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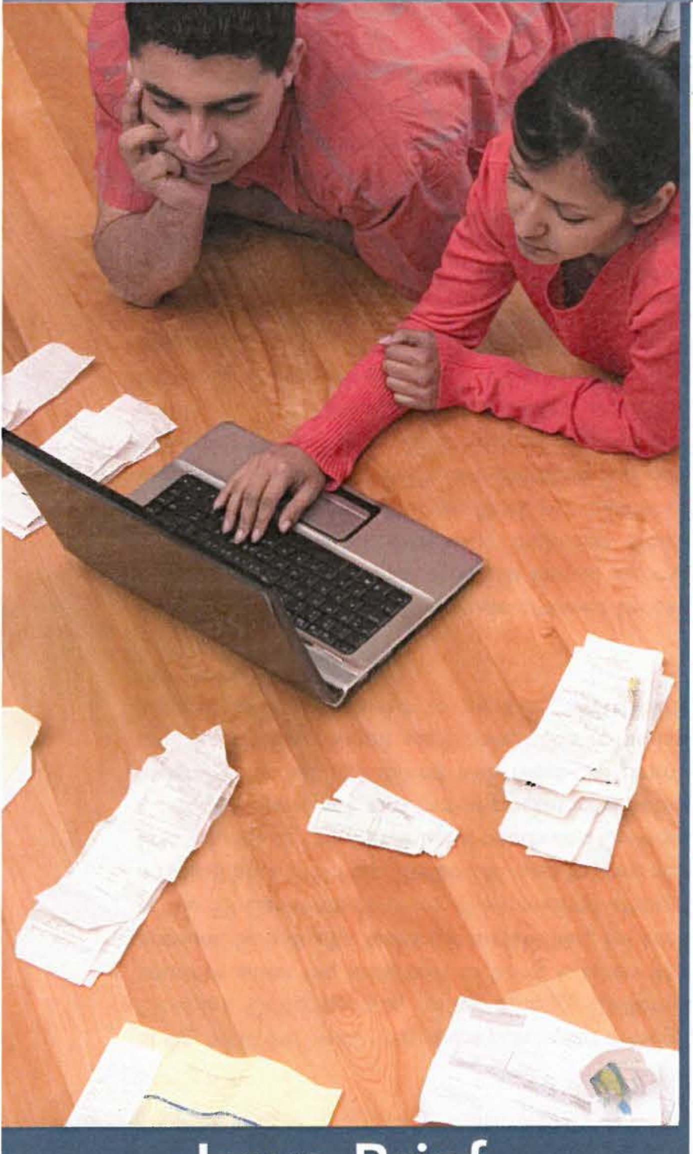
May 2016



Issue Brief

Balancing the Books: How Affordable Is Health Insurance Through Covered California When Local Cost of Living Is Taken Into Account?

You and your spouse are shopping for health insurance through Covered California. Your salary as a restaurant manager and your spouse's freelance income add up to a little more than $75,000 each year. You look at your household expenses — rent, transportation, child care for your two kids, food, and more — to make sure you can afford health insurance premiums and out-of-pocket (OOP) costs. According to a UC Berkeley analysis, you'd be able to afford the premium and out-of-pocket costs if you lived in Modoc County, but not if you lived in Marin County, even with the federal subsidies available under the Affordable Care Act (ACA).

Federal Subsidies Are Not Always Enough

Premium and cost-sharing subsidies offered to eligible individuals through the health insurance marketplaces established under the ACA have reduced the cost of health insurance for millions of Americans. However, premium and cost-sharing subsidy amounts are set nationally, and do not account for differences in local cost of living, which can vary dramatically across counties and regions in California.

Subsidies are no guarantee that coverage through Covered California, the state's health insurance marketplace, will be affordable, especially for those living in areas where a high cost of living already strains household budgets. In fact, many eligible Californians still find the premium and out-of-pocket costs for health insurance plans offered through Covered California unaffordable despite subsidies — and despite the slowing rates of premium increases in the post-ACA individual market and Covered California's success in holding down premium costs. According to a survey by the Kaiser Family Foundation, the most common reason (44%) for remaining uninsured in California in 2015 was not being able to afford insurance.[1]

Local Cost of Living Plays a Role

This analysis by the UC Berkeley Center for Labor Research and Education illustrates how people's

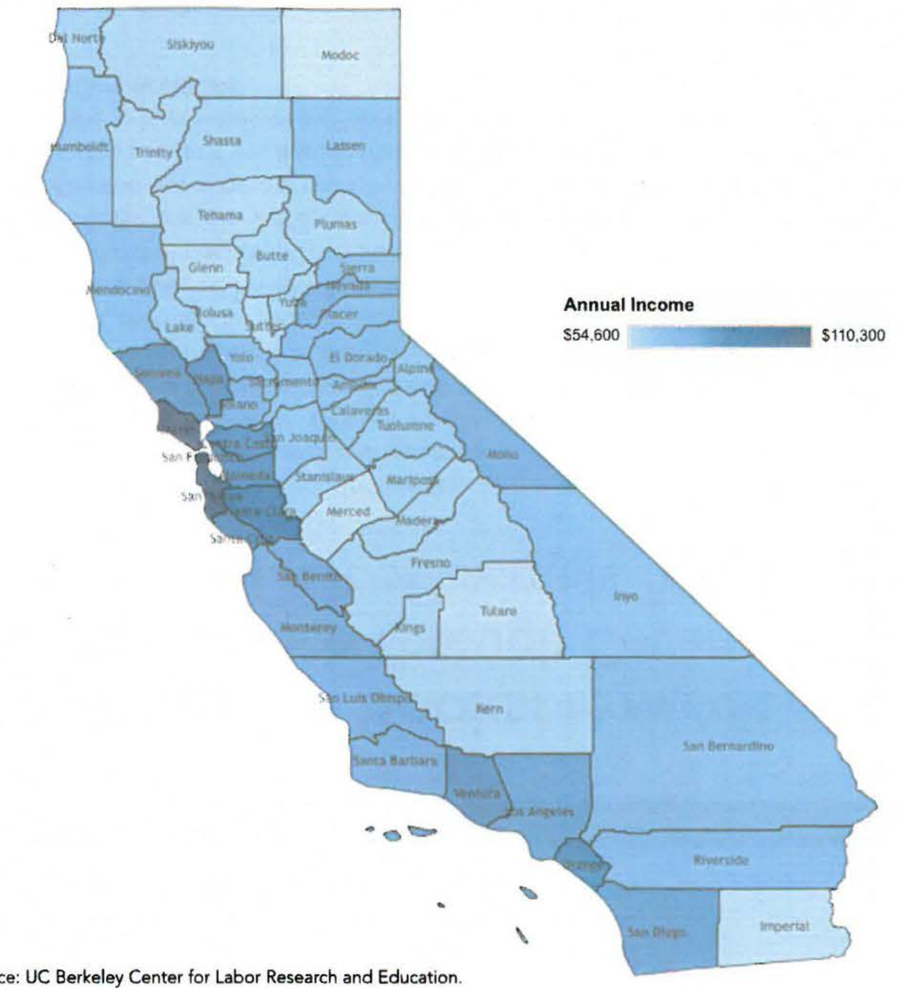
ability to afford health insurance purchased through Covered California may differ among California counties when the local cost of living is taken into account. Specifically, researchers identified, for each of the 58 California counties, the minimum amount a typical household would need to earn to have sufficient funds to cover their basic needs and Covered California premiums and out-of-pocket costs after federal subsidies (combined with Medi-Cal premiums for children, when applicable). This minimum income level is referred to as the "affordability threshold."

The affordability threshold was determined by calculating the income level at which annual income exceeded estimated expenses, including housing, child care, transportation, food, miscellaneous expenses, taxes, and health care premium and out-of-pocket costs. This analysis assumes low medical use by all family members. Health costs would be higher for consumers who use medical services more frequently.

Not surprisingly, the ability to afford Covered California premiums and out-of-pocket costs while meeting basic needs is more challenging for lower-income individuals and families living in counties with a high cost of living, compared with their counterparts with higher incomes and those in counties with a lower cost of living. Specifically, the analysis found that:

- In every county, the affordability threshold fell above the maximum income allowed to qualify for Medi-Cal as an adult (138% FPL). This suggests that in every county, a segment of the population — specifically those earning above 138% FPL and below the local affordability threshold identified here — is likely unable to afford basic living expenses and Covered California premiums and out of pocket costs.
- The affordability threshold for families of four (two parents with two children) varied widely by county (see Figure 1). Similarly,

Figure 1. Affordability Thresholds for Families of Four, by County, California, 2016



Source: UC Berkeley Center for Labor Research and Education.

wide variation in the affordability threshold for single individuals was also observed across counties.

- The low and high ends of the spectrum were represented by Modoc and Marin Counties, respectively. In Modoc, the affordability threshold for a family of four was 225% of the Federal Poverty Level (FPL), or $54,600 annually, compared with 455% FPL, or $110,300, in Marin County. In Modoc, the affordability threshold for single individuals was 165% FPL, or $19,400 annually, compared with 345% FPL, or $40,600, in Marin. See Appendix A for a list of California counties and their affordability thresholds.
- The differences in the affordability threshold found in this analysis were mainly a reflection of the variation in cost of living among counties rather than premium variation among Covered California's pricing regions.

Local Solutions

This analysis suggests that many Californians — especially low-income individuals and families living in counties with a high cost of living — need more help to afford health insurance through Covered California. In the absence of federal or state-level action, local policymakers can help. For example, the City and County of San Francisco is implementing a "Bridge to Coverage" program originally developed by the San Francisco Department of Public Health, to provide additional local subsidies to help eligible San Francisco workers afford Covered California premiums and cost-sharing expenses.[2] Other counties that have the means may want to explore similar efforts.

About the Author

Laurel Lucia, MPP, is manager of the Health Care Program at UC Berkeley Center for Labor Research and Education.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Endnotes

1. Bianca DiJulio, Jamie Firth, and Mollyann Brodie, "California's Previously Uninsured After the ACA's Second Open Enrollment Period," Kaiser Family Foundation, July 30, 2015, kff.org.
2. "Webinar — Addressing Affordability of Health Insurance at the Local Level," October 28, 2015, California Health Care Foundation, www.chcf.org; Memorandum: Proposal to Modernize the City Option and Create a New Employee Wellness Fund, July 17, 2015, San Francisco Department of Public Health, www.sfdph.org (PDF).
3. "Making Ends Meet: How Much Does It Cost to Raise a Family in California?" December 2013, California Budget Project, calbudgetcenter.org (PDF).
4. "Individual Area Final Fiscal Year 2016 Fair Market Rent Documentation," downloaded February 2016, U.S. Department of Housing and Urban Development, www.huduser.gov.
5. "2016 Product Prices for All Health Insurance Companies," downloaded February 2016, Covered California, hbex.coveredca.com.
6. Plan Preview tool for 2016 plans, accessed February 2016, Covered California, v.calheers.ca.gov.

Appendix A. Affordability Threshold* for Families and Individuals, by California County

	FAMILY OF FOUR		INDIVIDUAL	
COUNTY	% FPL WHERE AFFORDABLE†	ANNUAL INCOME EQUIVALENT‡	% FPL WHERE AFFORDABLE†	ANNUAL INCOME EQUIVALENT‡
Modoc	225%	$54,600	165%	$19,400
Imperial	230%	$ 55,800	165%	$ 19,400
Merced	230%	$ 55,800	165%	$ 19,400
Tulare	230%	$ 55,800	180%	$ 21,200
Glenn	235%	$ 57,000	185%	$ 21,800
Kern	240%	$ 58,200	185%	$ 21,800
Kings	240%	$ 58,200	185%	$ 21,800
Siskiyou	240%	$ 58,200	170%	$ 20,000
Sutter	240%	$ 58,200	190%	$ 22,400
Tehama	240%	$ 58,200	170%	$ 20,000
Trinity	240%	$ 58,200	190%	$ 22,400
Butte	245%	$ 59,400	185%	$ 21,800
Colusa	245%	$ 59,400	175%	$ 20,600
Del Norte	245%	$ 59,400	205%	$ 24,100
Fresno	245%	$ 59,400	190%	$ 22,400
Madera	245%	$ 59,400	195%	$ 23,000
Plumas	245%	$ 59,400	190%	$ 22,400
Shasta	245%	$ 59,400	195%	$ 23,000
Yuba	245%	$ 59,400	190%	$ 22,400
Lake	250%	$ 60,600	195%	$ 23,000
Mariposa	250%	$ 60,600	200%	$ 23,500
Stanislaus	250%	$ 60,600	190%	$ 22,400
Humboldt	255%	$ 61,800	195%	$ 23,000
Tuolumne	255%	$ 61,800	210%	$ 24,700
Alpine	260%	$ 63,100	190%	$ 22,400
Calaveras	260%	$ 63,100	200%	$ 23,500
Lassen	260%	$ 63,100	195%	$ 23,000
San Joaquin	265%	$ 64,300	185%	$ 21,800
Inyo	270%	$ 65,500	215%	$ 25,300
Amador	275%	$ 66,700	195%	$ 23,000
Mendocino	275%	$ 66,700	210%	$ 24,700
Sacramento	275%	$ 66,700	205%	$ 24,100
Sierra	275%	$ 66,700	230%	$ 27,100
San Bernardino	280%	$ 67,900	220%	$ 25,900
Yolo	280%	$ 67,900	230%	$ 27,100
El Dorado	285%	$ 69,100	215%	$ 25,300
Placer	285%	$ 69,100	215%	$ 25,300
Riverside	285%	$ 69,100	220%	$ 25,900
Nevada	305%	$ 74,000	225%	$ 26,500
San Luis Obispo	305%	$ 74,000	235%	$ 27,700
Solano	305%	$ 74,000	230%	$ 27,100
Mono	310%	$ 75,200	245%	$ 28,800
Santa Barbara	310%	$ 75,200	270%	$ 31,800
Monterey	315%	$ 76,400	250%	$ 29,400
San Benito	315%	$ 76,400	250%	$ 29,400
Los Angeles	320%	$ 77,600	245%	$ 28,800
San Diego	325%	$ 78,800	265%	$ 31,200
Sonoma	335%	$ 81,200	250%	$ 29,400
Ventura	335%	$ 81,200	265%	$ 31,200
Napa	340%	$ 82,500	250%	$ 29,400
Alameda	345%	$ 83,700	265%	$ 31,200
Contra Costa	345%	$ 83,700	270%	$ 31,800
Orange	345%	$ 83,700	290%	$ 34,100
Santa Cruz	350%	$ 84,900	260%	$ 30,600
Santa Clara	385%	$ 93,400	325%	$ 38,300
San Francisco	445%	$ 107,900	325%	$ 38,300
San Mateo	450%	$ 109,100	335%	$ 39,400
Marin	455%	$ 110,300	345%	$ 40,600

*Researchers identified, for each county, the minimum amount a typical household would need to earn to have sufficient funds to cover their basic needs (including housing, child care, transportation, food, miscellaneous expenses, and taxes) and Covered California premiums and out-of-pocket costs after federal subsidies (combined with Medi-Cal premiums for children, when applicable). This minimum income level is referred to as the "affordability threshold." When the affordability threshold falls to 267% FPL or below for a family of four, the analysis assumes the two children are on Medi-Cal, while the two adults are enrolled in insurance through Covered California. See the Appendix B for further details.

†Affordability takes into account the cost of premiums, median out-of-pocket expenses, and other household needs.

‡Annual income figures rounded to the nearest $100.

Appendix B. Methodology and Caveats

Methodology

This analysis focused on two household examples: single 40-year-old individuals and families with two 40-year-old working parents, one infant, and one school-age child.

The estimates of household expenses other than health care relied on several sources, including "Making Ends Meet" budget estimates from the California Budget and Policy Center (formerly the California Budget Project).[3]

Housing. Housing cost estimates for families are based on the U.S. Department of Housing and Urban Development (HUD)'s Fair Market Rent (FMR) for a two-bedroom apartment in each county in fiscal year 2016. Housing costs for single individuals assume renting a studio apartment. FMRs are published annually by HUD to estimate the cost of shelter and utilities, excluding telephone and Internet service. FMRs represent the 40th percentile of rents paid by recent movers into an area.[4]

Child care. Using estimates from the California Budget and Policy Center, child care costs were based on monthly estimates for full-time infant care and part-time care for school-age children in each county in 2009, assuming that care is provided in licensed family child care homes. The costs were adjusted for inflation using the consumer price index (CPI) for child care.

Transportation. Estimates from the California Budget and Policy Center utilized the U.S. Department of Transportation's 2009 National Household Travel Survey (NHTS). The estimates assumed that families with two working parents require two vehicles on weekdays, but only one car on the weekend. Mileage is based on county-specific average weekday vehicle miles traveled per household adult plus an estimate of miles driven on weekends based on the driving habits of California households. The costs were adjusted for inflation using the CPI for transportation.

Food. Estimates from the California Budget and Policy Center include food consumed both at home and away from home, using the June 2013 U.S. Department of Agriculture (USDA) Low-Cost Food Plan and the 2012 Consumer Expenditure Survey (CES). Food estimates for families with children assume that one child is age 1 and one child is between the ages of 6 and 8. Conservatively, the basic family budget estimate for food away from home is half of the amount reported for families in the second-lowest quintile (the 21st through 40th percentile) of the income distribution in the CES. Food away from home includes lunches purchased out or the occasional family meal eaten in a restaurant. Food costs are assumed to be the same throughout the state. The costs were adjusted for inflation using the CPI for food.

Miscellaneous. Estimates from the California Budget and Policy Center include items such as clothing and diapers, school supplies, toiletries, cleaning supplies, and household products. Miscellaneous expenses were assumed to be the same throughout the state. Estimates were made using the CES and were adjusted for inflation using the CPI for all items.

Taxes. Tax expenditures were estimated by income level using 2015 federal and state tax schedules. Taxes included federal and state income tax, the federal Earned Income Tax Credit, Social Security and Medicare taxes, and State Disability Insurance taxes. The California Earned Income Tax Credit was not included in this analysis because tax credit-eligible families are generally eligible for Medi-Cal rather than Covered California.

Health care expenses were estimated assuming that all adults were enrolled in insurance through Covered California and had no other source of health insurance. Children were assumed enrolled in Medi-Cal when household income fell to 267% FPL or below (per Medi-Cal eligibility rules); children in higher-income households were assumed enrolled in insurance through Covered California.

Premium cost estimates reflected the maximum premium amount a household is required to spend under the ACA after subsidies, or the pricing region-specific Covered California premium for the second-lowest-cost silver plan for each family member's age, whichever was lower.[5] (For Los Angeles County, the analysis used the midpoint of the premiums in the two pricing regions in the county.) Premium costs also included the $13 monthly per-child Medi-Cal premium, when applicable.

Out-of-pocket expenses were based on estimates from Covered California's Plan Preview tool, which estimates out-of-pocket expenses for a particular plan given a predicted level of medical use.[6] The analysis assumed that all family members eligible for

Covered California subsidies had low medical use. (No out-of-pocket costs were included for children in Medi-Cal.) Low medical use is defined as one or two doctor visits, one or two lab tests, and up to one prescription per year. Out-of-pocket costs would be higher for families with any members who have moderate or greater medical use. For example, if one member of the family of four in Modoc County had moderate medical use, the income level at which the family would have sufficient room in their budget to cover health insurance premiums and out-of-pocket costs would be slightly higher: 235% FPL, or approximately $57,000 annually (as compared with 225% FPL, or approximately $54,600 annually, assuming all family members had low medical use).

Caveats

Affordability thresholds are rounded to the nearest 5% FPL threshold. This analysis assumed adult premium costs for 40-year-olds. Premium costs will be higher for older individuals who are not eligible for premium subsidies.

Out-of-pocket costs vary widely between individuals and for the same individual in different years, based on medical need.

Many Californians with incomes below the affordability thresholds calculated in this analysis already have insurance through Covered California. Some of these families may prioritize health care spending above other basic needs. Some families may be using savings to pay for health expenses or other basic needs, or may be going into debt in order to make ends meet.

Additionally, this analysis was based on a household budget covering basic needs. Actual household budgets will vary according to the specific needs and situation of each family. Individuals and families seeking housing may not be able to locate units at the rents used in this analysis, particularly in parts of the state where housing markets are tight. Conversely, other individuals and families may have lower-than-assumed housing costs because their rent is atypically low or they share housing with individuals outside of their immediate family. As another example of atypical expenses, some families have access to unpaid child care services from family members or friends.

State Health Reform Assistance Network
Charting the Road to Coverage
A Robert Wood Johnson Foundation program

ISSUE BRIEF
June 2016

Improving Online Health Insurance Marketplaces: The Critical Nature of Direct Observation in Assessing the Consumer User Experience (UX)

Prepared by ***Claudia Page***

The Affordable Care Act (ACA) promised a single, streamlined, user-friendly online enrollment process—one in which consumers could apply online without assistance. While enrollment in the ACA has been steady, many consumers still face frustrating, and sometimes insurmountable, challenges to enrolling on their own. Many of these problems are fixable and are related to website design and navigation flaws.

As the fourth open enrollment period approaches, states and the Centers for Medicare and Medicaid Services (CMS) are making ongoing improvements to their online marketplaces. They are considering a variety of analytic data to understand problem areas and set priorities. An underutilized assessment channel, direct consumer observation, known as Consumer User Experience (UX) assessment, can yield important and actionable findings, and states are encouraged to include this research in their strategic planning.

This issue brief examines UX assessment channels and provides a closer look at what can be learned by directly observing actual consumers as they apply for coverage.

> *"It is standard business practice for any e-business to conduct consumer user assessments—any good business does it, and the "bigs," like Facebook and Google, do it relentlessly. [Online Exchanges] need to behave like these businesses; it is incumbent upon us to do so."* (Andrew Ratner, Director of Marketing and Strategic Initiatives, Maryland Health Benefit Exchange)

Strong numbers, but can motivated consumers enroll without assistance?

The third open enrollment period closed on January 31, 2016. Enrollment numbers exceeded the Congressional Budget Office projections, with roughly 12.7 million consumers enrolling in coverage or changing their health plans during the three-month period. Consumers in 38 states (9.6 million) used HealthCare.gov and the remainder (3.1 million) used one of 12 state-based marketplaces.

While the numbers are strong, there are no consistent or detailed published statistics on the number of consumers who used HealthCare.gov or the state-based

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State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

ABOUT CLAUDIA PAGE
Claudia Page is an independent health care consultant focused on eligibility and enrollment in public programs and private coverage, IT systems, and data security and privacy.

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For more information, please contact Claudia Page at *chpage@mac.com* or 510.604.1212.

online marketplaces without needing help along the way. Nor is it clear how often consumers began the process on their own but needed in-person or telephonic assistance to complete it.

Findings from UX research across several states show that most individuals trying to "go it alone" needed phone or in-person assistance to get through the process, if they made it through at all. Participants in the studies were technically savvy and many were millennials who are accustomed to conducting business online. They were frustrated to need help with basic site navigation and accomplishing routine tasks such as creating accounts and resetting passwords.

Gauging the consumer experience

There are a variety of channels to assess UX and not all online marketplaces use all channels. The illustration below calls out the most frequently used channels and touches on what might be learned from each.

Call Center Data: What are the top reasons for calls resulting from design or functionality problems with the site? Could they be alleviated by tweaking the website? Do call center staff have insights on consumer usability issues?

Website Analytics: On which screens do consumers spend most of their time? Where do they leave and not return? Where do they seek online or call center help?

Real-Time Consumer Observation:

- Scripted – Using scripted scenarios or having facilitators ask consumers to undertake specific tasks.
- Unscripted – No script, no task assignments, the consumer drives the direction and flow. Emotional impact of problems and "bail" points become clear when watching them take the journey with minimal outside intervention.

Online Chat Data: Where in process are consumers seeking chat help? What are the problems and/or questions (e.g., confusion about insurance concepts vs. unclear navigation or confusion with a question)?

Social Media: What are consumers saying about their online experience on Twitter, Facebook? Any actionable feedback from a site design usability perspective?

Surveys: If an exchange administers post-enrollment surveys, do they ask about specific areas in the application process consumers found challenging and recommendations for making the site more user-friendly?

Focus Groups: By the time consumers are in a focus group, their memory about specific design or usability challenges may have faded, but including questions on usability in focus group sessions can be helpful.

Ideally, states are using all of these channels and cross-walking data to have a clear sense of the problems and to set priorities. However, discussions and survey work with state exchange administrators suggest unscripted consumer UX assessment is not a business practice among most online exchanges. While website analytics can tell part of the story, it is impossible to understand the impact on the user without watching, listening, and learning from the actual consumer.

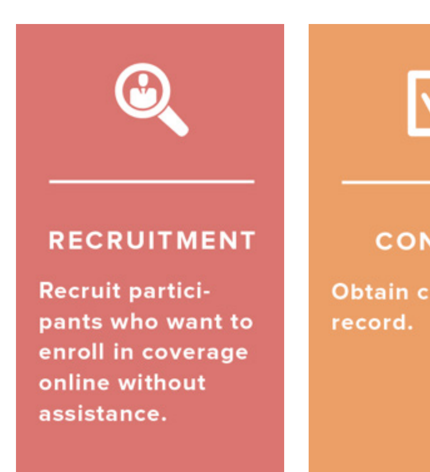
> *"Successful companies are obsessed with customer feedback and self-improvement. They listen to their customers, hardwire customer insights everywhere in the organization, and make improvements based on what their customers say is most important. Ultimately, they inspire customer love by continually making their products, services, and overall experiences better and better."* (Medallia.com blog)

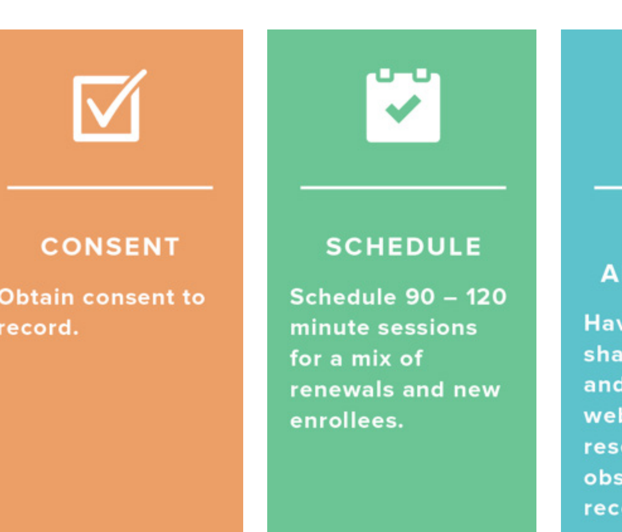
> *"Anyone running an e-commerce site knows it is evolutionary, and it's no different with our site. Turbo Tax, Amazon, Ebay—those sites looked and worked differently a decade ago than they do today. People come to our site expecting the kind of experience they are used to from their other online experiences—OE4 is the year for all marketplaces to apply a more critical eye to the consumer experience."* (Andrew Ratner, MHBE)

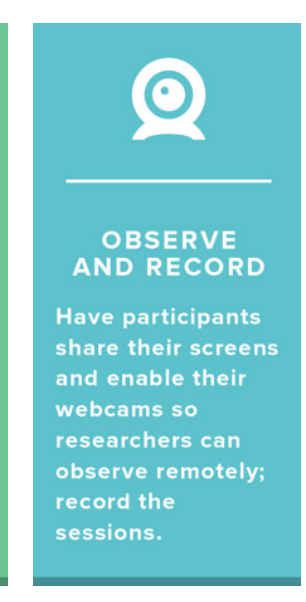
The UX research methodology

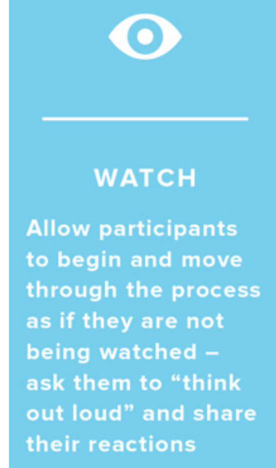
The consumer usability insights that informed this issue brief were conducted during the first three open enrollment periods by gotoresearch, an international consulting firm specializing in user experience research and design. Research was conducted in California (OE1, 2, 3), Minnesota (OE1, 2), Maryland (OE3), and across five states using HealthCare.gov (OE1, 2).

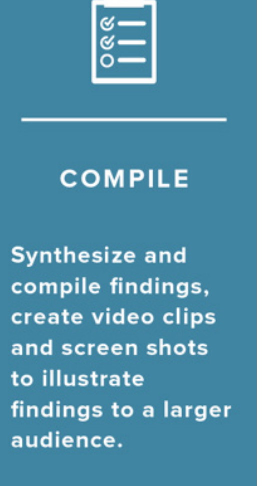
The usability assessments involved watching consumers as they applied for coverage, in their homes, offices, and at relatives' or neighbors' homes. The graphic below depicts the steps in the research process:











While each marketplace has unique findings, some shared outcomes from the three open enrollment periods across the studies include:

- Mounting frustration from multiple small errors (e.g., unclear data formats), inconsistent terminology, and unclear navigational pathways
- Users spending an inordinate amount of time in the anonymous shopping section, not realizing they have not yet applied for coverage and will have to shop again once they are in the actual application
- Confusing income and household questions that threaten the accuracy of the eligibility determination for financial assistance
- Struggling with routine tasks that should be easy, such as account creation, causing some participants to state they would abandon the process if not part of a study

Most of the frustration and confusion identified in this research could not have been identified through any other assessment channel other than direct observation. By watching consumers apply, researchers were able to uncover reasons why consumers resorted to guessing, why they would quit at certain points, and why and where they encountered the most difficulty in applying online.

> *"After three years, we're finally seeing a shift in the way state and federal exchanges view direct observation as a tool for improvement rather than finger pointing and criticism. Our research allows a deeper level of feedback, not captured through any other method, yet needed to make fundamental improvements at both screen and navigational levels. Improving the user experience takes continuous integration over time. It is essential and unfortunately too often overlooked."* (Kelly Goto, CEO, gotoresearch)

Observations from three states

The observations from Maryland, California, and Minnesota (below) help to illustrate the power of findings gleaned from observing consumers using online marketplaces.

OBSERVATIONS FROM MARYLAND

At the close of OE3, qualified health plan (QHP) enrollment in Maryland was up 33 percent from OE2 to 162,600. The Maryland Health Benefit Exchange (MHBE) processed 525,000 new and renewal enrollments in both QHPs and Medicaid, more than twice as many as in OE2. In spite of increased volume, administrators were aware of ongoing challenges with the Maryland Health Connection website and were eager to add consumer usability assessment to their list of analytic methods. The state was also motivated to reduce the volume of calls coming in to the call center.

MHBE conducted UX research in January 2016, observing four new enrollees and four renewal participants. High-level findings include:

- Only one renewal and one new enrollee were able to successfully enroll
- Renewal participants were unsure how to start the renewal process or change plans
- The "help with costs" section of the site confused people as did household income and size questions
- Insurance terminology was confusing to participants and could be made more clear and consistent
- As indicated by analyzing call center data, the password reset process resulted in significant user frustration and contributed to wait times and overload at the call center

MHBE took the following action based on the research:

- Findings and video clips were presented to staff across departments
- Consultants and IT staff began using the findings immediately to inform priority setting for OE4
- Password reset improvements were completed in April 2016

- Design and content wireframes have been created to improve the informational section of the site
- Findings were cross-walked with other data, such as website analytics and call center data to further inform the priority list for improvements and changes

> *"The third party research allowed all the players to get on the same page—IT vendors, Marketing, Policy, Customer Service. We all had the same goal to improve the consumer experience, but we had different perspectives. We had a small sample size, but the video clips were incredibly powerful at helping us see how emotionally frustrating parts of our process were for consumers."* (Andrew Ratner, MHBE)

OBSERVATIONS FROM CALIFORNIA

California's enrollment numbers were strong in OE3 with 1.57 million plan selections (27% new enrollees and 73% renewals, of which 46% were automatically renewed). In spite of solid enrollment growth and retention, consumers still struggled with the online marketplace.

Consumer research in California has been sponsored in all open enrollment periods by the California Health Care Foundation (CHCF), which has produced two reports on findings and recommendations.

Across OE2 and OE3, only one of 31 people eligible for and wanting to enroll in or renew a Covered California health plan did so during the 90 to 120 minute observed session. While there were some improvements between the two enrollment periods, many of the problems in OE2 persisted in OE3.

The excerpt below captures the sentiment of OE3 observations:

> *"Anthony, a 29-year-old entertainment professional from Los Angeles wanted to renew his coverage with Covered California and explore the plan options offered for 2016. Like many consumers, he preferred to investigate his options through the Covered California website and expected it to be a straightforward process.*
>
> *It wasn't. He had trouble understanding the instructions for entering his income. Another screen asked him to confirm changes to his application that he didn't recall making. When he was ready to compare plans, the website's "Shop" button was broken. At the end of a 90-minute session, he had yet to review a single health plan option. The process left him frustrated and disappointed."* (CHCF Website, March 2016)

Findings from the most recent testing resulted in the following specific recommendations, which reflect some of the major frustrations expressed by consumers:

- Further emphasize to the consumer that the site's window shopping tools are not final plan selection
- Add a feature that allows users to save favorite plans identified in "Shop and Compare" to easily review them at the point of actual plan selection
- Define terms such as "household member" explicitly and consistently
- Clearly list all password creation requirements in advance

Covered California and the Department of Health Care Services (DHCS) have met with CHCF and researchers to better understand these and other findings that have persisted during all three open enrollment periods. One goal of CHCF's investment in this activity is to encourage Covered California to incorporate ongoing direct unscripted observation research to improve the user experience in future open enrollment periods.

> *"We think direct user testing, along with data analytics, is a critical tool for improving consumers' experiences with online enrollment and are encouraging Covered California and DHCS to embrace them."* (Catherine Teare, Associate Director, High Value Care, CHCF)

Visit the foundation's website to see video clips of consumers and to read the full report, "Room for Improvement: Consumers' Experience Enrolling Online With Covered California."

OBSERVATIONS FROM MINNESOTA

Nearly 143,000 applications were processed in OE3 and Minnesota has now reduced its overall uninsured rate to four percent. MNsure also released a mobile version of its informational website during the last open enrollment period.

MNsure first engaged gotoresearch to conduct consumer testing during a challenging launch in OE1. Findings from the study brought usability issues into clear focus and led to significant changes to the informational section of the MNsure site (the part of the site over which the state has development and design control).

MNsure undertook a second round of assessments at the beginning of OE2 to quickly get a pulse on how certain changes to the site were working and where new and ongoing challenges existed. This early look at actual consumers using the site allowed the state to continue to hone priorities and to prepare call center staff for specific questions from consumers.

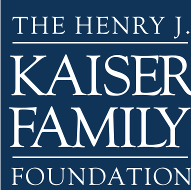
> *"Based on the initial UX assessments, usability became a central focus for MNsure. Like other states, we are navigating an array of challenges and priorities, but we know ongoing UX improvements are critical and it was powerful to actually watch consumers using the MNsure site. I don't think we could have understood the true impact of site design challenges without having seen real people interact with the site."* (Allison O'Toole, CEO, MNsure)

As MNsure moves into the fourth open enrollment period, they will assess whether and when to conduct additional consumer observation research, as they are still working to implement findings from previously conducted research.

Call to action for all states

Researchers and stakeholders understand that making a final decision about health insurance can be a daunting task and consumers may need help before actually purchasing a plan. But marketplaces should limit the need for help to the high value task of explaining complex terminology and the trade-offs between health plan options.

Consumers should not need help with basic tasks or navigation, nor should they abandon their efforts due to frustration with the online experience. Including direct observation UX assessments in ongoing website improvement efforts will help marketplaces see exactly where and why consumers struggle and potentially quit. It should be a part of the ongoing and iterative improvement process for all online marketplaces.



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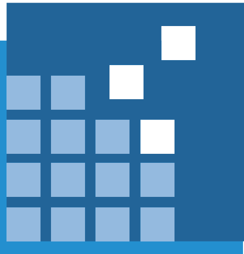

June 2016

2016 Survey of Health Insurance Marketplace Assister Programs and Brokers

Prepared by:

Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee

Kaiser Family Foundation

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Executive Summary

The new system for Marketplace enrollment assistance under the Affordable Care Act (ACA) is becoming well established. Some 5,000 Assister Programs helped consumers apply for financial assistance and select health plans for 2016 during the third Open Enrollment (OE3). Eighty-seven percent of Programs have been in operation three years, and 7 in 10 of three year Programs report most or nearly all of their staff have also worked all three years. Eighty-four percent of brokers certified to sell non-group Marketplace health plans this year also have worked all three Open Enrollments. As this system of in-person help matures, important distinctions are emerging among entities which could provide opportunities to develop strategies for identifying and building on those that accomplish the most. At the same time, substantial challenges face many Assister Programs and brokers that hinder their ability to help consumers access and successfully enroll in health coverage.

This report is based on findings from the 2016 Kaiser Family Foundation survey of Health Insurance Marketplace Assister Programs and Brokers. The online survey was conducted from February 11 to March 4, 2016 as OE3 concluded. As was the case in prior years, federal and state-operated Marketplaces provided contact information for directors of their Assister Programs, all of whom were invited to participate. In addition, most Marketplaces provided contact information for brokers certified to sell their qualified non-group health plans, and for the second year, a sample of brokers was also invited to participate in the survey.

Assister Programs combined helped an estimated 5.3 million consumers during the third Open Enrollment, roughly a 10% decline from last year. This decline is significant in light of concerns over the slowing rate of annual Marketplace enrollment growth. It may be that some already-enrolled consumers didn't seek help again this year, particularly those in Medicaid who face a more straightforward annual redetermination process in many states, or those who elected to auto-renew their qualified health plans. It may also be that other factors, including lack of public awareness and affordability concerns, affect the extent to which eligible uninsured individuals seek help. Survey respondents described several key challenges, including limited resources and inherent complexities in the application and plan choice process that may also constrain the reach and productivity of Assister Programs.

Most help from Assister Programs was provided by those with very large caseloads. About 1 in 4 Assister Programs helped more than 1,000 consumers during OE3, accounting for 80% all consumers helped by Assister Programs. By contrast, 30% of Assister Programs helped 100 or fewer consumers during OE3, and these small caseload Programs account for just 1% of all consumers helped by Assister Programs. Large caseload Programs include all types of Assister Programs – Navigator, Federally Qualified Health Center (FQHC) and Certified Application Counselor (CAC). These large Programs are distinguished from smaller ones in several respects. Large Programs were more likely to help consumers with more complex needs such as language translation (28% of large caseload Programs vs 8% of small caseload Programs), immigration-related problems (23% vs 5%), problems reporting income or household size (56% vs 35%). In addition, large caseload Programs were more likely to help resolve Marketplace data verification problems (96% vs 81%). Large caseload Programs were also more likely to engage in outreach activities, to help consumers resolve post-enrollment problems, and to coordinate with other Assister Programs.

Enrollment assistance shifted toward renewing consumers in 2016, though most who sought in- person help still were uninsured. Last year 53% of Assister Programs said most or nearly all

consumers they helped were new Marketplace participants. This year, 29% said this was the case. Increasingly Programs are serving a mix of new and renewing consumers – evidence that consumers need help to remain covered, not just to enroll for the first time. At the same time, a majority of Programs say that most of their clients were uninsured when they sought help. This may indicate some consumers are returning at Open Enrollment having lost their Marketplace coverage during the year. In addition, it suggests Assister Programs remain focused on reaching the uninsured.

Some capacity shortages continue. Overall 79% of Programs said they could serve everyone who sought help throughout OE3, but 21% had to turn some away during surge weeks in December and January. This is unchanged from 2015. Among large caseload Programs, 30% had to turn away at least some consumers.

Enrollment assistance remains time intensive. For the third year, it took 90 minutes on average to help consumers enroll for the first time and like last year, it took 60 minutes on average to help renewing consumers. Like last year, most Programs (71%) said they could help most consumers complete the plan selection process. Also like last year, most consumers who seek help have limited understanding of the ACA and difficulty understanding insurance and comparing plan choices. Complexity in the application itself also challenges many consumers, according to Assisters.

Assister Programs helped hundreds of thousands of consumers with Marketplace real-time data verification problems. Programs helped nearly 230,000 consumers resolve problems related to Marketplace identity proofing. The automated federal identity proofing system, based on credit reporting data, poses challenges for consumers without established credit history, and those who cannot pass it can face significant delays in applying for Marketplace coverage. Several state Marketplaces have streamlined the system, including by authorizing certified Assisters to visually verify identity documents. SBM Programs were more likely than FFM Programs (22% vs 14%) to say identity proofing problems usually could be resolved quickly during the initial visit.

Marketplaces also conduct real time verification of applicants' immigration status and income, matching it to online data sources. This system also poses challenges to certain consumers, for example, those who are self-employed or experience other income volatility. In 2015, the federal Marketplace alone terminated coverage for 500,000 individuals who could not resolve data match inconsistencies (DMI) related to immigration, and reduced subsidies for 1.2 million individuals who could not resolve DMI related to income. Nationwide, Assister Programs helped an estimated 172,000 consumers with immigration-related DMI during OE3, and 259,000 consumers with income-related DMI. This may be an indication that the volume of DMI problems is declining overall, or it may signify that many consumers faced with such problems are not getting in-person help to resolve them. Small caseload Programs were more likely than large caseload Programs to say they would not help consumers resolve immigration DMI (19% vs. 4%) or income DMI problems (11% vs. 3%).

Medicaid file transfers can still pose challenges, especially in federal Marketplace states. Nearly all SBM states have a single, integrated system that makes eligibility determinations for both Medicaid and Marketplace coverage. In contrast, in the 34 FFM and 4 SBM states that rely on healthcare.gov for Marketplace eligibility and enrollment functions, electronic accounts must be transferred between the federal and state systems to provide coordinated enrollment across Programs. Eight FFM states have authorized the federal system to make final Medicaid eligibility determinations, which can expedite the enrollment process. In the

remaining 30 FFM states and 4 SBM states that use healthcare.gov, the federal system assesses Medicaid eligibility and the final determination is completed by the state. Among Programs in assessment states, 34% said the Medicaid eligibility determination was usually completed in a timely manner. Many Programs said they will try to expedite the process by helping clients file a separate application for Medicaid (44% in assessment states and 13% in determination states). Among Programs that helped clients complete separate applications, 46% said one follow up visit was typically required, 20% said 2 or more follow up visits were typical.

Significant numbers of Assister Programs (37%) and brokers (53%) said most clients had questions about health plans that were not answered by information on the Marketplace web site. Most Assister Programs (61%) and brokers (67%) said most or nearly all consumers had difficulty understanding basic insurance concepts. This number is down from years one and two (75%), though still substantial. Two-thirds of Assister Programs said most QHP-eligible clients could select a plan during the initial visit; the rest said at least one follow up visit was needed. Brokers made similar observations.

During the year, Assister Programs also helped consumers enroll through special enrollment periods (SEP) and resolve post-enrollment problems. Assisters helped at least 830,000 consumers enroll through SEPs between Open Enrollments last year. This is a 30% increase over SEP help we estimated following OE1 – possibly because OE1 was much longer leaving fewer months available for SEP sign ups. Assister Programs also helped at least 349,000 consumers report mid-year changes (e.g. in income) to the Marketplace last year. And Programs provided post-enrollment help to at least 745,000 consumers between OE2 and OE3. Like last year, once enrolled many consumers needed help if coverage was terminated unexpectedly, claims were denied, their provider was not in the plan network or their medication was not on the plan formulary. Again as was the case last year, when Assister Programs can't help resolve post enrollment problems on their own, usually they do not refer to Consumer Assistance Programs, but more often refer consumers back to their health plan or to the Marketplace call center.

On average, brokers each helped 110 consumers apply for Marketplace policies during the third Open Enrollment, unchanged from last year. In addition, nearly all brokers also sold policies off the Marketplace, on average 48 during OE3, also statistically unchanged from last year. Like last year, brokers served consumers with somewhat different characteristics than those helped by Assister Programs and provided somewhat different kinds of help. Compared to Assister Programs, brokers were less likely to help uninsured individuals (30% of brokers said most clients were uninsured vs. 56% of Assister Programs) or consumers who lack Internet at home (60% of brokers said few/no clients lacked Internet vs. 24% of Assister Programs). Forty-eight percent of brokers helped Latino clients vs. 76% of Assister Programs. In addition, brokers were less likely to help consumers with Medicaid applications (47% did so vs. 89% of Assister Programs.) Brokers reported higher rates of client continuity from one year to the next; 64% of brokers said most clients they helped this year were people they had helped the year before, vs. 40% of Assister Programs.

Brokers in FFM states initiate about half of Marketplace applications using alternative enrollment sites. The FFM permits use of alternative enrollment channels that meet federal minimum standards. On average, brokers said they started about 26% of FFM applications directly on insurance company websites and 23% of FFM applications on private web broker sites. By comparison, SBM brokers initiated two-thirds of QHP applications on the Marketplace website. Permitting direct enrollment through

alternative channels was adopted with the intent of maximizing public awareness and enrollment opportunities and encouraging technology advances such as new plan comparison tools and apps for mobile devices. In follow up interviews, some brokers cited technology advantages of these enrollment channels including easier data entry and the availability of "dashboard" features to help them track all clients. Others said that not having to set up a healthcare.gov account saved time. Still others noted this shortcut could later prove disadvantageous if consumers needed to follow up with the Marketplace but did not have an account.

Beyond logistics, several brokers mentioned that some alternative enrollment channels also offer non-QHP products, such as cancer policies, short term policies, and other "excepted benefit" products that do not have to follow ACA market rules, such as the prohibition on pre-existing condition exclusions. Alternative enrollment channels made it simpler to obtain premium quotes and enroll consumers in these products, as well. CMS is working on improved ways to monitor the sale of QHPs through alternative enrollment channels. It does not track sale of other types of products through these channels.

Some insurers are ending or reducing broker commissions, especially for SEP policies. Nearly half of brokers (49%) say at least some insurers have stopped paying commissions on all Marketplace policies; 17% say most or all of the insurers they do business with have taken this action. More often brokers (60%) say at least some insurers have stopped paying commissions on Marketplace policies sold outside of Open Enrollment to consumers eligible for SEPs; 33% of brokers say most or all insurers have stopped paying SEP commissions for Marketplace policies. Insurers report that SEP enrollees have higher health care claims on average than people who sign up during open enrollment, and therefore want to discourage use of SEPs. Changes to SEP commissions appear to be taking place more often in FFM states than in SBM states. Nearly half of brokers in FFM states (46%) say most or all insurers they regularly do business with have ended commissions on SEP policies, compared to 10% of brokers in SBM states. Twenty-nine percent of FFM brokers say no insurers have ended SEP commissions on Marketplace policies, compared to 61% of SBM brokers.

Regulators in several SBM states have prohibited these commission changes. Other state regulators and CMS, which directly regulates insurance in five FFM states, have not taken such action. The net impact on consumer access to coverage is not clear. Some brokers commented they will continue to help consumers enroll in QHPs during SEPs, even if unpaid, as a public service and to earn client good will. Others said they will consider selling other coverage, such as short-term non-renewable policies, to SEP-eligible consumers instead.

Most Assister Programs (65%) and brokers (55%) said OE3 went better than OE2. This year, respondents were also asked to rate the ACA overall out of a possible 10 points. On average, Assister Programs rated the ACA 6.5, while brokers on average gave a rating of 4.5. To make the ACA work better, respondents were also asked to select the top three changes they would recommend. Changes most frequently recommended by Assister Programs among their top three were to (1) reduce health plan cost sharing (named by 51% of Programs as one of their top three), (2) expand Medicaid eligibility in all states (32%), and (3) expand premium subsidies for Marketplace plans (30%). Changes most frequently recommended by brokers among their top three were to (1) increase broker commissions (named by 47% as one of their top three), (2) repeal the law altogether (28%), and (3) reduce health plan cost sharing (28%).

About the Assister Programs and Brokers Described in this Report

Several types of Assister Programs provide outreach and enrollment assistance in the Marketplace.

Navigator refers to Assister Programs that contract directly with State Marketplaces or with federally facilitated Marketplace to provide free outreach and enrollment assistance to consumers. The ACA requires all Marketplaces to establish Navigator Programs and to finance Navigators using Marketplace operating revenue. Some states use a different name to describe these Programs, though in this report all Assister Programs funded directly by Marketplaces are referred to as Navigators. CMS provided $67 million for Navigators to work in 34 FFM and FPM Marketplaces this year, compared to $60 million last year and $67 million in year one.[1] SBM state funding for Navigators exceeded $100 million in year one, that amount declined by about 15% in year two.[2] Moving forward, funding for Navigators has become more ad hoc in at least some SBM states. The Connecticut Marketplace, for example, no longer provides for year-round Navigators. Instead, during Open Enrollment, Access Health CT staff and temporary hires provide in-person enrollment assistance through temporary storefront sites and public libraries. During the rest of the year help is available through volunteer CAC assister Programs and the state's ombudsman office. In Colorado, the Marketplace provides roughly 20 percent of resources for its Navigator Program and applies for philanthropic grants for the rest.

Certified Application Counselor (CAC) refers to Assister Programs that are recognized by a Marketplace but do not receive funding from a Marketplace. This designation was created prior to the first Open Enrollment – when funding for Marketplace-paid Assisters, at least in the FFM, was still uncertain – to ensure that willing volunteer Programs would also be available to help. CACs must be sponsored by an organization that will attest to the Marketplace that all of its individual Assisters meet minimum requirements. CACs also must provide help to consumers free of charge. Under federal rules, CACs are not required to engage in all activities required of Navigators, and they are not required to undergo training as extensive as that required for Navigators. All Marketplaces are required to recognize and certify CAC Programs, and states have flexibility to establish additional rules for CAC Programs. Marketplaces are not required to provide funding to CACs; most of these Programs are primarily privately funded, supported by their own sponsoring organizations and other outside sources such as foundations.

Federally Qualified Health Center (FQHC) Programs are operated by health centers funded by the Health Resources and Services Administration (HRSA). FQHCs treat patients regardless of ability to pay and, prior to enactment of the ACA, actively helped patients apply for Medicaid, CHIP, or other available coverage. For the first year of ACA implementation, HRSA awarded $208 million to FQHCs to support enrollment assistance. In the second year, HRSA made permanent enrollment assistance grants to FQHCs, which now total about $150 million per year. All FQHC Assisters are required to complete at least the level of training required of CACs. About 5% of FQHCs also serve as Navigators and so received Marketplace funding in addition to HRSA grants. For purposes of this report, FQHCs that also receive Marketplace funding are referred to as Navigators.

Federal Enrollment Assistance Program (FEAP) refers to Assister Programs that contracted with CMS to provide supplemental enrollment help within FFM and FPM states in selected communities where large numbers of uninsured individuals reside. Duties and requirements of FEAPs are similar to those of federal

Navigators except that FEAPs provide “surge” assistance. Most have rolled back staff and operations since Open Enrollment ended. In this report, unless otherwise indicated, description of findings about Navigators will include FEAPs because the two types are so similar. For the 2016 coverage year, CMS awarded contracts totaling about $29 million to two organizations to establish FEAPs in 10 states.[3] FEAP contracts were initiated for the 2014 plan year and have been renewed subsequently. CMS will continue to contract with FEAPs in year four, though the contract amount and work sites have not yet been determined.

Finally, in addition to Marketplace Assister Programs, the ACA authorized creation of state-based ombudsman programs, also called Consumer Assistance Programs, or CAPs. The law requires CAPs to provide outreach and public education and provide enrollment assistance to consumers in the Marketplace. In addition, CAPs must help all state residents resolve questions and disputes with their private health insurance coverage, including helping consumers to appeal denied claims. The ACA requires Marketplace Assisters to refer consumers with post-enrollment problems to state CAPs. The law provided initial funding for states to establish CAPs and 35 were established in 2010. However no new appropriations have been enacted since and most CAPs have not received any new federal funding since 2012.[4] Pending additional federal funding, many CAPs remain operational, albeit at reduced levels.

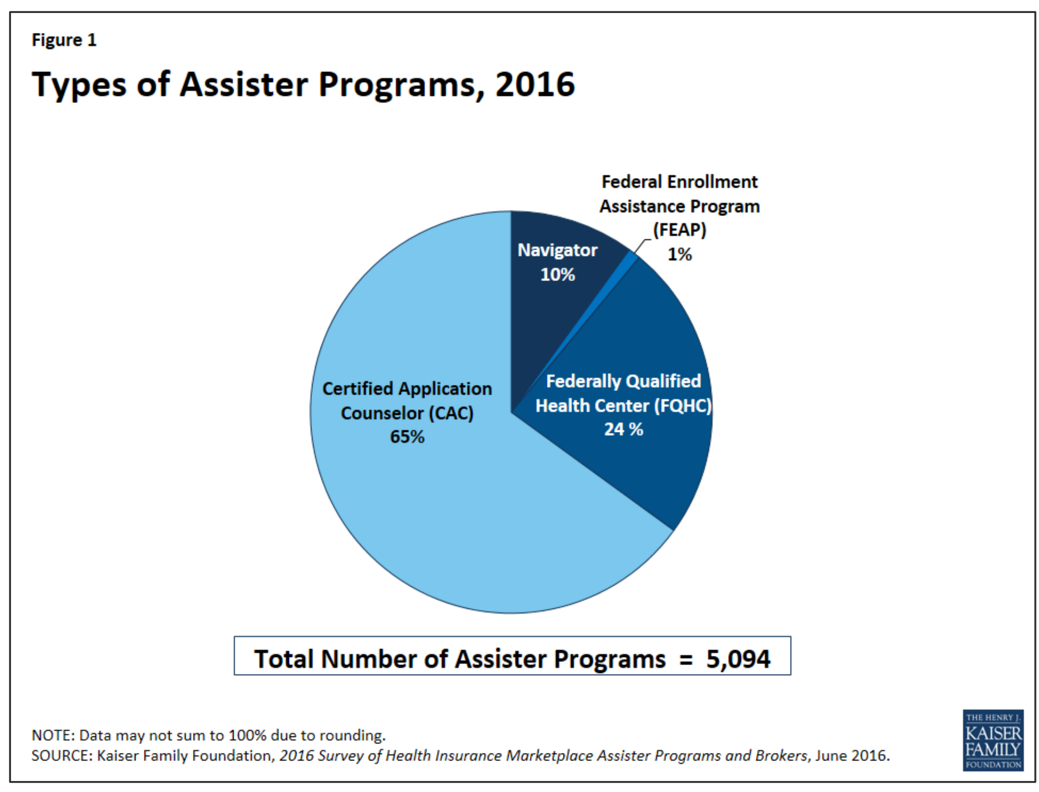
Broker refers to a state-licensed professional who sells private health insurance to individuals and/or businesses. Brokers are sometimes called agents or producers. To sell non-group or small group health plans offered through a state Marketplace, brokers must register with the Marketplace annually, sign a participation agreement, and complete required training. This year more than 80,000 brokers in federal Marketplace states and 30,000 in state-based Marketplaces were certified to help consumers apply for financial assistance financial assistance and explain coverage options. Brokers are paid a commission by the health insurance company offering the policy that the consumer selects. Typically insurers pay commissions when a policy is first issued and at renewal for at least several years. Brokers also offer ongoing services to consumers once they’re covered, including help with post-enrollment questions and help buying other insurance products or financial services.

Key Findings

Section 1: Assister Programs Characteristics and People Helped

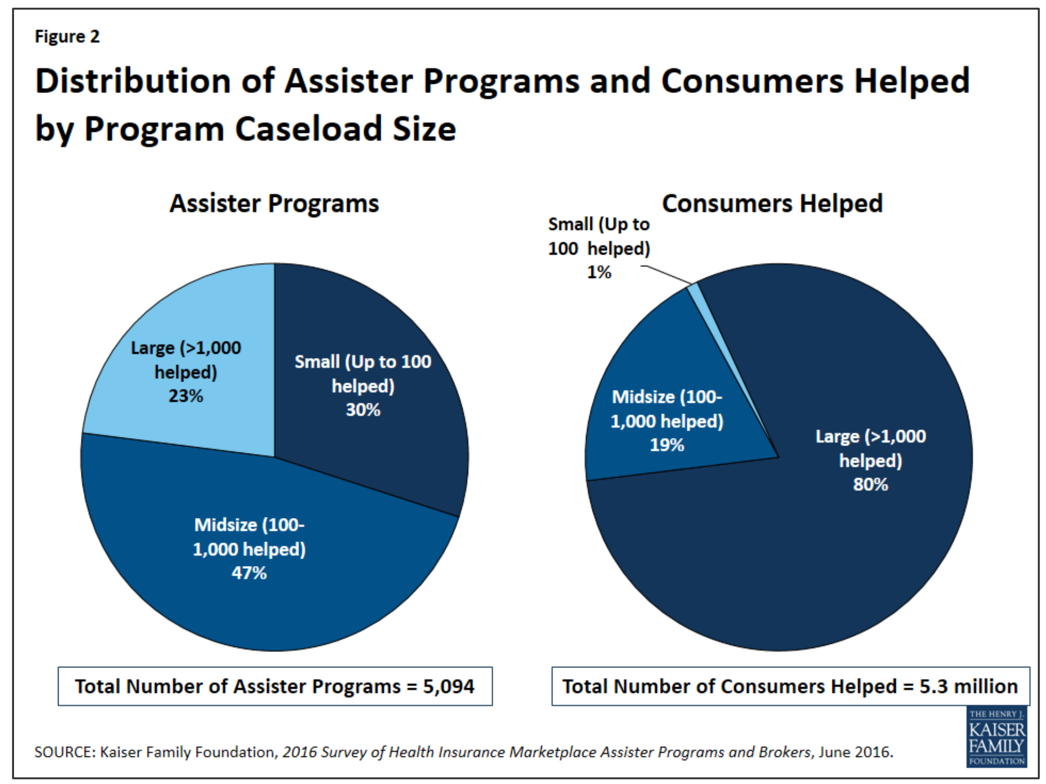
In all, more than 5,000 Marketplace Assister Programs provided outreach and enrollment help to consumers during the third Open Enrollment. This total is based on Program data provided by all state and federal Marketplaces, and represents a 9% increase in the number of Programs operating a year ago.

Once again, most Assister Programs that help people enroll through the Marketplace are not funded by Marketplaces. Navigators and FEAPs, which are funded directly by the Marketplace, comprise about 11% of total Programs. Assister Programs in FQHCs, primarily supported by HRSA grants, comprised another 24% and CAC Programs, which generally receive little or no public funding, comprised 65% (Figure 1). The distribution of Assister Program types is similar to that observed last year



An estimated 30,400 Assisters together helped about 5.3 million people during the third Open Enrollment period. The total number of full-time equivalent (FTE) Assisters remained the same this year, and the total number of consumers helped by Assister Programs fell by about 10% compared to last year.

The vast majority of consumers helped (80%) received assistance from Programs that helped more than 1,000 people. These large caseload Programs constituted 23% of all Assister Programs this year. Programs with mid-size caseloads (that helped between 100 and 1,000 consumers) account for 47% of all Programs and helped 19% of all consumers who received assistance. Thirty percent of all Programs had small caseloads, helping 100 or fewer consumers during Open Enrollment; together these small caseload Programs helped just 1% of the total number of consumers who received assistance (Figure 2).



Large caseload Programs include all three types – Navigator, FQHC, and CAC Programs. This year 37% of Navigator, 31% of FQHC, and 16% of CAC Programs said they helped more than 1,000 people during Open Enrollment. All three types of Assister Programs are also found among medium- and small-caseload Programs. Marketplaces only contract with Navigator Programs, however, and so generally do not provide the same level of support and monitoring for most of the large caseload Programs that are responsible for most consumer assistance.

Large caseload Programs had more staff (14.5 FTEs on average) compared to small caseload Programs (average 2.2 FTEs). The average number of consumers helped per FTE was also much greater in large caseload Programs (251) compared to small caseload Programs (16).

In addition, large caseload Programs differed from smaller Programs in the amount and type of work they did and the types of problems they helped consumers address. Large caseload Programs were more likely than small caseload Programs to help consumers with more complex needs such as language translation (28% vs 8%), immigration-related problems (23% vs 5%), problems reporting income or household size (56% vs 35%). In addition, large caseload Programs were more likely to help resolve Marketplace data verification problems (96% vs 81%) and more often could help consumers successfully resolve identity proofing problems (97% vs 89%). Large caseload Programs were also more likely to engage in outreach activities (94% vs. 54%), to help consumers resolve post-enrollment problems (88% vs 53%), and to coordinate with other Assister Programs on enrollment events (39% vs 12%).

Most Assister Programs have now operated for three years. This year 94% of Programs are returning from last year and 87% have been in operation since the first Open Enrollment. Staff tenure is also increasing. Nearly seven in ten three-year-old Programs report that most or all of their staff worked during all three Open

Enrollments. More experienced Programs may be more familiar with their Marketplace systems and procedures and may have developed closer ties with communities they serve (Table 1).

Most Assister Programs generally don't coordinate with each other. Although two-thirds say coordination with other Programs improves effectiveness, most (59%) rarely if ever coordinate with other Programs. Among those that do regularly coordinate with others, 95% said coordination is key to effectiveness. In general, Navigators were more likely to coordinate with other Programs on activities such as planning outreach and enrollment events and resolving complex cases. One-third of small caseload Programs said they never coordinated with others, compared to 10% of large caseload Programs.

Table 1. Characteristics of Assister Programs						
Program Characteristics	**All Assister Programs**	**Program Type**			**Program Caseload**	
		Navigator	**FQHC**	**CAC**	**Large**	**Small**
Returning Program	**94%**	**91%^**	**97%**	**94%^**	**99%**	**91% ǂ**
Worked all three Open Enrollments	**87%**	**81^**	**94%**	**86%^**	**97%**	**78% ǂ**
Service area						
					15%	12%
Specific area within state	81%	73%	86%*	81%*	79%	82%
					5%	6%
Paid staff vs. volunteer						
			4%	13%	4%	17% ǂ
Most/all paid staff	88%	94%	96%	84%*^	96%	80% ǂ
Number of full-time-equivalent staff and volunteers						
5 or fewer	77%	64%	78%*	79%*	41%	94% ǂ
6-10	13%	16%	16%	11%*^		
11-20	5%	11%	3%*	5%^	16%	1% ǂ
21-50	3%	6%	1%*	3%*^		
More than 50	1%	3%	1%	1%	6%	- ǂ
Don't know/No answer	1%		2%	1%		
Mean FTE staff size	5.9	9.5	4.3*	5.9	14.5	2.2ǂ
Number of consumers helped during Open Enrollment						
100 or fewer	32%	12%	14%	41%*^	-	100 ǂ
501-1,000	14%	19%	16%	12%	-	-
2,501-5,000	4%	7%	8%	2%*^	18%	- ǂ
Don't know/No answer	3%	1%	1%	4%	-	-
Coordinate often with other Programs to:						
Share staff	16%	24%	15%*	15%*	24%	12% ǂ
Share appointment scheduler	15%	57%	16%*	15%*	23%	8% ǂ
Plan enrollment events	24%	35%	24%*	22%*	39%	12% ǂ
Plan outreach events	24%	36%	24%*	23%*	38%	12% ǂ
Resolve complex cases	22%	31%	21%*	20%*	31%	14% ǂ
Most/nearly all renewing or changing	39%	36%	42%	39%	42%	37%
Half new/half renewing or changing	24%	29%	26%	22%	31%	17% ǂ
Most/nearly all new to Marketplace	29%	29%	24%	31%	20%	40% ǂ

*Significantly different from Navigator at the 95% confidence level; ^Significantly different from FQHC at the 95% confidence level; ǂ Significantly different from Large Caseload Program at the 95% confidence level NOTE: Numbers may not sum to 100% due to rounding.

Assister Program budgets are mostly modest. Twenty seven percent of all Programs reported having an annual budget for consumer assistance of $50,000 or less. Twenty-nine percent had annual budgets between $50,000 and $500,000. Only 5% of Programs reported annual budgets larger than $500,000. CACs tended to have the smallest budgets (Table 2).

Navigators were more likely to receive most of their funding from the Marketplace, while FQHCs relied more heavily on grants from HRSA. CACs were most likely to rely on re-programmed resources from their sponsoring organization or other private sector support.

Table 2. Assister Program Budgets and Sources of Funding, FY 2016

	All Assister Programs	Program Type			Program Size	
		Navigator	FQHC	CAC	Large Caseload	Small Caseload
FY 2016 Program budget						
Up to $50,000	27%	19%	14%	34%*^	3%	47%‡
$50,001 - $200,000	22%	30%	33%	17%*^	32%	7%‡
$200,001 - $500,000	7%	20%	10%*	4%*^	20%	1%‡
$500,001 - $1,000,000	3%	6%	4%	3%	12%	1%‡
More than $1,000,000	2%	5%	1%*	1%*	6%	-‡
Don't know/No answer	39%	20%	39%	41%	27%	44%
Programs receiving most (>50%) of budget from this funding source						
Grants or other direct payment from Marketplace	9%	39%	3%*	5%*	15%	4%‡
Grants from HRSA, other federal agency	19%	7%	36%*	15%*^	38%	9%‡
Grants or payments from other state agencies	6%	9%	1%*	7%^	6%	5%
Grants from private foundations	4%	1%	1%	5%*^	2%	3%
Grants from other outside private sources	1%	1%	1%	2%	1%	2%
Funds re-programmed from sponsoring organization's own budget	15%	4%	2%	22%*^	5%	24%‡

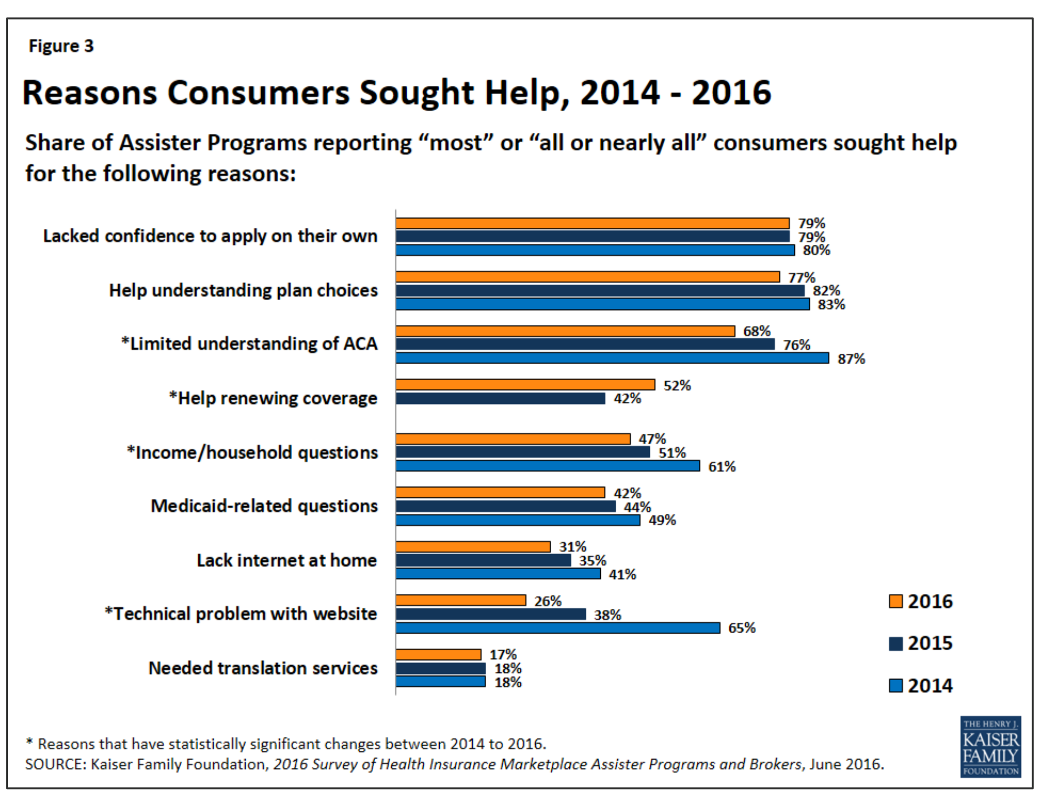
*Significantly different from Navigator at the 95% confidence level; ^Significantly different from FQHC at the 95% confidence level; ‡Significantly different from Large Caseload Programs at the 95% confidence level.

NOTE: Columns may not sum to 100% because not all Programs received a majority of funding from a single source.

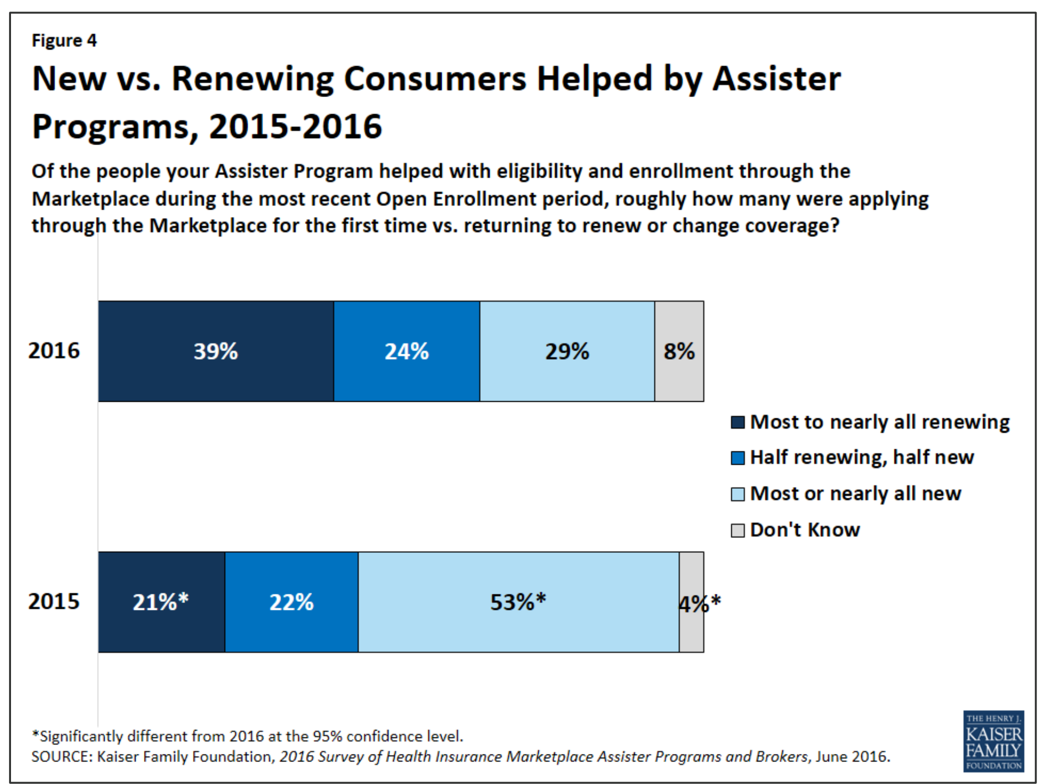
Funding uncertainty continues for some Programs. Thirty-two percent of Assister Programs are not at all certain funding will be available next year, and 35% are only somewhat certain. This finding held across all types of Assister Programs and in FFM and SBM states. Marketplaces are required by law to pay Navigators out of operating revenue, though most fund consumer assistance year by year instead of dedicating a portion of revenue for this purpose. FQHC Programs receive ongoing funding from HRSA. Overall about six in ten returning Programs report their budget this year is about the same as it was last year. Twenty-eight percent say this year's budget is less than last year and 35% say it is less than in year one. Navigator Programs were more likely than others to report budget increases.

Section 2: In-Person Assistance During Open enrollment

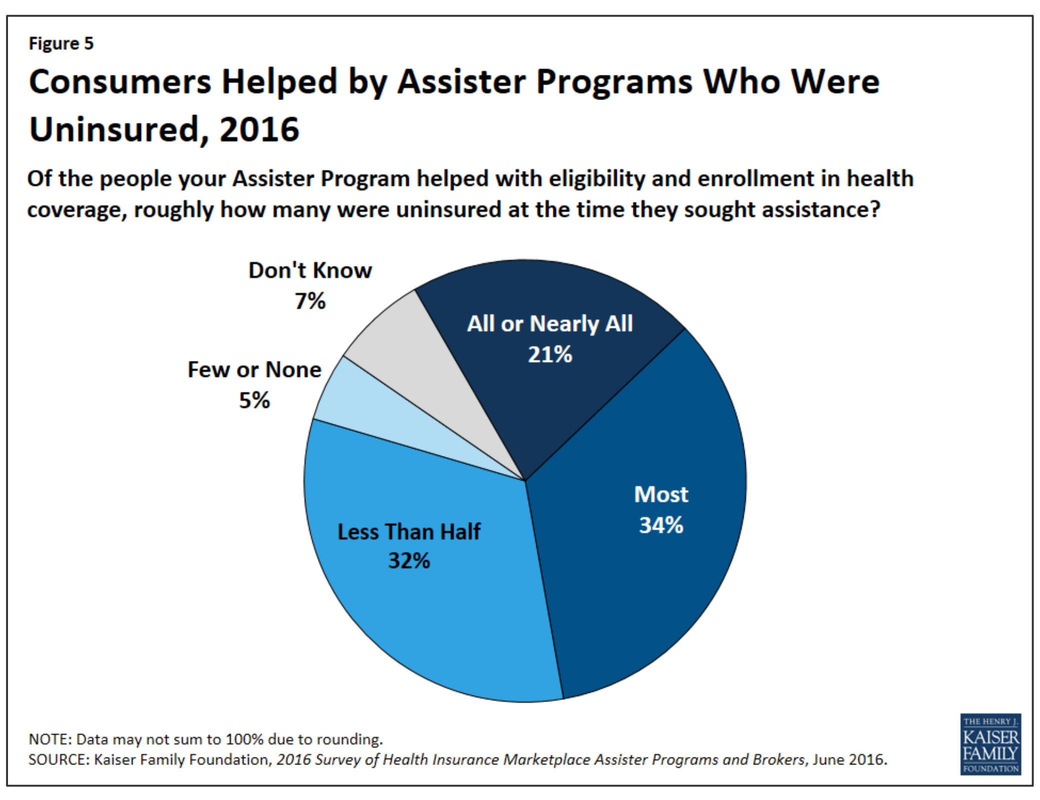
The need for in-person assistance remains strong. About eight in ten Assister Programs said most-to-nearly-all consumers sought help because they lacked confidence to apply for coverage and financial assistance on their own. As well, about eight in ten Programs said most-to-nearly-all consumers needed help evaluating plan choices. Fewer Assister Programs this year said that most consumers sought help with technical problems related to the Marketplace website, a sign that Marketplace IT systems continue to improve. But similar numbers report that most consumers also had problems with various aspects of the application process, including questions about how to report their income, family status, or citizenship/immigration status. There was a drop in the share of Programs reporting most clients had limited understanding of the ACA, though this remains a leading reason consumers seek help. In addition, this year there was an increase in Programs who said most of their clients sought help renewing coverage (Figure 3).



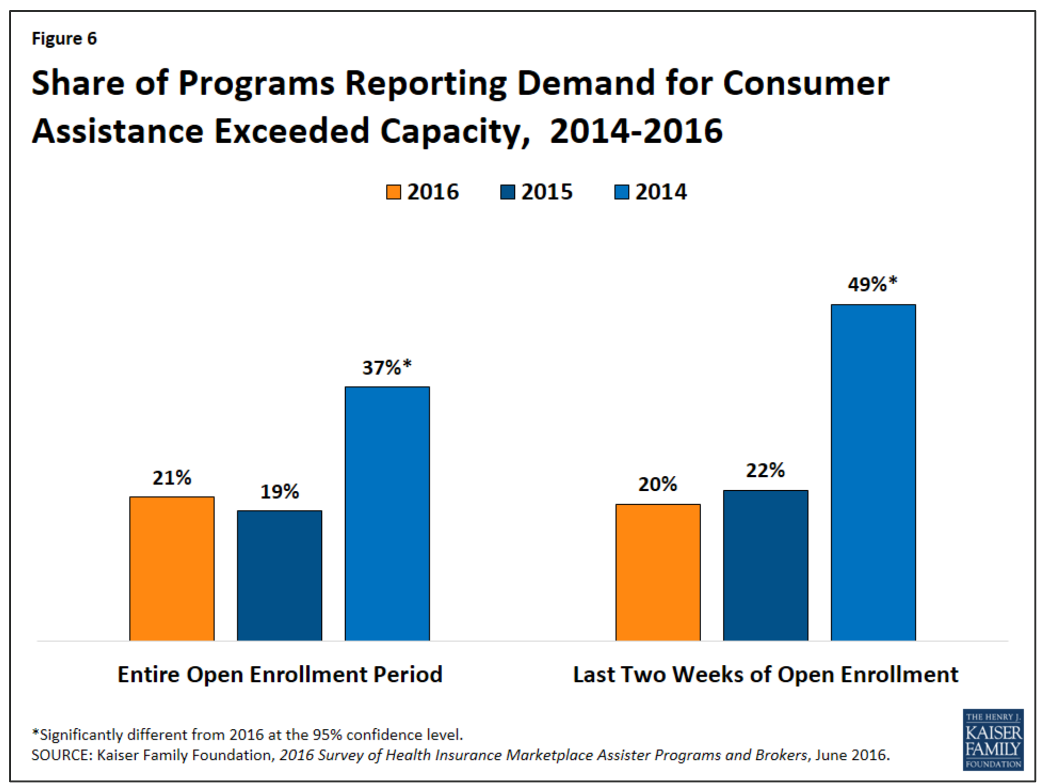
Enrollment assistance shifted toward renewing consumers in 2016. This year, renewing consumers made up a substantial share of the caseload for most Assister Programs. Twenty-nine percent of Assister Programs this year reported that most or nearly all consumers they helped were new to the Marketplace. By comparison, last year 53% of Assister Programs said most or nearly all consumers helped were new to the Marketplace (Figure 4). Although auto-renewal is an option, the Centers for Medicare and Medicaid Services (CMS) reported that 60% of plan renewals for 2016 were active renewals.[5] This finding suggests many consumers believe they need in-person help to remain enrolled in Marketplace health plans and maintain their subsidies, not just to enroll for the first time.



Even so, most who sought help during the third Open Enrollment were uninsured. This year, a majority of Assister Programs (55%) reported that most to nearly all of the consumers they helped were uninsured at the time they sought assistance. This is significantly lower than 83% of Programs last year and 89% of Programs in year one who said most people they helped were uninsured at the time they sought assistance (Figure 5). Even with the shift toward helping Marketplace enrollees renew coverage, a primary focus of Assister Programs continues to be on enrolling the uninsured.

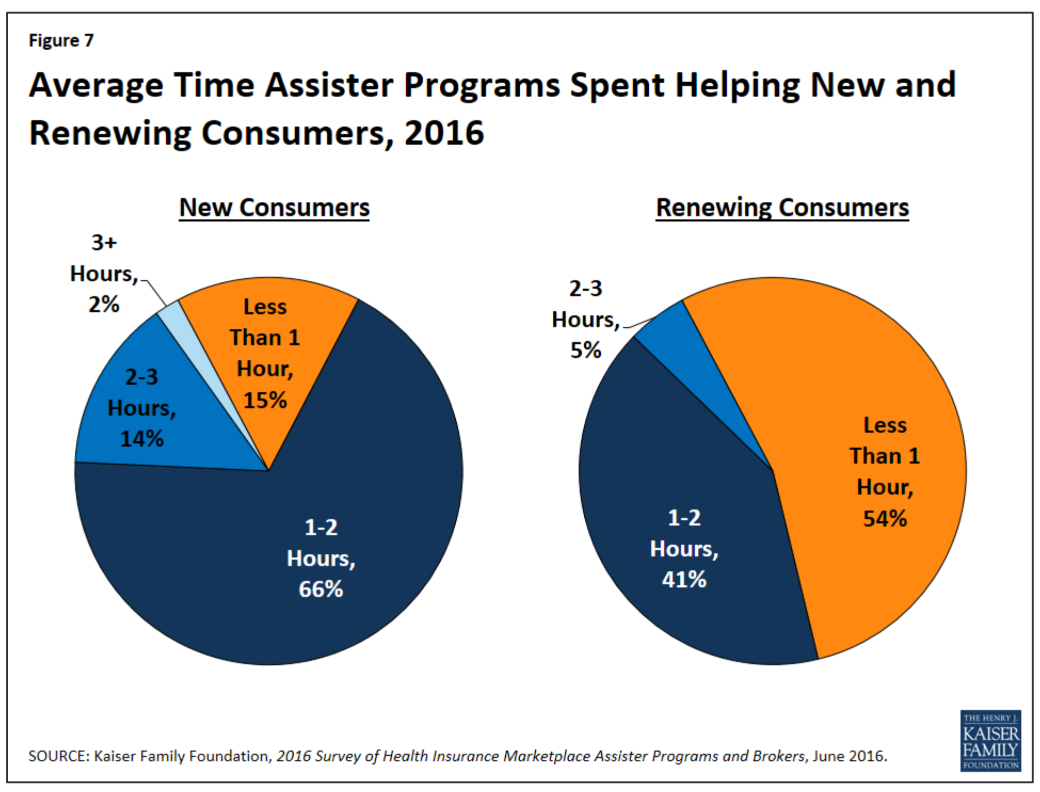


Demand for consumer assistance sometimes exceeded capacity. Twenty-one percent of Programs said they could not help all who sought it during the third Open Enrollment period overall. Similar numbers this year and last year had to turn away at least some consumers during the final weeks of Open Enrollment when a surge in demand always happens (Figure 6).



This year capacity to meet demand was especially stretched among large caseload Programs (30% had to turn at least some consumers away) compared to small caseload Programs (16%). Programs that reported a budget decrease in 2016 were more likely to say demand for help far exceeded capacity compared to Programs whose budget stayed the same or increased from the prior year (12% vs. 4%).

Eligibility and enrollment assistance remains time-intensive. As was the case in years one and two, Assister Programs reported that, on average, it took 90 minutes to help consumers who were applying to the Marketplace for the first time. In addition, like last year, Programs said it took one hour on average to help consumers who were returning to the Marketplace to renew or change coverage (Figure 7).



Why does the average time required for in-person help remain the same, even as Assisters and consumers gained experience and Marketplace websites have grown more reliable? The answer may lie in the inherent complexity of applying for coverage and financial assistance under the ACA. This year's survey provides new data about specific aspects of the eligibility and enrollment process that can be challenging – real time verification by the Marketplace of applicants' identity and application information, coordination between the Marketplace and state Medicaid programs, and the process of comparing and selecting Marketplace QHPs.

Real Time Verification by the Marketplace

On-line applications were expected to be easier and faster to complete because Marketplace websites would be able to verify consumer's information in real time, matching it to other online databases. However, sometimes IT system problems, or the fact that some consumers don't have matching information in the databases Marketplaces check, result in significant delays and may even pose a barrier to enrollment for some people.

Many consumers sought help with Marketplace identity-proofing requirements. To protect against enrollment fraud, Marketplaces first verify in real time the identity of applicants before they can submit an application for coverage and financial assistance. FFM states use an automated remote identity proofing process (RIDP) that compares applicant information against credit files and other online data sources. Many SBM states also use the federal RIDP system. One study found that certain groups of individuals are especially likely to have difficulty completing RIDP, including young adults and recent immigrants with limited credit history.[6] The same study observed some SBM states have adopted alternatives or modifications to the RIDP system to streamline the process of proving one's identity and expedite resolution of problems when they arise.

During the third Open Enrollment period, Assister Programs helped at least 230,000 consumers with identity-proofing problems. Depending on Program size, on average between 3% and 10% of consumers helped by Assister Programs during Open Enrollment encountered identity-proofing problems.

Overall, about 90% of Programs that helped consumers with identity proofing problems said they usually could help resolve them. Those in SBM states were more likely than in FFM states (22% vs. 14%) to say they usually could resolve problems quickly during the initial visit. This is probably because several SBM states use an alternative to RIPD. For example in Colorado and California, certified Assisters can visually verify an applicant's identification document, upload a copy to the Marketplace, and then proceed immediately with the application.

Across all states, most Programs said that when identity proofing problems arose they usually added significantly to visit time or necessitated a follow up visit (Table 3). Programs in SBM states were less likely than in FFM states (3% vs. 10%) to say identity proofing problems usually could not be resolved. Across all Marketplaces, large caseload Programs were less likely than small Programs (3% vs 11%) to say these problems usually could not be resolved.

Table 3: How did ID proofing problems affect the consumer's application process?

	SBM Assister Programs	FFM Assister Programs	Large Caseload Programs	Small Caseload Programs
We usually could resolve problem quickly during initial visit	22%	14%*	14%	17%
We usually could resolve problem during initial visit, but with significant additional time	31%	36%	40%	32%^
We usually could resolve problem though at least one follow up visit was usually required	44%	40%	42%	39%
We usually could not resolve the problem	3%	10%*	3%	11%

*Significantly different from SBM programs at the 95% confidence level; ^Significantly different from Large Caseload programs at the 95% confidence level

NOTE: Numbers may not sum to 100% due to rounding.

Overall, about one in four Assister Programs said they would like more training in resolution of online identity proofing problems. Large caseload Programs were twice as likely as small caseload Programs (35% vs 17%) to say they would like more training on this topic.

Many consumers sought help for Marketplace data match inconsistencies (DMI). Marketplaces also require real time verification of consumers' citizenship or immigration status and income. Applicant information is matched against other online data, for example, held by the Social Security Administration, Department of Homeland Security, and Internal Revenue Service. When the Marketplace can't verify application information online, consumers receive a notice of data match inconsistency (DMI) and are provided a temporary eligibility determination based on information they submitted. Consumers can enroll in coverage right away, but must provide additional documentation to the Marketplace within 90 days, otherwise their coverage or subsidies may be terminated. During 2015, the FFM terminated coverage for 500,000 individuals with citizenship or immigration DMI, and terminated or reduced premium tax credits and cost sharing subsidies for 1.2 million consumers with income DMI.[7]

Most Assister Programs said they helped consumers resolve DMI problems relating to immigration or citizenships during the third Open Enrollment. We estimate these Programs helped at least 172,000 consumers with immigration-related DMIs. In addition, most Programs reported helping consumers with DMI problems related to income. We estimate at least 259,000 consumers sought in-person help with income-related DMIs from these Programs.

In comparison to the number of FFM enrollees who could not resolve DMI problems last year and who lost coverage or subsidies as a result, these estimates suggest that either the number of consumers affected by DMI fell substantially this year, or most consumers with DMI are not getting help from Assister Programs.

Most Assister Programs will try to help consumers resolve DMI problems when they arise, though smaller Programs are more likely than large caseload Programs to refer consumers elsewhere for help or advise them to resolve inconsistencies on their own. In general, large caseload Programs were also more likely to know the resolution of their client's DMIs compared to smaller Programs (Table 4).

Table 4: Data Match Inconsistency Help by Assister Programs

	All Programs	Large Caseload Programs	Small Caseload Programs
Immigration DMI			
Helped consumer and usually knew the resolution	69%	76%	58%*
Helped consumer but mostly did not know the resolution	19%	20%	23%
Referred consumer elsewhere or advised to solve on their own	11%	4%	19%*
Income DMI			
Helped consumer and usually knew the resolution	72%	80%	62%*
Helped consumer but mostly did not know the resolution	21%	17%	27%
Referred consumer elsewhere or advised to solve on their own	7%	3%	11%*

*Significantly different from Large Caseload Programs at the 95% confidence level

Marketplace notices about DMI may also present a challenge. For example, in case of an income-related DMI, FFM notices list examples of documents consumers might submit to verify different sources of projected income but do not specify which would be most appropriate for the individual applicant.[8] With respect to DMI notices related to immigration or citizenship, 39% of Assister Programs said most of the time it was not clear what documentation the Marketplace wanted to the consumer to provide; 29% of Assister Programs responded this way with respect to income-related DMI notices.

One-in-five Assister Programs overall said they would like more training on the resolution of DMI problems. Large caseload Programs were more likely to want such training (about one in three) compared to small Programs (about one in seven).

Medicaid–Marketplace Coordination

Depending on the state, consumers also needed extra help enrolling in Medicaid. The ACA outlines a "no wrong door" approach to applying for coverage and requires a "single streamlined" application for financial assistance that can be used to determine eligibility for both QHP subsidies and Medicaid or the Children's Health Insurance Program (CHIP). All 13 State-based Marketplaces that do not use healthcare.gov have integrated their eligibility systems with Medicaid, eliminating the need to transfer data between systems to make eligibility determinations for coverage. Eight FFM states allow healthcare.gov to determine Medicaid eligibility, though files are then transferred to state Medicaid agencies to complete enrollment.

In the remaining 30 states, healthcare.gov assesses Medicaid eligibility, then transfers the consumer's file to the state Medicaid program for a final eligibility determination and to complete enrollment. Among Programs in states with integrated eligibility systems or in FFM determination states, 74% said the Medicaid enrollment process was usually completed in a timely manner. By contrast, 34% of Programs in assessment states said that the Medicaid eligibility determination was completed in a timely manner. To expedite the process, 44% of Programs in assessment states and 13% in determination states said they would help clients who were assessed eligible complete a separate Medicaid application.

Follow up interviews with Assister Program directors were conducted to learn why they created separate Medicaid applications. Some observed that direct applications were often processed faster than transferred files. Others cited difficulty in obtaining confirmation from healthcare.gov that transfers were successfully completed. Still others noted that applying directly to Medicaid in some states can also expedite application for other benefits, such as the Supplemental Nutrition Assistance Program. Some directors said they pre-screen consumers, then submit the application to the Marketplace or the state Medicaid portal depending on the coverage the individual will most likely be eligible for. Among Assister Programs that typically help consumers complete a separate Medicaid application, two-thirds said at least one additional follow up visit was needed to complete the separate application (Table 5).

Table 5: When the Marketplace determined or assessed consumers eligible for Medicaid, what steps did you take next?			
Action	**All Programs**	**Determination states**	**Assessment states**
Followed up with Medicaid until eligibility and enrollment was complete	27%	34%	22%*
Helped consumer complete a separate Medicaid application	31%	13%	44%*
Referred consumer to another Assister Program	3%	2%	4%
Advised consumer to follow up with Medicaid on their own	13%	7%	18%*

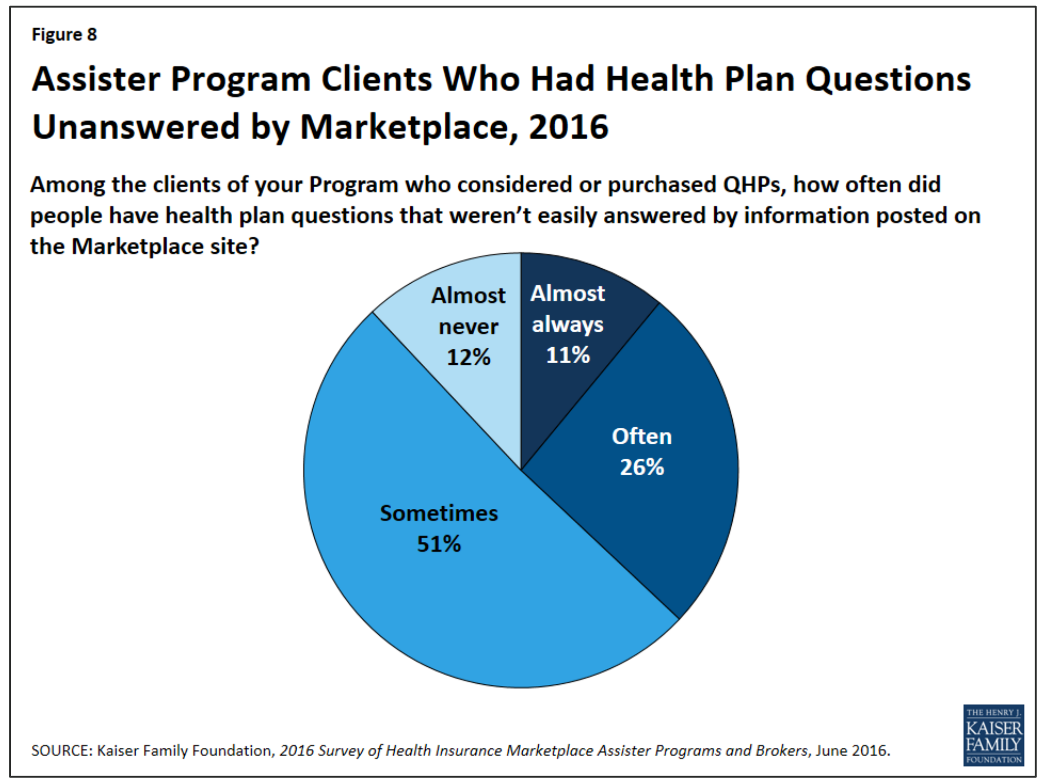
* Significantly different from Determination states at the 95% confidence level

Comparing and Selecting Health Plans

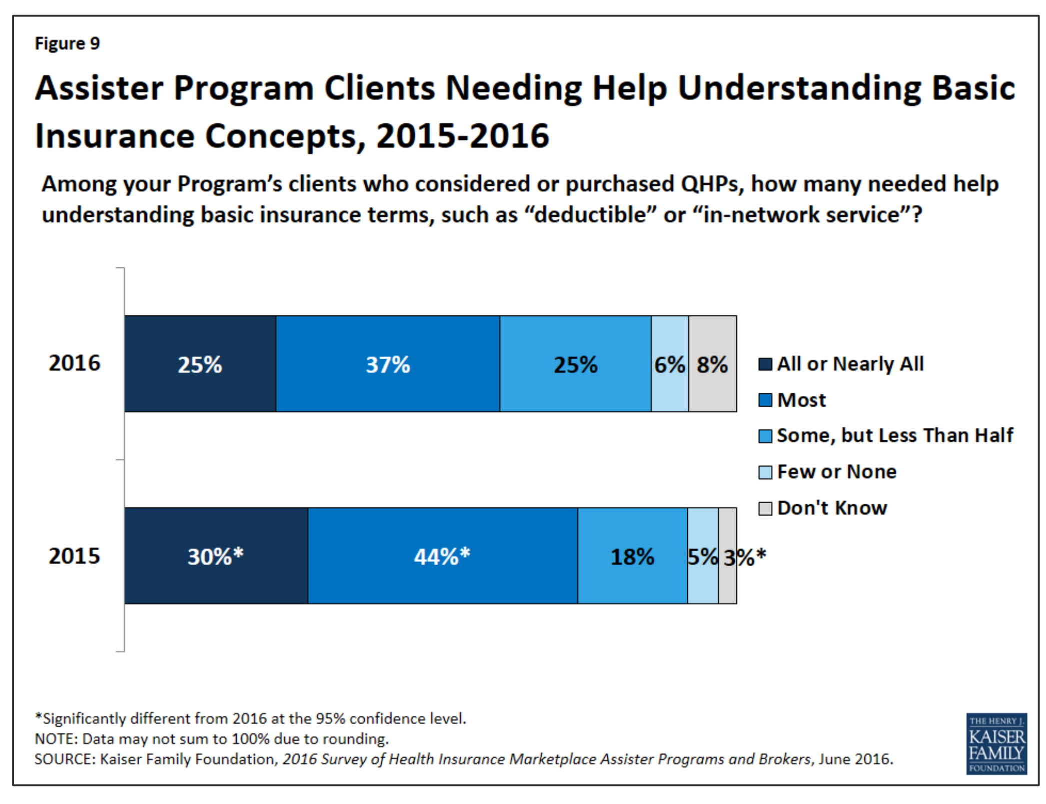
The process of comparing and selecting health plans can also be complex. The sheer number of plan choices can be one reason. People living in FFM states, on average, had a choice of 50 Marketplace plans this year.[9] Research on plan choice finds that having more than 10 options makes it harder for consumers to compare and evaluate.[10] In addition, relatively small variations in QHPs can sometimes be meaningful to consumers. For example, while most QHPs (not modified by cost sharing reductions) have annual deductibles well in excess of $1,000 per person, many plans impose separate deductibles for at least some services, and many exempt key services, such as primary care visits, from the deductible.[11, 12] Another survey found that most consumers said it was somewhat or very easy to compare Marketplace plans generally; 74% found it easy to compare premiums, 69% found it easy to compare plan cost sharing features, and 60% found it easy to compare plan provider networks.[13]

Marketplace health plan information sometimes leaves consumer questions unanswered. This year, 37% of Programs said consumers often or almost always had questions about health plans that were not answered by information on the Marketplace website (Figure 8). This is an increase from last year (31%) and attributable mostly to Programs in FFM states. Thirty-seven percent of FFM Programs this year, compared to 27% last year, said client's health plan questions often were unanswered by information on healthcare.gov. Most Marketplaces have developed new plan comparison tools since the first Open Enrollment, for example, to sort options based on participating providers or to estimate consumer out-of-pocket expenses. For 2017, new standardized plan choices may be offered in the FFM to simplify plan comparison by consumers. Improvements to summary of benefits and coverage (SBC), a plain language summary of health plan provisions, were also approved and will be implemented in 2018. These changes may make it easier for consumers to understand and compare plan choices in the future.

