Health Insurance Exchange eligibility and enrollment process

The Centers for Medicare and Medicaid Services (CMS) operates the Federally Facilitated Exchange and works with States to establish State-Based and State Partnership Exchanges, including overseeing their operations. During the Calendar Year 2014 health insurance enrollment period, the District of Columbia and 14 States operated their own Exchanges (hereafter referred to as State Exchanges), while the remaining 36 States partnered with the Federally Facilitated Exchange. Figure 2 shows the Federally Facilitated and State-Based Exchanges during Calendar Year 2014.

Figure 2: Federally Facilitated and State-Based Exchanges for Calendar Year 2014

Federally Facilitated Exchange[5]			State-Based Exchanges
Alabama	Louisiana	Ohio	California
Alaska	Maine	Oklahoma	Colorado
Arizona	Michigan	Pennsylvania	Connecticut
Arkansas	Mississippi	South Carolina	District of Columbia
Delaware	Missouri	South Dakota	Hawaii
Florida	Montana	Tennessee	Kentucky
Georgia	Nebraska	Texas	Maryland
Idaho	New Hampshire	Utah	Massachusetts
Illinois	New Jersey	Virginia	Minnesota
Indiana	New Mexico	West Virginia	Nevada
Iowa	North Carolina	Wisconsin	New York
Kansas	North Dakota	Wyoming	Oregon
			Rhode Island
			Vermont
			Washington

Source: The CMS as of September 30, 2014.

The Exchanges have sole responsibility for determining if an individual is eligible to purchase health insurance as well as determining the amount of the PTC that is paid in advance. The Exchanges use a combination of Federal and State data sources to determine eligibility, including information provided by the Department of Homeland Security, the Internal Revenue Service (IRS), and the Social Security Administration. For example, the IRS provides tax return information for applicants and their family members. The Exchange can use the tax information

[5] Idaho and New Mexico were Supported State-Based Exchanges in Calendar Year 2014, and the eligibility and enrollment process was completed by the Federally Facilitated Exchange.

in conjunction with other income data to verify an individual's estimated income for the next calendar year. The Exchange uses this estimated income and family status to determine if an individual is eligible to receive an Advance PTC (APTC).

Once the Exchange determines the amount of the APTC an individual is entitled to receive, the individual then elects the actual amount to be sent to the individual's insurer on a monthly basis. Individuals can elect to send all, a portion, or none of the APTC to which they are entitled. Once an individual selects insurance coverage and determines the amount of the APTC to be sent to the insurer, the insurer submits the information to the CMS, which then sends a request to the U.S. Department of the Treasury's Bureau of the Fiscal Service to issue monthly APTC payments to the individual's insurance provider. According to the IRS, total APTC disbursements for Fiscal Year[6] 2014 were nearly $11 billion ($15.5 billion in Calendar Year 2014).

Reconciliation of APTC amounts received and PTC claims

The IRS is responsible for determining the amount of the PTC a taxpayer is entitled to receive based on the income and family size reported on his or her tax return. Beginning in January 2015, taxpayers who purchased insurance through an Exchange during the Calendar Year 2014 health insurance enrollment period are required to file a tax return and attach Form 8962, *Premium Tax Credit (PTC)*, to claim the PTC and reconcile any APTC payments that were made to an insurer on their behalf. This reconciliation is necessary because the actual income and family size reported on their tax return can be different from the estimates used by the Exchange to determine the allowable APTC.

Taxpayers who are entitled to more PTC than was received in advance receive the additional credit as a refund on their tax returns. However, taxpayers who received more PTC in advanced payments than they were entitled to must repay the excess when filing their tax return. The amount required to be repaid is subject to certain limitations because the ACA limits the amount of tax that individuals with income between 100 percent and 400 percent of the FPL will have to repay. However, individuals whose actual income exceeds 400 percent of the FPL are not eligible to receive the PTC and are required to repay the full amount of any APTC they received. Figure 3 lists the repayment limits for individuals with household income less than 400 percent of the FPL.

[6] 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.

Figure 3: Limit on Repayment – Individuals Receiving Excess APTC

Household Income Percentage of the FPL	Repayment Limit – Filing Status Single	Repayment Limit – Filing Status Other Than Single
• Less Than 200%	$300	$600
• 200% but Less Than 300%	$750	$1,500
• 300% but Less Than 400%	$1,250	$2,500
• 400% or More	No Limit	No Limit

Source: Treasury Regulation Section (§) 1.36B-4.

The ACA requires Exchanges to provide the IRS with enrollment data

The ACA requires Exchanges to provide the IRS with information regarding individuals who are enrolled by the Exchange on a monthly basis. These data are referred to as Exchange Periodic Data (EPD). In addition, the Exchange is also required to provide an annual summary to both the IRS and the individual detailing specific information relating to the individual's enrollment. This is referred to as Form 1095-A, *Health Insurance Marketplace Statement*. The data provided by Exchanges monthly and annually include:

- Individuals and families enrolled in a Qualified Health Plan (QHP) through the Exchange.
- Coverage start and end date of the QHP.
- The monthly premium amount of the QHP.
- Amount of the APTC paid for coverage under the QHP.
- Employer-offered Minimum Essential Coverage.

The House Committee on Appropriations requested an evaluation of the administration of the PTC

On June 17, 2014, the House Committee on Appropriations requested that the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) and the Treasury Inspector General for Tax Administration (TIGTA) conduct an audit of the administration of the PTC. The Committee identified three primary areas on which it asked the Inspectors General to focus their audit coverage.

- How the Exchanges use IRS, self-reported, third-party, and other income data to determine eligibility for the PTC.

- The programmatic justification for and the accounting processes used to document, control, process, and report on PTC obligations.
- The processes the IRS and the CMS have to ensure that PTC payments are only made to eligible individuals and that unauthorized payments or overpayments of the PTC are fully recouped.

The Explanatory Statement to the Consolidated and Further Continuing Appropriations Act of 2015[7] requested that no later than June 1, 2015, the HHS OIG, in consultation with TIGTA, submit a report to Congress that assesses the IRS procedures to reconcile APTC amounts paid to individual taxpayers and how the HHS uses IRS information to reduce fraud and overpayments. On May 29, 2015, we issued an interim report on the IRS's efforts to verify PTC claims.[8] The interim report also included preliminary results from the HHS OIG on its review of the controls used by the Federal Exchange to ensure that individuals are eligible to enroll in a QHP and to receive assistance, including the APTC. As part of this review, the HHS OIG gathered information on how the CMS uses IRS information at the Federal Exchange in combination with information obtained from other sources to determine eligibility for the PTC.

The HHS OIG issued its final report on the internal controls at the Federal Exchange in August 2015.[9] In addition, the HHS OIG issued its assessment of controls at two State Exchanges in September[10] and October 2015.[11] The HHS OIG plans to issue reports during Fiscal Year 2016 on the controls at five other State Exchanges. In addition, the HHS OIG plans to summarize the results of its reviews of seven State Exchanges and describe the CMS's oversight and monitoring activities related to the State Exchanges. The HHS OIG will also examine inconsistencies at the Federal Exchange, which will include determining how many inconsistencies the Federal Exchange resolved, their characteristics, how they were resolved, and how long their resolution took.

This review was performed with information obtained from the IRS Headquarters in Washington, D.C.; the ACA Office in Washington, D.C.; the ACA Program Management Office within the IRS Chief Technology Office in New Carrollton, Maryland; and the IRS Wage and Investment Division in Atlanta, Georgia. We also obtained information from the HHS OIG, the HHS CMS, and the California Exchange. This audit was conducted during the period

[7] Pub. L. No. 113-235 (2014).
[8] TIGTA, Ref. No. 2015-43-057, *Affordable Care Act: Interim Results of the Internal Revenue Service Verification of Premium Tax Credit Claims* (May 2015).
[9] HHS OIG, A-09-14-01011, *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* (Aug. 2015).
[10] HHS OIG, A-02-14-02020, *Not All Internal Controls Implemented by the New York Marketplace Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements* (Sept. 2015).
[11] HHS OIG, A-04-14-08036, *The Kentucky Marketplace's Internal Controls Were Generally Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements* (Oct. 2015).

December 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

As of June 11, 2015, the IRS processed more than 2.9 million tax returns in which taxpayers received approximately $9.8 billion in PTCs that were either received in advance or claimed at the time of filing. Figure 4 presents PTC statistics as of June 11, 2015.

Figure 4: PTC Statistics as of June 11, 2015

Total Tax Returns With the PTC	**2,960,786**
Total PTC Amount (includes the APTC and the PTC)	$9.8 billion[12]
Total APTC Amount	*$9 billion*
Total PTC Claimed at Filing in Excess of the APTC	*$750.5 million*
Tax Returns for Which the PTC Equals the APTC Received	
Tax Returns	137,207
Total PTC Amount	$566.4 million
Tax Returns With Additional PTC – (taxpayer was entitled to more PTC than what was received in the APTC)	
Total Tax Returns	1,247,100
Total PTC Amount (includes the APTC and the PTC)	$4.9 billion
Total APTC Amount	*$4.1 billion*
Total PTC Claimed at Filing in Excess of the APTC	*$750.5 million*
Tax Returns With Excess APTC Payments – (taxpayer received more APTC than the PTC entitled and had to repay)	
Total Tax Returns	1,576,479
Total APTC Amount	$4.4 billion[13]
Total APTC Reported in Excess of the PTC	$1.9 billion
Total APTC Above the Repayment Limit (not repaid)	*$652.9 million*
Total APTC Below the Repayment Limit (repaid)	*$1.3 billion*

Source: TIGTA analysis of Individual Master File posted tax return information as of June 11, 2015 (Cycle 23). Totals shown are rounded.

[12] Subtotals do not equal the totals due to rounding.

[13] This number represents the amount of APTC paid by the Federal Government as of June 11, 2015. It includes the APTC equal to allowable PTC ($3,722,919,300) and the excess APTC that taxpayers are not required to repay ($652,898,340). We did not include the $1,275,067,850 in excess APTC that taxpayers must repay because once recovered it no longer represents a payment by the Federal Government.

Delays in Receiving Exchange Data Reduced the Internal Revenue Service's Ability to Efficiently Verify Premium Tax Credit Claims

The Exchanges did not provide the EPD to the IRS prior to the start of the 2015 Filing Season as required. In addition, IRS system issues prevented the IRS from being able to use most of the EPD received between January 20, 2015, and March 29, 2015. Without the required EPD, the IRS is unable to ensure that individuals claiming the PTC met the most important eligibility requirement – that insurance was purchased through an Exchange. In addition, the IRS cannot effectively and efficiently prevent erroneous PTC payments or ensure that the APTC paid in error is recovered. The IRS has to expend additional resources in an attempt to manually rather than systemically verify these claims. The IRS and Exchanges continued to work collaboratively throughout the 2015 Filing Season in an effort to provide the IRS with the data needed and to improve processes to help ensure that accurate EPD are submitted timely for use in future filing seasons.

Internal Revenue Code Section (§) 36B(f)(3) requires the Federal Exchange and State Exchanges to report EPD information to the IRS. Treasury Regulation § 1.36B–5, *Information Reporting by Exchanges*, issued May 7, 2014, requires this information to be reported both monthly (by the 15th of each month) as well as annually (by January 31). However, the CMS did not send the EPD for 1.7 million of the 4.2 million Federal Exchange enrollment records prior to the start of the filing season. The IRS did not receive these records from the CMS until February 2015, and the records were not used by the IRS until after March 28, 2015.

In addition, as of January 20, 2015 (the start of the filing season), six of the 15 State Exchanges[14] had not sent the IRS their required EPD.[15] As of June 25, 2015, the IRS received and was able to use EPD from all of the 15 State Exchanges. It should be noted that some States' EPD were not available until well after the April 15 return filing due date. Figure 5 provides a summary of when the EPD were available for the IRS to use to verify tax returns with PTC claims throughout the filing season.

[14] Fourteen State Exchanges and the District of Columbia. See Figure 2.
[15] Two of the six State Exchanges submitted no EPD. Four of the six State Exchanges attempted to submit EPD, but the IRS rejected all or part of the data.

Figure 5: IRS Use of Calendar Year 2014 EPD

	States Used	No EPD Provided by States or the IRS Unable to Use the EPD
Filing Season – January 1 through April 15		
January 20, 2015, through February 7, 2015	40[16]	11[17]
February 8, 2015, through March 28, 2015	42	9
March 29, 2015, through April 15, 2015	48	3
Post Filing Season		
May 3, 2015, through May 30, 2015	49	2
May 31, 2015, through June 27, 2015	50	1
June 28, 2015, and later	51[18]	

Source: IRS EPD Submissions Reports and EPD load information.

The IRS developed processes to verify PTC claims associated with Exchanges that did not provide the required EPD

Our analysis of tax returns filed between January 20, 2015, and May 28, 2015, identified 438,603 tax returns for which the IRS did not have EPD at the time the tax returns were processed or the EPD were incorrect.[19] The IRS did develop manual processes in an effort to verify PTC claims associated with Exchanges that did not provide the required EPD. However, these processes resulted in the IRS having to suspend tax returns during processing, which uses additional resources and increases the burden on taxpayers entitled to these claims.

The processes established include a combination of "at filing" data filters (*i.e.*, when tax returns are processed) to identify claims for manual verification and post processing compliance activities to address claims that cannot be verified using the EPD. In addition, once the IRS received Form 1095-A data, it revised its processes to use the data in an effort to verify PTC claims. These data were made available to IRS employees for manual research to verify PTC claims not supported by EPD. If the Form 1095-A data did not verify that the individual purchased insurance through an Exchange, the return was suspended from processing and the IRS corresponded with the taxpayer for additional supporting documentation.

[16] All of this data were partial year and reflected information for January through November.
[17] Six of the 15 State Exchanges did not provide EPD prior to January 20, 2015. In addition, some of the States that provided EPD did not submit the data to the IRS in time for the IRS to validate them prior to the start of the filing season.
[18] Fifty States and the District of Columbia.
[19] These tax returns are not included in our analysis of the 2.6 million tax returns on page 10.

However, even with the use of the Form 1095-A data, the IRS was unable to verify all PTC claims because not all State Exchanges submitted Forms 1095-A to the IRS timely or in a usable format. For example, as of January 31, 2015, the IRS received Form 1095-A data from 40 of the 50 States and the District of Columbia, but it could not use some of the Form 1095-A data received because the records did not meet the required data format. Throughout the filing season, the Exchanges continued to correct the format of their Form 1095-A filings provided to the IRS. As of April 15, 2015, the IRS had accepted Forms 1095-A from 47 of the 50 States and the District of Columbia.

Delays in loading the EPD into return processing systems further reduced the IRS's ability to efficiently verify PTC claims

IRS management indicated that the computer application the IRS uses to load the EPD into its tax return processing systems was not functioning properly. As a result, the IRS was unable to load most EPD received after January 20, 2015, for all 36 States in the Federal Exchange and 12 of the 15 State Exchanges until March 29, 2015. According to IRS management, improvements were made to the computer application used to receive and load the EPD into its processing systems and, as a result, it has been able to successfully load submitted EPD into its processing systems since March 29, 2015.

We believe that the majority of the delays in the IRS receiving the EPD for the 2015 Filing Season can be attributed to this being the first year that the Exchanges were required to provide these data. Our discussions with the Exchanges and the IRS indicated that some Exchanges experienced problems with their enrollment systems while others experienced delays in verifying the enrollment data with the insurance carriers as required by HHS regulation. Both conditions affected the Exchanges' ability to timely provide the IRS accurate EPD.

We plan to continue our evaluation of the effectiveness of IRS verification of PTC claims during the 2016 Filing Season, including an assessment of the IRS's receipt of required EPD and Forms 1095-A from the Federal and State Exchanges.

The Allowable Premium Tax Credit Was Computed Correctly for the Majority of Tax Returns; However, Programming Errors Resulted in Some Erroneous Claims

Our analysis of more than 2.6 million tax returns[20] filed between January 20, 2015, and May 28, 2015, in which the taxpayer either claimed the PTC or should have reconciled APTCs

[20] We reviewed 2.6 million of the 3.3 million tax returns filed as of May 28, 2015. We were unable to calculate the PTC for tax returns that we could not find support for in the EPD or that involved more complex calculations. We will attempt to review these more complex cases in our next review. See Appendix I for additional details.

per the EPD found that the IRS accurately determined allowable PTCs[21] on more than 2.4 million (93 percent) returns. The process to verify the amount of allowable PTC is complicated. The data provided by the Exchanges need to first be grouped or identified by tax household[22] and then the premium amount fields need to be totaled, which requires using multiple files. The calculated taxpayer contribution amount along with the insurance premium amount and the Second Lowest Cost Silver Plan (SLCSP) premium amount is then used to determine the taxpayer's allowable PTC. Finally, the allowable PTC amount needs to be reconciled with information from the Exchanges regarding the amount of APTC the taxpayer received to determine if the taxpayer is entitled to an additional PTC amount or must repay excess APTC.

For the remaining 182,884 tax returns for which our allowable PTC calculation differed from the IRS, we determined the following:

- 19,651 tax returns – the IRS incorrectly projected EPD amounts for months when the EPD were incomplete. Due to the timing of the filing of the EPD, the IRS does not have EPD for the entire prior calendar year at the start of the filing season. For example, the EPD submitted to the IRS in January 2015 included data for January through December 2014. However, the IRS did not load the data until after January 20, 2015. As a result, the IRS developed a program to extrapolate the APTC paid to insurers in December if the EPD shows a payment was made in November. This program was not extrapolating the APTC for December accurately. IRS management agreed that the program was not correctly extrapolating the APTC and informed us that the computer programing was corrected for the 2016 Filing Season. We will evaluate the IRS's corrective action in our next review.
- 7,895 tax returns – because of systemic problems with the computer hardware, the IRS did not identify these tax returns, which had APTC reported in the EPD, for further review during processing. As a result, 7,849 taxpayers received approximately $21 million more in PTCs than they were entitled to receive[23] and 46 taxpayers received $5,390 less in PTCs than they were entitled to receive.[24] According to IRS management, the IRS took actions in November 2015 to mitigate the systemic problems, and they have not recurred since then. We will evaluate the IRS's corrective action in our next review.

[21] The IRS correctly identified questionable returns for review. Tax returns that meet certain dollar tolerances are verified. Tax returns below the tolerances are processed as filed.
[22] The tax household consists of the taxpayer and any individuals who are claimed as dependents on one Federal income tax return. A tax household may include a spouse and dependents.
[23] Of these, 7,839 taxpayers did not repay $21,392,978 in APTC that they were required to repay.
[24] Of these, 36 taxpayers repaid $2,414 more in APTC than they were required to repay. We determined these amounts by comparing PTC calculated using the EPD to PTC calculated by the IRS using taxpayer amounts.

- 4,672 tax returns – taxpayers' reported income was over 400 percent of the FPL, but the IRS did not require the taxpayers to repay all of the APTCs they received. The ACA requires individuals who receive APTCs and who have income that is over 400 percent of the FPL to repay 100 percent of the APTC received. As a result, these taxpayers received approximately $6.5 million in APTCs that they were not entitled to receive.

  IRS management indicated that they did not require the taxpayers to repay all of the APTCs because the ACA does not grant the IRS the authority to systemically correct tax returns with PTC claims when a discrepancy exists between information reported by the taxpayer and the EPD. For the 4,672 tax returns we identified above, the IRS cannot systemically assess the entire amount of APTCs reported in the EPD as the taxpayer's repayment amount. The IRS can only assess the amount of APTCs that the taxpayer self-reports on the tax return. For each of these 4,672 tax returns, the taxpayers, despite having income that should result in a 100 percent repayment of the APTC, did not self-report all APTCs received on their tax return. The Department of the Treasury has submitted a legislative proposal that would expand the IRS's authority to correct errors in cases for which the information provided by the taxpayer does not match the information contained in Government databases, including the EPD.

  However, it should be noted that the IRS can take other actions during processing to correct tax returns when the EPD do not support the amounts reported on the tax return. For example, the IRS developed processes to identify tax returns during processing for which the income reported exceeds the FPL threshold. If the discrepancy between what is reported by the taxpayer and the EPD is above a certain dollar limit, the IRS will suspend the tax return and correspond with the taxpayer to request that he or she verify the information on the tax return. The IRS can then adjust the tax return based on the taxpayer's response. The IRS did not correspond with the taxpayer on 4,560 (98 percent) of the 4,672 tax returns we identified because the returns were below the dollar limit.

- 281 tax returns – due to a computer programming error, the IRS incorrectly allowed the PTC to taxpayers who did not claim an exemption for themselves on their tax return. The ACA requires an individual to claim themselves on their tax return to receive the PTC. The IRS indicated that due to a programming error, some taxpayers who filed a paper tax return were allowed the PTC even though they did not claim a personal exemption. These 281 taxpayers received $777,105 more in PTCs than they were entitled to receive. IRS management informed us that the computer programing error was corrected for the 2016 Filing Season. We will evaluate the IRS's corrective action in our next review.

We are continuing to work with the IRS to determine the cause for the calculation differences we identified for the remaining 150,385 tax returns where our calculation did not agree with the IRS's calculation. We plan to incorporate any findings into our next review of the IRS's verification of PTC claims on Tax Year 2015 tax returns.

Recommendation

Recommendation 1: The Commissioner, Wage and Investment Division, should ensure that a review is completed of the 27,827 tax returns TIGTA identified for which the IRS incorrectly verified the PTC claim to ensure that individuals receive the correct PTC amount.

> ***Management's Response:*** The IRS agreed with this recommendation. The IRS will conduct a review of the 27,827 tax returns to prioritize them against existing workload demands and resource constraints so that they may be addressed accordingly.

Programming Errors Resulted in Some Processing Controls Not Functioning As Intended

In an effort to identify erroneous PTC claims, the IRS developed the following processes:

- ***Preprocessing error screening.*** Prior to the IRS accepting an electronically filed (e-filed) tax return with a PTC claim, the tax return is screened through 80 PTC reject conditions. For example, one reject condition ensures that a Form 8962 is included with the tax return when the PTC is claimed. Another identifies a discrepancy between the number of exemptions reported on Form 1040, *U.S. Individual Income Tax Return*, and Form 8962. If a reject condition is identified, the tax return will be rejected back to the taxpayer for correction.

  Similar to the verifications performed for e-filed tax returns, paper-filed tax returns are perfected by tax examiners in the IRS's Code and Edit function before the tax return information is entered into the IRS computer system. For example, employees verify whether a Form 8962 is attached to the tax return. Once perfected by the Code and Edit function, the information from the paper-filed tax return, along with the perfected return coding, is entered into IRS computers.

- ***Real-time error identification.*** Once a tax return with a PTC claim is accepted for processing (e-filed and paper), the tax return is screened for 20 additional error conditions specific to the PTC:

  - 10 error conditions identify PTC mathematical errors on the tax return or Form 8962. Using its math error authority,[25] the IRS will correct the math error and notify the taxpayer of any resulting change in his or her PTC claim.

  - 10 error conditions identify discrepancies between PTC information reported on Form 1040 and Form 8962 as well as discrepancies between the PTC tax return information and the EPD the IRS receives from the Exchanges. Tax returns with

[25] Authority granted to the IRS in the Internal Revenue Code that allows the IRS to systemically correct certain mathematical or clerical errors on a tax return.

these conditions are sent to the IRS Error Resolution function for review. Depending on the dollar amount of the discrepancy, the IRS will correspond with the taxpayer for additional information to support his or her PTC claim or process the tax return and identify it for evaluation for post-processing compliance activity.

Evaluation of preprocessing error screening

As we reported in an interim report,[26] our analysis of tax returns processed as of March 26, 2015, verified that tax examiners were coding paper-filed tax returns with PTC error conditions. In addition, the IRS correctly accepted only those e-filed tax returns that did not contain 79 of the 80 reject conditions (codes). As of May 27, 2015, the IRS rejected more than 300,000 tax returns that included 624,371 PTC reject conditions.[27] For the remaining reject code, we found that tax returns are not rejecting when**********2**********[28] ********** **********2**********. IRS management agreed that a programming error was causing some of this information to not be evaluated, which resulted in the reject code not functioning correctly. IRS management indicated the programming will be corrected on December 27, 2015, for Processing Year 2016.

Evaluation of real-time error identification

As we reported in our interim report, our analysis of tax returns processed as of March 26, 2015, also identified concerns with the functionality of four (20 percent) of the 20 PTC error codes. Figure 6 provides a breakdown of the approximately 2.4 million PTC error conditions identified on tax returns processed as of May 27, 2015.[29]

Figure 6: Analysis of PTC Error Codes as of May 27, 2015

Error Code	Code Type	Description	Tax Returns With Error Condition
276	Math Error	**********2********** **********2**********	65,408
274	Math Error	**********2********** **********2**********	63,988

[26] TIGTA, Ref. No. 2015-43-057, *Affordable Care Act: Interim Results of the Internal Revenue Service Verification of Premium Tax Credit Claims* (May 2015).
[27] A tax return can have more than one reject condition.
[28] **********2********** **********2**********.
[29] A tax return can have more than one error condition.

Error Code	Code Type	Description	Tax Returns With Error Condition
271	Math Error	**********2********** **********2********** ********2*******.	62,989
346	Math Error	**********2********** **********2**********.	39,950
270	Math Error	**********2********** **********2********** **********2********** ***********2**********.	14,547
275	Math Error	**********2********** **********2**********.[30]	10,340
344	Math Error	**********2********** **********2**********.	5,215
345	Math Error	**********2********** **********2********** **********2********** **********2********** ***********2**********.	3,380
272	Math Error	**********2**********[31] ********** **********2**********.	28
273	Math Error	**********2********** **********2********** **********2**********.	20
195	Other	**********2********** ***********2**********.	1,014,592
190	Other	**********2********** **********2********** **********2********** ***********2**********.	729,000
198	Other	**********2********** **********2**********.	153,554

[30] **********2********** **********2********** **********2********** **********2********** **********2**********.

[31] **********2********** **********2**********.

Error Code	Code Type	Description	Tax Returns With Error Condition
196	Other	**********2********** **********2**********.	110,974
199	Other	**********2********** **********2**********.	93,058
197	Other	**********2********** **********2**********.	85,892
194	Other	**********2********** **********2********** **********2********** **********2**********.	15,948
191	Other	**********2********** **********2********** **********2********** ***2*******.	6,496
192	Other	**********2********** **********2********** **********2**********.	2,265
193	Other	**********2********** **********2********** **********2********** *****2******.	99

Source: IRS Internal Revenue Manual and Error Code Volume reports.

As of May 13, 2015, the IRS confirmed that because of programming errors, the four error codes we identified did not always identify tax returns with the particular error condition.

- Error Codes 197 and 198: Computer programming did not identify returns for which the **********2********** **********2********** **********2**********. To address the programming errors, the IRS implemented revised programming on June 7, 2015, to reflect **********2********** **********2**********. Analysis of tax returns processed as of July 9, 2015, found that the computer system changes implemented on June 7, 2015, were successful. Analysis of tax returns processed as of November 5, 2015, found that the computer system changes implemented on October 4, 2015, were successful.
- Error Code 199: Computer programming did not identify returns for ****2*** **********2**********. The IRS

indicated that programming errors resulted in a tolerance amount being incorrectly used and the system failing to compute an essential calculation that determines whether the error code was set. The IRS implemented computer system changes on June 7, 2015, to ensure that the error code **********2********** ********2********. Analysis of tax returns processed as of July 9, 2015, found that these computer system changes were successful.

- Error Code 275: Computer programming did not identify returns for ****2********** **********2********** **********2********** **********2**********. The IRS implemented computer system changes on October 4, 2015, to check **********2********** **********2**********. Analysis of tax returns processed as of November 5, 2015, found that the computer system changes were successful.

Processes Have Been Established to Identify and Prevent Fraudulent Premium Tax Credit Claims

In an effort to identify and prevent potentially fraudulent PTC claims at the time tax returns are processed, the IRS developed the following processes:

- **Identity theft filters.** The IRS developed 10 PTC-specific filters to identify and stop tax returns with PTC claims that are potentially fraudulent and involve identity theft. When a tax return is identified as potentially fraudulent, the tax return will not post until the taxpayer authenticates his or her identity. If the taxpayer authenticates his or her identity, the return will then be sent for screening through the other remaining PTC-related filters.
- **Dependent Database[32] filters.** The IRS developed 11 PTC-related Dependent Database filters. These filters also check the tax returns against various predetermined scenarios aimed at identifying potentially fraudulent PTC claims. Tax returns meeting Dependent Database filter criteria are scored and considered for either the Automated Questionable Credit program[33] or examination.

Our analysis of tax returns processed as of May 14, 2015, verified that the identity theft and Dependent Database filters are operating as intended and correctly identifying potentially

[32] The Dependent Database is a risk-based audit selection tool used by the IRS to identify tax returns for audit. The Dependent Database is made up of a collection of information databases that include birth certificate information and court documents used to establish a relationship and residency between the taxpayer and the qualifying children claimed on the tax return.

[33] The Automated Questionable Credit program is a prerefund compliance program that uses systemic treatments such as automated taxpayer notifications and adjustments to work straightforward cases not handled by other traditional compliance processes.

erroneous PTC claims for further review. As of July 23, 2015, the IRS reported that more than 18,000 tax returns with a PTC claim were identified as potentially fraudulent. Figure 7 shows information on potentially fraudulent ACA-related tax returns.

Figure 7: Potentially Fraudulent ACA-Related Tax Returns Selected and Closed by Function (as of July 23, 2015)

Function	Total Returns Selected	Total Closures	PTC Dollars Protected
Identity Theft	22,114	16,761	$40,576,454
Automated Questionable Credit Program	21,117	952	$1,084,700
Examination	9,281	980	$1,135,979
Total	52,512	18,693	$42,797,133

Source: The IRS's Return Integrity and Compliance Services function.

Processes Do Not Use the Most Current Tax Filing Data to Identify Individuals Who Received Advance Premium Tax Credit Payments and Did Not File a Tax Return As Required

The IRS has established processes to identify individuals who received the APTC but did not file a tax return (hereafter referred to as nonfilers) to reconcile the amount of APTC received as required. The IRS has two data sources that can be used to identify nonfilers – the EPD and Form 1095-A. Our initial evaluation of the methodology the IRS used to identify nonfilers showed that the IRS primarily used Form 1095-A data to identify individuals who received the APTC. The IRS later used the EPD for two States that had not submitted any Forms 1095-A.

On August 3, 2015, the IRS provided us a list of 712,393 individuals who had received APTCs and had not filed a tax return or requested an extension of time to file. On September 4, 2015, we received a list of an additional 5,295 individuals. However, we found that some individuals were duplicated in the IRS's lists. As such, there were actually 703,934 unique nonfilers whom the IRS identified. These 703,934 nonfilers received more than $2.4 billion in APTCs.

Our analysis of the 703,934 nonfilers identified 17,761 (3 percent) who had filed a tax return or extension. When we brought this to IRS management's attention, they agreed with our findings and explained that they were under time constraints to get notices to as many taxpayers as possible to minimize any effect to the taxpayers who do not reconcile their APTCs. The IRS identified nonfilers using only those tax returns that had completed processing rather than using data showing that a tax return was received and was being processed. IRS management agreed that some taxpayers may have been inappropriately notified that they had not yet filed a tax

return. According to IRS management, to mitigate the impact of these unnecessary letters, all of the letters discussed above notify the taxpayer that he or she may disregard the letter if a return has already been filed.

Taxpayers receiving APTC payments must file a tax return and reconcile the APTC amounts received with their allowable PTC. This reconciliation is necessary because the Exchanges base APTC amounts on estimates of an individual's income and family size for the upcoming calendar year. The amount of PTC an individual should receive is based on the income and family size reported on his or her annual tax return. This is often different from the estimates computed at enrollment. If a taxpayer does not file a tax return and reconcile the amount of APTC payments received, the taxpayer should not be eligible to receive the APTC from an Exchange in future enrollment years. During the Income and Family Size Verification process for the subsequent enrollment year, the IRS will provide Exchanges with a response code identifying those taxpayers who did not file a tax return for the tax year they received the APTC and, therefore, should be ineligible to receive the APTC.

We plan to further address the IRS's identification of nonfilers as part of a separate ongoing audit to address a July 20, 2015, request from the Chairman of the Senate Committee on Finance. The Chairman requested that TIGTA conduct a review of the applications, correspondence, and other documentation associated with Calendar Year 2014 APTC recipients who did not file a tax return to reconcile their APTC payments or seek an extension to file. The Committee asked us whether these individuals claimed eligibility under their true identities and were qualified for the APTC amount received. We expect to issue our audit report later this fiscal year.

The IRS issued letters to nonfilers alerting them of the requirement to file a tax return to reconcile the APTC received

The IRS mailed notices between July 10, 2015, and August 21, 2015, to 717,664 nonfilers[34] and 337,065 extension filers the IRS identified. The IRS notices (Letter 5591, Letter 5591-A, and Letter 5596) encouraged nonfilers to file a tax return and reconcile their APTCs as soon as possible. These notices also explained that not filing a tax return may affect their eligibility to receive the APTC next year.

- ***Letters 5591 and 5591-A*:** These letters state that IRS records show that the recipient did not file a Tax Year 2014 tax return to reconcile APTC payments. They also state that the recipient should file a return as soon as possible; otherwise, the recipient will not be eligible for financial assistance for Marketplace health insurance coverage in Calendar Year 2016. The IRS sent Letters 5591 and 5591-A to 717,664 individuals.
- ***Letter 5596*:** This letter states that IRS records show that the recipient has not yet filed a Tax Year 2014 tax return to reconcile APTC payments. Even if the recipient has an

[34] The number of specific notices provided by the IRS reflects 24 less notices than were actually included in the lists that the IRS provided to us.

extension, he or she should file a return as soon as possible; otherwise, he or she will not be eligible for financial assistance for Marketplace health insurance coverage in Calendar Year 2016. According to the IRS, Letter 5596 was sent to individuals who had requested an extension of time to file. The IRS sent Letter 5596 to 337,065 individuals.

Our review of 698,277 individuals who were identified by the IRS as nonfilers found that 210,027 filed a tax return after May 28, 2015, which is when the IRS identified them as a nonfiler.

The IRS will provide notification to Exchanges identifying individuals who have not filed tax returns to reconcile the APTC as required

The IRS has developed an external response code that is returned to the Exchanges when the Exchanges request tax return information during the Calendar Year 2016 Exchange open enrollment period. For example, when the Exchange requests tax information for an individual and that individual received the APTC in Calendar Year 2014 but has not yet filed his or her Tax Year 2014 tax return, the IRS will return a code indicating that the individual has not yet filed a tax return. The Exchanges are to use this information when determining if an individual remains eligible to receive the APTC in Calendar Year 2016.

However, not all individuals for whom the IRS returns the nonfiler code may be nonfilers at the time their coverage is being renewed. IRS management informed us that to be able to timely respond to Exchange requests for tax information beginning in October 2015, the IRS had to compile its nonfiler information as of September 10, 2015. This information was available to the Exchanges as of September 27, 2015. Subsequent updates occur monthly and will represent tax returns filed as of approximately the 10th of the month and will generally be available to the Exchanges on the fourth Sunday of the month. As a result, the IRS could incorrectly notify the Exchange that an individual has not filed a tax return when in fact the individual may have filed a tax return. For example, if a taxpayer filed a tax return on the October 15 extension due date, this would not be reflected in the data made available to the Exchanges until late November.

Our review of nonfilers identified by TIGTA found that 23,836 nonfilers subsequently filed a tax return between October 1, 2015, and October 23, 2015. If these taxpayers applied for insurance from the Exchange during this time period, the IRS would have incorrectly informed the Exchange that the taxpayer had not filed a Tax Year 2014 tax return. The IRS's decision to not use the most current tax information when responding to enrollment requests from Exchanges could cause burden and hardship on individuals who in fact filed their required tax return.

Recommendation

Recommendation 2: The Chief Technology Officer in conjunction with the Director, Affordable Care Act Office, should modify the Income and Family Size Verification processes to use the most current data available at the time a request is received from an Exchange when determining if a taxpayer has reconciled APTCs received in the prior calendar year.

Management's Response: The IRS agreed with this recommendation. However, the implementation of requisite programming changes is subject to budgetary constraints, limited resources, and competing priorities. Consequently, and due solely to those constraints, the IRS cannot provide an implementation date at this time.

Taxpayer Use of Incorrect Forms 1095-A, Health Insurance Marketplace Statement, Resulted in Incorrect Premium Tax Credit Claims

Our analysis of PTC claims filed between January 20, 2015, and May 26, 2015, identified 168,447 taxpayers whose PTC or APTC repayment amounts were incorrect as a result of the taxpayer receiving an incorrect Form 1095-A from the Exchange. This included 70,854 taxpayers who received approximately $8.3 million more in PTCs than they were entitled to receive and 69,405 taxpayers who received approximately $1.9 million less in PTCs than they were entitled to receive. Each of these taxpayers used an originally issued Form 1095-A rather than a subsequently issued corrected Form 1095-A when computing the PTC.

On February 20, 2015, the CMS reported that it issued incorrect Forms 1095-A to approximately 800,000 individuals who participated in the Federal Exchange. According to the CMS, a computer programming error caused the SLCSP premium amount for Calendar Year 2015 to be shown instead of Calendar Year 2014 on some Forms 1095-A issued by the Federal Exchange. Taxpayers use the SLCSP premium amount to compute their allowable PTC. The Department of the Treasury (Treasury Department) estimated that 50,000 of these taxpayers had already filed their tax return as of February 2015.

In addition, on February 13, 2015, the California State Exchange announced that approximately 100,000 of the Forms 1095-A it issued contained errors in coverage dates, enrolled individuals, or policy changes. Representatives from the Exchange indicated that these errors resulted from discrepancies between the Exchange's records and the information used by the insurance carriers. Representatives also estimate that approximately 50,000 individuals who should have received a Form 1095-A did not receive one as required. Exchange representatives indicated that corrected Forms 1095-A were issued in late February to replace the 100,000 incorrect forms. The Exchange was working to issue the remaining corrected Forms 1095-A by the end of March.

The IRS issued a number of press alerts to taxpayers and tax return preparers reiterating the importance of using the corrected Form 1095-A should they receive one to prepare their tax return. On February 24, 2015, the Treasury Department announced that taxpayers enrolled in the Federal Exchange who have already filed their tax return do not need to file an amended tax return to correct errors in their PTC claim resulting from an incorrect Form 1095-A. The Treasury Department stated that the IRS would not pursue action to recoup the excess PTC these taxpayers may have received as a result of the error. On March 20, 2015, the Treasury Department expanded relief from filing an amended tax return to all taxpayers who received and filed a tax return based on an incorrect Form 1095-A.

Appendix I

Detailed Objective, Scope, and Methodology

Our overall objective was to evaluate the effectiveness of the IRS's verification of PTC claims during the 2015 Filing Season. To accomplish this objective, we:

I. Assessed the adequacy of the IRS's processes to validate EPD and Form 1095-A, *Health Insurance Marketplace Statement*, data provided to the IRS.

A. Obtained a copy of the EPD files received from the Exchanges in October and November 2014.

1. Analyzed the data extracts to identify any potential issues with the reliability of the data. We obtained the raw data files for one Exchange and compared limited fields to the EPD file provided and determined that there were no discrepancies in these fields. Also, we obtained the EPD as of February 2, 2015, from 24 Exchanges and performed analysis on limited fields to identify unreasonable values. We determined that the data were sufficiently reliable for our intended purpose.

2. Determined whether the IRS was accurately processing all EPD records received.

B. Determined whether the IRS's processes ensured that all required data were included in the EPD and Form 1095-A.

II. Determined if the IRS was adequately validating the accuracy of APTC reconciliations and PTC claims at filing.

A. Determined if IRS business rules relevant to PTC processing accurately confirm PTC eligibility requirements and accurately calculate APTC reconciliations and PTC claims using taxpayer data provided on Forms 1040, *U.S. Individual Income Tax Return*, and 8962, *Premium Tax Credit (PTC)*.

1. Reviewed desk procedures and Internal Revenue Manuals for Error Resolution and Code and Edit functions for the PTC forms to determine if they adequately addressed issues identified during processing.

2. Independently developed an APTC calculation and cross-checked the independent calculation against the IRS's APTC calculations.

B. Determined if the IRS accurately calculated the repayment amount when the taxpayer received too much APTC during the coverage year. For taxpayers who chose not to receive the APTC at the time of enrollment, we determined how the IRS verified the accuracy of the PTC claim.

1. Obtained 3,313,505 2014 tax returns filed between January 20, 2015, and May 28, 2015, that either contained a Form 8962, reported a Net PTC or Excess APTC Repayment on Form 1040, or contained an ACA Resolution Code.[1] We validated the reliability of the data extracts by selecting a judgmental sample and ensuring that the tax return data fields were supported by data contained in the IRS's Integrated Data Retrieval System.[2] We determined that the data were sufficiently reliable for our intended purpose.
2. Identified 215,677 tax returns for which both TIGTA and the IRS did not have the EPD available.
3. Identified 222,926 tax returns for which TIGTA and the IRS showed different EPD amounts.
4. Identified 260,817 tax returns for which TIGTA could not verify the PTC due to a complex situation not built into the scope of TIGTA's PTC calculation. These included 60,972 tax returns requiring extrapolation due to missing months of EPD and tax returns with a Shared Policy Allocation or Alternative Calculation for Year of Marriage, *etc*. This also included 199,845 tax returns for which TIGTA was unable to verify the PTC due to TIGTA estimating allowable PTC when the taxpayer did not claim the PTC and the IRS not assuming eligibility for the PTC when the taxpayer did not claim the PTC.
5. Identified 2,431,201 tax returns for which TIGTA calculated a PTC that matched IRS calculations.
6. Identified 182,884 tax returns for which TIGTA calculated a PTC that did not match IRS calculations.

C. Determined if the IRS adequately identified and addressed potentially fraudulent requests for the PTC at filing.

1. Assessed the effectiveness of the IRS's current fraud filters for addressing potentially fraudulent requests for the PTC at filing and if the filters operated correctly.
2. Determined how the IRS identified taxpayers who received the APTC during the coverage year but either did not file a tax return or did not reconcile the amount of the APTC on their tax return during the filing season.

[1] The ACA Resolution Code is an alphanumeric field that contains codes input by Error Resolution function examiners during tax return processing that indicate whether an ACA-related error check has been bypassed and the taxpayer entry is accepted.
[2] The Integrated Data Retrieval System is an IRS computer system capable of retrieving or updating stored information. It works in conjunction with a taxpayer's account records.

III. Assessed the impact on tax administration of the issuance of incorrect Forms 1095-A by the Exchanges.

A. Quantified the number of taxpayers who received an incorrect Form 1095-A and subsequently received an incorrect amount of the PTC or an incorrect APTC repayment amount. We obtained a data extract, provided by TIGTA's Strategic Data Services, of original and corrected Forms 1095-A from the Information Returns Database.[3] We selected a judgmental sample from our data extract and validated the data using Business Objects Enterprise.[4] We determined that the data were sufficiently reliable for our intended purpose.

B. Matched the Form 1095-A data received by the IRS to the EPD for the 2014 enrollment year and identified discrepancies in the data. We determined if the individuals who received an incorrect Form 1095-A have discrepancies between the EPD and IRS Form 1095-A data.

IV. Monitored IRS workloads and current staffing resources related to the processing of PTC claims.

A. Determined the number of PTC claims received by the IRS during the 2015 Filing Season. We obtained the IRS PTC-related Individual Master File[5] fields for the 3,313,505 returns extracted in Step II.B.1. We validated the reliability of the fields extracted by selecting a judgmental sample and ensuring that the data fields matched the source system using the IRS's Integrated Data Retrieval System. We determined the data were sufficiently reliable for our intended purpose.

B. Monitored the total Error Resolution inventory volume and the volume of PTC error codes and determined whether the error codes were functioning as intended.

C. Monitored e-filed tax returns for conditions that should have been rejected and determined whether the reject codes were functioning as intended.

[3] The Information Returns Database contains ACA information returns received through the ACA Information Returns system. The ACA Information Returns system receives Forms 1095-A; 1095-B, *Health Coverage*; 1095-C, *Employer-Provided Health Insurance Offer and Coverage;* 1094-B, *Transmittal of Health Coverage Information Returns*; and 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*, submitted by Health Insurance Marketplaces, insurance companies, and employers.

[4] The Business Objects Enterprise is the IRS's business intelligence platform that provides users tools and applications for reporting, querying, and analyzing ACA information.

[5] The Individual Master File is the IRS database that maintains transactions or records of individual tax accounts.

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 obtaining, validating, and using the EPD provided by the Exchanges and the IRS's policies and procedures for monitoring and validating the accuracy of APTC reconciliations and PTC claims at filing. We evaluated these controls by interviewing IRS management, reviewing key system documentation related to the verification and processing of APTC reconciliations and PTC claims at filing, and performing an independent calculation of the PTCs that taxpayers were entitled to receive. We also evaluated the controls that are incorporated directly into computer applications to help ensure the validity, completeness, and accuracy of transactions and data during application processing of tax returns for the 2015 Filing Season.

Appendix II

Major Contributors to This Report

Russell P. Martin, Assistant Inspector General for Audit (Returns Processing and Account Services)
Deann L. Baiza, Director
Sharla J. Robinson, Audit Manager
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Karen C. Fulte, Senior Auditor
Sandra L. Hinton, Senior Auditor
Lance J. Welling, Senior Auditor
Jeffrey D. Cullum, 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
Associate CIO, Affordable Care Act (PMO)
Director, Affordable Care Act Office
Director, Customer Account Services, Wage and Investment Division
Director, Filing and Premium Tax Credit Strategy, Affordable Care Act Office
Director, Office of Legislative Affairs
Director, Program Management Office, Affordable Care Act Office
Director, Submission Processing, Wage and Investment Division
Director, Office of Audit Coordination

Appendix IV

Outcome Measures

This appendix presents detailed information on the measurable impact that our recommended corrective actions will have on tax administration. These benefits will be incorporated into our Semiannual Report to Congress.

Type and Value of Outcome Measure:

- Cost Savings, Funds Put to Better Use – Potential; 8,130 taxpayers receiving $22,185,990 more in PTCs than they were entitled to receive as a result of the IRS not identifying potentially erroneous PTC claims during processing for further review (see page 10).

Methodology Used to Measure the Reported Benefit:

We obtained Tax Year 2014 tax returns filed between January 20, 2015, and May 28, 2015, which had indications of PTC. We independently developed a calculation to compute allowable PTCs and the amount of APTC required to be repaid and compared these figures to the IRS's calculations. We identified 8,130 tax returns for which the taxpayers received $22,185,990 in PTCs to which they were not entitled.

- 7,849 taxpayers who received $21,408,885 in PTCs to which they were not entitled as a result of programming errors that prevented the IRS from identifying the tax return during processing for further review. Our analysis of the tax returns for which TIGTA and IRS calculations did not match identified 7,895 tax returns for which the exposure amount computed by the IRS was equal to $0 and the IRS had set an error flag indicator showing that a Form 8962, *Premium Tax Credit (PTC)*, was not filed but for which the IRS had EPD. The exposure amount is an amount created by the IRS during processing that is calculated based upon differences between estimated amounts calculated by the IRS and amounts reported by the taxpayer. This amount represents the risk facing the IRS or risk facing the taxpayer for each tax return. When the taxpayer does not claim the PTC, the exposure amount should be equal to the amount of APTC payments received. Further analysis was completed to determine the amounts of PTCs allowed by the IRS and the amounts of APTCs reported after the returns had been processed. We compared the IRS amounts to the allowable PTCs computed and the APTCs obtained from the EPD by TIGTA to determine the amounts of PTCs taxpayers received to which they were not entitled. We determined that 7,849 of the 7,895 taxpayers we identified received $21,408,885 in PTCs to which they were not entitled.
- 281 taxpayers who received $777,105 in PTCs to which they were not entitled as a result of the IRS incorrectly allowing PTCs to taxpayers who did not claim an exemption for

themselves on their tax return. The ACA requires an individual to claim himself or herself on his or her tax return to receive the PTC. Our analysis of the tax returns for which TIGTA and IRS calculations did not match identified 281 tax returns for which the taxpayer did not claim himself or herself as an exemption on Form 1040 and the PTC was allowed by the IRS. Further analysis was completed to determine the amount of PTC allowed by the IRS after the return had been processed. We compared the IRS amounts to the allowable PTCs computed and the APTCs obtained from the EPD by TIGTA to determine the amounts of PTCs taxpayers received to which they were not entitled.

Type and Value of Outcome Measure:

- Taxpayer Rights and Entitlements – Potential; 46 taxpayers receiving $5,390 less in PTCs than they were entitled to receive as a result of the IRS not identifying potentially erroneous PTC claims during processing for further review (see page 10).

Methodology Used to Measure the Reported Benefit:

We obtained Tax Year 2014 tax returns filed between January 20, 2015, and May 28, 2015, that had indications of PTCs. We independently developed a calculation to compute allowable PTCs and the amount of APTCs required to be repaid and compared these figures to the IRS's calculations. We identified 46 taxpayers who received $5,390 less in PTCs than they were entitled to receive as a result of programming errors that prevented the IRS from identifying the tax return during processing for further review. Our analysis of the tax returns for which TIGTA and IRS calculations did not match identified 7,895 tax returns for which the exposure amount computed by the IRS was equal to $0 and the IRS had set an error flag indicator showing that a Form 8962 was not filed but for which the IRS had EPD. The exposure amount is an amount created by the IRS during processing that is calculated based upon differences between estimated amounts calculated by the IRS and amounts reported by the taxpayer. This amount represents the risk facing the IRS or risk facing the taxpayer for each tax return. When the taxpayer does not claim the PTC, the exposure amount should be equal to the amount of APTC payments received. Further analysis was completed to determine the amounts of PTCs allowed by the IRS and the amounts of APTCs reported after the returns had been processed. We compared the IRS amounts to the allowable PTCs computed and the APTCs obtained from the EPD by TIGTA to determine the amounts of PTCs taxpayers received to which they were not entitled. We determined that 46 of the 7,895 taxpayers received $5,390 less in PTCs than they were entitled to receive.

Appendix V

Management's Response to the Draft Report

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
ATLANTA, GA 30308

COMMISSIONER
WAGE AND INVESTMENT DIVISION

MAR 2 1 2016

MEMORANDUM FOR MICHAEL E. MCKENNEY
DEPUTY INSPECTOR GENERAL FOR AUDIT

FROM: Debra Holland
Commissioner, Wage and Investment Division

SUBJECT: Draft Audit Report – Affordable Care Act: Internal Revenue Service Verification of Premium Tax Credit Claims During the 2015 Filing Season (Audit #201540317)

Thank you for the opportunity to review and comment on the subject draft report. We appreciate the acknowledgement of our successful efforts in processing and verifying the Premium Tax Credit (PTC) claims during the 2015 Filing Season. This was the first year in which taxpayers were required to reconcile, on their Tax Year 2014 returns, any advanced PTC (APTC) paid on their behalf with the actual amount to which they were entitled. Any excess APTC over PTC was to be repaid with the 2014 tax return, while those taxpayers whose APTC was less than the allowable PTC could receive a refund of the difference. The planning and preparation for administering the reconciliation process was a substantial effort over the course of several years, culminating in the processing of more than 2.9 million tax returns with approximately $9.8 billion in PTC. The IRS achieved a confirmed reconciliation accuracy rate of at least 93 percent, despite challenges associated with required marketplace data not being provided to the IRS in a timely fashion and some programming issues that affected data usability in the reconciliation process. As noted in the report, the Treasury Inspector General for Tax Administration (TIGTA) and the IRS continue to work toward reconciling calculation differences affecting approximately 150,000 returns, comprising another five percent of the total PTC returns.

The high accuracy rate of PTC reconciliation processing was achieved, in part, through the implementation of 80 return validation checks, and another 20 error detection checks. During the 2015 Filing Season, more than 300,000 electronic returns were rejected back to the sender for correction of PTC-related errors, inconsistencies, or missing forms, while other error checking routines detected approximately 2.4 million error conditions that were addressed and resolved before the returns were allowed to continue processing. Marketplace data and information reported on Form 1095-A,

Health Insurance Marketplace Statement, issued by Marketplace providers, was researched and used to resolve errors to the greatest extent possible. Corresponding for missing or incomplete information, in many cases, permitted the correction of inconsistent return entries and allowed the returns to complete the processing cycle.

For those 27,827 returns where the PTC claim may have been incorrectly verified, due to the reliance on projected partial-year data and programming errors, it is important to note that the IRS does not have the statutory authority to correct discrepancies without following deficiency procedures. Deficiency procedures, also known as audit procedures, are costly and compete with other enforcement priorities for scarce resources. We will review those returns to identify those that merit appropriate follow-up activity. While we agree with the TIGTA's computation of the Outcome Measure of $22.2 million associated with a subset of the 27,827 returns, we do not agree that it is an achievable outcome, as any actions taken on these returns will displace other compliance work with a corresponding loss of revenue equal to or greater than the amount of recovered APTC.

We also agree with TIGTA's recommendation to use the most current data available at the time an Exchange request is made, to determine if the taxpayer has reconciled APTC received for the prior year. The requisite programming to implement this recommendation is subject to budgetary constraints, limited resources, and competing priorities for those limited resources. We will pursue the programming changes, but continued funding constraints mean that we cannot provide an implementation date for the corrective action.

Attached are our comments to your recommendations. If you have any questions, please contact me, or a member of your staff may contact Ivy McChesney, Director, Customer Account Services, Wage and Investment Division, at (404) 338-8910.

Attachment

Attachment

RECOMMENDATIONS

RECOMMENDATION 1
The Commissioner, Wage and Investment Division, should ensure that a review is completed of the 27,827 tax returns TIGTA identified for which the IRS incorrectly verified the PTC claim to ensure that individuals receive the correct PTC.

CORRECTIVE ACTION
We agree with this recommendation. We will conduct a review of the 27,827 tax returns to prioritize them against existing workload demands and resource constraints so that they may be addressed accordingly.

IMPLEMENTATION DATE
September 15, 2016

RESPONSIBLE OFFICIAL
Director, Refundable Credits Policy and Program Management, Return Integrity and Compliance Services, Wage and Investment Division

CORRECTIVE ACTION MONITORING PLAN
We will monitor this corrective action as part of our internal management control system.

RECOMMENDATION 2
The Chief Technology Officer in conjunction with the Director, Affordable Care Act Office should modify the Income and Family Size Verification processes to use the most current data available at the time a request is received from an Exchange when determining if a taxpayer has reconciled APTC received in the prior calendar year.

CORRECTIVE ACTION
We agree with this recommendation; however, the implementation of requisite programming changes is subject to budgetary constraints, limited resources, and competing priorities. Consequently, and due solely to those constraints, the IRS cannot provide an implementation date at this time.

IMPLEMENTATION DATE
N/A

RESPONSIBLE OFFICIAL
Director, Affordable Care Act Program Management Office

CORRECTIVE ACTION MONITORING PLAN
N/A

The COMMONWEALTH FUND

New Commonwealth Fund Report: Insurers Increasingly Selling More of Their Individual Health Insurance Plans in ACA Marketplaces; Fears That Insurers Would Pull Healthy Enrollees Away From Marketplaces Unfounded

Report Finds That Individual Plans Sold Outside of ACA Marketplaces Saw Larger Premium Increases and Had Higher Administrative Costs

June 2, 2016

New York, NY, June 2, 2016—Insurance companies are increasingly selling more individual health insurance plans through the Affordable Care Act (ACA) marketplaces, according to a Commonwealth Fund report out today. The report found that in 2016, 17 percent of individual health insurance plans are sold exclusively outside the marketplaces, down from 28 percent in 2014. In addition, insurers projected that in 2016 there would be 12.8 million people enrolled in plans sold predominantly through the ACA marketplace and 2.6 million in off-marketplace plans. This marks a shift from 2014, when insurers projected 11.1 million would enroll in marketplace plans and 4.2 million in off-marketplace plans.

In *Promoting Value for Consumers: Comparing Individual Health Insurance Markets Inside and Outside the ACA's Exchanges (/publications/issue-briefs/2016/june/insurance-exchanges-promote-value)*, Michael J. McCue and Mark A. Hall compared the two segments of the individual health insurance market—plans sold on the ACA marketplaces and those sold outside the marketplaces through insurers or brokers. The researchers found concerns unfounded that insurers would sell cheaper, bare bones plans that would attract healthy enrollees outside the marketplaces and shift the sicker and more costly enrollees to marketplace plans.

According to the report, bronze-level plans, which are the least expensive and provide the lowest amount of coverage, are equally popular on and off the marketplaces. The plans that are most expensive and provide the most coverage (gold and platinum plans) are much more prevalent off the marketplaces.

"Collectively, the data in this report make a strong case for the viability of the Affordable Care Act marketplaces," said Sara Collins, Vice President for Health Care Coverage and Access at the Commonwealth Fund. "Insurers inside the marketplaces appear to be competing well on price and continue to sell more of their business through them. And, the measures designed to encourage insurers to enroll healthier as well as sicker people in the marketplaces are working."

The report also found:

- **Administrative costs** are 2.5 percentage points higher in plans sold exclusively outside the marketplaces. Medical loss ratios—the percentage of a premium that pays for medical costs—are 2 percentage points lower in plans sold off the marketplaces.
- Premiums increased somewhat more off the marketplaces than on—$48 vs. $40 per member per month. The authors attribute this to an enrollment shift in the **ACA marketplaces** away from more expensive preferred provider organizations (PPOs) and point-of-service (POS) plans to HMOs and exclusive provider organization (EPO) plans that limit coverage to contracted providers.
- **Health insurers** do not appear to be segregating their enrollees according to health status between on and off marketplace plans. The Affordable Care Act requires that insurers most provide the same products inside and outside the marketplaces. In addition, the law includes a risk-adjustment mechanism that requires plans that have enrollees in better health and who are less costly to subsidize plans with sicker, costlier enrollees. This reduces the risk of the

Affordable Care Act's marketplaces destabilizing because enrollees are too sick and expensive for insurers.

- **HMO and EPO** plans are increasingly popular in the marketplaces as buyers look for lower premiums. According to the report, plans sold predominantly in the marketplaces projected a 37 percent increase in HMO/EPO enrollment, and a 22 percent decrease in PPO/POS enrollment.

Moving Forward

The authors conclude that the ACA's health insurance market reforms appear to be working as intended in the individual health insurance market, both inside and outside the marketplaces.

"It is important to remember that historically, people buying health insurance on their own were at the mercy of insurers who could turn them away due to preexisting conditions or charge high prices for meager plans that left them exposed to medical debt or bankruptcy if they became ill," said Commonwealth Fund President David Blumenthal, M.D. "The Affordable Care Act changed that by requiring that individual consumers would be sold plans that cover the services they need and protect them financially. These data show that those reforms appear to be working toward creating a stable marketplace."

About This Study

Data come from the "unified rate review template" (URRT) spreadsheets for 2016 that insurers must file with CMS' Center for Consumer Information and Insurance Oversight (CCIIO), documenting how they develop their premium rates for ACA-compliant plans. The URRT includes two sections: the market-level analysis section, which develops a projected single risk pool rate from prior experience data; and the product/plan section, which reports projected premiums and enrollment for the coming year, in each health plan. This database provides the change in pre¬mium per member for plans offered on and off of marketplace exchanges, as well as the components of costs (claims, administrative) and profit margins driving premium changes.

There were 543 unique insurers in different states. We used projected membership to classify insurers and products as selling predominantly on exchanges versus outside of the government exchanges. For plans sold on exchanges, insurers also must offer these plans outside of the exchanges. Therefore, some "on-exchange" plans also have off-exchange enrollment. However,

because the majority of enrollees receive subsidies that are available only through the exchanges, enrollment in these plans is predominantly on-exchange and therefore the exchange dynamics determine the pricing of these plans even when sold off exchange.

The Commonwealth Fund is a private, nonprofit foundation supporting independent research on health policy reform and a high performance health system.

Promoting Value for Consumers: Comparing Individual Health Insurance Markets Inside and Outside the ACA's Exchanges

June 2, 2016

Authors

Michael J. McCue, Mark Hall

Citation

M. J. McCue and M. A. Hall, *Promoting Value for Consumers: Comparing Individual Health Insurance Markets Inside and Outside the ACA's Exchanges,* The Commonwealth Fund, June 2016.

Abstract

The new health insurance exchanges are the core of the Affordable Care Act's (ACA) insurance reforms, but insurance markets beyond the exchanges also are affected by the reforms. This issue brief compares the markets for individual coverage on and off of the exchanges, using insurers' most recent projections for ACA-compliant policies. In 2016, insurers expect that less than one-fifth of ACA-compliant coverage will be sold outside of the exchanges. Insurers that sell mostly through exchanges devote a greater portion of their premium dollars to medical care than do insurers selling only off of the exchanges, because exchange insurers project lower administrative costs and lower profit margins. Premium increases on exchange plans are less than those for off-exchange plans, in

large part because exchange enrollment is projected to shift to closed-network plans. Finally, initial concerns that insurers might seek to segregate higher-risk subscribers on the exchanges have not been realized.

BACKGROUND

The Affordable Care Act does not require insurers to sell through the new insurance exchanges, or marketplaces.[1 (#/#1)] Although subsidized insurance for individual policies is available only through the exchanges, insurers can choose to sell outside of the exchanges to people who do not qualify for or claim premium subsidies.

Accordingly, two distinct segments have emerged in the individual market: coverage sold on the exchanges, mostly to people who qualify for a subsidy; and coverage sold through traditional channels to people who pay full price. This subdivision of the individual market provides an opportunity to explore how effectively the ACA exchanges are promoting value for consumers.

To investigate this question, we use insurers' filings with the federal government that demonstrate their compliance with the ACA's rating rules (for details, see the About This Study (#/#methods) box). In this issue brief, we analyze insurers' filings for premium rates that took effect in 2016, for ACA-compliant products sold both on and off of the exchanges.[2 (#/#2)]

STUDY FINDINGS

Market Shares

Because the ACA's premium subsidies are available only through the federal and state exchanges, it is no surprise that the great majority of ACA-compliant coverage in the individual market is sold through the exchanges. For 2016, insurers project that only 17 percent of their anticipated 15 million ACA-compliant subscribers will purchase plans sold off of exchanges.[3 (#/#3)] There has been a steady decline of projected nonexchange enrollment since 2014 (Exhibit 1).

Medical Loss Ratios

The ACA's insurance exchanges were intended to improve the value of health coverage for consumers in two ways: 1) by making insurers compete on price, and 2) by reducing overhead sales costs. One indication of whether these goals are being achieved is the medical loss ratio that insurers target, on and off of the exchanges. The medical loss ratio reflects what portion of total premiums an insurer expects to spend on health care services and quality improvement, with the remainder earmarked for overhead costs and profits.

We compared the projected medical loss ratios in 2016 for insurers that sell all of their products on the exchanges with those that only sell off of the exchanges.[4 (#/#4)] To minimize the effect of outliers, we report median rather than mean values. As shown in Exhibit 2, insurers selling exclusively off of the exchanges project a median medical loss ratio that is two percentage points lower than those that sell on the exchanges. This reduced loss ratio is largely accounted for by greater administrative costs: median administrative costs are 2.5 percentage points higher off of the exchanges. Also, median profit ratios are almost one point higher off of the exchanges.

Although exchange insurers projected lower administrative costs and planned to devote less of their earnings to profits, they do project higher taxes and fees—a result of the fees insurers must pay to exchange administrators for plans purchased through them.[5 (#/#5)] These exchange fees are spread, however, across all of an insurer's business, including off-exchange business. Accordingly, the median tax and fee ratio on the exchanges in 2016 is only 1.4 points higher than the ratio off of the exchanges.

It's not clear whether the exchanges themselves cause insurers to devote a lower proportion of premiums to overhead and profits. It is possible that insurers with historically higher overhead or profits choose not to participate in the exchanges. However, it is also possible that the exchange structure makes insurers more efficient by reducing sales and administrative costs and by increasing competition. If so, then those advantages also should be reflected in their off-exchange policies, because they must pool their ACA-compliant business on and off the exchanges for rating and medical loss ratio calculations.

Changes to Premiums and Plan Types

We also analyzed how insurers projected their enrollment and premiums would change in 2016, based on the type of provider networks offered.[6 (#/#6)] As shown in Exhibit 3, premiums increased somewhat more for plans sold off of the exchanges than for those sold on them ($48 vs. $40 per member per month). In large part, this lower premium increase among exchange plans appears attributable to a shift of enrollment toward HMO and "exclusive provider organization" (EPO) plans that limit coverage to contracted provider networks except in emergencies, and away from PPOs or "point of service" (POS) plans that include out-of-network coverage.[7 (#/#7)] Also shown in Exhibit 3, premiums increased substantially more for PPO/POS plans than for HMOs and EPOs, both on and off the exchanges. The plan-type differential was especially large on exchanges, where PPO/POS premium increases were 77 percent greater than for HMOs/EPOs ($53 vs. $30 per member per month).[8 (#/#8)]

Also notable is the substantial increase in HMO/EPO enrollment projected for on-exchange enrollment (Exhibit 4).[9 (#/#9)] Plans sold predominantly on exchanges projected a 37 percent increase in HMO/EPO enrollment, but a 22 percent decrease in PPO/POS enrollment. For off-exchange plans, insurers predicted a 21 percent decrease in PPO enrollment, but no increase in HMO/EPO enrollment.

These differences may indicate that consumers shopping for individual plans on the exchanges are more sensitive to prices. Alternatively, insurers with fewer HMO/EPO provider networks may be less inclined to sell through exchanges. And, both may be true: HMO/EPO insurers may be increasing their presence on exchanges because that is where they gain the greater market advantage over PPO insurers.

Risk Selection

Prior to the exchanges opening for business, analysts speculated that insurers might attempt to segregate higher-risk subscribers on the subsidized exchanges and use the off-exchange market as a way to sell to lower-risk people at lower rates. If successful, such an "adverse selection" strategy could increase the cost of government subsidies.

The ACA, however, has several provisions that keep risk segregation in check. First, it requires insurers to maintain a single risk pool for their ACA-compliant plans in the individual and small-group markets in each state. A single risk pool means that insurers must use the same premium rating factors for all subscribers and plans within a state's individual or small-group market, rather than using different rates for separate risk pools. Second, the ACA has a risk-adjustment mechanism in the individual and small-group markets that requires insurers with lower-risk subscribers to subsidize those that enroll people who are expected to incur more medical claims.

These risk-spreading mechanisms appear to be working. We see little evidence of insurers actively pursuing risk segmentation, for example by offering leaner (i.e., lower cost but less generous) plans off of the exchanges to attract healthier people. Based on our analysis of insurers' federal filings, this does not appear to be occurring (Exhibit 5). Bronze-level plans, which cover only 60 percent of medical expenses on average, constitute a similar proportion of coverage both on and off of the exchanges, about one-fourth of projected enrollment in 2016.

Notably, the richest plans, at the gold and platinum levels, are much more prevalent off of the exchanges than on them, constituting 35 percent of nonexchange enrollment versus only 14 percent of exchange enrollment. Greater sales of gold and platinum plans off of the exchanges is likely due, at least in part, to the fact that wealthier purchasers do not qualify for subsidies, and so those who can afford plans that come with lower deductibles and other cost-sharing are more likely to shop outside of the exchanges.[10 (#/#10)]

Another factor dampening the potential for adverse selection against the exchanges are differences in the provider networks that insurers offer on and off of the exchanges. The exchanges facilitate shopping based on head-to-head price comparisons; therefore, to be competitive, insurers formed narrower provider networks with physicians and hospitals that were willing to give deeper

discounts.[11 (#/#11)] Narrow networks may not be appealing to people with complex health problems who tend to prefer a wide choice of specialists. Therefore, people with preexisting conditions may be more likely to shop for off-exchange plans.

CONCLUSION

The ACA's market reforms appear to be working as intended in the individual market, both on and off of the exchanges, based on available data that compare these two market segments in 2016. Nationally, the portion of the individual market operating outside of the exchanges is diminishing steadily. Projected median profit levels are similar between companies that sell on and off of the exchanges. However, insurers that sell only outside of the exchanges project that a higher percentage of premium dollars will go to administrative costs than do insurers that sell all products on the exchanges. Premium increases on exchanges are less than for plans sold off of the exchanges, in large part because exchange enrollment is projected to shift to closed-network plans. Finally, we see little indication that risk segmentation is causing adverse effects within the ACA-compliant individual market.

About This Study

Data come from the "unified rate review template" (URRT) spreadsheets for 2016 that insurers must file with CMS' Center for Consumer Information and Insurance Oversight (CCIIO), documenting how they develop their premium rates for ACA-compliant plans. The URRT includes two sections: the market-level analysis section, which develops a projected single risk pool rate from prior experience data; and the product/plan section, which reports projected premiums and enrollment for the coming year, in each health plan. This database provides the change in premium per member for plans offered on and off of marketplace exchanges, as well as the components of costs (claims, administrative) and profit margins driving premium changes.

There were 543 unique insurers in different states. We used projected membership to classify insurers and products as selling predominantly on exchanges versus outside of the government exchanges. For plans sold on exchanges, insurers also must offer these plans outside of the exchanges. Therefore, some "on-exchange" plans also have off-exchange enrollment. However, because the majority of enrollees receive subsidies that are available only through the exchanges, enrollment in these plans is predominantly on-exchange and therefore the exchange dynamics determine the pricing of these plans even when sold off exchange.

Acknowledgments

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Notes

[1] States could, if they chose to, make use of the exchanges mandatory in the individual and small-group markets, but so far only Washington, D.C., has done so.

[2] These data do not include grandfathered or other noncompliant plans in which people have renewed their enrollment from 2014. In 2015, such plans accounted for only 16 percent of individual market enrollment, which is half the level of the previous year. L. Hamel, M. Norton, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 2 (http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-2/)* (Henry J. Kaiser Family Foundation, May 2015).

[3] As explained in the About This Study (#/#methods) box, however, plans sold predominantly on exchanges also can have some off-exchange enrollment. Therefore, these projected percentages are not precise market shares.

[4] These are simple, unadjusted loss ratios that do not take account of several factors allowed by the ACA's minimum loss ratio regulation.

[5] S. J. Dash, J. Giovannelli, K. Lucia et al., "State Marketplace Approaches to Financing and Sustainability (/publications/blog/2014/nov/state-marketplace-approaches-to-financing-and-sustainability)," *To the Point (Commonwealth Fund blog),* Nov. 6, 2014.

[6] We identified 6,627 plans with premium rate increase data in 2016, of which 3,755 are sold on exchanges, consisting of 2,158 HMO and EPO plans and 1,597 PPO and POS plans. An additional 2,872 plans are sold off of the exchanges, consisting of 1,279 HMO and EPO plans, 1,547 PPO and POS plans, and 46 indemnity plans.

[7] States often regulate HMOs and PPOs under different sets of insurance laws. These separate regulatory regimes have given rise to the alternative terms, EPO and POS, when insurers established under one regulatory regime decide to offer a plan that is structured like those in the other regime. Thus, EPOs are essentially the same as HMOs but are sold by companies that are regulated as PPOs. Likewise, POS networks are structured like PPO networks but are sold by insurers regulated as HMOs. Regardless of the state regulatory regime, the key distinction, for our purpose, is whether the plan limits coverage to a contracted provider network (HMO and EPO) or covers care provided out of network (PPO and POS).

[8] See also J. Appleby and J. Rau, "As HMOs Dominate, Alternatives Become More Expensive (http://khn.org/news/as-hmos-dominate-alternatives-become-more-expensive/)," *Kaiser Health News,* Nov. 25, 2015.

[9] See also K. Hempstead, *Burnt Offerings? PPOs Decline in Marketplace Plans (http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf424457)* (Robert Wood Johnson Foundation, Nov. 3, 2015).

[10] Also, one likely reason that exchanges have a much greater proportion of their enrollment at the silver level (62% versus 36%) is that lower-income people who are eligible for reduced out-of-pocket cost-sharing must choose a silver plan to receive the full benefit of that subsidy.

[11] S. F. Haeder, D. L. Weimer, and D. B. Mukamel, "Narrow Networks and the Affordable Care Act," *Journal of the American Medical Association,* Aug. 18, 2015 314(7):669–70.

prices. CMS is nudging physicians to prescribe wisely because it can. Nudging manufacturers to price wisely is more contentious and would require congressional approval. The experiment may have trickle-down effects that slow price growth, but ultimately, controlling Medicare spending will require addressing the underlying pricing problem.

An audio interview with Dr. Schrag is available at NEJM.org

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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The ACA and Risk Pools — Insurer Losses in the Setting of Noncompliant Plans

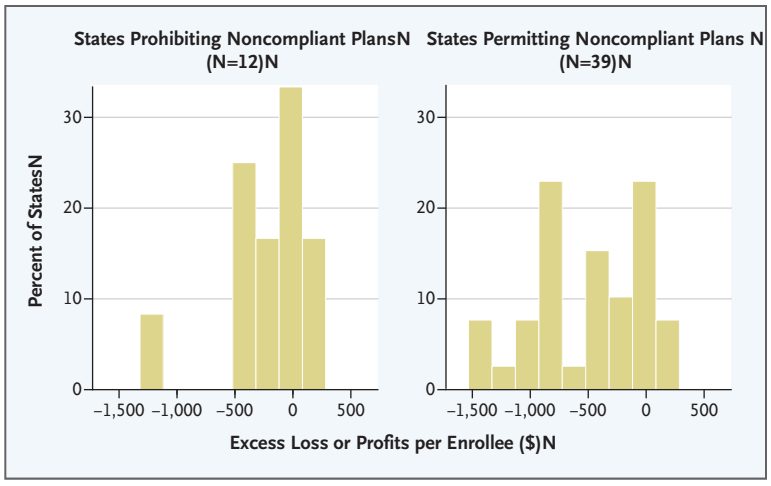
John Hsu, M.D., M.B.A.

The viability of health insurance exchanges established under the Affordable Care Act (ACA) is in doubt. Many insurers, including the newly created Consumer Operated and Oriented Plans, or CO-OPs, incurred losses in 2014, and some withdrew from the program.[1] Several explanations for those losses have been proposed, including decisions by insurers to set premium prices too low; poorly enforced enrollment rules, including multiple extensions of enrollment deadlines; liberal special enrollment periods; and Congress's stipulation that the risk-corridor program, under which the federal government shares profits and losses with insurers, be budget-neutral. Another important factor was the government's decision to allow noncompliant insurance plans to continue operating, which shrank the ACA's intended insurance risk pools.

To drum up support for the ACA, President Barack Obama famously told Americans, "If you like your health care plan, you can keep it." Although he might originally have been referring only to plans that met the ACA's basic requirements, the administration announced in November 2013 that state insurance commissioners could allow consumers with noncompliant plans to keep them for 2014 — a deadline that was subsequently extended to the end of 2017.

The noncompliant plans, whose existence predated the ACA, did not adhere to several important standards that the law required new plans to meet; such plans were permitted to discriminate on the basis of preexisting conditions, typically provided low levels of coverage, and lacked some of the essential benefits required by the ACA. Because they restricted enrollment to healthier people and offered only limited coverage, these plans could generally have modest premiums and appealed largely to people with low expected medical expenses. In-

Ninety percent of the $2.55 billion in reported losses were claimed by insurers in states that permitted continuation of noncompliant plans, which also reported a substantially larger average loss per enrollee.



Mean Excess Losses or Profits per Enrollee in the 2014 Individual Insurance Market, by State.

Shown are percentages of states (plus the District of Columbia) among those prohibiting versus permitting noncompliant plans that had losses or profits per enrollee under the risk-corridor program (shared risk beyond 3%). There were 228 insurers that offered plans in one or more of the states that permitted noncompliant plans; 91 insurers offered plans in states that did not. If a single insurer offered plans in multiple states, it was counted once in each state. Data are from the Centers for Medicare and Medicaid Services.

surers, however, had priced their exchange plans assuming that noncompliant plans would no longer be allowed and that people formerly enrolled in such plans would be purchasing new insurance on the exchanges. Allowing consumers to keep their noncompliant plans meant that people purchasing plans on the exchanges were on average less healthy than insurers had assumed they would be when setting their premiums.

Granted federal permission to allow ACA-noncompliant plans to continue, insurance commissioners in 39 states did so; commissioners in 11 states plus the District of Columbia did not.[2] Insurers' subsequent filings under the risk-corridor program show the importance of those decisions. That program stipulated that the government would share any profits earned or losses incurred by insurers beyond 3% of their expected claims. In 2014, a total of 53% of insurers filed claims for losses totaling $2.55 billion, whereas only 24% shared profits of $346 million. Because of a provision enacted after the passage of the ACA that required the risk-corridor program to be budget-neutral, it could cover only $346 million, or 14%, of what would have been the government's share of the losses.

Ninety percent of the $2.55 billion in reported losses were claimed by insurers in states that permitted continuation of noncompliant plans. By contrast, profits shared under the program were more evenly split between the two groups of states: 34% were earned by insurers in states with noncompliant plans, and 66% by insurers in states without them. Furthermore, insurers in states with noncompliant plans reported a substantially larger average loss per enrollee: $493 versus $222 (see graph). Because insurers in both groups of states priced their policies under the same set of assumptions, most of this difference could be attributed to a failure to anticipate changes in risk pools resulting from the last-minute decision to allow noncompliant plans to continue operating.

Although insurers had limited experience with the new marketplaces when they set their 2015 premiums in May 2014, by the following year they had substantially more data on the type of consumers purchasing plans on the exchanges. Thus, changes in premiums from 2015 to 2016 may in part reflect adjustments made by insurers to account for the effect of noncompliant plans on risk pools. Premiums for benchmark plans — the silver plan with the second-lowest premium in each state — increased by an average of 12% in states with noncompliant plans, as compared with only 5% in states without them.[3]

This disparity in rate hikes emphasizes the importance of broad participation in the insurance risk pool. In 2014, slightly more than 5% of the population chose to pay a penalty rather than purchase insurance.[4] If the majority of these people were healthier than the average insurance enrollee, their lack of participation in the risk pool would result in higher premiums for people buying insurance on the exchanges and could raise costs for the federal government as well. On the one hand, premium tax credits provided by the government are larger when premiums are higher. On the other hand,

people choosing to pay the penalty instead of purchasing insurance do not collect a tax credit — though some unknown proportion of them (those with incomes exceeding 400% of the federal poverty level) would not have been eligible for one anyway.

Although the ACA's expansion of coverage has substantially reduced the number of uninsured Americans, the sustainability of the new health insurance marketplaces depends on the affordability of insurance for both individual consumers and the government. That affordability, in turn, depends on the policy decisions that determine the structure of the individual marketplaces. It's estimated that at least 20 million Americans who were eligible to purchase insurance on the exchanges in 2015 did not do so.[5] Moreover, with expiration of the reinsurance program in 2016, premiums will almost certainly increase in 2017, which could discourage some people from becoming insured and others from remaining so. Thus, continued efforts to increase and maintain participation are needed — such as greater outreach to people on the entire spectrum of the risk pool, more publicity about and enforcement of the mandate to obtain health insurance, and sparse use of exemptions from the mandate's penalties. The expiration of the grace period for noncompliant plans in December 2017 should also help expand the risk pool.

The effect of allowing ACA-noncompliant plans emphasizes the importance of ensuring near-universal participation in the risk pool and provides a cautionary tale about the unintended consequences of altering a single policy within the interwoven set of ACA reforms.

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A Modern *Ars Moriendi*

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My father the rancher was stoic and taciturn. His cowboy hat and boots were no affectation: the boots protected him from snakebites; the hat shaded his face from the strong sun of the Colorado plains. He loved everything about his 3300-acre ranch — from the stark, flat, expansive landscape to the house whose dining table hosted countless family meals and whose living room welcomed an untold number of friends. Until fairly recently, he had tended his land and cattle with vigor and joy.

One Monday afternoon in the spring of 2015, my sister telephoned to say that Dad's neighbor Rocky had just contacted her. "Dad is alive, but he can't speak or move his right side. Rocky found him lying on the kitchen floor. The ambulance is on its way."

Decisions about his health care loomed, and during the next 4 days I shifted among the roles of daughter, health care proxy, and physician. It was disorienting, difficult . . . and transformative. After 20 years of taking care of patients as an internist, I was now plying my trade with my closest family member. I didn't want him to suffer. I wanted him to have a good death — something akin to the *ars moriendi*.

Latin for "art of dying," the *ars moriendi* is a body of literature that originated in Europe during the 15th century, on the heels of the bubonic plague. Its aim was to provide a practical and spiritual framework for the prepara-

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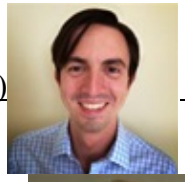
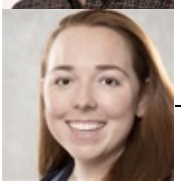
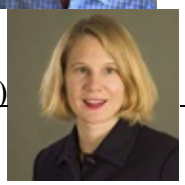
 (/about-us/experts/lucia-kevin)  (/about-us/experts/giovannelli-justin)

 (/about-us/experts/curran-emily)  (/about-us/experts/corlette-sabrina)

Wednesday, June 1, 2016

By Kevin Lucia (/about-us/experts/lucia-kevin), Justin Giovannelli (/about-us/experts/giovannelli-justin), Emily Curran (/about-us/experts/curran-emily) and Sabrina Corlette (/about-us/experts/corlette-sabrina)

Following full implementation of the Affordable Care Act (ACA) two-and-a-half years ago, nearly 12.7 million Americans (https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf) have signed up for a health plan through the insurance marketplaces. Nevertheless, much ink has been spilled—and understandably so—over whether the law's new marketplaces are stable and sustainable. In the media, at least, these discussions have intensified following news that UnitedHealthcare (United) has decided not to participate next year in most of the marketplaces in which it currently sells plans.

United is the nation's largest insurer; however, it has not played a major role (http://www.urban.org/research/publication/what-does-failure-some-co-ops-and-possible-pullout-united-healthcare-mean-affordable-care-act) in driving competition in many of the marketplaces and its share of

enrollment has been modest. To gain a wider perspective on marketplace stability, we reviewed the first-quarter earnings calls (http://chirblog.org/insurance-company-earnings-calls-a-useful-resource-for-your-toolbox/) and regulatory filings of some of the largest, publicly traded insurers that participate in the marketplaces, including Aetna, Anthem, Centene, Cigna, Humana, Molina, and United.[1](#/#1) These communications shed light not just on a company's financial performance, but also on major business developments and strategic thinking, making them useful resources for understanding a company's experiences in and perspective on its market.

What Are Insurers Telling Investors?

Insurers Aren't Heading for the Exits. While United suffered significant losses on its ACA products, only one other insurer we monitored, Humana, explicitly suggested it may exit certain markets in 2017. Though insurers are likely to make changes to the number of products they offer and the markets they participate in, earnings calls and filings show that most of the large, publicly traded insurers remain committed to the marketplaces. Anthem will continue to participate in 14 marketplaces and expressed optimism that its proposed acquisition of Cigna could help with future expansion.

Marketplace Membership Remains Stable. Consistent with the overall increase in marketplace enrollment, most insurers experienced membership growth in their marketplace business relative to the fourth quarter of 2015. For example, Aetna and Anthem reported enrollment above expectations, with gains of about 200,000 and 184,000 respectively, while Molina experienced the largest total membership gain during sequential quarters—in part because of 420,000 new marketplace enrollees—in the company's history. Most also gained or held steady compared to this time last year, though not all did: Humana's ACA-compliant individual market plans have lost approximately 180,000 members since the first-quarter of 2015, partly because of plan terminations that resulted when some enrollees couldn't provide documentation to confirm marketplace eligibility.

Many Insurers See Opportunities for Growth. In the first two years of marketplace coverage, many insurers have reported losses in their ACA-compliant individual market business. These early results have prompted companies to make changes to product offerings and pricing, and in some instances, (http://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-co-ops-failing) to exit markets. Even so, most insurers continue to assert that the marketplaces offer value and claim they are, for example, "well-positioned" (Anthem) or in a "very good place" (Aetna) to grow and sustain this business over time.

Several insurers, including Anthem, Aetna, and Molina, used their quarterly call to remind analysts that they remain committed to the marketplaces, with the understanding that this line of business may not be profitable for some years. For example, Molina explained, "We have never expected our marketplace product to perform better than our Medicaid business, nor operate at significantly better margins over the long term."

Risk Pools Continue to Evolve, But Some Are Experiencing a Healthier Mix Than Others. While evidence suggests, unsurprisingly, (http://www.nytimes.com/2016/04/01/upshot/new-health-insurance-customers-are-sicker-should-we-be-surprised.html) that marketplace consumers have been sicker, on average, than enrollees in the nongroup market prior to the ACA, the risk experiences of individual insurers have varied. Molina, for example, commented that its marketplace enrollees have been comparatively healthy, while Centene noted that its risk mix remains consistent with expectations. Anthem cautioned that it would have a clearer sense of its risk profile in the next few months, as claims come in, but reported it "like[s] what [it's] seeing" so far and offered the view that the market "is starting to recognize the true cost" of insuring marketplace enrollees.

Challenges Persist. Insurers also used their calls to flag perceived challenges to their marketplace business and, occasionally, to offer regulatory changes that might ameliorate them. For example, two insurers argued for loosening rules governing health plan design, a suggestion in some tension with federal efforts to strengthen consumer protections around networks (http://healthaffairs.org/blog/2016/03/03/cms-releases-final-2017-letter-to-issuers-in-the-federally-facilitated-marketplaces/) and plan cost-sharing features (http://healthaffairs.org/blog/2016/03/02/the-2017-benefit-and-payment-parameters-final-rule-drilling-down-part-2/#eight). Several others reiterated calls for federal regulators to consider changes to the ACA's risk-adjustment program or to tighten eligibility standards for special enrollment periods—two areas that officials have said (https://blog.cms.gov/2016/03/30/the-marketplace-risk-adjustment-program-promoting-access-quality-and-choice-for-consumers/) they are reassessing (https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/IFC-Fact-Sheet-FINAL-5-6-16.pdf).

Looking Forward

Recent insurer investor calls and filings place United's market moves in context, and remind us that the insurance industry doesn't have a monolithic perspective on the marketplaces. The truth is that not all insurers will thrive in this new and still developing (http://www.realclearmarkets.com/articles/2016/05/24/the_next_stage_of_obamacare_reform_102183.html) marketplace, where consumer protective rules reward effective risk management and prohibit the discriminatory underwriting practices that insurers could rely on in the past. Nevertheless, there are

clearly insurers that see business value in marketplace participation and are committed to the underlying principles of the ACA. These companies will be important partners in achieving the ACA's goals going forward.

Notes

[1] Because of proposed mergers with other health insurance companies, Cigna (merging with Anthem) and Humana (merging with Aetna) did not host quarterly calls. For purposes of our analysis, we reviewed the companies' press releases and financial reports. Insurer WellCare was not included in this analysis because of its limited participation in the marketplaces.