One in four Assister Programs say they would like additional training on qualified health plan features and how to distinguish differences between plan options.



Insurance literacy limitations among consumers persist. This year most Assister Programs (62%) said most or almost all of their clients needed help understanding basic insurance terms and concepts such as "deductible" and "in-network service." This is an improvement from 74% of Programs who answered this way in the first two years, though still evidence of widespread limitations (Figure 9). Three-in-ten Assister Programs would like additional training in health insurance literacy.



Assister Programs knew the plan choice for most/nearly all of QHP-eligible clients. This year again, when asked how often they knew the plan choice of their QHP-eligible clients, 71% of Assister Programs said this was the case for most or almost all such clients – the same number who reported this in year two and an increase over year one, when website breakdowns required Assisters to spend most appointment time helping consumers with the application. Large caseload Programs were more likely than smaller Programs to observe the plan choice for most or nearly all clients who were eligible for QHPs (82% vs. 62%). Two-thirds of Programs said most or nearly all of their QHP-eligible clients were able to complete the plan selection during the initial visit. The other 34% said clients typically required multiple visits.

Section 3: Help Between Open Enrollment Periods

Returning Assister Programs helped at least 830,000 consumers with special enrollment periods in the past year. Again this year we asked returning Assister Programs about help they provided consumers outside of Open Enrollment periods. Most Programs were available throughout the year to help consumers who became eligible for special enrollment periods (SEP) or who needed to report other mid-year income or family changes to the Marketplace in order to update their application for subsidies.

Large caseload Programs helped more people with SEPs and reporting other mid-year changes compared to small caseload Programs (Table 6). Nationwide, we estimate Assister Programs helped at least 830,000 consumer apply for SEPs in 2015, which is a 30% increase over the amount of SEP assistance reported for 2014. This change may be due to the fact that the first Open Enrollment extended through April of 2014, leaving fewer remaining months that year for SEP to arise.

Table 6. Help with Special Enrollment Periods and Mid Year Changes During 2015

	All Returning Programs	Large Caseload Programs	Small Caseload Programs
Number of People Helped with Special Enrollment Periods			
Up to 50 people	46%	15%	69%*
51-100 people	12%	15%	6%*
101-500 people	12%	26%	1%*
More than 500 people	8%	25%	- *
Don't know/No answer	22%	18%	23%
Number of People Helped to Report Mid-Year Changes			
Up to 50 people	53%	28%	77%*
51-100 people	9%	14%	2%*
101-500 people	10%	24%	- *
More than 500 people	3%	13%	- *
Don't know/No answer	24%	20%	21%

*Significantly different from Large caseload Programs at the 95% confidence level

NOTE: Columns may not sum to 100% due to rounding.

Assister Programs also helped consumers report mid-year changes in their subsidy eligibility, though fewer people came in for this type of help. Large caseload Programs, again, provided more of this type of help (Table 46). Nationwide, we estimate Assister Programs helped at least 349,000 consumers report mid-year changes to the Marketplace in 2015.

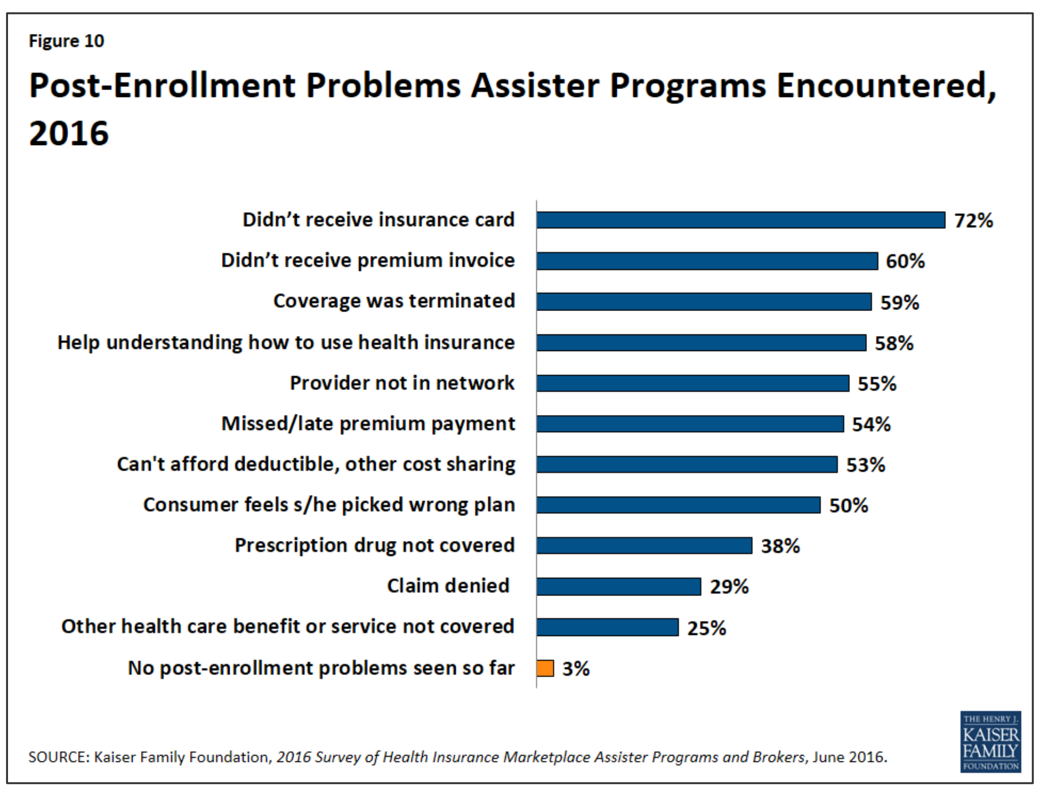
Assister Programs provided post-enrollment help to at least 745,000 consumers between the second and third Open Enrollment periods. This year, nearly all returning Assister Programs also offered to help consumers with post-enrollment problems, though they are not required to do so. Large caseload Programs provided most of this assistance (Table 7).

Table 7. Help with Post Enrollment Problems			
	All Assister Programs	Large Caseload Programs	Small Caseload Programs
Number of People Helped with Post-Enrollment Problems			
Up to 50 people	44%	11%	80%*
51-100 people	13%	12%	7%
101-500 people	17%	27%	±*
More than 500 people	10%	34%	-*
Don't know/No answer	17%	15%	13%

± Less than 1 percent; *Significantly different from Large caseload Programs at the 95% confidence level

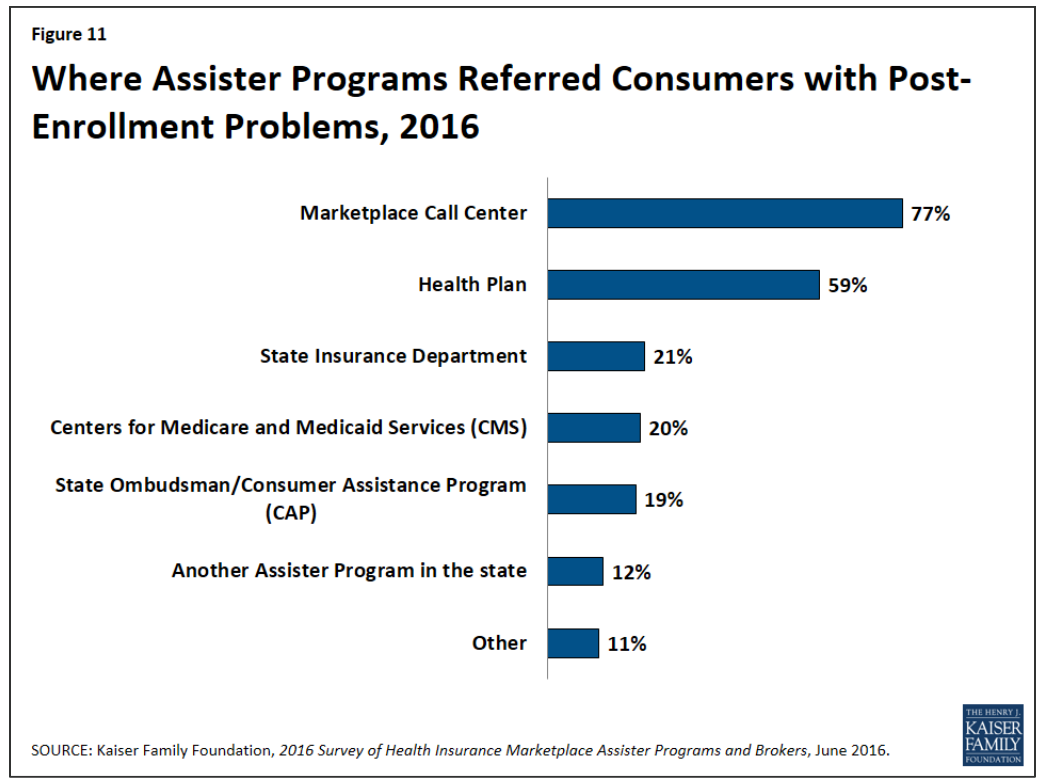
NOTE: Columns may not sum to 100% due to rounding.

Consumers sought help with premium payment and invoicing problems, claims denials, and when their health providers were not in-network. Consumers also returned for help because they did not understand how to use their health coverage (Figure 10). Like last year, most Assister Programs (70%) said they could help consumers successfully resolve post-enrollment problems most of the time; 25% said they succeeded just some of the time and 5% said not very often.



The ACA requires Navigators to refer consumers with post-enrollment problems to state Consumer Assistance Programs, or CAPs. However, federal funding for CAPs has not continued, and while many remain

operational, Marketplace Assisters mostly refer consumers with post-enrollment problems elsewhere. When asked where they refer consumers with post-enrollment problems they cannot resolve, only 19% of Assister Programs mentioned CAPs. Instead, like last year, Assisters mostly referred consumers to the Marketplace Call Center (77%) or back to their health plan (59%) (Figure 11).



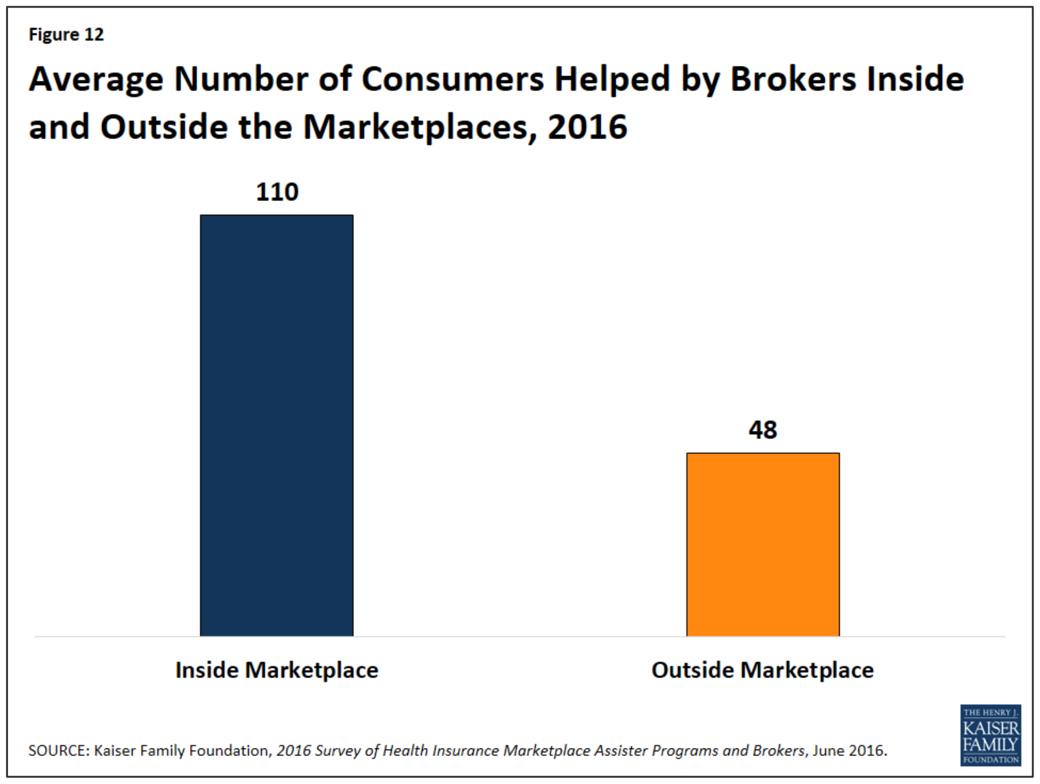
SECTION 4: CONSUMER ASSISTANCE BY HEALTH INSURANCE BROKERS

For the second year, the survey included health insurance brokers who were certified by the Marketplace to help consumers apply for non-group coverage. Most, though not all state Marketplaces provided contact information for at least some of their certified brokers. As a result, survey findings may not reflect experiences generalizable to the nation as a whole.

ENROLLMENT ASSISTANCE BY BROKERS

Virtually all (92%) of brokers who sold non-group coverage in the Marketplace this year had done so last year and 84% were registered with the Marketplace during the first Open Enrollment period.

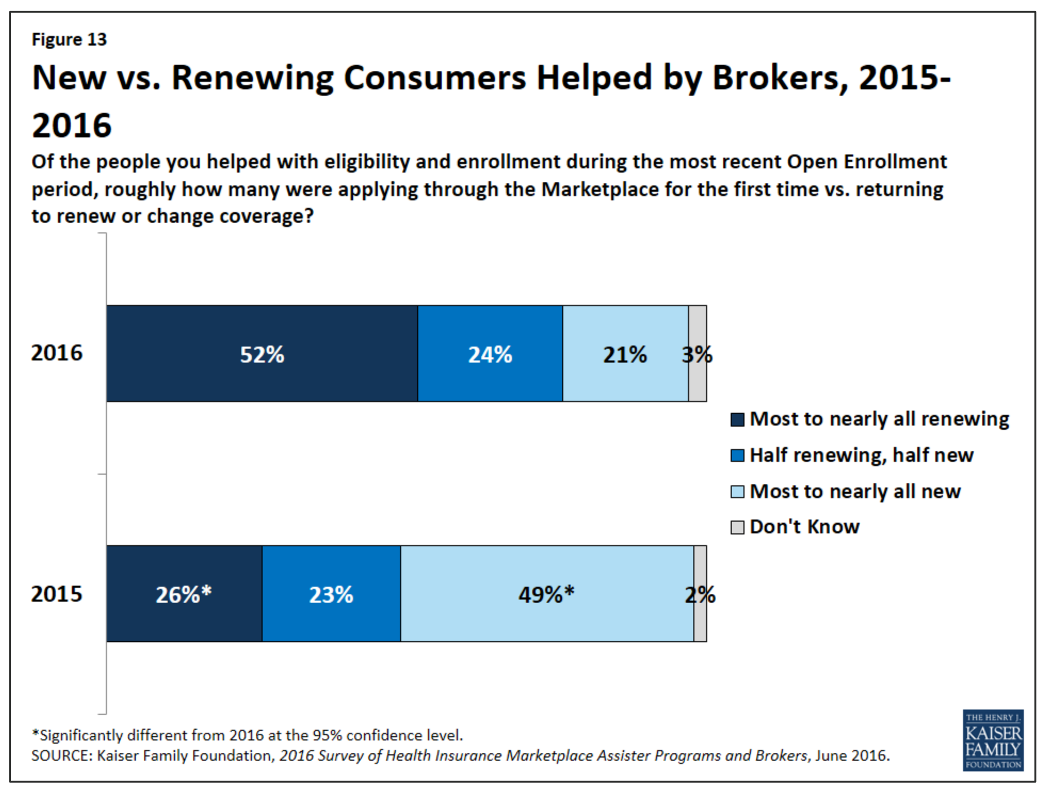
Most brokers who sold Marketplace coverage (82%) also sold policies outside of the Marketplace. On average, brokers reported helping 158 consumers, both in and outside of the Marketplace, with eligibility and enrollment during the third Open Enrollment period. On average, brokers helped more than twice as many clients apply for coverage through the Marketplace (110) compared to outside of the Marketplace (48) (Figure 12).



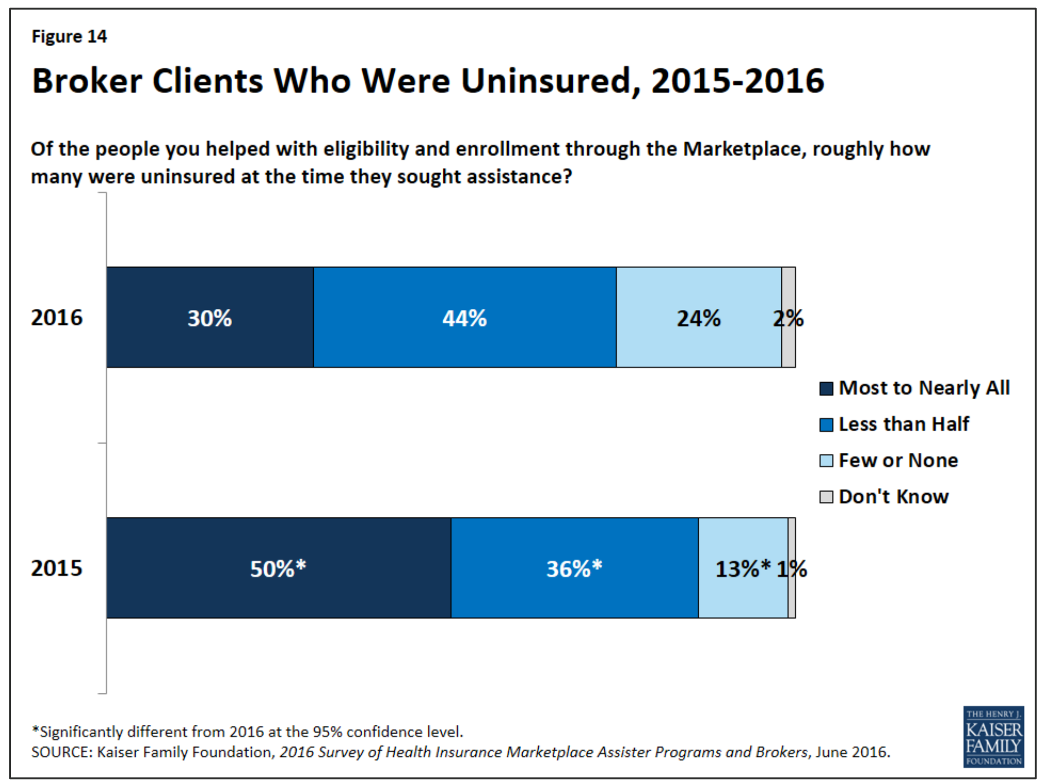
Some brokers were busier than others. Most (56%) said they helped up to 50 Marketplace consumers during this Open Enrollment period, while 26% of brokers said they helped more than 100. In Medicaid expansion states, brokers helped an average of 94 people enroll in Marketplace plans during Open Enrollment; in non-expansion states, the average was 138. These findings are similar to what brokers reported last year.

Though we cannot make estimates of the number of consumers helped by brokers nationally due to methodological limitations, brokers clearly play a significant role in helping consumers to enroll in Marketplace coverage. For example, the California Marketplace reported last year that 43% of new enrollees in 2015 were broker-assisted.[14]

This year brokers helped more renewing consumers than new enrollees. This year 52% of brokers said most consumers they helped during Open Enrollment were clients who were returning to the Marketplace to renew or change their QHP and 21% said most clients they helped were new to the Marketplace. By comparison, last year 49% of brokers said most consumers they helped were new to the Marketplace and 26% said most clients were renewing (Figure 13).



In addition, this year, brokers say fewer consumers were uninsured at the time they sought help. Thirty percent of brokers this year said most or nearly all consumers they helped were uninsured, compared to 50% last year (Figure 14).



Enrollment assistance was also time intensive for brokers. Like Assister Programs, brokers reported it took, on average, 1 to 2 hours to help a new Marketplace consumer enroll in coverage, and just over an hour to help a returning consumer. On average, brokers encountered 8 clients with identity proofing problems during Open Enrollment. Similar to Assister Programs, brokers in SBM states were twice as likely to report these problems could be resolved quickly during the initial visit (28%) compared to brokers in FFM states (14%). Also, brokers reported 12 clients, on average, encountered DMI problems related to immigration and 21 clients, on average, encountered DMI problems related to income. Even more often than Assister Programs, brokers said that Marketplace DMI notices were unclear; 54% said immigration DMI notices were unclear most or nearly all of the time, 60% said this about DMI income notices.

Similar to Assister Programs, 27% of brokers said that for OE3 overall, they were unable to help all who asked for it and had to turn at least some consumers away. Brokers were much more likely to say that demand exceeded their capacity in early December, just prior to the deadline for selecting or renewing coverage for January 1. Thirty-one percent of brokers found it hard to serve all consumers during this surge period, compared to 17% who said demand for help exceeded their capacity during the final two weeks of Open Enrollment.

Between Open Enrollments, brokers helped consumers with SEPs and post-enrollment problems. On average, brokers helped about 27 SEP-individuals enroll in coverage, or less than one per week, about the same number they reported for the prior year. Nearly all (94%) brokers will help clients with post-enrollment problems that may arise. Between the second and third Open Enrollment periods, brokers report they helped 47 clients, on average, with post-enrollment problems, similar to the number they reported last year.

Comparing Activities of Brokers and Assister Programs

Like last year, brokers generally engaged in similar consumer assistance activities as Assister Programs, but with emphasis on different services. For example, the vast majority of both brokers and Assister Programs said they help consumers compare and select QHPs, apply for premium tax credits, and resolve post-enrollment problems. But as was also the case last year, compared to Assister Programs, brokers were less likely to engage in outreach and public education activities (40% vs 76%) and less likely to help consumers apply for exemptions from the individual mandate (24% vs 50%). Compared to Assister Programs brokers were more likely to help small businesses select coverage (29% vs 4%).

Compared to Assister Programs, when clients received a notice of data match inconsistency from the Marketplace, brokers were somewhat less likely to help the consumer; 76% said they will help consumers resolve immigration-related DMI, compared to 89% of Assister Programs. Brokers were also less likely, compared to Assister Programs, to help individuals eligible for Medicaid and CHIP (47% vs 89%). Brokers who said they helped consumers with Medicaid applications were more likely to be from SBM states, where Marketplace eligibility systems are better integrated with Medicaid.

Also similar to Assister Programs, most brokers said they would like to receive additional training on a range of topics, including tax related issues, Marketplace appeals and renewal procedures, Medicare, and Medicaid.

Comparing Clients of Brokers and Assister Programs

Similar to Assister Programs, brokers overwhelmingly said consumers they helped had limited understanding of the ACA and limited health insurance literacy. In other respects, though, broker clients differed somewhat from consumers served by Assister Programs. For example,

- 85% of brokers said few or none of their clients needed language translation help, compared to 54% of Assister Programs
- 60% of brokers said few or none of their clients lacked internet at home, compared to 24% of Assister Programs
- 48% of brokers said they helped Latino clients, compared to 76% of Assister Programs
- 30% of brokers said most or nearly all clients they served were uninsured when they sought help, compared to 56% of Assister Programs
- 8% of brokers said most or nearly all clients had income low enough to qualify for Medicaid, compared to 42% of Assister Programs.

Brokers also were more likely than Assister Programs (64% vs 40%) to say most of the consumers they helped this year were people whom they had also helped during the previous Open Enrollment period.

Use of Alternative Enrollment Channels

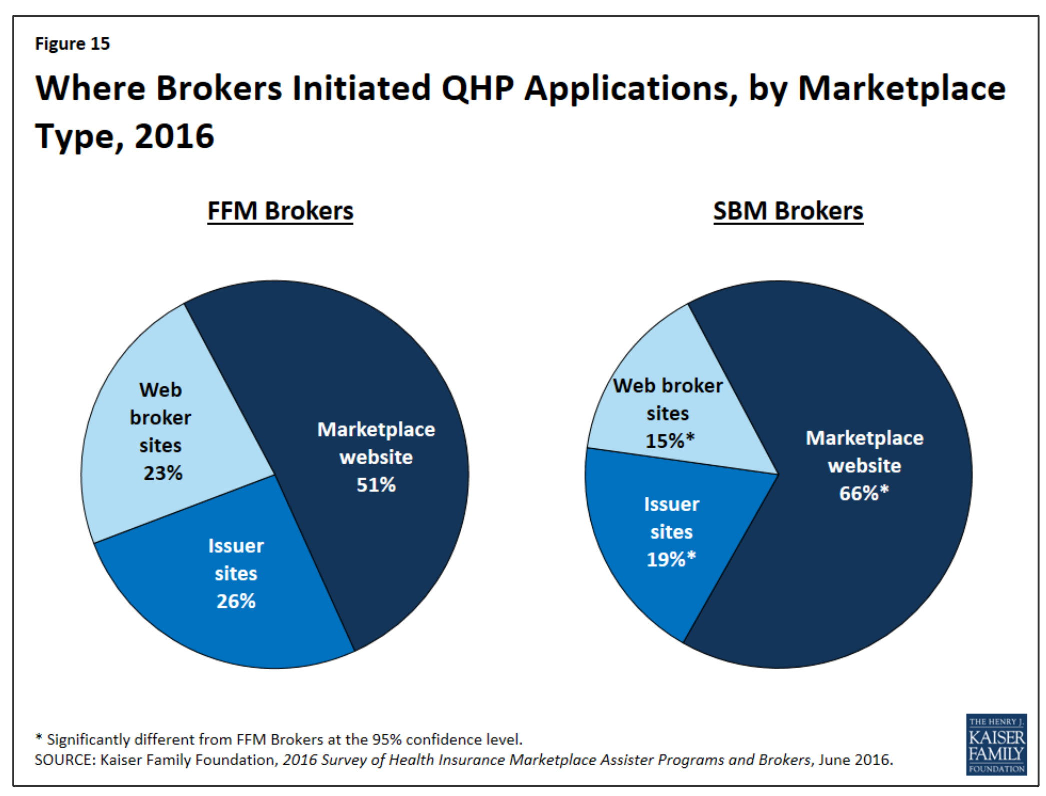
This year we asked brokers about their use of Marketplace websites vs. alternative enrollment channels when helping clients apply for Marketplace health plans. Federal regulations permit direct enrollment by individuals through insurance company websites into the Marketplace health plans they offer, and also through private web broker sites which are required to display all qualified health plans offered in the Marketplace. Permitting

direct enrollment into QHPs through these alternative channels was adopted with intent of maximizing public awareness and enrollment opportunities and to encourage technological innovations such as plan compare tools and apps for mobile devices. State Marketplaces can decide whether to allow enrollment into QHPs through insurance company or web broker sites; the FFM allows use of these alternative enrollment channels.

Alternative enrollment channels must meet federal standards for accuracy and completeness of health plan information. Alternative enrollment channels may also market other products that are not QHPs (for example, supplemental policies, accident-only policies, dread-disease policies); those that do must clearly distinguish non-QHP products from QHPs and indicate that federal premium and cost sharing subsidies only apply to QHPs. In addition, alternative enrollment channels in the federal Marketplace must follow other standards. All insurance companies that sell plans on the FFM have the capability of enrolling consumers directly on their own website. According to CMS staff, fewer than two dozen web broker sites have been certified and are actively used in FFM states currently.[15] To be certified, sponsors of these sites must complete training similar to that required of brokers and attest to CMS that their site meets all other standards.

In FFM states, consumers (or their brokers) who enroll through alternative channels enter information about themselves, their dependents, income. Then they are re-directed to healthcare.gov which determines eligibility to participate in the Marketplace and for subsidies. Finally, consumers are re-directed back to the alternative enrollment site where they can view the resulting net cost of health plan options, select a plan, and enroll.

On average, FFM brokers initiated 51% of QHP applications on healthcare.gov, 26% on insurance company sites, and 23% on web broker sites. SBM brokers initiated two-thirds of QHIP applications on the state Marketplace site, 19% on insurance company sites, and 15% on web broker sites (Figure 15).



Some survey participants volunteered additional information about the pros and cons of using alternative enrollment channels. Some noted technical and functionality advantages of alternative enrollment channels they used. For example, some web broker sites provide a dashboard to track client accounts. Ease of data entry was also mentioned as an advantage in some alternative enrollment channels; for example, some alternative channels provide a single screen to enter data on all family members, compared to healthcare.gov which requires data entry on separate screens for each household member. Some alternative channels permit consumers to apply even if they do not have an email address. By contrast, healthcare.gov requires consumers to provide an email address to open an account, and this is burdensome for some consumers who do not have internet at home. Brokers also said they sometimes started applications on other channels when the FFM site was functioning slowly, or vice versa.

Several mentioned one disadvantage of using alternative enrollment channels, namely that when an application is started off healthcare.gov, the consumer does not have an account created on the FFM site. Without an account, consumers can't access the healthcare.gov Message Center, for example, where important updates about requests for additional documentation and other information are posted and easily accessible. Another broker observed that, without a healthcare.gov account, consumers who need to report mid-year changes can only submit them by phone to the call center.

Finally, some brokers noted that some alternative channels also sell non-QHP products and can provide quotes for these products along with the QHP. A few said that they sell a significant volume of accident-only policies, cancer policies, short term policies, and other excepted benefit products to consumers who feel they need added protection from high cost sharing under QHPs. Excepted benefit policies are not required to follow ACA market rules, such as the prohibition on pre-existing condition exclusions. Currently, CMS does not require alternative channels to report data on non-QHP products sold to QHP enrollees. Staff say they are working on improved ways to monitor the sale of QHP products through alternative enrollment channels.[16]

Changing Broker Commissions

Some insurers are ending or reducing broker commissions, especially for SEP policies. Nearly half of brokers (49%) said at least some insurers have stopped paying commissions on all Marketplace policies; 17% said most or all of the insurers they do business with have taken this action. Twenty-nine percent of brokers reported most or all insurers they do business with have reduced commissions on all Marketplace policies, while 14% said most or all insurers have reduced commissions on certain Marketplace policies, such as gold policies. Late in 2015, United HealthCare announced first that it would cut agent commissions from as much as 10% to 2%, then, effective in 2016, suspend commissions entirely for the sale of Marketplace policies.[17] In response several other insurers announced they, too, would end or reduce broker commissions for at least some Marketplace policies or enrollments.[18]

More often, brokers reported insurers were terminating or reducing commissions for policies sold to people eligible for SEP. Insurers report that SEP enrollees have higher health claims on average than people who sign up during Open Enrollment, and therefore want to discourage use of SEPs.[19] Sixty percent of brokers said at least some insurers have stopped paying commissions on Marketplace policies sold outside of Open Enrollment. One-third reported most or all insurers have stopped paying SEP commissions for Marketplace policies (Table 8).

Table 8: Changing Broker Commissions				
	Marketplace Plans		Off-Marketplace Plans	
Insurer Change to Broker Commissions	**Brokers Who Say All/Most Insurers Made This Change**	**Brokers Who Say No Insurers Made this Change**	**Brokers Who Say All/Most Insurers Made This Change**	**Brokers Who Say No Insurers Made this Change**
Open Enrollment				
· End commission all plans	17%	51%	11%	59%
· End commission certain plans (eg, gold)	14%	56%	12%	60%
· Reduce commission all plans	29%	35%	22%	43%
· Reduce commission certain plans (eg gold)	14%	56%	14%	54%
Special Enrollment				
· End commission all plans	33%	40%	27%	46%
· End commission certain plans (eg, gold)	22%	55%	21%	54%
· Reduce commission all plans	15%	58%	15%	55%
· Reduce commission certain plans (eg gold)	11%	64%	12%	62%

Changes in SEP commissions appear to be taking place more often in FFM states than in SBM states. Nearly half of brokers in FFM states (46%) reported most or all insurers they regularly do business with have ended commissions on SEP policies, compared to 10% of brokers in SBM states. Twenty-nine percent of FFM brokers reported no insurers have ended SEP commissions on Marketplace policies, compared to 61% of SBM brokers. So far, authorities in several SBM states have prohibited such broker commission reductions. The Connecticut Insurance Department ruled against United's action for 2016 on grounds that broker commissions had been incorporated into health plan rate filings the state had already approved.[20] Colorado's regulator ruled that elimination of broker commissions on certain policies, including SEP policies, would constitute discrimination and an unfair marketing practice.[21] The Kentucky Department of Insurance issued an advisory opinion that failure to pay agent commissions in accordance with filed rates would be a violation of the Insurance Code.[22] The California Marketplace is considering new requirements for participating insurers to pay the same commission rates for all their policies year round.[23]

In other states, including those directly regulated by CMS, which have not blocked commission modifications, the effect on access to coverage remains to be seen. Some agents who volunteered information after the survey said they would continue to help SEP-eligible consumers enroll in major medical health plans, even if they aren't paid a commission, because it's the right thing to do and because they hope consumers will ask for help renewing coverage at the next Open Enrollment, when commissions would apply. Others said they would consider selling short-term non-renewable policies to SEP-eligible consumers instead.

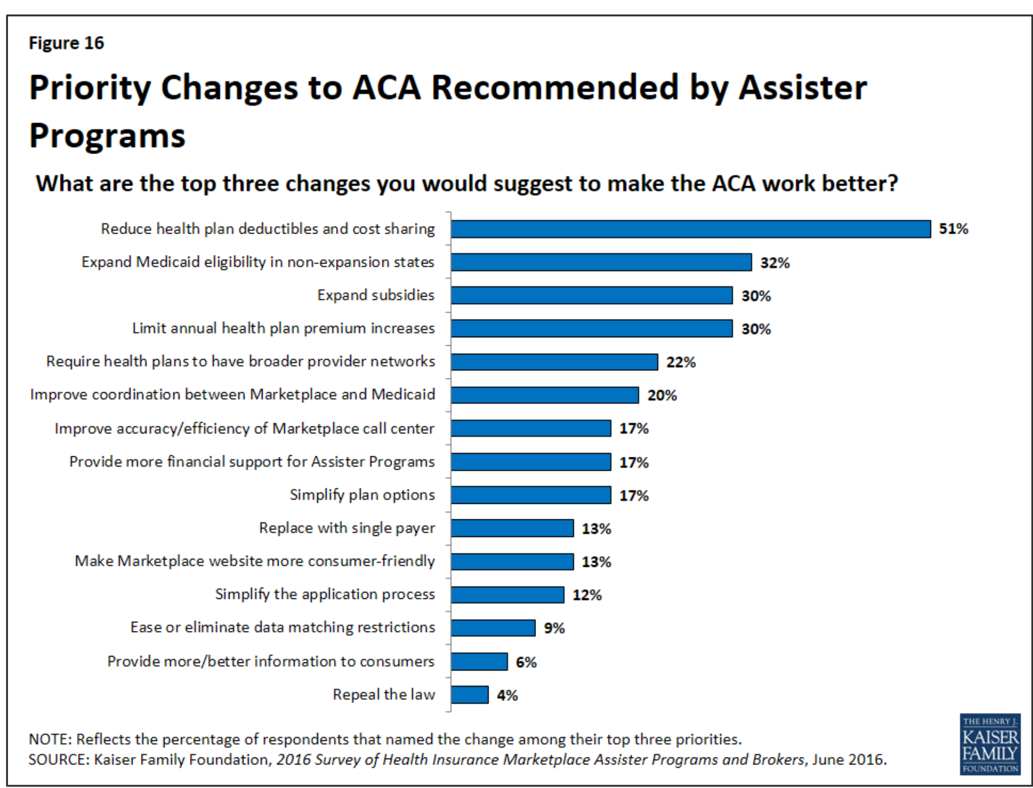
SECTION 5: ASSISTER AND BROKER OPINIONS OF THE ACA

Assister Programs and brokers were asked, in general, how the third Open Enrollment compared to the second. Both acknowledged improvements: 65% of Assister Programs and 55% of brokers said OE3 went much better or somewhat better than OE2.

In addition, this year the survey asked both Assister Programs and brokers to rate the ACA overall on a scale of 1-10, with 10 signifying the law is working perfectly and 1 that it is not working at all. Respondents were also offered a menu of possible ways to change the law and asked to select the top three changes they would recommend.

Assister Programs gave the ACA a rating of 6.5 out of 10, on average. The top three recommended changes by Assister Programs were:

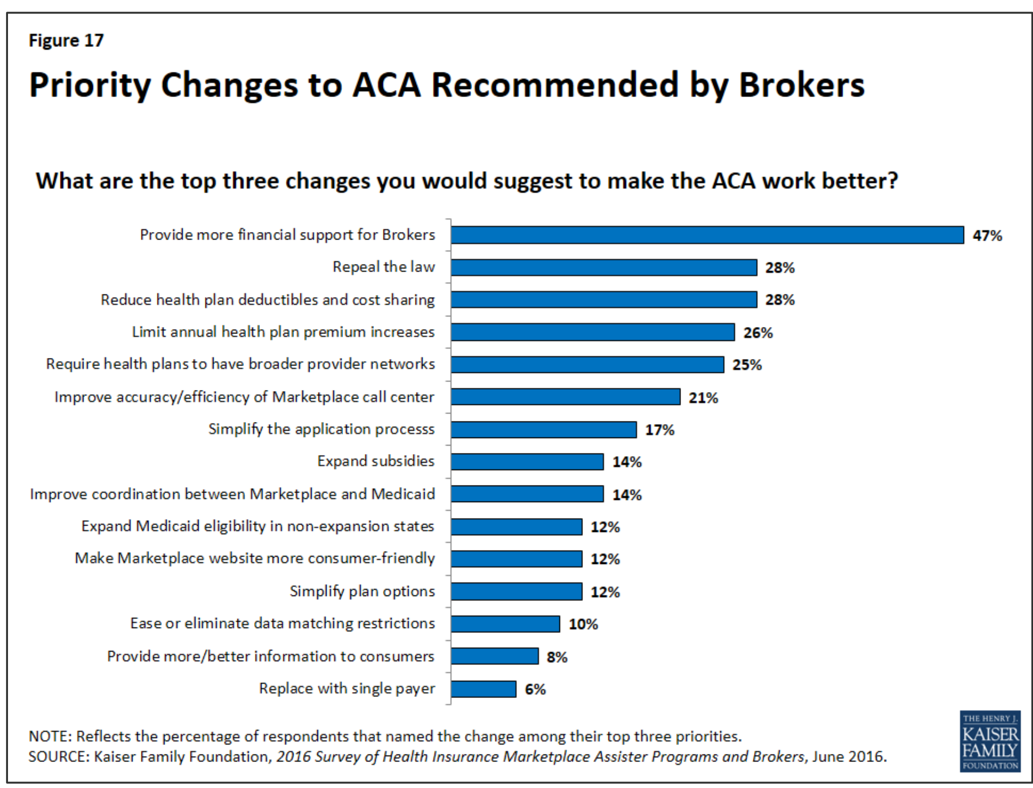
- Reduce health plan deductibles and cost sharing (51% included this among top three changes; 23% named this change as their first priority);
- Expand Medicaid eligibility in non-expansion states (32% named among top three changes; 16% designated as first priority); and
- Expand subsidies (30% named among top three; 12% as first priority) (Figure 16).



Brokers gave the ACA a rating of 4.5 out of 10, on average. Their top priority changes were:

- Increase broker commissions (47% included among the top three changes; 20% named this as the top priority);
- Repeal the law altogether (28% listed among top three changes; 20% as first priority): and

- Reduce health plan deductibles and cost sharing (28% included among their top three changes; 6% named as first priority (Figure 17).



Discussion

The new ACA system for in-person enrollment assistance through Marketplaces is becoming well established. The vast majority of Programs have operated for three years and most of their staff have worked all three years, as well. With tenure comes increasing expertise with Marketplace rules and procedures and familiarity with communities served. There are now opportunities to build on the strengths of the most seasoned Programs and Assisters – perhaps offering more in-depth training and continuing education to develop specialized skills.

Fewer consumers were helped by Assister Programs this year. Perhaps not coincidentally, the annual rate of Marketplace enrollment growth slowed this year, as well. Investing in consumer assistance could help to increase enrollment, although those investments have to compete against other needs in federal, state, and marketplace budgets. Evidence suggests consumers' need for in-person help won't go away any time soon: an increasing share of consumers seeking help this year were renewing vs. applying for the first time; most still have limited understanding of health insurance and the ACA; and many still lack confidence to apply on their own. There is also substantial churn in Marketplace enrollment – for example, as people gain or lose jobs with health benefits – creating an influx of new consumers seeking coverage and in-person help between Open Enrollment periods.

Uncertainty is also a challenge for Assister Programs, with one in three not certain that funding will be available next year. The FFM has reduced funding uncertainty by adopting multi-year agreements with Assister Programs, though the amount of funding is decided year-by-year.

The survey reveals that the bulk of consumer help through Assister Programs is provided by a minority of large Programs–80% of all consumers helped in OE3 were served by just one-quarter of all Assister Programs. These large-caseload Programs include Navigators, which contract directly with Marketplaces, and FQHC and CAC Programs, which are certified by Marketplaces but not necessarily as familiar to Marketplace officials. Large caseload Programs may provide the greatest opportunity for improving consumer assistance in the future; however, these programs face resource constraints and were the most likely to say that demand for help exceeded their capacity to provide it, especially during surge times.

Assisters continue to report that it takes 90 minutes on average to help new Marketplace participants, and 60 minutes on average for returning consumers. That the process remains time intensive, even after IT systems have improved, indicates how complicated the application process can be for consumers. Consumers face particular challenges when "real time" data verification and file transfers don't work, and significant delays and enrollment barriers can result. It appears that many, if not most individuals who experience data verification difficulties are not being helped by Assister Programs.

Brokers, who have emerged as an important avenue for marketplace enrollment, are, not surprisingly, concerned about the loss of revenue as insurance companies reduce or end commissions, actions taken most often this year for SEP enrollments. Millions of consumers are estimated to become eligible for SEPs during the year, but only a fraction take up the opportunity to enroll.[24] SEP enrollments can help offset normal churn of individuals who return to group health plans or public coverage during the year. Loss of broker

commissions, combined with adoption of new SEP eligibility verification requirements by the FFM, could dampen Marketplace enrollment.

The survey shows that brokers in FFM states rely heavily on alternative enrollment channels, especially to the extent these offer enhanced functionality. However, little is known about the experiences of consumers who apply through them or how often consumers buy other products through these sites, such as short-term policies or plans that target specific diseases.

Finally, Assisters and brokers on the front lines have valuable insights into how health reforms are working for consumers. Lower cost sharing in Marketplace health plans was identified as a priority by both Assister Programs and brokers. Reducing cost sharing presents tradeoffs – increasing premiums or government subsidies for low-income consumers – but could also be a factor helping to sustain enrollment growth.

Methods

The Kaiser Family Foundation 2015 Survey of Health Insurance Marketplace Assister Programs and Brokers was designed and analyzed by KFF researchers and administered by Davis Research. This nationwide survey was conducted through an online questionnaire from February 11, 2016 through March 4, 2016.

Assister Programs

To recruit Assister Program survey participants, we asked officials CMS and from States operating SBM or FPM Marketplaces to provide contact information for the directors of their certified Assister Programs. In addition, we requested contact information for the directors of enrollment assistance activities in each of the FQHCs from HRSA. All Assister Programs received an email with a link to the survey inviting the director to participate. In the event the person receiving the survey was not the appropriate person to complete it, they were asked to provide the contact name and email for the appropriate person within their organization.

To analyze results, we assigned Assister Programs to one of four types based on their primary source of funding. The first type, Navigators, were those identified by Marketplace officials contracted with and received grant funding directly from the Marketplace. The second type, FEAP, were those identified by CMS as contractors that operate in certain FFM states and that otherwise act as Navigators. We tracked FEAP responses separately in the survey, but for most data analysis presented in this report we combined responses of FEAPs and Navigators. The third type, FQHCs, were those that received grant funding from HRSA to provide enrollment assistance. We identified FQHCs using the contact list provided by HRSA. A small percentage of FQHC Programs receive both HRSA grants and Marketplace Navigator grant funding; these were categorized as Navigators for our analysis. All other Assister Programs certified to provide assistance in Marketplaces were designated as CACs.

A total of 5,094 Programs were invited to participate in the study, and 688 Programs responded and were included (for a response rate of 13.5%). Because response rates varied by Program type, data were weighted to reflect the distribution in the initial sample by Program type and Marketplace type; for our analysis, FFM and FPM Marketplaces were grouped together. (FFM + FPM, and SBM). Weighted and unweighted proportions of the final sample by Program type are shown in the table below.

	Unweighted % of total	Weighted % of total
FFM/FPM CAC	33%	46%
FFM/FPM FQHC	16%	16%
FFM/FPM Navigator/FEAP	10%	3%
SBM CAC	16%	18%
SBM FQHC	10%	9%
SBM Navigator/FEAP	14%	8%

Nationwide Estimates

Using responses provided by Assister Programs in the study, we were able to estimate the number of Assister Program staff and the number of consumers they helped with eligibility and enrollment in Medicaid/CHIP and

Qualified Health Plans during the second Open Enrollment period nationwide, by extrapolating response data to the national level. Survey participants were asked to provide the number of full-time equivalent Assisters in their Program and the number of consumers helped. Respondents who did not provide a numeric value for the number of consumers helped were asked to estimate a number using a range of options. In making our calculation, we used the midpoint value for responses that provided a range of numbers of consumers helped. Non-responses were imputed based on the type of Assister Program. A limitation of our national-estimates methodology is that outliers in our response data (i.e. assister programs that helped over 10,000 people during open enrollment, or who had more than 100 staff), when extrapolated to the national level may have an outsize influence on our estimates of total helped and total assister staff nationwide.

We also surveyed the work of Assister Programs outside of Open Enrollment as they helped people apply for Special Enrollment Periods, report mid-year changes to the Marketplace, and resolve post-enrollment problems. Using response data provided by returning Assister Programs, we were able to estimate the number of people nationally who received help from Assister Programs between the first and second Open Enrollment periods with each of these types of issues.

Brokers

To recruit brokers in the Federally-Facilitated Marketplace (FFM) states, we obtained contact information from a file of brokers in the FFM states, made publicly available through healthcare.gov.[25] To obtain broker contact information from the SBM and FPM states, we asked Marketplaces to provide contact information, and when that was not provided, compiled contact information that was publicly available on Marketplace websites. As we estimate that there are tens of thousands of brokers selling non-group Marketplace policies nationwide, we drew a sample of 9,432 brokers based on their distribution by Marketplace type (FFM, FPM, or SBM). Our general sampling rule was to randomly select 10% of all contacts in each state; we oversampled in ten states where we had fewer than 500 contacts to begin with. Because we did not have a complete sample of Marketplace brokers in all states, we were not able to compute national estimates of the numbers of consumers helped by brokers.

Out of the 9,432 brokers who were invited to participate in the study, 418 responded and were included (for a response rate of 4%).

Toplines and Margin of Sampling Error

Survey toplines with overall frequencies of both Assister Programs and Brokers for all survey questions are available at http://kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

The sample size and margin of sampling error (MOSE) for the total sample and key subgroups of Assister Programs are shown in the table below. All statistical tests of significance account for the effect of weighting.

Group	N (unweighted)	MOSE
Total	688	+/-4 percentage points
CAC	341	+/-5 percentage points
FQHC	179	+/-7 percentage points
Navigator and FEAP	168	+/-8 percentage points

Brokers	N (unweighted)	MOSE
Total	418	+/-5 percentage points

Endnotes

[1] Center for Consumer Information and Insurance Oversight, "Navigator Grant Recipients for States with Federally-facilitated or State Partnership Marketplace," available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Navigator-Grantee-Summaries-UPDATED-05-05-15.pdf.

[2] In year 3, the 14 SBM states were California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont and Washington. The 3 consumer assistance FPM states were Delaware, New Hampshire and West Virginia. Arkansas and Illinois were approved for status as a consumer assistance FPM in year one, but have since ceased providing state support for consumer assistance. The FPM states were included with FFM states for this analysis.

[3] During the third Open Enrollment period, FEAPs operated in Arizona, Florida, Georgia, Indiana, Louisiana, North Carolina, New Jersey, Ohio, Pennsylvania, and Texas.

[4] Twelve CAP programs received limited supplemental grants for FY 2015: California, Connecticut, District of Columbia, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New York, North Carolina, and Vermont.

[5] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-30.html

[6] http://www.cbpp.org/research/remote-identity-proofing-impacts-on-access-to-health-insurance

[7] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html

[8] http://khn.org/news/paperwork-inconsistencies-causing-thousands-to-lose-obamacare-subsidies/

[9] https://aspe.hhs.gov/basic-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace

[10] See for example A Frakt, "Too Many Choices," Academy Health, 2013, available at http://blog.academyhealth.org/too-many-choices/

[11] Patient Cost Sharing in Marketplace Plans, 2016, Kaiser Family Foundation, available at http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/

[12] "Five Facts About Deductibles" CMS blog post November 17, 2015, available at https://blog.cms.gov/2015/11/

[13] 2016 Survey of Non-Group Health Insurance Enrollees, Wave 3, Kaiser Family Foundation, available at http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/

[14] http://www.coveredca.com/news/

[15] Personal communication, April 29, 2016

[16] Personal communication, April 29, 2016.

[17] http://insurancenewsnet.com/oarticle/unitedhealthcare-to-stop-paying-insurance-agents-for-selling-aca-health-plans

[18] http://www.usatoday.com/story/news/nation/2016/03/31/insurers-cut-commissions-restrict-when-and-what-plans-people-buy/82210946/

[19] http://khn.org/news/licking-wounds-insurers-accelerate-moves-to-limit-health-law-enrollment/

[20] http://ctmirror.org/2016/02/12/state-says-unitedhealthcare-cant-ax-broker-commissions/

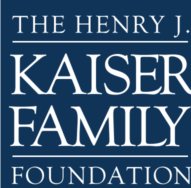
[21] http://csahu.org/images/B-4_87_Prohibition_on_Differing_Commission_Structures_for_the_Sale_of_Health_Benefit_Plans.pdf

[22] http://insurance.ky.gov/Documents/AdvOp16_01AgentCommissionPayments010616.pdf

[23] http://www.benefitspro.com/2016/04/08/covered-california-posts-agent-comp-draft

[24] See for example, M Buettgens et al, "More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods," November 2015, available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf

[25] https://localhelp.healthcare.gov/



THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

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RESEARCH REPORT

Helping Special Enrollment Periods Work under the Affordable Care Act

Stan Dorn

June 2016

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The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

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Helping Special Enrollment Periods Work under the Affordable Care Act

In Brief

Under the Affordable Care Act (ACA), special enrollment periods (SEPs) were designed so people whose circumstances change because of job loss or other factors can obtain Marketplace coverage outside of the designated open enrollment period (OEP). After carriers claimed that ineligible people were using SEPs to obtain coverage for newly arising health problems, the Centers for Medicare and Medicaid Services (CMS) announced a new requirement for SEP applicants to document their eligibility. State-based Marketplaces (SBMs) are also considering similar approaches.

SEP utilization has fallen far short of its potential, with roughly 5 percent of SEP-eligible consumers enrolling in 2015. Although limiting SEP use to eligible consumers is important, other approaches to verification may be more effective at addressing underlying concerns:

- Unlike most ACA verification, which begins with data matches, CMS's new approach starts by asking consumers for documents. Fewer eligible people will likely enroll, especially among the relatively healthy. It is thus not clear whether risk pools will improve, on balance.
- CMS and SBMs could instead request documentation only when the Marketplace cannot verify eligibility by accessing data. Reducing consumers' procedural burdens would increase sign-ups, especially among healthy eligible people. Rapid verification would also limit the need to provide coverage while consumers' documentation is being analyzed.

Introduction

As a general rule, consumers may buy individual coverage, within and outside health insurance Marketplaces, only during an annual OEP. This rule seeks to prevent consumers from waiting until they get sick before they enroll. If the sick alone signed up, such "adverse selection" would raise premiums to unsustainable levels. Similar OEP requirements govern most employer-sponsored insurance (ESI) and Medicare.

However, events occurring between OEPs can create an unexpected need for coverage. For example, 28.8 million laid-off workers and their dependents lose ESI each year between OEPs; 2.6 million people lose Medicaid because of rising income; and 580,000 people lose spousal coverage through divorce (Buettgens, Dorn, and Recht 2015). Such consumers qualify for SEPs, during which they may sign up for Marketplace plans or other individual insurance.

Through January 2016, CMS did not verify SEP eligibility. Instead, applicants qualified for SEPs based on attestations. Insurers complained that consumers who developed health problems midyear were falsely claiming SEP eligibility and obtaining Marketplace coverage. Carriers cited as evidence higher claims for SEP than OEP enrollees. Several insurers claimed financial losses on SEP members as one reason they might stop offering Marketplace coverage;[1] at least one carrier later withdrew from multiple states.[2]

In February 2016, CMS announced a new policy of requiring consumers to document eligibility for common SEPs.[3] SEP applicants who provide documentation will receive coverage while their documents are being reviewed.[4] The new policy first took effect on June 17, 2016.

SBMs are also re-evaluating SEP verification. California's Marketplace, for example, which previously allowed SEP enrollment based on consumer attestations, is analyzing a sample of SEP enrollees, gathering information to shape the state's longer-term approach.[5]

In May 2016, CMS announced another change focused on SEPs triggered by consumers who change their residence by moving between counties or states. Responding to carrier concerns, CMS limited this SEP category to people who had coverage before their move. CMS sought to end "an opportunity for adverse selection where persons undertake a permanent move solely for the purpose of gaining health coverage" (CMS 2016).

This report asks three questions: Is verification of SEP eligibility a good idea? What are the trade-offs and limitations of CMS's new verification policy? Do alternative approaches merit consideration by CMS and SBMs?

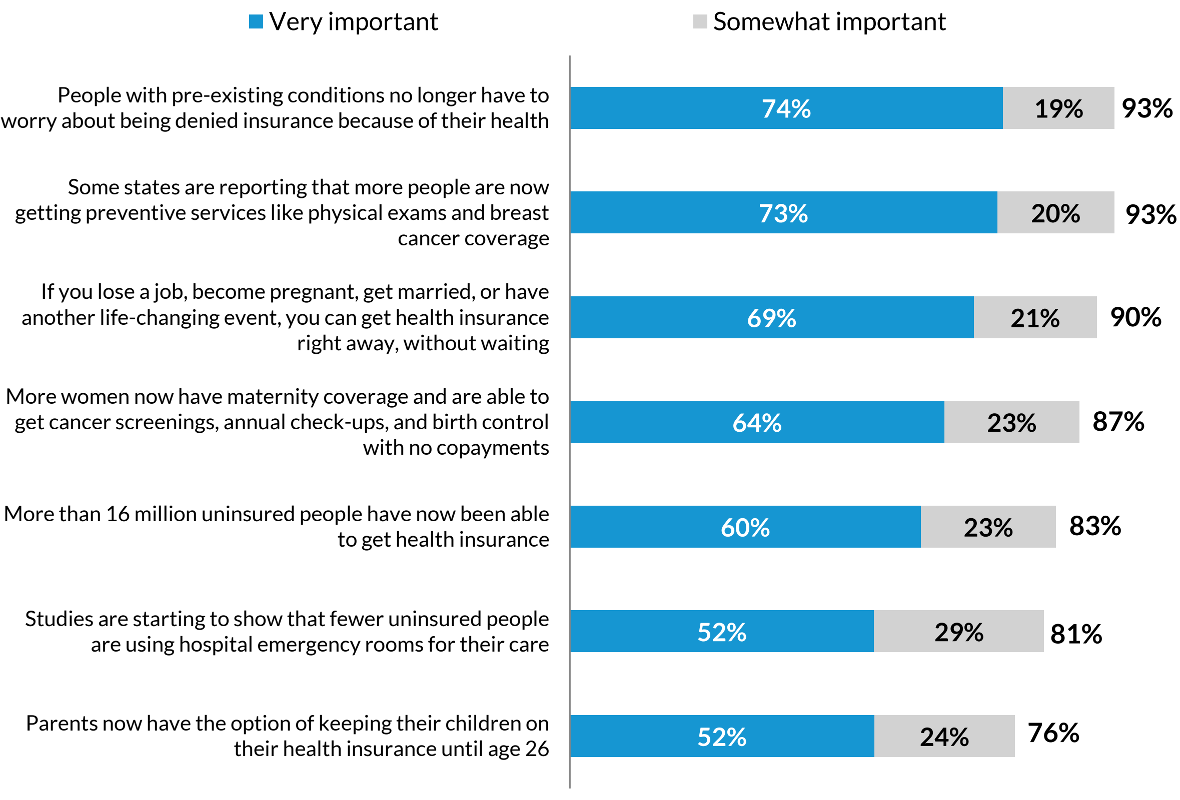
The Need for SEP Verification

SEPs' Importance

Survey data suggest that SEPs are one of the ACA's most valued components. In September 2015,[6] 90 percent of residents in five states said an "important" result of the ACA was that "if you lose a job, become pregnant, get married, or have another life-changing event, you can get health insurance right away without waiting"; 69 percent described this feature of the ACA as "very important." Coverage during life transitions was valued more than many other aspects of the ACA, including millions of uninsured gaining insurance and young adults staying on parental coverage through age 26 (figure 1).

FIGURE 1

Percentage of Potential Voters in Florida, Nevada, Ohio, Pennsylvania, and Virginia Who Describe Various Affordable Care Act Results as Important



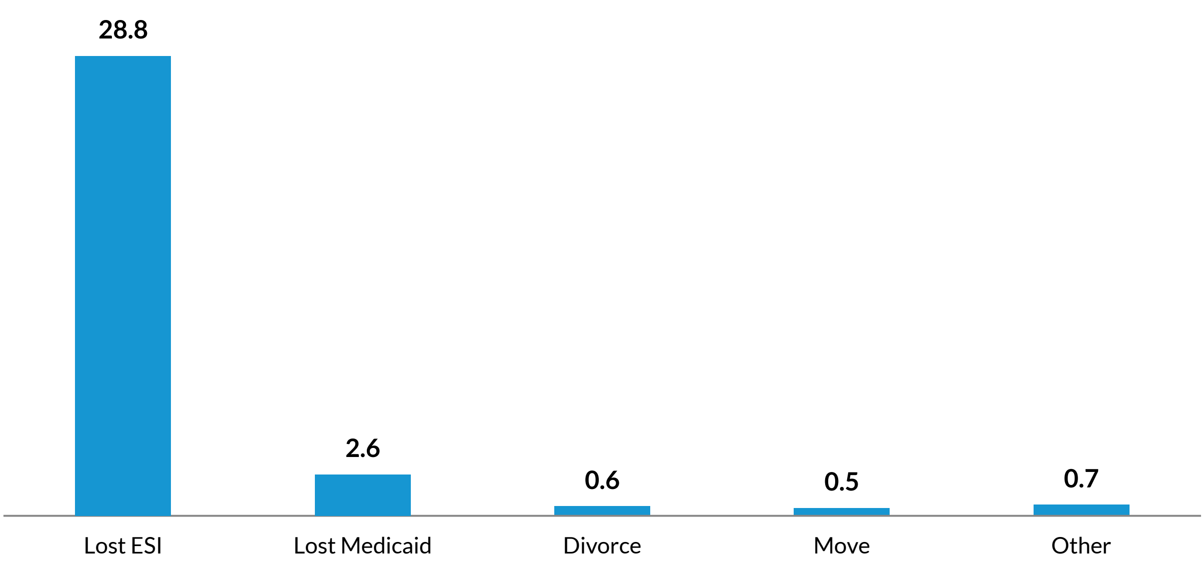
Source: PerryUndem Research/Communications, "Likely Voters Feel the Affordable Care Act Is Here to Stay. They Agree on Ways to Improve the Law," Oct. 8, 2015, www.communitycatalyst.org/news/press-releases/media-report.final.pdf.

It is understandable that SEPs are highly valued. Access to coverage during life transitions fills a major hole in America's insurance system. In a typical year, 33.5 million Americans lose coverage between OEPs for reasons that qualify for SEPs (figure 2). More than 6 in 10 of them (62 percent) regain coverage by the end of the year (data not shown), but even short-term gaps can reduce access to care and cause financial loss (Gulley, Rasch, and Chan 2011; Olson, Tang, and Newacheck 2005).[7]

Out of 33.5 million SEP-eligible Americans who experience coverage gaps, 28.8 million, or 86 percent, lose ESI when they become unemployed, as noted above. Adding the 2.6 million who lose Medicaid when their income rises, 94 percent of SEP coverage gaps involve loss of minimum essential coverage.

FIGURE 2

SEP-Qualifying Reasons for Coverage Gaps between OEPs (millions of people per year)



Source: Buettgens, Dorn, and Recht (2015).
Note: ESI = employer-sponsored insurance; OEP = open enrollment period; SEP = special enrollment period. Sources of SEP eligibility in the "other" category include marriage, adding a child to the family, gaining citizenship, turning 26 and losing access to parental insurance, and qualifying for tax credits by moving from below to above the federal poverty level in a state that has not expanded Medicaid.

Buettgens, Dorn, and Recht (2015) estimate that 1.5 million people enrolled via SEPs in 2015—roughly 5 percent of SEP-eligible consumers who experienced coverage gaps. SEP enrollees' high risk levels described by carriers thus reflect not just participation by those with health problems but likely also a lack of participation by eligible healthy consumers.[8] Consumers "with the greatest health care

needs are the most likely to seek out information about mid-year enrollment opportunities, spend the time necessary to complete the application process, and enroll within the limited enrollment window permitted (typically 60 days after their life change)."[9]

Marketplace attrition suggests SEPs' underutilization. Presumably, consumers leaving the Marketplace because of job offers with ESI should be roughly offset by consumers who lose employment and ESI, then join the Marketplace. Instead, Marketplace enrollment between OEPs declined significantly in 2014 and 2015.[10]

Increasing eligible consumers' SEP enrollment would lower the number of uninsured people. It could improve risk pools by adding healthier consumers, increase Marketplaces' administrative funding,[11] and establish Marketplaces as America's coverage source during life transitions. However, such results are unlikely if carriers believe they lose money on SEP enrollees. To limit SEP participation, some insurers neither advertise nor pay brokers between OEPs.[12] Reversing this trend may require SEP verification and other steps that mitigate carriers' claimed losses on consumers who enroll between OEPs.

Limited Evidence of SEP Abuse

Several consumer groups rightly note that many facts cited by carriers do not prove SEP abuse.[13] Higher health costs for SEP enrollees[14] are consistent with risk selection by eligible consumers, because medical problems increase the likelihood that such consumers enroll.[15]

Carriers also report that when non-Marketplace plans request proof of SEP eligibility, many consumers drop their applications.[16] However, "hassle factors" may be stopping eligible consumers from enrolling. According to behavioral economics research, minor procedural requirements—requesting the completion of simple forms[17] or requiring a box to be checked[18]—can greatly reduce participation.

Nevertheless, evidence from California suggests some SEP abuse:

- When California's non-Marketplace plans ask SEP applicants for proof of eligibility, many shift to the Marketplace, where verification is not required.[19]
- If hassle factors alone were preventing the completion of SEP applications, average costs would be higher in plans that request documentation, because the sickest people are most likely to make the effort needed to prove eligibility. Instead, average costs of SEP enrollees are lower in

California's non-Marketplace plans, which request documentation, than in the state's Marketplace plans, which do not.[20] This finding supports carriers' argument that, when consumers drop their SEP applications after being asked to show eligibility, some do so because they are ineligible, not because hassle factors stop them from moving forward.

Potential Challenges with CMS's New Policy

CMS's new policy begins SEP verification by asking consumers for documents to confirm their SEP eligibility. This approach departs from standard ACA practice, which avoids burdening consumers if the government can find proof of eligibility on its own. The ACA statute states, "to the maximum extent practicable," Marketplaces and Medicaid must "determine . . . eligibility on the basis of reliable, third-party data."[21] ACA regulations thus begin verification with data matches. Only if matches fail to confirm eligibility may consumers be asked for documentation.[22]

CMS's new SEP documentation procedures could reduce the number of eligible consumers who enroll, as suggested by experience with the Deficit Reduction Act of 2005, which required Medicaid applicants to document citizenship. Consistent with the behavioral economics research noted above, adding this procedural step reduced eligible citizens' participation:[23]

- The Government Accountability Office found that, in less than a year, 22 of 44 states found documentation requirements lowered enrollment, 12 saw no effect, and 10 could not yet assess the impact. The first group mainly attributed the drop to "delays in or losses of coverage for individuals who appeared to be eligible citizens." The one state that carefully tracked results reported that 15.6 percent of all Medicaid applications were denied for lack of citizenship documentation.[24]
- By 2007, 13 states found documentation requirements had a "significant negative impact on enrollment"; 24 observed some or modest effects; and 11 found insignificant or no effects (Smith et al. 2007).
- The Children's Health Insurance Program Reauthorization Act of 2009 repealed citizenship documentation requirements. The Congressional Budget Office estimated that 500,000 people would receive coverage as a result, noting that "virtually all of those who have been unable to provide the required documentation are U.S. citizens."[25]

Given this history, requiring SEP documentation will probably reduce enrollment among eligible people,[26] which is likely to raise the average cost of eligible SEP enrollees. All else equal, consumers with health problems are the ones most likely to take the time needed to submit requested documentation.[27] It is not clear whether this unfavorable effect on Marketplace risk pools outweighs the risk-pool benefits of SEP verification. Compounding uncertainty about the overall risk-pool effects of CMS's policy, carriers suggest that some SEP-ineligible consumers with health problems may obtain months of coverage while their documents are being processed.[28]

Alternative Approaches

SEP Verification

Instead of requiring documentation from all SEP applicants, Marketplaces could first seek to confirm eligibility on their own. Such approaches may be possible for several SEPs.[29] However, we focus on loss of minimum essential coverage, which causes 94 percent of SEP eligibility, as noted above. Such loss could be verified as follows:

1. The SEP application form requests information about the applicant's former insurer.
2. The Marketplace attempts verification by automated data matches with the former insurer, using an established automated procedure through which providers routinely query insurers to verify patient coverage.[30]
3. If such data matching does not show the consumer had minimum essential coverage that recently ended, the Marketplace calls the consumer's former insurer for verification.
4. If eligibility remains unconfirmed, the Marketplace calls the consumer for verification.
5. If eligibility continues to be unconfirmed, the Marketplace sends the consumer a written notice requesting documentation.

No research shows the effect of procedures like these under the ACA. However, previous research shows the effectiveness of similar policies used by several Medicaid programs before the ACA:

- Starting in 2010, Oklahoma's Medicaid program requested documentation from consumers only if data matches did not prove eligibility; 55 percent of applications and 80 to 85 percent of renewals were then verified electronically without asking consumers for documents.[31]

- Louisiana's pre-ACA renewal process obtained enough information to determine eligibility for more than 99 percent of enrolled children.[32] This process contributed to a program-wide eligibility error rate of 0.3 percent, roughly one-tenth the national average (CMS 2012). Among renewing children, 56 percent had eligibility verified through data matches, 20 percent were verified manually by agency staff without contacting families, 15 percent were verified by telephoning families, and only 4 percent required families to submit written paperwork (Dorn, Minton, and Huber 2014). The state kept 95 percent of children insured,[33] a share significantly above the national average.[34]

Two factors would improve Marketplace risk pools if the verification process suggested here replaced CMS's approach. First, reducing applicant burdens should increase enrollment among eligible consumers who are relatively healthy, as explained above. Second, the first steps of the process suggested here would seek verification before enrollment. Such a practice would reduce the need to provide coverage while documents are being processed, thus lowering the number of ineligible, high-cost consumers who obtain interim coverage. Moreover, with the latter result, fewer consumers would face the financial risks of receiving coverage for which they later turn out to be ineligible.[35]

However, this five-step verification process has trade-offs and limitations:

- Necessary information technology investments may be costly, although some offsetting operational savings will result. Electronic verification of SEP eligibility eliminates the need to pay staff for manual verification. Oklahoma and Louisiana found that ongoing savings from data-based verification exceeded information technology investment costs (Hoag et al. 2013).
- Automated SEP verification systems will take time to develop and test. Until such systems are deployed, Marketplaces could verify eligibility by calling the former carriers identified on SEP application forms.[36]
- Even if lost minimum essential coverage is confirmed, some consumers may be ineligible. Those who lose coverage because they stop paying premiums, for example, do not qualify for SEPs.[37]
- Carrier cooperation is needed for manual verification, which generates costs for responding insurers. Some carriers may not cooperate.

Increasing SEP Take-up by Healthy Consumers

Public education could address consumers' lack of knowledge about SEPs, but information alone is unlikely to substantially increase take-up.[38] Based on past experience with laid-off workers, enrollment gains will likely require hands-on application assistance for consumers who lose ESI (Dorn 2006). Such consumers comprise 86 percent of SEP-eligible people, as noted above, which argues for making them a priority.

If insurers see SEP enrollees as profitable, brokers who have relationships with employers would have incentives to enroll departing employees into Marketplace coverage. For this change to occur, however, more than SEP verification is needed. Risk adjustment must also change to compensate carriers for the short-term costs that can prompt SEP enrollment, an issue currently under CMS consideration.[39] Another potential contribution to carrier engagement is CMS's recent limitation of eligibility for SEPs that are triggered by a change in residence, as described above.

Along with encouraging carriers to market between OEPs, Marketplaces could partner with state workforce agencies to add health application assistance to services for the unemployed. Moreover, improving electronic linkages between Medicaid and Marketplace eligibility systems could prevent some consumers from "falling between the cracks" when they lose Medicaid because of rising incomes (Wishner et al. 2015).[40]

However, the enrollment and risk-pool gains from these efforts will be constrained by consumer affordability concerns. Many uninsured people cite such concerns as reasons they have chosen not to join Marketplace plans during OEPs (Dorn 2014).[41]

Conclusion

Some carriers are reportedly avoiding SEP members because of their high average cost. This higher cost results from three factors: (1) enrollment by costly consumers who are *ineligible* for SEPs, (2) enrollment by costly consumers who are *eligible* for SEPs, and (3) limited enrollment by *healthy and eligible* consumers. CMS's policy to verify eligibility by requesting consumer documentation addresses the first factor. However, it does not address the second, and it worsens the third by adding procedural requirements that are likely to lessen eligible consumers' participation, especially among the healthy.

To reduce consumer burdens and align with broader ACA principles, both CMS and SBMs could instead

- use data matches to verify eligibility whenever possible,
- verify eligibility manually if data matches do not suffice, and
- request consumer documentation only if these proactive steps fail to confirm eligibility.

To increase SEP take-up by healthy, eligible consumers, Marketplaces could target application assistance to the most common SEP categories and facilitate the involvement of insurers and brokers. If carriers stop seeing SEP enrollment as financially harmful, they could join Marketplaces in recruiting consumers between OEPs. This would help Marketplaces fill an important gap in America's health insurance system by routinely providing coverage during major life transitions.

Notes

1. Julie Appleby, "UnitedHealth Warns of Marketplace Exit," Kaiser Health News, Nov. 20, 2015, http://khn.org/news/unitedhealth-warns-of-marketplace-exit-start-of-a-trend-or-push-for-white-house-action/.

2. Phil Galewitz, "UnitedHealthcare to Exit All but 'Handful' of Obamacare Markets in 2017," Kaiser Health News, April 19, 2016, http://khn.org/news/unitedhealthcare-to-exit-all-but-handful-of-obamacare-markets-in-2017/.

3. These SEPs are based on loss of health insurance; permanent moves between counties or states; birth; adoption; and marriage (CMS, "Fact Sheet: Special Enrollment Confirmation Process," Feb. 24, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html).

4. CMS (2016, June) Eligibility Notice: Special Enrollment Periods (2016 Coverage). JoAnn Volk, "NAIC Roundup: Catching Up on the Spring Meeting and Looking Ahead," CHIRblog, April 28, 2016, http://chirblog.org/naic-roundup-catching-up-on-the-spring-meeting-and-looking-ahead/.

5. Anne Price, "Special Enrollment Period Policies," Covered California Policy and Action Items, April 7, 2016, http://board.coveredca.com/meetings/2016/4-07/PPT%20-Covered%20California%20Policy%20and%20Action%20Items%20April%207%202016%20-%20DRAFT.pdf.

6. PerryUndem Research/Communications, "Likely Voters Feel the Affordable Care Act Is Here to Stay. They Agree on Ways to Improve the Law," Oct. 8, 2015, www.communitycatalyst.org/news/press-releases/media-report.final.pdf.

7. See also the Incidental Economist, "The Consequences of Health Insurance Coverage Gaps," Academy Health blog, Jan. 6, 2014, http://blog.academyhealth.org/the-consequences-of-health-insurance-coverage-gaps/.

8. Sarah Lueck, "Insurers' Push to Restrict Special Enrollment Periods Would Block Uninsured People," Center on Budget and Policy Priorities, Feb. 10, 2016, http://www.cbpp.org/health/insurers-push-to-restrict-special-enrollment-periods-would-block-uninsured-people. Also, short-term plans that are not ACA compliant may siphon off better risks. Such plans can lower premiums by denying insurance to consumers with pre-existing conditions, capping paid claims per year, and so on (Sabrina Corlette, "One Way Insurers Could Improve Marketplace Risk Pools? Stop Cannibalizing Their Own Business," CHIRblog, April 22, 2016, http://chirblog.org/one-way-insurers-could-improve-marketplace-risk-pools/). However, these plans do not meet the ACA's individual-coverage requirement. The penalty for violating that requirement is slated to increase, and more people could learn about the penalty over time. If so, some market share may shift from non-ACA short-term coverage to ACA-compliant plans. More important, in June 2016, federal authorities proposed new regulations to greatly limit the operation of short-term plans outside of the ACA's insurance framework. See CMS (2016, June) "Strengthening the Marketplace—Actions to Improve the Risk Pool."

9. Laurel Lucia, "How Do We Make Special Enrollment Periods Work?" *Health Affairs* blog, Feb. 16, 2016, http://healthaffairs.org/blog/2016/02/16/how-do-we-make-special-enrollment-periods-work/.

10. For example, by the end of the 2015 OEP, the federally facilitated Marketplace lost 22 percent of its 2014 enrollees, and SBMs lost 31 percent (Carolyn F. Pearson, "State-Based Exchanges Saw Higher Attrition from 2014 to 2015 Than Federally Facilitated Exchanges," April 7, 2015, Avalere Health LLC). Factors other than new employment contribute to attrition, including members' financial reversals that stop premium payments, members completing treatment for a condition that originally motivated enrollment, and so on.

11. In most Marketplaces, administrative costs are financed by carrier fees that reflect the number of Marketplace enrollees.

12. J. Hancock, “Licking Wounds, Insurers Accelerate Moves to Limit Health-Law Enrollment,” Kaiser Health News, Feb. 4, 2016.
13. Sarah Lueck, “Insurers’ Claims about Special Enrollment Periods Deserve Tougher Scrutiny,” Center on Budget and Policy Priorities, Feb. 25, 2016, http://www.cbpp.org/blog/insurers-claims-about-special-enrollment-periods-deserve-tougher-scrutiny.
14. Paul Demko, “Gaming Obamacare,” Politico, Jan. 12, 2016; John Bertko, “Emerging Potential Trends for Covered California Special Enrollment Period Enrollees,” Covered California, Feb. 18, 2016. See also Chris Carlson and Kurt Giesa, “Special Enrollment Periods and the Non-Group, ACA-Compliant Market,” Oliver Wyman, Feb. 24, 2016, https://www.ahip.org/wp-content/uploads/2016/03/Oliver-Wyman-Analysis-of-SEP-Enrollment-in-ACA-Nongroup-Market.pdf.
15. SEP enrollees also retain coverage for shorter periods, on average, than OEP members (Carlson and Giesa, “Special Enrollment Periods”). These shorter coverage periods do not prove SEP misuse, however, because (as noted above) more than 60 percent of SEP-eligible consumers regain coverage from employers or Medicaid before the end of the year.
16. Bertko, “Emerging Potential Trends.”
17. For example, David Laibson found that application requirements lowered early participation in 401(k) plans from 90 to 33 percent (“Impatience and Savings,” NBER Reporter Online, 2005). Blavin, Dorn, and Dev (2014) report that in four states, application requirements limited take-up of Medicaid targeted-enrollment offers to 27 and 33 percent (in two states) and 41 and 46 percent (in two states that attempted to call nonrespondents) of consumers who were sent mailings of enrollment materials.
18. For example, Johnson and Goldstein (2004) found that check-box completion requirements lowered consent rates to organ donation from 82 to 42 percent; and Dorn, Wilkinson, and Benatar (2012) found that check-box requirements reduced by 62 percent the average number of Louisiana children receiving Medicaid based on monthly Supplemental Nutrition Assistance Program applications and express lane eligibility.
19. Bertko, “Emerging Potential Trends.”
20. Bertko, “Emerging Potential Trends.”
21. ACA §1413(c)(3)(A).
22. See, for example, 42 CFR §435.952(c); 45 CFR §155.315(b), (c), (e), (f), and (i); and 45 CFR §155.320(b)(1), (c)(1)(i), (c)(3)(ii)(C) and (D), (c)(3)(iii), (c)(3)(v)(A), and (c)(3)(vi)(A).
23. See also the finding that seven states with relatively good enrollment data reported significant enrollment declines that officials attributed to citizenship documentation requirements (Donna Cohen Ross, “New Medicaid Citizenship Documentation Requirement Is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up,” Center on Budget and Policy Priorities, revised March 13, 2007, http://www.cbpp.org/archiveSite/2-2-07health.pdf) and Sommers’s (2010) finding that citizenship documentation requirements may have contributed to roughly 2 million Medicaid-eligible children becoming uninsured.
24. Other states estimated between 1 and 14 percent increases in monthly denials (Government Accountability Office 2007).
25. P. R. Orszag, Congressional Budget Office, letter to Speaker Nancy Pelosi, Oct. 25, 2007.
26. Additional reductions may result if Marketplaces continue to have problems processing consumers’ documents (Sandy Ahn, “Healthcare.gov Changing Approach to Special Enrollment Periods, May Be Bumpy Road for Consumers,” CHIRblog, Feb. 25, 2016, http://ccf.georgetown.edu/all/healthcare-gov-special-enrollment-periods-may-be-bumpy-road-for-consumers/).

27. As Austin Frakt notes, "Any barrier, any work an individual must do to enroll is a form of payment. Adverse selection results" ("Simply Put: Adverse Selection," The Incidental Economist, April 15, 2011, http://theincidentaleconomist.com/wordpress/simply-put-adverse-selection/). See also Maria Polyakov ("Regulation of Insurance with Adverse Selection and Switching Costs: Evidence from Medicare Part D," Dec. 22, 2013, http://www.igier.unibocconi.it/files/9376-Polyakova.pdf), who found that more procedural requirements for changing Medicare Part D plans were associated with higher levels of adverse selection.
28. Gabriel McGlamery, Blue Center for Health Policy, personal communication, May 2016.
29. For the SEP category related to moving, for example, WhitePagesPro.com, a commercial vendor, has address data for roughly 90 percent of the US adult population (Andrea Falling, WhitePagesPro.com, personal communication, April 2016).
30. Nationally standardized forms for data exchange show whether an insurer has a particular individual on file and, if so, the details of the individual's past and current coverage. These forms are among the standardized national formats of electronic data exchange required by the Health Insurance Portability and Accountability Act of 1996. Coverage inquiries use the "270 Benefit Inquiry" form, and responses from insurers or their contractors use the "271 Information Response" form.
31. Sheila Hoag and Adam Swinburn, "CHIPRA Express Lane Eligibility Evaluation: Case Study of Oklahoma's SoonerCare Online Enrollment System," Mathematica Policy Research, May 31, 2013, https://www.statereforum.org/system/files/mathematica-_case_study_of_oklahomas_online_enrollment_system_5_31_13.pdf.
32. Tricia Brooks, "The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute, Feb. 26, 2009, http://ccf.georgetown.edu/ccf-resources/louisiana-experience-successful-steps-improve-retention-medicaid-schip/.
33. Brooks, "The Louisiana Experience."
34. Sommers (2005) estimated that 29 percent of Medicaid and Children's Health Insurance Program children lost coverage at renewal nationally, and 44 percent of children losing coverage remained eligible.
35. See Price, "Special Enrollment Period." Current statutes and regulations do not seem to require repayment of advance premium tax credits from consumers who enroll through SEPs for which they were ineligible. See 26 USC §36B(b)(2)(A) and 26 CFR §1.36B-4(a)(1)(iii), (a)(4) Example 9. However, depending on state law and the applicable insurance contract, some consumers who enroll by wrongly attesting to SEP eligibility might be required to refund carriers' paid claims. See, for example, Imperial Casualty & Indemnity Co. v. Sogomonian, 198 Cal. App. 3d 169 (1988). See also California Insurance Code §§ 330, 331 and California Civil Code §1692.
36. To significantly lower the administrative costs of this manual approach, a Marketplace could test consumers' use of SEP applications. Most applicants who complete the form may turn out to qualify, as applicants will see that the Marketplace can contact their supposed former carriers for verification. With federal income taxes, when taxpayers know that W-2s or 1099 forms allow verification, returns have an accuracy rate of almost 99 percent (Government Accountability Office 2012). If initial testing shows minimal SEP ineligibility among those who complete the SEP application form, the Marketplace could manually verify samples of SEP applicants, rather than all such applicants, much as the Internal Revenue Service audits selected income tax returns. Describing its document review process as "modeled after approaches used by the Internal Revenue Service," CMS may be planning a similar, audit-based strategy (CMS 2016). However, the auditing approach discussed here is intended, not as an ongoing policy, but as an interim measure that transitions to verifying all SEP applications once a data-matching system comes online, based on the 270/271 transactions described earlier.
37. 45 CFR 155.420 (e)(1).

38. Mary June Flores and Laurel Lucia, "Maximizing Health Insurance Enrollment through Covered California during Work and Life Transitions," UC Berkeley Center for Labor Research and Education, May 13, 2013, http://laborcenter.berkeley.edu/maximizing-enrollment/.

39. CMS is planning to change current risk adjustments for "partial year" enrollees (Center for Consumer Information and Insurance Oversight, "March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper," March 24, 2016, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf); Center for Consumer Information and Insurance Oversight (2016, June) March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting Questions & Answers. However, CMS's analysis, which is based primarily on ESI claims, shows the cost of, for example, people who change jobs and health plans midyear—a very different group from SEP enrollees into individual-market plans. CMS may also need to create new risk adjustments for acute care costs that (1) do not currently qualify for risk adjustment because they do not involve chronic conditions but (2) can prompt SEP use. Illustrating the magnitude of such effects, trauma-related health care costs exceed those associated with any other diagnosis(Agency for Healthcare Research and Quality, "Total Expenses and Percent Distribution for Selected Conditions by Type of Service, United States, 2013," Table 3, Medical Expenditure Panel Survey Household Component Data https://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2013&Table=HCFY2013_CNDXP_C&_Debug=.

40. Samantha Artiga, Jennifer Tolbert, and Robin Rudowitz, "Implementation of the ACA in Kentucky: Lessons Learned to Date and the Potential Effects of Future Changes," April 20, 2016, http://kff.org/health-reform/issue-brief/implementation-of-the-aca-in-kentucky-lessons-learned-to-date-and-the-potential-effects-of-future-changes/.

41. See also Sara R. Collins, Munira Gunja, Michelle M. Doty, and Sophie Beutel, "To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance under the Affordable Care Act While Others Have Not," The Commonwealth Fund, September 2015, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/sep/1837_collins_to_enroll_not_enroll_tb.pdf; Enroll America, "Reaching Consumers in the Third Open Enrollment Period: Who Are They and What Do They Need to Hear?," Oct. 28, 2015, https://www.enrollamerica.org/research-maps/webinars/third-open-enrollment-period-messaging-mike-perry/.

References

Blavin, Fredric, Stan Dorn, and Jay Dev. 2014. “Using Behavioral Economics to Inform the Integration of Human Services and Health Programs under the Affordable Care Act.” Washington, DC: Urban Institute.

Buettgens, Matthew, Stan Dorn, and Hannah Recht. 2015. “More Than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods.” Washington, DC: Urban Institute.

CMS (Centers for Medicare and Medicaid Services). 2012. “FY 2011 Louisiana Medicaid: Payment Error Rate Measurement (PERM) Cycle 3 Summary Report.” Washington, DC: Centers for Medicare and Medicaid Services. http://ccf.georgetown.edu/wp-content/uploads/2013/01/LA.Error_.Rates_.Super_.Low_.pdf.

———. 2016. “Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program.” *Federal Register* 81 (91): 29146–56.

Dorn, Stan. 2006. “Take-Up of Health Coverage Tax Credits: Examples of Success in a Program with Low Enrollment.” Washington, DC: Urban Institute.

———. 2014. “Affordability of Marketplace Coverage: Challenges to Enrollment and State Options to Lower Consumer Costs.” Washington, DC: Urban Institute.

Dorn, Stan, Sarah Minton, and Erika Huber. 2014. “Examples of Promising Practices for Integrating and Coordinating Eligibility, Enrollment and Retention: Human Services and Health Programs under the Affordable Care Act.” Washington, DC: Urban Institute.

Dorn, Stan, Margaret Wilkinson, and Sarah Benatar. 2012. “CHIPRA Express Lane Eligibility Evaluation: Case Study of Louisiana’s Express Lane Eligibility.” Washington, DC: Urban Institute.

Government Accountability Office. 2007. “Medicaid: States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens.” GAO-07-889. Washington, DC: Government Accountability Office.

———. 2012. “Tax Gap: Sources of Noncompliance and Strategies to Reduce It.” GAO-12-651T. Washington, DC: Government Accountability Office.

Gulley, Stephen P., Elizabeth K. Rasch, and Leighton Chan. 2011. “Ongoing Coverage for Ongoing Care: Access, Utilization, and Out-of-Pocket Spending among Uninsured Working-Age Adults with Chronic Health Care Needs.” *American Journal of Public Health* 101 (2): 368–75.

Hoag, Sheila, Adam Swinburn, Sean Orzol, Margaret Colby, Brenda Natzke, Christopher Trenholm, Fredric Blavin, Genevieve M. Kenney, Michael Huntress, Brigette Courtot, Ian Hill, Margaret Wilkinson, Stan Dorn, and Sarah Benatar. 2013. “CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings.” Washington, DC: Urban Institute. http://www.urban.org/research/publication/chipra-mandated-evaluation-express-lane-eligibility-final-findings.

Johnson, Eric J., and Daniel G. Goldstein. 2004. “Defaults and Donation Decisions.” *Transplantation* 78 (12): 1713–16.

Olson, Lynn M., Suk-fong S. Tang, and Paul W. Newacheck. 2005. “Children in the United States with Discontinuous Health Insurance Coverage.” *New England Journal of Medicine* 353 (4): 382–91.

Smith, Vernon, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, Molly O’Malley, and Caryn Mark. 2007. “As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008.” Menlo Park, CA: Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured.

Sommers, Benjamin D. 2005. "From Medicaid to Uninsured: Drop-Out among Children in Public Insurance Programs." *Health Services Research* 40 (1): 59–78.

———. 2010. "Enrolling Eligible Children in Medicaid and CHIP: A Research Update." *Health Affairs* 29 (7): 1350–55.

Wishner, Jane B., Sandy Ahn, Kevin Lucia, and Sarah M. Gadsden. 2015. "Special Enrollment Periods in 2014: A Study of Select States." Washington, DC: Urban Institute.

About the Author

Stan Dorn is a senior fellow in the Health Policy Center at the Urban Institute. He focuses on national and state implementation of the Affordable Care Act, including strategies to enroll the eligible uninsured into subsidized health coverage. He has worked on low-income health care issues at the state and national levels for more than 30 years. Before joining Urban, Dorn was a senior policy analyst at the Economic and Social Research Institute, health division director at the Children's Defense Fund, director of the Health Consumer Alliance, and managing attorney at the National Health Law Program's office in Washington, DC. Dorn is a graduate of Harvard College and the University of California, Berkeley, School of Law.

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Research Report

Consumer Decisionmaking in the Health Care Marketplace

Erin Audrey Taylor, Katherine Grace Carman, Andrea Lopez, Ashley N. Muchow, Parisa Roshan, Christine Eibner

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Preface

For this report, researchers conducted a literature review to better understand how consumers make choices about health insurance enrollment and to assess how website design can influence choice when consumers select plans online. The team also considered how such factors as imperfect information and bounded rationality can influence consumers' health plan choices and whether errors in decisionmaking caused by information failures or bounded rationality can be reduced with better website design. In addition to conducting the literature review, the team reviewed 20 health insurance websites, including 14 websites operated by state-based marketplaces, four private health insurance websites, and two public health insurance websites (the Medicare Plan Finder [Centers for Medicare & Medicaid Services, undated (b)] and the California Public Employees' Retirement System website [California Public Employees' Retirement System, 2016]). In reviewing these websites, the team attempted to understand how the design of the sites might influence choices. After a review of the team's findings, the report concludes with a discussion about how websites could be improved to better support consumers' enrollment decisions. We conducted the literature review and the review of the websites in the spring of 2015.

This report will be of interest to policymakers and industry experts involved in designing health insurance websites and researchers who are interested in consumer choice. The work was sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. However, the views, opinions, and findings presented here are ours and should not be construed as official government positions unless so designated by other documents. Questions concerning this report can be addressed to Christine Eibner (eibner@rand.org) or Erin Taylor (etaylor1@rand.org). This research was conducted within RAND Health. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

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Summary

Overview of Study

The Patient Protection and Affordable Care Act (ACA) (Pub. L. 111-148, 2010) introduced the health insurance marketplaces, new online clearinghouses for buying and selling insurance. One of the benefits of the marketplaces is that they enable consumers to compare a large number of health insurance plans and—ideally—select the plans that best suit their needs. In theory, the ability to shop through the marketplaces could both enhance the consumer experience by providing an easy way to comparison-shop across many plans and improve competition by making cost and quality differences across plans obvious to consumers. Consumers with low incomes might be eligible for subsidies for their insurance premiums and possibly for cost sharing, which could help reduce their out-of-pocket costs for coverage. In addition, the ACA encourages consumers to enroll in health insurance plans through an individual mandate that imposes penalties on those who do not have health insurance. Thus, consumers seeking insurance through the marketplaces have an additional incentive to comparison-shop because the status quo of nonenrollment might be an unattractive option.

However, a large body of evidence suggests that health insurance shopping might be overwhelming to consumers because of the complexity of products offered, limited health literacy and numeracy, inadequate decision-support tools, and an excessive number of choices. Consumers might be susceptible to the way choices are presented (e.g., they might be more likely to select plans that are presented first on the website). Limited health insurance literacy and poor numeracy could lead to flawed logic in making choices, such as focusing primarily on premiums without considering total anticipated spending. In some cases, having too many options could lead to fatigue, reducing the probability that a consumer will enroll in a plan at all. Furthermore, when consumers are myopic or not well informed, they might make suboptimal choices that could lead market outcomes to be inefficient.

Although little evidence exists so far regarding whether consumers in fact made poor choices in the marketplaces, there are several possible outcomes associated with poor choices. Consumers who enroll in plans with higher deductibles or other cost sharing than they can afford might forgo health care altogether. Consumers who are not aware of the potential for receiving subsidies for their premiums and cost sharing might choose not to enroll in coverage. And finally, consumers who enroll in plans with expected spending greater than alternative plans could end up spending far more on their health care during the year than they otherwise would have. Thus, website design can have a significant effect on consumers' ability to make good choices of health plans and avoid some of these adverse outcomes.

Some of the challenges associated with online shopping for health insurance could potentially be alleviated by improving web design and enhancing decision support for consumers. For example, sites could eliminate health insurance jargon and explain key terms in plainer language, decision-support tools could nudge consumers to consider total costs rather than just premiums, and default settings could prioritize plans that best meet consumers' needs (e.g., by listing such plans first). For this study, we reviewed the literature on how consumers make choices in the context of health insurance enrollment to determine what plan characteristics matter most, what types of errors in decisionmaking are common, and what (if any) best practices exist for helping consumers make optimal (or at least improved) decisions. We considered in particular whether default settings and other nudges could be used to help enhance the consumer experience and improve the quality of plan choice.

In addition to the literature review, we reviewed 20 health insurance enrollment websites to determine what type of information is presented to consumers, how that information is presented, what types of decision-support tools are available, and how these factors might influence consumer choices. The websites we analyzed included those for the 14 states that operated their own online marketplaces in 2015 (California, Colorado, Connecticut, the District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington), four private organizations that operate websites that aggregate information from the marketplaces (Consumers' Checkbook, HealthSherpa, HealthPocket, and ValuePenguin), and two public agencies that operate websites (California Public Employees' Retirement System and the Centers for Medicare & Medicaid Services [its Medicare Plan Finder website]). In selecting websites, we had a primary goal of analyzing all of the state-based marketplace websites and comparing these sites with a mix of other public and private health insurance comparison and enrollment websites. We selected the sites in conjunction with our client, the U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation. In addition to analyzing the design of the websites and the manner in which they presented choices to users, we assessed how the sites communicated information about subsidy eligibility, the ACA's individual mandate, and potential exemptions from the mandate.

Findings from the Literature Review

Consumers Suffer from Bounded Rationality

Behavioral economics research suggests that consumers can be affected by bounded rationality, in which they might make suboptimal choices because of difficulty processing complex information, fatigue, and other factors that limit critical thinking skills. Bounded rationality could be especially important in the context of health insurance given that products are complicated and the benefits of purchasing insurance are not immediately salient. That is,

insurance protects people against future uncertain events but does not always provide an immediate tangible benefit.

The literature presents examples of bounded rationality that influence health insurance choices. Health insurance consumers are susceptible to choice overload. Particularly in experimental settings, the literature shows, the quality of plan selections falls as more options are added to the consumers' choice set. Consumers are also prone to status quo bias—they stick with initial choices even if prices change or if new, potentially better choices become available. When consumers are selecting plans, studies also show, the order in which choices are presented significantly influences consumers' decisions. Evidence from the Massachusetts Health Connector and elsewhere shows that a consumer is most likely to select the first plan presented on a website display. Additionally, consumers can be susceptible to framing biases, such that the manner in which choices are described can affect decisions. Of importance for the marketplaces is the fact that people prefer plans labeled "gold" even in experiments in which these plans had actuarial values and premiums similar to those of bronze plans.

Consumers Have Limited Health Literacy and Numeracy

Consumers are susceptible to biases stemming from bounded rationality, and their ability to make insurance choices might be hindered by a lack of understanding of key concepts. Studies have shown that many people lack familiarity with such terms as *deductible*, *coinsurance rate*, and *provider network*. Furthermore, low-income and uninsured consumers, the target populations for the marketplaces, have a more-limited understanding of these concepts than higher-income and insured consumers do.

More generally, consumers lack numeracy skills, such as the ability to calculate probabilities, which can be particularly important for understanding insurance. Insurance choices, by definition, require consideration not only of expected costs but also of risk. Even if expenditures were known in advance, calculating out-of-pocket spending requires mathematical reasoning to address the financial implications not only of premiums but also of deductibles, copayments, and other cost sharing. Studies have found that consumers tend to put undue emphasis on premiums in selecting plans, suggesting that they do not fully take into account the impact of cost sharing.

Studies have also found that conveying information on plan quality to consumers is difficult, an issue that is at least partly related to consumers' lack of familiarity with quality metrics, such as the Healthcare Effectiveness Data and Information Set and the Consumer Assessment of Healthcare Providers and Systems. In addition, there are many dimensions of quality, not all of which are important for every consumer, making summary measures relatively unhelpful for some consumers. At the same time, providing detailed information on multiple quality metrics can become overwhelming. Some studies have found that consumers might tend to view price as a proxy for quality.

Some Options to Improve Plan Selections

The literature suggests that it might be possible to improve consumers' choices by simplifying the information presented to the greatest extent possible. Such simplifications could include eliminating jargon and removing extraneous text or information. Some studies have found that people make better choices when price and quality differences are ranked using symbols (e.g., $$$ or ***) instead of actual dollar values or numbers. More generally, some studies have shown, people make better choices when information is presented graphically (as opposed to using text or numbers) and when key information, such as premiums, deductibles, and copays, can be compared side by side. In experimental settings, out-of-pocket cost calculators can improve choice.

Some consumer-oriented organizations and partnerships, including the Pacific Business Group on Health, Enroll UX 2014, and Consumers Union, have made recommendations for website design in the health insurance marketplaces. Suggestions include providing out-of-pocket cost calculators, incorporating provider directories into websites, allowing consumers to sort and filter plans based on key characteristics, and using defaults to strategically nudge consumers toward best-fit plans (e.g., listing such plans first in web displays). Ideally, best-fit plans would be identified based on multiple characteristics that the consumer rates as important, such as total costs, provider networks, and plan quality.

Although these recommendations seem sensible, they are based on evidence from small, experimental studies or extrapolated from such populations as Medicare enrollees. No studies have yet tested whether marketplace websites with these features lead to better outcomes in terms of plan selection.

Findings from the Review of Websites

Our website review documented the design and default settings used by 20 websites. For example, we note that about half the sites we reviewed listed plans with the lowest premiums first, an approach that might induce people to enroll in low-premium plans. However, only two of the 14 state marketplace sites directed subsidy-eligible people into a menu of silver-plan options. Because the value of a subsidy is benchmarked to the premium of the second-lowest-cost silver plan, and because cost-sharing subsidies are available only to silver-plan enrollees, this type of default could improve choices for some consumers. Most sites presented clear and prominent information about individuals' eligibility for subsidies, and most sites included at least some informational materials and tools to allow consumers to learn more about health insurance and decide among various options. For example, the majority of sites provided glossaries of key terms and video tutorials to help consumers navigate the website and learn more about health insurance options. Most sites also allowed consumers to sort, filter, and compare plans on various characteristics.

Three potentially useful tools—out-of-pocket cost calculators, directories of provider networks, and information on plan quality ratings—were only occasionally available on health insurance websites. Only one site, Minnesota's, attempted to assess consumers' preferences and use this information to prioritize plans. Specifically, the Minnesota website asked consumers questions about their health needs and preferences and sorted plans based on a composite metric as a default. Although all sites contained information on the individual mandate and potential exemptions to the mandate, this information was often difficult to find.

Discussion

The literature points to a variety of approaches to improve decisions on marketplace websites. Several recommended design features that we did not typically find in our website review included use of out-of-pocket cost calculators, incorporation of provider directories, provision of plan quality ratings, and use of tailored sorting approaches that allow consumers to identify best-fit plans, such as the "my preferences" approach used in Minnesota.

If well designed, such tools as out-of-pocket cost calculators, provider directories, and tailored sorting options could improve the consumer experience. However, these tools might be difficult to keep current and could be misleading if the information is outdated or incorrect. Among sites that included out-of-pocket cost calculators, most based these calculations on prior utilization, which might be a poor predictor of future utilization, particularly for the newly insured (who might use more care after becoming insured). Studies have found that algorithms used for cost calculators have varied widely. The Massachusetts Health Connector decided not to display out-of-pocket cost estimates on its website because site designers did not believe that there was an appropriate or accurate algorithm to create such a calculator.

The literature review showed that plan quality ratings were particularly difficult to convey to consumers, in part because there are many dimensions of quality, and a summary measure might be of limited use to consumers with specific health care needs. Some consumers were confused about the underlying concepts that quality ratings conveyed—such as the meaning of a high quality rating for vaccination (e.g., does this mean that these doctors provide better vaccines, that they vaccinate more patients, or something else?).

Although consumers often indicate that it is important to them that their doctor be in their provider networks, few websites currently provide integrated provider directories or enable consumers to sort and filter plans based on provider participation in network. Ideally, up-to-date provider directories could be extremely helpful to consumers. But such directories will be only as good as the underlying information supporting these tools. If these underlying data sources become quickly outdated or contain inaccuracies, adding such information might not improve the consumer experience.

The literature also supports using defaults and nudges to attempt to help consumers select the best plan. However, successful application of these tools requires that decisionmakers be able to

identify best-fit plans for consumers. This might be difficult given the many parameters of potential importance and the difficulty of assigning weights to these parameters. For example, determining how much weight should be put on expected spending in a typical year compared with expected spending in a bad year requires an understanding of consumers' preferences for risk. Similarly, effective nudging might require decisionmakers to make an assumption about consumers' willingness to make trade-offs on such dimensions as cost, convenience, breadth of the provider network, and plan quality ratings.

Much of the literature draws from highly stylized experiments in which study participants are presented choices that researchers can easily rank. For example, participants might be presented with a set of plans that vary on only three or four financial dimensions (e.g., premium, deductible, and maximum out-of-pocket spending), and nonfinancial attributes, such as provider networks, are not considered. Consumers might also be told exactly how much health care expenditure they should expect to incur in a given year. With such an approach, it is possible for researchers to definitively determine the best plan for consumers by objectively calculating expenditure under the fixed set of plans. Optimal choices are far harder to determine in real-world settings, in which plans vary on nonfinancial dimensions and future expenditure is uncertain.

In addition, provider directories, quality rankings, out-of-pocket calculators, and nudges toward optimal plans will be only as good as the underlying data used to support these tools. In theory, ensuring that provider directors are up to date should be relatively straightforward because information on providers' participation in plans is necessary for billing. However, there is a lack of consensus regarding how best to convey plan quality information to consumers or how to design an ideal out-of-pocket cost calculator. Developing algorithms to identify best-fit plans might be even more complicated, particularly in the context of health insurance, in which there are many parameters and what is best for one person is not likely to be best for another. More research is needed to determine how to present information to consumers and how to develop plan rankings that are tailored to consumers' preferences and that account for multiple characteristics.

In addition, more research is needed to understand how features of website design influence consumers' decisions to enroll in marketplace plans and what types of plans they select. To date, no study has attempted to determine how specific features of marketplace websites influence consumers' enrollment decisions. Given that websites varied across states and over time, there might be opportunities to use quasi-experimental research designs to determine which features were most effective at nudging consumers to make good choices.

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Abbreviations

ACA	Patient Protection and Affordable Care Act
APTC	advanced premium tax credit
ASPE	Assistant Secretary for Planning and Evaluation
CalPERS	California Public Employees' Retirement System
FAQ	frequently asked question
HMO	health maintenance organization
ID	identification
PBGH	Pacific Business Group on Health
PPO	preferred provider organization
SBM	state-based marketplace

Chapter One. Introduction

Two central goals of the health insurance marketplaces that the Patient Protection and Affordable Care Act (ACA) (Pub. L. 111-148, 2010) introduced are to empower consumers to make choices about their health insurance and to encourage competition among health plans. To accomplish these goals, the marketplaces make substantial changes to the way in which consumers shop for insurance. Traditionally, shopping for health insurance has involved selecting from a limited number of insurance plans available through an employer or on the individual market. Most people with employer coverage face extremely limited options; for example, 50 percent of workers at firms that offer health insurance have access to only one plan, and only 17 percent of covered workers have access to three or more plans (Claxton et al., 2014). Prior to enactment of the ACA, those seeking individual market coverage might have found more plans, but the ability to choose was limited by the underwriting process, which might have led to denials or unaffordable premiums for some shoppers. The ACA's rating and regulatory reforms in the individual market make the same plans available to all shoppers and provide substantial choice. For example, in 2014, the average consumer shopping in the marketplaces had more than 15 plan options from which to choose within the silver tier alone (Taylor et al., 2015). The ACA increases standardization of plans, introduces more choices, and restricts medical underwriting; together, these should make comparison-shopping easier for consumers.

However, the literature in behavioral economics, psychology, and decision sciences points to some important limitations in consumers' ability to engage in comparison-shopping. Behavioral economics departs from neoclassical economics by relaxing the assumption that people behave rationally. Behavioral economics brings together the findings of economics and psychology in hopes of better understanding the choices that people make. In particular, as Simon (1955, 1956) discussed, humans are limited in their ability to make fully rational choices, a limitation often referred to as bounded rationality. Similarly, many are limited by bounded willpower, a tendency to put undue weight on the present relative to the future. Although many behavioral biases have been discussed in the literature, the following are among the most important in the context of health insurance:

- the inability to process all information
- misperceptions of risk and optimism
- limited attention
- aversion to losses is stronger than attraction to gains (loss aversion)
- the tendency to remain in the current status (status quo bias)
- focus on the present as opposed to the future (present bias)
- framing effects (the idea that presenting choices in different ways can lead to different outcomes).

These behavioral biases make consumers susceptible to nudges and make their choices highly contingent on the manner in which options are presented. In their seminal book *Nudge*, Thaler and Sunstein (2008) defined *choice architecture* as the context in which people make decisions and a *nudge* as

> any aspect of the choice architecture that alters people's behavior in a predictable way without forbidding any options or significantly changing their economic incentives. To count as a mere nudge, the intervention must be easy and cheap to avoid. Nudges are not mandates. Putting fruit at eye level counts as a nudge. Banning junk food does not. (p. 6)

The precise design of a website is likely to influence consumer choice through the overall choice architecture, including both intended and unintended consequences. For example, the information displayed, the default sorting of options available, and the number of options will all influence the choices that consumers make. Careful choice architecture can be used to nudge people toward certain choices while still allowing consumers to make autonomous decisions. Thaler and Sunstein (2008) referred to this as libertarian paternalism, the idea that nudges are paternalistic because they are selected to push people toward the best option but libertarian because consumers still face the full set of options.

In the context of shopping for health insurance, the fact that many consumers have limited experience with the services that health insurance is intended to cover could exacerbate difficulties in making optimal choices. For example, most consumers do not make frequent visits to the hospital and therefore might have difficulties assessing the benefits that hospital coverage provides. Second, consumers often do not fully understand the terminology used to describe insurance policies and health care. If consumers do not know what a deductible is, the process of comparing insurance policies becomes more difficult, and they are unlikely to be able to make appropriate choices about health insurance. Furthermore, health insurance plans are expensive. For many, the costs might seem insurmountably high. Finally, low health literacy could limit individuals' understanding of the benefits provided. Because the marketplaces are geared toward previously uninsured households earning less than 400 percent of the federal poverty guidelines, the problems of low health literacy and limited knowledge of insurance are likely to be particularly severe.

A further complication for researchers studying health insurance choices is the difficulty in identifying the optimal choice: the one that maximizes the consumer's utility. This is because health insurance plans can vary the benefit structure on a wide variety of features, and consumers' preference might vary in an even wider variety of ways, including the plan features that matter to them, the relative importance consumers place on these features, and consumers' tolerance for risk. Researchers therefore often focus on dominant plans rather than optimal plans: If two plans are identical in all regards except for premiums and other forms of cost sharing, the one with the lowest out-of-pocket costs for all forms of cost sharing would be considered the dominant plan, while a plan with higher costs is referred to as dominated. For example, when

comparing two plans from the same insurer covering the same network of providers, if one plan has a lower premium, deductible, copay, coinsurance, *and* maximum out-of-pocket costs, it would be considered dominant. Note that this requires that all other aspects of the plan, including the network of providers, are exactly the same. When dominant plans exist, they are plans that all consumers would prefer over the dominated plans, ex ante and ex post, regardless of their utility function. Much of the literature discussed here focuses on hypothetical choice experiments in which researchers can define hypothetical plans to be identical simply by stating, "assume that these plans are identical except for the following features." Table 1.1 provides a simple example of a dominant plan. If all other characteristics, such as benefit design and provider networks, are equivalent, consumers can choose the dominant plan based only on the characteristics shown. In this case, the last option would be dominant because all potential forms of out-of-pocket costs are less than or equal to those that other plans offer.

Table 1.1. Example of a Dominant Plan's Expenses, in Dollars

Monthly Premium	Annual Deductible	Annual Out-of-Pocket Maximum	Doctor-Visit Copay	Generic-Medicine Copay
290	2,000	3,000	25	20
300	2,000	2,500	20	5
310	1,200	3,000	25	20
280	1,000	2,500	20	5

In considering real plans, it might be hard to imagine that such dominant plans exist: Why would an insurer offer two plans if one strictly dominates another? However, as Bhargava, Loewenstein, and Sydnor (2015) discussed, this can happen. It is also important to point out that, when considering which options are optimal or dominant, plans are typically evaluated ex ante—that is, at the time of purchase—to determine which plan is best.

Bounded willpower and present bias can also affect consumers' choices about health insurance. A large literature suggests that people focus on the present. This can lead people to overweight present gains or costs compared with those that occur in the future. This might manifest as procrastination, putting off costly effort, or disregarding future benefits entirely. This can have implications for health insurance, especially if present bias leads consumers to focus too much on premiums and not enough on other forms of out-of-pocket costs, such as deductibles and cost sharing, that are likely to occur in the future. However, the literature on health insurance choices has not addressed these issues.

In much of what follows, we focus on those consumers who were previously uninsured, but, even for those with a good understanding of insurance, calculating the total value of a given health insurance policy is difficult, requiring consideration of premiums, potential out-of-pocket spending, risk, potential eligibility for subsidies, and the value of any benefits that one might receive. In the short run, marketplaces will serve primarily poorer and subsidized consumers, so

their experiences are particularly important. In the long run, the marketplaces could serve a broader population, especially as other marketplaces, including Small Business Health Options Program marketplaces, take off. Although the mix of consumers will change, it will continue to be important to keep in mind the needs of those with the lowest levels of numeracy and health literacy.

Designing choice architecture with these behavioral biases and consumer experiences in mind can help mitigate the potentially negative impact of these complex calculations. For example, providing consumers with the ability to sort and filter options to identify those plans that are most suited to their needs can help reduce the number of plans viewed and thus limit the amount of information consumers have to process. In addition, providing clear descriptions of key features of insurance, with examples, could help address limited knowledge of the jargon in the insurance industry. Some sites have provided total out-of-pocket costs under different scenarios so that consumers do not have to do complex calculations.

The report proceeds as follows: The next chapter describes and discusses the literature on consumer choice in health insurance. We then present the methods and results for the 20 websites we reviewed based on the review of the literature, and the final chapter offers conclusions.

Chapter Two. Literature Review

Background

In this chapter, we review the literature on consumer choice in the context of health care, focusing on how people make decisions and the types of challenges involved. We highlight the existing literature on defaults, nudges, and choice architecture, as well as limitations on consumer knowledge and information. However, we do not limit our search to behavioral economics research; we also review papers that investigate consumer health insurance choices in general. To understand best practices and lessons learned, we also consider how websites and exchanges providing health insurance have been structured in other contexts. Finally, we discuss opportunities and challenges associated with improving online decisionmaking about health insurance plans going forward.

The research on consumer choice of health plans has used a variety of methodologies. Because the implementation of the ACA is still in its earliest stages, little research has been done to assess behavior in the new exchanges. As such, many of the papers discussed here are based on simple laboratory experiments; surveys (sometimes with convenience samples or very small samples); focus groups; qualitative interviews; or choices made in other contexts, such as employer-sponsored insurance, Medicare Advantage, or Medicare Part D. Although these settings are likely to differ from the marketplaces, many of the lessons are generalizable.

In this chapter, we first discuss the methods used for our literature review. Second, we discuss literature on consumer choices. Third, we discuss literature on website design. Finally, we present recommendations from other authors about how to best design choice architecture for health insurance websites.

Methods

We identified literature for this review through three main channels. First, we did a search of online databases, including gray literature. Second, we searched the references of these articles for additional relevant literature. Third, we drew on our own knowledge of the literature.

To obtain peer-reviewed literature, we searched four online databases: PubMed, EconLit, IDEAS, and PsycINFO. Our search covered the time period between January 1, 2005, and February 10, 2015. Search terms included *decision tree*, *decision support*, *decision making*, *choice behavior*, *choice architecture*, *dominated option*, *default option*, *default choice*, *chooser tool*, *consumer tool*, *website*, *nudge*, *menus*, *health insurance*, *Medicare*, *Medigap*, *health plan*, *health insurance exchange*, and *Affordable Care Act*. We also used the bibliographies in these articles to identify additional and relevant literature.

Prominent topics in the literature include analyses of the number of choices affecting consumer behavior, consumers' ability to select the appropriate health insurance plan, and Medicare selection among the elderly.

We searched the gray literature using Google and the Grey Literature Report. We searched the Grey Literature Report using the terms *choice behavior*, *choice architecture*, *menus*, *default choices*, *decision making*, *insurance*, and *health plans*. We ran Google searches using the terms *choice architecture*, *default choice*, *website*, *health insurance*, and *health insurance exchange*.

We also used a snowball methodology, adding to our database relevant papers cited by those found through the above means. We identified relevant articles through the titles listed in the references and through our reading of the first group of articles.

Finally, some of the literature included in our review was based on our own knowledge of the literature on health insurance choice. We have also included some canonical papers in behavioral economics from other settings.

In this review, we have included the most-relevant articles. We excluded articles that did not explicitly address consumers' selection of plans or emphasize behavioral research. However, because this is nascent literature, much of the research is exploratory in nature. We have not limited our review to only those studies that used careful scientific design.

Consumer Choice in the Context of Health Care

Our review of the literature has pointed to some key factors that influence consumers' choices about health care. In what follows, we first discuss how consumers make decisions, focusing on the role of prices and product attributes, the number of choices, and the roles of the status quo and defaults. Next, we discuss challenges to effective decisionmaking in this domain, including the role of choice architecture and the presentation of information, consumer knowledge and awareness, and the complexity of the decision. Finally, we discuss recommendations from the literature on ways to address these challenges.

The literature discussed here has used a variety of different methodologies. First, some have focused on surveys measuring stated preferences, hypothetical choices, or comprehension and knowledge of insurance products to understand what contributes to consumer choice. Stated preference studies provide an opportunity to ask consumers to make choices in a controlled environment, allowing for careful testing of different alternatives. A stated preference survey allows for the opportunity to investigate what matters to consumers. However, these choices are rarely incentivized, so the results might not be generalizable to actual choices. Second, some papers have used incentivized laboratory experiments. Incentivized lab experiments have many of the benefits of hypothetical choice and stated preference surveys, but the results might be more generalizable because consumers are compensated based on the choices that they make. These incentives help to address the external validity of the results; however, if the stakes are very low, the results might not be generalizable. Finally, some papers study actual health

insurance decisions as reported through surveys or administrative data. These papers have the distinct advantage of being based on actual choices; however, in the literature discussed here, few are true field experiments or even natural experiments, so results might represent correlation rather than causation. Furthermore, many take place in very specific settings, such as one employer. Therefore, the results from many of these papers might not be generalizable, which is an important limitation of the literature.

How Do Consumers Make Decisions?

Consumers' choices are, at the most basic level, a function of their preferences, the prices of goods, and those goods' attributes. However, when facing many options, consumers can struggle to make good choices or any choice at all and might be less satisfied with their choices than if they had fewer options. Furthermore, when given the opportunity to not make a choice, consumers have a tendency to stick with the status quo or the default. In this section, we discuss the literature on how consumers make choices in the context of health insurance.

The Role of Prices and Product Attributes

The literature on consumer choice begins in neoclassical economics. Out-of-pocket costs and product attributes influence rational consumers. Cutler and Zeckhauser (2000) provided an overview of the economics literature on health insurance that is still valid today. Although this is a broad literature and beyond the scope of this review, consumers are sensitive to out-of-pocket costs, especially premiums (Feldman et al., 1989; Cutler and Reber, 1998; Royalty and Solomon, 1999; Strombom, Buchmueller, and Feldstein, 2002; Nichols et al., 2004; Marquis, Buntin, Escarce, Kapur, et al., 2006; Marquis, Buntin, Escarce, and Kapur, 2007; Abraham et al., 2006; Buchmueller, 2006; J. Schwartz et al., 2013; Politi et al., 2014). Einav et al. (2013) found that consumers might even select into plans based on the potential sensitivity to cost sharing, to which the authors refer as selection on moral hazard. However, price is certainly not the only factor that influences choices. Consumers are also sensitive to providers included in the network (Shepard, 2015; Tumlinson et al., 1997; Nichols et al., 2004; Ericson and Starc, 2014), benefits (Tumlinson et al., 1997; Romley et al., 2012; Politi et al., 2014), benefit design (Polsky et al., 2005), and perceived quality (Rice et al., 2014; van den Berg et al., 2008).

Furthermore, consumer characteristics influence preferences. Naessens et al. (2008) found that consumers with worse health status are likely to choose costlier plans than those with better health status choose. In a series of focus groups with plan enrollees, Gibbs, Sangl, and Burrus (1996) found that Medicare, Medicaid, and commercially insured populations prioritized different plan characteristics. For example, Medicaid populations mentioned convenience of location as one of their primary considerations in choosing health plans. Medicare enrollees, in contrast, placed a relatively high value on provider choice. The privately insured population placed a higher priority on price than Medicare enrollees did, and they endorsed waiting times and customer service as important considerations in choosing health plans.

Too Much Choice Can Be Difficult to Navigate

Although economic models typically assume that expanding the choice set can only improve welfare, many papers have found the opposite. Supporting the idea that having more options is better, Dafny, Ho, and Varela (2013), for example, showed that, when employees have more health insurance choices, they are more likely to face lower total costs than those with fewer choices do. Similarly, Dafny, Gruber, and Ody (2015) found that, in the first year of the federally facilitated marketplaces, prices were higher in areas with less competition. In contrast, the behavioral literature has focused on the problem of choice overload. *The Paradox of Choice* (B. Schwartz, 2004) discusses this literature, highlighting studies that have found that too much choice can lead to suboptimal decisionmaking and can even reduce consumers' satisfaction with the choices they make. One of the most-cited examples is by Iyengar and Lepper (2000). Consumers in an actual grocery store were given the opportunity to taste one of 24 different types of jam. On another day, they were given the opportunity to taste one of six types of jam. When facing more options, consumers were less likely to make any purchase at all. Choice overload, as it is often referred to, has now been documented in a variety of settings. Nearly all of the literature discussed here supports the results from other domains that choice overload reduces the quality of consumers' choices. Choice overload derives not only from the increasing cost of search as the number of options increases but also from the fear of making an incorrect choice. Many consumers exhibit loss aversion: They weight the costs of loss more than the benefits of gain. For example, they feel that it hurts more to lose $10 than to gain a similar amount, which leads them to work harder to avoid losses than they would to achieve similar gains. Because of this, they might be paralyzed by the possibility of making the wrong choice, and this paralysis worsens as the number of available choices grows. In a less extreme form, consumers might procrastinate, putting off making a choice, because of the complexity of the choice. If consumers procrastinate too long, they might miss the opportunity to make a choice. Choice overload can lead people to choose suboptimally or avoid making a choice altogether and can lead some consumers to regret their choices.

Stated Preferences and Comprehension

Several papers have used data from surveys asking consumers to evaluate different insurance plans, either to choose the best plan or to report which plans meet certain criteria.

Hanoch and coauthors conducted several related studies using examples based on Medicare Part D. Hanoch, Rice, Cummings, et al. (2009) surveyed 192 people of all ages and asked respondents to review three, ten, or 20 plans and then select the one that met specific criteria, such as lowest cost, and answer other factual questions about the plans. Increasing the number of plans significantly reduced the number of correct answers. Hanoch, Wood, et al. (2011) used a computer-based program to assess how people compare information and plans. The survey asked 150 respondents of all ages to assess either three or nine plans for a hypothetical friend. Respondents had to click on different boxes to reveal each attribute of each plan. Increasing the

number of choices decreased the likelihood that consumers selected the lowest-cost plan, for an average loss of nearly $50 per month. Furthermore, consumers investigated a smaller share of the available information as the number of plans increased. Hanoch, Rice, Cummings, et al. (2009) and Hanoch, Wood, et al. (2011) found that the quality of answers declined with age. Wood et al. (2011) conducted a similar experiment to the two above, with 121 adults of all ages, adding a detailed cognitive battery. The survey asked each participant to choose a plan that was either the lowest-cost plan or lowest-cost plan that included a mail-order option for prescriptions. The authors found that the number of participants who found the correct option decreased as the number of choices increased and that, like in the other studies, the quality of the answers declined with age. After controlling for cognitive function, they found that age no longer influenced the quality of choice but that numeracy continued to affect choices.

Bundorf and Szrek (2010) conducted a hypothetical choice experiment with 295 members on an online Internet panel. The survey asked respondents to select Medicare Part D plans and answer key questions about these plans in settings with two, five, ten, or 16 plans. Although the authors did not find evidence that the number of choices led to paralysis (choosing not to choose, like in Iyengar and Lepper, 2000), they did find that the number of options reduced the quality of choice. In a similar study, Szrek and Bundorf (2014) investigated the role of numeracy and choice-set size. The authors found that more-numerate adults make better choices when faced with smaller choice sets than less numerate adults do but that these differences disappear when the size of the choice set increases.

Barnes, Hanoch, and Rice (2015) conducted a hypothetical choice experiment with 276 tech-savvy uninsured people who use Amazon's Mechanical Turk[1] and 161 uninsured rural Virginians. The survey included information about health status, health care utilization, numeracy, risk and time preferences, and a hypothetical choice task. The authors found that a larger choice set increases the likelihood of choosing a plan that costs $500 or more than the lowest-cost plan and that comprehension of insurance mediates these effects.

Johnson, Hassin, et al. (2013) conducted six experiments to assess consumers' ability to make health insurance choices. In each experiment, the authors compared the quality of decisions when given four or eight options and found that decision quality improves when the number of options is limited to four.

Mikels, Reed, and Simon (2009) surveyed 53 college students and 53 older adults recruited at senior centers to measure their willingness to pay for access to five, ten, 25, or 55 Medicare Part D plans. The authors found that older adults place a lower value on having more options

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[1] Amazon's Mechanical Turk is an online marketplace in which requesters can hire workers to complete small tasks. Although most of the tasks are actual *tasks*, such as coding or sorting files, researchers are increasingly using the setting to field surveys and conduct experiments. The advantages of using Mechanical Turk include the ability to quickly recruit subjects and very low costs. Barnes, Hanoch, and Rice paid respondents a total of $1.25. One concern is that Mechanical Turk workers are unlikely to be similar to a general population.

than younger adults do. However, these results could be related to familiarity with the product; few college students are likely to be well informed about Medicare Part D and therefore might not appreciate the complexity of the choice.

Tanius et al. (2009) randomized a group of 192 adults to one of two Medicare Part D plan choice conditions: The first group received six plan choices, including one strictly dominant and one strictly dominated plan, and the second group received 24 plan choices, including one strictly dominant and one strictly dominated plan. People randomized to the first group were more likely to select the strictly dominant plan than people in the second group.

An important weakness of each of these studies is that they based their results on unincentivized choices. Furthermore, in the exchanges, the average consumer faces 15 plans in the silver tier alone. Thus, the choices that participants had in these experiments involved far fewer options than consumers have in the ACA exchanges.

Incentivized Experiments

Improving on these methods, several studies have used incentivized experiments to assess choice overload. Johnson, Hassin, et al. (2013) added incentives to one of the experiments to assess whether compensating people for making better choices improves their decisionmaking in a setting that mimics health insurance choices, but the authors found that incentives did not improve outcomes. This could be due to the size of the incentives; those choosing the most cost-effective plan earned an additional dollar and a chance at $200. Although small incentives can improve decisions in experiments, these incentives are significantly smaller than the potential cost savings associated with choosing a better option in the health insurance exchanges.

Schram and Sonnemans (2008) studied the effect of increasing the number of choices among Dutch consumers. The researchers asked 148 respondents to review four or ten policies. Like Hanoch, Wood, et al. (2011), Schram and Sonnemans allowed participants to reveal information about each policy by clicking on a separate box for each attribute, allowing the researchers to observe precisely how much information they used. A unique feature of this study is that the plan attributes were based on the costs associated with five different potential health outcomes of varying degrees of risk and cost. The survey asked respondents to select insurance over the course of 35 periods, with the probability of the different health outcomes varying over time. In each period, a health outcome was selected randomly. The authors found that increasing the number of options reduces the fraction of information boxes that participants clicked and decreases the quality of their decisions. They also found that consumers are less likely to switch plans, exhibiting status quo bias that we discuss in more detail below.

A limitation of many of the experimental studies (both with incentivized and hypothetical choice designs) is that, when comparing consumer choice with a small or large number of options, an implicit assumption of the research is that both the large and small choice sets will contain the so-called best plan. In reality, a larger choice set might be more likely to contain the

optimal plan for a given individual because larger choice sets can include a wider variety of options.

Real-World Settings

Confusion over too much choice has been found in real-world settings, as well as the survey and experimental settings above. Informed by on interviews with 33 young adults who were navigating the HealthCare.gov website in real time, Wong et al. (2014) found that respondents were overwhelmed by the amount of information provided. The Massachusetts health reform experience also revealed that consumers might prefer fewer choices and standardization of plan benefits. Accordingly, regulators in the state reduced the number of plans offered on the Massachusetts Health Connector over time; simultaneously, plan benefit designs were increasingly standardized (Day and Nadash, 2012).

McWilliams et al. (2011) examined the effect that the increase in the number of plan options and plan generosity has on the likelihood of Medicare beneficiaries to enroll in a Medicare Advantage plan, using real-world data on enrollment and plan numbers for U.S. counties. An increase of fewer than 15 plans in a county significantly increased enrollment in Medicare Advantage, while an increase of more than 15 plans was associated with no significant (16 to 30 plans) or negative (more than 30 plans) enrollment effects. Plan generosity did significantly increase enrollment for beneficiaries with high cognitive function but had no effect for those with low cognitive function.

For a new paper, Bhargava, Loewenstein, and Sydnor (2015) assessed the quality of health insurance decisions made by more than 50,000 employees of a single firm who were permitted to build their own health plans based on a standardized menu that included a significant share of financially dominated options. Employees were given the opportunity to select options along four cost-sharing dimensions (deductible, out-of-pocket maximum, copay, and insurance), such that the 48 options presented to them differed in terms of cost sharing and premiums but were otherwise equivalent across all remaining dimensions, including the network and services covered, and, in that sense, constituted a comparatively simple choice set. The choice architecture that all employees saw included the use of visual nudges, real-time learning tools, and deliberate design decisions to increase the ease of comparing plans. The authors found that the majority of employees chose dominated options. By choosing a dominated plan, these employees spent an extra $373 per year on average. Using several hypothetical choice experiments, the authors also found that the structure, size, and complexity of a choice set significantly affect the quality of health insurance decisions but that health literacy and numeracy are arguably more important indicators of individual decisions.

The results presented in this section suggest that consumers struggle when faced with too many choices. Many of the papers report that consumers are more likely to make suboptimal decisions as the number of choices goes up. This is in contrast to the standard economic models that predict that more options should improve welfare because more people will be able to find a

product that suits their preferences. Taken together, these results suggest the need for careful choice architecture that helps consumers sort and filter to reduce the number of options that they must consider.

Status Quo Bias and Default Bias

When facing a complex choice, many seek to minimize their effort. One way to do that is to make no choice at all. This behavior can result from one of two closely related biases documented in the behavioral economics literature. The first is status quo bias, the idea that, rather than making a new choice, one sticks with the current status. Samuelson and Zeckhauser (1988) first defined this phenomenon. One of the authors' main examples was in the context of the health insurance choices that Harvard University employees made. The authors noted that, when new health insurance plans were offered and other plans were retained, the choices that new employees made differed from the choices made by incumbent employees, who had first enrolled in insurance several years prior. Some refer to status quo bias as inertia. Status quo bias can result from loss aversion: People perceive that the losses associated with a change would have a greater impact on them than the gains would. Status quo bias might also be the result of procrastination: People might intend to make a change but never get around to implementing it. In practice, it is difficult to disentangle different explanations for the tendency to prefer the status quo; in particular, consumers might face switching costs that limit their willingness to change insurers. Researchers might perceive that consumers are unwilling to switch to a dominant plan, when, in fact, the reason for not favoring the dominant plan is that the switching costs are too high. These switching costs can result from access to specific providers.

The second related bias is the default bias. Default bias also arises from making no choice but does not rely on the previous status. The most-famous examples of default bias are in the contexts of organ donation and 401(k) saving plans. Johnson and Goldstein (2003) showed that, in countries where people have to opt in to organ-donation programs, organ-donor rates are significantly lower than in countries where people have to opt out. Similarly, Madrian and Shea (2001) described an employer that changed the default for 401(k) enrollment. Rather than actively choosing to join the 401(k), employees had to actively choose to *not* join. This raised participation rates dramatically and was found to be so powerful that many companies now automatically enroll employees in 401(k) saving plans. Default bias might be particularly common in situations in which consumers experience choice overload. Default bias can also be a consequence of fear of regret: People are so concerned that they will make a bad choice and regret it that they prefer to make no choice at all.

Status quo bias and default bias are not always distinguished in the literature; this is in part because, in many cases, the default is to stay in the status quo. However, there is no requirement that the status quo and the default be the same. Consumers who are defaulted away from the status quo might still prefer to stick with the status quo. Furthermore, defaults can exist even when there is no status quo.

Each of these two biases can influence health insurance choices. Many already enrolled in insurance plans might stay enrolled in dominated plans as new plans become available. This could be due to status quo bias or default bias. In many settings, the default is that, if no active choice is made, one remains enrolled in the same insurance plan. There might be status quo bias even when active choice is required; many will stick with the same plan or insurer. For those not currently enrolled, the default is to remain unenrolled.

Most of the work in this area relies on real-world data; however, we found one incentivized laboratory experiment that investigates status quo bias in health insurance choice (Krieger and Felder, 2013). In one arm of the experiment, participants were defaulted into their insurance choice from the previous round; in the other arm of the experiment, they had to make a new choice each round. The authors did find evidence of a status quo bias, but this bias diminished over time. However, these results might differ from those in the real world because participants in an experiment learn much faster, making four choices in 90 minutes, rather than one choice per year. Additionally, after repeating the same game, they might seek novelty and switch plans just for the sake of switching.

Strombom, Buchmueller, and Feldstein (2002) studied insurance choices made by employees of the University of California system. The authors found that new and incumbent employees make substantially different health insurance choices. However, they found that new and incumbent employees are similarly price sensitive, suggesting that "many individuals pay closer attention to enrollment materials when they first sign up for coverage" (p. 114). We interpret this to suggest a default bias: Employees are less likely to make choices when they are defaulted into their existing plans.

Frank and Lamiraud (2009) studied the effect that the number of choices available has on insurance-plan switching in Switzerland. In Switzerland, consumers are required to purchase health insurance on the private market. Insurance policies are standardized in many ways, which should allow for frequent switching between plans based on cost. Over the period of the study, the average number of options for health insurance grew from 39 per canton to 52. This could potentially increase choice overload. The authors identified very low switching rates, typically less than 5 percent. They considered several possible explanations for consumers switching or not switching policies. First, consumers might seek to maximize expected utility taking into account the costs of search and thus switch when the benefits of lower-cost insurance outweigh the costs of search. Second, choice overload, either due to the costs of choosing or the fear of choosing the wrong option, could lead consumers to stick with the default option. Finally, status quo bias might limit switching. The authors found that switching is more common in areas with fewer health insurance options, suggesting that status quo bias and choice overload might interact. They also found that consumers new to a particular market make very different decisions from those who have lived in the area for a while.

Sinaiko and Hirth (2011) studied health insurance choices at the University of Michigan following the introduction of a new plan that strictly dominates an existing plan. Like Samuelson

and Zeckhauser (1988), the authors found that new employees make very different choices from those of incumbent employees, with incumbent employees much more likely to stick with the status quo and new employees more likely to choose the dominating options.

Handel (2013) built on the papers above; the author looked at a company where employees are observed in periods in which they can default into the status quo and periods in which they must make an active choice. As in the other papers, he observed that, when incumbent employees can stick with the status quo, they make very different choices from those of the new employees. Using a structural model, he estimated that people forgo, on average, more than $2,000 per year because of inertia.

Ericson (2014) looked at Medicare Part D choices in which the author found that many consumers stick with the initial defaults for long periods of time. The inertia makes consumers susceptible to paying higher premiums over time because insurers might raise the price of their products, possibly in response to consumers' inertia.

All of these papers find very low switching rates between insurance plans. Status quo bias, as well as switching costs and choice overload, is likely to keep switching rates low over time. Although consumers might be better off switching plans, this behavior is rare.

What Is the Appropriate Choice Architecture? Challenges to Effective Decisionmaking

A central premise of *Nudge* (Thaler and Sunstein, 2008) is that choice architecture, or how options are presented, matters. In designing health insurance marketplace websites, one must be aware of how consumers respond to different information. Although no one paper has carefully studied all of the choices that go into designing the choice architecture for health insurance marketplaces, there are some important areas to keep in mind. The presentation of risk, quality information, and cost structure can all influence choices, as can the total amount of information being conveyed.

Appelt et al. (2014) found that consumers choose health insurance plans that meet more of their stated preferences when presented with plan options in a manner that simplifies the options available than when choices are presented without a specific choice architecture. However, the authors also found that consumers prefer the choice architecture that presents more information, in direct contradiction to the fact that they chose the better option in the simplified environment.

Uhrig et al. (2006) conducted a hypothetical choice experiment that attempts to address many of the issues of choice architecture surrounding health insurance. The experiment compared three information settings that differ in terms of color and the use of pictures, quotes, stars, or graphs to convey information about health plan costs and quality. Although the authors found that one of their settings helps people to make better choices, their experiment is difficult to interpret. There are so many differences between their three treatments that it is difficult to know what to recommend. This paper speaks to the difficulty of designing an appropriate choice architecture for such a complex product. So many factors can be varied, and the factors can interact with each other. Careful experimentation is necessary to draw meaningful conclusions.

Framing and Labeling Affect Consumer Choices

The way in which information is presented can influence consumers' choices. Presenting numbers rather than symbols, the choice of words to describe product, and even the time frame for calculating premiums can all influence choices.

In a recent paper, Ubel, Comerford, and Johnson (2015) pointed to the importance of labels and the way in which price information is reported. In their first experiment, the authors asked consumers to make an unincentivized hypothetical choice between gold, silver, and bronze plans; however, for half the consumers, the authors switched the labels on the gold and bronze plans, so that gold plans were less expensive and provided lower actuarial value. They found that respondents with low numeracy are more likely to choose gold plans regardless of the actuarial value. Second, they investigated whether displaying premiums at a monthly or weekly level affects price sensitivity, again in an unincentivized hypothetical choice experiment. They found that respondents were more sensitive to equivalent price differences when prices were presented at a weekly level.

Barnes, Hanoch, Wood, and Rice (2012) conducted a hypothetical choice experiment using a sample of 126 adults of all ages that investigated the effects that price framing, brand names, and choice-set size have on the selection of Medicare Part D plans. When prices were represented by symbols ($ to $$$$, with $ indicating a low-cost plan and $$$$ indicating a high-cost plan), the authors found that more people selected the lowest-cost plan than when the dollar amount of the price was presented.

Order Matters

The default sort on a marketplace website is likely to influence consumers' choices. Citing Brockington (2003) and Lynch and Ariely (2000), Ubel, Comerford, and Johnson (2015) noted that the ordering of information on a page significantly affects choice. Brockington (2003) looked at the effect that ordering has on political ballots; the author found that those at the top of the ballot are more likely to win. Lynch and Ariely (2000) looked at on the ordering of wine on a wine list; the authors found that people are more likely to select the first wine.

In the context of health care, Ericson and Starc (2012) found that, in Massachusetts, many select the first plan. The authors point out that plans are sorted by premium. However, we note that it is not possible to tell whether people are selecting the cheapest option or the first on the list. Furthermore, sorting on premium might suggest to some consumers that premium is the most relevant factor to consider in choosing a health insurance plan, minimizing the role of out-of-pocket expenditures and other factors.

Information on Plan Quality Is Difficult to Convey to Consumers

Effectively providing information on quality can prove to be very difficult. In the case of health insurance and health care, quality can be measured on many attributes. Quality of both insurers and providers can influence consumers' choices, but that information must be displayed

in a way that is easy to understand. Providing too many quality measures can increase choice overload. Using symbols can help consumers better comprehend quality information, as discussed above in the context of Barnes, Hanoch, Wood, and Rice (2012) and below in Peters, Dieckmann, et al. (2007).

Kolstad and Chernew (2009) reviewed the literature on quality and consumer choices of health insurance and health care. Although the authors' reading of the literature suggests that conveying quality information can help consumers to make better choices, they point out that these effects are concentrated among a subset of the population. They point to two papers, by Jin and Sorensen (2006) and Dafny and Dranove (2008), that suggest that consumers seem to make choices on the basis of quality information that is not explicitly provided, perhaps because they are seeking quality information on their own or because the formal measures of quality are correlated with consumers' perceptions of quality.

However, other studies have found that people have difficulty understanding and effectively using information on quality, even when it is directly presented to them. For example, Gibbs, Sangl, and Burrus (1996) found that focus-group respondents had concerns that information conveyed could be biased, especially if the health plans had provided the information. Consumers also noted challenges with ratings that are too closely grouped—e.g., if every plan gets four or five stars, the information is not particularly valuable. Finally, in some cases, consumers interpreted information differently from how it was intended. For example, Medicare beneficiaries raised a concern that plans with low rates of hospitalization for pneumonia were failing to admit patients in need of care. Consumers perceived other indicators, such as childhood immunization rates, as being primarily determined by the patient rather than the plan or provider and therefore not informative.

Using data from the United Kingdom, Hanoch and Rice (2011) reported that few patients use hospital quality information to make decisions. Possible reasons include difficulty in understanding the information, lack of standardized measures, and poor communication of information. Harris-Kotejin et al. (2007) described a similar issue in the United States, noting that Medicare beneficiaries have traditionally shown limited interest in using comparative quality information when selecting health plans.

Several papers on quality of health *care*, rather than health insurance, point to the importance of how quality information is presented in a related context. Peters, Dieckmann, et al. (2007) described several experiments that change how quality information is presented. The authors' overall conclusion is that less is more: Limiting quality information to the most-relevant measures and using clear symbols to make information easier to interpret can help people to better comprehend quality information. In one experiment, they used simple symbols to rate hospitals based on the number of registered nurses per 100 patients. Without a reference point, it was difficult for consumers to decide whether 21 nurses per patient was excellent, adequate, or subpar. Because a symbolic rating was included, consumers could easily interpret this information.

Also in the context of quality of health care, Hibbard, Greene, et al. (2012) pointed out that many consumers interpret cost as a signal of quality. Extrapolating from this, we would not be surprised if consumers interpreted low costs for insurance as a signal of low-quality insurance as well. If consumers evaluating particularly low-cost health insurance plans assume that the low cost is obtained by contracting with low-cost providers, they might be less likely to select these plans.

Spranca et al. (2007) presented a cautionary tale about providing too much information. The authors conducted a hypothetical choice experiment in which they investigated the effects of providing detailed quality information from Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems, as well as information about the number of plan participants who disenroll. They found that providing information on disenrollment can cause consumers to underweight important quality measures from the Consumer Assessment of Healthcare Providers and Systems and the Healthcare Effectiveness Data and Information Set. Quality measures are particularly susceptible to overprovision because there are many possible measures of quality, each of which might be valuable to different consumer types. Therefore, it is crucial to balance providing helpful information with the possibility of providing too much information.

Consumers Lack Awareness and Understanding of Health Insurance Concepts

Choosing a health insurance plan requires consumers to compare plans based on such characteristics as deductibles and copays. To compare plans this way, consumers must understand these concepts. However, research suggests that they do not.

Using survey data from the RAND American Life Panel, Barcellos et al. (2014) found that 42 percent of Americans ages 18 to 64 could not correctly describe a deductible, and 62 percent did not understand key differences between health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Health insurance knowledge was lower among low-income people than among other populations.

Loewenstein et al. (2013) found similar results in a survey of insured adults; in particular, many do not understand coinsurance. The authors found greater levels of knowledge than Barcellos et al. (2014) did, likely because Loewenstein et al. surveyed only those with insurance, while Barcellos et al. surveyed a representative sample. Using these results, Loewenstein et al. designed a simplified health plan that involved only copays, eliminating coinsurance and deductibles, and used a stated preference survey to estimate potential demand for such a product. Their results suggest that consumers would better understand these simplified plans but that there might be limited demand for them. We suspect that this limited demand might be the result of the simplified plan's unfamiliarity to respondents and because even the simplified plan was complex, with different prices for different types of services.

Consumers Union conducted a series of focus groups and in-depth interviews about consumer knowledge (Quincy, 2012a). It similarly found that many consumers do not understand

the jargon used to describe health insurance plans or how to combine the information available to make a good choice.

Politi et al. (2014) reported, following a small survey of uninsured, predominantly low-income people in St. Louis, significant confusion about such terms as *coinsurance*, *deductible*, *out-of-pocket maximum*, *prior authorization*, and *formulary*. Lack of knowledge was particularly pronounced among people who had never had insurance. Barnes, Hanoch, and Rice (2015) reported that those with greater health insurance comprehension are likely to choose lower-cost plans.

Older surveys of the Medicare-eligible population have found similar challenges related to health insurance literacy. For example, among a sample of Medicare beneficiaries living independently, Hibbard, Jewett, et al. (1998) found, 30 percent had no understanding of the difference between Medicare HMOs and traditional Medicare. Even among respondents who understood this basic difference, only 16 percent had adequate knowledge to effectively choose between an HMO and traditional Medicare.

Given this broad evidence on the difficulties many have understanding health insurance, it is important that consumers be provided with easy-to-understand explanations. Although many can identify the correct definition of *deductible*, for example, explaining terms clearly and keeping in mind low levels of literacy among some subsets of the population is crucial. Furthermore, these problems must be kept in mind when designing choice architecture; providing information might not be sufficient.

Consumers Need to Understand Probability and Risk

Understanding health insurance options might also require people to make numerical calculations and to understand and assess the value of avoiding risk. Yet many Americans lack the basic math skills needed to make these comparisons. In a summary paper commissioned by the Institute of Medicine, Peters, Meilleur, and Tompkins (undated), reported major deficiencies in numeracy in general and health numeracy in particular. For example, the majority of Americans cannot translate a 1-in-1,000 chance into a percentage (Galesic and Garcia-Retamero, 2010). Numeracy rates are lower among those who are uninsured, with only 8.6 percent estimated to be proficient in basic math (Peters, Meilleur, and Tompkins, undated; Apter et al., 2008). Bundorf, Mata, et al. (2013) conducted a hypothetical choice experiment in which researchers asked a representative panel of respondents to choose between two Medicare Part D plans for a hypothetical friend. The task was repeated two times. The experiment had a 2 × 2 design: Some saw a graphical representation of risk, while others received text-based information, and some received an abstract description of the friend's health, while others received a specific diagnosis. In each task, respondents could choose between plans that offered more or less protection from risk. They then measured whether choices were consistent across the two tasks. Although most people were consistent, more were consistent with the graphical

version of the task than with the textual one. When communicating complex risk, a graphical depiction might help some consumers.

The Decision Is Complex

If consumers understand the jargon used to describe insurance, then, to fully determine which is the best option in terms of cost, consumers might want to know how much the plan would cost under different scenarios. Although comparing premiums is relatively simple, to calculate total expected out-of-pocket costs, one must combine estimates of the probability of illness and the potential costs of treatment. Furthermore, to fully compare plans, consumers must decide how to weight provider networks and quality ratings, which can be difficult for many people. More broadly, health insurance plans differ on many characteristics, further complicating the comparisons consumers must make and adding to the difficulty in weighting the various dimensions of coverage.

Greene et al. (2008) conducted a hypothetical choice experiment to test different ways of presenting information to consumers about high-deductible health plans and PPOs. Some saw a side-by-side comparison, while other saw a table that explained how the plans were similar and how they were different. Some participants were provided a framework to help them understand the advantages and disadvantages of the high-deductible plan. The survey asked participants six knowledge-based questions about the plans, which plan they would be more likely to choose, and how easy it was to understand the information about the plans. The authors also measured participants' numeracy and literacy. The side-by-side comparison led both the highly numerate and less numerate people to get more answers correct on the knowledge question than the table explaining similarities and differences. However, the more numerate reported greater subjective understanding of the material with tables. The framework provided information on a limited number of attributes of plans. Providing the framework improved comprehension of those attributes covered but reduced comprehension of those attributes not covered, suggesting that it led people to focus on the attributes covered in the framework. The authors concluded that the study highlighted "the difficulty many consumers have in understanding comparative plan information and making informed health care choices" (Greene et al., 2008, p. 369).

Johnson, Hassin, et al. (2013) added a cost calculator in two of their experiments and found that this improved choices. In another experiment reported in the same article, the authors provided just-in-time education on health insurance choices in conjunction with calculators. Just-in-time education is targeted to consumers when they most need it rather than providing education with the expectation that it will prove valuable at some point in the future. The authors found that just-in-time education did not improve choices but that cost calculators did.

Handel and Kolstad (2015) used detailed administrative data on health insurance choices and claims with survey data to estimate a structural model of how consumers make choices. The data came from a large employer. This allowed the authors to separate risk attitudes, information, and perceived hassles associated with different plans. Previous research suggests that consumers are

very risk averse; however, by building a model with all of these features, the authors found that risk aversion is capturing consumers' limited information. So many factors enter into consumers' choices that it is difficult not only for consumers to make choices but also for modelers to accurately model the decision process. In particular, the authors found that, in this setting, consumers' limited information about high-deductible health plans causes them to underutilize these plans.

Ericson and Starc (2013) took advantage of a policy change in the Massachusetts Health Connector that required insurers to standardize the characteristics of the plans they offered and limit the plans to seven defined options based on such characteristics as copays and deductibles. After the reform, plans were still free to set their own premiums and define the network of providers covered. This reform not only altered the plans offered but also changed how plans were sorted; prior to the reform, all plans were sorted by premium, and, since the reform, the consumer picks a tier of insurance and then sees plans. Following this reform, consumers selected more-generous health insurance plans. These results suggest that simplifying the choice set changed the way in which consumers compared plans. With plan standardization, consumers were better able to compare plans, and the types of plans they selected changed. The authors point out, "standardization may alter decision utility because it shifts consumers attention (DellaVigna, 2009) or changes the salience of product characteristics (e.g., as in Bordalo, Gennaioli and Shleifer, 2012)" (Ericson and Starc, 2013, p. 3).

Some papers have examined the choices Medicare beneficiaries make in the context of either the Medicare prescription drug benefit (Part D) or Medicare Advantage programs. These programs offer Medicare beneficiaries a variety of options for their medical and prescription drug coverage, run by private insurers. The benefit design and variations across plans in both Medicare Advantage and Part D create a complex choice for Medicare beneficiaries deciding on a plan.

Economists focus on minimization of out-of-pocket costs as the determinant of whether a consumer selects the best plan. Abaluck and Gruber (2011) used prescription drug claims data matched to Part D plan benefit design information to examine whether beneficiaries chose the Part D plan with the lowest out-of-pocket costs. Results indicated that only a small proportion of beneficiaries ended up choosing the lowest-cost plan in their areas. Further, the authors ran a multinomial choice model to estimate the effect that individual and plan characteristics have on Part D plan choices. The authors found that Medicare beneficiaries placed more weight on premium than they did on the expected out-of-pocket costs associated with the plan and that they placed too much emphasis on plan characteristics (e.g., deductible and plan quality) as opposed to considering their individual cases and requirements for coverage. This suggests that Medicare beneficiaries are making their Part D plan enrollment decisions based on incomplete information, a situation the authors suggest could be remedied by providing additional information about expected plan costs.

Heiss et al. (2013) used Medicare claims data to estimate beneficiaries' total out-of-pocket costs (premium plus cost sharing) for both the plan in which they are enrolled and alternative plan options. The authors found that beneficiaries usually did not choose the lowest-cost plan and, as a result, spent an average of $300 more per year than they would have had they chosen the lowest-cost plan. The lowest-cost plan in this case was the option that would have been presented on the Medicare Plan Finder had the beneficiary taken time to enter his or her drugs into the online tool. As a result, the authors suggested that encouraging the use of the Plan Finder tool and its associated out-of-pocket estimates might help beneficiaries select the best plans in terms of expected out-of-pocket costs.

Another aspect of the choice complexity problem is the process that Medicare beneficiaries and consumers in general use to screen and then select their plans. Li and Trivedi (2012) examined Medicare beneficiary choices of Medicare Advantage plans using a screening model that assumes that every beneficiary goes through a stage whereby he or she screens all available plans. From the screening phase, a beneficiary reduces the choice set by including only those plans that fulfill the beneficiary's requirements on all plan characteristics. The authors found that Medicare beneficiaries tended to screen the full choice set based on premium, drug coverage, and vision coverage (in that order) but that, once the choice set is established, these characteristics do not play an important role in the final choice of plan. Because screening is an important part of the choice process in a market in which many choices are available with lots of information and attributes, presentation and marketing of plans can have an important impact on the ultimate choice of plan.

Kling et al. (2012) conducted an experiment designed to determine whether Medicare Part D enrollees chose to switch to lower-cost Part D plans when mailed printouts showing their expected out-of-pocket costs in their current plans compared with the lowest-cost plans in their areas. The authors found that 28 percent of beneficiaries switched plans when mailed the expected cost information, while only 17 percent of beneficiaries who received only mailings with the link to the Medicare Plan Finder tool switched plans. Because the same cost information could be obtained from the Plan Finder tool, these results suggest that reducing the costs associated with comparing alternative options (called comparison friction) might assist beneficiaries in making better decisions about their health plans.

For a report similar to the work on Medicare, in the context of employer-sponsored insurance, Atanasov and Baker (2014) investigated the barriers to selecting high-deductible plans using a survey of employees from a single large employer. Although many realized that the high-deductible plan could save them money, only 3 percent of employees selected this plan. The most significant barrier was the perception that the network of providers would be limited with the high-deductible plan, when in fact the providers were the same. This result suggests that many lack information about the details of the plan and that, in lacking that information, they miss out on the opportunity to save money.

Summary

Overall, effective decisionmaking when purchasing health insurance is challenging in many ways. Consumers are easily swayed by the framing of information and the sorting of plans. Many lack the knowledge needed to understand the products being offered. Furthermore, the choices are complex, involving many possible scenarios and the need to understand risk and probabilities. Keeping these challenges in mind when designing choice architecture is crucial.

Furthermore, because of the numerous challenges discussed in this section, it is possible that insurers might take advantage of consumers' bounded rationality or limited information. In a general context, Gabaix and Laibson (2006) developed a model of "shrouded attributes" in which firms can exploit consumer myopia and complexity of the decision. They do this by obscuring (or shrouding) attributes that might be particularly important in selecting a product. Some consumers might not realize that these characteristics are important and might unwittingly purchase a suboptimal product. The authors showed that this could lead to allocation-related inefficiencies. If this is the case, competition might not succeed in producing efficient market outcomes with low prices for consumers. Markets for health insurance are potentially at risk for this behavior because of the complexity of the product.

Previous Research on Health Insurance Website Design

Two aspects of the health insurance market have influenced website design for the marketplaces. The first are regulations, at either the state or federal level, that impose requirements on the design of the insurance market in the state or nation. These requirements can affect the number of choices available and the design of the plans offered and can therefore influence the consumer's decisionmaking process. The second aspect is consumer research on specific design aspects for the websites. This section briefly describes some key regulations that can affect choice in the marketplaces, then discusses the development and evaluation of marketplace plan websites.

Marketplace Regulations Affect Website Design and Choices

Regulations placed on marketplaces at the state and federal levels can affect website design or choice sets. Monahan et al. (2013) detailed some of the regulations that states operating their own marketplace websites have implemented to simplify consumers' choice environments. Table 2.1 shows the states that have taken three types of actions. Nine states have limited the number of plans or benefit designs that insurers can offer, six states have standardized benefit design, and eight states have required that each of an insurer's plans differ substantially from its own other plans offered in a given market. Each of these regulations is designed to make it easier for consumers to compare plans. Limiting the number of options helps to avoid choice overload. Standardized benefit designs limit the number of attributes of a plan that consumers have to

compare. Finally, requiring substantial differences between plans should make differences more salient to consumers.

Table 2.1. State Actions to Simplify Consumer Choices in the Marketplace

State	Limited the Number of Plans or Benefit Designs	Standardized Benefit Designs	Adopted Meaningful-Difference Standards
California	x	x	x
Colorado			x
Connecticut	x	x	x
Kentucky	x		
Maryland	x		
Massachusetts	x	x	x
Nevada	x		x
New York	x	x	
Oregon	x	x	
Utah			x
Vermont	x	x	x
Washington, D.C.			x

SOURCE: Monahan et al., 2013.
NOTE: Not every state here ran its own state-based marketplace (SBM) as of 2015.

Consumer Research Informed Website Design

A variety of different activities were undertaken prior to the launch of the marketplaces in order to design consumer-friendly websites that assist in plan selection and enrollment. These activities included consumer research, website development and refinement, and the launch of a prototype website for marketplaces to use as a model. This section describes some of these activities and the findings and recommendations from the preparatory work.

Enroll UX 2014 (Enroll UX 2014, undated [a]) was formed as a public–private partnership with the federal government, 11 state governments, and private foundations, with the goal of developing a "design reference for states and federal health insurance exchanges" (Enroll UX 2014, undated [b]). The partnership spanned multiple years, during which time web developers and partners met to discuss the design, conduct testing on consumers, and make refinements. A prototype web tool was then launched. Some of the materials on the Enroll UX 2014 website describe lessons learned from the process of developing the website. These include the difficulties of designing easy-to-understand questions to elicit income information from consumers; consumer testers' appreciation of filters and other questions designed to help the selection process; and consumers seeing the ability to remain on the same page while comparing

plans as a positive. In addition, the visual design of the website was an important aspect of the development; maintaining consistency of hierarchies, providing easy access to help, and supporting multilingual options were all described as important aspects of the design. The final prototype is included as a possible private website for review using the framework.

The Pacific Business Group on Health (PBGH) conducted a series of experiments designed to better understand how consumers who were likely to enroll in exchange plans would respond to different web design options (PBGH, 2012). As a result of this research, PBGH (2013) issued five recommendations for website design; PBGH selected the five recommendations that would have a significant impact on the choice process and ultimate choice of health plan:

- Provide consumers with an estimate of the total out-of-pocket costs under the plan.
- Organize the initial result page to first present plans that are the so-called best fit for the individual consumer, and allow the consumer to sort and filter after seeing the initial page.
- Allow the consumer to take shortcuts based on how quickly the consumer wants to select a plan and how many different attributes the consumer wants to consider.
- Provide information in such a way that highlights the attributes that have been found to be most important to consumers (for example, costs and whether a doctor is included in the plan).
- Incorporate a provider directory so consumers can see plans in which their doctors participate.

PBGH also includes recommendations for how to approximate the above tools given the short time frame available to implement the health exchange websites.

Health Insurance Choice Websites Sometimes Reflect Consumer Research Results

Once the exchange plan websites were up and running, researchers began examining the design of those websites to see how well they reflected the research results and principles described above. Some researchers also offered suggestions for improvement for some of the websites reviewed. This section describes the website review research conducted after ACA implementation.

Using the five PBGH recommendations as a guide, Baker et al. (2014) reviewed HealthCare.gov and all of the state-based websites during the first 15 days of the open-enrollment period in 2014. In general, the reviewers found that sites had implemented some of the easier recommendations. For example, six of the state-based websites incorporated tools that allowed consumers to determine which providers participated in plans. However, only a couple of websites provided estimates of total costs or organized result pages to present best-fit plans first, and no sites allowed for shortcuts for those who wished to see the results more quickly.

Quincy (2012b) reviewed six web tools designed to help consumers choose health insurance plans and conducted interviews with key informants at the organizations sponsoring those tools. The author focused on the initial (default) set of plan options presented to consumers because the default becomes the anchor or baseline for consumers' decision processes. The results of the

reviews and interviews informed the design of the framework for this project. The author found that the websites differed in their display of the initial page of results, based on three key aspects: (1) emphasis on total expected costs, (2) whether all plans or only a subset are displayed, and (3) the types of plan characteristics displayed in the results (for example, premium, total costs, and quality ratings).

Some websites she reviewed did make use of an estimated out-of-pocket cost calculator, but the algorithm used to calculate total expected costs varied by site. Some sites asked only a few questions about the consumer and then matched those questions to an actuarial estimate of costs, while others asked more-detailed questions about the consumer's desired level of risk and expected utilization. The Massachusetts Health Connector did not display total out-of-pocket costs because the designers did not feel that there was an appropriate, accurate algorithm for predicting costs (Quincy, 2012b).

Quincy found a range of opinions on the most appropriate set of choices to present to consumers. Some sites did not limit the initial results displayed but allowed consumers to filter options either before or after the initial results appeared. The Massachusetts Health Connector filtered based on the actuarial value of the coverage (level of insurance coverage) and presented the results based on the level that the consumer selected. Other sites presented only what they called "best sellers," as they defined them, or three plan options selected based on consumer responses to screening questions.

The types of plan attributes presented in the initial result page included premium, deductibles, copayments, estimated out-of-pocket costs, and plan quality measures. Not all websites displayed all of the above information. Quincy also explored three plan attributes in more detail because of their known importance to the plan selection process. The first attribute is cost, which we discussed above in terms of how the expected costs are displayed on the different sites. The second is whether the consumer's provider is in the plan's network. Some websites incorporate the provider directory into the tool, so a consumer could see whether a particular doctor is included in the plan's network as part of the plan screening process. Finally, plan quality ratings can provide cognitive shortcuts for the consumer by summarizing a variety of quality data into one overall rating. All sites reviewed display some type of quality rating for each plan, but the measures included in those quality ratings differ by site.

Consumers are usually given the option to sort or filter their results or both. Sometimes, the filtering occurs as part of the initial screening questions, and the website presents results based on the answers to those questions. Other times, all results are displayed, and the consumer can either sort or filter options based on preferred plan attributes. In some cases, the filters are nested, meaning that consumers can filter based on more than one plan characteristic at a time. Quincy (2012b) points out that the ability to filter on multiple characteristics at once makes filters "more powerful than sort options in terms of engaging consumers and customizing the display to meet their needs" (p. 16).

Quincy also found that websites used some design elements that might make the experience more user-friendly for consumers. These included the use of pop-up tools to define health insurance terms, such as *premium* and *deductible*; video tutorials; glossaries; lists of frequently asked questions (FAQs); and rollover definitions, for which a consumer need only place the mouse over the word to see the definition.

Other studies that have explicitly reviewed the ACA's marketplace websites have noted several opportunities for improvement, including a need to more clearly convey which types of services are exempted from cost-sharing requirements (Wong et al., 2014), a need for clearer and more–readily accessible information on provider networks (Baker et al., 2014), and a need to more clearly convey the value of the ACA's cost-sharing reductions and the applicability of these reductions to silver plans (Wong et al., 2014; Baker et al., 2014).

Summary

When it comes time to implement decision-support tools designed to help consumers make good health insurance choices, state regulations restricting both the number of plans offered and design of websites can play an important role in the ultimate website design. In addition, findings from website reviews conducted after the ACA was implemented indicate variation in the use of recommended tools and approaches. This variation highlights the complexity inherent in designing websites to help consumers choose health plans that are good fits for them.

Approaches to Future Website Development from the Literature

In addition to the research on consumer decisionmaking and choice architecture, some authors have been synthesizing these results and making recommendations for future health insurance marketplace website development. In what follows, we present some of the key recommendations discussed in the literature to address the biases and challenges discussed above. We have organized the recommendations under headings identifying the primary problems they intend to resolve.

In a recent *New England Journal of Medicine* article, Ubel, Comerford, and Johnson (2015) made several unique suggestions. First, they suggest deemphasizing the metal labels because the labels suggest a rank ordering that might not be appropriate for all consumers. Second, they recommend that policymakers and designers partner with researchers to design experiments that can help to better identify best practices in this setting.

Consumers Might Incorrectly Calculate Cost or Put Undue Emphasis on Premiums

Quincy (2012b) noted that the major next steps for the websites reviewed include improved expected-cost calculations and helping consumers better understand the total costs in a plan, as well as better integration of the provider network directories. Medicare is planning changes to

the Plan Finder web tool to better enable beneficiaries who are new to Medicare to navigate the system and find plan options.

One possible way to make the choice process easier is to provide consumers with easy-to-read printed information detailing their expected costs for different plans in their areas. Thaler and Sunstein (2008) proposed this type of approach.

However, a potential pitfall with providing consumers with information on expected costs is that this approach minimizes the role of insurance in reducing exposure to unexpected, catastrophic risk. In a *Health Affairs* blog post (Krughoff, Francis, and Ellis, 2012), the architects of Consumers' Checkbook argue that using patients' past spending to populate out-of-pocket calculators will not necessarily convey the costs a consumer might incur in the event of a serious accident or unanticipated illness. One of insurance's primary functions is to protect consumers against exactly this type of catastrophic risk. The authors suggest that a better approach would provide consumers with expected spending under typical, best-case, and worst-case scenarios using data from a population with similar demographic characteristics (e.g., age, family size). Ubel, Comerford, and Johnson (2015) also recommended reporting costs under several scenarios. In addition to better conveying potential financial risks under an extreme scenario, this approach has the benefit of requiring less detail on individuals' personal health spending history. The concern that calculators might not accurately convey information about worst-case spending scenarios is underscored by the fact that insurance counselors reported that consumers often fail to understand insurance's function as a hedge against catastrophic financial risk (Paez et al., 2014).

Choice Overload Might Lead to Suboptimal Decisions

Bundorf and Szrek (2010) suggested that, in a multiattribute, multichoice environment, such as that of health insurance, errors in decisionmaking are more likely because people will develop a heuristic (or simple rule of thumb) to simplify the decision process at the risk of possibly removing valuable options from their choice sets. As described in more detail above, in some cases, excessive choice can increase the probability that a consumer gives up and makes no choice at all.

One obvious solution to the problem of choice overload is to limit the number of options available to consumers. This approach has been adopted in some contexts, such as in the Massachusetts Health Connector. However, limiting the choice set can detract from consumer well-being if desirable options are excluded from the choice set (Dafny, Ho, and Varela, 2013). As an alternative, filtering and sorting can limit the number of options any given consumer has to consider, without limiting the entire choice set. Quincy (2012b) pointed out that the ability to filter on multiple characteristics at once might make filters more beneficial to consumers than sort options.

To address the problem of choice overload, Maher (2012) and King et al. (2013) recommended being more strategic about default settings. The marketplaces could establish

default settings to correlate with public policy goals set by the U.S. Department of Health and Human Services to generate both individual and public value in the long term. Some studies illustrate that people often wish to choose not to choose, preferring to delegate decisionmaking to a trusted person (e.g., their employers) to help them select a health insurance plan (Maher, 2012; Day and Nadash, 2012; Marquis, Buntin, Escarce, Kapur, et al., 2006). In the current setting, the default is that people are uninsured, which might not be in the best interests of the consumer or public policy goals.

Consumers Might Have Difficulty Understanding Complex Health Insurance Information

In addition to using modified design to reduce the burden of choice, the exchanges could deploy decision-support tools to facilitate more-effective, higher-quality decision processes and outcomes. Hibbard and Peters (2003) made some recommendations. One possibility is to use a computer-aided decision tool to help consumers structure their decision processes. Consumers would be asked simple questions that help to identify their preferences. This tool would then use a consumer's reported preferences to point him or her toward the choices that best fit his or her needs. The authors also recommend advisers, such as navigators, either in person or through an online live chat tool, who can help consumers make choices. Alternatively, websites could include personal narratives or vignettes that describe anecdotal experiences with insurance. These narratives can help some consumers better understand the options they face. Pop-ups and rollover definitions of terms, like Quincy (2012b) described, could also reduce the burden of making a choice.

To improve consumers' experiences in the complex health insurance choice environment and optimize their decisions, the government and the exchanges could look to non–Internet-based support mechanisms as well. Although more people are finding information online, certain segments of the U.S. population remain unconnected and fall outside the reach of modern technologies. For some consumers, information about their options (and the defaults embedded in said information) would likely have to be disseminated via hard-copy materials, in person, or by telephone (Maher, 2012).

Prior studies on Medicare and Medicaid acknowledged the role that different support mechanisms could have in promoting health insurance take-up, especially among subgroups that have limited access to or comfort with the Internet. Wood et al. (2011) noted that Internet sites and toll-free hotlines are available to Medicare beneficiaries but that both are underused. Hanoch and Rice (2006) commented on the misinformation that customer service representatives provided to seniors who did use the toll-free hotline. Although there are divergent views on the usefulness and reliability of toll-free hotlines, for some consumers, human support might be necessary to make choices in the complex health plan environment. Navigators can also serve as an important resource (Maher, 2012). Baicker, Congdon, and Mullainathan (2012) argued that counseling from employer administrators and human resource departments could reduce the burden of decisionmaking and that these third parties could supplement marketplaces' efforts to

properly articulate the benefits of being insured and the risks of being uninsured, thereby promoting take-up. Third parties could be employer-based, or they could be hospital-based, such that they would be able to share information and enroll people at the time and point of service (Baicker, Congdon, and Mullainathan, 2012).

Consumers Might be Subject to Inertia or Status Quo Bias

Often cited as a key element in decisionmaking, status quo bias and default bias often lead people to make no active choice. This might be rooted in choice overload, or in some cases, inadequate literacy or numeracy on the part of the individual consumer (Barnes, Hanoch, Wood, and Rice, 2012; Day and Nadash, 2012). The default settings that are established on a website can be wielded as powerful nudges, leading people to make better decisions that serve the individual as well as public interest, especially if defaults can be tailored to an individual's characteristics. However, some websites might prefer to require active choice. In this case, consumers could be required to actively select health insurance plans each year; however, they would be free to reenroll in the same plans. If they did not actively enroll, they could be uninsured and face a penalty. If consumers are loss averse, penalties rather than rewards can help to spur action. That is, introducing a risk message and associating a certain penalty with noncompliance or inaction are likely to have a greater influence on individual behavior than a reward-based incentive scheme would (King et al., 2013; Baicker, Congdon, and Mullainathan, 2012; Hanoch and Rice, 2006). Even if consumers are risk averse, penalties can help to spur active choice.

Ericson and Starc (2014) developed a model of dynamic defaults. Dynamic defaults can be used to ensure that insurers do not take advantage of status quo biases by raising prices for those who do not change plans. In this case, when plan prices increase significantly, a consumer could be defaulted to a lower-cost plan that includes the consumer's doctor and has similar out-of-pocket costs to those of the previous plan. When plan prices do not rise significantly, the consumer could be defaulted to renew the existing plan.

Limited Numeracy, Literacy, and Knowledge of Health Insurance Adversely Affect Individual Decisions

Although exchange design and decision-support tools can help reduce the burden of choice, some argue that choice overload is not the central problem. Rather, they argue that poor numeracy and literacy, as well as a general lack of familiarity with health insurance, are the driving forces behind individuals' suboptimal health insurance decisions. One policy solution would be to invest in improving both literacy and numeracy in general, although such a change is beyond the purview of those developing marketplace websites.

For a more practical solution, Maher (2012) recommended making the system "simple and transparent": It should not take a consumer long to make a choice (simplicity), and, after making a choice, a consumer should feel confident that he or she has made the right choice

(transparency). A review of Medicare Advantage, O'Brien and Hoadley (2008), similarly concluded that standardizing, simplifying, and streamlining comparison across different options would force plan providers to actually compete on the dimensions that are most important to the beneficiaries, as opposed to the dimensions that are easiest to identify and compare in a complex information environment. Using symbols, such as five-star ratings, to convey cost and quality information could also help to minimize choice overload (Barnes, Hanoch, Wood, and Rice, 2012; Peters, Meilleur, and Tompkins, undated).

In addition, some studies have suggested moving away from health insurance jargon in presenting choices and focusing instead on practical implications (Harris-Kojetin et al., 2007; Krughoff, Francis, and Ellis, 2012). As discussed above, presenting consumers with expected costs under several scenarios (e.g., average or worst case in the event of a common condition, such as pregnancy) might be more helpful than simply describing deductibles and copays. Gibbs, Sangl, and Burrus (1996) recommended that information be presented to consumers in a layered manner, so that people can choose how much detail is conveyed. For example, an overall consumer satisfaction score could be provided as a top-line assessment of the plan, with the ability to access satisfaction rankings on specific dimensions (e.g., through a click menu) should the consumer desire more information. Similarly, Hibbard, Jewett, et al. (1998) suggested presenting "big ideas" first, to help consumers narrow choices, before moving on to more-complex differences. For example, some plans offer tighter network restrictions in exchange for lower premiums and out-of-pocket costs. This type of big-picture trade-off could be presented before describing more-specific differences in plan design. In presenting plan distinctions, it might be more informative to present clear differences (e.g., does the plan allow patients to see specialists without referral?) than to present labels, such as *HMOs* or *PPOs*. This is especially true if distinctions can be hazy across plan types—for example, if some HMOs require referrals for specialists and other HMOs do not (Harris-Kojetin et al., 2007).

Standardization of Products Might Promote Competition

As shown in their paper on shrouded attributes discussed above, Gabaix and Laibson (2006) noted that, in markets with complex products, competition might not lead to efficiently functioning markets. White (2011) suggested that health insurance markets are likely to suffer from these problems. The author stated that, although some consumers will focus on price, others will select insurance randomly. Furthermore, some consumers will make mistakes and realize these mistakes only ex post. White stated, "Standardization can help promote price competition by reducing the number of dimensions on which plans can differ, simplifying comparisons among plans and helping guarantee that all plans meet minimum standards" (White, 2011, p. 2). There is a trade-off, however, because increased standardization of plans limits how innovative insurers can be in developing new insurance products. A well-known example of standardization is the Medigap insurance option, which has been reformed multiple times in the past few

decades. These reforms have resulted in ten standardized plan options from which Medicare beneficiaries can choose (Jacobson, Huang, and Neuman, 2014).

Is Nudging the Solution?

Nudges could hold great promise: They are a simple way to help people to make choices without limiting their freedom to choose. But, for nudges to work as intended, there must be consensus about which product or set of products is optimal for the consumer. For example, in the context of health insurance, a nudge that pointed consumers to plans that included their current providers might lead to very different outcomes from those produced by a nudge that pointed consumers to plans with the lowest costs. McWilliams (2013) pointed out that nudging is a form of agency and notes that the interests of the agent doing the nudging (e.g., an employer, provider, health plan, or government) might not necessarily be aligned with the interests of the consumer. Furthermore, unless different nudges can be applied to different people, choice architects run the risk of helping some consumers at the detriment of others. The process of making health insurance choices might be so complex that those with particularly low knowledge of health insurance might not be able to identify whether the products toward which they are being nudged are appropriate for their own circumstances. In this context, libertarian paternalism, which offers nudges but still requires the consumer to choose a plan, might be insufficient to lead to optimal choices. For those who find it overwhelming to make an adequate choice, a stronger approach might be required, such as default enrollment into a health insurance plan.

In conclusion, a broad literature has noted the difficulties that are likely to arise in designing choice architecture for health insurance decisions. These papers have pointed to suggestions that might help consumers make more-effective choices, such as out-of-pocket cost calculators, limits to the number of choices, decision-support tools, and appropriate nudges or defaults.

Summary

There is clear evidence that consumers have trouble with making choices about health insurance plans. They often fail to select the best options, especially when facing many options; they lack necessary knowledge about health insurance; sometimes, they take no action at all (status quo and default bias); and choice architecture can easily sway their choices. At the same time, allowing consumers to make their own choices provides them with autonomy and allows them to select the option that matches their own personal circumstances from the set of available choices. Furthermore, markets with many options can enhance social welfare if people can adequately sort through the options, understand the implications, and make optimal choices. When more options are available, each consumer can get closer to his or her own optimal product; the products that Bhargava, Loewenstein, and Sydnor (2015) discussed attempted to do this by allowing consumers to customize their insurance plans in terms of cost sharing. If priced

in an actuarially fair manner and if consumers are capable of making these choices, this sort of customization could help consumers purchase optimal insurance plans. Additionally, with more options in the market, there is more competition between insurers, which has led to lower prices.

Chapter Three. Website Reviews

Introduction

The application of choice and behavioral economics research to real-life website design involves many decisions regarding how to present the available information. From a consumer's perspective, the manner by which the information on marketplace insurance websites is presented might affect his or her ability to understand the options available and might nudge the consumer toward a specific plan or type of plan. In addition, web tools that enable the potential enrollee to calculate estimated out-of-pocket costs, see whether his or her preferred provider is in a plan's network, and sort plans based on available quality ratings might further assist the consumer in understanding the differences between the plan choices available. Finally, the availability of information about the consumer's eligibility for an exemption from insurance coverage likely affects the consumer's decision to enroll or not enroll in a plan.

We used the findings from the literature review to develop a framework for reviewing SBM websites, as well as federal, state, and other private websites related to choice of health insurance. The framework captured information on the choice architecture, defaults, and decision-support tools that are presented to consumers seeking information about health insurance options. Broadly speaking, the framework addressed the following areas of interest:

- whether the websites used any defaults (e.g., offering consumers only silver plans, or presenting the silver plans as the first options) or nudges
- whether any websites used web tools (e.g., out-of-pocket cost calculators) to help consumers, navigators, or assisters
- the type of information that the website provided related to eligibility for exemptions and how to apply for exemptions.

With the exception of the third area, which no past research has explicitly addressed, the framework generally tried to capture whether the websites reflected the recommendations that arose from the literature review. Using the draft framework, we conducted a review of 20 websites selected in conjunction with the U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation (ASPE). This chapter describes the methods used to develop the framework and conduct the reviews and presents the findings from those reviews. Overall, we found that all websites reviewed did make use of at least some of the recommendations that arose from the literature review, but the most common tool to assist consumers in making decisions was the application of sorts and filters to help consumers focus on and narrow their options.

Methods

Framework Design

We developed a framework for the website reviews based on the key lessons learned in the literature review. We divided the draft framework into specific sections, which generally reflected the pathway a consumer would take to navigate the given site: personal information, plan display (including default settings and sort and filter options), informational materials, and exemptions and penalty information. The framework was in a Microsoft Excel spreadsheet and generally required the website reviewers to enter data in a 0/1 (no/yes) format.

Websites can use personal information to provide consumers with tailored information on the available plan options. In the personal-information section, we captured the amount and type of information a website requested or required consumers to enter in order to see plan options. These types of information included age, gender, smoking status, pregnancy status, income, health status, and information on other members of the consumer's household.

The use of specific design elements (a website's choice architecture) can focus users' attention on certain plans and nudge them to select specific options that are highlighted or appear more prominently on the page. To see the plan options, we entered personal information for a sample consumer, who was a single female, age 28, nonsmoker, and not pregnant. For each site, we entered the personal information twice, using two income levels in order to determine how and whether websites displayed information differently depending on whether the consumer was eligible for the premium or cost-sharing subsidies created by the ACA. The first annual income was $18,000 (low-income scenario, approximately 155 percent of the federal poverty guideline), which is an income eligible for both premium and cost-sharing subsidies in all states and for all ages of potential enrollees. The second income level was $40,000 (high-income scenario, approximately 340 percent of the federal poverty guideline), which is not eligible for cost-sharing subsidies but might be eligible for premium subsidies if the consumer's expected annual spending on the premium is above 9.5 percent of the second-lowest cost silver-plan premium in his or her area. This might occur if the consumer is older and in a rating area with a second-lowest-cost silver-plan premium that is above $3,800 (9.5 percent of $40,000). For the sample consumer we used, the $40,000 income level was eligible for premium subsidies for four of the websites and insurance plan rating areas we reviewed (in Hawaii; New York; Vermont; and Washington, D.C.).

Reviewers captured information on the plan display, including whether the consumer was asked whether he or she wanted to view only a subset of plans before seeing the result display; whether the consumer was automatically routed to a filtered group of plans; how the website sorted initial results; the types of plan information that were explicitly presented as part of the initial results; and whether the consumer could sort and filter on specific design elements.

One key lesson from the literature review is that consumers have difficulty understanding the concepts associated with insurance. As a result, the provision of informational materials on

websites can help consumers make a more informed choice of plan. We captured whether sites provided consumers with additional information on plan benefit design, glossaries of key insurance terms, FAQs on aspects of the ACA marketplace and the coverage options available, and other relevant information. Finally, we also captured whether and how well websites presented information on the possibility of receiving an exemption from the coverage requirement and the possibility of having to pay a penalty if the consumer does not meet the individual coverage requirement (mandate).

We incorporated comments from ASPE staff and two quality assurance reviewers into the draft framework. In addition, each of the four website reviewers tested the draft framework on one site (Maryland). The reviewers met to compare their results, resolved any differences, and updated the framework to make clarifications and add questions that arose during the testing phase. We also asked reviewers to take qualitative notes on interesting or unique aspects of the websites, which we also used in summarizing the findings.

Website Selection

In consultation with ASPE, we selected 20 websites for review (see Table 3.1).

Table 3.1. Websites We Reviewed

Type	Site	Jurisdiction
SBM	Covered California (undated)	California
	Connect for Health Colorado (undated)	Colorado
	Access Health CT (undated)	Connecticut
	DC Health Link (undated)	District of Columbia
	Hawai'i Health Connector (undated)	Hawaii
	Your Health Idaho (undated)	Idaho
	kynect (undated)	Kentucky
	Maryland Health Connector (undated)	Maryland
	Massachusetts Health Connector (undated)	Massachusetts
	MNsure (undated)	Minnesota
	NY State of Health (undated)	New York
	HealthSource RI (undated)	Rhode Island
	Vermont Health Connect (undated)	Vermont
	Washington Healthplanfinder (undated)	Washington
Privately run aggregator	HealthSherpa (undated)	
	ValuePenguin (undated)	
	HealthPocket (undated)	
	Consumers' Checkbook (2016)	
Other public insurance	CalPERS (2016)	CalPERS
	Centers for Medicare & Medicaid Services (undated [b])	Medicare

NOTE: CalPERS = California Public Employees' Retirement System.

They can be broken down into three groups: SBM sites, aggregator sites, and public insurance sites. The SBM sites are the 14 websites run by individual states that chose to offer SBMs for individual coverage under the ACA. The aggregator sites are privately run sites that aggregate marketplace and other types of insurance information from various sources and present the options to consumers. Three of the aggregator sites cover the entire country and allow the consumer to explore plan options regardless of the state in which the consumer lives. One site, Consumers' Checkbook, presents an example of a marketplace website, using Illinois as its illustration for how such a site could work. Some of these sites (e.g., HealthSherpa) also allow the consumer to select and enroll in a plan via the site, while others (e.g., HealthPocket) require the consumer to call an insurance broker to learn more and enroll in a plan. The last two websites we reviewed were sites presenting options to a subset of Americans eligible for specific types of public insurance: CalPERS and Medicare. CalPERS is available to all California public employees and retirees, and Medicare is available to Americans who are either disabled or 65 years of age or older. We reviewed plan options for Medicare Advantage (Part C of

Medicare) in order to capture how the website presented information on medical benefit, as opposed to just pharmacy benefit (Part D) coverage.

Website Review Process

Three of the four reviewers each reviewed six sites, and one reviewer examined two sites. Each reviewer selected a specific geographic location for a given website; usually, this selection process was done at random. For example, if a site required the consumer to select a county to see plan options, the reviewer might select the first county in the list. For sites requiring ZIP Codes, sometimes a reviewer would enter his or her own ZIP Code or a ZIP Code for the state or area the reviewer happened to know. For the three aggregator sites offering information nationwide, we searched for plans in California (ValuePenguin and HealthPocket) and Virginia (HealthSherpa). We have no reason to believe that the result display or website design would change based on different geographic areas.

The initial site reviews took approximately one to one and a half hours to complete per site. After the initial review of all sites, we conducted data cleaning and quality checks to verify the results. The quality checks consisted of an additional two website reviews by each of the three reviewers; results were compared to the original reviewer's results, and the original reviewer resolved any discrepancies. The lead reviewer tabulated the initial results and asked individual reviewers to make clarifications and edits where discrepancies and questions arose.

We also conducted some additional reviews to address questions that arose after the framework was completed and the initial reviews had begun. These additional reviews addressed two specific questions: (1) whether a person eligible for Medicaid would receive information to that effect when entering his or her income ($10,000 for this scenario) and (2) the general appearance of each website, in terms of the types of photos (if any) used.

Limitations

There are a few limitations to these reviews. First, many of the sites had different pathways, or routes a person can follow, in order to obtain the desired information. This led to some disagreements among the reviewers that arose during the quality check reviews, which the team resolved through discussion. Given some of these findings, the review team also returned to some of the sites for which quality checks were not conducted, in order to double check and make changes to the answers in the framework as necessary.

A second limitation is that it was difficult at times for reviewers to capture all of the information and nuances of a site. Some of the reviewed sites differed substantially from the others, so the information captured by the framework was not necessarily sufficient to adequately describe the site's choice architecture. To address this limitation, the website review team took notes on unusual or different website appearances. In our findings, we highlight some of the sites that offered distinctly different experiences.

Third, we reviewed these sites on computers, not on mobile devices. It is possible that a consumer using a mobile device would have a different experience navigating the websites from those reported here.

Finally, because we did not have accounts with these sites, we could not see how and whether the websites presented a different display of options based on prior year's enrollment. This is a limitation because the manner by which a consumer's current plan is compared with other plan options could lead to different enrollment choices. We therefore conducted our reviews from the point of view of a consumer thinking about enrolling in a marketplace plan for the first time.

Findings

Many Pathways Exist to Navigate Sites

In general, the reviewer first went to the site's home page and searched for the option to compare plans or browse plan options. The reviewer was then prompted to enter personal information, was sometimes told whether he or she was eligible for a subsidy, and was then shown the available plans in his or her area (the initial result display). Separately from the process to view plan options, the reviewer also searched for the types of informational materials available on the site, as well as information on the possibility of receiving exemptions from the coverage requirement and the consequences of noncompliance with the individual mandate (penalty).

However, the websites often presented different navigation options, which could affect the consumer's experience. This section describes some aspects related to the overall experience of navigating the sites, in terms of the distinction between account creation and browsing for plans, the different tools websites used to convey plan and subsidy eligibility information, the appearance of the websites, and the informational materials that the sites provided in order to educate consumers about their coverage options.

As noted in the "Limitations" section above, there were often different pathways through a given site. The lack of a clear road map through sites sometimes led the website reviewers to different conclusions about the presence or absence of a given piece of information on the site (for example, whether a site requested the consumer's income in order to see plan options). When reviewers returned to the websites to resolve these differences, they sometimes discovered that the sites offered different tools designed to meet different consumer needs and that one reviewer had found or used one tool, while the other reviewer had used the other.

Of note is the fact that three pairs of websites used similar site platforms, which meant that the user would have a very similar experience on each pair of sites. These pairs were the sites for Connecticut and Maryland; Massachusetts and Colorado; and Washington, D.C., and Minnesota. Also worth noting, some private organizations have their own sites that offer consumers the

ability to search for marketplace and other plans for specific states. Consumers could mistake these sites for a state's official marketplace site, and they would likely have different search experiences on the private and public sites.

Some Sites Required Account Creation While Others Permitted Just Browsing

A key feature of most sites was the distinction between account creation and the ability to browse for plan options. It was possible to create an account with most sites; account creation facilitates enrollment into a marketplace plan and sometimes facilitates the plan selection process. However, requiring the consumer to create an account can create an additional barrier to those interested in learning about options without going through the additional steps of creating an account. Many sites allowed the consumer to browse without creating an account in order to see the plan options available. The browse option often allowed for the entry of some personal information in order to see tailored results.

Websites approached the use of accounts and the browse option differently. Nine of the 14 state sites defaulted the consumer to browsing for plans and allowed for later account creation. Four state sites gave the option to either create an account or browse for plans up front. One site, DC Health Link (undated), was the only one to require account creation. All of the aggregator sites allowed for browsing as a default.

Medicare (undated) allowed the consumer to browse plans in his or her area using only a ZIP Code. If the consumer wished to see more-tailored information, he or she had to enter a Medicare identification (ID) number, birth date, and other personal information. On its initial page, CalPERS presented both the option to create an account and a browse option.

In general, we captured the findings presented below using the browse feature. However, because browsing was not possible on DC Health Link (undated), we created an account to access information from that site. We were also able to obtain Medicare ID information from a beneficiary in order to review the site; therefore, the results for Medicare reflect what a Medicare beneficiary with a Medicare ID would see.

Websites Used a Variety of Tools to Provide Information

The first type of tool, which was separate and distinct from the standard browse feature of a site, was a subsidy-estimator tool. This tool, which had different names on different sites, existed solely to allow the consumer to enter his or her household income and see whether he or she might be eligible for the premium or cost-sharing subsidies in the marketplace. These tools, which were available on five state websites (but not on any of the aggregator sites), requested only household size and income and did not ask for any additional personal information. Some of these five state websites also had a separate browse feature for plans, some of which requested personal information and presented results based on that personal information.

One site, Covered California (undated), also had multiple browse tools available, which asked for similar personal information up front but did so in a different way (for example, one

tool had the user select their age from a dropdown box, while another tool allowed the user to type age into a box). Consumers who went to the Covered California home page and selected "Preview Health Plans" at the top of the page were directed to a tool that provided detailed information on plan options, including estimated out-of-pocket costs and plan cost sharing. Consumers who chose "Shop and Compare" near the bottom of the page, however, saw a plan result page that included only basic plan information (for example, insurance carrier, premium, and metal level) and a button to initiate the enrollment process. Figure 3.1 shows a screen shot of the Covered California website with the two options at the top and bottom of the page. The plan selection experience appears to vary significantly depending on the path the consumer chose. These different choice architectures could lead consumers to very different perceptions about the best plans available, but whether consumers who are browsing choose "Preview Health Plans" or "Shop and Compare" seems arbitrary. Even members of our team selected different options for how to browse plans.

Figure 3.1. Screen Shot of the Covered California Home Page

SOURCE: Covered California, undated. Screen shot taken April 2015.

For the purposes of this report, the website reviewers focused on the browse-plans options, and not the subsidy-estimator tools, when answering the questions contained in the framework. For Covered California, reviewers used the "Preview Health Plans" browse option for all results presented in this report, but it is important to keep in mind that other options are available.

Websites Varied in Appearance

More than half of the websites reviewed made use of pictures or other visual tools on the home page and other pages. Eleven state sites and one aggregator site (HealthPocket, undated) included pictures of people; these people were usually smiling and happy, and many sites also included photos of families, some of which reflected diverse backgrounds. Two sites (kynect, undated, and Your Health Idaho, undated) did not use pictures but instead made use of animation to draw people into the site. Three of the four aggregator sites did not have any pictures but instead focused users directly on the entry of personal information to see plan options.

Informational Materials Varied

Research has shown that consumers have a great deal of trouble understanding the concepts related to health insurance (Barcellos et al., 2014; Loewenstein et al., 2013). If easily accessible, informational materials can help consumers make more-informed choices. All 14 state sites had FAQs and provided plan summaries of benefits and coverage. Twelve state sites, one aggregator site, and both public sites provided glossaries of terms, while seven state sites provided personal narratives as additional means of orientation. Eleven state sites and one other site allowed the user to view the site in another language, usually Spanish. Seven state sites, three aggregator sites, and one other site were mobile friendly, which provides another means by which consumers can access the information they need to make decisions. Finally, seven state sites, two aggregator sites, and two other sites provided video tutorials to help consumers learn about insurance and their coverage options.

Websites' Requirements for Personal Information Varied

Collecting personal information from consumers, such as age, income, and geographic location, is essential to providing accurate information about the plans available and the premiums a consumer could expect to pay. However, requesting this information can also create a burden on consumers, who might prefer an easy browsing experience or to not provide such information. Thus, sites must balance the need to provide consumers with accurate information with the potential burden.

The first framework category captured the amount and types of personal information the website requested or required a consumer to enter in order to see plan options. Sites can use personal information to tailor plan results and help focus the consumer on plans that might be a good fit. Table 3.2 shows the number of sites that required or requested that consumers enter specific types of personal information. All sites, with the exception of HealthSource RI (undated) and Vermont Health Connect (undated), required users to enter some type of geographic location information, such as ZIP Code or county. Each of these two states has only one rating area for the entire state, so there is no variation in plan offerings within certain areas of the state.

Table 3.2. The Amount and Types of Personal Information That Websites Requested or Required

Type of Personal Information	Number of Sites That Require: State Sites	Aggregator Sites	Other[a]	Number of Sites That Request but Do Not Require: State Sites	Aggregator Sites	Other[a]
Gender	1	0	0	1	0	0
Age						
Date of birth	5	0	0	1	1	1
Year of birth	0	0	0	0	0	0
Age (number)	6	2	0	0	1	0
Smoking status	2	2	n/a	5	2	n/a
Pregnancy status	2	1	n/a	3	0	n/a
Household income	5	1	n/a	4	3	n/a
Average number per site[b]	1.7	1.5	1.5	1.1	2.3	1.0
Range across sites[b]	0–6	0–3	0–3	0–5	0–3	0–2

NOTE: n/a = not applicable to Medicare and CalPERS. Table A.1 in the appendix shows the specific sites providing each of these pieces of information.
[a] Because Medicare and CalPERS do not provide information on marketplace plans but instead relate to other insurance products, the types of information they collect is not always the same as that for the marketplace plans.
[b] These summary statistics also include the types of personal information collected related to health care utilization and health status. We discuss these types of information in the "Out-of-Pocket Cost Calculator" section below.

Sites used a variety of approaches to requiring versus requesting information from consumers. Some sites left a field blank but included a star next to the field indicating that it was a required entry (i.e., the field provided no default value, so the consumer had to fill it in before proceeding). Other fields were left blank but the user did not have to fill them in to see the plan options available (i.e., the fields were blank but the consumer did not have to fill them in before proceeding). Sites also made use of auto-fill options, in which a response was shown by default for a question (for example, a "no" response related to pregnancy or smoking status), but the user had the option to change the response. Reviewers treated the first case as personal information that was required to see plan options and the last two cases as optional personal information.

The three different site types (states, aggregators, and other) required, on average, similar amounts of personal information; some sites did not require consumers to enter any personal information in order to see plan results, while others required as many as three (aggregators and other sites) or six (one state site, Kentucky's kynect, undated) pieces of personal information.

The most frequently required piece of information was age (a key factor in determining premiums), which was usually captured via date of birth or simply the numerical age. Eleven of the 14 state sites and two aggregator sites required some entry of age. Some sites also requested information on smoking status, which can affect out-of-pocket premium costs under the ACA, and pregnancy status, which can affect Medicaid eligibility. Few sites requested information

(required or optional) about estimated utilization of health care services; those sites that did request this information generally provided estimates of out-of-pocket costs in a given plan. We discuss these pieces of information and the out-of-pocket cost calculators below.