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CENTER FOR CHILDREN
AND FAMILIES

The Future of Children's Health Coverage

Children in the Marketplace

by Kelly Whitener, JoAnn Volk,
Sean Miskell, and Joan Alker

First in a series of reports on the future of children's health care coverage

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SUMMARY

This paper addresses changes needed to improve the ability of Marketplace coverage to meet children's needs.[1] As the paper notes, relatively few children (approximately one million) receive their coverage through the Marketplace; most in public coverage are served through Medicaid and the Children's Health Insurance Program. As a new source of coverage, and one that may grow over time, it is important for policymakers to consider ways to improve Marketplace coverage for children.

INTRODUCTION

Addressing Benefits and Costs as More Gain Coverage

Prior to the Affordable Care Act (ACA), children who were insured had coverage either through publicly financed programs such as Medicaid and the Children's Health Insurance Program (CHIP), through private employer-sponsored plans, or through the individual insurance market. As employer-sponsored coverage for children has either declined or flat-lined over many years,[2] Medicaid and CHIP have filled the gap for low- to moderate-income children. These two programs are largely responsible for the decline in the overall rate of uninsured children from 9.3 percent in 2008 to 6 percent in 2014 and together covered 38 percent of children.[3]

With the goal of expanding coverage to uninsured working adults and their families, the ACA created health insurance Marketplaces. Individuals who are not eligible for Medicaid or CHIP, or who do not have access to affordable employer-sponsored insurance (ESI) that meets minimum coverage standards, can use the Marketplaces to shop for private insurance plans and apply for subsidies.

Children do not currently make up a significant share of Marketplace enrollees. Overall, children make up 9 percent of enrollees in the federally facilitated Marketplace (FFM) and 6 percent of enrollees in the state-based Marketplaces

(SBM), for a total of slightly more than one million children below the age of 18 covered under insurance from the Marketplace.[4] The percentage of children enrolled in Marketplace coverage varies considerably at the state level and may change in the future. Not surprisingly, states with lower CHIP income eligibility levels have higher child enrollment in the Marketplace. For example, in North Dakota, CHIP income eligibility is limited to children with incomes below 175 percent of the federal poverty level (FPL) and 23 percent of their Marketplace enrollees are under the age of 18. By contrast, in New York, where the upper limit for CHIP income eligibility is 405 percent of FPL, only 4 percent of Marketplace enrollees are under the age of 18.[5]

This paper summarizes the available literature on children's coverage under Marketplace plans, with a focus on how well those plans are serving children along three primary dimensions: adequacy of coverage, affordability of coverage, and access to providers. It includes recommendations on how to ensure that Marketplace plans meet the unique needs of children.

Until significant policy changes are implemented to improve children's coverage under Marketplace plans, funding for CHIP should continue so that no child loses benefits that are essential to his or her health and development.

As numerous studies, including a congressionally-mandated analysis comparing CHIP and Marketplace coverage, have shown, CHIP coverage is better at meeting children's needs across the country.[6]

Adequacy of Coverage

Prior to the ACA, Medicaid set the standard for pediatric coverage through its comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which has also been adopted by CHIP plans in 14 states.[7] Pediatric benefits in the remaining CHIP programs are based on a benchmark chosen by the state from the following: either the standard Blue Cross/Blue Shield preferred provider option offered to federal employees, the state employees' coverage plan, or the health maintenance organization (HMO) with the largest commercial enrollment within the state (or comparable coverage approved by the Secretary of the Department of Health and Human Services).

The ACA established a different minimum standard for benefits to be covered by private plans sold to individuals and small employers, including those sold in Marketplaces. The ACA's Essential Health Benefits (EHB) package includes 10 categories of services,[8] one of which is "pediatric services, including oral and vision care." The definition of pediatric services was intended to be broad, but it has been implemented only with respect to oral and vision care.

Ten Categories of Essential Health Benefits

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
10. Pediatric services, including oral and vision care

States must select a benchmark plan to serve as the EHB standard. There are 10 EHB benchmark options in each state: three small employer plans, three federal employee plans, three state employee plans, and the non-Medicaid HMO in the state with the greatest enrollment. Nearly all states selected a benchmark from one of the three small employer plans with the greatest enrollment. If the benchmark plan does not adequately meet pediatric standards for oral and vision care, states may use the vision and dental benefits required in their CHIP plan or those available under the federal employee benefit program (known as FEDVIP). In addition, habilitative services must now meet the uniform federal definition. If the selected benchmark plan does not appropriately cover habilitative services, the benefit must be supplemented. While EHB plans cannot have dollar limits, federal rules do permit treatment limits.

A 2014 review of EHB benchmark plans in 35 states found that the coverage available in the Marketplace was similar to CHIP on typical major medical benefits but was more limited on benefits that are critical to children's health and development. The study found that benefits such as physician services, inpatient services, prescription drugs, lab services, and mental health services were relatively comparable between the Marketplace and CHIP, but that dental, vision, and audiology, as well as habilitative, physical, occupational, and speech therapies in the Marketplace fell short of CHIP coverage. In Marketplace plans, those benefits were more likely to be absent or provided with treatment limits. Only 30 percent of Marketplace plans cover the services without limits and nearly half exclude the services completely.[9] Additionally, Marketplace plans were more likely to impose limits on the coverage of durable medical equipment.[10]

The benefit limitations in Marketplace plans have the most profound effects for children with special health care needs. For example, only 37 percent of states require that Marketplace plans cover audiology exams (based on EHB benchmark selections) and almost half (46 percent) of states' Marketplace plans do not cover hearing aids. When hearing aids are covered, there is greater cost-sharing and/or limits on utilization (for example, aids are covered just once every two to five years) as compared to CHIP.[11]

Children's Unique Needs: Audiology

Treating a child with hearing loss is different than treating an adult with the same condition because as children grow, they are developing critical language skills. Regular audiology exams are required to identify whether a child has hearing loss and if so, to determine the appropriate treatment. Children with hearing loss will typically need two hearing aids every three to five years (or sooner if the prescription changes); new ear molds (as often as every month) to ensure proper fit, and speech therapy (often multiple times weekly) to promote language development. All of these services must be provided in a timely way and with frequent monitoring to help the child develop age-appropriate language skills.

While both CHIP and Marketplace plans cover physical therapy, occupational therapy, and speech and language services, 80 percent of states' EHB requirements impose limits on these services.[12] Marketplace coverage was intended to look like the typical employer-sponsored coverage, and though employer-sponsored coverage varies widely, Marketplace and employer-sponsored coverage do have more similarities with respect to dental and audiology services and physical, occupational, and speech therapies than either has with Medicaid or CHIP.[13] Medicaid covers all of these benefits as part of its EPSDT benefit, as do the CHIP programs that provide EPSDT benefits.

Dental Coverage

In addition, some Marketplace enrollees must purchase dental coverage under a separate policy. Although pediatric dental benefits are required under the EHB standard, federal rules and most Marketplaces allow carriers to omit pediatric dental benefits if stand-alone dental plans (SADP) are available. SADPs are dental plans that are not included as part of a health plan. As a result, it is possible for a family to purchase Marketplace coverage without having coverage for pediatric dental services. Moreover, when families purchase dental coverage separately, the premium cost, as well as any cost-sharing, are not included in the families' expected premium contribution and annual cost-sharing limit. Thus, families are paying extra for these services when they should be included within their overall cost-sharing requirements (see more details below).[14]

Finally, one review of EHBs found many plans excluded services for children with special needs and disabilities. For example, the review found exclusions of services for learning disabilities and for speech therapy for developmental delays, stuttering, or both.[15]

Policy Options to Improve Adequacy of Coverage

Define pediatric services.

The ACA statute specifically lists pediatric services as one of the 10 essential health benefits (EHBs) and mentions vision and dental as examples of such services. However, under current regulations, only pediatric vision and dental services are required to be supplemented if the coverage in the selected benchmark plan is absent. Even if a state chose to supplement its benchmark further, for example, to add missing services like hearing aids, the state might be required to pay 100 percent of the cost if this were considered to be a new state mandate.

Define EHB pediatric benefits using the definition of CHIP "child health assistance services."

A better way to define pediatric services under EHB would be to require that these services include those spelled out in CHIP regulation as "child health assistance"—a list of those services that may be paid for under the program.[16] Child health assistance under CHIP includes benefits already covered under EHB, such as inpatient and outpatient hospital services, prescription drugs, and prenatal care. However, child health assistance also includes important services—such as inpatient and residential mental health and substance use disorder services; durable medical equipment such as eyeglasses and hearing aids: and physical therapy—that are not specifically required under EHB; and physical therapy—that are not currently provided under EHB. Defining pediatric services under EHB as those available under CHIP adds specificity to EHB and will help ensure coverage adequacy. Doing so will also provide an incentive for states to cover more services under EHB. States would be required to examine their benchmark selections for all pediatric services and supplement the benchmark to meet the federal definition. This would include instances where the benefit is covered but inadequate and those where the benefit is absent. The federal premium and cost-sharing subsidies would then account for the full range of services, avoiding a cost-shift to states or families, and children would have access to a pediatric benefit package that meets their needs.

Define medical necessity to include services necessary for healthy development.

When defining pediatric services, it is critical to consider the needs of all children, including children with special health care needs, as well as the unique needs that are associated with healthy development. Children require many of the same types of services as adults, but because they are continuing to develop and grow, they may need certain services more frequently or intensely. For example, children may need durable medical equipment like wheelchairs to be replaced more frequently to accommodate their growth or they may need therapeutic services like speech therapy more intensely as they acquire and develop language skills for the first time.

Acknowledging the challenge of defining medical necessity in a way that adequately captures the needs of all children, the National Health Law Program has articulated criteria that should guide

any attempt to define medical necessity (beyond a doctor prescribing a particular treatment).[17] These criteria specify that any definition of medical necessity should:

1. Incorporate appropriate outcomes within a framework that promotes physical, intellectual, and psychological development, including preventing or ameliorating the effects of a condition, assisting in maintaining or facilitating functional capacity.
2. Address the information that will be needed in the decision-making process, with an emphasis on treatment strategies tailored toward an individual's needs.
3. Identify who will participate in the decision-making process.
4. Start by drawing on specific standards, including scientific evidence, practice guidelines, and consensus statements from experts where available.
5. Support flexibility in the sites of service delivery.

Defining medical necessity through federal rulemaking in a way that is faithful to these criteria would prevent children from being subjected to harmful treatment limitations.

Strictly enforce the ACA's antidiscrimination rules.

The ACA prohibits discrimination based on age and health condition, among other factors, through a number of mechanisms. Rules implementing the EHB requirement prohibit plans that must offer EHB from using discriminatory benefit design. This prohibition includes cost-sharing that would discriminate against individuals based on age or health conditions. For example, plans cannot limit benefits based on age if there is no evidence-based reason to do so, nor can they put all the drugs used to treat a particular condition on the highest cost-sharing tier of a formulary. In addition, Section 1557 of the ACA prohibits insurers that receive federal funding (e.g., Marketplace plans and Medicaid managed care organizations) from discrimination based on age or disability, among other factors. These provisions are critical to prevent plans from having benefit designs that discriminate against children generally and children with special health care needs in particular. State and federal regulators should carefully review benchmark plans to ensure that they meet these federal standards and should thoroughly investigate complaints where there is evidence that plans are offering discriminatory benefits.

Ensure plans are available that embed dental coverage.

In states using the federal Marketplace platform, only 8 percent of enrollees under the age of 18 purchased a stand-alone dental plan (SADP).[18] There are no data on the take-up rates for plans with dental coverage embedded by age, but only about one-third of plans in the federally facilitated Marketplace (FFM) embedded dental, so it is likely that many children do not even have the option to enroll in a plan with dental included.[19] The low take-up rate of SADPs and the fact that embedded dental coverage is not prevalent suggest that children enrolled in the Marketplace are not able to obtain dental benefits as intended by the ACA. Ensuring that all children have access to a health plan with dental coverage included would help make sure that children get the full range of benefits to which they are entitled. However, in order to make sure the dental benefit is valuable to enrolled children, embedded plans should also standardize the benefit design to either eliminate or greatly reduce the deductible for pediatric dental coverage.[20] If the deductible for dental coverage is too high, the benefit will be rendered meaningless given typical dental utilization patterns. The low take-up rate could also be linked to the additional costs of SADP coverage, which would require additional policy changes (see more details below).

Affordability of Coverage for Children and Families

Affordability of coverage includes both the cost of obtaining coverage (premiums) and the cost of using health services once enrolled in a plan (cost-sharing, including copayments and deductibles). The ACA provides tax credits to reduce premiums for Marketplace plan enrollees who meet income guidelines and do not have access to coverage that meets minimum standards. Individuals that are eligible for Medicaid or CHIP, or for affordable and adequate employer coverage, cannot obtain premium tax credits. The ACA also provides cost-sharing subsidies to reduce the amount that families with incomes up to 250 percent of FPL are expected to pay out-of-pocket to obtain services.

While the ACA's Marketplaces and financial assistance have led to significant coverage gains, many families nonetheless face considerable costs. A recent congressionally mandated analysis conducted by the federal Centers for Medicare & Medicaid Services (CMS) provides a useful guide to illustrate the cost that families face for pediatric coverage in Qualified Health Plans (QHPs) through the Marketplace relative to CHIP. For this analysis, CMS compared the second lowest cost silver plan available through the Marketplace in the largest rating area in each state with that state's CHIP coverage. This analysis found that families can expect to pay higher costs for QHPs compared with CHIP in all 36 states that operate a separate CHIP program.[21] In states that provide health insurance to CHIP-eligible children through Medicaid, this coverage is assumed to be better than Marketplace coverage, given Medicaid's robust EPSDT benefit package and very low cost-sharing.

The analysis looks at two measures. First, the report looks at actuarial value (AV), which measures the percentage of expected medical costs that a health plan will cover and offers a way to compare plans based on overall cost-sharing.[22] The remaining charges are not covered by the plan and would be paid by families out-of-pocket. With regard to actuarial value, CHIP pays a higher portion of a child's health care costs in all states except Utah, where CHIP and the second lowest cost silver plan pay an equivalent portion of a family's cost. Though differences in actuarial value depend on each state's CHIP program and available Marketplace plans, *CHIP provided coverage that was, on average, 25.7 percent greater in actuarial value than the second lowest cost silver plan available through the Marketplace* in states that operate their own CHIP program.[23]

The second measure presented in the CMS "comparability study" is out-of-pocket costs from cost-sharing charges, including copayments, coinsurance, and deductibles. CMS found that families spend more on a per-child basis in the second lowest cost silver plan through the Marketplace compared with CHIP. While out-of-pocket charges vary by state in both the Marketplace and in CHIP, families could expect to pay an average of $969 more per child in the Marketplace compared with state CHIP programs.[24]

These findings provide an important cautionary note about the nature of the coverage that children and families receive through the Marketplace. Beneath the remarkable gains in the number of children and families with access to coverage as a result of the ACA, this coverage may still entail costs that are out of reach for many families, especially compared with the coverage available to children through Medicaid and CHIP. Policymakers must consider how to reduce these costs for coverage through the Marketplace, which enrolled over a million children in 2016, and may potentially enroll many more as Marketplace enrollment increases.

A March 2016 report from the Medicaid and CHIP Payment and Access Commission (MACPAC) concluded that, due to their higher out-of-pocket costs, Marketplace plans are not ready to serve as an adequate alternative for children enrolled in CHIP.[25] The report found that the average actuarial value of CHIP coverage in the 36 states with separate CHIP is 98 percent per child compared with 82 percent for benchmark plans available in the Marketplace. MACPAC also reports that families faced an average of $158 in out-of-pocket spending across separate CHIP programs compared with $1,073 for Marketplace coverage.

Premiums

A key concern for families regarding the implementation of the ACA is that the test for affordable employer coverage prevents half a million children from obtaining premium tax credits.[26] Under the ACA, employer coverage is considered "affordable," and thus ineligible for premium tax credits, if the cost to the employee for self-only coverage is less than 9.66 percent of family income. Dependent coverage is generally far more expensive than coverage for the employee only. The result—known as the "family glitch"—is that children and parents who have "access" to employer-sponsored dependent coverage can be excluded from premium tax credit eligibility even if the dependent coverage is unaffordable. The Government Accountability Office (GAO) estimated that 6.6 percent of uninsured children (approximately 460,000 children) would be ineligible for Medicaid and CHIP based on household income that was too high and also would be ineligible for the premium tax credit because one parent had access to employer-sponsored insurance (ESI) that had an estimated premium deemed "affordable."[27]

Even for families who qualify for premium tax credits, the expected family contribution can be so high that coverage remains out of reach. A recent report from the Kaiser Family Foundation found that 33 percent of those with Marketplace coverage had reported difficulty paying their premiums, compared with 17 percent of those with ESI. Of those reporting difficulty paying their premiums, 49 percent had dependent children in the home.[28]

Sliding scale tax credits cap the amount a family is expected to contribute based on household income. For the 2016 plan year, families are expected to pay from 2.03 percent of household income for those at the poverty line to 9.66 percent of household income for those at four times the poverty level (See Table 1). Thus, families at the higher end of the sliding scale for premium tax credits face costs in excess of what the ACA itself defines as affordable. While families between 250 and 400 percent of FPL receive financial assistance under the ACA, their expected contribution ranges from 8.18 to 9.66 percent of income for silver level plans—even though the ACA exempts those with health costs above 8 percent of income from the individual mandate.[29]

Table 1: Expected Family Contribution Under the ACA's Premium Tax Credit Caps, 2016[30]

Percent of Federal Poverty Level	For Family of 3		
	Total earnings	Expected premium contribution percentage, 2016	Expected premium contribution in dollars, 2016
100%	$20,160	2.03%	$409
133%	$27,813	3.05%	$848
150%	$30,240	4.07%	$1,231
200%	$40,320	6.41%	$2,585
250%	$50,400	8.18%	$4,123
300%	$60,480	9.66%	$5,842
350%	$70,560	9.66%	$6,816
400%	$80,640	9.66%	$7,790

Subsidized Marketplace premiums are generally lower than those typically faced by families enrolled in employer coverage, particularly at lower income levels. However, premiums for Marketplace coverage are higher than in CHIP, where premiums are nominal in most states. At 151 percent of FPL, more than half of states' CHIP programs do not charge a premium to enroll, and at 201 percent of FPL, half of states with a separate CHIP program charge premiums of less than $10 per child.[31] Additionally, some states charge per-family premiums rather than per-child premiums, or limit the per-child premiums to two or three children per family.[32] By comparison, the required contribution for Marketplace premiums for those in the CHIP income range is between 3.05 and 9.66 percent of family income.

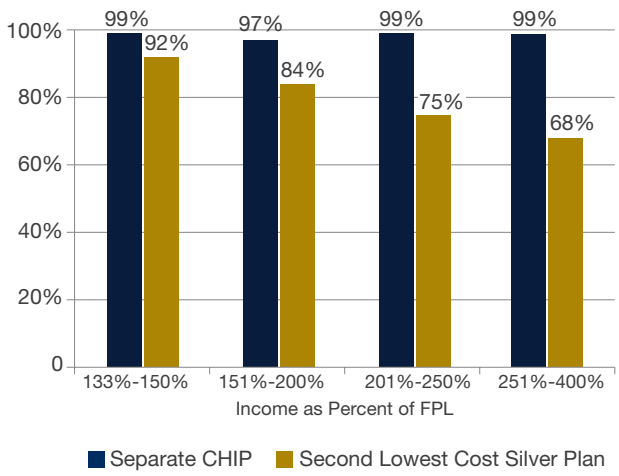
Cost-Sharing

Using health services in a Marketplace plan is another area where children may face high costs. Families with incomes up to 250 percent of FPL qualify for additional cost-sharing reduction (CSR) subsidies. Families enrolled in Marketplace plans with the lowest incomes (those with income between 100 and 150 percent of FPL) qualify for plans with an actuarial value of 94 percent, meaning enrollees pay, on average, 6 percent of health care costs out-of-pocket. This level of enrollee cost-sharing is more than that required of families with CHIP coverage and, by definition, higher than for families with children in Medicaid—where copayments are prohibited for children. Further, the difference for families with slightly higher incomes is more pronounced.

Despite those protections, a 2016 MACPAC study illustrates how out-of-pocket costs for Marketplace coverage are higher than those in separate state CHIP programs. For example, CHIP and the second lowest cost silver plan offer actuarial value levels for families between 133 and 150 percent of FPL at 99 percent and 92 percent, respectively. The difference between an actuarial value of 99 percent and 92 percent is not negligible, especially for families at this income level. These values progressively diverge as family income goes up, such that for families between 251 and 400 percent of FPL, CHIP still provides coverage with a 99 percent actuarial value while the effective actuarial value for coverage through the second lowest cost silver plan is 68 percent (figure 1). In comparison, the majority of employer-sponsored plans have an actuarial value of 88 percent.[33]

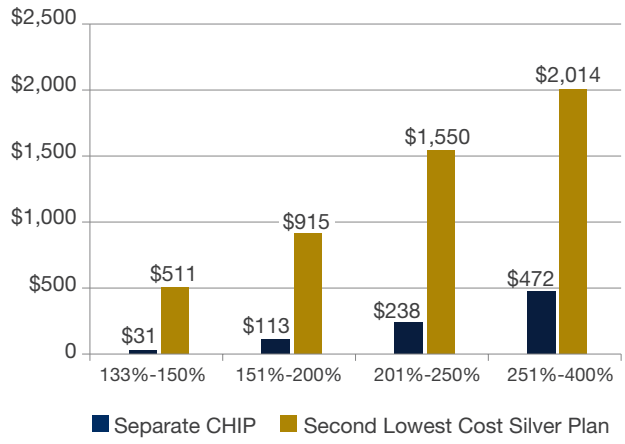
Figures 1 and 2 illustrate how out-of-pocket costs increase with enrollee income in CHIP and Marketplace coverage. Costs for coverage available in the Marketplace become greater as premium tax credits and cost-sharing reductions phase out as income rises.

Figure 1. Actuarial Value, CHIP vs. Second Lowest Cost Silver Plan



Source: MACPAC

Figure 2. Total Out-of-Pocket Costs, CHIP vs. Second Lowest Cost Silver Plan



Note: Total costs include cost-sharing and premiums.
Source: MACPAC

CHIP regulations limit total cost-sharing for families to 5 percent, but most states are not near this cap. According to MACPAC, only 1 percent of children in separate CHIP programs have out-of-pocket costs in excess of 2 percent of their income.[34] By contrast, 48 percent of children enrolled in the second lowest cost silver plan face out-of-pocket costs in excess of 2 percent of income.

While 2 percent of income may seem small, families in this range face a variety of cost-of-living expenses that constitute a significant share of their incomes. A Kaiser Family Foundation recently found that those who had difficulty paying their health costs were more likely to face financial challenges in other aspects of their lives.[35]

Families of children with health problems also face higher out-of-pocket costs. MACPAC found that children being treated for chronic conditions (including mental health treatment, asthma, or trauma) as well as those that needed unexpected hospital care faced the highest out-of-pocket spending in Marketplace coverage.[36]

As a result, total out-of-pocket costs in Marketplace plans—from both higher cost-sharing and coverage gaps created by service limits—are higher than the costs found in CHIP coverage. These differences pose the greatest challenges for children with the most health care needs. Using three real-life scenarios of children and their actual use of health care services, a Georgetown study of Arizona Marketplace coverage found typical children would face cost-sharing that is between 2.2 and 8.3 times higher, and children with special health care needs would face cost-sharing that is between 35 and 38 times higher, than would be required under CHIP.[37]

Marketplace plan coverage of pediatric dental services raises additional cost concerns for families. Families that purchase dental coverage separately from their Marketplace plan must pay an additional premium, and they are subject to separate deductibles. Average SADP premiums in 2014 were $238 per child per year.[38] The cost-sharing limit for SADPs is $350 for one child, $700 for two or more children.

Premium tax credits (PTCs) do not apply to premiums for stand-alone dental plans unless enrollees have unspent tax credits after applying them toward a QHP.[39] In addition, cost-sharing for SADPs does not count toward the maximum out-of-pocket limit that applies to QHPs ($5,200 for an individual, $10,400 for a family at 250 percent of FPL in 2015).[40] Therefore, the costs of SADP premiums, dental deductibles and other cost-sharing are not included in the family's overall expected contribution, effectively requiring families to pay more than the stated out-of-pocket maximum in order to obtain dental coverage.

Policy Options Related to Affordability of Coverage

Improve federal financial assistance.

The financial assistance available through PTCs and CSR subsidies has had a significant impact on insurance affordability in the individual and small group markets. However, in some cases, coverage is still out of reach for children and families. Increasing the value of the PTCs would help more families afford the premium payments. An analysis by the Urban Institute highlighted several ways to make coverage more affordable, including the following: decreasing the expected premium contribution amounts and eliminating the indexing, extending CSR assistance to those with higher incomes, and changing the reference premium to gold rather than silver.[41] Alternatively, the value of the CSR for families with incomes between 200 and 250 percent of FPL could be increased to reflect actuarial values in the employer market, as was done for those with incomes between 100 and 200 percent of FPL.

Incentivize state-based supplemental financial assistance.

In the absence of federal action to improve financial assistance, two states, Massachusetts and Vermont, provide additional cost-sharing assistance for families with incomes too high to qualify for federal cost-sharing reduction payments (i.e., 250 percent of FPL), but below 300 percent of FPL. Two other states, Minnesota and New York, adopted the Basic Health

Program and are providing additional financial protection to enrollees up to 200 percent of FPL. These and other approaches may also serve low- to moderate-income families well by helping make Marketplace coverage more affordable.

Fix the family glitch.

Incorporating the cost of dependent coverage into the affordability test when determining PTC eligibility would help some children who are currently uninsured gain coverage. Further, many legal and policy experts believe legislation is not required to address this problem. The Internal Revenue Service already uses the required contribution for coverage of family members when considering exemptions from the individual mandate.[42]

Even so, as modeled by MACPAC and the Urban Institute, fixing the family glitch would not solve the affordability problem completely. According to their analyses, approximately one million children previously in a separate CHIP program would remain uninsured even if the affordability test accounted for family premiums.[43]

Eliminate premium stacking.

Families relying on multiple sources of coverage, like QHPs for the parents and CHIP for the children, or families enrolling in multiple plans, such as medical and dental, face multiple premiums. However, only the premium for the Marketplace medical plan is considered when determining the expected premium contribution amounts. Expected premium contributions for QHPs should be reduced to reflect other premium obligations that families face. Families seeking an exemption from the individual responsibility payment are able to include multiple premiums to show the available coverage is unaffordable, and the same principle should apply to expected premium contributions for those seeking coverage.

Offer standardized benefit designs that promote pediatric benefits.

States may standardize the benefit and cost-sharing structures across all participating Marketplace plans so that the deductibles, copayments and coinsurance promote utilization of pediatric benefits. Many pediatric services are low cost relative to adult services, making high-deductible plans of little value to children because all of the child's services may still not reach the deductible. High-deductible plans could be prohibited for children, or states could require that some pediatric benefits, such as dental, have zero or low deductibles.

States such as California offer standardized plan designs that allow consumers to easily compare plans, as consumers know that each plan has the same cost-sharing levels and benefits.[44] While a plan option with standardized in-network deductibles, cost-sharing limits, and copayments and coinsurance amounts will be available through the federal platform for the 2017 plan year,[45] children would benefit if these standardized options specifically promote pediatric services.

Apply affordability rules to dental coverage.

Dental is one of the pediatric benefits that is expressly identified in the ACA, and yet, many children enrolling in the Marketplace are not getting dental coverage. The affordability provisions of the ACA have limited or no application to dental benefits, making them unaffordable for many families. Requiring application of the PTC to dental coverage would increase take-up of SADPs, and counting dental expenditures toward maximum out-of-pocket limits would promote access to dental services, as guaranteed by the ACA.

Access to Providers

The ACA requires Marketplace plans to "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[46] Insurers selling plans in the FFM in for the 2017 plan year must also include 30 percent of available "essential community providers" (ECPs), such as community health centers, that serve predominantly low-income, medically underserved individuals. Insurers must also offer contracts "in good faith" to all Indian health providers, and to at least one ECP in each of six categories of ECPs (family planning providers, federally qualified health centers, hospitals, Indian health care providers, Ryan White providers, and "other" ECPs) in their service area.[47] States can impose more stringent standards on networks, including quantitative standards that require providers to be accessible within defined timeframes and/or distances. In 2015, 30 states required at least some Marketplace plans to meet one or more quantitative standards for network adequacy.[48]

To date, there has been relatively little data on how Marketplace plans are meeting network adequacy standards and what it means for children's access to needed providers.[49] However, there is some evidence that plans are excluding some providers that charge higher prices from their network or are using tiered networks that require enrollees to pay higher out-of-pocket costs to obtain care from a less-preferred provider.[50] And in one highly publicized case, the Washington state insurance commissioner's interpretation of "reasonable access" was in conflict with that of the state's Marketplace. The commissioner rejected some plans for participation in the Marketplace because their networks lacked access to a children's hospital that provides critical tertiary care, but the state's Marketplace and an administrative law judge overruled his recommendation.[51]

In the absence of comprehensive data on Marketplace plans, it is difficult to know if consumers are able to obtain care through in-network providers. However, even networks that work relatively well for most enrollees do not necessarily work well for those with special health care needs, especially children. Families that must get care out-of-network are subject to higher cost-sharing and their out-of-pocket costs do not count toward the ACA out-of-pocket cap. Plans will consider requests to obtain care from an out-of-network provider at in-network rates if an enrollee can demonstrate that the network does not provide access to needed services, but the burden falls on the enrollee to seek and obtain plan approval, and the enrollee may still receive a bill from the provider for costs not covered by the plan (known as balance billing). For example, families may face surprise medical bills for out-of-network services when they seek care during emergencies (and thus are not able to choose where they receive care) or receive care at an in-network facility that incorporates out-of-network providers for some services (such as anesthesia).[52] Medicaid managed care plans, in contrast, are required to cover contracted services out-of-network if they are unable to cover them in-network and must coordinate with the provider to ensure the cost to the enrollee is no greater than it would have been in-network.[53] The final rule on Medicaid and CHIP managed care subjects CHIP managed care plans to this same requirement.[54]

Policy Options Regarding Access to Care

Develop and enforce pediatric network adequacy requirements.

The combination of narrow networks and the inapplicability of affordability provisions such as maximum out-of-pocket limits for out-of-network care create an environment in which children may be unable to get the care they need. To ensure that families across all states have sufficient access to providers, there should be a federal default standard for network adequacy that contains quantitative measures of distance standards, minimum ratios of patients to providers, and wait-time limits. These default standards should apply to plans sold through the Marketplace in states that have not adopted their own federally approved set of network adequacy standards. Further, these standards should specifically apply to services relevant to children,

such as pediatric mental health care, pediatric urgent care, and pediatric dental care. If pediatric network adequacy standards were developed and enforced, children would be more likely to find in-network care that is affordable.

Limit out-of-network charges.

In order to limit the costs that families face when they need to receive out-of-network care and reduce surprise medical bills when families inadvertently do so, insurers selling in the Marketplace should be required to cover any out-of-network services unavailable through in-network providers at network rates, especially for children with special health care needs. Further, the costs that families incur through services received from out-of-network providers should count towards their maximum out-of-pocket costs.

Strengthen requirements for including Essential Community Providers in plan networks.

Currently, plans are only required to offer a contract in good faith to one essential community provider in each class in order to fulfill the contracting thresholds for these providers.[55] Federal rule-makers should strengthen this requirement so that QHPs must actually cover an essential community provider, rather than just attempt to do so. Further, pediatric providers should be added to the classes of essential community providers that insurers must include in their networks.

Collect and report coverage and utilization data for use by consumers and regulators.

Adopting standardized reporting requirements for insurers would assist policymakers and regulators in monitoring how children and families are faring in the various network arrangements available in Marketplace plans. For example, standardized reporting requirements would better document the frequency with which families receive out-of-network services, as well as the cost of these services, and could help identify areas where families need additional protections. Plans should also collect and report complaints from consumers regarding problems obtaining care or regarding inaccurate provider directories. In addition to providing this data to consumers via public forums such as Marketplace and state Department of Insurance websites, health plans themselves should also make this information available to families.

More generally, section 1311(e) of the ACA requires QHPs to submit and make public data regarding claims payment policies and practices, financial disclosures, enrollment, disenrollment, denied claims, rating practices, cost-sharing and payment for out-of-network coverage, enrollee rights, and other information as determined appropriate by the Secretary of Health and Human Services. Collecting and making public these data would help regulators target enforcement and oversight and inform evidence-based policymaking on non-discrimination, network adequacy, overall adequacy of the benefit package, and many other critical issues. Additionally, stakeholders could use the data to identify trends and offer solutions for ongoing coverage improvement efforts. To date, federal regulators have required only limited data from QHPs to begin in 2017.

Summary of Recommendations

The ACA has achieved some major milestones, including helping to bring the rate of uninsured children to the lowest point in history at just 6 percent.[56] However, Marketplace coverage should be modified to improve access for children enrolled in QHPs today and in the future. Budgetary and political constraints may make it difficult to make many of the suggested policy changes, but they must be considered in combination to ensure that children's coverage in the Marketplace meets their needs. For example, fixing the family glitch would make more children eligible for a premium tax credit, but such a change would have limited benefit if Marketplace coverage were not strengthened for children. Moreover, as policymakers consider CHIP's future, the inadequacies of Marketplace coverage for children raise serious concerns about proposals that would move children into the Marketplace.

Policy Options to Strengthen Marketplace Coverage for Children

Adequacy of Coverage

- Define pediatric services to include the full range of services children need—not just vision and dental services, but particularly services that are essential to development and frequently absent from EHB benchmark plans, such as audiology exams and hearing aids. One way to accomplish this would be to require that pediatric services include the services spelled out in CHIP regulation as being "child health assistance" services that may be paid for under the program.
- Ensure that medical necessity definitions include services necessary for healthy development.
- Strictly enforce the antidiscrimination rules to prevent discrimination based on age and diagnosis.
- Ensure that every child has access to a plan with dental coverage embedded.

Affordability of Coverage

- Improve the federal financial assistance to reduce premiums and make services more affordable. Ways to accomplish this include decreasing the expected premium contribution amounts, extending CSR assistance to those with higher incomes, and changing the reference premium to gold rather than silver.
- Fix the family glitch by accounting for the cost of family rather than individual coverage.
- Address premium stacking by including premiums for other coverage family members have in calculations of the expected premium contributions for QHPs.
- Incentivize state-based supplemental financial assistance.
- Standardize benefit designs to promote utilization of pediatric services.
- Apply affordability rules to SADP.

Access to Providers

- Develop and enforce pediatric network adequacy requirements. Establish a federal default standard for network adequacy that contains quantitative measures of distance standards, minimum ratios of patients to providers, and wait-time limits.
- Limit out-of-network charges by requiring insurers selling in the Marketplace to provide any out-of-network services unavailable through in-network providers at network rates and by counting these costs towards families' Maximum Out-of-Pocket costs.
- Strengthen requirements for including Essential Community Providers in plan networks.
- Collect and report coverage data to support oversight and inform future policymaking and family choices.

Adopting these recommendations would set a standard for pediatric coverage; the recommendations could be applied flexibly to allow states and issuers to take different approaches. The ACA made a commitment to protecting patients by providing them with meaningful access to affordable coverage. In order to live up to that promise, some modifications need to be made, particularly for children. As children grow and develop, they must meet critical milestones to put them on the path to realize their full potential.

Endnotes

[1] Other planned papers in the series will examine topics such as ensuring that all children receive health coverage and rethinking pediatric dental coverage.

[2] M. Long et al., "Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014," Kaiser Family Foundation, March 21, 2016, available at http://kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/.

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[4] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," March 11, 2016, available at https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.

[5] T. Brooks et al. "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-SharingPolicies as of January 2016: Findings from a 50-State Survey," The Kaiser Commission on Medicaid and the Uninsured, January 21, 2016, available at http://kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey/.

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[11] Ibid.

[12] Ibid.

[13] Medicaid and CHIP Payment and Access Commission (MACPAC), "Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer-Sponsored Insurance," Report to Congress on Medicaid and CHIP, March 2015, available at https://www.macpac.gov/publication/march-2015-report-to-congress-on-medicaid-and-chip/.

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[17] J. Perkins and M. Youdelman, "Q & A: Defining Medical Necessity," National Health Law Program, June 24, 2004, available at http://www.healthlaw.org/about/staff/mara-youdelman/all-publications/qa-defining-medical-necessity#.VwQPGRMrL_9.

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[21] CMS, 2015.

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The Affordable Care Act and Children's Coverage in California

OUR PROGRESS AND OUR FUTURE

The Children's Partners

JUNE 2016
CHILDRENSPARTNERSHIP.ORG

The Children's Partnership is a California-based nonprofit children's advocacy organization committed to improving the lives of children where they live, learn, and play. Our mission is to better the health and well-being of underserved children through strong community partnerships, forward-looking research, and informed policy. We build meaningful partnerships with communities and decision-makers to provide a powerful voice for children and champion programs and policies that break down barriers to advancement. Since 1993, TCP has been a leading voice for children and a critical resource for communities across California, working every day to provide all children with the resources and opportunities they need to thrive.

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Foreword

Over the past six years, the Affordable Care Act (ACA) and subsequent efforts to build on its impact have made incredible improvements in the lives of tens of millions of Americans. As a result, health insurance is fairer, more affordable, and more accessible across the country. In California, one of the greatest success stories for health reform, the law has opened doors to coverage for over six million consumers. California was the first state in the nation to enact legislation creating a health insurance marketplace, Covered California, and an early adopter of the Medicaid expansion to ensure more low-income Californians enrolled in coverage. In taking a lead on implementation, California has put the needs of consumers first and provided greater security for children and families.

Providing quality health insurance and care is an investment in the future of our children and provides a foundation for children to succeed in school and life. Before the passage of the ACA, uninsured rates had been falling for children nationwide. Between 1997 and 2015, the national rate of uninsured children fell more than 65 percent from 14.9 percent to 4.8 percent. Increases in public coverage through both Medicaid and the Children's Health Insurance Program (CHIP) placed a national focus on children's coverage and yielded tremendous success that created a foundation for the ACA. While the ACA created new coverage opportunities for the majority of the uninsured—primarily adults—these previous children's coverage successes should not be undermined but, instead, furthered.

Today, over 5.6 million children, more than half of California's children, are enrolled in Medi-Cal. Medi-Cal provides affordable health care to children who need it most—especially millions of children of color who have historically faced disproportionately poorer health outcomes. A strong future for health care in America will build on the progress of the Affordable Care Act, but it also requires us to defend and enhance Medicaid and CHIP programs at the federal and state levels, given their historic success in providing child-specific health benefits to the nation's most vulnerable children.

At The Children's Partnership, we have proudly joined national and statewide partners to advocate critical health care reforms impacting millions of children and families, before and as part of the Affordable Care Act. As we reflect on these past six years and celebrate the incredible accomplishments to advance the health of American families, we will continue to serve as a voice for children and work to improve a system of coverage and care that serves our children and their specific needs. The pages that follow offer a look into the incredible progress California has made in health care reform and the future actions we must take to continue to support a healthy future for all California children. We look forward to continuing the work with our partners to make this a reality.

Mayra Alvarez

Mayra E Alvarez, MHA

Introduction

The Patient Protection and Affordable Care Act (ACA), enacted in March 2010, has powerful implications for the health and well-being of children and their families in California and across the country. In the past six years, the ACA has taken important steps toward providing Americans with quality, affordable health care, improving consumer protections, slowing health care cost growth, expanding covered benefits, and improving health care quality and delivery. Specifically, the ACA has increased the number of individuals who have access to health insurance, simplified enrollment, required that benefits include core essential health services, and has promoted innovations to help coordinate the fragmented delivery of care. Without a doubt, the law's enactment forever reshaped the nature of coverage and health care delivery for families and their children in the United States, including millions of children in California.

5.7 million
children in California are enrolled in either Medi-Cal or Covered California—more than half of all children in the state.

Six years after the ACA set into motion a series of game-changing reforms for health care, California's leadership in implementation has helped provide health coverage to more families and children than ever before. California was the first state in the nation to enact legislation creating a health insurance marketplace,* an opportunity provided to states by the ACA. The creation of Covered California, the state-based marketplace, provided a place for Californians to shop for and buy affordable health coverage and has allowed California to lead the way in state efforts to implement the ACA. The State also chose early adoption of the Medicaid expansion under the ACA in order to ensure more low-income Californians were able to enroll in coverage while also claiming its share of federal health care dollars made available to states through the ACA.

While much attention has been paid to the enrollment and experience of adults under the ACA, the law has also had tremendous impact on children's health coverage and opportunities to improve the overall health of children in California. Children have reaped the benefits of enrollment simplifications, free preventive services, mandated essential pediatric health benefits (including pediatric oral and vision services), outreach and enrollment activities, and other provisions of the ACA. As a result of the State's leadership and commitment to expanding health coverage to its residents, 5.6 million children are currently covered through Medi-Cal, California's Medicaid program, and just over 70,000 children are covered through Covered California. This amounts to well over half of all California children.[1] Overall, the rate of uninsured Californians dropped from nearly 15 percent in 2009 to just under 12 percent in 2014.[2] For children, the uninsured rate dropped from 5.7 percent to 4.5 percent during the same period.[3]

Further, the expansion of Medi-Cal to low-income adults earning up to 138 percent of the federal poverty level (FPL) created a pathway for enrolling already eligible uninsured children into coverage. The ACA requires, as a condition to covering eligible parents in Medicaid, that those parents must also enroll their eli-

*This document uses the term "marketplace" to refer to what are also known as the "Health Insurance Marketplace," "Health Benefit Exchange," or "Exchange." In some states, the marketplace is run by the state, such as Covered California in California. In others, the marketplace is run by the federal government (HealthCare.gov).

Major Children's Coverage Milestones: 2010–2016

POST-AFFORDABLE CARE ACT HEALTH CARE REFORMS

2010

MARCH 23, 2010
President Barack Obama signs the **Patient Protection and Affordable Care Act** into law

SEPTEMBER 23, 2010
Significant reforms take effect, including:
- Children cannot be denied coverage for **pre-existing conditions**
- Those under the **age of 26** can stay on their parents' insurance
- **Lifetime limits** on coverage eliminated so those with chronic conditions or in need of costly treatment will be able to count on health coverage no matter the cost.
- Most health plans must cover a set of **preventive health services** for children at no cost.

SEPTEMBER 30, 2010
California passes legislation creating a **health insurance marketplace**—the first state in the country to do so

NOVEMBER 12, 2010
California's **Bridge to Reform Medi-Cal Waiver** is approved to start local coverage for adults in advance of the ACA Medicaid expansion.

2012

OCTOBER 30, 2012
The newly established **DACA program** offers deportation relief and work authorization to certain undocumented immigrants. In California, approximately 125,000 young Californians with DACA are estimated to be eligible for Medi-Cal.

2013

JANUARY 1, 2013
California began consolidation of its stand-alone CHIP program, the Healthy Families Program, into **Medi-Cal.**

OCTOBER 1, 2013
Open enrollment for the California marketplace begins through **Covered California**

2014

JANUARY 1, 2014
- **Covered California** insurance coverage begins
- **Expanded Medi-Cal coverage** for adults with incomes up to 138% FPL takes effect.
- Beginning this year, all individuals must have health insurance or face a **tax penalty**

FEBRUARY 2014
California offers **Express Lane Enrollment** for CalFresh enrollees to enroll in Medi-Cal.

2015

JANUARY 1, 2015
All children enrolled in Covered California plans are automatically enrolled in **dental coverage**

APRIL 16, 2015
CHIP funding is extended through 2017 with an enhanced federal match.

JUNE 24, 2015
California expands Medi-Cal to **all children**, regardless of immigration status, to begin in May 2016.

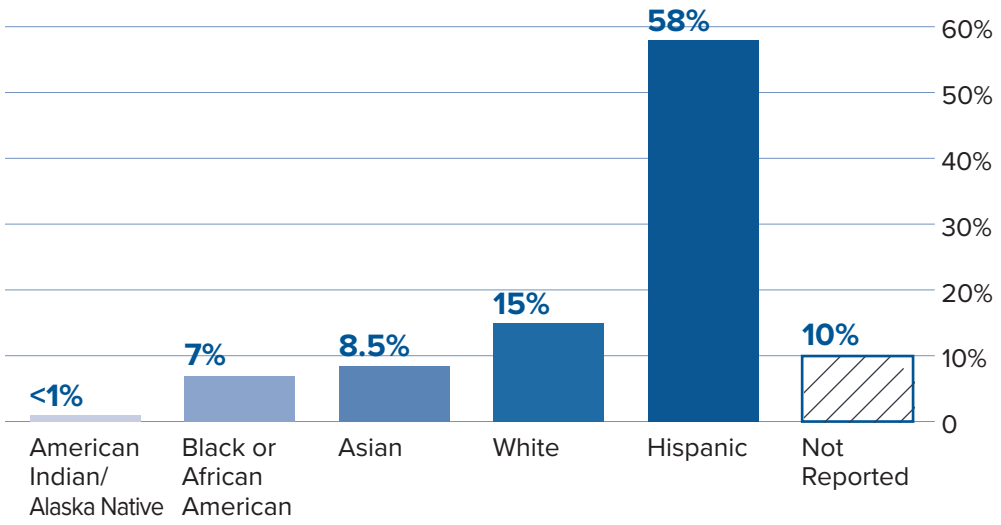
DECEMBER 30, 2015
California's 1115 waiver renewal, **"Medi-Cal 2020,"** is approved with provisions to help improve children's access to quality health and dental care

2016

MAY 16, 2016
Medi-Cal expands to **all children**, regardless of immigration status.

Racial Demographics of Children Enrolled in Medi-Cal

Note: Data compiled based on eligibility and enrollment data in Medi-Cal as of June 1, 2015, and includes children ages 0–20. N = 5,609,192. Source: California Department of Health Care Services, "Medi-Cal Children's Health Dashboard," March 2016, accessed April 12, 2016, www.dhcs.ca.gov/services/Documents/March_2016_Pediatric_Dashboard.pdf.



gible children.[4] Studies show that increasing coverage for parents also increases the number of children with health coverage, creating what's known as a "welcome mat" effect for children.[5] This proved particularly true in California's expansion of Medi-Cal to low-income adults. In the first year of open enrollment, nearly 80,000 children enrolled in Covered California, while about 500,000 children enrolled in Medi-Cal (October 2013 to September 2014), demonstrating the critical role Medi-Cal plays in the health care system for California's children.[6]

There is no better population to examine than children when considering the promise of the ACA, for the changes to health coverage and delivery will have an impact on their health for a lifetime. This report provides a review of the major impacts ACA reforms have had on California children's coverage through Medi-Cal and Covered California* since the passage of the ACA in 2010, as well as additional coverage reforms that the State chose to implement independent of the ACA during the same time period. Specifically, this report highlights what the progress made possible by the ACA has meant for the health of children as well as policy solutions to make further progress. The report also provides actionable recommendations for the future related to: eligibility for coverage, health care benefits for children, the affordability of coverage, how families enroll in and renew coverage, and how families are using their coverage and getting care for their children. In some cases, the major impacts affect children and adults similarly. In other cases, there are impacts specific to children and their unique health care needs. Recommendations are primarily California focused, but some federal recommendations are also included to underscore the nationwide impact of those issues. As we look forward, these findings help illustrate where we can help build consensus and public will to further the success of the ACA and continue to do what is best for the health and well-being of California's children.

*This report does not examine the effects of reforms on children's insurance in the individual and employer markets.

The Affordable Care Act: Improvements for Children's Health Coverage

Prior to the ACA, most uninsured children were already eligible for coverage through existing programs but were not enrolled. However, major ACA policy changes to increase access to preventive services and improve care have broadly benefited children and their families in California. Across the nation, these improvements include:

- A comprehensive package of benefits, known as Essential Health Benefits (EHB), is the minimum that the ACA requires to be offered by non-grandfathered health plans in the individual and small group markets, both within and outside of the marketplaces. The ACA lists ten categories of benefits that must be part of the EHB package, among them "Pediatric services, including oral and vision care." In 2015, California began requiring all health plans sold through Covered California to include pediatric dental benefits, meaning every child who enrolls in coverage through Covered California also has dental benefits.

- Free preventive services, such as well-child visits, immunizations, and developmental screenings for children, are required in most health plans.[7] An estimated 2.2 million children in California gained preventive services coverage with zero cost sharing due to the ACA.[8]

- Young adults can stay on their parents' health insurance plans until the age of 26. The ACA recognizes that young adults newly entering the work environment may have difficulty obtaining affordable, comprehensive coverage on their own, and that the cost of coverage can interfere with plans for college or embarking on a career.[9] In 2011, over 435,000 California young adults under age 26 gained coverage as a result of this provision of the ACA.[10]

- States must provide Medicaid coverage to youth under age 26 if they were in foster care at age 18. This ensures that former foster youth can access the health care services they need, just as non-foster youth who can stay on their parents' health insurance until age 26 are able to do. In California, about 12,000 youth formerly in foster care now have coverage through Medi-Cal as a result of this provision.[11]

- Children and adults can no longer be denied coverage by health insurance companies for pre-existing health conditions, such as asthma and diabetes. Nearly 600,000 California children had pre-existing health conditions in 2010.[12] Families no longer have to worry about being denied coverage for those conditions.[13]

- Eligible low- and middle-income families have access to financial assistance when purchasing private insurance through federal and state marketplaces, such as Covered California, making coverage more affordable for more Californians. In June 2015, 90 percent of members in Covered California were eligible for subsidies.[14]

- The ACA maintained the Children's Health Insurance Program (CHIP) through 2019. Maintaining CHIP's comprehensive, child-specific benefits package and low to no cost sharing has been critical for children nationwide. Without the ACA's commitment to CHIP, California children and all other CHIP children across the nation may have been the only population to have lost benefits.* CHIP, like Medicaid, is a proven success in providing child-specific coverage for millions of low- to moderate-income working families.

*In California, CHIP children are covered under Medi-Cal. Without a federal CHIP program and CHIP enhanced match, California would have to pay a greater share of the cost of the Medi-Cal coverage. If the State reversed course and moved back to a separate CHIP program, and if federal CHIP was not continued, California CHIP children would be moved into Covered California with lower benefits and greater cost sharing.

Coverage—Expand Eligibility & Cover Child-Focused Benefits

The first step to ensuring children can benefit from health reform is to ensure children are eligible for health coverage and that such coverage includes comprehensive and child-specific benefits. Widespread political support for the ACA in California gave the State early momentum to seize on opportunities to expand coverage provided by the law and use this momentum as an impetus for additional expansions in eligibility for coverage and creation of robust benefits. As a result of the culmination of coverage expansions during this period, all low- to moderate-income children* in California now have an affordable coverage option.

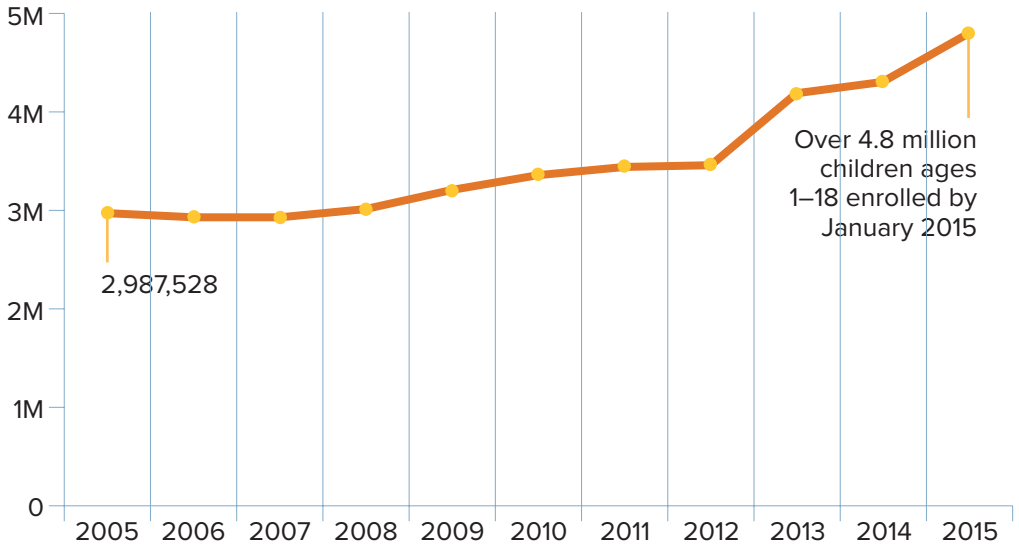
Eligibility

California was one of the initial states to take advantage of federal incentives to expand its Medicaid program to low-income adults. Under the ACA, states can expand Medicaid to adults with incomes at or below 138 percent of the federal poverty level (FPL). Coverage for these newly eligible adults is fully federally funded (100 percent federal match) for three years, phasing down to 90 percent by 2020. California's Medi-Cal expansion for adults began in January 2014. As of September 2015, about 3.2 million California adults were enrolled in Medi-Cal as a result of this expansion.[15] Not only are these adults finally able to get affordable health coverage, but many of their children were also enrolled, illustrating the "welcome mat" effect (described above).[16]

Like Medi-Cal, the federal Children's Health Insurance Program (CHIP) is a critical source of coverage for children. In 2015, CHIP was funded for an additional two years (through 2017). CHIP provides states with a set amount of funding that must be matched with state dollars to provide coverage to uninsured children and pregnant women who earn too much to qualify for traditional Medicaid. CHIP's federal match rate was enhanced as part of the ACA, bringing California's federal match rate up to 88 percent from 66 percent. In 2013, California consolidated its stand-alone CHIP program, known as the Healthy Families Program, into Medi-Cal, which brought over 750,000 Healthy Families children into Medi-Cal.[17] Overall, federal CHIP funding covered over 1.2 million California children and pregnant women in 2015 and will remain a critical source of affordable and child-specific comprehensive benefits for children.[18]

*Certain California children still do not have affordable insurance options, namely undocumented immigrant children with incomes above the Medi-Cal income eligibility level and those offered parents' employer-based coverage that is not affordable and yet disqualifies them from getting Covered California coverage.

Trend in Medi-Cal's Child Population from 2005–2015, Ages 1–18



Source: California Department of Health Care Services, "Understanding Medi-Cal's Child Population," October 2015, accessed April 12, 2016, www.dhcs.ca.gov/Documents/Medi-Cal_Utilization_Data_for_Children.pdf.

In addition to the expansion of Medi-Cal, California was the first state in the nation to enact legislation creating a health insurance marketplace—Covered California—offering affordable private insurance options to Californians. Federal tax credits are offered to help offset premium costs for qualified individuals with incomes up to 400 percent of the FPL. Additional assistance to reduce cost sharing is available for those with incomes between 100 and 150 percent of the FPL, which lowers the amount of out-of-pocket costs for deductibles, coinsurance, and copayments. Both children and adults are eligible for subsidies through Covered California if they meet the income guidelines, are US citizens or lawfully present, do not qualify for Medi-Cal, and are not offered what the ACA deems as "affordable" employer-sponsored insurance. Over 70,000 children were enrolled in Covered California as of June 2015, of which approximately 50,000 were receiving financial assistance.[19]

The creation of the marketplace has also had implications for existing California coverage options for pregnant women and their newborns. As with other adults in California, the State raised the Medi-Cal income eligibility level for pregnant women to get full-scope Medi-Cal benefits during their pregnancy from 60 percent of the FPL to 138 percent of the FPL.[20] This change in eligibility gave these women the option to stay on pregnancy-related Medi-Cal or to switch to the regular Medi-Cal program. While pregnancy-related Medi-Cal provides full health coverage benefits—not just a narrow set of prenatal and hospital labor and delivery services—it is delivered through a fee-for-service system, while regular Medi-Cal is predominantly delivered through managed care organizations. Pregnant women with incomes above 138 percent and below 213 percent of the FPL are eligible for pregnancy-related Medi-Cal. Previously, these pregnant women were eligible to enroll in both pregnancy-related Medi-Cal and Covered California during pregnancy, enabling them to receive both services related to their pregnancy and comprehensive health benefits. Now, eligible women enrolled in Covered California who become pregnant are informed of their eligibility for Medi-Cal but have the choice to remain in Covered California.[21] Generally, if a person is eligible for Medi-Cal, they are not eligible for Covered California. The above scenario is an exception.

Beyond Medi-Cal expansion for childless adults and the availability of private coverage through Covered California, the State also provided youth under age 26 who were in foster care at age 18 an opportunity for coverage through Medi-Cal. This coverage opportunity ensures former foster youth can access the health care services they need, just as non-foster youth who can stay on their parents' health plans until age 26 are able to do. In California, about 12,000 youth formerly in foster care now have coverage through Medi-Cal as a result of this provision.[22]

As coverage opportunities for the majority of Americans expanded under the ACA, California continued its coverage opportunities for those left out of the ACA, namely members of the immigrant community. With the creation of the federal Deferred Action for Childhood Arrivals (DACA) program, a new group of immigrant children qualified for Medi-Cal coverage in California. Beginning in 2012, the DACA program began offering deportation relief and work authorization to certain undocumented immigrants who arrived in the US as children and meet several other requirements relating to age, education, and residency.[23] Individuals with DACA are granted what is called Permanently Residing in the United States Under Color of Law (PRUCOL). In California, individuals with PRUCOL, who meet income and other qualifications, are eligible for Medi-Cal, which California pays for with state-only funds.[24] Approximately 125,000 young Californians with DACA are estimated to be eligible for Medi-Cal, but approximately 11,000* have enrolled as of 2014.[25]

Furthering its commitment to Californians not covered by the ACA, the State went further in its efforts to cover immigrant children. Historically, many undocumented immigrant children received coverage through local county health insurance programs and Kaiser Permanente's Child Health Program because these children were locked out of full-scope Medi-Cal. Over time, several local county programs have restricted their coverage population or shut down, due to funding challenges. To ensure all children have access to health coverage, Senate Bill (SB) 75 was signed into law as part of the 2015–2016 state budget. Beginning in May 2016, SB 75 expanded the Medi-Cal program to allow an estimated 170,000 to 250,000 income-eligible children,** regardless of immigration status, to qualify for full-scope Medi-Cal coverage (certain undocumented immigrants are currently eligible for restricted-scope Medi-Cal benefits). In providing health coverage for California's undocumented immigrant children, the State cements its commitment to a statewide system of coverage for all low-income children in California.

*The UC Berkeley Labor Center assumes the 11,000 estimated enrollees based on increases in PRUCOL enrollment in 2014.
**UC Berkeley-UCLA CalSIM 1.91 estimates that 250,000 undocumented immigrant children will be newly eligible for full-scope Medi-Cal once the law is implemented. State budget estimates for FY16–17 assumed 170,000 children would enroll.

Benefits

Children enrolled in Medi-Cal receive comprehensive health care benefits tailored to children's specific needs. Specifically, children enrolled in Medi-Cal receive Early Periodic Screening, Diagnosis, and Treatment (EPSDT), which is a federally mandated comprehensive set of health services designed to ensure that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services, as well as meet the special physical, emotional, and developmental needs of low-income children.[26] The Medi-Cal program provides child-specific benefits with no cost sharing for low-income children and very modest premiums for slightly higher-income children (above 150 percent of the FPL). As such, Medi-Cal is a model of affordable, child-appropriate insurance for California children, even in comparison to the benefits packages offered in Covered California.[27] Similar to the EPSDT package provided through Medi-Cal, the federal CHIP program supports a comprehensive level of benefits more specific to children's needs. In fact, the federal Centers for Medicare and Medicaid Services recently certified that the current marketplace qualified health plans (QHP) do not provide the same level of benefits provided through CHIP.[28]

The ACA bolstered the package of products and services offered by health plans in the individual and small group markets, both inside and outside of the marketplace. Now, most health plans must provide a comprehensive package of ten categories of products and services, known as Essential Health Benefits (EHB). A critical component of the EHB is free preventive services, which means that enrolled children receive vaccinations and annual well-child visits in addition to other recommended preventive services, without cost sharing.[29] The package of preventive services for children is outlined in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.[30] Supported by the Health Resources and Services Administration, *Bright Futures* is the definitive standard of pediatric well-child and preventive care developed by an evidence-informed, active collaboration led by the American Academy of Pediatrics (AAP).[31]

The EHB package also includes "pediatric services, including pediatric oral and vision care." However, federal regulations to date have not clarified what benefits should be included in the pediatric services EHB category, other than the general pediatric dental and vision care. In the absence of specific guidance, state marketplaces are given minimal information from the federal government as to what benefits should supplement their benchmark plan in order to fulfill the pediatric services EHB. States' benchmark plan options (except for the pediatric dental benchmark plan options) are essentially employer-based coverage plans, which are generally concerned with the coverage needs of adults. As such, relevant mandates for coverage of child-specific services may not be included in benchmark plans,

What are Essential Health Benefits?

The ACA bolstered the package of covered benefits and services offered by health plans in the individual and small group markets, both inside and outside the health insurance marketplace. Most health plans must provide a comprehensive package of products and services, known as Essential Health Benefits (EHB), 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
10. Pediatric services, including oral and vision care*

* The pediatric services EHB requires further refinement and clarification.

preventing children from accessing services necessary for their healthy development. The current California benchmark plan (Kaiser Small Group HMO 30), recently reauthorized until 2017, does provide more generous preventive care services than what is currently available in most plans sold to individuals or small businesses.[32] However, despite the broad range of covered benefits, there are still some services particularly important for children's development that are not covered under this benchmark plan, such as hearing aids.[33]

In addition, while children's dental coverage is part of the pediatric services EHB, the way states offer dental coverage for children varies. In fact, in many states and on the federal marketplace, children's dental coverage is sold separately from medical coverage, subjecting families to additional costs and bureaucracy to enroll in dental coverage. Initially, California was one of these states, selling only "stand-alone" pediatric dental benefits to families. Using this approach, only 30 percent of children enrolled in medical coverage through Covered California were also enrolled in dental coverage.[34] Advocates spent the first year of open enrollment making the case for integrating pediatric dental plans into health plans offered by Covered California. By the second open enrollment period, all children who received their health coverage through Covered California automatically received dental benefits, without an additional cost or extra enrollment step. California is one of three states and the District of Columbia that offers embedded dental plans.[35] As a result, all children enrolled in Medi-Cal and Covered California have affordable, comprehensive dental care. In fact, for 2017, California chose its CHIP/Medi-Cal dental benefits as the pediatric dental benefit benchmark, which includes EPSDT dental coverage.

Coverage—where we need to go

While there have been tremendous strides in improving and expanding coverage options and benefits for children and families, there are gaps to fill and benefits to improve. Many recommendations for future advancements may require federal policy changes, but there are several steps California policymakers can take to ensure the state's children receive the most affordable, comprehensive health coverage.

Fix the "family glitch" so more families can access affordable coverage. The "family glitch" refers to how some moderate-income families may be locked out of access to financial assistance for marketplace health plan coverage. In order to be eligible for premium tax

credits or cost-sharing reductions, families must have incomes below 400 percent of the FPL and not have access to what the ACA deems as affordable employer-sponsored insurance.[36] But the federal government defines "affordable" based only on the cost of individual coverage offered by an employer and not the significantly higher cost of a family plan. Thus, if a family's income would otherwise make family members eligible for subsidized coverage through Covered California, those dependent family members are ineligible for Covered California subsidies because they have access to employer-sponsored coverage, even if the family cannot afford such coverage. It is estimated that an additional 144,000 Californians* would qualify for and use premium subsidies in California, half of whom are children, if the family glitch was resolved by calculating affordability using the cost of the full family coverage plan and not just the employee-only coverage.[37] To make good on the promise of affordable health coverage for all and to accurately reflect Congress's intent, the federal Administration should correctly interpret the eligibility provision defining "affordable" to include the true cost of family coverage. In the absence of a reinterpretation, Congress must clarify the provision as such, so these working families and their children are not unfairly denied affordable coverage.

In the absence of federal action, the State could address the family glitch through a federal Section 1332 waiver proposal. Section 1332 of the ACA

*This number is based on a specific scenario: If the cost of self-only coverage is less than 9.5 percent of household income, but the cost of family coverage is greater than 9.5 percent of household income, then family members—but not the employees themselves—would be eligible for subsidized coverage in the marketplace.

permits states to apply for a waiver to pursue innovative strategies for providing their residents with access to high-quality, affordable health insurance, while retaining the basic protections of the ACA.[38] While the current deficit neutrality guardrails of the 1332 waiver guidelines make this difficult to achieve, guidance under future Administrations might offer enough flexibility to allow a state 1332 waiver remedy for the family glitch.

Expand Medi-Cal to low-income undocumented immigrant adults and allow undocumented immigrants to purchase coverage through Covered California. There are 1.5 million Californians who will remain ineligible for full-scope coverage through Medi-Cal or Covered California due to their immigration status.[39] To ensure access to coverage for all Californians, the State should expand Medi-Cal coverage to low-income adults, regardless of immigration status, and seek permission from the federal government via a Section 1332 waiver to allow undocumented Californians to purchase coverage (without subsidies) through Covered California. When parents are also eligible for coverage, the whole family is more likely to enroll and more children will be able to get the health care they need.

Provide child-specific, comprehensive coverage for children enrolled in health plans through Covered California. In considering an appropriate definition of pediatric services, Medicaid's EPSDT benefit offers the gold standard because it provides all the medically necessary health services that children need. Until there is a federal definition of the pediatric services EHB category, offering at least a CHIP-comparable benefits package, California should pursue a Section 1332 waiver through the federal government to offer Covered California children Medi-Cal-contracted health plans (as non-QHPs), as a means of providing a comprehensive pediatric services benefits package.

Provide the "Pediatric Services" Essential Health Benefit to youth up to age 21. Despite federal regulations stating that states have the flexibility to extend pediatric services coverage beyond the age of 19 and receive federal financial assistance for doing so, California policymakers have yet to exercise this option.[40] Extending eligibility for pediatric benefits to age 21 in Covered California would align with existing standards in Medi-Cal and ensure that children receive critical, comprehensive services, including oral and vision care, until age 21, regardless of which coverage option they are in. This is particularly important as many families experience fluctuating incomes that cause their eligibility to teeter back and forth between Covered California and Medi-Cal.

Fund the Children's Health Insurance Program (CHIP) in 2017. CHIP has demonstrated unequivocal success at reducing the number of uninsured children and providing affordable, comprehensive, and high-quality child-specific health benefits for children whose family incomes are above the Medicaid eligibility level but not high enough to afford private coverage. Until an alternative means of child-centered coverage exists and can demonstrate the same cost-sharing protections and child-specific benefits, CHIP will need to be funded beyond 2017. CHIP was reauthorized by Congress through 2019, yet fully appropriated only through 2017. Not only should CHIP be fully funded throughout its authorization period, but it should also be reauthorized beyond 2019. If CHIP is not funded and reauthorized and marketplace coverage continues to pale in comparison, the CHIP children may be the first group to dramatically lose benefits under health care reform.

Affordability—Ensure Families Can Afford Coverage & Care

Eligibility for health coverage only goes as far as families' ability to afford it. California has been largely successful in containing costs in the marketplace for the 1.3 million people currently enrolled through Covered California.[41] Covered California has been explicit in its effort to put consumers first and, as a result, is a leader in efforts to control costs and keep coverage within financial reach for consumers while giving them additional coverage options.

Through the operation of its marketplace, California is using all the tools provided by the ACA to ensure that consumers get the most affordable coverage. Unlike most state marketplaces and the federal marketplace, Covered California does not allow all health insurance companies to participate in the marketplace. Instead, Covered California is an "active purchaser," which means it selects insurers to participate in the marketplace, designs the products it wants those insurers to offer, and negotiates premiums on consumers' behalf.[42] In its role as an "active purchaser," Covered California negotiated lower rate increases on average than the increases experienced by other states or by individual consumers prior to enactment of the ACA.[43]

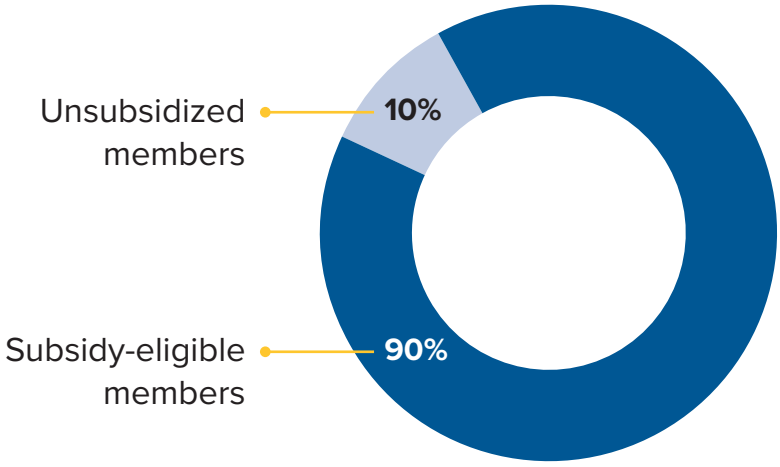
Lack of affordability remains the most common reason cited for going without health insurance in California.

Another tool Covered California used to focus competition based on premiums, networks, and quality (and not benefits) was to create a standard benefits design, which establishes the services that all qualified health plans must offer. With standardized benefits, Covered California consumers can more accurately compare health insurance plans. Without a standard benefits design, there are often too many product options that are confusing and can lead to poor choices by consumers, either by picking a plan that is too expensive or picking one that has more out-of-pocket cost sharing than expected.[44]

As a result of the provisions in the ACA and cost containment tools Covered California has chosen to utilize, Californians are benefiting from multiple efforts to keep coverage affordable. In 2015, 90 percent of members in Covered California benefited from financial assistance made possible by the availability of subsidies through the ACA. In addition, over 670,000 Covered California enrollees (of which nearly 50,000 are children) benefit from cost-sharing subsidies that help reduce out-of-pocket health care costs in the form of reduced copayments for office visits, lab tests, and more.[45] State efforts furthered this work to help make coverage more affordable. For example, Covered California provides a cost estimator tool on its website to help consumers calculate their potential out-of-pocket costs under various plans.[46] In addition, California was the first marketplace in the country to impose a cap on out-of-pocket costs for specialty prescription drugs, beginning this year, ranging from $150 to $500 per month.[47] The vast majority of consumers will see their specialty drugs capped at $250 per month, per prescription.[48]

Medi-Cal clearly offers the most affordable insurance options, as it is serving those families with the lowest incomes. Children particularly benefit from Medi-Cal's very low costs: low-income children enrolled in Medi-Cal have no cost sharing, such as copayments, deductibles, or coinsurance. For those children with family incomes between 160 and 266 percent of the FPL, only a very modest premium of $13 per child, per month is imposed, with a maximum of $39 per family, per month.[49] Nationally, Medicaid's affordability, coupled with the comprehensive child-specific benefits, is highly valued by parents and outweighs other family coverage considerations, such as parents being in separate plans than their children. Parents far prefer affordable, quality coverage for their children over having the same plan as their children.[50]

Percentage of Individuals Receiving Financial Help in Covered California



Note: N = 1,306,520 which includes both children and adults. Source: California Health Benefit Exchange, "Covered California Active Member June 2015 Profile," accessed February 18, 2016, http://hbex.coveredca.com/data-research/Active%20Member%20Profile/CC_Active_Member_Profile_2015_06_June_rev_2015_10_08.xlsx.

Affordability—where we need to go

While the proportion of uninsured Californians reporting cost as the reason for lacking coverage fell from 53 percent to 43 percent in 2014, lack of affordability remains the most common reason cited for going without insurance in California.[51] Among people with health insurance, one in five working-age Americans reports having problems paying medical bills in the past year that often cause serious financial challenges and changes in employment and lifestyle.[52] When insured individuals received medical bills, three-quarters said that the amount they had to pay for their insurance copayments, deductibles, or coinsurance was more than they could afford. As the ACA implementation moves forward, ensuring coverage is affordable for children and their families remains critical.

Support families and individuals' ability to afford health coverage and care by lowering the cap on Covered California plans' overall out-of-pocket costs. A recent national analysis from the Medicaid and CHIP Payment and Access Commission (MACPAC), as required by the ACA, found that out-of-pocket spending (premiums and cost sharing) in the second lowest cost silver marketplace plans was an average of $1,073 versus $148 in average separate CHIP plans—almost seven times as much.[53] The Commonwealth Fund found that, nationally, for those without cost-sharing reductions, average copayments, deductibles, and out-of-pocket limits under catastrophic, bronze, and silver plans are considerably higher than those under employer-based plans on average.[54] Marketplace plans are also far more likely than employer-based plans to require enrollees to meet deductibles before they receive coverage for prescription drugs.[55] While many enrollees are benefiting from financial assistance in Covered California, lowering the current cap on overall out-of-pocket costs to make affordable coverage a reality for children and families who do not qualify for Medi-Cal or have employer-based coverage should be a policy priority.

Provide subsidies for adults to purchase dental coverage through marketplaces, including Covered California. Currently, dental benefits are offered to adults for purchase through Covered California, but with no subsidy. Making dental benefits more affordable for adults—and, thus, the whole family—will likely lead to more children using the dental benefits they have, based on evidence that when parents have health coverage and care, all family members, including children, are more likely to use their benefits.[56] The federal government should include dental coverage as an Essential Health Benefit. Alternatively, the State could offer adult dental benefits and pay for the subsidy using state-only funds.

Enrollment—Streamline Health Coverage Enrollment & Renewal

Once families are aware of their coverage opportunities, enrollment and renewal in health coverage should be an easy process. Now that California has a system of coverage for all low-income children, enrollment need not be a matter of whether or not they qualify, but instead a matter of for which insurance options children are eligible. The ACA created an enormous opportunity to revamp health coverage enrollment processes to be more efficient and easier for families. All states are required to have electronic enrollment systems, which offered California the opportunity to create a user-friendly interface to shop for coverage through Covered California or enroll in Medi-Cal, but it also offered an opening to explore other ways to simplify enrollment and renewal.

Enrollment

After the passage of the ACA, California immediately began work to develop the software backbone for California's online eligibility, enrollment, and renewal system, known as the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS serves an array of functions, including application processing, plan comparisons and selection (Covered California only), renewals, appeals, notices,* and calculations for financial assistance. It also houses the eligibility business rules used to determine eligibility for Medi-Cal categories and Covered California. Families can now apply for coverage online (in English and Spanish), in addition to the option to apply in person, by phone, fax, or mail. One of the ACA's stated goals was to enable individuals and families to apply for coverage using a single application and have their eligibility determined for all insurance affordability programs through one simple process.[57]

While CalHEERS houses the business rules for eligibility for both Medi-Cal and Covered California, this system only processes and determines enrollment for Covered California. Individuals eligible for Medi-Cal who apply for coverage through CalHEERS have their application transferred to their local county for a final Medi-Cal eligibility determination and management of Medi-Cal cases.

County Medi-Cal workers have the expertise and experience in Medi-Cal eligibility and enrollment procedures, as well as existing systems, as compared with the more recent CalHEERS system and service center representatives. Nonetheless, as with bifurcated enrollment assistance, having two enrollment systems carries with it the risk of coordination glitches, particularly for families with parents enrolled in Covered California and children enrolled in Medi-Cal.

Getting the new enrollment system operational in time for open enrollment in 2013 resulted in several application and enrollment glitches affecting both Covered California and Medi-Cal enrollment. These system glitches and the tremendous volume of Medi-Cal applications overall led to an unprecedented backlog of unprocessed Medi-Cal applications. During the backlog period, the State estimated that 195,000 children had pending Medi-Cal applications and were not receiving coverage while waiting.[58] While the backlog has vastly improved, in 2015 there was still a small backlog and California is only processing 25 to 50 percent of Medi-Cal applications in "real time."[59] Medi-Cal-eligible children applying online are afforded an important expedited policy, called Accelerated Enrollment, which allows them to receive immediate coverage while their application is processed. Unfortunately, the State rejected providing Accelerated Enrollment to Medi-Cal-eligible children who applied via the county or over the phone, on the assumption that enrollment through these direct pathways would be virtually immediate. However, the 2014 backlog and less than "real time" enrollment disproves that assumption.

California is only processing 25 to 50 percent of Medi-Cal applications in "real time."

With regard to encouraging enrollment, the State took advantage of early implementation opportunities to

*Under AB 1341 (2014), counties are to send out Medi-Cal notices.

efficiently enroll or renew children and adults into coverage in other innovative ways. California chose the federal option to offer "facilitated" enrollment for individuals who were currently enrolled in the Supplemental Nutrition Assistance Program (SNAP), or CalFresh in California, through its "Express Lane Enrollment (ELE)" Project. ELE allows the State to use eligibility information from CalFresh to determine CalFresh beneficiaries as eligible for Medi-Cal and enroll them into coverage with no additional application and only enrollee consent. Because California adopted the ACA Medicaid expansion, the State wanted to use this strategy. California identified and enrolled about 197,000 adults and 37,000 children who received CalFresh in 2014 into Medi-Cal.[60] ELE is a tremendously efficient strategy for identifying, reaching, and enrolling many uninsured children.

In 2014, California enrolled approximately 197,000 adults and 37,000 children who received CalFresh into Medi-Cal through Express Lane Enrollment.

At the inception of CalHEERS, the Medi-Cal Access Program (MCAP)* eligibility screening was not provided to pregnant women applying online through CalHEERS, leaving many pregnant women unaware of their eligibility for the more affordable coverage provided by MCAP and instead were notified that they qualified for Covered California. As of October 2015, a year and a half after CalHEERS went live, pregnant applicants eligible for MCAP are now being identified when they apply online through CalHEERS or at the county level.[61]

A more recent enrollment issue involves new documentation requirements for families intending to apply for Covered California coverage during the Special Enrollment Period (SEP), which allows eligible individuals to enroll in coverage if they experience a qualifying life event, such as having a baby, losing a job, or otherwise losing their health coverage.[62] Nationally, CMS issued its own documentation requirements for the SEP in the federal marketplace in response to assertions by health plans that families are erroneously enrolling in coverage during the SEP. CMS is now requiring applicants to provide documentation demonstrating their eligibility to use the SEP to enroll in the federal marketplace. For example, in order for a baby born outside of the open enrollment period to qualify to be enrolled through an SEP, the parent(s) must provide documentation, such as a birth certificate. This could delay coverage and thus critical health care for uninsured individuals, particularly newborns receiving critical care in their first few months of life, prior to receiving an official birth certificate. Covered California is developing a post-enrollment sampling process for verification documentation for SEP eligibility for 2016.[63]

Renewal

The ACA also includes provisions to help individuals keep their health coverage once enrolled by requiring streamlined renewal processes. Now, when possible, all states must use available data to renew Medicaid eligibility (called ex parte renewal), instead of requiring families to provide paper proof of their continued eligibility for coverage. Initially, Medi-Cal was slow to comply with the new ACA renewal requirements. But in 2014, California adopted a temporary federal renewal strategy—a type of "express" renewal, in which counties could renew coverage for Medi-Cal beneficiaries for those also enrolled in CalFresh, based on their recent CalFresh eligibility determination. Beginning in 2015, California counties were able to renew coverage for most Medi-Cal members automatically, based on existing eligibility information via CalWORKs (the state's welfare program), CalFresh, or Covered California, as well as other state and federal data records. If eligibility cannot be determined, the county now sends a renewal application to individuals with as much pre-populated information as possible for the beneficiary to confirm.[64] In 2015, California was one of 10 states that was able to renew 50 to 75 percent of Medi-Cal beneficiaries via ex parte renewals.[65] For Covered California members who want to stay with the same health care plan, renewal is essentially automatic, with some verifications—either online or by phone—in order to continue receiving tax credits.[66] These new renewal processes reduce the burden on families, save unnecessary administrative costs to the State, and, most importantly, help to eliminate lapses in coverage.

*Medi-Cal Access Program (formerly known as Access for Infants and Mothers) is a long-standing program that covers pregnant women with annual incomes between 213 and 322 percent of the FPL. Women can stay on MCAP until the second month after delivery, and their child can stay on MCAP for up to two years.

Enrollment—where we need to go

While progress has been made, efforts to ensure enrollment and renewal for coverage is as simple and streamlined for children and families as possible must continue. This means families, particularly those in families with members in multiple coverage options (e.g. Medi-Cal and Covered California), can easily apply for and enroll in coverage in real time through all entry points; receive the application assistance they need; compare and enroll in a plan; retain coverage easily; and transfer smoothly between insurance programs when circumstances change.

Ensure a smooth enrollment process for all undocumented immigrant children into full-scope Medi-Cal. As noted in the Coverage section of this report, low-income undocumented immigrant children are newly eligible for full-scope Medi-Cal benefits. For all newly eligible children, the enrollment process should be clear, understandable, and trusted for immigrant families. There are several core implementation elements necessary to ensure a smooth and seamless enrollment of undocumented immigrant children, including 1) monitoring the transition of restricted-scope enrollees to full-scope Medi-Cal; 2) understandable information for families in all threshold languages; 3) clear communications to families with official clarification of privacy protections and public charge rules; and 4) culturally competent outreach and enrollment assistance.

Provide Accelerated Enrollment for children regardless of where they enter the system. Medi-Cal-eligible children should be granted Accelerated Enrollment for Medi-Cal through all points of entry, whether a family applies for their coverage in person, via phone, online, or through a mailed paper application. No child should experience delays in receiving care because their parents chose to enroll them over the phone or in person. Until all entry points can provide real-time enrollment, Accelerated Enrollment will be the best alternative to ensuring children receive immediate coverage and can seek care.

Implement Express Enrollment strategies through CalFresh, WIC, and CHDP. The previously mentioned expedited enrollment approach, called SNAP-facilitated enrollment, became a permanent option for targeted enrollment strategies offered by CMS in 2015.[67] Given its success in using this facilitated enrollment strategy, called Express Lane Enrollment in California, the State should seek federal authority to formally adopt and continue Express Lane Enrollment for CalFresh as a permanent option in California.*

There is also a separate federal Express Lane Eligibility (ELE) option, which allows states to use data and eligibility findings from other public benefits programs to determine if children are also eligible for Medicaid and CHIP. ELE offers a particularly effective strategy for maximizing children's enrollment under California's new system of coverage for all low-income children. For example, now that all low-income children, regardless of immigration status, are eligible for Medi-Cal, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)—which provides nutrition and health education and financial assistance to buy healthy foods to women and children with family incomes at or below 185 percent of the FPL—would serve as an effective and efficient pathway to Medi-Cal enrollment for pregnant women, parents, and children.

In addition, the Children's Health Disability Prevention (CHDP) program—a well-child and development screening program for all low-income California

*DHCS indicated that it intends to pursue a waiver to continue its Express Lane Enrollment project. Announced at the March 4, 2016, meeting of the Medi-Cal Consumer Focused Stakeholder Working Group.

children—has a gateway to Medi-Cal enrollment. CHDP application information can serve as an initial screen for Medi-Cal eligibility and provides temporary coverage while families complete a Medi-Cal application. The CHDP Gateway could be further improved to offer Express Eligibility, in which the CHDP application can serve as the beginning of a Medi-Cal application, not just a screen, and provide ongoing coverage while any follow-up information is obtained.

Improve the online application experience through regular consumer testing to identify what causes delays and confusion. Consumers are still experiencing technical difficulties with both Medi-Cal and Covered California online enrollment and renewals through the Covered California website. A recent report found that unclear guidance and questions related to income and household size resulted in errors in critical sections of the application used for Medi-Cal eligibility and Covered California subsidy eligibility calculations.[68] In addition, poorly designed online renewal forms frustrated users.[69] Given that over half of consumers are applying for coverage online, Covered California should monitor the online enrollment experience with actual consumers as well as test for quality improvements to identify where in the online enrollment process applicants experience delays or confusion and implement solutions to address identified problems.[70]

Monitor enrollment experiences of families with members in different coverage programs to identify what is working and areas for further or improved coordination. Covered California and DHCS are required to report application, enrollment, and renewal data on a regular basis.[71] It would be of great value for these enrollment and retention reports to include data on families in which some members are enrolled in Medi-Cal and others through Covered California, in order to identify challenges facing these families and pursue solutions. While little is known about these families' specific enrollment and renewal experiences, given their complicated circumstances, these families are most likely at particular risk of losing coverage or being confused about which communications from which agency require a response. With a few years of experience having two insurance options implemented in tandem under the State's belt, it is time to critically examine how families with members in both coverage options are faring and whether more coordination is needed to facilitate enrollment and renewal.

Streamline health coverage enrollment and renewal processes for families transitioning from Medi-Cal to Covered California. Many Californians transition between Covered California and Medi-Cal health coverage as their incomes change. In fact, it is estimated that 16.5 percent of all Medi-Cal enrollees will become eligible for health coverage through Covered California during the course of a year because of income increases.[72] Conversely, about one in five people with subsidized Covered California plans will become eligible for Medi-Cal.[73] These transitions intrinsically leave families at risk for having gaps in coverage. Thus, particularly tight coordination between Covered California and Medi-Cal related to requests for family information is essential. For example, families leaving Medi-Cal and transitioning to Covered California need to be informed as soon as possible about their Medi-Cal termination. They also need to be given information about the critical timelines and actions needed to complete their Covered California enrollment, such as the need to sign up for a Covered California plan before the end of the month in order to be enrolled by the time their Medi-Cal coverage terminates. Given the difficulties with seamless, uninterrupted coverage between two programs, families would benefit from "bridge" coverage, in which transitioning families continue receiving Medi-Cal coverage until their Covered California enrollment is complete. The bridge Medi-Cal coverage would, in essence, be temporary Covered California coverage, paid with federal tax credit subsidies if the family was determined eligible for Covered California tax credit subsidies. The State could submit a federal Section 1332 waiver proposal to create such a bridge, maintaining coverage levels and deficit neutrality.

Implement a flexible standard for accepting eligibility information for enrollment and renewal of coverage in Medi-Cal. California could adopt other eligibility and enrollment simplifications, such as a "reasonable compatibility" standard for income, as done in 34 other states.[74] Such a standard allows a discrepancy between certain reported eligibility information on an application or renewal that comes up in the verification process to be accepted if it is a relatively small discrepancy, without further paper documentation by families. These "reasonable compatibility" standards provide useful enrollment flexibilities to states in determining eligibility efficiently and to families who are otherwise eligible.