Income information is essential to calculating whether a consumer is eligible for premium or cost-sharing subsidies within the marketplace. Consumers who are eligible for the subsidy and who can see the estimated final costs (including the subsidy) that they will incur if they enroll in a marketplace plan might be more likely to enroll than those who do not see final costs that take into account the subsidy. As noted above, all state websites had some method for consumers to enter their incomes and receive estimates as to whether they were eligible for the subsidy. However, although all four aggregator sites captured income information (either required or optional) via the browse feature, only nine state sites did so. This suggests that consumers viewing plan options on those state sites that did not collect income information were seeing plan options that did not take into account their likely lower subsidized premium.

Plan Display

Sites Provided Tools to Determine Subsidy Eligibility, but Not All Applied Eligibility Results to Plan Displays

As mentioned above, it is important for consumers to know whether they are eligible for premium or cost-sharing subsidies because their costs might be significantly lower with the subsidy. Given that a consumer's costs might be lower, knowing the final amount that he or she might pay for a plan could increase the likelihood that a subsidy-eligible consumer chooses to enroll in a plan. All websites (both state-based and aggregator sites) provided information on the possibility of receiving a subsidy for premiums or cost sharing. However, the sites varied in the extent to which an eligibility calculator, based on income, was incorporated into the plan results in the browse feature. Nine state sites and the four aggregator sites incorporated income into the browse feature, while five state sites had a separate subsidy-estimator tool that requested the consumer's income. Of note, some of the state sites that incorporated income into the browse feature also had separate subsidy-estimator tools; results presented here focus on the browse feature as opposed to these other tools.

Of the sites that displayed subsidy eligibility based on income as part of the browse feature, most notified the consumer of his or her potential eligibility. Under our $18,000 scenario, in which the consumer was eligible for both the premium and cost-sharing subsidies, nine state sites and all four aggregator sites applied the estimated subsidy to lower the premiums shown on the initial result page. In addition, five state sites and three aggregator sites also applied the subsidy to lower the cost-sharing estimates displayed. Of note, Covered California lowered the premiums because of subsidy eligibility but did not display cost sharing at all for the low-income person, simply noting that, because the person was likely eligible for the cost-sharing subsidies, the cost sharing would likely be lower than the information contained in the plan finder.

Table 3.3 shows an example comparing the high- and low-income scenarios for the same plan on Maryland Health Connector (undated). For the low-income scenario, the premium subsidy has been applied to the estimate for the Kaiser Permanente plan, and the cost-sharing subsidy, which serves to reduce the consumer's out-of-pocket maximum costs, deductible, and cost sharing for specific services (for example, emergency room and primary care), has also been applied.

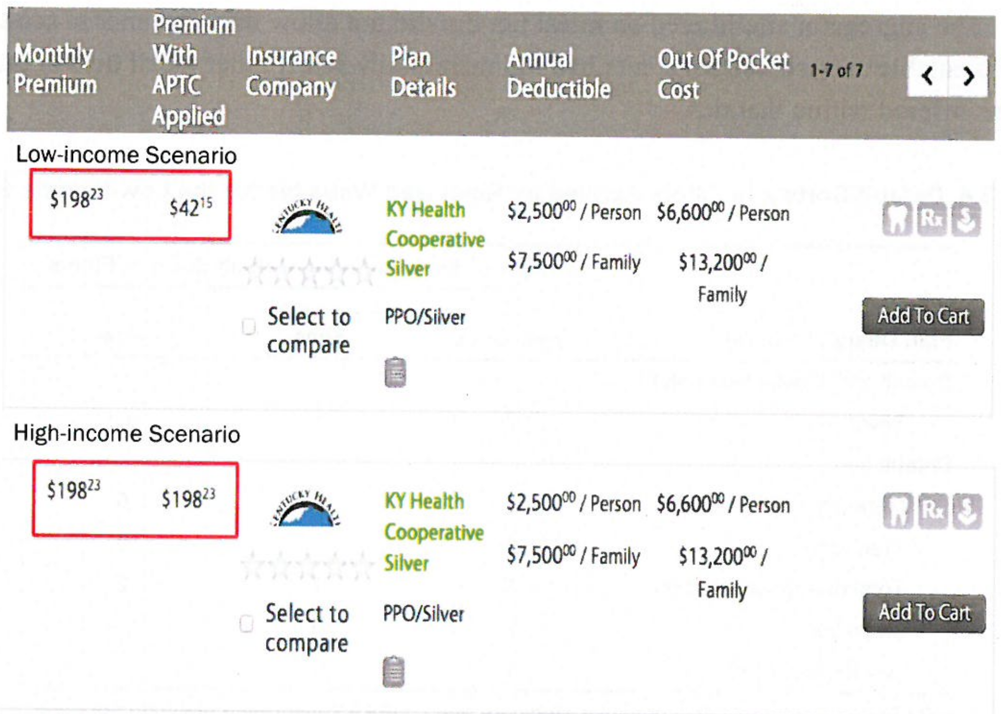
Table 3.3. Example of Premium and Cost-Sharing Subsidies in Initial Result Display, for Maryland, Kaiser Permanente Silver 1750/25-Percent Plan

Scenario	Estimated Monthly Premium, in Dollars	Annual Out-of-Pocket Maximum, in Dollars	Emergency Room, Percentage, After Deductible	Primary Care Copayment, Percentage, After Deductible	Annual Deductible, in Dollars
Low income ($18,000)	62.50	2,250	10	10	500
High income ($40,000)	192.55	5,000	25	25	1,750

Kentucky's kynect (undated) provides another example of the application of the subsidy to lower the premium but not the cost sharing (see Figure 3.2). The Kentucky site presents the same total monthly premium estimate on the far left of the initial result display and, next to that premium, shows the "Premium with APTC Applied." The site does not provide a definition of *APTC* via a rollover definition or other simple-to-access source, but, when comparing the low-income scenario with the high-income scenario, our reviewers found that this is the premium with the tax credit subsidy applied: The low-income scenario shows a far lower premium. For consumers trying to choose among plans and see the total costs, this display might be confusing because they will first note the total, higher premium on the left side and must look for the lower premium next to it (and understand what "APTC" means).[2]

[2] *APTC* stands for advanced premium tax credit (Centers for Medicare & Medicaid Services, undated [a]).

Figure 3.2. Screen Shot of Kentucky's Initial Result Display, Showing Premium Subsidies Applied to the Low-Income Scenario Only



SOURCE: kynect, undated. Screen shot taken March 2015.

Default Filtering and Sorting Varied

One manner by which websites and other decision-support tools can help a consumer select a plan is by automatically sorting or filtering the results the consumer sees on the initial result page. Filtering in particular can be beneficial because choice overload is likely to occur in these markets, where more than ten and sometimes as many as 136 plans are available. We have termed this automatic sorting or filtering approach default sorting and filtering because the website usually takes this approach without the user selecting it. Default result displays can have an important effect on plan choice because they focus the consumer on specific plans. Such defaults can be beneficial if tools are well designed and accurately select the best (for that consumer) plan options to display. However, if tools select poorly or focus on plan design elements that are not conducive to selecting a good fit, such defaults could do more harm than good.

Table 3.4 shows the number of sites that applied specific types of default filters or sorts to the initial result display. Default filtering, or the reduction of displayed plan options via some algorithm, was applied only in the low-income scenario. Two state sites (those for Connecticut and Maryland) and one aggregator site (ValuePenguin's) filtered low-income consumers to the silver-tier plans. For the high-income consumer, only ValuePenguin automatically filtered to

silver plans. Both state sites notified the consumer in advance that the filtering would occur, while the aggregator site simply filtered the plans and did not notify the user. Both state sites gave the user the option to see the full list of results, both before and after seeing the initial result display. The aggregator site filtered on metal tier but did not allow the consumer to see all of the options available at once; the consumer had to intentionally select other metal tiers in order to see plans offered within that tier.

Table 3.4. Default Sorts and Filters Applied by Reviewed Websites for the Low-Income Scenario

	Number of Sites Applying Default Sorts or Filters		
Plan Design Element	**State Sites**	**Aggregator Sites**	**Other**
Default filter (metal tiers only)			
Silver	2	1	n/a
Default sort			
Metal tier, then premium	1	0	0
Premium	8	3	0
Total out-of-pocket costs	1	1	2
Metal tier	2	0	n/a
"My Preferences"	1	0	0

NOTE: n/a = not applicable because Medicare and CalPERS insurance plans do not have metal tiers.Table A.2 in the appendix shows the specific sites providing each of these pieces of information.

Every site used some type of default sorting approach. It was possible to determine the sorting approach for all but one site (Kentucky's kynect, undated). One site (Washington state) used a nested sorting approach for low-income consumers, in which they sorted first to silver-tier plans and then on premium. Other sites used different default sorting approaches; the two most common were premium (eight state sites and three aggregator sites) and total estimated out-of-pocket costs (one state site, one aggregator site, and both other sites). Minnesota presented results sorted based on user-provided answers to questions; we discuss this approach more below. Two sites (Vermont Health Connect, undated, and Rhode Island's HealthSource RI, undated) sorted on metal tier alone.

Although default filtering and sorting can be a website-initiated option to focus consumers on specific plans, three sites (Medicare's Centers for Medicare & Medicaid Services, undated [b]; Minnesota's MNsure, undated; and DC Health Link, undated, for Washington, D.C.) allowed consumers to apply filters prior to seeing the initial results. This could have a different effect from user-selected filters, which we describe below and occur after the initial results are displayed. Medicare in particular allowed consumers to apply a significant number of filters before seeing plan results, including insurance carrier, premium, drug coverage, deductible, plan

quality rating, and whether the plan offered nationwide coverage. Minnesota and Washington, D.C., allowed consumers to apply filters, such as plan type, metal tier, and deductible, before seeing the initial results.

Minnesota's MNsure (undated) is an example of a unique sorting approach. The website asks users to enter responses to screener questions ranking the importance of various aspects of insurance (for example, premium or deductible). The website then requests information on expected utilization, then filters the initial results based on the user-entered responses to the questions. Results are also sorted based on those best matching the consumer's expressed preferences, with the best matches at the top of the page. Figure 3.3 shows how the process works on the Minnesota website. This type of approach is similar to what experts suggest would help people choose a plan, in that Minnesota has attempted to implement a decision-support tool that elicits information from the consumer regarding the relative importance of various plan features and then presents results that are tailored to those responses. However, reviewers could not determine how well the Minnesota tool actually performed. Thus, it is difficult to say whether the approach should be replicated elsewhere.

Figure 3.3. Minnesota's "My Preferences" Filter and Sort Options

1. Consumer enters basic demographic information

2. Then consumer is prompted to answer questions on medical visits and medications

3. Results are displayed

SOURCE: MNsure, undated. Screen shot taken March 2015.

Sites Consistently Presented the Same Plan Design Elements in the Initial Result Display

The information that websites initially display in plan results will make those elements most salient to consumers. This can help focus consumers on specific aspects of coverage that might be an important part of their decisionmaking. However, there are two important caveats. First, those characteristics might not be the characteristics that a given consumer values most. If that is the case, that consumer could end up selecting a plan that is not appropriate for him or her. For example, if websites focus on premiums but provide limited or no information about expected out-of-pocket costs, some consumers could end up picking a suboptimal plan that leads to higher expected out-of-pocket costs. Second, the quality of the data behind the information provided is extremely important, and the quality varies significantly by type of information. For example, premium, deductible, and insurance carrier are fairly simple plan design elements and are easily verified. By contrast, the inclusion of specific physicians or hospitals in a plan's network can be difficult to confirm; in addition, the physician network can change frequently, so databases containing plan network information might not only be incorrect but quickly out of date. In addition, the out-of-pocket estimators included on some sites (discussed in greater detail below) vary significantly in terms of the types of information used to calculate the out-of-pocket costs and the quality of the estimate itself.

Although choices can increase competition and lower prices, the number of available options on the websites we reviewed suggests that choice overload is highly possible. Of the sites we reviewed, four state sites, three aggregator sites, and one other site (that for CalPERS) displayed all of the plans available in the area on the initial page, which ranged from 11 (CalPERS) to 136 (HealthPocket). It is important to note that the number of plans displayed, for the sites that display all available plans, varies by rating area; thus, the range presented here is dependent on the rating areas we selected for entry on the individual sites. Six state sites displayed ten options on the initial result page, and four state sites displayed from three to five options. Restricting the number of options displayed on the first page might reduce the initial burden on consumers but at the cost of focusing consumers only on those plans that are listed first. If the best plan for a given individual shows up on the third or fourth screen, some consumers might never find the best plan for them.

One method by which consumers can narrow and compare choices is the ability to select a certain number of plans for comparison and then to see those plans displayed in a separate window in a manner that facilitates comparison. Twelve state sites, two aggregator sites, and both other sites allowed consumers to select a certain number of plans for comparison; the most common number of plans a consumer could select was three (11 state sites and one other site). The other state site (Rhode Island's HealthSource RI, undated) allowed consumers to select four plans for comparison.

Table 3.5 presents the number of sites that presented specific plan design elements in the initial result display. Of note is the fact that all sites displayed the insurance carrier, premium, and metal tier for a plan (all easy data elements to verify and ensure accuracy). Most sites also

displayed the plan's deductible and maximum out-of-pocket costs. About half of the sites displayed cost-sharing information, and seven sites presented some information on the drug coverage that the plan offered.

Table 3.5. Number of Sites Presenting Specific Design Elements in Initial Result Displays, for the Low-Income Scenario

Plan Design Element	State Sites	Aggregator Sites	Other
Insurance carrier	14	4	2
Premium	14	4	2
Metal tier	14	4	n/a
Deductible[a]	12	3	2
Maximum out-of-pocket costs[a]	10	1	2
Cost sharing[a]	6	1	2
Total estimated out-of-pocket costs	4	1	2
Plan quality rating[b]			
Based on established metrics	1	2	1
Based on surveys	1	0	0
Other method	3	1	0
Drug coverage information	5	0	2
Whether physician is in network	0	1	0
Average number per site	6.0	5.5	8.0
Range across sites	3–9	3–7	7–9

NOTE: Table A.3 in the appendix shows the specific sites providing each of these pieces of information.
[a] California does not display these three elements for those with low incomes who are eligible for cost-sharing subsidies but does display them for high-income consumers.
[b] The numbers do not add to the total of eight sites that included quality ratings because one aggregator site used two methods for calculating quality ratings—based on established metrics and some other algorithm.

Sites Sometimes Include Notable Elements Requiring Significant Additional Data

Plan quality ratings, estimated out-of-pocket costs, and physician networks are all notable pieces of information that can provide a consumer with important additional information to aid in plan choice but were included in less than half of the reviewed sites. Information that is not salient might be ignored in the decisionmaking process. This could lead consumers to select suboptimal insurance plans. For example, although premiums are most salient, expected out-of-pocket costs have a larger impact on consumer welfare; if consumers are made aware only of premiums and not expected out-of-pocket costs, they could end up choosing less-comprehensive insurance coverage. In some cases, those who become insured with less-comprehensive coverage might avoid seeking needed health care because of concerns about out-of-pocket costs. Of note is the fact that these three elements are among those for which the data are particularly difficult to

obtain and verify; in addition, the first two require significant additional analysis and calculation in order to generate the final information for use on the site. We discuss how sites treat each of these elements in turn.

Plan Quality Ratings

Five state sites, two aggregator sites, and one of the other sites (Medicare's Centers for Medicare & Medicaid Services, undated [b]) included plan quality ratings in the initial result display. Reviewers were able to find basic explanations of plan quality ratings for all but two sites. Among the six sites for which it was possible to interpret the quality rating, two sites used established quality measures (one state site and one other site), three sites used surveys of previous enrollees (possibly conducted by the plan itself), and one site (Maryland Health Connector, undated) compared plans to what it called a national benchmark but did not indicate the source of this benchmark. One aggregator site combined the established quality metrics with an additional measure of quality that was opaque to the reviewer. Of note, some of the plans displayed on some of the sites did not yet have a quality rating; therefore, the rating for that plan was grayed out. In addition, two sites (Kentucky's kynect, undated, and Minnesota's MNsure, undated) included quality ratings in the site design but had not yet populated the ratings with data.

Out-of-Pocket Cost Calculators

Information related to the amount a consumer might expect to pay over the course of the year for health care in a specific plan can be very valuable in the decisionmaking process. Out-of-pocket cost calculators, which can use a variety of different methods to calculate estimates of the expenses a consumer can expect to incur when using a given plan's benefits, are sometimes included in the reviewed sites. Seven sites (four state sites, one aggregator site, and both other sites) present estimated total out-of-pocket costs as part of the display. This is an important piece of information because many consumers are likely to focus only on premiums, especially if the consumer does not understand the different characteristics of insurance. The sole focus on premium can lead to suboptimal choices on the part of the consumer. Where out-of-pocket cost estimates can be provided, they can provide another valuable piece of information to the consumer that could enable more-informative comparisons of plans. However, these calculators should be tested to ensure that the estimates are as informative as possible, and, as noted above, it is difficult to construct these estimates.

The sites that present out-of-pocket cost estimates use different pieces of information from the consumer, some or all of which can be used to estimate these costs. Of note, we could not always determine the methodology that the site used to estimate costs; therefore, although some pieces of information likely contribute to out-of-pocket costs for an individual, we could not always determine whether the specific site took them into account when presenting the estimates. The sites do appear to use different approaches to estimating these out-of-pocket costs, and it is

not possible to determine the accuracy of these cost estimates. As a result, it is difficult to assess whether the inclusion of out-of-pocket cost estimates is beneficial to consumers.

Table 3.6 shows the information that these sites requested that might contribute to the calculation of estimated out-of-pocket costs. Five sites ask consumers to estimate their medical utilization (usually based on number of doctor's visits) for the coming year; four sites ask for estimates of the number of prescriptions the consumer (and household members) take per month. The Medicare and Consumers' Checkbook sites (Centers for Medicare & Medicaid Services, undated [b]; Consumers' Checkbook, 2016) also allow consumers to enter their health status, while two sites (those for Rhode Island and CalPERS) ask users to specify chronic and medical conditions, and Consumers' Checkbook also asks users to select specific procedures they anticipate having during the coming year. Four of the sites that present estimated out-of-pocket costs request users to enter their pregnancy status; however, we cannot tell whether this information is requested to estimate out-of-pocket costs or solely to identify women who might be eligible for Medicaid.

Table 3.6. Information Collected by Websites That Offer Total Out-of-Pocket Cost Calculators

Website	Information Collected	Additional Information That the Cost Calculator Might Use	Website-Provided Information About the Cost Algorithm
California's Covered California, undated	Age, household size, pregnancy status, and disability	Medical service use and medication use	Estimate based on user-provided medical-visit and medication information
Kentucky's kynect, undated	Age, gender, household size, pregnancy status, smoking status, and disability	Medical service use	None
Your Health Idaho, undated	Age, pregnancy status, and smoking status	Medical service use, medication use, and key services[a]	Estimate based on user-provided medical-visit and medication information
Rhode Island's HealthSource RI, undated	Age, and household size	Medical service use, chronic conditions, and preferences for lower premiums versus lower cost sharing	Unclear
Consumers' Checkbook, 2016	Age, household size, pregnancy status, and smoking status	Perceived health status and anticipated procedures[b]	Calculates "typical" costs for people like the consumer, assuming use of preferred providers
CalPERS, 2016	Household size	Medical service use, medication use, key services[a], and medical conditions	None
Medicare's Centers for Medicare & Medicaid Services, undated (b)	Age	Medication use Perceived health status	Calculates costs based on actual Medicare beneficiary service utilization

[a] Key services include acupuncture visits, dental, vision, and other outpatient services.
[b] Anticipated procedures include childbirth, angioplasty, coronary artery bypass, hysterectomy, and hip replacement.

Although reviewers could determine the types of information the sites might have used to inform the out-of-pocket cost estimates, in general, the method by which these costs were estimated was unclear. This is likely because the information that the site provided to consumers was presented in a way that those with low or limited health literacy could understand. Where we could find some information regarding the information used in the algorithm, we include it in Table 3.6.

The out-of-pocket estimates provided on these seven sites are usually a dollar estimate based on average expected spending, with two notable exceptions. First, the Idaho site (Your Health Idaho, undated) presents an estimate expressed as low, average, or high, with a colored flag next to the estimate (green, yellow, or red, respectively). This provides the consumer with a rough idea of whether his or her costs will be low or high in a given plan but does not attach a specific dollar estimate to the information. The other exception is Consumers' Checkbook (2016), which presents costs in an average year and in a bad year. The site also provides the consumer with the probability (based on user-provided information) that the bad year will occur.

Provider Networks

Finally, the ability to enroll in a plan that includes a specific provider or hospital in its network can be extremely important to consumers. However, as mentioned, the quality of the data used to inform consumers as to whether or not their providers are in the plan's network is extremely important and varies. Most sites offered some means by which consumers could see the plans' provider networks (12 state sites, three aggregator sites, and both other sites), but the ease of access to that information varied significantly by site. Of the 17 sites offering provider network information, 12 (eight state sites, two aggregator sites, and both other sites) simply linked to the plan's website, requiring the consumer to go to another website to obtain the information. Five sites (four state sites and one aggregator site) had built-in tools for the consumer to enter a provider's name to check on network status. Three of these sites (all state sites) also included hospitals in the search option. (Table A.4 in the appendix lists the specific sites referenced here.)

Distinctive Plan Result Displays

A few sites had plan result displays that were worth highlighting. California's site displays three plans on the initial page, with each plan appearing as a separate box next to another. Below each plan box is a list of several characteristics that the user can click. When the user clicks those boxes, additional information about each plan is revealed. The user has the option to hide some or all of the boxes at once, which could help the user focus on specific plan design elements at different times. Your Health Idaho (undated) also uses the plan box approach but displays additional information in the initial box (i.e., does not require a dropdown click to display the information) and includes 12 plans on each page (displayed as a grid). Focusing on a limited

number of plans could help consumers avoid choice overload but only because they do not consider all choices.

The CalPERS site includes a table that has five separate tabs, allowing users to view different plan characteristics and rate the level of fit for those characteristics. The tabs allow users to rate or remove plans based on four different plan characteristics that include estimated costs (e.g., premium contributions, estimated out-of-pocket costs based on expected medical service and prescription use levels selected by the user on the preceding information entry page); provider networks; health plan features (e.g., HMO and PPO network characteristics, referral requirements, special assistance or disease-management programs); and a detailed cost comparison of copays, deductibles, annual maximums, coinsurance, and drug copays for services that include hospital care, doctor visits, drugs, home health, vision, and mental health. The final result tab colors each plan based on the preference ratings that the user entered in the preceding tabs.

Two of the aggregator sites take a different approach to plan displays and the entry of personal information. Both HealthSherpa (undated) and HealthPocket (undated) ask the user to enter only a ZIP Code or geographic area on the main page, then immediately show the plans available in the user's area. On the top of the result page, users have the option to change the default information that the website prepopulates (for example, age, income, and location), and the plan options are automatically updated based on the new information.

Finally, Rhode Island's HealthSource RI (undated) allows the consumer to select up to four plans to compare, then exports the results to a Portable Document Format document that the consumer can save and review later.

User-Selected Sort and Filter Options

Once the consumer reaches the initial result page, the ability to sort and especially filter plan results can help reduce the problem of choice overload. Table 3.7 shows the number of sites that allow for sorting or filtering on different types of options. Premium and deductible were the most-common sort and filter options, with insurance carrier and metal tier also being fairly common filters. On average, sites incorporated anywhere from 3 to 3.8 different sort options, and 4.5 to 4.8 filter options (note that the CalPERS site did not have any sort or filter options). Medicare's Centers for Medicare & Medicaid Services (undated [b]), allowed for nine filters, as discussed above, because the user was able to apply the filters before seeing the initial results.

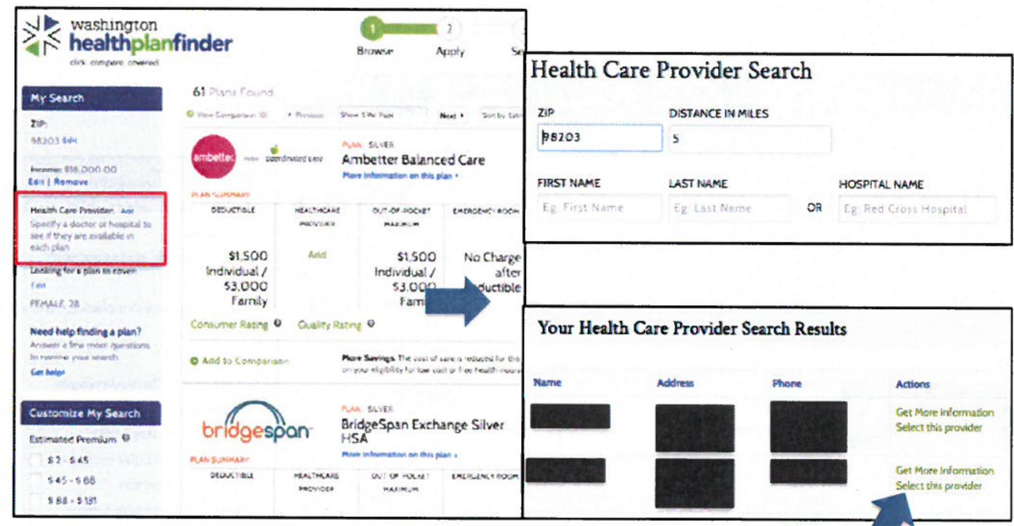
Table 3.7. Number of Sites That Offer User-Selected Sort and Filter Options

Plan Design Element	Sorting: State Sites	Sorting: Aggregator Sites	Sorting: Other	Filtering: State Sites	Filtering: Aggregator Sites	Filtering: Other
Premium	11	3	1	7	2	1
Insurance carrier	3	2	0	11	3	1
Deductible	9	2	1	9	2	1
Estimated out-of-pocket costs	3	1	1	2	1	0
Maximum out-of-pocket costs	2	1	0	2	1	0
Cost sharing	0	0	0	0	0	0
Plan quality rating	4	2	1	3	2	1
Metal tier	3	1	n/a	14	4	n/a
Plans that include a specific physician or hospital	1	0	0	2	0	0
Average number per site	3.0	3.8	3.0	4.7	3.0	4.5
Range across sites	0–6	0–7	0–6	1–8	0–6	0–9

NOTE: n/a = not applicable because Medicare and CalPERS do not have metal tiers.Table A.5 in the appendix shows the specific sites providing each of these pieces of information.

One site (Washington Healthplanfinder, undated) allowed consumers to sort based on plans that did or did not include a specific physician or hospital, while two sites (Connect for Health Colorado, undated, and Kentucky's kynect, undated) allowed consumers to filter based on inclusion in a physician network. Figures 3.4 and 3.5 show how the sort for Washington and the filter option for Kentucky work for the physician network tools.

Figure 3.4. Washington Healthplanfinder's Physician Network Sort Option



1. Consumer selects add my doctor or hospital to my search
2. Prompted to search and select provider/hospital
3. Results are sorted by provider/hospital

SOURCE: Washington Healthplanfinder, undated. Screen shot taken March 2015.

Figure 3.5. kynect's Physician Network Filter Option

SOURCE: kynect, undated. Screen shot taken March 2015.

Coverage Exemptions and Penalty Information

Some key aspects of the ACA do not pertain to specific insurance plan design features but instead to requirements to obtain coverage or an exemption from coverage. The ACA includes an individual coverage mandate, which requires most consumers to obtain health insurance coverage or pay a penalty. However, there are some exemptions to this requirement. The consumer's ability to access information both about the possible penalty he or she might pay, as well as the possibility of receiving an exemption from the mandate, can also help the consumer decide whether to enroll in a marketplace plan.

In general, we found that consumers are likely to find information on mandate penalties and exemptions only if they actively look for it. This means that the consequences of not obtaining health insurance might not be apparent to uninformed consumers.

Of the 18 sites that offer information on marketplace plans (excluding Medicare and CalPERS, which provide information on other insurance programs), all state sites and one aggregator site provided information on the possibility of receiving an exemption from the

coverage requirement. This information often appeared on a marginal area of the page or required the reviewer to search through multiple pages to find it.

Although reviewers could not test the browse feature to see whether it informed users of the possibility of receiving an exemption from coverage for all types of exemptions, we did test whether someone with an income low enough to be Medicaid eligible ($10,000) would be advised of possible eligibility. Although 13 state sites and three aggregator sites provided notification of a consumer's potential eligibility for Medicaid, Your Health Idaho (undated) did not notify the consumer of potential Medicaid eligibility. It simply informed the consumer that she was not eligible for subsidies and then presented the full-cost plan options.

Similar to the exemption information, most sites (13 state sites and two aggregator sites) acknowledged the possible consequences of noncompliance with the coverage mandate. However, this information was generally difficult to find and often required searching through various web pages in order to find it.

Summary

Our findings indicate that state, aggregator, and other insurance sites use choice architecture to assist consumers with plan choice. This choice architecture takes a variety of forms, such as the collection of personal information to present tailored results; default filtering and sorting to focus consumers on specific plans; initial result displays that provide information on specific aspects of plan benefit design that might be most important to consumers; and additional pieces of information (for example, plan quality ratings and estimated out-of-pocket costs) designed to help consumers make a good choice.

All websites we reviewed provide at least some informational materials and tools designed to help consumers learn about coverage and decide among the various options available. About half of the sites default-sort only on premium, but most sites allow for other types of sorting and filtering of results once they are displayed. Only two sites encourage low-income people to focus on silver plans via default filtering, but both sites do allow consumers to see all of the options available if they so desire.

Websites generally provide clear and prominent information on potential eligibility for premium and cost-sharing subsidies, but some sites do not apply the subsidy to the premium and cost sharing displayed in the initial results. Failing to apply subsidies could confuse subsidy-eligible consumers who think that the premium they see is what they will pay (when it could be much lower).

Chapter Four. Conclusion

Our review of the literature has suggested some ways to overcome roadblocks to optimal choices that consumers' behavioral biases and limited knowledge created. However, when we look to actual website design, we find that these theoretical best practices are often not implemented. One reason for this disconnect is that health insurance choices are quite complex. In the literature reviewed, many papers use hypothetical choice experiments in which it is easy to say that all characteristics of the plans, except those listed, are equivalent. In practice, there are many features of health insurance plans, and plan standardization is not the norm. Even those papers that have considered actual insurance choices have considered settings with more plan standardization or fewer insurance options than found in the existing health insurance marketplaces. Although coming up with suggestions to improve choice architecture is relatively easy, implementing them can be difficult in practice.

Our findings suggest that there are a variety of ways to apply behavioral economics and choice research results to real-life decision-support tools. Our reading of the literature suggests the following best practices:

1. **Provide sorting and especially filtering tools**, which will eliminate some options and can help consumers narrow down the set of options and reduce choice overload. Decision-support tools that use easy-to-answer questions to apply filters might be even more beneficial. The vast majority of websites offer these tools already, but there might be room to improve these tools and add features based on further research on actual consumer behavior on the marketplace websites.
2. **Provide accurate out-of-pocket calculators that estimate several possible outcomes**, including consumers' expected spending under typical and worst-case scenarios. This type of tool might help people better compare health insurance plans that differ in terms of premiums, deductibles, coinsurance, and copays. Less than half of websites currently offer this tool; of those that do, only one presents expected spending under different scenarios.
3. **Provide clear and accurate information about provider networks.** Provider lists should be easily accessible on websites, and the data behind the lists should be accurate and up-to-date. Ideally, consumers would be able to sort plans based on whether their preferred providers are in network. Although most of the reviewed websites provide access to information on provider networks, most (13 of 18) simply link to the plans' websites.
4. **Display plan and network quality in a simple, easy-to-understand format.** This need must be balanced with the risk of providing too much information about each option.
5. **When optimal choices can be identified, list them first.** As noted previously, however, determining the optimal choice for a given consumer can be a complicated task. Decision-support tools could help to identify these plans.

6. **Base the default—what happens when consumers make no choice—on either the status quo or the optimal choice.** In some contexts, people become so overwhelmed that they simply do not make a choice. Default enrollment can be a solution to address this issue. However, again, if defaults are used, it is important that there be some consensus about which choices should be prioritized. Furthermore, if initial choices are suboptimal, a status quo default might keep people in suboptimal plans; in that case, a dynamic default might be preferable.

We believe that the literature supports these conclusions, but there are important caveats. First, many of the studies described here rely on unincentivized choices or small convenience samples. The results from these papers might not apply when choices have real consequences or in larger, more-representative samples. Second, most of the studies based on actual insurance choices presented here have not considered the marketplaces specifically. Some have considered settings, such as employer-sponsored insurance, in which the set of options varies dramatically from those available in the marketplaces. Although the general conclusions are likely to apply, there might be unforeseen differences. Importantly, the marketplaces involve premium tax credits and cost-sharing subsidies, which could complicate the decisionmaking process. Additionally, the data needed to support the proposed website functions might be costly to obtain and prone to inaccuracies. For example, provider directories are useful only if they are accurate and up-to-date. Similarly, out-of-pocket cost calculators could be misleading if they are supported by inaccurate data. Our analysis did not explore the feasibility of obtaining accurate data to support these tools or the cost–benefit of improving such tools.

To better understand the implications of website design in the context of health insurance choice, Ubel, Comerford, and Johnson (2015) suggested, carefully designed randomized field experiments would be beneficial. This would overcome the problems of unincentivized hypothetical choice experiments and would avoid potential problems with generalizability that come from studying choices in other settings in which choice architecture might differ.

In addition, with the ACA and the continued progress of technology, the experience of purchasing insurance online is continually evolving. Consumers are becoming more Internet savvy and, over time, might demand different types of web navigation tools. Technologies are also changing, with more and more people using smartphones as their primary way to access the Internet. Because of these changes, web design features that make sense now might not make as much sense in the future. Therefore, conclusions drawn from the literature here, most of which is less than ten years old, might be already out of date. People over 65 ten years ago might have had significant trouble with online decisionmaking, but this might be less true today. Furthermore, consumers will learn more about health insurance and about the ACA over time. As we learn more about how to display information and as technology changes, we might develop new ways to communicate choices to people.

Finally and most importantly, the use of a default or a nudge is effective only if consumers are nudged toward the optimal, or at least not clearly dominated, outcome. However, this is

problematic in the context of health insurance, in which there are so many parameters and what is best for one person is not likely to be best for another.

We found that, to reduce the number of choices available or allow the user to focus on specific options, most sites provided consumers with the ability to sort and filter their plan options. However, few sites provided out-of-pocket cost calculators or built-in tools enabling consumers to see whether their preferred providers were in a plan's network. In addition, few sites provided information on plan quality, and some of those that did had yet to populate the display with data.

Given the complexity and number of plan options available in most marketplaces, our findings suggest that the websites available to help consumers sort through their options could be improved. However, the quality of the data behind all of these sites is extremely important: Any tool is only as good as the data behind it. The consumer needs high-quality, easy-to-use tools that can help him or her choose a plan that is a good fit.

Appendix

Table A.1. Sites That Request Specific Types of Personal Information

Type of Personal Information	Sites That Require			Sites That Request but Do Not Require		
	State Sites	**Aggregator Sites**	**Other**	**State Sites**	**Aggregator Sites**	**Other**
Gender	Kentucky	0	0	Washington	0	0
Date of birth	Colorado; Idaho; Massachusetts; Minnesota; and Washington, D.C.	0	0	Washington	HealthPocket	Medicare
Age (number)	California, Connecticut, Hawaii, Kentucky, Maryland, and Rhode Island	Consumers' Checkbook and ValuePenguin	0	0	HealthSherpa	0
Smoking status	Kentucky and Minnesota	Consumers' Checkbook and ValuePenguin	n/a	Colorado, Hawaii, Idaho, Massachusetts, and Washington	HealthPocket and HealthSherpa	n/a
Pregnancy status	California and Kentucky	Consumers' Checkbook	n/a	Connecticut, Maryland, and Washington	0	n/a
Household income	California, Hawaii, Idaho, Kentucky, and Rhode Island	ValuePenguin	n/a	Connecticut, Maryland, New York, and Washington	HealthPocket, HealthSherpa, and Consumers' Checkbook	n/a

NOTE: n/a = not applicable because Medicare and CalPERS do not use metal tiers.

Table A.2. Sites Applying Default Sorts and Filters for the Low-Income Scenario

	Sites Applying Default Sorts and Filters		
Plan Design Element	**State Sites**	**Aggregator Sites**	**Other**
Default filters (metal tiers only)			
Silver	Connecticut and Maryland	ValuePenguin	n/a
Default sorts			
Metal tier, then premium	Washington	0	0
Premium	Colorado; Connecticut; Hawaii; Idaho; Maryland; Massachusetts; New York; and Washington, D.C.	HealthPocket, HealthSherpa, and ValuePenguin	0
Total out-of-pocket costs	California	Consumers' Checkbook	CalPERS and Medicare
Metal tier	Rhode Island and Vermont	0	n/a
"My Preferences"	Minnesota	0	0

NOTE: n/a = not applicable because Medicare and CalPERS do not use metal tiers.

Table A.3. Sites Presenting Specific Design Elements in Initial Result Displays, for the Low-Income Scenario

Plan Design Element	State Sites	Aggregator Sites	Other
Insurance carrier	All sites	All sites	All sites
Premium	All sites	All sites	All sites
Metal tier	All sites	All sites	n/a
Deductible	California; Colorado; Connecticut; Idaho; Kentucky; Maryland; Massachusetts; Minnesota; Rhode Island; Vermont; Washington; and Washington, D.C.	Consumers' Checkbook, HealthPocket, and HealthSherpa	All sites
Maximum out-of-pocket costs	California, Colorado, Connecticut, Idaho, Maryland, Massachusetts, Minnesota, Rhode Island, Vermont, and Washington	HealthPocket	All sites
Cost sharing	California, Connecticut, Idaho, Maryland, Vermont, and Washington	HealthSherpa	All sites
Total estimated out-of-pocket costs	California, Idaho, Kentucky, and Rhode Island	Consumers' Checkbook	All sites
Plan quality rating			
Based on established metrics	Connecticut	Consumers' Checkbook and HealthPocket	Medicare
Based on surveys	California	0	0
Other method	Kentucky, Maryland, and Minnesota	HealthPocket	0
Drug coverage information	California, Colorado, Idaho, Massachusetts, and Vermont	0	All sites
Whether physician is in network	0	Consumers' Checkbook	0

Table A.4. Sites That Offer Information on Provider Networks

Type of Provider Network Information	State Sites	Aggregator Sites	Other
Links to plan's website for provider information	California; Connecticut; Hawaii; Idaho; Massachusetts; Minnesota; Vermont; and Washington, D.C.	Consumers' Checkbook and HealthSherpa	CalPERS and Medicare
Built-in tool for checking on network status (physician or hospital)	Colorado, Kentucky, Maryland, and Washington	HealthPocket	None

Table A.5. Sites That Offer User-Selected Sort and Filter Options

	Sorting[a]		Filtering[a]	
Plan Design Element	**State sites**	**Aggregator Sites**	**State sites**	**Aggregator Sites**
Premium	California; Colorado; Connecticut; Hawaii; Idaho; Kentucky; Maryland; Massachusetts; Minnesota; Washington; and Washington, D.C.	Consumers' Checkbook, HealthPocket, and HealthSherpa	Colorado, Connecticut, Hawaii, Kentucky, Maryland, Massachusetts, and Washington	Consumers' Checkbook and HealthPocket
Insurance carrier	Connecticut, Hawaii, Maryland	Consumers' Checkbook and HealthPocket	Colorado; Connecticut; Hawaii; Idaho; Kentucky; Maryland; Massachusetts; New York; Rhode Island; Washington; and Washington, D.C.	Consumers' Checkbook, HealthPocket, and HealthSherpa
Deductible	Colorado; Connecticut; Idaho; Kentucky; Maryland; Massachusetts; Minnesota; Washington; and Washington, D.C.	HealthPocket and HealthSherpa	Colorado; Connecticut; Idaho; Kentucky; Maryland; Massachusetts; Minnesota; Washington; and Washington, D.C.	Consumers' Checkbook and HealthPocket
Estimated out-of-pocket costs	California, Idaho, and Kentucky	Consumers' Checkbook	Kentucky	Consumers' Checkbook
Maximum out-of-pocket costs	Idaho and Washington	HealthPocket	Massachusetts and Washington	HealthPocket
Plan quality rating	California, Connecticut, Kentucky, and Maryland	Consumers' Checkbook and HealthPocket	Connecticut, Maryland, and New York	Consumers' Checkbook and HealthPocket
Metal tier	Connecticut, Maryland, and Minnesota	HealthPocket	All sites	All sites
Plans that include specific physician or hospital	Washington	0	Colorado and Kentucky	0

[a] Medicare is the only "other" site that provides user-selected sort and filter options, so we do not list it here.

Bibliography

Abaluck, Jason, and Jonathan Gruber, "Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program," *American Economic Review*, Vol. 101, No. 4, June 2011, pp. 1180–1210.

Abraham, Jean M., Roger Feldman, Caroline Carlin, and Jon Christianson, "The Effect of Quality Information on Consumer Health Plan Switching: Evidence from the Buyers Health Care Action Group," *Journal of Health Economics*, Vol. 25, No. 4, July 2006, pp. 762–781.

Access Health CT, home page, undated. As of May 6, 2016:
https://www.accesshealthct.com

Appelt, Kirstin, Jie Gao, Eric Johnson, and Ted von Glahn, "Choosing How to Choose: Can People Choose the Best Choice Architecture?" *Advances in Consumer Research*, Vol. 42, January 2014, pp. 395–396.

Apter, Andrea J., Michael K. Paasche-Orlow, Janine T. Remillard, Ian M. Bennett, Elana Pearl Ben-Joseph, Rosanna M. Batista, James Hyde, and Rima E. Rudd, "Numeracy and Communication with Patients: They Are Counting on Us," *Journal of General Internal Medicine*, Vol. 23, No. 12, December 2008, pp. 2117–2124.

Atanasov, Pavel, and Tom Baker, "Putting Health Back into Health Insurance Choice," *Medical Care Research and Review*, Vol. 71, No. 4, August 2014, pp. 337–355.

Baicker, Katherine, William J. Congdon, and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *Milbank Quarterly*, Vol. 90, No. 1, March 2012, pp. 107–134.

Baker, Tom, Adrienne Beatty, Gabbie Nirenburg, and Janet Weiner, "Window Shopping on Healthcare.gov and the State-Based Marketplaces: More Consumer Support Is Needed," Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation, December 2014. As of May 3, 2016:
http://www.rwjf.org/en/library/research/2014/12/window-shopping-on-healthcare-gov-and-the-state-based-marketplac.html

Barcellos, Silvia Helena, Amelie C. Wuppermann, Katherine Grace Carman, Sebastian Bauhoff, Daniel L. McFadden, Arie Kapteyn, Joachim K. Winter, and Dana Goldman, "Preparedness of Americans for the Affordable Care Act," *Proceedings of the National Academy of Sciences of the United States of America*, Vol. 111, No. 15, April 2014, pp. 5497–5502.

Barnes, Andrew J., Yaniv Hanoch, and Thomas Rice, "Determinants of Coverage Decisions in Health Insurance Marketplaces: Consumers' Decision-Making Abilities and the Amount of Information in Their Choice Environment," *Health Services Research*, Vol. 50, No. 1, February 2015, pp. 58–80.

Barnes, Andrew J., Yaniv Hanoch, Stacey Wood, and Thomas Rice, "One Fish, Two Fish, Red Fish, Blue Fish: Effects of Price Frames, Brand Names, and Choice Set Size on Medicare Part D Insurance Plan Decisions," *Medical Care Research and Review*, Vol. 69, No. 4, February 2012, pp. 460–473.

Bhargava, Saurabh, George Loewenstein, and Justin Sydnor, *Do Individuals Make Sensible (Health) Insurance Decisions? Evidence from a Menu with Dominated Options*, Pittsburgh, Pa.: Carnegie Mellon University, working paper, February 2015.

Bordalo, Pedro, Nicola Gennaioli, and Andrei Shleifer, *Salience Theory of Consumer Choice*, Cambridge, Mass.: National Bureau of Economic Research Working Paper 17947, March 2012. As of May 3, 2016:
http://www.nber.org/papers/w17947

Brockington, David, "A Low Information Theory of Ballot Position Effect," *Political Behavior*, Vol. 25, No. 1, March 2003, pp. 1–27.

Buchmueller, Thomas, "Price and the Health Plan Choices of Retirees," *Journal of Health Economics*, Vol. 25, No. 1, January 2006, pp. 81–101.

Bundorf, M. Kate, Rui Mata, Michael Schoenbaum, and Jay Bhattacharya, "Are Prescription Drug Insurance Choices Consistent with Expected Utility Theory?" *Health Psychology*, Vol. 32, No. 9, September 2013, pp. 986–994.

Bundorf, M. K., S. J. Singer, T. H. Wagner, and L. Baker, "Consumers' Use of the Internet for Health Insurance," *American Journal of Managed Care*, Vol. 10, No. 9, September 2004, pp. 609–616.

Bundorf, M. Kate, and Helena Szrek, "Choice Set Size and Decision Making: The Case of Medicare Part D Prescription Drug Plans," *Medical Decision Making*, Vol. 30, No. 5, September–October 2010, pp. 582–593.

California Public Employees' Retirement System, home page, updated May 4, 2016. As of May 4, 2016:
https://www.calpers.ca.gov/

CalPERS—*See* California Public Employees' Retirement System.

Centers for Medicare & Medicaid Services, "Advanced Premium Tax Credits (APTC)," undated (a). As of May 6, 2016:
https://www.healthcare.gov/glossary/advanced-premium-tax-credit/

———, "Medicare Plan Finder," *Medicare.gov*, undated (b). As of May 4, 2016: https://www.medicare.gov/find-a-plan/questions/home.aspx

Claxton, Gary, Matthew Rae, Nirmita Panchal, Anthony Damico, Nathan Bostick, Kevin Kenward, and Heidi Whitmore, *Employer Health Benefits: 2014 Annual Survey*, Menlo Park, Calif.: Henry J. Kaiser Family Foundation and Health Research and Educational Trust, publication 8625, September 2014. As of May 3, 2016: http://kff.org/health-costs/report/2014-employer-health-benefits-survey/

Connect for Health Colorado, home page, undated. As of May 6, 2016: http://connectforhealthco.com/

Consumers' Checkbook, "Plan Comparison Tool 2016," c. 2016. As of May 6, 2016: https://www.healthplanratings.org/hie/

Covered California, home page, undated. As of May 6, 2016: http://www.coveredca.com/

Cutler, David M., and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics*, Vol. 113, No. 2, May 1998, pp. 433–466.

Cutler, David M., and Richard J. Zeckhauser, "The Anatomy of Health Insurance," in Anthony J. Culyer and Joseph P. Newhouse, eds., *Handbook of Health Economics*, Vol. 1A, Part 3: *Insurance Markets, Managed Care, and Contracting*, Amsterdam: Elsevier, 2000, pp. 563–643.

Dafny, Leemore, and David Dranove, "Do Report Cards Tell Consumers Anything They Don't Already Know? The Case of Medicare HMOs," *RAND Journal of Economics*, Vol. 39, No. 3, Autumn 2008, pp. 790–821.

Dafny, Leemore, Jonathan Gruber, and Christopher Ody, "More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces," *American Journal of Health Economics*, Vol. 1, No. 1, Winter 2015, pp. 53–81.

Dafny, Leemore, Kate Ho, and Mauricio Varela, "Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and Toward an Individual Exchange," *American Economic Journal: Economic Policy*, Vol. 5, No. 1, February 2013, pp. 32–58.

Day, Rosemary, and Pamela Nadash, "New State Insurance Exchanges Should Follow the Example of Massachusetts by Simplifying Choices Among Health Plans," *Health Affairs*, Vol. 31, No. 5, May 2012, pp. 982–989.

DC Health Link, home page, undated. As of May 6, 2016: https://dchealthlink.com/

DellaVigna, Stefano, "Psychology and Economics: Evidence from the Field," *Journal of Economic Literature*, Vol. 47, No. 2, 2009, pp. 315–372.

Einav, Liran, Amy Finkelstein, Stephen P. Ryan, Paul Schrimpf, and Mark R. Cullen, "Selection on Moral Hazard in Health Insurance," *American Economic Review*, Vol. 103, No. 1, February 2013, pp. 178–219.

Enroll UX 2014, home page, undated (a). As of May 6, 2016:
http://www.ux2014.org/

———, "About UX 2014," undated (b). As of May 2, 2016:
http://www.ux2014.org/about-ux-2014

Ericson, Keith M., "Consumer Inertia and Firm Pricing in the Medicare Part D Prescription Drug Insurance Exchange," *American Economic Journal: Economic Policy*, Vol. 6, No. 1, February 2014, pp. 38–64.

Ericson, Keith, and Amanda Starc, "Heuristics and Heterogeneity in Health Insurance Exchanges: Evidence from the Massachusetts Connector," *American Economic Review*, Vol. 102, No. 3, May 2012, pp. 493–497.

———, *How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange*, Cambridge, Mass.: National Bureau of Economic Research, Working Paper 19527, October 2013. As of May 4, 2016:
http://www.nber.org/papers/w19527

———, *Measuring Consumer Valuation of Limited Provider Networks*, Cambridge, Mass.: National Bureau of Economic Research, Working Paper 20812, December 2014. As of May 4, 2016:
http://www.nber.org/papers/w20812

Feldman, Roger, Michael Finch, Bryan Dowd, and Steven Cassou, "The Demand for Employment-Based Health Insurance Plans," *Journal of Human Resources*, Vol. 24, No. 1, Winter 1989, pp. 115–142.

Frank, Richard G., and Karine Lamiraud, "Choice, Price Competition and Complexity in Markets for Health Insurance," *Journal of Economic Behavior and Organization*, Vol. 71, No. 2, August 2009, pp. 550–562.

Gabaix, Xavier, and David Laibson, "Shrouded Attributes, Consumer Myopia, and Information Suppression in Competitive Markets," *Quarterly Journal of Economics*, Vol. 121, No. 2, 2006, pp. 505–540.

Galesic, Mirta, and Rocio Garcia-Retamero, "Statistical Numeracy for Health: A Cross-Cultural Comparison with Probabilistic National Samples," *Archives of Internal Medicine*, Vol. 170, No. 5, March 8, 2010, pp. 462–468.

Gibbs, Deborah A., Judith A. Sangl, and Barri Burrus, "Consumer Perspectives on Information Needs for Health Plan Choice," *Health Care Financing Review*, Vol. 18, No. 1, Fall 1996, pp. 55–73.

Greene, J., E. Peters, C. K. Mertz, and J. H. Hibbard, "Comprehension and Choice of a Consumer-Directed Health Plan: An Experimental Study," *American Journal of Managed Care*, Vol. 14, No. 6, June 2008, pp. 369–376.

Handel, Benjamin R., "Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts," *American Economic Review*, Vol. 103, No. 7, December 2013, pp. 2643–2682.

Handel, Benjamin R., and Jonathan T. Kolstad, "Health Insurance for 'Humans': Information Frictions, Plan Choice, and Consumer Welfare," *American Economic Review*, Vol. 105, No. 8, August 2015, pp. 2449–2500.

Hanoch, Yaniv, and Thomas Rice, "Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance," *Milbank Quarterly*, Vol. 84, No. 1, 2006, pp. 37–73.

———, "The Economics of Choice: Lessons from the U.S. Health-Care Market," *Health Expectations*, Vol. 14, No. 1, March 2011, pp. 105–112.

Hanoch, Yaniv, Thomas Rice, Janet Cummings, and Stacey Wood, "How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit," *Health Services Research*, Vol. 44, No. 4, August 2009, pp. 1157–1168.

Hanoch, Yaniv, Stacey Wood, Andrew Barnes, Pi-Ju Liu, and Thomas Rice, "Choosing the Right Medicare Prescription Drug Plan: The Effect of Age, Strategy Selection, and Choice Set Size," *Health Psychology*, Vol. 30, No. 6, November 2011, pp. 719–727.

Harris-Kojetin, Lauren D., Jennifer D. Uhrig, Peyton Williams, Carla Bann, Elizabeth M. Frentzel, Lauren McCormack, Nancy Mitchell, and Nathan West, "The 'Choose with Care System': Development of Education Materials to Support Informed Medicare Health Plan Choices," *Journal of Health Communication: International Perspectives*, Vol. 12, No. 2, 2007, pp. 133–156.

Hawai'i Health Connector, home page, undated. As of May 6, 2016: http://www.hawaiihealthconnector.com/

HealthPocket, home page, undated. As of May 6, 2016: https://www.healthpocket.com/

HealthSherpa, home page, undated. As of May 6, 2016: https://www.healthsherpa.com/

HealthSource RI, home page, undated. As of May 6, 2016:
http://healthsourceri.com/

Heiss, Florian, Adam Leive, Daniel McFadden, and Joachim Winter, "Plan Selection in Medicare Part D: Evidence from Administrative Data," *Journal of Health Economics*, Vol. 32, No. 6, 2013, pp. 1325–1344.

Hibbard, Judith H., Jessica Greene, Shoshanna Sofaer, Kirsten Firminger, and Judith Hirsh, "An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs*, Vol. 31, No. 3, March 2012, pp. 560–568.

Hibbard, Judith H., J. J. Jewett, S. Engelmann, and M. Tusler, "Can Medicare Beneficiaries Make Informed Choices?" *Health Affairs*, Vol. 17, No. 6, November 1998, pp. 181–193.

Hibbard, Judith H., and E. Peters, "Supporting Informed Consumer Health Care Decisions: Data Presentation Approaches That Facilitate the Use of Information in Choice," *Annual Review of Public Health*, Vol. 24, 2003, pp. 413–433.

Iyengar, Sheena S., and Mark R. Lepper, "When Choice Is Demotivating: Can One Desire Too Much of a Good Thing?" *Journal of Personality and Social Psychology*, Vol. 79, No. 6, December 2000, pp. 995–1006.

Jacobson, Gretchen, Jennifer Huang, and Tricia Neuman, *Medigap Reform: Setting the Context for Understanding Recent Proposals*, Henry J. Kaiser Family Foundation, issue brief, January 13, 2014. As of May 4, 2016:
http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/

Jin, Ginger Zhe, and Alan T. Sorensen, "Information and Consumer Choice: The Value of Publicized Health Plan Ratings," *Journal of Health Economics*, Vol. 25, No. 2, March 2006, pp. 248–275.

Johnson, Eric J., and Daniel Goldstein, "Do Defaults Save Lives?" *Science*, Vol. 302, No. 5649, November 21, 2003, pp. 1338–1339.

Johnson, Eric J., Ran Hassin, Tom Baker, Allison T. Bajger, and Galen Treuer, "Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture," *PLOS ONE*, Vol. 8, No. 12, December 18, 2013, p. e81521.

King, Dominic, Felix Greaves, Ivo Vlaev, and Ara Darzi, "Approaches Based on Behavioral Economics Could Help Nudge Patients and Providers Toward Lower Health Spending Growth," *Health Affairs*, Vol. 32, No. 4, April 2013, pp. 661–668.

Kling, Jeffrey R., Sendhil Mullainathan, Eldar Shafir, Lee Vermeulen, and Marian Wrobel, "Comparison Friction: Experimental Evidence from Medicare Drug Plans," *Quarterly Journal of Economics*, Vol. 127, No. 1, February 2012, pp. 199–235.

Kolstad, Jonathan T., and Michael E. Chernew, "Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services," *Medical Care Research and Review*, Vol. 66, No. 1, Suppl., February 2009, pp. 28S–52S.

Krieger, Miriam, and Stefan Felder, "Can Decision Biases Improve Insurance Outcomes? An Experiment on *Status Quo* Bias in Health Insurance Choice," *International Journal of Environmental Research and Public Health*, Vol. 10, No. 6, June 2013, pp. 2560–2577.

Krughoff, Robert, Walton Francis, and Robert Ellis, "Helping Consumers Choose Health Plans in Exchanges: Best Practice Recommendations," *Health Affairs Blog*, February 29, 2012. As of May 20, 2016:
http://healthaffairs.org/blog/2012/02/29/helping-consumers-choose-health-plans-in-exchanges-best-practice-recommendations/

kynect, home page, undated. As of May 6, 2016:
https://kynect.ky.gov/

Li, Qian, and Pravin K. Trivedi, "Medicare Health Plan Choices of the Elderly: A Choice-with-Screening Model," *Journal of Business and Economic Statistics*, Vol. 30, No. 1, January 2012, pp. 81–93.

Loewenstein, George, Joelle Y. Friedman, Barbara McGill, Sarah Ahmad, Suzanne Linck, Stacey Sinkula, John Beshears, James J. Choi, Jonathan Kolstad, David Laibson, Brigitte C. Madrian, John A. List, and Kevin G. Volpp, "Consumers' Misunderstanding of Health Insurance," *Journal of Health Economics*, Vol. 32, No. 5, September 2013, pp. 850–862.

Lynch, John G., Jr., and Dan Ariely, "Wine Online: Search Costs Affect Competition on Price, Quality, and Distribution," *Marketing Science*, Vol. 19, No. 1, 2000, pp. 83–103.

Madrian, Brigitte C., and Dennis F. Shea, "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior," *Quarterly Journal of Economics*, Vol. 116, No. 4, November 2001, pp. 1149–1187.

Maher, Brendan S., "Some Thoughts on Health Care Exchanges: Choice, Defaults, and the Unconnected," *Connecticut Law Review*, Vol. 44, No. 4, April 2012, pp. 1099–1115. As of May 4, 2016:
http://connecticutlawreview.org/articles/some-thoughts-on-health-care-exchanges-choice-defaults-and-the-unconnected/

Marquis, M. Susan, Melinda Beeuwkes Buntin, José J. Escarce, and Kanika Kapur, "The Role of Product Design in Consumers' Choices in the Individual Insurance Market," *Health Services Research*, Vol. 42, No. 6, Part 1, December 2007, pp. 2194–2223.

Marquis, M. Susan, Melinda Beeuwkes Buntin, José J. Escarce, Kanika Kapur, Thomas A. Louis, and Jill M. Yegian, "Consumer Decision Making in the Individual Health Insurance Market," *Health Affairs*, Vol. 25, No. 3, May 2006, pp. W226–W234.

Maryland Health Connection, home page, undated. As of May 6, 2016: https://www.marylandhealthconnection.gov/

Massachusetts Health Connector, home page, undated. As of May 6, 2016: https://www.mahealthconnector.org/

McWilliams, J. Michael, "Information Transparency for Health Care Consumers: Clear, but Effective?" *Journal of General Internal Medicine*, Vol. 28, No. 11, November 2013, pp. 1387–1388.

McWilliams, J. Michael, Christopher C. Afendulis, Thomas G. McGuire, and Bruce E. Landon, "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decisionmaking," *Health Affairs*, Vol. 30, No. 9, August 2011, pp. 1786–1794.

Mikels, Joseph A., Andrew E. Reed, and Kosali I. Simon, "Older Adults Place Lower Value on Choice Relative to Young Adults," *Journals of Gerontology*, Series B: *Psychological Sciences and Social Sciences*, Vol. 64, No. 4, June 2009, pp. 443–446.

MNsure, home page, undated. As of May 6, 2016: http://www.mnsure.org/

Monahan, Christine, Sarah J. Dash, Kevin Lucia, and Sabrina Corlette, *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces*, New York: Commonwealth Fund, issue brief, publication 1720, Vol. 34, December 2013. As of May 4, 2016: http://www.commonwealthfund.org/publications/issue-briefs/2013/dec/simplify-health-plan-choice

Naessens, James M., Mahmud Khan, Nilay D. Shah, Amy Wagie, Rebecca A. Pautz, and Claudia R. Campbell, "Effect of Premium, Copayments, and Health Status on the Choice of Health Plans," *Medical Care*, Vol. 46, No. 10, October 2008, pp. 1033–1040.

Nichols, Len M., Paul B. Ginsburg, Robert A. Berenson, Jon Christianson, and Robert E. Hurley, "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence Is Waning," *Health Affairs*, Vol. 23, No. 2, March 2004, pp. 8–21.

NY State of Health, home page, undated. As of May 6, 2016: https://nystateofhealth.ny.gov/

O'Brien, Ellen, and Jack Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice*, New York: Commonwealth Fund, issue brief, Vol. 33, publication 1117, April 2008. As of May 4, 2016:
http://www.commonwealthfund.org/publications/issue-briefs/2008/apr/medicare-advantage--options-for-standardizing-benefits-and-information-to-improve-consumer-choice

Pacific Business Group on Health, *Consumer Choice of Health Plan Decision Support Rules for Health Exchanges: Installments I, II and III*, 2012.

———, "Consumer Choice of Health Plan Decision Support Rules for Health Exchanges: Issue Brief—Top 5 Rules for Decision Support, and Strategies to Bridge the Gaps," c. 2013. As of May 4, 2016:
http://www.pbgh.org/storage/documents/PBGH_PlanChoiceBrief_Top5Rules_022113.pdf

Paez, Kathryn A., Coretta J. Mallery, HarmoniJoie Noel, Christopher Pugliese, Veronica E. McSorley, Jennifer L. Lucado, and Deepa Ganachari, "Development of the Health Insurance Literacy Measure (HILM): Conceptualizing and Measuring Consumer Ability to Choose and Use Private Health Insurance," *Journal of Health Communication*, Vol. 19, Supp. 2, October 14, 2014, pp. 225–239.

PBGH—*See* Pacific Business Group on Health.

Peters, Ellen, Nathan Dieckmann, Anna Dixon, Judith H. Hibbard, and C. K. Mertz, "Less Is More in Presenting Quality Information to Consumers," *Medical Care Research and Review*, Vol. 64, No. 2, April 2007, pp. 169–190.

Peters, Ellen, Louise Meilleur, and Mary Kate Tompkins, *Numeracy and the Affordable Care Act: Opportunities and Challenges*, paper commissioned by the Roundtable on Health Literacy, Institute of Medicine, undated. As of May 4, 2016:
http://www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/PublicHealth/HealthLiteracy/Commissioned-Papers/Numeracy-and-the-Affordable-Care-Act-Opportunities-and-Challenges.pdf

Politi, Mary C., Kimberly A. Kaphingst, Matthew Kreuter, Enbal Shacham, Melissa C. Lovell, and Timothy McBride, "Knowledge of Health Insurance Terminology and Details Among the Uninsured," *Medical Care Research and Review*, Vol. 71, No. 1, February 2014, pp. 85–98.

Polsky, Daniel, Rebecca Stein, Sean Nicholson, and M. Kate Bundorf, "Employer Health Insurance Offerings and Employee Enrollment Decisions," *Health Services Research*, Vol. 40, No. 5, Pt. 1, October 2005, pp. 1259–1278.

Public Law 111-148, Patient Protection and Affordable Care Act, March 23, 2010. As of May 4, 2016:
https://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html

Quincy, Lynn, *What's Behind the Door: Consumer Difficulties Selecting Health Plans*, Consumers Union, Health Policy Brief, January 2012a. As of May 3, 2016:
http://consumersunion.org/research/whats-behind-the-door-consumer-difficulties-selecting-health-plans/

———, *Choice Architecture: Design Decisions That Affect Consumers' Health Plan Choices*, Consumers Union, July 9, 2012b. As of May 4, 2016:
http://consumersunion.org/research/report-choice-architecture-design-decisions-that-affect-consumers-health-plan-choices/

Rice, Thomas, Gretchen Jacobson, Juliette Cubanski, and Tricia Neuman, "The Private Health Insurance Choices of Medicare Beneficiaries: How Much Does Price Matter?" *Medical Care Research and Review*, Vol. 71, No. 6, December 2014, pp. 661–689.

Romley, John A., Yuri Sanchez, John R. Penrod, and Dana P. Goldman, "Survey Results Show That Adults Are Willing to Pay Higher Insurance Premiums for Generous Coverage of Specialty Drugs," *Health Affairs*, Vol. 31, No. 4, April 2012, pp. 683–690.

Royalty, Anne Beeson, and Neil Solomon, "Health Plan Choice: Price Elasticities in a Managed Competition Setting," *Journal of Human Resources*, Vol. 34, No. 1, Winter 1999, pp. 1–41.

Samuelson, William, and Richard Zeckhauser, "Status Quo Bias in Decision Making," *Journal of Risk and Uncertainty*, Vol. 1, No. 1, March 1988, pp. 7–59.

Schram, Arthur, and Joep Sonnemans, "How Individuals Choose Health Insurance: An Experimental Analysis," working paper, 2008.

Schwartz, Barry, *The Paradox of Choice: Why More Is Less*, New York: Ecco, 2004.

Schwartz, Janet, Nortin M. Hadler, Dan Ariely, Joel C. Huber, and Thomas Emerick, "Choosing Among Employer-Sponsored Health Plans: What Drives Employee Choices?" *Journal of Occupational and Environmental Medicine*, Vol. 55, No. 3, March 2013, pp. 305–309.

Shepard, Mark, *Hospital Network Competition and Adverse Selection: Evidence from the Massachusetts Health Insurance Exchange*, working paper, 2015.

Simon, Herbert A., "A Behavioral Model of Rational Choice," *Quarterly Journal of Economics*, Vol. 69, No. 1, 1955, pp. 99–118.

———, "Rational Choice and the Structure of the Environment," *Psychological Review*, Vol. 63, No. 2, March 1956, pp. 129–138.

Sinaiko, Anna D., and Richard A. Hirth, "Consumers, Health Insurance and Dominated Choices," *Journal of Health Economics*, Vol. 30, No. 2, March 2011, pp. 450–457.

Spranca, M. D., M. N. Elliott, R. Shaw, and D. E. Kanouse, "Disenrollment Information and Medicare Plan Choice: Is More Information Better?" *Health Care Financing Review*, Vol. 28, No. 3, Spring 2007, pp. 47–59.

Strombom, Bruce A., Thomas C. Buchmueller, and Paul J. Feldstein, "Switching Costs, Price Sensitivity and Health Plan Choice," *Journal of Health Economics*, Vol. 21, No. 1, January 2002, pp. 89–116.

Szrek, Helena, and M. Kate Bundorf, "Enrollment in Prescription Drug Insurance: The Interaction of Numeracy and Choice Set Size," *Health Psychology*, Vol. 33, No. 4, April 2014, pp. 340–348.

Tanius, Betty E., Stacey Wood, Yaniv Hanoch, and Thomas Rice, "Aging and Choice: Applications to Medicare Part D," *Judgment and Decision Making*, Vol. 4, No. 1, February 2009, pp. 92–101.

Taylor, Erin A., Evan Saltzman, Sebastian Bauhoff, Rosalie L. Pacula, and Christine Eibner, "More Choice in Health Insurance Marketplaces May Reduce the Value of the Subsidies Available to Low-Income Enrollees," *Health Affairs*, Vol. 34, No. 1, January 2015, pp. 104–110.

Thaler, Richard H., and Cass R. Sunstein, *Nudge: Improving Decisions About Health, Wealth, and Happiness*, New Haven, Conn.: Yale University Press, 2008.

Tumlinson, Anne, Hannah Bottigheimer, Peter Mahoney, Elliot M. Stone, and Ann Hendricks, "Choosing a Health Plan: What Information Will Consumers Use?" *Health Affairs*, Vol. 16, No. 3, May–June 1997, pp. 229–238.

Ubel, Peter A., David A. Comerford, and Eric Johnson, "Healthcare.gov 3.0: Behavioral Economics and Insurance Exchanges," *New England Journal of Medicine*, Vol. 372, 2015, pp. 695–698.

Uhrig, Jennifer D., Lauren Harris-Kojetin, Carla Bann, and Tzy-Mey Kuo, "Do Content and Format Affect Older Consumers' Use of Comparative Information in a Medicare Health Plan Choice? Results from a Controlled Experiment," *Medical Care Research and Review*, Vol. 63, No. 6, December 2006, pp. 701–718.

ValuePenguin, "Affordable Care Act (Obamacare) Health Insurance Exchanges: Compare Health Insurance Exchange Plans," undated. As of May 6, 2016: http://www.valuepenguin.com/ppaca/exchanges

Van den Berg, Bernard, Paula Van Dommelen, Piet Stam, Trea Laske-Aldershof, Tom Buchmueller, and Frederik T. Schut, "Preferences and Choices for Care and Health Insurance," *Social Science and Medicine*, Vol. 66, No. 12, June 2008, pp. 2448–2459.

Vermont Health Connect, home page, undated. As of May 6, 2016: https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

Washington Healthplanfinder, home page, undated. As of May 6, 2016: https://www.wahealthplanfinder.org

White, Chapin, *Promoting Healthy Competition in Health Insurance Exchanges: Options and Trade-Offs*, Washington, D.C.: National Institute for Health Care Reform, Policy Analysis 6, November 2011. As of May 4, 2016: http://www.nihcr.org/Healthy_Competition

Wong, Charlene A., David A. Asch, Cjloe M. Vinoya, Carol A. Ford, Tom Baker, Robert Town, and Raina M. Merchant, "The Experience of Young Adults on HealthCare.gov: Suggestions for Improvement," *Annals of Internal Medicine*, Vol. 161, No. 3, August 5, 2014, letter to the editor following p. 231.

Wood, Stacey, Yaniv Hanoch, Andrew Barnes, Pi-Ju Liu, Janet Cummings, Chandrima Bhattacharya, and Thomas Rice, "Numeracy and Medicare Part D: The Importance of Choice and Literacy for Numbers in Optimizing Decision Making for Medicare's Prescription Drug Program," *Psychology and Aging*, Vol. 26, No. 2, June 2011, pp. 295–307.

Your Health Idaho, home page, undated. As of May 6, 2016: https://idahohix.yourhealthidaho.org/hix/

Benchmarking California Health Care Quality and Cost Performance

Dolores Yanagihara, M.P.H., Vice President, Performance Measurement
Angela Kline, M.P.H., Project Manager
Jill Yegian, Ph.D., Senior Vice President, Programs and Policy

Benchmarking and tracking regional performance on key quality and cost measures is critical to monitoring the state's progress toward the goal of high-value care for all Californians. Along with a clearer picture of population-level health care quality and costs across the state, the Regional Cost & Quality Atlas *at costatlas.iha.org identifies so-called hot spots for targeted performance improvement.*

ABSTRACT

Across California—and the nation—health care quality and cost vary dramatically. While some variation reflects differences in patient populations, other variation is unexplained and may signal missed opportunities for patients to receive the right care at the right time as efficiently as possible. Benchmarking and tracking performance on key quality and cost measures is critical to reducing unwarranted cost and quality variation and achieving high-quality, affordable, patient-centered care for all Californians. A new online tool—the *California Regional Health Care Cost & Quality Atlas*—developed by the Integrated Healthcare Association (IHA), in partnership with the California Health Care Foundation and the California Health and Human Services Agency, illuminates the wide geographic variation in clinical quality, costs, and hospital utilization across the state.

And, a new IHA analysis of Atlas data for 14.5 million of the 19.4 million Californians enrolled in commercial health insurance products—health maintenance organizations (HMOs) and preferred provider organizations (PPOs)—confirms earlier research documenting wide geographic and insurance product variation on quality measures while shining new light on regional and product cost variation. From a regional perspective, Northern California shows the strongest performance on clinical quality for commercially insured enrollees but at relatively high cost; Southern California performs solidly on quality at much lower cost; and Central California shows weaker performance on quality with mixed cost performance. Comparing commercial HMOs to commercial PPOs, HMOs frequently outperform PPOs on both clinical quality and cost measures across the state's 19 geographic regions, reflecting underlying differences between product types, including the use of integrated care delivery systems in HMO provider networks.

TRACKING PERFORMANCE BY GEOGRAPHIC REGION AND INSURANCE TYPE

Most health care cost and quality transparency initiatives typically focus on individual health plan and provider performance to target quality improvement and guide consumer decisions. The Atlas takes a different approach by tracking performance by geographic region and insurance product type to provide a clearer picture of population-level health care quality and costs (see page 8 for more information about the Atlas).

This Issue Brief examines Atlas data for 14.5 million Californians enrolled in commercial insurance products—both HMOs and PPOs collectively, and each product type individually—across geographic regions. Brief summaries of Medicare and Medi-Cal results also are available on pages 12 and 9, respectively. Future analysis will include more extensive review of both Medicare and Medi-Cal performance.

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Key findings from an analysis of 2013 Atlas data for commercial enrollment include:

- **Northern California shows strongest quality performance.** Northern California outperforms Central and Southern California on clinical quality measures, with Central California falling below the statewide average on key clinical measures for the priority health conditions of cancer, diabetes, and asthma. Clinical quality scores vary significantly from region to region for some measures. For example, 32.7 percent of commercial enrollees with diabetes in Alameda County (Region 6) have blood sugar that is poorly controlled, compared to 75.4 percent in the Eastern Region (Region 13).
- **Average risk-adjusted total cost of care for commercial enrollees is lower in Southern California than in Northern.** With one exception, all Northern California regions have higher annual per-enrollee costs than the statewide commercial average of $4,300, while all Southern California regions fall below the statewide average; Central California regions show mixed results on cost. Geographic variation in cost of care is dramatic—a difference of $1,800 in the average annual per-enrollee total cost of care between the most costly and least costly regions—respectively, San Francisco County (4) at $5,400 and Kern County (14) at $3,600.
- **Commercial HMO products generally outperform commercial PPO products on both clinical quality measures and risk-adjusted cost.** Commercial HMOs, which typically rely on integrated care delivery networks, outperform commercial PPOs on five of six clinical quality measures while consistently providing less costly care, on average—$4,245 per enrollee per year for commercial HMOs vs. $4,455 for commercial PPOs, or a difference of $210 per enrollee annually.
- **Hospital utilization varies considerably, but no significant regional patterns emerge from the data.** Variation in hospital utilization does not appear to drive cost differences among regions or commercial product types.

Atlas Measures and Regions

The Atlas tracks six clinical quality measures for cancer, diabetes, and asthma, along with a composite measure combining the individual measures; three hospital utilization measures, along with a composite utilization measure; and average annual per-enrollee total cost of care (see Exhibit 1, Data Sources, and Technical Appendix for more detailed information about the data, measures, participating health plans, and regions). Health plans contributing data selected these measures as important and representative of overall performance.

Exhibit 1: California Regional Health Care Cost & Quality Atlas Measures

Clinical Quality	Hospital Utilization	Total Cost of Care
1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Blood Sugar Screening for People with Diabetes 4. Poorly Controlled Blood Sugar for People with Diabetes 5. Kidney Disease Monitoring for People with Diabetes 6. Medication Management for People with Asthma 7. Clinical Quality Composite	1. Emergency Department Visits per thousand member years (PTMY) 2. All-Cause Readmissions 3. Inpatient Bed Days PTMY 4. Hospital Utilization Composite	1. Risk-Adjusted Cost (average per enrollee per year) 2. Observed (unadjusted) Cost 3. Total Cost Index

The Atlas divides California into 19 distinct regions following boundaries defined by Covered California, the state's health insurance exchange. Across the 19 regions, the Atlas contains data on approximately 14.5 million of the 19.4 million Californians enrolled in commercial HMOs and PPOs (see Exhibit 2).

Exhibit 2: California Regional Health Care Cost & Quality Atlas Commercial Insurance Enrollment, by Product Type, 2013

Product Type	Atlas Enrollment	Total California Enrollment	% of Commercially Insured Californians in Atlas
Commercial HMO	10,139,764	10,612,776	96%
Commercial PPO	4,340,218	8,793,070	49%
Total Commercial	14,479,982	19,405,846	75%

Sources: California commercial insurance enrollment gathered from the California Health Care Foundation (http://www.chcf.org/) and the Department of Managed Health Care (https://www.dmhc.ca.gov/).

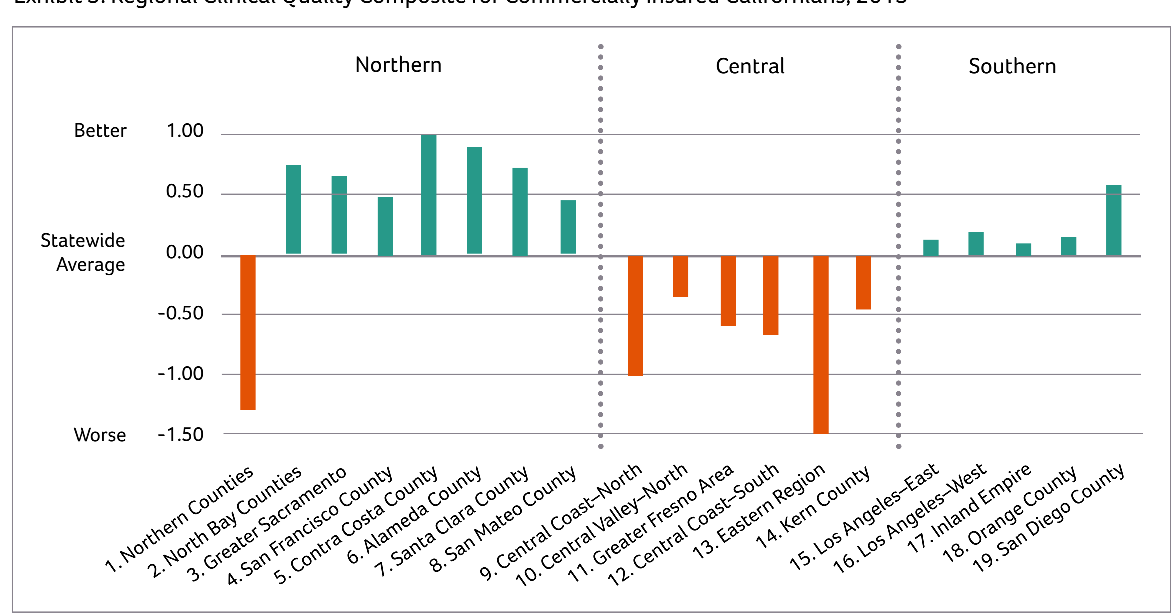
REGIONAL QUALITY AND COST PERFORMANCE VARIES

Across California commercial enrollment—combining HMO and PPO—wide geographic variation exists on clinical quality, cost, and hospital utilization measures. When comparing performance across the 19 regions, distinct patterns emerge for Northern, Southern, and Central California. All Northern California regions perform comparably with the exception of the Northern Counties (Region 1, north of the Bay Area to the Oregon border). Likewise, all Southern California regions perform similarly, and all Central regions perform comparably with the exception of Kern County (Region 14) (see the Technical Appendix for regional boundaries, associated counties, and enrollment per region).

Quality Highest in Northern California, Solid in Southern, and Weak in Central. Overall, Northern California outperforms Central and Southern California on clinical quality measures. Along with providing regional performance on individual quality measures, the Atlas combines performance on the six clinical quality measures into a clinical quality composite that places the statewide average commercial performance at zero and assigns each region a positive score if performance is better than the statewide average and a negative score if performance is worse than the statewide average.

As shown in Exhibit 3, the lowest performing region based on the clinical quality composite is the Eastern Region (13), comprised of Mono, Inyo, and Imperial counties in Central California, while the highest performing region is Contra Costa County (5) in Northern California. Overall, with the exception of the Northern Counties region (1), Northern California shows the strongest clinical quality performance. In Southern California, San Diego County (19) is the highest performing region and outperforms two Northern California regions—San Mateo County (8) and San Francisco County (4).

Exhibit 3: Regional Clinical Quality Composite for Commercially Insured Californians, 2013



Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.

Performance on individual clinical quality measures also varies widely across regions, indicating substantial opportunities to improve care for many patients. For example, as shown in Exhibit 4, the region with the highest clinical performance, Alameda County (6), meets breast cancer screening clinical guidelines for 83.9 percent of women aged 50 to 74 as opposed to only 69.4 percent of women in the Northern Counties (1). If all commercially enrolled California women represented by the Atlas data were screened at the same rate as those in Alameda County, almost 50,000 more women statewide would have received mammograms in 2013.

Overall, the highest performing regions on each clinical quality measure, with the exception of medication management for people with asthma, are in Northern California, with North Bay Counties (2), Contra Costa County (5), and Alameda County (6) leading in quality.

Commercial Risk-Adjusted Total Cost of Care Highest in Northern, Mixed in Central, and Lowest in Southern California. Average commercial total cost of care also varies considerably across the state, with Southern California regions consistently demonstrating lower costs. The statewide average annual per-enrollee total cost of care for commercially insured Californians is $4,300. All Northern California regions have higher costs than the statewide average, all Southern regions have lower costs than the state average, and Central California regions have mixed costs (see Exhibit 5). The most costly region is San Francisco County (4) in Northern California at $5,400 per enrollee per year on average, while the least costly region is Kern County (14) in Central California at $3,600, for a difference of $1,800 per enrollee annually.

Exhibit 4: Regional Clinical Quality Performance Rates for Commercially Insured Californians, by Measure, 2013

Area	Region	Breast Cancer Screening %	Colorectal Cancer Screening %	Blood Sugar Screening for People with Diabetes %	*Poorly Controlled Blood Sugar Screening for People with Diabetes %	Kidney Disease Monitoring for People with Diabetes %	Medication Management for People with Asthma %
Northern California	1. Northern Counties	69.4	50.0	79.7	74.2	68.6	48.5
	2. North Bay Counties	83.9	70.0	92.1	33.8	88.6	40.3
	3. Greater Sacramento	82.3	67.2	90.0	38.5	87.1	42.9
	4. San Francisco County	81.0	69.1	89.2	37.7	86.0	41.7
	5. Contra Costa County	83.7	71.1	90.8	33.2	88.6	43.1
	6. Alameda County	83.9	71.0	91.8	32.8	88.8	40.7
	7. Santa Clara County	82.5	66.9	91.6	36.2	87.2	42.8
	8. San Mateo County	83.2	68.4	89.6	36.9	87.3	38.5
Central California	9. Central Coast-North	72.4	51.1	81.7	69.0	75.6	45.1
	10. Central Valley-North	78.5	61.3	86.2	50.1	82.9	40.8
	11. Greater Fresno Area	76.1	61.0	85.8	52.2	79.6	40.9
	12. Central Coast-South	75.9	56.1	85.3	58.1	78.0	43.7
	13. Eastern Region	70.6	45.8	79.2	75.4	74.0	44.9
	14. Kern County	74.2	57.1	86.9	56.4	81.7	44.9
Southern California	15. Los Angeles-East	78.4	61.6	89.2	37.6	86.8	40.8
	16. Los Angeles-West	79.7	62.0	89.3	39.1	85.7	41.5
	17. Inland Empire	80.3	62.6	88.8	35.4	86.6	38.6
	18. Orange County	79.1	62.2	89.1	39.7	84.2	41.4
	19. San Diego County	81.8	66.0	91.2	38.7	88.3	41.1
Statewide		80.0	63.7	89.0	40.6	85.4	41.6

Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Note: The top three regional performers for each measure are highlighted in green and the bottom three performers are highlighted in red.
*Lower is better.

Exhibit 5: Regional Average Annual Per-Enrollee Total Cost of Care for Commercially Insured Californians, 2013

Northern
Central
Southern
Risk-Adjusted Total Cost of Care
$5,400
$5,000
$4,600
$4,200
$3,800
$3,400
California Statewide Average: $4,300
1. Northern Counties ($4,400)
2. North Bay Counties ($4,800)
3. Greater Sacramento ($4,800)
4. San Francisco County ($5,400)
5. Contra Costa County ($5,000)
6. Alameda County ($5,000)
7. Santa Clara County ($5,200)
8. San Mateo County ($5,200)
9. Central Coast–North ($5,400)
10. Central Valley–North ($4,800)
11. Greater Fresno Area ($4,000)
12. Central Coast–South ($4,400)
13. Eastern Region ($4,200)
14. Kern County ($3,600)
15. Los Angeles–East ($3,600)
16. Los Angeles–West ($4,000)
17. Inland Empire ($3,600)
18. Orange County ($4,000)
19. San Diego County ($4,000)

Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Note: All cost values are risk adjusted and rounded to the nearest $200.

Hospital Utilization All Over the Map

While there is dramatic variation in hospital utilization for emergency department (ED) visits, all-cause readmissions, and inpatient bed days across the 19 regions (see Exhibit 6), there is no clear geographic pattern. Wide variation characterizes all three measures included in the Atlas. For example, the lowest ED visit rate is 114 per thousand member years (PTMY) in Central Coast-North (9), while the highest rate is 256 visits PTMY in the Eastern Region (13)—a spread of more than double the lowest rate.

Bringing Together Commercial Quality and Cost Performance

As shown in Exhibit 7, in Southern California (Regions 15-19), commercial enrollees receive relatively high-quality care at a lower cost (top left quadrant), while those in Northern California (Regions 2-8) receive higher-quality care but at a much higher cost (top right quadrant). Northern Counties (1) is the only region that does not track other Northern California regions, landing in the lower-quality, higher-cost quadrant. In Central California (Regions 9-14),

DATA SOURCES

This Issue Brief is based on data from the California Regional Health Care Cost & Quality Atlas for 14.5 million commercially insured Californians enrolled in HMOs and PPOs in 2013. Commercial HMO and commercial PPO Atlas data were provided by participating health plans. Clinical quality results were calculated by plans directly, while hospital utilization rates and total cost of care were calculated by Truven Health Analytics, an IBM Company, using claims/encounter, eligibility, and cost data provided by the plans.

The six clinical quality and three hospital utilization measures are standard measures from the Healthcare Effectiveness Data and Information Set (HEDIS). The total cost of care measure represents average annual payments to providers to care for each enrollee and includes payments by insurance and enrollees for all covered professional, pharmacy, hospital, and ancillary care. The total cost of care measure is risk adjusted to account for differences in enrollee age, gender, and health status but not differences in geographic input costs.

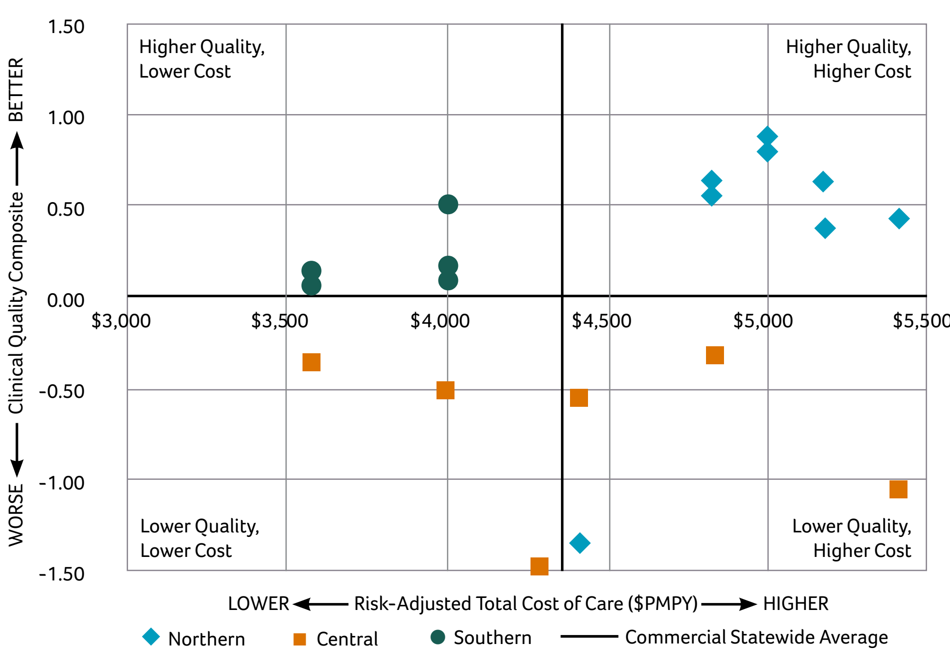
With the exception of total cost of care, which was risk adjusted, the results presented are descriptive—without adjustments for factors such as population socioeconomic characteristics, disease severity, or availability of medical services across geographic regions. While such adjustments may be of interest, the scope of this Issue Brief is simply to present observed rates of quality and hospital utilization on key measures (see the Technical Appendix for more detailed information about the data, measures, participating health plans, and regions).

Exhibit 6: Hospital Utilization Ranges for Commercially Insured Californians, 2013

Utilization Measure	Minimum Region Rate	Statewide Average Rate	Maximum Region Rate
Emergency Department Visits (PTMY)	114	141	256
All-Cause Readmissions (% of admissions)	6.6	8.1	8.4
Inpatient Bed Days (PTMY)	109	133	157

Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Note: PTMY = per thousand member years.

Exhibit 7: Bringing Together California Commercial Quality-Cost Performance, by Region, 2013



Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Notes: All cost values are risk adjusted and rounded to the nearest $200. PMPY = per member per year.

commercial enrollees generally receive lower-quality care with significant cost variation across geographic regions.

QUALITY AND COST PERFORMANCE: COMMERCIAL HMO VS. COMMERCIAL PPO

When examining performance by commercial product type—HMO vs. PPO—clinical quality and cost results vary widely across California. However, commercial HMOs almost uniformly far outperform commercial PPOs on clinical quality across the state's 19 geographic regions and demonstrate lower total cost of care in two-thirds of the regions.

HMO Clinical Quality Superior to PPO. HMOs on average perform notably better on clinical quality—based on the clinical quality composite—than PPOs in all but one region, Eastern Region (13) (see Exhibit 8). This is especially noteworthy as California outperforms the nation as a whole on clinical quality, based on comparison of the individual clinical quality measures in the Atlas to the corresponding national averages reported by the National Committee for Quality Assurance (NCQA).

At the national level, clinical quality results follow similar patterns, with commercial HMOs outperforming commercial PPOs on every clinical quality measure except medication management for people with asthma. As shown in Exhibit 9, the quality differential between commercial product types in California is larger than the national differential. California commercial HMOs perform better than their national counterparts on every

Exhibit 8: California Regional Clinical Quality Composite for HMO and PPO, 2013

Northern | Central | Southern

Better
Worse
Clinical Quality Composite
1.5
1.0
0.5
0.0
-0.5
-1.0

1. Northern Counties
2. North Bay Counties
3. Greater Sacramento
4. San Francisco County
5. Contra Costa County
6. Alameda County
7. Santa Clara County
8. San Mateo County
9. Central Coast–North
10. Central Valley–North
11. Greater Fresno Area
12. Central Coast–South
13. Eastern Region
14. Kern County
15. Los Angeles–East
16. Los Angeles–West
17. Inland Empire
18. Orange County
19. San Diego County

HMO PPO Commercial Statewide Average

Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.

Exhibit 9: Comparison of California and National Commercial HMO and PPO Quality Performance on Select Measures, 2013

Measure Name	Commercial HMO		Commercial PPO	
	California (%)	National (%)	California (%)	National (%)
Breast Cancer Screening	84.5	73.7	69.7	69.5
Colorectal Cancer Screening	71.1	62.9	47.5	56.5
Blood Sugar Screening for People with Diabetes	91.6	89.6	80.7	87.3
Poorly Controlled Blood Sugar for People with Diabetes (lower is better)	29.7	30.7	75.5	37.6
Kidney Disease Monitoring for People with Diabetes	90.1	83.8	70.7	78.8
Medication Management for People with Asthma	40.1	46.8	44.1	49.6

Sources: For national data, NCQA Quality Compass, 2014 (reflects performance in 2013); and for California data, California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.

clinical quality measure except medication management for people with asthma, while California commercial PPO performance lags national PPO performance on five of the six measures and is about the same for the breast cancer screening measure.

One would expect California's Atlas rates to lag national performance somewhat, simply because the national rates rely on patient chart reviews to capture more complete data, which should result in higher scores than scores based on the administrative-only claims and encounter data used in the Atlas. Therefore, the California PPO clinical quality rates compared to national rates are not particularly surprising, while the better California HMO rates indicate performance strong enough to overcome the disadvantage of using only administrative data.

ABOUT THE CALIFORNIA REGIONAL HEALTH CARE COST & QUALITY ATLAS

A collaboration of the Integrated Healthcare Association (IHA), the California Health Care Foundation (CHCF), and the California Health and Human Services (CHHS) Agency, the California Regional Health Care Cost & Quality Atlas uses 2013 data to track clinical quality measures for the priority health conditions of cancer, diabetes, and asthma; hospital utilization measures; and average annual per-enrollee total cost of care across 19 California geographic regions. For continuity and ease of comparison, the regions follow boundaries defined by Covered California, the state's health insurance exchange.

The Atlas includes information about 24 million Californians, nearly two-thirds of the state's total population, and spans health coverage provided by commercial insurance products—both HMO and PPO—Medicare Advantage, traditional Medicare fee for service (FFS) (see page 12 for a brief description of the Atlas Medicare results), Medi-Cal managed care, and Medi-Cal FFS (see page 9 for a brief description of the Atlas Medi-Cal results).

Atlas data represent care delivered during 2013, before full implementation of the Affordable Care Act (ACA)—including the expansion of Medi-Cal and launch of Covered California. Including total cost of care for all insurance product types except Medicare FFS, the Atlas captures $95.5 billion in spending on health care in California in 2013.

Building on a previous IHA-CHCF collaboration to highlight geographic variation in quality and resource use known as HEDIS by Geography, the Atlas adds data on the average annual per-enrollee total cost of care for people covered by public and private health insurance. As such, the Atlas was an avenue for CHHS to test the feasibility of a voluntary effort to create a state and regional cost and quality reporting system.

Along with giving purchasers, providers, payers, policymakers, and the public a clearer picture of population-level health care quality and costs across the state, the Atlas identifies so-called hot spots for targeted performance improvement and establishes regional benchmarks to track performance improvement over time.

Coming Soon: Cost & Quality Atlas 2.0

With continued CHCF support, IHA in 2017 will update the Atlas with 2015 data, highlighting changes from the 2013 baseline data following implementation in 2014 of ACA coverage expansions. The second edition will contain several enhancements, including more quality, utilization, and cost measures and a greater share of the state's population.

Atlas Edition 1 (available online)	Atlas Edition 2 (coming in 2017)
2013 data	2015 data
6 clinical measures + composite score	10-15 clinical measures + composite score
3 hospital utilization measures + composite	10-15+ hospital utilization measures + composite
2 cost measures + index	9 cost measures + index
24 million Californians	30 million Californians

Commercial HMO Costs Generally Lower than PPO. Average commercial HMO total cost of care is less than commercial PPO in 12 of 18 regions, as shown in Exhibit 10. The statewide average total cost for commercial HMOs is $4,245 per enrollee per year, compared to $4,455 for commercial PPOs, for a difference of $210 per enrollee per year. Of note, total cost of care includes both enrollee cost-sharing—for example, deductibles and coinsurance—as well as insurance payments to providers, so differences in benefit design among commercial products do not explain the cost variation. The relatively narrow difference in the statewide average masks significant variation across both geographic regions and product types. The least costly HMO region, Kern County (14), is $1,800 per enrollee per year less than the most costly HMO region, Santa Clara County (7). The least costly PPO region, Los Angeles-East (15), is $2,400 less than the costliest PPO region, which is San Francisco County (4).

Exhibit 10: California Commercial HMO and PPO Average Annual Per-Enrollee Total Cost of Care, by Region, 2013

Region	HMO Cost	PPO Cost	HMO Compared to PPO
1. Northern Counties	$4,800	$4,400	$400
2. North Bay Counties	$4,800	$5,000	-$200
3. Greater Sacramento	$4,800	$5,400	-$600
4. San Francisco County	**$5,200**	**$6,000**	-$800
5. Contra Costa County	$5,000*	$5,200	-$200
6. Alameda County	$5,000*	$5,400	-$400
7. Santa Clara County	**$5,200**	$5,400	-$200
8. San Mateo County	$4,800	**$6,000**	-$1,200
9. Central Coast-North	**$5,000**	**$5,600**	-$600
10. Central Valley-North	$5,000*	$4,600	$400
11. Greater Fresno Area	$4,400	**$3,800**	$600
12. Central Coast-South	$4,800	$4,200	$600
14. Kern County	**$3,400**	$3,800*	-$400
15. Los Angeles-East	**$3,600**	**$3,600**	$0
16. Los Angeles-West	$3,800	$4,200	-$400
17. Inland Empire	**$3,600**	**$3,800**	-$200
18. Orange County	$4,000	$4,000	$0
19. San Diego County	$4,000	$4,600	-$600

Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.

Notes: The top three regional performers for each product are highlighted in **green** and the bottom three performers are highlighted in **red**. Region 13, Eastern Counties, is excluded because of insufficient data. All cost values are risk adjusted and, except the statewide values, are rounded to the nearest $200.

* The rankings are based on underlying risk-adjusted cost data that are more precise than the values in the table, which are rounded to the nearest $200.

As shown in Exhibit 11, the magnitude of difference between HMO and PPO average annual per-enrollee total cost of care within a region varies considerably. The largest cost gap between HMO and PPO is $1,200 per enrollee in San Mateo County (8), with PPO being significantly costlier than HMO. Two regions, Los Angeles-East (15) and Orange County (18), have about the same total cost of care for both HMO and PPO.

Given that measurement of total cost of care is an emerging practice, with California among the leaders nationally in expanding measurement, there are no established national benchmarks. However, using its MarketScan database, a Truven Health Analytics study of commercial PPO enrollees in national employer-sponsored plans found that the average total cost of care (not risk adjusted) for 2013 was $4,578, compared to the California commercial average total cost of care of $4,300.

Readmissions and Inpatient Days Similar for HMO and PPO; HMO ED Use Higher

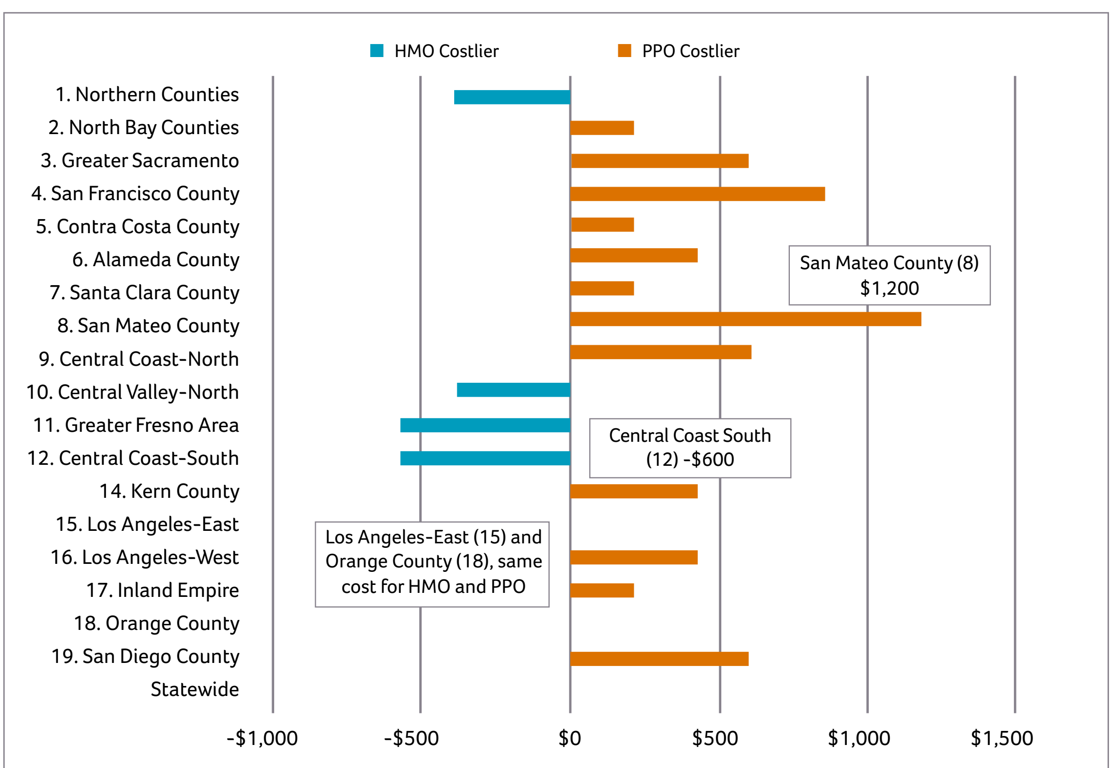
Average commercial HMO and PPO utilization rates statewide are similar for all-cause readmissions and inpatient bed days. As shown in Exhibit 12, the readmission rate is just over 8 percent for both commercial HMOs and PPOs, and inpatient bed days are different by only 3 per thousand member years. However, commercial HMOs have higher emergency department utilization than commercial PPOs, averaging 52 more ED visits annually per thousand member years. Both HMOs and PPOs in California substantially outperform their national counterparts on all three measures, according to NCQA national utilization rates, especially for ED visits and inpatient bed days.

A SNAPSHOT OF MEDI-CAL RESULTS

Atlas data from 2013 for Medi-Cal managed care enrollees show wide variation in quality across geographic regions. For example, Orange County (Region 18) had the highest breast cancer screening rate at 66.4 percent—about 50 percent higher than the lowest performing region, Greater Fresno Area (11), at 44.2 percent. The performance spread was even greater for colorectal cancer screening: San Mateo (8) had the highest rate at 35.2 percent, twice that of Los Angeles-West (16) at 18.3 percent. Comparing Medi-Cal managed care to Medi-Cal FFS, breast and colorectal cancer screening rates across regions are higher, on average, in managed care than in FFS. Specifically, 50.7 percent of eligible enrollees in Medi-Cal managed care received breast cancer screening compared to 44.8 percent in FFS. Similarly, 23.6 percent of Medi-Cal managed care enrollees received colorectal cancer screening compared to 21.3 percent in Medi-Cal FFS.

The 2013 data reflect Medi-Cal enrollment prior to the program's substantial expansion in January 2014. Future Atlas updates will allow for comparisons against this baseline data.

Exhibit 11: California Commercial HMO and PPO Average Annual Per-Enrollee Total Cost of Care Differences by Region, 2013



Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Notes: Region 13, Eastern Counties, is excluded because of insufficient data. All cost values are risk adjusted and rounded to the nearest $200.

Exhibit 12: Comparison of California and National Commercial HMO and PPO Hospital Utilization Rates, 2013

Measure Name	Commercial HMO		Commercial PPO	
	California	National	California	National
Emergency Department Visits (PTMY)	159	192	107	179
All-Cause Readmissions (% of admissions)	8.1	8.4	8.1	8.4
Inpatient Bed Days (PTMY)	134	180	131	170

Sources: For national data, NCQA Quality Compass, 2014 (reflects performance in 2013); and for California data, California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Note: PTMY = per thousand member years.

Only HMOs in Higher-Quality, Lower-Cost Quadrant

In Exhibit 13, each circle represents a region's PPO products and each triangle represents a region's HMO products. Placing these in quadrants, based on the statewide commercial averages for clinical quality (vertical axis) and for total cost of care (horizontal axis), reveals a clear pattern: Only HMOs fall into the higher-quality, lower-cost quadrant (top left), while only PPOs fall into the lower-quality, higher-cost quadrant (bottom right), again noting that total cost of care includes both enrollee cost-sharing amounts and insurance payments to providers. All HMO regions are above the statewide average for clinical quality, while all PPO regions fall below the statewide average for clinical quality. Cost performance is more variable: 12 of the 18 HMO regions are above the statewide cost average, placing them in the higher-quality, higher-cost quadrant.

Exhibit 13: Linking California Commercial HMO and PPO Quality and Cost Performance, 2013

Higher Quality, Lower Cost
Higher Quality, Higher Cost
Lower Quality, Lower Cost
Lower Quality, Higher Cost
WORSE ← Clinical Quality Composite → BETTER
1.5
1.0
0.5
0.0
-0.5
-1.0
-1.5
$3,000
$3,500
$4,000
$4,500
$5,000
$5,500
$6,000
n=2
n=3
n=2
LOWER ← Risk-Adjusted Total Cost of Care ($PMPY) → HIGHER
HMO
PPO
Commercial Statewide Average

Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data. Notes: Region 13, Eastern Counties, is excluded because of insufficient data. When data points overlap on the chart, the number of regions represented is labeled as "n=". All cost values are risk adjusted and rounded to the nearest $200.PMPY = per member per year.

IMPLICATIONS

An analysis of data from the California Regional Health Care Cost & Quality Atlas highlights wide geographic and product type variation in the quality and cost of care provided to commercially insured people across the state. Such sizable performance differences indicate that there are significant and pressing opportunities to improve both the quality and cost of care for many Californians. For example:

- If care for all commercially insured Californians represented by the Atlas were provided at the same quality as top-performing regions, nearly 200,000 more people would have been screened for colorectal cancer and 50,000 more women would have been screened for breast cancer in 2013.
- If care across the state for all commercially insured Californians represented by the Atlas were provided at the same cost as observed in San Diego—a relatively high-quality, low-cost region—overall cost of care would decrease by an estimated $4.4 billion annually, or about 10 percent of the $44 billion total cost of care for the commercially enrolled people represented in the Atlas in 2013.

Many factors contribute to the performance of regions, including socioeconomic characteristics of the population (e.g. income, education level) and health care infrastructure (e.g. availability of medical services). And, the characteristics of high-performing regions may differ from low-performing regions in ways that make it challenging to replicate performance. At the same time, all Californians deserve high-quality, affordable health care, and high-performing regions may have lessons to share that can raise performance across the state.

HMO and PPO Performance Differences. In addition to regional variation, the Atlas data reveal important differences in the performance of commercial HMOs and PPOs across the state. On quality, commercial HMOs outperform PPOs on five of six clinical quality measures and have a lower statewide average total cost of care. When combining regional ratings for clinical quality and total cost of care by commercial product type, for a total of 36 observations (18 regions each for PPO and HMO), only six fall into the higher-quality, lower-cost quadrant—all are HMO regions (see Exhibit 13.) Eleven observations fall into the lower-quality, higher-cost quadrant—all are PPO regions. These striking findings raise questions about the drivers of performance differences between HMO and PPO products across the state.

Integrated Delivery Networks. Considering the clinical quality results, one leading explanation for the higher performance among HMO products is their use of and reliance on integrated care delivery networks, which typically feature more sophisticated infrastructure, such as data systems, and more robust care coordination processes. Such

A SNAPSHOT OF MEDICARE RESULTS

Across California, the quality and cost of care varies widely for seniors enrolled in Medicare Advantage, according to 2013 Atlas data. For example, in North Bay Counties (Region 2), about nine in 10 women (90.6%) received appropriate screening for breast cancer, compared to seven in 10 (70.2%) in the Eastern Region (13). Similarly, the average annual per-enrollee total cost of care varies for Medicare Advantage enrollees, ranging from a high of $14,500 a year in Los Angeles-East (15) to $11,500 in San Diego County (19). Hospital utilization is also highly variable, with Kern County (14) using 451 inpatient bed days per thousand member years, and Central Valley-North (10) using 991 inpatient bed days. No clear geographic patterns are evident for clinical quality, cost, or hospital utilization.

Results for seniors enrolled in traditional Medicare fee for service (FFS) use a slightly different methodology than results for Medicare Advantage, so are not directly comparable. Nonetheless, the difference in hospital utilization is so striking that it is worth noting. The FFS statewide averages for emergency department visits, all-cause readmissions, and inpatient bed days are all between 50 percent and 75 percent higher than the statewide averages for Medicare Advantage (567 vs. 373 emergency department visits per thousand member years, 18.4 percent vs. 11.2 percent readmissions, and 1,363 vs. 789 bed days per thousand member years). The statewide averages for total cost of care are much closer, with Medicare FFS at $13,111 and Medicare Advantage at $12,783 per enrollee annually. This suggests that pricing may be influencing total cost of care more than utilization.

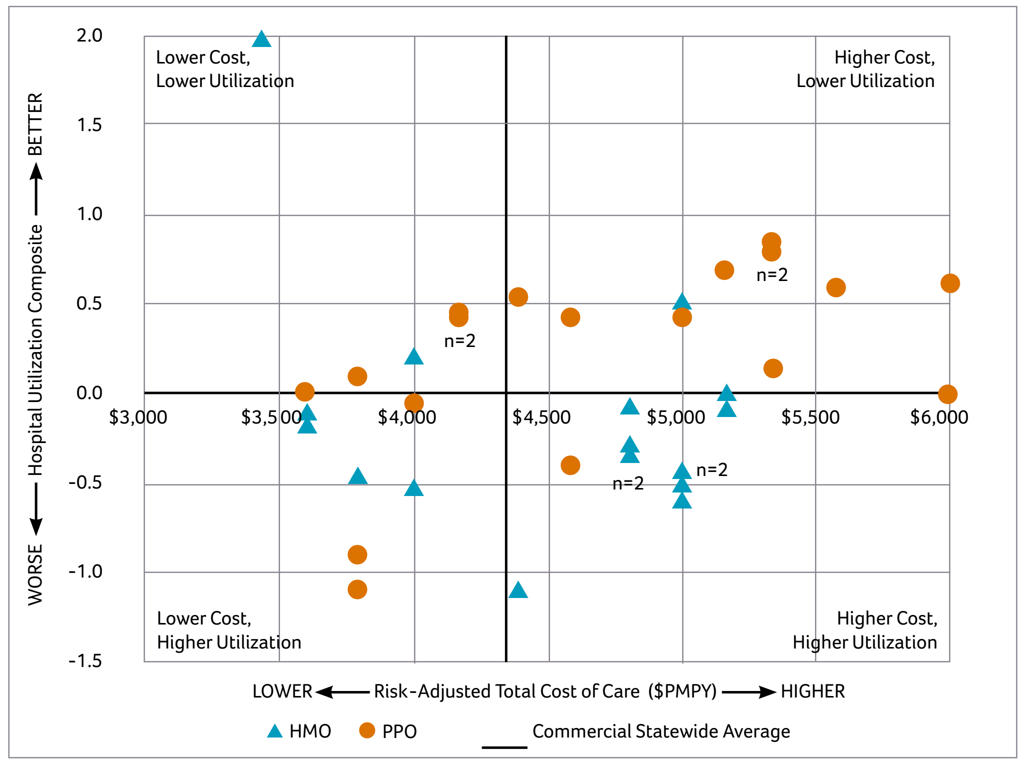
networks generally accept capitation—fixed per-member, per-month payments—so they are accountable for, and generally rewarded for, the health of a defined patient population. This organizational model is, in fact, wholly consistent with the overall goal of the Centers for Medicare & Medicaid Services to drive more care and payments through so-called alternative payment models (APMs), as noted in the *APM Framework White Paper* released in January 2016 by the Health Care Payment Learning & Action Network. The goal of reducing unwarranted variation could be advanced by learning more about what factors drive performance differentiation and characteristics of top performers.

Examining Utilization and Price. Turning to differences in total cost of care, the data show that in 12 of the 18 regions, HMO products have lower average total cost of care than PPO products. One explanation might be utilization; more tightly managed care in HMO products could be contributing to lower total cost of care. Yet, inpatient bed days and readmission rates are similar for HMOs and PPOs. And, far from explaining lower costs in HMOs, emergency department visit rates are actually higher for HMOs. Exhibit 14 provides a visual representation of the relationship between hospital utilization, based on a composite score representing all three utilization measures, and total cost of care. Overall, after removing one outlier region (Kern County, Region 14), the data show a moderate negative correlation ($r^2 = -0.48$, $p = 0.003$) between hospital utilization and cost—that is, lower utilization is associated with higher costs. Given that cost is a function of price and utilization, the results point toward unit price driving cost and not utilization, but it should be noted that limited utilization measures were used for this specific analysis.

Kaiser Permanente Effect? A question likely to be asked a is the degree to which Kaiser Permanente's significant market share could be driving the results observed in the Atlas data. Kaiser Permanente is a large integrated delivery system that accounts for more than half of the commercial HMO enrollment in California. Comparisons of HMO and PPO performance excluding Kaiser Permanente show that the general trends still hold, but differences diminish. When Kaiser Permanente is removed, the overall clinical quality performance difference between HMO and PPO is reduced by about half; there is little impact on hospital utilization; and the overall performance difference between HMO and PPO on risk-adjusted total cost of care narrows substantially—but HMO still outperforms PPO.

Declining HMO Enrollment. In spite of better than average quality and cost performance, commercial HMO coverage—outside of Kaiser—has declined in recent years. If HMOs provide better "value," why is enrollment declining? One explanation may be employers' efforts to reduce premiums. Compared to HMOs, PPO benefit design tends to feature higher enrollee cost-sharing, such as deductibles and coinsurance, which reduces premiums; accordingly, PPO products often are less costly for employers. From a value perspective, however—taking into account both quality and total cost of care—HMOs appear to produce superior results. Those purchasing or arranging coverage, such

Exhibit 14: Linking Hospital Utilization and Total Cost of Care for Commercially Insured Californians, by Product Type, 2013



Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Notes: Region 13, Eastern Counties, is excluded because of insufficient data. When data points overlap on the chart, the number of regions represented is labeled as "n=". All cost values are risk adjusted and rounded to the nearest $200.
PMPY = per member per year.

as large employers, may want to consider these findings and recalculate their quality-cost value equation.

Increasing Transparency. The inaugural release of the California Regional Health Care Cost & Quality Atlas represents a major step forward for transparency. The Atlas brings together data on clinical quality, hospital utilization, and total cost of care from across the state and provides a first-ever opportunity to assess geographic and insurance product type variation in a way that allows for apples-to-apples comparisons. The Atlas also highlights the need for information sources using multi-payer and multi-provider data to support more regular performance improvement activities for plans, providers, and health care systems. Ideally, this information should be timelier, actionable, and include both claims and electronic health record data.

While this analysis focused on data from commercial—HMO and PPO—enrollment, the Atlas also includes Medicare and Medi-Cal data, and future analyses will focus on these insurance types and populations. Indeed, much more can be done with the data, which are downloadable from the Atlas website—costatlas.iha.org. When the Atlas is updated with 2015 data, it will include additional data sources and measures, enhancing the ability to generate insights that enable better health care performance across the state.

Acknowledgments

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TECHNICAL APPENDIX

IHA Issue Brief No. 21

Benchmarking California Health Care Quality and Cost Performance

This Issue Brief is based on data from the California Regional Health Care Cost & Quality Atlas for 14.5 million commercially insured Californians enrolled in HMOs and PPOs in 2013. Measures include clinical quality, hospital utilization, and total cost of care. The full enrollee population that meets the measurement criteria is included in the measurement; there is no sampling.

CLINICAL QUALITY MEASURES

Six key clinical quality measures for the priority health conditions of cancer, diabetes, and asthma are standard measures from the Healthcare Effectiveness Data and Information Set (HEDIS) and are defined as follows:

- **Breast Cancer Screening:** Percentage of female enrollees 50 to 74 years old who had one or more mammogram to screen for breast cancer during 2012 or 2013.
- **Colorectal Cancer Screening:** Percentage of enrollees 50 to 75 years old who had one or more screening for colorectal cancer—including fecal occult blood tests, flexible sigmoidoscopies, and colonoscopies.
- **Blood Sugar Screening for People with Diabetes**: Percentage of enrollees 18 to 75 years old with either Type 1 or Type 2 diabetes who had an HbA1c test performed in 2013.
- **Poorly Controlled Blood Sugar for People with Diabetes**: Percentage of enrollees 18 to 75 years old with either Type 1 or Type 2 diabetes whose most recent HbA1c level during 2013 was above 9 percent or was missing (Note: lower rates of poor control indicate better care).
- **Kidney Disease Monitoring for People with Diabetes**: Percentage of enrollees 18 to 75 years old with either Type 1 or Type 2 diabetes who had nephropathy screening or evidence of nephropathy during 2013.
- **Medication Management for People with Asthma**: Percentage of enrollees with persistent asthma who remained on an asthma controller medication for at least 75 percent of their treatment period in 2013.
- **Clinical Quality Composite:** A composite combining performance on all six clinical measures. Performance on each individual measure is converted to a Z-score, where 0 = average performance for a particular insurance type (i.e., for commercial, for Medicare, or for Medi-Cal), >0 = better than average, and <0 = worse than average performance. The Z-scores are then averaged to determine the composite score.

HOSPITAL UTILIZATION MEASURES

Three hospital utilization measures are standard measures from HEDIS and are defined as follows:

- **Emergency Department Visits:** Number of ED visits during 2013 which did not result in an inpatient admission, on a per thousand member years (PTMY) basis. No risk adjustment is applied.
- **All-Cause Readmissions:** Percentage of acute inpatient hospital says during 2013 that were followed by an acute readmission within 30 days for any diagnosis. Ages 18-64 included for commercial population; ages 18 and over included for Medicare Advantage and Medi-Cal populations. Unlike HEDIS, no risk adjustment is applied.
- **Inpatient Bed Days**: Total number of days enrollees were hospitalized for acute inpatient care during 2013, on a PTMY basis. No risk adjustment is applied.
- **Hospital Utilization Composite:** A composite combining performance on all three hospital utilization measures. Performance on each individual measure is converted to a Z-score, where 0 = average performance for a particular insurance type (i.e., for commercial, for Medicare, or for Medi-Cal), >0 = better than average, and <0 = worse than average performance. The Z-scores are then averaged to determine the composite score.

TOTAL COST OF CARE MEASURES

The total cost of care measures are defined as follows:

- **Risk-Adjusted Total Cost of Care:** The average risk-adjusted costs of providing care per enrollee per year, including payments by insurance and by enrollees for all covered professional, pharmacy, hospital, and ancillary care. Payments for mental health/chemical dependency, chiropractic, acupuncture, vision and dental are excluded. Risk adjustment accounts for differences in age, gender, and health status across populations. No adjustments were made for differences in geographic input costs.

- **Measurement varies slightly across insurance types:** Commercial costs are rounded to the nearest $200. Medicare results are rounded to the nearest $500, which represents about the same percent of total costs as the rounding for commercial. Medi-Cal total cost of care includes mental health and chemical dependency costs and uses a different risk-adjustment methodology based on pharmacy data. See the Atlas at http://costatlas.iha.org for more details.
- **Total Cost of Care Index:** An index that shows relative performance on total cost. Risk-adjusted total cost of care is converted to a Z-score, where 0 = average performance for a particular insurance type (i.e., for commercial, for Medicare, or for Medi-Cal), >0 = better than average, and <0 = worse than average performance.

DATA SOURCES

Ten health plans participated in the Atlas, contributing 2013 commercial HMO, commercial PPO, and/or Medicare Advantage data, as applicable. Clinical quality results were calculated by plans directly, while hospital utilization rates and total cost of care were calculated by Truven Health Analytics, an IBM Company, using health plan claims/encounter, eligibility, and cost data. For Medicare FFS, county-level results were obtained from public use files published by the Centers for Medicare & Medicaid Services and aggregated to the 19 regions. Medi-Cal results for all types of measures for both managed care and fee for service were calculated by the California Department of Health Care Services.

Participating Health Plans
Aetna
Anthem Blue Cross
Blue Shield of California
Cigna
Health Net
Kaiser Permanente
SCAN Health Plan
Sharp Health Plan
UnitedHealthcare
Western Health Advantage

POPULATIONS AND GEOGRAPHIC REGIONS

The Atlas includes data for about 14.5 million of the 19.4 million Californians enrolled in commercial health insurance products. The Atlas also covers 1.6 million Californians enrolled in Medicare Advantage, as well as 8.3 million Californians enrolled in Medi-Cal.

The Atlas maps data according to the 19 regions used by Covered California, the state's health insurance exchange, which groups counties as follows:

Area	Region	Counties	Region Population	Commercial Atlas Enrollment
Northern California	1. Northern Counties	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba	1,328,056	228,825
	2. North Bay Counties	Marin, Napa, Solano, Sonoma	1,280,190	564,547
	3. Greater Sacramento	El Dorado, Placer, Sacramento, Yolo	2,142,566	952,558
	4. San Francisco County	San Francisco	807,758	372,417
	5. Contra Costa County	Contra Costa	1,047,659	515,326
	6. Alameda County	Alameda	1,514,494	725,211
	7. Santa Clara County	Santa Clara	1,791,109	821,689
	8. San Mateo County	San Mateo	715,718	352,547
Central California	9. Central Coast-North	Monterey, San Benito, Santa Cruz	732,537	171,460
	10. Central Valley-North	Mariposa, Merced, San Joaquin, Stanislaus, Tulare	1,907,913	476,113
	11. Greater Fresno Area	Fresno, Kings, Madera	1,223,984	269,560
	12. Central Coast-South	San Luis Obispo, Santa Barbara, Ventura	1,514,204	566,882
	13. Eastern Region	Imperial, Inyo, Mono	206,508	28,514
	14. Kern County	Kern	836,691	183,588
Southern California	15. Los Angeles-East	Los Angeles (partial)	4,056,806	1,739,713
	16. Los Angeles-West	Los Angeles (partial)	5,774,325	2,208,536
	17. Inland Empire	Riverside, San Bernardino	4,201,182	1,618,241
	18. Orange County	Orange	3,018,544	1,388,875
	19. San Diego County	San Diego	3,082,661	1,295,381
	Statewide		37,182,903	14,479,982

Sources: Counties mapped to regions based on Covered California regional boundaries: http://www.coveredca.com/. Region population gathered from U.S. Census data at the zip code level and then rolled up to regions: http://factfinder.census.gov/faces/nav/jsf/pages/download_center.xhtml. Commercial Atlas enrollment gathered from eligibility files provided by participating health plans.

ACA Implementation—Monitoring and Tracking

Missed Opportunities: State-Based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefit Designs

July 2016

Sabrina Corlette, Sandy Ahn, Kevin Lucia, and Hannah Ellison

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.

ABSTRACT

The federally facilitated health insurance marketplace (FFM) is attempting to improve consumers' ability to make plan-to-plan comparisons during the 2017 open enrollment season by encouraging insurers to offer standardized benefit designs. In doing so, the FFM is following the path of several state-based marketplaces (SBMs) that require insurers to offer standardized health plans, although the FFM and most SBMs also allow insurers to offer nonstandardized options. Through an analysis of policy guidance, consumer-facing marketplace websites, and interviews with state officials and key stakeholders, this paper explores the experiences of SBMs in Connecticut, Massachusetts, New York, and Oregon that have required participating insurers to offer standardized plans. The authors find that although broad consensus exists among state officials and stakeholders that the primary goal of health plan standardization is to facilitate "apples-to-apples" plan comparisons, these states' policy choices and website interfaces have curtailed their ability to achieve these stated goals. In particular, by allowing insurers to offer nonstandardized options in addition to standardized options and failing to use web-based decision support tools to differentiate between plan options, consumers in these SBMs have limited ability to conduct the plan-to-plan comparisons as originally envisioned by policymakers.

INTRODUCTION

Buying a health insurance plan that meets an individual's or family's health and financial needs is challenging. Consumers must weigh the plan price, benefits, cost-sharing (deductibles, co-payments and co-insurance) and annual cost-sharing limits, provider networks, and, in many cases, drug formularies. The Affordable Care Act (ACA) is designed to simplify this shopping experience through several insurance market reforms and the establishment of health insurance marketplaces that can facilitate the apples-to-apples comparison of health plans.

Under federal rules, health plans sold through the marketplaces must cover similar essential health benefits, and plans are categorized into levels of bronze, silver, gold and platinum based on their actuarial value.[1,2] Until recently, however, federal regulators have not proposed standardizing the cost-sharing associated with benefits covered under participating plans. Consequently, in many markets consumers must choose among hundreds of health plans at each actuarial value level, with different permutations of deductibles, co-payments, and co-insurance, for different services with varying provider networks covered by the plan.

This may soon change. In an effort to simplify the consumer shopping experience and facilitate plan-to-plan comparisons, the Centers for Medicare & Medicaid Services (CMS), which operates the federally facilitated marketplaces (FFM), has encouraged participating insurers in 2017 to begin offering standardized benefit designs in addition to other nonstandardized options. In making this shift, CMS is following the lead of several state-based marketplaces (SBMs) that have used their active purchasing authority to require insurers to offer standardized health plans.[3] These states have done so primarily with the goal of supporting

apples-to-apples plan comparisons. The experience of these SBMs in developing and displaying standardized plans, as well as the experiences of consumers in shopping for and enrolling in such plans, could provide valuable insights for federal officials and other states contemplating a similar policy.

ABOUT THIS STUDY

Seven SBMs currently require participating insurers to offer standardized options.[4] For this report, we study Connecticut, Massachusetts, New York, and Oregon. These states have policies similar to the FFM's rule for 2017, which allows insurers to offer nonstandardized plans in addition to standardized options. The Massachusetts' marketplace has a unique bifurcated structure, described below. In that state, we focus on the portion of the marketplace that offers both standardized and nonstandardized plans. We conducted a review of each state's legal authority related to standardized benefit design, policy guidance to insurers, and the plan shopping experience on each SBM's website. We supplemented this review with 18 interviews with SBM officials, insurance company executives, consumer advocates, and in-person assisters (marketplace navigators, insurance brokers, and certified application counselors). The interviews were conducted between March 2016 and April 2016.

BACKGROUND

The ACA requires that health insurance marketplaces, or exchanges, be established in every state. The goal of that requirement is to increase competition and transparency to expand health insurance coverage and reduce costs.[5] States were given the option to create their own marketplaces with their own regulatory authority or defer to the FFM. As of 2016, 34 states have chosen to operate their marketplaces via the federal platform, Healthcare.gov.[6] All marketplaces, whether state or federally run, must handle plan management, financial management, eligibility and enrollment, and consumer assistance and outreach.[7] Additionally, under federal rules, all participating plans must meet actuarial value standards and offer minimum essential health benefits. SBMs may set higher standards or take a more active role in selecting and managing participating health plans.

Several SBMs have chosen to be active purchasers, with some taking action to selectively contract with insurers, organize their markets, and promote the reporting and display of a plan's performance on quality metrics. For example, the FFM and many SBMs require all participating plans to have "meaningful differences" from one another to help consumers differentiate among plan options.[8] Further, seven of the SBMs have required that standardized plans be offered within their marketplaces.[9,10] Of these, six also allow insurers to offer nonstandardized plans. Only California's SBM requires all plans sold via the marketplace to be standardized. Massachusetts' SBM has a unique bifurcated structure. One of Massachusetts's SBMs (ConnectorCare) serves people with incomes under 300 percent of the federal poverty level (FPL) and requires all participating plans to be standardized. For those with incomes above 300 percent of FPL, the other Massachusetts SBM (the Health Connector) offers both standardized and nonstandardized plans.[11]

Standardized plans typically share defined cost-sharing parameters (deductibles, co-payments, and co-insurance) within each metal level, allowing consumers to more easily compare plans based on network, brand, and price. For example, a standardized benefit design might require all gold plans in the marketplace to include an annual deductible of $1,000, a $500 co-payment for inpatient hospital services, a $30 co-payment for primary care visits, a $45 co-payment for specialty visits, and so on. In addition, states can pursue a range of policy options related to benefit design standardization. For example, a state could require all nongroup insurers, both inside and outside the marketplace, to offer standardized benefit designs, or they could be required only of marketplace insurers. States can also require standardization at only selected tiers, such as only for silver and gold plans. States can also choose the specific types of benefits or services for which cost-sharing will be standardized. For example, Massachusetts now standardizes cost-sharing for 14 benefits but will be expanding to 21 benefits in 2017.[12]

Massachusetts, whose marketplace was the first to implement plan standardization in 2010, found that standardizing plan designs made consumers more likely to accurately differentiate among plans, leading them to choose more generous benefit designs.[13] Behavioral economics research has also shown that giving consumers too many choices can harm their ability to

make good decisions.[14,15] Perhaps for these reasons, plan standardization is not unique to SBMs. Several private health insurance exchanges, such as those operated by Aon, Mercer, and Towers Watson, require some standardization across their plans.[16]

In addition to facilitating improved consumer decision-making through "apples-to-apples" comparisons, some states have also embraced standardized designs to help deliver more up-front value to consumers, such as reducing or eliminating cost-sharing for primary care services and lowering co-payments for generic drugs. Requiring standardized plans can also curb the ability of an insurer to set discriminatory cost-sharing structures that discourage enrollment by sicker people. For example, one study found the average annual cost of a generic HIV drug to be three times more expensive in nonstandardized plans than in standardized plans.[17]

Starting in 2017, insurers participating in the FFM will also be encouraged, though not required, to offer standardized plans.[18] Called "simple choice" plans, the FFM will display them prominently via Healthcare.gov. "Simple Choice plans will help consumers make apples-to-apples cost-sharing comparisons as they shop," according to federal officials.[19] After seeking public input on how to best to display these plans, federal officials indicated they would test different options and plan descriptions, so that consumers can "best understand what they offer, a clear, easy-to-understand choice."[20]

FINDINGS

Study States Share Common Policy Goals for Plan Standardization

Marketplace officials across our four study states identified three policy goals associated with standardizing benefit designs. First, these SBM officials universally conveyed that the primary goal of plan standardization is to streamline consumers' shopping experiences and make comparing plans easier. Massachusetts's SBM, often cited as the model for the health insurance marketplaces in the ACA, was the first to standardize its health plan benefits. In doing so, officials told us, "The ultimate goal was to give consumers 'apples-to-apples' comparison capabilities…and take as much mystery out of the game as possible." Officials and stakeholders alike in the state analogize the Massachusetts SBM to a store, with health plan products on its shelves. "When [consumers] look across that shelf," one official said, "we want them to see the same thing over and over—with the goal of facilitating comparison on the most important variables," such as network design and price.

Officials in the other study states—Connecticut, New York, and Oregon—similarly identify the goal of apples-to-apples shopping as the "fundamental" goal of standardizing benefit designs. In Oregon, by equalizing cost-sharing across benefits, SBM officials wanted to narrow consumers' focus to a plan's price and quality. A Connecticut official observed, "We found that consumers tend to focus on price, but we want people to worry about network, the formulary, and then plan coverage." This shared goal, however, was ultimately undermined in all four of our study states by other policy and operational choices, discussed below.

In Connecticut, SBM officials identify a second important goal for standardizing plan benefits: "We wanted a more patient-centered plan design," said one official. State officials thus approached the design of standard plans with the goal of improving access to valued services, such as primary care.

Third, although perhaps not explicitly articulated as a goal of standardization, several SBM officials cited its ancillary benefit of easing the regulatory oversight of health plans. By prescribing the deductibles and cost-sharing for specific services at each plan level, the policy narrows insurers' ability to use benefit design to select favorable risk and deter enrollment by those who are sick. An insurance executive in New York further suggested that the policy has taken away "some of the gaming" in product design. Further, as one state official observed, the policy makes it easier for regulators to "monitor the market and find outliers more quickly."

Insurer and consumer stakeholders alike generally agree on value of standardization

Insurance company executives and consumer advocates in all the study states consistently noted the value in the availability of standardized plan offerings for consumers. "From my perspective, it's all about the consumer understanding their choices," noted an insurance executive. "The prospective member can compare easily; it's essentially the same thing across the plans."

In addition, most insurers with whom we spoke believe their state marketplace had found an appropriate balance between standardization and innovation of plan design. "We thought [plan standardization] was fine—we didn't have any

objections to it," noted one insurance company executive in Connecticut. However, in all of our study states, insurers pushed hard to ensure they could market nonstandardized plans alongside the standardized options. And some state officials conceded that insurers are generally in the best position to design plan benefits and cost-sharing. "The carriers can innovate and react to changes in the market and medicine much quicker than we can," one official said.

Insurers stress that the ability to offer nonstandardized options is important to maintaining their competitive edge, and they successfully argued before marketplace officials that if all plans were standardized there would be little to differentiate them from other insurers. However, other stakeholders noted that health plans have several key facets other than benefit design upon which insurers can compete, such as provider network, pricing, quality ratings, and customer service.

Generally, insurers with whom we spoke indicated that, several years in, the policy was working reasonably well. These comments of a New York insurer reflect similar comments from representatives in other states: "I think New York got the balance [between standardization and innovation] pretty well…. Maybe even got it just right."

Consumer advocates and assisters, including insurance brokers, also expressed support for the SBMs' standardization policy; in all four states consumer advocates were among those that initially lobbied for the policy and continue to push for maintaining and expanding it. Assisters told us that the standardized designs have made comparisons easier when they help consumers select a plan. As noted, Massachusetts' marketplace is unique because consumers with incomes under 300 percent of FPL are eligible for plans via ConnectorCare, which offers only standardized plans. Consumer assisters report that shopping for a plan in ConnectorCare is much easier than shopping for one in the Health Connector, where nonstandardized options are available. They note that in ConnectorCare, "all we have to explain is network and premium differences. It really is that apples-to-apples comparison."

At the same time, some assisters and state officials acknowledge the value of maintaining nonstandardized options. For example, an Oregon broker has found that some nonstandardized plans have lower cost-sharing for lab services than the standardized options, leading clients with certain health conditions, such as diabetes, to prefer these plans. Similarly, in New York some of the nonstandardized options cover adult dental services, which has been appealing to many consumers helped by one assister we interviewed.

Evolving SBM approaches to standardization in support of policy goals

To meet their stated goals of facilitating apples-to-apples plan comparisons, all four of our study states will require participating insurers in 2017 to offer gold, silver, and bronze health plans with predefined cost-sharing amounts (table 1). This approach is similar to the states' 2016 policies except for Massachusetts, which does not currently require a bronze standardized plan. In Massachusetts and New York, insurers must also continue to offer a platinum plan with predefined cost-sharing amounts. Consistent with the marketplaces' 2016 standards, insurers in all four states will be permitted (but not required) to offer nonstandardized plans at each plan level.[21,22]

Our study states also limit the total number of plans, either standard or nonstandard, to provide a more manageable number of plans for consumers to consider. Only Massachusetts limits the number of standard plans offered by an insurer on alternative or additional provider networks; all study states limit the number of nonstandard plans.

Table 1. Study-State Approaches to Standardization for 2017

State	Availability of standardized plan	Limits total number of standard plans?[a]	Limits total number of nonstandard plans?[a]
Connecticut	Gold, silver, bronze[b]	No	Yes, up to 11
Massachusetts	Platinum, gold, silver, bronze[c]	Yes, up to 8	Yes, up to 3
New York	Platinum, gold, silver, bronze[d]	No	Yes, up to 11
Oregon	Gold, silver, bronze	No	Yes, up to 9

a Does not include catastrophic plans.
b Connecticut allows, but does not require, individual market insurers to offer a standard platinum plan.
c Massachusetts requires insurers to offer standardized plans on their broadest commercial network and allows for the same standard plan to be offered on a different type of network (i.e., tiered or narrow).
d New York will allow, but not require, insurers to offer standardized products with three primary care visits not subject to the deductible; if insurers opt to offer this type of standard product, they must do so in the gold and silver plan levels.

Massachusetts adds an additional layer of standardization by defining three types of provider networks ("broadest commercial," "narrow," and "tiered"); the state requires insurers to offer standardized plans with the broadest commercial network, with the option to also offer standardized plans with narrow or tiered networks. Connecticut also differs from the other states because it requires that the standard silver plan offered by insurers be the lowest-cost silver plan offered by that insurer.[23] Consequently, the standardized plans in Connecticut have attracted 72 percent of enrollment compared with nonstandardized plans.[24]

In addition to simplifying the consumer shopping experience, some states are trying to provide consumers with a better value through their standardized benefit designs. For example, Connecticut limits cost-sharing in most plans for certain high-value services, such as primary care, and limits the number of services subject to co-insurance. The latter is a form of cost-sharing that makes it difficult for consumers to calculate their out-of-pocket costs.[25] In Massachusetts, the marketplace is seeking public feedback on proposed insurance designs for 2018 that would lower cost-sharing for high-value services.[26] For 2017, New York allows (but does not require) insurers to offer standard plans that offer three visits to a primary care provider not subject to the deductible.[27] Whether insurers there will choose to do so is unknown; unlike the FFM, New York will not provide insurers with standardized plans "preferential" display on the marketplace website. In Oregon, the standard benefits were modeled off of an existing popular plan design.

All the states with standardized benefit designs must adjust them annually to ensure that they meet the actuarial value targets for each plan level. Officials in all four states further acknowledge that their benefit designs should change over time to keep pace with customer demands and medical evidence (table 2). For example, Connecticut and Massachusetts report that they have made substantive policy and benefit design changes in the face of feedback from consumer advocates and other stakeholders. Connecticut's marketplace has also changed the benefit design over time in an attempt to bring more up-front value to consumers (i.e., by lowering cost-sharing for primary care services).

Another standard that states continue to adjust is the number of nonstandardized plans allowed on a state's marketplace. Massachusetts' approach has evolved the most. Initially, that state's marketplace required all plans to be standardized, but it soon shifted to allow insurers to offer nonstandardized options. The marketplace did so in response to concerns from insurers and small-business stakeholders who argued that employers were demanding more innovative plan designs than individual consumers (Massachusetts has a merged small-group and nongroup market).

In addition, in 2016, Massachusetts reduced the total number of nonstandardized plans that an insurer can offer. "Having less is more" with health insurance, said one assister, remarking that with less choice, consumers are more likely to "dig deeper into the plans." Going forward, officials suggest that returning to all-standardized offerings could further improve the consumer shopping experience. "We're on a path to move away from having any nonstandard plans, but we're not there yet," officials said.

Similarly, Oregon officials have reduced the limit on the number of plans insurers can offer each year, dropping from a limit of five per plan level in 2014 to three in 2017. According to one Oregon insurer, the goal of limiting plans is to "make things less confusing" and potentially "limit the 'analysis paralysis'" that consumers face when confronted with too many plans.

Table 2. Study SBMs' Changes to Standardization Policy, 2014–2016

SBM	Changed benefit design?	Changed maximum number of standardized or nonstandardized plans?	Changed website display of standardized vs. nonstandardized plans?
Connecticut	Yes	No	Yes
Massachusetts	Yes	Yes	Yes
New York	No[a]	No	Yes
Oregon	No	Yes	No

a In 2017, insurers in New York have the option to provide standardized plans with three primary care visits not subject to the deductible. If insurers opt to offer this type of standardized plan, they must offer them at the gold and silver levels.

Websites of the SBMs we studied are not being leveraged to achieve stated policy goals

Although a general agreement appears to exist among SBM officials and stakeholders about the value of plan standardization, and SBM officials and board members indicate that they have devoted "many, many hours" to their approach to standardizing benefits, the SBMs we studied have generally not taken steps to achieve the desired policy goal.

The marketplace websites are the route through which most consumers shop for and select a plan. And although these sites deploy several decision-support tools to simplify and streamline consumers' shopping experiences, none of our four study state websites have leveraged the benefits of standardization to ease plan-to-plan comparisons, thus limiting their ability to meet their stated policy goals (table 3).

None of the four states provide educational information about standardized plans on the web pages most consumers see (Massachusetts provides a fact sheet, but it's on a separate page). Standardized plans are not prioritized or highlighted on these websites, and consumers are unable to filter or sort for them. One consumer advocate noted that after all the effort spent in his state to design the standard plans, no commensurate effort has been made to "advertise them as standard or tell people how great they are." Stakeholders in the other study states reported the same phenomenon.

Three of the four states differentiate standardized plans from nonstandard plans by including the word "standard" in the plan name (or, in New York, the abbreviation "ST"). The fourth state, Massachusetts, currently does not mark its standardized plans but will for the 2017 open enrollment period. Several stakeholders agree that consumers on their own are unlikely to pay much attention to the plan name and, even if they do pay attention to it, are unlikely to know what "standard" refers to. "The public doesn't understand the terminology," noted one insurer.

Some of our study states do, however, educate assisters about terminology so that those assisters can help consumers compare and select plans. For example, Connecticut and Oregon officials, conceding that the website alone does not help consumers differentiate among plans, pointed out that the state has a very strong broker community that understands the differences among plans and helps educate consumers. "We believe brokers are the key parties equipped to assist a consumer in selecting a suitable plan," said a Connecticut official.

Assisters in New York also indicated that they had received good training from the state on the differences between standard and nonstandard plans. "We're trained and know the difference," one New York assister said, "but a consumer on [his or her] own isn't going to understand." Similarly, an Oregon broker observed, "When you take the professional out of the equation, standardized plans are probably not serving a purpose." Assisters in all of our study states are a significant source of enrollment. For example, New York officials have found that more than 50 percent of enrollees receiving marketplace subsidies use an in-person assister.

Table 3. Display of 2016 Standardized Plans on Study States' Websites

	Connecticut	Massachusetts[a]	New York	Oregon[b]
Is "standard" in name of plan?	Yes	No[c]	Yes, denoted by "ST"	Yes
Are they given any special designation (i.e., pop up box or flag)?	No	No	No	No
Are they prioritized on default landing page?	No	No	No	No
Can you sort for them?[d]	No	No	No	No
Can you filter for them?[e]	No	No	No	No
Any educational or marketing information about them?	None found	Fact sheet on standardized plans available on a separate "Resources" page	None found	None found

a Analysis reflects the website of Massachusetts's Health Connector, which offers both standardized and nonstandardized options. Researchers did not assess the website for ConnectorCare, where all plans are standardized.
b Oregon's website is www.healthcare.gov, the platform for the federally facilitated marketplace.
c Massachusetts will require "standard" to be in plan name for 2017.
d Site may have an initial screen to allow consumer to "sort" plans (e.g., by "High to Low Premiums" or "Low to High Deductibles").
e Site may allow you to "filter" plans (e.g., by plan level, name of carrier, or quality rating).

However, this training may not be adequate or universal across assister types. One assister in Massachusetts asked several of her "most experienced and knowledgeable" colleagues if they knew what a standardized plan was—none did. Similarly, an assister in Connecticut doubted any of her colleagues were using standardized plans to help consumers compare options, noting a lack of training.

To some degree, the lack of website tools that might steer consumers to standardized plans reflects the tension shared across our study states. On one hand, officials in the four states strongly supported simplifying and streamlining the plan shopping experience for consumers. On the other hand, they expressed a real hesitancy to be perceived as limiting consumer choices or steering consumers to a particular kind of plan. Some officials noted that depending on some consumers' finances and health, standardized plans might not always be the best option. For example, Connecticut officials rejected the idea of prioritizing standardized plans on their site, saying: "We want the opportunity for the consumer to look at everything. We don't want to necessarily steer them to the standard plans." Insurers too were concerned that filtering out nonstandard plans or making standard plans the default option would be inappropriate. "For someone with specific needs," one insurer said, "the standardized plans might not be the best option."

The SBMs have commissioned little or no consumer testing to assess how best to display standardized plan options on their websites

Of our four study states, none are conducting the kind of one-on-one observational consumer testing that experts recognize is critical to designing a website that allows consumers to make the best decisions about health plans.[28] SBM officials report that they have fielded consumer surveys, but none have asked about how consumers use standardized plans to shop for coverage or about their experience accessing services in standard versus nonstandard plans.

Further, the SBMs do not report consistent data on whether and why consumers choose standardized vs. nonstandardized plans. Of our four study states, only Connecticut and Massachusetts had data from the 2016 enrollment season. As noted above, Connecticut's enrollees clearly favored the standardized options, with 72 percent choosing those plans. This is most likely because the state requires insurers to make the standardized plan at the silver level their lowest cost option. In Massachusetts, approximately 55 percent chose standardized plans.[29] New York does not yet have data on 2016 enrollment, but for 2015, 61 percent of consumers enrolled in a standardized plan option.[30] Oregon does not publicly report this data. Officials in these states were uncertain why consumers might be selecting standardized over nonstandardized plans.[31]

Some SBMs report conducting consumer focus groups, but such groups appear primarily designed to help the SBMs develop effective outreach and enrollment messages. Connecticut reports conducting usability testing, in which marketplace officials convened groups of consumers to see how they interacted with the website. Officials report that the usability study was very helpful in generating a prioritized list of improvements. However, it was conducted during the initial development of the website and has not been repeated. Massachusetts officials have conducted consumer testing of their display of standardized plan offerings before the ACA, but they have not done so since shifting to a new plan comparison platform in 2014.

Simultaneously, state officials in Connecticut, Massachusetts, and New York highlight the importance of their relationships with local consumer advocacy groups and assister organizations, which regularly inform them of trouble areas and issues that make the enrollment process more challenging. Officials indicate that many changes both to plan and website designs were made in response to their feedback. For example, New York changed, and Massachusetts will change, the health plans' names to reflect their standardized status, in part because of assisters' concerns about the lack of differentiation between standardized and nonstandardized plans.

Limited flexibility of information technology (IT) platforms hinders efforts to improve the shopping experience

SBM officials generally acknowledge that most consumers would have difficulty differentiating standard and nonstandard plans on their websites. Officials point to the lack of flexibility of their IT systems as one reason, and they note that adding filtering or sorting options or pop-up windows to flag standardized plans can be expensive add-on features. "Our website limits our ability to achieve the goal [of highlighting standardized plans]," said a Massachusetts official. New York and Connecticut officials claim that any changes to the external-facing website are a difficult operational and resource challenge. "There's been some frustration around this," said one. In particular, the SBMs' limited financial resources have required them to prioritize system improvements that had more urgency than the development of decision-support tools and display options for standardized plans.

In Oregon, where the marketplace uses the federal IT platform, officials observe that the state's goals for plan standardization "never materialized" for consumers because of the platform's limits. Oregon residents can currently only differentiate standardized plans from nonstandardized via the plan name. State officials are also uncertain how their state's policy for plan standardization would be integrated into the emerging federal one.

LOOKING AHEAD: MANAGING THE TENSION BETWEEN SIMPLICITY AND CHOICE

A difficult balancing act

SBMs pursuing plan standardization have attempted to balance improving consumers' ability to make plan choices with insurers' interest in greater flexibility to develop "innovative" plan designs. For our study states, this has meant allowing insurers to market nonstandardized plans alongside standardized ones. Some SBM officials acknowledge that in doing so they are to some extent undermining the goals of plan standardization. "There is value in having nonstandard options," said one Oregon executive, "but it takes away from the benefit of having standardized plans in the first place. I can't say which approach is better."

Others believe that standard and nonstandard plans can comfortably coexist, but the website shopping experience must clearly allow consumers to differentiate among them and provide tools to facilitate the "apples-to-apples" comparisons that the marketplaces are supposed to provide. In any event, requiring all plans to be standardized does not, by itself, guarantee a smooth and easy plan selection process. In California's marketplace, where all plans are standardized, a minority of visitors to the website report being satisfied with their shopping experience.[32]

Support for limiting the number of plans

All four study states require insurers to offer standardized plan designs and to limit the total number of nonstandard plans they can offer. Limiting the number of plan choices in the study-state SBMs is an idea with broad support, including among insurers. For example, an Oregon insurer told us: "The most helpful thing for Oregon consumers was placing plan limits on each carrier…. Most people are only going to look at the first couple of pages [of the website] anyway for plan options." Insurers in the three other states shared similar sentiments.

Assisters reported that reducing the number of plans offered at each plan level made the shopping experience easier, although a common refrain was that the number and variety of plan choices remains "overwhelming" for most consumers. A consumer survey in Massachusetts found that the optimal number of plans consumers wanted to choose among is three to five (although whether respondents were referring to insurers or their plan offerings was unclear).

At the same time, our study states generally have many insurers participating on their marketplaces. There were 15 in New York, 11 in Massachusetts, 10 in Oregon, and 4 in Connecticut, although not all of these companies offer plans statewide.[33] Some SBM officials acknowledge that in parts of the country with fewer insurers competing, there might be less of a need to limit the number of plans being offered.

Get data on the consumer experience and use it

SBM officials highlight the value of collecting data and feedback from their customers about their experiences shopping for and using standardized health plan designs. "Listening to the people using your system is always a good idea—both users and stakeholders are really important," said a New York official. At the same time, officials acknowledge that other, more urgent priorities have limited their ability to collect and act on such data.

However, SBM officials and stakeholders broadly agree that the development and offering of standardized plan options will be iterative. "It's going to be a year-over-year learning experience," said one insurer. "We have to see how these products work." Marketplace officials also stated their commitment to keeping up with a rapidly evolving market. Doing so, however, will require SBMs to commit to consumer testing, surveys, and data analysis efforts that are more robust than currently underway.

Marketplace websites can deploy more tools to support plan comparisons

Officials and stakeholders generally agree that the current structure and tools available on the study-state websites do little to help consumers differentiate between standard and nonstandard options. Assisters, consumer advocates, and some marketplace officials propose that standardized plans should be the first ones that consumers see when they visit the marketplace website. Others suggest that the

sites allow consumers to filter for standard plans at each plan level. Consumer advocates further argue that the websites should clearly denote those standard plans that may deliver a particular value, such as covering primary care services or certain drugs before the deductible. However, insurer stakeholders tend to disagree, arguing that nothing is inherently better about standardized plans.

Assisters also point out that, even after cost sharing for plan benefits has been standardized, many important facets of coverage exist that consumers must research and understand, including provider networks and drug formularies. Those working with consumers emphasize the lack of health insurance literacy and question whether adding more educational information or tools to SBM websites would sufficiently support consumer decision-making. “There is such a huge health insurance literacy challenge, no matter how easy you make it, people are still going to be confused,” a Connecticut assister noted.

CONCLUSION

SBM officials and stakeholders in our study states universally agree that health plan standardization helps consumers understand their choices and compare plans. The four SBMs in this study established their marketplaces with standardized health plans to simplify the shopping experience for consumers.

Between adopting the policy and operationalizing it, however, these SBMs may have missed an opportunity to fully realize the policy’s purpose. Competing policy goals and IT capacity challenges have limited the SBMs’ ability to help shoppers make an “apples-to-apples” comparison among plans. Currently, the states’ SBM websites do not allow for filtering or a meaningful differentiation between standardized or nonstandardized plans. Limited or no data on the consumer shopping experience and website usability have also stalled progress toward making marketplace websites a place for consumers to more easily assess plan features.

In comparison, the FFM, which is just now establishing a standardization policy for 2017 (via the “simple choice” plan), will use a “prominent display” and “visual support cues,” designed with input from consumer testing, to facilitate apples-to-apples plan comparisons. Although FFM officials can likely benefit from the SBMs’ experiences working with stakeholders such as insurers and marketplace assisters to effectively implement a standardized plan policy, both the FFM and the SBMs should consider ways for states to leverage the greater resources of the FFM to conduct consumer testing, website design, and data analysis.

ENDNOTES

1. "Actuarial value" represents the average percentage of covered health care expenses that will be paid by the insurer.

2. 45 C.F.R. § 156.115 and 45 C.F. R. § 156.140.

3. Monahan CH, Dash SJ, Lucia KW, Corlette S. *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces*. Washington: The Commonwealth Fund, 2013. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Dec/1720_Monahan_what_states_are_doing_simplify_rb.pdf. Accessed May 2016.

4. California, Connecticut, the District of Columbia, Massachusetts, New York, Oregon, Vermont. See Dash S, Lucia KW, Keith K, Monahan C. *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges.* Washington: The Commonwealth Fund, 2013. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Jul/1696_Dash_key_design_decisions_state_based_exchanges.pdf. Accessed May 2016.

5. Jost TS. *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues.* Washington: The Commonwealth Fund, 2010. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2010/jul/1426_jost_hlt_insurance_exchanges_aca.pdf. Accessed May 2016.

6. The Affordable Care Act's Health Insurance Marketplace by Type. The Commonwealth Fund. http://www.commonwealthfund.org/interactives-and-data/maps-and-data/state-exchange-map. Accessed May 2016.

7. Dash et al., 2013.

8. The meaningful difference standard requires a plan's features, such as cost-sharing levels, scope of covered services, or networks, to be substantially distinct from those of other plans offered in the same area by the same insurer. See 45 C.F.R. § 156.298.

9. 45 C.F.R. § 156.298.

10. DC Health Benefit Exchange Authority. *Standard Plans 2016.* Washington: DC Health Benefit Exchange Authority, 2016. http://hbx.dc.gov/publication/standard-plans-2016. Accessed May 2016.

11. Massachusetts Health Connector. *2017 Qualified Health and Dental Plan Seal of Approval (SoA).* Board of Directors Meeting, March 10. Boston: Massachusetts Health Connector, 2016. https://betterhealthconnector.com/wp-content/uploads/board_meetings/2016/2016-03-10/2017-SoA-Launch-031016.pdf. Accessed May 2016.

12. Ibid.

13. Ericson KMM and Starc A. *How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange.* Cambridge, MA: National Bureau of Economic Research, 2013. http://www.nber.org/papers/w19527.pdf. Accessed May 2016.

14. Consumers Union. *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making.* Yonkers, NY: Consumers Union, 2012. http://consumersunion.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf. Accessed May 2016.

15. Hanoch Y, Rice T, Cumming J, Wood S. How much choice is too much? The case of the Medicare prescription drug benefit. *Health Services Research.* 2009;44(4): 1157–1168. http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2009.00981.x/epdf. Accessed May 2016.

16. Alvarado A, Rae M, Claxton G, Levitt L. *Examining Private Exchanges in the Employer-Sponsored Insurance Market.* Menlo Park, CA: Kaiser Family Foundation, 2014. http://files.kff.org/attachment/examining-private-exchanges-in-the-employer-sponsored-insurance-market-report. Accessed May 2016.

17. Jacobs D. CMS' standardized plan option could reduce discrimination. *Health Affairs.* January 6, 2016. http://healthaffairs.org/blog/2016/01/06/cms-standardized-plan-option-could-reduce-discrimination/. Accessed May 2016.

18. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule. 45 CFR Parts 144, 147, 153 et al. https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf. Accessed May 2016.

19. Counihan K and Conway P. Simplifying choices in the marketplaces-simple choice plans and quality star ratings. *Centers for Medicare and Medicaid Services* (blog). April 29, 2016. https://blog.cms.gov/2016/04/29/simplifying-choices-in-the-marketplace-simple-choice-plans-and-quality-star-ratings/. Accessed May 2016.

20. Ibid.

21. Massachusetts Health Connector, *2017 Qualified Health and Dental Plan Seal of Approval.*

22. Connecticut is the only study state that requires predefined cost-sharing amounts for services delivered by out-of-network providers. See Access Health CT. *Connecticut Health Insurance Exchange Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options (SHOP) Marketplaces Plan Year 2017*. New Haven, CT: Connecticut Health Insurance Exchange, 2016. http://www.ct.gov/hix/lib/hix/2017_QHP_Solicitation_04042016_Final_Website.pdf. Accessed May 2016; Massachusetts Health Connector, *2017 Qualified Health and Dental Plan Seal of Approval.* 2017 Invitation to Participate in New York State of Health. New York State of Health. http://info.nystateofhealth.ny.gov/invitation. Published April 11, 2016. Accessed May 2016; *Carrier Request for Application (RFA).* Cover Oregon. On file with authors.

23. Massachusetts Health Connector, *2017 Qualified Health and Dental Plan Seal of Approval;* Access Health CT, *Connecticut Health Insurance Exchange Solicitation;* Access Health CT. *Board of Directors Special Meeting: March 1, 2016.* New Haven, CT: Access Health Connecticut, 2016. http://www.ct.gov/hix/lib/hix/Presentation03012016.pdf. Accessed May 2016.

24. Access Health Connecticut, *Board of Directors Special Meeting.*

25. Requirement does not extend to plans that are compatible with health savings accounts; most of these require co-insurance for several services. Access Health CT, *Connecticut Health Insurance Exchange Solicitation;* Access Health CT. *Board of Directors Special Meeting.*

26. Massachusetts Health Connector, *2017 Qualified Health and Dental Plan Seal of Approval.*

27. New York State of Health, 2017 Invitation to Participate in New York State of Health.

28. Consumers' Checkbook is a nonprofit that for more than 30 years has published the popular *Guide to Health Plans for Federal Employees* and, more recently, has developed web-based plan comparison tools for several SBMs. In developing its website interface and decision-support tools, Consumers' Checkbook does extensive consumer testing, primarily involving one-on-one observational studies of consumers interacting with the site and shopping for plans. These studies generate important data for web designers about how consumers shop for and make decisions about health plans. The FFM is also conducting consumer testing of the display options and descriptions of standardized plans before they will be available for the 2017 open enrollment season.

29. Massachusetts Health Connector, *2017 Qualified Health and Dental Plan Seal of Approval.*

30. New York Department of Health, *Health Insurance Coverage in New York State Surges: Enrollment Data Show More Than 2 Million New Yorkers Have Enrolled Through NY State of Health Marketplace* (press release). July 29, 2015. https://www.health.ny.gov/press/releases/2015/2015-07-29_nysoh_enrollment_report.htm. Accessed May 2016.

31. Surveys about consumer experiences with standardized plans appear to be lacking. Even California, which publishes a consumer tracking survey, currently does not have public data on the consumer experience once enrolled in their standardized plans. *See* California Health Benefit Exchange. Data and Research. http://hbex.coveredca.com/data-research/. Accessed June 2016.

32. Fifty-one percent of renewing enrollees report being satisfied with the shopping experience, while only 34 percent of enrollees who were previously uninsured report being satisfied. Uninsured consumers who did not purchase a plan found the process the most difficult: 60 percent reported dissatisfaction with the web-based shopping experience. Covered California, *Overview of Main Findings from the Third California Affordable Care Act Consumer Tracking Survey*, October 22, 2015. http://hbex.coveredca.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf. Accessed June 2016.

33. Curran E, Giovannelli J, Lucia K. Insurer participation in state-based marketplaces in 2016: A closer look. *The Commonwealth Fund* (blog). January 21, 2016. http://www.commonwealthfund.org/publications/blog/2016/jan/insurer-participation-in-state-based-marketplaces-in-2016. Accessed May 2016.

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Sabrina Corlette and Kevin Lucia are research professors and project directors at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms; Sandy Ahn is an associate research professor and Hannah Ellison a research associate.

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By Simon F. Haeder, David L. Weimer, and Dana B. Mukamel

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Secret Shoppers Find Access To Providers And Network Accuracy Lacking For Those In Marketplace And Commercial Plans

Simon F. Haeder (simon.haeder@mail.wvu.edu) is an assistant professor in the Department of Political Science at the John D. Rockefeller IV School of Policy and Politics, West Virginia University, in Morgantown. Previously he was a doctoral student in the Department of Political Science at the University of Wisconsin-Madison.

David L. Weimer is a professor in the La Follette School of Public Affairs at the University of Wisconsin–Madison.

Dana B. Mukamel is a professor in the Department of Medicine and the director of the iTEQC Research Program (Program of Research in Translational Technology Enabling High Quality Care), both at the University of California, Irvine.

ABSTRACT The adequacy of provider networks for plans sold through insurance Marketplaces established under the Affordable Care Act has received much scrutiny recently. Various studies have established that networks are generally narrow. To learn more about network adequacy and access to care, we investigated two questions. First, no matter the nominal size of a network, can patients gain access to primary care services from providers of their choice in a timely manner? Second, how does access compare to plans sold outside insurance Marketplaces? We conducted a "secret shopper" survey of 743 primary care providers from five of California's nineteen insurance Marketplace pricing regions in the summer of 2015. Our findings indicate that obtaining access to primary care providers was generally equally challenging both inside and outside insurance Marketplaces. In less than 30 percent of cases were consumers able to schedule an appointment with an initially selected physician provider. Information about provider networks was often inaccurate. Problems accessing services for patients with acute conditions were particularly troubling. Effectively addressing issues of network adequacy requires more accurate provider information.

Gaining access to health care services is often a complex undertaking. Under the best circumstances, patients have affordable insurance plans, are able to select providers covered by the plans, and are able to see their selected providers in a timely manner when necessary for either preventive or urgent care. The Affordable Care Act (ACA), despite various shortcomings, has improved the first two steps in the process and implicitly assumes that patients will be able to take the essential third step. Very limited empirical evidence is available to assess the ease of taking that step, however.

We report the results of a study that assessed the ease of scheduling an appointment and the waiting time until the scheduled appointment for participants in plans offered both through an ACA exchange, or Marketplace, and commercially. Specifically, we compared the experiences of consumers with plans sold through the Covered California insurance Marketplace to the experiences of those obtaining equivalent "mirrored" plans sold outside of the Marketplace.[1] Mirrored plans have the same panel of providers and same benefit structure both inside and outside the exchange.[2] However, physicians can differentially accept or schedule patients by insurance status, thus potentially leading to access barriers for people with Marketplace plans. For example, physicians could deem such people sicker and thus costlier in terms of time and care provided.

We surveyed primary care providers in five Covered California pricing regions during the summer of 2015 using representative "secret

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shoppers." In addition, we assessed the accuracy of provider directories and potential differences between plans sold on and off the insurance Marketplace—topics at the center of much recent controversy.[3]

Insurance Marketplaces, Covered California, And Provider Networks

Insurance Marketplaces are one of the central components of the ACA. They are the mechanism through which millions of Americans obtain coverage in the private market by facilitating the comparison and purchase of insurance products. Nonetheless, their implementation has been highly politicized, and many states have in varying degrees refused cooperation with the federal government.[4–6] Covered California was the first Marketplace to be established under the ACA and is generally considered to be one of the more successful, better-funded, and better-maintained Marketplaces in the country.[7]

Much of the recent controversy surrounding insurance Marketplaces has focused on the role of so-called narrow networks—that is, provider networks that restrict patient choice, particularly in terms of participating physicians or hospitals.[3,8–11] Indeed, there is overwhelming evidence, especially with respect to hospital access, that insurance plans sold in the ACA Marketplaces are narrower, sometimes significantly so, than comparable plans sold outside the Marketplaces. Nationally, more than half of these plans are considered "narrow,"[9] although comparisons to other plans instead of the overall number of providers are not quite as negative.[8]

At the same time, narrow networks—despite restricting choice of providers—could have certain beneficial aspects. For one, premiums are generally lower in plans with narrower networks.[9] Moreover, geographic access—that is, travel time to hospitals—appears to be similar, and quality might actually be higher, in plans sold in the ACA Marketplaces as compared to standard commercial plans.[8] One aspect that has not been assessed empirically is whether people who obtained coverage through their insurance Marketplace are actually able to access physician services when they are needed.

Study Data And Methods

DATA We collected data on access to physicians in June and July of 2015 from five of the nineteen pricing regions established by Covered California. Our selection included rural, urban, and mixed areas of the state (Exhibit 1). Region 1 covers a number of small, rural counties in Northern California; region 4 covers the City and County of San Francisco; region 11 covers the Central Valley counties of Merced, Kings, and Fresno; region 17 covers the Inland Empire counties of Riverside and San Bernardino; and region 19 covers San Diego County. In each of the five regions, we randomly selected a total of at least seventy primary care providers who were listed in the insurers' directories as accepting new patients in both Marketplace and non–Marketplace plan networks from two major insurers: at least thirty-five from Blue Cross provider directories and at least thirty-five from Blue Shield directories. We restricted our selection to directories for mirrored plans—that is, plans that have the same panel of physicians and benefit structures both within and outside the Marketplace—which, a priori, should provide the same level of access to consumers. This dyadic approach[8] holds all observable and unobservable variables constant and varies only with regard to whether or not coverage was obtained through the Marketplace.

Blue Cross is California's largest provider of individual coverage inside and outside of the Marketplace (47 percent and 30 percent of cov-

EXHIBIT 1

Characteristics of five of the nineteen insurance pricing regions established by Covered California, June and July 2015

Pricing region	Region type	No. enrolled in Marketplace plans during first enrollment period	Percent receiving premium assistance	Combined enrollment of Blue Cross and Blue Shield in Marketplace plans	Premium for 40-year-old single person at 200 percent of federal poverty level, silver plan (with/without subsidy)
1–Northern counties	Rural	49,665	91%	99.7%	$30/$248
4–San Francisco area	Urban	40,825	82	40.1	$28/$294
11–Central Valley area	Mixed/rural	29,159	92	87.6	$48/$229
17–Inland Empire counties	Mixed/urban	122,971	90	48.6	$90/$228
19–San Diego County	Urban	121,900	87	40.2	$61/$252

SOURCE Covered California.

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ered individuals in these markets, respectively), and Blue Shield is the second-largest provider (19 percent and 29 percent, respectively).[10] Together these two insurers provide more than half of the individual coverage in each of the two markets. Moreover, they are the only insurers that have a presence across the entire state.

We confined our data collection efforts to primary care providers because of the importance of these types of providers for initial access to the health care system. For the purposes of this study, primary care providers included physicians listed as internal medicine, family practice, general medicine, and obstetrics-gynecology (OB-GYN). A total of 743 primary care providers were selected across all five regions.

We then instructed two "secret shoppers" to each call the offices of these 743 providers, presenting themselves as consumers seeking to schedule appointments as new patients.[12] One caller presented as insured through the Marketplace plan, and the other, with the respective mirrored plan obtained outside the Marketplace. In half of the cases, the callers presented with the request to schedule an appointment for a physical; in the other half, the callers presented with symptoms (high fever, stomach flu, sore muscles, or heavy bleeding and pain during menstruation) that were deemed urgent. In all cases, the only difference between the calls to any specific provider was the difference in insurance coverage presented. While the insurance products selected were comparable,[8] providers might have preferred to treat patients with plans purchased outside of Marketplaces for a variety of reasons, including potentially higher reimbursement or capitation rates, patient demographics, or expected health status.

While our analysis was geographically limited, we believe that our results are at the very least indicative, if not representative, of the situation in much of the country, and not purely idiosyncratic to California. For one, the regions we selected offer a diverse range of demographic, economic, political, health care delivery, and financial environments.[13] Blue Cross of California's parent company, Anthem, does business outside of California and offers insurance products in more than a dozen states. Furthermore, one of the carriers is a for-profit company, while the other one is a not-for-profit health plan provider. Both carriers are also some of the nation's largest insurers and leaders in the BlueCross and BlueShield Association. Finally, and despite certain state-specific circumstances, the incentive structure and hence the behavior of insurers and providers should be rather similar across the country.

Study Results

We attempted 1,486 calls to 743 providers. Of the 743 randomly selected providers, 29 percent were listed as family physicians, 9 percent as generalists, 38 percent as internists, and 21 percent as OB-GYNs, with the remainder as some combination of these categories. Our sample was reduced to 707 providers because some providers requested additional information, such as a medical history, before scheduling appointments. All statistical significance tests were conducted at the 10 percent level.

In about 10 percent of cases, the providers listed in the respective directory either were no longer with the group listed or had never been with the group at all (ranging from 8 percent to 15 percent across regions) (Exhibit 2). In addition, in about 30 percent of the cases the specialty listed in the provider directory did not match the one stated by the receptionist at the practice

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EXHIBIT 2

Survey results comparing Covered California Marketplace plans to non-Marketplace plans in the ease of scheduling an appointment with a provider, June and July 2015

Pricing region	No such physician in practice	Wrong specialty listed	Unable to reach		No new patients accepted		Insurance not accepted		Unable to get appointment with original provider	
			NMP	MP	NMP	MP	NMP	MP	NMP	MP
1–Northern counties	10.42%	15.97%	18.75%	20.14%	24.31%	25.69%	1.39%	2.78%	70.83%	75.00%
4–San Francisco area	8.39	26.45	31.61	26.45	8.39	8.39	2.58*	5.81*	77.42	75.48
11–Central Valley area	14.93	32.09	14.18	12.69	8.96	8.21	1.49	2.99	71.64	70.90
17–Inland Empire counties	9.42	34.06	14.49	15.94	4.35	4.35	0.72	2.17	63.04	65.94
19–San Diego County	8.09	42.65	13.97	13.24	4.41	3.68	0.74*	8.09*	69.85	75.74
All regions	10.18	29.99	18.95	17.96	10.18	10.18	1.41*	4.38*	70.72	72.70

SOURCE Authors' calculations. **NOTES** NMP is non-Marketplace plan. MP is Marketplace plan. *$p < 0.10$

(ranging from 16 percent to 43 percent).

We were also unable to contact 19 percent of providers of non-Marketplace plans and 18 percent of providers of Marketplace plans at the telephone number listed in the directory, despite repeated attempts, because the line was disconnected, three messages were not returned, the wrong number was given, or the line was constantly busy (ranging from 14 percent to 32 percent for non-Marketplace plans and from 13 percent to 26 percent for Marketplace plans). The differences between the Marketplace and non-Marketplace networks were not statistically significant overall or in any specific region.

Ten percent of providers listed in the non-Marketplace directories did not accept any new patients (ranging from 4 percent to 24 percent).[14] The same was true for 10 percent of providers listed in the Marketplace directories (ranging from 4 percent to 26 percent). These differences also were not statistically significant overall or in any specific region.

For non-Marketplace plans, in only about 1 percent of cases did the provider not accept the insurance plan presented by the caller (ranging from 1 percent to 3 percent). The number reached 4 percent for Marketplace plans (ranging from 2 percent to 8 percent). The differences overall and in two of the regions were statistically significant.

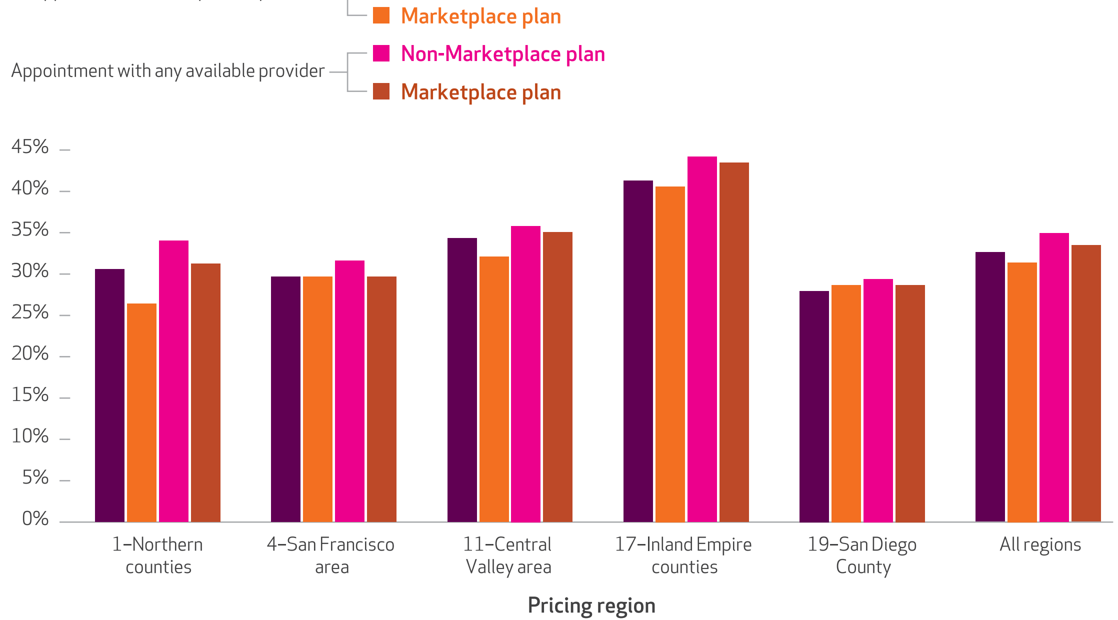
Overall, in almost 71 percent of calls based on non-Marketplace directories and 73 percent of calls based on Marketplace directories, we were unable to set up an appointment with the original provider contacted. The differences were not statistically significant overall or in any specific region.

When callers reached a different primary care provider at the phone number listed in the directory, the secret shoppers were nonetheless instructed to ask to schedule an appointment with that provider. At times, the receptionist offered this option without being prompted. Callers were hence ultimately able to schedule appointments in 33 percent of non-Marketplace calls and 31 percent of Marketplace calls, although the appointment might not have been with the provider they originally sought to contact. There was no statistically significant difference between the two plan types with regard to the ability to set up appointments with the available provider (Exhibit 3).

After the initial appointment was scheduled, callers were also instructed to ask whether any earlier appointment was available with another provider at the practice, including physician extenders such as nurse practitioners and physician assistants. Again, some receptionists of-

EXHIBIT 3

Percentage of appointment requests scheduled in "secret shopper" survey of selected California insurance pricing regions comparing Marketplace plans to non-Marketplace plans, June and July 2015



SOURCE Authors' calculations. **NOTES** Includes appointments with original provider contacted or, if the original provider was not available, with any other available provider. The differences shown are not statistically significant.

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fered this option without being asked. As shown in Exhibit 3, this increased the overall percentages slightly, to 35 percent for non-Marketplace plans and to 34 percent for Marketplace plans. Again, no statistically significant difference was detected.

Finally, we assessed how long it would take for a patient to actually see a provider. With regard to appointments scheduled with physicians, patients were able to gain quicker access to care if their coverage was provided by non-Marketplace plans (Exhibit 4). Gaining access to these plans was also faster than for Marketplace plans, on average, in every region, although the results were statistically significant in only region 1, northern counties. We also found statistically significant differences between plans for one insurance carrier, Blue Shield, as well as for both acute need and physical exams. All three cases showed better results for non-Marketplace plans. With regard to appointments scheduled with the first available provider, we again noted that in every case, non-Marketplace plans fared better than Marketplace plans. The results were statistically significant overall but not for any particular region. The differences were also statistically significant for the second insurance carrier, Blue Cross.

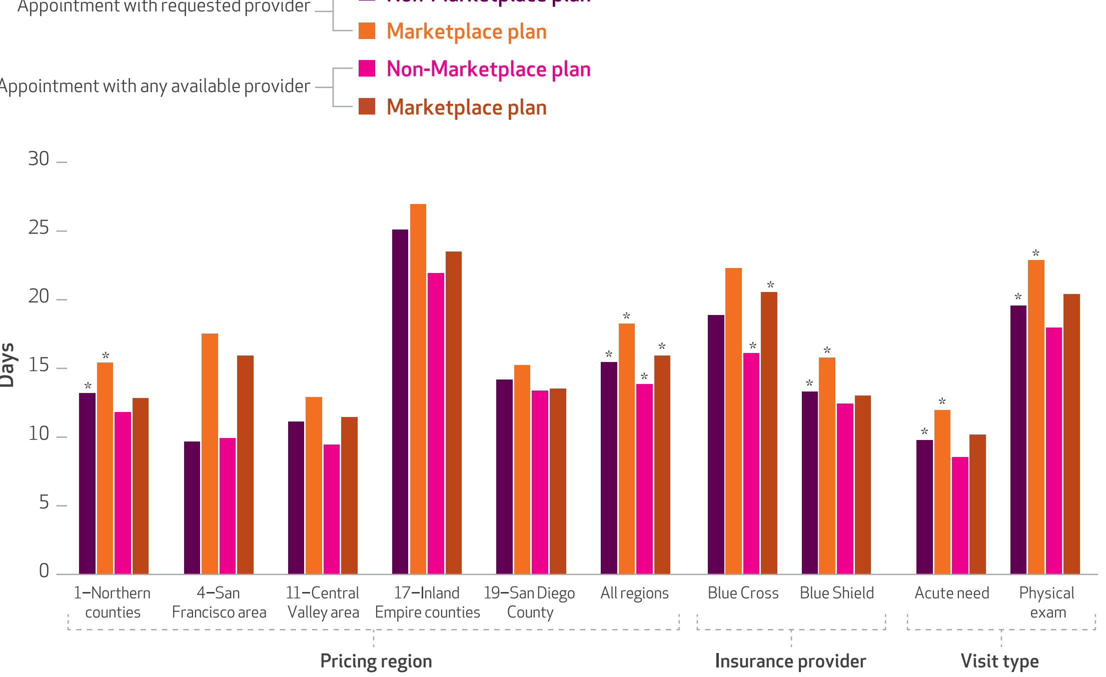
It is also noteworthy that the mean time to appointment for callers presenting with an acute complaint in all cases was more than a week (data not shown). It ranged from a low of 8.5 days for an appointment with the earliest available provider for patients with non-Marketplace coverage to 11.9 days for an appointment with the requested provider for patients with Marketplace coverage. The difference of about three days by coverage type was statistically significant only for appointments with the requested provider.

Discussion

Two patterns emerged from our survey. First, and most striking, new patients in either Covered California or the comparable commercial plan had very low prospects—less than 30 percent—of securing an appointment with any randomly chosen provider. The odds got only slightly better in terms of getting an appointment with any provider in the practice. The results were particularly disheartening in the case of patients presenting with acute conditions. Although the average wait time was reduced by about half when compared to physical exams, it nonetheless took eight to twelve days to

EXHIBIT 4

Days to scheduled appointment in "secret shopper" survey of selected California insurance pricing regions comparing Marketplace plans to non-Marketplace plans, June and July 2015



SOURCE Authors' calculations. **NOTE** Includes appointments with original provider contacted or, if the original provider was not available, with any other available provider. * $p < 0.10$

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These findings suggest that the third step in health care access, scheduling an appointment with a physician, has much room for improvement.

get an appointment with a physician or physician extender. Moreover, only a handful of providers suggested that patients seek care at an urgent care center. These findings suggest that the third step in health care access, scheduling an appointment with a physician, has much room for improvement. At least accurate lists of providers, including whether the provider is accepting new patients, should be available for patients when they make choices about health plans.

Second, patients in commercial plans tended to fare somewhat better than their counterparts in Covered California plans, in terms of both getting appointments and the time to appointment. However, not only were these differences relatively small and often statistically insignificant, they were dwarfed by the overall difficulty of getting appointments with the desired provider. So, although it was marginally more difficult to get timely care in Covered California plans than their commercial counterparts, substantially increasing access requires more than just equalizing access in the two types of insurance coverage. Accessing services appears to be particularly difficult in the rural counties of Northern California and the Inland Empire, as well as in San Francisco.

Network listing accuracy issues are distinct but inherently related to network adequacy issues. Inaccurate provider directories are challenging for patients attempting to access providers, and they make it difficult for regulators to assess network adequacy. If the findings from California that we present here generalize to other states, it is highly likely that the twenty-seven states that set up quantitative standards for network adequacy in 2014 have greatly overestimated the access their Marketplace insurers provide.[15] A number of the network accuracy problems can be resolved relatively easily through administrative fixes. Requiring frequent updates of the listings will likely increase accuracy by ensuring that only providers actually participating in the plans' networks are listed and that specialties and contact information for those providers are accurate. Only ten states have mandated update frequency, with updates required anywhere from every six months to fourteen days from the time a change is made.[15] California currently requires updates every quarter, yet our findings showed very high incidence of errors. The problem was identified and publicized by the State of California at the end of 2014, and yet by the summer of 2015, when this study was done, it seemed to have become more serious, with larger error rates than before.[16] As a result, the state is implementing stricter oversight requirements as well as penalties for noncompliance for both insurers and providers beginning in July 2016.[17] Moreover, California took more stringent actions in November 2015, fining two large insurers substantial amounts ($250,000–$350,000) for "unacceptable inaccuracies in their directories."[18] The desirable frequency of necessary updates is open to debate, but undeniably the problems presented in this study are quite disheartening.

The California experience suggests that mandating electronic provider directories, updated frequently with (relatively) real-time information,[15] might be the only path to truly improved access for patients and, because being seen in a provider's office in a timely manner often can prevent a costly emergency department admission, possibly lower costs. However, only future analyses will be able to tell whether or not the situation has improved.

Conclusion

Improving access to care by improving access to affordable health insurance is one of the main goals of the Affordable Care Act. However, as our analysis has shown, access to health insurance is not necessarily synonymous with access to health care services. Network accuracy is an important, albeit heretofore largely overlooked, component of access for patients. At the same time, as earlier reforms in Massachusetts have shown, increasing the number of insured people without a commensurate increase in capacity further exacerbates the situation.[19] The more frustrated people become as they are trying to access care, the more likely they are to defer or forgo care, or to choose more expensive options such as emergency departments. ■

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The authors thank Yashna Nandan and Joseph Chen for their research assistance.

NOTES

1 California Medical Association. Blue Shield exchange/off-exchange plans leading to confusion among physicians [Internet]. Sacramento (CA): CMA; 2014 Feb 10 [cited 2016 May 18]. Available from: http://www.cmanet.org/news/detail/?article=blue-shield-exchangeoff-exchange-plans-leading

2 Two of California's largest providers, Kaiser Permanente and Blue Shield, do not offer any non-mirrored plans. Blue Cross offers both mirrored and non-mirrored plans.

3 Haeder SF, Weimer DL, Mukamel DB. Narrow networks and the Affordable Care Act. JAMA. 2015;314(7):669–70.

4 Haeder SF, Weimer DL. Inching toward universal coverage: state-federal health-care programs in historical perspective. J Policy Hist. 2015;27(4):746–70.

5 Rigby E, Haselswerdt J. Hybrid federalism, partisan politics, and early implementation of state health insurance exchanges. Publius. 2013;43(3):368–91.

6 Béland D, Rocco P, Waddan A. Implementing health care reform in the United States: intergovernmental politics and the dilemmas of institutional design. Health Policy. 2014;116(1):51–60.

7 Haeder SF, Weimer DL. You can't make me do it, but I could be persuaded: a federalism perspective on the Affordable Care Act. J Health Polit Policy Law. 2015;40(2):281–323.

8 Haeder SF, Weimer DL, Mukamel DB. California hospital networks are narrower in Marketplace than in commercial plans, but access and quality are similar. Health Aff (Millwood). 2015;34(5):741–8.

9 Bauman N, Coe E, Ogden J, Parikh A. Hospital networks: updated national view of configurations on the exchanges. New York (NY): McKinsey and Company; 2014 Jun.

10 Wilensky GR. Asking the right questions about narrow networks. Healthc Financ Manage. 2014;68(11):30,2.

11 Carroll J. Plans use narrow networks in exchanges; public, politicians predictably perturbed. Manag Care. 2014;23(1):5–6.

12 The secret shoppers presented as follows: First, they sought to verify the name and specialty of the provider listed in the directory; they then presented their insurance coverage verbatim as listed by the insurance carrier; finally, they stated the reason they sought care, for either an acute condition or a physical exam.

13 California Health Care Foundation. California Health Care Alamanac: regional markets. Sacramento (CA): CHCF; 2009.

14 Included in the 10 percent was a handful of cases in which providers demanded a "membership" fee in addition to insurance payments. This membership fee to be paid by the patient was as high as $2,200 per year.

15 Giovannelli J, Lucia KW, Corlette S. Implementing the Affordable Care Act: state regulation of Marketplace plan provider networks. Washington (DC): Commonwealth Fund; 2015 May.

16 Herman B. Insurers draw heat for error-riddled provider directories. Modern Healthcare [serial on the Internet]. 2014 Nov 19 [cited 2016 May 18]. Available from: http://www.modernhealthcare.com/article/20141119/NEWS/311199972

17 Abram S. California bill that requires accurate health provider directories signed into law. Los Angeles Daily News [serial on the Internet]. 2015 Oct 10 [cited 2016 May 18]. Available from: http://www.dailynews.com/government-and-politics/20151010/california-bill-that-requires-accurate-health-provider-directories-signed-into-law

18 California Department of Managed Health Care [Internet]. Sacramento (CA): DMHC; 2015. Press release, DMHC fines Blue Shield and Anthem for inaccurate provider directories; 2015 Nov 3 [cited 2016 May 18]. Available for download from: https://www.dmhc.ca.gov/AbouttheDMHC/Newsroom.aspx#2015

19 Bodenheimer T, Pham HH. Primary care: current problems and proposed solutions. Health Aff (Millwood). 2010;29(5):799–805.

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CalSIM

California Simulation of Insurance Markets

The California Simulation of Insurance Markets (CalSIM) model is designed to estimate the impacts of various elements of the Affordable Care Act on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. It was developed by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research, with generous funding provided by The California Endowment.

Preliminary CalSIM v 2.0 Regional Remaining Uninsured Projections

Miranda Dietz,
Dave Graham-Squire,
Tara Becker, Xiao Chen,
Laurel Lucia, and Ken Jacobs

August 2016

This report provides updated regional estimates of the number of non-elderly uninsured Californians in 2017. The estimates build on prior versions of the California Simulation of Insurance Markets (CalSIM) microsimulation model and incorporate updated survey and administrative data. For background on the CalSIM model and prior estimates, see http://healthpolicy.ucla.edu/calsim.

These preliminary CalSIM 2.0 regional estimates of the uninsured are subject to change and do not reflect final CalSIM 2.0 results. They are being released in Summer 2016 to aid in county planning processes.

Populations Identified

Uninsured, not eligible for coverage due to immigration status, age 0-64: Undocumented Californians are excluded by federal law from the provisions of the Affordable Care Act (ACA). Californians in this category are eligible for Medi-Cal if they are under the age of 19 and are income-eligible or if they have been granted Deferred Action for Childhood Arrivals (DACA) and are income-eligible. Children who are eligible for Medi-Cal are excluded from these numbers and estimated separately. Individuals with DACA, however, are included in this category because we cannot properly identify them in our data.

This estimate does assume that some undocumented individuals decide to purchase individual market coverage outside of Covered California. However, our estimate does not include the effect of a possible 1332 waiver that would enable undocumented Californians to purchase coverage through Covered California.

Uninsured, income-eligible for Medi-Cal, age 0-64: These Californians are eligible for full-scope Medi-Cal based on their income but were uninsured prior to the ACA and are predicted to remain so. In some cases very few are predicted to remain uninsured, which we report as less than 5,000 (< 5,000). These numbers do not include uninsured undocumented Californians who may be eligible for Medi-Cal if they are children or have been granted deferred action.

Uninsured, eligible for Covered California with Subsidies, age 0-64: These Californians were uninsured and are not predicted to take up coverage through Covered California, despite being eligible for subsidized coverage. Eligibility is based on not having an employer offer, having income between 138% and 400% FPL, and being a citizen or lawfully present immigrant. This group includes only those who would get a subsidy to help pay for coverage. Others whose incomes fall below 400% FPL but whose premiums are below their expected contribution could purchase coverage (either through Covered California or the outside market) but would not receive a subsidy. These people are included in the estimates of those eligible for Covered California without subsidies.

Uninsured, eligible for Covered California without Subsidies, age 0-64: These Californians are eligible to purchase coverage through Covered California, but would not receive subsidies to help pay for that coverage. This includes anyone with income over 400% FPL, as well as those mentioned above whose premiums fall below their expected contribution. This group does not include the undocumented, who as of August 2016 were unable to purchase coverage through Covered California.

Undocumented children eligible for Medi-Cal, age 0-18: Under recently enacted California law, children from families with incomes at or below 266% FPL are eligible for full-scope Medi-Cal coverage regardless of their documentation status. We present an estimate of the number of undocumented children eligible for Medi-Cal

who report an insurance status of "Medi-Cal" (which we understand to mean enrollment in Emergency Medi-Cal), "individual market," "other public," or "uninsured," but excludes those who report having employer sponsored coverage. This is an attempt to provide a maximum enrollment target for Medi-Cal for this population.

Methodology

We model the population and demographics of each region prior to the Affordable Care Act, including insurance status, age, income, and immigrations status. We inflate the population to future years, including adjustments to income to reflect planned statewide and local minimum wage increases. We then calculate eligibility for Medi-Cal and subsidies through Covered California.

For these preliminary estimates of the remaining uninsured after ACA implementation, we do not actually run our microsimulation model to predict insurance decisions based on individual characteristics, or to predict employer behavior. Instead we apply the take-up rates calculated in CalSIM version 1.91 to populations based on their eligibility and insurance status pre-ACA.

For those who are uninsured non-subsidy eligible citizens and lawfully present immigrants, we apply a take-up rate directly from CalSIM 1.91. Those who do not take up are projected to remain uninsured. Similarly for those who are undocumented we apply a modified take-up rate from CalSIM 1.91 (see below).

We estimate changes in enrollment in the Covered CA and Medi-Cal post ACA using a combination of administrative and survey data. We subtract out those who are projected to have taken up coverage in these programs but would have had insurance in the absence of the ACA. The remainder are assumed to have come from those who were previously uninsured.

Covered California: We use 2015 Covered California administrative numbers of effectuated subsidized enrollment by geography. This gives us the number of enrollees we must account for in each geography in 2015.

We use rating region-specific premiums for the second lowest cost silver plan to calculate whether individuals who qualify for Covered California and have incomes at or below 400% FPL would actually be get a subsidy. This helps define our eligible population.

People enrolled in subsidized coverage through Covered California could have had, in the absence of the ACA, Employer Sponsored Insurance (ESI),[1] coverage in the individual market, or no insurance.

- ESI: We estimate the share of subsidized Covered California enrollees who would otherwise have had ESI. In CalSIM 1.91 we projected that 10% of enrollees would have come from this group. We make the same assumption here.
- Individual Market: Using the take-up rate from CalSIM 1.91, we assume that nearly all (95%) of those eligible for subsidies who otherwise have individual market coverage take up subsidized coverage.
- Uninsured: We assume that the remaining enrollees must come from the ranks of the uninsured. This allows us to back out a take-up rate for those otherwise uninsured who are eligible for subsidized coverage. We calculate this take-up rate for 2015 for each region and then apply the 2015 take-up rate

[1] People who would have ESI without the ACA could be eligible for subsidies through Covered California if they have COBRA or early retiree coverage; if they have an unaffordable offer of ESI; or if their employer drops coverage as a result of the ACA.

to the 2017 population identified as eligible and uninsured. We thus assume stable enrollment rates between 2015 and 2017. Take-up rates for Covered California among the otherwise uninsured range from 26% to close to 100%, averaging 54% for the state as a whole.

Medi-Cal: Administrative Medi-Cal numbers are always higher than those reported in surveys. As such, we do not try to match administrative totals. Rather, we take California Health Interview Survey totals for 2014, match the proportions by geography reported by Medi-Cal, and assume CHIS will see the same percentage overall growth seen administratively from 2014 to 2015.

We take into account that some enrollees in the LIHP program may have reported having Other Public Coverage in the CHIS in 2011-12, and count LIHP enrollees as newly enrolling in Medi-Cal because of the ACA.

From our adjusted estimate of the total number of enrollees per region, we subtract the number anticipated to have been enrolled in Medi-Cal without the ACA. The difference is the number of new enrollees due to the ACA that we must account for.

Given these totals, we use a similar methodology to that used to estimate take up in Covered California. We apply take-up rates from CalSIM 1.91 to the populations eligible for Medi-Cal with ESI coverage and those eligible for Medi-Cal with individual market coverage, and assume that the remainder of enrollees we must account for are from the ranks of the uninsured. This allows us to back out a take-up rate for those eligible for Medi-Cal who would be uninsured without the ACA. However, we limit the lower-bound for take up among the otherwise uninsured Medi-Cal eligible to the base-scenario estimates from CalSIM 1.91 (70% for those newly eligible but uninsured, 10% for those previously eligible but uninsured, with an average of 48%). We limit the upper-bound for take up among the otherwise uninsured Medi-Cal eligible to be 90%.

Undocumented: Undocumented adults who report having Medi-Cal coverage are assumed to have Emergency-only Medi-Cal and are thus considered uninsured for the purposes of these estimates. The take-up rate for insurance coverage among uninsured undocumented not eligible for Medi-Cal is based on the 1.9 estimates, but reduced by a "dampening factor" that reflects that the undocumented are less likely than similarly situated citizens and lawfully present immigrants to take up coverage in the individual market. From analysis of CHIS 2011-12 we estimate that undocumented take up at 65% the rate of those who are citizens or lawfully present immigrants.

Minimum Wage: We take into account planned minimum wage increases at the state and in certain geographies, namely within Los Angeles, San Francisco, Santa Clara, Contra Costa, Alameda, and San Diego counties. In each county we take into account the share of the low-wage population affected (e.g. not all cities in Alameda county have increased their minimum wage); the size of the wage increase using as a proxy the minimum wage schedule in the city with the most low-wage workers; and, for Bay Area counties, the commuting patterns and share of workers from a given county who work in a county with higher minimum wage. In general, because minimum wage increases raise incomes they move people from being Medi-Cal eligible to being Covered California eligible.