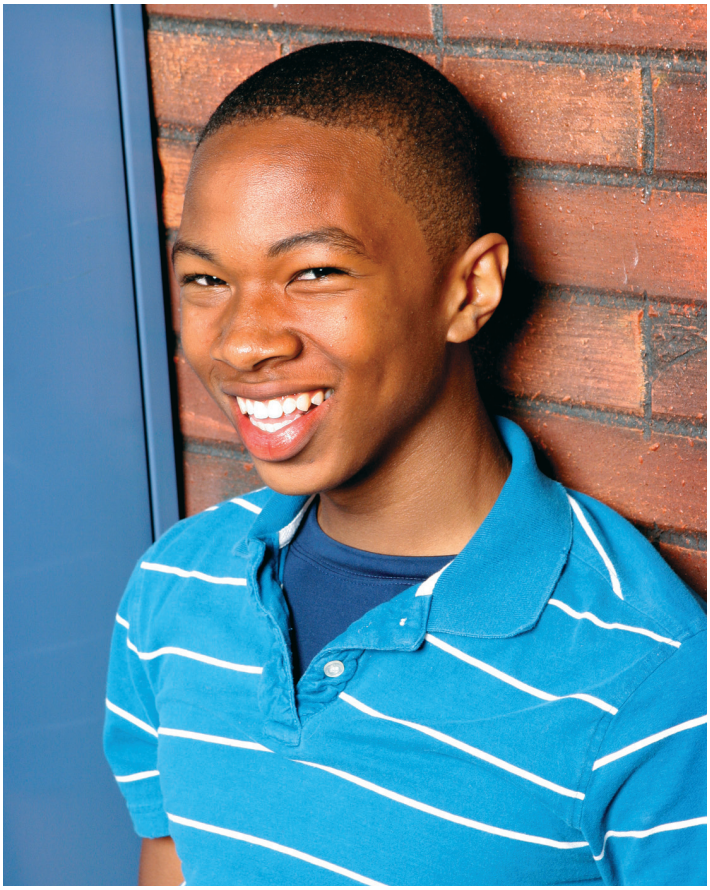
Outreach & Enrollment Assistance—Educate & Connect Families to Coverage

Outreach is key to making sure families are aware of health coverage options and have the assistance they need to enroll—for both themselves and their children. Experience with previous expansions of health coverage and other public benefits has shown that simply offering new coverage options does not ensure people will take advantage of them.[75] For example, the creation of CHIP in 1997 resulted in the reduction of the child uninsured rate by 36 percent nationally.[76] However, such coverage gains did not come easily or quickly. It took a significant financial investment by the federal government, states, foundations, and others to educate the millions of eligible but uninsured families about the new program and to connect their children to coverage. As a result of outreach grants and campaigns, enrollment assistance, and simplification of the enrollment process, many states were then able to significantly reduce their rates of uninsured children.[77]

Similarly, outreach related to the new coverage options available through the ACA required a robust, multifaceted effort to reach newly eligible populations. To raise awareness around coverage options available through the ACA and the launch of Covered California in 2013, Covered California invested in community mobilization and grassroots education as essential elements in reaching eligible Californians. Covered California initially established two grant programs. One focused on outreach and education to reach and inform consumers about coverage options and encourage enrollment primarily through community-based organizations. The second focused on enrollment assistance through Certified Enrollment Counselors (CECs) and insurance agents, but also included outreach and education activities. Covered California also invested in robust paid media campaigns, designed to reach both broad and targeted audiences in urban and rural markets across California, including print, radio, social media, and television.

As to be expected in the rollout of a brand new coverage option, there were shortcomings in the outreach programs in the first year of implementation. In the first open enrollment period, for example, there were too few CECs to help families enroll, and payments to them were not only critically delayed but also insufficient to cover the true costs of enrollment assistance. It also quickly became clear that most customers needed multiple contacts in multiple venues to get enrolled.[78]

As a result of these and other lessons, Covered California has made improvements to its education and enrollment assistance activities. Before the start of the second open enrollment period, Covered California made significant operations and marketing adjustments including: 1) instituting a new navigator model in 2014 and awarding grants to organizations to handle outreach, education, and enrollment; 2) doubling the capacity of the Service Center—where individuals call for information and enrollment assistance—and extending Service Center hours; and



3) redesigning the consumer website to include a full Spanish-language site and more culturally appropriate materials in additional languages than originally offered.[79] During the second open enrollment period, consumers were also able to access in-person assistance at more than 500 storefront sites statewide.[80] All of these changes resulted in approximately 70 percent of eligible consumers enrolling or renewing with assistance from certified insurance agents, CECs/navigators, or with the help of Covered California Service Center representatives over the phone, which was up from 58 percent in the first open enrollment period.[81]

Building on these enhancements, multiple efforts were implemented for the third open enrollment period to improve outreach and education. A holistic, multicultural marketing campaign was launched to better assist Californians, particularly those still uninsured, in understanding the value of health insurance and being covered.[82] For consumers requiring in-person assistance, storefronts provided community locations to access free assistance from certified enrollers during a variety of hours. Covered California streamlined eligibility and criteria for storefronts and worked to strengthen this critical piece of community engagement through a cleanup effort of existing storefronts and the creation of support materials, such as a toolkit and Storefront Finder User Manual.[83]

Despite improvements to outreach and enrollment assistance by Covered California, application assistance support is bifurcated. Due to federal requirements, Medi-Cal enrollment cannot be compensated by Covered California.[84] As a result, CECs and agents were neither trained in Medi-Cal eligibility and enrollment nor could they use Covered California grant funding to support their Medi-Cal application assistance. The lack of coordinated support for application assistance particularly impacted children since far more children are eligible and applied for Medi-Cal, as compared to Covered California. While Covered California outreach served as an effective opening for Medi-Cal children to also apply, the Covered California grantees were less equipped to assist them.

There were, however, some outreach programs specifically targeted to those eligible for Medi-Cal. In 2013, the federal government awarded funding through the Connecting Kids to Coverage Outreach and Enrollment grants* to state agencies, nonprofits, health centers, and school-based organizations to identify and enroll children eligible for Medicaid and CHIP—nine of which were California grantees that received a total of $5.2 million through July 2015.[85] The California Department of Health Care Services (DHCS) also received funds from The California Endowment, matched by the federal government, for local outreach to connect to hard-to-reach populations and enroll them in Medi-Cal. As a result, $25 million was distributed to the state's 58 counties to cover outreach and enrollment activities conducted between February 2014 and June 2016.

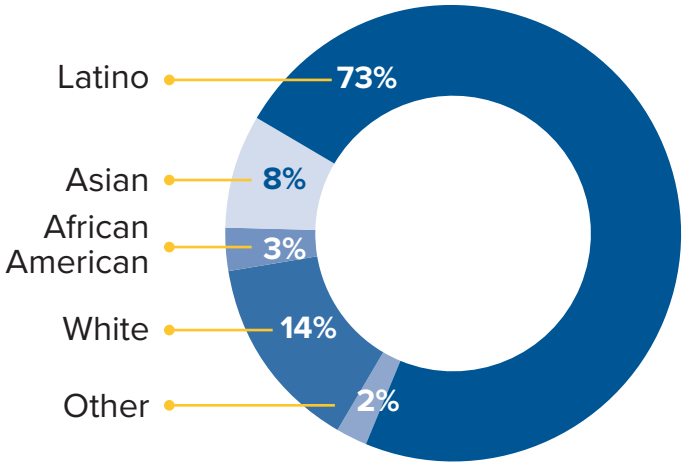
Successful enrollment into health coverage requires a multifaceted approach to outreach and education efforts. Research from Covered California found that consumers require multiple contacts before completing enrollment.[86] Reaching consumers requires an aggressive media strategy, coupled with on-the-ground, culturally sensitive education by community-based entities, such as schools, and organizations that families trust.[87] Finally, families need assistance with the application process. Without such help, families either do not submit applications or submit incomplete applications.[88] In either case, the result is that children and families remain uninsured, defeating the purpose of health reform.

Outreach—where we need to go

While we have made great strides in reducing the number of uninsured children, there are 437,000 remaining uninsured children** in California, and the majority of them are eligible for Medi-Cal or subsidized coverage in Covered California.[89] The remaining uninsured population of children is much harder to reach than those who enrolled in the initial years of coverage expansions and outreach campaigns. For example, uninsured children in traditionally hard-to-reach populations include those in very low-income and homeless families, families in which parents do not speak English, and families in rural areas.[90] Furthermore, the uninsured rate among children varies based on demographic factors, including income, race, ethnicity, age, and geographic location. School-aged children, those of Latino descent, and near-poor children are disproportionately represented among the uninsured.[91] In 2010, almost half (42 percent) of uninsured children nationally lived in an immigrant family.[92] Two-thirds (69 percent) of these uninsured children are citizens; furthermore 39 percent are Medicaid-

*The Connecting Kids to Coverage Outreach and Enrollment Grant funds are provided through the Affordable Care Act to continue the grant program first funded under the Children's Health Insurance Program Reauthorization Act (CHIPRA). The objective is to reduce the number of children who are eligible for but not enrolled in Medicaid and CHIP and to keep them covered for as long as they qualify.
**With the signing of Senate Bill 75 in 2015, undocumented immigrant children are now eligible for Medi-Cal. The State estimates that 50,000 children who are undocumented and uninsured will enroll in the program and are not reflected in the latest data of uninsured children.

Demographics of Californians Under Age 65 Projected to Remain Uninsured, 2019



Note: Projections are based on a "High Sign-Up Scenario" which takes into account the extent and effectiveness of outreach and enrollment efforts in the state. N = 3,380,000. Source: Laurel Lucia et al., Which Californians will Lack Health Insurance under the Affordable Care Act? (Berkeley, CA: UCLA Center for Health Policy Research and UC Berkeley Labor Center, January 2015)

eligible, 39 percent are not eligible for Medicaid, and eligibility is unknown for the 21 percent that are low-income, non-citizens.[93] Reaching these families will require an ongoing investment in time-intensive, targeted, culturally competent, innovative outreach and enrollment assistance strategies, including outreach to families through schools, small businesses, religious organizations, and other non-health channels.

Invest in culturally competent, targeted in-person assistance to reach underserved populations. California is a diverse state and the services provided should reflect the needs of the community. Of the 9.6 million kids in California, 51 percent are Latino, 27 percent are white, 11 percent are Asian, 5 percent are African American, almost 5 percent are multiracial, and fewer than 1 percent are American Indian/Alaska Native or Native Hawaiian/Pacific Islander.[94] As mentioned, Latinos represent the largest group of uninsured Californians; by 2019, it is projected that approximately three-quarters of the remaining uninsured will be Latino.[95] Research has shown that the availability of culturally and linguistically competent in-person assistance is particularly important for communities of color and those with limited English proficiency.[96] Reaching consumers through trusted messengers lends legitimacy to outreach and enrollment programs and makes a complex and confusing system less intimidating.[97] Support for local initiatives, such as community enrollment events, and community-driven programs, such as promotoras or community health workers, can help reach underserved populations in a more effective manner.[98] Ongoing efforts to provide effective in-person education and assistance to consumers should focus on funding groups that are trusted community members with experience in providing culturally competent assistance.

Equip community leaders with tools to connect families to health coverage and care. Working with trusted community partners that already interact with children and families is a critical and effective strategy to reach the uninsured. Faith-based organizations have been a tremendous partner in educating certain communities. For example, the Congregations Organized for Prophetic Engagement (COPE) used community meetings held at local churches, where the focus was school engagement and the meetings run by congregants they already trusted as educators, to inform parents about the availability of affordable health care and encourage them to enroll.[99] Schools are also particularly powerful, trusted messengers.[100] The Children's Partnership's ALL IN For Health Campaign works with California's schools and early learning providers to provide families information about Medi-Cal and Covered California coverage options. In addition, because one-third of uninsured children in California have a parent working for a small business,[101] the small business community is another partner to help provide their employees' families information about coverage options, if they are not providing coverage themselves.* The State and stakeholders should continue to identify partnerships where eligible families and children congregate—at places of worship, school,

*For example, the small business community could be equipped with resources to help small businesses educate employees about coverage options, especially Medi-Cal, for children. For more information, visit http://www.childrenspartnership.org/our-work/health-care/small-business-for-kids-health.

and work—as additional avenues to educate families about health coverage options for their children and themselves.

Provide assurances for mixed-status families, including families with undocumented immigrant children, regarding the use of their immigration status information. Many immigrant families that have members who are uninsured but eligible for Medi-Cal or Covered California fear that enrolling in health insurance will draw attention to their own or another family member's undocumented status.[102] This is particularly relevant given the new Medi-Cal eligibility for undocumented immigrant children. This fear understandably persists, even though there has been clear communication from US Immigration and Customs Enforcement (ICE) that it will not use information from health insurance applications in immigration enforcement.[103] Fears are particularly pronounced given the recent enforcement actions taking place in many immigrant communities around the country, including at least one site in California, that are separating families. Further, many families fear that receiving public benefits puts at risk their ability to become a permanent resident.

Outreach, as well as official communications to families, will need to include family-friendly and official information that outlines the existing privacy assurances and public charge limitations. Moreover, partnerships with trusted sources of information will help ensure comfort with the application process for immigrant families. Additionally, pending a court decision, immigration relief through the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA)* program would allow parents to come out of the shadows and allay their fears of deportation, thereby encouraging enrollment of citizen or lawfully residing children in DAPA families.[104]

Ensure education to uninsured individuals emphasizes the availability of financial assistance. Research shows that more than one-third of those eligible but uninsured are not aware of financial assistance available to them.[105] Yet, the availability of financial assistance was the most important factor for a majority of those that signed up for coverage.[106] Trusted messengers can relay facts about the financial help available to reduce the cost of insurance through subsidies or that they may be eligible for free or low-cost coverage through Medi-Cal.

Increase and sustain funding for application assisters who are trained and certified in Medi-Cal enrollment assistance. With Covered California unable to fund enrollment assistance for Medi-Cal enrollments and renewals, application assistance for families eligible for Medi-Cal is not widely available. Funding for Medi-Cal application assistance has been piecemeal and inconsistent, primarily reliant on generous private philanthropic support. To ensure the quality of enrollment and renewal assistance families and individual receive, the State should develop a standardized training and certification program for community organizations, CECs, and agents and allow only certified assisters to receive funding for enrollment and renewal assistance. The State can build on the similar Certified Application Assistance program created by the organization that ran California's now-defunct Healthy Families Program.

*In November 2014, President Obama announced several immigration executive actions that included DAPA. DAPA will allow undocumented parents with US citizen or lawful permanent resident children to apply for work authorization and protection from deportation. As of the writing of this report, no one can apply for the program. It is currently on hold until the Supreme Court rules on the matter where lower courts have put a hold on this executive action.

Care—Ensure Children Get the Care They Need

As more children than ever have access to quality, affordable health coverage, equal attention must be paid to ensuring families are knowledgeable about how to use their coverage and that providers in the coverage network are prepared to meet the needs of those enrolled. Decades of efforts to expand coverage and increase enrollment have culminated in the opening of marketplaces and the expansion of Medicaid across the country. While fine-tuning the enrollment system and outreach will always be important, the next phase of implementation shifts toward making sure children and families receive the care they need. Unmet health, dental, and mental health needs can result in developmental delays in children that affect their health, social, and academic outcomes.[107] Low-income children and children of color, in particular, face greater barriers to getting needed care and exhibit critical health disparities, which may cause them to lag behind their wealthier and healthier white peers.[108] The change in focus from enrollment to care presents an important opportunity to explore how and where the health care system can best meet the needs of children and families in a high-quality, targeted manner.

Families' Understanding of Health Insurance and the Health Care System

As millions more enroll in coverage, informing families of how to use their insurance is necessary to assist families in getting and staying healthy. Children's access to care through their insurance depends on their parents' ability to understand and navigate the coverage system on their behalf. When at least 1 in 3 parents of young children has limited health literacy skills, there is cause for concern regarding the risk children face, as measured by health care utilization, health behaviors, and other health outcomes.[109] More broadly, various studies have demonstrated a lack of health literacy among American families. In 2014, the Kaiser Family Foundation conducted a survey of Americans focused on health insurance literacy. While the general public did fairly well, those who scored lower included people with lower levels of education, younger Americans, and the uninsured.[110] Another report, from 2013, found that 51 percent of Americans did not understand such basic health insurance terms as premium, deductible, and copay.[111] According to America's Health Insurance Plans, nearly nine out of ten adults have difficulty using health information to make informed decisions about their health.[112]

51 percent of Americans did not understand basic health insurance terms such as premium, deductible, and co-pay in 2013.

Greater knowledge of health insurance may also lead to increased utilization of preventive services. Generally, Americans with higher education levels consume more preventive medical care as a result of being better informed or better able to process available information about preventive services.[113] Studies have found that individuals with low levels of health literacy are less likely to receive a flu shot or utilize other forms of preventive care.[114] With financial barriers mitigated by the ACA and the requirement of preventive services without cost sharing, utilization of preventive services is increasingly dependent on consumer knowledge and awareness of the importance of such services.

Health insurance policies, terms, and requirements are complex and overwhelming, especially for populations that are newly insured. Gaps remain in the amount of knowledge families have to make informed decisions. Without this knowledge, families may face a loss of coverage, not utilize care, and become further frustrated with the health care system.

Access to Care

In the last 10 years, the number of children enrolled in Medi-Cal has increased by 61 percent.[115] Significant growth occurred between 2012 and 2015, as Medi-Cal absorbed the Healthy Families Program population and the ACA was implemented.[116] And, with the implementation of SB 75, an additional 170,000 to

250,000 undocumented immigrant children are newly eligible for full-scope Medi-Cal this year. This significant growth calls into question whether Medi-Cal and its contracted managed care plans have enough participating providers in the right places to care for the millions of children and adults in the program and if it can keep pace and provide care as the pool of newly enrolled individuals expands. A recent review of rates for dental providers serving the Medi-Cal population showed a significant reduction in dental providers in the Medi-Cal program since 2008 (12.6 percent decrease in rendering providers and a 14.5 percent decrease in billing providers), demonstrating that, at least in Medi-Cal's dental program, there are not enough providers to serve the increased number of Medi-Cal enrollees.[117]

In order to monitor and report on children's access to care in the Medi-Cal program, several important advances at both the federal and state level have occurred. In 2016, CMS finalized the first major update to Medicaid and CHIP managed care regulations in more than a decade. These regulations prioritize delivery system reform, modernization and transparency of access and performance monitoring as well as quality of care that considers, in part, the specific needs of children and improves accessibility and the quality of information for consumers. For the first time, under these new rules, states must develop specific network adequacy standards for primary pediatric care, specialty pediatric care, pediatric behavioral health, and pediatric dental care. With these distinct child-specific standards, we will be able to discern and ensure children's access to care.

Additionally, the new federal rules require plans to document their compliance with network adequacy standards and other access to care requirements.

This is particularly welcome in California after a 2015 State Auditor report found that DHCS did not verify the provider network adequacy data it received from Medi-Cal health plans.[118] Another advancement is a new state law that puts in place new requirements for health plans to regularly update their provider directories and enhances state oversight of the accuracy of those directories.

The approval of California's Medicaid Section 1115 waiver renewal, entitled Medi-Cal 2020, provides the State an opportunity to transform the delivery of care for its Medi-Cal population. The waiver provides at least $6.2 billion in federal funding over the next five years for hospital financing and delivery innovation, local health care integration innovation through "Whole Person Care" pilots, consolidated care opportunities for California's remaining uninsured, and a Dental Transformation Initiative (DTI) to improve children's access to preventive dental care—all of which may have a significant impact on access and the quality of children's care. Notably, the waiver's required Medi-Cal managed care access evaluation also offers a valuable opportunity to systematically examine child-specific access issues, which have not yet been examined.

Due to the clear evidence that California children are not getting the dental care they need, the DTI presents a particularly exciting opportunity. Over half of all children in Medi-Cal did not see a dentist in 2013, according to a December 2014 State Auditor report.[119] The DTI leverages an unprecedented amount of new federal support to reward dental providers for 1) providing preventive dental care to additional children; 2) assessing children's risk for dental disease and implementing treatment plans based on that risk; and 3) maintaining continuity of dental care for children enrolled in Medi-Cal.[120] Critically, the DTI sets aside millions of dollars for local pilot programs. If leveraged well, these pilots can make a huge difference in deploying innovative ways to bring dental care to children in community settings. These are children who would otherwise go without care due to socioeconomic barriers and the lack of dentists that take Medi-Cal in their community. The DTI, coupled with the suggestions below, could make a huge dent in the dental care crisis California's underserved children currently face.

Over half of all children in Medi-Cal did not see a dentist in 2013.

Quality of Care

DHCS requires Medi-Cal health plans to report on a set of quality indicators, which includes a number of federally recommended quality indicators as well. In Federal Fiscal Year 2014, California reported only 12 out of the 22 child health quality indicators, compared to the median 16 reported nationally by other states.[121] While only two states measure all of the federally recommended child health quality indicators, most other states—but not California—have already adopted the measures for well-child visits in the first 15 months of

life (42 states), adolescent well-care visits (44 states), and follow-up care for children prescribed ADHD medications (34 states).

Although children comprise a small proportion of Covered California enrollees, it is important that Covered California understands the health care experience of this population and ensures that the needs of each child are being met, recognizing that children's unique needs are distinct from those of adults. That means Covered California health and dental plans should include: child-specific monitoring measures for enrollment, plan performance indicators, a thorough analysis of network adequacy, and assessments of timely access and utilization rates. For example, while challenges in network adequacy for Medi-Cal are highlighted above, Covered California has its own. In 2015, California ranked fourth in the nation in the narrowness of the networks offered in marketplace plans. In Covered California, three-quarters of plans only had 25 percent or less of available physicians in their rating region.[122] Though studies have shown that network narrowness was not associated with hospital quality in California,[123] continued surveillance of the impact of such networks on access to care is necessary to ensure children and families are able to seek the services they need, when they need them.

Increasing the availability of providers, the quality of services, and families' knowledge of the health care system will help us realize the promise of health care reform.

Care—where we need to go

Increasing the availability of providers, the quality of services, and families' knowledge of the health care system will help us realize the promise of health care reform. The delivery of health care services and promotion of innovative approaches to improve such delivery will be critical to improving the health and well-being of children.

Explore integration of health care literacy in existing educational venues for children and their families. Awareness campaigns utilizing schools as partners to inform families about health insurance have demonstrated success in reaching uninsured children.[124] Medi-Cal, Covered California, philanthropy, health plans, schools, and other stakeholders should use avenues where families are already receiving education about a topic related to improving their families' well-being to educate families about using their children's health coverage and getting needed care. Health plans are a critical source for reaching new enrollees with information regarding how to understand their coverage and be active health care consumers. Financial education seminars and other programs focused on financial literacy for families are an opportune avenue to reach families with insurance-related information and make clear the link between health insurance and a family budget. An examination of model health education and navigation from other states could also prove fruitful in identifying promising opportunities for use in California.

Support community partners to educate families about their children's benefits and how to get care. Families, especially those who are new to health coverage, may not understand the health insurance system and how to use it to access preventive and treatment-related health care. The best messengers for this education and support are those who know these families best, including schools, community health workers or community-based public health workers who have a close understanding of the community they serve, religious organizations, and others whom families trust. The State should support community-based education and support models, not only because such models improve families' health literacy, but also because such an investment is also an investment in preventive care, which leads to both healthier children and adults and is cost effective in the long run.

Increase the number of providers serving children enrolled in Medi-Cal through targeted innovative payment reforms. Medi-Cal payments to providers are now among the lowest in the nation: 80 percent of the national average.[125] This creates a disincentive for providers to treat Medi-Cal-enrolled children. California could incentivize contracted health plans and providers by paying enhanced rates for improved performance on currently reported quality measures, such as increases in timely immunization rates for two year olds, well-child visits, and ambulatory care/reduced emergency room visits. For health plans struggling to retain pediatric providers in designated Health Professional Shortage Areas or Medically Underserved Areas, increased capitation rates could be awarded to plans struggling with network adequacy. Plans would share the increase with newly

empanelled providers. This would build on the Dental Transformation Initiative model, described above.

Conduct an audit of children's access to care in Medi-Cal to ensure children are getting the care they need. A comprehensive audit of children's health care access in Medi-Cal should be conducted if the Medi-Cal 2020 waiver access assessment does not sufficiently examine children's specific access conditions. An access assessment should include direct provider surveys regarding their willingness to accept Medi-Cal children as patients.

Increase child-specific data monitoring, performance indicators, and reporting. More child-specific quality measures are needed to clarify the types of specific and targeted solutions needed to improve access to quality care in Medi-Cal. Covered California should similarly work with stakeholders to create child-specific quality measures to track the health experiences of enrolled children. Additionally, data should be disaggregated by age, race/ethnicity, geographic location, and other factors to identify health care disparities. In Medi-Cal specifically, California should, at a minimum, adopt quality measures for well-child visits in the first 15 months of life, adolescent well-care visits, and follow-up care for children prescribed ADHD medications. Covered California should implement child-specific monitoring measures for enrollment as well as plan performance indicators, a thorough analysis of network adequacy, and assessments of timely access to care and utilization rates. These measures should include children's experiences in getting needed dental care.

Ensure efforts to reform the delivery of care consider the specific needs of children. As implementation of the ACA demonstrates continued progress in enrollment of uninsured Americans, increased attention is placed on the delivery of health care and how to contain costs and improve quality. Much of the discussion around delivery system reform has moved away from a focus on the quantity of services delivered to ensuring quality care that is safe, timely, effective, equitable, and efficient. However, the focus around care delivery tends to concentrate on care delivered in a medical setting. As we continue to see the progress made possible by the ACA, performance standards and incentives must be established to ensure a comprehensive approach to child health care, linking health and non-health sectors to address critical social, environmental, and developmental factors impacting the health of children. Discussions should also consider the interconnectedness of the social, economic, and environmental conditions that affect children's health and, in doing so, more specifically consider the relationship between the health care system, schools, juvenile justice facilities, and child protective services in order to more adequately respond to the needs of children.[126] The federal Center for Medicare and Medicaid Innovation recently announced an initiative to test whether an Accountable Health Community model that systematically identifies and addresses health-related social needs and connects consumers to services can impact total health care costs, overall health, and quality of care.[127] Similarly, California has launched an effort to support a model that incorporates health care groups, community initiatives, and public health in improving community health and reducing unnecessary health care utilization and costs.[128] Creating a more holistic system of care breaks down administrative silos between these sectors and eliminates the isolation in which each is currently operating. In California, where one in two children is enrolled in Medi-Cal, changes to public programs will have a profound effect on the health and well-being of children. Any changes must consider such an effect, prior to implementation. A holistic approach to health care delivery for children can serve to benefit the diverse experiences of California children, meeting families where they are.

Use advances in technology to bring health care to children and families. Low-income children—such as those enrolled in Medi-Cal—living in medically underserved areas, including rural and parts of urban areas, face geographic and economic barriers to getting health care. Telehealth—the use of technology to provide health care from a distance—has proven to be a high-quality and cost-effective solution to bring care to underserved children in their communities, especially children with special health care needs, those who have mental health care needs, and those who live in rural and other medically underserved areas.[129] In addition, telehealth helps keep children in school and parents at work, while saving families time and money for costs related to transportation, hotel stays, and child care for their other children. The State should facilitate wider adoption of telehealth by providing Medi-Cal reimbursement for all care delivered through telehealth, as clinically appropriate, just as they reimburse care delivered through an in-person visit.

Where We Go From Here

Children in California have seen considerable gains in coverage and benefits as a result of the ACA and other reforms made in the period since the enactment of the ACA. In fact, the ACA bolstered momentum within California to provide coverage to even more children and helped usher in opportunities to finish the job of covering all California children, starting with extending Medi-Cal coverage to all low-income children, regardless of immigration status.

This overview of how the ACA and related reforms have impacted children in California is a review of the effects. With six years of implementation of the major reforms of the ACA, the focus can now shift from establishing and building operations to the more detailed tracking, monitoring, and assessment of how specific populations are faring and what modifications, if any, might make further improvements. Because children are a small portion of the population that gained eligibility under the new ACA coverage expansions, children have not been a particular focus of inquiry when examining how the new system is working. As noted, quality and utilization measures specifically related to children's care, as well as systematic examinations of children's access to care, are critical components of any next steps in advancing health coverage in California.

As children's advocates, we are challenged to examine how children are best served in predominantly adult-focused coverage and care systems when little child-specific care data are available. For example, what modifications to Covered California cost-sharing design features best serve the affordability of children's care, and are there unique considerations related to delivering care for children as compared to adults? Clearly, in many cases, the experience of children is similar to those of adults, such as in the enrollment process. Nonetheless, without a more fine-tuned lens and child-specific filter, children are more likely to be shoehorned into a system that may or may not fit their specific health care needs.

Further, as we move forward, what becomes clear is that the foundation of coverage for California children is the Medi-Cal program. As such, it's critically important to focus on the child-specific features of Medi-Cal, such as the new statewide system of coverage for all low-income children through the expansion of Medi-Cal, and the Medi-Cal EPSDT benefit for children, a benefit that by definition provides children what they need. With national discussions to dismantle the current Medicaid and CHIP programs heating up, maintaining and increasing investments in these insurance programs that serve half of all California children becomes all the more necessary. Children are a relatively inexpensive population to take care of, but, in doing so, the State makes an investment for their lifetime, supporting their development into healthy, productive adults. While work needs to be done to improve the system of coverage and care for all Californians, we must continue to explore the specific needs of children and ensure their well-being for today and tomorrow.

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The Children's Partnership

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California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

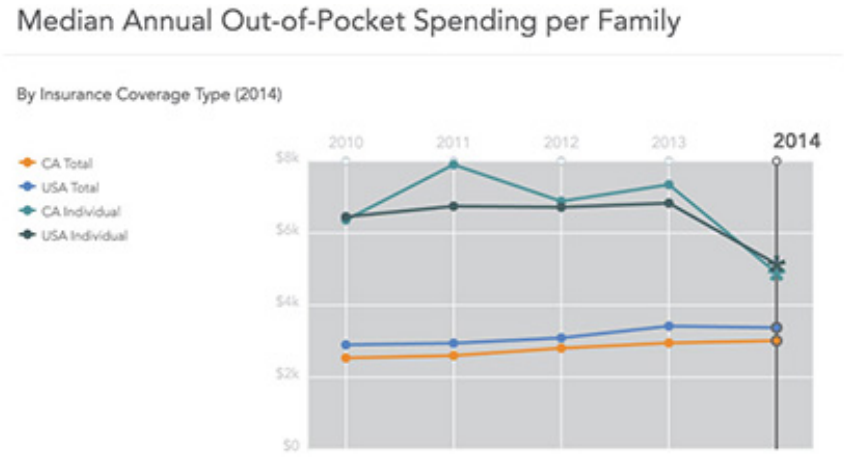
Californians with Individual Health Insurance Spent Almost $2,500 Less on Care in Year One of Health Reform

Amy Adams, California Health Care Foundation and Sam Patnoe, State Health Access Data Assistance Center

Median out-of-pocket spending for families with individual coverage dropped sharply in 2014 as the Affordable Care Act was implemented.
The data tracked on CHCF's ACA 411 will tell the story of how health care reform is changing coverage, access, and affordability in California.

May 2016

Newly available data on the CHCF's ACA 411 tool show that state residents who bought insurance through the individual market spent significantly less on health care in 2014, year one of the Affordable Care Act (ACA), than they did the year before. The first year that ACA premium tax credits and cost-sharing subsidies were available was 2014.

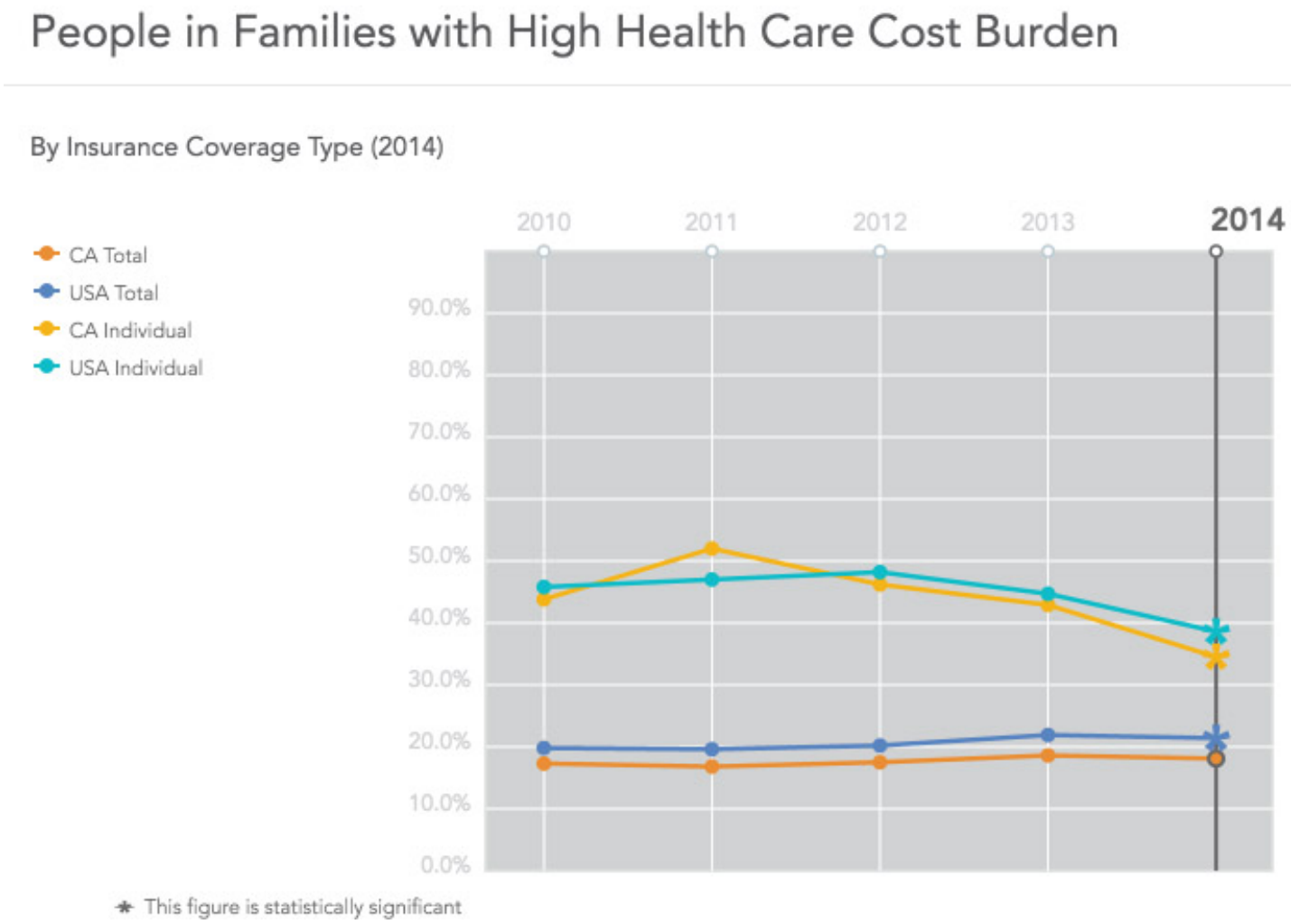


Median out-of-pocket spending for families with individual coverage dropped from $7,345 in 2013 to $4,893 in 2014 (see green line in first graph below). The percentage of Californians with individual coverage who reported a "high health care cost burden" — health care costs ate up more than 10% of household income — dropped from 42.9% in 2013 to 34.5% in 2014 (see yellow line in second graph).

While these declines in spending among those with individual coverage mirrored national trends in 2014, they were more pronounced in California. In fact, it's likely that the declines in spending for this group in California, the most populous state, helped pull down the national averages.

Median Annual Out-of-Pocket Spending per Family

By Insurance Coverage Type (2014)



ACA Largely Credited with Declines in Spending for Those with Individual Coverage

Spending for those with individual coverage was likely driven down primarily by the premium tax credits and cost-sharing subsidies made available for the first time in 2014 through Covered California, the state's ACA health insurance marketplace. In 2014, 2.2 million Californians had individual health coverage — and 51% of them purchased it through Covered California. Ninety percent of Covered California enrollees were eligible for premium tax credits (valued on average at $436 a month); over half were eligible for additional cost-sharing subsidies (worth on average $100 a month) to defray the cost of deductibles and copays.

Looking across all coverage types (including Medi-Cal, Medicare, employer/military, and uninsured), changes in spending varied in 2014 — and were far less dramatic. Improvements were also seen for those on Medicare: the percentage of beneficiaries reporting a high health care cost burden dropped from 28.4% to 23.9%, and out-of-pocket spending declined by $476. However, out-of-pocket spending increased by approximately $200 for those with employer/military coverage. There were no statistically significant changes in high health care cost burden or in out-of-pocket spending for those on Medi-Cal or the uninsured. It will be important to continue monitoring these data in the coming years.

More Work Needed to Improve Affordability

Data newly available on ACA 411 shows that striking progress was made in the ACA's first year to reduce the burden of health care costs for those with individual coverage. Yet even with the substantial declines in their spending, more than one in three with individual coverage still spent more than 10% of their income on health care. Cost was the top reason reported by California's uninsured for not obtaining coverage in 2014.

CHCF is studying cost barriers to low-income consumers' ability to purchase, maintain, and use health coverage in order to inform policy solutions. This includes an analysis of how high local cost of living impacts Californians' ability to afford health insurance. The county-by-county analysis, performed by the UC Berkeley Center for Labor Research and Education, will be released in the coming weeks.

Stay tuned for ongoing updates to ACA 411. Share your thoughts on this latest affordability data on social media using #ACA411.

Avalere

May 24, 2016

Early Analysis Finds 2017 Proposed Exchange Rates Exceed 2016 Increases But Vary Widely By State

Popular Low Cost Options See Smaller Increases

A new analysis from Avalere finds wide geographic variation in 2017 premiums for individual insurance plans available on market exchanges. The analysis is based on proposed rate filings in nine states where complete data are available. Specifically, average proposed rate increases across all silver plans in the nine states examined range from 44 percent in Vermont to 5 percent in Washington. In 2016, 68 percent of exchange enrollees selected silver plans. Avalere experts suggest that lower-than-expected exchange enrollment, higher healthcare costs among enrollees, and the end of the reinsurance and risk corridor programs are all likely contributors to premium growth in 2017.

According to the data, in most states, proposed premiums for lower cost silver plans increased less dramatically or even went down for 2017, compared to higher-cost plans on the same tier. Lower-cost silver plans tend to be most popular with consumers, making this portion of the market more competitive as plans seek to attract enrollees. Of the states analyzed, only the District of Columbia and Oregon saw higher cost increases among the lowest and second lowest cost silver plans than among all plans in their market.

”As in years past, proposed premium increases vary dramatically by state and by region within states,” said Elizabeth Carpenter, senior vice president at Avalere. “In most states, premiums for the lowest cost plans appear to be rising less than for the silver metal level as a whole.”

Proposed Premiums for 2017 Compared to Final Premiums for 2016 in 9 States, Based on 50-Year-Old Male, Nonsmoker

	Average Silver Plan			Average Lowest Cost Silver Plan			Average Second Lowest Cost Silver Plan		
State	**2016**	**2017**	**% Change**	**2016**	**2017**	**% Change**	**2016**	**2017**	**% Change**
DC	$400	$434	**9%**	$336	$404	**20%**	$358	$414	**16%**
IN	$466	$493	**6%**	$365	$366	**<1%**	$383	$379	**-1%**
MD	$412	$474	**15%**	$348	$383	**10%**	$361	$405	**12%**
ME	$495	$583	**18%**	$449	$511	**14%**	$458	$532	**16%**
NY	$458	$492	**7%**	$372	$265	**-29%**	$401	$302	**-25%**
OR	$441	$540	**22%**	$366	$521	**42%**	$380	$540	**42%**
VA	$451	$535	**19%**	$404	$420	**4%**	$417	$442	**6%**
VT	$476	$685	**44%**	$465	$493	**6%**	$468	$516	**10%**

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WA	$429	$449	**5%**	$366	$335	**-8%**	$377	$350	**-7%**
Average	**$447**	**$521**	**16%**	**$386**	**$411**	**7%**	**$400**	**$431**	**8%**

While rates can come down dramatically between proposed and final filings, Avalere analysts say premium increases in 2017 appear to be higher than in 2016. An Avalere analysis conducted at a similar point in the rate filing process in 2016 found much smaller proposed premium increases than the figures included above.

“Despite premiums rising overall, many consumers will be insulated from higher rates due to premium subsidies that limit monthly costs for many exchange enrollees” said Caroline Pearson, senior vice president at Avalere. “Consumers may have to switch plans in order to avoid dramatic rate increases, but competitive options should still be available in most regions in the U.S.”

This initial rate preview provides preliminary information about how the exchange markets will change in 2017, and more information will emerge in the coming months as other states release data. Avalere experts expect rate data for additional states will be available in the coming months. As consumers and other industry stakeholders review 2017 rate filings, Avalere offers the following considerations:

- **Final rates will vary from proposed premiums.** The analysis released today reflects insurers’ initial proposed rates. Departments of Insurance and insurers will continue to negotiate and revise rates between now and final plan certification in the fall. Final rates are often lower than proposed.
- **Many consumers are protected from premium increases.** Premium subsidies cap eligible consumers’ premiums at a set percentage of their income based on the second lowest premium plan in their area. Consumers earning less than 400 percent of poverty ($47,520 for an individual in 2016) are eligible for subsidies. As a result, these exchange consumers may avoid significant premium increases, particularly if they are willing to switch plans. Eighty-three percent of exchange consumers in 2016 receive premium subsidies.
- **National premium increases do not represent the potential impact on real consumers**. Insurance markets are inherently local. 2017 premiums are likely to vary significantly based on geography. As a result, national premium figures are unlikely to represent the experience of actual consumers. Specifically, premium patterns tend to vary widely between urban and rural areas, which means that average statewide rate changes, which are not enrollment weighted, overstate premium increases for the bulk of enrollees.
- **Most consumers enroll in the lowest cost plans.** Just as national premium data may be misleading, average premium changes by metal level may not capture actual patient experience. Consumers tend to gravitate toward the lowest premium plans. As a result, premium averages for all plans within a metal level may not reflect what most patients experience.

- **2017 marks the end of the risk corridor and reinsurance programs.** The two temporary premium stabilization programs created by the Affordable Care Act end in 2016. While payments from the risk corridors program have been significantly lower than expected (only 12.6% of requests), the loss of these programs could lead some insurance companies to raise premiums of exchange plans. Meanwhile, insurance companies will have a one-year moratorium on the health insurer fee in 2017 as a result of legislation approved by Congress at the end of 2015.
- **Exchange enrollment is below expectations.** Original Congressional Budget Office analyses predicted 21 million individuals would be enrolled in exchanges in 2016. Avalere projects just over 10 million people will have exchange coverage by year-end. As a result, the risk pool is smaller and sicker than many carriers initially assumed. Premium increases may be necessary to account for the population enrolled and make the market sustainable over time.

Methodology

Analysis includes final 2016 premiums and proposed 2017 premiums in the District of Columbia, Indiana, Maryland, Maine, New York, Oregon, Vermont, Virginia, and Washington. States were selected based on rate filings available and accessible, through Department of Insurance websites or the System for Electronic Rate and Form Filing (SERFF), as of May 23, 2016. For the purposes of this analysis, average premiums are not weighted by exchange enrollment in a given rating region or state. 2016 premium data for federally-facilitated exchange (FFE) states based on the 2016 HHS Individual Market Landscape file, updated as of November 2015. 2016 premium data for DC, MD, NY, OR, VT and VA were collected from each states' respective exchange website by Avalere Health, updated as of November 2015. 2017 proposed premiums were collected via rate filings that were publicly available as of May 23, 2016. All premiums are for an individual, 50-year-old non-smoker. Proposed 2017 rate filings are currently under review; final approved rates may be different.

###

ACA Implementation—Monitoring and Tracking

Children's Coverage Climb Continues: Uninsurance and Medicaid/ CHIP Eligibility and Participation Under the ACA

May 2016

Genevieve M. Kenney, Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens

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.

INTRODUCTION

Public coverage options for children have expanded dramatically over the past several decades. By 2014, before the major coverage provisions of the Affordable Care Act (ACA) were implemented, a majority of states—28 states—covered children in families with incomes up to 250 percent of the federal poverty level (FPL) or higher under Medicaid and the Children's Health Insurance Program (CHIP), while only three states limited eligibility to children living below 200 percent of the FPL. In contrast, in 2000, shortly after the implementation of CHIP, only 11 states had eligibility levels of 250 percent of FPL or higher and 14 states had eligibility levels below 200 percent of FPL (Artiga and Cornachione 2016). Many states have also eliminated barriers to children's Medicaid/CHIP enrollment and renewal, providing streamlined enrollment and renewal processes, greater outreach and availability of enrollment assistance, continuous enrollment, electronic data matching, and simplified verification procedures (Stephens and Artiga 2013).

Together, the expansions in eligibility and efforts to reach and enroll eligible children have contributed to declines in children's uninsurance rates. The uninsurance rate for children was cut in half between 1997 and 2012 (Rosenbaum and Kenney 2014). Nevertheless, millions of eligible children remained uninsured despite their parents' interest in enrolling them, and families faced barriers such as lack of knowledge about how to enroll and confusion about the eligibility requirements (Kenney et al. 2015).

Although the ACA's Medicaid expansion was targeted at adults, a number of other ACA provisions were expected to affect children directly or indirectly. In particular, the ACA changed the way income and family size are calculated for Medicaid and CHIP, shifted children of families with incomes below 138 percent of FPL from separate CHIP programs to Medicaid, and provided tax credits for coverage in the new marketplaces for some families with incomes up to 400 percent of FPL. In addition, the increase in coverage options for parents through Medicaid expansions and the marketplaces, together with the outreach and enrollment efforts occurring under the ACA, were expected to increase enrollment in Medicaid and CHIP among eligible children (Kenney et al. 2012). Although the ACA expanded affordable coverage options for uninsured adults in all states, poor parents and other adults in the states that have elected not to expand Medicaid may fall into an assistance gap, whereby they are too poor to qualify for tax credits to purchase coverage in the marketplace but do not meet the Medicaid eligibility requirements in their state. To the extent that the availability of coverage options for parents affects the enrollment of their children in Medicaid and CHIP and states vary in ACA implementation along other dimensions, coverage changes occurring for children under the ACA are also likely to vary across states.

Several studies have found that uninsurance rates fell among children between 2013 and 2014 but that coverage rates continue to vary across states, income groups, and subgroups of children (Alker and Chester 2015; Gates et al. 2016, Lukanen, Schwehr, and Fried 2016). This brief focuses on the issue of how participation and uninsurance rates changed for children

who were eligible for Medicaid or CHIP between 2013 and 2014, the first year of implementation of the ACA's major coverage provisions. It builds on prior analyses of Medicaid/CHIP participation and of the extent to which uninsured children are eligible for Medicaid or CHIP but not enrolled (Blumberg et al. 2016; Kenney et al. 2012; Kenney, Anderson, and Lynch 2013; Kenney et al. 2015).

MAIN FINDINGS

- **Medicaid/CHIP participation among eligible children rose by 2.3 percentage points from 88.7 percent in 2013 to 91.0 percent in 2014;** as a result, the number of eligible uninsured children fell from 3.5 million to 2.8 million.
- By 2014, **Medicaid/CHIP participation rates for children were over 90 percent in 32 states (including the District of Columbia) and near or above 80 percent in all states.** On average, gains in participation between 2013 and 2014 were **larger in states expanding Medicaid under the ACA in 2014 (3.0 percent) than in nonexpansion states (1.8 percent);** the 10 states with the largest participation gains all participated in the Medicaid expansion in 2014.
- Of the remaining 4.5 million uninsured children, **the majority—62.1 percent—**of uninsured children **in 2014 were eligible for Medicaid or CHIP but not enrolled.**
- The **uninsurance rate for children age 18 and under fell by 1.2 percentage points between 2013 and 2014,** the first year of implementation of the major coverage provisions of the ACA. Between 2013 and 2014, children's uninsurance declined from **7.0 percent in 2013 to 5.8 percent in 2014 and the number of uninsured children fell from 5.4 million to 4.5 million.**
- While **uninsurance fell between 2013 and 2014 among all subgroups of children examined,** some groups of children, such as adolescents (ages 13 to 18) and Hispanic children without an English-speaking parent in the home, remained **disproportionately likely to lack coverage.**
- **Uninsurance among children declined in a variety of states and cross-state variation in uninsurance rates narrowed; however, state variation in uninsurance remained,** with uninsurance below 4 percent in 14 states but above 9 percent in 4 states. Although uninsurance was already lower for children in expansion states in 2013, the **differential between expansion and nonexpansion states in uninsured rates for children grew larger in 2014.**
- **Medicaid/CHIP participation rose by nearly 10 percentage points over the 2008-2014 period, increasing from 81.7 percent to 91.0 percent.** Concurrently, **the number of eligible uninsured children fell by over 40 percent between 2008 and 2014, dropping from 4.9 million to 2.8 million.**
- **In 2014, fewer than 3 million uninsured children were eligible for Medicaid or CHIP**—reflecting a drop of over 700,000 between 2013 and 2014, which is the largest one-year drop since we started tracking this statistic in 2008. Overall, our analysis indicates that **the number of uninsured children who are eligible for Medicaid or CHIP declined by approximately 2 million between 2008 and 2014.** The extension of CHIP in 2015, with its new outreach funding, could help states reach and enroll additional eligible uninsured children; however, because CHIP was reauthorized for just two years, **considerable uncertainty remains about future coverage options for children, which could, in turn, put these gains at risk.**

DATA & METHODS

In this brief, we examine coverage status, eligibility for Medicaid/CHIP, and participation in Medicaid/CHIP among children age 18 and under using the 2013 and 2014 American Community Survey (ACS). Each year of the ACS includes a public use sample of more than 700,000 children age 18 and under.

To assess Medicaid/CHIP eligibility, we use information about the child and family provided by survey respondents in combination with the Medicaid/CHIP eligibility rules in place in each family's state of residence in the year in which they were surveyed. For 2013, we use the Urban Institute Health Policy Center's Medicaid/CHIP Eligibility

Simulation Model, which applies the pre-ACA Medicaid/CHIP eligibility rules for 2013 (Lynch, Haley, and Kenney 2014). For 2014, we use the Health Insurance Policy Simulation Model–ACS version (HIPSM-ACS), which builds on the Medicaid/CHIP Eligibility Simulation Model and applies rules as defined in the ACA that took effect in 2014 (Buettgens 2011). For noncitizen children, both the 2013 model and the 2014 model take into account length of U.S. residency in states where this is a factor in eligibility determination, and documentation status is imputed using a new method.[1] To address potential misreporting of coverage on the ACS, we applied a set of coverage edits.[2]

Medicaid/CHIP participation rates are calculated as the ratio of Medicaid/CHIP–eligible enrolled children to Medicaid/CHIP–eligible enrolled children plus Medicaid/CHIP–eligible uninsured children, excluding children with both Medicaid/CHIP and employer-sponsored coverage, including military coverage, and those with Medicaid/CHIP coverage who do not have a known eligibility pathway. Participation rates excluding those with private coverage are often used to indicate how successfully Medicaid/CHIP programs are reaching their primary target populations. We examine changes in insurance coverage status, Medicaid/CHIP participation, and Medicaid/CHIP eligibility for children nationally, by state, when grouping states according to their Medicaid expansion implementation status as of mid-2014, and among subgroups of children as defined by their individual, family, and geographic characteristics. Further detail on the data and methodology is included in a Methodological Appendix, below. As with our prior estimates of health insurance coverage and Medicaid/CHIP eligibility and participation, and all estimates that rely on survey data and simulated program eligibility, one must note that both coverage and eligibility status are likely measured with error.[3]

RESULTS

Changes in Health Insurance Coverage, 2013–2014. The estimated uninsurance rate for children age 18 and under declined from 7.0 percent in 2013 to 5.8 percent in 2014, a statistically significant decline of 1.2 percentage points (table 1). The number of uninsured children fell from 5.4 million to 4.5 million over this period. Underlying the decline in uninsurance among children were increases in Medicaid/CHIP coverage; the number of children with Medicaid/CHIP coverage grew from 31.2 million in 2013 to 33.0 million in 2014 (data not shown).

Table 1. Uninsurance and Medicaid/CHIP Participation of Children Ages 0 to 18, 2013 and 2014

	2013	2014	Change	
All Children				
Uninsurance Rate	7.0%	5.8%	-1.2%	**
Number of Uninsured (1,000s)	5,428	4,519	-908	
Medicaid/CHIP Eligible Children				
Uninsurance Rate	7.7%	6.4%	-1.3%	**
Number of Uninsured (1,000s)	3,548	2,807	-741	
Medicaid/CHIP Participation Rate	88.7%	91.0%	2.3%	**

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

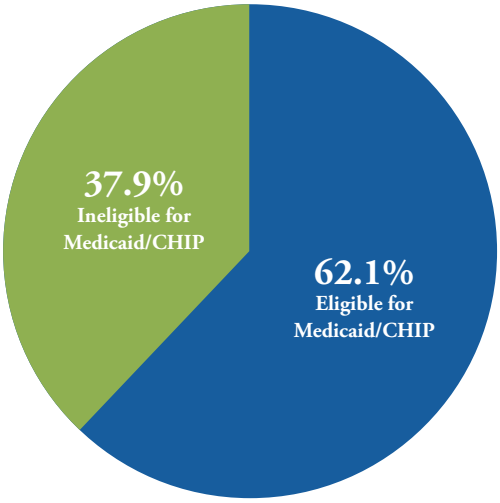
Table Notes: See text for how eligibility, participation, and uninsurance are defined.
***indicates estimate is statistically different from 2013 estimate at the 0.05 level.*
Estimates reflect edits for apparent misreporting of coverage on the ACS.
Numbers are presented in thousands.

Participation and Uninsurance among Medicaid/CHIP–Eligible Children. Uninsurance also declined among Medicaid/CHIP–eligible children, falling from 7.7 percent to 6.4 percent. Between 2013 and 2014, Medicaid/CHIP participation increased from 88.7 percent to 91.0 percent. As a result, the number of eligible uninsured children declined from 3.5 million in 2013 to 2.8 million in 2014.

Eligibility among Uninsured Children. Of the remaining 4.5 million uninsured children in 2014, just over 6 in 10, or 62.1 percent, qualified for Medicaid or CHIP but were not enrolled (figure 1). This compares to an estimated 65.3 percent of uninsured children in 2013 who qualified for Medicaid/CHIP (data not shown).

Variation in Changes in Uninsurance and Participation. Uninsurance rates declined between 2013 and 2014 for each of the subgroups we examined (table 2). In 2013, uninsurance rates were below 5 percent for only a few subgroups (children of other/mixed race or ethnicity, children in families receiving Supplemental Nutrition Assistance Program (SNAP)/food stamps, children in families with more than one full-time working parent, and children in the Northeast region). However, by 2014, uninsurance rates were below 5 percent for a number of additional subgroups, including children under age 6, children who are white non-Hispanic or black non-Hispanic, children who have a functional limitation, children

Figure 1. Medicaid/CHIP Eligibility Among Uninsured Children Ages 0 to 18, 2014



Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

Notes: See text for how eligibility, participation, and uninsurance are defined. Estimates reflect edits for apparent misreporting of coverage on the ACS.

Table 2. Uninsurance Among Children Ages 0 to 18, by Characteristics, 2013 and 2014

	Uninsured Rate Among All Children						# (in 1000s) of Uninsured Children		
	2013		2014		Change		2013	2014	Change
National	**7.0%**		**5.8%**		**-1.2%**	**	**5,428**	**4,519**	**-908**
Age									
0 to 5	5.2%	++	4.4%	++	-0.8%	**	1,025	865	-160
6 to 12	6.2%	++	5.3%	++	-0.9%	**	2,035	1,724	-310
13 to 18	9.4%	++	7.6%	++	-1.8%	**	2,368	1,929	-438
Sex									
Male	7.0%		5.8%		-1.2%	**	2,777	2,307	-469
Female	7.0%		5.8%		-1.2%	**	2,651	2,212	-439
Race/ethnicity									
White only	5.2%	++	4.4%	++	-0.8%	**	2,131	1,779	-353
Black only	5.9%	++	4.7%	++	-1.2%	**	627	496	-131
Hispanic	11.4%	++	9.6%	++	-1.7%	**	2,073	1,775	-299
At least one English speaking parent in home	6.4%	++	5.2%	++	-1.2%	**	314	263	-51
No English speaking parent in home	12.6%	++	10.9%	++	-1.7%	**	1,560	1,350	-210
No parent in the household	19.8%	++	16.0%	++	-3.8%	**	199	161	-38

Asian/Pacific Islander	7.2%	+	5.3%	++	-1.9%	**	263	197	-66
American Indian/Alaska Native	11.8%	++	10.1%	++	-1.7%	**	194	165	-29
Other/Multiple	4.8%	++	3.6%	++	-1.3%	**	139	108	-31
Functional limitation status (Age 5+)									
Has a functional limitation	5.0%	++	3.8%	++	-1.2%	**	148	115	-32
No functional limitation	7.9%	++	6.5%	++	-1.3%	**	4,020	3,343	-677
Family income									
0-99% FPL	7.0%		6.0%	++	-1.1%	**	1,459	1,263	-196
100-137% FPL	9.6%	++	8.8%	++	-0.8%	**	657	631	-26
138-199% FPL	9.5%	++	7.7%	++	-1.8%	**	987	719	-268
200-299% FPL	7.4%	++	6.3%	++	-1.2%	**	855	712	-143
300+% FPL	5.2%	++	4.1%	++	-1.0%	**	1,469	1,178	-291
Household SNAP/food stamp recipiency									
Does not receive SNAP/food stamps	7.8%	++	6.4%	++	-1.4%	**	4,479	3,715	-764
Receives SNAP/food stamps	4.7%	++	4.1%	++	-0.6%	**	948	802	-146
Family work status									
More than one full-time worker	4.6%	++	3.7%	++	-0.9%	**	799	653	-145
One full-time worker	7.3%	++	6.1%	++	-1.1%	**	2,908	2,458	-450
Only part-time worker(s)	8.3%	++	6.7%	++	-1.6%	**	540	414	-126
Not working or not in labor force	6.7%	++	5.8%		-1.0%	**	664	544	-120
No parent in the household	12.4%	++	9.8%	++	-2.6%	**	517	451	-66
Census region									
Northeast	4.1%	++	3.7%	++	-0.4%	**	527	473	-53
Midwest	5.4%	++	4.6%	++	-0.8%	**	893	758	-135
South	8.5%	++	7.2%	++	-1.3%	**	2,511	2,147	-365
West	7.9%	++	6.1%	++	-1.9%	**	1,497	1,141	-356
Metropolitan status									
Not in metropolitan area	7.8%	++	7.1%	++	-0.7%	**	488	443	-45
Metropolitan	6.8%	++	5.6%	++	-1.2%	**	4,148	3,428	-721
Unclassifiable	7.7%	++	6.3%	++	-1.4%	**	791	648	-143

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

Table Notes: See text for how eligibility, participation, and uninsurance are defined.
**** indicates estimate is statistically different from 2013 estimate at the 0.05 level.*
++(+) indicates estimate is statistically different from national average at the 0.05 (0.1) level.
See Appendix for details on how values are defined.
Estimates reflect edits for apparent misreporting of coverage on the ACS.
Numbers are presented in thousands.

in families with incomes above 300 percent of FPL, and those living in the Midwest region.

Nevertheless, uninsurance rates in 2014 continued to vary across subgroups; for example, uninsurance was higher among older children than among younger children, with 7.6 percent of adolescents (ages 13 to 18) lacking coverage, compared with 4.4 percent of children under age 6. More than 1 in 10 Hispanic children without an English-speaking parent in the home and American Indian/Alaska Native[4] children had no coverage, the highest rates among the subgroups we examined.

Among Medicaid/CHIP–eligible children, participation rose among all of the subgroups examined, with some groups experiencing participation gains of 3 percentage points or more, including children who are adolescents (ages 13 to 18); Asian/Pacific Islanders; American Indians/Alaska Natives;[5] without functional limitations; in families that have incomes above 138 percent of FPL, that do not receive SNAP/food stamps, or that include more than one full-time worker; or living in the West (table 3). In some instances, gains in 2014 leveled differences between groups. For example, although participation was higher in the Northeast and Midwest than in the South and West before the ACA, greater participation gains in the South and West resulted in somewhat less regional variation in 2014.

As was the case in 2013, the eligible but uninsured population remained disproportionately concentrated in certain subgroups. Of the remaining 2.8 million eligible uninsured children in 2014, most (2.2 million, or 78.0 percent) were school age (above age 5). The majority of eligible uninsured children were nonwhite (1.7 million, or 60.3 percent), although white non-Hispanic (1.1 million, or 39.7 percent) and Hispanic (1.0 million, or 36.5 percent) children were the largest single groups when categorizing children according to their race/ethnicity. Among Hispanic children who were eligible but uninsured, the majority had no English-speaking parents in the home; these children constituted over a quarter (755,000, or 26.9 percent) of all eligible uninsured children in 2014. Furthermore, 1.8 million of the 2.8 million eligible uninsured children had family incomes below 138 percent of FPL and another 678,000 had family incomes between 138 and 200 percent of FPL. Although the majority of eligible uninsured children lived with working parents, 1 in 10 had no parents in the household, and the vast majority lived in metropolitan areas.

State-Level Changes in Participation. Table 4 displays state-level estimates of children's participation in Medicaid/CHIP in 2013 and 2014, grouping states according to whether they participated in the ACA's Medicaid expansion as of mid-2014. In 2013, participation varied from under 80 percent in Nevada and Utah to over 96 percent in Massachusetts and the District of Columbia.[6] Participation in 2013 was lower on average among children in states that did not expand Medicaid in 2014 (87.1 percent) than in states that did expand Medicaid (89.9 percent).

Participation increased nationally by 2.3 percentage points, with significantly higher increases in expansion states (3.0 percent) than in nonexpansion states (1.8 percent). The 10 states with the largest gains in participation (Nevada, Minnesota, Arizona,[7] Vermont, Colorado, Washington, Rhode Island, Oregon, Iowa, and West Virginia) were all states that expanded Medicaid in 2014. Building on the already-higher participation rates in expansion states, the overall participation rate in 2014 for children was 92.9 percent for expansion states compared with 89.0 percent in nonexpansion states, a 3.9 percentage point difference.

By 2014, Medicaid/CHIP participation rates for children were over 90 percent in 32 states (including the District of Columbia) (Figure 2). This group includes states from all regions and both Medicaid expansion and nonexpansion states. Of the top 20 states in terms of participation, 16 are Medicaid expansion states, and just 4—Alabama, Maine, North Carolina, and Mississippi—are nonexpansion states. The 10 states with the highest participation rates in 2014 (Vermont, the District of Columbia, Massachusetts, West Virginia, Arkansas, Hawaii, Connecticut, Rhode Island, Michigan, and New York) all expanded Medicaid but also had high participation before 2014, having enrolled 9 of 10 eligible children or more in 2013.

Even for the 19 states with participation rates below 90 percent, every state had a participation rate near or above 80 percent in 2014. In 2014, the lowest participation rates were found in four Western states (Utah, Alaska, Wyoming,[8] and Nevada). In total, these 19 states were home to 1.5 million eligible uninsured children in 2014, or over half of all eligible uninsured children (data not shown).

State-Level Changes in Uninsurance. For most states, the improvements in participation between 2013 and 2014 were associated with declines in uninsurance among all children and among Medicaid/CHIP–eligible children, as shown in table 5. In 2013, less than 3 percent of children in Massachusetts and the District of Columbia were uninsured, while more than 10 percent of children in Nevada, Texas, Alaska, Arizona, Florida, and Oklahoma lacked coverage. By 2014, uninsurance rates were under 2 percent in two states (Vermont and Massachusetts) and were above 10 percent in only two states (Texas and Alaska).

Table 3. Medicaid/CHIP Participation and Uninsurance of Medicaid/CHIP Eligible Children Ages 0 to 18, by Characteristics, 2013 and 2014

	Participation Rate Among Medicaid/CHIP Eligible Children						Uninsured Rate Among Medicaid/CHIP Eligible Children						# (in 1000s) of Uninsured Medicaid/CHIP Eligible Children		
	2013		2014		Change		2013		2014		Change		2013	2014	Change
National	**88.7%**		**91.0%**		**2.3%**	**	**7.7%**		**6.4%**		**-1.3%**	**	**3,548**	**2,807**	**-741**
Age															
0 to 5	91.7%	++	93.1%	++	1.4%	**	6.0%	++	5.1%	++	-0.9%	**	758	617	-140
6 to 12	89.9%	++	91.8%	++	1.9%	**	6.2%	++	5.8%	++	-0.3%	**	1,375	1,107	-268
13 to 18	83.6%	++	87.6%	++	4.0%	**	9.4%	++	8.4%	++	-1.0%	**	1,416	1,083	-333
Sex															
Male	88.6%		91.1%		2.5%	**	7.7%		6.3%		-1.4%	**	1,813	1,414	-399
Female	88.7%		90.9%		2.2%	**	7.7%		6.5%		-1.2%	**	1,735	1,393	-342
Race/ethnicity															
White only	87.1%	++	89.9%	++	2.8%	**	7.3%	++	6.1%	++	-1.2%	**	1,430	1,114	-317
Black only	92.3%	++	94.1%	++	1.8%	**	5.9%	++	4.6%	++	-1.2%	**	490	377	-113
Hispanic	88.5%		90.4%	++	1.9%	**	9.2%	++	7.7%	++	-1.5%	**	1,246	1,025	-221
At least one English speaking parent in home	89.3%	++	91.1%		1.8%	**	7.2%	++	6.1%		-1.1%	**	215	182	-33
No English speaking parent in home	88.7%		90.6%	++	2.0%	**	9.5%	++	7.9%	++	-1.6%	**	926	755	-171
No parent in the household	83.8%	++	84.8%	++	1.0%	**	13.1%	++	12.4%	++	-0.7%	**	105	88	-17
Asian/Pacific Islander	86.1%	++	89.9%	++	3.8%	**	9.2%	++	6.9%	++	-2.2%	**	143	107	-36
American Indian/Alaska Native	83.6%	++	87.1%	++	3.5%	**	12.4%	++	10.2%	++	-2.3%	**	146	114	-32
Other/Multiple	91.6%	++	94.0%	++	2.3%	**	5.6%	++	4.2%	++	-1.4%	**	92	70	-22
Functional limitation status (Age 5+)															
Has a functional limitation	94.3%	++	95.5%	++	1.2%	**	4.4%	++	3.5%	++	-0.9%	**	96	75	-21
No functional limitation	86.4%	++	89.4%	++	3.0%	**	8.9%	++	7.3%	++	-1.6%	**	2,528	1,988	-541
Family income															
0-99% FPL	92.0%	++	93.3%	++	1.3%	**	7.0%	++	5.9%	++	-1.1%	**	1,420	1,214	-206
100-137% FPL	86.8%	++	89.2%	++	2.4%	**	9.5%	++	8.0%	++	-1.5%	**	644	572	-72
138-199% FPL	83.0%	++	86.8%	++	3.7%	**	9.5%	++	7.5%	++	-2.0%	**	936	678	-258
200-299% FPL	80.5%	++	86.7%	++	6.2%	**	6.7%	++	5.1%	++	-1.6%	**	418	313	-105
300+% FPL	85.9%	++	89.6%	++	3.7%	**	4.7%	++	2.9%	++	-1.9%	**	131	30	-101
Household SNAP/food stamp recipiency															
Does not receive SNAP/ food stamps	80.0%	++	84.8%	++	4.8%	**	10.5%	++	8.6%	++	-1.9%	**	2,828	2,209	-619
Receives SNAP/food stamps	95.8%	++	96.4%	++	0.6%	**	3.8%	++	3.3%	++	-0.5%	**	720	598	-122

Family work status														
More than one full-time worker	81.5%	++	87.3%	++	5.8%	**	7.5%	++	6.2%	++	-1.4%	**	338	238	-100
One full-time worker	86.8%	++	89.7%	++	2.9%	**	8.1%	++	6.7%	++	-1.4%	**	1,877	1,541	-336
Only part-time worker(s)	91.2%	++	93.1%	++	1.9%	**	7.3%	++	5.8%	++	-1.5%	**	421	318	-104
Not working or not in labor force	93.2%	++	94.4%	++	1.2%	**	6.0%	++	4.9%	++	-1.0%	**	545	425	-120
No parent in the household	84.9%	++	86.7%	++	1.9%	**	11.3%	++	10.1%	++	-1.2%	**	366	285	-81
Census region														
Northeast	92.3%	++	93.1%	++	0.9%	**	4.7%	++	4.4%	++	-0.3%	**	367	334	-33
Midwest	89.4%	++	91.3%	++	1.9%	**	6.7%	++	5.8%	++	-0.9%	**	648	532	-116
South	87.9%	++	90.0%	++	2.1%	**	8.9%	++	7.6%	++	-1.4%	**	1,533	1,253	-280
West	87.1%	++	91.0%		3.8%	**	8.9%	++	6.5%		-2.4%	**	999	688	-312
Metropolitan status														
Not in metropolitan area	87.8%	++	89.2%	++	1.5%	**	8.4%	++	7.7%	++	-0.8%	**	357	309	75
Metropolitan	89.0%	++	91.4%	++	2.3%	**	7.5%	++	6.1%	++	-1.4%	**	2,636	2,066	-2,636
Unclassifiable	87.1%	++	90.1%	++	3.0%	**	8.4%	++	6.9%	++	-1.6%	**	555	432	-555

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

Table Notes: See text for how eligibility, participation, and uninsurance are defined.
*** indicates estimate is statistically different from 2013 estimate at the 0.05 level.*
++ indicates estimate is statistically different from national average at the 0.05 level.
See Appendix for details on how values are defined.
Estimates reflect edits for apparent misreporting of coverage on the ACS.
Numbers are presented in thousands.

Table 4. Medicaid/CHIP Participation of Eligible Children Ages 0 to 18, 2013 and 2014

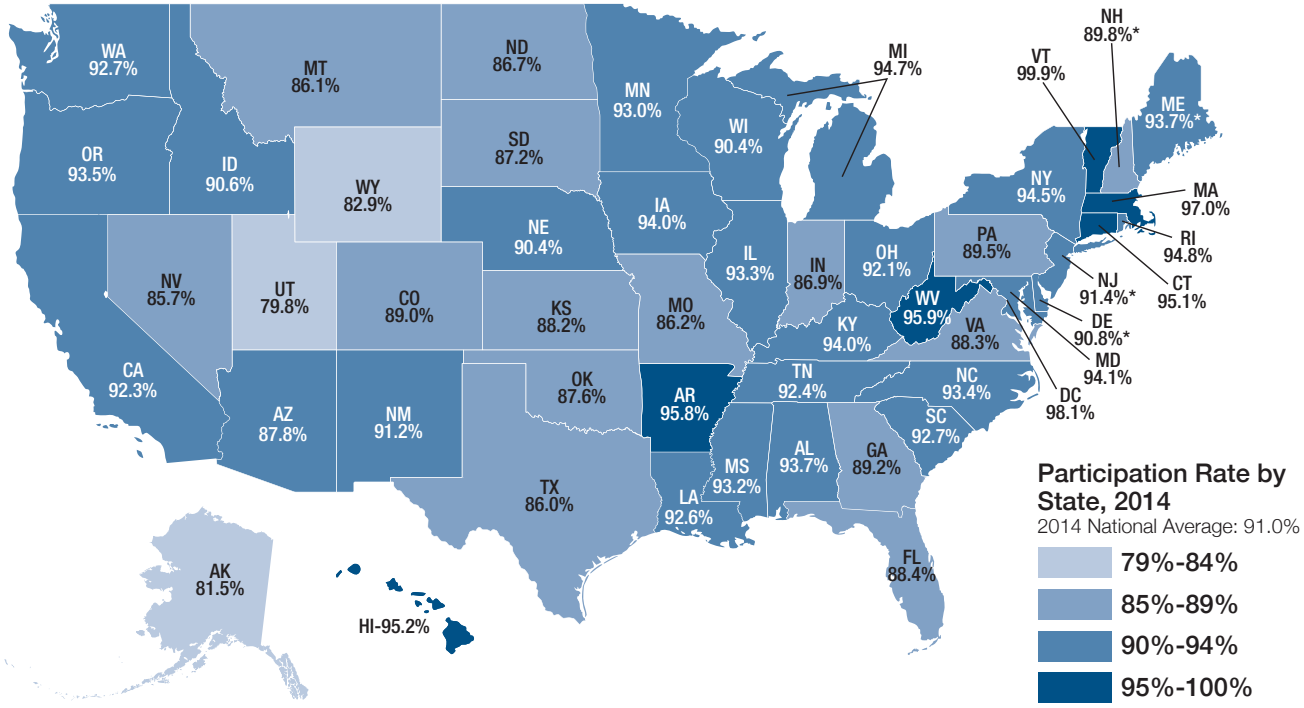
	Participation Rate Among Medicaid/CHIP Eligible Children					
	2013		2014		Change	
National	**88.7%**		**91.0%**		**2.3%**	**
Expanded Medicaid in 2014	**89.9%**	++	**92.9%**	++	**3.0%**	**
Arizona[1]	81.6%	++	87.8%	++	6.1%	**
Arkansas	93.1%	++	95.8%	++	2.6%	**
California	88.9%		92.3%	++	3.4%	**
Colorado	84.0%	++	89.0%	++	5.0%	**
Connecticut	93.0%	++	95.1%	++	2.1%	**
Delaware	92.5%	++	90.8%		-1.7%	
District of Columbia	97.8%	++	98.1%	++	0.3%	
Hawaii	92.7%	++	95.2%	++	2.5%	*
Illinois	92.3%	++	93.3%	++	1.0%	**
Iowa	89.7%	+	94.0%	++	4.3%	**
Kentucky	90.3%	++	94.0%	++	3.6%	**
Maryland	91.5%	++	94.1%	++	2.7%	**
Massachusetts	96.8%	++	97.0%	++	0.2%	
Michigan	92.8%	++	94.7%	++	1.9%	**
Minnesota	84.9%	++	93.0%	++	8.1%	**
Nevada	74.3%	++	85.7%	++	11.4%	**
New Jersey	89.8%	++	91.4%		1.6%	**
New Mexico	90.3%	++	91.2%		0.9%	
New York	93.0%	++	94.5%	++	1.5%	**
North Dakota	84.3%	++	86.7%	++	2.5%	
Ohio	90.3%	++	92.1%	++	1.8%	**
Oregon	89.1%		93.5%	++	4.4%	**
Rhode Island	90.3%		94.8%	++	4.4%	**
Vermont	94.3%	++	99.9%	++	5.5%	**
Washington	88.1%		92.7%	++	4.6%	**
West Virginia	91.7%	++	95.9%	++	4.2%	**
Did Not Expand Medicaid in 2014	**87.1%**	++	**89.0%**	++	**1.8%**	**
Alabama	91.6%	++	93.7%	++	2.1%	**
Alaska	81.8%	++	81.5%	++	-0.2%	
Florida	85.0%	++	88.4%	++	3.4%	**
Georgia	85.5%	++	89.2%	++	3.7%	**
Idaho	87.8%		90.6%		2.8%	*
Indiana	84.3%	++	86.9%	++	2.5%	**
Kansas	87.7%		88.2%	++	0.5%	
Louisiana	92.4%	++	92.6%	++	0.2%	
Maine	94.0%	++	93.7%	++	-0.3%	

Mississippi	89.2%		93.2%	++	4.1%	**
Missouri	85.5%	++	86.2%	++	0.7%	
Montana	85.8%	++	86.1%	++	0.3%	
Nebraska	88.4%		90.4%		2.0%	*
New Hampshire	90.3%		89.8%		-0.5%	
North Carolina	91.9%	++	93.4%	++	1.5%	**
Oklahoma	85.6%	++	87.6%	++	2.0%	**
Pennsylvania	90.5%	++	89.5%	++	-1.0%	*
South Carolina	89.9%	++	92.7%	++	2.8%	**
South Dakota	86.2%	++	87.2%	++	1.0%	
Tennessee	91.1%	++	92.4%	++	1.3%	**
Texas	84.7%	++	86.0%	++	1.3%	**
Utah	79.0%	++	79.8%	++	0.8%	
Virginia	89.1%		88.3%	++	-0.8%	
Wisconsin	90.9%	++	90.4%		-0.5%	
Wyoming[2]	88.4%		82.9%	++	-5.5%	*

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

Table Notes: See text for how eligibility, participation, and uninsurance are defined.
***(*) indicates estimate is statistically different from 2013 estimate at the 0.05 (0.1) level.*
++ indicates estimate is statistically different from national average at the 0.05 level.
Estimates reflect edits for apparent misreporting of coverage on the ACS.
1. Arizona's CHIP program expired in January 2014. Eligibility was therefore modeled differently in 2013 and 2014, reducing the number of children classified as eligible in 2014 compared with 2013. Therefore, estimates of participation in Arizona are less comparable in the two years than for other states.
2. Estimates for Wyoming changed under our new methodology; see text.

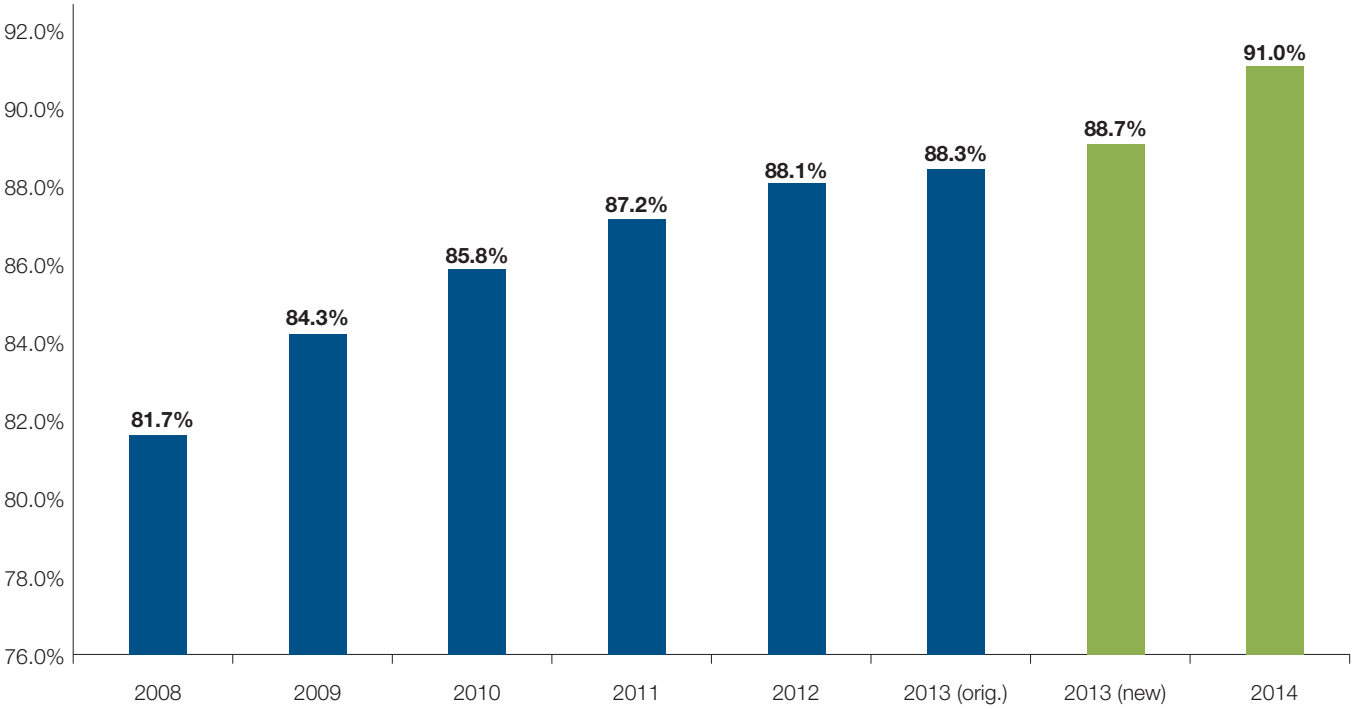
Figure 2. Medicaid/CHIP Participation of Eligible Children Ages 0 to 18, 2014



Source: Urban Institute tabulations of 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

Figure Notes: See text for how eligibility, participation, and uninsurance are defined. Estimates reflect edits for apparent misreporting of coverage on the ACS.
** Estimate is not significantly different from the national average at the .05 level.*

Figure 3. Medicaid/CHIP Participation of Children Ages 0 to 18, 2008-2014



Source: Urban Institue tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). 2008-2010 data from Kenney et al. 2012; 2011 data from Kenney et al. 2013; 2012 data from Kenney et al. 2015; original 2013 data from Kenney and Anderson 2015.

Notes: See text for how eligibility, participation, and uninsurance are defined and a discussion of differences between original and new 2013 estimates. Estimates reflect edits for apparent misreporting of coverage on the ACS.

Table 5. Uninsured Rates Among Children Ages 0 to 18, by State and Eligibility Status, 2013 and 2014

	All Children						Medicaid/CHIP Eligible Children					
	2013		2014		Change		2013		2014		Change	
Total	**7.0%**		**5.8%**		**-1.2%**	**	**7.7%**		**6.4%**		**-1.3%**	**
Expanded Medicaid in 2014	**5.8%**	++	**4.5%**	++	**-1.3%**	**	**6.8%**	++	**4.9%**	++	**-1.8%**	**
Arizona	11.9%	++	9.8%	++	-2.1%	**	13.7%	++	10.4%	++	-3.3%	**
Arkansas	5.9%	++	4.4%	++	-1.5%	**	5.4%	++	3.4%	++	-2.0%	**
California	7.3%	++	5.2%	++	-2.0%	**	8.1%	++	5.8%	++	-2.3%	**
Colorado	8.4%	++	6.0%		-2.4%	**	10.5%	++	7.6%	++	-2.9%	**
Connecticut	4.1%	++	3.8%	++	-0.3%		4.6%	++	3.4%	++	-1.3%	**
Delaware	4.9%	++	5.1%		0.2%		5.5%	++	6.4%		0.8%	
District of Columbia	2.5%	++	2.3%	++	-0.2%		1.7%	++	1.6%	++	-0.2%	
Hawaii	3.0%	++	2.3%	++	-0.7%	*	3.5%	++	2.5%	++	-1.0%	
Illinois	4.3%	++	3.8%	++	-0.5%	**	5.1%	++	4.5%	++	-0.6%	**
Iowa	4.5%	++	2.9%	++	-1.7%	**	5.0%	++	3.3%	++	-1.7%	**
Kentucky	5.9%	++	4.2%	++	-1.7%	**	7.0%	++	4.5%	++	-2.5%	**
Maryland	4.5%	++	3.4%	++	-1.1%	**	5.3%	++	3.9%	++	-1.4%	**
Massachusetts	1.5%	++	1.7%	++	0.2%		1.9%	++	2.0%	++	0.0%	
Michigan	4.1%	++	3.3%	++	-0.8%	**	5.1%	++	3.8%	++	-1.3%	**
Minnesota	5.9%	++	3.1%	++	-2.8%	**	8.3%	+	4.1%	++	-4.2%	**
Nevada	13.4%	++	9.4%	++	-4.0%	**	16.3%	++	9.6%	++	-6.7%	**
New Jersey	5.5%	++	4.4%	++	-1.1%	**	6.1%	++	5.5%	++	-0.6%	*
New Mexico	8.5%	++	7.5%	++	-0.9%	*	7.5%	++	6.8%		-0.7%	
New York	3.9%	++	3.2%	++	-0.7%	**	4.3%	++	3.5%	++	-0.8%	**
North Dakota	6.9%		6.2%		-0.8%		9.3%		9.0%	++	-0.3%	
Ohio	4.9%	++	4.6%	++	-0.3%	*	6.7%	++	5.8%	++	-0.8%	**
Oregon	6.1%	++	4.1%	++	-2.0%	**	6.5%	++	4.2%	++	-2.3%	**
Rhode Island	5.6%	++	3.1%	++	-2.5%	**	6.2%	++	3.6%	++	-2.6%	**
Vermont	3.0%	++	0.8%	++	-2.2%	**	4.0%	++	0.1%	++	-3.9%	**
Washington	6.1%	++	4.2%	++	-1.9%	**	7.3%		4.8%	++	-2.6%	**
West Virginia	4.6%	++	3.1%	++	-1.4%	**	5.0%	++	2.7%	++	-2.4%	**
Did Not Expand Medicaid in 2014	**8.2%**	++	**7.2%**	++	**-0.9%**	**	**8.8%**	++	**8.0%**	++	**-0.8%**	**
Alabama	4.6%	++	3.7%	++	-0.9%	**	5.4%	++	4.2%	++	-1.3%	**
Alaska	12.1%	++	11.6%	++	-0.5%		11.8%	++	12.6%	++	0.8%	
Florida	10.9%	++	8.9%	++	-2.0%	**	11.6%	++	9.2%	++	-2.4%	**
Georgia	9.0%	++	7.1%	++	-1.9%	**	10.3%	++	7.9%	++	-2.4%	**
Idaho	8.4%	++	7.4%	++	-1.0%	*	7.7%		6.6%		-1.1%	
Indiana	8.2%	++	6.9%	++	-1.3%	**	9.8%	++	8.7%	++	-1.1%	**
Kansas	6.6%		6.0%		-0.6%		7.0%	+	7.8%	++	0.8%	
Louisiana	5.6%	++	4.8%	++	-0.8%		5.6%	++	5.7%	++	0.1%	
Maine	5.0%	++	5.9%		1.0%		4.4%	++	4.9%	++	0.5%	

Mississippi	7.1%	++	5.3%	+	-1.8%	**	8.4%		5.5%	++	-2.8%	**
Missouri	6.8%		6.6%	++	-0.3%		8.6%	++	8.5%	++	-0.1%	
Montana	9.0%	++	8.3%	++	-0.7%		9.9%	++	10.1%	++	0.2%	
Nebraska	5.5%	++	4.5%	++	-1.0%	**	7.6%		6.3%		-1.3%	
New Hampshire	3.5%	++	4.7%	++	1.2%	**	5.3%	++	5.8%		0.5%	
North Carolina	6.0%	++	5.0%	++	-1.0%	**	6.2%	++	5.1%	++	-1.1%	**
Oklahoma	10.3%	++	8.6%	++	-1.7%	**	10.6%	++	9.6%	++	-1.0%	*
Pennsylvania	4.6%	++	4.9%	++	0.3%		5.6%	++	6.5%	++	1.0%	**
South Carolina	6.7%		5.2%	++	-1.5%	**	7.6%		5.6%	++	-2.0%	**
South Dakota	6.9%		7.2%	++	0.3%		9.9%	++	9.7%	++	-0.2%	
Tennessee	5.4%	++	4.9%	++	-0.5%	**	6.1%	++	5.2%	++	-0.8%	**
Texas	12.2%	++	11.0%	++	-1.2%	**	12.0%	++	11.2%	++	-0.8%	**
Utah	8.6%	++	8.5%	++	-0.1%		11.8%	++	11.9%	++	0.1%	
Virginia	5.5%	++	5.8%		0.3%		7.2%	+	8.3%	++	1.1%	**
Wisconsin	4.4%	++	4.4%	++	0.0%		5.2%	++	5.7%	++	0.6%	
Wyoming[1]	6.3%		6.9%		0.6%		7.6%		12.0%	++	4.3%	**

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

Table Notes: See text for how eligibility, participation, and uninsurance are defined.
***(*) indicates estimate is statistically different from 2013 estimate at the 0.05 (0.1) level.*
++(+) indicates estimate is statistically different from national average at the 0.05 (0.1) level.
Estimates reflect edits for apparent misreporting of coverage on the ACS.
1. Estimates for Wyoming changed under our new methodology; see text.

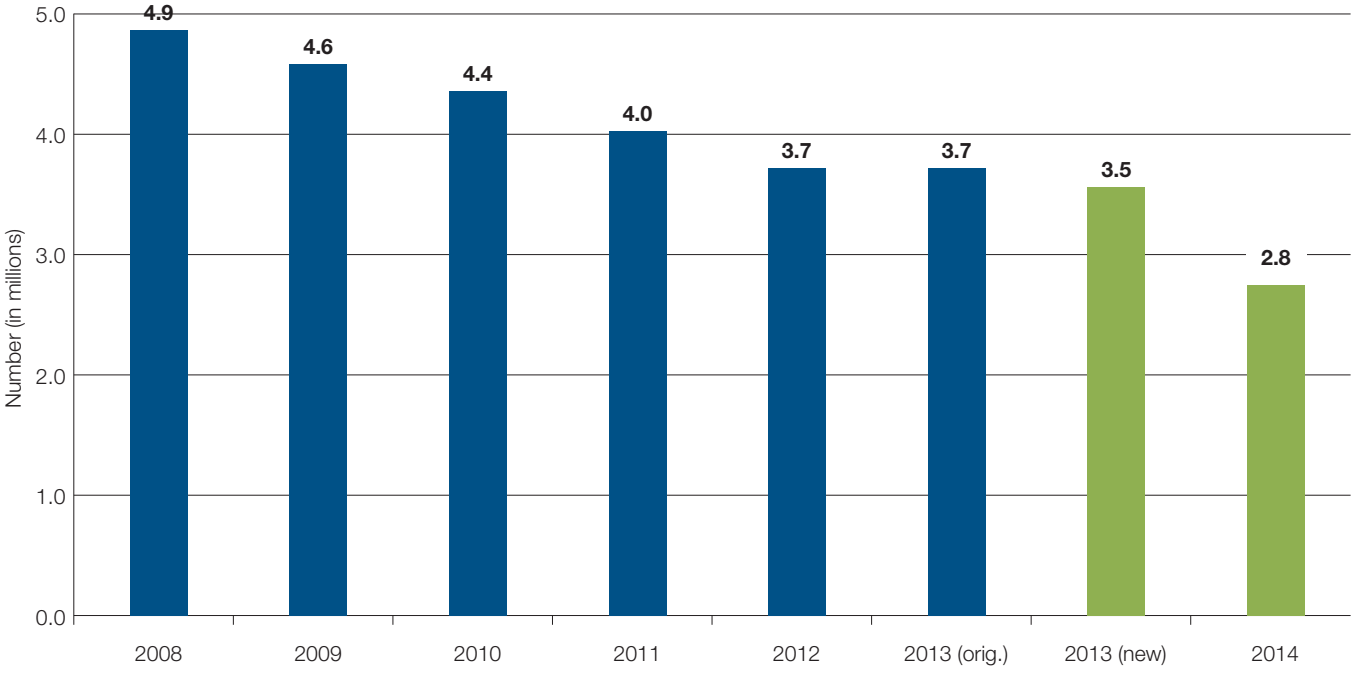
Among eligible children in 2013, uninsurance rates ranged from 1.7 percent in the District of Columbia to 16.3 percent in Nevada, a range of 14.6 percentage points. By 2014, this range had narrowed somewhat, with less than 1 percent of eligible children in Vermont not enrolled and over 12 percent of eligible children in Alaska not enrolled. Corresponding with their increases in participation, the states with the largest increases in participation were also the states with the largest declines in uninsurance.

Even with these changes, state variation remained in 2014: for instance, 14 states had uninsurance rates for children below 4 percent, with another 12 states below 5 percent, but 4 states (Alaska, Texas, Arizona, and Nevada) had uninsurance rates above 9 percent. Cross-state variation in uninsurance rates among eligible children narrowed but remained substantial in 2014. Among eligible children, uninsurance rates were below 5 percent in 19 states but were above 10 percent in another 6 states (Alaska, Wyoming, Utah, Texas, Arizona, and Montana).[9] In addition, the gap between expansion and nonexpansion states widened in 2014. In 2013, 6.8 percent of eligible children in expansion states were uninsured, compared with 8.8 percent in nonexpansion states. In 2014, uninsurance in expansion states fell to 4.9 percent, while the decline for nonexpansion states was less dramatic, with 8.0 percent of eligible children remaining uninsured. In 2014, an estimated 1.1 million eligible uninsured children were in the 26 states (including the District of Columbia) participating in the Medicaid expansion and 1.7 million were in the 25 states not participating (data not shown).[10]

Children's Medicaid/CHIP Participation and Uninsurance Trends since 2008. Figures 3 and 4 provide estimates of children's Medicaid/CHIP participation and uninsurance rates from 2008 through 2014, comparing the analysis presented here to previously published analyses of the ACS, which used a slightly different methodology.[11] In 2008, just over 8 in 10 (81.7 percent) eligible children were participating in Medicaid/CHIP (figure 3). By 2014, Medicaid/CHIP participation had risen by nearly 10 percentage points from the 2008 level, reaching 91.0 percent.

These gains in participation translated into a decline in the number of eligible uninsured children over this period (figure 4). In 2008, an estimated 4.9 million children were eligible for Medicaid/CHIP but not enrolled. This number fell below 4 million for the first time in 2012 and below 3 million in 2014, reaching 2.8 million. The number of eligible uninsured children declined by over 40 percent between 2008 and 2014, with approximately 2 million fewer eligible uninsured children in 2014 than in 2008.[12]

Figure 4. Number of Eligible Uninsured Children Ages 0 to 18, 2008-2014



Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). 2008-2010 data from Kenney et al. 2012; 2011 data from Kenney, Anderson, and Lynch 2013; 2012 data from Kenney et al. 2015; original 2013 data from Kenney and Anderson 2015.

Notes: See text for the way eligibility, participation, and uninsurance are defined and a discussion of differences between original and new 2013 estimates. Estimates reflect edits for apparent misreporting of coverage on the ACS.

DISCUSSION

Nationwide, our analysis of ACS data finds that children experienced a reduction in uninsurance between 2013 and 2014. Building on already-low levels of uninsurance before 2014, we observe that the uninsurance rate for children fell to 5.8 percent in 2014, representing 4.5 million uninsured children. This was accompanied by an increase in Medicaid/CHIP participation of 2.3 percentage points, with the national average reaching 91 percent in 2014 and 32 states having participation rates over 90 percent. Furthermore, statistically significant increases in participation occurred between 2013 and 2014 in each subgroup that was examined and in 34 states.

Increases in participation were found in both Medicaid expansion and nonexpansion states, but with larger increases in expansion states, on average. As a result, a larger differential exists in the uninsurance rate for children between expansion and nonexpansion states in 2014 than in 2013, with 4.9 percent of eligible children uninsured in expansion states compared with 8.0 percent in nonexpansion states in 2014. Together with the increased availability of Medicaid for adults in those states, other policy differences between expansion and nonexpansion states may have affected coverage of children in Medicaid and CHIP. More research is needed to assess the extent to which Medicaid expansion is bringing about positive spillover effects on children's coverage. Other changes under the ACA could also be contributing to differential enrollment changes across states. For example, the transfer of children from families with income between 100 and 138 percent of FPL from separate CHIP programs into Medicaid in January 2014 meant that families in seven states no longer had to make premium payments, which, based on prior experience, would be expected to increase take-up of coverage (Abdus et al. 2014; MACPAC 2014; Georgetown University Health Policy Institute Center for Children and Families 2015; Saloner, Hochhalter, and Sabik 2016). Further analysis of state-level changes in participation rates suggests that larger increases occurred for children between 2013 and 2014 in these seven states than in other states, which could indicate that the reduction in premiums may be playing a role in raising participation rates (data not shown).[13]

Our analysis focuses on 2014, very early in the implementation of the ACA coverage expansions. Evidence suggests that uninsurance continued to decline and Medicaid enrollment continued to increase during 2015 (Centers for Medicare and Medicaid Services 2016; Martinez et al. 2016), indicating that additional gains in children's coverage have occurred since 2014. Moreover, this analysis examined states' expansion status as of mid-2014, but additional states have implemented the expansion since then, with 32 states participating as of 2016 (NASHP 2016). Therefore, the nature of the coverage gap for children between expansion and nonexpansion states is also likely to be changing over time as well.

In 2014, fewer than 3 million uninsured children were eligible for Medicaid or CHIP—a decline of over 700,000 in a single year, which is the largest one-year drop since we started tracking this statistic in 2008. Overall, our analysis indicates that the number of uninsured children who are eligible for Medicaid and CHIP fell by approximately 2 million between 2008 and 2014.

However, 63 percent of the nation's uninsured children were eligible for Medicaid or CHIP in 2014. Among the eligible but unenrolled, this analysis identified groups of children who remain at higher risk of being uninsured despite being eligible for Medicaid or CHIP, such as the almost-8-in-10 eligible uninsured children who are school age and the 1-in-4 eligible uninsured children who are Hispanic and do not have an English-speaking parent. Recent analysis found that the majority of Medicaid/CHIP–eligible uninsured children live in families receiving the earned income tax credit, SNAP benefits, free/reduced-price school lunch, or other public benefits, which could hold promise as opportunities to connect these families to coverage (Blumberg et al. 2016). In addition, increased efforts to retain enrolled children in the programs could contribute to further reductions in uninsurance. Before 2014, a majority of low-income uninsured children reported prior experience with Medicaid/CHIP, either through having been enrolled or having applied unsuccessfully in the past (Kenney et al. 2015), and "churning" in and out of programs is expected to increase even more under the ACA (Buettgens, Nichols, and Dorn 2012), making retention of eligible children in Medicaid/CHIP even more important.

The extension of CHIP in 2015 included new outreach funding, which could help states make further inroads into enrolling hard-to-reach uninsured groups of children. However, because CHIP was reauthorized for just two years, considerable uncertainty remains about future coverage options for children, which could, in turn, put these gains at risk.

METHODOLOGICAL APPENDIX

American Community Survey. The American Community Survey (ACS) is an annual survey sponsored by the U.S. Census Bureau. We use an augmented version of the ACS, prepared by the University of Minnesota's Population Center, known as the Integrated Public Use Microdata Series, or IPUMS (Ruggles et al. 2010). The ACS had a household response rate of 89.9 percent in 2013 and 96.7 percent in 2014 (U.S. Census Bureau 2014). It uses an area frame that includes households with and without telephones (landline and cellular) and is a mixed-mode survey that can be completed by mail or (new for 2013) online, followed by telephone interviews for initial nonresponders and further followed by in-person interviews for remaining nonresponders. Estimates are weighted, and standard errors take into account the complex sample design of the survey. Our analysis uses the 2013 and 2014 ACS; each year of the public use sample includes over 700,000 children age 18 and under in the civilian noninstitutionalized population.[14]

Measurement of Insurance Coverage. Coverage status was added to the ACS in 2008 and is measured as an individual's point-in-time coverage at the time of the survey using a single question asking about multiple coverage types. Estimates represent an annual average over the 12 months of the year in which the data were collected. Following prior research, reported coverage through the Indian Health Service (IHS) is not counted as health insurance coverage because of limitations in the scope of available services and geographic reach of IHS facilities.[15]

Although research suggests the ACS coverage estimates released by the U.S. Census Bureau are generally valid and are fairly consistent with those from other widely used national surveys, there are limitations to this question methodology and known measurement error (Boudreaux et al. 2015). Therefore, this analysis uses edits that are applied if other information collected in the ACS implies that coverage for a sample case likely has been misclassified (Lynch, Boudreaux, and Davern 2010; Lynch et al. 2011; Lynch and Kenney 2013), drawing on approaches that have been applied to other surveys and primarily relying on simulated eligibility, income, coverage type, and family relationships for sample members and any family members. As in our prior analyses (Kenney et al. 2012; Kenney, Anderson, and Lynch 2013; Kenney et al. 2015), the edit rules target underreported Medicaid/Children's Health Insurance Program (CHIP) coverage and overreported nongroup coverage among children and affect other coverage types as sample people are edited to and from other types of coverage. For nongroup coverage, the rules primarily move people from nongroup to another type of reported coverage if evidence shows that the other type is their primary coverage. For Medicaid/CHIP, the rules primarily move eligible people who have some evidence of underreported Medicaid/CHIP coverage. The 2013 and 2014 rules differ because of changes to eligibility rules and pathways to coverage under the Affordable Care Act (ACA); the 2014 rules were developed to be as similar as possible to those used for prior years while incorporating changes to align with policy shifts. For example, the edits incorporate the availability of subsidized Marketplace coverage starting in 2014, using lower income thresholds to identify people who likely cannot afford nongroup coverage. Given the policy changes, editing consistently across the 2013–2014 period is impossible, which could introduce bias in our estimates of changes in coverage type over time. However, the overall effect of our edits is not large and is relatively similar across years, so the magnitude of any potential bias is likely to be small.

Measurement of Medicaid/CHIP Eligibility. To assess Medicaid/CHIP eligibility, we compare information about the child and family provided by survey respondents to the Medicaid/CHIP eligibility rules in place in each family's state of residence in the year in which they were surveyed (Brooks et al. 2015; Heberlein, Brooks, Alker et al. 2013; Heberlein, Brooks, Artiga et al. 2013). For 2013, we use the Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model, which estimates eligibility for Medicaid and CHIP using available information on eligibility guidelines, including the amount and extent of income disregards, for each program and state as of mid-2013 (Lynch, Haley, and Kenney 2014).

For 2014, we use the Health Insurance Policy Simulation Model–ACS version, or HIPSM-ACS (Buettgens 2011), which builds on the Medicaid/CHIP Eligibility Simulation Model and applies rules as defined in the ACA and in guidance provided by the Centers for Medicare and Medicaid Services that took effect in 2014. Although the law was not designed to dramatically change eligibility for children, the model takes into account changes to the way eligibility is calculated for children.[16]

For noncitizen children, both the 2013 model and the 2014 model take into account length of U.S. residency in states where this is a factor in eligibility determination. Because the ACS does not contain sufficient information to determine whether an individual is an authorized immigrant, we impute documentation status for noncitizens.[17]

Measurement of Medicaid/CHIP Participation. Medicaid/CHIP participation rates are calculated as the ratio of Medicaid/CHIP–eligible enrolled children to Medicaid/CHIP–eligible enrolled children plus Medicaid/CHIP–eligible uninsured children, excluding children with both Medicaid/CHIP and employer-sponsored coverage, including military coverage, and those with Medicaid/CHIP coverage who do not have a known eligibility pathway. Participation rates excluding those with private coverage are often used to indicate how successfully Medicaid/CHIP programs are reaching their target populations.

Individual, Family, and Geographic Characteristics. In this analysis, we examine changes in insurance coverage status, Medicaid/CHIP participation, and Medicaid/CHIP eligibility for children nationally, by state, and by grouping states according to their Medicaid expansion decision as of June 1, 2014 (the middle of the 2014 data collection period).

In addition, we examine children based on their own characteristics, including age (age 5 and under, ages 6–12, or ages 13–18); sex (male or female); race/ethnicity (white only, black only, Hispanic [classified into presence of a parent in the household who speaks English or not and lack of a parent in the household], Asian/Pacific Islanders, American Indians/Alaska Natives, or other/multiple races); and for those age 5 or older only, existence of a functional limitation (answering yes to any of the following questions: "Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?," "Does this person have serious difficulty walking or climbing stairs?," "Does this person have difficulty dressing or bathing?").

Further, we examine their family/household characteristics (including their family income as a percentage of the federal poverty level [FPL], receipt by their household of Supplemental Nutrition Assistance Program (SNAP)/food stamp benefits, and their family's work status) and geographic characteristics (region, classified as Northeast [Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont], Midwest [Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin], South [Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia] or West [Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming]; and metropolitan status, classified as living within or outside of a metropolitan area or living in an unclassifiable area [13–16 percent of the sample]).

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ENDNOTES

1. Our imputations of documentation status for 2013 and 2014 differ from our prior method; the 2013 and 2014 approach incorporates estimated patterns of documentation status within families as reported on the Survey of Income and Program Participation and includes additional state-level information that is calibrated to replicate estimates of the undocumented population in 15 states and nationwide produced by the Pew Hispanic Center (see chapter 1 of Passel and Cohn [2014]), the age distribution of undocumented immigrants estimated by the Department of Homeland Security, and the share of undocumented immigrants lacking insurance estimated by the Center for Migration Studies (2016).

2. See Methodological Appendix for descriptions of how edit procedures differ between 2013 and 2014.

3. In addition, more error is inherent in estimates reported for smaller states. For estimates of participation, four states have sample sizes of fewer than 1,000 cases—Wyoming, North Dakota, New Hampshire, and South Dakota. Estimates with smaller samples are more volatile and sensitive to changes in methodology.

4. Estimates of coverage for American Indians/Alaska Natives are sensitive to the treatment of Indian Health Service (IHS) access. If IHS access were considered as coverage, the uninsured rate for American Indian/Alaska Native children would be lower, at 6.8 percent in 2013 and 5.7 percent in 2014 (see Methodological Appendix).

5. Estimates of participation for American Indians/Alaska Natives are sensitive to the treatment of IHS access (see Methodological Appendix).

6. The treatment of IHS access as uninsured has some effect on state rates and rankings. The 2014 participation rates for Montana, Oklahoma, and South Dakota would be about 3–4 percentage points higher if IHS access were treated as insurance coverage.

7. Arizona's CHIP program expired in January 2014. Eligibility was therefore modeled differently for 2013 and 2014, reducing the number of children classified as eligible in 2014 compared with 2013. Therefore, estimates of participation in Arizona are less comparable in the two years than for other states.

8. Although estimates for Wyoming show a decline in participation between 2013 and 2014 under all of the methodological approaches we have explored, estimates changed under a new methodology for identifying documentation status; previous analysis produced estimated participation of 85.2 percent for 2013, slightly lower than the 88.4 percent for the updated approach. This change may also be driven in part by the relatively smaller size of the Wyoming sample.

9. If IHS access were considered coverage, only three of these states—Texas (11.2 percent), Utah (11.8 percent) and Wyoming (10.4 percent)—would have uninsured rates above 10 percent.

10. As more states have expanded Medicaid, the number of eligible but uninsured children living in Medicaid expansion states has likely increased.

11. See endnote 1 for information on changes in the methodology implemented in 2013 and 2014.

12. Patterns of change over time are very similar when we recalibrate the 2008–2012 estimates to approximate the effect of using the revised documentation status imputation, resulting in an estimated increase in participation of 9 percentage points between 2008 and 2014 and an estimated decline in the number of eligible uninsured children of 1.9 million over that period.

13. Seven states (Alabama, Arizona, Delaware, Florida, Georgia, Nevada, and Utah) transitioned children ages 6 to 18 from separate CHIP coverage with premiums to Medicaid coverage with no required premium payments in 2014. Participation rates increased more for children ages 6 to 18 from families with incomes below 138 percent of FPL in these seven states than in other states (6.4 vs. 4.1 percentage points), with larger increases among both expansion (7.8 vs. 4.1 percentage points) and nonexpansion (5.9 vs. 3.8 percentage points) states than in other states. However, more analysis is needed to attribute that differential to the movement of children from CHIP into Medicaid.

14. Results presented here differ somewhat from those published elsewhere because of differences in data sources or variation in the way the same data source has been analyzed. For example, one recent analysis (Alker and Chester 2015) used the ACS but excluded 18-year-olds, and data were tabulated through American FactFinder, which draws on the full sample rather than the microdata available as a public use file. Results from Lukanen, Schwehr, and Fried (2016) are more similar to those presented here because they also rely on public use samples of ACS microdata and classify children as ages 0 to18. However, data processing procedures such as coverage edits differ, and findings may therefore vary for certain analyses. A recent analysis of the remaining uninsured children in 2015 that relies on a different data source (the Current Population Survey Annual Social and Economic Supplement of the U.S. Census Bureau) found broadly similar results, with an estimated 6.9 percent uninsured rate for children in spring 2015, an estimated 66.5 percent of uninsured children as Medicaid/CHIP eligible, and similar distributions of eligible uninsured children according to characteristics such as income level and race/ethnicity (Blumberg et al. 2016).

15. Nationwide, approximately 111,000 children in 2013 and 130,000 children in 2014 were found to have IHS but did not report any other insurance coverage. For most states in 2014, the participation rates did not change in a meaningful way when IHS was considered a source of health insurance coverage. However, in three states—Montana, Oklahoma, and South Dakota—the participation rate increased by more than 3 percentage points when IHS was reclassified as insurance coverage. The participation rate among American Indian/Alaska Native children was also sensitive to the way IHS was treated; it increased from 83.6 percent in 2013 to 88.9 percent and from 87.1 percent in 2014 to 92.6 percent when the IHS was classified as health insurance coverage.

16. Several changes to children's Medicaid/CHIP eligibility were implemented in 2014, including the following:

- Changes in the way that income is counted, using a system based on Modified Adjusted Gross Income (MAGI) that treats certain kinds of incomes differently than under pre-ACA rules
- Changes in the definition of the family unit (including how many individuals are included in the child's family and whose income is deemed available to the child)
- Conversion of Medicaid and CHIP eligibility thresholds to MAGI-based thresholds resulting in new thresholds that are, on the aggregate, not less than the effective income levels that were in place at the time of the ACA's enactment
- A shift from state specific income disregards to a standard income disregard of 5 percentage points of FPL
- The movement of children eligible for separate CHIP programs in states with Medicaid thresholds below 138 percent of FPL to Medicaid to account for a new national Medicaid floor of 138 percent of FPL.

17. See endnote 1. The results for 2013 are slightly different from our previously published results (Kenney and Anderson 2015), because they incorporate the change in modeling of documentation status described above. This difference resulted in a small change to some estimates (for example, the national estimate of children's Medicaid/CHIP participation shifted from 88.3 percent to 88.7 percent when we incorporated the new documentation status imputation).

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What to Look for in 2017 ACA Marketplace Premium Changes

May 05, 2016 | Gary Claxton (http://kff.org/person/gary-claxton/) **and Larry Levitt** (http://kff.org/person/larry-levitt/) (https://twitter.com/larry_levitt)

Insurers are in the process of filing proposed premiums for ACA-compliant nongroup plans that will be available inside and outside of Marketplaces in 2017.

Recent reports by insurers about their experiences during the first two years under the ACA suggest that some assumed that enrollees would be healthier than they turned out to be and set their premiums too low, leading in some cases to significant financial losses for ACA-compliant plans and an expectation that premiums could rise faster in 2017. Some insurers took relatively large premium increases for 2016 to better match premium levels with the costs of their enrollees — which would help to offset the need for 2017 premium increases — but it is too soon to know if these effort were generally successful or whether losses have continued into 2016. At the same time, some insurers have had better experiences and may be able to sustain current pricing, while new product offerings and new competitors may offer opportunities fo consumers who are willing to shop around to find reasonably priced plans in 2017. This still is a new market, with insurers still finding their way, and as with 2016, it is likely that we will see a wide range of requests for rate changes and new product approvals across insurers and geographic areas.

State and federal regulators will be reviewing the proposed rates over the next few months in advance of the next open enrollment period, which will begin on Novembe 1, and in some cases approved rates will likely end up being lower than proposed rates.

This brief discusses the key factors that will influence the rate changes that insurers are requesting.

ARE CURRENT PREMIUMS ADEQUATE?

The first step in looking at how an insurer would want to adjust their premiums for a new year is assessing whether their existing premium levels were reasonable for the people who enrolled in the previous year. While rate requests are mostly about projecting future costs and enrollment, the first step is to determine the proper

starting point. Insurers whose prior-year's premiums were too low relative to their claims costs will look for increases to better align premiums with costs; this does not mean that insurers can recoup past losses, but rather that it allows them to go forwar with premiums that better match their claims experience. Conversely, insurers that overestimated prior costs may look to start from a lower premium level.

One complicating factor is that insurers must estimate costs after risk adjustment, which protects insurers that enrolled a disproportionate share of higher-risk enrollee and penalizes insurers that enrolled healthier than average people. This means insurers are essentially attempting to judge the risk level market-wide in areas that they serve, not the risk of their actual enrollees. However, final payments into and out of the risk adjustment system are unknown at the time insurers must propose their rates, introducing an element of uncertainty (which should dissipate as payments under the program become more stable and predictable).

Adjustments for previous mispricing were an important contributor to premium requests from some companies in 2016 and will be again in 2017. The ACA transformed the nongroup market, enhancing benefits, limiting cost sharing, improving affordability for low and moderate income families through federal subsidies, while eliminating rating and coverage restrictions based on health. Insurers are required to establish rates in the nongroup market based on a "single risk pool," meaning the rates are tied to the health care use of enrollees in ACA compliant plans both inside and outside the marketplaces.

When they set their initial rates for 2014, insurers (and the regulators reviewing rates were not certain how many people would enroll, how long they would stay enrolled ("churn"), and what their health care needs would be. As a result, in many cases insurers used their small group insurance rates as a starting point, with various adjustments. As mentioned above, the risk adjustment program, as well as the temporary reinsurance program, were new and a source of some uncertainty. Insurers also were not aware of the initial problems Healthcare.gov and some of the state exchanges would have, nor of the "grandmothering" policy announced by the Administration, discussed below. Many of these uncertainties carried over into 2015 rate setting: because rates for 2015 were prepared in the spring of 2014, insurers had somewhat better sense of the demographic characteristics of who was enrolling, but only a few months of actual claims experience to begin to gauge the health care needs of their enrollees. It really was not until the third year (2016) that insurers were able to begin to use claims experience in the new market in their rate setting process, and some (but by no means all) had rather large rate increases because they had underestimated the health care costs of their enrollees. (We note that in some cases premium requests for 2014 and 2015 may have been reduced by State insurance regulators.)

One issue that some insurers have focused on recently is the relatively poorer health status of people who enrolled during special enrollment periods (SEPs). Under the ACA, people without health insurance are generally expected to enroll during annual open enrollment periods; if they do not, they must wait until the following year to enroll. This short open enrollment period, along with the individual responsibility penalty, is designed to discourage people from waiting until they have a health problem to seek coverage. There are occasions, however, when people who do not need to purchase their own coverage during an open enrollment period have changes in their circumstances that mean that they need to seek coverage in the nongroup market. The most common reason occurs when people lose their coverage, for example if they lose a job or become ineligible for Medicaid. Other reasons include a change in family status (e.g., birth, adoption, or divorce) or changing where you live. People in circumstances such as these are given SEPs in between the annual open enrollment periods where they can choose a health plan and apply for premium tax credits and cost sharing assistance.

Insurers have increasingly voiced concerns about how the SEP process is conducted and the poorer health of those who enroll during these periods, in general arguing that there are too many recognized circumstances and that in most cases enrollees in Marketplaces were not required to document their situation in order to enroll.[1] In response, the Centers for Medicare and Medicaid Services (CMS) has eliminated some of the SEPs and announced that it will begin requiring documentation for some of the more common SEPs, although people will be able to enroll before their documentatio is submitted.[2] While several insurers have stated that these changes are moves in the right direction, it is unclear how the changes will impact premium requests for 2017.

Adjustments to correct prior mispricing related to the health of nongroup enrollees likely will continue for 2017 rates as insurers gain more actual experience (they had only a limited amount of 2015 claims experience when 2016 rates were filed) and as the market settles in. Given the apparently large losses that some insurers had in 201 and 2015, an important question for 2017 is whether rate adjustments that insurers made in 2016 were largely sufficient or whether some will still need significant increases to reflect the actual health costs of their enrollees. There is a mix of experience. Some insurers, for example UnitedHealthCare (http://www.wsj.com/articles/unitedhealth-reports-profit-decline-amid-exchange-weakness-145320440 and Blue Cross and Blue Shield Plans in North Carolina (http://mediacenter.bcbsnc.com/news/blue-cross-2015-financials:-aca-losses-grow;-improvements-in-other-lines-of-business-strong-investments-create-small-profit) and Pennsylvania (http://www.businessinsurance.com/article/20160404/NEWS03/160409952/), reported significant losses in their nongroup business in 2015, while others, such as Centene (http://www.modernhealthcare.com/article/20160426/NEWS/160429943), Aetna

(http://www.nasdaq.com/aspx/call-transcript.aspx?StoryId=3969400&Title=aetna-aet-mark-t-bertolini-on-q1-2016-results-earnings-call-transcript) and Anthem (http://www.cbsnews.com/news/anthem-expects-a-profit-this-year-from-aca-exchanges/), had more favorable reports.

HOW WILL ENROLLMENT CHANGE IN 2017?

In setting rates, insurers try to anticipate how their mix of enrollees will change for the coming year — both what types of new enrollees they may attract and which enrollees they are most likely to lose. This involves examining factors such as the age gender and location of projected enrollees, as well as their health care needs and wha type of policies (level of coverage and networks) they will enroll in.

This task has been complicated for insurers during the implementation of the ACA because, as noted above, the market structure and rules are entirely new and it is uncertain how quickly enrollment will grow and how large it will be when the marke matures. It was clear at the onset that the introduction of premium tax credits and the individual responsibility penalty would significantly expand the number of nongroup enrollees, and the elimination of health status as a rating and coverage factor would permit more people with health problems to enroll in the market. From the perspective of setting rates, the intent was that these two factors would to some extent balance each other out: the tax credits and individual responsibility requirement attract healthy people who otherwise might decide not to purchase insurance, and their lower costs help offset the higher costs of enrollees with preexisting health needs. It also was generally anticipated that the higher-risk people would enroll at a somewhat higher rate during the first year, because they have the highest demand for coverage, and that over time the average health of nongroup enrollees would improve as more of the healthier uninsured sought coverage. However, the magnitudes of these enrollment dynamics and how quickly they would play out were highly uncertain.[3]

How insurers view this process in the market areas where they operate will have an impact on their rate requests for 2017. While situations vary across different areas, overall, participation in the new Marketplaces grew fairly rapidly in the first two years of the program, but slowed in 2016: 8 million people had made a plan selection by the end of the 2014 open enrollment period, 11.7 million by the end of the 2015 period, and 12.7 million by the end of the 2016 period.[4]

A substantial number of uninsured people remain in many markets, and on average they likely are healthier than current nongroup enrollees, so enrolling a large numbe of them would improve the average health of people in nongroup policies and help moderate premiums. People in so-called grandmothered plans (nongroup plans sold after the ACA passed and before 2014 were allowed to continue at state discretion

until 2018) are another relatively healthy group who will be transitioning into ACA compliant plans over the next couple years. There are not good estimates of the number of people in these plans, but they should be another, though smaller, source of new enrollment. The questions for insurers will include how easy it will be to reach these groups and whether they will view the premiums as affordable (even wit premium tax credits). If insurers are optimistic about reaching these groups, their premium requests will factor in some improvement in health for incoming enrollees.

For insurers requesting large premium increases, an additional consideration is that a large increase will cause some current enrollees to leave, and that those who leave ar likely to be healthier than those who choose to stay and pay the increase (as with all insurance, people who are willing to pay more typically have greater needs than thos who will not). People with premium tax credits are protected from premium increases so long as they stay enrolled in one of the lower-cost plans in their area, though that could involve switching insurers, which some enrollees may not want to do. People without premium tax credits may leave because they do not view their plan as worth the higher premium. This means that insurers requesting larger increases will assume that the health mix of their enrollees will likely become worse due to the increase.

INCREASES IN PRICES AND USE OF SERVICES ("TREND")

A significant part of any premium rate request is the insurer's estimate of how health care costs are going to change in the coming year, often called trend. Insurers use prior claims to calculate how the use of services and the prices paid for them have been changing, and use the results – in conjunction with other factors that could affec health care spending growth, such as new drugs coming on the market or price increases built into contracts with providers – to project future claims costs. These calculations are done separately for different types of services (e.g., inpatient hospital outpatient, physician, prescription drugs) and may reflect the insurer's overall business, with adjustments made to reflect differences in service mix or other attributes for a particular policy or market. Trend is meant to estimate the future cos for existing coverage, before changes in policy attributes (such as network) or enrollment mix.

Health care trend has been relatively low in recent years (with the exception of prescription drug prices), although insurers have been warning that cost pressures are increasing and there has been some suggestion that trend may be a little higher i 2017 than last year. From looking at a handful of early rate filings, low end projections are in the 3 to 5 percent range while some insurers are projecting trend of 7 to over 9 percent. Note that trend may appear somewhat higher than other measures of health care costs. For example, growth in total national health spending

includes other programs that are increasing more slowly (for example Medicare), and growth in the average premium in employer-sponsored plans reflects changes in benefits or cost sharing that tend to depress premium increases.

Trend is often a factor in rate increases that insurance regulators scrutinize carefully.

CHANGES IN POLICY DESIGN OR NETWORK

The ACA prescribes the basic benefits that each nongroup health plan must cover and establishes value tiers (i.e., bronze, silver, gold, and platinum), so there is not too much that insurers can do to the benefits or even the overall patient cost sharing to change the cost structure of a particular health plan. Insurers can reduce the cost of a health plan, however, by limiting the provider network to lower-cost providers; by revising the drug formulary to reduce the number of options (or increase cost sharing for higher-cost medicines; or by increasing management over service use, such as increasing the use of prior authorization or requiring the use of a specialty pharmacy provider for certain higher-cost medicines. Moving to a narrower network can have a large impact on premiums (savings can be as much as 20 percent or more for insurers using broad networks). These changes can help reduce the premium increase reques that an insurer might make, or the insurer may offer the revised plan as a new product option.

CHANGES IN LAW OR REGULATION

Changes in the regulatory framework also affect the premium changes that insurers request. There are several for 2017. Firstly, the health insurance tax included in the ACA was waived for 2017, which should lead to a reduction in costs and premiums of about 3 percent. Moving in the other direction, the ACA reinsurance program ends in 2016. The reinsurance program worked by making an assessment on all health insurance payers and distributing the proceeds to insurers with nongroup enrollees who had enrollees with high medical expenses. For 2016, these reinsurance payment reduced nongroup premiums by approximately 4 to 6 percent.[5] Without the reinsurance program, insurers will need to raise their premiums in 2017 by a comparable percentage to make up for the loss of the reinsurance funds. Finally, as discussed above, CMS made changes to the SEP rules, which should moderate some of the concerns that insurers have about adverse selection from SEP enrollees.

COMPETITION

Analyses have shown that premiums are lower in competitive markets, and with premium tax credits tied to the second-lowest-cost plan in a rating area, it is difficult for insurers to get customers if their premiums rise too far above their competitors.[6,7] One of the issues affecting Marketplaces in some states has been a lack of competitors

in some of their rating areas (often rural): in 2016, there are 1,121 counties (36%) with two or fewer insurers offering Marketplace coverage. The exit of UnitedHealthCare will meaningfully expand the number of counties with limited competition unless new competitors enter.[8] Insurers who have had losses and who have few or no likely competitors may feel free to take significant rate increases. And because enrollees who are eligible for premium tax credits contribute based on a share of their income rather than the actual premium, most of the enrollees of these insurers will be shielded from the high increases. Unless regulators limit increases, we may see significant increases in some of these areas.

One protection from big premium increases in uncompetitive markets is the ACA requirement that insurers who fail to spend at least 80% of premium revenues on health care expenses in the nongroup market as a whole in a state must return the excess to consumers as rebate. However, this medical loss ratio calculation is now based on a three-year moving average so the effect is muted and lagged.

DISCUSSION

Insurers are gaining experience under the ACA and are in a better position than in previous years to project the health and claims of their enrollees. Some have realized that their enrollees are less healthy on average than they had anticipated, and for these insurers, relatively large premium increases are likely. Others, whose current premiums are more in line with their costs, will generally request smaller changes. Other factors influencing premium changes for all insurers for 2017 include increasing prices and service use, the end of the federal reinsurance program (which reduced premiums in previous years), and the one-year waiver of the federal health insurance tax.

How enrollees experience premium changes will depend on whether they receive premium tax credits and on the competitive position of the plan they are in. A large share of Marketplace enrollees receive premium tax credits, which means that they pay a set percentage of their income toward the cost of the second-lowest-cost premium in their rating area, plus all of the additional cost for a plan with a higher premium.[9] As long as these enrollees stay in one of the low-cost plans, any increase they face would be modest. If they are enrolled in a higher-cost plan, or if their current plan becomes a higher-cost plan, they would pay all of the premium increase unless they changed to a lower-cost plan. A recent HHS report showed that shopping for new plans is quite common and can lead to substantial savings for enrollees: for 2016, 43 percent of Marketplace enrollees switched plans during open enrollment, saving on average $43 per month.[10]

Given the highly competitive nature of the Marketplaces in much of the county, as wel as the uncertainty insurance companies faced in the early years of ACA implementation, it's not surprising that premium increases may be higher in 2017 as the market matures and more data become available to insurers. This can be seen as something akin to a one-time market correction. However, bigger premium increases do not necessarily mean that that the Marketplaces are unsustainable. Some markets are functioning effectively, demonstrating that the approach can work. And, most Marketplace enrollees are receiving premium tax credits that cushion the effects of premium increases. If insurers now losing money are able to adjust premiums to become profitable, the market could begin to stabilize.

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8. Cynthia Cox and Ashley Semanskee, *Analysis of UnitedHealth Group's Premiums and Participation in ACA Marketplaces* (Washington, DC: Kaiser Family Foundation, April 18, 2016), http://kff.org/health-reform/issue-brief/analysis-of-unitedhealth-groups-premiums-and-participation-in-aca-marketplaces/ (http://kff.org/health-reform/issue-brief/analysis-of-unitedhealth-groups-premiums-and-participation-in-aca-marketplaces/)
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Accessed May 4, 2016, http://kff.org/health-reform/state-indicator/marketplace-plan-selections-by-financial-assistance-status/ (http://kff.org/health-reform/state-indicator/marketplace-plan-selections-by-financial-assistance-status/)

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JAMA Infographic | May 3, 2016

VISUALIZING HEALTH POLICY

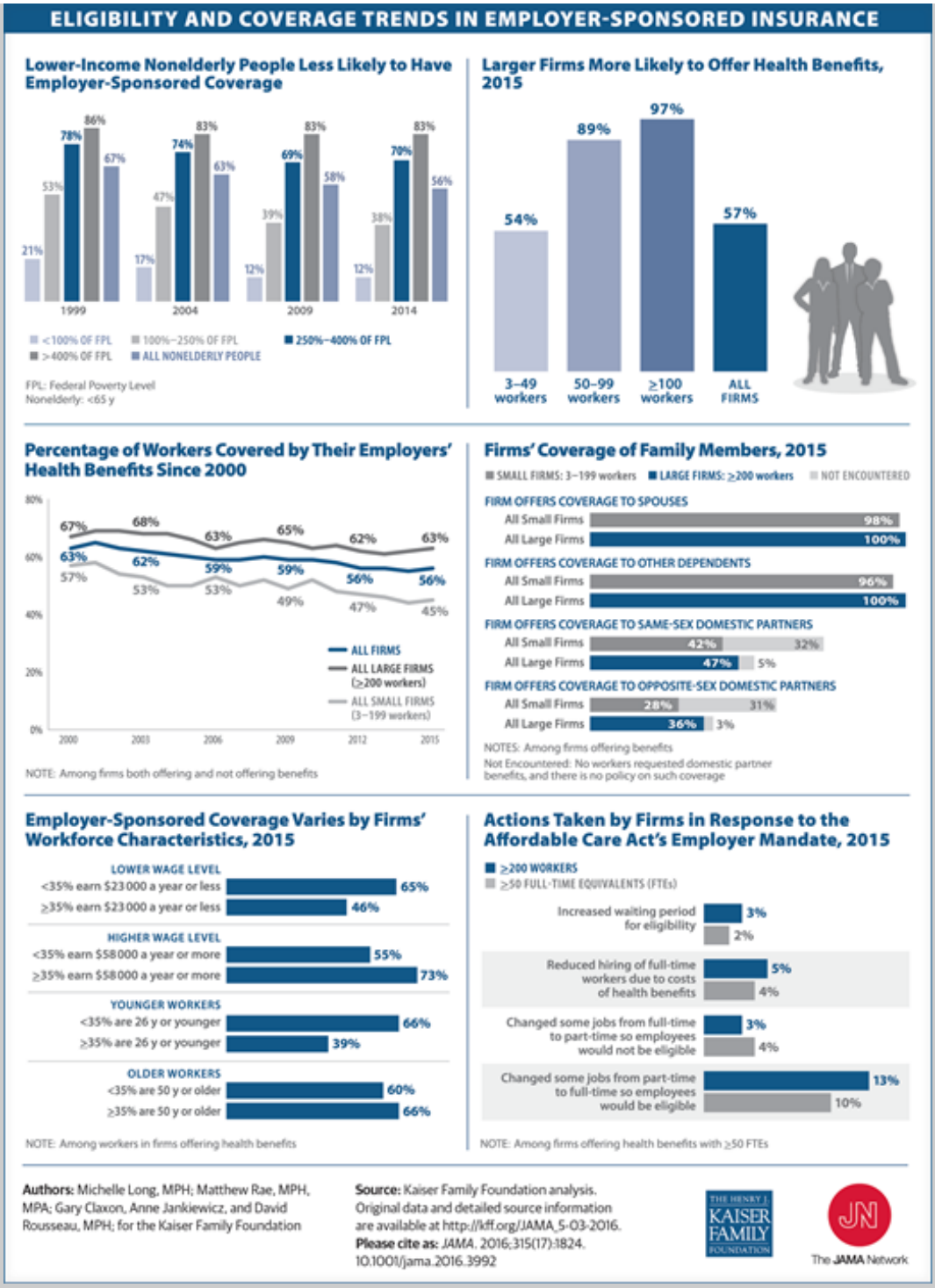
Eligibility and Coverage Trends in Employer-Sponsored Insurance

FREE

Michelle Long, MPH; Matthew Rae, MPH, MPA; Gary Claxon; Anne Jankiewicz; David Rousseau, MPH ; for the Kaiser Family Foundation

JAMA. 2016;315(17):1824. doi:10.1001/jama.2016.3992.

This Visualizing Health Policy infographic looks at eligibility and coverage trends in employer-sponsored health insurance. Since 2000, the share of workers covered by employers' health benefits at both offering and nonoffering firms has dropped to 56%, with the biggest decrease among employees working for small firms (3-199 workers). Among people younger than 65 years, those with lower incomes continued to be less likely to have coverage from an employer-sponsored health plan, as has been the trend since 1999. In 2015, larger firms were more likely than smaller ones to offer health benefits, as were organizations with more higher-wage employees, fewer lower-wage employees, and fewer workers 26 years or younger. Most large employers offered coverage to spouses and other dependents, while fewer than half of these firms offered coverage to same-sex or opposite-sex domestic partners. Few firms took action in 2015 in response to the Affordable Care Act's employer mandate, including changing some jobs from part-time to full-time so employees would be eligible for coverage.



ARTICLE INFORMATION

Source: Kaiser Family Foundation analysis. Original data and detailed source information are available at http://kff.org/JAMA_5-03-2016.

When Differences Between Marketplace and Medicaid MAGI Result in Ineligibility for Either Program

Prepared By: Wayne Turner
Date: May 2, 2016

Q. I am preparing for a fair hearing challenging the denial of Medicaid eligibility for two children. They live with their parents who are not married. The mother earns $20,000/year and the father earns $31,500/year. The mother claims the children as tax dependents. The Marketplace determined that the children do not qualify for Premium Tax Credits because they are under income. However, the state Medicaid agency determined they are not eligible for Medicaid because they are over income. Instead, the state found the children eligible for spend-down once the family incurs $2,750 a month, per child, in medical expenses. Is this correct?

A. The children are eligible for Medicaid with no spend-down. Federal regulations address situations when differences between Marketplace and Medicaid methodologies render an individual financially ineligible for either program. The state should use the Marketplace methodology (e.g. annual income) to determine Medicaid MAGI eligibility, applying 42 C.F.R. § 435.603(i).

Discussion

The rules under Modified Adjusted Gross Income (MAGI) methodologies differ for Marketplace and Medicaid eligibility determinations. Because of those differences, there may be instances in which an individual seemingly is financially ineligible for both programs. This can arise due to two main issues: (1) the differences in household composition rules; and (2) differences in determining income – Medicaid uses a "point in time" or ***current monthly*** income while the Marketplace uses ***projected annual*** income.

Federal MAGI regulations address this situation to ensure an individual is not left without any coverage. Under 42 C.F.R. § 435.603(i), when an individual is determined financially ineligible for both Medicaid and Marketplace subsidies, the Marketplace MAGI methodology should be used to determine eligibility for Medicaid.

1. Differences in household composition

Medicaid and the Marketplace have different MAGI rules for determining who is in an applicant's household. For Marketplace eligibility for Premium Tax Credits (PTCs) and Cost Sharing Reductions (CSRs), the household is comprised of the tax filer (or filers for married couples filing jointly) and persons they can claim as dependents.[1]

Marketplace MAGI

In the situation described above, the mother claims both children as tax dependents. Therefore, the children's Marketplace household is three – mother plus the two children. The father's income is not included in the children's Marketplace household because he and the children's mother are unmarried and cannot file federal income taxes jointly.

Because the total annual household income for the mother and her two children is $20,000, below 100% FPL for a family of 3, they are not eligible for PTCs or CSRs.[2]

Medicaid MAGI

In Medicaid, when a child under 19 (or 21 for full time students under state option) is claimed as a tax dependent by just one parent, but lives with both parents, ***both*** parents are included in the child's Medicaid MAGI household.[3] Although the father is not included in the children's Marketplace household because they have no tax relationship, he is included in the children's Medicaid household because they live together. The children's Medicaid MAGI household is four – mother, father, plus the two children.

In this instance, including the father's income raises the total household income to $51,500 annually, or $4,290 per month, which, at 212% FPL for a family of 4, is over the state's threshold for Medicaid eligibility. Therefore, a state's initial determination might find the children ineligible for Medicaid because they are over income with a four person household.

In this instance, the state erroneously concluded that 42 C.F.R. § 435.603(i) does not apply and instead found the children eligible for Medically Needy (also known as spend-down).[4] However, when a state finds an individual eligible under Medically Needy, it

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[1] 26 U.S.C. § 36B(d)1).
[2] 26 U.S.C. § 36B(c)(1)(A). Note that lawfully present immigrants under 100% FPL can receive PTCs and CSRs if they are not eligible for Medicaid. *See* 26 U.S.C. § 36B(c)(1)(B).
[3] 42 C.F.R. §§ 435.603(f)(2)(ii), (3)(iv).
[4] States may provide Medicaid coverage to persons who are over-income if they meet other eligibility requirements – a category known as "Medically Needy" or "spend-down." States that must establish a "medically needy income level" (MNIL) and choose a budget period of between one month and six months for calculating the spend-down. To receive Medicaid services, an individual must spend down the determined amount on medical expenses within the budget

means that the applicant is *financially ineligible* for Medicaid, but meets all eligibility requirements (e.g., residency). As HHS explains in a Dear State Health Official Letter:

> "At the beginning of the budget period, an individual with income above the MNIL *will not be eligible*. As soon as the individual has incurred sufficient medical expenses, such that, after subtracting incurred medical expenses, her income falls below the MNIL, she is eligible for coverage for the rest of the budget period."[5]

Hence, 42 C.F.R. § 435.603(i) *does apply*, because using the general Medicaid MAGI rules results in "financial ineligibility for Medicaid," and the children's Marketplace income is below 100% FPL.

Solution

When someone has been determined financially ineligible for Medicaid using Medicaid MAGI methodologies, but is under 100% FPL and thus ineligible for Marketplace subsidies, 42 C.F.R. § 435.603(i) requires states to use the Marketplace MAGI methodology to determine Medicaid eligibility.

Here, the children are seemingly ineligible for Medicaid because, using the four person household, their current monthly income is 212% FPL. However, the children are ineligible for Marketplace subsidies because their projected annual income, based upon a household of three, is below 100% FPL.

Instead of using the four person household to decide their Medicaid eligibility, the state must use the three person Marketplace household and income to determine Medicaid eligibility. The children are eligible for Medicaid because their total three-person household income, using the Marketplace methodology, is under 100% FPL.[6]

2. Differences in Income Rules

As noted above, financial eligibility Medicaid under MAGI is based upon current monthly income.[7] However, eligibility for Marketplace subsidies is based upon projected annual income.[8] As a result, an individual applying for coverage may have different income

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period. *See* 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. §§ 435.300-.350, 435.800-.845, 436.800-.845; see also *Atkins v. Rivera*, 477 U.S. 154 (1986); *Brobst v. Dep't of Pub. Welfare*, 915 A.2d 160 (Pa. Commw. Ct. 2007) (requiring claimant to spend down certain amount on expenses every month to be eligible for medically needy program).

[5] Dear State Health Official Letter, Re: Minimum Essential Coverage, SHO-14-002 (Nov. 7, 2014) at 6, (emphasis added) *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf.

[6] 42 C.F.R. § 435.603(i).

[7] 42 U.S.C. § 1396(a)(e)(14)(H); 42 C.F.R. § 435.603(h)(1)).

[8] 45 C.F.R § 155.305(f)(i)).

determinations due to the differing methodologies. While the example above focused on household composition, another example can illustrate how differences in income counting can affect eligibility, particularly for persons with fluctuating income.

For example, a freelance writer has a current monthly income of $1,400. However, her projected annual income is $11,000 (under 100% FPL). She is over income for Medicaid, but under-income for Marketplace subsidies.

Marketplace MAGI

Because her projected annual income is under 100% FPL, she is not eligible for Marketplace subsidies.

Medicaid MAGI

Because her current monthly income is $1,400, she is determined financially ineligible for Medicaid because she is over income (147% FPL while her state's Medicaid expansion eligibility only covers up to 138% FPL).

Solution

When someone has been determined financially ineligible for Medicaid using Medicaid MAGI methodologies, but is under 100% FPL and thus ineligible for Marketplace subsidies, 42 C.F.R. § 435.603(i) requires states to use the Marketplace MAGI methodology to determine Medicaid eligibility. The freelance writer is thus eligible for Medicaid because her income, using the Marketplace MAGI methodology, is 98% FPL.[9]

Conclusion

The introduction of MAGI methodologies to determine financial eligibility across multiple insurance affordability programs, including Medicaid, CHIP, and subsidies for Marketplace coverage, was intended to simplify and streamline eligibility processes. However, the differences in Medicaid and Marketplace MAGI can be complex, and some states continue to experience implementation challenges. The failure of states to properly apply MAGI rules leads to wrongful eligibility determinations. It is important for legal services and other advocates to master the new MAGI rules to assist low income clients in obtaining the coverage they need.

[9] 42 C.F.R. § 435.603(i).

The COMMONWEALTH FUND

TRACKING TRENDS IN HEALTH SYSTEM PERFORMANCE

MAY 2016

Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction

Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016

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

Abstract The fourth wave of the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016, finds at the close of the third open enrollment period that the working-age adult uninsured rate stands at 12.7 percent, statistically unchanged from 2015 but significantly lower than 2014 and 2013. Uninsured rates in the past three years have fallen most steeply for low-income adults though remain higher compared to wealthier adults. ACA marketplace and Medicaid coverage is helping to end long bouts without insurance, bridge gaps when employer insurance is lost, and improve access to health care. Sixty-one percent of enrollees who had used their insurance to get care said they would not have been able to afford or access it prior to enrolling. Doctor availability and appointment wait times are similar to those reported by insured Americans overall. Majorities with marketplace or Medicaid coverage continue to be satisfied with their insurance.

For more information about this brief, please contact:

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BACKGROUND

Three years after the Affordable Care Act's major health insurance expansions went into effect, nearly 28 million people are estimated to have coverage either through the marketplaces or through Medicaid.[1] Yet there remains considerable controversy over how well these reforms are working for Americans.

The fourth Commonwealth Fund Affordable Care Act (ACA) Tracking Survey interviewed a nationally representative sample of 4,802 working-age adults, of whom 881 have new marketplace or Medicaid coverage under the health reform law, to find out how their insurance is affecting their lives (Table 1). The survey firm SSRS conducted the interviews between February 2 and April 5, 2016. In this issue brief, we examine

the law's effects on insurance coverage and how people are using their coverage to get health care. Upcoming briefs in this series will discuss the survey's findings on affordability and choice, as well as the reasons why millions of people remain uninsured.

SURVEY FINDINGS

12.7 Percent of U.S. Working-Age Adults Are Uninsured

The survey found that the percentage of adults who were uninsured as of February–April 2016 is significantly below 2013 and 2014 levels, though coverage gains were smaller. The uninsured rate for adults ages 19 to 64 was 12.7 percent in February–April 2016, compared with 13.3 percent in March–May 2015, 14.8 percent in April–June 2014, and 19.9 percent in July–September 2013 (Exhibit 1). The 2016 rate is not statistically different from the 2015 rate.[2] This represents an estimated decline of 13 million uninsured adults since the law's major coverage reforms have taken effect in 2013. These changes are within the range of estimates reported by other recent surveys (see Appendix).

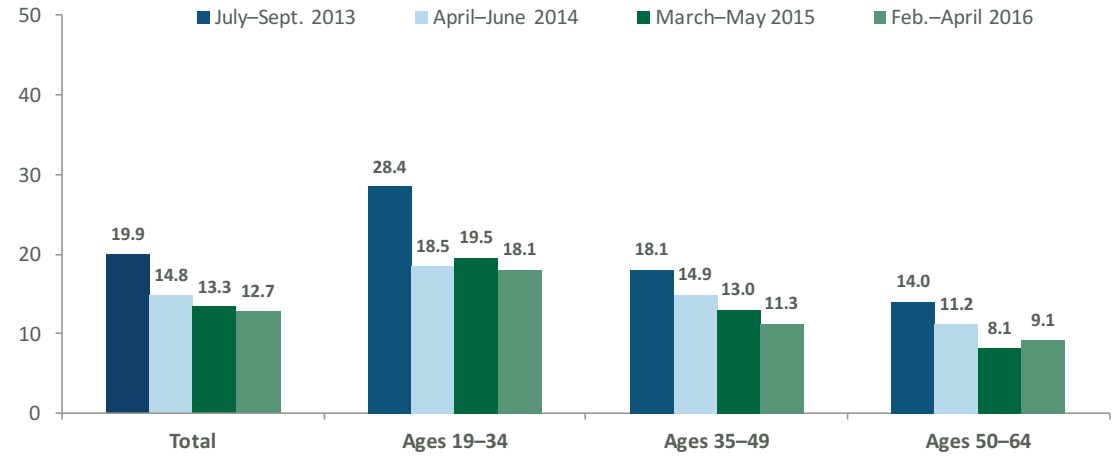
Gains in coverage differ across age and income groups. The steady decline in uninsured rates continues for adults ages 35 to 49.[3] Meanwhile, the uninsured rate for adults 19 to 34 remains at about the same level it was after the sharp drop in 2014. Older adults ages 50 to 64 continue to have the lowest uninsured rates of any age group, but the rate for 2016 is statistically unchanged.

People with low and moderate incomes—the population targeted in particular by the ACA's reforms—had the highest uninsured rates prior to the law's enactment and subsequently have experienced the greatest gains in coverage by far (Exhibit 2). But after declining steeply in 2014, uninsured rates for adults with incomes below 138 percent of the federal poverty level ($16,243 for an

Exhibit 1

After The End of the Affordable Care Act's Third Open Enrollment Period, the Percentage of Uninsured U.S. Adults Was 12.7 Percent

Percent of adults ages 19–64 uninsured

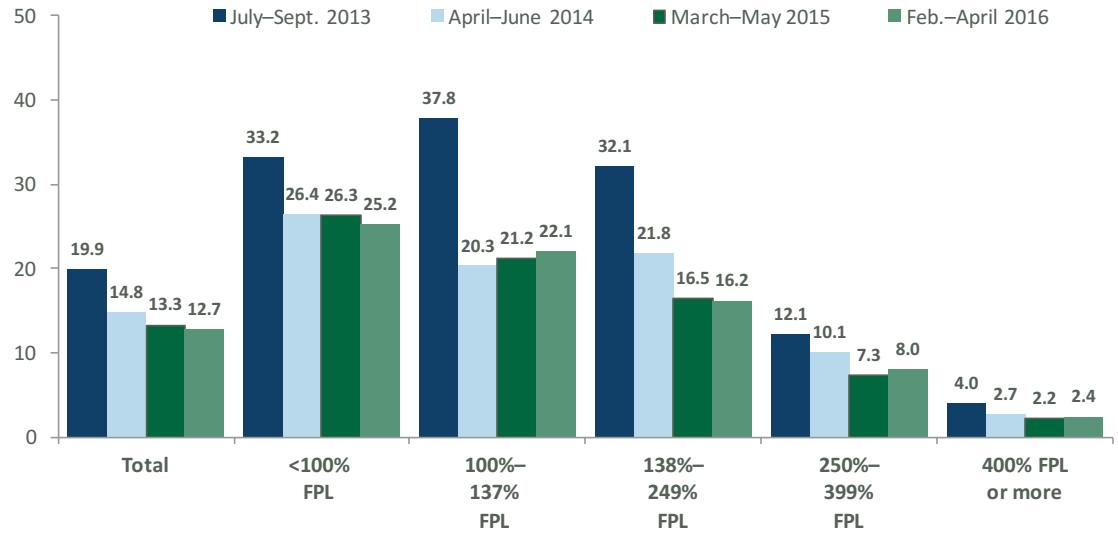


Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013, April–June 2014, March–May 2015, and Feb.–April 2016.

Exhibit 2

Uninsured Rates Among Low-Income Adults Have Fallen the Most But Remain Substantially Higher Than Those for Adults with Higher Incomes

Percent of adults ages 19–64 uninsured



Note: FPL refers to federal poverty level.

Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013, April–June 2014, March–May 2015, and Feb.–April 2016.

individual and $33,465 for a family of four) have remained about the same. Similarly, uninsured rates for those with incomes between 138 percent and 249 percent of poverty ($29,425 for an individual and $60,625 for a family of four) had fallen by half by 2015 but remain nearly the same this year. Consequently, low- and moderate-income adults are uninsured at rates as much as 10 times higher as those for adults with higher incomes.

Marketplace Plans and Medicaid Are Ending Long Bouts Without Insurance and Bridging Gaps

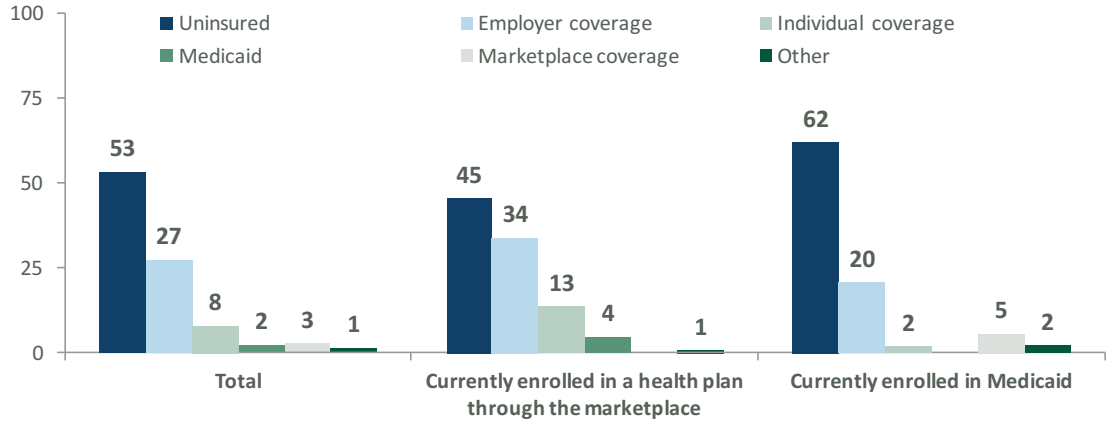
Our survey findings suggest that the overall growth in marketplace and Medicaid coverage has not resulted from Americans leaving their employer-based plans but from people who previously lacked health insurance now able to get coverage. The share of adults enrolled in employer plans has remained relatively stable, falling from 56 percent in 2013 to 53 percent in 2016 (data not shown). Consistent with this, we find that 45 percent of adults enrolled in marketplace plans and 62 percent of adults newly covered by Medicaid were uninsured before they enrolled (Exhibit 3). Of this group, 59 percent with a marketplace plan and 49 percent with Medicaid had been without insurance for a more than two years (Exhibit 4).

But the survey findings also suggest that the marketplaces and Medicaid may be helping to bridge coverage gaps when people lose employer-based health insurance. One-third (34%) of marketplace enrollees said they had had employer coverage prior to getting their current coverage. Among surveyed adults with employer coverage for less than a year, 7 percent reported that they had marketplace coverage prior to enrolling in their employer plan and 11 percent had been enrolled in Medicaid (Exhibit 5).[4]

Exhibit 3

Nearly Half of Adults in Marketplace Plans and Three of Five Adults Enrolled in Medicaid Were Uninsured Before Getting Their New Insurance

What type of health insurance did you have prior to getting your marketplace or Medicaid coverage?



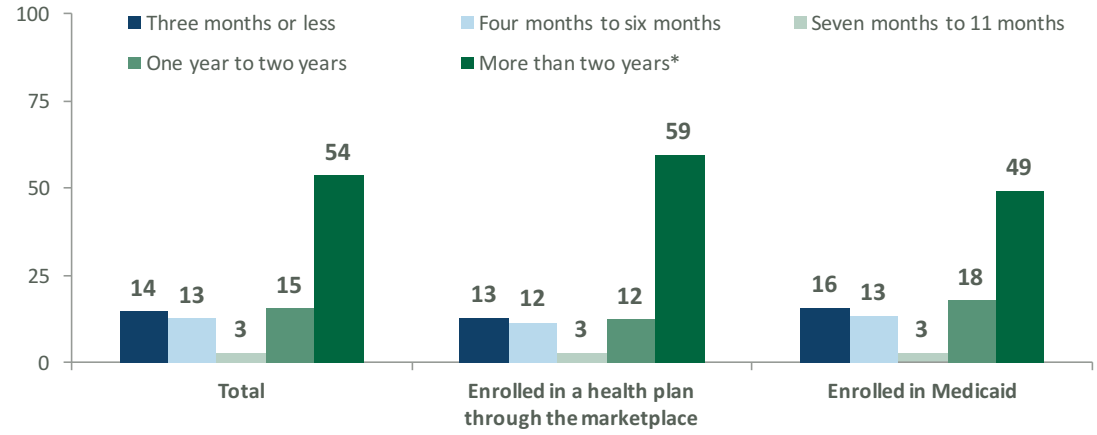
Percent of adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid for less than three years

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

Exhibit 4

Over Half of Adults Who Were Uninsured Before Getting Their New Coverage Had Been Uninsured for More Than Two Years

At the time you got your marketplace or Medicaid coverage, how long had you been uninsured?



Percent of adults ages 19–64 who were uninsured before gaining their Medicaid or marketplace coverage

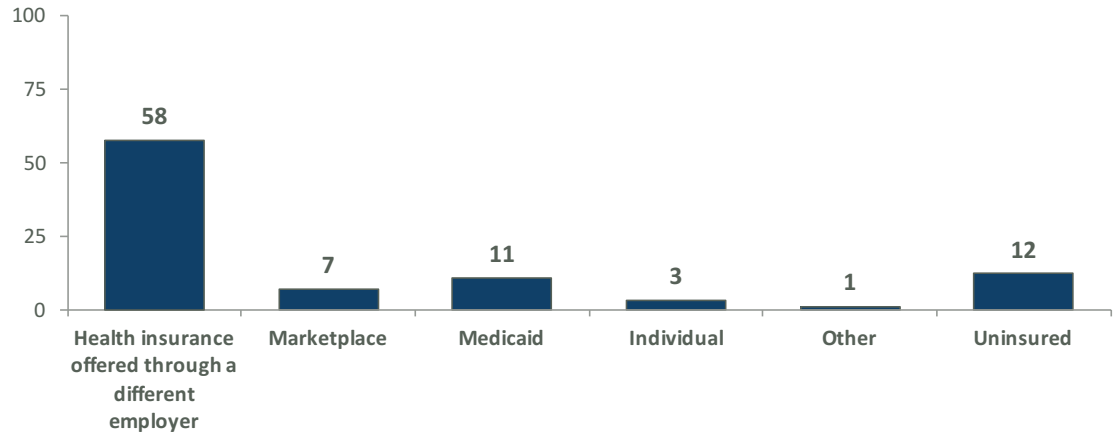
* Includes those who reported never having had insurance.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

Exhibit 5

Seven Percent of Adults Who Had Employer Insurance for Less Than a Year Previously Had Insurance Through the Marketplaces

Why type of health insurance did you have prior to getting health insurance through your current employer?



Percent of adults ages 19–64 who have had employer insurance for less than a year

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

Most Marketplace and Medicaid Enrollees Continue to Be Satisfied with Their Coverage

In each of the three years since the ACA's major coverage expansions, majorities of marketplace and new Medicaid enrollees have reported that they are satisfied with their new health insurance overall. In 2016, 77 percent of adults with marketplace plans and 88 percent of those newly enrolled in Medicaid were very or somewhat satisfied with their health insurance (Exhibit 6). And when asked to rate their insurance, 66 percent of marketplace enrollees and 77 percent of new Medicaid enrollees said their coverage was good, very good, or excellent (Exhibit 7).

Marketplace Plans and Medicaid Are Enabling People to Get Health Care

To provide people with the means to get the health care they need, insurance must come with reasonable levels of cost-sharing and adequate provider networks. The survey findings suggest that for the majority of those insured through the marketplaces or Medicaid, their new coverage appears to be facilitating access to care.

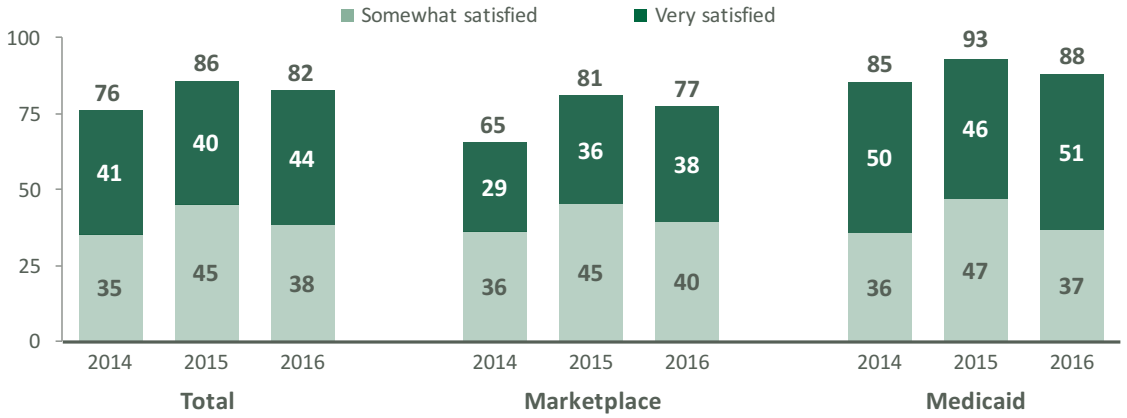
Seven of 10 adults (72%) enrolled in a marketplace plan or newly enrolled in Medicaid said they had used their coverage to go to a doctor, hospital, or other health care provider or to fill a prescription (data not shown). Of this group, 61 percent said they would not have been able to access or afford this care prior to getting their new coverage (Exhibit 8). People enrolled in Medicaid, those previously uninsured, and those with low incomes were the most likely to say they could not have accessed or afforded this care before.

But even individuals who were previously insured noted improvement: 48 percent of these adults said they would not have been able to access or afford this care before getting their new insurance.

Exhibit 6

Most Adults with Marketplace or Medicaid Coverage Continue to Be Satisfied with It

Overall, how satisfied are you with your health insurance?



*Percent of adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid since expansion**

* For 2014 we included adults who had Medicaid for less than one year, for 2015 we included adults who had Medicaid for less than two years, and for 2016 we include adults who have had Medicaid for less than three years.

Note: Segments may not sum to indicated total because of rounding.

Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, April–June 2014, March–May 2015, and Feb.–April 2016.

Exhibit 7

Most Adults with Marketplace or Medicaid Coverage Continue to Rate It Highly

Now thinking about your health insurance coverage, how would you rate it?

*Percent of adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid since expansion**

* For 2014 we included adults who had Medicaid for less than one year, for 2015 we included adults who had Medicaid for less than two years, and for 2016 we include adults who have had Medicaid for less than three years.

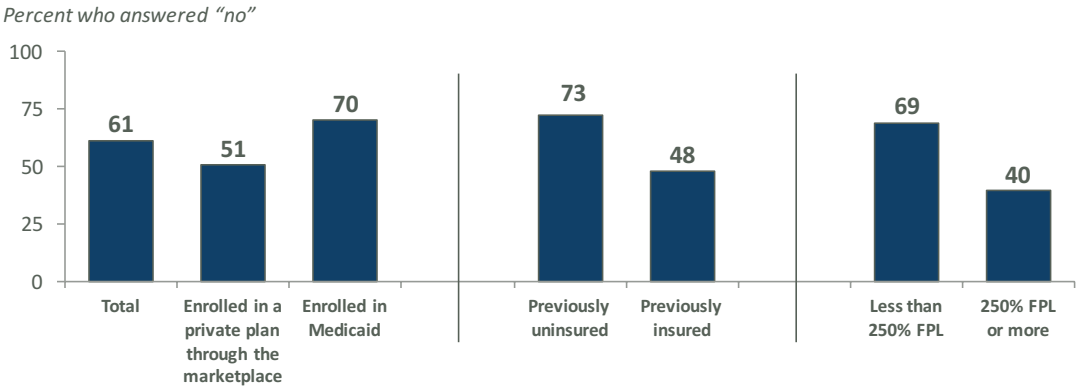
Note: Segments may not sum to indicated total because of rounding.

Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, April–June 2014, March–May 2015, and Feb.–April 2016.

Exhibit 8

Three of Five Adults with Marketplace or Medicaid Coverage Who Had Used Their Plan Said They Would Not Have Been Able to Access or Afford This Care Before

Prior to getting your Medicaid or health coverage through the marketplace, would you have been able to access and/or afford this care?



*Adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid for less than three years and have used their new health insurance plan**

* 72% of adults ages 19 to 64 who are currently enrolled in marketplace coverage or with Medicaid for less than three years reported they had used their coverage to visit adoctor, hospital, or other health care provider, or to pay for prescription drugs.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

According to the survey, three-quarters (73%) of marketplace enrollees and 93 percent of Medicaid enrollees who have had coverage for two months or less said their ability to get health care had improved or stayed the same since getting their insurance (Exhibit 9). However, about 11 percent of those with new marketplace coverage and 4 percent of those with new Medicaid coverage said their ability to obtain care had gotten worse.

Experiences Finding Doctors and Getting Appointments Similar to Those of Insured Americans as a Whole

From the outset, certain characteristics intrinsic to the ACA's coverage options have increased the likelihood that enrollees would have trouble finding doctors and getting appointments in a timely fashion. The law's designation of the second-lowest-cost silver plan in the marketplaces as the benchmark for determining premium subsidies, and limits on cost-sharing, have incentivized insurers to use narrow provider networks to drive down premiums.[5] In addition, Medicaid's historically low provider reimbursement rates compared with commercial plans' limit provider participation in the program.

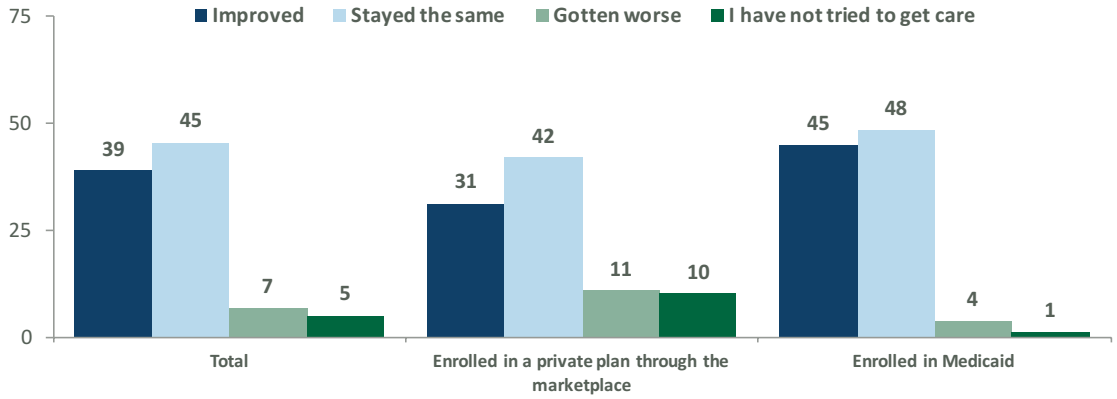
Yet over the three years of the insurance expansions, our ACA Tracking Survey has found that the experience of marketplace and Medicaid enrollees in finding doctors and getting appointments is similar to that reported by insured Americans as a whole.

Access to primary care doctors. In 2016, one-quarter of marketplace or new Medicaid enrollees had tried to find a new primary care or general doctor since getting their insurance (data not shown). Of those, 58 percent said it was somewhat or very easy to find one (Exhibit 10). That is similar to the rate for insured adults overall reported in other surveys.[6]

Exhibit 9

Eight of Ten Adults with New Coverage Said Their Ability to Get Health Care Has Improved or Stayed the Same

Since obtaining Medicaid or health coverage through the marketplace, would you say your ability to get the health care that you need has improved, stayed the same, or gotten worse?



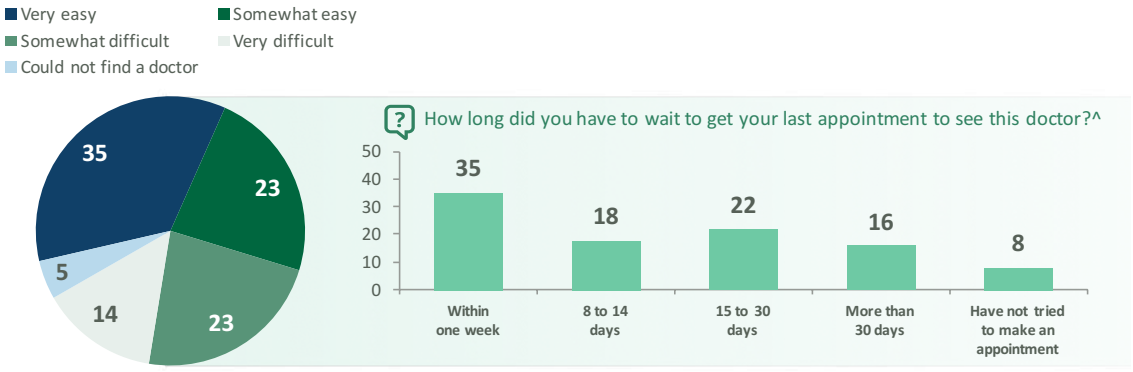
Percent of adults ages 19–64 who have had a private plan through the marketplace or Medicaid for two months or less

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Exhibit 10

Three of Five Adults with Medicaid or Marketplace Coverage Who Tried to Find a New Primary Care Doctor Found It Very or Somewhat Easy to Do So and More Than Half Waited Two Weeks or Less to See Them

How easy or difficult was it for you to find a new primary care doctor or general doctor?



*Percent of adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid for less than three years and tried to find a primary care doctor or general doctor since getting new coverage**

* 25% of adults ages 19 to 64 who are currently enrolled in marketplace coverage or with Medicaid for less than three years tried to find a primary care or general doctor. Among those who found a primary care doctor.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

Likewise, 53 percent of the combined sample of marketplace and new Medicaid enrollees who found a new primary care doctor were able to get an appointment with that doctor within two weeks the last time they tried (Exhibit 10).[7] Again, this is similar to wait times reported by insured adults overall.[8]

Access to specialists. Wait times for specialists were also similar to rates found for other insured adults.[9] Two of five (41%) marketplace and new Medicaid enrollees needed to see a specialist during the time they had had their coverage (data not shown). Of those, 60 percent were able to secure an appointment within two weeks (Exhibit 11).[10]

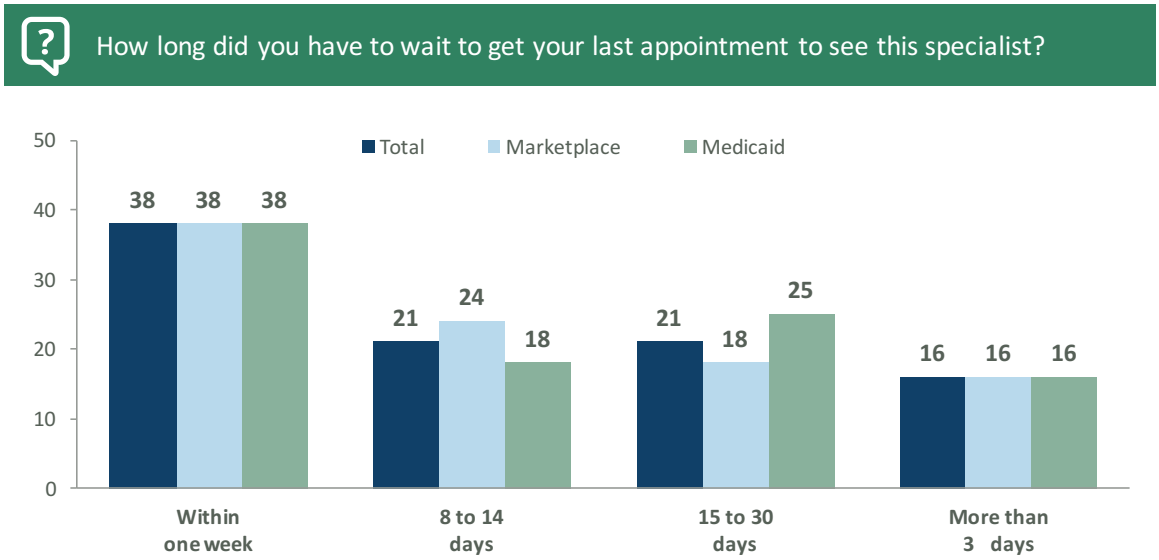
CONCLUSION AND POLICY IMPLICATIONS

After falling sharply in 2014 upon rollout of the ACA's major coverage expansions, the uninsured rate for U.S. working-age adults has been declining at a slower pace. The chasm in insurance coverage between lower- and higher-income adults remains troubling. We will explore the possible reasons for this in a forthcoming brief.

In each year since the coverage expansions, our survey findings have indicated that overall enrollment has been propelled by people who were previously uninsured—a year or longer for the vast majority. Consistent with other national surveys and Congressional Budget Office analyses, enrollment has not been driven by people shifting out of employer coverage: the share of adults insured through an employer has declined only slightly since 2013.[11] The survey findings do suggest that for people who lose their job-based health benefits, the expanded insurance options may be helping to bridge the coverage gap.

Exhibit 11

Three of Five Adults with Medicaid or Marketplace Coverage Who Needed to See a Specialist Waited Two Weeks or Less



*Percent of adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid for less than three years and needed to see a specialist**

* 41% of adults ages 19 to 64 who are currently enrolled in marketplace coverage or with Medicaid for less than three years needed to see a specialist doctor.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

The improvements in access to care found in the survey demonstrate that the ACA's coverage options have filled gaps in coverage and care for millions of adults (Table 1). Majorities of enrollees are using their plans to get care they could not have afforded before. And a majority of recent enrollees indicate their ability to get care since obtaining their coverage has improved or stayed the same. Moreover, their ability to find doctors and get appointments is similar to that of insured Americans overall.

All these findings may explain why majorities of enrollees give their health plans high ratings. If the fundamental purpose of health insurance is to provide people with adequate access to needed health care, then it would seem that, on balance, the Affordable Care Act's coverage expansions are working well for most of the people who have enrolled in them.

Table 1. Demographics of Overall Sample, Uninsured Adults, and Marketplace and Medicaid Enrollees

	Total adults (% ages 19–64)	Uninsured adults (%)	Total current marketplace and Medicaid enrollees[a] (% ages 19–64)	Enrolled in a private health plan through the marketplace (%)	Enrolled in Medicaid[b] (%)
Unweighted n	4,802	642	881	432	446
Prior coverage status					
Uninsured	–	–	53	45	62
Insured	–	–	45	54	36
Age					
19–34	34	48	39	32	46
35–49	32	28	30	28	32
50–64	32	23	30	37	22
Race/Ethnicity					
Non-Hispanic White	61	41	55	60	50
Black	13	12	15	14	16
Latino	17	40	23	21	25
Asian/Pacific Islander	5	3	3	2	4
Other/Mixed	2	2	3	1	4
Poverty status					
Below 138% poverty	30	57	48	27	69
138%–249% poverty	20	26	25	32	18
250%–399% poverty	18	11	15	22	8
400% poverty or more	32	6	12	19	5

	Total adults (% ages 19–64)	Uninsured adults (%)	Total current marketplace and Medicaid enrollees[a] (% ages 19–64)	Enrolled in a private health plan through the marketplace (%)	Enrolled in Medicaid[b] (%)
Health status					
Fair/Poor health status, or any chronic condition or disability[c]	52	53	54	48	60
No health problem	48	47	46	52	40
Political affiliation					
Democrat	29	23	33	34	31
Republican	19	12	16	20	13
Independent	24	22	23	23	24
Something else	17	22	16	14	17
State Medicaid expansion decision[d]					
Expanded Medicaid	59	48	65	52	80
Did not expand Medicaid	41	51	35	48	20
Marketplace type[e]					
State-based marketplace	33	27	42	31	53
Federally facilitated marketplace	67	72	58	69	47
Adult work status					
Full-time	53	37	36	43	29
Part-time	14	19	24	25	23
Not working	33	43	39	32	47
Employer size[f]					
1–24 employees	26	57	40	49	29
25–99 employees	14	18	18	18	17
100–499 employees	14	8	12	11	13
500 or more employees	43	14	25	18	33

[a] The number of people in the "Enrolled in a private health plan through the marketplace" and the "Enrolled in Medicaid" columns do not sum to the number in "Total current marketplace and Medicaid enrollees" column because some adults are not sure whether they are enrolled in Medicaid or private coverage.

[b] Includes those who signed up for Medicaid through the marketplace and those who have been enrolled in Medicaid for less than three years.

[c] At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

[d] The following states expanding their Medicaid program and began enrolling individuals in February 2016 or earlier: AK, AR, AZ, CA, CO, CT, DE, HI, IA, IN, IL, KY, MA, MD, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, WV, and the District of Columbia. All other states were considered to have not expanded.

[e] The following states have state-based marketplaces: CA, CO, CT, ID, KY, MA, MD, MN, NY, RI, VT, WA, and the District of Columbia. All other states–including HI, NM, NV, and OR, which operate their own marketplaces but use HealthCare.gov for enrollment–are considered to have federally facilitated marketplaces.

[f] Base: full- and part-time employed adults ages 19–64.

– Not applicable.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

APPENDIX. COMPARISON OF UNINSURED ESTIMATES FROM RECENT SURVEYS

Several health policy research organizations and federal agencies have conducted surveys to capture the change in coverage since implementation of the Affordable Care Act. Each of these surveys uses slightly different methods, but they all were conducted over similar periods, with a baseline survey measuring the uninsured rate prior to implementation of the health reform law's major coverage provisions and follow-up surveys once implementation began. Although the surveys have produced slightly different estimates, they are directionally the same, showing a significant decline in the rate and number of uninsured adults in the United States.

Survey Estimates of Changes in U.S. Uninsured Rates Since 2013

Survey	Pre-implementation uninsured rate (%) [95% CI]	Post-implementation uninsured rate (%) [95% CI]	Change in millions [95% CI]
The Commonwealth Fund Affordable Care Act Tracking Survey	19.9% [18.5%–21.4%]	12.7% [11.5%–14.0%]	13.0 million [7.8 million–18.3 million]
Gallup Healthways Well-Being Index[1,2]	20.7%	13.1%	–
ASPE Analysis of Gallup-Healthways Well-Being Index[3]	20.3%	11.5%	20 million
Urban Institute Health Reform Monitoring Survey[4]	17.6%	10.4%	14.3 million [10.8 million, 17.8 million]
RAND Health Reform Opinion Survey[5]	–	–	16.6 million
National Health Interview Survey[6]	20.4%	12.8%	14.5 million

Notes: Confidence intervals are shown where they were reported out by the organization; ASPE estimates adjust for age, race, ethnic group, sex, employment status, state of residence, and time trends.

– Percent estimates were not reported.

[1] K. Finegold and M. Z. Gunja, *Survey Data on Health Insurance Coverage for 2013 and 2014*, ASPE issue brief (Office of the Assistant Secretary for Planning and Evaluation, Oct. 31, 2014).

[2] N. Uberoi, K. Finegold, and E. Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016* (Office of the Assistant Secretary for Planning and Evaluation, March 3, 2016).

[3] Ibid.

[4] M. Karpman and S. K. Long, "QuickTake–Taking Stock: Gains in Health Insurance Coverage Under the ACA Continue as of September 2015, But Many Remain Uninsured" (Urban Institute Health Policy Center, Nov. 4, 2015).

[5] K. G. Carman and C. Eibner, "Insurance Enrollment Holds Steady in Advance of the 2016 Open Enrollment Period," *The RAND Blog,* Nov. 12, 2015.

[6] M. E. Martinez, R. A. Cohen, and E. P. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2015* (National Center for Health Statistics, Feb. 2016).

Methodological Differences Between Private Surveys

Survey	Population	Time frame	Sample frame	Response rate
The Commonwealth Fund Affordable Care Act Tracking Survey	U.S. adults ages 19–64	July–Sept. 2013 to February–April 2016	Dual-frame, RDD telephone survey	2013: 20.1% 2016: 13.9%
Gallup-Healthways Well-Being Index[1,2]	U.S. adults ages 18–64	2013 to January–March 2016	Dual-frame, RDD telephone survey	5%–10%
ASPE Analysis of Gallup-Healthways Well-Being Index[3]	U.S. adults ages 18–64	January 2012–Oct. 2013 to January–March 2016	Dual-frame, RDD telephone survey	5%–10%
Urban Institute Health Reform Monitoring Survey[4]	U.S. adults ages 18–64	Sept. 2013 to Sept. 2015	KnowledgePanel-probability-based internet panel of 55,000 households	Approximately 5% each quarter
RAND Health Reform Opinion Survey[5]	U.S. adults ages 18–64	Sept. 2013 to August 2015	American Life Panel-internet panel of 5,500 adults	9%
National Health Interview Survey[6]	U.S. adults ages 18–64	2013 to 2015	Multistage area probability design	80%

Notes: Information for this table was gathered from survey data releases and from an Urban Institute report comparing surveys; see: M. Karpman, S. K. Long, and M. Huntress, *Nonfederal Surveys Fill a Gap in Data on ACA* (Urban Institute, March 13, 2015).