Range of Results

As with all projections, the numbers presented involve considerable uncertainty. They represent the current best estimates using a

combination of the California Simulation of Insurance Markets (CalSIM) version 2.0 input data set and take-up rates from CalSIM version 1.91, applied to each rating region (or combined rating regions) and select large counties.

Our results are presented as point estimates. To give a sense of a reasonable range within which these estimates fall, we vary our assumptions to create a high and low scenario for take up at the statewide level. This shows the considerable variation generated by changing our assumptions, though does not take into account the variation inherent in the survey data we use. For statewide results, our range and preferred point estimates for the remaining uninsured are as follows:

Table 1. Range of results, California statewide uninsured age 0-64, 2017

	Low take up scenario	Preferred Estimate	High take up scenario
Not Eligible due to Immigration Status	1,863,000	1,787,000	1,658,000
Eligible for Medi-Cal	425,000	322,000	187,000
Eligible for Subsidies through Covered CA	458,000	401,000	317,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	817,000	550,000	458,000
Total Uninsured	**3,563,000**	**3,049,000**	**2,620,000**

Geographies

We report results for the following geographies, based on Covered California rating regions and large counties in California:

Table 2. Geographies reported

Covered California Rating Region number	Name	Counties included
1	Northern Counties	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba
2	North Bay Counties	Marin, Napa, Solano and Sonoma
3	Sacramento Valley	Sacramento, Placer, El Dorado and Yolo
4 & 8	San Francisco & San Mateo	San Francisco, San Mateo
5	Contra Costa	Contra Costa
6	Alameda	Alameda
7	Santa Clara	Santa Clara
9 & 12	Central Coast	Monterey, San Benito and Santa Cruz; San Luis Obispo, Santa Barbara and Ventura
10 & 11	Central Valley	San Joaquin, Stanislaus, Merced, Mariposa and Tulare; Fresno, Kings and Madera
13	Eastern Counties	Mono, Inyo and Imperial
14	Kern	Kern
15 & 16	Los Angeles	Los Angeles
17	Inland Empire	San Bernardino and Riverside
18	Orange	Orange
19	San Diego	San Diego
Large Counties		
(part of 11)		Fresno
(part of 3)		Sacramento
(part of 10)		San Joaquin
(part of 17)		San Bernardino
(part of 12)		Ventura

Results: Californians Under Age 65 Projected to be Uninsured by Rating Region and Select Large Counties

Statewide Summary (sum of regions 1 19)	2017
Not Eligible due to Immigration Status	1,787,000
Eligible for Medi-Cal	322,000
Eligible for Subsidies through Covered CA	401,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	550,000
Total Uninsured	**3,049,000**
Undocumented Children Eligible for Medi-Cal	225,000

Californians Under Age 65 Projected to be Uninsured by Rating Region and Select Large Counties

Northern Counties (Rating Region 1)	2017
Not Eligible due to Immigration Status	27,000
Eligible for Medi-Cal	6,000
Eligible for Subsidies through Covered CA	18,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	22,000
Total Uninsured	**73,000**
Undocumented Children Eligible for Medi-Cal	< 5,000

North Bay Counties (Rating Region 2)	2017
Not Eligible due to Immigration Status	58,000
Eligible for Medi-Cal	< 5,000
Eligible for Subsidies through Covered CA	< 5,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	10,000
Total Uninsured	**73,000**
Undocumented Children Eligible for Medi-Cal	10,000

Sacramento Valley (Rating Region 3)	2017
Not Eligible due to Immigration Status	53,000
Eligible for Medi-Cal	11,000
Eligible for Subsidies through Covered CA	26,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	33,000
Total Uninsured	**112,000**
Undocumented Children Eligible for Medi-Cal	9,000

San Francisco and San Mateo Counties (Rating Regions 4 & 8)	2017
Not Eligible due to Immigration Status	39,000
Eligible for Medi-Cal	< 5,000
Eligible for Subsidies through Covered CA	< 5,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	13,000
Total Uninsured	**55,000**
Undocumented Children Eligible for Medi-Cal	< 5,000

Contra Costa County (Rating Region 5)	2017
Not Eligible due to Immigration Status	51,000
Eligible for Medi-Cal	< 5,000
Eligible for Subsidies through Covered CA	5,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	14,000
Total Uninsured	**73,000**
Undocumented Children Eligible for Medi-Cal	7,000

Californians Under Age 65 Projected to be Uninsured by Rating Region and Select Large Counties

Alameda County (Rating Region 6)	2017
Not Eligible due to Immigration Status	65,000
Eligible for Medi-Cal	< 5,000
Eligible for Subsidies through Covered CA	< 5,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	17,000
Total Uninsured	**84,000**
Undocumented Children Eligible for Medi-Cal	8,000

Santa Clara County (Rating Region 7)	2017
Not Eligible due to Immigration Status	100,000
Eligible for Medi-Cal	< 5,000
Eligible for Subsidies through Covered CA	5,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	19,000
Total Uninsured	**127,000**
Undocumented Children Eligible for Medi-Cal	12,000

Central Coast (Rating Regions 9 & 12)	2017
Not Eligible due to Immigration Status	143,000
Eligible for Medi-Cal	24,000
Eligible for Subsidies through Covered CA	19,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	30,000
Total Uninsured	**217,000**
Undocumented Children Eligible for Medi-Cal	18,000

Central Valley (Rating Regions 10 & 11)	2017
Not Eligible due to Immigration Status	166,000
Eligible for Medi-Cal	108,000
Eligible for Subsidies through Covered CA	36,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	41,000
Total Uninsured	**351,000**
Undocumented Children Eligible for Medi-Cal	23,000

Eastern Counties (Rating Region 13)	2017
Not Eligible due to Immigration Status	12,000
Eligible for Medi-Cal	5,000
Eligible for Subsidies through Covered CA	< 5,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	< 5,000
Total Uninsured	**23,000**
Undocumented Children Eligible for Medi-Cal	< 5,000

Californians Under Age 65 Projected to be Uninsured by Rating Region and Select Large Counties

Kern County (Rating Region 14)	2017
Not Eligible due to Immigration Status	42,000
Eligible for Medi-Cal	5,000
Eligible for Subsidies through Covered CA	8,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	9,000
Total Uninsured	**64,000**
Undocumented Children Eligible for Medi-Cal	7,000

Los Angeles County (Rating Regions 15 & 16)	2017
Not Eligible due to Immigration Status	579,000
Eligible for Medi-Cal	48,000
Eligible for Subsidies through Covered CA	110,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	156,000
Total Uninsured	**893,000**
Undocumented Children Eligible for Medi-Cal	64,000

Inland Empire (Rating Region 17)	2017
Not Eligible due to Immigration Status	175,000
Eligible for Medi-Cal	79,000
Eligible for Subsidies through Covered CA	101,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	70,000
Total Uninsured	**424,000**
Undocumented Children Eligible for Medi-Cal	23,000

Orange County (Rating Region 18)	2017
Not Eligible due to Immigration Status	166,000
Eligible for Medi-Cal	13,000
Eligible for Subsidies through Covered CA	27,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	58,000
Total Uninsured	**264,000**
Undocumented Children Eligible for Medi-Cal	19,000

San Diego County (Rating Region 19)	2017
Not Eligible due to Immigration Status	111,000
Eligible for Medi-Cal	12,000
Eligible for Subsidies through Covered CA	37,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	56,000
Total Uninsured	**216,000**
Undocumented Children Eligible for Medi-Cal	17,000

Californians Under Age 65 Projected to be Uninsured by Rating Region and Select Large Counties

Fresno County	2017
Not Eligible due to Immigration Status	46,000
Eligible for Medi-Cal	26,000
Eligible for Subsidies through Covered CA	15,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	13,000
Total Uninsured	**100,000**
Undocumented Children Eligible for Medi-Cal	6,000

Sacramento County	2017
Not Eligible due to Immigration Status	40,000
Eligible for Medi-Cal	9,000
Eligible for Subsidies through Covered CA	9,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	25,000
Total Uninsured	**83,000**
Undocumented Children Eligible for Medi-Cal	6,000

San Joaquin County	2017
Not Eligible due to Immigration Status	34,000
Eligible for Medi-Cal	5,000
Eligible for Subsidies through Covered CA	< 5,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	9,000
Total Uninsured	**49,000**
Undocumented Children Eligible for Medi-Cal	5,000

San Bernardino County	2017
Not Eligible due to Immigration Status	85,000
Eligible for Medi-Cal	17,000
Eligible for Subsidies through Covered CA	68,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	40,000
Total Uninsured	**210,000**
Undocumented Children Eligible for Medi-Cal	11,000

Ventura County	2017
Not Eligible due to Immigration Status	49,000
Eligible for Medi-Cal	< 5,000
Eligible for Subsidies through Covered CA	13,000
Non-subsidy Eligible Citizens & Lawfully Present Immigrants	13,000
Total Uninsured	**77,000**
Undocumented Children Eligible for Medi-Cal	5,000

UC Berkeley Center for Labor Research and Education

Institute for Research on Labor and Employment
2521 Channing Way
Berkeley, CA 94720-5555
(510) 642-0323
laborcenter.berkeley.edu

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UCLA Center for Health Policy Research

10960 Wilshire Blvd, Suite 1550
Los Angeles, CA 90024
(310) 794-0909
www.healthpolicy.ucla.edu

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ASPE
ISSUE BRIEF

IMPACTS OF THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION ON INSURANCE COVERAGE AND ACCESS TO CARE

June 20, 2016

The Affordable Care Act (ACA) expanded Medicaid by providing federal matching funds to cover 100 percent of the cost in states expanding coverage to nonelderly adults (ages 19 to 64) with income ≤138 percent of the federal poverty level (FPL) during 2014 to 2016. [i] This expansion includes parents and childless adults who were previously ineligible for Medicaid coverage. To date, a total of 31 states and the District of Columbia have expanded Medicaid.

This issue brief provides a literature review of the effects of Medicaid expansion, with a focus on the impacts of the ACA's Medicaid expansion in 2014 and 2015. Specifically, the brief focuses on the effects of expansion on health coverage and access, affordability and quality of care. The first section of this issue brief examines the evidence to date on the impact of Medicaid expansion on health coverage. The second section explores the beneficiary impacts of Medicaid expansion, by examining access to care and utilization. The third section examines research to date on affordability and quality including enrollee financial well-being, satisfaction and experience. This literature review adds to prior ASPE research on the economic impacts of Medicaid expansion including the impact on the cost of uncompensated care.[1]

[i] The 100 percent federal match rate applies only to newly eligible individuals in the expansion population and will be phased down incrementally to 90 percent by 2020.The President's FY 2017 Budget includes a proposal to further create incentives for states to expand Medicaid by covering the full cost of expansion for the first three years, regardless of when a state expands coverage. Currently, the ACA covers the full costs through calendar year 2016 before gradually reducing the level of support to 90 percent.

Key Highlights

- Medicaid expansion has had an effect on insurance coverage.
    - Expansion states realized a 9.2 percentage point reduction in the number of uninsured adults (a 49.5 percent decline in the uninsured rate).
    - Non-expansion states realized a 7.9 percentage point reduction in the uninsured rate among uninsured adults (a 33.8 percent decline in the uninsured rate).
    - Recent research demonstrates that the raw difference in trends between expansion and non-expansion states actually understates the benefits of expansion because non-expansion states started with higher uninsured rates.

- Medicaid expansion has increased access to primary care, expanded use of prescription medications, and increased rates of diagnosis of chronic conditions for new enrollees.

- Medicaid expansion has improved the affordability of care for expansion enrollees. According to the Health Reform Monitoring Survey:
    - The percentage of low-income adults reporting problems paying medical bills declined by 10.5 percentage points (34.7 percent pre-expansion to 24.2 percent post-expansion).
    - Unmet health care among low-income adults declined 10.5 percentage points (55.3 percent pre-expansion to 44.8 percent post-expansion).

- Medicaid expansion has provided quality care to new enrollees. According to the Commonwealth Fund's Affordable Care Act Tracking Survey:
    - Nearly two-thirds (61 percent) of adults with Medicaid expansion coverage consider themselves to be better off now than they were before enrolling in Medicaid.
    - 93 percent of adults are very or somewhat satisfied with their Medicaid health plans.
    - 92 percent are very or somewhat satisfied with their plan doctors.

SECTION I. IMPACT OF MEDICAID EXPANSION ON HEALTH INSURANCE COVERAGE

Medicaid Enrollment

As of March 2016, the Centers for Medicare and Medicaid Services (CMS) reported that nearly 72.5 million individuals were enrolled in Medicaid/CHIP. Since the beginning of the ACA's first Open Enrollment Period in October 2013, Medicaid/CHIP enrollment has grown by 15.0 million individuals, or 26.5 percent.[2] Enrollment growth in Medicaid expansion states has been significantly larger than in non-expansion states. On average, Medicaid expansion states have experienced a 35.5 percent growth in

enrollment, compared to a 10.4 percent growth in non-expansion states.[3] This difference in Medicaid enrollment growth is consistent with the difference in coverage gains between expansion and non-expansion states described below.

The Reduction in Uninsured

Associated with the expansion of Medicaid has been a reduction of the uninsured. An analysis of the Gallup-Healthways Well-Being Index data through early 2016 (February 22, 2016), shows that the reduction in the uninsured rate for non-elderly adults was greater among Medicaid expansion states than among non-expansion states (see Figure 1).[ii] These estimates imply that Medicaid expansion contributed significantly to reducing the number of uninsured people in the nation.

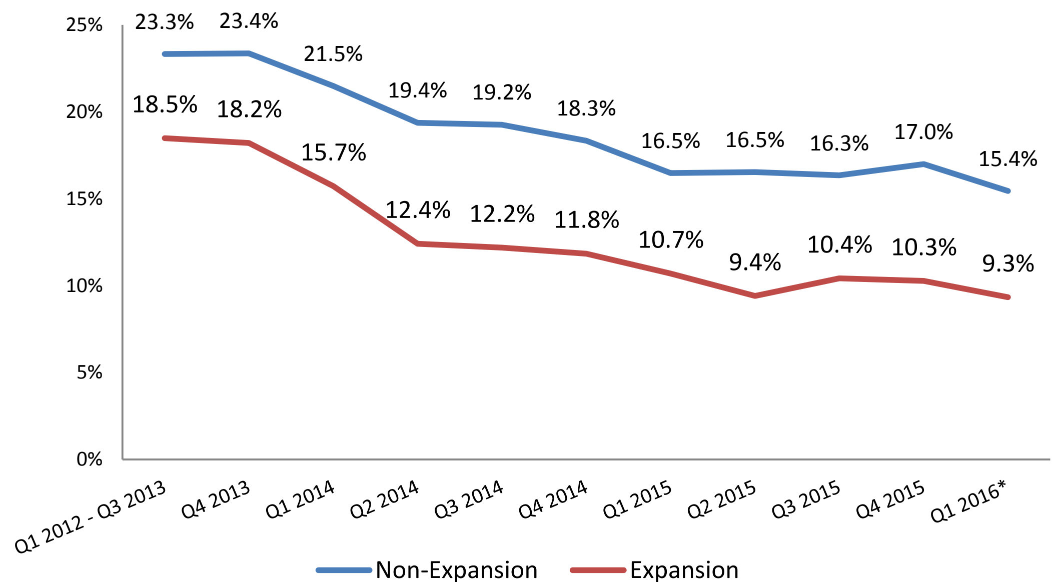
- Among Medicaid expansion states, the uninsured rate for non-elderly adults declined 9.2 percentage points (a 49.5 percent decline), from a baseline uninsured of 18.5 percent to 9.3 percent.
- Among non-expansion states, the uninsured rate for non-elderly adults declined 7.9 percentage points (a 33.8 percent decline), from a baseline uninsured of 23.3 percent to 15.4 percent.

In fact, the raw difference in the reduction in the uninsured rate between expansion and non-expansion states likely substantially *understates* the effect of Medicaid expansion. Figure 1 shows that the uninsured rate was substantially lower in expansion states than in non-expansion states before the ACA's coverage provisions took effect at the beginning of 2014. Recent research has found that, due to the uninsured populations in expansion states, the ACA's other coverage provisions have generated smaller reductions in the uninsured rate in those states, partially masking the beneficial effect of Medicaid expansion (Courtemanche et al., 2016; Furman, 2015).[4,5]

The impact of Medicaid expansion on reducing uninsurance extends beyond the expansion population. Kenney, Haley, Pan, Lynch, and Buettgens found the uninsurance rate for children age 18 and under fell by 1.2 percentage points 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.[6] Alker and Chester (2016) found expansion states saw nearly double the rate of decline in uninsured children as compared to states that didn't expand Medicaid.[7] This is likely due to a robust "welcome mat" effect as parents enrolled their children when they signed up for newly available coverage. Even states that did not expand Medicaid appear to have experienced a welcome mat effect due to the ACA.

[ii] The Gallup estimates presented here are from January 2012 through February 2016 and encompass the total population, not just individuals with income ≤138 percent FPL. Accordingly, the estimates in this issue brief differ from the estimates presented in the Sommers, et al., "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," *JAMA* 2015.

Figure 1. Quarterly Uninsured Rate Estimates for Nonelderly Adults (Ages 19 to 64) by Medicaid Expansion Status Using the Gallup-Healthways Well-Being Index, 2012 to 2016



SOURCE: The Office of the Assistant Secretary for Planning and Evaluation's (ASPE) analysis of the Gallup-Healthways Well-Being Index survey data through February 22, 2016.

SECTION II. IMPACT OF MEDICAID EXPANSION ON ACCESS

Usual Source of Care

Usual source of care (e.g., a particular medical professional, office, clinic, or community health center) is a key metric for measuring access to care because it reflects a stable connection with the health care delivery system. Beneficiaries with a usual source of care often receive more preventive services and better manage chronic conditions; and in turn receive more effective and efficient health care. Overall, the literature indicates that Medicaid expansion is associated with an increase in individuals reporting a usual source of care. Furthermore, focus group findings show that low-income adults reported that obtaining coverage enabled them to access needed care such as primary and preventive care, as well as to address their specific health problems. Highlighted below are key findings to date in the literature related to sources of care and appointment availability (Table 2).

Table 2. Summary of Findings Related to Medicaid Expansion and Sources of Care and Appointment Availability

Measure	Findings
Access to personal physician	• Medicaid expansion was associated with a significant reduction in low-income adults who lack a personal physician (-1.8 percentage points) compared to non-expansion states. • Individuals with chronic conditions who obtained regular care increased by 11.6 percentage points after the first year of Arkansas' private option expansion and Kentucky's traditional Medicaid expansion compared to Texas a non-expansion state.
Community health center visits	• Community health center visit rates increased by 46 percent in expansion states compared to 12 percent in non-expansion states.
Appointment availability	• A study that focused on Michigan found that primary care appointment availability increased by 6 percentage points (from 49 percent pre-Medicaid expansion to 55 percent) for all new Medicaid patients after expansion. • A study of 10 states found that availability of primary care appointments for Medicaid patients increased by 7.7 percentage points (from 58.7 percent in late 2012 to early 2013 to 66.4 percent in mid-2014).

Personal Physician. According to Sommers, Gunja, Finegold, and Musco (2015), Medicaid expansion has significantly increased the proportion of low-income adults who report having a personal physician.[8] Using the Gallup Healthways Well-Being Index survey data, Sommers et al. (2015) finds that Medicaid expansion was associated with a significant reduction in low-income adults who lack a personal physician (-1.8 percentage points) compared to non-expansion states. Sommers, Blendon and Orav (2016) found the share of low-income adults with chronic conditions who obtained regular care increased by 11.6 percentage points after the first year of expansion in Arkansas and Kentucky compared to the non-expansion state Texas.[9] Wherry and Miller (2016) found that low-income nonelderly adult citizens in Medicaid expansion states were 6.6 percentage points more likely to have seen or talked to a general physician in the previous 12 months than counterparts in non-expansion states. [iii]

Community Health Centers. Hoopes et al. (2016) examined changes in community health center visits between Medicaid expansion states and non-expansion states.[10] The authors found that one-year after Medicaid expansion, community health center visit rates increased by 46 percent in expansion states compared to 12 percent in non-expansion states.

Appointment Availability. Another study measured primary care wait times for appointments and appointment availability pre- and post- Medicaid expansion for new Medicaid patients in Michigan and concluded that access to services improved post-expansion.[11] Specifically, Tipirneni et al. (2015) found that wait times for primary care appointments remained stable (1-2 weeks) and appointment availability increased by 6 percentage points (from 49 percent pre-Medicaid expansion to 55 percent for new Medicaid patients after expansion). Similarly, Polsky et al. (2015) measured the availability of and

[iii] The Wherry and Miller analysis was based on data from the second half of 2014, the look back period includes months prior to the January 1, 2014 expansion and does not capture gains in subsequent months, so it may understate the increase in physician visits in states that expanded Medicaid.

waiting times for appointments in 10 states in late 2012 to early 2013 and again in mid-2014.[12] The authors in this study found that the availability of primary care appointments for Medicaid beneficiaries increased by 7.7 percentage points (from 58.7 percent to 66.4 percent). This increase in appointment availability was attributed to an ACA requirement temporarily increasing Medicaid reimbursement to primary care providers. The states with the largest increases in appointment availability also were most likely to have the largest increases in reimbursements.

Health Care Services

A review of the literature examining the impacts of Medicaid expansion on specific services has generally found that the newly enrolled Medicaid population is better able to access preventive services, needed prescription medications, be screened and diagnosed for chronic conditions, and access dental care. Furthermore, the payer mix for hospital admissions appears to have changed in expansion states with a decline in uninsured admissions (Table 3).

Table 3. Summary of Findings Related to Medicaid Expansion and Access to Care

Measure	Findings
Preventive services	• 41 percent increase in preventive visits in Medicaid expansion states compared to no change in non-expansion states in community health centers.
Prescription Drugs	• In 2014, Medicaid prescription rates increased 25.4 percent in states that expanded coverage, compared to only 2.8 percent in states that didn't expand coverage. • A 10 percentage point reduction in low-income adults skipping prescribed medications due to cost after the first year of expansion in Arkansas and Kentucky compared to non-expansion state Texas.
Early diagnosis and treatment of chronic medical conditions	• An increased number of Medicaid patients with diabetes are being diagnosed in Medicaid expansion states (23 percent increase in Medicaid expansion states versus a .4 percent increase in non-expansion states).
Dental care	• Cost related barriers to dental care fell from 30 percent in 2013 prior to Medicaid expansion to 25 percent in 2014 post Medicaid expansion.
Hospitalizations	• Among Medicaid expansion states, hospital admissions for uninsured patients decreased by 6 percentage points (50 percent decrease in uninsured hospital discharges). • Among Medicaid expansion states, percentage of admissions paid for by Medicaid increased by 7 percentage points (20 percent increase in Medicaid discharges). • A greater decline in the uninsured share of hospitalizations for people with HIV in four Medicaid expansion states (60 percent decline) compared to non-expansion states (8 percent increase).

Preventive Services. Hoopes et al. (2016) found that in addition to increases in community health center visits after Medicaid expansion, the centers provided a greater number of preventive services visits. Community health centers experienced a 41 percent increase in preventive visits in Medicaid expansion states compared to no change in non-expansion states.

Dental Care: Medicaid expansion may be reducing cost-related barriers to needed dental care. In 80 percent of expansion states, Medicaid provides at least some coverage for outpatient dental services.[13] Nasseh, Wall, and Vujicic (2015) found that for adults with income below 100 percent FPL, cost related barriers to dental care fell from 30 percent in 2013 prior to Medicaid expansion to 25 percent in 2014 post Medicaid expansion.[14]

Early Diagnosis and Treatment of Chronic Medical Conditions: Improved access to coverage can also result in earlier diagnosis and treatment of chronic medical conditions. Recent analysis of laboratory data from Kaufman, Chen, Fonseca, and McPhaul (2015) found that an increased number of Medicaid patients with diabetes are being diagnosed in Medicaid expansion states (23 percent increase in Medicaid expansion states versus a .4 percent increase in non-expansion states).[15] Wherry and Miller (2016), using survey data, found increases in diagnosis of diabetes and high cholesterol for low-income adult citizens in Medicaid expansion states compared with those in non-expansion states.

Prescription Medications: Access to prescription medications has also expanded for low-income adults in Medicaid expansion states compared to non-expansion states. In 2014, Medicaid prescription rates increased 25.4 percent in states that expanded coverage, compared to only 2.8 percent in states that did not expand coverage.[16] The large increase suggests that expanded access to coverage has helped many Medicaid beneficiaries obtain affordable treatment for their health conditions with the long-term goal of improving their health.[17] Sommers, Blendon and Orav found a 10 percentage point decline in the number of low-income adults claiming they skipped prescribed medication because of cost in their survey of low-income adults after the first year of expansion in Kentucky and Arkansas compared to non-expansion state Texas.

Hospitalizations: Improving access to coverage due to Medicaid expansion may also be measured by a changing payer mix for providers. Studies have found that Medicaid expansion is ensuring more consistent reimbursement to hospitals for care provided and is also producing benefits for patients who require hospitalization. Estimates from the Nikpay, Buchmueller, and Levy (2016) study show that since expansion, among Medicaid expansion states, hospital admissions for uninsured patients decreased by 6 percentage points (50 percent decrease in uninsured hospital discharges) while the percentage of admissions paid for by Medicaid increased by 7 percentage points (20 percent increase in Medicaid discharges) in the first half of 2014.[18] A study conducted by Hellinger (2015) found a greater decline in the uninsured share of hospitalizations for people with HIV in four Medicaid expansion states (60 percent decline) compared to non-expansion states (8 percent increase).[19] Further, the study concluded that uninsured HIV patients who were in the hospital were 40 percent more likely to die during their stay as compared to patients with insurance.

SECTION III. IMPACT OF MEDICAID EXPANSION ON AFFORDABILITY AND QUALITY

In addition to increased coverage and access to care, studies and survey results show Medicaid beneficiaries report satisfaction with the affordability and quality of Medicaid, their health coverage, and the doctors included in their plans (Table 4).

Table 4. Summary of Findings Related to Medicaid Expansion and Affordability and Quality

Measure	Findings
Affordability and Financial well-being	• 78 percent of Medicaid post expansion enrollees who have used their plan indicated that they would not have been able to access and/or afford their care prior to Medicaid expansion and enrollment. • The percentage of low-income adults reporting problems paying medical bills also declined by 10.5 percentage points (34.7 percent pre-expansion to 24.2 percent post-expansion). • Both traditional Medicaid expansion and private option expansion led to a decline in the percentage of low-income adults reporting trouble paying medical bills (12.9 percent decrease and 4.8 percent decrease respectively). • Unmet health care needs decreased among low-income adults, declining 10.5 percentage points (55.3 percent pre-expansion to 44.8 percent post-expansion). • Post-Medicaid expansion in California, the likelihood of any family out-of-pocket medical spending among low-income adults declined by 10 percentage points. • Medicaid expansion reduced third-party collections by $600 to $1,000 per individual.
Quality – Enrollee Satisfaction and Experience	• 61 percent of adults with Medicaid expansion coverage consider themselves to be better off now than they were before enrolling in Medicaid. • 93 percent of adults were very or somewhat satisfied with their Medicaid health plans. • 92 percent were very or somewhat satisfied with their plan doctors.

Affordability

Affordability. According to results from the Commonwealth Fund Affordable Care Act Tracking Survey of nonelderly adults (ages 19 to 64), among Medicaid enrollees who have had Medicaid for less than two years and have used their coverage, 78 percent indicated that they would not have been able to access and/or afford their care prior to Medicaid expansion and enrollment. [20]

Estimates from a study using data from the Health Reform Monitoring Survey, also found that affordability of care improved post-expansion.[21] Unmet health care needs decreased among low-income adults, declining 10.5 percentage points (55.3 percent pre-expansion to 44.8 percent post-expansion). The authors concluded that the decline was likely an effect of the strong cost-sharing protections associated with Medicaid plans. The percentage of low-income adults reporting problems paying medical bills also declined by 10.5 percentage points (34.7 percent pre-expansion to 24.2 percent post-expansion). The reduction in problems paying for medical bills also held true by Medicaid expansion status – Medicaid expansion states saw a 4.8 percentage point decline and non-expansion states saw a 2.8 percentage point decline from pre- to post-expansion. Furthermore, Sommers, Blendon and Orav found compared to a non-expansion state (Texas) both traditional Medicaid expansion (Kentucky) and private option expansion (Arkansas) lead to a decline in the number of individuals reporting trouble paying medical bills (12.9 percent decrease and 4.8 percent decrease, respectively).

Studies that examined the impact of Medicaid expansion on affordability at the state level also found results similar to those found using survey data. For example, Golberstein, Gonzales, and Sommers

(2015) examined the affordability of care after the early Medicaid expansion in California and found that expansion significantly reduced the likelihood of any family out-of-pocket medical spending among low-income adults by 10 percentage points.[22]

Financial Well-Being. The ACA Medicaid expansion has also had important financial impacts on enrollees. Hu, Kaestner, Mazumder, Miller, and Wong (2016) analyzed a large random sample of credit reports to compare people living in the zip codes most likely to be affected by Medicaid expansion with a synthetic control group from non-expansion states.[23] This method controls for potential selection effects due to differences in covariates such as income, race, and ethnicity between expansion and non-expansion states. The authors estimated that Medicaid expansion reduced third-party collections by $600 to $1,000 per individual. With fewer unpaid bills to reduce their credit ratings, these individuals may experience better financial well-being in future years.

Quality

Enrollee Satisfaction. The Commonwealth Fund survey found satisfaction with the new insurance coverage overall was also high. Of the Medicaid adults enrolled in Medicaid for less than two years, more than nine in ten (93 percent) were very or somewhat satisfied with their Medicaid health plans. The survey also indicated that among adults enrolled in Medicaid plans for less than two years who used their plan, 92 percent were very or somewhat satisfied with their plan doctors.

Enrollee Experience. In addition to the decrease in reported unmet need care found by the Health Reform Monitoring Survey, nearly two-thirds (61 percent) of adults with Medicaid expansion coverage in the Commonwealth Fund survey consider themselves to be better off now than they were prior to Medicaid expansion.

SECTION IV: CONCLUSION

Medicaid expansion has resulted in improved rates of coverage for low-income adults and improved access to care and affordability for enrollees. States that have expanded Medicaid have experienced increased enrollment in their state programs and greater reductions in their uninsured population.

Evidence shows that once covered, the newly enrolled population can obtain primary care services, be screened and diagnosed for chronic conditions, and access needed prescription medications and dental care. Enrollees report satisfaction with their health coverage, the doctors included in their plan and the affordability of Medicaid.

Going forward, additional research will be critical to documenting the longer-term impacts of the Medicaid expansion in terms of long-term rates of coverage, health care access, and the impact of expansion on health outcomes and overall population health. Sommers, Baicker and Epstein found pre-2014 Medicaid expansions to cover low-income adults were significantly associated with reduced mortality as well as improved coverage, access to care, and self-reported health. [24] The long term effect of Medicaid expansion on health outcomes therefore merits close examination in future research.

APPENDIX: Data Methodology

The estimates of changes in the uninsured rate for nonelderly adults in expansion and non-expansion states presented in this brief (Figure 1) are based on ASPE analysis of data from the Gallup-Healthways Well-Being Index, which surveys about 500 adults per day. The Gallup-Healthways Well-Being Index estimates presented here are based on data from January 1, 2012 through February 22, 2016.[iv]

[iv] For additional analysis using these data, see Namrata Uberoi, Kenneth Finegold, and Emily Gee, "Health Insurance Coverage and the Affordable Care Act, 2010–2016," ASPE Issue Brief, March 3, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf.

REFERENCES

[1] "The Economic Impacts of Medicaid Expansion, Uncompensated Care Costs and the Affordable Care Act," March 1, 2015. https://aspe.hhs.gov/economic-impacts-medicaid-expansion-uncompensated-care-costs-and-affordable-care-act-aspe-issue-brief-march-2015

[2] "Medicaid and CHIP: January 2016 Monthly Applications, Eligibility Determinations and Enrollment Report," April 13, 2016, https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/january-2016-enrollment-report.pdf.

[3] Ibid.

[4] Charles Courtemanche, James Marton, Benjamin Ukert, Aaron Yelowitz, and Daniela Zapata. "Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States" National Bureau of Economic Research Working Paper No. 22182. April 2016. http://nber.org/papers/w22182.

[5] Furman, Jason. "Next Steps for Health Care Reform." October 2015. https://www.whitehouse.gov/sites/default/files/page/files/20151007_next_steps_health_care_reform.pdf.

[6] Genevieve M. Kenney, Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens "Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA" Urban Institute, May 2016. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000787-Childrens-Coverage-Climb-Continues-Uninsurance-and-Medicaid-CHIP-Eligibility-and-Participation-Under-the-ACA.pdf.

[7] Joan Alker, Alissa Chester, "Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements," Center for Children and Families, Health Policy Institute, Georgetown University, October 2015. http://ccf.georgetown.edu/ccf-resources/childrens-uninsured-rate-2014-affordable-care-act/.

[8] Benjamin Sommers Munira Gunja, Kenneth Finegold and Thomas Musco, "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," *JAMA* 2015;314(4):366-374. doi:10.1001/jama.2015.8421

[9] Benjamin D. Sommers, Robert J. Blendon, and E. John Orav, "Both The 'Private Option' And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults" *Health Affairs*, 35, No.1 (2016): 96-105.

[10] Megan J Hoopes, Heather Angier, Rachel Gold, Steffani R Bailey, Nathalie Huguet, Miguel Marino, and Jennifer E DeVoe, "Utilization of Community Health Centers in Medicaid Expansion and Nonexpansion States, 2013-2014," *Journal of Ambulatory Care Management,* January 2016.

[11] Renuka Tipirneni, Karin V. Rhodes, Rodney A. Hayward, Richard L. Lichtenstein, Elyse N. Reamer and Matthew M. Davis, "Primary Care Appointment Availability for New Medicaid Patients Increased After Medicaid Expansion in Michigan," *Health Affairs,* August 2015.

[12] Daniel Polsky, Michael Richards, Simon Basseyn, Douglas Wissoker, Genevieve M. Kenney, Stephen Zuckerman, and Karin V. Rhodes. "Appointment Availability after Increases in Medicaid Payments for Primary Care," *The New England Journal of Medicine*, January 2015.

[13] "Medicaid Adult Dental Coverage," *NASHP,* April 2015, http://www.nashp.org/map-of-current-adult-dental-coverage/.

[14] Kamyar Nasseh, Tom Wall, and Marko Vujicic, "Cost Barriers to Dental Care Continue to Decline, Particularly Among Young Adults and the Poor," *Health Policy Institute,* October 2015.

[15] Harvey W. Kaufman, Zhen Chen, Vivian A. Fonseca, and Michael J. McPhaul, "Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act," *Diabetes Care,* March 2015, http://care.diabetesjournals.org/content/early/2015/03/19/dc14-2334.full.pdf+html.

[16] "Medicines use and Spending Shifts: A Review of the Use of Medicines in the US in 2014," *IMS Institute for Healthcare Informatics,* April 2015, http://www.imshealth.com/portal/site/imshealth/menuitem.762a961826aad98f53c753c71ad8c22a/?vgnextoid=3f140a4331e8c410VgnVCM1000000e2e2ca2RCRD&vgnextchannel=736de5fda6370410VgnVCM10000076192ca2RCRD&vgnextfmt=default.

[17] Ibid.

[18] Sayeh Nikpay, Thomas Buchmueller, and Helen Levy, "Affordable Care Act Medicaid Expansion Reduced Uninsured Hospital Stays in 2014," *Health Affairs,* January 2016, http://content.healthaffairs.org/content/35/1/106.abstract?sid=a6bdd2ee-5ff5-4d58-82b5-8682b3c3d040.

[19] Fred Hellinger, "In Four ACA Expansion States, The Percentage of Uninsured Hospitalizations for People with HIV Declined, 2012-14," *Health Affairs,* December 2015, http://content.healthaffairs.org/content/34/12/2061.abstract.

[20] Sara Collins, et al., "Americans' Experiences with Marketplace and Medicaid Coverage," Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March-May 2015,"*The Commonwealth Fund*, June 2015, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jun/1822_collins_americans_experience_marketplace_medicaid_tb.pdf

[21] Adele Shartzer, Sharon K. Long, and Nathaniel Anderson, "Access to Care and Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain," *Health Affairs,* December 2015, http://content.healthaffairs.org/content/35/1/161.abstract?sid=0256c321-9bcf-4d2e-b15f-85e9bdbd01c9.

[22] Ezra Golberstein, Gilbert Gonzales, and Benjamin Sommers, "California's Early ACA Expansion Increased Coverage and Reduced Out-of-Pocket Spending for the State's Low-Income Population," *Health Affairs,* October 2015, http://content.healthaffairs.org/content/34/10/1688.abstract?sid=bee8a797-4f26-4ec8-b4be-95f7764fabb4.

[23] Luojia Hu, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, and Ashley Wong, "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research Working Paper 22170 (http://www.nber.org/papers/w22170).

[24] Benjamin D. Sommers, Katherine Baicker, Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," N Engl J Med 2012; 367:1025-1034 September 13, 2012 (http://www.nejm.org/doi/full/10.1056/NEJMsa1202099).

House Committee on Energy and Commerce
Majority Staff
energycommerce.house.gov

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JOINT CONGRESSIONAL INVESTIGATIVE REPORT INTO THE SOURCE OF FUNDING FOR THE ACA'S COST SHARING REDUCTION PROGRAM

JULY 2016

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II. Executive Summary

More than two centuries ago, this country adopted the Constitution as the blueprint and basis for our federal government. While this framework has been amended over the years, the system of checks and balances among the Legislative, Executive, and Judicial branches remains firmly intact. Congress passes laws, and the Executive branch implements them. The Constitution further makes clear that the power of the purse lies with Congress—"No money shall be drawn from the Treasury but in Consequence of Appropriations made by Law[.]" This requirement ensures that the Executive branch does not spend taxpayer money without the approval of Congress.

The Administration, however, has done just that. Since January 2014, the Administration has been paying for the cost sharing reduction (CSR) program established by the Patient Protection and Affordable Care Act (ACA) without a lawful congressional appropriation. This action is a clear constitutional violation of the most fundamental tenet of appropriations law.

Found under Section 1402 of the ACA, the CSR program requires health insurance companies that offer qualified health plans to reduce co-payments, deductibles, and other out-of-pocket expenses for eligible beneficiaries. Section 1412(c)(3) authorizes the federal government to make direct payments to insurance companies to offset estimated costs incurred by providing these CSRs to eligible beneficiaries. Nothing in the ACA provides an appropriation or a source of funding for the CSR program. Therefore, the Administration needed to request an appropriation from Congress to make CSR payments to insurance companies.

The Administration, however, has been making CSR program payments through a permanent appropriation, found at 31 U.S.C. § 1324. This appropriation can only be used to disburse money for specific, enumerated programs, including tax refunds and several enumerated refundable tax credits. Congress must amend this appropriation to include other programs. Congress did just that for one part of the ACA—the premium tax credit. Congress did not do so, however, for the CSR program. Nevertheless, the Administration has been funding the CSR program through this permanent appropriation.

The House Committee on Energy and Commerce and the House Committee on Ways and Means launched an investigation in February 2015 to understand the rationale behind the Administration's decision to fund the CSR program through the permanent appropriation, including who made that decision. The committees' questions have included: Why did the Administration initially request an annual appropriation for the CSR program from Congress? How was that decision made? Who made it? When did the Administration determine that an annual appropriation for the CSR program was not necessary? Who made that decision? When was the decision made to use the permanent appropriation at 31 U.S.C. § 1324 to fund the CSR payments, and on what grounds?

Despite the Administration's relentless efforts to obstruct the committees' investigation, the committees have been able to shed some light on the Administration's decision.

The Administration knew it could not use the permanent appropriation to fund the CSR program.

After Congress passed the ACA, the Administration took multiple actions that indicated it understood that it needed an annual appropriation to fund the CSR program. For example, beginning in 2011, during its planning efforts to develop a payment mechanism for the ACA premium tax credits, the Administration understood that it could not use the 31 U.S.C. § 1324 permanent appropriation to pay for the CSR program. The ACA established the premium tax credit (PTC)—a refundable tax credit available to eligible taxpayers—under Section 1401. The ACA also amended 31 U.S.C. § 1324 to specifically allow the use of this permanent appropriation to pay for premium tax credits. The ACA, however, did not detail the process through which the Department of Health and Human Services (HHS) would make the advanced payments for premium tax credits (APTC) from the 31 U.S.C. § 1324 permanent appropriation, given that the Internal Revenue Service (IRS) manages that permanent appropriation.

Ultimately, the Administration settled on using an allocation account structure—which created a sub-account or "child account" from which HHS could draw funds for APTC payments. CSR payments, however, were never a part of this planning process. In fact, a Memorandum of Understanding (MOU) between IRS and the Centers for Medicare and Medicaid Services (CMS) was signed in January 2013 regarding how to administer APTC payments, but it did not address CSR payments.

Moreover, as the Administration was developing the allocation account payment structure for APTC payments, the Department of the Treasury wrote a memorandum to the Office of Management and Budget (OMB) asserting that although the 31 U.S.C. § 1324 permanent appropriation would be used to make the APTC and PTC payments, it could not be used to make CSR payments. The memorandum stated that "there is currently no appropriation to Treasury or to anyone else, for purposes of the cost-sharing payments."[1]

The Administration requested an annual appropriation for the CSR program, but shortly thereafter, informally withdrew the request.

Further demonstrating that the Administration knew that Congress did not fund the CSR program in the ACA itself, the Administration initially requested an annual appropriation for the program. On April 10, 2013, the Administration submitted its FY 2014 budget request to Congress. This budget requested $3.9 billion for the CSR program.

Also on April 10, 2013, OMB submitted to Congress its sequestration preview report explaining what would happen to the President's budget in the event of sequestration. According to this OMB report, the $3.9 billion the Administration had requested to fund the CSR program was subject to a mandatory 7.3 percent budget cut under sequester mandates. Notably, most permanent appropriations—including the permanent appropriation for tax refunds and credits—were not subject to sequestration. OMB's revised sequestration report, submitted to Congress on May 20, 2013, similarly reflected a 7.2 percent budget reduction for the CSR program.

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[1] Memorandum from U.S. Dep't of the Treasury to Office of Mgmt. and Budget (July 31, 2012) [hereinafter Treasury APTC Memorandum].

On July 11, 2013, the Senate Committee on Appropriations expressly denied the President's request for nearly $4 billion to fund the CSR program. Between April 10, when the President submitted his budget request and OMB issued its Sequestration Preview, and July 11, when the Senate Committee on Appropriations' denied the appropriation request, HHS Assistant Secretary for Financial Resources Ellen Murray engaged in several key conversations about the source of funding for the CSR program, including: (1) a telephone conversation with someone in the Executive Office of the President, the name of whom the Administration refuses to disclose; (2) a conversation with HHS General Counsel William Schultz; and (3) a telephone conversation with the then-Staff Director of the Senate Appropriations Committee. During the telephone conversation with the Senate Appropriations Committee, Ms. Murray informally withdrew the Administration's FY 2014 request for the annual appropriation for the cost sharing reduction program. Rather than include the withdrawal in the President's formal budget amendment, the Administration took the highly unusual step of withdrawing the appropriations request via a telephone conversation.

The Administration developed a new—albeit illegal—path forward to pay for the CSR program.

Around the same time that the Administration informally withdrew its CSR funding request, OMB began to develop a memorandum justifying another way to fund the CSR program. The Administration has refused to provide the committees with a copy of this memorandum—even pursuant to two congressional subpoenas. Nevertheless, the committees learned through witness testimony that the memorandum provided OMB's final legal analysis and justification for making CSR payments using the premium tax credit account—the account funded through the 31 U.S.C. § 1324 permanent appropriation.

In late 2013, OMB shared this memorandum with top Administration officials at several departments and agencies. For example, OMB showed the memorandum to both the Treasury and HHS general counsel offices. Additionally, then-OMB General Counsel Geovette Washington briefed then-Attorney General Eric Holder on the issue. According to witness testimony, the Attorney General personally approved the legal analysis in the memorandum.

High-level IRS officials raised concerns about this plan, but the decision had already been made.

Toward the end of 2013, several high-level IRS officials began raising concerns about the source of funding for the CSR program. The first CSR payments were scheduled to be paid out at the end of January 2014. Only a couple of months earlier, the IRS learned that the Administration would be using an IRS-administered permanent appropriation—not subject to sequestration—to fund the CSR program instead of an annual appropriation to HHS. According to the former-IRS Chief Risk Officer, "[t]he question at hand became whether or not the [ACA] actually authorized, appropriated those dollars using the permanent appropriation [under 31 U.S.C. § 1324]."[2] After the IRS raised these concerns to OMB, OMB permitted the IRS officials to review its memorandum at the Old Executive Office Building. At this meeting, OMB officials instructed the IRS officials not to take notes or take a copy of the memorandum with them. The

[2] H. Comm. on Ways & Means, Deposition of David Fisher, at 53 (May 11, 2016) [hereinafter Fisher Depo.].

legal memorandum did not alleviate all of the IRS officials' concerns that the Administration's course of action violated appropriations law.

A few days later, the IRS held an internal meeting with IRS Commissioner John Koskinen. The IRS officials who attended the OMB meeting were given an opportunity to raise their concerns directly to the Commissioner. Although Commissioner Koskinen listened to those concerns, the Administration already had decided to move forward with its plan. The Administration intended to make the CSR payments through the premium tax credit account. At the meeting with Commissioner Koskinen, participants reviewed a final Action Memorandum to Treasury Secretary Jacob Lew. This Action Memorandum, which recommended that the IRS administer the CSR payments through the § 1324 permanent appropriation in the same way it administered the APTC payments, had already been approved by Secretary Lew. Despite two subpoenas issued by two congressional committees, the Administration has produced only a redacted version of the final Action Memorandum to the committees and has not provided any legal basis or explanation for the redactions.

When Congress started asking questions about the source of funding, the Administration refused to provide answers.

For well over a year, the committees have steadily pursued requests for documents and testimony about the Administration's funding of the CSR program. Using a number of different tactics, the Administration has impeded and obstructed the investigation at every turn. This level of obstruction by an Administration is unprecedented at both the Committee on Energy and Commerce and the Committee on Ways and Means.

The Administration has, in part, attempted to argue that the ongoing *House v. Burwell* litigation effectively preempts any oversight by the committees of the CSR program. It does not. The lawsuit involved no discovery. The parties stipulated to the facts. The question before the court was purely a question of law. The committees' separate and independent oversight inquiry focuses on the underlying facts surrounding the Administration's decisions. Nevertheless, the Administration has attempted to use the lawsuit to excuse it from cooperating with the committees' oversight.

The Administration has refused to comply with subpoenas issued by Congress. As of the drafting of this report, neither the Department of the Treasury, nor the Department of Health and Human Services, nor the Office of Management and Budget are in compliance with subpoenas issued by the committees. None of the three have produced a meaningful number of responsive documents. None of the three have certified that their production is complete or produced a log of documents withheld from the committees, or even provided a legal basis—to the extent one applies—to justify withholding large amounts of information from Congress. Further, the committees have evidence that the Department of the Treasury has not even conducted a reasonable search for documents responsive to the subpoena and the committees' document requests dating back for eighteen months.

The Department of the Treasury has refused to confirm to the Committee on Ways and Means whether it ever delivered deposition subpoenas to witnesses. Treasury counsel refused to

let the witnesses answer the committee's questions regarding when—or if—they had received their own subpoenas, and Treasury counsel itself refused to provide that information to the committee. This failure raises questions about the courtesies provided by Congress to the Administration and its employees with respect to the service of congressional subpoenas.

The Department of the Treasury limited its employees' and former employees' testimony to Congress by issuing testimony authorizations to witnesses based on over-broad *Touhy* regulations inconsistent with federal law. The Treasury regulations, found at 26 C.F.R. § 301.9000, require IRS employees to obtain permission from the IRS before speaking to Congress, and then to limit their speech to Congress to those topics approved by the IRS, at risk of losing their jobs if they do not meet the terms dictated by the IRS. Treasury used these regulations, and the testimony authorizations based on them, to unilaterally and grossly restrict the testimony that current and former IRS officials were permitted to provide to Congress. Furthermore, Treasury selectively and inconsistently enforced the terms of the testimony authorizations by allowing witnesses to answer certain questions clearly prohibited by the authorizations without objection.

The Department of Health and Human Services and the Office of Management and Budget also severely restricted the scope of testimony provided by current and former employees. Lawyers for the Administration repeatedly instructed witnesses not to answer substantive questions regarding the source of funding for the CSR program. Despite repeated inquiries from committee counsel, Administration counsel refused to provide a valid justification for restricting the witnesses' testimony. The excuses provided—that the Administration can withhold information that seeks internal or interagency deliberations, or seeks information it deems protected by a vague and undefined "confidentiality interest," or "embeds a deliberative fact" into a question the Administration did not want a witness to answer—are not legally cognizable bases on which the Administration can withhold information from Congress.

The Administration further instructed witnesses not to answer purely factual questions—including questions seeking the names of individuals involved in decisions about the source of funding for the CSR program, or confirmation of the occurrence of meetings about the CSR program. When asked what barred the witnesses from answering these questions, Administration lawyers explained that the Executive branch has "confidentiality interests" and "heightened sensitivities" that allow it to withhold this information from Congress. When asked to explain the basis of those "interests" and "sensitivities," Administration lawyers refused to do so. No such legal privilege exists—nor has one ever existed—that supports the Administration's position that it can withhold purely factual information from Congress.

The position of the Administration—that it can unilaterally block from disclosure to Congress the answer to any question that seeks internal or interagency communications, or an undefined "confidentiality interest," or even a fact that it does not want Congress to know—effectively exempts the entire Executive branch from congressional oversight.

Finally, lawyers for the Administration pressured at least one witness into following the restrictions set forth in his testimony authorization issued by the IRS after the witness questioned the Administration's ability to limit his testimony. The answers this witness provided in a

compelled deposition—without Treasury counsel present—provided more insight into the Administration's decision-making process than did testimony from any other individual. His answers also shed light onto why the Administration restricted the testimony of every other witness—going so far as to not letting witnesses answer questions about the names of individuals involved—and why the Administration has failed to comply with the committees' document subpoenas.

Congress relies on access to documents and witnesses from the Executive branch in order to conduct the oversight critical to a functioning government. The Administration's actions in restricting the scope of testimony provided by witnesses and refusing to provide documents to the committees shows that it does not believe in transparency. Instead, the Administration's actions make clear it believes congressional oversight to be an unnecessary nuisance. As a result, the committees are left with no choice but to conclude that the Administration has intentionally obstructed this investigation. The Administration did so because it broke the law and violated the Constitution in funding the CSR program through the permanent appropriation for tax refunds and credits.

III. Findings

- The Administration began to have discussions about the source of funding for the cost sharing reduction program after Congress passed the Patient Protection and Affordable Care Act in 2010.

- In 2012, the Administration developed an allocation account structure to pay for the premium tax credits. At that time, Treasury counsel concluded that 31 U.S.C. §1324—the permanent Treasury appropriation for tax credits—could not be used to make CSR payments.

- HHS' typical budget process is—for the most part—a thorough, institutionalized, and well-documented process.

- The Administration can withdraw an appropriation request without going through the formal and documented budget amendment process.

- The Administration requested an annual appropriation of almost $4 billion for the cost sharing reduction program in its FY 2014 budget request, submitted to Congress on April 10, 2014.

- According to OMB's April 10, 2013 sequestration preview report, the annual appropriation for the cost sharing reduction program would have been subject to a 7.3 percent reduction if the sequester went into effect.

- The Administration did not submit a formal budget amendment withdrawing its request for the annual appropriation for the cost sharing reduction program.

- Between April 10, 2013 and July 11, 2013, in an unusual move, the Administration informally withdrew its request for an annual appropriation for the cost sharing reduction program by calling the Senate Committee on Appropriations.

- OMB prepared a memorandum that provided the Administration's legal analysis and justification for funding the cost sharing reduction program through the premium tax credit account.

- OMB shared its memorandum with both the Treasury and HHS general counsel offices in late 2013.

- OMB shared its memorandum with Attorney General Eric Holder in late 2013 and briefed him on the issue.

- Some senior IRS officials raised concerns about the source of funding for the CSR program.

- OMB shared its memorandum with IRS officials in a meeting weeks before the first cost sharing reduction payments were to be made. The IRS officials were not permitted to take notes at the meeting or take a copy of the memorandum.

- After reviewing the memorandum, some of the IRS officials still had concerns about the source of funds, and wanted to make sure that these payments were not in violation of appropriations laws or the Antideficiency Act.

- Secretary Lew approved an Action Memorandum dated January 15, 2014, authorizing the IRS to administer the cost sharing reduction payments in the same manner as the advanced premium tax credit payments.

- A few days after the meeting at OMB to review OMB's memorandum, several high-level IRS officials met with IRS Commissioner John Koskinen to discuss how the Administration planned to fund the cost sharing reduction program. It was clear that the decision had already been made to move forward with making the cost sharing reduction payments through the premium tax credit account.

- The Administration could not make cost sharing reduction payments until a Memorandum of Understanding was in place.

- The Administration did not request an annual appropriation for the cost sharing reduction program in its FY 2015 budget request, submitted to Congress on March 14, 2014.

- The Administration has not complied with subpoenas issued by the United States Congress.

- The Department of the Treasury improperly withheld and redacted documents responsive to the committees' subpoenas without any valid legal basis to do so.

- The Department of the Treasury did not undertake a reasonable or thorough search for records responsive to the committees' subpoenas.

- The Department of Health and Human Services improperly withheld documents responsive to the committees' subpoenas without any valid legal basis to do so.

- The Office of Management and Budget improperly withheld documents responsive to the committees' subpoenas without any valid legal basis to do so.

- The Department of the Treasury did not provide deposition subpoenas issued by the Committee on Ways and Means to the relevant deponents in a timely manner.

- The Department of the Treasury has promulgated *Touhy* regulations that—contrary to federal statute—limit the rights of IRS employees to provide information to Congress.

- Treasury used its *Touhy* regulations and Testimony Authorizations to prohibit current and former IRS employees from providing testimony to Congress about the source of funding for the CSR program.

- Treasury officials selectively enforced the Treasury Authorizations by allowing witnesses to answer certain questions prohibited by the authorizations without objection.

- HHS and OMB imposed scope restrictions to prevent current and former employees from providing full and complete testimony to the Congress.

- HHS counsel prevented witnesses from answering substantive questions regarding the cost sharing reduction program, citing the need to protect "internal deliberations" and "confidentiality interests" as justification to withhold information from Congress.

- Witnesses were instructed not to reveal to Congress the names of White House and Department of Justice officials involved in decisions regarding the cost sharing reduction program.

- OMB prevented a witness from answering factual questions regarding the dates or times of a meeting or conversation, refusing to invoke a legal privilege to justify withholding the information from Congress.

- The Administration sought to withhold information from Congress by effectively claiming the deliberative process privilege. That privilege does not apply in this instance.

- The Department of the Treasury pressured at least one witness into following the restrictions set forth in his Testimony Authorization after the witness questioned Treasury's ability to limit his testimony.

IV. Background

A. The ACA Authorizes Cost Sharing Reductions and Premium Tax Credits

On March 23, 2010, President Obama signed the ACA into law.[3] The law imposed numerous taxes and regulations affecting health insurance offered to individuals and families, including a mandate requiring all individuals to obtain insurance or pay a penalty. The ACA also created several new entitlement programs aimed at helping people pay for health insurance coverage. These entitlements included an expansion of the Medicaid program, as well as subsidies available to individuals who purchase coverage through health insurance exchanges created by the law.

The law's exchange subsidies consist of two components:

1. Premium Tax Credits (PTC): A refundable tax credit available for eligible taxpayers who purchase a qualified health plan (QHP) on the health insurance exchanges created by the ACA.[4] The government can pay this credit to insurance companies in advance to offset an individual's monthly premium (in which case it is known as an Advanced Premium Tax Credit (APTC)), or a taxpayer may claim it as a credit on a tax return.

2. Cost Sharing Reductions (CSR): The law requires insurance companies to reduce copayments, deductibles, and other expenses paid by eligible beneficiaries. The law authorizes the federal government to offset the cost of these reductions by making payments to the insurance companies.[5]

The law established a process to determine an applicant's eligibility for PTCs and CSRs in advance, which allows individuals to have PTCs applied to their monthly premiums and qualify for cost sharing reductions.[6]

1. Section 1401 Establishes Premium Tax Credits

Section 1401 of the ACA added Section 36B to the Internal Revenue Code, establishing the PTC. This credit is available to taxpayers with incomes between 100 and 400 percent of the federal poverty level (FPL). In order to qualify for the credit, eligible individuals cannot have an offer of coverage through their employer, or be enrolled in a government program like Medicaid.[7] Additionally, to claim the credit, the taxpayer must purchase a QHP through one of the health insurance exchanges created by the law. The PTC amount is based on the taxpayer's

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[3] Patient Protection and Affordable Care Act, Pub. L. No 111-148, 124 Stat. 119 (2010).
[4] 26 U.S.C. § 36B.
[5] 42 U.S.C. § 18071.
[6] 42 U.S.C. § 18081 and 18082.
[7] 26 U.S.C. § 36B(c)(2)(B)(i).

income, family size, and the price of a benchmark health plan.[8] For eligible individuals, the government can pay the credit in advance to the insurance companies so that the insurance companies reduce those individuals' premiums. These payments are referred to as advanced premium tax credits (APTC).[9]

2. Section 1402 Establishes the Cost Sharing Reduction Program

Section 1402 of the ACA created the CSR program. The statute requires insurers to reduce co-payments, deductibles, and other out-of-pocket costs for eligible insured individuals. These individuals must have an income between 100 and 250 percent of the FPL, must be eligible for PTCs, and must have purchased a specific type of QHP on the exchange.[10]

Although the ACA authorizes the government to offset insurance companies' expense for the cost of providing cost sharing reductions, the law did not designate any funds for such payments.[11]

3. How Advanced Premium Tax Payments Work

One of the key features of the ACA is the creation of the health insurance exchanges, government-created entities that facilitate the purchase of health insurance. The exchanges also make determinations about insurance purchasers' eligibility for APTCs and CSRs when individuals sign up for coverage.[12] Sections 1411 and 1412 of the ACA outline this process. The exchanges connect with various federal agencies such as the IRS, the Social Security Administration, the Department of Homeland Security, and others to verify eligibility information provided by applicants. Based on this information, the exchanges determine whether an individual qualifies for APTC and CSR, and, if so, in what amounts.

While both the APTC and PTC reduce premiums, they operate differently from each other. As the name implies, insurance purchasers receive the benefit of APTCs in advance. An exchange projects an estimate of an individual's income, family size, and other information and makes the APTC payment to the individual's insurance company based on those projections. At the end of the tax year, those individuals must reconcile the amount of the APTCs they received with the amount of the PTC to which they are actually entitled.[13] That is, if taxpayers receive too much in APTC, they must repay the excess payment to the government. If taxpayers receive too little in APTC, they are able to claim the difference as a refund on their tax returns for that year.[14]

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[8] 26 U.S.C. § 36B(b)(2)(B)(i).
[9] 42 U.S.C. § 18082(c)(2).
[10] 42 U.S.C. § 18071(b)(1).
[11] 42 U.S.C. § 18082(c)(3).
[12] 42 U.S.C. § 18081(a).
[13] 26 U.S.C. § 36B(f).
[14] *Id*.

4. How Cost Sharing Reductions Work

Cost sharing reductions are different from both APTC and PTC. CSRs are not a tax credit, and they do not affect premium costs. The CSR program requires insurance companies to reduce co-payments, deductibles, and other out-of-pocket costs for eligible insurance purchasers. While APTC payments can be applied to any metal level health plans (bronze, silver, gold, or platinum), CSRs are available only if an eligible individual chooses a silver level plan.[15] Further, unlike with the APTC, an individual receiving a cost sharing reduction receives no payment, and is not required to reflect the reduction on any IRS tax filing.

For example, an APTC-eligible individual with an expected income equal to 175 percent of the federal poverty level (approximately $20,790 in 2016) who enrolls in a silver plan on the exchange will see the actuarial value of the plan increase from 70 percent to 87 percent. This means that the individual will be required to pay approximately 13 percent of the total covered costs (as opposed to 30 percent), with the health plan covering the rest. Under the ACA, the government is authorized to provide a payment to the insurer to cover the expected cost of providing these reductions.[16]

Unlike APTCs, individuals are not required to reconcile any excess CSRs that they may have received: if an insurance company reduces co-payments or deductibles too much for an individual, that company cannot recoup the cost from that policyholder. On the other hand, if an insurance company does not reduce costs enough for an individual, that person cannot claim additional CSRs on a tax return.

5. Premium Tax Credit Payment Mechanism

The ACA amends a permanent indefinite appropriation established for the payment of specifically listed income tax refunds and specifically listed tax credits by adding premium tax credit payments to the list of approved tax credits that can be paid out of the permanent appropriation.[17] The IRS manages this particular appropriation, which is used for other tax refund payments as well as the PTC and APTC. This created a logistical problem for APTC payments: the Centers for Medicare and Medicaid Services (CMS) determines applicants' eligibility for APTC payments and makes the payments to issuers, but cannot directly use the permanent indefinite appropriation to make the payments because it is managed by the IRS.[18]

To resolve this problem, the IRS created a sub account—known as an "allocation account" or a "child account" within the "parent" tax-credit appropriation account—which CMS

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[15] 42 U.S.C. § 18071(b)(1).

[16] U.S. Dep't of Health & Human Servs., Notice of Payment and Benefit Parameters for 2014 Plan Year, 78 Fed. Reg. 15481(Mar. 11, 2013).

[17] Patient Protection and Affordable Care Act, Pub. L. No 111-148, Section 1401(d)(1), 124 Stat. 119 (Mar. 23, 2010).

[18] U.S. DEP'T OF HEALTH & HUMAN SERVS. OFFICE OF INSPECTOR GEN. AND TREASURY INSPECTOR GEN. FOR TAX ADMIN., REVIEW OF THE ACCOUNTING STRUCTURE USED FOR THE ADMINISTRATION OF PREMIUM TAX CREDITS (Mar. 31, 2015) [hereinafter HHS OIG/TIGTA PTC REPORT].

can access.[19] CMS provides the IRS an estimate of the funds needed to make APTC payments in a given year, and the IRS transfers the necessary funds into the allocation account.[20] CMS then directs payments to insurers from the allocation account.[21]

In January 2013, CMS and the IRS signed a Memorandum of Understanding (APTIC MOU) that outlined the roles and responsibilities of both agencies for administering APTC payments and making the payments from the § 1324 permanent appropriation.[22] The APTC MOU did not apply to CSR payments—CMS established a separate account intended for CSR payments and requested an annual appropriation of approximately $4 billion to make CSR payments in fiscal year 2014.[23]

At some point, however, the Administration changed its strategy for making CSR payments. In response to questions posed by Senators Mike Lee and Ted Cruz, then-Office of Management and Budget Director Sylvia Mathews Burwell wrote that HHS would not be using the account set up by CMS for the CSR program to make CSR payments. Instead, for "efficiency" purposes, payments would be "paid out of the same account from which the premium tax credit portion of the advance payments for that program are paid."[24]

The IRS accordingly set up a second allocation account specifically for CSR payments within the premium tax credit account.[25] The IRS and CMS signed a second MOU specifically related to CSR payments on January 2014 (the CSR MOU), just days before the first payments were to be made.[26] As with APTC payments, CMS would inform the IRS how much it estimated CMS would need for the year, the IRS would then transfer the requested funds into the child account, and CMS would pay the insurers through that account.[27]

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[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] Memorandum of Understanding between the Internal Rev. Serv. and the Ctrs. for Medicare & Medicaid Servs., MOU13-150 (Jan. 2013).
[23] Ctrs. for Medicare and Medicaid Servs., Justification of Estimates for Appropriation Committees for Fiscal Year 2014 (2013).
[24] Letter from Hon. Sylvia Mathews Burwell, Office of Mgmt. and Budget, to Hon. Ted Cruz and Hon. Mike Lee, U.S. Senate (May 21, 2014).
[25] Memorandum of Understanding between the Internal Rev. Serv. and the Ctrs. for Medicare & Medicaid Servs., MOU14-127 (Jan. 2014) [hereinafter CRS MOU].
[26] *Id.*
[27] *Id.*

B. The Cost Sharing Reduction Program Requires an Annual Appropriation

The U.S. Constitution reserves to Congress decisions regarding taxation and spending. With regard to spending, the Constitution provides that "[n]o Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law[.]"[28] The power of the purse is one of Congress' most important roles, and it is essential to maintain the separation of powers envisioned by the founders to ensure that representatives of the American people determine how taxpayer funds are spent.

Appropriations can take different forms. Typically, Congress appropriates funds for a given program on an annual basis through an appropriations bill. Occasionally, Congress enacts permanent appropriations that provide funds until Congress repeals or modifies the appropriation. In these instances, payments can be made without the need for Congress to pass any additional appropriations legislation.

The Executive branch may only spend money that Congress has appropriated. Originally passed in 1870 to curb Executive branch abuses, the Antideficiency Act prohibits any federal officer or employee from "involv[ing] [the] government in a contract or obligation for the payment of money before an appropriation is made . . . ."[29] If a U.S. government officer or employee violates the Antideficiency Act, that person "shall be subject to appropriate administrative discipline including, when circumstances warrant, suspension from duty without pay or removal from office."[30] Further, if the officer or employee "knowingly and willfully" violates the Act, that person can be sentenced for up to two years in prison and fined up to $5000.[31]

Congress has a process that guides the creation and funding of programs it establishes. Generally, Congress establishes programs through authorization acts and funds them through appropriations acts. Legislative committees with jurisdiction over a particular program develop authorization legislation. Congress can authorize programs on an annual basis or for any other length of time specified in statute. Appropriations committees then consider whether to appropriate funds for the Executive branch to use in implementing or maintaining programs. While authorizations often prescribe specific funding amounts, they do not in themselves appropriate any funds unless explicitly stated, as described below. As the Government Accountability Office (GAO), the foremost experts on appropriations law, explains, authorizing legislation "is basically a directive to Congress itself, which Congress is free to follow or alter (up or down) in the subsequent appropriation act."[32]

In order for legislation to constitute an appropriation, the law must meet clear requirements. While it is not necessary for legislation to use the word "appropriation," "an

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[28] U.S. CONST. art. I, § 9, cl. 7.
[29] 31 U.S.C. § 1341.
[30] 31 U.S.C. § 1350.
[31] *Id*.
[32] GOV'T ACCOUNTABILITY OFFICE, PRINCIPLES OF FEDERAL APPROPRIATIONS LAW, 2–56 (4th ed. 2016).

appropriation must be expressly stated" and "cannot be inferred or made by implication."[33] Additionally, appropriations must meet two specific criteria: they must (1) designate that payment is to be made, and (2) indicate a source of funds to be used. Unless the law meets both criteria, it does not constitute an appropriation. As the GAO explains, "[b]oth elements of the test must be present. Thus a direction to pay without a designation of the source of funds is not an appropriation."[34]

Congress both authorized and funded the premium tax credit program in the ACA. Section 1401 of the ACA added Section 36B to the Internal Revenue Code, which authorizes the PTC program.[35] Additionally, Section 1401 amended an existing permanent appropriation—31 U.S.C. § 1324—and designated the permanent appropriation as the source of funding for the PTC program.[36] The appropriation's statutory language also limits payments from the appropriation to only tax refunds and specific credit provisions within Internal Revenue Code, including the PTC provision, Section 36B.[37]

With respect to the CSR program, however, Congress provided only an authorization, and not an appropriation, in the ACA. The CSR program is not a tax provision and not codified within the Internal Revenue Code. Further, there is no language in the ACA or anywhere else tying the CSR program to the 31 U.S.C. § 1324 appropriation.[38] Despite statements by the Administration, it has never been a principle of appropriations law that an authorized program can be funded from the account of another program simply for "efficiency" purposes if Congress does not appropriate money to the program.

C. *House v. Burwell* Lawsuit

On November 21, 2014, the U.S. House of Representatives filed a lawsuit against Secretary Burwell, Secretary Lew, and the Departments of Health and Human Services and the Treasury.[39] Among other claims, the complaint alleged that the cost sharing reduction payments made pursuant to Section 1402 of the ACA violated article I, section 9, clause 7 of the Constitution and the Administrative Procedure Act.[40] On September 9, 2015, Judge Collyer of the U.S. District Court for the District of Columbia held that the House had standing to pursue these claims because the claims were "predicated on a constitutional violation."[41] The lawsuit involved no discovery. The parties stipulated to the facts. The question before the court was purely a question of law.

On May 12, 2016, Judge Collyer ruled in favor of the House on the merits of the claim. She wrote:

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[33] *Id. at* 2–54.
[34] *Id. at* 2–-23.
[35] Patient Protection and Affordable Care Act, Pub. L. No 111-148, 124 Stat. 119 (2010).
[36] *Id.* (amending 31 U.S.C. § 1324 by adding "36B" to the list of tax credits available to be paid from the permanent appropriation).
[37] 31 U.S.C. § 1324.
[38] Patient Protection and Affordable Care Act, Pub. L. No 111-148, 124 Stat. 119 (2010).
[39] *U.S. House of Reps. v. Burwell*, No. 1:14-cv-01967, Complaint (D.D.C. Nov. 21, 2014).
[40] *Id*. at 17–18, 22–23.
[41] *U.S. House of Reps. v. Burwell*, No. 1:14-cv-01967, Memorandum Op. at 32 (D.D.C. Sept. 9, 2015).

> This case involves two sections of the Affordable Care Act: 1401 and 1402. Section 1401 provides tax credits to make insurance premiums more affordable, while Section 1402 reduces deductibles, co-pays, and other means of "cost sharing" by insurers. Section 1401 was funded by adding it to a preexisting list of permanently-appropriated tax credits and refunds. Section 1402 was not added to that list. **The question is whether Section 1402 can nonetheless be funded through the same, permanent appropriation. It cannot.**[42]

In other words, the court concluded that the Administration *unconstitutionally* paid for the CSR program through the permanent appropriation for tax credits and refunds. The litigation is still pending, waiting for the appeals process to conclude.

D. The Committees' Investigation

The committees' oversight inquiry is separate and independent from the lawsuit. It focuses on the underlying facts surrounding the Administration's decision to fund the CSR program using the § 1324 permanent appropriation. On the other hand, the lawsuit focuses on the legality of the Administration's decision and does not delve into the reasons why the Administration shifted course.

For more than a year, the committees have requested documents, witness testimony, and other information from the Administration about the source of funding for the CSR program. From the outset, the committees have clearly stated the purpose of their investigation: to fully understand the facts surrounding the Administration's decisions to fund the cost sharing reduction program from the permanent appropriation for tax refunds and credits. In the course of this investigation, the committees have sent fifteen letters, issued six subpoenas for documents, and conducted twelve transcribed interviews of current and former Administration officials involved in decisions regarding the source of funding for the CSR program. The Committee on Ways and Means additionally issued four subpoenas for testimony and conducted one deposition.

Throughout this investigation, the Administration has argued that the *House v. Burwell* litigation effectively preempted any oversight by the committees into the cost sharing reduction program. At every turn, the Administration has conflated the committees' separate and independent factual inquiry with the legal arguments posed by both sides in the litigation. The Departments of Health and Human Services and the Treasury have accused the committees of "utilizing oversight to accomplish inappropriate litigation objectives," including by conducting interviews "in an attempt to elicit information outside the bounds of traditional district court discovery."[43]

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[42] *U.S. House of Reps. v. Burwell*, No. 1:14-cv-01967, Op. at 1 (D.D.C. May 12, 2016).

[43] Letters from Anne Wall, Assistant Sec'y for Legis. Affairs, U.S. Dep't of the Treasury, and Jim R. Esquea, Assistant Sec'y for Legis., U.S. Dep't of Health & Human Servs., to Hon. Kevin Brady, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Jan. 19, 2016).

There was, however, no discovery in the lawsuit. Because the lawsuit purely focused on the legality of the Administration's decision, the only relevant, and stipulated, fact was that the Administration made the CSR payments from the permanent appropriation for tax refunds and credits. The Administration has failed to explain how the committees can seek information "outside the bounds of…discovery" in a case with no discovery. Further, at no time has the Administration explained why the *House v. Burwell* litigation prevents the committees from exercising their constitutional oversight responsibilities.

In refusing to acknowledge the committees' separate and fact-based inquiry, the Departments wrote, "If, as we suspect, our agencies ultimately prevail, that would eliminate the legal issue that is the stated predicate for the oversight." In fact, the Administration did not prevail. But, as the committees have maintained throughout this investigation, the committees' questions could not and would not be answered by the lawsuit, regardless of which party prevailed on the merits. The committees' questions are fundamentally different: they seek to understand the facts underlying the Administration's decisions, not the legality of the final decision itself.

At every turn, the Administration has misrepresented and distorted the scope of Congress' authority to conduct oversight of the laws it has passed, and of the circumstances of this present case. It has attempted to argue that Congress' constitutional oversight authority is somehow suspended while litigation is pending. It has argued that while Congress may have "authority" to conduct oversight, there is no "need" while the issue is being litigated. But none of these arguments are valid.

Under the powers set forth in the Constitution, Congress has an obligation to understand the facts of the Administration's decisions here. The committees have an oversight interest in the laws and regulations passed by Congress, and must ensure that the Administration spends taxpayer dollars prudently and in accordance with the law. That oversight interest cannot be tolled as the Administration requests. Further, it is the committees of the United States House of Representatives, not the Administration, that have sole authority to determine the type of information necessary to conduct effective oversight. The lawsuit did not, and will not, answer the committees' questions about the source of funding for the CSR program. The answers to these questions are ones that Congress alone must seek.

The committees' investigation is extensively detailed in Section VII.

V. After Requesting an Annual Appropriation for the Cost Sharing Reduction Program, the Administration Withdraws Its Request via a Telephone Conversation

The Administration requested an annual appropriation to make cost sharing reduction payments to insurance companies in the President's Fiscal Year 2014 (FY 2014) Budget submitted to Congress on April 10, 2013. Yet, a year later, the President's FY 2015 Budget did not include any such request. What happened during that intervening time? The Administration surreptitiously decided to pay for the CSR program through a Department of the Treasury managed-permanent appropriation dedicated to funding tax credits and refunds.

A. In 2010, the Administration Begins to Discuss How to Fund the Cost Sharing Reduction Program

FINDING: The Administration began to have discussions about the source of funding for the cost sharing reduction program after Congress passed the Patient Protection and Affordable Care Act in 2010.

High-level discussions about the source of funding for the CSR program began soon after the law's enactment. During the fall of 2010, several top IRS officials—including Associate Chief Counsel Mark Kaizen, Deputy Associate Chief Counsel of General Legal Services Linda Horowitz, and Chief of the Ethics and General Law Branch of General Legal Services Kirsten Witter—discussed the source of funding issue both internally and with OMB, specifically with OMB attorney Sam Berger. Associate Chief Counsel Linda Horowitz testified:

> Q. Do you remember if that was the first that you had been made aware of a question about source of funding, around December 2013?
>
> A. It was not the first time.
>
> Q. Do you remember what the first time was?
>
> A. I think sometime in 2010.
>
> Q. Do you remember how you became aware of that?
>
> A. Not specifically, no.
>
> Q. Do you remember with whom you had those conversations?
>
> A. I certainly had those conversations internally within our own office in GLS. And I believe there were some conversations with folks outside of IRS as well.

Q. And when you say "outside of IRS"–

A. Other agencies.

Q. Would that be HHS?

A. I'm not sure.

Q. Would it be OMB?

A. **It was OMB. Yes, I recall that.**

Q. **Okay. Who at OMB have you worked the most with on this issue?**

A. **Counsel from OMB.**

Q. **Do you remember their names?**

A. **I remember only one name. That's Sam Berger.**

Q. Okay. Did you work with Mr. Berger back in 2010 on this question?

A. Yes. Sorry.[44]

According to Ms. Horowitz, the conversations took place specifically within her office—which handles appropriations law questions—and between her office and OMB. She stated:

Q. And who in your office was working on that question in 2010?

A. Kirsten Witter, who is the branch chief in the Ethics and General Government Law Branch, and Mark Kaizen, who is my immediate supervisor who is the associate chief counsel in General Legal Services.

Q. Did they communicate with OMB as well, or was it just you that was communicating?

A. I believe we all communicated with OMB.

Q. Did you have conference calls where everyone was communicating with OMB at that point?

[44] H. Comm. on Ways & Means, Transcribed Interview of Linda Horowitz, at 20–23 (Apr. 22, 2016) [hereinafter Horowitz Tr.] (Although Ms. Horowitz could not recall when in 2010 the conference call occurred, according to public records, Mr. Berger graduated from law school in 2010 and began his tenure at OMB in September 2010).

A. I recall one conference call.

Q. And I'm sorry. Was that around 2010, or was that around 2013?

A. I'm referencing 2010.[45]

As early as 2010, the Administration began having conversations about how to fund the CSR program. Based on subsequent actions, the Administration appeared to believe that the CSR program required an annual appropriation.

B. The Administration Develops a Plan for the Mechanics of Making Premium Tax Credit Payments

FINDING: In 2012, the Administration developed an allocation account structure to pay for the premium tax credits. At that time, Treasury counsel concluded that 31 U.S.C. § 1324—the permanent Treasury appropriation for tax credits—could not be used to make CSR payments.

Section 1402 of the ACA authorized the CSR program, but did not provide a funding source for CSR payments.[46] Conversely, the ACA specifically provided funding for the PTCs through 31 U.S.C. § 1324, a permanent Treasury appropriation.[47] The ACA's PTC provisions, however, did not detail how HHS would be able to use a Treasury appropriation to make advanced payments as specified in the statute.[48]

Therefore, the Administration took steps early on to determine how to make the APTC payments authorized by and appropriated in the ACA. Ultimately, OMB decided that HHS and Treasury should use an allocation account structure. An allocation account is used "when a law requires departments (or agencies) to transfer budget authority to another Federal entity."[49] A 2015 report by the HHS Office of Inspector General (OIG) and the Treasury Inspector General for Tax Administration (TIGTA) described the steps the Administration took to set up a payment structure for APTC payments.[50]

As the Administration developed its plan to make the PTC payments, it also analyzed the statutory language surrounding the CSR program.

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[45] Horowitz Tr.18–23 (emphasis added).
[46] Patient Protection and Affordable Care Act, Pub. L. No 111-148, Sec. 1402, 124 Stat. 119 (2010).
[47] Patient Protection and Affordable Care Act, Pub. L. No 111-148, Sec. 1401(d), 124 Stat. 119 (2010).
[48] Patient Protection and Affordable Care Act, Pub. L. No 111-148, Sec. 1412, 124 Stat. 119 (2010).
[49] HHS OIG/TIGTA PTC REPORT, *supra* note 18. According to OMB, "Allocation means a delegation, authorized in law, by one agency of its authority to obligate budget authority and outlay funds to another agency. When an agency makes such a delegation, the Treasury Department establishes a subsidiary account called a 'transfer appropriation account', and the receiving agency may obligate up to the amount included in the account." Office of Mgmt. and Budget, OMB Circular A-11, Sec. 20, at 22 (June 2015), *available at* https://www.whitehouse.gov/sites/default/files/omb/assets/a11_current_year/a11_2015.pdf.
[50] HHS OIG/TIGTA PTC REPORT, *supra* note 18.

1. Inter-Agency Discussions on How to Implement the Premium Tax Credit Program Begin in 2011

In late 2011, HHS, Treasury, and OMB discussed options for how the Administration would make advanced premium tax credit payments. IRS Deputy Chief Financial Officer Greg Kane explained that the IRS began working with a number of other agencies and departments to implement the advanced premium tax credit program. He stated:

> Q. And in your capacity as Deputy CFO at the IRS, how have you been involved in the implementation of the Patient Protection and Affordable Care Act?
>
> A. So my role was to provide advice in regard to how we would account for, test internal controls, and administer the account from which payments would be made.
>
> Q. What projects did you work on with relation to the ACA?
>
> A. **So, in late 2011, we began working with CMS, HHS, IRS and Treasury, and OMB to prepare for the implementation of the advanced premium tax credit and the premium tax credit.** I am a part of the ACA program office meetings for other provisions to see if they would have any impact on financial reporting or financial accounting and provide input if I see anything that they need to be advised of.[51]

2. In a Memorandum Regarding Premium Tax Credit Payments, Treasury Acknowledges that the ACA did Not Provide an Appropriation for the Cost Sharing Reduction Program

In 2012, the Administration examined the possibility of using an allocation account structure to make premium tax credit payments. According to TIGTA and HHS OIG, "the IRS had no prior experience with allocation accounts in connection with tax refund activity and was concerned initially with the legality of this approach."[52] Mr. Kane confirmed that using allocation accounts was a unique arrangement for the IRS. Mr. Kane stated:

> Q. Is this the first time, to your awareness, that CMS and Treasury have worked together to have an account to make payments?
>
> A. Yeah. Based on the uniqueness of the law, where the Secretary of HHS makes determination and we make payment, IRS had never

[51] H. Comm. On Ways & Means, Transcribed Interview of Greg Kane at 30–31 (Mar. 10, 2016) [hereinafter Kane Tr.] (emphasis added).
[52] HHS OIG/TIGTA PTC REPORT, *supra* note 18.

> had any experience in administering, you know, an account like that.[53]

At OMB's request, Treasury prepared a memorandum analyzing the legal basis on which the IRS could make these payments using an allocation structure.[54] The committees obtained this memorandum, which, in part, examines whether the ACA provides a source of funding for the CSR program (see below). Despite the IRS' concerns, Treasury concluded in the memorandum that "ACA §§ 1411 and 1412 may be interpreted to authorize the transfer of funds from Treasury's refund appropriation to an HHS allocation account for purposes of making the advanced payments of the tax credit."[55]

Although Treasury's memorandum focused on whether an allocation account for APTC payments was allowed by the statute, it also mentioned advanced payments for CSRs. When discussing the meaning of the statutory direction in the ACA that the "Secretary of the Treasury shall make the advanced payment" for premium tax credits,[56] Treasury counsel wrote:

> We note that section 1412(c)(3) [related to advanced payments for cost sharing reductions] contains similar language to section 1412(c)(2)(A) with respect to the cost-sharing payments under section 1402 **for which the Secretary of the Treasury has no funding or program responsibility**.[57]

Treasury continued that "[s]uch a reading, of course, would not be applicable to the largely parallel language in section 1324(c)(3); **there is currently no appropriation to Treasury or to anyone else, for purposes of the cost-sharing payments to be made under section**."[58] At this point in 2012, Treasury understood that the 31 U.S.C. § 1324 appropriation would be available for APTC payments, but not for CSR payments where "the Secretary of the Treasury has no funding or program responsibility."[59] Additionally, based on its analysis, Treasury believed no appropriation for CSR payments existed at the time.[60] The entirety of Treasury's analysis related to the CSR program is produced below:

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[53] Kane Tr. at 34.
[54] Treasury APTC Memorandum, *supra* note 1.
[55] *Id.*
[56] Patient Protection and Affordable Care Act Section 1412(c), codified at 42 U.S.C. § 18082 (c).
[57] Treasury APTC Memorandum, *supra* note 1 (emphasis added).
[58] *Id.* (emphasis added).
[59] *Id.*
[60] *Id.*

Role of the Secretary of the Treasury

Finally, the direction to the Secretary of the Treasury to make the advanced payment under section 1412(c)(2)(A) should not preclude reading sections 1411 and 1412 as requiring certification of payments by HHS, whether directly under the statute or as a consequence of a transfer of funds to an HHS allocation account.. Section 1412(c)(2)(A) can be read simply as a direction to the Secretary of the Treasury to make the payment to the issuer of a qualified health plan on a specified schedule rather that to the taxpayer who would normally receive the payment for a refundable credit. We note that section 1412(c)(3) contains language similar to section 1412(c)(2)(A) with

[1] In 1996, 31 USC 1304(a)(2) was amended to substitute the Secretary of the Treasury for the Comptroller General.

respect to the cost-sharing payments under section 1402 for which the Secretary of the Treasury has no funding or program responsibility. Therefore, we believe that the statute should be read in accordance with its plain meaning as referring to Treasury's disbursing authority and instructing the Secretary to whom to make the payment and when. This reading does not alter the overall statutory scheme placing programmatic responsibility for the advanced payments of the tax credits with HHS.

We acknowledge that other statutes authorize or require agencies to "pay" or "make payments" when the payments will in fact be made by Treasury's Financial Management Service (FMS) under its statutory disbursing function. Even if OMB disagreed that section 1412(c)(2)(A) referred to FMS's disbursing function, it would not follow that IRS was required to certify payments under the statute. Although the reference to the Secretary of the Treasury in section 1412(c)(2)(A) must be presumed to have meaning, the plain meaning of "shall make the advance payment" is not "shall certify the advance payment." Moreover, as discussed above, a requirement that Treasury certify the payments determined by HHS would be hollow at best. There is no reason to assume that Congress would have imposed such an illogical requirement, much less that it would have done so through oblique language.

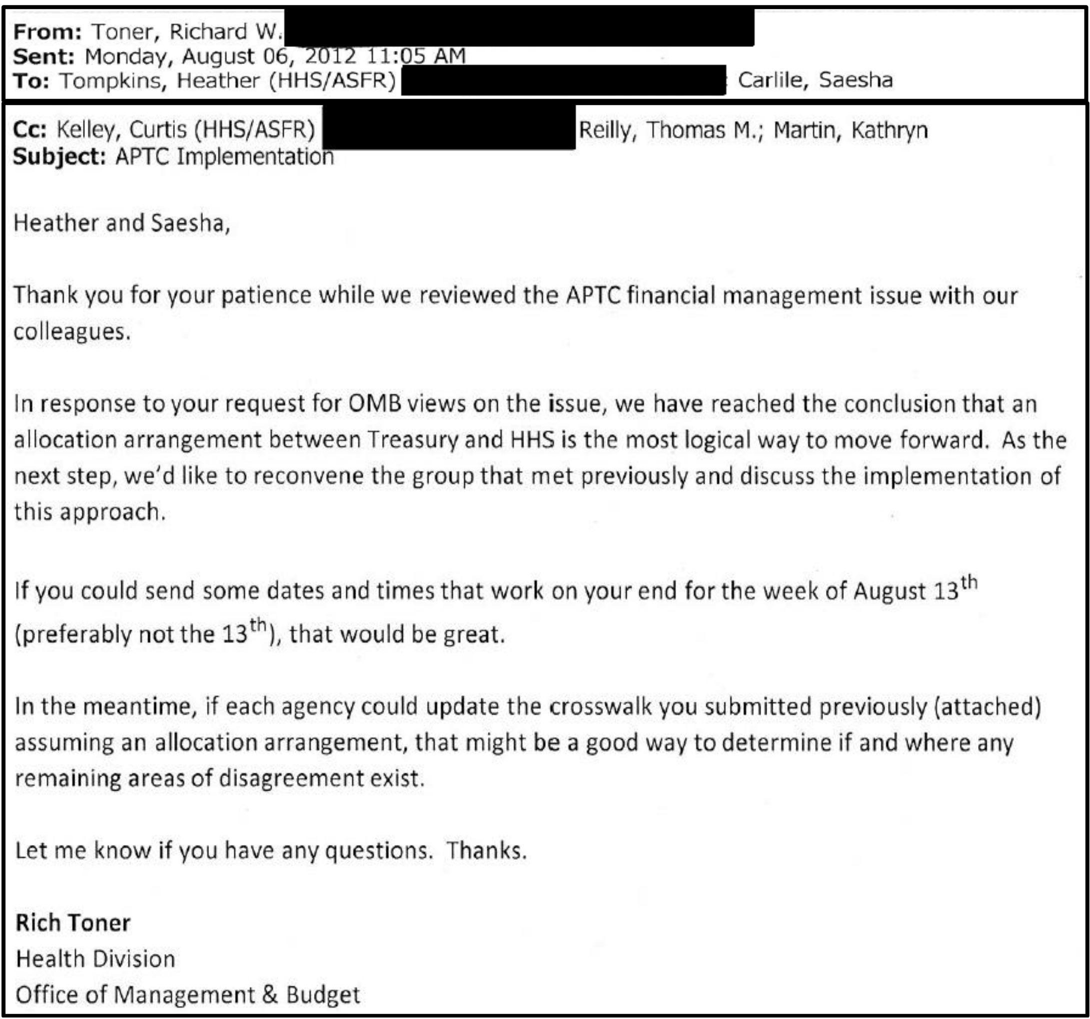
Instead, the reference to the Secretary of the Treasury can be read to refer, not to the mechanics of the payment process, but to the source of funds. Title 31 U.S.C. § 1324, amended by section 1401 to cover refunds under section 36B of the tax code, appropriates funds "to the Secretary of the Treasury." Thus, the language requiring that the Secretary of the Treasury shall make the payments can be read simply to mean the payments shall be made from funds available to that Secretary.[2] Had Congress written section 1412(c)(2)(A) to say that "[t]he Secretary [of HHS] shall make the advance payment . . ." it would have been at best unclear whether the appropriation under 31 U.S.C. § 1324 was available for that purpose.

Such a reading, of course, would not be applicable to the largely parallel language in section 1324(c)(3); there is currently no appropriation, to Treasury or to anyone else, for purposes of the cost-sharing payments to be made under that section. However, this does not suggest that section 1412(c)(2)(A) should be read to require certification of payments by Treasury; such a reading would be equally inapplicable to section 1412(c)(3). Rather, if the latter section does not refer to the FMS disbursement function, its meaning can be determined only in connection with whatever statute ultimately appropriates funds for the cost-sharing payments.

[2] Such a reading would not make the notification to the Secretary of the Treasury of HHS advance determinations, as required under section 1412(c)(1), superfluous. Regardless of who performs the payment certification function, Treasury will require such notice to ensure that budgetary resources are available, and ultimately to reconcile advance payments with individual tax returns.

3. OMB Makes the Final Decision Regarding Advanced Premium Tax Credit Accounting Structure

Despite the IRS' concerns with the legality of the allocation account approach,[61] OMB ultimately decided to move forward and use an allocation account to make the APTC payments. On August 6, 2012, an official in OMB's Health Division emailed HHS and Treasury officials to inform them that OMB had decided that "an allocation account arrangement between Treasury and HHS is the most logical way to move forward:"[62]



From: Toner, Richard W. [redacted]
Sent: Monday, August 06, 2012 11:05 AM
To: Tompkins, Heather (HHS/ASFR) [redacted] Carlile, Saesha
Cc: Kelley, Curtis (HHS/ASFR) [redacted] Reilly, Thomas M.; Martin, Kathryn
Subject: APTC Implementation

Heather and Saesha,

Thank you for your patience while we reviewed the APTC financial management issue with our colleagues.

In response to your request for OMB views on the issue, we have reached the conclusion that an allocation arrangement between Treasury and HHS is the most logical way to move forward. As the next step, we'd like to reconvene the group that met previously and discuss the implementation of this approach.

If you could send some dates and times that work on your end for the week of August 13th (preferably not the 13th), that would be great.

In the meantime, if each agency could update the crosswalk you submitted previously (attached) assuming an allocation arrangement, that might be a good way to determine if and where any remaining areas of disagreement exist.

Let me know if you have any questions. Thanks.

Rich Toner
Health Division
Office of Management & Budget

The Treasury recipient forwarded the email to Gregory Kane, Kirsten Witter, and other Treasury officials and commented that, "[t]his probably will not be a surprise to anyone, but OMB moved forward on HHS's recommendation that APTC should be done through an allocation account":[63]

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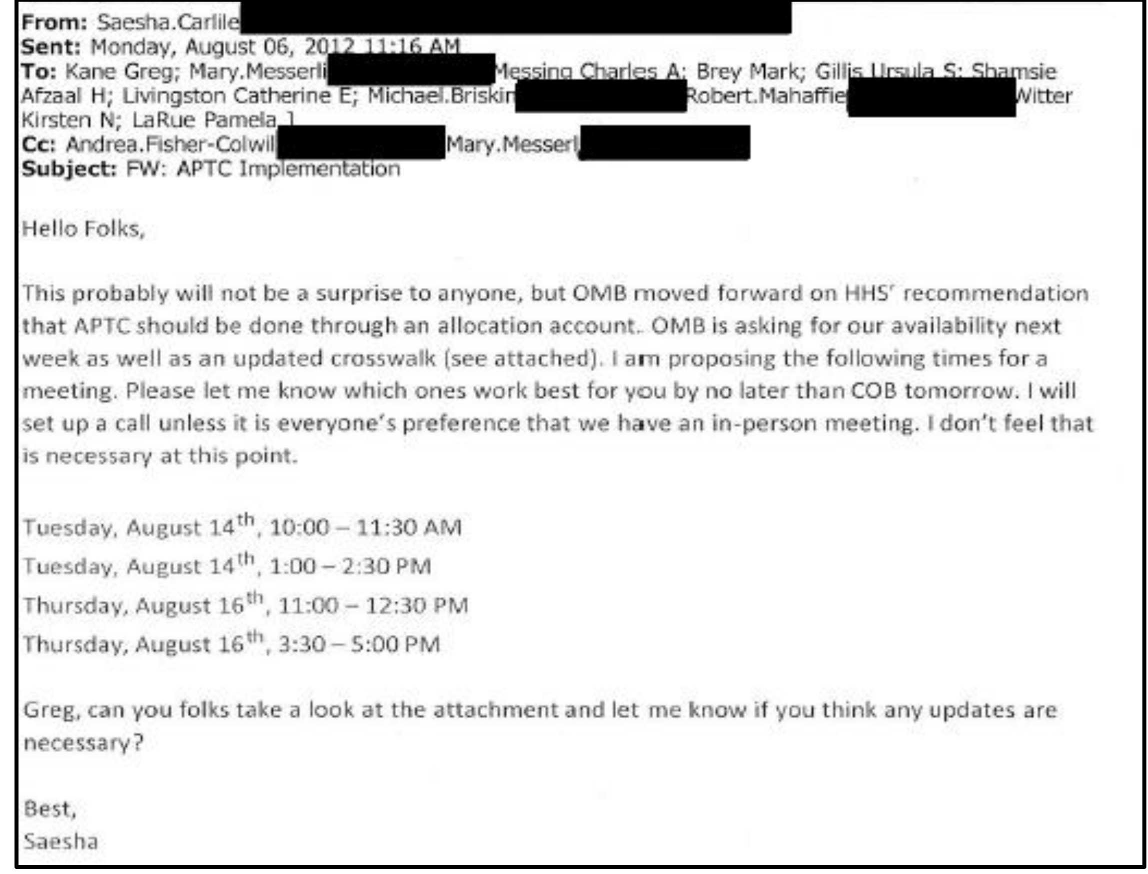
[61] *Id.* at 8.
[62] Email from Richard Toner, Office of Mgmt. & Budget, to Heather Tompkins, U.S. Dep't of Health & Human Servs., and Saesha Carlile, U.S. Dep't of the Treasury (Aug. 6, 2012, 11:05 a.m.).
[63] Email from Saesha Carlile, U.S. Dep't of the Treasury, to Gregory Kane, Kristen Witter, *et al.*, U.S. Dep't of the Treasury (Aug. 6, 2012, 11:16 a.m.).