[1] K. Finegold and M. Z. Gunja, *Survey Data on Health Insurance Coverage for 2013 and 2014*, ASPE issue brief (Office of the Assistant Secretary for Planning and Evaluation, Oct. 31, 2014).

[2] N. Uberoi, K. Finegold, and E. Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016* (Office of the Assistant Secretary for Planning and Evaluation, March 3, 2016).

[3] Ibid. All models adjust for age, sex, race, ethnicity, employment, state of residence, marital status, rural location, and a linear time trend.

[4] M. Karpman and S. K. Long, "QuickTake–Taking Stock: Gains in Health Insurance Coverage Under the ACA Continue as of September 2015, But Many Remain Uninsured" (Urban Institute Health Policy Center, Nov. 4, 2015).

[5] K. G. Carman and C. Eibner, "Insurance Enrollment Holds Steady in Advance of the 2016 Open Enrollment Period," *The RAND Blog,* Nov. 12, 2015.

[6] M. E. Martinez, R. A. Cohen, and E. P. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2015* (National Center for Health Statistics, Feb. 2016).

HOW THIS SURVEY WAS CONDUCTED

The Commonwealth Fund Affordable Care Act (ACA) Tracking Survey, February–April 2016, was conducted by SSRS from February 2 to April 5, 2016. The survey consisted of 15-minute telephone interviews in English or Spanish, conducted among a random, nationally representative sample of 4,802 adults ages 19 to 64 living in the United States. Overall, 1,496 interviews were conducted on landline telephones and 3,306 interviews on cell phones.

This survey is the fourth in a series of Commonwealth Fund surveys to track the implementation and impact of the ACA. The first was conducted by SSRS from July 15 to September 8, 2013, by telephone among a random, nationally representative U.S. sample of 6,132 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 1.8 percentage points at the 95 percent confidence level.

The second survey in the series was conducted by SSRS from April 9 to June 2, 2014, by telephone among a random, nationally representative U.S. sample of 4,425 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 2.1 percentage points at the 95 percent confidence level. The sample for the April–June 2014 survey was designed to increase the likelihood of surveying respondents who were most likely eligible for new coverage options under the ACA. As such, respondents in the July–September 2013 survey who said they were uninsured or had individual coverage were asked if they could be recontacted for the April–June 2014 survey. SSRS also recontacted households reached through their omnibus survey of adults who were uninsured or had individual coverage prior to the first open enrollment period for 2014 marketplace coverage.

This third survey in the series was conducted by SSRS from March 9 to May 3, 2015, by telephone among a random, nationally representative U.S. sample of 4,881 adults ages 19 to 64. The March–May 2015 sample also was designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. SSRS recontacted households reached through their omnibus survey of adults between November 5, 2014, and February 1, 2015, who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. The survey had an overall margin of sampling error of +/– 2.1 percentage points at the 95 percent confidence level.

The February–April 2016 sample also was designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. Interviews in wave 4 were obtained through two sources: stratified random-digit-dialing sample, using the same methodology as in waves 1, 2 and 3; and households reached through the SSRS omnibus survey, where interviews were previously completed with respondents ages 19 to 64 who were uninsured, had individual coverage, had a marketplace plan, or had public insurance.

As in all waves of the survey, SSRS oversampled adults with incomes under 250 percent of poverty to further increase the likelihood of surveying respondents eligible for the coverage options as well as allow separate analyses of responses of low-income households.

The data are weighted to correct for the stratified sample design, the use of recontacted respondents from the omnibus survey, the overlapping landline and cell phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. 19-to-64 adult population by age, gender, race/ethnicity, education, household size, geographic division, and population density using the U.S. Census Bureau's 2014 American Community Survey, and weighted by household telephone use using the U.S. Centers for Disease Control and Prevention's 2014 National Health Interview Survey.

The resulting weighted sample is representative of the approximately 189 million U.S. adults ages 19 to 64. Data for income, and subsequently for federal poverty level, were imputed for cases with missing data, utilizing a standard regression imputation procedure. The survey has an overall margin of sampling error of +/– 2.0 percentage points at the 95 percent confidence level. The land-line portion of the main-sample survey achieved a 22.6 percent response rate and the cellular phone main-sample component achieved a 13.9 percent response rate. The overall response rate, including the prescreened sample, was 13.9 percent.

NOTES

[1] By the end of The Affordable Care Act's third open enrollment period, marketplace plan selections had climbed to 12.7 million people and 15 million more people were enrolled in Medicaid compared to three years earlier. Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report, For the Period: November 1, 2015–February 1, 2016,* ASPE Issue Brief (U.S. Department of Health and Human Services, March 11, 2016); Centers for Medicare and Medicaid Services, *Medicaid & CHIP: February 2016 Monthly Applications Eligibility Determinations and Enrollment Report* (CMS, April 29, 2016).

[2] The 2016 estimate is statistically different from both the 2014 and 2013 estimates.

[3] The uninsured rate of 11.3% for adults between the ages of 35 and 49 years in 2016 is statistically different from the uninsured rate of 14.9% for the same group in 2014 and 18.1% in 2013. The 2016 uninsured rate is not statistically different from the uninsured rate of 13.0% in 2015.

[4] We do not know, however, whether those adults who had Medicaid prior to gaining employer coverage were enrolled through the ACA coverage expansions.

[5] As Jon Gabel and colleagues point out, the law's metal tiers defined by actuarial value do not exist in the employer market and protect consumers from ever-higher cost-sharing that would inevitably result from greater price competition. See J. Gabel, M. Green, A. Hall et al., *Changes in Consumer Cost-Sharing for Health Plans Sold in the ACA's Insurance Marketplaces, 2015 to 2016* (The Commonwealth Fund, May 2016).

[6] In the Commonwealth Fund Biennial Health Insurance Survey, 2014: among adults who were insured all year and had tried to find a primary care provider, 57 percent said it was somewhat or very easy to find one (unpublished data).

[7] Sample size limitations prevented the reporting of results by coverage source.

[8] In the Commonwealth Fund Biennial Health Insurance Survey, 2014: among adults who were insured all year, 56 percent of those who found a new primary care doctor got an appointment within two weeks (unpublished data). Similarly, a 2011 Commonwealth Fund survey of 19-to-64-year-old adults found that among those insured all year who had tried to find a primary care physician in the past three years (either respondent or spouse/partner), 57 percent got an appointment within two weeks, including 35 percent who got an appointment within 1 week and 22 percent within one to two weeks. See S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *The Income Divide in Health Care: How the Affordable Care Act Will Help Restore Fairness to the U.S. Health System* (The Commonwealth Fund, Feb. 2012).

[9] According to the 2013 Commonwealth Fund International Health Policy Survey, among continuously insured adults ages 18 to 64, 42 percent of U.S. adults who needed to see a specialist reported that they were able to get an appointment in one week or less (unpublished data).

[10] Differences in reported wait times between marketplace and new Medicaid enrollees are not significant.

[11] Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (Washington, D.C.: CBO, March 2016).

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MAY 2016

Changes in Consumer Cost-Sharing for Health Plans Sold in the ACA's Insurance Marketplaces, 2015 to 2016

Jon Gabel, Matthew Green, Adrienne Call, Heidi Whitmore, Sam Stromberg, and Rebecca Oran

Abstract This brief examines changes in consumer health plan cost-sharing—deductibles, copayments, coinsurance, and out-of-pocket limits—for coverage offered in the Affordable Care Act's marketplaces between 2015 and 2016. Three of seven measures studied rose moderately in 2016, an increase attributable in part to a shift in the mix of plans offered in the marketplaces, from plans with higher actuarial value (platinum and gold plans) to those that have less generous coverage (bronze and silver plans). Nearly 60 percent of enrollees in marketplace plans receive cost-sharing reductions as part of income-based assistance. For enrollees without cost-sharing reductions, average copayments, deductibles, and out-of-pocket limits remain considerably higher under bronze and silver plans than under employer-based plans; cost-sharing is similar in gold plans and employer plans. Marketplace plans are more likely than employer-based plans to impose a deductible for prescription drugs but no less likely to do so for primary care visits.

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BACKGROUND

Cost-sharing has been at the center of health care policy debates for the past five decades. Proponents argue that health insurance plans' deductibles, copayments, coinsurance, and out-of-pocket limits prevent overuse of services and provides an incentive to seek lower-cost care. Opponents assert that substantial cost-sharing constitutes rationing by income and that high deductibles reduce the use of both cost-effective and cost-ineffective services.

In the 1970s and 1980s, a study by the RAND Corporation showed that when deductibles were imposed for physician services and prescription drugs, their use declined substantially, but the reductions were similar for effective and ineffective services and drugs.[1] More recent data are generally consistent with these findings.[2]

We have reported that cost-sharing for individual and family plans obtained through the state and federal marketplaces established under the

Affordable Care Act remained largely unchanged from 2014 to 2015, as did premiums.[3] However, premiums increased, by an average of 6 percent, from 2015 to 2016.[4] To determine whether cost-sharing under marketplace plans also increased over the last year, we analyzed data from 49 states and Washington, D.C., in all plan tiers—platinum, gold, silver, and bronze.[5] We also analyzed cost-sharing for employer-based plans, since employers have turned to high-deductible plans as a major cost-control strategy since 2004.[6]

Data in this issue brief are for all marketplace plans. But we excluded silver-level plans with cost-sharing reductions that are available for people with lower incomes.[7] Because enrollment data for purchased plans are not available, our data are for plans that are *offered* rather than purchased. For 2015 plans, data were collected from August to November of 2014. For the 2016 plan year, data are from August through November of 2015.

For an explanation of the sampling and weighting methods that we used, see About This Study.

ENROLLMENT IN THE METAL TIERS

On September 30, 2015, silver plans accounted for 68 percent of enrollment, bronze plans 20 percent, gold plans 7 percent, platinum plans 4 percent, and catastrophic plans 1 percent. Some 57 percent of individuals and families had plans with cost-sharing reductions, 47 percent in states with their own marketplace and 59 percent in states that rely on the federal marketplace.[8] Estimates for 2016 federal marketplace enrollment are similar.[9]

At the time of the passage of the Affordable Care Act, the median "actuarial value" of health insurance–the proportion of enrollees' health care costs it covers–was 83 percent for an employer-based plan and 59 percent for an individual plan.[10,11] Thus, the typical employer plan was a gold plan, and the typical individual plan would not qualify to be sold in today's marketplaces.[12] Low-income individuals and families that purchase silver plans are eligible for cost-sharing reductions, such as reduced deductibles, copayments, coinsurance, and out-of-pocket limits, making the silver plan closer in value to a platinum or gold plan.[13,14]

FINDINGS

Trends in Cost-Sharing

Of the seven types of cost-sharing in the plans that we examined, one—copayments for generic drugs—decreased in 2016, by 3 percent (Exhibit 1). Three types of cost-sharing increased significantly: out-of-pocket limits increased by 7 percent, general annual deductibles by 10 percent, and copayments for nonpreferred drugs by 14 percent.[15] However, these overall figures may not reflect a given plan's year-to-year changes in cost-sharing, since changes in the available mix of plans—an increase in bronze and silver plans and a decline in gold and platinum plans—could also contribute to increases in average deductibles and out-of-pocket payments. (Our 2015 analysis and figures are available here.)

Deductibles

Actuaries often regard the presence and size of deductibles as the most important determinants of the share of health care expenses borne by enrollees. In 2016, the proportion of marketplace plans with a general annual deductible ranges from 40 percent of platinum plans to nearly 100 percent of bronze plans to (Exhibit 2); 81 percent of employer-based plans had general deductibles in 2015, the most recent year for which data are available.

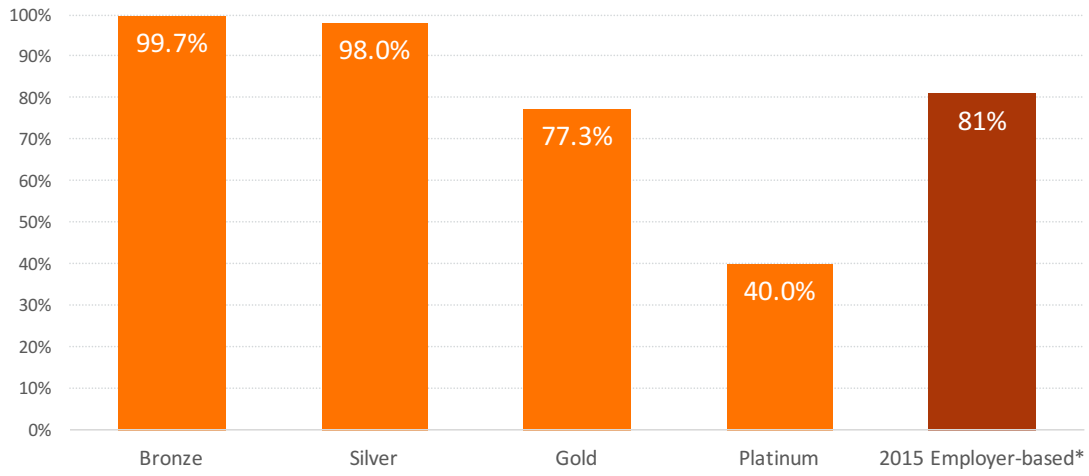
Exhibit 1. Average Change in Cost-Sharing Under Marketplace Plans, by Metal Tier, 2015–2016

	Marketplace plans				
	Bronze	Silver	Gold	Platinum	*All plans*
Out-of-pocket limit	2.7%*	6.4%*	8.1%	16.2%	*7.1%**
General annual deductible	10.4%*	5.0%	5.0%	-15.7%	*10.3%**
Copayment, primary care provider visit	10.2%	1.9%	-3.4%	-0.6%	*0.4%*
Copayment, specialty visit	26.1%*	1.7%	0.2%	8.4%	*4.9%*
Copayment, generic drugs	-3.7%	-2.3%	-6.9%	1.5%	*-3.2%*
Copayment, preferred-brand drugs	-1.9%	1.4%	9.4%	0.7%	*4.7%*
Copayment, non-preferred-brand drugs	16.0%*	11.6%*	7.8%	27.9%	*13.6%**

Note: * Significant at p<0.05.
Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015.

Exhibit 2

Percentage of Plans with General Annual Deductible, Marketplace and Employer-Based Plans, 2016



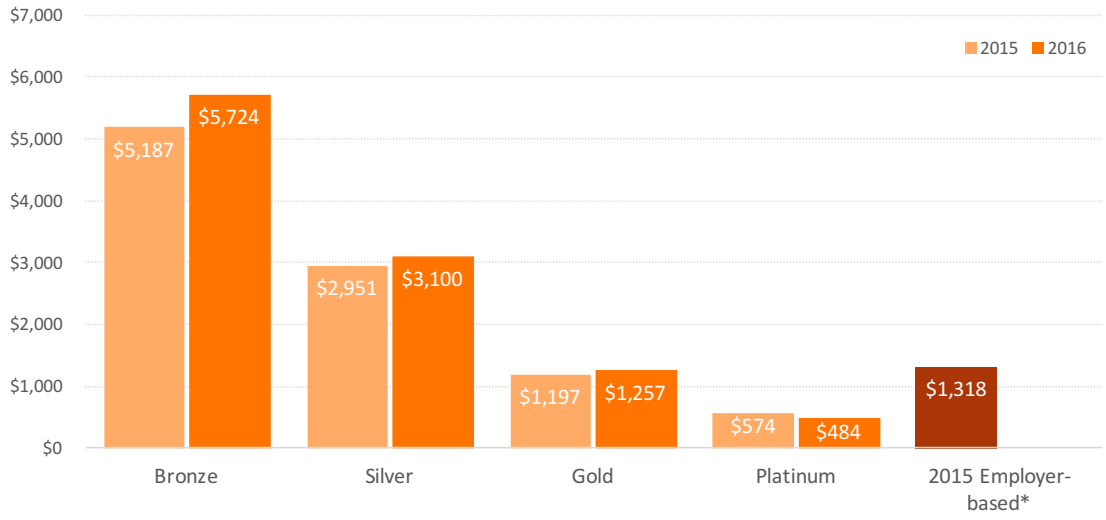
* Most recent employer survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplace, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey,* Sept. 2015.

Among 2016 marketplace plans with deductibles, the average deductible ranges from $484 for platinum plans to $5,724 for bronze plans (Exhibit 3). Employer-based plans had an average deductible of $1,318 in 2015. From 2015 to 2016, general deductibles increased by 10 percent for bronze plans and by 5 percent for silver and gold plans, whereas platinum plans had a 16 percent decrease in deductibles.

Exhibit 3

Average General Annual Deductible, in Plans with Deductibles, Marketplace and Employer-Based Plans, 2015–2016



* Most recent employer survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplace, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey,* Sept. 2015.

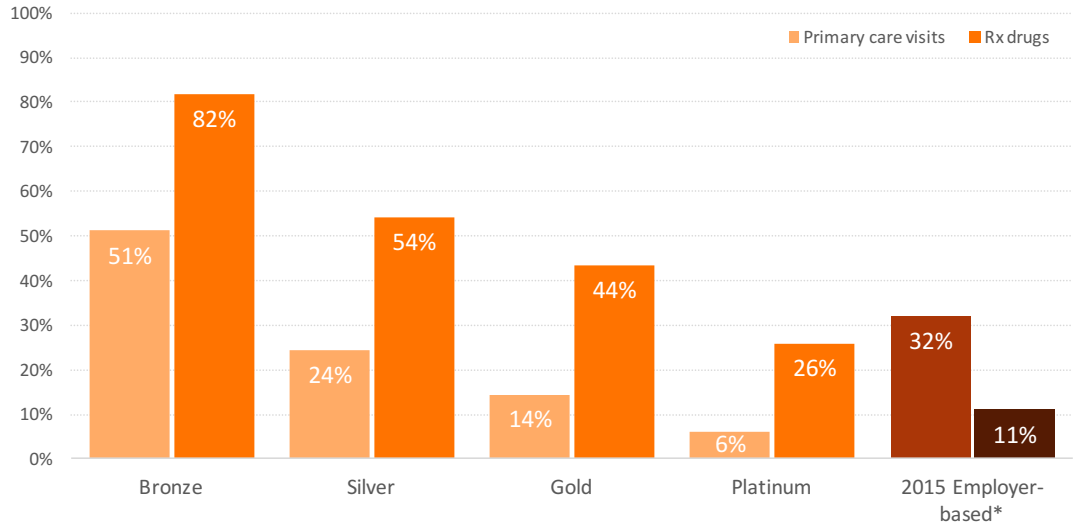
The plan mix also changed from 2015 to 2016, with the share of platinum and gold plans declining slightly and the share of silver and bronze plans increasingly slightly. Thus, the annual deductible changes within plan tiers, with the exception of bronze plans, are smaller than the overall deductible change of 10 percent, reflecting the market shift toward plans with higher deductibles.

Many plans sold through the marketplaces and provided by employers exclude certain services from the deductible. That is, enrollees do not have to first meet their deductible before their coverage kicks in.[16] The proportion of marketplace plans in the analysis that require that people first meet their deductible before coverage for primary care office visits begins ranges from 6 percent for platinum plans to 51 percent for bronze plans to (Exhibit 4). The corresponding proportion of 2015 employer-based plans was 32 percent.[17] In all tiers, the proportion of marketplace plans requiring a deductible for primary care office visits decreased from 2015 to 2016 (Exhibit 5). The decreases were largest for bronze plans and gold plans.

The proportion of plans requiring enrollees to meet their deductible prior to prescription drug coverage ranges from 26 percent for platinum plans to 82 percent for bronze plans (Exhibit 4), as compared with 11 percent for employer-based plans.[18] These percentages increased from 2015 to

Exhibit 4

Percentage of Plans Where the Beneficiary Must Meet a Deductible Before Primary Care Office Visits or Prescription Drugs Are Covered, Marketplace and Employer-Based Plans, 2016

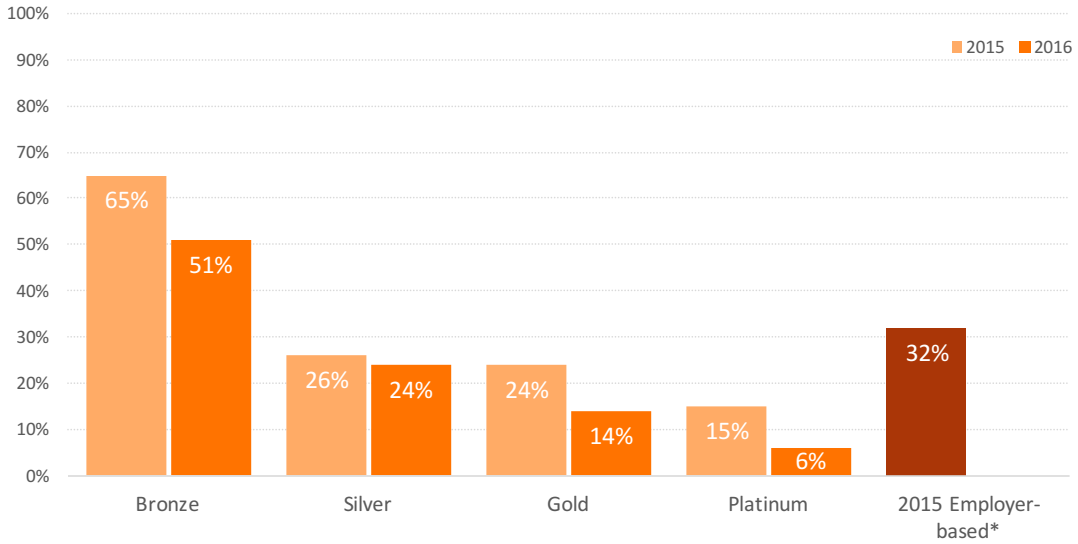


* Authors' calculations from Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey,* Sept. 2015. Most recent employer survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplace, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015.

Exhibit 5

Percentage of Plans Where the Beneficiary Must Meet a Deductible Before Primary Care Office Visits Are Covered, Marketplace and Employer-Based Plans, 2015–2016



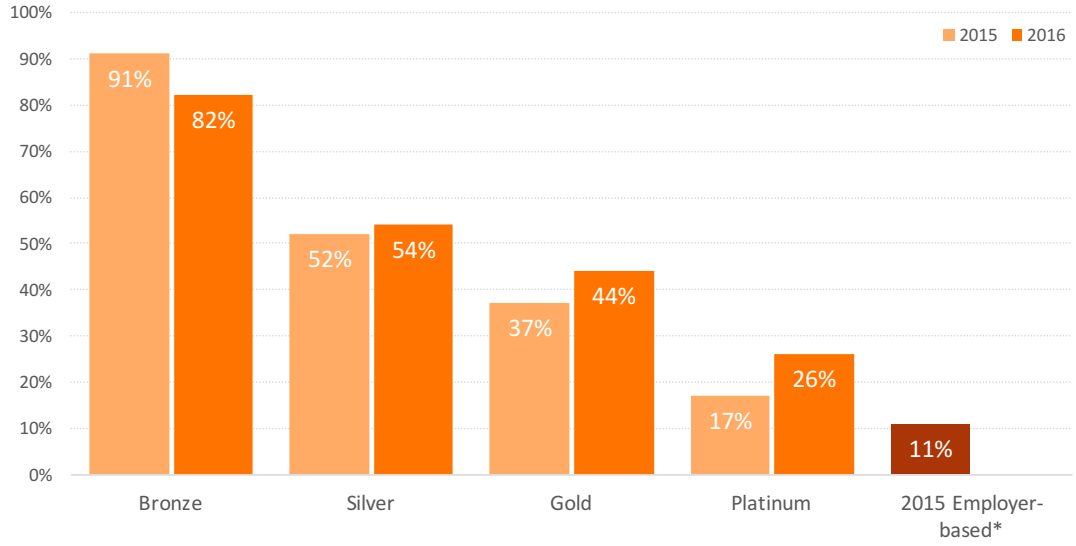
* Authors' calculations from Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey,* Sept. 2015. Most recent employer survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplace, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015.

2016 (Exhibit 6) for silver, gold, and platinum plans, with the largest increase in platinum plans. The proportion of bronze plans requiring a deductible for prescription drugs decreased by 10 percent.

Exhibit 6

Percentage of Plans Where the Beneficiary Must Meet a Deductible Before Prescription Drugs Are Covered, Marketplace and Employer-Based Plans, 2015–2016



* Authors' calculations from Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey,* Sept. 2015. Most recent employer survey data are from 2015.

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplace, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015.

Copayments and Coinsurance for Office Visits

Copayments require enrollees to pay a fixed fee (for instance, $25 for an office visit), regardless of the costs incurred during that visit. Coinsurance obligates enrollees to pay a percentage of the cost for an office visit, commonly around 20 percent under employer-based coverage.[19] With coinsurance, enrollees assume greater financial risk for the cost of care and therefore have a greater incentive to monitor that cost. With employer-based plans, declining enrollment in HMOs and a growing reliance on high deductibles, with options for tax-preferred savings to pay out-of-pocket medical expenses, have led to larger numbers of employees who are covered by plans requiring coinsurance rather than copayments for office visits.[20]

Under marketplace plans, copayments are the major vehicle for sharing the costs of office visits. The ratio of plans requiring copayments to plans requiring coinsurance for primary care visits is 4 to 1; for specialty care visits, the ratio is 3 to 1. The average copayment for primary care visits ranges from $17 under platinum plans to $43 with bronze coverage (Exhibit 7); the average copayment across plans is similar to the average for 2015 employer-based plans ($29 and $24, respectively).

Exhibit 7. Percentage of Plans Using Copayments or Coinsurance for Primary Care and Specialty Care Visits, and Average Copayment and Coinsurance, Marketplace and Employer-Based Plans, 2016

Cost-sharing type	Marketplace plans					Employer-based plans, 2015
	Bronze	Silver	Gold	Platinum	*All plans*	
Primary care						
Copayment	39.3%	76.7%	85.0%	95.0%	*67.5%*	68%
Coinsurance	25.5%	10.4%	8.0%	5.0%	*14.3%*	23%
Average copayment	$43.04	$30.97	$22.38	$17.13	*$28.68*	$24
Specialty care						
Copayment	29.0%	74.4%	85.0%	93.9%	*63.4%*	68%
Coinsurance	32.5%	14.8%	11.1%	6.1%	*19.3%*	24%
Average copayment	$83.81	$58.66	$45.31	$33.87	*$54.08*	$37

Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015.

Out-of-Pocket Limits

Out-of-pocket limits protect enrollees from catastrophic bills. From 2015 to 2016, the average out-of-pocket limit for all marketplace plans increased by 7 percent (Exhibit 8). The increase ranged from 3 percent for bronze plans to 16 percent for platinum plans. The average out-of-pocket limit for all marketplace plans was $5,819 in 2016. Out-of-pocket limits are capped at $6,850 for individual coverage (and $13,700 for family coverage) in 2016, representing a 4 percent increase from 2015.

Exhibit 8. Average Out-of-Pocket Limit and Percentage Change in Marketplace Plans, by Metal Tier, 2015 to 2016

	Marketplace plans				
Year	Bronze	Silver	Gold	Platinum	*All plans*
2015	$6375.80	$5865.84	$4634.20	$2346.52	*$5433.92*
2016	$6545.68	$6240.21	$5008.59	$2727.06	*$5819.45*
Change	2.7%	6.4%	8.1%	16.2%	*7.1%*

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015.

Copayments and Coinsurance for Prescription Drugs

Copayments are the predominant form of cost-sharing for generic drugs; for more expensive drugs, the use of copayments declines and the use of coinsurance increases. The proportions of plans that require copayments for drugs are 68 percent for generic drugs, 62 percent for preferred drug brands, 41 percent for nonpreferred brands, and 16 percent for specialty drugs (Exhibit 9).[21] The figures for employer-based plans in 2015 are 84 percent for generic drugs, 75 percent for preferred drug brands, 70 percent for nonpreferred brands, and 50 percent for fourth tier or specialty drugs.

The higher the plan tier, the greater the proportion of plans within the tier that require copayments rather than coinsurance for prescription drugs. Those proportions range from 35 percent for bronze plans to 94 percent for platinum plans (Exhibit 9). The average copayment increases with the price of the drugs, ranging from $12 for generic drugs to $252 for specialty drugs (Exhibit 10). The copayment generally falls as the actuarial value of the plan increases. For example, the average copayment for generic drugs is $18 for bronze plans, $13 for silver plans, $10 for gold plans, and $8 for platinum plans. Copayments are considerably lower under employer-based plans than under marketplace plans for all formulary tiers other than generic drugs.

Exhibit 9. Percentage of Plans Using Copayments and Coinsurance for Generic Drugs, Preferred Brands, Nonpreferred Brands, and Specialty Drugs, Marketplace and Employer-Based Plans, 2016

Cost-sharing type	Marketplace plans					Employer-based plans, 2015
	Bronze	Silver	Gold	Platinum	*All plans*	
Generic drugs						
Copayment	34.9%	81.7%	84.9%	94.0%	*68.4%*	84%
Coinsurance	31.7%	7.7%	5.0%	2.3%	*14.3%*	11%
Preferred brands						
Copayment	21.8%	77.2%	83.8%	91.9%	*62.3%*	75%
Coinsurance	41.5%	16.8%	12.8%	7.0%	*23.1%*	24%
Nonpreferred brands						
Copayment	11.9%	49.5%	58.6%	67.4%	*41.4%*	70%
Coinsurance	47.3%	34.8%	29.8%	31.4%	*36.7%*	26%
Specialty drugs						
Copayment	7.4%	17.1%	20.1%	31.0%	*15.8%*	*
Coinsurance	49.8%	65.2%	67.2%	65.9%	*60.4%*	*

* The Kaiser Family Foundation employer survey did not ask about specialty drugs separately in 2015.
Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015.

Exhibit 10. Average Copayment for Generic Drugs, Preferred Brands, Nonpreferred Brands, and Specialty Drugs, Marketplace and Employer-Based Plans, 2016

Cost-sharing type	Marketplace plans					Employer-based plans, 2015
	Bronze	Silver	Gold	Platinum	*All plans*	
Generic drugs	$18.32	$12.68	$10.24	$7.54	*$12.23*	$11
Preferred brands	$59.42	$48.22	$40.57	$25.59	*$44.72*	$31
Nonpreferred brands	$118.73	$93.46	$78.24	$60.06	*$87.07*	$54
Specialty drugs	$265.87	$269.99	$203.01	$202.60	*$252.38*	*

* The Kaiser Family Foundation employer survey did not ask about specialty drugs separately in 2015.
Sources: Qualified Health Plan Landscape Files for federally facilitated marketplaces, Nov. 2015; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2015; Henry J. Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey*, Sept. 2015.

BEHIND THE NUMBERS

For the more than 40 percent of marketplace enrollees who are not receiving cost-sharing reductions, cost-sharing rose moderately from 2015 to 2016. The changes were substantial in some cost-sharing categories and minimal in others. For example, out-of-pocket limits increased by 7 percent, copayments for nonpreferred drug brands rose sharply, and deductibles increased substantially for bronze plans. In contrast, copayments for primary care office visits were flat, copayments for generic drugs declined, and there was little change in the percentage of plans requiring a deductible for drugs and office visits. Hence, increases in cost-sharing, although substantial in some instances, were not of the magnitude depicted in the media.[22] Moreover, a portion of the overall increase in cost-sharing is a consequence of the increasing number of marketplace plans offered (rather than purchased) that are bronze or silver plans—the tiers with the lowest actuarial values.

Marketplace plans are considerably more likely than 2015 employer-based plans to impose a deductible for prescription-drug coverage (for example, 54 percent of silver plans vs. 11 percent of employer-based plans). However, the proportion of silver plans requiring a deductible for primary care office visits is similar to the proportion of employer-based plans. The increasing number of employers offering high-deductible plans with features such as health savings accounts or health reimbursement arrangements, which exempt fewer services on average, from deductibles,[23] contributes to this equivalency.

Some supporters of the Affordable Care Act view cost-sharing requirements for persons who are not eligible for cost-sharing reductions as a major area in need of reform.[24] A single person earning $30,000 a year (272 percent of the federal poverty level) and enrolled in a silver plan has an average deductible of approximately $3,000, or 10 percent of pretax income. Individuals spending more than 10 percent of their incomes on medical care or insurance are usually considered to be underinsured.[25]

As with premiums, future trends in cost-sharing will be linked to trends in medical care expenses. With rising expenses, insurers will need to increase deductibles, copayments, out-of-pocket limits, and other fixed-amount forms of cost-sharing to maintain a constant actuarial value (e.g., 0.7 for a silver plan). Coinsurance, in contrast, automatically stays in tandem with rising medical care expenses.

Future increases in cost-sharing under marketplace plans are likely to be smaller than cost-sharing increases in employer-based insurance, since the former, unlike the latter, are pegged to constant actuarial values. Over the past 15 years, there has been a shift in employer-based coverage from high-actuarial-value HMO and point-of-service plans to lower-value plans with high deductibles. From 2014 to 2015, the average deductible in employer-based coverage (including plans with and those without deductibles) increased by approximately 9 percent. Since 2005, the average deductible for this same group of plans grew from approximately $266 to $1,068, an average annual increase of 15 percent per year.[26]

What is clear from the RAND experiment and other research is that increased cost-sharing will reduce the use of both appropriate and inappropriate services.

NOTES

1 J. P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Harvard University Press, 1993).

2 S. R. Collins, P. W. Rasmussen, S. Beutel, and M. M. Doty, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey* (The Commonwealth Fund, May 2015); and A. Chandra, J. Gruber, and R. McKnight, "The Impact of Patient Cost-Sharing in Low-Income Populations: Evidence from Massachusetts," *Journal of Health Economics,* Jan. 2014 33:57–66.

3 J. Gabel, H. Whitmore, S. Stromberg et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," *The Commonwealth Fund Blog,* Dec. 22, 2014.

4 J. Gabel, H. Whitmore, A. Call et al., "Modest Changes in 2016 Health Insurance Marketplace Premiums and Insurer Participation," *The Commonwealth Fund Blog,* Jan. 28, 2016.

5 New York is not included because data were unavailable.

6 K. Davis, *Will Consumer-Directed Health Care Improve System Performance?* (The Commonwealth Fund, Aug. 2004).

7 For an explanation of the cost-sharing reduction payments, see 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).

8 Centers for Medicare and Medicaid Services, "September 30, 2015 Effectuated Enrollment Snapshot" (CMS, Dec. 22, 2015).

9 Centers for Medicare and Medicaid Services, "December 31, 2015 Effectuated Enrollment Snapshot" (CMS, March 11, 2016).

10 Actuarial value is the percentage of the bill paid by the insurer for a large population. For example, a plan with an actuarial value of 0.7 pays for, on average, 70 percent of the total health care expenditures incurred by the covered population.

11 J. Gabel, R. Lore, R. McDevitt et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs* Web First, published online May 23, 2012.

[12] A plan with an actuarial value of 0.59 can be sold as either a catastrophic plan or a bronze plan (if the state allows plans to round up the actuarial value for the tier).

[13] Cost-sharing reductions are available to enrollees in a silver plan who have incomes at 100 percent to 250 percent of the federal poverty level and choose a silver plan. Premium subsidies are available to enrollees with incomes at 100 percent to 400 percent of the federal poverty level and are calibrated to each region's benchmark plan premium. For more details, see J. Gabel, H. Whitmore, S. Stromberg et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," *The Commonwealth Fund Blog,* Dec. 22, 2014.

[14] Silver plans have an actuarial value of 0.7, gold plans have an actuarial value of about 0.8, and platinum plans have an actuarial value of 0.9.

[15] Carriers may or may not label their tiers of prescription drugs when presenting cost-sharing information. In our analysis, we call the least-expensive tier "generic," followed by "preferred," "nonpreferred," and "specialty." Almost all plans have four tiers for prescription drugs; less than 5 percent of plans have only three tiers (generic, preferred, and nonpreferred), and 1 percent have five or more tiers.

[16] See for example, M. Gunja, S. R. Collins, and S. Beutel, *How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services* (The Commonwealth Fund, March 2016).

[17] Authors' calculations from Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey* (Henry J. Kaiser Family Foundation, Sept. 2015).

[18] Ibid.

[19] Ibid.

[20] Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey* (Henry J. Kaiser Family Foundation, Sept. 2015).

[21] Preferred drugs are drugs for which generic equivalents are not available. They have been on the market for a while, are widely accepted, and are on the plan's formulary. The insurer has typically negotiated discounts with the supplier. Nonpreferred drugs are not on the formulary, and the plan has not negotiated discounts. These drugs are typically higher-cost medications that have recently come on the market. Specialty drugs, which are structurally complex and often require special handling or delivery, are typically priced much higher than traditional drugs.

[22] E. Planin, "Obamacare Enrollees Are Reeling from Higher Deductibles," *The Fiscal Times,* Nov. 16, 2015.

[23] Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey* (Henry J. Kaiser Family Foundation, Sept. 2015).

[24] T. S. Jost and H. Pollack, "Key Proposals to Strengthen the Affordable Care Act," *The Century Fund Blog,* Nov. 23, 2015; and L. J. Blumberg and J. Holahan, *After* King v. Burwell*: Next Steps for the Affordable Care Act* (Urban Institute, Aug. 2015).

[25] S. R. Collins, P. W. Rasmussen, S. Beutel, and M. M. Doty, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey* (The Commonwealth Fund, May 2015).

[26] Authors' calculations from Kaiser Family Foundation, *Employer Health Benefits: 2015 Annual Survey* (Henry J. Kaiser Family Foundation, Sept. 2015).

ABOUT THIS STUDY

We analyzed data on 4,153 plans in 2015 and 3,700 in 2016 that were offered in individual marketplaces in 49 states and Washington, D.C. Data on plans in states that rely on the federal exchange are from Qualified Health Plan Landscape Files maintained by the Centers for Medicare and Medicaid Services. Data on states with their own exchanges are from marketplace websites maintained by state departments of insurance.

For PY (program year) 2014–2015, we downloaded data from all carriers and plans within three "rating areas," which all insurers must use to set their rates: one urban, one suburban, and one rural. For PY 2016, we collected data on up to six rating areas, up to two within each sampling stratum (urban, suburban, and rural), depending on how many rating areas were present within each state. After a series of rating areas had been sampled, NORC conducted a second stage of sampling in 2016 for state-based marketplaces; for each carrier offering plans in a given rating area, one plan was sampled from each of the four plan tiers (if the carrier offers at least one plan in each tier). In states that rely on the federal exchange, all plans within the sampled rating areas were collected. Weights reflect the probability that we would have selected the rating area from among the sample, as well as the population of the rating area, with an additional sampling weight in PY 2016 reflecting the probability of sampling a plan in a given tier in a given rating area. We designated statistical significance at $p<0.05$.

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Jon R. Gabel, M.A., is a senior fellow in the Health Care Department at NORC at the University of Chicago. Previously, he served as vice president of the Center for Studying Health System Change and vice president of health system studies at the Health Research and Educational Trust, director of the Center for Survey Research for KPMG Peat Marwick LLP, and director of research for the American Association of Health Plans and the Health Insurance Association of America. Mr. Gabel is the author of more than 140 published articles and serves on the editorial boards of a number of scholarly journals. He holds degrees in economics from the College of William and Mary and Arizona State University.

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Evaluating the CARE Act

Implications of a Proposal to Repeal and Replace the Affordable Care Act

Christine Eibner and Sarah Nowak

May 2016

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Evaluating the CARE Act: Implications of a Proposal to Repeal and Replace the Affordable Care Act

Christine Eibner and Sarah Nowak

MAY 2016

ABSTRACT

The Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act is an alternative to the Affordable Care Act (ACA) offered by Sens. Richard Burr (R–N.C.) and Orrin Hatch (R–Utah) and Rep. Fred Upton (R–Mich.). It would eliminate the ACA's individual and employer mandates, loosen regulations on insurers, roll back funding for Medicaid expansion, eliminate taxes and fees, and offer tax credits to low-income individuals to help them purchase insurance. We analyzed the effects of the CARE Act on insurance enrollment, premiums, federal spending, and out-of-pocket costs, relative to current law. We estimate that, in 2018, the CARE Act would reduce federal spending but increase the deficit by $17 billion, relative to current law. It also would increase the number of uninsured individuals by 9 million, and leave some population segments, including low-income individuals and older adults, with substantially higher costs for health insurance and medical care.

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ABOUT THE AUTHORS

Christine Eibner, Ph.D., is a senior economist at the RAND Corporation, and associate director for RAND's Health Services and Delivery Systems Research Program. Dr. Eibner's recent studies have considered changes in health insurance enrollment since 2013, use of pharmaceuticals among marketplace enrollees compared with employer-insured individuals, and geographic variation in marketplace premiums and cost-sharing. In addition, she has led a series of analyses using the RAND COMPARE microsimulation model to assess how changes to the ACA could affect key outcomes, including federal spending, Medicaid enrollment, and individual market coverage. Dr. Eibner's research has been published in journals such as *Health Affairs*, *Health Services Research*, and the *New England Journal of Medicine*. She earned her Ph.D. in economics from the University of Maryland and her bachelor's degree from the College of William and Mary.

Sarah Nowak, Ph.D., is a physical scientist at the RAND Corporation, specializing in mathematical modeling. Much of Dr. Nowak's recent work has focused on using the RAND COMPARE microsimulation model to evaluate health insurance reforms including assessing the impact of the ACA on individual and family spending, and how alternatives to current ACA provisions would impact health insurance coverage and enrollment, government spending, and families' health care spending. Dr. Nowak also led a recent study that used a survey of patients and agent-based modeling to examine the role of social networks on women's breast cancer screening decisions. Dr. Nowak holds a Ph.D. in biomathematics from the University of California, Los Angeles, and a bachelor's degree in physics from the Massachusetts Institute of Technology.

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Evaluating the CARE Act: Implications of a Proposal to Repeal and Replace the Affordable Care Act

INTRODUCTION

Background

Since the Affordable Care Act (ACA) was enacted in 2010, the U.S. Department of Health and Human Services estimates that 20 million people have become newly insured, and approximately 24 million people have gained access to subsidized or free care through marketplace tax credits and Medicaid expansion.[1] Despite these successes, there have been repeated calls to repeal the law and replace it with an alternative set of policy reforms. Those wishing to replace the law often argue that it goes too far in imposing requirements on individuals, businesses, and health insurers. The individual mandate, requiring most Americans to obtain coverage or face penalties, and the employer mandate, requiring large businesses to offer coverage or face penalties, are particular targets of criticism. Those opposing the law also argue that regulations restricting insurers' ability to charge higher premiums to older and sicker adults may lead to unnecessarily high premiums for younger and healthier individuals. An additional concern is that the law could substantially increase federal spending in the long run, given the cost of Medicaid expansion and the ACA's approach to subsidizing health insurance coverage in the marketplaces. Both the Medicaid expansion and the marketplace tax credits offer a minimum level of benefits to individuals and restrict cost-sharing amounts in a manner that protects enrollees from rising health care spending. Many proponents of repeal-and-replace alternatives favor a premium-support approach, in which federal subsidies are based on a fixed amount that grows over time at a predictable rate (e.g., based on the Consumer Price Index, or CPI).

In this report, we analyze the effects of the Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act, a comprehensive proposal to repeal and replace the ACA offered by Senator Richard Burr (R–N.C.), Senator Orrin Hatch (R–Utah), and Representative Fred Upton (R–Mich.).[2] The CARE Act addresses many of the criticisms of the ACA raised by those wishing to repeal and replace the law, including capping federal Medicaid funding allotments, providing premium-support subsidies for low-income individuals, and relaxing health insurance rating regulations to allow age variation in premiums along the lines of variation in spending. The CARE Act would also eliminate the individual and employer mandates. To incentivize people to obtain health insurance, the CARE Act imposes a "continuous coverage" provision that would allow insurers to charge higher premiums or deny coverage to individuals who have not remained continuously enrolled.

One challenge in modeling options to repeal and replace the ACA is that there are many current proposals, and there is no clear coalescence around a single policy. We focus on the CARE Act because it is a relatively detailed proposal that addresses most of the standard criticisms of the ACA. Many other repeal-and-replace proposals contain similar ideas, although specifics vary. For example, like the CARE Act, proposals offered by Paul Ryan, Jeb Bush, John McCain, and Marco Rubio contained alternatives to the ACA's marketplace tax credits that involve premium-support tax credits. Among the various alternatives, the CARE Act offers a particularly useful subject for analysis because it was written by legislators who have contributed to the health care reform debate for decades, and builds on a related proposal offered in 2012 by Sens. Burr, Tom Coburn (R–Okla., now retired), and Hatch.

Overview of the CARE Act

Below, we describe the reforms introduced by the CARE Act:

Individual Market Reforms: The ACA requires insurers to offer coverage to all willing buyers at standard rates that vary only by age, place of residence, and smoking status. Older adults can be charged no more than three times as much as younger adults (3-to-1 rate banding). Under the CARE Act, insurers would be required to offer coverage to all willing buyers at standard rates that vary only by age and place of residence, as long as buyers maintain continuous coverage for at least 18 months. There would be a one-time open enrollment period during which standard rates would be offered to everyone, regardless of prior health insurance status. Insurers would be permitted to charge older individuals no more than five times as much as younger individuals (5-to-1 rate banding).

Tax Credits for Low-Income Individuals and Small-Business Workers: The ACA provides tax credits to individuals with incomes between 100 percent and 400 percent of the federal poverty level (FPL) who do not have access to employer-sponsored coverage (including small-group coverage) or Medicaid. These credits can be used to purchase coverage in the health insurance marketplaces. Eligible individuals must pay a percentage of their income toward health insurance premiums; in 2014 these percentages started at 2 percent for those with incomes between 100 percent and 138 of the FPL and rose to 9.5 percent for those with incomes between 300 percent and 400 percent of the FPL. Over time, the required contributions increase based on the ratio of premium growth to CPI growth, so that enrollees and the federal government share the costs of premium growth in excess of CPI growth. Once an individual or family reaches the required contribution amount, the federal government covers the remaining cost of coverage, up to the price of the second-lowest-cost silver plan available to the enrollee.[3] Those with incomes between 100 percent and 250 percent of the FPL are additionally eligible for cost-sharing reductions to defray the cost of copayments, deductibles, and other cost-sharing.

The CARE Act would offer refundable, advanceable (i.e., credits are available upfront, rather than delayed until the end of the tax year), means-tested tax credits to small-business workers and individuals who 1) do not work for a large business, and 2) do not have an alternative offer of health insurance. The tax credit amounts would vary with age, income, and family status. Those with incomes below 200 percent of the FPL would be eligible for the full amount of the tax credit, and the value of the credit would fall to zero as income approaches 300 percent of the FPL. Small-business workers could apply their credits to a small-group plan (if offered) or to individual-market coverage. Medicaid-eligible individuals could opt to use the credit rather than enrolling in the Medicaid program. Because the credit would increase over time based on CPI plus one percentage point, enrollees would bear the full cost of any premium growth that exceeded that. We consider the CARE Act tax credits to reflect a "premium-support" model of health insurance subsidization because they are not adjusted based on regional variation in premium levels or health care cost growth.

Exhibit 1 shows the tax credit schedule proposed in the CARE Act for individuals and families with income under 200 percent of the FPL.

Exhibit 1

CARE Act Tax Credits, 2014

Age	Individual	Family
18–34	$1,970	$4,290
35–49	$3,190	$8,330
50–64	$4,690	$11,110

Notes: Tax credits are proposed for 2014, and would increase with CPI+1 in subsequent years. Those with incomes <200 percent of the federal poverty level (FPL) are eligible for the full tax credit. The value of the credit declines for individuals with incomes between 200 percent and 300 percent FPL, and is zero for those with higher incomes.

CARE Act Tax Credits vs. ACA Tax Credits

The premium tax credits offered by the CARE Act differ substantially from the ACA tax credits in terms of amounts, eligibility criteria, and the degree to which they scale with income and age. As a result, some people will pay more for health insurance under the CARE Act relative to the ACA, and some will pay less. Exhibit 2 shows the estimated difference between CARE Act and ACA premiums after tax credits for people who enroll in a 70 percent actuarial value plan. We consider three family structures: single adults, married couples, and a family of four. In general, the CARE Act favors younger enrollees, and is more favorable for single adults and married couples than for families. In some cases, 40-year-olds fare better than 30-year-olds under the CARE Act. This is because of the stepwise nature of the CARE Act credits. A 30-year-old individual is close to the top of the age eligibility range for the 18-to-34-year-old tax credit, while a 40-year-old is near the bottom of the age eligibility range for the 35-to-49-year-old tax credit. Because premiums increase steadily with age, those at the bottom of the tax credit age range fare better than those at the top.

Exhibit 2

Percent of Families Eligible for Premium Subsidies Under the ACA Who Would Pay Less for a 70 Percent Actuarial Value Plan Under the ACA Relative to the CARE Act

Age of adults in family	Single	Couple (both spouses same age)	Family of four (both parents same age)
21	15%	0%	66%
30	41%	75%	95%
40	25%	25%	80%
50	100%	80%	100%
60	100%	100%	100%

Notes: ACA tax credit amounts are estimated based on output from the RAND COMPARE microsimulation model. Orange shading indicates that the majority of families fare better under the CARE Act; blue shading indicates that the majority of families fare better under the ACA.

Medicaid Capped Allotment: The ACA allows states to expand Medicaid to cover all individuals with incomes at or below 138 percent of the FPL. The CARE Act would eliminate funding for this expansion. Instead, federal funding for Medicaid would reflect a capped allotment based on pre-2014 spending in each state, adjusted for inflation (based on growth in the CPI plus 1 percentage point) and demographic change.

We assume that, with the elimination of federal funding for Medicaid expansion, all states would roll back their Medicaid eligibility thresholds to pre-ACA levels. Because the capped allotment allows states flexibility in managing their Medicaid programs, it is possible that some states would maintain expansion and finance the extra costs with state funds. We assume this possibility is unlikely because—under current law—the federal government finances at least 90 percent of Medicaid expansion costs, and states would be hard-pressed to make up this difference. Further, while the CARE Act would not continue to support Medicaid expansion, it would allow many individuals with incomes in the Medicaid-expansion range (<=138 percent of the FPL) to obtain means-tested tax credits to purchase private insurance.[4]

State High-Risk Pools: Under the CARE Act, states would have the option to implement high-risk insurance pools for people with costly conditions, using targeted federal funding. High-risk pools would keep the most expensive people out of the individual health insurance market, reducing premiums for the remaining population.

Malpractice Reform: Although medical malpractice reform has been a perennial area of focus among many of those seeking to reduce health spending in the U.S., the ACA did not make direct changes to medical malpractice law. The CARE Act, in contrast, supports a "range of solutions to tackle the problem of junk lawsuits and defensive medicine." Although the proposal lacks specificity on what malpractice reforms would be adopted, it offers at least four examples of potential reforms, including capping noneconomic damages (e.g., compensation for pain and suffering), limiting attorneys' fees, encouraging the adoption of dispute resolution through expert panels, and adopting payment compensation reforms modeled after workers' compensation.

Tax Exclusion Cap for Employer-Sponsored Insurance: The ACA imposed a 40 percent excise tax on employer health insurance plans with premiums above $10,200 for individuals and $27,500 for families. However, this change was delayed, and is not expected to take effect until 2020. The CARE Act would make a slightly different change to the tax treatment of employer insurance, capping the existing tax exclusion at $12,000 for single coverage and $30,000 for family coverage. These caps would be indexed to grow at CPI plus one percentage point.

There are several additional provisions of the CARE Act that we do not model in this report, including targeted changes to eligibility for Health Savings Accounts and reforms aimed at increasing transparency in the health care system. In general, we have not modeled these provisions because implementation details in the CARE Act proposal are sparse. In addition, some of these provisions are dependent on state decisions, which are difficult to predict. We provide a more complete description of the reforms proposed in the CARE Act in the Appendix to this report.

Medicare Reform Under the CARE Act

One important aspect of the ACA that the CARE Act *does not* change involves Medicare reform. The ACA implemented many changes to the Medicare program, including reducing the growth of payment rates over time, penalizing hospitals with excessive readmission rates, and imposing an additional hospital insurance tax on individuals with high incomes. The Congressional Budget Office estimates that these changes will reduce the deficit by $802 billion between 2016 and 2025, with $44 billion in savings in 2018.[5] Based on the text of the CARE Act, we assume these Medicare reforms will remain in place. We further assume that the CARE Act will retain the ACA's increase in the Medicare hospital insurance tax, which is levied on those with incomes over $200,000 for single individuals or $250,000 for married couples.

RESEARCH FINDINGS

Methods

We assessed the effects of the CARE Act using the RAND COMPARE microsimulation model, an analytic tool that uses economic theory and data to estimate the effects of health policy changes. COMPARE creates a representation of the U.S. population using data from the Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), and the Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) Annual Survey of Employer Benefits. In the model, simulated people and businesses make decisions about whether to enroll in health insurance or, if a business, offer coverage by weighing the costs and benefits of available options, taking into account tax credits and other inducements. The model accounts for regulatory policies and incentives, including rate-banding policies, insurers' ability to deny coverage or levy upcharges for those with preexisting conditions, individuals' financial risk associated with remaining uninsured, and the availability of tax credits to purchase insurance. The Appendix provides a more detailed overview of COMPARE, as well as information on the specific approaches we have taken to model the CARE Act.

Coverage

Exhibit 3 shows the estimated effects on insurance enrollment, overall and by source of coverage. We include columns for the ACA and the CARE Act, as well as a "no reform" scenario. The "no reform" column reflects outcomes that could be expected if the ACA had never been enacted. All results are estimated for the year 2018.

Exhibit 3

Total Insured Under Alternative Health Reforms, Overall and by Source of Coverage (millions of individuals under age 65), 2018

	No Reform	ACA	CARE Act
Total insured	224.7	251.5	242.5
Employer insurance	155.6	158.3	157.4
Large employer	115.6	122.4	117.9
Small employer	40.0	35.9	39.5
Individual market coverage*	11.4	23.9	33.3
Regular-risk pool	11.4	23.9	33.0
High-risk pool	0.0	0.0	0.3
Total Medicaid	45.9	57.2	39.6
Other	11.8	12.2	12.2
Uninsured	49.7	27.7	36.7

* Individual market coverage in the ACA scenario includes both marketplace and off-marketplace plans.
Notes: Results are based on output from the RAND COMPARE microsimulation model, with outcomes estimated for the year 2018. The population analyzed includes all U.S. residents under age 65. The "other" insurance category includes Medicare and military coverage.

Relative to the no-reform scenario, both the ACA and the CARE Act increase the size of the insured population. However, the ACA insures about 9.0 million more people than the CARE Act. We estimate that about 17.6 million people would disenroll from Medicaid under the CARE Act relative to the ACA, either because they are no longer eligible or they opt to use the CARE Act's tax credit rather than retaining Medicaid coverage. Simultaneously, individual-market coverage would increase by a net 9.4 million relative to the ACA, not enough to fully offset the declines in Medicaid enrollment. The net increase in individual-market enrollment reflects a gross influx of 20.9 million people into the individual market, mostly from Medicaid (12.4 million new enrollees) and from the ranks of the uninsured (5.9 million new enrollees), which is partially offset by a gross 11.5 million person decline in individual-market enrollment. The large influx from Medicaid stems from the fact that the CARE Act eliminates funding for Medicaid expansion but enables people in the Medicaid-eligible range to receive means-tested tax credits to enroll in individual-market plans. Those moving into the individual market after being uninsured tend to be young, and would thus face lower premiums with the CARE Act, as well as those who receive higher tax credits under the CARE Act relative to the ACA (see Exhibit 2 and Appendix Table A.4). Those who leave the individual market tend to be older, and would thus face higher premiums under the CARE Act, as well as those who receive lower tax credits under the CARE Act than under the ACA. Nearly 80 percent of the 11.5 million people who transition out of the individual market under the CARE Act would become uninsured.

There also would be about 900,000 fewer employer-sponsored insurance enrollees under the CARE Act than under the ACA. This decline occurs because some firms and workers would drop employer coverage under the CARE Act because of the elimination of the employer and individual mandates. The overall decline, however, masks very different trends for small and large businesses. Small-group coverage would increase under the CARE Act relative to the ACA, because of new tax credits available to small-group enrollees. However, large-employer coverage would fall under the CARE Act relative to the ACA. As modeled, some married couples and families with access to both small- and large-employer health insurance would drop large-employer coverage and enroll in the small-group market to take advantage of the CARE Act's small-group tax credits. In reality, it is unclear from the CARE Act whether families with both large- and small-business workers would be eligible for tax credits. The CARE Act emphasizes that a key purpose of the tax credits is to provide assistance to small businesses and their workers, but precludes large-business workers from receiving the credits. The proposal does not address how married couples would be handled in cases where one spouse works for a large employer and the other spouse works for a small employer. In sensitivity analyses, reported in the Appendix, we consider a more restrictive reading of the proposal that precludes family members from accessing tax credits if one spouse works for a large business.

We estimate that relatively few people (300,000) would enroll in the high-risk pool. In part this is driven by assumptions; we assume that only people with extremely high risk of health spending would be eligible. Details on exactly how the high-risk pool would be implemented, and who would be eligible, are sparse. In sensitivity analyses (reported in the Appendix), we explore alternative approaches to modeling the high-risk pool.

Age and Income Distribution of the Uninsured

In addition to their differing effects on the overall number of people insured and the distribution of coverage across public and private sources, the ACA and the CARE Act may have different implications for the number of uninsured in different demographic groups. Because the CARE Act allows insurers to charge higher premiums to older people to reduce the costs for younger enrollees, it might affect the age distribution of the uninsured. Similarly, the CARE Act might have implications for the income distribution of uninsured individuals. While the CARE Act would repeal the Medicaid expansion, it extends tax credits to low-income people in all states. In contrast, the 2012

Supreme Court decision allowing states to opt out of the ACA's Medicaid expansion left low-income individuals without coverage in many states.

In Exhibit 4, we explore these issues by comparing the uninsured populations under the ACA and the CARE Act by age and family poverty category. The results suggest that uninsurance would increase across all age and income categories under the CARE Act relative to the ACA. These increases, however, would be most pronounced for individuals ages 50 to 64, among whom the number of uninsured approximately doubles across the two scenarios. The CARE Act also would lead to a notable increase in the number of uninsured children because its family premium tax credits do not increase with family size. It also would increase the number of uninsured among those with incomes above 400 percent of the FPL. A disproportionate share of older individuals, who now face higher individual-market premiums, fall into this higher-income range. The repeal of the individual mandate also causes some individuals to drop coverage.

Exhibit 4

Uninsured by Age and Family Poverty Category, ACA vs. CARE Act (millions of individuals)

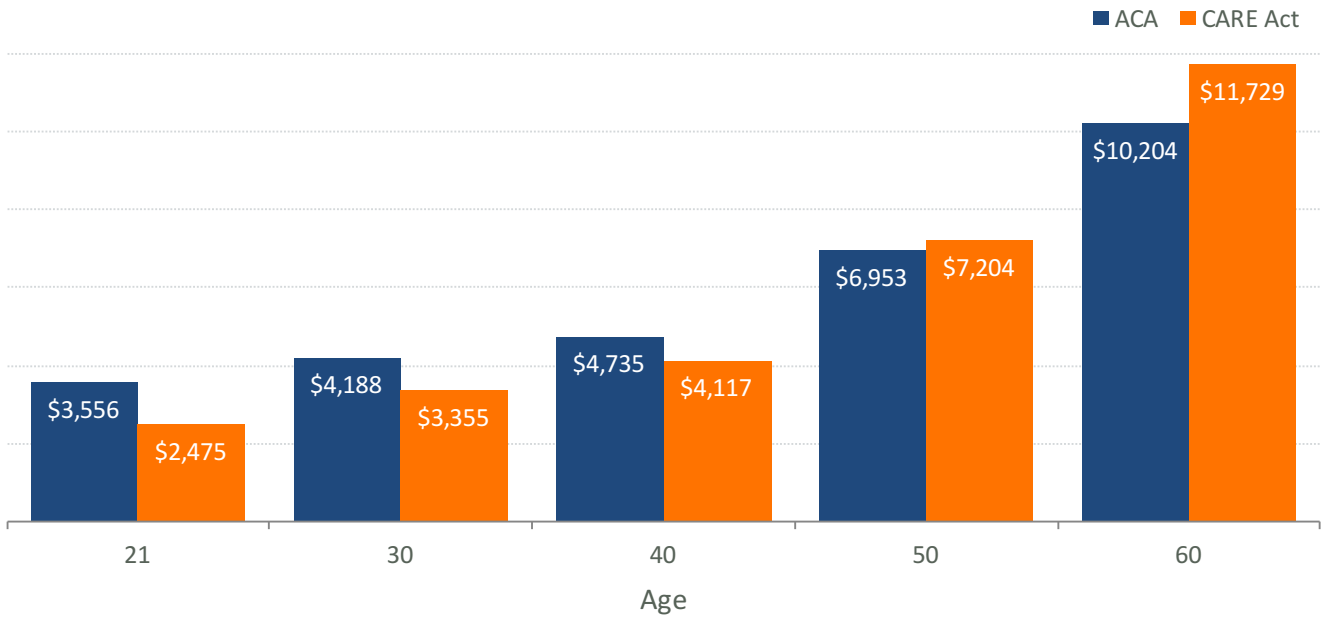
	ACA	CARE Act	Difference (CARE Act - ACA)
Uninsured by age			
<18	**3.8**	6.3	2.5
18–34	**12.8**	13.6	0.9
35–49	**6.5**	7.8	1.2
50–64	**4.5**	9.0	4.5
Uninsured by family poverty category			
<=138% FPL	17.1	18.2	1.1
138% FPL to 200% FPL	2.2	4.1	1.9
201% FPL to 300% FPL	2.9	5.0	2.0
301% FPL to 400% FPL	2.1	3.8	1.7
401% FPL and up	3.3	5.6	2.3

Notes: FPL = federal poverty level. Estimates based on output from the RAND COMPARE microsimulation model.

One reason why older adults would have higher uninsurance rates under the CARE Act relative to the ACA is that the CARE Act allows insurers to charge older people higher premiums. Exhibit 5 shows estimated 2018 individual-market premiums for a 70 percent actuarial value plan (e.g., a silver plan on the marketplaces), by age, under the two reforms. As expected, premiums for adults under age 50 would be lower under the CARE Act compared with the ACA, while premiums for adults age 50 and older would be higher.

Exhibit 5

Individual Market Premiums (for a 70% actuarial value plan) by Age, ACA vs. CARE Act, 2018



Notes: Premiums estimates based on output from the RAND COMPARE microsimulation model. Estimates for the ACA reflect total premiums (before tax credits) for nonsmokers.

Federal Deficit Impact

While the CARE Act would reduce federal Medicaid spending obligations, it would provide new tax credits for individual and small-group coverage. Both of these changes could affect federal outlays. Simultaneously, the CARE Act would eliminate several sources of revenue, including the individual and employer mandates, and various taxes and fees imposed by the ACA. Other differences between the two proposals that could affect the federal deficit include the federally funded high-risk pools authorized under the CARE Act, new medical malpractice regulations under the CARE Act, and differences between the two reforms in the tax treatment of high-cost employer health plans. Exhibit 6 shows the estimated effects of each policy on the federal deficit.

Federal spending under the CARE Act would fall by $27 billion in 2018 relative to the ACA. This reduction would be driven primarily by the $62 billion decrease in federal Medicaid spending. While the CARE Act would increase spending on individual and small-group tax credits relative to the ACA, the net effect of the CARE Act on spending would be negative. Despite the net decrease in subsidies for health insurance, we estimate that the CARE Act would increase the federal deficit by $17 billion in 2018 relative to the ACA. This increase would be driven primarily by a loss of federal revenue. The ACA generates $48 billion in federal revenue as a result of the individual mandate, the employer mandate, the section 9010 tax on group health insurers, a tax on tanning services, fees on branded prescription drugs and medical devices, and several other tax reforms. The CARE Act would repeal these revenue-generating measures and add only $3 billion in new tax revenue, stemming from a tax on high-cost health plans and medical malpractice reform. The $2 billion increase in revenue from malpractice reform would come from additional income and payroll taxes that could be collected if employer health insurance premiums fell because of reduced malpractice costs and wages, in turn, increased.

Exhibit 6

Federal Deficit Impact (in $ billions) Relative to "No Reform" Scenario, ACA vs. CARE Act, 2018

	ACA	CARE Act	Difference (CARE Act - ACA)
Additional federal outlays			
Medicaid and CHIP spending	$54	-$8	-$62
Premium tax credits	$61	$79	$18
Cost-sharing subsidies	$4	$0	-$4
Small-group tax credits	$0	$26	$26
High-risk pool	$0	$2	$2
Malpractice reform	$0	-$6	-$6
Total outlays	$119	$92	-$27
Additional federal revenues			
Individual mandate	$8	$0	-$8
Employer mandate	$13	$0	-$13
Tax on high-cost health plans	$0	$1	$1
Revenue from malpractice reform	$0	$2	$2
Revenue from ACA taxes and fees*	$27	$0	-$27
Total revenue	$48	$3	-$45
Net deficit impact (outlays – revenue)	$72	$89	$17

* Excludes revenues from the ACA's increased Medicare hospital insurance tax, which we assume will be retained under CARE Act.
Notes: Estimates based on output from the RAND COMPARE microsimulation model. Numbers may not sum to exact values because of rounding.

Individual and Family Spending

Exhibit 7 considers the effects on health care spending among insured individuals and families under both the CARE Act and the ACA. We do not include uninsured people in these estimates because those without insurance typically spend less money on health care, but face a higher risk of catastrophic financial loss because of an unexpected health need and are more likely than insured individuals to forgo necessary care. Total health spending in this framework includes premium contributions net of any tax credits received or employer contributions and out-of-pocket spending net of any cost-sharing subsidies. In addition to average spending, we also consider the share of families spending more than 10 percent and more than 20 percent of their income on health care.

Among all insured individuals, we find that premium spending would fall slightly while out-of-pocket spending would increase slightly under the CARE Act relative to the ACA. In addition, a slightly higher share of individuals and families would face health spending in excess of 10 percent or 20 percent of income under the CARE Act relative to the ACA. However, these differences are small and may mask important differences in spending for different population subgroups.

Exhibit 7

Differences in Average Health Spending, Families and Individuals Enrolled in Insurance, ACA vs. CARE Act, 2018

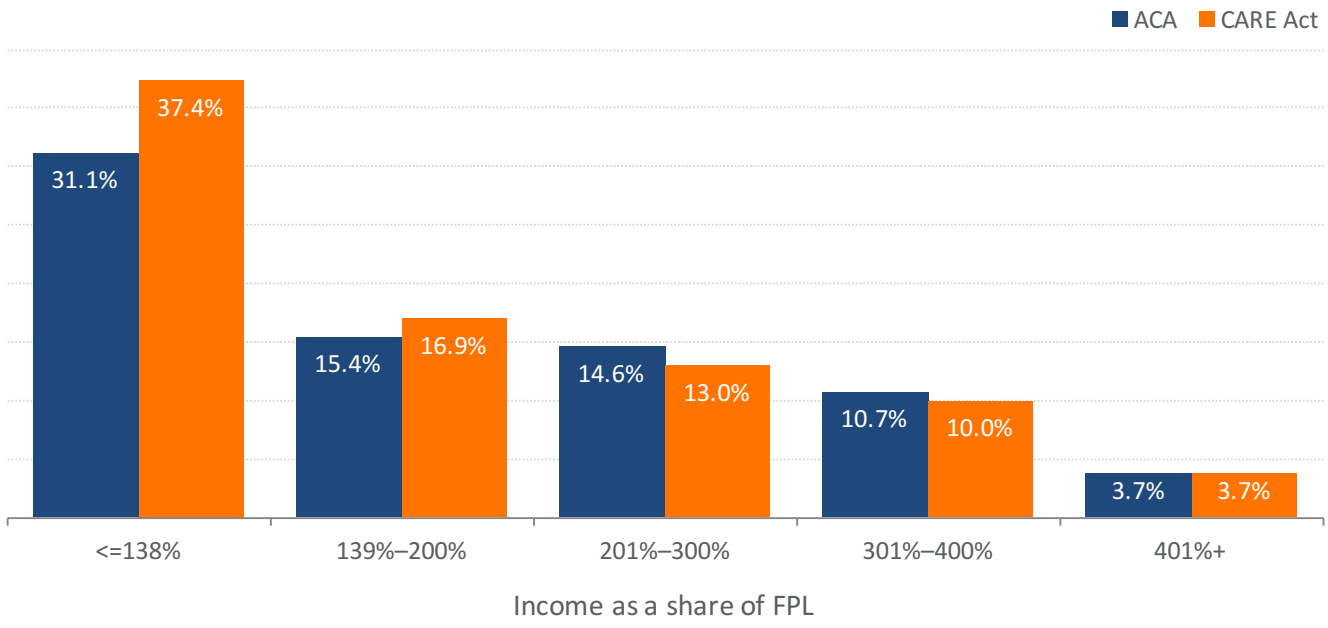
	ACA	CARE Act
Premium contributions (A)	$1,292	$1,269
Out-of-pocket spending (B)	$655	$682
Total health spending (A+B)	$1,947	$1,951
Share spending more than 10% of income on health care	14.7%	16.1%
Share spending more than 20% of income on health care	7.6%	8.8%

Notes: Estimates based on output from the RAND COMPARE microsimulation model. Premium contributions include premium spending net of employer contributions and tax credits. Out-of-pocket spending includes spending on copayments, deductibles, and other cost-sharing. The universe for the analysis includes people who are insured under both the ACA and the CARE Act. Individuals who are uninsured in either scenario are excluded (including those who are insured under one plan, but not the other).

Because one of the major differences between the ACA and the CARE Act is that the latter eliminates funding for Medicaid expansion and replaces it with tax credits for low-income individuals, spending differences by income might be of particular interest. Exhibit 8 shows the spending effects for people in different income ranges,

Exhibit 8

Percent of Families Spending More Than 10 Percent of Income on Health Care by Family Poverty Category, All Individuals and Families Enrolled in Insurance, ACA vs. CARE Act, 2018



Notes: FPL = federal poverty level. Estimates based on output from the RAND COMPARE microsimulation model. Health care spending includes the sum of premium contributions (net of employer contributions and tax credits) and out-of-pocket spending (e.g., copayments, deductibles).

focusing on the share who spend more than 10 percent of their income on health care, a commonly used measure of health care cost burden.[6] For low-income individuals and families, particularly those with incomes at or below 138 percent of the FPL, the share spending more than 10 percent of income on health would be higher under the CARE Act than under the ACA.

Exhibit 9 explores this issue in more detail, focusing specifically on the 12.4 million people who would transition from Medicaid to individual-market coverage under the CARE Act.

For low-income people who transition from Medicaid to individual-market coverage, average total health spending would rise from $96 per year under the ACA to $1,429 per year under the CARE Act. In addition, we estimate that this group would face large increases in health spending relative to income; the share of individuals paying more than 10 percent of their income toward health care would rise from 41 percent to 70 percent.

Exhibit 9

Differences in Average Health Spending, Families and Individuals Who Transition from Medicaid to Individual-Market Coverage, ACA vs. CARE Act, 2018

	ACA	CARE Act
Premium contributions (A)	$0	$972
Out-of-pocket spending (B)	$96	$457
Total health spending (A+B)	$96	$1,429
Share spending more than 10% of income on health care	40.9%	70.4%
Share spending more than 20% of income on health care	39.6%	57.0%

Notes: Estimates based on output from the RAND COMPARE microsimulation model. Premium contributions include premium spending net of employer contributions and tax credits. Out-of-pocket spending includes spending on copayments, deductibles, and other cost-sharing.

Another group at particular risk for high spending under the CARE Act includes adults ages 50 to 64 who enroll in individual-market coverage. As shown in Exhibit 5, these individuals may face higher premiums under the proposal because of 5-to-1 rate banding. In Exhibit 10, we report health spending outcomes for individual-market enrollees ages 50 to 64; the analysis includes spending for single adults in this age range, as well as for families in which at least one member is between the ages of 50 and 64.

Exhibit 10 indicates that individuals and families with household members between the ages of 50 and 64 would face substantially higher costs under the CARE Act if they enroll in individual-market coverage. We estimate that total health spending by those in this group would increase from $5,654 to $9,544, a difference of 69 percent. In addition, the probability of spending more than 10 percent of income on health care would increase by nearly 36 percentage points, and the probability of spending more than 20 percent of income on health care approximately would triple.

Exhibit 10

Differences in Average Individual-Market Health Spending, Individuals and Families with Oldest Member Between the Ages of 50 and 64, ACA vs. CARE Act, 2018

	ACA	CARE Act
Premium contributions (A)	$4,280	$7,631
Out-of-pocket spending (B)	$1,375	$1,913
Total health spending (A+B)	$5,654	$9,544
Share spending more than 10% of income on health care	49.9%	85.4%
Share spending more than 20% of income on health care	18.1%	59.5%

Notes: Estimates based on output from the RAND COMPARE microsimulation model. Premium contributions include premium spending net of employer contributions and tax credits. Out-of-pocket spending includes spending on copayments, deductibles, and other cost-sharing. Analysis focuses on individual market enrollees only, and excludes people who would enroll in the individual market under the ACA but would be uninsured under the CARE Act.

LIMITATIONS

Like all models, RAND COMPARE has limitations. We assume that people behave rationally, making health insurance choices by weighing the costs and benefits of available options. In reality, consumer confusion over insurance products may reduce the chance that an individual makes a rational choice. Estimating the effects of penalties and incentives to encourage health insurance enrollment is particularly challenging. We have only two years of experience to date with the individual mandate, and—because people don't pay penalties until tax season during the following year—there are limited data available to estimate how well the individual mandate is enforced or who has complied.

We have a similar challenge in estimating how people will respond to the CARE Act's continuous coverage provisions. While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides some protections that parallel the continuous coverage provisions proposed under the CARE Act, there are key differences, including the CARE Act's one-time open enrollment period. Our approach to estimating the effects of the CARE Act assumes that people will look ahead for one year and consider the potential future costs of facing higher charges or being denied coverage when making insurance decisions. In the Appendix, we report sensitivity analyses in which people ignore future costs when making current year insurance decisions and in which people look ahead for two years when making decisions.

Because there is no legislative language or set of regulations describing specific aspects of the proposal in detail, we had to make assumptions about how the CARE Act would be implemented. In some cases, these implementation decisions could have important effects on results. For example, it is unclear in the current proposal how tax credit eligibility would be determined for married couples in which spouses work for firms of different sizes. There is also uncertainty in the proposal regarding which states will implement optional reforms such as high-risk pools, and what type of minimum generosity requirements might be imposed on health plans to meet requirements for the continuous coverage provisions and tax credit eligibility. We assume that individuals must obtain a plan with an actuarial value of at least 60 percent in order to use the tax credit or to fulfill the continuous coverage provisions.

If no minimum benefit limits are established, it is possible that insurance companies could develop extremely limited plans that cost no more than the tax credit amounts. If this were to occur, the number of people covered under the CARE Act and the number of enrollees facing substantial out-of-pocket spending could be higher than estimated in this report.

With more detail on these specific issues, we would be able to develop a more precise estimate of the costs and benefits of the CARE Act proposal, and it is possible our results would be different from those estimated here. In sensitivity analyses presented in the Appendix, we address some of these uncertainties. None of these analyses revealed a case in which the CARE Act insured more people with a smaller deficit impact than the ACA.

POLICY IMPLICATIONS

Relative to the ACA, we estimate that the CARE Act would insure fewer people, raise the federal deficit, and impose greater financial burden on some vulnerable groups, including older adults and people with incomes under 138 percent of the FPL. We caution, however, that the increase in the deficit associated with the CARE Act is the result of the repeal of numerous small revenue-generating taxes and fees enacted under the ACA. If the CARE Act were turned into a bill, it is possible that legislators would seek to retain some of the ACA's revenue-generating provisions, or to adopt alternative revenue-generating provisions. If we ignore the revenue effects and focus only on spending, the CARE Act leads to a reduction in federal outlays relative to the ACA.

In addition to addressing the likely revenue shortfalls, policymakers who are considering adopting the CARE Act or related reforms might want to pay particular attention to older adults and low-income individuals and consider how to prevent them from experiencing financial strain and adverse health outcomes. Options could include adding cost-sharing subsidies in addition to tax credits, increasing subsidy amounts for older adults, or ensuring that funding remains available for states opting to retain Medicaid expansion. Notably, the CARE Act is one of relatively few repeal-and-replace proposals in which tax credits are means-tested. For example, a proposal offered by Rep. Tom Price (R–Ga.) in 2015 included tax credits that scaled with age but not income. Proposals that offer the same tax advantage to everyone, without consideration of financial need, may increase the financial strain on lower-income families.

Policymakers wishing to retain the ACA might consider whether there are any policy options included in the CARE Act that would be worthwhile to pursue in addition to current law. For example, the ACA did little to address medical malpractice costs, yet the Congressional Budget Office (CBO) estimates that adopting medical malpractice reform options could save around $8.4 billion in 2018 and $54 billion over a 10-year time horizon.[7] While the reforms modeled by the CBO do not fully parallel the reforms suggested in the CARE Act, the text of the CARE Act implies that a range of malpractice reforms would be considered.

Another consideration is the effect of the two policies on labor market and employment incentives. The ACA imposes a steep marginal tax rate on people as they transition from Medicaid eligibility (income less than or equal to 138 percent of the FPL in expansion states) to marketplace tax credit eligibility (between 139 percent and 400 percent of the FPL). Steep marginal tax rates could reduce the incentive for people with incomes just below 138 percent of the FPL to earn additional income.[8] The CARE Act addresses this distortion by offering the same tax credits to individuals with incomes below and immediately above 138 percent of the FPL, and by eliminating funding for Medicaid expansion. The consequence of this approach, however, is that low-income individuals are less protected against high health care spending relative to the ACA.

At the same time, the CARE Act may create other distortions by offering new tax credits for small-business employees to obtain health insurance. These tax credits are added on top of existing tax advantages for

employer-sponsored coverage, the cost of which is currently excluded from income and payroll tax calculations. Our analysis predicts that the strong tax advantages offered to small businesses under the CARE Act will cause 3.6 million people to gain coverage through a small employer, including people who switch from large-employer to small-employer coverage if, for example, they have small-group eligibility through a spouse. An additional effect, which we do not model, is that some large firms may opt to split into small firms and some small firms may limit size growth in order to gain or maintain eligibility for these substantial tax advantages. Prior work has shown that health insurance rating reforms targeted at firms of specific sizes may influence hiring and growth decisions.[9]

CONCLUSION

There are currently many proposals to repeal and replace the Affordable Care Act, including proposals offered by presidential candidate Donald Trump, Rep. Tom Price (R–Ga.), and former presidential candidates including Jeb Bush, Scott Walker, and Marco Rubio. Interest in such proposals may increase as the 2016 presidential election approaches. Our analysis of the CARE Act, a longstanding and relatively detailed repeal-and-replace proposal, suggests that finding an approach that insures the same number of people while simultaneously reducing federal costs will be difficult. We estimate that the CARE Act will increase the federal deficit relative to the ACA, while insuring fewer people. Further, the CARE Act leads to higher individual spending among some subsets of enrollees. In particular, older adults who enroll on the individual market pay higher premiums than they would under the ACA, and low-income individuals who would have otherwise enrolled in Medicaid face both higher premiums and higher cost-sharing. A disproportionate share of older adults also becomes uninsured under the CARE Act relative to the ACA. Because older adults tend to have more significant health care needs, an increase in the size of the uninsured population ages 50 to 64 could lead some individuals to have adverse health outcomes.

As described above, there are many uncertainties regarding CARE Act implementation decisions that could affect our estimates. However, based on sensitivity analyses reported in the Appendix, we believe that—even under alternative assumptions—the combination of policies offered by the CARE Act is unlikely to insure more people at a lower cost to the federal government than the ACA.

While the CARE Act would likely insure fewer people than the ACA, it would eliminate federal mandates and relax regulations that affect businesses in general and insurance companies in particular. For many critics of the ACA, there is a genuine tension between the goals of reducing the number of federal requirements imposed on businesses and individuals and keeping people insured. Whether reducing federal involvement and oversight of health care markets is worth having potentially greater numbers of uninsured requires a value judgement. Different citizens and policymakers are likely to have different opinions about whether such a trade-off would be worthwhile.

Our analysis also demonstrates that, as currently specified, the CARE Act is unlikely to reduce the federal deficit. Policymakers seeking to adopt the CARE Act, or to pursue a similar repeal-and-replace policy, may need to maintain some of the ACA's revenue-generating provisions, adopt alternative revenue-generating provisions, or reduce the generosity of tax credits to achieve budget neutrality.

Notes

[1] Centers for Medicare and Medicaid Services, *Medicaid & CHIP: November 2015 Monthly Applications, Eligibility Determinations and Enrollment Report* (CMS, Jan. 27, 2016); N. Uberoi, K. Finegold, and E. Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016,* ASPE issue brief (Office of the Assistant Secretary for Planning and Evaluation, March 3, 2016); and Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report,* ASPE issue brief (ASPE, March 10, 2015).

[2] U.S. Senate Committee on Finance, "Burr, Hatch, Upton Unveil Obamacare Replacement Plan," news release (Senate Finance Committee, Feb. 5, 2015).

[3] The silver plan, on average, covers 70 percent of an enrollee's health care expenses.

[4] Individuals working for large employers would be ineligible for tax credits, regardless of income.

[5] Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act,* pub. no. 50252 (CBO, June 2015).

[6] J. Abramowitz and B. O'Hara, "The Financial Burden of Medical Spending: Estimates and Implications for Evaluating the Impact of ACA Reforms," *Medical Care Research and Review,* April 2015 72(2):187–99; and P. J. Cunningham, "The Share of People with High Medical Costs Increased Prior to Implementation of the Affordable Care Act," *Health Affairs,* Jan. 2015 34(1):117–24.

[7] D. W. Elmendorf, "Letter dated October 9, 2009, from Douglas W. Elmendorf, Director, Congressional Budget Office, to the Hon. Orrin G. Hatch, U.S. Senate," (CBO, Oct. 9, 2009).

[8] C. B. Mulligan, *Average Marginal Labor Income Tax Rates Under the Affordable Care Act,* NBER working paper no. 19365 (National Bureau of Economic Research, Aug. 2013).

[9] K. Kapur, P. Karaca-Mandic, S. M. Gates et al., "Do Small-Group Health Insurance Regulations Influence Small Business Size?" *Journal of Risk and Insurance,* March 2012 79(1):231–60.

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Health Care Costs 101: ACA Spurs Modest Growth

MAY 2016

Introduction

After five years of slow growth, national health spending grew by 5.3% in 2014, up from 2.9% in 2013. The faster growth was due in part to coverage expansion under the Affordable Care Act (ACA) and increased spending on prescription drugs. US health spending reached $3.0 trillion in 2014, or $9,523 per capita, and accounted for 17.5% of gross domestic product (GDP).

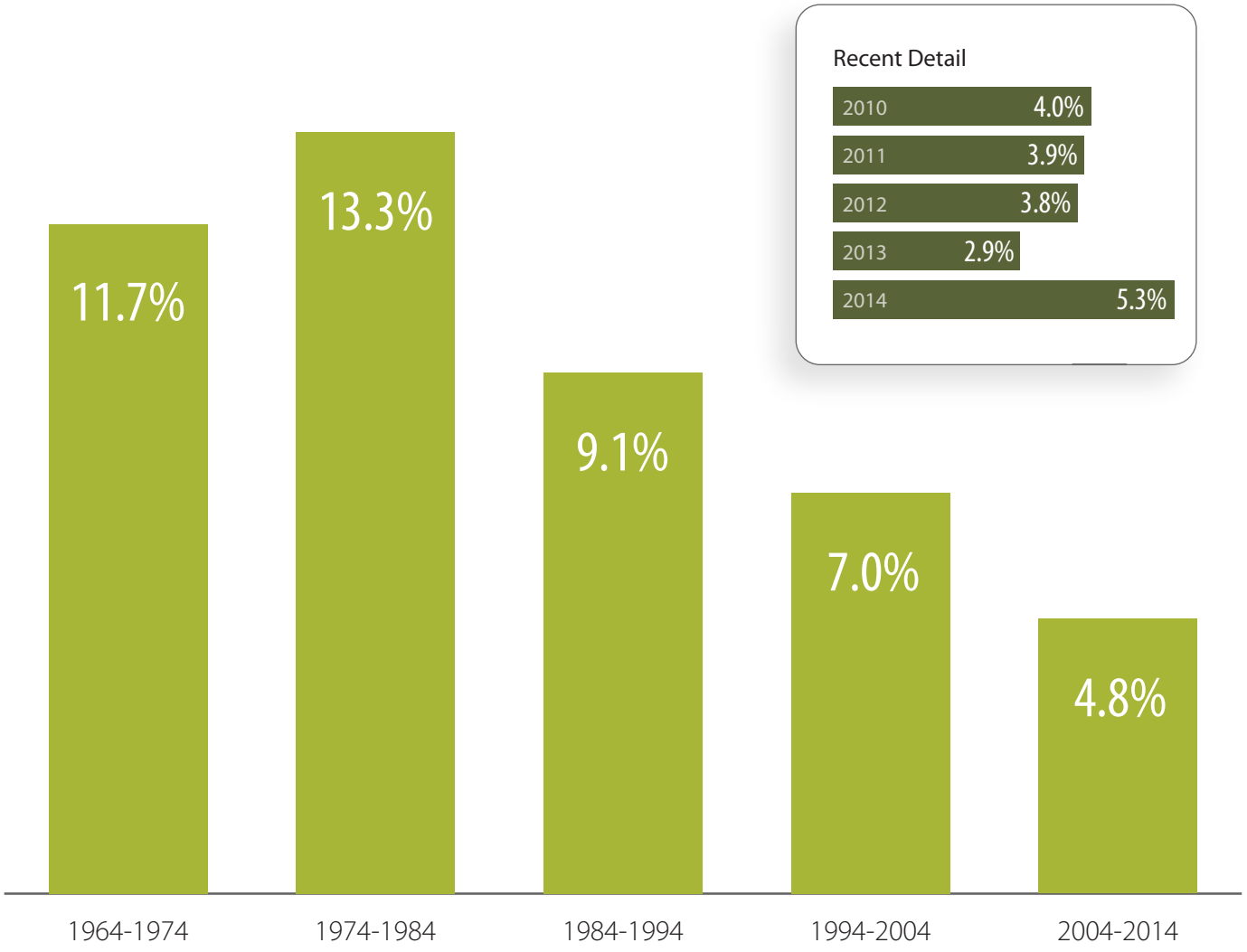
Health Care Costs 101: ACA Spurs Modest Growth, which relies on the most recent data available, details how much is spent on health care in the US, which services are purchased, and who pays.

KEY FINDINGS INCLUDE:

- Federal subsidies for ACA Marketplace premiums and cost sharing totaled $18.5 billion, accounting for 12% of the $151 billion in new health spending in 2014.
- Federal spending on Medicaid increased 18.4% (compared to 0.9% for states), as the federal government fully funded the ACA's expansion of Medicaid eligibility in participating states.
- Spending on prescription drugs increased by $32.4 billion, or 12.2%, much faster than recent years. New Hepatitis C drugs accounted for $11.3 billion, more than one-third of the increase in all prescription drug spending.
- Household spending on direct purchase insurance rose only 2.2% (more slowly than overall spending at 5.3% and similar to overall household spending at 2.0%), despite a 19.5% increase in enrollment levels for direct purchase insurance.
- Growth rate in per capita spending more than doubled from 2.1% in 2013 to 4.5% in 2014.

CONTENTS

Average Annual Growth Rates in Health Spending
United States, 1964 to 2014



Note: *Health spending* refers to national health expenditures.

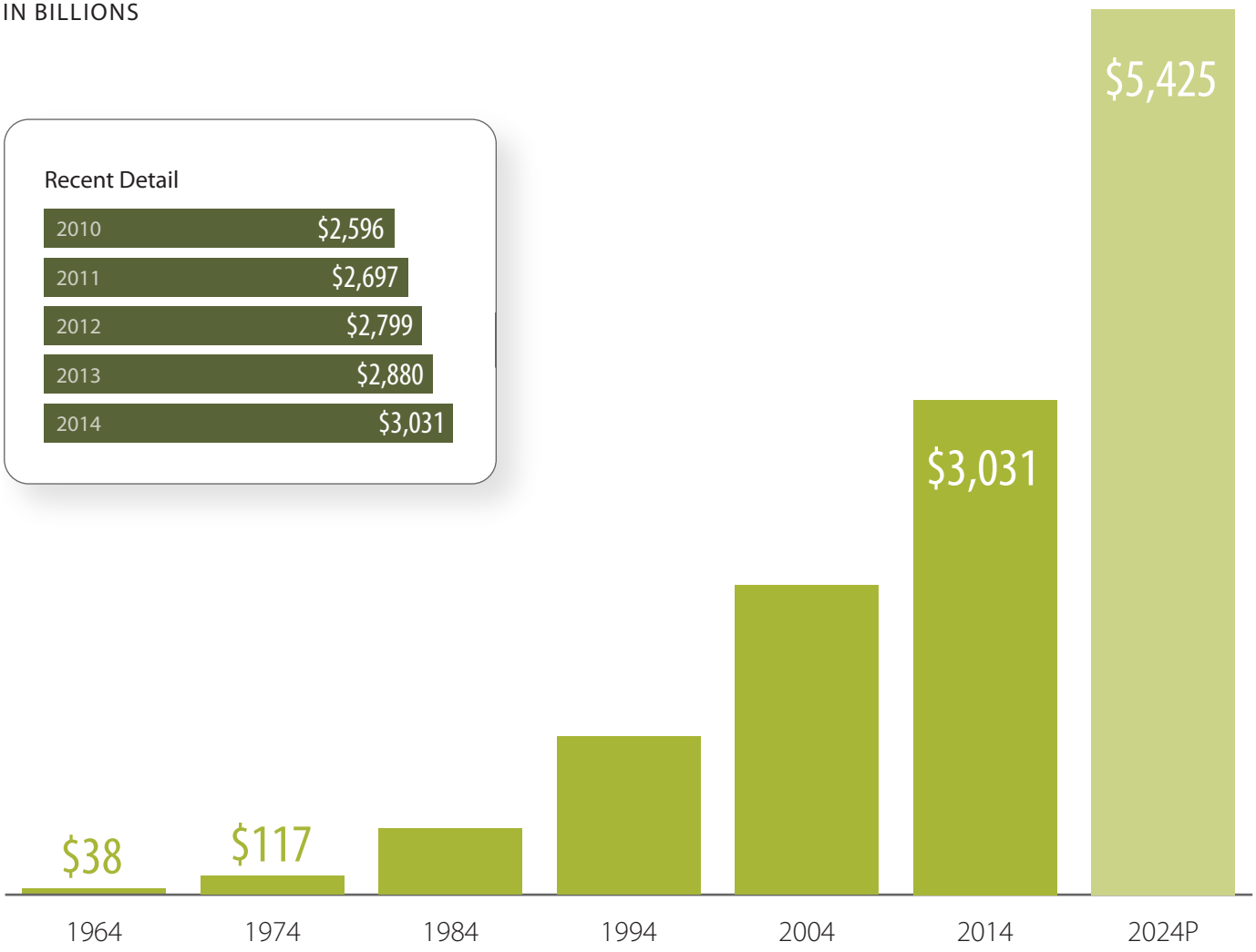
Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Growth in 2014 accelerated to 5.3%, ending a multiyear run of stable low growth. Health spending growth in 2014 was faster than the last decade but slower than the decades between 1964 and 2004.

Health Spending

United States, 1964 to 2024, Selected Years

IN BILLIONS



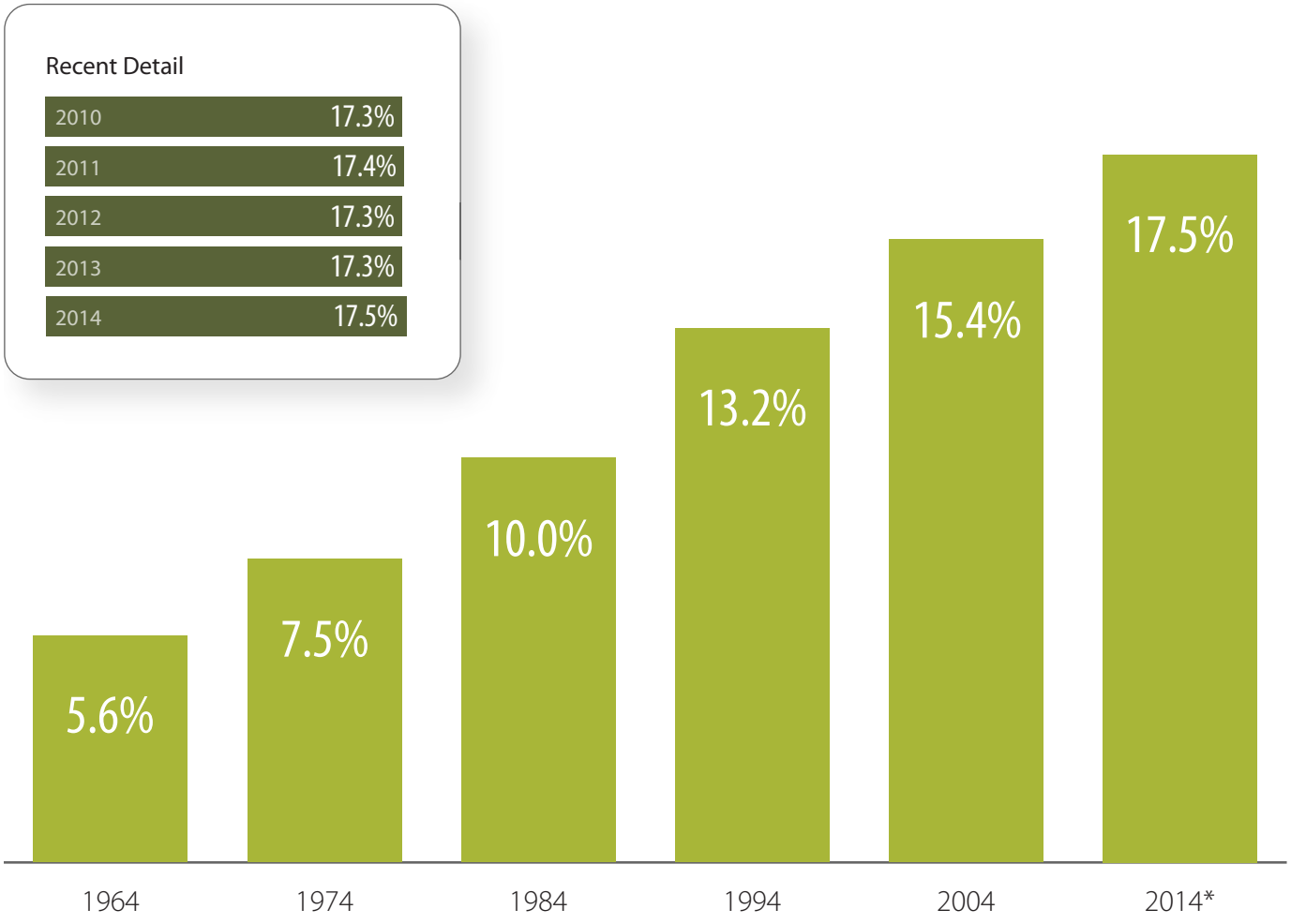
Notes: *Health spending* refers to national health expenditures. Projections shown as *P*.

Sources: National Health Expenditure Data, Historical, 1960-2014 (www.cms.gov) and Projections, 2013-2024 (www.cms.gov), Centers for Medicare & Medicaid Services, 2015.

National health spending reached $3.0 trillion in 2014 and is projected to reach $5.4 trillion by 2024. Between 2014 and 2024, health spending is projected to grow at an average rate of 6.0% per year.

Health Spending as a Share of GDP

United States, 1964 to 2014, Selected Years



*2014 figure reflects a 4.1% increase in gross domestic product (GDP) and a 5.3% increase in national health spending over the prior year. See page 30 for a comparison of economic growth and health spending growth.

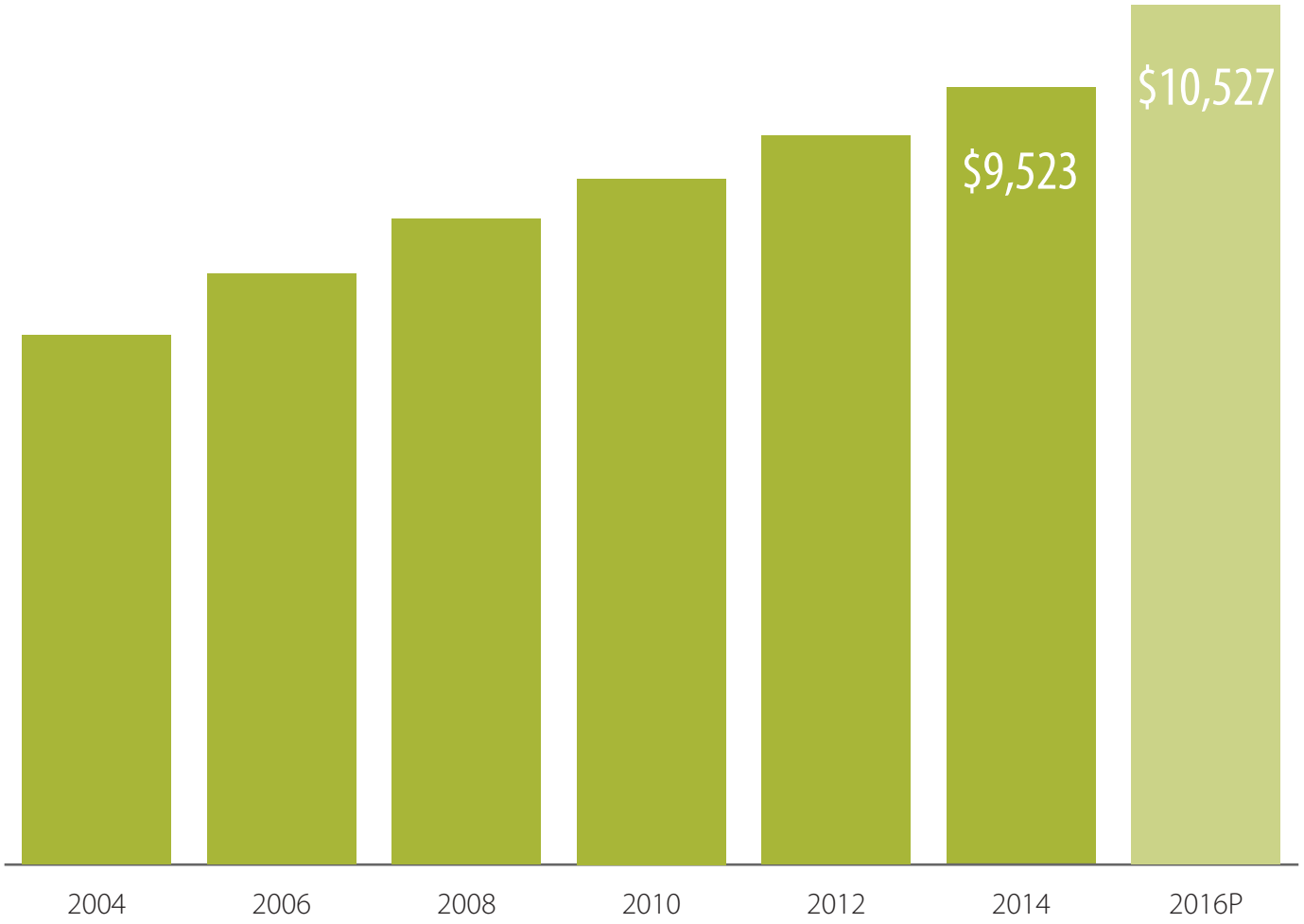
Note: *Health spending* refers to national health expenditures.

Sources: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov; "Interactive Data Table 1.1.5. Gross Domestic Product," Bureau of Economic Analysis, bea.gov.

Health spending as a share of GDP increased 0.2 percentage points in 2014 following a four-year flat period in which the economy and health spending grew at a similar pace. Over the past 50 years, health spending has accounted for an increasing share of GDP.

Health Spending per Capita

United States, 2004 to 2016, Selected Years



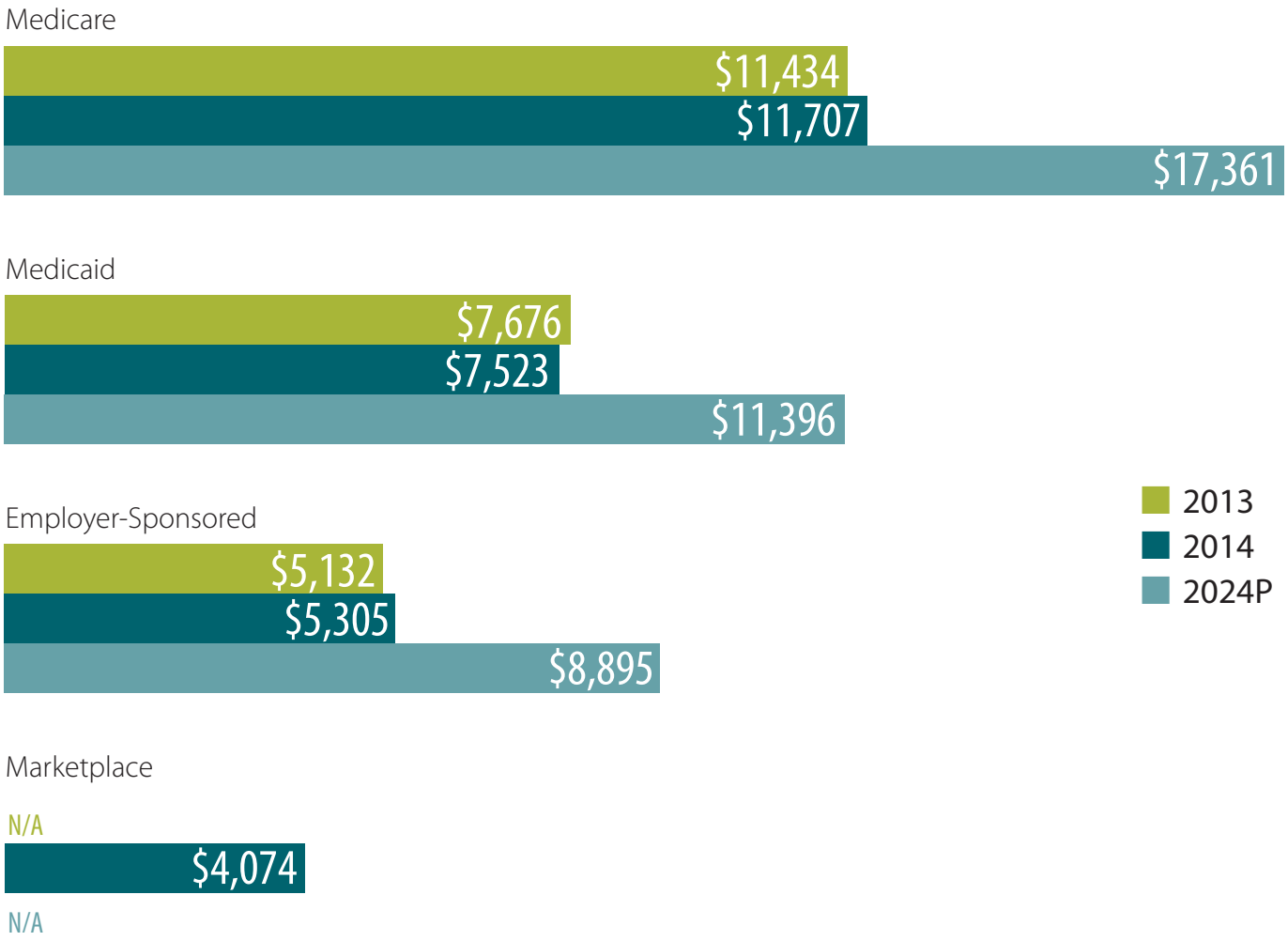
Health spending per capita increased 47% between 2004 and 2014, or an average of 3.9% annually. In 2016, US health spending is projected to reach $10,527 per person.

Notes: *Health spending* refers to national health expenditures. Projections shown as *P*.

Sources: National Health Expenditure Data, Historical, 1960-2014 (www.cms.gov) and Projections, 2013-2024 (www.cms.gov), Centers for Medicare & Medicaid Services, 2015.

Health Insurance Spending per Enrollee

United States, 2013 to 2024, Selected Years



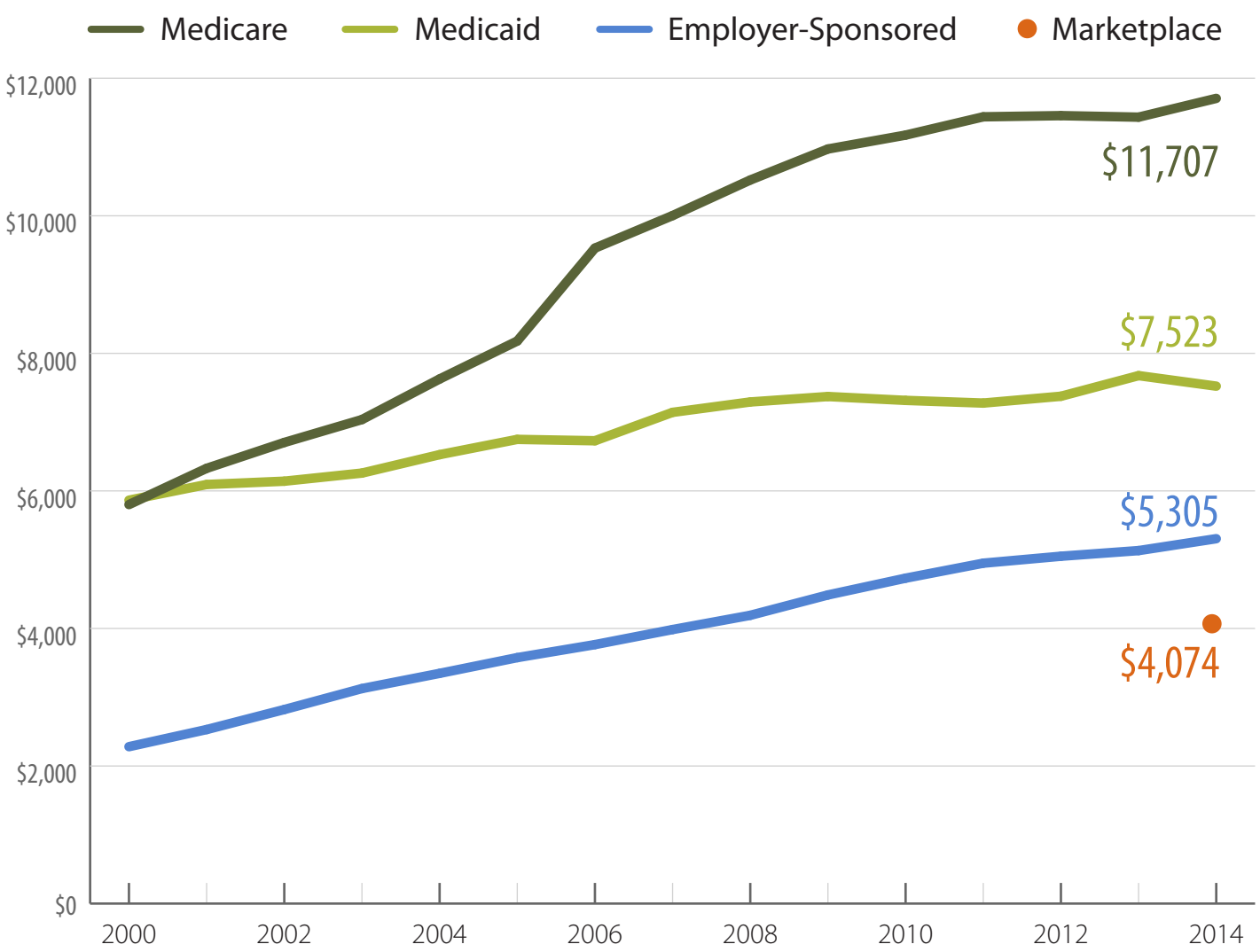
Notes: Projections shown as *P. Marketplace* is individual health insurance coverage purchased on federal- and state-run health exchanges such as Covered California and healthcare.gov.
Sources: National Health Expenditure Data, Historical, 1960-2014 (www.cms.gov) and Projections, 2013-2024 (www.cms.gov), Centers for Medicare & Medicaid Services, 2015.

Per enrollee amounts for Medicaid declined slightly as the ACA took effect in 2014 and more nondisabled adults gained eligibility for the program. Spending per enrollee for ACA's marketplace plans, first available in 2014, was lower than employer-sponsored plans by about $1,200 (23%).* Medicare spending per enrollee is projected to remain about twice that of employer-sponsored per enrollee spending due to the greater needs of the senior population.

*Differences in per enrollee costs can include differences in risk and benefit levels.

Health Insurance Spending per Enrollee

United States, 2000 to 2014



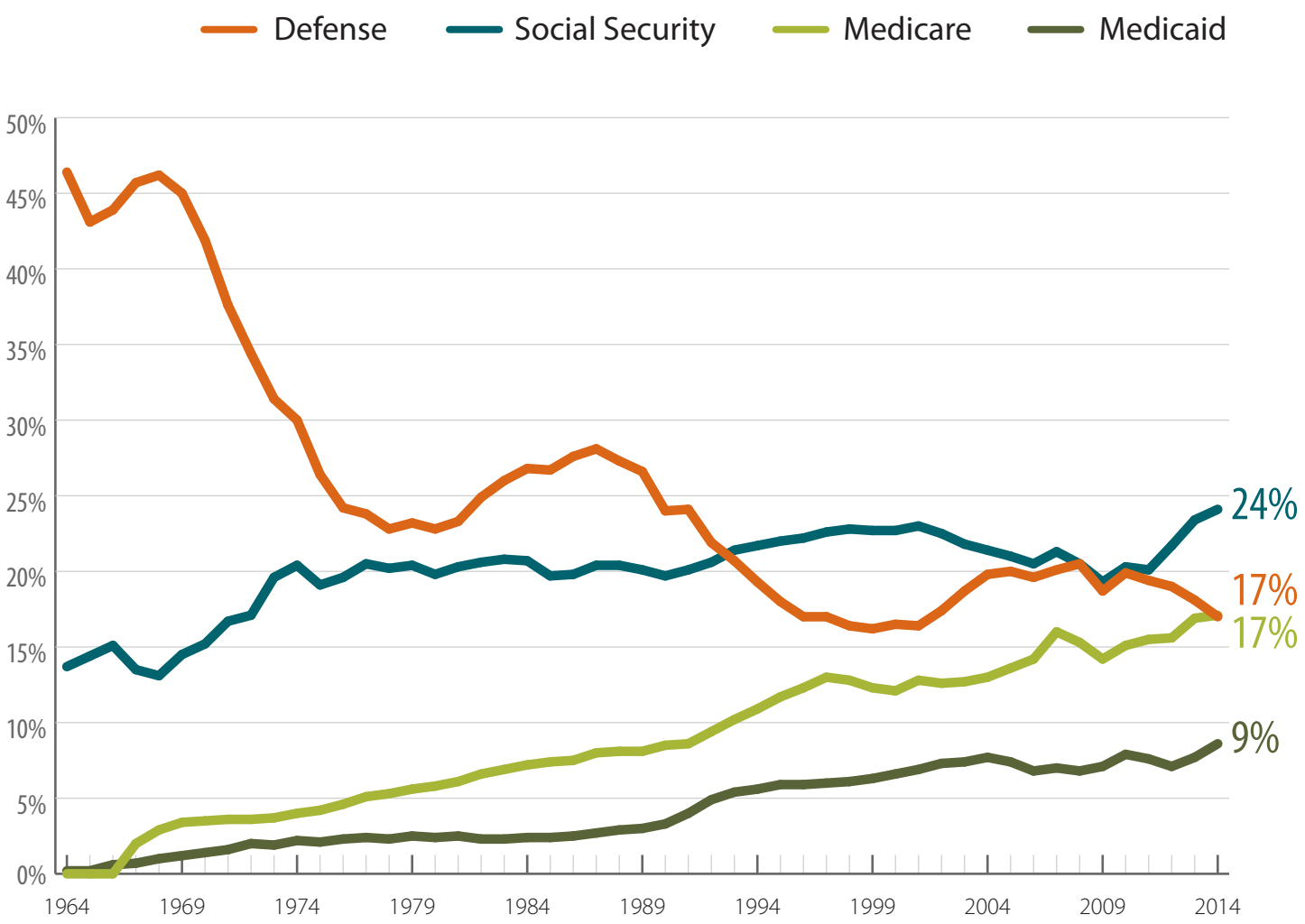
Note: *Marketplace* is individual health insurance coverage purchased on federal and state-run health exchanges, such as Covered California and HealthCare.gov.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Despite covering a much older population, spending per enrollee was about the same for Medicare and Medicaid in 2000. By 2014, Medicare was 56% higher than Medicaid, a difference of more than $4,000 a year.

Major Programs as a Share of the Federal Budget

United States, 1964 to 2014



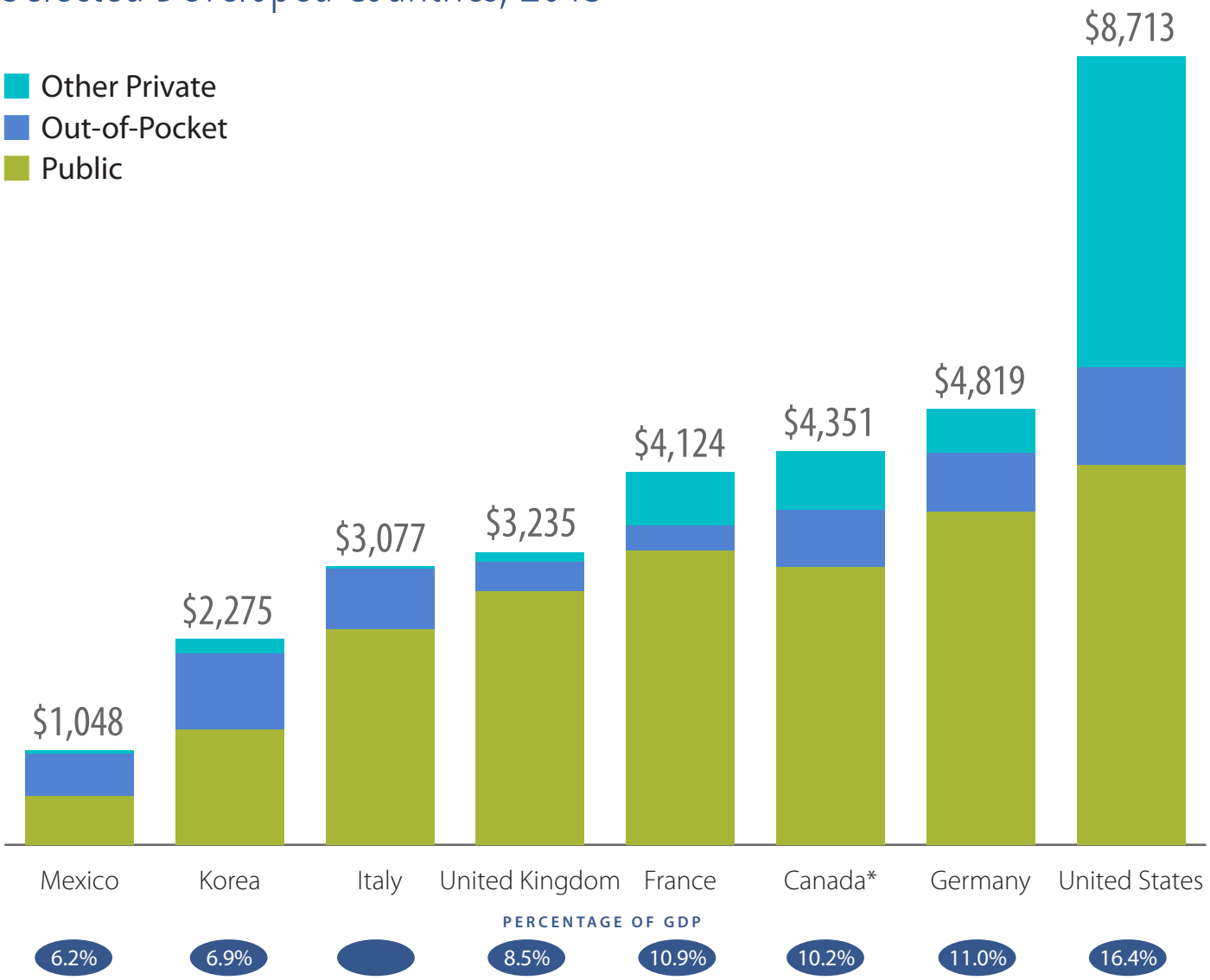
Notes: Spending shares computed as a percentage of federal outlays. All outlays reflect federal spending only (i.e., Medicaid outlays shown reflect federal portion).

Sources: *The Budget and Economic Outlook: 2015 to 2025*, Congressional Budget Office (CBO), January 2015, www.cbo.gov; *The Budget and Economic Outlook: Fiscal Years 2003 to 2012*, CBO, January 2002, www.cbo.gov.

For the first time since the introduction of the Medicare program, spending on Medicare and defense consumed the same share (17%) of federal outlays.

Health Spending per Capita and as a Share of GDP

Selected Developed Countries, 2013



*Estimate.

Note: US spending per capita as reported by OECD differs from figures reported elsewhere in this report.

Source: "OECD Health Statistics 2015, Frequently Requested Data," Organisation for Economic Co-operation and Development, July 2015, www.oecd.org.

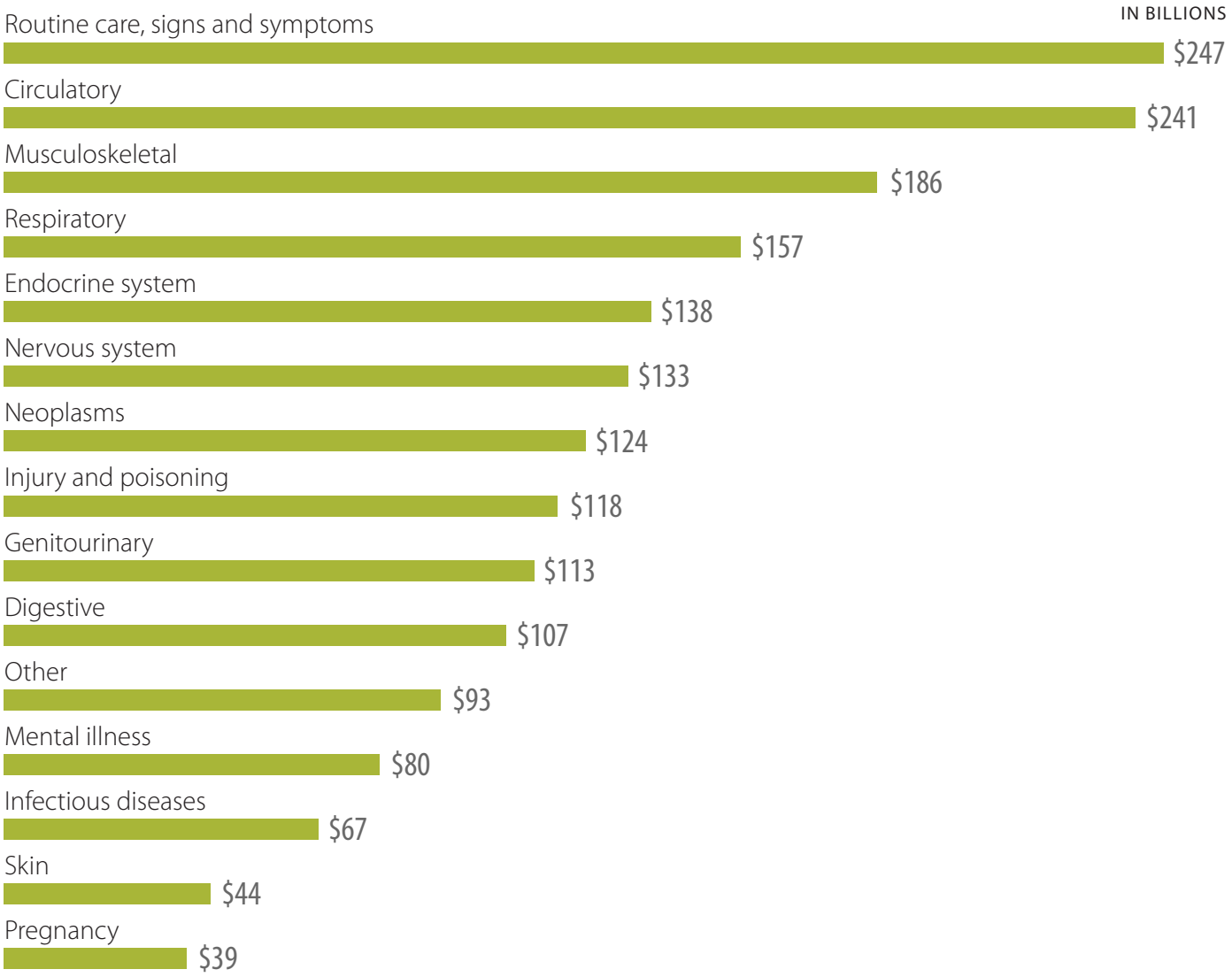
Health spending in the US far exceeded that of other developed countries, both in per capita spending and as a percentage of GDP. Unlike the US, in most developed countries the public sector dominated health spending.

PAYER DEFINITIONS

Out-of-pocket is consumer spending on copays, deductibles, and goods and care not covered by insurance; it does not include premiums.

Other private is computed as total spending less public spending and out-of-pocket spending.

Health Spending, by Type of Medical Condition
United States, 2012



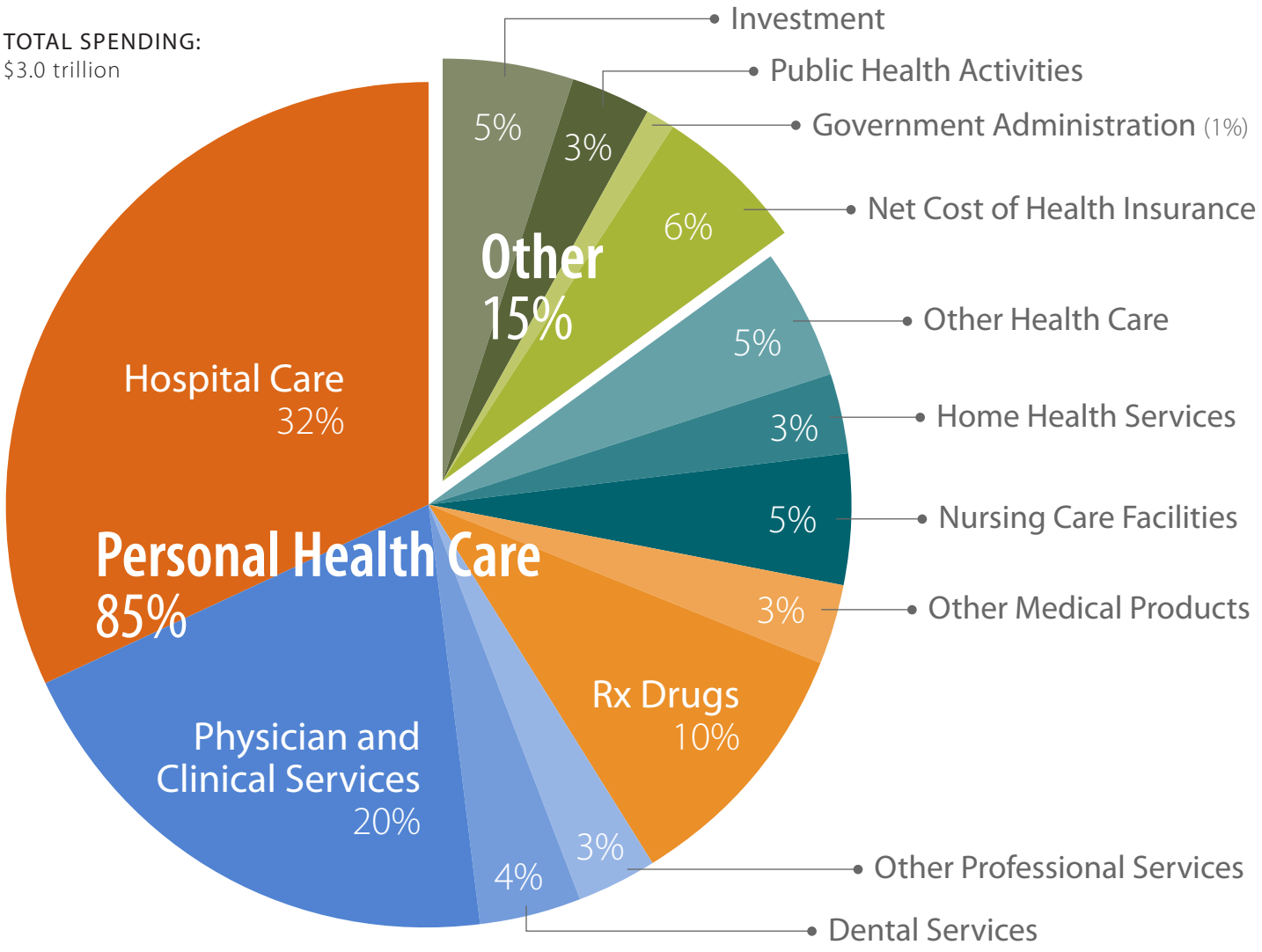
Notes: Spending by medical condition accounted for 83% of personal health spending in 2012. Medical condition spending does not account for spending on dental services, nursing homes, or medical products and equipment. The most recent data series ends with 2012. See Appendices C and D for medical condition detail.

Source: "Health Care Satellite Account: Blended Account, 2000-2012," Bureau of Economic Analysis, www.bea.gov.

When spending was classified by medical condition, routine care ranked highest, accounting for $247 billion in spending. It was closely followed by circulatory system conditions (which include hypertension and heart disease). Pregnancy was the smallest of the 15 spending categories, despite being the most common reason for hospitalization.

Health Spending Distribution, by Category
United States, 2014

TOTAL SPENDING:
$3.0 trillion



Notes: *Health spending* refers to national health expenditures. For additional detail on spending categories, see Appendix A. Further definitions available at www.cms.gov.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Hospital and physician services combined accounted for just over half of health care spending. Prescription drugs, the third-largest category, accounted for another 10%.

SPENDING CATEGORY DEFINITIONS

Government administration includes the administrative costs of government health care programs such as Medicare and Medicaid.

Investment includes research, structures, and equipment.

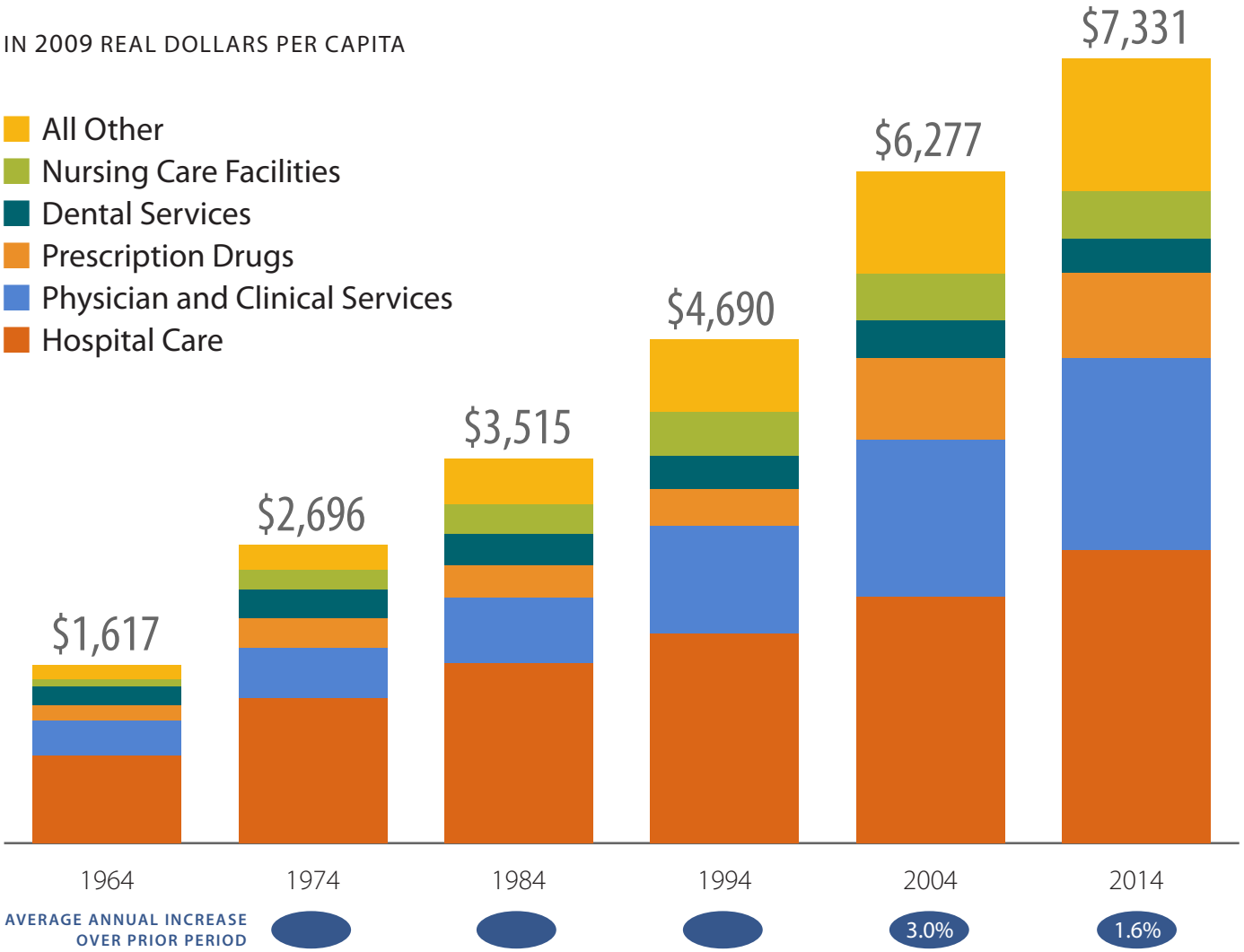
Net cost of health insurance reflects the difference between benefits and premiums for private insurance.

Other health care refers to the category other health, residential, and personal care.

Other medical products refers to durable medical equipment and nondurable medical products.

Personal Health Care Spending, Adjusted for Inflation

United States, 1964 to 2014, Selected Years



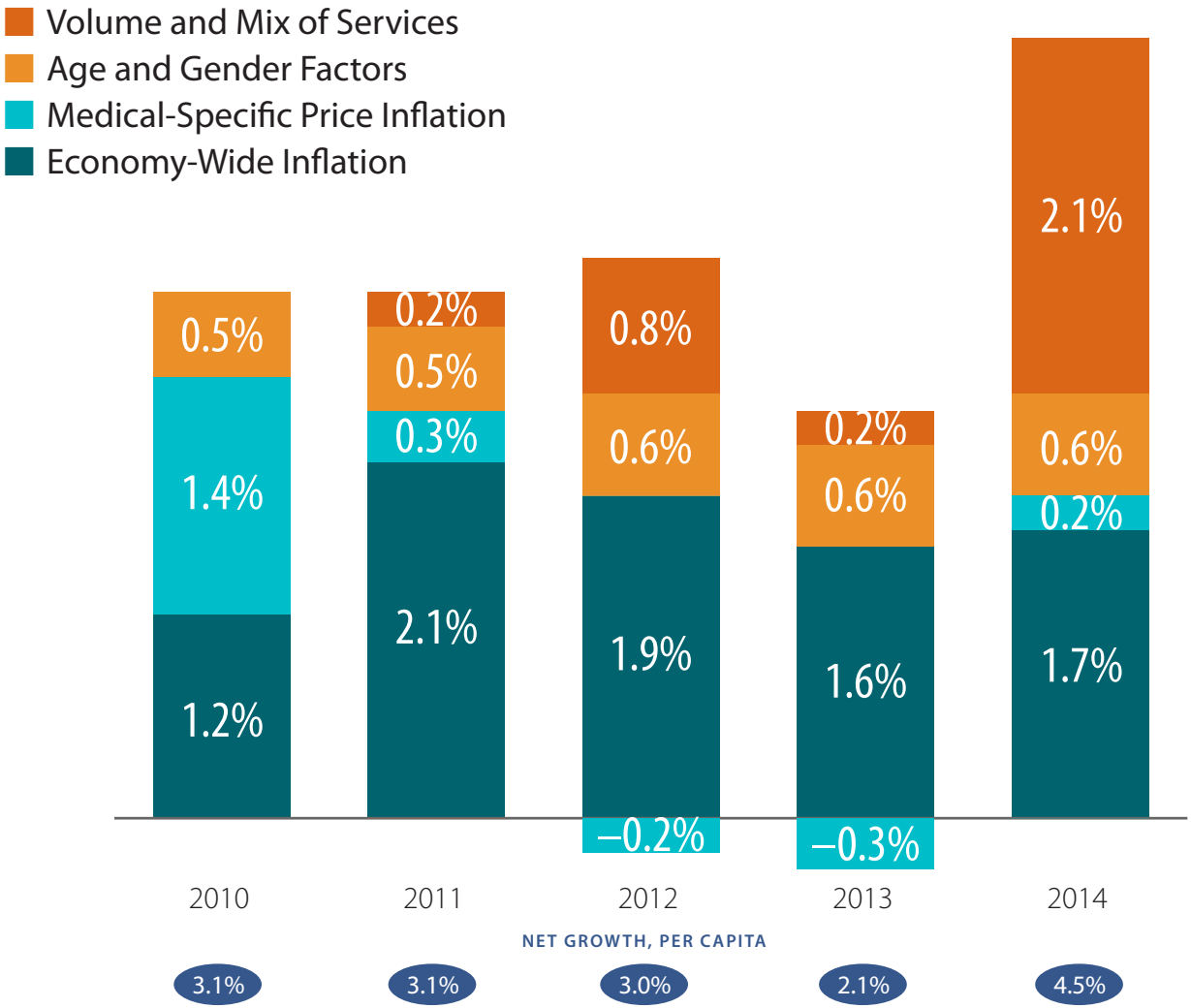
Notes: Because aggregate categories are deflated using chain-weighted price indexes, the sum of real spending for the deflated categories will not equal the totals. *Personal health care spending* excludes government administration, the net cost of health insurance, research, and investment. For additional detail on spending categories, see Appendix A.

Sources: Author calculation using National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services (CMS), 2014, including unpublished CMS data (complete 1960-2014 series), associated with Table 23, "National Health Expenditures; Nominal Dollars, Real Dollars, Price Indexes, and Annual Percent Change: Selected Calendar Years."

The rise in health spending is not simply due to medical price increases. In inflation-adjusted dollars,* per capita spending grew more than four-fold, from $1,617 per person in 1964 to $7,331 in 2014. Reasons for this growth include changes in the volume and mix of services, technological advances, and shifts in the age and gender mix of the population.

*Inflation adjustments remove the impact of changes in health care prices. For further information on price deflators, see *Definitions, Sources, Methods* and *NHE Deflator Methodology* at **www.cms.gov**.

Factors Contributing to per Capita Spending Growth
United States, 2010 to 2014



Notes: Price factors (*economy-wide inflation* and *medical-specific inflation*) and nonprice factors (age, gender, and volume and mix of services) contribute to spending growth. *Volume and mix of services,* also referred to as use and intensity, is computed as a residual and includes any measurement error. The impact of population growth is removed.

Sources: Anne B. Martin et al., "National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending," *Health Affairs* 35, No. 1 (December 2, 2015), Exhibit 4; unpublished data points related to article's Exhibit 4 provided by Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

The overall growth rate of per capita spending more than doubled from 2013 to 2014. Increases in insurance coverage led to expanded use of health care services, as seen in the increase in the volume and mix of services. The portion of the population covered by insurance rose during this period from 86.0% to 88.8%.

Health Spending Summary, by Category

United States, 1994 to 2014, Selected Years

	SPENDING LEVEL (IN BILLIONS)			DISTRIBUTION			GROWTH RATE*		
	1994	2013	2014	1994	2013	2014	1994-2014	2013	2014
National Health Expenditures	**$967.2**	**$2,879.9**	**$3,031.3**	**100%**	**100%**	**100%**	**5.9%**	**2.9%**	**5.3%**
Hospital Care	328.4	933.9	971.8	34%	32%	32%	5.6%	3.5%	4.1%
Physician and Clinical Services	210.5	576.8	603.7	22%	20%	20%	5.4%	2.5%	4.6%
Dental Services	41.6	110.4	113.5	4%	4%	4%	5.2%	1.5%	2.8%
Other Professional Services	24.0	80.3	84.4	2%	3%	3%	6.5%	3.5%	5.2%
Nursing Care Facilities	58.4	150.2	155.6	6%	5%	5%	5.0%	1.3%	3.6%
Home Health Services	27.3	79.4	83.2	3%	3%	3%	5.7%	3.3%	4.8%
Other Health Care	37.5	144.5	150.4	4%	5%	5%	7.2%	4.7%	4.1%
Prescription Drugs	53.0	265.3	297.7	5%	9%	10%	9.0%	2.4%	12.2%
Other Medical Products	39.6	100.5	103.3	4%	3%	3%	4.9%	3.2%	2.8%
Net Cost of Health Insurance	44.9	173.2	194.6	5%	6%	6%	7.6%	5.3%	12.4%
Government Administration	11.0	36.3	40.2	1%	1%	1%	6.7%	8.5%	10.7%
Public Health Activities	29.6	76.6	79.0	3%	3%	3%	5.0%	0.7%	3.1%
Investment	61.6	152.5	153.9	6%	5%	5%	4.7%	–0.5%	0.9%

*Growth rate for 1994-2014 is average annual; others are annual changes.

Notes: *Health spending* refers to national health expenditures. For additional detail on spending categories, see Appendix A. Further definitions available at www.cms.gov.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Health spending in 2014 accelerated, growing 5.3% compared to 2.9% in the prior year. Nearly all categories grew faster in 2014 than 2013, especially prescription drugs (12.2% vs. 2.4% the prior year). The share of total spending accounted for by prescription drugs doubled in the past 20 years, from 5% to 10%.

SPENDING CATEGORY DEFINITIONS

Government administration includes the administrative costs of government health care programs such as Medicare and Medicaid.

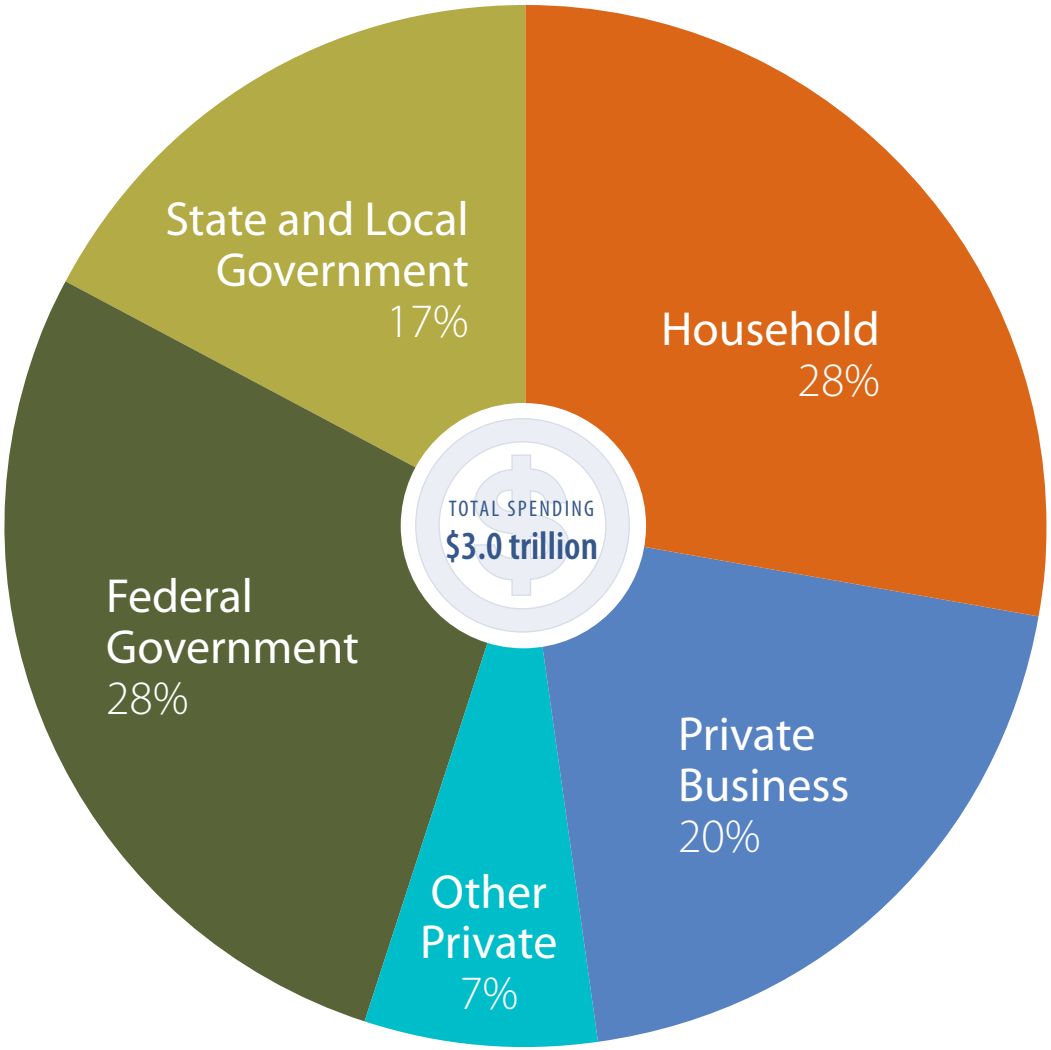
Investment includes research, structures, and equipment.

Net cost of health insurance reflects the difference between benefits and premiums for private insurance and includes administrative expenses, premium taxes, and profits.

Other health care refers to the category other health, residential, and personal care.

Other medical products refers to durable medical equipment and nondurable medical products.

Health Spending Distribution, by Sponsor
United States, 2014



Notes: *Health spending* refers to national health expenditures. *Sponsors* are the entities that are ultimately responsible for financing the health care bill. See page 18 for trend data.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Sponsors finance the nation's health care bill by paying insurance premiums, out-of-pocket expenses, and payroll taxes, or by directing general tax revenues to health care. In 2014, the federal government and households accounted for the largest share of health spending, 28% each.

SPONSOR DEFINITIONS

Federal government sponsors health care via general tax revenues, plus payroll tax and employer contributions to health insurance premiums for its workers.

Households sponsor health care through out-of-pocket costs, health insurance premiums, and payroll taxes.

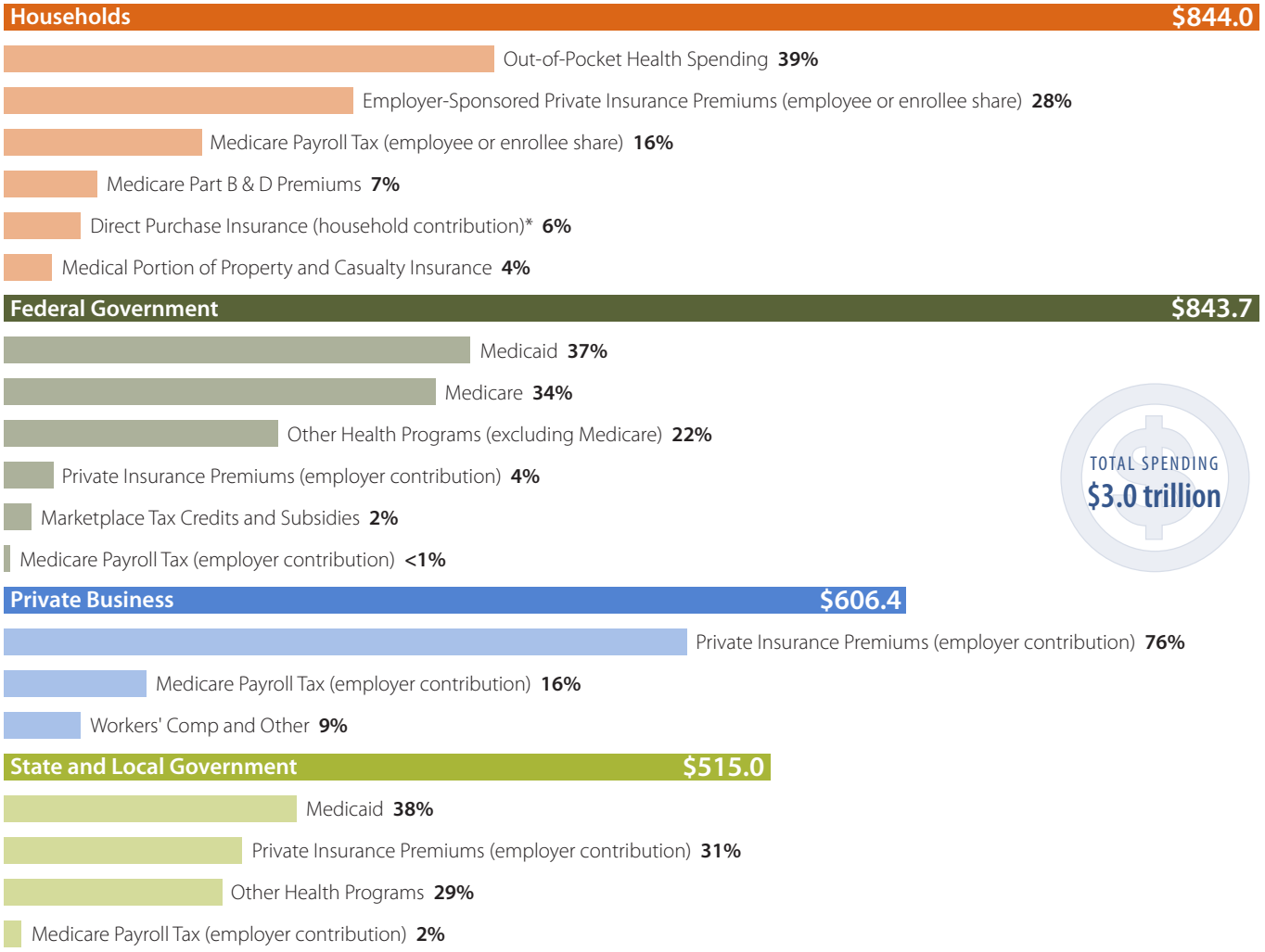
Other private contributions include philanthropy, privately funded structures and equipment, and investment income.

Private business sponsors health care through employer contributions to health insurance premiums and payroll taxes.

State and local government sponsors health care programs and pays payroll taxes and health insurance premiums for its workers.

Health Spending Distribution, Sponsor Detail

United States, 2014



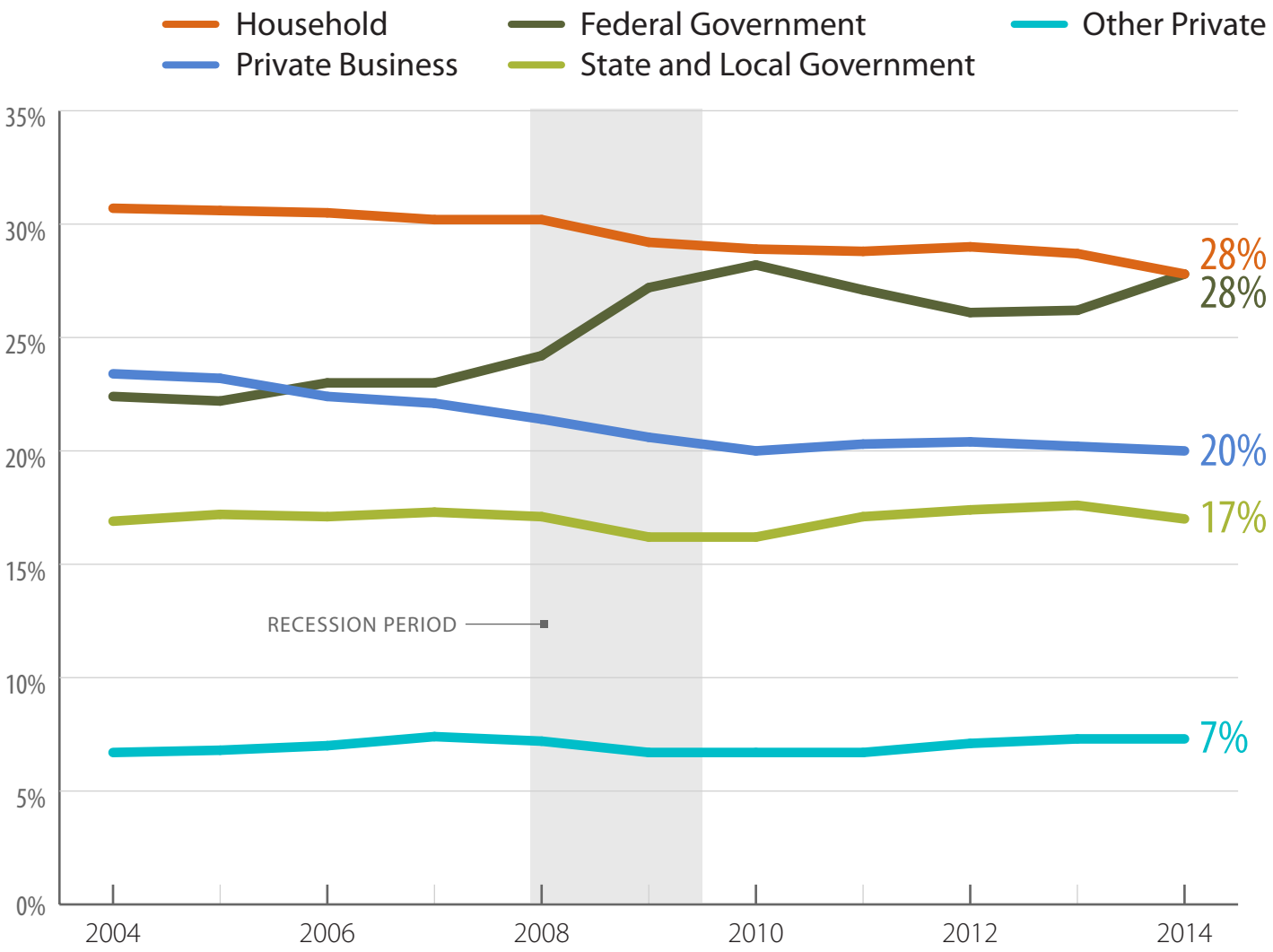
*Includes premiums paid by individuals for marketplace plans, Medigap, and other directly purchased health insurance, such as coverage purchased off-exchange.

Notes: *Health spending* refers to national health expenditures. *Sponsors* are the entities that are ultimately responsible for financing the health care bill. *Other health programs* includes Department of Defense and Veterans Affairs health care, maternal and child health, and Children's Health Insurance Program (CHIP). *Marketplace* is individual coverage purchased on federal- and state-run health exchanges, such as Covered California and healthcare.gov. Medicaid buy-in premiums for Medicare are reflected under Medicaid. Not shown: other private revenues ($222.2 billion), which includes philanthropy, investment income, and private investment in research, structures, and equipment. Figures may not sum due to rounding.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Out-of-pocket spending consumed the largest share of health spending for households, with contributions to employer-sponsored insurance representing the second-largest health expense. In contrast, households allocated 6% of their health care spending toward the direct purchase of insurance, a portion unchanged from the previous year. Federal spending on the new ACA marketplace premium tax credits and subsidies totaled 2% of federal health spending.

Health Spending Distribution, by Sponsor
United States, 2004 to 2014



Notes: *Health spending* refers to national health expenditures. *Sponsors* are the entities that are ultimately responsible for financing the health care bill. See page 34 for additional detail on factors contributing to the increase in the federal share of health spending.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Over the past 10 years, the share of health care spending by households and private businesses declined while the federal government share increased. The 2014 increase in the federal share reflects, in part, federal funding of ACA Medicaid expansion and the premium tax credit subsidies for insurance purchased through the health care exchanges.

Health Spending Summary, by Sponsor
United States, 1994 to 2014, Selected Years

	SPENDING LEVEL (IN BILLIONS)			DISTRIBUTION			GROWTH RATE*		
	1994	2013	2014	1994	2013	2014	1994-2014	2013	2014
National Health Expenditures	**$967.2**	**$2,879.9**	**$3,031.3**	**100%**	**100%**	**100%**	**5.9%**	**2.9%**	**5.3%**
Household	312.1	827.4	844.0	32%	29%	28%	5.1%	1.9%	2.0%
Private Business	220.3	581.9	606.4	23%	20%	20%	5.2%	1.7%	4.2%
Federal Government	203.0	755.5	843.7	21%	26%	28%	7.4%	3.5%	11.7%
State and Local Government	158.1	506.0	515.0	16%	18%	17%	6.1%	3.7%	1.8%
Other Private Revenue	73.8	209.1	222.2	8%	7%	7%	5.7%	5.9%	6.3%

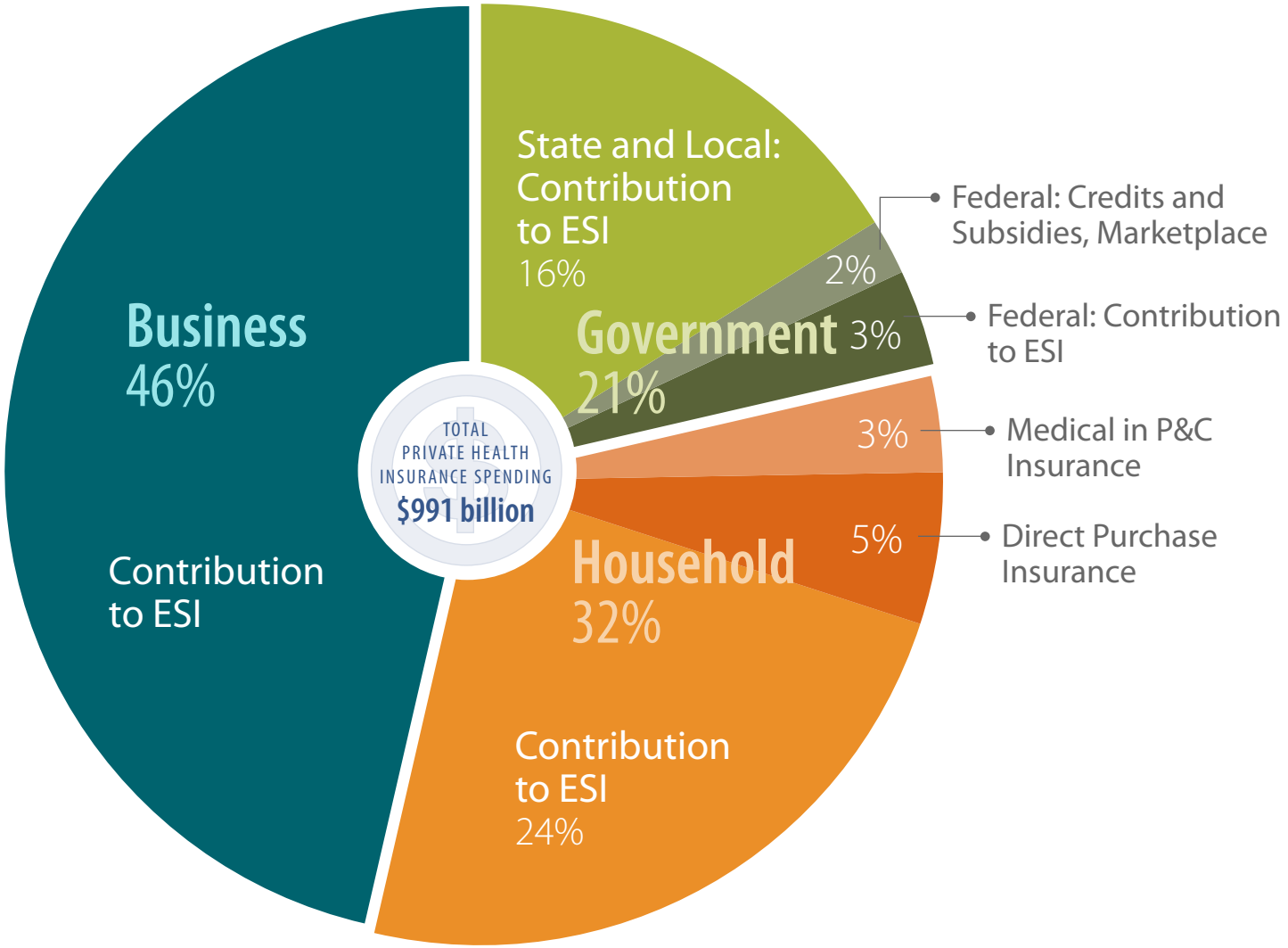
*Growth rate for 1994-2014 is average annual; others are annual increases.

Notes: *Health spending* refers to national health expenditures. *Sponsors* are the entities that are ultimately responsible for financing the health care bill. *Other private revenues* includes philanthropy, privately funded structures and equipment, and investment income. See page 17 for detail on how sponsors finance health care spending.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Over the past 20 years, the federal government has become a more significant sponsor of health care, with its share increasing from 21% to 28% in this period. During this same time, the share of health spending sponsored by households and private business declined. In 2014, the federal government's spending grew 11.7%, much faster than other sponsors.

Sponsors of Private Health Insurance
United States, 2014

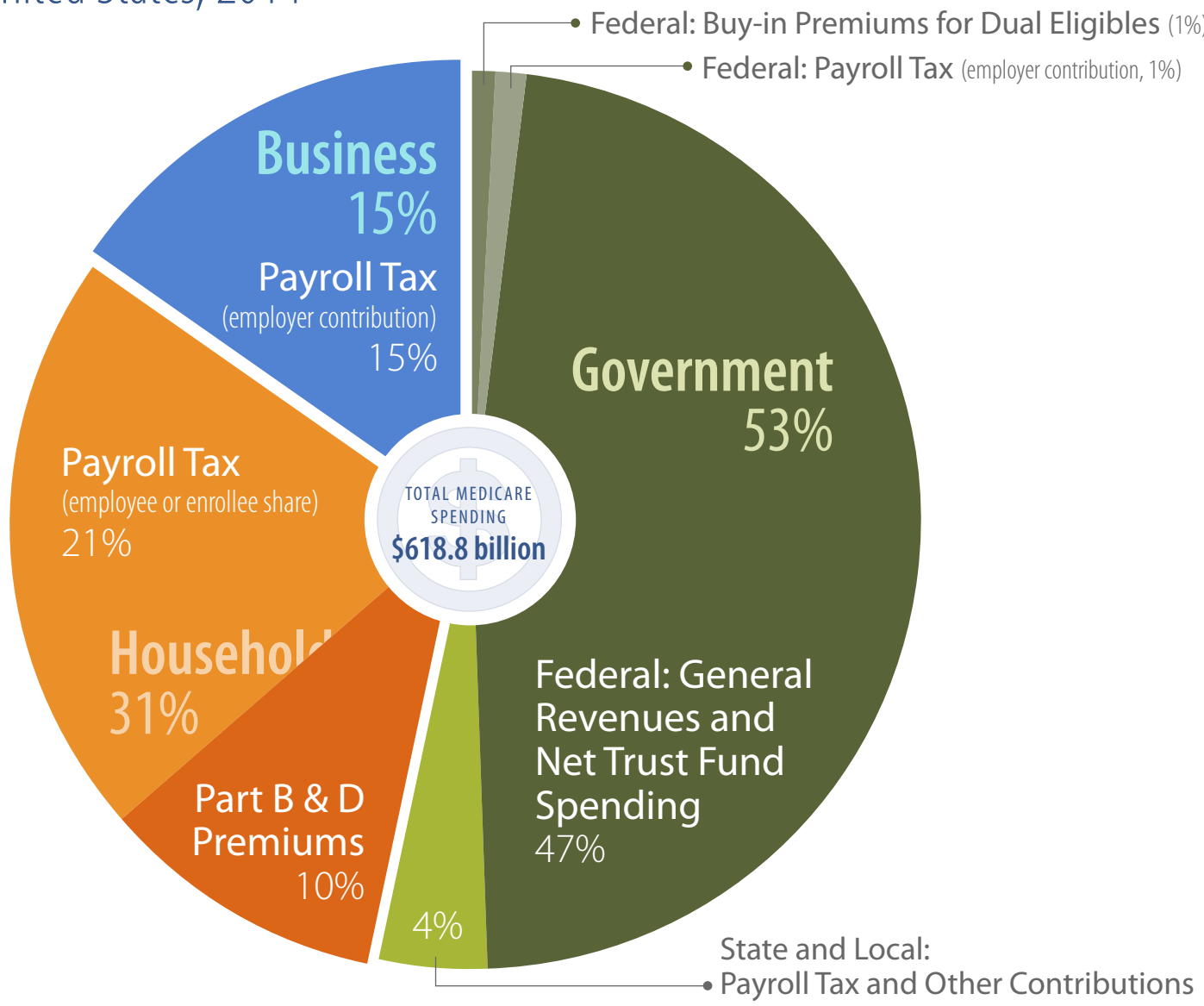


Notes: *Sponsors* are the entities that are ultimately responsible for financing the health care bill. *ESI* refers to employer-sponsored insurance; *P&C* refers to property and casualty insurance. *Direct purchase insurance* includes premiums paid by individuals for marketplace plans, Medigap, and other directly purchased health insurance, such as coverage purchased off-exchange. *Marketplace* is individual health insurance coverage purchased on federal- and state-run health exchanges, such as Covered California and healthcare.gov. Not shown: other federal (<1%). Segments don't add to 100% due to rounding.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Private business and households were the largest funders of private insurance. The federal government spent $18.5 billion (2% of all private health insurance spending) on premium tax credits and cost-sharing subsidies for the newly implemented marketplace plans.

Sponsors of Medicare
United States, 2014



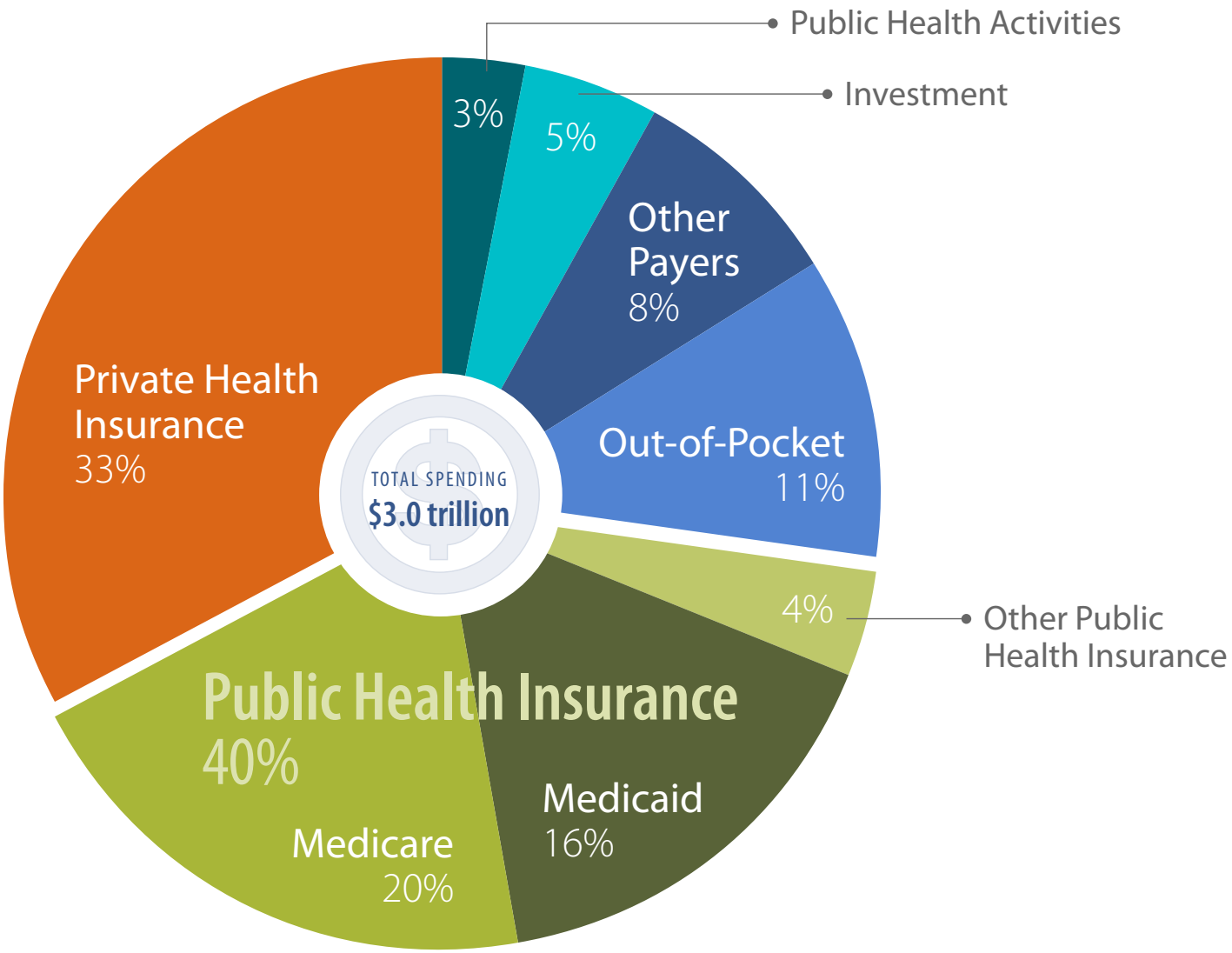
Government funds paid for more than half of Medicare spending.

Notes: *Sponsors* are the entities that are ultimately responsible for financing the health care bill. Segments don't add to 100% due to rounding.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Health Spending Distribution, by Payer

United States, 2014



Notes: *Health spending* refers to national health expenditures. See page 23 for historical distribution.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

In 2014, public health insurance paid the largest share of health care costs (40%). Private health insurance paid for 33% of health spending, while consumers' out-of-pocket spending acccounted for 11%.

PAYER DEFINITIONS

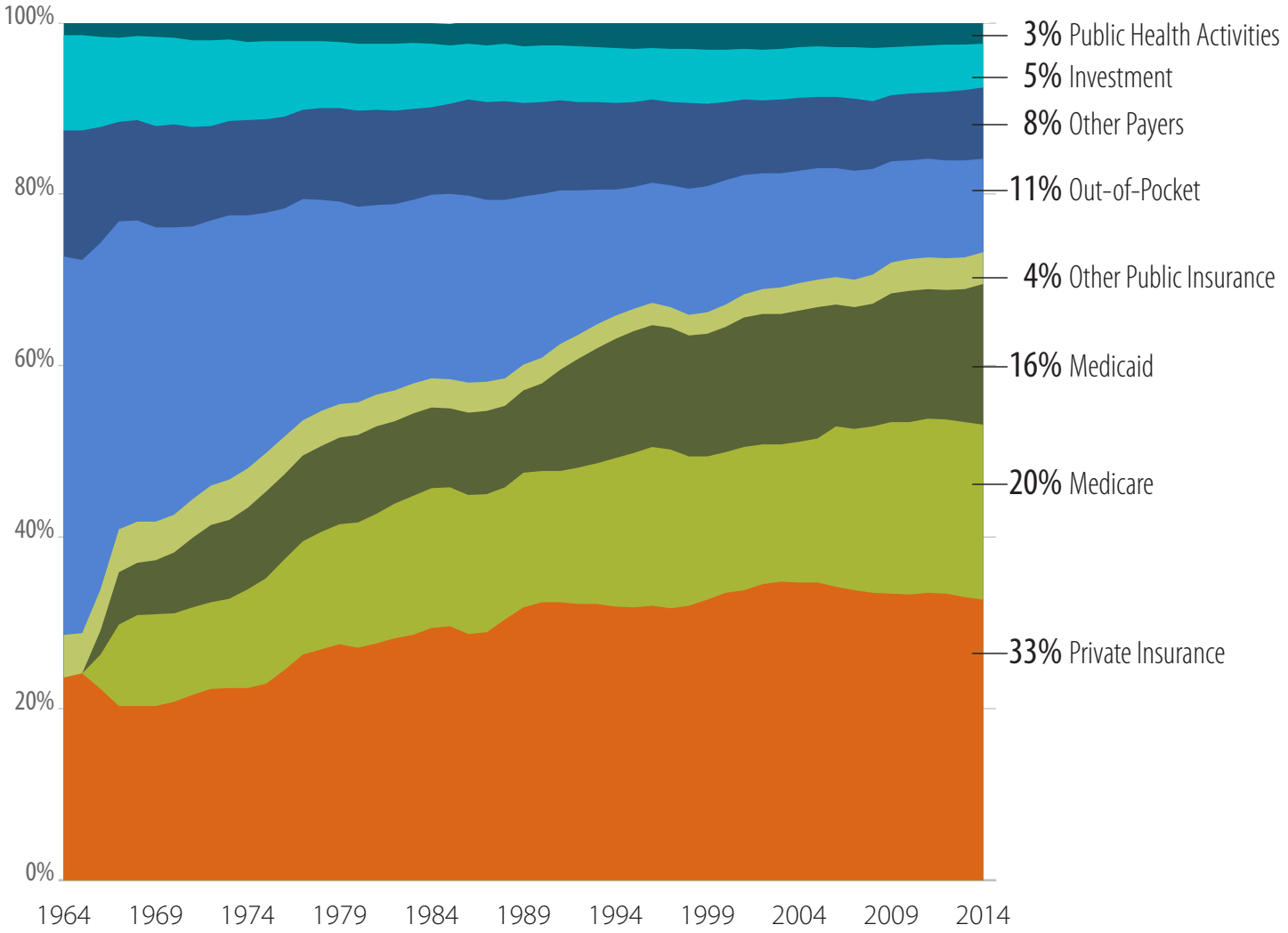
Other payers includes worksite health care, Indian Health Services, workers' compensation, maternal and child health, and vocational rehabilitation.

Other public health insurance includes Departments of Defense and Veterans Affairs health care and the Children's Health Insurance Program (CHIP).

Out-of-pocket includes consumer spending on copays, deductibles, and goods and care not covered by insurance; it does not include premiums.

Investment includes research, structures, and equipment.

Payment Sources
United States, 1964 to 2014



Note: *Health spending* refers to national health expenditures.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Out-of-pocket spending, as a share of all health spending, has shrunk dramatically over time as the share of spending by Medicare and Medicaid has expanded.

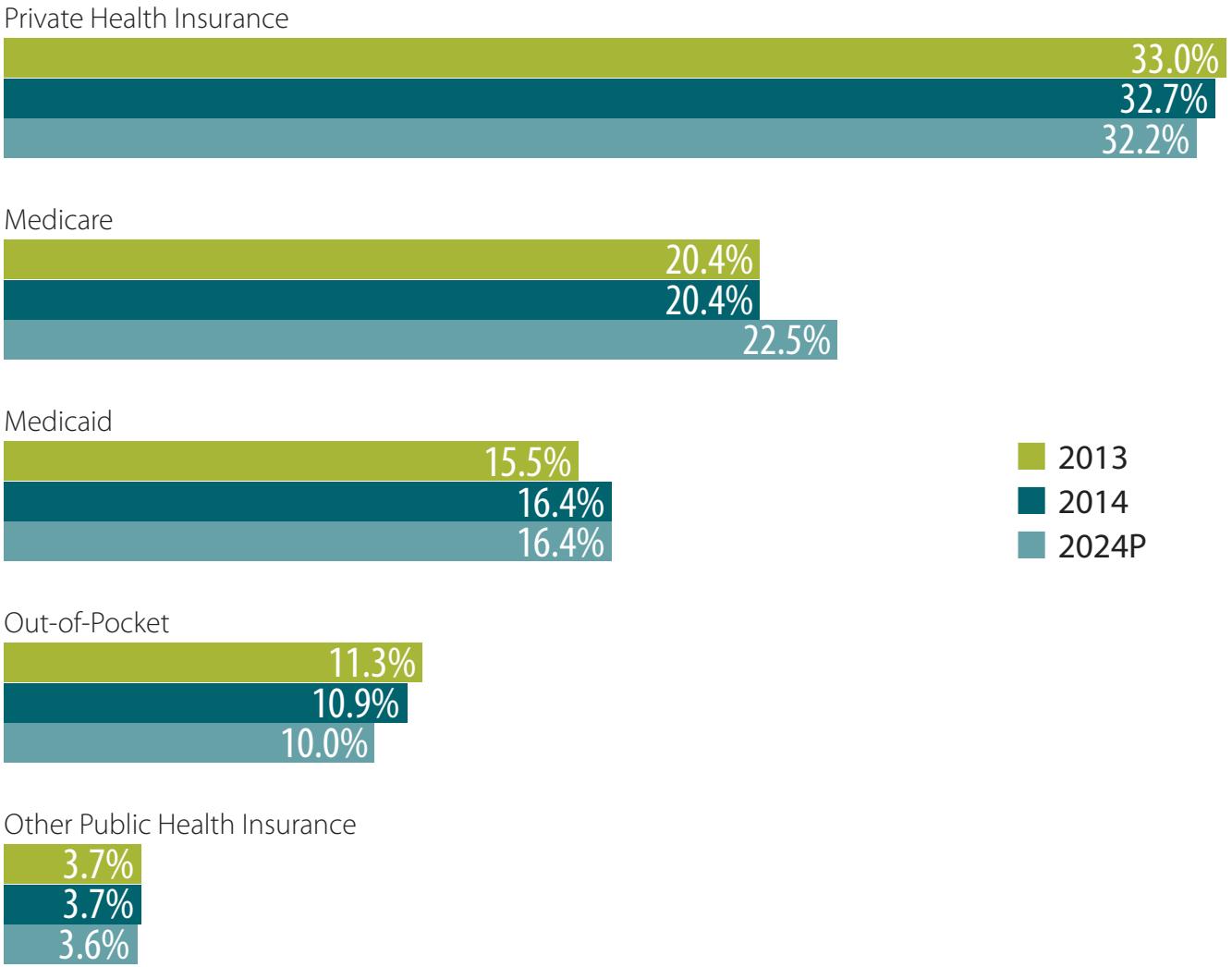
PAYER DEFINITIONS

Other payers includes worksite health care, Indian Health Services, workers' compensation, maternal and child health, and vocational rehabilitation.