From: Saesha.Carlile[redacted]
Sent: Monday, August 06, 2012 11:16 AM
To: Kane Greg; Mary.Messerli[redacted] Messing Charles A; Brey Mark; Gillis Ursula S; Shamsie Afzaal H; Livingston Catherine E; Michael.Briskin[redacted] Robert.Mahaffie[redacted] Witter Kirsten N; LaRue Pamela J
Cc: Andrea.Fisher-Colwill[redacted] Mary.Messerli[redacted]
Subject: FW: APTC Implementation

Hello Folks,

This probably will not be a surprise to anyone, but OMB moved forward on HHS' recommendation that APTC should be done through an allocation account. OMB is asking for our availability next week as well as an updated crosswalk (see attached). I am proposing the following times for a meeting. Please let me know which ones work best for you by no later than COB tomorrow. I will set up a call unless it is everyone's preference that we have an in-person meeting. I don't feel that is necessary at this point.

Tuesday, August 14th, 10:00 – 11:30 AM

Tuesday, August 14th, 1:00 – 2:30 PM

Thursday, August 16th, 11:00 – 12:30 PM

Thursday, August 16th, 3:30 – 5:00 PM

Greg, can you folks take a look at the attachment and let me know if you think any updates are necessary?

Best,
Saesha

4. IRS and CMS Sign a Memorandum of Understanding in January 2013 to Govern the Payment of Advanced Premium Tax Credits but Not Cost Sharing Reductions

In January 2013, IRS and CMS signed a Memorandum of Understanding regarding the administration of APTC payments (APTC MOU). According to the APTC MOU:

> This Memorandum of Understanding (MOU) between the Internal Revenue Service (IRS) and the Centers for Medicare and Medicaid Services (CMS) identifies the roles and responsibilities of each party for program operations **supporting the payment of and accounting for the advance payment of the premium tax credit (APTC) under section 1412 of the Patient Protection and Affordable Care Act (PPACA).**[64]

This agreement applied only to the payment of premium tax credits. Nowhere in the nine page document are CSRs mentioned.[65] In fact, in the same time frame, HHS created a separate

[64] Memorandum of Understanding between the Internal Rev. Serv. and the Ctrs. for Medicare & Medicaid Servs., MOU13-150 (Jan. 2013) (emphasis added).
[65] *Id.*

account to make CSR payments once Congress appropriated funds. IRS Deputy Chief Financial Officer Greg Kane testified:

> Q. So, aside from that child [allocation] account we were just discussing, was a different account ever established to make the cost sharing reduction payments?
>
> A. There was.
>
> Q. Where was that established?
>
> A. There was one in the original HHS budget.
>
> Q. The account would have then been located at HHS? Is that accurate?
>
> A. Correct.
>
> ***
>
> Q. How did you become aware of that account?
>
> A. **So, in the early stages of 2011, 2012, when we were all getting prepared, the cost sharing reduction discussions were with HHS and OMB, and we were talking about the APTC/PTC process.**
>
> Q. **And at that point you became aware that HHS had already set up an account?**
>
> Treasury Counsel. **That's a "yes" or "no" question.**
>
> A. **Yes.**[66]

As shown, the Administration decided to use an allocation account structure to make APTC payments. In the same legal memorandum justifying this approach, however, Treasury counsel concluded that the 31 U.S.C. § 1324 permanent Treasury appropriation was available for APTC payments, but not for the CSR payments. Treasury counsel also believed no appropriation for CSR payments existed at that time.

Around this same time, HHS was preparing its FY 2014 budget request to submit to Congress. HHS had already created a separate account to make payments for the CSR program—likely in preparation for requesting an annual appropriation for the program in its FY 2014 budget.

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[66] Kane Tr.at 44–45 (emphasis added).

C. The Administration Requests an Annual Appropriation for the Cost Sharing Reduction Program

At the same time that the Administration was finalizing its APTC payment structure, it was also preparing its request for an annual appropriation for the CSR program through HHS' annual budget process.

1. The Typical HHS Budget Process

FINDING: HHS' typical budget process is—for the most part—a thorough, institutionalized, and well-documented process.

Each year, the Executive branch embarks on an institutionalized process to draft and prepare the President's annual budget request to Congress. Each department and agency holds countless meetings, prepares several budget drafts and accompanying charts, and engages in extensive negotiations within the department or agency as well as with OMB to finalize its budget request. HHS is no different—its budget process is similarly in-depth and institutionalized.

HHS' Office of the Assistant Secretary for Financial Resources orchestrates the HHS budget process.[67] Typically, HHS' budget process begins during the spring of a given year and finishes when the President's final budget request is submitted to Congress the following February. For example, HHS began preparing its proposed FY 2017 budget during the spring of 2015. The President submitted his FY 2017 Budget to Congress in February 2016.

a. HHS Prepares Its Initial Budget Request

HHS begins to prepare its budget request during the spring the year before the President's final budget request is submitted to Congress. The process begins when the Department sends instructions to each of its operating divisions. Assistant Secretary for Financial Resources Ellen Murray described these instructions during her transcribed interview with the committees. She stated:

> [The operating divisions] asked for, of course, by program, their recommendation for budget request. They're asked for any statutory language that they would request. They're asking for justification for their dollar request. There's information[] about FTE [full-time employees], you know, a lot of detailed information, IT specifics and so on.[68]

[67] *See* Office of the Ass't Sec. for Fin. Resources, U.S. Dep't of Health and Human Servs., http://www.hhs.gov/about/agencies/asfr/index.html ("The Office of the Assistant Secretary for Financial Resources (ASFR) provides advice and guidance to the Secretary on all aspects of budget, financial management, grants and acquisition management, and to provide for the direction and implementation of these activities across the Department.").

[68] H. Comm. on Energy & Comm., Transcribed Interview of Ellen Murray, at 14 (Mar. 4, 2016) [hereinafter Murray Tr.].

After the operating divisions receive the instructions and prepare the requested information, HHS begins meetings with the operating divisions during the summer. Ms. Murray stated:

> Q. So once [the operating divisions] start submitting information that you requested, via the instructions, what then happens?
>
> A. We have meetings with each operating division and the larger staff divisions. Included in those meetings is what is called the Secretary's Budget Council, which includes the deputy secretary, and some of the senior officials, and the office of the secretary, and myself, and my staff, and we have a fulsome discussion of their budget request. Obviously, we concentrate on those areas of proposed reductions or increases or new programs.
>
> Q. Apart from the instructions that you submitted, are there other documents that are created during this summer process?
>
> A. Well, as each operating division comes and gives a short introduction, they provide usually a PowerPoint presentation. But it's really to facilitate sort of a fulsome discussion of their request. We talk about duplications with other agencies. We have an interest in secretarial priorities. Opioids, mental health; those are particularly addressed. So it's a very good discussion, but it's mainly on initiatives.
>
> Q. So mainly, it sounds like during the summer there's a lot of meetings that are happening and discussions about what's going to be important to make sure to have in HHS's budget request?
>
> A. Right.[69]

As the Assistant Secretary for Financial Resources, Ms. Murray's role is to lead these budget meetings with the Secretary's Budget Council. Ms. Murray testified:

> I think my biggest role is really to lead these budget meetings and to talk about the budget the Agency is proposing. Ask questions, ask questions about areas of concern, maybe program integrity issues that have come up in programs.
>
> I'm a lot focused on duplication, focused on our priorities. We then have to make some recommendations to the Secretary, and so that's another whole round of meetings where she has to make tough choices between different requests to come up with our final proposal to OMB.[70]

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[69] *Id.* at 14–15.
[70] *Id.* at 17.

Deborah Taylor, the former Chief Operating Officer for the Centers for Medicare and Medicaid Services (CMS), one of HHS' operating divisions, similarly described the HHS summer budget process. During her transcribed interview with the committees, she stated:

> [S]ometime in the summer, OPDIVs [the operating divisions] typically do a presentation to the Secretary's budget council, where they explain their budget requests; they walk through any places where they maybe deviated from Department instructions.[71]

After the operating divisions submit their budget requests to HHS, the department makes decisions on those requests and then passes them back—or returns them—to the operating divisions. Ms. Taylor testified:

> And then the Department gives a passback. They either accept the budget as proposed, or they make some changes to it. Agencies have an opportunity to appeal it, and then, at that point, the Department has a process for sending it to OMB for approval.[72]

Meanwhile, as HHS is preparing its initial budget request, the Office of Management and Budget (OMB) issues its Circular A-11.[73] This document provides guidance to the Executive branch on how to prepare and submit a particular fiscal year budget and execute the budget.[74] Typically, the OMB Circular A-11 is issued during the summer before the President's final budget is submitted to Congress. The Executive branch agencies and departments have usually begun to prepare their budget requests when OMB issues its Circular A-11.

b. OMB's Fall Review

HHS submits its initial budget request to OMB around Labor Day. Ms. Murray described the submission:

> This submission includes the primary part of—it is a letter from the Secretary that describes our initiatives, describes the budget, but then there's a lot of required tables that are included, [by the] FTE, dollar amounts.[75]

After OMB receives HHS' budget request—along with the other Executive branch departments' and agencies' budget requests—it begins its "fall review." During OMB's fall review, OMB

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[71] H. Comm. on Energy & Comm., Transcribed Interview of Deborah Taylor, at 15 (Apr. 14, 2016) [hereinafter Taylor Tr.].
[72] *Id*.
[73] *See, e.g.,* Office of Mgmt. & Budget, Preparation, Submission, and Execution of the Budget, Circular A-11 (June 2015), *available at* https://www.whitehouse.gov/sites/default/files/omb/assets/a11_current_year/a11_2015.pdf.
[74] *See, e.g.,* Office of Mgmt. & Budget, Memorandum to the Heads of Executive Departments and Establishments, Preparing, Submitting, and Executing the Budget, Transmittal Memorandum No. 89 (June 30, 2015) *available at* https://www.whitehouse.gov/sites/default/files/omb/assets/a11_current_year/2015_letter.pdf.
[75] Murray Tr. at 16.

meets directly with HHS and its operating divisions about HHS' budget request submission. Ms. Murray stated:

> Q. So after HHS submits its budget request to OMB in roughly September –
>
> A. Around Labor Day.
>
> Q. – what's the next step? What happens next?
>
> A. Well, OMB meets with each of our operating divisions. There's a lot of questions back and forth between OMB and my staff. OMB has internal meetings that we're not part of, and they give us what's called pass-back, which is sort of their response to our budget request, and that happens right after Thanksgiving.
>
> Q. So during this fall review, OMB does at points engage with you and the Agency and staff as it's hashing out the budget request?
>
> A. They actually have meetings with each of our operating divisions, but there is probably daily communication between my staff and analysts at OMB.[76]

After OMB completes its fall review, it passes back its budget decision to HHS. This passback, which generally occurs around late November, is a separate, stand-alone document. Ms. Murray testified:

> Q. Just going back to the pass-back, what exactly does it look like? Is it what you submitted with –
>
> A. No, it's a separate document.
>
> Q. It's a totally different looking document?
>
> A. Yes.[77]

Usually, OMB's decisions in the passback do not perfectly align with HHS' original request. Ms. Murray stated that OMB "come[s] back with their decision, which would be in most cases different than what we requested."[78]

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[76] *Id.* at 17.
[77] *Id.* at 20.
[78] *Id.* at 19.

c. HHS' Appeals Process

When HHS receives the passback, it decides whether and what budget decisions to appeal. The Department often makes an appeal. Assistant Secretary Murray testified that in "[m]y experience, we have always appealed the decision."[79] HHS appeals the decision by sending a formal appeal letter to OMB. Ms. Murray stated:

> Q. So when HHS appeals OMB's budget decisions, how does that process work?
>
> A. We send a formal appeal letter to OMB.
>
> Q. And does the letter include the different items that HHS is appealing?
>
> A. Yes.
>
> Q. Is there any other—I'm assuming—document attachments to the letter?
>
> A. No. The letter is pretty general. And I don't mean to jump in, but this is really a collegial process to document final determination on sort of large policy issues. So nuts and bolts may not necessarily be addressed in these letters.
>
> Q. With respect to the individual items that are being appealed though, what information is provided to make the case and the appeal?
>
> A. There would often be a justification on our part as to why we would disagree.
>
> Q. Is that within the letter?
>
> A. Often it is.[80]

Although HHS sends a formal letter appealing OMB's budget decisions, HHS begins to communicate with OMB about its appeal before the letter is sent. Ms. Murray testified about her and her office's role in the appeals process:

> Q. What exactly is your role?

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[79] *Id.*
[80] *Id.* at 20–21.

A. Well, I would actually work with my staff to draft the appeal letter based on secretarial decisions. And I would be in communication with OMB as we work out some of these issues verbally.

Not everything may be captured in these letters. Again, this is two officers attempting to collegially put together what we think is the best budget for HHS.[81]

HHS, specifically the Office of the Assistant Secretary for Financial Resources, appears to handle the appeals process. The operating divisions, however, also play a role. Former CMS Chief Financial Officer Deborah Taylor testified:

Q. If the appeal involves the CMS component of the budget, would you be involved at that point?

A. So "involved" may be the Department saying to us: We think we're going to appeal this; are you okay with that?

And, typically, we will say yes. Or it is: We don't think we are going to appeal this; do you have any strong objections?

Q. If the Department does appeal something that affects the CMS budget, do you play any role in preparing documents or any sort of materials to support the appeal?

A. It depends, but I think we – you know, depending on how much help they would need, yes, we could certainly be asked to do that.[82]

After OMB receives HHS' letter appealing aspects of OMB's budget decision, OMB makes a final determination. Assistant Secretary Murray explained that she is not part of the final decision-making, but she emphasized that HHS and OMB try to come to a consensus. She stated:

Q. Do you know who actually makes the decisions on the appeals? Is it different? Is it usually at a very high level, or do you know how that works?

A. I would not be part of those discussions. They would be at OMB.[83]

Assistant Secretary Murray later testified:

Q. Going back to the appeals process quickly, if there is a disagreement between HHS and OMB, with respect to the funding

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[81] *Id.* at 22.
[82] Taylor Tr. at 19.
[83] Murray Tr. at 22.

for a specific program, who makes the final decision? Which agency makes the final decision on what will be included in the budget?

A. I would like to think that we would come to a consensus, but if, obviously OMB is part of the Office of the President.

Q. So does OMB have the final decision ultimately?

A. I would like to think that our final decisions have been one of consensus where we agree to OMB's number.[84]

d. The President Submits His Budget to Congress

After the appeals process is complete, HHS works to finalize its budget and submits it to OMB. Assistant Secretary Murray stated:

> During the period after we finish the appeals until the budget is submitted to Congress, we are working with our operating divisions at OMB to figure out our congressional justifications. We put together a document called the budgeting brief which summarizes our budget for HHS.
>
> We sometimes review language that OMB is going to include in their budget documents that relate to OMB. We are preparing the Secretary for hearings. It's a busy time.[85]

Typically, the President's final budget request is submitted to Congress around the first week of February, although it is sometimes submitted late.

e. The Department Discusses the Budget Request with Congress

Once the President submits his proposed budget to Congress, HHS begins to engage directly with Congress through budget hearings and frequent communications with the congressional appropriations committees. Ms. Murray testified:

Q. After the budget is submitted to Congress, what role does HHS have at that point?

A. Once the budget is submitted to Congress, we begin the hearings, as you're well aware, and we work with the Secretary and prepare for those hearings. We work with our appropriations committees and other committees, giving technical assistance, discussing our proposals, and we follow closely the process through Congress.

[84] *Id.* at 23.
[85] *Id.* at 23–24.

Q. What is your role throughout this process?

A. I communicate with the appropriations committees. I work with the Secretary to keep her apprised of the process, and then we start the next year.

Q. So do the appropriations committees ask for additional information from HHS other than what's included in the formal submission?

A. Yes, they do.

Q. Can you describe the type of information they may request.

A. They may ask the justification for a particular number. They may ask information about how many grants this number would allow the program to put out. They may ask clarifying questions about language. It's a continual back-and-forth process.

Q. Does HHS provide answers to the questions from the appropriators?

A. We try to be very responsive to our appropriators. We deal with them individually.

Q. What do you mean by that?

A. Well, we have Democrat and Republican, Senate and House, so we call them the four corners, so there's discussions with all four groups. We actually have—some of our programs—we're funded in three different subcommittees, so there's twelve subcommittees with which we work.

Q. Can you tell us the timeframe typically in which the conversations with the appropriations committees take place?

A. They would begin probably the day we send up the budget and would continue until the night before they markup their bill.[86]

According to Assistant Secretary Murray, HHS has an ongoing dialogue with the appropriations committees until they pass the respective appropriations bills. Through this dialogue, HHS provides technical assistance, addresses questions, and produces additional information in response to requests. Meanwhile, HHS has started the budget process for the next fiscal year.

[86] *Id.* at 24–25.

f. The President Can Amend His Budget through a Budget Amendment

FINDING:	**The Administration can withdraw an appropriation request without going through the formal and documented budget amendment process.**

After the President submits his proposed budget to Congress, it can still be amended through a formal budget amendment. According to the OMB Circular A-11, amendments "are proposed actions that revise the President's Budget request and are transmitted prior to completion of action on the budget request by the Appropriations Committees of Both Houses of Congress."[87] The circular describes the process, including when OMB will consider an amendment and what an agency needs to submit to OMB.[88] Assistant Secretary Murray described the budget amendment process from her experience. She testified:

> Q. After the President submits his budget to Congress, his budget request to Congress, is there a process for him to revise that request if—after it has already been submitted?
>
> A. I understand. The President could issue a budget amendment.
>
> Q. Can you describe briefly how that process works, to your understanding?
>
> A. Well, again, that would be a collaborative process between the agency in question and the White House, and it would reflect a change in the initial submission of the budget.[89]

She further stated:

> Q. Have you been involved, or do you get involved if HHS—if there is an amendment that the White House is going to submit to Congress that affects HHS? Do you or HHS get involved with that process?
>
> A. Yes.
>
> Q. In what way?
>
> A. As we would [with] the original budget, certainly communication between the two offices as to the substance and the amount of that request.[90]

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[87] Office of Mgmt. and Budget, Circular No. A-11, Section 110—Supplementals and Amendments 2 (2015).
[88] *Id.*
[89] Murray Tr. at 70.
[90] *Id.* at 71.

The Administration can also amend the President's budget request through informal and undocumented means. Ms. Murray testified:

> Q. So if a request for supplemental funds is requested, that would be an amendment to the budget request?
>
> A. That would be a budget amendment, yes.
>
> Q. **What if the administration decides it no longer needs funds for something, would that also require a budget amendment request?**
>
> A. **That request could be made to the Hill through a budget amendment, or through a less formal means.**
>
> Q. **Could you describe the less formal means there which that could be [r]elayed?**
>
> A. **That could be done simply as I decided with the CSR program, where I made a call to the appropriations clerk.**[91]

As demonstrated, HHS' budget process is—for the most part—a thorough, institutionalized, and documented process. HHS' final budget request is the product of not just several drafts of tables and budget justifications, but also countless meetings and communications between its operating divisions and the main Department as well as between HHS and the President's Office of Management and Budget. The President then publishes his budget request as a statement of his Administration's priorities and submits it to Congress for consideration. The Administration, however, can also amend its final budget request by simply calling one of the congressional appropriations committees.

2. The President's FY 2014 Budget Includes a Request for an Annual Appropriation

FINDING: The Administration requested an annual appropriation of almost $4 billion for the cost sharing reduction program in its FY 2014 budget request, submitted to Congress on April 10, 2013.

The President's FY 2014 Budget—submitted to Congress on April 10, 2013—included a request for an annual appropriation for the CSR program. At what point HHS decided to include an appropriation request in the Department's budget request is unclear. HHS counsel repeatedly refused to allow witnesses to answer the committees' questions about when or whether the Administration decided to include a request for an annual appropriation for the CSR program in the FY 2014 budget.

[91] *Id.* at 72–73 (emphasis added).

a. HHS' FY 2014 Budget Process

Similar to a typical budget cycle, HHS started preparing its FY 2014 budget request during summer 2012. HHS submitted its initial budget request to OMB around Labor Day 2012. Initially, HHS allowed Ms. Murray to answer whether HHS' initial request to OMB included an annual appropriation for the CSR program. Ms. Murray testified:

> Q. Do you recall when HHS submitted its budget, its fiscal year 2014 budget to OMB?
>
> A. I believe, again, at the Labor Day timeframe.
>
> Q. Did HHS request an annual appropriation for the Cost Sharing Reduction Program when it submitted its request to OMB?
>
> HHS Counsel 1. I'm going to caution the witness not to reveal the substance of internal interagency deliberations.
>
> Committee Counsel. This is a factual question. It's a yes or no answer whether it was included. It doesn't speak to internal deliberations.
>
> HHS Counsel 1. Do you think it's okay?
>
> HHS Counsel 2. Yes.
>
> HHS Counsel 1. Okay. The witness can answer.
>
> A. **We did. We did request an appropriation.**[92]

This was the first and only time HHS allowed a witness to answer questions about whether HHS' draft budget requests included a request for an annual appropriation for the CSR program. From that point forward, HHS claimed that the committees' questions jeopardized HHS' confidentiality interests in these internal deliberations and refused to allow witnesses to answer.

b. President's FY 2014 Budget Request to Congress

The President's FY 2014 Budget included a request for an annual appropriation for the cost sharing reduction program. The President's budget requested:

[92] *Id.* at 26–27 (emphasis added).

Reduced Cost Sharing for Individuals Enrolling in Qualified Health Plans

For carrying out, except as otherwise provided, sections 1402 and 1412 of the Patient Protection and Affordable Care Act (Public Law 111–148), such sums as necessary.

For carrying out, except as otherwise provided, such sections in the first quarter of fiscal year 2015 (including upward adjustments to prior year payments), $1,420,000,000.

Program and Financing (in millions of dollars)

Identification code 75–0126–0–1–551	2012 actual	2013 CR	2014 est.
Obligations by program activity:			
0001 Benefit payments	....	....	3,978
0900 Total new obligations (object class 42.0)	....	....	3,978
Budgetary Resources:			
Budget authority:			
Appropriations, mandatory:			
1200 Appropriation	....	....	3,978
1260 Appropriations, mandatory (total)	....	....	3,978
1930 Total budgetary resources available	....	....	3,978
Change in obligated balance:			
Unpaid obligations:			
3010 Obligations incurred, unexpired accounts	....	....	3,978
3020 Outlays (gross)	....	....	–3,978
Budget authority and outlays, net:			
Mandatory:			
4090 Budget authority, gross	....	....	3,978
Outlays, gross:			
4100 Outlays from new mandatory authority	....	....	3,978
4180 Budget authority, net (total)	....	....	3,978
4190 Outlays, net (total)	....	....	3,978

Section 1402 of the Patient Protection and Affordable Care Act (P.L. 111–148) provides for reductions in cost sharing for certain individuals enrolled in qualified health plans purchased on the Exchanges, and section 1412 of the Patient Protection and Affordable Care Act (P.L. 111–148) provides for the advance payment of these reductions to issuers. This assistance helps eligible low- and moderate-income qualified individuals and families afford the out-of-pocket spending associated with health care services provided through Exchange-based qualified health plan coverage.

In total, the Administration requested almost $4 billion for the CSR program in FY 2014.[93]

[93] Office of Mgmt. and Budget, The Budget for the U.S. Government Fiscal Year 2014, Appendix 448 (Apr. 10, 2013).

CMS' budget justifications also explained how and why it requested nearly $4 billion for the CSR program. In its overview of the budget request, it states:

> CMS requests funding for its **five annually-appropriated accounts** including Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, Payments to the Health Care Trust Funds (PTF) and **beginning in FY 2014, Reduced Cost Sharing for Individuals Enrolled in Qualified Health Plans (Cost Sharing Reductions**.[94]

The budget justification further explains the request for the CSR program:

> **The FY 2014 request for Reduced Cost Sharing for Individuals Enrolled in Qualified Health Plans is $4.0 billion in the first year of operations** for Health Insurance Marketplaces, also known as Exchanges. CMS also requests a $1.4 billion advance appropriations for the first quarter of FY 2015 in this budget to permit CMS to reimburse issuers who provided reduced cost-sharing in excess of the monthly advanced payments received in FY 2014 through the cost-sharing reduction reconciliation process.[95]

CMS also stated in its conclusion that its "request includes funding for a new appropriation for reduced cost-sharing provided to individuals enrolled in plans through the Marketplaces, beginning in 2014."[96] The President's FY 2014 Budget and the CMS budget justifications submitted with the budget are clear: the Administration requested an annual appropriation for the CSR program.

3. OMB Submits its Sequestration Report to Congress

FINDING:	**According to OMB's April 10, 2013 sequestration preview report, the annual appropriation for the cost sharing reduction program would have been subject to a 7.3 percent reduction if the sequester went into effect.**

The Budget Control Act of 2011, as amended by the American Taxpayer Relief Act of 2012, required nearly across-the-board budget cuts for most annually appropriated programs.[97] Known as "sequestration," the cuts would reduce federal spending by more than $1 trillion over ten years. Most permanent appropriations—including the permanent appropriation for tax credits and refunds—were not subject to sequestration.[98] On April 10, 2013, the same day the President submitted his FY 2014 Budget, OMB sent Congress its *OMB Sequestration Preview Report to the President and Congress for Fiscal Year 2014 and OMB Report to the Congress on*

[94] U.S. Dep't. of Health and Human Servs., Ctrs. for Medicare and Medicaid Servs., Justifications of Estimates for Appropriations Committees, Fiscal Year 2014, at 2 (April 10, 2013) (emphasis added).
[95] *Id.* at 7 (emphasis added).
[96] *Id.*
[97] Budget Control Act of 2011, Pub. L. 112-25 (2011).
[98] 2 U.S.C. § 905(d).

the Joint Committee Reductions for Fiscal Year 2014.[99] Similar to other annual appropriations, the report confirmed that the CSR program would be subject to sequestration.[100]

Centers for Medicare and Medicaid Services					
009-38-0115 Affordable Insurance Exchange Grants					
Nondefense	Mandatory	Appropriation	1,343	7.3	98
009-38-0126 Reduced Cost Sharing for Individuals Enrolling in Qualified Health Plans					
Nondefense	Mandatory	Appropriation	3,978	7.3	290
009-38-0511 Program Management					
Nondefense	Mandatory	Appropriation	253	7.3	18
Nondefense	Mandatory	Spending authority	944	7.3	69
		Account Total	1,197		87

According to the OMB report, approximately 7.3 percent, or $290 million, of the annual appropriation for the CSR payments would be subject to sequestration and unavailable to pay insurance companies if the sequester went into effect. Under the terms of the ACA, however, the insurance companies still would be required to reduce cost sharing for qualified insurance purchasers. OMB's revised sequestration report, submitted to Congress on May 20, 2013, similarly reflected a 7.2 percent budget reduction for the CSR program.

At what point other agencies outside of OMB, including HHS, discovered that the CSR program would be subject to sequestration is unclear. But based on subsequent events, it is reasonable to assume that the sequestration report factored into the Administration's decision to find a separate source of funding for the CSR program—one that was not subject to sequestration.

4. The President Did Not Withdraw His Request for an Annual Appropriation for the CSR Program with a Budget Amendment

FINDING: The Administration did not submit a formal budget amendment withdrawing its request for the annual appropriation for the cost sharing reduction program.

The President submitted his FY 2014 Budget to Congress on April 10, 2013. On May 13, 2013, the Administration submitted a formal budget amendment.[101] That budget amendment, however, did not withdraw the original request for an annual appropriation for the CSR program.

[99] OFFICE OF MGMT. AND BUDGET, OMB SEQUESTRATION PREVIEW REPORT TO THE PRESIDENT AND CONGRESS FOR FISCAL YEAR 2014 AND OMB REPORT TO THE CONGRESS ON THE JOINT COMMITTEE REDUCTIONS FOR FISCAL YEAR 2014 (April 10, 2013) (OMB submitted a corrected version on May 20, 2013 that reduced the cut to the CSR program to 7.2 percent, or $286 million.).
[100] *Id.* at 23; Budget Control Act of 2011, Pub. Law No. 112-25 (Aug. 2, 2011).
[101] Letter from President Barack Obama to the Hon. John Boehner, Speaker, U.S. House of Reps. (May 17, 2013), enclosing Letter from Hon. Sylvia M. Burwell, Dir., Office of Mgmt. and Budget, to the President (May 16, 2013), enclosing amendments to FY 2014 Budget for various departments, including U.S. Dep't of Health and Human Servs., H. Doc. No. 113-31.

D. The Administration Informally Withdraws Its Appropriation Request by Phone

FINDING: Between April 10, 2013 and July 11, 2013, in an unusual move, the Administration informally withdrew its request for an annual appropriation for the cost sharing reduction program by calling the Senate Committee on Appropriations.

Although the budget amendment process is formal and documented, in this case, the Administration took an informal and undocumented route to withdraw the Administration's request for billions of dollars for the CSR program. Rather than including the withdrawal in the President's formal budget amendment submitted to Congress on May 17, 2013, Administration officials testified that the Administration informally withdrew the appropriation request via a telephone call to the then-Staff Director of the Senate Committee on Appropriations.

1. The Administration Tells the Court that it Informally Withdrew the Request by Not Requesting an Appropriation in its FY 2015 Budget Request

In the *House v. Burwell* litigation, the Administration claimed that it informally withdrew the request by not requesting the annual appropriation in its subsequent FY 2015 budget request to Congress. During oral argument, the Administration mentioned that it withdrew its request after it initially made the request based on principles of appropriations law. The Administration stated:

> There was initially a request and that request was later withdrawn because the administration took a second look and realized that there were principles of appropriations law that made the request unnecessary.[102]

After the oral argument, the Court took the unusual measure of requesting that the Administration provide evidence of how the Administration withdrew the request. The Court's Order directed the parties to:

> [S]ubmit a stipulated record of the request(s), consideration, and funding decisions for Section 1401 and 1402 of the Affordable Care Act in the FY 2014 Appropriation Bills, including **any action by the Defendant(s) to withdraw the funding request for Section 1402**, with supporting documentation.[103]

The Administration submitted a response to the Court, and, in a footnote, claimed that its statement during the oral argument referred to OMB not requesting an annual appropriation in the FY 2015 budget. The Administration stated:

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[102] *U.S. House of Reps. v. Burwell*, No. 14-cv-01967, Tr. of Rec. at 23 (D.D.C. May 28, 2015).
[103] *U.S. House of Reps. v. Burwell*, No. 14-cv-01967, Minute Order (D.D.C. June 1, 2015) (emphasis added).

> **The reference of a withdrawal is to OMB's submission of the Fiscal Year 2015 Budget, which did not request a similar line item.** Defendants' counsel did not intend to suggest that there was a separate formal withdrawal document, and apologizes for being unclear on that point.[104]

In other words, the Administration claimed that it implicitly withdrew its request for annual appropriation for the CSR program by not including it in its FY 2015 budget request to Congress, and not through a separate, explicit action, like a telephone call asking the Senate Appropriations Committee to remove it from the appropriations bill.

2. Assistant Secretary for Financial Resources Ellen Murray Calls the Senate Appropriations Committee

On July 11, 2013, the Senate Committee on Appropriations issued its report, which denied the Administration's request for an annual appropriation for the CSR program.[105] This is the only budget request impacting the Department of Health and Human Services denied by the Senate Committee on Appropriations. The report provided no reason or justification for denying the request. This report stated:

> REDUCED COST SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS
>
> | | |
> |---|---|
> | Appropriations, 2013 | .... |
> | Budget estimate, 2014 | $3,977,893,000 |
> | Committee recommendation | .... |
>
> The Committee recommendation does not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance for individuals enrolling in qualified health plans purchased through the Health Insurance Marketplace, as provided for in sections 1402 and 1412 of the ACA.
>
> This program helps eligible low- and moderate-income individuals and families afford the out-of-pocket costs associated with healthcare services.

Ms. Murray, however, knew that the committee would deny the Administration's appropriation request before it issued its report. She testified:

> Q. Were you aware before that report was released on July 11 that the Senate Appropriations Committee would not be [recommending an appropriation for the CSR program]—
>
> A. Yes.

[104] *U.S. House of Reps. v. Burwell*, No. 14-cv-01967, Joint Submission in Response to This Court's June 1, 2015 Minute Order (D.D.C. June 15, 2015) (emphasis added).

[105] S. Comm. on Appropriations, *Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2014*, 113th Cong. (S. Rept. 113-71).

Q. You knew before the report. When did you know?

A. I spoke to the staff director, Erik Fatemi.

Q. Roughly when?

A. To the best of my recollection, the June or July timeframe.

Q. But it was before that report was released?

A. Correct.

Q. Is that one conversation with Mr. Fatemi or were there several?

A. I can remember one specific conversation.

Q. **What do you recall about that conversation?**

A. **I called Mr. Fatemi and said they would not need an appropriation for the Cost Sharing Reduction Program.**[106]

Although the Administration had formally asked for an annual appropriation in its FY 2014 budget request to Congress, it suddenly determined it no longer needed one. Ms. Murray stated:

Q. Did you provide an explanation to Mr. Fatemi about why an appropriation was not necessary?

HHS Counsel. Thank you.

Witness: Yes, we did. Yes, I did.

Q. What explanation did you provide to him?

A. I told him that there was already an appropriation for the program, and we did not need the bill to include one.[107]

Mr. Fatemi did not ask why the Administration no longer wanted the annual appropriation for the CSR program. Ms. Murray testified:

Q. What did you say would be the appropriation for the CSR program?

[106] Murray Tr. at 35–36 (emphasis added).
[107] *Id.* at 37.

A. I do not believe I was specific with Erik Fatemi, and he did not ask.

Q. Did you tell him anything about the basis for that decision?

A. I did not.

Q. And he did not even question –

A. I did not.

Q. He did not ask you any questions about what money would be used to fund that program?

A. He did not.[108]

Assistant Secretary Murray amended the President's FY 2014 budget request by calling the Senate Appropriations Committee to withdraw an appropriations request. The Administration could have withdrawn its request through the formal budget amendment process. Instead, it unusually withdrew the request through a phone call, leaving no record of the "amendment." In fact, it is so rare that Assistant Secretary Murray cited only this example—withdrawing the request for an annual appropriation for the CSR program via a telephone call to the Senate Appropriations Committee—as a way to informally amend the President's budget request. She stated:

Q. So if a request for supplemental funds is requested, that would be an amendment to the budget request?

A. That would be a budget amendment, yes.

Q. **What if the administration decides it no longer needs funds for something, would that also require a budget amendment request?**

A. **That request could be made to the Hill through a budget amendment, or through a less formal means.**

Q. **Could you describe the less formal means there which that could be [r]elayed?**

A. **That could be done simply as I decided with the CSR program, where I made a call to the appropriations clerk.**[109]

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[108] *Id.* at 55.
[109] *Id.* at 72–73 (emphasis added).

Additionally, HHS General Counsel William Schultz was not even aware of "less formal means" to amend the President's budget request. Mr. Schultz testified:

> Q. But do you specifically – are you specifically aware of any less formal ways that revise or change a budget request?
>
> A. I'm not sure what you mean.
>
> Q. Sure. So my understanding, and I'm not a budget expert, is that there is a formal amendment process by which the Administration can change its budget request. We've also learned that there are less formal ways, such as phone calls, to change a budget request. So are you aware of any less formal ways?
>
> A. I mean, I wouldn't have any knowledge of that.[110]

Although the Administration requested an annual appropriation for the CSR program in its FY 2014 budget request to Congress, it decided shortly after submitting that budget request—which took almost a year to draft and prepare—that it no longer needed one. Instead of including this withdrawal in its formal budget amendment, the Administration chose to wipe out a request for billions of taxpayer dollars through an undocumented, informal telephone call the Senate Committee on Appropriations. This unusual move ensured that there was no record that the Administration had changed its mind about how to fund the CSR program.

3. The Administration has Meetings and Makes Phone Calls Before the Senate Appropriations Committee Denies the Appropriation Request

Prior to the Senate Committee on Appropriations denying the appropriations request for the CSR program, and prior to Ms. Murray calling the committee to withdraw the request, but after the FY 2014 budget request was submitted to Congress, high level officials within the Administration held meetings and had telephone conversations about the CSR program. Despite shaky memories and the Administration's obstruction, this investigation shed light on some of these conversations. Ms. Murray recalled one conversation with HHS General Counsel William Schultz. She testified:

> Q. Did any meetings take place between April 10 of 2013 [and] your conversation with the Senate Appropriations staff director about the Cost Sharing Reduction Program?
>
> A. Yes.
>
> Q. When did those meetings take place?

[110] H. Comm. on Energy & Comm., Transcribed Interview of William Schultz, at 60–61 (Apr. 26, 2016) [hereinafter Schultz Tr.].

A. I can't give a specific date but within that time period.

Q. Was it May?

A. I don't remember a specific date.

Q. Do you recall the number of meetings?

A. I do not. I remember one specific conversation.

Q. Was that conversation with one individual or with multiple individuals?

A. With one.

Q. Do you recall any other conversations around that time about the appropriation requests for the Cost Sharing Reduction Program?

A. Again, I'm trying to be responsive but very careful not to misspeak, and I don't have any other specific recollections of conversations or meetings.

Q. **The conversation you recollect, was that with an HHS official?**

A. **Yes, it was.**

Q. **Who was that official?**

A. **General counsel, William Schultz.**

Q. And that conversation between you and Mr. Schultz was about the Cost Sharing Reduction Program and about whether or not it needed an annual appropriation?

HHS Counsel. So if you stopped your question after the first part, she would be able to answer that question.

Committee Counsel. If I stopped it at Cost Sharing Reduction Program?

HHS Counsel. Yes.

Q. Was that conversation about the Cost Sharing Reduction Program?

A. Yes.

Q. Was it about the fiscal year 2014 budget request?

HHS Counsel. That is, I think, crossing the line into internal deliberations.[111]

Ms. Murray also recalled another conversation with someone from the Executive Office of the President, but HHS counsel would not allow her to provide the name of this person. Ms. Murray stated:

Q. Do you recall any conversations with – about the Cost Sharing Reduction Program before or after that report in the summer of 2013 with anyone outside of HHS, apart from the Senate Appropriations staff director?

A. I do.

Q. With whom, or with what agency or capacity were they in?

A. With the office of the – Executive Office for the President.

Q. Did you have any other conversations with anybody from Congress about the Cost Sharing Reduction Program in the summer of 2013?

A. Not to my recollection.

Q. Do you recall when the conversation with the Executive Office of the President took place?

A. I do not.

Q. Was it after the Senate report was released in July?

A. It was before.

Q. **Do you recall who the conversation was with?**

HHS Counsel 1. **You can answer that.**

Witness. **Yes, I do.**

Q. **Who was the conversation with?**

HHS Counsel 1. **Again, because of our deliberative interests in maintaining executive branch confidentiality, Ms. Murray is not prepared to answer that question today.**

[111] Murray Tr. at 41–42 (emphasis added).

Q. **This conversation was with—this conversation was with somebody from the Executive Office of the President was [regarding] the Cost Sharing Reduction Program, correct?**

A. **Yes, it was.**[112]

Despite the Administration's refusal to provide information to Congress and allow witnesses to answer Congress' questions, this investigation has yielded evidence suggesting that the key decision-making about how to fund the CSR program likely occurred between April 2013 and July 2013. The Administration requested an annual appropriation for the CSR program in its FY 2014 budget request submitted to Congress on April 10, 2013. On that same day, OMB submitted its sequestration preview report to Congress stating that the CSR program would be cut by 7.3 percent in the event of sequestration. On July 11, 2013, the Senate Committee on Appropriations denied the request. Between April 10 and July 11, Assistant Secretary Murray called the Senate Committee on Appropriations to withdraw the Administration's request for an annual appropriation. Also during that time, Ms. Murray had a least one conversation with the Executive Office of the President and at least one conversation with HHS General Counsel William Schultz about the CSR program.

[112] *Id.* at 63–64 (emphasis added).

VI. The Administration Surreptitiously Raids a Permanent Appropriation to Pay for the Cost Sharing Reduction Program

A. OMB Drafts a Memorandum to Justify Paying for the Cost Sharing Reduction Program through the Premium Tax Credit Account

FINDING: OMB prepared a memorandum that provided the Administration's legal analysis and justification for funding the cost sharing reduction program through the premium tax credit account.

OMB attorneys prepared a memorandum, which allegedly provided the legal basis for the decision to make CSR payments from the premium tax credit account. The Administration has refused to provide this memorandum to Congress—even pursuant to subpoena. Nevertheless, Administration witnesses made it clear during transcribed interviews and a deposition that this memorandum was key to obtaining buy-in from the highest levels of the Administration to move forward with paying for the CSR program through the PTC account.

1. OMB Looks for Sources of Funding for the Cost Sharing Reduction Program

By June 2013—shortly after OMB submitted its sequestration report and around the same time Assistant Secretary Ellen Murray called the Senate Committee on Appropriations to informally withdraw the Administration's request for an annual appropriation—OMB began developing a legal justification to justify an alternative source of funding for the CSR program. In June 2013, Geovette Washington became OMB's General Counsel. Soon after, Ms. Washington became aware that "there were questions about the funding that was available for the cost sharing program."[113] One of her staff counsels, Sam Berger, briefed her on the issue. Ms. Washington stated:

Q. Are you familiar with the Affordable Care Act Cost Sharing Reduction Program?

A. Yes.

Q. In what context?

A. During my time at OMB, there were questions about the funding that was available for the cost sharing program.

[113] H. Comm. on Ways & Means, Transcribed Interview of Geovette Washington, at 20 (May 6, 2016) [hereinafter Washington Tr.].

Q. When did those questions first arise?

A. I first became aware that this was an issue right after I arrived at OMB.

Q. Who made you aware of the issue?

A. My staff briefed me on this issue that they had been working on before I arrived, and I don't recall. It would have been Sam [Berger].[114]

Ms. Washington and Mr. Berger also worked with other agencies affected by this issue. Ms. Washington stated that Mr. Berger worked directly with the HHS General Counsel's Office. She testified:

Q. Do you know if [Sam Berger] was working with anyone outside of OMB on the issue?

A. Yes.

Q. With whom?

A. So as a matter of course, because this is an issue that would have involved other agencies, he would have been working—as a general matter, we would work with the agencies that were involved, and my memory is that he had been in discussions with other the relevant agencies on the issue.

Q. When you say the relevant agencies, was he in communication with HHS?

A. Yes.

Q. **Do you know with whom in HHS?**

A. **We worked with the General Counsel's Office at HHS.**

Q. **Do you recall any of the names of those individuals?**

A. **My primary contact would have been the general counsel, Bill Schultz.[115]**

[114] *Id.* at 20–21.
[115] *Id.* at 22–23 (emphasis added).

Ms. Washington testified that she spoke directly with the HHS General Counsel, William Schultz, as well as the Treasury General Counsel's Office about the source of funding issue for the CSR program. She stated:

> Q. Did you talk directly with Mr. Schultz?
>
> A. Yes.
>
> Q. Did you talk with anyone at Treasury?
>
> A. Yes.
>
> Q. With whom over there?
>
> A. I would have worked with people in the General Counsel's Office over there.
>
> Q. Do you recall the names of those people?
>
> A. God, my memory is bad. Chris Meade, the general counsel.[116]

HHS General Counsel William Schultz also remembers discussing the CSR program with Ms. Washington during the summer and fall of 2013. Mr. Schultz testified:

> Q. Going back to my question, you said that you recalled having discussions or conversations during the summer or fall, late 2013, with folks both at the White House and OMB. What are the names of the OMB officials that you recall having meetings with?
>
> A. The one I recall is with general counsel, Geovette Washington. I think there are others, but I don't even know their names.
>
> Q. Do you recall how many times you met with Geovette Washington?
>
> A. No.
>
> Q. Was it more than once?
>
> A. Yes.
>
> Q. Do you recall generally when you met with Ms. Washington?
>
> A. You mean what timeframe?

---

[116] *Id.* at 23–24.

Q. Yes.

A. I mean, generally, it's in the timeframe you're talking about, the summer or fall of 2013.[117]

Ms. Washington also consulted with the Department of Justice regarding the source of funds for the CSR program, although OMB counsel refused to allow Ms. Washington to provide the names of those with whom she consulted.[118] Ms. Washington stated:

Q. Did you ever talk with anyone at the Department of Justice about the Cost Sharing Reduction Program?

A. Yes, I did.

Q. Do you remember if those conversations occurred before or after the January 14th [*sic*] meeting that we've discussed at length today?

<u>OMB Counsel</u>: Ms. Washington has acknowledged that she consulted or discussed this with the Department of Justice, but she is not going to discuss individual interactions that she had with the Department of Justice.[119]

Ultimately, Ms. Washington stated that she "recall[ed] conversations with officials at the Department of Justice about cost sharing reductions in 2013."[120] Ms. Washington's testimony clarifies OMB's role in addressing the source of funding issue for the CSR program: although OMB consulted with other agencies, including HHS, Treasury, and the Department of Justice, OMB took the lead in identifying a source of funding to make the CSR payments.

2. <u>OMB Prepares a Memorandum that Allegedly Supports Funding the Cost Sharing Reduction Program Using the Appropriation for Tax Credits and Refunds</u>

At some point in 2013, OMB drafted a memorandum that allegedly explained the legal basis for making CSR payments from the 31 U.S.C. § 1324 permanent Treasury appropriation dedicated to tax credits and refunds.[121] Former OMB General Counsel Geovette Washington explained the purpose of the memorandum. She testified:

[117] Schultz Tr. at 39.
[118] Washington Tr. at 87.
[119] *Id.* at 85.
[120] *Id.* at 87.
[121] *See* Fisher Depo. at 28, 50; Washington Tr. at 44–45.

Q. In some cases, a high level official has to sign off on the course of administrative actions. In order to make the cost sharing reduction payments, was signoff on the memo necessary?

A. Can I ask you a question about your question?

Q. Of course.

A. So in the course of my time in the government, there were processes – clearance processes is what we called them. Before you could … say, the director could take action, people had to sign.

Is that the type of process you're asking me?

Q. Exactly.

A. No. That was not the purpose of this memo.

Q. What was the purpose of the memo?

A. The purpose of the memo was to discuss the available funding for the Cost Sharing Reduction Program.[122]

Ms. Washington acknowledged that the memorandum was addressed to her. She stated:

Q. To whom was the memo addressed then?

A. The memo was addressed to me.

Q. And who wrote the memo?

A. The memo was from members of my staff.

Q. Do you recall which members?

A. Sam Berger, John Simpkins, and Steve [Aitken].

Q. Did you help edit this memo?

OMB Counsel. Ms. Washington is not going to discuss the drafting or editing of the memo.[123]

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[122] Washington Tr. at 49–50.
[123] *Id.* at 44–45.

This memorandum was integral to the Administration's decisions regarding funding the CSR program. It became the legal basis on which the Administration depended to justify making CSR payments from an appropriation meant to pay for tax credits and refunds, and it was reviewed and approved by the highest levels of the Administration.

3. OMB Shows the Memorandum to the Treasury and HHS General Counsel Offices

FINDING: OMB shared its memorandum with both the Treasury and HHS general counsel offices in late 2013.

After OMB prepared its memorandum, it shared it with different agencies at meetings held at OMB. These in-person meetings appeared to occur in late 2013. For example, OMB showed the memorandum to the Treasury's General Counsel's Office. Ms. Washington stated:

Q. When did you show this memo to people at Treasury?

A. I don't recall the time.

Q. Did you E-mail it to them?

A. No.

Q. Did they see it in person?

A. Yes.

Q. Do you recall who from Treasury saw the memo?

A. I don't recall, but I was talking to people in the General Counsel's Office. Our contact on – generally, on matters when we're talking about appropriations issues, we deal primarily with the General's Counsel Office. As I previously testified, I was talking to people in the General Counsel's Office.

My practice would have been to talk to people – if I was going to the share the final memo with people, it would have been people in the General Counsel's Office.

Q. Was that before this meeting, the January 13, 2014 meeting?

A. I believe, yes. Yes.[124]

OMB also shared it with the HHS General's Counsel's Office. Ms. Washington testified:

[124] *Id.* at 42–43.

Q. When did you show the memo to people at HHS?

A. I don't recall a time. I don't recall a date.

Q. Was it before this meeting?

A. Yes.

Q. And to whom did you show it at HHS?

A. So the memo, the final memo, would have been shared with someone in the General Counsel's Office. Let me be clear. I'm not sure that I – because I don't recall a specific meeting, I'm not sure that I'm the person who did it. It may have been someone on my staff who did it.

Q. Would Sam Berger be the person on your staff most likely to do that?

A. Mostly likely, it would have been Sam.[125]

HHS General Counsel William Schultz also acknowledged reviewing OMB's memorandum. He testified:

Q. How did you receive a copy of the memorandum?

A. I didn't receive a copy. I reviewed it.

Q. Where did you review the memorandum?

A. At OMB.

Q. Were you given a copy to take with you from OMB?

A. No. No.

Q. Do you recall when, approximately, you reviewed the memorandum at OMB?

A. I believe it would be in the fall, maybe late fall of 2013.

Q. Were any other HHS employees with you when you reviewed the memorandum?

A. I don't know for sure, but it's likely that Ken Choe was there, my

[125] *Id.* at 43–44.

deputy.

Q. Do you recall if anyone from other agencies were present when you reviewed the memorandum?

A. No. I don't recall anybody else from another agency.

Q. It was just yourself and Mr. Choe?

A. From outside OMB.

Q. Okay. Do you recall which OMB officials were present?

A. I recall Geovette Washington.[126]

Administration lawyers would not allow witnesses to answer more questions about the review of OMB's memorandum.

4. Attorney General Eric Holder Reviews OMB's Memorandum

FINDING: OMB shared its memorandum with Attorney General Eric Holder in late 2013 and briefed him on the issue.

At some point during this process in fall or winter 2013, Ms. Washington briefed Attorney General Eric Holder on the CSR funding issue. He also reviewed and signed off on the analysis contained in OMB's memorandum. Former IRS Chief Risk Officer David Fisher testified that he recalled that Attorney General Eric Holder had reviewed and approved the memorandum. In an exchange with Congressman Jim McDermott, Mr. Fisher stated:

Q. Do you know specific names of individuals who reviewed and approved the memo?

A. The only name that I recall that was mentioned was Eric Holder, the Attorney General.

***

Mr. McDermott. This document you held, was there at any point anyplace where people's initials had been put on it as having read it or approved it or anything?

Frequently, in the Federal Government, people have to sign off on stuff—

[126] Schultz Tr. at 41–42.

The Witness. Yep.

Mr. McDermott. —before it comes to a meeting. Did you see any formal acknowledgment by anybody that they had actually read this and approved it?

The Witness. On the document, no. There was the comment – I don't recall seeing anything to that effect on the memo. The reference to the Attorney General was made verbally. It was not noted on the memo.

Mr. McDermott. Made by whom?

The Witness. Ms. Washington.

Mr. McDermott. Ms. Washington said, "The Attorney General has seen this and approves of it"?

The Witness. It stood out in my mind only because there was sort of a lighthearted comment along those lines, that it appeared to be this was the first time she had met the Attorney General. And she was relatively new to OMB. And it stood out in my mind that it sort of made an impression on her, the fact that she had an opportunity to brief the Attorney General himself.

So that was really the only reason that it's a recollection of mine, is that she had made this sort of anecdote along the lines of having had the first opportunity to brief the Attorney General personally. That was the only reason his name, I believe, came up.[127]

5. White House Meetings Regarding the Cost Sharing Reduction Program

Administration officials appear to have discussed the CSR program in meetings at the White House. For example, former HHS General Counsel William Schultz testified:

Q. Do you recall who those conversations were with at either the White House or OMB during this time period?

A. Well, I recall some people they were with, yeah.

Q. Who were these people?

HHS Counsel. **He's not going to get into participants in White House**

[127] Fisher Depo. at 31–33.

meetings.

Committee Counsel. Why?

HHS Counsel. We have certain Executive Branch confidentiality interests.[128]

Similarly, former OMB General Counsel Geovette Washington testified:

Q. Exhibit 7 is another White House Visitor Record Request from November 27th at 11 a.m. with Mr. Choe, Mr. Delery, Mr. Gonzalez, Mr. Meade, Mr. Schultz, Mr. Verrilli. Do you remember attending a meeting on November 27, 2013 at the White House with those persons I just listed?

OMB Counsel. As I mentioned, the Executive Branch has significant confidentiality interests in internal discussions or interagency deliberations and Ms. Washington is not going to discuss interagency deliberations today.

Q. The committee disagrees that the question has called for any kind internal deliberations at all, just merely the existence of the meeting. Are you willing to answer whether or not you attended a meeting with those individuals listed?

A. I am not authorized to answer that question today.[129]

White House Visitor Access Records indicate that another meeting with the same participants took place the day prior, on November 26, 2013.[130]

Because the Administration refused to provide any information about meetings at the White House regarding the CSR program, this investigation has been unable to confirm whether the source of funds for the CSR program was a topic of discussion at these meetings.

[128] Schultz Tr. at 33–34 (emphasis added).
[129] Washington Tr. at 87–88.
[130] White House Visitor Access Records released 2013, *available at* https://www.whitehouse.gov/briefing-room/disclosures/visitor-records.

6. The IRS Expresses Concerns about the Cost Sharing Reduction Program's Source of Funds

FINDING:	Some senior IRS officials raised concerns about the source of funding for the CSR program.

As OMB was preparing and vetting its legal memorandum both internally and with other agencies, senior officials at the IRS expressed concerns about the funding source for the CSR program. For example, IRS employees raised questions about establishing sufficient IRS audit trails, especially because CMS would be directing CSR payments out of an IRS-managed account. Former IRS Chief Risk Officer David Fisher explained:

> And there was a concern, an internal control concern, as well, just from an accounting standpoint, of an auditor looking for the full audit trail, as I believe IRS was getting summary information and the details were going to be in the HHS books, if you will. **And so there was already some confusion and concern about IRS from an audit standpoint, about being able to trace these payments all the way back to the source, which is fundamental for a financial audit.**[131]

IRS officials also expressed confusion over whether the funds for the CSR payments would be subject to the sequester. In late fall 2013, Mr. Kane approached both the Chief Risk Officer and the IRS Chief Counsel's office to express those concerns. Mr. Fisher testified:

> Q. Do you recall the first time that you heard of the cost-sharing reduction program generally?
>
> A. It would have been fall of 2013, late fall of 2013.
>
> Q. In what context did you become aware of it?
>
> A. There was a discussion I had with the Deputy Chief Financial Officer at the IRS regarding some, at the time, sort of accounting-related issues associated with the pending payments that would come from the cost-sharing program when that program would start, which I believe was the end of January 2014, was when the first payment was due.
>
> As the Chief Risk Officer, I am commonly engaged with senior leaders from around the IRS. **And there was a potential concern about these payments. So it was from the Deputy Chief Financial Officer's perspective.**

---

[131] Fisher Depo. at 19 (emphasis added).

Q. And the Deputy Chief Financial Officer was at that time Gregory Kane?

A. Correct.

Q. Do you recall specifically what month he approached you?

A. No. It would have been late fall, probably October, maybe November.

Q. What concern did Mr. Kane raise to you about the CSR program?

A. The concern was related to sequestration. And in his role, as planning for the potential sequester, he needed to identify all funding sources that needed to have the sequester applied against it. **And he raised a little confusion about the funding source for the cost-sharing program, as to whether or not that source was going to be subject to sequester or not subject to sequester.**[132]

Mr. Fisher further stated:

> It was [Deputy Chief Financial Officer Greg Kane's] understanding that HHS either had or was going to submit a budget request – or, through the budget process, a request for an appropriation for the cost sharing program. That would be subject to sequester.
>
> And it's relevant to the IRS because the IRS is the one who's actually, quote, writing the check, if you will, disbursing the funds. The way the law was written, HHS identifies the need for a payment to the Treasury. Treasury then has the IRS go make the payment. But, from an accounting standpoint, payment is on the IRS's books. And, therefore, the IRS would need to decide whether or not to sequester those funds if sequestration kicked in.
>
> The original understanding, I believe, from Mr. Kane was that these funds were going to be appropriated funds and, therefore, subject to the sequester. **But it had recently come to his attention that the budget request, I believe, had been withdrawn and that the expectation was that these payments would come out of the permanent appropriation, from which refunds and other credits like the Advance Premium Tax Credit would be paid. And that appropriation is not subject to sequester.**
>
> **So this was entirely an accounting related discussion related to, you know, appropriations law, as to whether or not the payments for this**

[132] *Id.* at 12–13 (emphasis added).

> **part of the Affordable Care Act would be subject to sequestration.** And he wasn't exactly sure because of what he saw as somewhat of a shift in where the funds had originally been planned to come out of, which would've been subject to the sequester, to now this change in thought process which would no longer make it necessary to sequester any of those funds.[133]

Around that same time, Mr. Kane also expressed his concerns to IRS Deputy Associate Chief Counsel Linda Horowitz. Ms. Horowitz testified:

> Q. Has anyone come to you with questions about the cost sharing reduction program?
>
> A. Yes.
>
> Q. Did those questions pertain to how the payment process was set up?
>
> A. Generally, yes.
>
> Q. Who came to you with questions?
>
> A. The CFO Office.
>
> Q. Do you recall whom within the CFO Office?
>
> A. I think it was Greg Kane, the deputy CFO.
>
> Q. When did he come to you with those questions?
>
> A. I think in December of 2013.
>
> Q. Did he first approach you in person or over email or by telephone?
>
> A. I'm not sure.
>
> Q. After the initial approach, did you communicate with him any more about the cost sharing reduction program?
>
> A. Yes.
>
> Q. How did those communications take place?
>
> A. I think they were telephonic, but I'm not – I can't be certain.

---

[133] *Id.* at 16–17 (emphasis added).

Q. At a high level, would you describe why he was coming to you personally about those issues?

A. So he came to me because I work with Greg on a lot of fiscal law issues. We have a, you know, client/attorney relationship. So he came to me on that particular issue with regard to the source of funding for those payments.[134]

According to Ms. Horowitz, Mr. Kane's questions were related to the source of funding for the CSR program. Ms. Horowitz testified:

Q. You had indicated that there were questions about the source of the funding as the general kind of parameters of the issue. Is that the same issue that was discussed both in 2010 [with OMB] and in 2013 [with Mr. Kane]?

A. Yes.

Q. And when you say "source of funding," is it a larger question of kind of the traditional source of funding as an issue of appropriations law when, as you discussed, when describing fiscal year law, or was it a question of more the mechanical which account makes payments?

A. At what time?

Q. Either. How about 2010?

A. In 2010, I think it was simply the question of the source of the funding.[135]

In late 2013, the discussions initially revolved around whether CSR payments would be subject to the sequester. According to Mr. Fisher, in the beginning of 2014, the discussion shifted to a broader question regarding the legality of using the premium tax credit appropriation to make CSR payments. Mr. Fisher testified:

Q. Did the questions about the sequester expand into broader questions about appropriations law from late 2013 to the beginning of 2014?

A. Yes.

Q. Do you understand how that expansion occurred?

---

[134] Horowitz Tr. at 18–19.
[135] *Id.* at 21–22.

A. I could sort of track the evolution. How it occurred, I don't know.

Q. You said you could track the evolution?

A. Well, I mean, if the question is what was the nature of the change or evolution of the discussion regarding appropriations law associated with the cost sharing reduction payments, I can recall how it evolved. I don't remember, sort of, who, what, when in terms of what instigated it or things along those lines. So that was what I thought your initial question was. So that one, the answer is no.

Q. Would you describe how it evolved?

A. Sure.

Given our understanding that the intent was to use the permanent appropriation, then the sequestration question was no longer – it was moot, because the permanent appropriation is not subject to sequester. So any concerns related to sequestration and the accounting for it and those kinds of things that had been the genesis of some of the early discussions were no longer relevant.

The question at hand became whether or not the statute actually authorized, appropriated those dollars using the permanent appropriation. And as we said just before the break, there was question on the cost sharing reduction payments. There was no question on the Advance Premium Tax Credit, which, as outlined in section 1401 of the Affordable Care Act, which introduces section 36B of the Internal Revenue Code under the section I had previously highlighted, was clear in the intent, expectation, and authorization to use the permanent appropriation as the funding source, the account for the Advance Premium Tax Credits.

In section 1402 that describes the cost sharing reduction payments, there was no such reference to the Internal Revenue Code. Actually, as I recall reading last night, there was one reference to section 36B of the Internal Revenue Code in section 1402, but it was a definitional point about defining what an individual is or something like that. It had nothing to do with payments. So there was a reference to the Internal Revenue Code but not in the kind that you would, I think, naturally interpret as meaning, "Go use the permanent appropriation based on this." It was simply a definitional reference.

> **Other than that, there was nothing clear in the statute that I believe the accounting folks are always looking for. Before they go, you know, touch that permanent appropriation, they want to make sure that that is legally authorized.**[136]

According to Mr. Fisher, Mr. Kane was concerned about the use of the permanent appropriation as a source of funds for the CSR program because such a use was contrary to his experience. Mr. Fisher testified:

> [I]n Mr. Kane's experience—and he's been at the IRS for a long time—was that **every time the use of the permanent appropriation for a new credit had come about, it had been explicitly referenced in the statute**, just like it was for the Advance Premium Tax Credit, but, to our reading in the next section, was not done for the cost-sharing reduction payments.[137]

7. Top IRS Officials Attend a Meeting at OMB to Review the Memorandum

FINDING:	**OMB shared its memorandum with IRS officials in a meeting weeks before the first cost sharing reduction payments were to be made. The IRS officials were not permitted to take notes at the meeting or take a copy of the memorandum with them.**

After IRS officials raised concerns about how the Administration planned to fund the CSR program, OMB organized a meeting to allow several IRS officials to review its memorandum providing the Administration's legal justification for the sources of funds. At the meeting, the IRS officials were given an opportunity to review the memorandum, but were not permitted to take notes or take the memorandum with them. After reviewing the memorandum, the officials were given an opportunity to ask some questions. The answers provided by OMB did not alleviate everyone's concerns that this was a correct and legal course of action.

a. The Purpose of the Meeting

The first CSR payments were supposed to be paid to insurance companies at the end of January 2014.[138] Yet, in early January, IRS officials still had concerns about the source of funding for the payments. Around this time, IRS General Counsel William Wilkins reached out to OMB General Counsel Geovette Washington regarding the source of funding for the CSR payments. Shortly after Mr. Wilkins reached out to her, Ms. Washington invited IRS officials to meet with her at the Old Executive Office Building. The meeting took place on January 13, 2014. The IRS officials in attendance were: IRS General Counsel William Wilkins, Chief Financial Officer Robin Canady, Deputy Chief Financial Officer Greg Kane, Chief Risk Officer David Fisher, Associate Chief Counsel Mark Kaizen, Deputy Associate Chief Counsel of

[136] Fisher Depo. at 52–54 (emphasis added).
[137] Fisher Depo. at 63 (emphasis added).
[138] Kane Tr. at 40.

General Legal Services Linda Horowitz and Chief of Ethics and General Law Branch of General Legal Services Kirsten Witter.[139] Several OMB officials also attended including OMB General Counsel Geovette Washington and OMB lawyers Sam Berger, Steve Aitken, and John Simpkins.[140] Mr. Wilkins testified:

> Q. I'll represent that this is a printout of several of the columns from the White House visitors log from January 13, 2014.
>
> Do you see your name here on this list in the highlighted portion?
>
> A. Yes.
>
> Q. Do you recall this meeting at the White House?
>
> A. It was in the Old Executive Office Building, but yes. I do recall it.
>
> Q. Sorry. Apologies. It is the White House visitors log, but you're right. It is the OEOB, as noted on the visitors log.
>
> Do you recall the purpose of this meeting?
>
> A. Yes.
>
> Q. **What was the purpose of this meeting?**
>
> A. **The purpose was to hear from the general counsel of Office of Management and Budget on legal analysis surrounding appropriations for cost sharing payments.**
>
> Q. Who was the general counsel of the Office of Management and Budget at that time?
>
> A. Geovette Washington.
>
> ***
>
> Q. **Who initiated this meeting?**

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[139] White House Visitors Access Records released 2014*, available at* https://www.whitehouse.gov/briefing-room/disclosures/visitor-records.

[140] Washington Tr. at 51; *see also* H. Comm. on Ways & Means, Transcribed Interview of David Fisher, at 16–17 (May 3, 2016) [hereinafter Fisher Tr.]; H. Comm. on Ways & Means, Transcribed Interview of William Wilkins, at 53 (Mar. 17, 2016) [hereinafter Wilkins Tr.]; H. Comm. on Ways & Means, Transcribed Interview of Mark Kaizen, at 18–19 (Apr. 15, 2016) [hereinafter Kaizen Tr.].

A. **I believe that invitation came from Geovette Washington, but I had earlier put in a call to her which may have led to the invitation.**

Q. **Did you ask her to hold this meeting?**

A. **No.**

Q. **But is it fair to say that a conversation between you and her prompted this meeting?**

A. **Yes.**

Q. Do you recall how far in advance you spoke with her before January 13?

A. Only a few days. Less than a week.[141]

Ms. Washington also recalled the meeting. She stated:

Q. Do you recall why this meeting was initiated?

A. Yes.

Q. Why was this meeting initiated?

A. The first payments on the Cost Sharing Reduction and Premium Tax Credit Programs were needing to be made at the end of January. **We at OMB had discussed the final – shown the final memo to people in the office at Treasury and at HHS and we needed to show the memo to the people at IRS so that they could understand the rationale for the payments.**[142]

Mr. Fisher was not originally invited to attend the meeting at OMB. After learning about the meeting, however, he requested to attend because he believed, as the Chief Risk Officer, he should attend. Mr. Fisher explained:

A. But I think my insights to that point had led me to believe that there was at least some risk here and it was appropriate for the Chief Risk Officer to be involved in the discussion and requested that I be permitted to attend. And that was, you know, approved without any difficulty, and the Chief Counsel made those arrangements for me to attend.

[141] Wilkins Tr. at 52–54 (emphasis added)..
[142] Washington Tr. at 42 (emphasis added).

So it would have been an informal understanding sometime during the week leading up to the meeting. And then I suggested that I think the Chief Risk Officer should be there. That request was granted without questions.

Q. What was the risk, specifically, that you identified?

A. **Entirely related to appropriations law and whether or not the utilization of the permanent appropriation for the cost-sharing program had been appropriately appropriated by the law, you know, through the vehicle of the statute. And that was, I'll say, unclear at the time. And that was the purpose, that we were going to go understand the administration's thought process in coming to the conclusion that, yes, that could be used.**

Q. At the January 13th, 2014, meeting.

A. That was really the purpose of that meeting.[143]

Mr. Fisher further explained that he believed the meeting was held to address the IRS' concerns about how the CSR program would be funded. In an exchange with Congressman Jim McDermott, he testified:

Mr. McDermott. Just to follow up on Mr. Roskam's question, why do you think that meeting occurred?

The Witness. The meeting at the Office of Management and Budget?

Mr. McDermott. Yes. Yes.

The Witness. So it was set up prior to my even knowing about the meeting, but my understanding, through the accounting folks, is that the IRS had raised some concerns and was looking for, whether it was a legal analysis or – something more authoritative that would provide confidence that these payments were, in fact, authorized out of the permanent appropriation.

Because that – my understanding of past practice had been, every time the permanent appropriation had been referenced and utilized for credit payments or for refunds because that's what it's for, is for refunds and credit payments, specific credit payments – there had always been a discrete update to the Internal Revenue Code. It's my understanding that it always occurred.

***

[143] Fisher Depo. at 25–26 (emphasis added).

> **And we, the IRS, were looking for the administration's perspective on this. From an appropriations law standpoint, is this an appropriate thing, to use the permanent appropriation?**[144]

These senior IRS officials were understandably concerned about the legality of making the CSR payments through a permanent appropriation. Hearing of these concerns, OMB called the meeting to provide these IRS officials the Administration's legal justification for doing just that—raiding a permanent appropriation to make the CSR payments.

b. What Happened at the Meeting

The January 13, 2014 meeting took place at the Old Executive Office Building at the White House complex. OMB officials distributed hard copies of the OMB memorandum to the IRS officials and gave them a chance to review it. After the IRS officials reviewed the memorandum, they were given an opportunity to ask some brief questions before the meeting concluded. Mr. Fisher testified:

> Q. Could you describe what happened at that meeting?
>
> A. So a bunch of us went in vans from the IRS to the Old Executive Office Building. We were taken into the General Counsel's conference room. There were some brief introductions of the IRS attendees and the OMB attendees.
>
> We were given a memo to read. **We were instructed we were not to take notes and we would not be keeping the memo, we'd be giving it back at the end of the meeting. But we had an opportunity to read the detailed memo identifying why – or justifying the payments out of the permanent appropriation.**
>
> The OMB team left the room. The IRS team stayed in the room. We all individually read the memo. At the end of that, the OMB people came back in. There was some brief conversation with a small number of questions that were asked and answered back and forth. The meeting concluded, and we got in the vans and went back to the IRS.[145]

As Mr. Fisher stated, Ms. Washington instructed the IRS officials that they could review the legal memorandum, but they could not take notes or take the document with them. Associate General Counsel Mark Kaizen further testified:

> A. We were provided a written document to take a look at.

[144] *Id.* at 49–50 (emphasis added).
[145] *Id.* at 26–27 (emphasis added).

Q. Did you keep a copy of that document?

A. No.

Q. Was each person in the room given a copy of the document?

A. No.

Q. How many copies, approximately, were distributed?

A. I don't remember the number of documents. There just wasn't enough for everybody, so there was some sharing that was taking place.

Q. Did you take notes on the document?

A. No.

Q. Were you instructed not to take notes?

A. Yes.[146]

c. The OMB Memorandum's Rationale

Although OMB refused to produce the memorandum to Congress—even pursuant to a subpoena—the committees received testimony describing the contents of the memorandum. For example, Mr. Fisher testified:

Q. What did the memo discuss?

A. I guess, in my words, it would be **a rationale for why using the permanent appropriation for the cost sharing reduction payments was appropriate.**

* * *

Q. What was the rationale in the memo?

A. I don't recall most of the details of the memo, in large part because it didn't make much of an impression on me. It was a lengthy, sort of, list of small justifications of individual things trying to identify why the administration believed that it was Congress' intent to have the payments for both the Advance Premium Tax Credit and

[146] Kaizen Tr. at 21–22.

> the cost sharing reduction payment being made in the same manner.
>
> And there was allusions to a statement that had been made on the floor. There were allusions, I believe, to statements that might have been made in the media. There was the coupling of the fact that in section 1412, the payment authorization section, is that both of these payments were in the same section, for both the Advance Premium Tax Credit and the cost sharing reduction payment both being referenced and discussed in section 1412.
>
> And there were a number of other justifications on why the administration concluded that it was appropriate to use that appropriation for these payments. But, as I recall, there was no sort of single, main argument. It was more of a collection of almost a commentary on elements that, in total, would draw the conclusion that these payments out of the permanent appropriation would be appropriate.[147]

Mr. Fisher further testified:

> **Because it became clear that, while we were seeing the memo for the first time here in mid-January, this memo had been discussed both within the Office of Management and Budget and in the Justice Department.** Whether there were other parties involved in those discussions, I don't know, but those were the two that stood out that had been involved in, you know, supporting or approving of Mr. Berger's memo.
>
> And our understanding, as I believe it was explained in the meeting, was that the administration has gone through the legal analysis and has come up with the opinion that, based on the information contained in this memo, it was appropriate to use the permanent appropriation to pay for not only the Advance Premium Tax Credit but also the cost-sharing reduction payments.
>
> And that was the administration's conclusion, and, therefore, the payments should be made. I mean, I think that was the assumption out of that legal analysis that the administration had performed, is that the law as stated should now be fulfilled, with HHS identifying to whom and how much payments should be made for the cost-sharing reduction program. That information would be communicated to the Treasury Department, and the IRS would then go make those payments out of the permanent appropriation based on this legal analysis.[148]

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[147] Fisher Depo. at 27–28 (emphasis added).
[148] *Id.* at 29 (emphasis added).

At the meeting, OMB characterized the document as the Administration's legal analysis and conclusion regarding the source of funding for the CSR program. Mr. Fisher testified:

> Q. You said initially that one of the lines of questioning was a question of whether this document was a decision or what type of document it was.
>
> A. Uh-huh.
>
> Q. What was the answer to that question?
>
> A. So it was characterized as: **This is the administration's legal analysis, that a conclusion has been made, a legal conclusion has been made, and that it was appropriate to move forward on the payments per the schedule, beginning in late January, using the permanent appropriation.**
>
> So that was their legal conclusion. And I think the expectation was that it would be now followed in practice by the implementing agencies.[149]

OMB organized the meeting to provide the Administration's "legal conclusion" to these IRS officials and to let them know they could move forward with making the CSR payments from the permanent appropriation. OMB believed everyone was on the same page following the meeting. In fact, after the meeting, then-OMB General Counsel Washington testified: "I would have told the director [Sylvia Mathews Burwell] that the meeting had occurred and that things seemed to be fine."[150]

8. IRS Officials Still Have Concerns Following Review of OMB's Memorandum

FINDING:	**After reviewing the OMB memorandum, some of the IRS officials still had concerns about the source of funds, and wanted to make sure that these payments were not in violation of appropriations laws or the Antideficiency Act.**

After the meeting at OMB, on the drive back to the IRS, the IRS officials who reviewed the OMB memorandum were not in consensus about the merits of OMB's legal analysis of the source of funds issue. Mr. Fisher testified that "as we returned to the IRS, there was a discussion about what do we do next. The group was not in consensus on the merits of the argument as conveyed to us through the memo and in this discussion."[151]

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[149] *Id.* at 29–30 (emphasis added).
[150] Washington Tr. at 57.
[151] Fisher Depo. at 33.

Mr. Fisher and others suggested that the group should meet with Commissioner Koskinen before the first payment was to be made to ensure he was fully informed on the issue. He testified:

> **And I know I was certainly one of the advocates for setting up a meeting with the Commissioner of the IRS to make sure he's fully informed**.
>
> Exactly like we talk about in enterprise risk management, that's exactly what we're there to do, is to identify potential risks, manage them where we can, and things that rise to the level of the enterprise that really require senior-level engagement, it's our job to bring that to his attention.
>
> **And I don't believe I was the only one, but I was certainly one of the advocates for making sure that we set up a meeting with the Commissioner between that date and when the first payment was to be made.** I wanted to make sure that we had that discussion before the payment date, which, again, was late January.[152]

Mr. Fisher raised concerns that the CSR payments potentially violated the Antideficiency Act during the course of that conversation. He testified:

> Q. During the course of these discussions about the meeting with Commissioner Koskinen, did you or anybody else raise the topic of the Antideficiency Act?
>
> A. So, just to be clear, there was one discussion. It was not plural. It was a single meeting. And, yes, I raised those concerns.[153]

Mr. Fisher continued:

> **There could be many other people who think this is about health care. To us, this was not about health care. And I know that's hard to believe for some people, but this was about appropriations law**, which those of us—I was a CFO in the Federal Government at the Government Accountability Office. For those of us who work in financial management, when it comes to the Antideficiency Act, which has criminal penalties associated with it, we take it very seriously. **The IRS takes its audit very seriously. And we wanted to make sure that these payments were not going to be in violation of appropriation law and the Antideficiency Act. That's what this was all about.**[154]

[152] *Id.* at 33–34 (emphasis added).
[153] *Id.* at 36.
[154] *Id.* at 34 (emphasis added).

The IRS officials were given an opportunity to review the Administration's legal analysis and justification—which had already been reviewed and approved by the Attorney General of the United States—for funding the CSR program through the same appropriation as the premium tax credit. The IRS officials' concerns that this course of action violated appropriations law were noted, but not addressed or ameliorated by OMB's legal memorandum.

B. The Administration Begins to Prepare to Make Cost Sharing Reduction Payments

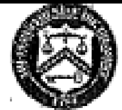
FINDING:	**Secretary Lew approved an Action Memorandum dated January 15, 2014, authorizing the IRS to administer the cost sharing reduction payments in the same manner as the advanced premium tax credit payments.**

While the Administration attempted to assuage the concerns of the IRS officials, Treasury Secretary Lew approved an Action Memorandum authorizing the IRS to administer the CSR payments in the same manner as the APTC payments. Although the IRS officials had an opportunity to raise their concerns to IRS Commissioner John Koskinen, by the time of that meeting, the Administration already had decided to move forward. It appears that the Action Memorandum was approved before the meeting with Commissioner Koskinen took place.

1. Secretary Lew Authorizes the IRS to Administer Cost Sharing Reduction Payments

On January 15, 2015—two days after the IRS officials met with OMB about OMB's legal memorandum—Treasury Assistant Secretary for Tax Policy Mark Mazur provided Treasury Secretary Lew an "Action Memorandum" for his approval.[155] The final Action Memorandum states, "[g]iven that the Internal Revenue Service (IRS) will administer the advance premium tax credit payments in coordination with HHS, we recommend that IRS similarly administer the cost-sharing payments in coordination with HHS."[156] The final memorandum (see below) reflected that Secretary Lew approved the recommendation and authorized the action. Only after the committees served subpoenas and only after a witness acknowledged in a transcribed interview did Treasury produce this final memorandum. But Treasury only produced a redacted version of the document to the committees:

[155] Action Memorandum from Mark Mazur, Ass't Sec'y for Tax Policy, U.S. Dep't of the Treasury, to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury, *Cost-Sharing Payments Under the Affordable Care Act* (Jan. 15, 2014).
[156] *Id.*



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

January 15, 2014

ACTION MEMORANDUM FOR SECRETARY LEW

FROM: Mark Mazur, Assistant Secretary for Tax Policy

SUBJECT: Cost-Sharing Payments Under the Affordable Care Act

RECOMMENDATION

That Treasury, through the Internal Revenue Service, administer cost-sharing payments pursuant to the Affordable Care Act.

___ Approve ________ Disapprove ________ Let's Discuss

BACKGROUND

The Affordable Care Act (ACA) mandates that health insurance issuers make reductions in cost-sharing (*e.g.*, co-pays and deductibles) for eligible individuals purchasing health insurance on an Exchange and requires the federal government to compensate issuers for the cost of those reductions. The Department of Health and Human Services (HHS) implemented these requirements in a final rule issued in March 2013. Cost-sharing payments are scheduled to commence in late January.

Under the ACA, the Secretary of the Treasury is required to make advance payments for premium tax credits and cost-sharing pursuant to instructions provided by HHS. Given that the Internal Revenue Service (IRS) will administer the advance premium tax credit payments in coordination with HHS, we recommend that IRS similarly administer the cost-sharing payments in coordination with HHS.

Redacted

Accordingly, IRS will use the section 1324(b) appropriation as the source for these payments.

Pending your approval of this memorandum, IRS will finalize its preparations to commence cost-sharing payments by late January and will keep us informed of its progress.

Although Mr. Mazur sent the Action Memorandum to the Secretary, he had only a minimal recollection of the details surrounding the purpose and creation of the document. Mr. Mazur's interview, however, raised questions about whether the Action Memorandum was an unusual mechanism for authorizing how the CSR payments were to be funded. He testified:

Q. Were you asked to prepare this memorandum?

A. I don't have a specific memory of being asked by a particular person to prepare this.

Q. Was this something that you would have done without being asked?

A. I am not sure I would have been asked or it would have been a group decision to do. But it would have come to my attention, somehow, to do that.

Q. If it had been a group decision, who would have been involved, either by name or by title, in kind of the determination that such a memo was necessary?

A. I can't recall any specific individuals on this. But in terms of topics you would have – I would expect the budget office.[157]

Mr. Mazur further testified that, while preparing this memorandum was within the scope of his office's responsibilities, the memorandum was outside the normal course of what his office handles. Underscoring the unusual nature of this memorandum, he could not even identify who or even what division within his office would be responsible for preparing such a document. He stated:

Q. So – and the way that the office is broken down, which division of the office would be responsible for creating a document of this nature?

A. Again, for a document like this, it could be any one of a number of people in my office or in the Treasury Department.

We have no one on my staff who directly works on this topic, you know. We work on revenue issues, revenue proposals. This topic seems to be outside that. So it is hard for me to say which of my direct reports

Q. So this is outside of – I am sorry.

A. **It is hard for me to say which of my direct reports would do this topic.**

Q. **So if this is beyond the scope of what your office does, why would you be in the position to make the recommendation to the Secretary of how to implement the program?**

A. **I disagree it is beyond the scope of what my office does.**

Q. Okay.

[157] H. Comm. on Ways & Means, Transcribed Interview of Mark Mazur, at 22–23 (Apr. 28, 2016) [hereinafter Mazur Tr.].

A. My office does work on implementing the Affordable Care Act.

Q. Who in your office works on implementing the Affordable Care Act?

A. Of our 100 people, probably 40 of them, depending

Q. Who is the direct report to you that deals with this subject matter?

A. Of what subject matter are you asking about?

Q. Implementation of the cost share reduction payments –

A. I do not have a direct report who works on that particular topic.

Q. **Okay. Do you have a direct report who has reports to them who work on that particular topic?**

A. **This particular topic is so narrow and outside of what our normal office is that I can't think of a direct report who I would say, "This is their job."**

Q. **Okay. So it is so narrow and outside of the normal course, but you have no recollection as to who could have prepared this document?**

A. **Correct.**[158]

Further, Mr. Mazur was unable to explain why his office—the office responsible for tax policy and tax provisions in the President's budget—prepared this Action Memorandum for Secretary Lew. In fact, cost sharing reductions would rarely fall within his purview, because they are not revenue (tax) provisions. Mr. Mazur stated:

Q. Going back to your role in the President's budget, just for my own knowledge, you were discussing the receipts side of things.

A. Yes.

Q. Did the advanced premium tax credits fall within the receipt side of things?

A. **So the advanced premium tax credits are a tax credit. When our staff was estimating the baseline receipts for the Federal**

[158] *Id.* at 30–33 (emphasis added).

Government, they would take into account those tax credits that were paid as a reduction in receipts. So yes.

Q. And so are the cost share reduction payments also treated as – in that same manner?

A. **I am not aware of how the cost sharing reduction payments are treated, in terms of the federal budget, how they flow through.** I do know that the premium tax credits are treated as a tax credit, and so they count as a minus on individual income tax receipts when individuals claim that.[159]

Mr. Mazur did not know how CSR payments were treated and could not identify who in his office would have handled this issue, yet he and his office were responsible for an Action Memorandum that recommended the IRS treat CSR payments in the same manner as APTCs.

Further demonstrating that this Action Memorandum was unusual, according to multiple witnesses, action memoranda were atypical, especially in this situation, where it was used to direct how a program should be executed. Mr. Mazur stated:

Q. When you say that you, Treasury, prepare hundreds of memoranda a year, are they action memoranda?

A. So in my office we have all different kinds of memoranda we prepare. Action memoranda are, I guess, one of those categories.

Q. What are action memoranda typically used for?

A. Typically to get the approval of a principal or a decision maker on a particular topic.

Q. This particular one was initialed by Secretary Lew. Who else typically initials or signs action memoranda?

A. In the Department of the Treasury it would depend on what the level of decision is. So there would be action memoranda for people who are going to go speak at an event, and the recommendation would be, "Speak at Event X," and they sign it. So whoever is doing that speech would sign that. And so it is a whole range of things.

Q. Could you just give us a couple of more examples about types of issues action memoranda are used for?

[159] *Id.* at 55–56 (emphasis added).

A. So I would think a couple of possible uses of action memoranda: speaking events; sending a formal letter or a formal report to someone; approving accounting for payments, I guess, as in this case. There is a range of things.

Q. Have you ever seen another action memoranda approving, like you said, a payment method for anything else?

A. I can't recall, but that doesn't mean they don't exist.[160]

The Chief of the IRS's Ethics and General Government Law Branch Kirsten Witter testified that she had not seen an action memorandum like this one before. She stated:

Q. **Have you seen an action memorandum like this before?**

A. **Not precisely like this, no.**

* * *

Q. Have you seen action memoranda before?

A. Yes.

Q. **What generally do action memoranda do?**

A. **The ones I have seen have generally been to permit the acceptance of gifts to the agency.**[161]

The IRS General Counsel understood the Action Memorandum to be a "decision document that authorized and commanded action,"[162] but he also stated that he could not recall ever seeing an action memorandum before. He testified:

Committee Counsel. Mr. Wilkins, when you received the document that was signed, did you understand it to be a final document or did you have an opinion on it one way or the other?

A. I understood it to be a decision document that authorized and commanded action.

Committee Counsel. Thank you.

Q. Are action memoranda typically used at Treasury?

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[160] Mazur Tr. at 19–20.
[161] H. Comm. on Ways & Means, Transcribed Interview of Kirstin Witter, at 23–25 (April 8, 2016) [hereinafter Witter Tr.] (emphasis added).
[162] Wilkins Tr. at 37.

A. I couldn't tell you one way or the other.

Q. Have you ever received an action memorandum before?

A. I don't think so.[163]

Based on these IRS counsels' testimony, this Action Memorandum—seeking the Secretary's approval to fund the CSR program through the permanent appropriation—was unusual.

Ultimately, Mr. Mazur acknowledged that he made the recommendation to Secretary Lew to administer the CSR payments similar to how the APTC credit payments were being administered. Mr. Mazur testified:

Q. Do you see the next sentence, where it says, "Given that the Internal Revenue Service, IRS, will administer the advanced premium tax credit payments in coordination with HHS, we recommend that IRS similarly administer the cost sharing payments in coordination with HHS"?

A. Yes.

Q. Who is the "we" making that recommendation?

A. The "we" would be me.[164]

On or around January 15, 2014, Treasury Deputy General Counsel Roberto Gonzalez emailed the final Action Memorandum to Mr. Wilkins.[165] After receiving the final Action Memorandum, Mr. Wilkins shared it with staff within the General Counsel's General Legal Services Office, including Mark Kaizen and Linda Horowitz, as well as staff within the CFO's office.[166]

[163] *Id.* at 37-38.
[164] Mazur Tr. at 26–27 (emphasis added).
[165] Wilkins Tr. at 33–34.
[166] *Id.* at 38–39.

2. Commissioner Koskinen Meets with Concerned IRS Officials

FINDING:	A few days after they met at OMB to review OMB's memorandum, several high-level IRS officials met with IRS Commissioner John Koskinen to discuss how the Administration planned to fund the cost sharing reduction program. It was clear that the decision had already been made to move forward with making the cost sharing reduction payments through the premium tax credit account.

Within a few days of the OMB meeting where IRS officials reviewed OMB's legal memorandum, a meeting was scheduled with IRS Commissioner John Koskinen. Former IRS Chief Risk Officer David Fisher explained the meeting:

> Q. Do you recall – or could you explain what happened in the course of that meeting?
>
> A. **So the Commissioner gathered together all of the people who had attended the meeting at OMB. There were some additional attendees that would typically attend a senior-leader meeting with the Commissioner** – as I recall, his chief of staff, his deputy chief of staff, the Deputy Commissioner for Services and Enforcement –
>
> Q. Who was that?
>
> A. John Dalrymple was there. There may have been a couple of others. But it was sort of the typical senior folks that you would expect to be with the Commissioner when a meeting of some import was taking place.[167]

Mr. Fisher described the meeting as a "free and open discussion."[168] Participants, including Commissioner Koskinen, discussed the final Action Memorandum from Mark Mazur to Secretary Lew and that the Department of Justice had seen and approved OMB's legal memorandum. Mr. Fisher stated:

> [Commissioner Koskinen] was informed of – well, two things. There was a memo that was circulated at that meeting that you shared with me last week in the transcribed interview that showed – I believe it was a memo from Mark Mazur to Secretary Lew that Secretary Lew had signed and initialed "Approve" that was more of the directive kind of note that Treasury had concluded that – now it was Treasury's counsel – had concluded that these payments were appropriate. I recall that memo. We discussed that briefly. And that was provided – I don't remember who

[167] Fisher Depo. at 38 (emphasis added).
[168] *Id.*

> brought that memo. It was either through the Chief of Staff or Chief Counsel – was brought to the group, and the Commissioner became aware of that.
>
> **He had also been informed that the Justice Department had seen the memo and had been approving of it, obviously was aware of OMB's position.** This is, again, mostly through the General Counsel or Chief Counsel's communication to the Commissioner. **And so there was a very strong consensus of the people who had been in the loop on this at, you know, fairly senior positions in government that these payments were appropriate.**[169]

Mr. Fisher admitted that he was in the dissent at the meeting. As the Chief Risk Officer, he expressed concerns about the risk associated with making the CSR payments through a permanent appropriation when the law does not expressly authorize such payments. He testified:

> I was in the dissent. I think I was wearing two hats in that perspective. **As the Chief Risk Officer, I felt there was some risk to making these payments with respect to the appropriations law and the Antideficiency Act, recognizing that there were other opinions on the other side.** I expressed that I felt that the memo that we read was not compelling to me to counter my concerns about the Appropriations Act issues related to the payment, as I read the law over and over again to try to convince myself, you know, what's the appropriate reading of this, recognizing that many others have now come to a different conclusion.[170]

Mr. Fisher felt that Commissioner Koskinen gave him the opportunity to express his concerns, even though the IRS ultimately decided to move forward with making the CSR payments through Treasury's permanent appropriation for tax credits. Mr. Fisher stated:

> [Commissioner Koskinen] listened to my concerns and thanked me, actually, in the meeting for expressing those concerns **but felt the appropriate course was to go forward and make the payments, you know, per the strong majority of folks who believed that they were appropriate**.[171]

As documents and testimony indicate, by the time the IRS officials had met with Commissioner Koskinen, it appeared that a decision to use the permanent appropriation had already been made. OMB and the Department of Justice had blessed this course of action. Secretary Lew had already signed the Action Memorandum.

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[169] *Id.* at 39 (emphasis added).
[170] *Id.* at 39–40 (emphasis added).
[171] *Id.* at 40 (emphasis added).

3. A Memorandum of Understanding between the IRS and CMS Sets Forth How to Make Cost Sharing Reduction Payments

FINDING: The Administration could not make cost sharing reduction payments until a Memorandum of Understanding was in place.

At the same time that IRS officials raised concerns about the source of funding for the CSR program, IRS Deputy Chief Financial Officer Greg Kane began drafting a Memorandum of Understanding (MOU) to govern the CSR payment process. He testified:

Q. Did you help create this memorandum of understanding?

A. Yes, I did.

Q. When did you begin working on this MOU?

A. Around the first of January.

Q. First of what year?

A. First week of January 2014.

Q. Were there previous versions of the MOU that you worked on?

A. Of this particular MOU? No.

Q. **Would you just explain generally what the MOU does?**

A. **So the memorandum of understanding clearly calls out the roles and responsibilities because of the shared process on what CMS does, what IRS does. There are references to the internal control process.**

And then the introduction and overview section were written by all the counsels – HHS, IRS, CMS, and Treasury – to ensure that these documents based on the process wouldn't have to be revisited multiple times if there were changes and people leaving organizations and all that; it would only have to be revisited if the process were to change.[172]

The Administration could not begin making CSR payments to the insurance companies until an MOU for CSR payments was in place. Mr. Kane stated:

[172] Kane Tr. at 36–37.

> Basically, this Memorandum of Understanding had to be in place so that they could begin to execute the process, and for any funds that were going to be moved into their allocation account for purposes of making the PTC, cost sharing payments done prior to the end of January.[173]

He further testified:

> Q. Would you just explain generally what the MOU does?
>
> A. So the memorandum of understanding clearly calls out the roles and responsibilities because of the shared process on what CMS does, what IRS does. There are references to the internal control process.
>
> And then the introduction and overview section were written by all the counsels – HHS, IRS, CMS, and Treasury – to ensure that these documents based on the process wouldn't have to be revisited multiple times if there were changes and people leaving organizations and all that; it would only have to be revisited if the process were to change.[174]

On January 17, 2014, CMS CFO and Director of the Office of Financial Management Deborah Taylor, CMS Deputy Director of Operations, Center for Consumer Information and Insurance Oversight James Kerr, and IRS Chief Financial Officer Robin Canady all signed the MOU governing how CMS and the IRS would make CSR payments.[175] On the first page, the MOU notes that "[p]er OMB guidance, CSR are not subject to sequestration."[176] Several days later, on approximately January 22, 2014, the Administration made the first CSR payments to insurance companies from funds appropriated for tax credits.[177]

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[173] *Id.* at 56.
[174] Kane Tr. at 36–37.
[175] CRS MOU, *supra* note 25.
[176] *Id.*
[177] Email from CMS Clearances to numerous HHS personnel (Jan. 21, 2014, 12:23 p.m.) (including a draft blog released to be rolled out "as early as . . . 1/22" that stated that "[t]oday, CMS is pleased to report that we are making the first payments to Marketplace health insurers on behalf of consumers who are receiving financial assistance with their premiums and cost-sharing.").

C. The Administration Does Not Request an Annual Appropriation in its FY 2015 Budget Request

FINDING:	The Administration did not request an annual appropriation for the cost sharing reduction program in its FY 2015 budget request, submitted to Congress on March 14, 2014.

While the Administration was finding and justifying another way to fund the CSR program, HHS began preparing its FY 2015 budget request. HHS counsel refused to let its witnesses answer whether this budget included a request for an annual appropriation for the CSR program at any stage in the lengthy process. But when the President submitted his final budget request to Congress on March 14, 2014, it did not include any request for appropriations for the CSR program. HHS Assistant Secretary for Financial Resources Ellen Murray testified:

> Q. Did that fiscal year 2015 budget request to Congress include a request for an annual appropriation from the Cost Sharing Reduction Program?
>
> A. It did not.
>
> Q. Do you know why not?
>
> A. We believed that we had an appropriation through the Treasury Department, and an appropriation through the Labor-H bill was not necessary.
>
> Q. Which particular appropriation?
>
> A. The appropriation for the tax credit.[178]

As this investigation has shown, the Administration initially believed that it needed an annual appropriation to fund the cost sharing reduction program—the FY 2014 budget would not have included a request for an annual appropriation for the CSR program if this were not true. Although the Affordable Care Act provided funding for the advanced premium tax credits, it did not do the same for the CSR program. Nevertheless, despite requesting an annual appropriation in its FY 2014 budget request submitted to Congress on April 10, 2013, the Administration switched course.

Around the same time that it understood that the CSR appropriation would be subject to sequestration, the Administration called the Senate Committee on Appropriations to informally withdraw its budget request. The Administration has refused to tell Congress who ultimately made the decision to withdraw the request. Meanwhile, the Administration scrambled to create a legal justification for raiding the premium tax credit account to pay for the cost sharing reduction program. A few high level IRS officials raised concerns about this course action, fearing it

[178] Murray Tr. at 77.

violated appropriations law. These same concerns were the basis of the district court's May 11, 2016 decision finding the Administration's actions unconstitutional.[179] But despite these valid concerns, the Administration went forward and began making CSR payments from the premium tax credit account by the end of January 2014.

[179] *See U.S. House of Reps. v. Burwell*, No. 1:14-cv-01967 , Op. (D.D.C. May 12, 2016).

VII. The Administration has Obstructed the Committees' Investigation

For more than a year, the committees have sought to understand the facts surrounding the Administration's decision to fund the cost sharing reduction program using the § 1324 permanent appropriation for tax refunds and credits. This investigation arose out of a concern that the source of funds was unconstitutional—and a federal court recently decided just that.[180]

To fully understand the rationale and process for the Administration's decision, the committees have sought answers to a number of questions, including:

- Who first identified the APTC account as a potential source of funds for the CSR program?
- When and how was that appropriation identified?
- Why did the Administration initially request an annual appropriation for the CSR program before deciding to informally withdraw it?
- Did sequestration play a role in the Administration's decision to fund the CSR program through the APTC account?
- Who at the White House and the Department of Justice was involved in these decisions?