Other public health insurance includes Departments of Defense and Veterans Affairs health care and the Children's Health Insurance Program (CHIP).

Out-of-pocket includes consumer spending on copays, deductibles, and goods and care not covered by insurance; it does not include premiums.

Health Spending Distribution, by Payer
United States, 2013 to 2024, Selected Years



Medicaid's share of health spending increased slightly in 2014 as the ACA was introduced, while Medicare's share remained unchanged. Projections for 2024 show a larger share of spending by Medicare as the population ages.

Notes: *Health spending* refers to national health expenditures. Projections shown as *P*. See page 23 for historical distribution. Not shown: other payers, public health activities, and investment, which totaled 16.2%, 16.0%, and 15.5% in 2013, 2014, and 2024P, respectively.

Sources: National Health Expenditure Data, Historical, 1960-2014 (www.cms.gov) and Projections, 2013-2024 (www.cms.gov), Centers for Medicare & Medicaid Services, 2015.

Health Spending Summary, by Payer
United States, 2014

	SPENDING LEVEL (IN BILLIONS)			DISTRIBUTION			GROWTH RATE*		
	1994	2013	2014	1994	2013	2014	1994-2014	2013	2014
National Health Expenditures	**$967.2**	**$2,879.9**	**$3,031.3**	**100%**	**100%**	**100%**	**5.9%**	**2.9%**	**5.3%**
Out-of-Pocket	142.0	325.5	329.8	15%	11%	11%	4.3%	2.1%	1.3%
Private Health Insurance	308.2	949.2	991.0	32%	33%	33%	6.0%	1.6%	4.4%
Medicare	167.7	586.3	618.7	17%	20%	20%	6.7%	3.0%	5.5%
Medicaid	134.4	446.7	495.8	14%	16%	16%	6.7%	5.9%	11.0%
Other Public Insurance	26.5	105.6	111.4	3%	4%	4%	7.5%	3.3%	5.5%
Other Payers	97.3	237.5	251.7	10%	8%	8%	4.9%	6.3%	6.0%
Public Health	29.6	76.6	79.0	3%	3%	3%	5.0%	0.7%	3.1%
Investment	61.6	152.5	153.9	6%	5%	5%	4.7%	–0.5%	0.9%

*Growth rate for 1994-2014 is average annual; others are annual changes.

Notes: *Health spending* refers to national health expenditures. Figures may not sum due to rounding.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

For most payers, spending grew faster in 2014 than in 2013. The Medicaid growth rate nearly doubled. Over the past 20 years, the share of out-of-pocket spending fell, while the share of spending by Medicare and Medicaid increased.

PAYER DEFINITIONS

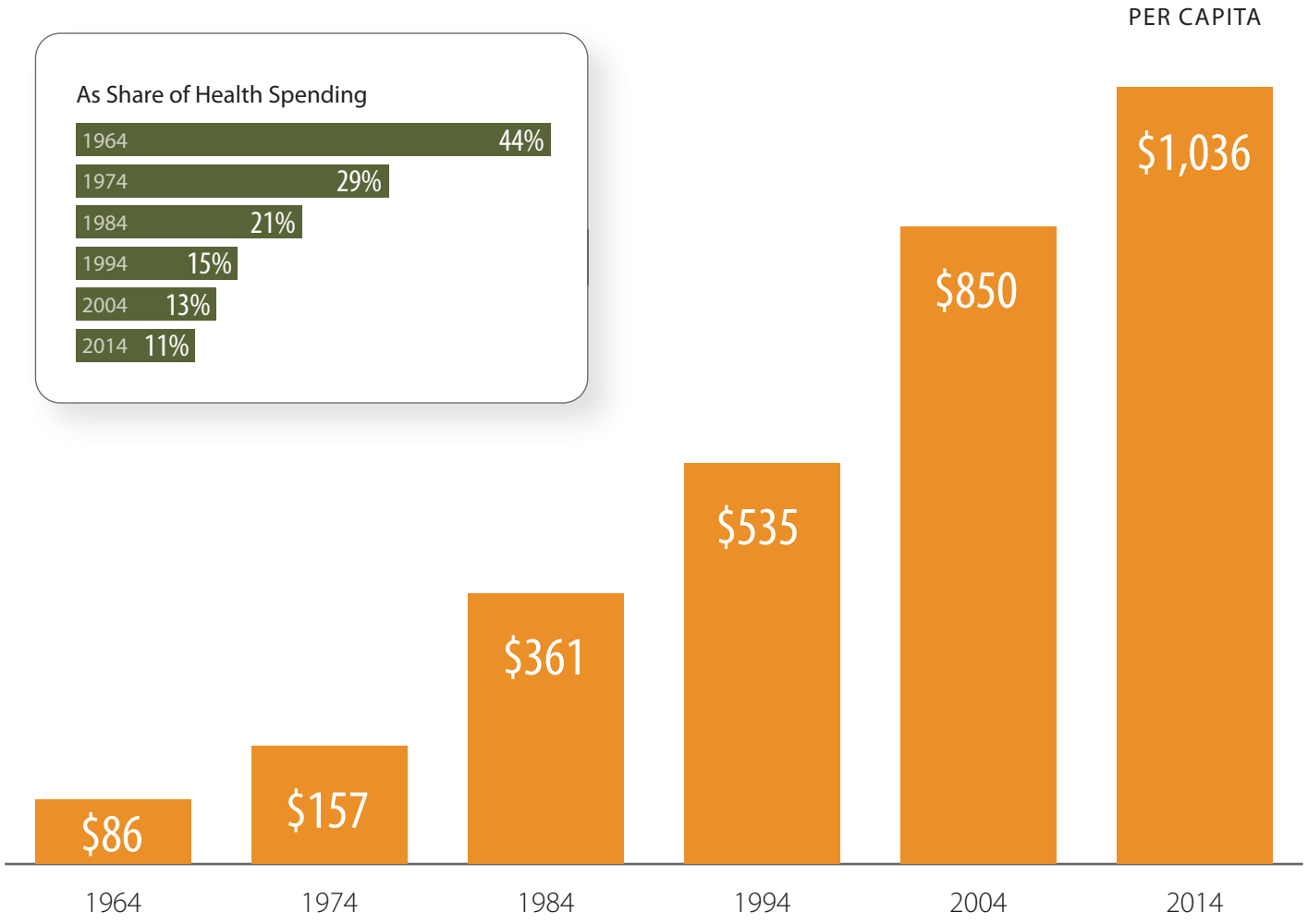
Other payers includes worksite health care, Indian Health Services, workers' compensation, maternal and child health, and vocational rehabilitation.

Other public health insurance includes Departments of Defense and Veterans Affairs and the Children's Health Insurance Program (CHIP).

Out-of-pocket includes consumer spending on copays, deductibles, and goods and care not covered by insurance; it does not include premiums.

Out-of-Pocket Spending, per Capita vs. Share of Spending

United States, 1964 to 2014, Selected Years



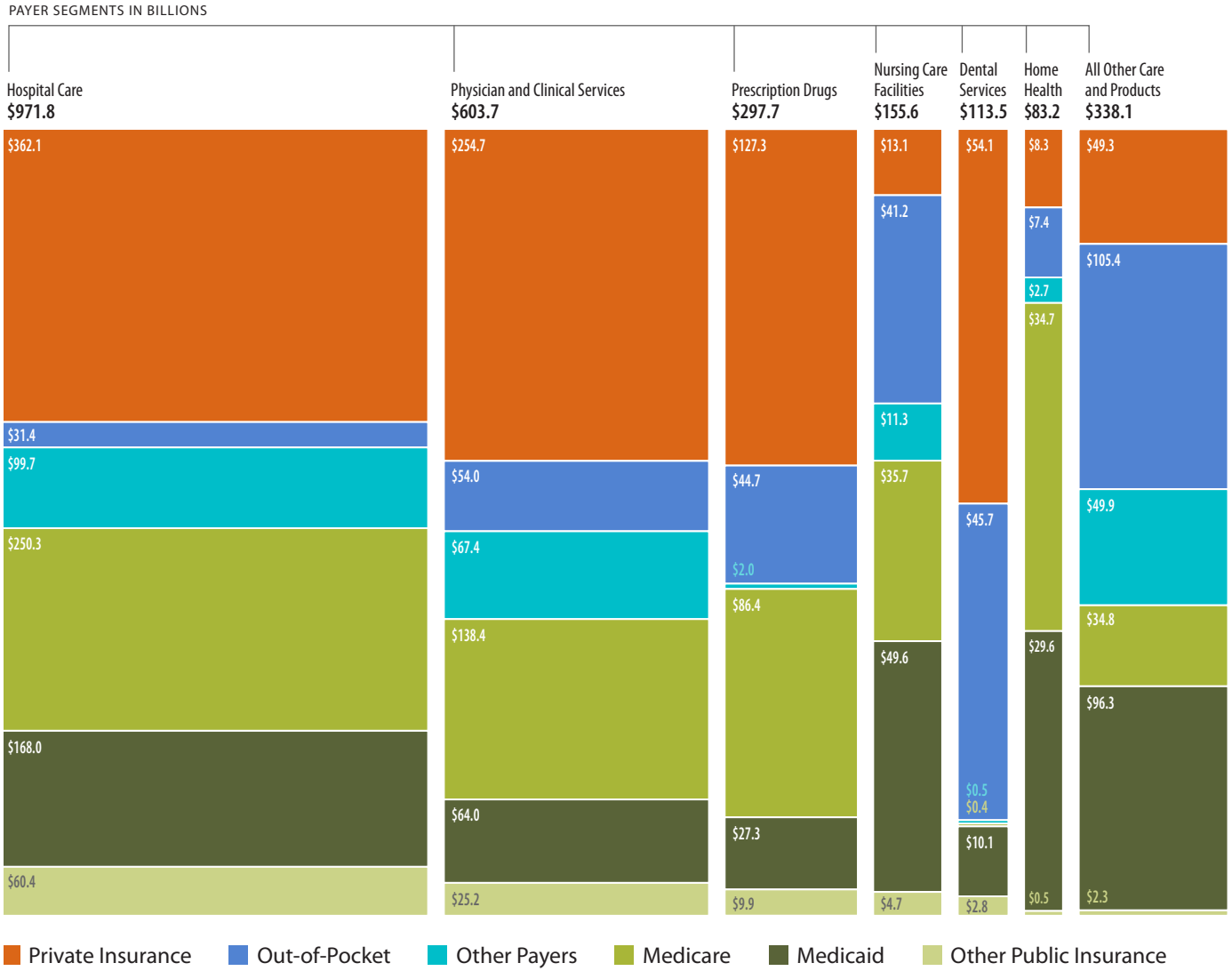
Notes: *Health spending* refers to national health expenditures. Figures not adjusted for inflation.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

While consumer out-of-pocket spending, as a share of all health spending, has declined steadily since 1964, the dollar amount each person spent has risen steadily. In 2014, an individual spent out of pocket an average of $1,036 for coinsurance, deductibles, and other health care expenses not covered by insurance (not including premiums).

Payer Mix, by Service Category
United States, 2014

Personal Health Care: **$2.6 trillion**



Notes: *All other care and products* consists of durable medical equipment, nondurable medical products, other professional services, and other health, residential, and personal care. Segments may not sum due to rounding. For additional detail on spending categories, see Appendix A. Further definitions available at www.cms.gov.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Private insurance paid for more than 40% of prescription drugs and physician and clinical services, while Medicare and Medicaid paid for most of home health care. A substantial portion of dental expenses are paid for out of pocket.

For an interactive look at how the payer mix by service category has changed over time, visit **www.chcf.org/hcc101.**

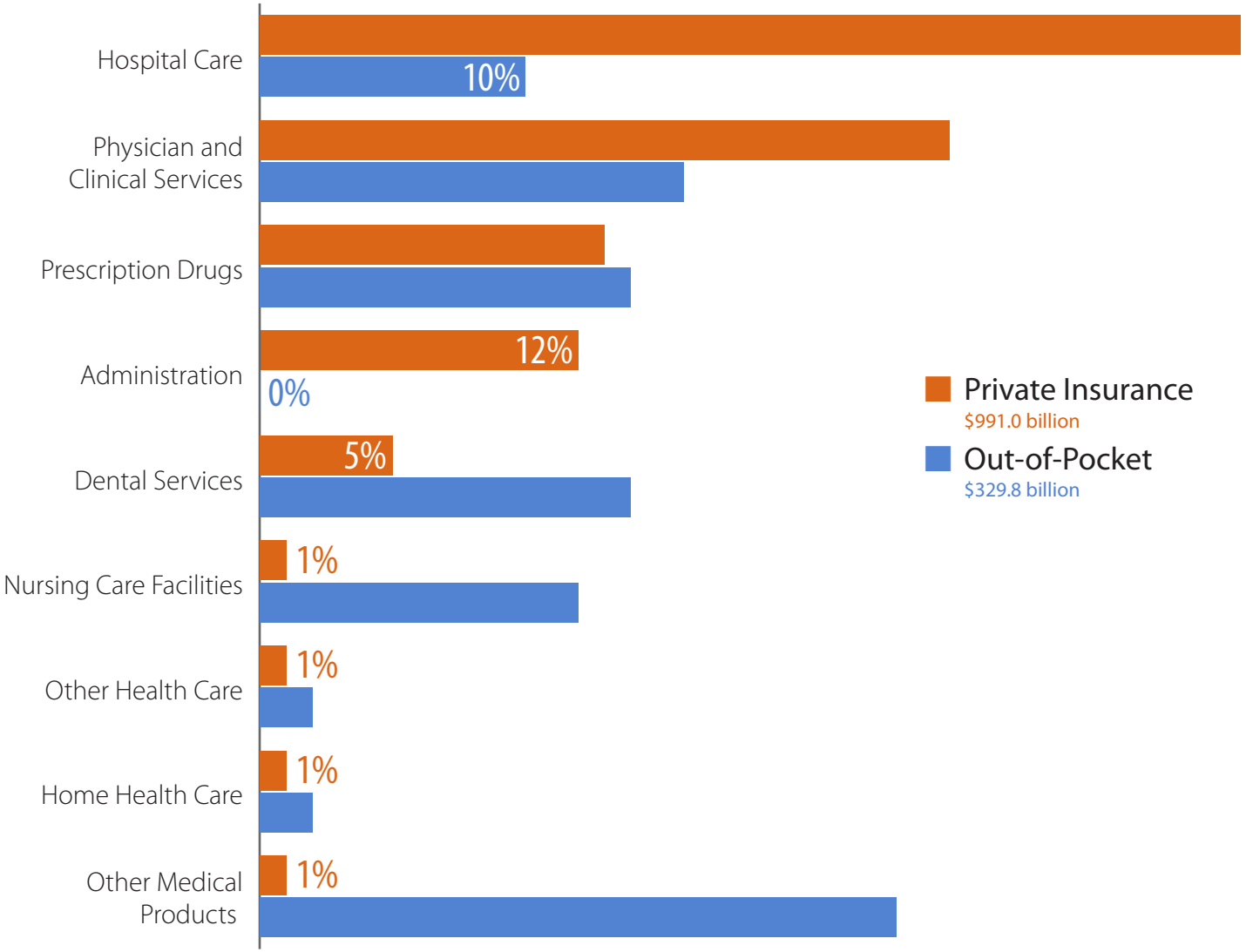
PAYER DEFINITIONS

Other payers includes worksite health care, Indian Health Services, workers' compensation, maternal and child health, and vocational rehabilitation.

Other public health insurance includes Departments of Defense and Veterans Affairs and the Children's Health Insurance Program (CHIP).

Out-of-pocket includes consumer spending on copays, deductibles, and goods and care not covered by insurance; it does not include premiums.

Spending Distribution, Private Insurance vs. Out-of-Pocket
United States, 2014



Notes: *Health spending* refers to national health expenditures. Not shown: other professional services (3% of private health insurance and 6% of out-of-pocket). For additional detail on spending categories, see Appendix A. Further definitions available at www.cms.gov.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Hospital care was the largest expense category for private health insurance, and accounted for 37% of total private insurance spending. In contrast, the other medical products category, which includes items such as eyeglasses and over-the-counter medications, was the largest category for out-of-pocket spending.

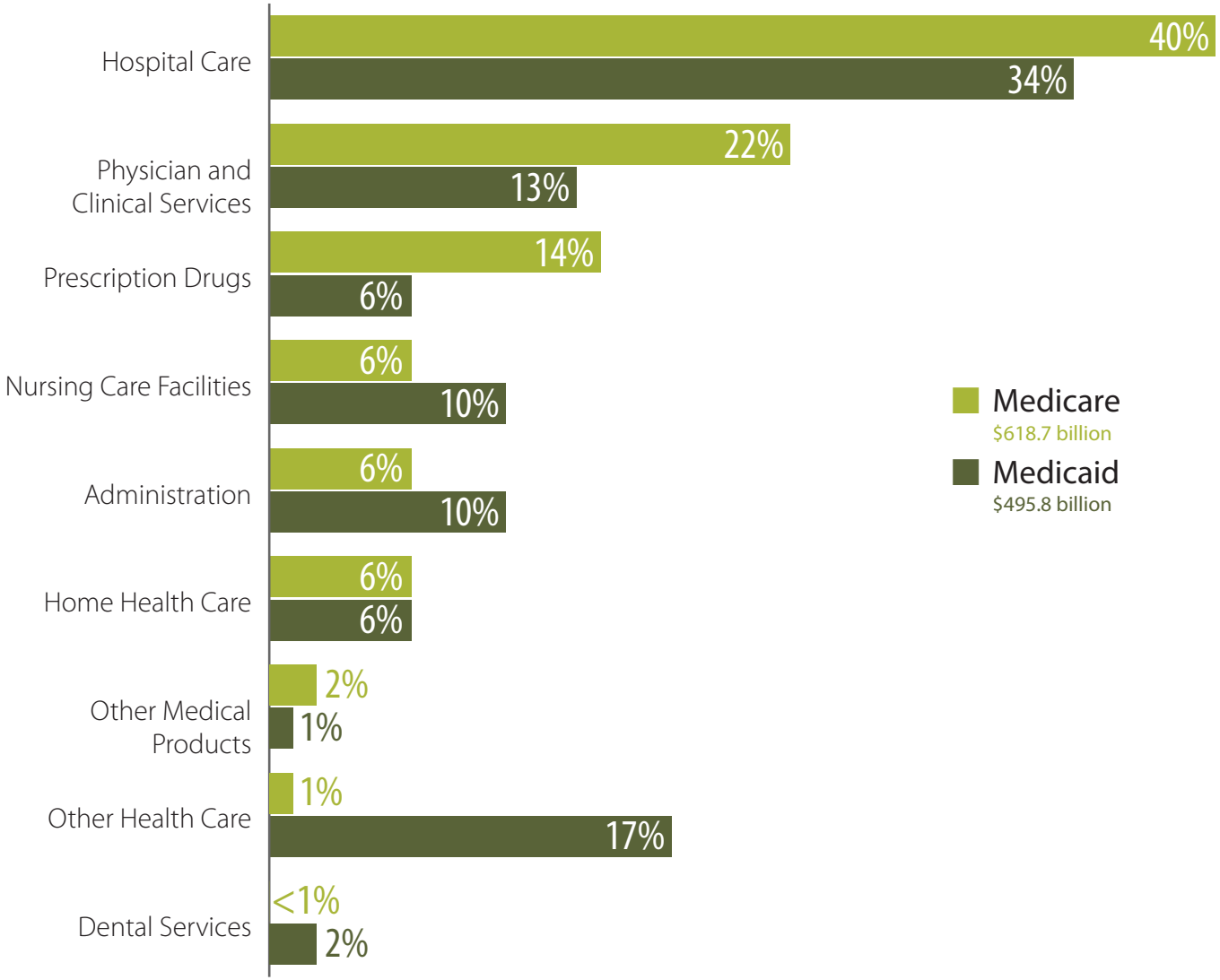
SPENDING CATEGORY DEFINITIONS

Administration includes the administrative costs of government health care programs such as Medicare and Medicaid as well as the net cost of health insurance.

Other health care refers to the category other health, residential, and personal care.

Other medical products refers to durable medical equipment and nondurable medical products.

Spending Distribution, Medicare vs. Medicaid
United States, 2014



Notes: *Health spending* refers to national health expenditures. Not shown: other professional services (3% of Medicare and 1% of Medicaid). For additional detail on spending categories, see Appendix A. Further definitions available at www.cms.gov.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

The largest expense category for both Medicare and Medicaid was hospital care. Medicaid's second-largest spending category, at $84 billion or 17% of spending, was other health care, which includes the Medicaid home and community-based waiver programs that provide alternatives to long-term insitutional services.

SPENDING CATEGORY DEFINITIONS

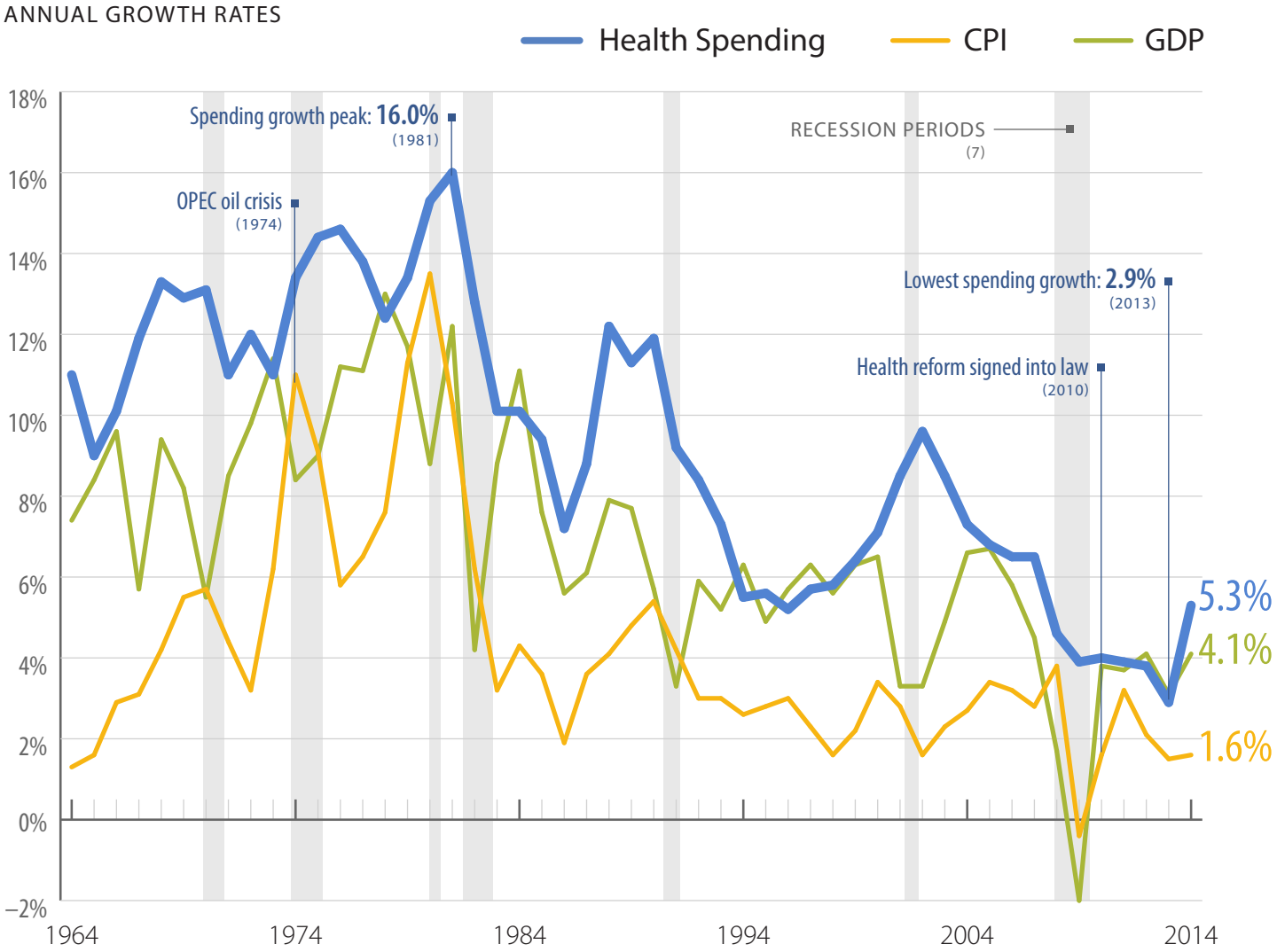
Administration includes the administrative costs of government health care programs such as Medicare and Medicaid as well as the net cost of health insurance.

Other health care refers to the category other health, residential, and personal care.

Other medical products refers to durable medical equipment and nondurable medical products.

Health Spending vs. Inflation and the Economy

United States, 1964 to 2014



Notes: *Health spending* refers to national health expenditures. *CPI* refers to consumer price index and *GDP* refers to gross domestic product.

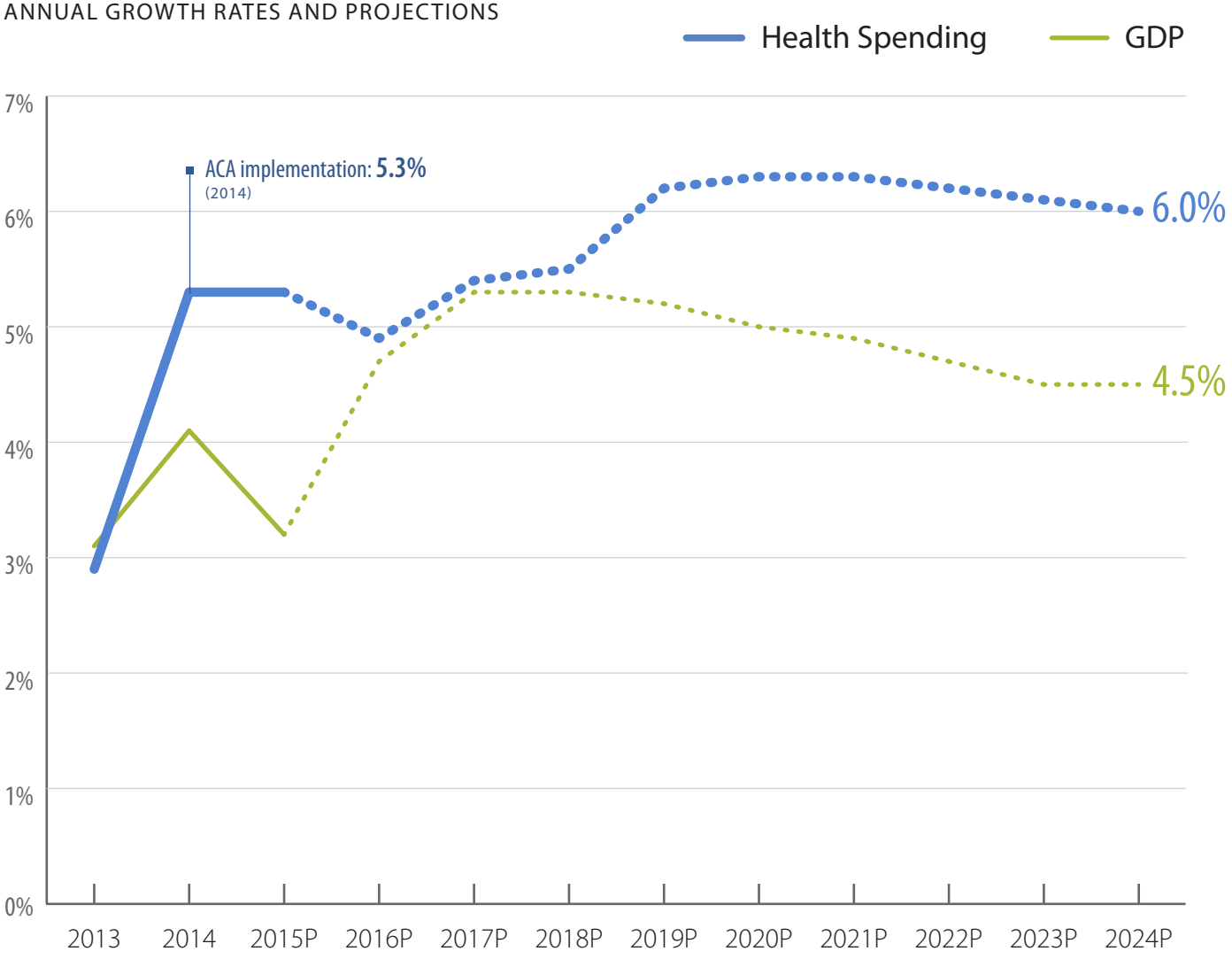
Sources: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov; CPI-U: US City Average, Annual Figures, Bureau of Labor Statistics.

Over the past 50 years, health spending growth has consistently outpaced inflation. For most of this period, health spending also grew faster than the economy, with the exception of 2010–2013, when GDP and health spending grew at a similar rate.*

*See page 14 for detail on the components of health spending growth.

Health Spending vs. the Economy
United States, 2013 to 2024

ANNUAL GROWTH RATES AND PROJECTIONS

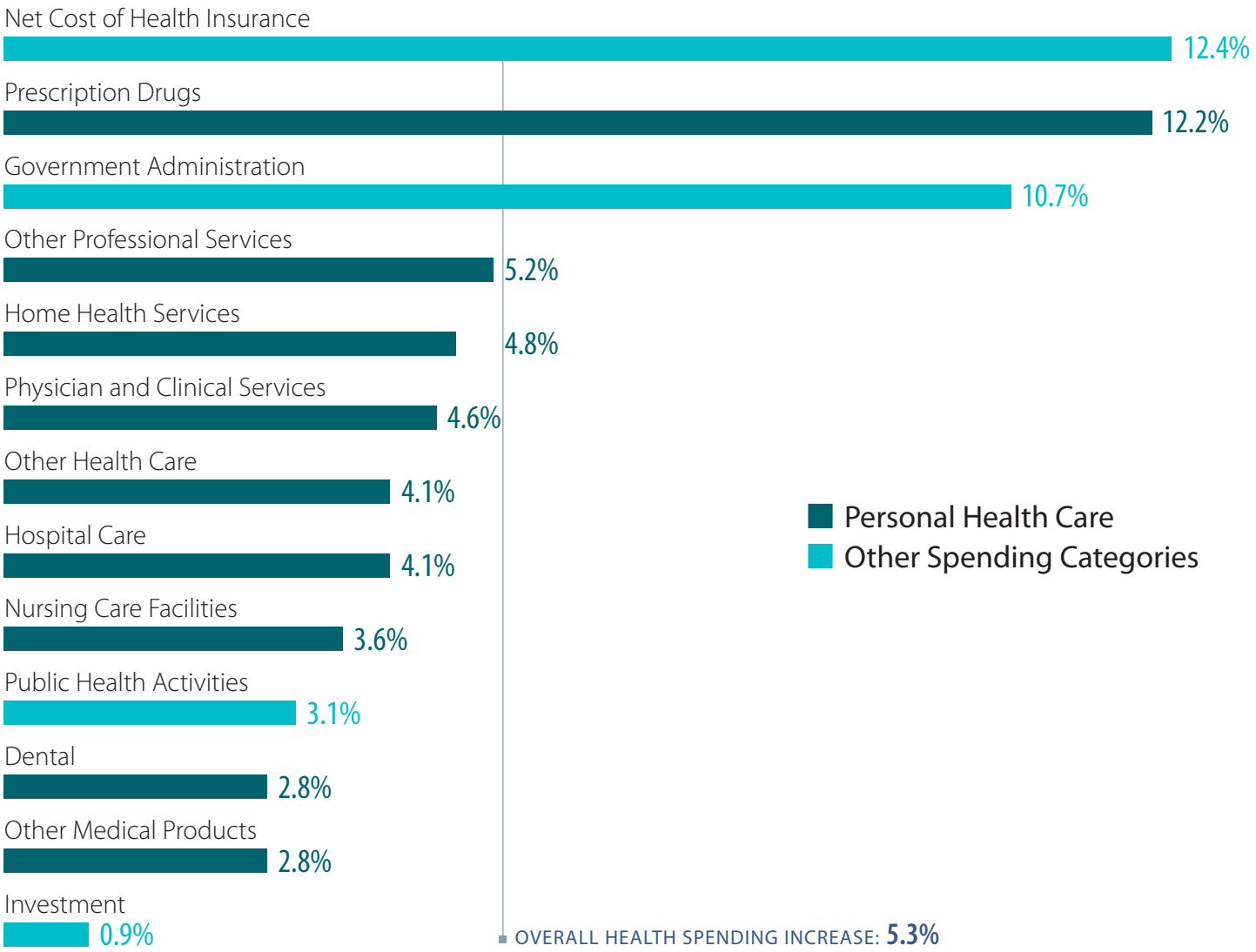


Notes: *Health spending* refers to national health expenditures. *GDP* refers to gross domestic product. Projections shown as *P*.

Sources: National Health Expenditure Data, Historical, 1960-2014 (www.cms.gov) and Projections, 2013-2024 (www.cms.gov), Centers for Medicare & Medicaid Services, 2015.

During the 2014 to 2024 period, health spending is projected to grow at an average rate of 5.8% per year, 1.1 percentage points faster than gross domestic product (GDP). Based on these projections, health care's share of GDP is projected to reach 19.6% by 2024.

Growth Rates, by Spending Category
United States, 2014



Notes: For additional detail on spending categories, see Appendix A. Further definitions available at www.cms.gov.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

The net cost of insurance, prescription drugs, and government administration categories of spending grew more than twice as fast as any other category. Prescription drug increases were due in part to spending on new medicines, especially specialty drugs. New hepatitis C drugs were the largest driver of specialty drug increases in 2014 and contributed $11.3 billion in new spending.

SPENDING CATEGORY DEFINITIONS

Government administration includes the administrative costs of health care programs such as Medicare and Medicaid.

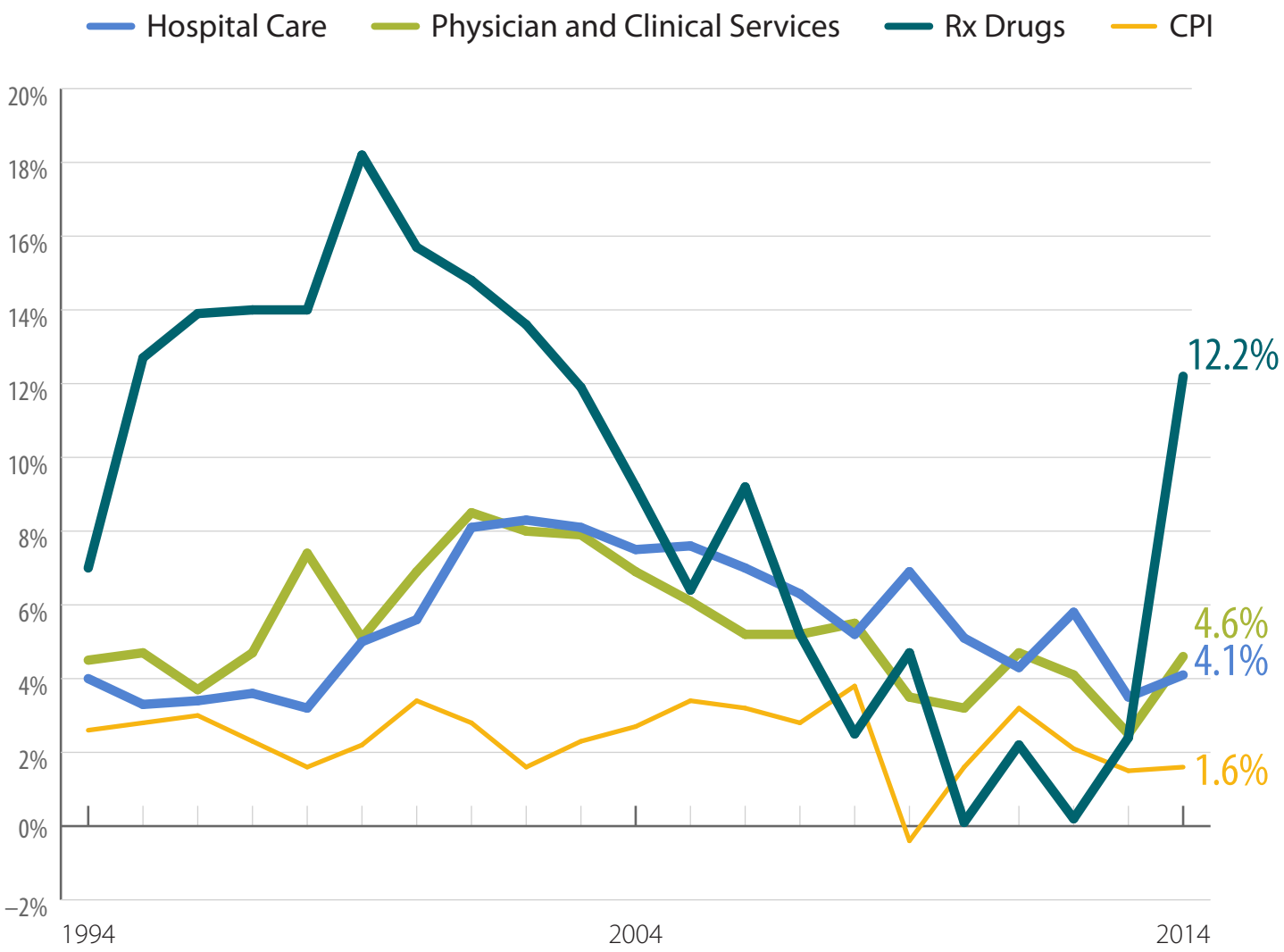
Net cost of health insurance refers to the difference between private health insurance expenditures and benefits, and includes administrative costs, additions to reserves, rate credits and dividends, premium taxes and fees, and profits or losses.

Other health care refers to the category other health, residential, and personal care.

Other medical products refers to durable medical equipment and nondurable medical products.

Other professional services consists of care provided in establishments operated by health care providers other than physicians or dentists, such as chiropractors, podiatrists, and speech therapists.

Annual Growth Rates, Largest Spending Categories
United States, 1994 to 2014

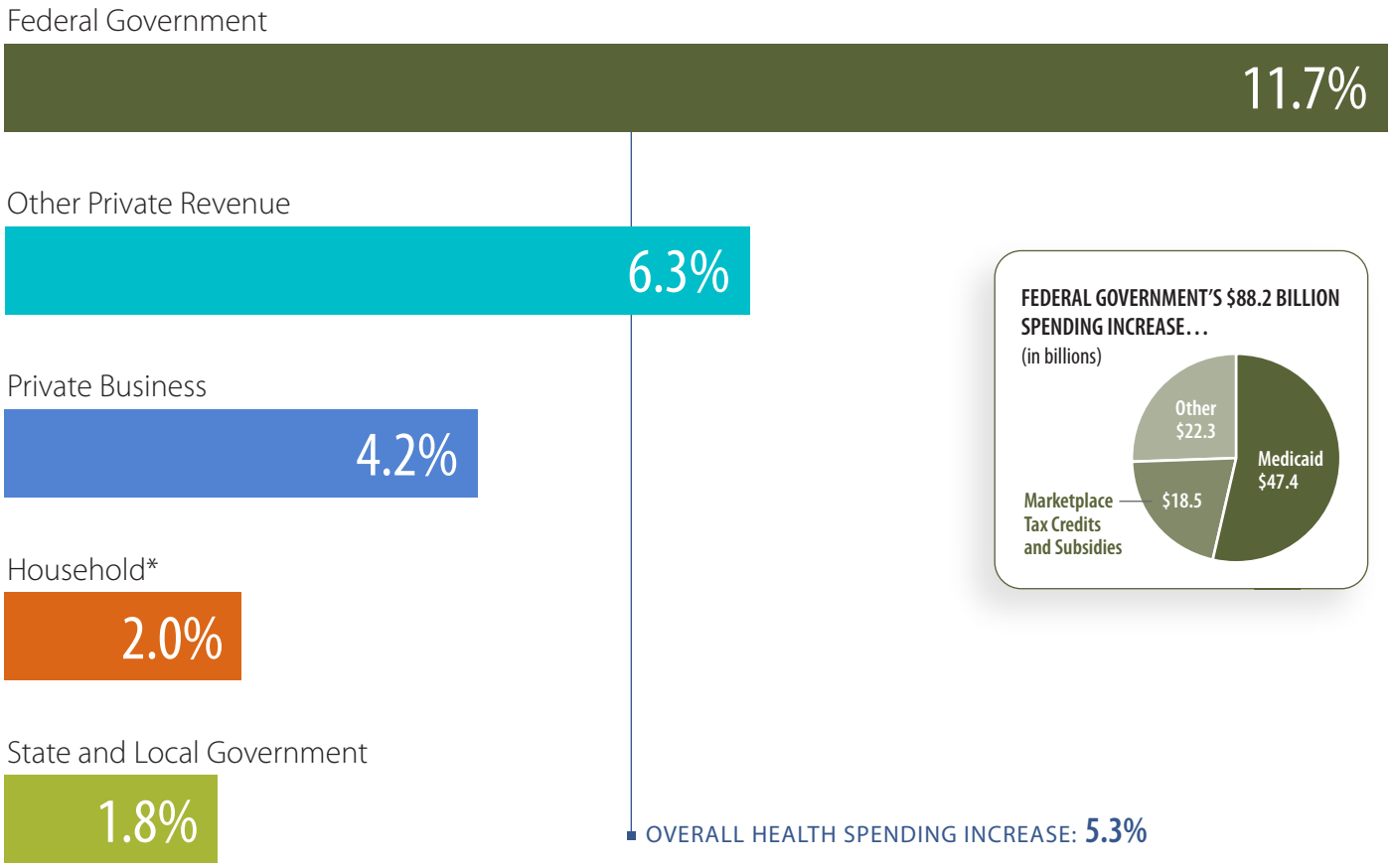


Notes: *Health spending* refers to national health expenditures. *CPI* is consumer price index.

Sources: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov; CPI-U: US City Average, Annual Figures, Bureau of Labor Statistics.

Historically, prescription drug spending has been more volatile than the other major spending categories. After a period of low growth, spending on prescription drugs skyrocketed in 2014. Growth in spending on hospital and physician services remained moderate.

Annual Growth in Health Spending, by Sponsor
United States, 2014



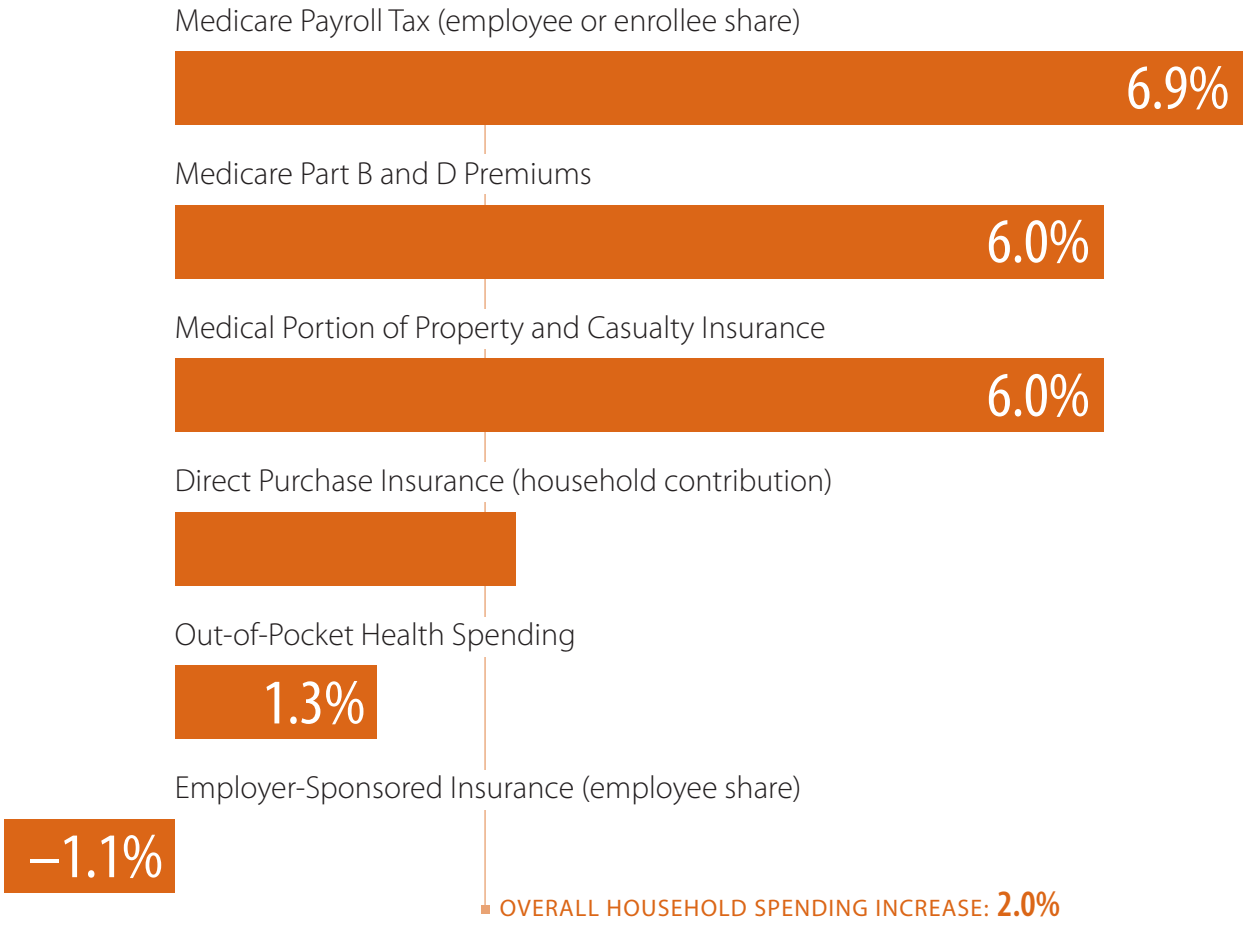
*See page 35 for detail on changes in household spending.

Notes: *Health spending* refers to national health expenditures. *Sponsors* are the entities that are ultimately responsible for financing the health care bill. *Other private revenues* includes philanthropy, privately funded structures and equipment, and investment income. *Marketplace* is individual health insurance coverage purchased on federal- and state-run health exchanges, such as Covered California and healthcare.gov. See page 16 for detail on how sponsors finance health care spending.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

In 2014, health spending by the federal government grew 11.7%, outstripping growth by households, private business, and state and local governments. The federal increase totaled $88.2 billion and included spending for the ACA's initial year of marketplace premium tax credits and cost-sharing subsidies, as well as the expansion of Medicaid eligibility in 27 states.

Changes in Household Health Care Spending
United States, 2014



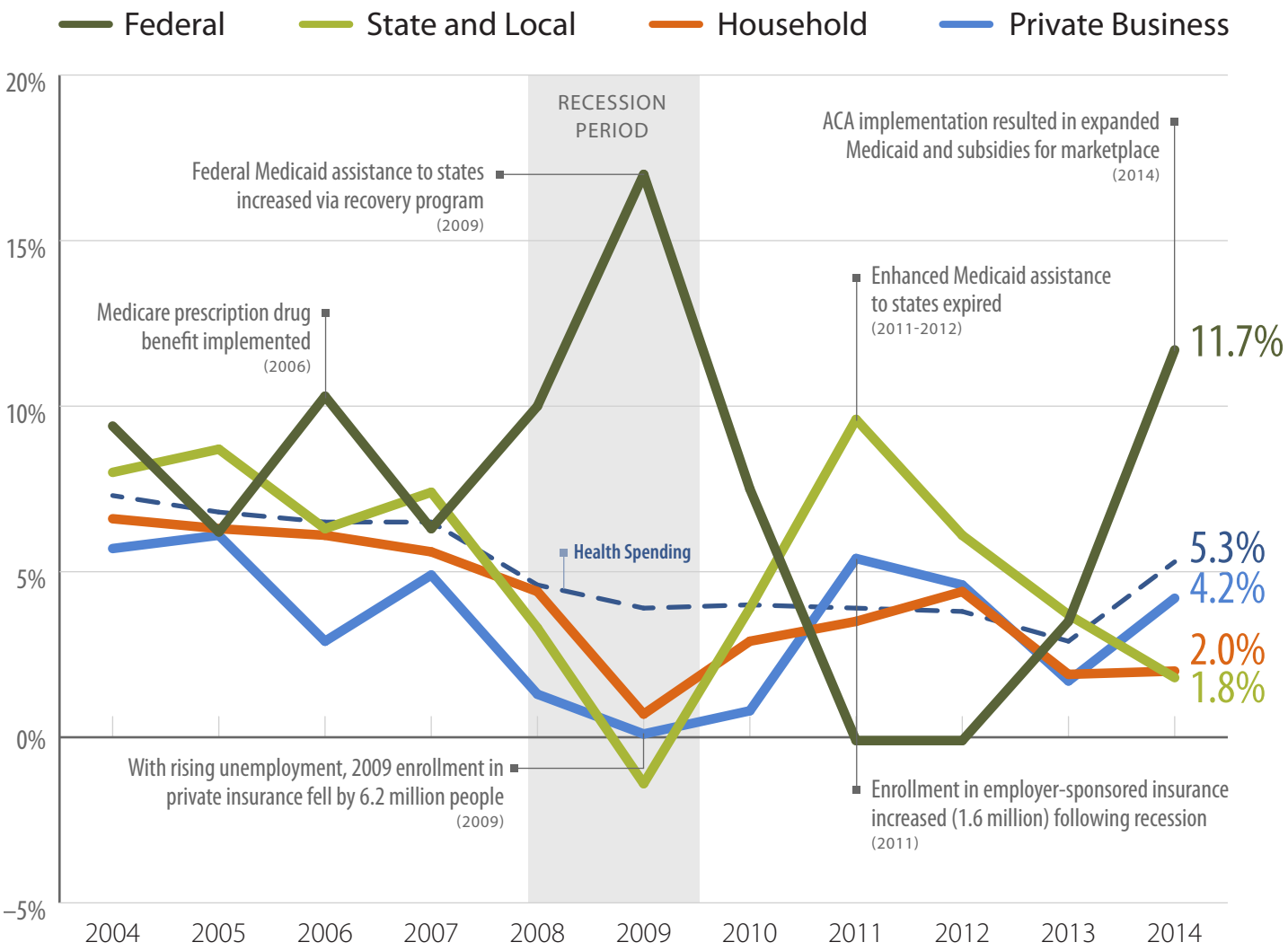
The 2014 ACA requirement that individuals be covered by insurance appeared to have little effect on household health spending. Household spending on direct purchase insurance grew 2.2%. In contrast, household spending on Medicare premiums and payroll taxes had the largest growth, due in part to higher employment levels and increased numbers of people eligible for Medicare.

Notes: *Health spending* refers to national health expenditures. *Direct purchase insurance* includes premiums paid by individuals for marketplace plans, Medigap, and other directly purchased health insurance, such as coverage purchased off-exchange. *Marketplace* is individual health insurance coverage purchased on federal- and state-run health exchanges, such as Covered California and healthcare.gov. Enrollment in direct purchase insurance increased by 19.5%; enrollment in employer-sponsored health insurance declined by 1.0%.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Annual Growth in Health Spending, by Sponsor

United States, 2004 to 2014

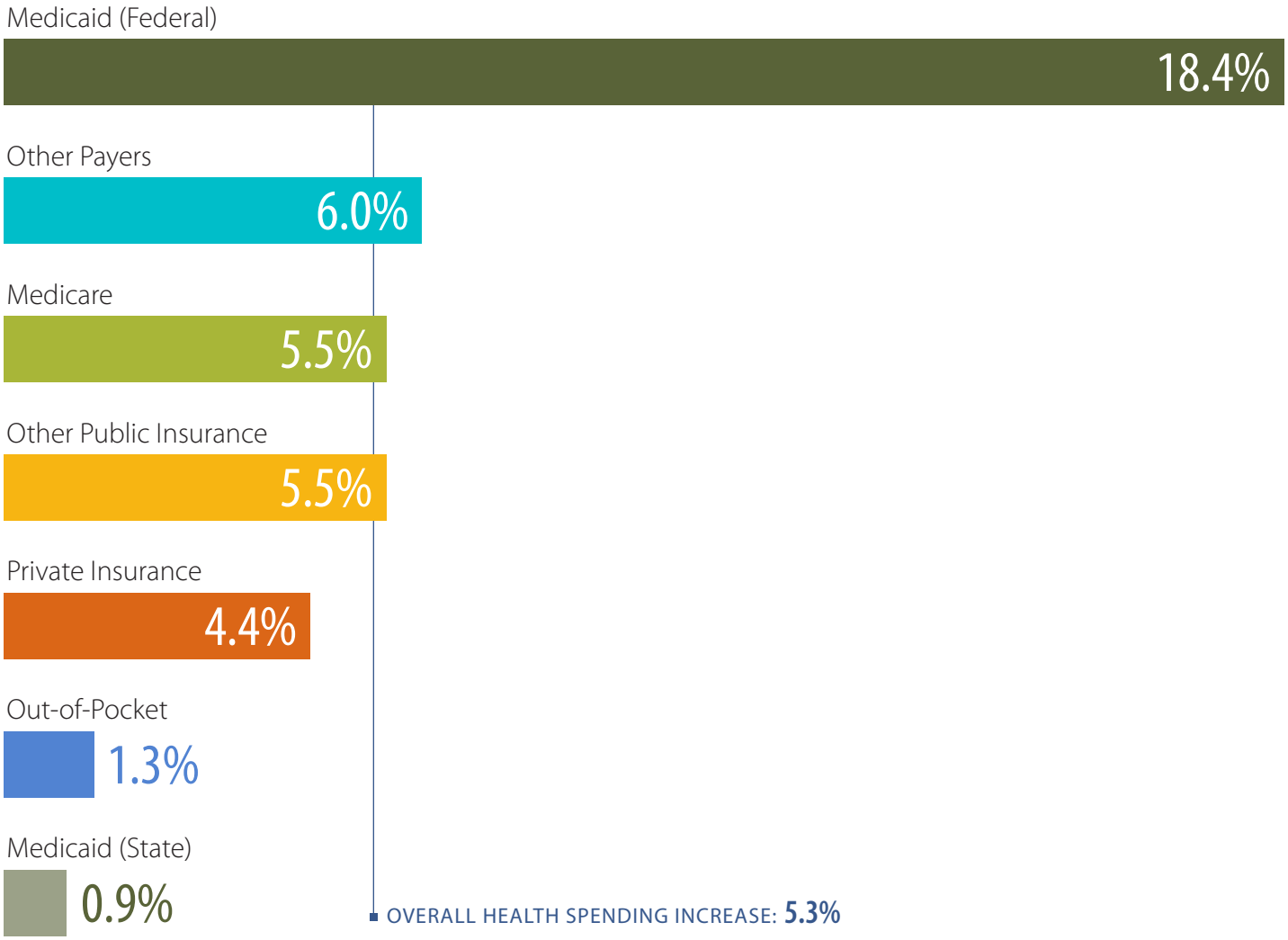


Notes: *Health spending* refers to national health expenditures. *Sponsors* are the entities that are ultimately responsible for financing the health care bill. *Federal* refers to federal government; *state and local* refers to state and local governments. *Marketplace* is individual health insurance coverage purchased on federal and state-run health exchanges, such as Covered California and healthcare.gov. Not shown: other private revenues. See pie chart on page 34 for breakdown of increase in federal spending.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Federal spending increased sharply in 2014 with implementation of the ACA. That year, the federal government funded Medicaid expansion, and premium and cost-sharing subsidies for eligible individuals in marketplace plans.

Annual Change in Health Spending Levels, by Payer
United States, 2014



Notes: *Health spending* refers to national health expenditures. Not shown: public health activities (3.1%) and investment (0.9%).

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Federal Medicaid spending grew by 18.4% as the federal government funded 100% of ACA-expanded Medicaid eligibility. Out-of-pocket and state Medicaid spending growth remained far below the overall 5.3% increase in spending.

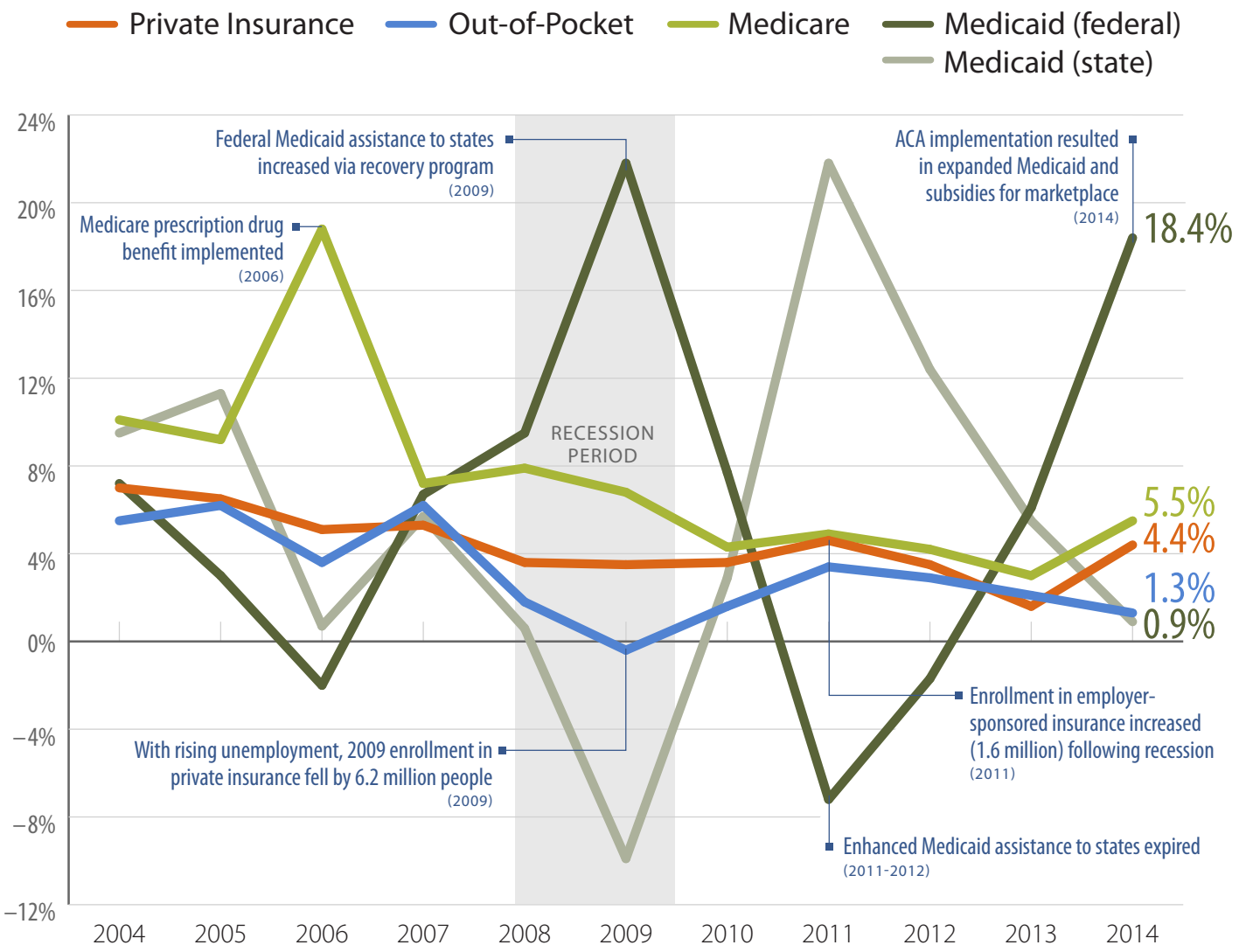
PAYER DEFINITIONS

Other payers includes worksite health care, Indian Health Services, workers' compensation, maternal and child health, and vocational rehabilitation.

Other public health insurance includes Departments of Defense and Veterans Affairs and the Children's Health Insurance Program (CHIP).

Out-of-pocket includes consumer spending on copays, deductibles, and goods and care not covered by insurance; it does not include premiums.

Annual Growth Rates, by Payer
United States, 2004 to 2014



Notes: *Marketplace* is individual health insurance coverage purchased on federal- and state-run health exchanges, such as Covered California and healthcare.gov. Not shown: other public health insurance, other payers, public health activities, investment. See page 25 for historical and page 39 for projected growth rates.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

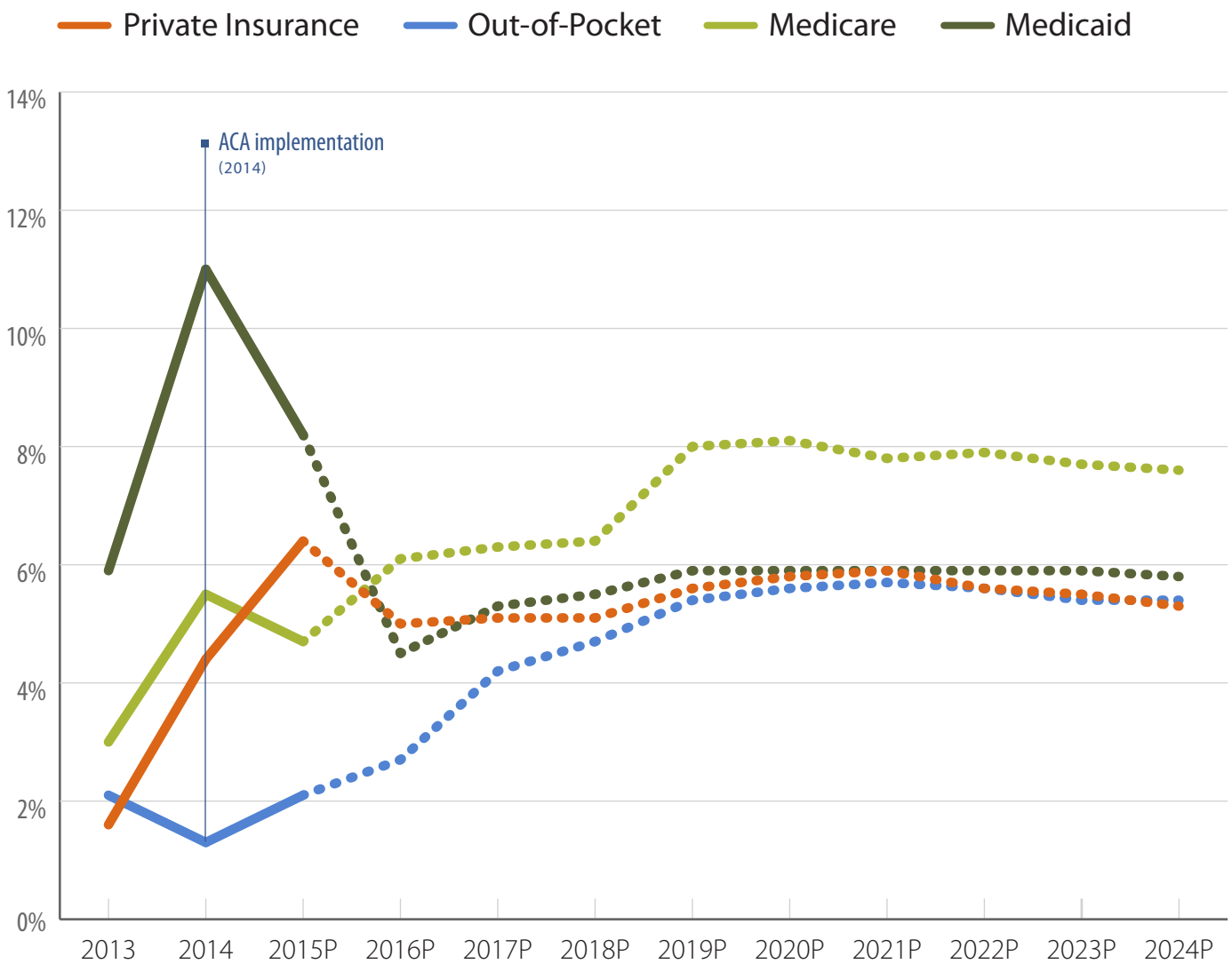
Major policy changes are visible in the growth rates of health care payers. The 2014 spike (18.4%) in federal Medicaid growth reflects the federal funding of the ACA Medicaid expansion. This 2014 increase was similar in scale to the 2006 implementation of Medicare Part D drug coverage and the 2009 federal Medicaid assistance to states for recession relief.

PAYER DEFINITION

Out-of-pocket includes consumer spending on copays, deductibles, and goods and care not covered by insurance; it does not include premiums.

Annual Growth Projections, by Payer

United States, 2013 to 2024

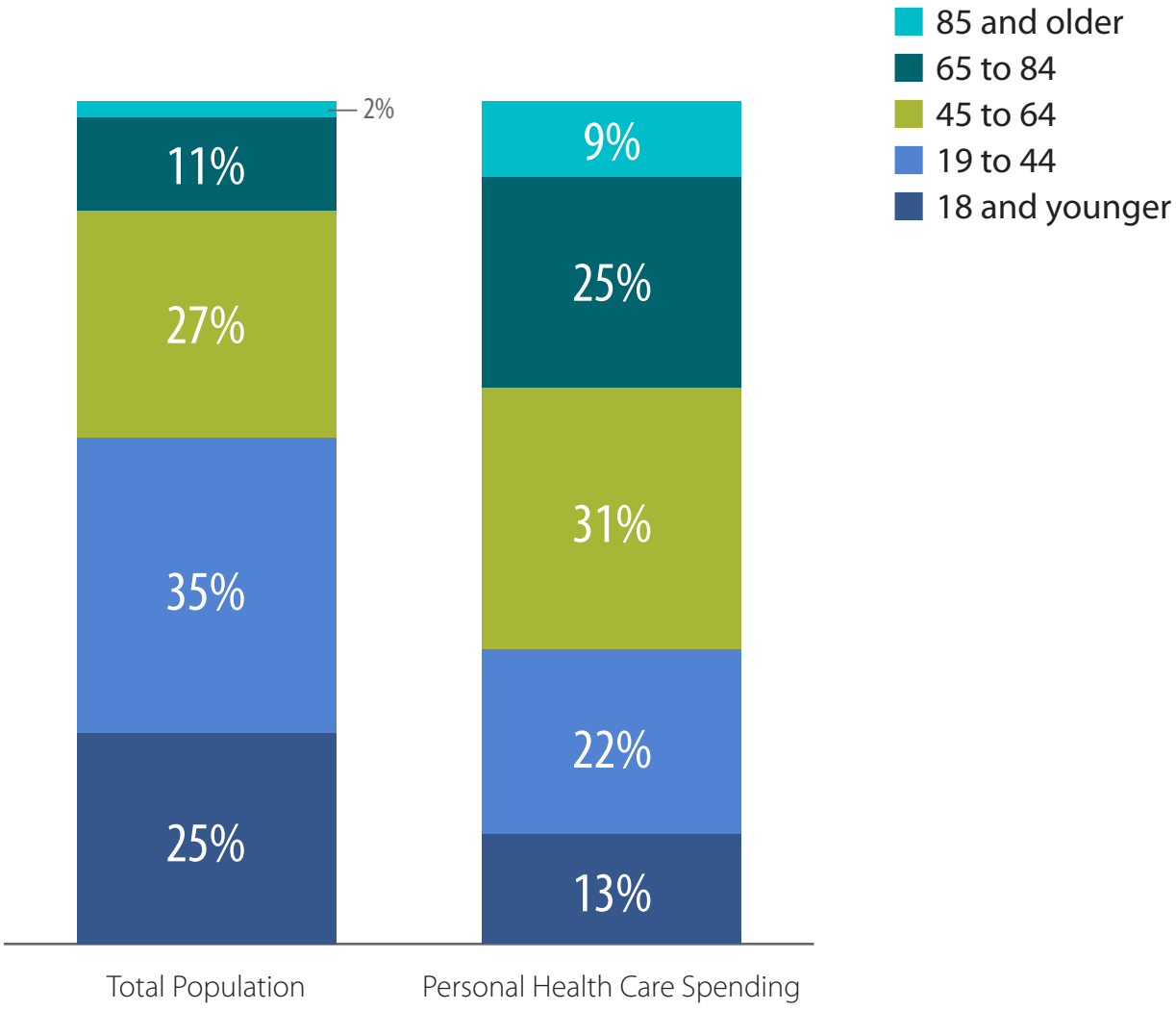


Note: Projections shown as *P*.

Sources: National Health Expenditure Data, Historical, 1960-2014 (www.cms.gov) and Projections, 2013-2024 (www.cms.gov), Centers for Medicare & Medicaid Services, 2015.

Medicaid spending accelerated and out-of-pocket spending slowed in 2014. By 2016, Medicaid growth is expected to return to levels similar to other payers, and Medicare growth will be the highest as the elderly population expands.

Share of Population vs. Personal Health Care Spending
by Age Group, United States, 2010

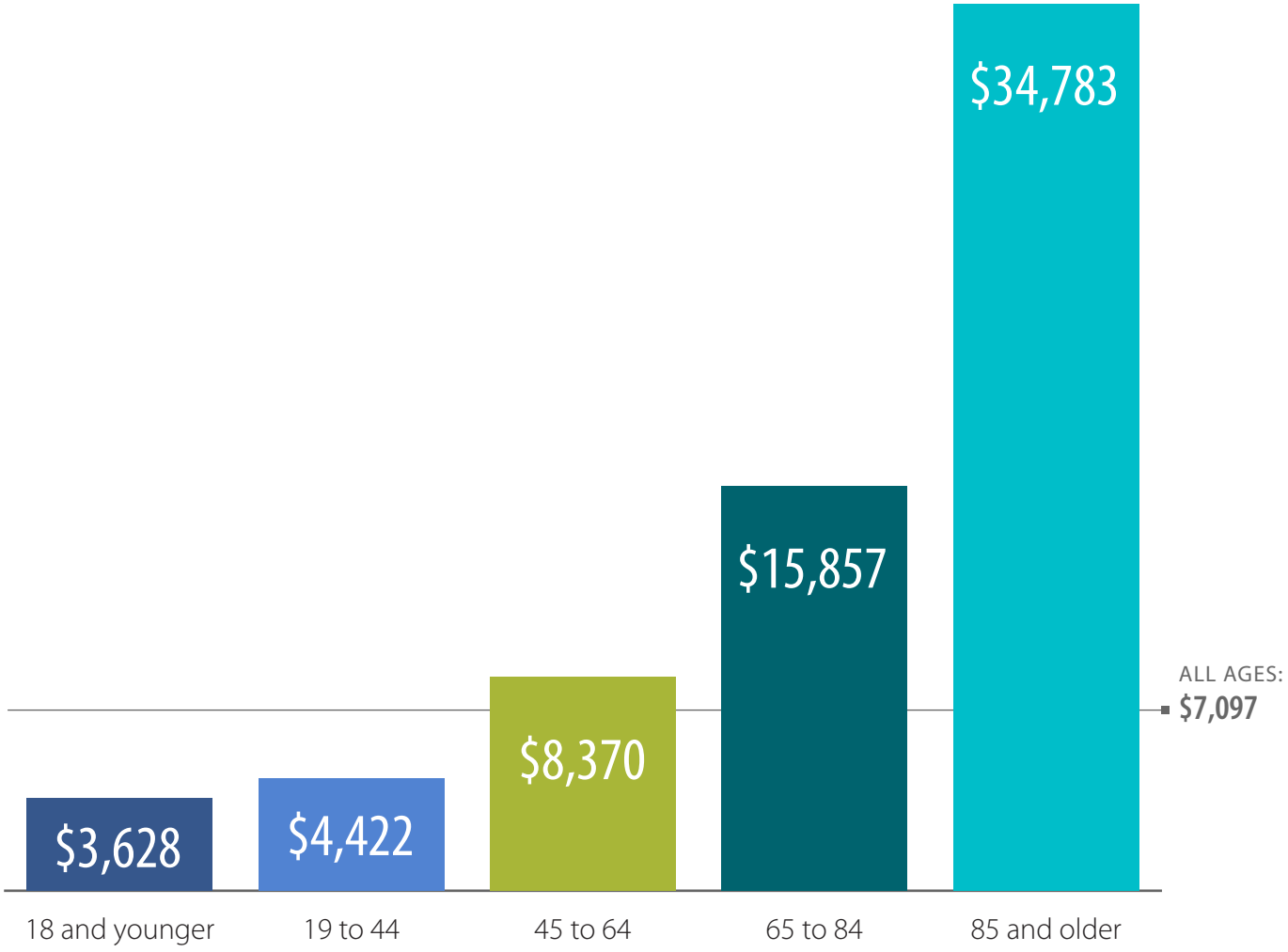


Notes: *Personal health care spending* excludes net cost of health insurance, government administration, public health activities, and investment. See Appendix B for spending category detail by age group and gender.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2014, www.cms.gov.

The elderly population, 65 and over, accounted for one-third of personal health care spending but made up 13% of the population. In contrast, children made up 25% of the population and accounted for only 13% of personal health care spending.

Personal Health Care Spending per Capita
by Age Group, United States, 2010

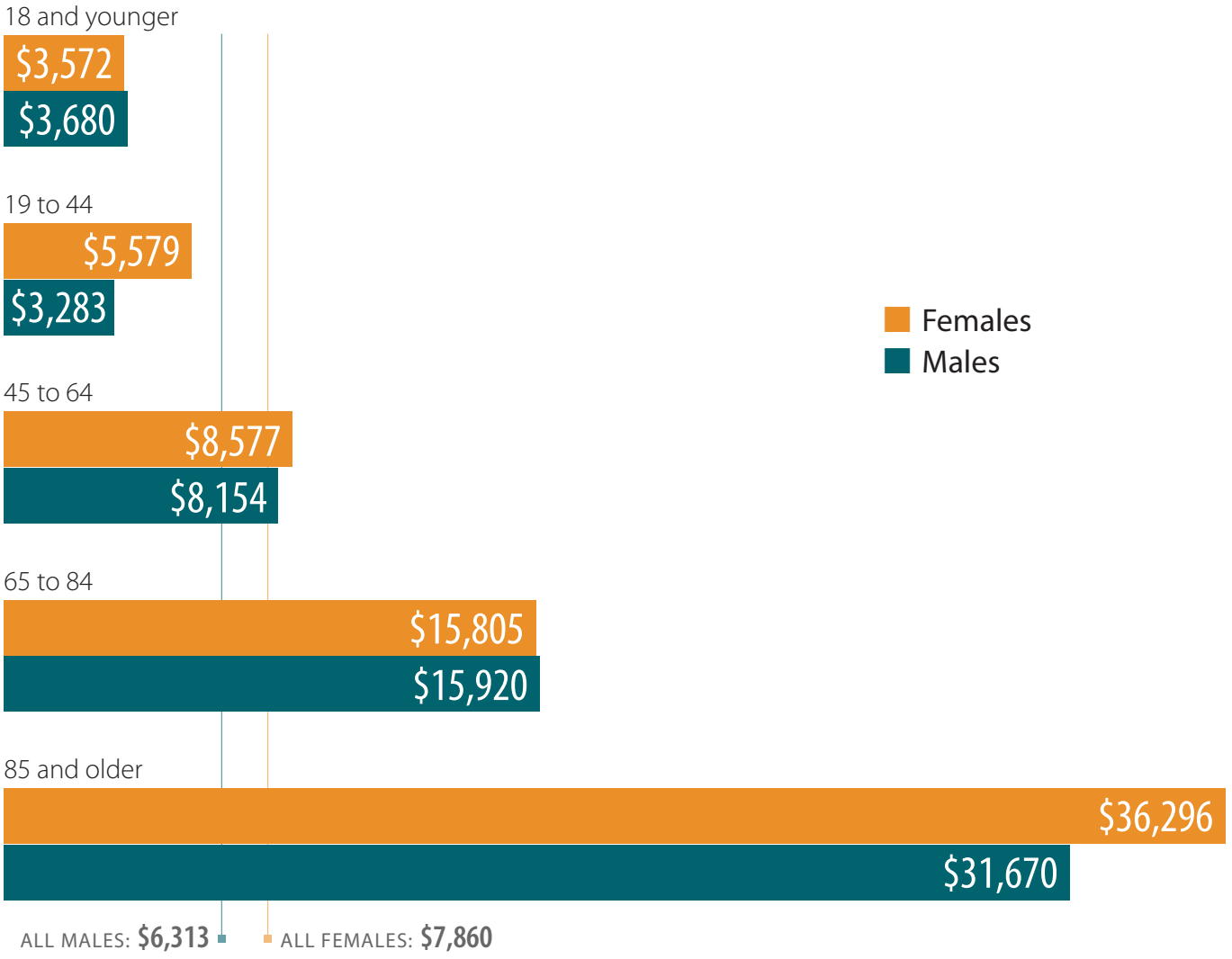


Notes: *Personal health care spending* excludes net cost of health insurance, government administration, public health activities, and investment. Per capita spending for all people age 65 and older was $18,424. See Appendix B for spending category detail by age group and gender.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2014, www.cms.gov.

Per capita spending illustrates the relationship between health spending and age. Young working-age adults (19 to 44) spent $4,422 per person in 2010 on personal health care, 20% more than children, but half as much as older working adults. Those age 85 and over spent nearly $35,000 per person.

Personal Health Care Spending per Capita
by Gender and Age Group, United States, 2010



Notes: *Personal health care spending* excludes net cost of health insurance, government administration, public health activities, and investment. Per capita spending for all people age 65 and older was $18,424 ($19,110 for females and $17,530 for males). See Appendix B for spending category detail by age group and gender.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2014, www.cms.gov.

Overall, females spent 25% more than males, a difference of $1,547 per year. Gender differences were greatest for women of childbearing age due to increased hospital and physican services and for women age 85 and older, due largely to more nursing facility care.

Personal Health Care Spending per Capita
by Category and Age Group, United States, 2010

	18 AND YOUNGER	19 TO 44	45 TO 64	65 TO 84	85 AND OLDER	ALL AGES
Personal Health Care	**$3,628**	**$4,422**	**$8,370**	**$15,857**	**$34,783**	**$7,097**
Hospital Care	$1,538	$1,696	$3,001	$5,887	$10,405	$2,630
Physician and Clinical Services	$972	$1,272	$2,035	$3,281	$4,342	$1,680
Dental Services	$375	$241	$427	$377	$311	$341
Other Professional Services	$103	$176	$281	$459	$672	$226
Nursing Care Facilities	$11	$28	$224	$1,782	$10,690	$463
Home Health Care	$85	$66	$143	$736	$3,640	$230
Other Health Care	$244	$366	$494	$622	$1,307	$415
Prescription Drugs	$229	$432	$1,398	$1,886	$1,935	$827
Other Medical Products	$70	$145	$366	$827	$1,481	$286

Spending on health services varied with age. For example, those 85 and older differed from those age 65 to 84 largely in their use of hospital care, nursing care facilities, and home health care.

Note: *Personal health care spending* excludes net cost of health insurance, government administration, public health activities, and investment.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2014, www.cms.gov.

Data Resources

Economic Data

- *The Budget and Economic Outlook: 2015 to 2025,* Congressional Budget Office, January 2015, www.cbo.gov.
- *The Budget and Economic Outlook: Fiscal Years 2003-2012,* Appendix F, Congressional Budget Office, January 2002, www.cbo.gov (PDF).
- Consumer Price Index, Bureau of Labor Statistics, www.bls.gov/cpi.
- Gross domestic product, Bureau of Economic Analysis, www.bea.gov.
- "OECD Health Statistics 2015: Frequently Requested Data," Organisation for Economic Co-operation and Development, July 2015, www.oecd.org.

Journal Publications Authored by CMS Staff

- Martin, Anne B., Micah Hartman, et al. "National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending." *Health Affairs* 35, no. 1: 150-160, healthaffairs.org.
- Keehan, Sean P., et al. "National Health Expenditure Projections, 2014-24: Spending Growth Faster Than Recent Trends." *Health Affairs* 34, no. 8 (August 2015): 1407-17, healthaffairs.org.
- Lassman, David, et al. "US Health Spending Trends by Age and Gender: Selected Years 2002-10," *Health Affairs* 33, no. 5 (May 2014): 815–822, healthaffairs.org.

National Health Expenditures

AGE AND GENDER

- Data and Resources: www.cms.gov

HEALTH CARE SATELLITE ACCOUNT

Disease-Based Health Care Measures, Bureau of Economic Analysis

- Introduction: www.bea.gov (PDF)
- Data and Resources: www.bea.gov

HISTORICAL INFORMATION / OVERVIEW

- Data by Service Category, Payer, and Sponsor: www.cms.gov
- Definitions, Sources, Methods: www.cms.gov (PDF)
- Overview of National Health Expenditure Resources: www.cms.gov
- Quick Reference Definitions: www.cms.gov (PDF)
- Summary of Benchmark Changes: www.cms.gov (PDF)

PROJECTIONS

- Data and Methodology: www.cms.gov
- Forecast Summary: www.cms.gov (PDF)

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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Appendix A: Health Spending, by Category, 1994 to 2014, Selected Years

	SPENDING LEVEL (IN BILLIONS)				DISTRIBUTION				GROWTH RATE*		
	1994	2004	2013	2014	1994	2004	2013	2014	1994–2014	2004–2014	2013–2014
National Health Expenditures	**967.2**	**1,896.5**	**2,879.9**	**3,031.3**	**100%**	**100%**	**100%**	**100%**	**5.9%**	**4.8%**	**5.3%**
Health Consumption Expenditures	**905.7**	**1,785.1**	**2,727.4**	**2,877.4**	**94%**	**94%**	**95%**	**95%**	**6.0%**	**4.9%**	**5.5%**
Personal Health Care	**820.2**	**1,588.2**	**2,441.3**	**2,563.6**	**85%**	**84%**	**85%**	**85%**	**5.9%**	**4.9%**	**5.0%**
Hospital Care	328.4	565.4	933.9	971.8	34%	30%	32%	32%	5.6%	5.6%	4.1%
Professional Services	276.0	522.1	767.5	801.6	29%	28%	27%	26%	5.5%	4.4%	4.4%
Physician and Clinical Services	210.5	390.4	576.8	603.7	22%	21%	20%	20%	5.4%	4.5%	4.6%
Dental Services	41.6	81.7	110.4	113.5	4%	4%	4%	4%	5.2%	3.3%	2.8%
Other Professional Services	24.0	49.9	80.3	84.4	2%	3%	3%	3%	6.5%	5.4%	5.2%
Nursing Care Facilities	58.4	105.4	150.2	155.6	6%	6%	5%	5%	5.0%	4.0%	3.6%
Home Health Services	27.3	44.6	79.4	83.2	3%	2%	3%	3%	5.7%	6.4%	4.8%
Other Health Care	37.5	89.3	144.5	150.4	4%	5%	5%	5%	7.2%	5.3%	4.1%
Retail Outlet Sales	92.6	261.3	365.8	401.0	10%	14%	13%	13%	7.6%	4.4%	9.6%
Prescription Drugs	53.0	192.8	265.3	297.7	5%	10%	9%	10%	9.0%	4.4%	12.2%
Other Nondurable Medical Products	24.3	38.1	55.6	56.9	3%	2%	2%	2%	4.3%	4.1%	2.4%
Durable Medical Equipment	15.3	30.4	44.9	46.4	2%	2%	2%	2%	5.7%	4.3%	3.2%
Administration	**55.9**	**142.0**	**209.5**	**234.8**	**6%**	**7%**	**7%**	**8%**	**7.4%**	**5.2%**	**12.1%**
Net Cost of Health Insurance	44.9	115.0	173.2	194.6	5%	6%	6%	6%	7.6%	5.4%	12.4%
Government Administration	11.0	27.0	36.3	40.2	1%	1%	1%	1%	6.7%	4.1%	10.7%
Federal Government Administration	6.8	16.5	26.8	30.1	1%	1%	1%	1%	7.8%	6.2%	12.1%
State and Local Government Administration	4.2	10.5	9.5	10.1	0%	1%	0%	0%	4.5%	-0.4%	6.6%
Public Health Activities	**29.6**	**54.9**	**76.6**	**79.0**	**3%**	**3%**	**3%**	**3%**	**5.0%**	**3.7%**	**3.1%**
Investment	**61.6**	**111.4**	**152.5**	**153.9**	**6%**	**6%**	**5%**	**5%**	**4.7%**	**3.3%**	**0.9%**
Noncommercial Research	17.8	38.6	46.5	45.5	2%	2%	2%	2%	4.8%	1.7%	–2.0%
Structures and Equipment	43.8	72.8	106.0	108.3	5%	4%	4%	4%	4.6%	4.1%	2.2%

*Growth rates for the 1994-2014 and 2004-2014 periods are average annual; 2013-2014 is the increase of 2014 over 2013 levels.

Notes: *Health spending* refers to national health expenditures. Further definitions available at www.cms.gov.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

Appendix B: Personal Health Care Spending, by Gender, Age, and Category, 2010

	FEMALES						MALES						TOTAL					
	0 to 18	19 to 44	45 to 64	65 to 84	85+	ALL	0 to 18	19 to 44	45 to 64	65 to 84	85+	ALL	0 to 18	19 to 44	45 to 64	65 to 84	85+	ALL
PER CAPITA	**$3,572**	**$5,579**	**$8,577**	**$15,805**	**$36,296**	**$7,860**	**$3,680**	**$3,283**	**$8,154**	**$15,920**	**$31,670**	**$6,313**	**$3,628**	**$4,422**	**$8,370**	**$15,857**	**$34,783**	**$7,097**
Hospital Care	1,548	2,205	2,728	5,429	10,076	2,763	1,528	1,195	3,284	6,445	11,080	2,493	1,538	1,696	3,001	5,887	10,405	2,630
Physician and Clinical Services	937	1,741	2,279	3,150	3,935	1,911	1,005	810	1,782	3,440	5,179	1,441	972	1,272	2,035	3,281	4,342	1,680
Dental Services	404	285	464	376	309	374	348	197	388	379	313	307	375	241	427	377	311	341
Other Professional Services	102	229	342	478	669	269	105	124	217	435	677	182	103	176	281	459	672	226
Nursing Care Facilities	9	24	206	2,003	12,379	602	14	32	243	1,512	7,218	320	11	28	224	1,782	10,690	463
Home Health Care	80	83	161	869	3,909	289	90	49	124	575	3,087	170	85	66	143	736	3,640	230
Other Health Care	223	319	464	678	1,408	404	263	413	525	553	1,099	426	244	366	494	622	1,307	415
Prescription Drugs	199	514	1,537	1,937	1,994	919	257	350	1,254	1,823	1,814	734	229	432	1,398	1,886	1,935	827
Other Medical Products	70	178	397	885	1,617	330	72	112	336	758	1,203	240	70	145	366	827	1,481	286
AGGREGATE (BILLIONS)	**$137.2**	**$298.9**	**$358.1**	**$302.8**	**$133.7**	**$1,230.7**	**$147.9**	**$178.9**	**$328.1**	**$250.6**	**$56.8**	**$962.2**	**$285.1**	**$477.7**	**$686.2**	**$553.4**	**$190.5**	**$2,192.9**
Hospital Care	59.5	118.1	113.9	104.0	37.1	432.6	61.4	65.1	132.2	101.4	19.9	379.9	120.9	183.2	246.0	205.5	57.0	812.6
Physician and Clinical Services	36.0	93.3	95.2	60.4	14.5	299.3	40.4	44.1	71.7	54.2	9.3	219.7	76.4	137.4	166.9	114.5	23.8	519.0
Dental Services	15.5	15.3	19.4	7.2	1.1	58.5	14.0	10.7	15.6	6.0	0.6	46.9	29.5	26.0	35.0	13.2	1.7	105.4
Other Professional Services	3.9	12.3	14.3	9.2	2.5	42.1	4.2	6.8	8.7	6.8	1.2	27.8	8.1	19.0	23.0	16.0	3.7	69.8
Nursing Care Facilities	0.4	1.3	8.6	38.4	45.6	94.2	0.5	1.7	9.8	23.8	12.9	48.8	0.9	3.0	18.4	62.2	58.5	143.0
Home Health Care	3.1	4.5	6.7	16.6	14.4	45.3	3.6	2.7	5.0	9.1	5.5	25.9	6.7	7.1	11.7	25.7	19.9	71.2
Other Health Care	8.6	17.1	19.4	13.0	5.2	63.2	10.6	22.5	21.1	8.7	2.0	64.9	19.2	39.6	40.5	21.7	7.2	128.1
Prescription Drugs	7.6	27.6	64.2	37.1	7.3	143.8	10.3	19.1	50.5	28.7	3.3	111.8	18.0	46.6	114.6	65.8	10.6	255.7
Other Medical Products	2.7	9.5	16.5	16.9	6.0	51.7	2.9	6.1	13.5	11.9	2.2	36.6	5.6	15.6	30.1	28.9	8.1	88.2
DISTRIBUTON	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Hospital Care	43%	40%	32%	34%	28%	35%	42%	36%	40%	40%	35%	39%	42%	38%	36%	37%	30%	37%
Physician and Clinical Services	26%	31%	27%	20%	11%	24%	27%	25%	22%	22%	16%	23%	27%	29%	24%	21%	12%	24%
Dental Services	11%	5%	5%	2%	1%	5%	9%	6%	5%	2%	1%	5%	10%	5%	5%	2%	1%	5%
Other Professional Services	3%	4%	4%	3%	2%	3%	3%	4%	3%	3%	2%	3%	3%	4%	3%	3%	2%	3%
Nursing Care Facilities	0%	0%	2%	13%	34%	8%	0%	1%	3%	9%	23%	5%	0%	1%	3%	11%	31%	7%
Home Health Care	2%	1%	2%	5%	11%	4%	2%	1%	2%	4%	10%	3%	2%	1%	2%	5%	10%	3%
Other Health Care	6%	6%	5%	4%	4%	5%	7%	13%	6%	3%	3%	7%	7%	8%	6%	4%	4%	6%
Prescription Drugs	6%	9%	18%	12%	5%	12%	7%	11%	15%	11%	6%	12%	6%	10%	17%	12%	6%	12%
Other Medical Products	2%	3%	5%	6%	4%	4%	2%	3%	4%	5%	4%	4%	2%	3%	4%	5%	4%	4%

Note: *Personal health care spending* excludes net cost of health insurance, government administration, public health activities, and investment.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2014, www.cms.gov.

Appendix C: Medical Conditions

TYPE OF CONDITION	EXAMPLES
Routine care, signs, and symptoms	preventive care, allergies, flu symptoms
Circulatory system	hypertension, heart failure, heart attack
Musculoskeletal	back problems, arthritis
Respiratory	COPD, pneumonia, asthma, influenza
Endocrine system	diabetes, high cholesterol, thyroid disorders
Nervous system	cataract, migraines, epilepsy, chronic nerve pain
Neoplasms	cancers, tumors
Injury and poisoning	trauma
Genitourinary	kidney and reproductive system diseases
Digestive	gastrointestinal disorders
Mental illness	depression, dementia, substance abuse
Infectious diseases	septicemia, HIV, hepatitis
Skin	infections, ulcers, acne, sunburn
Pregnancy	deliveries, contraceptives

Appendix D: Health Spending, by Medical Condition, United States, 2002 to 2012

	SPENDING LEVEL (IN BILLIONS)			DISTRIBUTION			GROWTH RATE*		
TYPE OF CONDITION	2002	2011	2012	2002	2011	2012	2002-2012	2011	2012
All conditions	**1,081.0**	**1,804.7**	**1,885.2**	**100%**	**100%**	**100%**	**5.7%**	**4.8%**	**4.5%**
Routine care, signs, and symptoms	113.6	233.4	247.3	11%	13%	13%	8.1%	7.9%	5.9%
Circulatory system	179.0	237.7	240.9	17%	14%	13%	3.0%	0.8%	1.3%
Musculoskeletal	99.8	178.0	185.9	9%	10%	10%	6.4%	4.3%	4.4%
Respiratory	105.5	152.7	156.5	10%	8%	8%	4.0%	5.0%	2.5%
Endocrine system	73.6	133.6	138.0	7%	7%	7%	6.5%	4.6%	3.4%
Nervous system	72.6	126.4	133.1	7%	7%	7%	6.2%	5.1%	5.3%
Neoplasms	74.0	122.8	123.5	7%	7%	7%	5.3%	4.7%	0.6%
Injury and poisoning	74.0	115.8	117.7	7%	6%	6%	4.8%	5.5%	1.6%
Genitourinary	62.9	109.4	112.7	6%	6%	6%	6.0%	2.1%	3.0%
Digestive	67.0	102.0	107.1	6%	6%	6%	4.8%	2.9%	4.9%
Other	43.2	78.2	93.4	4%	4%	4%	8.0%	12.8%	19.5%
Mental illness	43.2	75.4	79.6	4%	4%	4%	6.3%	4.2%	5.6%
Infectious diseases	25.7	62.6	66.9	2%	3%	3%	10.0%	6.8%	6.9%
Skin	25.6	41.7	44.2	2%	2%	2%	5.6%	5.7%	6.2%
Pregnancy	21.3	35.3	38.6	2%	2%	2%	6.1%	6.0%	9.3%

*Growth rate for 2002-2012 is average annual; others are annual change.

Notes: Spending by medical condition accounted for 83% of personal health spending in 2012. Medical condition spending does not account for spending on dental services, nursing homes, or medical products and equipment. The most recent data series ends with 2012. See Appendix C for medical condition detail.

Source: "Health Care Satellite Account: Blended Account, 2000-2012," Bureau of Economic Analysis, www.bea.gov.

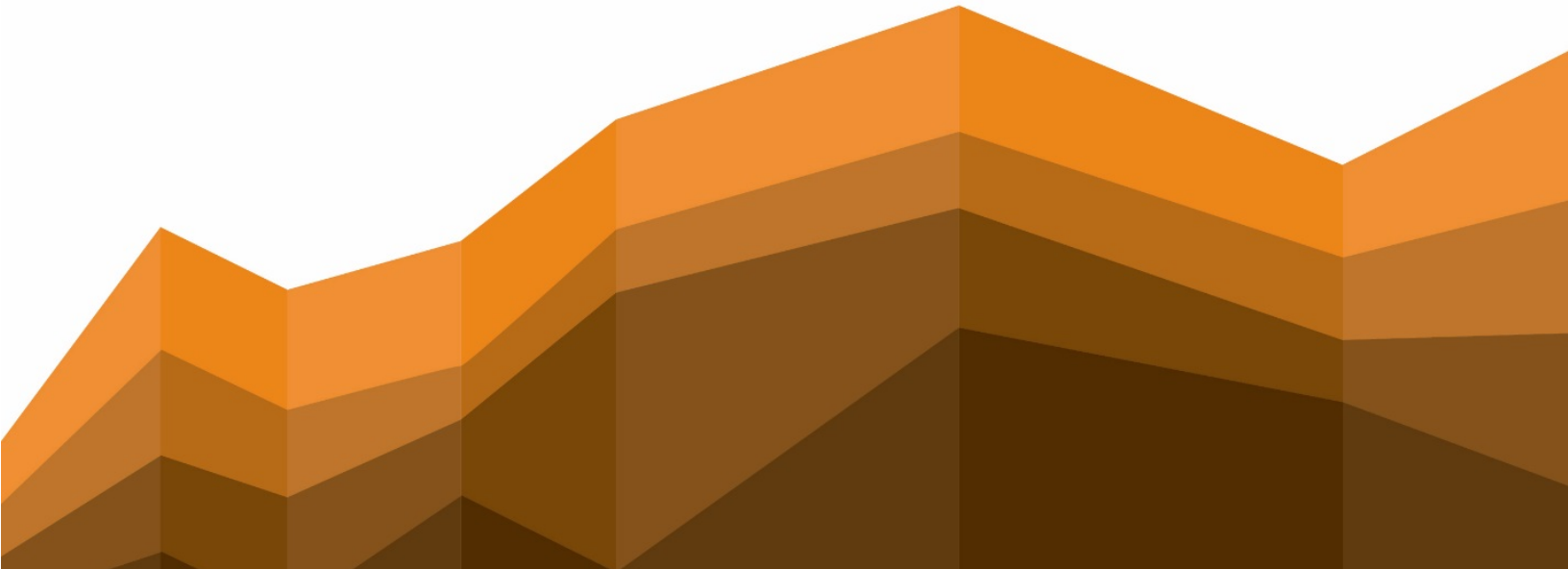
AMERICAN HEALTH POLICY INSTITUTE

2016

State of Employer-Sponsored Health Care

Part 1:
Top Concerns of CHROs and Their Teams

By Tevi D. Troy and Kara L. Jones



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Introduction

After passage of the Affordable Care Act (ACA), many experts predicted that employers would opt out of offering health insurance. The thought was that they would focus instead on providing defined contributions and directing employees to individual health insurance and the public marketplace. In May 2014, an S&P Capital IQ analysis projected that 90 percent of employees receiving employer coverage would be shifted to individual insurance and private and public exchanges by year 2020.[1] As the ACA exchanges stabilized, consumers would find more choices at better prices through avenues outside the employer.

So far, this prediction is not coming to fruition. The majority of Americans still get coverage via their employer: about 54 percent of U.S. residents with health insurance—or 169 million people.[2] The Congressional Budget Office (CBO) predicts that the number of those with employer coverage will fall slightly over the next three years, but estimates that it will remain stable through at least 2026.[3] This does not mean, however, that the employer-sponsored system is sustainable in the state it is currently in. Critical changes are needed to ensure employees receive the best care and to protect them from spiraling cost hikes.

AHPI interviewed 25 chief human resource officers (CHROs) and senior benefit managers from some of the largest companies in America to discover their thoughts on employer-sponsored health insurance (ESI). The vast majority of these representatives of large employers indicate that they are committed to maintaining ESI as an essential benefit for employees. These experts voiced many concerns, but at the same time expressed many more exciting opportunities for innovation. In this paper, we outline the main challenges large employers face in offering health insurance to employees and their dependents. The second installment will explore the steps employers are actively taking to address these problems and what the future holds for ESI.

Value of Employer-Sponsored Insurance

Employers agree that ESI is likely to remain in place for the foreseeable future. As Thomas Kadien, CHRO at International Paper, says of employer-sponsored care, “It’s not going away anytime soon.” Employers recognize that health coverage not only attracts employees, but it also keeps them healthy and productive on the job. Pamela Murray, Benefits Senior Consultant at DuPont, says, “ESI is important and it’s continuing. We see ESI as a competitive benefit that’s tailored to our employees’ needs so that they may be healthier and more productive individuals.” Indeed, there is a positive relationship between employer offers of health insurance and labor productivity. A U.S. Census Bureau study found that in the manufacturing industry, the average labor productivity in establishments offering health coverage is approximately two times larger than for those not offering coverage.[4] Murray’s position is a consistent theme among human resource (HR) executives: Health insurance is a driving force in employee retention and is vital to securing a robust workforce. One senior benefits manager at a Fortune 500 corporation echoes this sentiment: “The employer-based health care system is strong. We still see health benefits as a value add in terms of employee value proposition,” she says. “Employees still want health care. We don’t see ESI going away, given the challenges we see in the exchanges. This is not a time where you would say the employer-based system doesn’t provide value.”

ESI is an efficient way to administer health coverage to large numbers of people. Another Fortune 500 VP of Compensation and Benefits acknowledges, "Employer-based care is a financially reasonable and prudent way to get care to our employees. Other methods are not as efficient." As Peter Nelson, Director of Public Policy at the Center of the American Experiment, said during an American Enterprise Institute panel on the evolution of ESI, "Employers do get people covered—they very successfully get people covered."[5] On the employee side, they appreciate, desire, and expect health insurance. Two-thirds of employees say they are satisfied with their health benefits and 44 percent would forgo a wage increase to maintain their current coverage.[6]

Offering health insurance is one way employers show individuals they are cared for within the larger company. This is why providing high quality plans is so important and is one of the main goals of HR personnel. One CHRO of a health insurance company says the driver of everything his HR department does is "understanding with specificity the motivations, conditions, behaviors, and environment of employees." He says, "Commitment to employees' health lifts the engagement of the entire company. We encourage employees to take care of themselves first and foremost." Employers view quality, affordable health insurance plans as fundamental to maintaining a valuable and satisfied workforce. Employers, by and large, prefer having the ability to negotiate on behalf of their employees to secure the best possible deal for them.

HR executives stress that they are in a position to seek financially sustainable rates, whereas they would have less control if they were to send employees to the exchanges. DuPont's Murray says, "We, as an employer, have daily interaction with our employees, giving us the insights needed in order to create the best plans for our population. It's important that ESI continues, and that we don't go to national coverage that's outside of employers' control." This does not mean that employers are opposed to seeking guidance on how to properly choose the best benefits. Danielle Kirgan, CHRO of Darden Restaurants, Inc., says, "The benefits landscape has evolved significantly over the past few years. As CHRO, I am able to leverage external teams for knowledge that I would have traditionally had to have in-house. I like that concept—I don't feel alone as an organization. I am willing to let go of some control in order to receive a broader and deeper level of strategic counsel. That being said, I still want to preserve my unique voice in this space. When negotiating with carriers, no one can advocate on behalf of my company as well as I can."

Marriott International's CHRO, David Rodriguez, explains that the heart of his company's commitment to health benefits is the best interest of employees and their dependents: "Health insurance doesn't necessarily have to be an employer-sponsored plan—but we would never abdicate the quality of care for our associates, even if it were offered by the government—if we didn't have certainty of the overall wellbeing of our associates."

High Cost of Health Benefits and Lack of Transparency

Rising costs are perhaps the biggest challenge employers face in providing health benefits. Every employer we spoke to is frustrated with the high price of coverage and each is searching for new ways to hold down costs. Research shows medical expenses for employers are projected to increase 6.5 percent this year, slightly lower than the 6.8 percent rise in 2015.[7] International Paper's Kadien says, "As much as we think we're taking steps to manage costs, they're still going up. Anything we do to try and manage costs understandably frustrates our employees. If we could cut health care costs by, say, 50 percent, it would make a difference in employees'

opinions. But nobody cares about a single digit vs. double digit increase. It's still an increase." Thomas Plath, International Paper's VP of Human Resources and Global Businesses, agrees: "I do think people are frustrated that the medical industry is the only industry, other than the government, where when you move a seven percent cost increase down to six percent, it's claimed as cost savings. It's not really a cost saving at all."

"I do think people are frustrated that the medical industry is the only industry, other than the government, where when you move a seven percent cost increase down to six percent, it's claimed as cost savings. It's not really a cost saving at all."

American Water CHRO Brenda Holdnak notes that "the employer-sponsored health care system is not sustainable in its current form." She says, "It's painfully clear to anyone providing health care, whether you're a large company or a small company, there are limited choices." Those limited choices lead to higher rates, and while employers see the benefit of offering health care, they must weigh the tradeoff of growing costs. And when containing costs come in the form of higher premiums and deductibles, employees bear the consequences. A VP of a large retail company emphasizes the absence of price transparency: "Fundamentally, there is a lack of quality data and a lack of transparency on costs. This hampers the things we want to do: We want to send patients to the best providers, we want care to be well-coordinated, and we want to know the most efficient pricing. Without access to that data, which is nearly impossible to get, you can't steer people and help them get the right care." In the health care market, patients rarely know what they will pay for a service until they receive it and providers bill payers different prices for the same services, so prices for services vary significantly.[8]

If employees had the ability to choose higher quality services from more cost-efficient providers, this could encourage competition based on the value of care. Barry Cross, Total Rewards Lead at Michelin North America, says, "From our world, we are beginning to see health care providers interested in changing their business model, but it is pretty slow. At the same time, we realize it is an evolution and not a revolution. There are changes that need to take place. Many health systems have been getting automatic price increases without demonstrating quality year over year improvements and having performance shared risk arrangements."

Prescription drug prices also pose a threat. Total spending on pharmaceuticals reached $310 billion in 2015, up 8.5 percent from the previous year. Over the next five years, annual spending is expected to rise 22 percent, climbing as high as $400 billion in 2020. Using wholesale prices, spending increases to an exorbitant 46 percent, or $640 billion.[9] Large employers that are self-insured are stuck with paying the bill themselves. Dennis Delaney, Executive VP of Human Resources and Administration at Ingram Industries Inc., says, "Now, in the U.S., 60 percent of the population is taking some kind of prescription drug. So, the evolution of the pharmaceutical world is really part and parcel to the whole health care delivery system, but we have a tendency to bifurcate them and not look at them holistically in how we deliver health care."

Lagging Technology in the Health Sector

There is a lack of consistency around cost and quality of health care, in part, because the necessary technology is not easily accessible to patients, employers, or providers. Since there is no standardized electronic health record system, the transfer of information between providers

becomes complicated and disjointed. Riz Chand, CHRO at BNSF Railway Company, asserts, "As a nation, we don't use big data to inform medical care decisions. Today, doctors have to act based on their own knowledge. Why can't we take the tremendous amount of data on medical symptoms, procedures, medications, costs, and outcomes that exists across our fragmented health care sector and use 'big data' analytics to help those doctors with care decisions. Imagine the impact we could have on the effectiveness and cost of care if we would aggregate that data (while protecting individual patients' privacy). It's very doable with the technology that exists today." Hospitals and physicians may actually be disincentivized to adopt technologies that could lower costs. If a new technology has the potential to reduce patient visits, for instance, this could cost physicians who are paid fee-for-service.

Employers suffer from the discontinuity of health data too, says OhioHealth CHRO Johnni Beckel: "Probably for us, the biggest frustration is the fragmentation. We're frustrated about the access to data that could allow us to gain really deep insights to be innovative in problem solving. While data won't solve the problem, it is a ticket to entry to be able to manage health care better and engage everyone in behavior change which is critical to success." Tools are not readily available to give employees the opportunity to compare prices, either. CHROs who offer price comparison services say that although these tools are evolving, health plans remain reluctant to share data.

Kendell Sherrer, VP of Benefits at Cardinal Health, says, "If a patient goes to a doctor, the doctor has dozens of plans he's working with. If the patient could have something on his or her smartphone that gives options of where to have a quality and cost effective MRI, for example, based on the patient's individual health plan provisions, that would be phenomenal. The doctor could then refer the patient to that facility. We aren't there yet, it's more complicated than that." Another reason technological innovation in health care lags is because there is confusion regarding who is to pay for these new technologies, argues Robert Pearl, M.D., CEO of the Permanente Medical Group. As he writes in *Forbes*, "Patients, physicians, hospitals and insurance companies long for the benefits and value of new technology. However, each thinks someone else should pay for it."[10]

Consumerism and Employee Engagement

There is some degree of consensus that employees are suboptimal health consumers, and do little shopping or price comparison. When they do shop around, it is typically only during enrollment period. On the flipside, employees often lack the proper information to make cost-efficient decisions. HR executives as a whole believe there is a need to move toward more consumerism and in order to facilitate this, employees must be better educated on how to incorporate transparency and quality data into making specific health care decisions. BNSF's Riz Chand says the fragmented health care sector, the lack of transparency in cost and quality, and the complexity of insurance concepts and terms make it difficult and time-consuming for the average employee to be an informed, thoughtful consumer of health care: "We expect our employees to be engaged purchasers of health care services. Given the complexities of health care and the

> *"I am not sure how we expect employees and their families to decipher the system and use it well…unless they are a former Health and Human Services employee or HR person."*

lack of consistent data, I am not sure how we expect employees and their families to decipher the system and use it well…unless they are a former Health and Human Services employee or HR person."

Michelin's Barry Cross notes that health care is one of the few industries where consumerism does not come naturally: "As you know, not everyone is a good health care consumer. When you go to get a knee surgery, no one is shopping for the new knee like they would for a car, boat or home. Where else can you get $120,000 worth of services and not get a receipt on the spot? That's a real pet peeve of mine. You really have no immediate clue of what you just spent. Consumerism and accountability will improve when you get a receipt the moment the services are given. The pharmaceutical industry is there, now medical needs to catch up." Employee utilization of price comparison services is a common problem employers face. John Ohrnberger, Staff VP of Executive Compensation and Benefits at General Dynamics says, "We have Health Care Blue Book but we don't force our employees to use it in terms of pricing. I don't think many employees are utilizing the service, especially after they've already covered their deductibles. We aren't forcing the issue, but will maybe reconsider over the next couple of years."

"When you go to get a knee surgery, no one is shopping for the new knee like they would for a car, boat or home. Where else can you get $120,000 worth of services and not get a receipt on the spot?"

Employees with high deductibles are given little incentive to price shop since they know insurance will not kick in until they have spent a certain amount of health care usage. One VP at a large retail company says, "For the most part, employees are not engaged consumers. We protect them to a large extent with a $350 deductible and 80/20 percent copay for primary care because we don't want a financial barrier to be there. We try to provide rich benefits so employees can easily access care." Many HR executives note that employees are poor consumers when it comes to routine doctor visits, but more serious health issues motivate employees to be prudent in their choices. She continues, "When patients need to get a hangnail fixed, they aren't engaged health care consumers, but if they think they may have cancer, they are."

We also hear that overspending is most often seen in the executive group and corporate offices. Executives do not feel the cost of extra care when in one-size-fits-all plans. They also tend to be more educated and have access to contacts within the health care industry. They are therefore more likely to go out of network and attempt to navigate themselves.

Some CHROs have indeed seen an uptick in employee engagement, if only during enrollment. Darden Restaurants, Inc.'s Danielle Kirgan says she sees firsthand the high degree of switching employees do year over year between carriers: "We can see our people utilizing tools to model and make better choices, which is great. Switching plans every year is not fun—you have to want to do that. I've seen a healthy progression of people making informed decisions. I feel good about how they are behaving during open enrollment, but I think there is still a lot of opportunity for education when it comes to how they act throughout the year."

Some believe their employees are, in fact, all around engaged purchasers of health care. James Jones, CHRO at Emerson, contends, "We make sure employees are engaged consumers through our communications with them. We explain cost-sharing, what's driving costs, and that everyone has skin in the game. They're aware because we educate them." In order to further

promote consumerism, Jones raises the question of whether his HR department is reaching the right people in the household. “Does the actual employee make the health care decisions, or is it a dependent such as a spouse?” he asks.

Pam Murray says the level of engagement is growing—though slowly—within her company, especially since replacing health plans and copays with coinsurance. However, there is still much work to be done. “We give our employees tools to compare quality and cost, but the use of those tools continues to be low. When people need specialty care or imaging services, they will rely on their doctors to direct them where to go,” she says. “However, when I myself used the available consumer tools, I found there’s a huge difference in cost, depending on where I receive a service.” Under the ACA, employees receive preventive services at 100 percent coverage, so it does not matter if those services are priced competitively. Even outside of preventive care, the individual claimant does not have incentive to spend time shopping to select a cheaper service for the sake of other employees’ rates.

Typically, the same is seen with doctors, who have no reason to direct patients to the most cost-efficient care. Murray says, however, that doctors are beginning to care. “In some cases, doctors and hospitals are linked to Accountable Care Organizations (A.C.O.s), or doctors are directly employed by the hospitals.” Carole Watkins, CHRO at Cardinal Health, says she sees a trend of employees actually helping to educate providers on consumerism: “Providers don’t know the answer. We had a partnership with a health system and were talking to them about consumerism and they were struggling to understand their role. Providers need to be more engaged to understand what consumerism is and what it means for their patients.”

Policy Issues: Mandates and Regulations

Policies surrounding health care can make it difficult for employers to promote consumerism as well. This is one reason that complying with government legislation is another top concern to HR executives. David Stafford, CHRO at Michelin North America, notes that “The U.S. health care landscape is complex, and it is very difficult for a consumer or self-insured company provider like Michelin to manage and demonstrate continuous improvements with the basic concepts like quality, cost and value.” Emerson’s James Jones stresses the amount of time and energy his company devotes to providing health benefits. “From the employers’ perspective, we are frustrated with the bureaucracy that’s being created by the federal government,” he says. There is no such thing as an average plan member. Robert Foley, Director of Employee Benefits at Mutual of Omaha, says the ACA forcing employers to have plans of equal design has been burdensome: “The problem with this concept is that all patients are not equal. Some are sicker and require more care than others.” Carole Watkins agrees: “Many of the government mandates are at odds with consumerism. For example, if you look at what’s mandatory in coverage—even retiree plans are required to have coverage for birth control, which ends up costing the retiree more for coverage they will never need or use.” Anything that dictates what a plan must look like is problematic. General consensus is that the government should let the market decide that.

“Many of the government mandates are at odds with consumerism.”

In addition to the burden of current policies, anticipating the implementation of ACA mandates is another anxiety. Employers repeatedly list the Cadillac Tax, the ACA's 40 percent excise tax on high cost health plans, as a specific area of concern. This penalty applies to ESI spending more than $10,200 on an individual, or $27,500 for family coverage, and is expected to go into effect in 2020. Robert Foley says you would think the Cadillac Tax's threshold would be so high that it would not become a problem for most employers. However, "you have to add any employer contribution to a flexible savings account or HSA and soon, it becomes easier to reach that threshold," he points out. Indeed, by 2031, the cost of the average family health care plan is projected to hit the excise tax threshold.[11] Bruce Culpepper, U.S. Country Chair and President at Shell, says, "The Cadillac tax is still looming. Any policy changes that drive up costs and make it harder for employers to provide quality health coverage are a concern to us." One CHRO at a Fortune 100 company says, "Government needs to be as flexible as possible and make sure they don't enact anything that creates unintended consequences that might permit employers to provide health care. The Cadillac Tax is one illustration."

"Government needs to be as flexible as possible and make sure they don't enact anything that creates unintended consequences that might permit employers to provide health care."

Though federal laws get more attention and discussion, we find that employers are also having trouble navigating state laws. One senior benefits manager from a major corporation says, "Tracking and understanding state-level policy such as payroll and claims taxes has been hard. Some of these taxes are not coming through the legislatures, but from the governors' budgets. Half the time, you don't even know what's out there, which makes tracking these issues challenging." The same company's VP of Compensation and Benefits agrees, saying, "Large employers struggle to differentiate how the laws apply in all fifty states because we have employees everywhere." This goes along with the importance of abiding closely with the Employee Retirement Income Security Act of 1974 (ERISA), telemedicine laws, and data release laws.

General Dynamics' John Ohrnberger stresses that the government "needs to stop latching fees onto the whole system." He says, "The intended purpose of such fees never creates the desired outcome. For example, the government does not intend for businesses to cut back benefits to avoid the excise tax. In reality, businesses will opt to offer 'worse' benefits to avoid paying the tax. Government fees, the excise tax, Medicare fees, and state requirements are all a concern. . . . General Dynamics has employees in many states and is a global company, so we're implicated in many different environments and jurisdictions."

On the other hand, the number one provision employers want to see protected is the tax exemption on ESI. Mark Azzarello, VP of Global Compensation and Benefits at International Paper, says, "When you look at the opportunities for generating tax revenue, both the employer deduction of ESI and the employees' ability to deduct their premiums on a pretax basis are both considered to be value-added. If the government touches either of those provisions, it would be a game changer. Especially the employer deduction. If the employee deduction gets implicated, employees will ask their employers what they will do to make up for this." This concern is very timely, as congressional members are currently seeking ways to cap the tax exclusion. Further pushback from employers is needed to keep the status quo and to keep ESI strong.

Year 2017 will bring a change in White House leadership, and CHROs and their teams realize they must plan accordingly. Kendell Sherrer says, "Who knows, with the elections coming up, what the future will hold. If the new administration carves away at the ACA, that could actually make it more complicated. Trying to make things more simple can actually add complexity and frustration." Employers know they must make changes whether or not the ACA is still intact in the future. These changes must meet the standard of working regardless of where the health care law stands. Marriott International's David Rodriguez says that since government is already deeply entrenched in the health care system, "business and government have to figure out their respective roles and how they work synergistically, as opposed to what is happening now where they are stifling innovation and new opportunities to come together."

Conclusion

It is clear from this series of interviews that the employer based health care system is unlikely to disappear at any point in the foreseeable future. Moreover, the interviews reveal that senior executives are committed to remaining in the employer based health system for a variety of reasons. At the same time, it is also clear that CHROs and their teams have significant concerns about cost, quality, and levels of consumer engagement among their employees. Furthermore, senior human resource executives also worry about the policy environment, and what might be coming down the pike to complicate their efforts. In addition, technology is seen a significant potential game changer, albeit one that has not yet been fully realized. In sum, employers are committed to the ESI system but also that they recognize changes need to be made if that commitment is to continue.

Endnotes

Note: This paper is based on a series of interviews conducted with dozens of CHROs in late 2015 and early 2016. The CHROs were notified that their interviews would be included in a paper and that they would get to review their quotes before publication. Some chose to allow the quotes to run with their names and titles. Others chose to remain anonymous.

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Understanding the Consumer Enrollment Experience in Federally Facilitated Marketplaces

A Review of Calls to the Assister Help Resource Center (AHRC), November 2015 January 2016

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

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

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Introduction and Methodology

The Patient Protection and Affordable Care Act (ACA) has ushered in the largest expansion of health insurance coverage since Medicare's creation in 1965. Approximately 20 million people have gained coverage under the law, 12.7 million of them through health insurance plans offered on the newly created health insurance marketplaces.[1]

Unlike previous national coverage expansions, the ACA has extended coverage through a combination of expanded Medicaid programs and a system of advanced payments of tax credits to help defray the costs of commercial health insurance products for eligible individuals. Applying for these tax credits, which are only available through the health insurance marketplaces, and enrolling into health plans can be a complicated process. The marketplaces must take into account a consumer's immigration status, income, household size, access to other forms of coverage, and multiple other factors to assess his or her eligibility for coverage and financial assistance. Furthermore, health insurance is itself a complex product, and consumers must consider premiums, benefits, cost-sharing, and network design in selecting the optimal plan.

Consumers can obtain in-person help through the marketplace application and enrollment process from a range of assistance organizations, such as local Navigator programs, certified application counselors (CACs), in-person assisters (IPAs) and insurance agents and brokers. During the first year of marketplace enrollment, marketplace assisters helped an estimated 10.6 million consumers obtain coverage.[2]

However, assisters have faced enormous challenges staying on top of the complicated laws and rules that govern the eligibility and enrollment process. In response to feedback from assisters after the first year of marketplace enrollment, officials running the federally facilitated marketplace (FFM) created a specialized call center to provide assisters with technical and policy support. This call center, called the Assister Help Resource Center (AHRC), was piloted in a few states during the 2015 enrollment season and rolled out to assisters in states using the Federally Facilitated Platform. AHRC call center operators help assisters resolve complex individual cases related to application filings, eligibility determinations and redeterminations, enrollment and re-enrollment.

The AHRC keeps detailed daily logs that record each call, the assister's question, and the resolution of the case. Over the course of the 2016 open enrollment period (November 1, 2015 to January 31, 2016) or OE3, the AHRC received 1,384 calls from assisters from over 40 states. In general, assisters receive extensive training from the FFM and have numerous fact sheets, training slides and frequently asked questions to consult when they have questions. They can also contact the consumer call center for the FFM. Assisters were encouraged to contact the AHRC when these other resources were exhausted and when they needed highly specialized policy expertise. By their very nature, then, the questions posed in these call logs paint a picture of the complexity of the eligibility and enrollment process, and are not representative of the millions of interactions that assisters had with consumers during OE3. The vast majority of consumer issues that assisters handled were fully resolved without the need to seek assistance through the AHRC.

Methodology

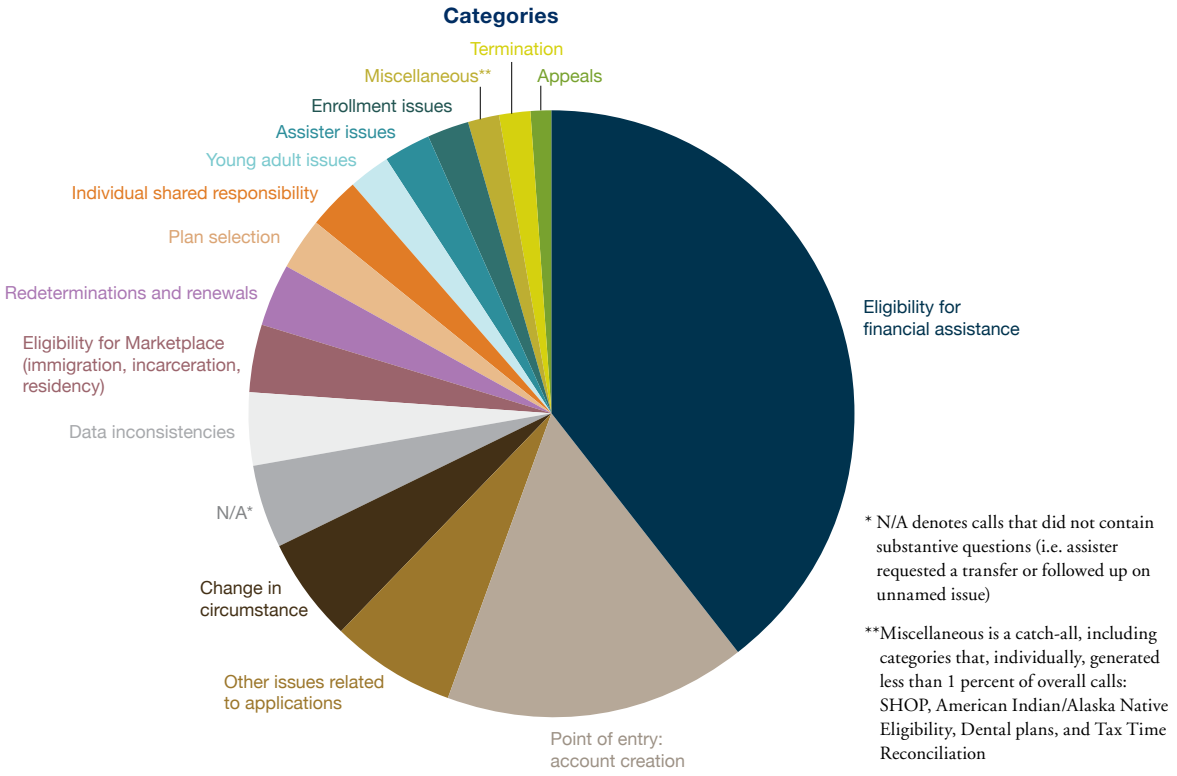
Prior to the start of the 2016 open enrollment period, the AHRC contracted with experts at Georgetown University's Center on Health Insurance Reforms (CHIR) to review daily call logs, support training for call center operators, and provide other policy and technical assistance. The AHRC's call logs form the foundation for this report, which attempts to categorize and assess the range of eligibility and enrollment challenges that assisters help consumers overcome. The authors hope that the findings, detailed below, can give state and federal officials greater insight into systemic problems that may still need to be addressed and help identify the resources and training materials that will be in the highest demand for future open enrollment periods.

To prepare this report, Georgetown researchers tagged each call entered into the log between November 1, 2015 and January 31, 2016 with an eligibility and enrollment category label.[3] We then reviewed each question within each category in an attempt to capture the range of issues with which assisters were confronted. The report is organized by call category, in descending order by call volume. Within each section below, we provide examples of calls that exemplify common problems or concerns.

The AHRC Call Logs: Key Consumer and Assister Challenges

Of the 1,384 calls that AHRC received between November 1, 2015 and January 31, 2016, the majority (546) requested help with the process of determining eligibility for marketplace financial assistance. (See Exhibit 1. For full table of volume of calls by category, see Appendix I). The next largest category (159 calls) related to account creation difficulties – primarily lost passwords and duplicate accounts from prior enrollment efforts. And although healthcare.gov has made great strides in functionality, a significant proportion of calls (93) came from assisters confronted with technical or other challenges completing applications. Remaining categories, discussed in greater detail below, ranged from questions about assister training and responsibilities, eligibility to enroll in marketplace plans, renewing plans and eligibility redeterminations, selecting a new plan, including a young adult on a family plan, marketplace appeals, special enrollment periods, the requirement to maintain coverage, and reconciling the previous year's premium tax credits, among others.

Exhibit 1. Volume and Categories of Calls Received by the AHRC



Eligibility for Financial Assistance

The AHRC received 546 questions relating to eligibility for financial assistance, representing 39.45 percent of total call volume. This was by far the largest category of questions for the AHRC. One of the most important responsibilities of the health insurance marketplace is to screen applicants for their eligibility for financial assistance – specifically, the advanced payments of premium tax credits (APTCs) and cost-sharing reductions (CSRs) that can help make premiums more affordable and health care services more accessible. However, determining who is eligible for these subsidies and at what level is enormously challenging, involving multiple variables, including tax filing status, a family's annual income and household size, the availability of other sources of coverage, and this year, whether or not recipients of 2014 tax credits reconciled those tax credits on their 2014 tax return.

Tax Filing Status

The AHRC received 39 questions about the appropriate tax filing status to report on a consumer's marketplace application, 2.82 percent of total call volume. The vast

majority of questions related to tax filing status (34 of the 39) came from married consumers. Married couples are ineligible for marketplace financial assistance if they file taxes as "married filing separately."[4] However, many married individuals who would otherwise be eligible for tax credits file taxes separately for varied reasons, including an inability to locate an estranged spouse and in cases of abuse. The Internal Revenue Service (IRS) has created narrow exceptions to the rule for abandoned spouses and victims of domestic violence,[5] but the AHRC fielded numerous questions about whether and how these exceptions might apply. The AHRC also heard from individuals in the process of divorcing from their spouse, many of whom were in a period of separation. For someone applying for marketplace coverage in December 2015, it could be more than 16 months before they would be required to file a 2016 tax return. Because they were unsure of when their divorce would be finalized, these individuals were uncertain what filing status to report on their marketplace application.

*Separated spouses**
"Counselor is seeking guidance on what to enter for filing status as married filing separately is not allowing any APTC. Consumer has been separated for 4 years from their spouse. The spouse lives in Texas and the consumer lives in South Carolina. The spouse provides support for the two children as needed. The consumer has filed as head of household on their taxes."

Divorcing spouses
"Navigator called in because her consumer lives apart from her husband. They plan to file for a divorce in 3 months. Her husband's income is not included in their household income. The consumer filled out the Marketplace application and answered the question about filing with her husband, she stated she will not file at the end of the year with him."

*Quotes excerpted from the AHRC call log have been lightly edited to fix typos, correct syntax and preserve anonymity.

Counting Income

The AHRC received 203 questions about how to count or project income; these represented almost half of the questions about eligibility for financial assistance and 14.67 percent of the AHRC's total call volume. This is not surprising - perhaps the most complicated issue for assisters and the consumers they serve is how to report income on a marketplace application. Individuals applying for premium tax credits must understand what income to count to arrive at "modified adjusted gross income" (MAGI), project their income over the course of the tax year, and provide acceptable documentation to substantiate the estimate if federal data sources cannot verify their reported income.

Questions to the AHRC primarily focused on what sources of income to include as part of MAGI. They provide a window to the myriad sources of revenue that sustain American families, in addition to wages. These include survivor benefits, disability payments, unemployment benefits, supplemental security income (SSI), student loans, rental payments (including from rental properties in foreign countries), real estate sale proceeds, structured settlement funds, annuities, child support and foster care payments, housing allowances, interest on investments, firemen's funds and veterans' benefits. Determining what counts or doesn't count towards MAGI is no easy task, particularly for non-tax professionals. Questions also revealed that many families don't have a steady flow of income; for example, many asked whether and how to report one-time income sources such as 401K withdrawals, inheritances, and lump sum settlements.

Self-employed individuals also face unique challenges, particularly if their income is likely to fluctuate over the course of the year. The AHRC received several questions about how to project such income (including what deductions are permissible), and what to do if the ultimate income over the tax year is higher or lower than originally projected. Others called on behalf of consumers who had recently lost their jobs and did not know how to document their lack of income.

Forms of income
"The consumer she is dealing with has a unique situation in that he is a member of the clergy. He has a housing expense that is paid for him and is included on his W-2. The housing expenses shows up under a different box than the actual income."

One-time sources of income
"Assister is assisting a consumer who in December will be selling some property that will affect a change in their income. The consumer wanted to know if she will have to pay back [tax credits] for the entire year or just for the month of December."

Projecting income
"Navigator would like to know what happens if someone estimates their income and it is really low and they receive a lot of tax credits all year then at the end of the year their income is below 100% of the FPL which would have made them not eligible at all. Do they have to pay back all the tax credits or is there a limit on how much they pay back?"

Foreign income
"The assister will be working with a consumer that is a U.S. citizen that lives in the United States a little more than half the year. The consumer lives outside of the U.S. the rest of the time. The consumer is self-employed. He buys merchandise in the U.S. and then he sells it in Mexico. He does file taxes in the U.S., but he doesn't pay any taxes. He does file and pay income taxes in Mexico. The assister wanted to know if he would be eligible for advanced premium tax credits."

Determining Household Size

The AHRC received 67 questions about determining household size, representing 4.84 percent of total call volume. An accurate portrayal of the applicant's tax household is critical to ensuring an accurate eligibility determination for financial assistance. To determine household size for premium tax credits, the IRS includes in the household anyone who is a dependent for tax filing purposes, regardless of family relationship or whether they live in the home. But the process can be complicated by the fact that Medicaid takes a different approach for people who don't file taxes and others who meet certain exceptions. For non-filers, for example, Medicaid does not include in the household dependents who are not immediate family members, even if they live in the home. It can be difficult for consumers and assisters to figure out how nuanced rules apply to often complicated family relationships.

Nineteen of the 67 questions were from assisters uncertain whether and how to include on the application older dependents, i.e., elderly parents or adult children. Divorced parents with children were also a common source of questions, particularly when non-custodial parents are obligated to purchase coverage for their children under divorce decrees. And the AHRC fielded several questions from "mixed status" families, in which one or more members of the household were undocumented.

Non-custodial parents
"CAC inquired about her client's complex case. He has a court mandate to provide health insurance to his two children. The children live with his ex-wife in Illinois. The father and mother do not communicate at all and are not married. The mother is the one that claims the children in her taxes. How can the father get the children health insurance?"

Older dependents
"The assister is working with a consumer that has a marketplace plan and is preparing to renew him for next year. The consumer has a wife and his 94-year-old father that he claims as a dependent. Both his wife and father are on Medicare. The assister wanted to know if they should be included on the application."

Mixed-status families
"The navigator is currently working with a family that is trying to insure their 15-year-old daughter. The daughter is a U.S. citizen and has her social security number. The parents are not legal residents but do have an ITIN (Individual Taxpayer Identification Number). Navigator insists the consumer should be eligible for the tax credits and it would help the family immensely if they can gain access to the financial help."

Access to Other Minimum Essential Coverage

The AHRC received 197 questions about the interplay between access to other forms of insurance coverage and marketplace financial assistance, 14.23 percent of total call volume. Under the ACA, individuals eligible for or enrolled in other forms of coverage, such as employer-sponsored insurance (ESI), retiree coverage, Medicaid, Medicare, and COBRA may not be eligible for financial assistance. But those other forms of coverage must be assessed on a case-by-case basis to determine whether or not they qualify as minimum essential coverage (MEC).

Employer Sponsored Insurance

The most common question (86 received) in this category came from consumers with access to an employer-based plan. If an individual is eligible for an employer-based health plan, and that plan is found to be both affordable[6] and adequate,[7] then the individual is not eligible for financial assistance through the marketplace. Many

assisters called the AHRC with questions about how to determine whether someone's ESI was either affordable or adequate or both. The largest category of ESI questions was on behalf of consumers caught in what is commonly referred to as the "family glitch;" these represented over one-third of all ESI-related calls. Under federal rules, if the premium for self-only coverage in the employer's lowest cost plan is less than 9.66 percent of household income, then no family member eligible for the employer's plan can qualify for a premium tax credit, no matter how expensive the premiums are for a family plan.

Several assisters also called on behalf of consumers who missed their employer's annual open enrollment season; others were in an employer's waiting period and not yet eligible for the ESI. Assisters wanted to understand what their clients' coverage options would be.

Variable employment
"Counselor is seeking guidance on determining the unaffordability of employer sponsored coverage for seasonal employment. Consumer is offered employer sponsored coverage at the cost of $212/month. The cost of premium may be more than income earned in a slow month."

Family glitch
"Certified Application Counselor has a family of 3 she is working with. The husband has health coverage through his job and is given the option to cover the wife and child but the cost to cover all 3 family members is too expensive. The CAC would like to know if the wife and child are eligible for tax credits."

COBRA Coverage

The AHRC received 13 questions about consumers' access to COBRA coverage. Consumers with access to COBRA face unique issues. COBRA coverage is considered to be MEC, but unlike employer-based coverage, generally an individual can be eligible for COBRA and still receive APTC, so long as she or he is not enrolled.[8] Most callers were working with consumers who had been offered COBRA coverage and were trying to determine their best options for maintaining affordable, comprehensive insurance. Some callers were enrolled in COBRA but found the premiums too expensive; they wanted to know if they could drop their COBRA coverage and obtain marketplace subsidies instead.

COBRA
"Navigator has a consumer who has active COBRA coverage that will end in June 2016 and they are looking to find something cheaper through the Marketplace. The Navigator would like to know if the consumer is stuck with the COBRA or does it act like employer insurance."

Medicaid/CHIP

The interaction between Medicaid or CHIP eligibility and marketplace coverage was another significant source of questions. The AHRC received 68 such questions, approximately one-third of all calls relating to access to MEC. When consumers are eligible for their state's Medicaid or CHIP program they are generally not eligible for marketplace subsidies, but there are some important exceptions. For example, certain state Medicaid programs, such as coverage for low-income pregnant women, coverage for "medically needy" individuals, and some waiver programs may not meet MEC standards. Seven questions required an assessment of whether the consumer was eligible for or enrolled in one of these non-MEC forms of Medicaid coverage.

Thirty-six questions – over half of those related to Medicaid – spoke to the often slow and uncoordinated efforts to align marketplace eligibility determinations with the process of the state's Medicaid agency. Consumers often got caught between the two: once the marketplace assesses them as eligible for Medicaid (and therefore ineligible for subsidies), their applications must be submitted to the state for an eligibility determination. This process is not easy, short or streamlined in most states, and assisters' questions reflected this.

Twelve assisters wanted to know if their clients could turn down government coverage (Medicaid or CHIP) and enroll in a marketplace plan instead. A number of these families expressed anxiety about the numbers and types of providers they would have access to if they enrolled in Medicaid.

Medicaid eligibility determination process
"The assister will be meeting with a family later today to enroll in a qualified health plan. The parents were found eligible for advanced premium tax credits and the children were assessed as possibly eligible for Medicaid. The parents would like to enroll their children in a qualified health plan without premium tax credits while they are waiting to determine if their children will be found eligible for Medicaid by their state. They are very concerned about the children not having any coverage."

Medicaid that is not MEC
"Navigator called in because she is helping a young woman who recently became pregnant. On the Marketplace eligibility determination she was directed to Medicaid. The consumer will qualify for Medicaid's pregnancy-only services; it does not meet MEC requirements. The consumer should technically qualify for the tax credits. The Marketplace call center suggested the consumer 'Click Denied Medicaid in last 60 days.' But she will not get denied Medicaid, she will get pregnancy-only services."

Medicare

The AHRC received only 22 questions (1.59 percent of total call volume) from assisters about the interaction of Medicare eligibility and marketplace coverage, but these often came with high financial stakes for consumers. Specifically, the AHRC received several questions on behalf of consumers over 65 who don't qualify for premium-free Medicare Part A (usually because they didn't contribute a sufficient number of working hours). However, determining whether a marketplace plan is the best option for these individuals requires highly specialized expertise and a case-by-case assessment. If an individual is eligible, failure to enroll in Medicare on a timely basis can mean higher health care costs, gaps in health coverage, disrupted access to needed care, and tax penalties.[9]

Beneficiaries with Medicare Part A only
"Consumer is concerned that her Medicare Part A is not considered minimum essential coverage (MEC). She would like to supplement her Part A with a marketplace plan."

Medicare disability coverage
"The Certified Application Counselor called regarding a consumer that she assisted with applying for a QHP during the last two Open Enrollments. The consumer was planning on re-enrolling for 2016. However, she received a card in the mail stating that she was approved for Medicare Disability coverage Parts A & B, effective as of June 1, 2011. The consumer, based on this coverage, will not re-enroll in a QHP for 2016. During the last two Open Enrollments, the consumer received premium tax credits. The CAC questioned if the consumer will have to pay back the premiums she received for the past two years?"

Beneficiaries with Medicare Part B only
"Certified Application Counselor called in to advise she has a consumer who has Medicare Part B only, and cannot afford Part A premiums. The Counselor would like to know if the consumer can enroll in a catastrophic plan."

Failure to file and reconcile 2014 APTCs

This year, for the first time, eligibility for 2016 financial assistance was contingent on consumers having filed and reconciled their 2014 APTCs, if they received them. The AHRC received 16 questions from assisters about this topic (1.16 percent of total call volume). These calls were frequently triggered when consumers received the marketplace notice about their failure to reconcile APTCs, or because they were surprised to discover that they would no longer be eligible for subsidies in 2016.

Failing to file 2014 tax return
"The assister had worked with two consumers last week that did not know they had to file their taxes. They are on social security and previously have not been filing taxes. The assister helped them complete their Marketplace application for 2016. That is when the couple discovered they had to file their 2014 taxes since they had received advanced premium tax credits. Their eligibility results showed they would no longer receive advanced premium tax credits until they file their taxes."

Point of Entry: Account Creation, I.D. Proofing, Personal Information

Of the calls logged during the third Open Enrollment period (OE3), 223 calls, representing 16.11 percent of the AHRC's total call volume, focused on the point of entry to the application system.

Account Creation

The AHRC received 159 calls (11.49 percent of overall call volume) from assisters helping consumers that had problems creating an account, resetting a password, or with duplicate accounts. Many called requesting help unlocking accounts or resetting passwords, including those who had requested the reset online but stated they never received the temporary password. Some assisters believed they were talking to the Marketplace Call Center or that the AHRC could unlock accounts. A frequent inquiry came on behalf of consumers who could not recall

the email address they had used to create their original account, nor could they remember the answers to security questions. Assisters also asked about handling duplicate accounts, especially about how to combine accounts or link applications completed by phone to the online system. Some consumers forgot they had an application in the system from a previous year, while others purposefully created a new application in order to correct personal information or use a different email address.

Application errors
"Assister is assisting consumer who has updated her application information. Upon updating her information consumer put in the wrong information. Assister went ahead and created a new Marketplace application for the consumer. Now they are in the process of trying to remove consumer's old application."

Identity Verification

Identity proofing was another challenge for consumers and assisters during OE3. The Marketplace requires consumers to verify their identity before creating an account to ensure the correct authorized person is signing up for health coverage. Identity verification uses information in a consumer's credit report, through consumer reporting agencies such as Experian and Equifax. This can pose challenges for young adults, recent immigrants, or others without significant credit histories. The AHRC received 61 calls, representing 4.41 percent of all calls received, about identity proofing issues. Most questions asked for advice on how to verify a consumer's identity after calls to Experian produced no resolution – whether as a result of Experian placing them on hold for extended periods of time, dropping their calls, or being unable to verify – and several assisters noted that they were "caught in the loop" between the Marketplace and Experian, where each was referring the consumer to the other. This "loop" seems to describe the process in which the online system directs consumers to call Experian after two failed attempts at identity proofing, and, if Experian is unable to verify identity, the system requires a subsequent failed attempt online before an option to upload verifying documents appears on the screen.[10]

Eleven of the calls included questions related to the consumer's immigrant status during the identity proofing process. Consumers were also unclear whether the documentation they submitted resolved the issue or what the timeline would be for getting verification so that they could get covered. Additionally, consumers renewing their coverage expressed confusion over being asked to contact Experian to verify their identity when they had not been asked to do so previously.

Proving identity
"In-Person Assister called while assisting a consumer with completing his online application. The consumer was unable to verify his identity with Experian. However, proof of identity documents were uploaded to the Marketplace account - income verification, resident card, and tax forms. A message displayed on the screen that the Marketplace was 'Still trying to verify your identity'."

Tobacco Use

One of the first things consumers do when creating an account is indicate whether or not they use tobacco products. Those who do are subject to a premium surcharge of up to 50 percent.[11] Three calls to the AHRC suggest that some consumers who use e-cigarettes are uncertain whether to answer "yes" to the tobacco-use question. The federal Food and Drug Administration has proposed that e-cigarettes be classified as a tobacco product, but the federal marketplace has not provided any guidance for consumers or assisters on this issue.

Other Issues Related to Applications

The AHRC received 93 questions from assisters related to problems or questions about completing consumer applications, representing 6.72 percent of total call volume. Slightly less than half of the questions (52) related to accessing healthcare.gov online or through the mobile application (41). These included a handful of questions about why the website was slow or "freezing." Other questions were from those with difficulties completing or updating applications by phone (11). Fourteen questions came from consumers having problems editing their submitted applications or accessing their applications. The remaining 27 questions included general inquiries about the application process, including the legitimacy of other insurance websites besides healthcare.gov, about AHRC itself, and about functions on healthcare.gov. These included questions about whether open enrollment would be extended, a report of broken links on an insurer's website, and a couple of inquiries on how to upload documents on healthcare.gov.

Data Matching Inconsistencies

Assisters had 53 questions related to data matching inconsistencies (DMIs), representing 3.83 percent of

total call volume. The Marketplace uses information from federal sources to verify citizenship or immigration status as well as projected income when an individual applies for Marketplace coverage.[12] In general, a DMI or inconsistency occurs when the Marketplace cannot verify an individual's citizenship, immigration status or projected income with its federal sources.[13] Income related inconsistencies occur when there is no income source on file or when an individual's projected income is ten percent lower than the amount from its federal sources.[14]

In the case of a DMI, the Marketplace provides individuals with a temporary determination that allows them to enroll in a plan with financial assistance, if applicable. Individuals, however, have 90 days to resolve an income inconsistency and 95 days to resolve a citizenship or immigration related inconsistency. If an income DMI or citizenship/immigration DMI is not resolved, the Marketplace will either redetermine the amount of financial assistance based on the information available through their federal sources (for income DMIs) or terminate eligibility (for citizen and immigration related DMIs).[15]

Of the 53 questions related to DMIs, more than half were from assisters working on behalf of consumers that had sent or uploaded verifying documents, but the Marketplace indicated there was still an inconsistency or requested additional verifying documents. Most of these questions were related to income DMIs. Assisters and consumers were also frustrated by the process and the time it takes for an inconsistency to be resolved once consumers submitted documentation. Eighteen questions focused on what types of verifying documents qualified, particularly to allow self-employed or unemployed individuals to prove income. A handful of questions focused on problems uploading documents through the Marketplace system.

Uploading documentation
"The CAC stated that she has several clients that have received a letter stating coverage will be canceled unless they resolve inconsistency issues. CAC stated that she uploaded all the supporting information on application and system stated that the information was successfully uploaded at the time of application and when she checks now it is not showing that."

Documenting income changes
"Certified Application Counselor (CAC) called regarding a consumer whose job based coverage will end this month. Beginning January 2016, the consumer will be self-employed. His income while employed was four times what his estimated income will be as self-employed. What information can he provide as proof of income?"

Eligibility for Marketplace Coverage

The AHRC received 50 questions about eligibility requirements for Marketplace coverage, representing 3.61 percent of total call volume. Under the ACA, an individual must meet three requirements to be eligible for Marketplace coverage: 1) be a U.S. citizen or lawfully present individual living in the United States; 2) not be incarcerated and 3) be a resident of the state where the individual is applying for coverage.[16]

The majority of questions (39 of the 50) focused on what categories of lawfully present status would qualify an individual for Marketplace coverage, and what supporting documentation would be needed. There are currently eleven broad categories of lawfully present immigration statuses, each with subcategories. For example, under a valid nonimmigrant status, individuals with various types of visas (i.e., student, worker visas) qualify for Marketplace coverage.[17]

Assisters also asked about the immigration requirements for the Marketplace versus for Medicaid. Unlike Medicaid, the Marketplace does not require lawfully present immigrants to be living in the United States for five years before they can access coverage. Others asked how to work with families with mixed immigration status, i.e., some members of the household were legal residents and others were undocumented. A handful asked questions about whether lawfully present individuals needed social security numbers to be eligible for Marketplace coverage. The remaining few questions related to the effect of an incarcerated spouse on a family's application and how the residency requirements apply in situations when individuals lived and worked or went to school in two different states.

Mixed status families
"The Certified Application Counselor (CAC) called regarding an immigrant family. The husband and children qualified for Medicaid; however, the wife has resided in the state for four years. Therefore, she does not meet the 5-year Medicaid residency threshold. Can she apply for health coverage through the Marketplace?"

Incarcerated individuals
"Navigator called to inquire about a consumer who is interested in signing up for health coverage on the Marketplace. However, the issue is that the husband has been convicted of a crime and is awaiting sentencing. The court date is set for some time in December. The husband will begin serving his sentence sometime in January 2016. The questions are: 1) Can the consumer include the husband on the application? 2) Should the consumer sign up for coverage now for herself, the child and the husband now?"

Meeting the residency requirement
"The assister is working with a couple that lives in Michigan six months out of the year and six months in Wyoming to attend school. She wanted to know what they needed to do when they are in Wyoming. They qualify for Medicaid while they are in Michigan."

Special Enrollment Periods and Changes in Circumstances

The AHRC received 49 questions related to special enrollment periods and 28 calls about reporting changes in circumstances; combined these represented 5.56 percent of total call volume. The calls included system-based questions about the process for reporting a life change or how to remove someone from an application because of divorce or death.

Marketplace consumers are required to update any changes in circumstances affecting their eligibility for coverage or financial assistance within 30 days of the change.[18] The Marketplace must also allow consumers who have a qualifying life event, such as losing minimum essential coverage, permanently moving, having a baby or getting married, to qualify for a special enrollment period to either obtain a health plan or to change their health plan, as well as qualify for financial assistance.[19]

Of the 49 calls related to special enrollment periods, a little less than half reflected consumers who were losing other minimum essential coverage (usually employer-sponsored insurance). Others asked about the timeframe for taking advantage of a special enrollment opportunity, which can vary depending on the triggering event.

Other special enrollment-related inquiries were from people having a baby, getting married and moving. Most often assisters asked whether a particular event would qualify for a special enrollment period, or how the special enrollment period worked. There were a handful of questions about coverage effective dates under special enrollments and switching plans or adding household members throughout the year.

Most of the 28 calls related to changes in circumstances were about how to remove people from pre-populated applications during open enrollment. Other questions focused on the effect of a change in circumstance like income or marriage on premium tax credits, or what would happen to consumers who had not reported a change in circumstances within the prescribed timeframe.

Loss of MEC
"The assister wanted to know the time frame for a special enrollment period for someone who had lost their job. The consumer and his spouse moved from California to Missouri to start a new job in August. In November the consumer lost his new job."

Failure to report changes in circumstances
"Certified Application Counselor called in to advise his consumer applied for 2015 coverage. During the year she was offered job based insurance but did not accept it, nor did she report it to the Marketplace. He also advised that the consumer job based coverage was considered affordable and meets minimum standards for coverage. CAC wanted to know if the coverage will end due to the consumer not reporting the offer from her job to the Marketplace."

Removing household members
"Certified Application Counselor is not able to remove a stepfather who is no longer a part of the household from a 2016 application. The counselor attempted to Report a Life Change on a 2015 application to reflect the change. The 2016 application is not allowing a Report a Life Change."

Redeterminations and Renewals

The AHRC received 48 calls related to the redetermination and renewal process, accounting for 3.47 percent of total call volume. The Marketplace, on an annual basis, must redetermine the eligibility of current Marketplace consumers for the next coverage year. The Marketplace must also re-enroll eligible consumers automatically to prevent a disruption in coverage. The redetermination process also includes a reassessment of eligibility for premium tax credits and cost-sharing reductions using the most recent household income data available through federal sources.[20]

For 2016 coverage, consumers could go back to the Marketplace to actively renew (which means to update their account information and select a plan). Active renewal ensures that consumers provide the Marketplace with the most recent information and that they have an opportunity to review and to select plans. Since health plans and their prices change year-to-year, including the second lowest cost silver plan that determines the amount of premium tax credits for eligible consumers, the Marketplace encouraged consumers to actively renew. Alternatively, if eligible consumers took no action, the Marketplace automatically reenrolled them (except for some specific and rare scenarios), but used information through federal sources and 2016 information (i.e., 2016 plan prices, updated federal poverty levels) to determine premium tax credits.[21]

Assisters had questions about the renewal process itself, both active and passive. In particular, there were questions about changes to premiums and the amount of premium tax credits when consumers had reported no changes to their income or household size. The substance of the calls suggest that consumers are unaware that the amount of premium tax credits can change annually depending on the price changes of plans in their area and updates to the federal poverty levels. There were also a number of questions from consumers who wanted to switch health plans and whether or not consumers would have to proactively terminate their old plans when doing so, particularly in situations in which health plans would no longer be available in 2016. Assisters also appeared to have problems with the Marketplace IT system when helping consumers update information, particularly when trying to remove household members from pre-populated applications.

Eligibility redeterminations
"A certified application counselor is helping a consumer who was enrolled in a Marketplace plan this year with premium tax credits. When they updated application for coverage this year it is not showing her eligible for premium tax credits and they would like to know why."

Updating account information
"The assister is helping a consumer re-enroll for 2016 Marketplace coverage. They are attempting to remove a dependent from the application for 2016. She has attempted two times to do this, and each time the dependent remained on the application. She also said this year she can no longer remove the previous application and can only update to make changes."

Selecting a Health Plan

Assisters called the AHRC with 37 questions about health plan selection, representing 2.67 percent of total call volume. These questions ranged from general inquiries about viewing and comparing plans, understanding the ability to switch plans during open enrollment, and clarifying the benefit designs of specific health plans.

Sixteen of the questions the AHRC received related to the availability of plans or plan information. There were questions about why some consumers could only see one plan offered in their area; others complained that too many plans were available. Assisters also had questions about how to use the plan preview tool as well as the provider and prescription look-up tool.

Seven assisters had questions about what certain plans covered (e.g., pregnancy, cochlear implants) and how cost-sharing worked under a plan. Six questions were from consumers seeking to switch plans during open enrollment, in some cases because they had discovered that a provider was not in-network or that they faced high cost-sharing amounts after they had effectuated coverage.

Lastly, a handful of questions related to multi-state plans, particularly from assisters and consumers who were under the mistaken impression that all multi-state plans offer

access to an out-of-state network of providers.[22] Others had questions about how to assist consumers whose health plans were no longer offered.

Locating benefit information
"The assister was working with the consumer to compare plans and enroll. The consumer has certain prescriptions that she takes and wanted to select a plan that offered them. The assister wanted to know how to locate that information."

Locating cost-sharing information
"Certified Application Counselor from Kansas inquired about her client's plan enrollment. Her client filled out an application in her home and called the CAC to ask about choosing a plan. The client wants a certain plan but wants to know if in that plan, you have to meet the deductible before services are provided."

Multi-state plans
"The CAC wanted to know if the consumer, who lives in Indiana, can get a Multi-State plan to have coverage in Illinois where his current doctors are."

Individual Shared Responsibility Penalty and Exemptions

Assisters contacted the AHRC 37 times with questions about the individual shared responsibility penalty, accounting for 2.67 percent of total call volume. All but two of the calls were about how to obtain an exemption from the penalty, with questions about immigration status, living abroad, having a hardship or having no income.

Under the ACA, all U.S. citizens and lawfully present individuals must have minimum essential coverage or pay a penalty for being uninsured.[23] The ACA, however, provides a number of exemptions to the health insurance requirement including unaffordability of coverage, undocumented status, living out of the country for a consecutive 330 days out of the year, and experiencing a hardship like bankruptcy or homelessness that makes purchasing health insurance difficult.[24] While some of these exemptions can be claimed by individuals through their annual tax filing, other exemptions, such as hardship exemptions, are only available through the Marketplace.[25]

Eight calls sought clarification about exemptions related to immigration status, including three related to Deferred Action Childhood Arrivals (DACA) who are not eligible for Marketplace coverage. Other questions were about whether certain situations qualify for the hardship exemption, how to apply for it, and how long the exemption lasted. There were also a handful of questions about how the individual mandate applied to individuals who did not regularly reside in the United States.

Immigration-related exemptions
"In-person Assister called to inquire about a consumer deemed ineligible for coverage due to her DACA status. Consumer wanted to know if she should file for exemptions and what form to use to do so."

Exemption for living abroad
"The assister states that the consumer has a daughter who has been living abroad for a year. She states that the consumer's child will be returning after aging out of the parents plan. The family wants to know if they qualify for an exemption for the time frame she has been living outside of the States."

Issues Unique to Young Adults

The AHRC received 33 questions on issues unique to young adults, representing 2.38 percent of total call volume. Navigators serving families with young adults had questions relating to their status as tax dependents of their parents, their ability to enroll on their parents' health plan, and residency, particularly for those living in a different state from their parents.

One common question (10 out of 33) came from parents who wanted their son or daughter to enroll in their family plan. The ACA includes a requirement that health plans permit children under age 26 to stay on their parents' health plan, regardless of whether or not the child is a tax dependent.[26] However, the FFM currently requires adults under age 26 who are not tax dependents to be assessed separately for eligibility for subsidies. Although they can ultimately enroll in the same plan as their parents, the system does not permit them to enroll together as a family if they want to receive subsidies.

This can have significant financial implications. For example, a young adult whose eligibility for subsidies is screened separately from his or her parents may not have sufficient income to meet the 100 percent FPL threshold

for premium tax credits. In a state that hasn't expanded Medicaid, this may mean that the young person falls into the coverage gap. In addition, a young adult child enrolling separately into a QHP must meet a separate deductible and out-of-pocket maximum from the rest of his or her family.

Other questions related to adult children who are tax dependents of their parents but who wish to apply on their own for financial assistance. In a few other cases, the adult children are over age 26, but remain as tax dependents of their parents; these families wanted to include them on their marketplace application.

The AHRC also heard from families whose children live out of state. Questions touched on marketplace residency requirements and how to find a plan with an out-of-state or "national" provider network.

Child who is not a tax dependent
"Certified Application Counselor has a consumer whose son is 22-years old. He works and files his own taxes and she files her own taxes. The CAC states the consumer would like to get a plan for her and her son and wanted to know if this could be done."

Dependent children aging off parents' coverage
"CAC is working with a consumer family whose household consists of father, mother, and son. The son is 26 years of age and just been dropped from his father's job coverage. The parents claim him as a dependent. The CAC wants to know if the son would be able to get coverage under the Marketplace as a dependent. The son isn't in school and has no income."

Children living in a different state
"Navigator is working with a consumer who has a daughter that will be attending college out of state. The consumer is trying to select and compare national plans that will best suit her daughter and her."

Assister Issues

The AHRC received 33 questions, representing 2.38 percent of total call volume, about issues that assisters faced in training for and fulfilling their responsibilities helping consumers enroll in health insurance. Assisters who called with questions included Navigators, CACs, IPAs, and an insurance broker. Ten callers needed help completing or obtaining training or certification. Five questions related to obtaining authorization to work on behalf of a consumer, and 2 assisters asked about using translators. Four assisters sought to correct or add information on the "Local Help" section of healthcare.gov, and 5 calls came from assisters looking for their assister ID number. The remaining questions related to reporting requirements, inputting assister information on applications, and technical trouble with the dedicated assister line.

Gaining client authorization
"CAC has client who has signed an authorization form giving her permission to complete application process on his behalf and she would like to know if that is sufficient documentation."

Access to training
"The navigator called to ask for assistance with the FFM Assister Training. Her colleague is locked out and has been unable to change his password. Can the AHRC assist him with resetting his password?"

Enrollment Issues

The AHRC received 32 questions relating to various aspects of enrollment into health plans, representing 2.31 percent of total call volume. These included questions about coverage effective dates, whether and how coverage could be made retroactive, and other challenges effectuating enrollment.

Coverage Effective Date

Nineteen of the 32 questions pertained to coverage effective dates. More often than not, these questions came from consumers who were losing MEC – ESI or COBRA, for example – and weren't certain how to enroll into a marketplace plan without a gap in coverage. Consumers seeking to change from one QHP to another during open enrollment had similar questions.

Four assisters called the AHRC because their clients were seeking retroactive coverage effective dates.

Lining up prior coverage with marketplace coverage
"Certified Application Counselor called in with a consumer who had questions regarding COBRA and Marketplace Coverage. Counselor was wanting to know if the consumer could end COBRA coverage by 12/31/2015 so that she could enroll in a new plan through the Marketplace beginning on 1/1/2016."

Obtaining retroactive coverage
"Certified Application Counselor has a consumer and family needing to get insurance. Consumer recently lost his job and his insurance through is set to end in a couple of days (December 4, 2015). Counselor stated that the family has already applied for coverage which is set to begin on 1/1/2016. Spouse is medically needy and is having to go to the doctor every 2 weeks and counselor was wondering if there was a way to have coverage retroactive."

Other Enrollment Problems

The AHRC received 13 additional questions from assisters about various other enrollment problems. These included queries from consumers waiting to receive insurance cards and those that reflected possible breakdowns of communication between the marketplace and the insurance company.

Obtaining insurance cards
"Navigator called in stating the consumer had registered for 2016 health coverage. He has selected his plan and paid his premium and has yet to receive his card or any other pertinent information regarding his plan."

Communication between marketplace and insurance providers
"CAC called in for a client that completed the application at the beginning of December. The CAC completed the enrollment with the consumer and suggested that consumer call the insurance carrier to make a payment. The insurance company states that they do not have any information on this consumer."

Plan Cancellation/Termination

Assisters called the AHRC with 21 questions, or 1.52 percent of the total call volume, related to plan cancellation or termination. Under federal rules, plan cancellation and termination are two discrete concepts, but the questions in the AHRC call log often use these terms interchangeably (see below). The FFM defines a cancellation to be a termination that takes place before coverage has been effectuated, whereas a termination would take place after coverage has been effectuated.[27]

Three questions in this category came from assisters helping consumers that had received unexpected termination notices. Three additional questions came from assisters helping people enroll in a 2016 plan when their 2015 coverage had been terminated due to non-payment of premiums. Marketplace consumers that receive premium tax credits are provided a consecutive three month grace period if they fall behind on premium payments, so long as they have paid their initial premium payment. At the end of the three month period, insurers can terminate coverage for consumers who fail to pay all outstanding premium payments.[28]

One question came from a consumer who continued to be billed months after terminating the plan through the Marketplace. Assisters also had problems when the primary subscriber needed to end coverage but wanted to keep other household members on the plan. Questions also arose from consumers with accidental overlapping coverage.

Eight questions involved consumers who were newly eligible for Medicare and wanted to terminate their Marketplace coverage. Many of the Medicare-related questions and others in this category sought advice on when to terminate to ensure seamless coverage, without experiencing a gap in coverage or having to pay back premium tax credits for duplicate coverage. Generally, if Marketplace coverage is being terminated for everyone on the application, whether the application contains one or more individuals, it takes 14 days for the termination to take effect. In such cases, a date can be set more than two weeks in advance to schedule coverage to end. However, if a consumer is ending coverage for only some people on a plan, thereby leaving others enrolled, termination generally takes effect immediately.[29]

Removing a member from a plan
"Certified Application Counselor called in with questions on how to remove someone from a Marketplace Application. Certified Application Counselor will be meeting with a family next week. The primary applicant is now eligible for Medicare and needs to cancel his coverage through the Marketplace. His spouse, however, would like to keep her coverage plan through the Marketplace. The Certified Application Counselor wants to know if they should cancel out their current plan and have spouse complete a new application to get coverage."

Failure to cancel a plan
"Navigator is calling in for a consumer who is having an issue with their insurance provider billing them from their policy for 2014. The consumer had insurance in 2014, the consumer called the Marketplace to cancel the coverage in September of 2014. The insurance company did not receive the cancellation request from the Marketplace. The consumer applied for coverage for 2016 and chose a different plan with same insurance provider. The provider is billing the consumer for the 4 months of coverage that the policy should have been cancelled."

Unexpected cancellation of a plan
"IPA has client whose insurance was cancelled in March 2015. IPA states that client wanted insurance to start in March of 2015. IPA stated that client thought she had coverage and wants to know why plan was cancelled so the same thing will not happen this year."

Appeals

The AHRC received 15 calls about appeals of Marketplace determinations, representing 1.08 percent of total call volume. The ACA provides individuals with the right to appeal Marketplace eligibility determinations for coverage including accessing coverage outside of open enrollment (i.e., special enrollment periods), eligibility for financial assistance such as the amount of premium tax credit, and for Marketplace granted exemptions.[30]

In some cases, assisters called because appeal decisions in favor of the consumer were not communicated to the insurance company. Others were generated because paperwork was lost or never received and consumers faced significant consequences as a result (i.e., termination of coverage or financial assistance). A few assisters called because they could not determine the status of an appeal, nor was there clear information about how the appeal would affect their client's coverage for 2016. There were also a few questions for assistance understanding appeal decisions.

Managing the appeals process
"Certified Application Counselor has a consumer who is in the middle of an appeal and she would like to know if the consumer can update her application or if she needs to wait until her appeal is over."

Executing an appeal decision
"Navigator has client that has won an appeal on premium amount that should have been retroactive back to May 2015 and the adjustment still has not been updated. Client has been told by the health plan that they have not made the adjustment because they have not been informed by CMS to do so. Client has made several calls to the marketplace trying to resolve issue and has not been able to do so."

Dental Coverage

The AHRC received 10 questions about dental coverage, representing less than 1 percent of total call volume (.72 percent). Marketplace consumers can purchase dental coverage as part of a health plan or as a stand-alone plan (SADP). Currently the FFM allows consumers to purchase dental insurance only when they are also enrolling into a health plan.[31] All of the AHRC questions focused on the process of enrolling in dental coverage as part of a health plan or as a stand-alone plan.

Adding dental coverage
"CAC called because her consumer has completed enrollment in a Marketplace health plan. A couple of days after completing their enrollment the consumer would now like to add dental coverage. How should the CAC go about adding dental coverage to the consumer's account?"

Tax Time Reconciliation and 1095 Forms

The AHRC received 7 questions (or 0.51 percent of total call volume) about the process of filing taxes and reconciling APTCs for the prior coverage year. All but one of these questions came in the final month of OE3.

Five assisters asked how to obtain a 1095-A form or correct mistakes on one that had already been provided. Form 1095-A is the IRS statement required to be filed by the Marketplace that allows consumers who are covered by a Marketplace plan to file an accurate tax return, accounting for any premium tax credit they are owed or reconciling any advance premium tax credits they received.[32] The Marketplace was required to provide the 2015 statements (by mail or electronically) to consumers on or before January 31, 2016.[33] Callers identified mistakes on these forms, such as an adult child included on the form even though the child files taxes separately, as well as forms that did not reflect a reported income change.

One questioner asked how filing for bankruptcy would affect repayment of premium tax credits.

Correcting 1095-A forms
"Certified Application Counselor called regarding a consumer who received an incorrect 1095-A form. The form does not include coverage that the consumer had for the months of January – February – March 2015. How can she have the 1095-A form corrected?"

American Indians/Alaska Natives

The AHRC received 4 questions about ACA provisions related to American Indians and Alaska Natives (AI/ANs), representing less than 1 percent of total call volume (.29 percent). Under the ACA, American Indians (i.e., members of a federally recognized tribe) and Alaska Natives receive protections and benefits related to Marketplace coverage, including the ability to enroll through the Marketplace at any time during the year and to change plans once a month under special enrollment periods.[34] AI/ANs can also enroll in health plans with zero or limited cost sharing, depending on their income eligibility.[35] The Marketplace must verify the status of AI/ANs applying for coverage.[36] AI/ANs are also exempt from the requirement to maintain health insurance coverage.[37]

Three of the 4 questions addressed marketplace eligibility for AI/ANs, including the process for verifying AI status. The remaining question was about how the exemption works for married couples when one spouse was an American Indian.

Mixed status families
"Navigator is working with a married couple. One individual is a member of a federal recognized tribe and the other is not a member. The navigator wanted to know if they both get the American Indian exemption."

Conclusion

Most of the early technical challenges facing the health insurance marketplaces have subsided, and millions of consumers now have dramatically improved access to comprehensive health coverage, often with financial assistance. But the rules governing eligibility for and enrollment into that coverage are complex and evolving, and are often challenging to apply to the myriad ways in which households are formed, income is gained, and coverage is obtained. Without doubt, one-on-one assistance is and will continue to be essential for many consumers, a large proportion of whom would not ultimately enroll into coverage without the guidance assisters provide. At the same time, marketplace assisters face a very steep learning curve, and no amount of training can prepare them for all of the different consumer interactions they are likely to have.

In response, federal and state officials have dramatically expanded the resources and support available to assisters. These include manuals, on-line educational materials, and the AHRC call center. There will be a long-term need for this support as assisters cycle in and out and marketplace rules continue to evolve.

At the same time, assisters are an important source of information for the marketplace about consumers' experiences applying to and enrolling in coverage. Monitoring and analyzing the questions posed to and by assisters can help marketplace officials identify and address systemic or policy-related problems as they arise.

Supporting assisters with policy and technical expertise and monitoring their interactions with consumers are both important marketplace functions. Yet the resources for performing these functions are not infinite, and officials will need to prioritize areas of the greatest need. The authors therefore hope that reports such as this one can help officials identify such areas and target resources appropriately.

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Appendix

Category	November	December	January	Total	Percent of Total
Eligibility for financial assistance	228	208	110	546	39.45%
General	10	11	3	24	1.73%
Tax filing status	17	14	8	39	2.82%
Counting income/MAGI	79	77	47	203	14.67%
Counting household size	31	24	12	67	4.84%
Minimum essential coverage	3	2	3	8	0.58%
ESI/family glitch	42	29	15	86	6.21%
COBRA	4	6	3	13	0.94%
Medicaid/CHIP interaction	25	31	12	68	4.91%
Medicare interaction	9	9	4	22	1.59%
Reconciling 2014 APTCs	8	5	3	16	1.16%
Point of entry	94	100	29	223	16.11%
Account creation/password problems/ duplicate accounts	72	69	18	159	11.49%
Identity verification	19	31	11	61	4.41%
Tobacco	3	0	0	3	0.22%
Other issues related to applications	39	48	6	93	6.72%
Data inconsistencies	23	13	17	53	3.83%
General	3	2	4	9	0.65%
Income	17	9	11	37	2.67%
Documented status	3	2	2	7	0.51%
Eligibility for Marketplace	14	20	16	50	3.61%
Immigration	10	15	14	39	2.82%
Incarceration	1	3	1	5	0.36%
Residency	3	2	1	6	0.43%
Change in circumstance	38	22	17	77	5.56%
Redeterminations and renewals	15	25	8	48	3.47%
Plan selection	14	13	10	37	2.67%
Individual shared responsibility	10	10	17	37	2.67%
Young adult issues	10	15	8	33	2.38%
Assister issues	19	11	3	33	2.38%
Enrollment issues	8	17	7	32	2.31%
Coverage effective date	6	10	3	19	1.37%
Other enrollment problems	2	7	4	13	0.94%
Plan cancellation/termination	12	5	4	21	1.52%
Appeals	4	10	1	15	1.08%
Miscellaneous	9	6	8	23	1.66%
Dental	4	5	1	10	0.72%
Tax Time Reconciliation	0	1	6	7	0.51%
American Indians/Alaska natives	3	0	1	4	0.29%
SHOP	2	0	0	2	0.14%
N/A	-	-	-	63	4.55%

Endnotes

1 Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Health Insurance Coverage and the Affordable Care Act, 2010-2016, Mar. 2016, https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf (last accessed Mar. 21, 2016).

2 Kaiser Family Foundation, 2015 Survey of Health Insurance Marketplace Assister Programs, Jul. 2014, http://kff.org/health-reform/report/survey-of-health-insurance-marketplace-assister-programs/ (last accessed Mar. 2016).

3 Each call was assigned to one category label. In a few cases, we either over- or under-counted. Specifically, a few calls covered more than one substantive issue. When that occurred, the call was categorized according to the issue that appeared to be the primary concern of the consumer. Conversely, there were also a few calls in which more than one call was needed to resolve an issue. Each of these calls was separately tagged. On balance, however, we believe this tally is an accurate representation of the range of issues assisters brought to the AHRC during the open enrollment period.

4 26 U.S.C. § 36B(c)(1)(C).

5 26 C.F.R. § 1.36B-2T(a)(2).

6 "Affordable" in this context means that the employee's annual premiums for a self-only plan do not exceed 9.66 percent of household income. 26 C.F.R. § 1.36B-2(c)(3)(v).

7 "Adequate" refers to the concept of "minimum value," which means that the plan must cover at least 60 percent of covered services for an average population. 26 C.F.R. § 1.36B-6.

8 26 C.F.R. §1.36B-2(c)(3)(iv). Note however that if someone becomes eligible for COBRA because their hours were reduced at work and they are no longer eligible for their employer-based plan, then they will have to show that their COBRA coverage is unaffordable or doesn't meet minimum value standard.

9 Medicare Rights Center, People with Medicare Can Ignore Marketplace Enrollment Deadline but Those with Marketplace Coverage Nearing Medicare Eligibility Must Act, News Release, Jan. 2016, https://www.medicarerights.org/newsroom/press-releases/12816-2 (last accessed May 2, 2016).

10 Centers for Medicare and Medicaid Services, Tips for Submitting Supporting Documents to the Health Insurance Marketplace, March 20, 2015, https://marketplace.cms.gov/technical-assistance-resources/submitting-supporting-documents.pdf (last accessed Feb. 24, 2016).

11 45 C.F.R. § 147.102(a)(1).

12 45 C.F.R. § 155.310.

13 Data matching issues can also occur when verifying American Indian/Alaskan Native status or access to other types of coverage.

14 Health Insurance Marketplace, Consumer Guide for Annual Household Income Data Matching Issues, CMS Product 11954, Oct. 2015, https://marketplace.cms.gov/outreach-and-education/household-income-data-matching-issues.pdf (last accessed Feb. 24, 2016).

15 Centers for Medicare and Medicaid Services, Tips to Resolve Outstanding Data Matching Issues (Inconsistencies), Dec. 2015, https://marketplace.cms.gov/technical-assistance-resources/resolve-data-match-issues.pdf (last accessed Feb. 24, 2016). The Marketplace provides a special enrollment period to individuals whose coverage was terminated because of a citizenship or immigration related data matching inconsistency if an individual misses the timeframe to resolve the inconsistency, but later provides verifying documentation.

16 45 C.F.R. § 155.305.

17 *See* Health Insurance Marketplace, Serving Special Populations: Immigrants Fast Facts for Assisters.

18 45 C.F.R. § 155.330.

19 45 C.F.R. § 155.420.

20 45 C.F.R. § 155.355; Centers for Medicare and Medicaid Services, Helping Consumers with the Eligibility Redetermination and Reenrollment Process for 2016, Nov. 2015.

21 Centers for Medicare and Medicaid Services, Helping Consumers with the Eligibility Redetermination and Reenrollment Process for 2016.

22 The Multi-State Plan (MSP) Program, established under the Affordable Care Act, directs the U.S. Office of Personnel Management to contract with private health insurers to offer Multi-State Plans. Some may offer access to an out-of-state network of providers, but, despite the name, many do not. *See* U.S. Office of Personnel Management, Multi-state Plan Program and the Health Insurance Marketplace, https://www.opm.gov/healthcare-insurance/multi-state-plan-program/.

23 26 U.S.C. § 5000A.

24 26 U.S.C. § 5000A(e).

25 45 C.F.R. § 155.605.

26 45 C.F.R. §147.120.

27 45 C.F.R. § 155.430.

28 45 C.F.R. § 156.270.

29 *See* Healthcare.gov, Cancel Your Marketplace Plan, https://www.healthcare.gov/reporting-changes/cancel-plan/.

30 45 C.F.R. § 155.355.

31 *See* Healthcare.gov, Dental Coverage in the Marketplace, https://www.healthcare.gov/coverage/dental-coverage/ (last accessed Mar. 15, 2016).

32 Internal Revenue Service, 2015 Instructions for Form 1095-A, https://www.irs.gov/pub/irs-pdf/i1095a.pdf (last accessed March 15, 2016).

33 Ibid.

34 45 C.F.R. §§ 155.350 and 155.420.

35 45 C.F.R. § 156.420.

36 45 C.F.R. § 155.350.

37 26 U.S.C. § 5000A(e)(3) and 45 C.F.R. § 155.605.

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