Unfortunately, the Administration has undertaken extraordinary efforts to frustrate the committees' investigation and to prevent it from answering these and other legitimate questions. Since the start of this investigation, the Administration has:

- Failed to comply with the committees' subpoenas;
- Failed to timely deliver subpoenas issued by the Committee on Ways and Means to Administration employees;
- Relied on an overbroad regulation inconsistent federal law to limit information provided to Congress;
- Unilaterally restricted the scope of the testimony that current and former employees provided to Congress;
- Instructed witnesses who appeared before the committees to not fully answer questions posed by Congress; and

[180] *U.S. House of Reps. v. Burwell*, No. 1:14-cv-01967, Op. (D.D.C. May 12, 2016).

- Pressured at least one witness who questioned the Administration's testimonial restrictions.

On numerous occasions, the Administration has cited the ongoing litigation as a justification for its refusal to cooperate with the committees' investigation. The Administration has misrepresented and distorted the scope of Congress' authority to conduct oversight of the laws passed by Congress, and of the circumstances of the present case. It has attempted to argue that Congress' constitutional oversight authority is somehow suspended while litigation is pending. It has argued that while Congress may have "authority" to conduct oversight, there is no "need" while the issue is being litigated. But none of these arguments are valid.

From the outset, the committees have clearly stated the purpose of their investigation: to fully understand the facts surrounding the Administration's decisions to fund the cost sharing reduction program from the permanent appropriation for tax refunds and credits. The lawsuit did not, and will not, answer the committees' questions about the source of funding for the CSR program because the committees' factual questions are fundamentally different from the legal issues presented in the *House v. Burwell* litigation.

Under the powers set forth in the Constitution, Congress has an obligation to understand the facts of the Administration's decisions here. The committees have an oversight interest in the laws and regulations passed by Congress, and must ensure that the Administration spends taxpayer dollars prudently and in accordance with the law. That oversight interest cannot be tolled as the Administration requests. Further, it is the committees of the United States House of Representatives, not the Administration, that have sole authority to determine the type of information necessary to conduct effective oversight.

Section A details the numerous steps the committees have undertaken to obtain information from the Administration, while Section B details the obstructive tactics used by the Administration to impede the committees' work.

A. Background of the Committees' Investigation

1. The Committees Initiate the Investigation and Request Documents and Information

On February 3, 2015, then-Ways and Means Committee Chairman Paul Ryan and Energy and Commerce Committee Chairman Fred Upton wrote to Treasury and HHS requesting documents and information about the Administration's decision to make CSR payments to the insurance companies without an appropriation. The committees explained the basis for the request:

> Congress has never appropriated any funds to permit the administration to make any Section 1402 Offset Program payments to insurance companies. Despite lacking an appropriation, Centers for Medicare and Medicaid Services ("CMS") Administrator Marilyn Tavenner informed the House Committee on Oversight and Government Reform in December 2014 that

> insurers, "have been paid a cumulative total of $2.7 billion in advance [Section 1402 Offset Program payments through the November 2014 payment cycle."
>
> Article I of the U.S. Constitution expressly prohibits the expenditure of public funds without an appropriation made by law. Accordingly, it appears the Department of Health and Human Services ("HHS") has directed the Treasury Department to make payments to insurers for the Section 1402 Offset Payments, and that the Treasury Department has made and continues to make these payments, even though no funds are lawfully available to do so.[181]

In the same letters, the committees requested that the Departments produce documents relating to:

> 1. The administration's decision to make Section 1402 Offset Program payments to insurers, despite a lack of appropriation to do so; and
>
> 2. The administration's abrupt reversal in course from its FY 2014 budget submission to Congress, in which it requested an "annual" appropriation to fund the Section 1402 Offset Program payments, to its FY 2015 Budget submission, which did not include [an] annual appropriation request.[182]

On February 25, 2015, more than a week past the letter's deadline, the committees received a three-paragraph response from both Departments referring Chairmen Ryan and Upton to the Department of Justice (DOJ). The Departments wrote, in part:

> As you know, the House of Representatives has filed a lawsuit against the Department of the Treasury and the Department of Health and Human Services asking the court to end these cost-sharing reduction payments. Your letters relate to matters that are the subject of the House lawsuit. The Department of Justice, which represented both defendants, filed a brief in the case on January 26, 2015. **For matters raised in this litigation, we refer you to the Department of Justice.**[183]

Regarding the committees' requests and questions, the Department provided only one sentence of responsive information:

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[181] Letters from Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury, and Hon. Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Serv. (Feb. 3, 2015) (citations omitted).
[182] *Id.*
[183] Letters from Randall DeValk, Acting Assistant Sec'y for Legis. Affairs, U.S. Dep't of the Treasury, and Jim R. Esquea, Assistant Sec'y for Legis., U.S. Dep't of Health & Human Servs., to Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Feb. 25, 2015) (referring to *U.S. House of Reps. v. Burwell*, No. 1:14-cv-01967 (D.D.C. filed Nov. 21, 2014)) (emphasis added).

> Cost-sharing reduction payments continue to be made to insurers on behalf of consumers and the cumulative amount of these payments for 2014 is $2.997 billion.[184]

The response did not otherwise answer any of the committees' questions or include any documents.

Nearly six months later, the Departments had not provided any documents to the committees. On July 7, 2015, the committees wrote again to the Departments to reiterate the request for documents and information. The committees wrote:

> We remain concerned that the administration is unlawfully and unconstitutionally misappropriating funds to make Section 1402 Offset Program payments to insurance companies. To understand the [Departments'] administration of the cost-sharing reduction program, the committees sent you a letter on February 3, 2015 requesting information and documents. To date, the [Departments have] not provided any documents or information in response to that request.[185]

The committees asked that the Departments produce all responsive documents and information by July 21, 2015. The committees concluded:

> If [the Departments] fail to produce the documents and information, the committees will have no choice but to consider the use of the compulsory process to obtain them.[186]

On July 21, 2015, the Departments responded to the committees' letters. The Departments' response again failed to address the committees' requests. Specifically, the response explained neither the Administration's decision to make the CSR payments from the permanent appropriation for tax credits and refunds, nor why the Administration requested an annual appropriation to fund the CSR payments in the fiscal year 2014 budget before reversing course. Instead, the Departments merely provided a summary of the legal arguments presented by the Administration in the *House v. Burwell* litigation.

In the same letters, the Departments explicitly refused to produce the documents requested by the committees. The Departments wrote:

> As we wrote in our February 25, 2015 response to you, the House of Representatives has filed a lawsuit against Treasury and HHS asking the court to end cost-sharing reduction payments. Your letters contain document requests that relate to the issues raised by the complaint the

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[184] *Id.*

[185] Letters from Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury, and Hon. Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Serv. (July 7, 2015).

[186] *Id.*

> House filed in that case. In January of this year, the Department of Justice, which represents both defendants, filed a motion to dismiss the case on the grounds that the suit is not justiciable. However, the court has not yet ruled on that motion, and the case remains pending. **It would therefore be premature for our agencies to address your document requests, as they relate to the issues raised in the lawsuit.**[187]

The Departments did not provide any other explanation for why they would not produce the requested documents and information to the committees.

2. The Administration Delays and Impedes Scheduling Transcribed Interviews

Given the Departments' explicit refusal to provide the requested documents, the committees next attempted to understand the Administration's decisions about the source of funding for the CSR program through witness testimony. To that end, the committees wrote to the Departments on December 2, 2015 requesting transcribed interviews of eight current and former employees of the Departments of Health and Human Services and the Treasury. The committees again explained the purpose of the oversight inquiry, which was separate from the legal issues involved in the *House v. Burwell* litigation. They wrote:

> **The Committees seek to fully understand the facts** that led to the administration's initial request for an annual appropriation to fund the CSR program payments to insurers, and the administration's subsequent actions, after Congress had rejected the appropriation request, to nevertheless pay insurers with funds from the permanent appropriation for tax refunds and credits. **Congress has a constitutionally-based responsibility to oversee all aspects of the administration's actions related to the CSR program.**[188]

The committees asked the Departments to make the requested individuals available for interviews no later than December 16, 2015. The committees concluded that, if the Departments "fail[ed] to timely respond or schedule the requested interviews," the committees would have no choice but to resort to compelled process. Not only did the Departments fail to make the requested individuals available for interviews by December 16, 2015, but they failed to even respond to the letter by that date.

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[187] Letters from Anne Wall, Assistant Sec'y for Legis. Affairs, U.S. Dep't of the Treasury, and Jim R. Esquea, Assistant Sec'y for Legis., U.S. Dep't of Health & Human Servs., to Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (July 21, 2015) (emphasis added).

[188] Letters from Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury, and Hon. Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Serv. (Dec. 2, 2015) (emphasis added).

On December 18, 2015, two days after the deadline, the Departments responded to the committees' letters.[189] Once again, the response focused entirely on the legal arguments at issue in the *House v. Burwell* litigation—even referring the committees to a recently-filed litigation brief for "further information regarding the basis for the conclusion that Congress intended for cost-sharing reduction payments to be funded through a permanent appropriation."[190] The Departments' response, however, in no way addressed the factual issues central to the committees' separate and independent oversight inquiry. The Departments also failed to address the committees' request for witness interviews.

At this juncture, and given the Departments' refusal to produce documents and refusal to make witnesses available, the committees prepared to issue subpoenas for the documents and information required to complete the investigation. As commonly occurs before the issuance of a congressional subpoena, committee staff called the Departments' staff to discuss service of subpoenas for documents and depositions.

On January 19, 2016, the Departments wrote to the committees again, claiming that the *House v. Burwell* litigation prevented the Departments from complying with the committees' requests for documents and interviews. In rejecting the Committees' request for transcribed interviews, the Departments wrote:

> Conducting the interviews you request on these topics could compromise the integrity of the judicial proceedings by circumventing the established rules of discovery and procedure, including judicial determination of the applicability of privileges designed to protect litigants in civil litigation. Indeed, as noted above, the House has expressly acknowledged that discovery is not required in this case, a point with which we and the district court agree. Two House committees requesting interviews about agency action on the same day that the House has relied on those actions in litigation against those same agencies raises the appearance of utilizing oversight to accomplish inappropriate litigation objectives.[191]

Once again, the Departments improperly conflated the committees' factual oversight inquiry with the legal issues involved in the litigation. The Departments further failed to explain how the facts gathered in the committees' investigation could be used to "accomplish inappropriate litigation objectives." As the Departments themselves pointed out, the *House v. Burwell* litigation required no discovery. Because the only issue involved was whether the Administration could legally make CSR payments from the permanent appropriation for tax refunds and credits, the only relevant fact was that the Administration made CSR payments using the permanent appropriation.

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[189] Letters from Anne Wall, Assistant Sec'y for Legis. Affairs, U.S. Dep't of the Treasury, and Jim R. Esquea, Assistant Sec'y for Legis., U.S. Dep't of Health & Human Servs., to Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Dec. 18, 2015).

[190] *Id.*

[191] Letters from Anne Wall, Assistant Sec'y for Legis. Affairs, U.S. Dep't of the Treasury, and Jim R. Esquea, Assistant Sec'y for Legis., U.S. Dep't of Health & Human Servs., to Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Jan. 19, 2016) (citations omitted).

The Departments' letter concluded by formally offering the committees a briefing with HHS Assistant Secretary for Financial Services Ellen Murray. HHS staff had informally conveyed this offer several days prior during a phone call with committee staff. At this point, and with the hope that Ms. Murray would answer the committees' questions, the committees agreed to postpone the issuance of subpoenas to HHS until after that briefing.[192] More than six weeks later, Ms. Murray provided a transcribed interview to the committees. In that interview, HHS counsel refused to permit her to answer most of the committee's basic and straightforward questions about the source of funding of the CSR program.

Ultimately, the committees conducted transcribed interviews of twelve current and former Administration employees. In the course of these interviews, counsel for the Administration present at the interviews prevented employees from answering most of the committees' questions about the source of funding for the CSR program.

The Committee on Ways and Means also deposed a former IRS official. Through this deposition, the committees finally gained some insight into the Administration's decision to fund the CSR program using the permanent appropriation for tax credits and refunds.

3. The Administration Refuses to Produce to the Committees a Final OMB Memorandum

The Office of Management and Budget drafted a legal analysis regarding the revised source of funding for the CSR program, which it shared with top Administration officials. The committees learned of this memorandum in the course of the transcribed interviews. On April 25, 2016, the committees wrote to OMB requesting a copy of this memorandum. The committees wrote:

> In recent transcribed interviews with Treasury officials, several officials described a legal memorandum drafted by the Office of Management and Budget regarding the funding of the CSR program. The memorandum was shared with several Treasury officials around January 2014. The Committees requested the document from both the Department of Treasury and the Department of Health and Human Services, but both departments have informed the Committees that they do not have a copy of the memorandum in their possession.[193]

On May 3, 2016, OMB refused to produce the requested document voluntarily, citing the Executive branch's "confidentiality interests in such pre-decisional deliberations and analysis," and the need to protect against the "chilling effect on future deliberations that would follow"

[192] Ways and Means Committee staff offered a similar accommodation to the Department of the Treasury—namely, that the Committees would postpone the issuance of subpoenas if the Department provided a similar briefing. Treasury did not accept this offer of an accommodation from Ways and Means.
[193] Letter from Hon. Kevin Brady, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Hon. Shaun Donovan, Dir., Office of Mgmt. & Budget (April 5, 2016).

disclosure of the document.[194] Instead, OMB offered a "summary of the government's legal analysis supporting the funding of the ACA's cost-sharing reduction program."[195] The committees subsequently informed OMB via staff telephone calls that a summary written in 2016 about a memorandum drafted in 2013 would not be sufficient, and that the committees required production of the actual memorandum.

4. Due to the Administration's Explicit Refusal to Produce Documents and Testimony, the Committees are Forced to Issue Subpoenas

For nearly a year, the Departments refused to voluntarily produce documents on the source of funding for the CSR program. Between February 2015 and January 2016, the Departments did not produce a single document.

On January 20, 2016, the committees issued subpoenas requiring the Department of the Treasury to produce documents related to the source of funding for the CSR program. The subpoenas compelled Treasury to produce:

> All documents and communications referring or relating to budget requests and the source of funding for cost-sharing reduction payments made by the Administration to health insurance issuers under Section 1402 of the Patient Protection and Affordable Care Act.[196]

The subpoenas required that Treasury produce unredacted documents to the committees by February 3, 2016—one year to the day that the committees first requested information regarding the CSR program.

Also on January 20, 2016, and after Treasury did not voluntarily provide transcribed interviews or even a briefing with requested officials, the Ways and Means Committee issued deposition subpoenas to three IRS officials. The committee issued these subpoenas to Chief Counsel William Wilkins; former CFO Robin Canady; and Deputy CFO Gregory Kane.[197]

On May 4, 2016, the committees issued subpoenas compelling the Department of Health and Human Services to produce documents related to the source of funding for the CSR program. The subpoenas required HHS to produce:

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[194] Letters from Tamara Fucile, Assoc. Dir. of Legis. Affairs, Office of Mgmt. & Budget, to Hon. Kevin Brady, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (May 3, 2016).
[195] *Id.*
[196] Subpoena to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury, from H. Comm. on Ways & Means (Jan. 20, 2016); Subpoena to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury, from H. Comm. on Energy & Commerce (Jan. 20, 2016).
[197] Subpoena to William Wilkins, Internal Rev. Serv., U.S. Dep't of the Treasury, from H. Comm. on Ways & Means (Jan. 20, 2016); Subpoena to Robin Canady, Internal Rev. Serv., U.S. Dep't of the Treasury, from H. Comm. on Ways & Means (Jan. 20, 2016); Subpoena to Gregory Kane, Internal Rev. Serv., U.S. Dep't of the Treasury, from H. Comm. on Was & Means (Jan. 20, 2016).

> All documents and communications referring or relating to budget requests and the source of funding for cost-sharing reduction payments made by the Administration to health insurance issuers under Section 1402 and/or 1412(c)(3) of the Patient Protection and Affordable Care Act.[198]

Also on May 4, 2016, the committees served subpoenas on the Office of Management and Budget compelling production of the memorandum requested by the committees, which OMB refused to produce voluntarily. The subpoenas required OMB to produce:

> All drafts, including the final version, of a memorandum drafted by Office of Management and Budget (OMB) personnel related to the Cost-Sharing Reduction program of the Patient Protection and Affordable Care Act, a version of which was distributed by OMB personnel to select Internal Revenue Service officials on January 13, 2014, at a meeting in the Old Executive Office Building.[199]

On May 12, 2016, Judge Collyer of the U.S. District Court for the District of Columbia rendered her decision on the merits of the *House v. Burwell* litigation. Judge Collyer held that the Department of the Treasury and the Department of Health and Human Services made billions of dollars in CSR payments to health insurers without an appropriation, and in violation of the Constitution.

On May 20, 2016, the committees wrote to Treasury, HHS, and OMB demanding immediate production of all documents responsive to the subpoenas. The committees wrote:

> Much of the Administration's objection to the Committees' oversight is seemingly rooted in its purported concerns about disclosing information related to the ongoing litigation brought by the House regarding the cost sharing reduction program. As we explained to you in December, the litigation did not deprive the Committees of their respective oversight authorities and obligations, and was not a valid basis for the Department to refuse to respond to congressional oversight requests.
>
> * * *
>
> The district court's ruling that the cost sharing reduction payments made by your Department violated the U.S. Constitution clearly demonstrates that misconduct has occurred. We remind you that the deliberative process privilege, if grounds for one ever existed, "disappears entirely when there is any reason to believe government misconduct [has]

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[198] Subpoena to Hon. Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Servs., from H. Comm. on Ways & Means (May 4, 2016); Subpoena to Hon. Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Servs., from H. Comm. on Energy & Commerce (May 4, 2016).

[199] Subpoena to Hon. Shaun Donovan, Dir., Office of Mgmt. & Budget, from H. Comm. on Ways & Means (May 4, 2016); Subpoena to Hon. Shaun Donovan, Dir., Office of Mgmt. & Budget, from H. Comm. on Energy & Commerce (May 4, 2016).

> occurred." Therefore, we expect your Department to immediately produce all documents responsive to the subpoenas.[200]

Neither Treasury, nor HHS, nor OMB have produced any additional documents to the committees since May 12, the date of Judge Collyer's ruling.

B. The Elements of the Administration's Obstruction

While the committees have steadily pursued requests for documents and information for over a year, the Administration has employed a number of different tactics to impede and obstruct the committees' investigation. For the past year, the Administration has:

- Failed to comply with the committees' subpoenas;
- Failed to timely deliver subpoenas issued by the Committee on Ways and Means to Administration employees;
- Relied on an overbroad regulation inconsistent with federal law to limit information provided to Congress;
- Unilaterally restricted the scope of the testimony that current and former employees provided to Congress;
- Instructed witnesses who appeared before the committees to not fully answer questions posed by Congress; and
- Pressured at least one witness who questioned the Administration's testimonial restrictions.

Given the level and types of obstruction, it appears that the Administration is using these tactics to keep information about the source of funding for the CSR program out of the hands of Congress, and therefore out of the hands of the American people.

[200] Letter from Hon. Kevin Brady, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Hon. Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Servs. (May 20, 2016) (similar letters sent to Hon. Shaun Donovan, Director, Office of Mgmt. & Budget and Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury).

1. The Administration has Not Complied with the Committees' Subpoenas

FINDING: The Administration has not complied with subpoenas issued by the United States Congress.

Each subpoena issued by the committees was accompanied by extensive instructions. The deposition subpoenas issued by the Committee on Ways and Means were also served with a copy of the staff deposition authority rules promulgated by the House of Representatives, as required by the rules of the House.

The subpoenas for documents demanded that the Departments produce responsive records "in unredacted form" as described by the various subpoena schedules. Instructions provided with the subpoenas explained the steps the Departments should take if documents were missing, redacted, or otherwise withheld. For example, the relevant instructions for the subpoena issued by the Committee on Energy and Commerce to HHS require:

> 10. If compliance with the subpoena cannot be made in full, compliance shall be made to the extent possible, and your production shall be accompanied by a written explanation of why full compliance is not possible.
>
> 11. In the event that a document or part of any document is withheld on any basis, provide the following information concerning each and every document or part of any such document withheld from production: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author and addressee; and (e) the relationship of author and addressee to each other. Note that subpoenas and requests issued by the U.S. House of Representatives and its Committees are not limited by: any of the purported non-disclosure privileges associated with the common law, including but not limited to, the deliberative process privilege, the attorney-client privilege, and attorney work product protections; any purported privileges or protections from disclosure under the Freedom of Information Act; or any purported contractual privileges, such as non-disclosure agreements.
>
> 12. If any document responsive to this subpoena was, but no longer is, in your possession, custody, or control, identify the document (stating its date, author, subject and recipient(s)) and explain the circumstances by which the document ceased to be in your possession, custody, or control.[201]

[201] Subpoena to Hon. Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Serv., from H. Comm. on Energy & Commerce (May 4, 2016).

The subpoena instructions further call for the relevant Department to provide a certification once document production is completed. For example, the relevant instruction for the subpoena issued by the Committee on Energy and Commerce to HHS requires:

> 18. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; (2) documents responsive to the request have not been destroyed, modified, removed, transferred, or otherwise made inaccessible to the Committee since the date of receiving the Committee's request or in anticipation of receiving the Committee's request, and (3) all documents identified during the search that are responsive have been produced to the Committee or identified in a log provided to the Committee, as described in Paragraph 11 above.[202]

As of the drafting of this report, neither the Department of the Treasury, nor the Department of Health and Human Services nor the Office of Management and Budget were in compliance with subpoenas issued by the committees. None of the three have produced all responsive documents. None of the three have certified that production is complete or produced a log of documents withheld from the committees, or even provided a valid legal basis—to the extent one applies—to justify withholding large amounts of information from Congress. Further, testimony from Administration officials demonstrates that the Department of the Treasury has not conducted a reasonably thorough search for documents responsive to the subpoena.

The Administration's CSR program was a multi-department endeavor. Decisions regarding the source of funding were made not just at one Department, but between at least three different components of the Executive branch, and involving some of the highest ranking officials in the government. It is inconceivable that there are so few documents responsive to the six subpoenas issued by the two committees.

As detailed below, the Administration took the position that all documents not already publicly available are somehow shielded from congressional oversight—and therefore shielded from the American people—without any basis in law, precedent, or fact. Indeed, the Supreme Court has reaffirmed that Congress has the power to investigate the agencies tasked with carrying out the laws Congress promulgates. The Court explained:

> A legislative body cannot legislate wisely or effectively in the absence of information respecting the conditions which the legislation is intended to affect or change; and where the legislative body does not itself possess the requisite information—which not infrequently is true—recourse must be had to other who do possess it. Experience has taught that mere requests for such information often are unavailing, and also that information which

[202] *Id.*

> is volunteered is not always accurate or complete; so some means of compulsion are essential to obtain what is needed.[203]

Moreover, the Administration took this position while refusing to assert any claim of privilege—to the extent any applies—over the documents sought by the committees. Asserting a privilege requires the Administration to provide information justifying the claim of privilege to Congress or a court. Yet, despite its refusal to assert a privilege, the Administration effectively asserted the deliberative process privilege by withholding documents that relate to "internal Executive branch deliberations," among other purported justifications.

Even if it were applicable here, the deliberative process privilege is a privilege that may be invoked by the Executive in response to a request for internal, or deliberative, documents or testimony. A proper invocation of the privilege involves two prongs: (1) the documents and communications must be predecisional, or created prior to the agency or department reaching a final decision, and (2) they must be deliberative.[204] To be deliberative, a document or communication must relate to the thought processes or opinions of relevant officials—the information cannot be purely factual.[205] This privilege, when applicable, protects only predecisional documents—final documents cannot be withheld.

The deliberative process privilege is not absolute; it can be overcome by a showing of need.[206] Moreover, the privilege "disappears altogether when there is any reason to believe government misconduct [has] occurred."[207] Here, a federal district court has ruled that the Administration spent monies to make CSR payments without an appropriation, in violation of the Constitution and the Antideficiency Act.[208] But even without that finding of illegality on the part of the Administration, the committees merely need to demonstrate a plausible claim of waste, fraud, abuse, or maladministration to overcome an assertion of the deliberative process privilege.

Under the position advanced by the Administration here, agencies could withhold internal or deliberative documents from Congress for any reason imaginable—even if they simply included an embarrassing comment. It is for this precise reason that any purported assertion of the deliberative process privilege can be so easily overcome. Furthermore, the Supreme Court has already dismissed the Administration's argument that producing documents containing internal deliberations to Congress would create a "chilling effect," discouraging agency employees from providing candid advice. In *NLRB v. Sears, Roebuck & Co.*, the Supreme Court stated:

> The probability that an agency employee will be inhibited from freely advising a decisionmaker for fear that his advice, *if adopted*, will become public is slight. First, when adopted, the reasoning becomes that of the agency and becomes its responsibility to defend. Second, agency

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[203] *McGrain v. Daugherty*, 273 U.S. 135, 174–75.
[204] *In re Sealed Case (Espy)*, 121 F.3d. 729 (D.C. Cir. 1997).
[205] *Id.*
[206] *Id.*
[207] *Id.*
[208] *U.S. House of Reps. v. Burwell*, No. 1:14-cv-01967, Op. at 1 (D.D.C. May 12, 2016).

employees will generally be encouraged rather than discouraged by public knowledge that their policy suggestions have been adopted by the agency. Moreover, the public interest in knowing the reasons for a policy actually adopted by an agency supports [disclosure.][209]

a. *The Department of the Treasury has Produced only 31 pages of Documents to the Committees, Including a Redacted Version of a "Final" Action Memorandum Signed by Secretary Lew*

FINDING: The Department of the Treasury improperly withheld and redacted documents responsive to the committees' subpoenas without any valid legal basis to do so.

When the committees issued subpoenas to the Department of the Treasury on January 20, 2016, Treasury had not produced a single page of documents in response to the committees' requests. Since the subpoenas have been issued, Treasury has produced only 31 pages of documents, one of which included substantial redactions. In addition, the committees have evidence that the Department has not even undertaken a reasonably thorough search for documents responsive to the subpoenas.

The committees' subpoenas issued to Treasury required that the Department produce all responsive records by February 3, 2016. On that day Treasury responded—not with a production of documents, but with a letter. The Department wrote:

> Prior to your recent subpoena, the Committee last requested documents from us on July 7, 2015. We responded at that time that it would be premature to address the response for documents given the pending litigation. We recognize that the Committee's subpoena is broader than the Committee's initial requests for documents, and we are moving forward with a search for responsive materials.[210]

On March 9, 2016, Treasury produced 30 pages of documents to the committees on the eve of the first transcribed interview of a Treasury official. The documents included:

- Memorandum of Understanding between the Internal Revenue Service (IRS) and the Centers for Medicare & Medicaid Services (CMS) related to the CSR program;
- Advance Premium Tax Credit, Cost Sharing Reductions, and Basic Health Program Cycle Memorandum, Internal Revenue Service, FY 2015 Financial Statement Audit; and

[209] *NLRB v. Sears, Roebuck & Co.*, 421 U.S. 132, 161 (1975) (emphasis in original).
[210] Letters from Anne Wall, Assistant Sec'y for Legis. Affairs, U.S. Dep't of the Treasury, to Hon. Kevin Brady, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Feb. 3, 2016).

- IITC and BITC Reports from the second quarter of fiscal year 2014 through the first quarter of fiscal year 2016, among other documents.

Each of the documents produced was responsive to the subpoena, as well as to the committees' original request.

On March 16, 2016, Treasury produced one additional document—a final, one page "Action Memorandum." This document was also responsive to the subpoena and to the committees' original request. But Treasury did not produce the document until after a witness described it during his transcribed interview, and even then, only after the committees specifically requested that Treasury provide this document. Furthermore, the document produced to the committees contains significant redactions.

As discussed throughout this report, the final Action Memorandum, which was signed by Secretary Lew, authorized the IRS to make CSR payments from the § 1324 permanent appropriation for tax refunds and credits. Moreover, and despite this being a final authorizing document, Treasury redacted a significant portion of this document. Despite multiple requests from the committees, including during subsequent transcribed interviews, Treasury has not provided the committees with any basis—let along a valid legal one—for the redaction. For instance, during Mr. Wilkins's transcribed interview, Committee counsel and Treasury counsel discussed the redaction in the final Action Memorandum. Counsels stated:

Q. Do you see this portion that is redacted?

A. Yes.

Q. In white. It says "redacted," right?

A. Yes, I see those redactions.

Q. Have you previously seen the text that's covered by the redactions?

A. Yes.

Q. Do you recall generally what that text pertained to?

Treasury Counsel. You can answer yes or no.

Mr. Wilkins. Yes, generally.

Q. What category of information does that text pertain to? Is it legal? Is it advice? Is it other analysis?

Treasury Counsel. So, Amanda, we're happy to engage with you, you know, offline about the basis for the redaction, but Mr. Wilkins

isn't here to – you know, to sort of testify about the basis for the redaction in this interview.

Committee Counsel 1: It would be helpful to have that discussion because I'm sure you saw the instructions that we provided in the subpoena for these documents which require that you provide a log of reasons for redactions, and so far you have not provided any reason for this redaction.

Treasury Counsel. So I think we understand your position on that. The document was just produced yesterday. I'm happy to discuss that with you.

Committee Counsel 2. Just so the record is clear, we did ask yesterday for an explanation of the redaction, and none has been forthcoming, so we will continue to await that.[211]

Treasury has never asserted any legal basis on which the Department may withhold information from Congress, instead cloaking itself in an effective assertion of the deliberative process privilege. It has raised the specter of the deliberative process privilege, but never actually asserted it. Treasury has not provided a valid legal basis to redact documents or withhold them from the committees, because no legal privileges apply in this instance. The Department has further failed to provide a log identifying the documents withheld from the committees, as required by the instructions provided with the subpoena.

Furthermore, there is no conceivable basis—let alone a legal one—for the Department of the Treasury to withhold part of the rationale for a final decision made by a cabinet-level official authorizing expenditures that could total $130 billion over ten years. As the Supreme Court made clear in *NLRB v. Sears, Roebuck & Co.*, the rationale behind a final decision cannot be withheld—"the public interest in knowing the reasons for a policy actually adopted by an agency"[212] requires that Treasury disclosure the rationale here and produce an unredacted version of the final Action Memorandum to the committees.

[211] Wilkins Tr. at 44–45.
[212] *NLRB v. Sears, Roebuck & Co.*, 421 U.S. 132, 161 (1975).

b. The Department of the Treasury has Not Undertaken a Reasonable—Let Alone a Thorough—Search for Records Responsive to the Committee's Subpoenas

FINDING: The Department of the Treasury did not undertake a reasonable or thorough search for records responsive to the committees' subpoenas.

Testimony from Administration officials demonstrates that the Department of the Treasury never undertook a thorough search for responsive documents, as required by the subpoena instructions. During a series of transcribed interviews with current and former Treasury and IRS officials, Treasury counsel appearing on behalf of the Department repeatedly refused to allow the witnesses to answer questions regarding whether they had collected documents pursuant to the committees' subpoenas. For example, Mr. Kane testified:

> Q. Between February 3rd, 2015, and today, has anyone ever instructed you to collect documents relating to the cost-sharing reduction program?
>
> Treasury Counsel. So I think this is another – you know, for the same reasons that we discussed a few moments ago, I think this is another question that is not among the things that Mr. Kane's here to discuss here.[213]

Similarly, Ms. Witter testified:

> Q. Ms. Witter, has anyone told you to collect records relating to the cost-sharing reduction program either recently or in the past year?
>
> Treasury Counsel. So, Amanda, that question about efforts that Ms. Witter has undertaken or not undertaken to respond to the committee's oversight requests, you know, is another area that we are not prepared to go into today. We have had some discussions with you, obviously, about documents. I'm happy to continue those discussions and that accommodations process.
>
> But Ms. Witter is here voluntarily today and is prepared to answer your questions about cost-sharing reduction payments consistent with the interests articulated in our correspondence. And so our suggestion would be to sort of move on to those questions. If there are other unresolved issues, we are happy to continue the dialogue with you about those.[214]

And, in a third instance, Mr. Kaizen testified:

[213] Kane Tr. at 22.
[214] Witter Tr. at 12–13.

Q. Has anyone instructed you to collect records related to the Cost Sharing Reduction Program?

Treasury Counsel. So, Amanda, I think that raises the same issue that I was explaining in response to the prior question.[215]

One witness, however, answered the question before Treasury counsel instructed him not to. Mark Mazur—the author of the Action Memorandum signed by Secretary Lew—said that no one had instructed him to collect records relating to the CSR program.[216] Mr. Mazur testified:

Q. Thank you. Has anyone asked you to collect records relating to the cost-sharing reduction program?

A. No.[217]

As the drafter of the memorandum authorizing the Department to make CSR payments from the permanent appropriation for tax credits and refunds, Mr. Mazur clearly possessed documents responsive to the committees' subpoenas. Mr. Mazur's interview took place on April 28, 2016, more than two months after the committees issued subpoenas to the Department and well over a year after the committees sent the original document requests.

The interviews also proved that records regarding the CSR program that Treasury and HHS should have collected and produced do exist. For instance, Mr. Mazur stated that he would have received the Action Memorandum returned with Secretary Lew's signature via email,[218] and Mr. Kane said that he received an electronic calendar invitation for the January 13, 2014 OMB meeting.[219] Similarly, IRS Chief Counsel Bill Wilkins received the Action Memorandum from Treasury Deputy General Counsel Roberto Gonzalez via email.[220] The committees have not received any of these documents.

Given this evidence, it is clear that the Department has not undertaken a reasonable, let alone thorough, search for responsive records pursuant to the subpoenas.

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[215] Kaizen Tr. at 12–13.
[216] Mazur Tr. at 10.
[217] Mazur Tr. at 10.
[218] Mazur Tr. at 40–41.
[219] Kane Tr. at 71.
[220] Wilkins Tr. at 34–35.

c. The Department of Health and Human Services has Not Produced All Records Responsive to the Subpoenas, and has Not Cited Any Valid Legal Basis to Withhold Any Materials

FINDING: The Department of Health and Human Services improperly withheld documents responsive to the committees' subpoenas without any valid legal basis to do so.

Since February 2015, HHS has made only three productions of documents to the committees. One of these productions consisted of only one substantive document, and another production consisted entirely of publicly available documents. The third production—the first containing any non-final internal documents—came only after each committee issued subpoenas compelling the production of all responsive documents. HHS continues to withhold information from the committees that it argues "implicates significant Executive Branch confidentiality interests in internal deliberations."

On March 3, 2016, more than a year after the committees first requested documents, HHS made its first production to the committees. The production consisted entirely of publicly available documents, and included excerpts from the Administration's fiscal year 2014 and 2015 budget requests, and five filings from the *House v. Burwell* litigation. In other words, the Department did not produce any documents the committees could not already access. In producing the documents, HHS acknowledged that it was withholding those that related to "internal Executive Branch deliberations" because they implicated "confidentiality interests."

On March 18, 2016, HHS produced two additional documents to the committees: a memorandum of understanding between the IRS and CMS that Treasury had recently produced to the committees, and a memorandum sent to Ellen Murray before her transcribed interview that "la[id] out the parameters of what she was authorized to discuss."[221] Once again, HHS refused to produce materials that it asserted "implicate[d] significant Executive Branch confidentiality interests."[222]

On May 6, 2016, HHS made a third production of documents to the committees. This was the first production made pursuant to the subpoena issued on May 4, 2016, and the first to include any non-final internal documents. For a third time, however, HHS refused to produce documents that, in its opinion, "implicate[d] significant Executive Branch confidentiality interests."[223]

HHS has failed to comply with the committees' subpoenas for documents. The stated reason that the Department is withholding information from Congress—that the materials

[221] Letters from Jim R. Esquea, Assistant Sec'y for Legis., U.S. Dep't of Health & Human Servs., to Hon. Kevin Brady, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Mar. 18, 2016).
[222] *Id*.
[223] Letters from Jim R. Esquea, Assistant Sec'y for Legis., U.S. Dep't of Health & Human Servs., to Hon. Kevin Brady, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (May 6, 2016).

"implicate significant Executive Branch confidentiality interests"—is vague and overbroad, and appears designed to block the committees from their pursuit of the facts surrounding the funding of the CSR program.

HHS has asserted no valid legal basis on which it can withhold this information from Congress, and has failed to provide a log of materials identifying the documents withheld from the committee, as required by the instructions provided with the subpoena. By citing the need to protect "internal Executive Branch deliberations" and "important Executive Branch confidentiality interests," HHS is effectively claiming the deliberative process privilege. This privilege, however, cannot be used to shield final documents or factual information. It further cannot be used to shield deliberative information when there are allegations of wrongdoing, let alone a finding of illegal and unconstitutional Executive branch actions by a federal court.

d. *The Office of Management and Budget has Refused to Produce a Memorandum Subpoenaed by the Committees, and has Not Cited any Valid Legal Basis to Withhold the Document*

FINDING: The Office of Management and Budget improperly withheld documents responsive to the committees' subpoenas without any valid legal basis to do so.

The committees subpoenaed OMB to compel production of a final memorandum regarding the source of funding for the cost sharing reduction program. On May 4, 2016, the committees subpoenaed OMB, requiring the office to produce the final memorandum. On May 18, 2016, in response to the subpoenas served by the committees on May 4, OMB again offered only "a summary of the government's legal analysis associated with the funding sources for the cost-sharing reduction program."[224] OMB explained that it would not produce the actual document because "the OMB memorandum contains internal deliberations and legal analysis associated with the funding sources for the cost-sharing reduction program."[225]

The document the committees seek provided the final advice of OMB and served as a basis for the Administration's final decision to use the permanent appropriation to fund the CSR program. A synopsis of this widely-reviewed memorandum, written years later, does not provide the information necessary to answer the committees' questions. And, similar to the responses of Treasury and HHS to subpoenas issued by the committees, OMB has not asserted a claim of privilege to withhold the document, nor provided a log justifying the withholding of the document as required by the subpoena.

As with Treasury and HHS, OMB is attempting to claim the protections of the deliberative process privilege without invoking the privilege because OMB knows full well that the privilege does not apply. The privilege cannot be used to shield final documents. Further, as

[224] Letters from Tamara Fucile, Assoc. Dir. of Legislative Affairs, Office of Mgmt. & Budget, to Hon. Kevin Brady, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (May 18, 2016).
[225] *Id.*

the Supreme Court made clear in *NLRB v. Sears, Roebuck & Co,* the privilege does not protect the rationale behind a final decision.[226] It also cannot be used to shield deliberative information when there are allegations of wrongdoing, let alone a finding of illegal payments by a federal court.

The Departments of the Treasury and HHS and the Office of Management and Budget have each explicitly refused to produce documents responsive to the committees' subpoenas. All have failed to provide logs detailing the documents withheld from the committees and the legal basis upon which they are withheld. Further, in withholding all internal and inter-agency documents from the committees, the Departments and OMB are effectively claiming the deliberative process privilege—which is inapplicable in these instances—without actually invoking the privilege.

Congress' oversight prerogatives would be severely undermined if it accepted the proposition that an agency could unilaterally decide to block disclosure of internal deliberations to Congress. This practice encourages agencies to withhold any documents that show flaws or limitations in the agency's position. These actions demonstrate that the Administration is engaging in obstruction tactics for the purpose of denying the United States Congress information and documents necessary to oversee the CSR program and to preserve its constitutional prerogative to determine how taxpayer money should be spent.

2. Treasury has Refused to Confirm to the Committee on Ways and Means whether the Department Timely Delivered Deposition Subpoenas to Witnesses

FINDING: The Department of the Treasury did not provide deposition subpoenas issued by the Committee on Ways and Means to the relevant deponents in a timely manner.

The issuance of a subpoena by a committee of the United States Congress imposes a legal obligation on the individual to whom the subpoena is directed. By its very nature, a subpoena compels specific action by a specific individual in a specific time frame. It is therefore necessary that subpoenaed individuals know about the legal obligations imposed on them by a subpoena.

As a courtesy to Administration employees, congressional committees customarily serve subpoenas for employees' testimony by allowing agencies to accept service on behalf of their employees in lieu of serving individuals the subpoenas directly. The department accepting service also assumes a responsibility of its own—that it will timely notify the subject that a subpoena has been issued to him or her, and deliver the subpoena and accompanying instructions to that person.

[226] *NLRB v. Sears, Roebuck & Co.*, 421 U.S. 132, 161 (1975).

On January 20, 2016, the Committee on Ways and Means issued deposition subpoenas to three IRS officials: Chief Counsel William Wilkins; former CFO Robin Canady;[227] and Deputy CFO Gregory Kane.[228] Each subpoena required the relevant deponent to appear before the Committee on Ways and Means and provide testimony on dates in late February and early March 2016. A Treasury Deputy Assistant Secretary for Legislative Affairs accepted service on behalf of these employees.[229]

In the normal course of its investigation, the committee sought to verify that Treasury timely provided notice of the subpoenas, and a copy of the subpoenas, to the employees themselves. Remarkably, however, Treasury has refused to confirm whether the Department ever provided those subpoenas and their attachments to the witnesses. Treasury has also refused to provide the date on which the witnesses were made aware of the subpoenas. Not only has the Department itself refused to answer these standard questions, but Treasury counsel has further prevented the witnesses themselves from telling the Committee on Ways and Means when they received the subpoenas.

All evidence, however, suggests that Treasury did not give the subpoenas and accompanying documents to the witnesses in a timely manner. Five days prior to the first scheduled deposition, on February 18, 2016, committee staff still had not heard from counsel for the witnesses. On that day, Treasury counsel informed Ways and Means staff that Robin Canady, who was scheduled to testify on February 23, 2016, was out of the country.[230] The next day, however, Treasury counsel called Ways and Means staff again to say that the IRS Chief Counsel's Office had learned the previous evening that Mr. Canady had already returned to the country, suggesting that Treasury had not previously been in touch with Mr. Canady about his deposition.

Further, during interviews of the three employees,[231] Treasury counsel refused to allow the witnesses to answer questions about the subpoenas, including when—or even if— they had

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[227] At the time the subpoena was issued, the committees believed that Mr. Canady was a current employee of the Internal Revenue Service. In fact, he had retired from the IRS shortly before the subpoena was issued. The Department of the Treasury arguably should not have even accepted service on behalf of a former employee. At a minimum, the Department should have immediately informed the committees that Mr. Canady had retired from federal service.

[228] Subpoena to William Wilkins, Internal Rev. Serv., U.S. Dep't of the Treasury, from H. Comm. on Ways & Means (Jan. 20, 2016); Subpoena to Robin Canady, Internal Rev. Serv., U.S. Dep't of the Treasury, from H. Comm. on Ways & Means (Jan. 20, 2016); Subpoena to Gregory Kane, Internal Rev. Serv., U.S. Dep't of the Treasury, from H. Comm. on Was & Means (Jan. 20, 2016).

[229] Email from Deputy Assistant Sec'y of Legis. Affairs, U.S. Dep't of the Treasury, to Committee Counsel, H. Comm. on Ways & Means (Jan. 20, 2016).

[230] Email from Maj. Oversight Staff Dir., H. Comm. on Ways & Means, to Deputy Assistant Sec'y of Legis. Affairs, U.S. Dep't of the Treasury. (Feb. 19, 2016).

[231] As an accommodation to the Department and the witnesses, the Committee on Ways and Means agreed to conduct the proceedings as transcribed interviews instead of depositions, thus allowing Treasury counsel to attend the proceedings. *See* 161 Cong. Rec. E21 (daily ed. Jan. 7, 2015) (statement of Rep. Sessions, Procedures for Use of Staff Deposition Authority), *available at* https://www.congress.gov/crec/2015/01/07/CREC-2015-01-07.pdf. The Procedures prohibit counsel for an agency under investigation to attend depositions, but under the practices of the Committee on Ways and Means, agency counsel may attend transcribed interviews.

received the subpoenas and accompanying documents from the Department.[232] For example, Treasury counsel permitted Mr. Wilkins to testify that he was "aware" of the deposition subpoena issued to him by the Committee on Ways and Means, but did not permit him to testify about when he received a copy of the subpoena. He testified:

> Q. Are you aware that Chairman Brady sent you personally a subpoena to testify at deposition, Mr. Wilkins?
>
> A. Yes.
>
> * * *
>
> Q. Mr. Wilkins, are you willing to tell us when you received a copy of that subpoena?
>
> Treasury Counsel. So for the reasons I've stated, we're not in a position to answer that question today. It's not what we're here voluntarily to discuss with the committee. And so on that basis, I instruct you not to answer.[233]

Similarly, Mr. Kane testified:

> Q. Are you aware that Chairman Brady sent you a subpoena to testify at a deposition?
>
> Treasury Counsel. You can answer that "yes" or "no."
>
> A. Yes.
>
> Q. When did you become aware of that subpoena?
>
> Treasury Counsel. I think this is another question that we're not in a position to answer today.[234]

Mr. Kane did answer, however, that "[t]he only letters I saw was eventually in the news article that had my subpoena in it where you could click on things. **That was the first time, when I went through that, I saw any of the documents that were going back and forth.**"[235]

During Mr. Wilkins' interview, counsel for the Committee on Ways and Means explained the importance of knowing if and when the Department provided the subpoena to the witness. Counsel for Treasury disagreed, claiming this was not information the committee needed to have in this instance. Counsel stated:

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[232] Kane Tr. at 26-27; Wilkins Tr. at 18–19. Counsel refused to allow Robin Canady to state whether he had received his subpoena, as well, although that interview was not transcribed.
[233] Wilkins Tr. at 18–23.
[234] Kane Tr. at 26.
[235] *Id.* at 19 (emphasis added).

Committee Counsel. But to be clear, we think that this is a little separately situated from the earlier questions, which you have made your position clear on.

The subpoena itself was actually issued directly to Mr. Wilkins by the chairman, not to the Department of the Treasury, and it's a legally binding document that requires his attendance at a deposition. So whether or not he received it and when he received it is vitally important to this committee's investigative work, as well as the prerogative of Congress to be able to conduct oversight.

I understand that you are saying that you would like us to be able to move forward with mutually agreeable practice, but if we have no way of knowing when or if the witnesses receive a legally-binding document, then we are in a very untenable position in enforcing this document. And so without an assurance of the date when he received the subpoena, and frankly, that the date he received the subpoena is the date it was issued, that's not a practice that we will be able to continue going forward. So I would ask you to consider allowing the witness to answer the question of when he received the subpoena.

Treasury Counsel. Right. So as I explained, and we talked about this offline, and to sort of restate, we honestly don't understand the issue here, given that each of these witnesses, we've arranged for them to appear voluntarily. If there is an issue with respect to going forward and continuing the practice of agencies accepting service of subpoenas, we are more than happy to work through that issue with you.

If there is some additional information you need, I'm happy to talk about what that information is and how to provide it to you. But I think we have a difference of views as to whether this line of questioning implicates the interest we've articulated about sort of protecting our ability to respond to congressional investigations.[236]

A Department that accepts service of a subpoena on behalf of one of its employees has an obligation to send the subpoena and any attachments to the employee as soon as practicable. Treasury has refused to confirm whether or when it provided lawfully-issued congressional subpoenas to the relevant deponents after a Treasury official accepted service on the deponents' behalf, even in informal telephone calls with staff. These refusals strongly suggest that Treasury failed in its obligation to provide the subpoenas to the relevant deponents after accepting service on their behalf. This failure raises questions about the courtesy provided by Congress to the Administration and its employees whereby congressional committees allow agency officials to accept service on behalf of their employees instead of serving individuals directly.

[236] Wilkins Tr. at 20–21.

3. The Department of the Treasury Issued Testimony Authorization Memoranda to Witnesses Based on Over-Broad Touhy Regulations

Before most IRS witnesses appeared before the committees, Treasury provided the witnesses a "Testimony Authorization" outlining the topics Treasury had decided the employee could and could not discuss.[237] These memoranda are issued "[p]ursuant to Delegation Order 11-2 and 26 C.F.R. 301.9000-1" and are based on Treasury's so-called *Touhy* Regulations.

In *United States ex rel. Touhy v. Ragen*, the Supreme Court held that the federal Housekeeping Statute permitted the DOJ to prohibit agency officers and employees from releasing "official files, documents, records and information," except in the Attorney General's discretion.[238] The Housekeeping Statute allows Executive branch agencies to prescribe regulations regarding the "custody, use, and preservation of its records, papers, and property."[239]

Seven years after the Court decided *Touhy*, Congress added a provision to the Housekeeping Statute explaining that that the statute "does not authorize withholding information from the public or limiting the availability of records to the public."[240]

Almost all agencies now have implemented some version of *Touhy* regulations to govern their record management and explain what employees may and may not do with agency records. While many of those rules are appropriate, Treasury relied on their *Touhy* regulations to obstruct this investigation and prevent witnesses from speaking freely with Congress. In those instances, a federal statute, specifically 5 U.S.C. § 7211, trump the regulations. The statute, which protects the right of federal employees to provide information to Congress, states:

> The right of employees, individually or collectively, to petition Congress or a Member of Congress, or to furnish information to either House of Congress, or to a committee or Member thereof, may not be interfered with or denied.[241]

Treasury's *Touhy* regulation, however, does precisely that.

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[237] Treasury Testimony Authorizations directed to Greg Kane, Robin Canady, Kirsten Witter, Mark Kaizen, Linda Horowitz, and David Fisher. Treasury staff sent emails to Ways and Means staff articulating similar limitations for Mr. Mazur's testimony. Mr. Wilkins did not receive a testimony authorization, likely because Delegation Order 11-2 gives him the same authority as the Commissioner to provide testimony. *See* IRS Delegation Order 11-2, Internal Rev. Manual at 1.2.49.3.

[238] *United States ex rel. Touhy v. Ragen*, 340 U.S. 462 (1951).

[239] 5 U.S.C. § 301, previously codified at 5 U.S.C. § 22. The current version states that "[t]he head of an Executive department or military department may prescribe regulations for the government of his department, the conduct of its employees, the distribution and performance of its business, and the custody, use, and preservation of its records, papers, and property. This section does not authorize withholding information from the public or limiting the availability of records to the public." *Id.*

[240] H. R. Rep. No. 85-1461, *as reprinted in* 1958 U.S.C.C.A.N. 335.

[241] 5 U.S.C. § 7211.

a. Treasury has Promulgated Extensive Touhy *Regulations that Allow the Department to Limit Information Current and Former IRS Employees Can Provide to Congress*

FINDING: The Department of the Treasury has promulgated *Touhy* regulations that—contrary to a federal statute—limit the rights of IRS employees to provide information to Congress.

Treasury's *Touhy* regulations and Testimony Authorizations impede congressional oversight, discourage congressional whistleblowers and the public airing of wrongdoing, and intrude on the prerogatives of Congress. Except in certain cases inapplicable here, the regulation provides:

> [W]hen a request or demand for IRS records or information is made, no IRS officer, employee, or contractor shall testify or disclose IRS records or information to any court, administrative agency or other authority, or to the Congress, or to a committee or subcommittee of the Congress without a testimony authorization.[242]

The regulation defines a testimony authorization as:

> [A] written instruction or oral instruction memorialized in writing within a reasonable period by an authorizing official that sets forth the scope of and limitations on proposed testimony and/or disclosure of IRS records or information issued in response to a request or demand for IRS records or information. A testimony authorization may grant or deny authorization to testify or disclose IRS records or information . . . .[243]

The regulation, which applies to current and former officers, employees, and contractors of the IRS, provides explicit instructions about what one should do upon receiving a request from Congress. The regulation requires:

> An IRS officer, employee, or contractor who receives a request or demand in an IRS congressional matter shall notify promptly the IRS Office of Legislative Affairs. The IRS officer, employee or contractor who received the request or demand shall await instructions from the authorizing official.[244]

If the IRS decides that it does not want the relevant employee to disclose information to Congress, the courts, or another body, the regulation states that the IRS can prohibit the person from speaking. The regulation states:

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[242] 26 C.F.R § 301.9000-3.
[243] 26 C.F.R. § 301.90000-1.
[244] 26 C.F.R. § 301.9000-4(e).

> If, in response to a demand for IRS records or information, an authorizing official…determines that the demand for IRS records or information should be denied, the authorizing official shall request the government attorney or other representative of the government to oppose the demand and respectfully inform the court, administrative agency or other authority, by appropriate action, that the authorizing official…has issued a testimony authorization to the IRS officer, employee, or contractor that denies permission to testify or disclose the IRS records or information.[245]

Further, if Congress, a court, or another authority insists that the relevant IRS official provide testimony or other information, the regulation requires the individual to risk contempt of court or Congress by refusing to disclose the information sought. The regulation states:

> In the event the court, administrative agency, or other authority rules adversely with respect to the refusal to disclose the IRS records or information pursuant to the testimony authorization…the IRS officer, employee or contractor who has received the request or demand shall, pursuant to this section, respectfully decline to testify or disclose the IRS records or information.[246]

If a current or former IRS officer, employee, or contractor violates the regulation, the IRS can subject him or her to severe penalties. The regulation states:

> Any IRS officer or employee who discloses IRS records or information without following the provisions of this section or § 301.9000-3, may be subject to administrative discipline, up to and including dismissal. Any IRS officer, employee, or contractor may be subject to applicable contractual sanctions and civil and criminal penalties[.][247]

While such punishment may be reasonable in instances in which an IRS employee discloses information protected by law, such as taxpayer files,[248] as applied to requests from Congress for information about IRS procedures, actions, and decisions, it is inconsistent with 5 U.S.C. § 7211. Treasury's *Touhy* regulations also, on their face, prevent whistleblowers and other concerned employees from disclosing malfeasance at the IRS, and may also run afoul of other federal statutes protecting disclosures made by whistleblowers.

[245] 26 C.F.R. § 301.9000-4(f).
[246] 26 C.F.R. § 301.9000-4(g).
[247] 26 C.F.R. § 301.9000-4(h).
[248] *See* 26 U.S.C. § 6103 (prohibiting disclosure of taxpayer information except in specified circumstances).

b. *Treasury Used Its* Touhy *Regulations to Prohibit Employees from Answering Questions from Congress about the CSR program*

FINDING:	**Treasury used its *Touhy* regulations and Testimony Authorizations to prohibit current and former IRS employees from providing testimony to Congress about the source of funding for the CSR program.**

The Testimony Authorizations given to most of the Treasury employees who appeared before the committees all provide that "[p]ursuant to Delegation Order 11-2 and 26 C.F.R. 301.9000-1, you are authorized to appear and give testimony, subject to the limitations listed below." The Testimony Authorizations provided one area in which the witness could provide testimony, and twelve areas in which they could not. These twelve prohibited areas of testimony greatly narrowed the one area in which witnesses could provide testimony. In fact, the Testimony Authorizations specifically prohibited witnesses from speaking about the exact issues Congress had been investigating for more than a year: namely, the deliberations and decisions surrounding the Administration's choice to use the § 1324 permanent Treasury appropriation to make the CSR payments. The Testimony Authorizations state:[249]

Unless prohibited in the next section, you may:

- Testify as to facts of which you have personal knowledge in your official capacity regarding cost-sharing reduction payments under the Affordable Care Act.

You may not:

- Testify as to facts of which you have no personal knowledge;
- Speculate as to matters of which you have no sure knowledge;
- Testify in response to general questions concerning the positions, policies, procedures, or records of the Internal Revenue Service that are not relevant to the investigation or reasonably calculated to lead to the discovery of relevant information;
- Testify as to any current litigation;
- Testify regarding legal advice provided, the thought processes of agency personnel or answer hypothetical questions;

[249] Memorandum from Leonard T. Oursler, Nat'l Dir. of Legis. Affairs, Internal Rev. Serv., to David Fisher, Former Chief Risk Officer, Internal Rev. Serv. (April 21, 2016).

- Disclose information about internal IRS deliberations, or deliberations between IRS and Treasury or other Executive Branch agencies or offices, regarding cost-sharing reduction payments under the Affordable Care Act;
- Testify as to any criminal investigation by the Treasury Inspector General for Tax Administration and his staff; agents and employees of the Federal Bureau of Investigation; and/or attorneys, agents and employees of the Department of Justice;
- Testify as to other cases or other matters of official business not relevant to the investigation or reasonably calculated to lead to the discovery of relevant information;
- Disclose information that may tend to identify a confidential informant, if any;
- Disclose returns or return information protected by I.R.C. sec. 6103, if any;
- Disclose tax convention information subject to I.R.C. § 6105, if any.
- Disclose information that is secret pursuant to Fed. Crim. P. 6(e), if any.

Treasury counsel instructed witnesses to refrain from not to answering numerous questions posed by Committee staff on the grounds that they were outside the scope of the Treasury's unilateral Testimony Authorization. Further, during Mr. Wilkins's transcribed interview, Treasury counsel stated that the Department has a say in whether or not Mr. Wilkins responded to questions. Treasury counsel stated:

> Committee Counsel. Right. But the question is to Mr. Wilkins, and he can either answer it or not answer it as he sees fit. As general counsel of the IRS, I'm sure he's capable of answering the question and making that judgment for himself.
>
> So the simple question is, are you willing to answer the question as to when you became aware of the subpoena issued by Chairman Brady of the Committee on Ways and Means?
>
> Treasury Counsel. And I just want to say – I just want to make clear that – and this may be another area where we have a difference of views. And I'm happy to, you know, discuss this with you, you know, offline in greater detail. But I – you know, **with respect to his official capacity actions, the agency does have, you know, a sort of say in how that works. It's not solely Mr. Wilkins' decision.** And so we think it's unfair to put him on the spot in the way that you're trying to do.

> We've tried to be very transparent with you about what these witnesses are going to be here voluntarily to talk about and what we're not going to be in a position to talk about. And this is a question that we're not in a position to discuss.[250]

Given Treasury counsel's statement, counsel for Ways and Means made clear to the witness that the Department could not restrict him from answering the committees' questions. Counsel stated:

> Committee Counsel. I want to be really clear, the committee disagrees with that position. Your ability to speak to Congress is guaranteed by law. Your right to speak to Congress is guaranteed under the First Amendment, and it is actually not the decision of the agency as to what you can answer. If you would like to take their guidance, of course, you're welcome to do that, you know that. But I want to make the record clear that we do not agree that the Department of the Treasury or the department -- or IRS itself has a legal right to restrict you from providing information to the United States Congress.
>
> Treasury Counsel. I just want to say we have a different view about that, you know.[251]

Treasury counsel's statement that he had a "different view" about the ability of the Department of the Treasury or the IRS to restrict an individual from providing information to Congress is extremely concerning. Any such restriction by the Department of the Treasury, or any other department or agency of the Executive branch, would be in violation of the First Amendment and 5 U.S.C. § 7211.

These regulations and testimony authorizations require IRS employees to get permission from the IRS before speaking to Congress, and then to limit their speech to Congress to those topics approved by the IRS, or else risk losing their jobs. By their explicit terms, they prevent whistleblowers and other concerned parties from disclosing malfeasance at federal agencies, and they are inconsistent with 5 U.S.C. § 7211, which protects federal employees' right to speak to Congress. Moreover, it is clear from the limitation prohibiting witnesses from testifying about the Administration's deliberations regarding the CSR payments that the Department intended to use the Testimony Authorizations to prohibit witnesses from testifying about the entire subject of the committees' investigation.

[250] Wilkins Tr. at 22.
[251] *Id.* at 24.

c. Treasury Officials Enforced Testimony Authorizations Inconsistently

FINDING:	**Treasury officials selectively enforced the Treasury Authorizations by allowing witnesses to answer certain questions prohibited by the authorizations without objection.**

Treasury itself demonstrated that the Testimony Authorizations were unsupported by legal authority and served only as a means to prevent officials and employees from turning over information to Congress that the agencies would rather keep private. Throughout the interviews, the agencies enforced the authorizations selectively. While agency counsels repeatedly prevented witnesses from answering questions posed by Majority staff, they allowed Minority staff to ask questions that implicated topics explicitly covered by the testimony authorizations.

Each authorization stated that, among other topics, witnesses may not "testify as to any current litigation."[252] Yet, during each transcribed interview of a current or former Treasury or IRS employee, the Minority staff of the Committee on Ways and Means asked a prepared set of questions about the *House v. Burwell* litigation. They asked each witness:

- In your understanding, is there ongoing litigation related to Section 1402 of the Affordable Care Act, which governs the cost-sharing subsidies?
- To your understanding, who filed that lawsuit?
- Who are the defendants in that lawsuit?
- In your understanding, what is the status of that lawsuit?
- Is it your understanding that both sides have stipulated that there are no material facts in dispute?
- To your understanding, what is the nature of the claims that are raised by the plaintiffs in the lawsuits?
- In your understanding, are you here today to discuss the same issues that are currently the subject of that lawsuit?[253]

Treasury counsel allowed each witness to respond to all of those questions without objection or interference.[254] During former IRS Chief Risk Officer David Fisher's interview, however, Ways and Means Majority counsel noted that, while those questions fit squarely within

[252] *See, e.g.,* Memorandum from Leonard T. Oursley, Nat'l Dir. of Legis. Affairs, Internal Rev. Serv., to Mark Kaizen, Gen. Legal Servs., Office of Chief Counsel, Internal Rev. Serv., Testimony Authorization (Apr. 6, 2016).
[253] Kane Tr. at 111-13; Wilkins Tr. at 49–51; Witter Tr. at 48–50; Horowitz Tr. at 57–58; Kaizen Tr. at 45–47; Mazur Tr. at 57–58.
[254] Kane Tr. at 111-13; Wilkins Tr. at 49–51; Witter Tr. at 48–50; Horowitz Tr. at 57–58; Kaizen Tr. at 45–47; Mazur Tr. at 57–58.

the Testimony Authorizations' prohibitions, agency counsel allowed Mr. Fisher to answer them anyway.[255] Counsel asked:

> According to the testimony authorization that we've discussed at length today that you received from the Department of Treasury, the Administration claims to limit your testimony, that you're not permitted to, quote, testify as to any current litigation.
>
> It seems to us that the Department of Treasury has not objected to four or five questions that the Minority just raised about the ongoing litigation and it's seems as though if not for Treasury's restriction, you would be willing to answer our questions. So in light of the four questions that the Minority just posed, I just have two additional questions on the topic of the ongoing litigation.
>
> Do you have any concerns about the legality of the cost-sharing reduction payments?[256]

Demonstrating the selective enforcement of the Testimony Authorizations, Treasury counsel objected and instructed Mr. Fisher not to answer the Majority's questions, stating why, in Treasury counsel's opinion, the witness could answer the Minority's questions. Treasury counsel stated:

> Treasury Counsel. So, Machalagh, that question, as you know, is very different from a question about, you know, publicly-available information about the ongoing status of the litigation and goes right to the core of the interests we've articulated in our prior correspondence.
>
> Committee Counsel. The testimony authorization simply says to ongoing litigation. I fail to see the distinction.
>
> Treasury Counsel. I'm happy to continue discussions with you about that.
>
> Majority Counsel. For the record, no objections were made when the Minority asked questions about something that's explicitly prohibited by the testimony authorization.
>
> Q. Did you have any concerns about this while you were chief risk officer at the IRS?
>
> Treasury Counsel. That question raises the same concern.[257]

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[255] Fisher Tr. at 124–26.
[256] *Id.* at 125.
[257] *Id.* at 125–26.

At this point, the witness, Mr. Fisher, interjected to protest Treasury counsel's inconsistent advice to him. He stated:

> I should have been advised, frankly, not to answer his question and I'm disappointed that I wasn't.
>
> The counsel here has advised throughout the entire morning things consistent with the authorization and I have followed every one of their pieces of guidance. It wasn't for me to go back and reread the authorization. That's what they're here for.
>
> Now that you've pointed it out, I look at the authorization and I should not have answered your questions because I also agree that it's inconsistent with the authorization. That doesn't – just because that has now been broken, that doesn't, to me, open any additional breaks in my testimony with respect to the things that are covered or not covered under the authorization.
>
> My position is the authorization holds and the things that I was prevented from discussing earlier remain prevented from being discussed as the questions I just answered related to litigation should have been covered and I should have been counseled not to answer them.[258]

This selective enforcement raises additional concerns about Treasury's promulgation of its *Touhy* regulations, and the subsequent reliance on those regulations in the course of the committee's interviews. Treasury has created a system in which the Department is the final arbiter of what a current or former official, employee, or contractor can say to Congress. Furthermore, Treasury can apparently amend the restrictions on an individual's testimony on the fly, and allow a witness to answer questions the Department views as favorable, but refuse to permit a witness to answer questions the Department deems unfavorable.

[258] *Id.* at 126.

4. HHS and OMB also Limited the Scope of Their Employees' and Former Employees' Testimony to the Committees

FINDING: HHS and OMB imposed scope restrictions to prevent current and former employees from providing full and complete testimony to Congress.

HHS and OMB also dramatically and unilaterally limited the scope of the testimony current and former employees were permitted to provide to the committees. Both entities precluded witnesses from providing information about internal agency deliberations, or deliberations between agencies within the Executive branch. Such restrictions are inconsistent 5 U.S.C. § 7211, cited above.

OMB Associate Director of Legislative Affairs Tamara Fucile sent a letter to the committees prior to the transcribed interview of Geovette Washington substantially and unilaterally limiting the scope of Ms. Washington's testimony. The letter stated:

> During the interview, Ms. Washington will not be in a position to disclose information about internal OMB deliberations or other Executive Branch deliberations in which OMB participated regarding the CSR program. The Executive Branch has significant confidentiality interests in these internal deliberations, including an interest in avoiding the chilling effect on future deliberations that would inevitably result from such disclosures.[259]

OMB relied on this letter to prevent Ms. Washington from answering the overwhelming majority of the committees' questions, including purely factual questions the answers to which are protected by no legal privilege. The broad testimonial restrictions imposed by this memorandum are inconsistent with 5 U.S.C. § 7211.

While OMB did not explicitly cite its own *Touhy* regulations as a basis for limiting Ms. Washington's testimony, it is concerning that the regulations do not expressly protect disclosure to Congress. OMB's *Touhy* regulations are codified at 5 C.F.R. § 1305.1. The regulation applies whenever a subpoena, order, or other demand of information from OMB is issued "in litigation (including administrative proceedings)."[260] The regulation requires that:

> No employee or former employee of OMB shall, in response to a demand of a court or other authority, produce any material contained in the files of OMB, disclose any information relating to materials contained in the files of OMB, or disclose any information or produce any material acquired as part of the performance of the person's official duties, or because of the

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[259] Letters from Tamara Fucile, Associate Dir. of Legis. Affairs, Office of Mgmt. and Budget, to Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Apr. 27, 2015)

[260] 5 C.F.R. § 1305.1.

> person's official status, without the prior approval of the General Counsel.[261]

The regulation further requires that the employee or former employee must refuse to produce the material or information even if a court so rules, thus risking contempt of court. The regulation states:

> If the court or other authority declines to stay the effect of the demand in response to a request made in accordance with § 1305.3(c) pending receipt of instructions from the General Counsel, or if the court or other authority rules that the demand must be complied with irrespective of the instructions from the General Counsel not to produce the material or disclose the information sought, the employee or former employee upon whom the demand has been made shall respectfully decline to comply with the demand.[262]

While the regulation makes clear that it applies "in litigation (including administrative proceedings)," OMB should amend the regulation to clearly protect the rights of OMB employees to provide information to Congress under 5 U.S.C. § 7211.

HHS' *Touhy* regulations, codified at 45 CFR 2.1, expressly exempt congressional requests or subpoenas for testimony or documents from its *Touhy* procedures.[263] Despite this exemption, however, HHS still dramatically, and unilaterally, restricted the scope of the testimony the Department would permit the witnesses to provide to Congress.

HHS Assistant Secretary for Legislation Jim Esquea sent each witness a memorandum providing "guidance on the extent to which you are authorized to provide information which may implicate Executive Branch confidentiality interests."[264]

[261] 5 C.F.R. § 1305.2.
[262] 5 C.F.R. § 1305.4 (citing *United States ex rel. Touhy v. Ragen*, 340 U.S. 462 (1951)).
[263] 45 C.F.R. § 2.1(a), (d)(2).
[264] *See, e.g.,* Memorandum from Jim Esquea, Assistant Sec'y for Legis., U.S. Dep't of Health & Human Servs., to Ellen Murray, Assistant Sec'y for Fin. Res., U.S. Dep't of Health & Human Servs. (Mar. 3, 2016).

DEPARTMENT OF HEALTH & HUMAN SERVICES | OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

TO: Ellen Murray, Assistant Secretary for Financial Resources

FROM: Jim Esquea, Assistant Secretary for Legislation JE

SUBJECT: Transcribed Interview before the House Committee on Energy and Commerce

DATE: March 3, 2016

It is my understanding that you will be participating in your official capacity as the Department of Health and Human Services' (HHS) Assistant Secretary for Financial Resources in a transcribed interview on March 4, 2016, pursuant to a request from the House Committee on Energy and Commerce in connection with its oversight inquiry regarding cost-sharing reduction payments under the Affordable Care Act. The purpose of this memorandum is to provide you with guidance on the extent to which you are authorized to provide information which may implicate Executive Branch confidentiality interests.

The Committee has indicated in its letters on this topic that they are seeking information regarding the development of the President's Budget as well as internal communications regarding appropriations available to implement this section of the ACA. As you know, HHS strives to cooperate with Congress and to respond to its requests for information regarding the programs we administer. In this case, we have been in regular communication with the Committee to reach an accommodation regarding its request. As part of that accommodation, the Department has agreed to the Committee's request that you participate in a transcribed interview tomorrow.

As you have discussed with my staff, and as reflected in the Department's correspondence with the Committee, particularly our March 3, 2016 letter, some of the information that the Committee is seeking implicates significant Executive Branch confidentiality interests. These confidentiality interests are heightened to the extent the questioning concerns the same issues as are before the court in the litigation brought by the House of Representatives. Accordingly, while you are generally authorized to respond to questions about the ACA's program for cost-sharing reductions, you should not disclose information about internal HHS deliberations or deliberations between HHS and other Executive Branch agencies or offices regarding this program. Of course, you should also be careful to testify as to those facts of which you have personal knowledge and to refrain from speculating as to matters of which you have no sure knowledge. Counsel from the Department will be available at the interview to answer any questions you may have regarding the scope of your authorization to discuss certain information.

Each memorandum instructed, "you should not disclose information about internal HHS deliberations or deliberations between HHS and other Executive Branch agencies or offices regarding [the cost sharing reduction] program."[265]

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[265] *See, e.g., id.*

Similar to OMB, HHS relied on this letter to prevent each HHS witness from answering the committees' substantive questions about the source of funding for the cost sharing reduction program. HHS counsel did not allow witnesses to provide purely factual information, such as the names of individuals involved in various decisions, and did not allow witnesses to answer substantive questions about the source of funding. Further, the broad testimonial restrictions imposed by this memorandum are inconsistent with 5 U.S.C. § 7211. On no occasion did counsel for the Administration provide the committees with a valid legal basis for restricting the testimony of witnesses appearing before Congress.

5. Lawyers for the Administration Did Not Allow Witnesses to Answer Substantive Questions about the CSR Program

From the start of this investigation, the committees were clear that they sought to understand the basis for the Administration's decision to fund the cost sharing reduction program through the permanent appropriation for tax refunds and credits, including who made relevant decisions about the source of funding. When the Departments refused to voluntarily produce documents to the committees, the committees sought to interview relevant fact witnesses. Each letter requesting interviews provided information on the scope of the interviews. For example, the committees' December 2, 2015 letters to Treasury and HHS each stated:

> The Committees seek to fully understand the facts that led to the administration's initial request for an annual appropriation to fund the CSR program payments to insurers, and the administration's subsequent actions, after Congress had rejected the appropriations request, to nevertheless pay insurers with funds from the permanent appropriation for tax refunds and credits.[266]

The committees' March 22, 2016 letter to Secretary Lew requesting additional transcribed interviews included the same statement, using nearly identical language, regarding the scope of the interviews.[267] The committees' letters to former Administration officials also asked that they "participate in a transcribed interview about the CSR program."[268] There was no question that the committees sought substantive information on the rationale for the Administration's decisions on the source of funding, including who made those decisions.

Yet, throughout every interview, counsels for the Administration consistently sought to prevent the witnesses from answering questions posed by the committees, effectively claiming some form of the deliberative process privilege in withholding large swaths of information from Congress.

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[266] Letters from Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury, and Hon. Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Serv. (Dec. 2, 2015).

[267] Letter from Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury (Mar. 22, 2016).

[268] Letters from Hon. Paul Ryan, Chairman, H. Comm. on Ways & Means, and Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Geovette Washington, Marilyn Tavenner, & David Fisher (Mar. 22, 2016).

A proper invocation of the deliberative process privilege involves two prongs: (1) the information must be predecisional, or created prior to the agency or department reaching a final decision, and (2) the information must be deliberative.[269] To be deliberative, a document or communication must relate to the thought processes or opinions of relevant officials—the information cannot be purely factual.[270] This privilege, when applicable, protects only predecisional documents—information about a final decision, including the rationale for the decision, cannot be withheld.

The deliberative process privilege is not absolute; it can be overcome by a showing of need.[271] Moreover, the privilege "disappears altogether when there is any reason to believe government misconduct [has] occurred."[272] The actions of the Administration in illegally making CSR payments from the permanent appropriation—as recently decided by a federal court—make the privilege inapplicable. Further, the testimony withheld by the Administration in this investigation far exceeds the bounds of the deliberative process privilege, even if it were to be applicable in this instance.

a. Counsel for HHS Instructed Witnesses Not to Answer Substantive Questions About the Source of Funding for the CSR Program

FINDING: HHS counsel prevented witnesses from answering substantive questions regarding the cost sharing reduction program, citing the need to protect "internal deliberations" and "confidentiality interests" as justification to withhold information from Congress.

HHS counsel repeatedly instructed witnesses not to answer substantive questions regarding the source of funding for the CSR program. Despite numerous inquiries from Committee counsel, HHS counsel refused to provide a valid justification for restricting the witnesses' testimony. The reasons provided—that the Department can withhold information that seeks internal or interagency deliberations, or seeks information it deems protected by a vague and undefined "confidentiality interest," or "embeds a deliberative fact" into a question the Department does not want a witness to answer—are not legally cognizable bases on which the Administration can withhold information from Congress.

Nearly every topic regarding the source of funding for the CSR program was deemed off limits by HHS counsel. For example, Ms. Murray could not answer questions about OMB's involvement in the initial request for an annual appropriation:

> Q. Do you recall when OMB did pass back its decision to HHS, what its decision was, with regard to the request for an annual appropriation for the Cost Sharing Reduction Program?
>
> <u>HHS Counsel</u>. So just to be clear, **from our perspective that that**

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[269] *In re Sealed Case (Espy)*, 121 F.3d. 729 (D.C. Cir. 1997).
[270] *Id.*
[271] *Id.*
[272] *Id.*

question calls for the witness to reveal internal interagency deliberations and so Ms. Murray is not in a position to be able to answer that question today.

Committee Counsel. Are you instructing her not to answer the question?

HHS Counsel. I'm explaining to the committee that obviously we are working hard to accommodate your interests in this investigation consistent with our interests in the executive branch's deliberative interests.

And so she's not – consistent with the letter that we sent you last night – prepared to answer that question today, but we'd be happy to talk about ways to address your interests after this interview.[273]

Or on whether any budget appeals during HHS' FY 2014 budget process implicated the CSR program:

Q. Do you recall whether there was any appeals that involve the Cost Sharing Reduction Program?

HHS Counsel. **And, again, because of the confidentiality interests of the executive branch, Ms. Murray is not prepared to answer that question today.**

Committee Counsel. Are you instructing the witness not to answer that question?

HHS Counsel. I am explaining that at this moment in this interview today, for the reasons laid out in our letter, consistent with the scope for this particular interview, that Ms. Murray is not prepared to answer that question today.[274]

Or on when HHS determined it did not need an annual appropriation for the CSR program:

Q. When did HHS determine that it didn't need an annual appropriation for the Cost Sharing Reduction Program?

HHS Counsel. **So to the extent that that question requires you to disclose the contents of internal deliberations relating to this issue, then I would caution you not to include those in your answer.**

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[273] Murray Tr. at 28 (emphasis added).
[274] *Id.* at 30–31 (emphasis added).

I would also caution you that this is a question about what HHS knows and that you should only answer as to your personal knowledge.[275]

Or on whether HHS requested an annual appropriation for the CSR program in the fiscal year 2015 budget:

Q. At that point, did HHS request annual appropriations for the Cost Sharing Reduction Program?

HHS Counsel. For the reasons that we talked about, **answering that question would require – would implicate the deliberative confidentiality interests that we have talked about, so Ms. Murray is not in a position to answer that question today.**

Committee Counsel: It is a factual question, it calls for a yes-or-no answer, we believe the answer to this question is distinguishable from any communications that may have taken place during that time.

HHS Counsel. I think the issue is that what we are talking about here is the communication between HHS and OMB, that is an interagency communication prior to the release of the President's budget. **And, so, that is a pre decisional deliberative communication.**[276]

In addition, HHS counsel did not consistently apply the agency's own determinations as to whether or not a question called for "internal deliberations." Ms. Murray testified:

Q. Did HHS request an annual appropriation for the Cost Sharing Reduction Program when it submitted its request to OMB?

HHS Counsel 1. **I'm going to caution the witness not to reveal the substance of internal interagency deliberations.**

Committee Counsel. This is a factual question. It's a yes or no answer whether it was included. It doesn't speak to internal deliberations.

HHS Counsel 1. Do you think it's okay?

HHS Counsel 2. Yes.

HHS Counsel 1. Okay. The witness can answer.

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[275] *Id.* at 38 (emphasis added).
[276] *Id.* at 67–68 (emphasis added).

Witness: We did. We did request an appropriation.[277]

Almost immediately thereafter, however, HHS counsel decided that Ms. Murray should not have answered that question because it was an "internal deliberation." The interview continued:

Q. Do you recall when OMB passed back its decision to HHS's budget request?

A. You know, I do not. That was a year where we were on a CR and there was not a final CR, I don't believe, until March of 2013. My memory is that the process was late, so I don't remember when OMB passed back. It could have been later than regular process would dictate.

HHS Counsel. I'm just going to interject here. We're sort of working through the process and the scope issues relating to this.

Ms. Murray provided an answer at my direction to that question, but I just want to make sure that the record reflects that from our perspective the question did ask for an answer relating to internal deliberations relating to the budget request.

So I just want to make sure that the record reflects that **from our perspective that question was within the scope of a question about internal deliberations relating to the budget process.** I just want to be clear for the record going forward.

Committee Counsel. The question was a factual question. It called for a yes or no answer. It didn't call for any internal deliberations.

HHS Counsel. But it called for the contents of an internal deliberation of an internal deliberative document between two agencies, between HHS and OMB. I'm happy to continue. I just wanted to make sure in order not to prejudice our sort of interests going forward. I just wanted to make sure that the record reflected that.[278]

At various times, HHS counsel explained that a witness could not answer a question because it "embedded a deliberative fact." For example, Committee staff asked Ms. Murray how she learned of HHS' determination that it did not need an annual appropriation for the CSR program:

Q. How did you learn of this decision?

[277] *Id.* at 26–27 (emphasis added).
[278] *Id.* at 26–28 (emphasis added).

HHS Counsel. Again, so I'm going to caution the witness that to the extent that you're going to answer something that is going to reveal – I actually don't think that you can answer that question without revealing the substance of the determination because of the way the question is phrased.

Committee Counsel. Who told you?

HHS Counsel. Then we have the same problem. **If the question embeds the deliberative fact, then she wouldn't be able to reveal the identity of the person with whom, if anybody, she had the conversation because the deliberative fact is embedded in the question.**

Committee Counsel. **To the extent the deliberative process even applies, and, obviously, we disagree on that –**

HHS Counsel. I appreciate that.

Committee Counsel. – you know, **the witness has to segregate out facts. Not everything is deliberative just because it involved individuals at HHS. So in our opinion, facts that can be segregated out from any internal deliberations must be answered.**

HHS Counsel. I appreciate that. And I think the problem that we're having here is when the question embeds a deliberation, when the question is so specific as to what the conversation was about then she's in a situation where answering the question would reveal the deliberation.[279]

In another interview, committee staff asked Mr. Schultz whether the CSR program was discussed at a meeting that White House visitor records indicated he attended:

Q. Do you know whether the Cost-Sharing Reduction Program would have been discussed at this meeting.

HHS Counsel. He's not going to get into specifics of White House meetings.

Committee Counsel. I'm asking him a yes or no question, whether he knows if a particular policy was discussed at the meeting.

HHS Counsel. I understand.

[279] *Id.* at 39–40 (emphasis added).

[Witness confers with counsel.]

HHS Counsel. Again, the witness is here to voluntarily answer questions, but he's not going to get into the specifics of what was discussed at meetings involving White House officials.

Committee Counsel. Jessica is not asking for substance. She's asking if he recalls whether the Cost-Sharing Reduction Program was discussed.

HHS Counsel. Understood, but that embeds a deliberative fact when you're asking him.

Committee Counsel. Well, I mean, if the answer is yes, then it's either, yes, he recalls that it was discussed or, yes, he recalls that it was not discussed. If the answer is no, then he doesn't recall, but I don't understand how that embeds a deliberative fact.

HHS Counsel. He is here voluntarily. He's answered a number of your questions, but, again, we are not to going to get into specifics of White House meetings, going meeting by meeting. He's said he had meetings at the White House on CSR, but that's as far as he's going to go.

Committee Counsel. **Can you identify the deliberative fact that is embedded in the question so we can try to rephrase it?**

HHS Counsel. **As I said, he is not going to get into specifics of White House meetings.**[280]

When committee staff directly asked HHS counsel to identify the "deliberative fact" embedded in the question, HHS counsel would not, or could not, do so.

The position of HHS counsel that the Administration can block from disclosure to Congress the answer to any question that seeks internal or interagency communications, or an undefined "confidentiality interest," or "embeds a deliberative fact," exempts the entire executive branch from congressional oversight. Accordingly, during Ms. Murray's interview, committee counsel asked HHS counsel to clarify the position. Counsel stated:

Committee Counsel. So it is the Department's position that all communications and all documents would be subject to this privilege that you are claiming?

HHS Counsel. Again, and we have talked about on a number of occasions, we are working very hard to be in a position where we can

[280] Schultz Tr. at 51–53 (emphasis added).

accommodate your interests consistent with our executive branch confidentiality interests.

Committee Counsel. I understand that. Can you provide an answer to the question, please, whether this would apply to all documents that went through HHS and other agencies?

HHS Counsel. I think that we need to take this on a question-by-question basis, and a document-by-document basis, and sitting here today -- and also, to some extent, this is for the purposes of this interview today. We agreed to come here as a significant accommodation to your interests, subject to certain scopes, and we can certainly continue to have these conversations. But today for today's interview, the particular question that you have asked is not a question that Ms. Murray is prepared to answer today.

Committee Counsel. I will just note, again, for the record, that the scope is one that was set by the Department, not set by the committee, and we very much disagree with that scope.[281]

Committee counsel explained the concerns with HHS' position that no internal or interagency communications could be disclosed to Congress:

> We obviously disagree with the letter the Department sent last night. The Department does not get to set the terms and conditions of congressional oversight. That's something that this committee gets to do.
>
> We also have severe concerns with the scope limitations the Department has placed writ large. **That scope would exempt the entire executive branch from congressional oversight and obviously we think that's a bit of an extreme position. We have a number of questions with respect to what appears will be deemed internal deliberations by the Department.**[282]

HHS counsel did not relent and did not allow Ms. Murray or any subsequent witnesses to answer the committees' substantive questions about the CSR program. HHS' unilateral decision—made without any valid justification—to instruct witnesses not to answer substantive questions about the source of funding for the CSR program effectively exempted all decisions about the source of funding from the committees' investigation.

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[281] Murray Tr. at 68.
[282] *Id.* at 28–29 (emphasis added).

b. Witnesses Were Not Permitted to Answer Questions about the Names of Individuals Involved in Decisions about the Source of Funding for the CSR Program Employed at the Department of Justice and the White House

FINDING: Witnesses were instructed not to reveal to Congress the names of White House and Department of Justice officials involved in decisions regarding the cost sharing reduction program.

HHS counsel did not permit witnesses to identify the names of individuals involved in decisions about the source of funding for the CSR program who work or worked at the White House. For example, Ms. Murray testified that she spoke with someone in the Executive Office of the President about the CSR program between April and July 2014. HHS counsel, however, did not permit her to tell Congress with whom she spoke. Ms. Murray testified:

Q. Do you recall when the conversation with the Executive Office of the President took place?

A. I do not.

Q. Was it after the Senate report was released in July?

A. It was before.

Q. Do you recall who the conversation was with?

HHS Counsel. You can answer that.

Witness. Yes, I do.

Q. Who was the conversation with?

HHS Counsel. Again, because of our deliberative interests in maintaining executive branch confidentiality, Ms. Murray is not prepared to answer that question today.[283]

HHS counsel also instructed Mr. Schultz not to reveal the names of individuals at the White House involved in decisions regarding the CSR program. He testified:

Q. Do you recall who those conversations were with at either the White House or OMB during this time period?

A. Well, I recall some people they were with, yeah.

Q. Who were these people?

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[283] *Id.* at 63–64.

HHS Counsel. He's not going to get into participants in White House meetings.

Committee Counsel. Why?

HHS Counsel. We have certain Executive Branch confidentiality interests.[284]

Committee counsel asked HHS counsel to explain what barred Mr. Schultz from identifying individuals he worked with at the White House. HHS counsel only answered that the Executive branch has "confidentiality interests" in withholding the names of White House employees involved in decisions regarding the CSR program from Congress. HHS counsel explained:

Committee Counsel. Okay, but before we go to that, what specifically bars him from telling us which White House officials?

HHS Counsel. **We have certain confidentiality interests.** They are only heightened by lawsuit brought by the House. This is an accommodations process. As you've seen, he has answered a lot of questions, but he is not prepared at this time to talk about White House participants.

Committee Counsel. **Can you identify those confidentiality interests for us –**

HHS Counsel. **We have certain confidentiality interests.** We've articulated them in our letters and we've had conversations with you.

As I say, he has answered a number of questions. He's here voluntarily, and if we could proceed, he's happy to answer questions on a question-by-question basis.

Committee Counsel. **Those confidentiality interests have not been specifically identified. It's been very vague and overbroad.** Specifically, with regard to this, what is the specific confidentiality interest, the identity of who these people are?

HHS Counsel. I mean, we're talking about the development of the President's budget and that whole process. So that's something the Executive Branch has a longstanding interest in protecting the nature of those confidential communications.

Committee Counsel. We appreciate your position. We disagree with it,

[284] Schultz Tr. at 33–34 (emphasis added).

but we understand in part what you're saying, but I'm just a little confused about why the identity of the people would also be protected by this. **Is there a specific privilege that you're asserting to withhold these names?**

HHS Counsel. **What I can say is the confidentiality interests are particularly strong when we're talking about presidential advisors and presidential staff, and that's what we're talking about here.**

Committee Counsel. **Even the names of the people involved?**

HHS Counsel. **Correct.**[285]

HHS counsel refused to provide additional information to the committees on why it would not permit witnesses to reveal the identity of White House staff involved in discussions about the CSR program. Committee staff sought to clarify from HHS counsel on the basis for which they were withholding the names of these individuals:

Committee Counsel. Are you saying that because these are internal deliberations? Is that why you don't want to disclose the names of these individuals?

HHS Counsel. **I'm saying, again, we have confidentiality interests.** They are particularly strong when we're dealing with presidential staff and advisors.

Committee Counsel. Are these staff that aren't known to work at the White House? I mean, they're federal employees.

HHS Counsel. As we've articulated to you in our letters and, again, **we have confidentiality interests.** They are heightened by the lawsuit. What you're talking about, **we are getting into areas that involve presidential advisors and staff and the confidentiality interests are only heightened.**

This is an accommodations process. We're happy to continue these discussions.

Committee Counsel. Can you tell us what the decision involved in this is that you don't want to reveal the identity of individuals? I can only assume that this is some of sort of deliberative process privilege that you're seeking to invoke here. Can you tell us what the decision is specifically that prevents the department from identifying the names of the individuals who participated in the

[285] *Id.* at 34–36 (emphasis added).

conversations, not the substance?

HHS Counsel. As we said, we are not going to get into internal deliberations about the President's budget. We are not prepared today to talk about these participants. We're happy to continue the conversation, but at this point in time, we're not prepared to get into that.

Committee Counsel. **When you're seeking to withhold information from Congress because it's deliberative, there are a couple prongs the department has to meet to make a valid showing on that issue. The information must not only be deliberative, but it must also be predecisional.**

So can you identify for us what the decision is that you are holding this information back from the Congress?

HHS Counsel. You know, Mr. Schultz is here voluntarily. He's answering your questions. **We're not prepared today to go further than this, but, again, we are happy to continue these discussions.** This is an accommodation process between the agency and the committee.

Committee Counsel. **So then it sounds like you are not willing to identify the decision for us today; is that correct?**

HHS Counsel. **We are telling you that we have confidentiality interests heightened by the lawsuit brought by the House.**[286]

The Administration cannot withhold factual information such as the names of individuals involved in various meetings or decisions from Congress. Counsel explained:

Committee Counsel. We have, as Jessica mentioned at the start of the interview today, we have grave concerns about the scope that has been set by the department. **I'm not aware of a privilege that would allow someone to withhold the names of people who participated in conversations or meetings.**

For instance, when you're creating a privilege log of information that you are withholding from the Congress or from parties in litigation, that log includes the names of people involved on the E-mail or in the conversation. You know, **the fact that you are not even willing to answer some simple foundational questions about the grounds on which the department is withholding this information is very concerning and it's something that this**

[286] *Id.* at 36–38 (emphasis added).

committee does not agree with.

HHS Counsel. Understood, and this is an accommodations process. We're happy to continue the conversation going forward.[287]

OMB counsel similarly refused to allow Ms. Washington to identify the names of individuals she met with or otherwise spoke to at the Department of Justice and the White House who were involved in decisions related to the source of funds for the CSR program. At no time did OMB claim any privilege or provide any clear reason for refusing to permit Ms. Washington to disclose this information to Congress. Ms. Washington testified:

Q. Exhibit 7 is another White House Visitor Record Request from November 27th at 11 a.m. with Mr. Choe, Mr. Delery, Mr. Gonzalez, Mr. Meade, Mr. Schultz, Mr. Verrilli. Do you remember attending a meeting on November 27, 2013 at the White House with those persons I just listed?

OMB Counsel. As I mentioned, the Executive Branch has significant confidentiality interests in internal discussions or interagency deliberations and Ms. Washington is not going to discuss interagency deliberations today.

Q. The committee disagrees that the question has called for any kind internal deliberations at all, just merely the existence of the meeting. Are you willing to answer whether or not you attended a meeting with those individuals listed?

A. I am not authorized to answer that question today.

Committee Counsel. Thank you.

Q. Have you ever met with Kathy Ruemmler or talked with Kathy Ruemmler about the Cost-Sharing Reduction Program?

OMB Counsel. **Ms. Washington is not going to discuss any interactions she may or may not have had with any White House personnel.**

Committee Counsel. A few minutes ago, you suggested that if we asked specific names and asked if she's ever talked to them about the Cost-Sharing Reduction Program, she could answer that question, but that does not apply to White House personnel?

[287] *Id.* at 38–39 (emphasis added).

OMB Counsel. **Ms. Washington is not going to discuss any conversations that she may have had with White House personnel.**

Q. Ms. Washington, did you have any conversation with Roberto Gonzalez about the Cost-Sharing Reduction Program?

A. I believe I previously testified that I did.

Q. Do you believe those –

A. To the extent that that is the person who was the deputy general counsel at Treasury. . . .

Q. Do you remember having conversations with Don Verrilli about the Cost-Sharing Reduction Program?

OMB Counsel. **Again, Ms. Washington described that she had conversations generally with the Department of Justice, but she is not going to discuss the specifics of those conversations.**

Committee Counsel. So, previously, you allowed her to answer whether she talked about the CSR program with Kenneth Choe, I believe Stuart Delery, Robert Gonzalez, Chris Meade, William Schultz. We're asking about one more person on this list of people, and I don't see the distinction between Mr. Verrilli versus these other individuals on this list that you allowed her to answer the same questions.

OMB Counsel. I don't think she answered the question with respect to Stuart Delery or a Department of Justice official.

Q. Ms. Washington, with whom did you speak at the Department of Justice about the Cost-Sharing Reduction Program.

OMB Counsel. **Again, Ms. Washington is not going to discuss conversations that she may have had with Department of Justice officials, particular officials, if, in fact, she had those conversations.**[288]

Neither HHS nor OMB counsel provided a justification for why witnesses could not disclose the names of White House or DOJ officials involved in decisions regarding the source of funding for the CSR program. Further, even if HHS or OMB had asserted a legal privilege over the names of individuals involved—which neither did—no privilege exists that would protect the *names* of individuals involved in a conversation.

[288] Washington Tr. at 87–90 (emphasis added).

c. OMB Counsel Refused to Allow an OMB Witness to Answer Questions Regarding the Dates or Times of Meetings or Conversations with Other Administration Officials About the CSR Program

FINDING:	**OMB prevented a witness from answering factual questions regarding the dates or times of a meeting or conversation, refusing to invoke a legal privilege to justify withholding the information from Congress.**

Understanding who participated in what meetings or conversations, and when, was a critical component of the committees' investigation. Setting out a clear timeline of when the Administration made decisions regarding the source of funding is necessary to understand why and how the Administration decided that it did not, in fact, need an annual appropriation to make CSR payments after it initially requested one in fiscal year 2014.

Ms. Washington played a central role in providing the legal justification for the source of funds used to make CSR payments. Yet, OMB counsel prevented Ms. Washington from answering questions about meetings and conversations she had about the source of funding for the CSR program. For example, OMB counsel allowed Ms. Washington to answer that she met with Treasury's General Counsel in 2013,[289] and that she did not meet with anyone from the IRS in 2013,[290] but refused to allow her to answer questions regarding when she met with Mr. Schultz, HHS's General Counsel. OMB counsel justified preventing the witness from answering these factual questions not by invoking any sort of legal privilege—she explicitly refused to do that—but by citing the "confidentiality interests" of the Executive Branch. Ms. Washington testified:

> Q. At what point did you have conversations with Mr. Schultz at HHS?
>
> <u>OMB Counsel</u>. **Ms. Washington is not going to get into like particular – the time period of particular discussions or conversations that she may have had with individuals in the development of this issue.** She's just spoken generally that she had a conversation with Mr. Schultz about this issue.
>
> <u>Committee Counsel</u>. We're not asking deliberative – the content of the conversations. We are asking about the timing of when issues became – were brought to the attention of OMB or when issues were brought to the attention of Ms. Washington. Just basic factual question of time are not at all deliberative.
>
> <u>OMB Counsel</u>. Can you repeat your question?

---

[289] *Id.* at 24 (Ms. Washington testified that she worked with Chris Meade, the General Counsel of the Department of the Treasury).

[290] *Id.*

Committee Counsel. Sure.

Q. At what point did you have conversations with Mr. Schultz?

We just talked about when she spoke with Mr. Berger and when she spoke with people at the IRS. It's the same question pertaining to Mr. Schultz.

OMB Counsel. Well, but it pertains to interagency deliberations, not something internal to OMB or just, you know, a general discussion that she may have had with her staff, but when you talk about interagency deliberations about a particular topic, there's a heightened sensitivity there. **So, therefore, Ms. Washington is not going to discuss the individual interactions that she had with a particular person about this subject.**

Committee Counsel. With all due respect, this is not asking for any deliberative information. It's just at what point did she have a conversation with Mr. Schultz, just a month.

OMB Counsel. On a particular topic.

Committee Counsel. And she's already acknowledged that she had conversations with Mr. Schultz.

OMB Counsel. That's right.

Committee Counsel. **I don't think the time period of that is going to implicate any sort of deliberative issue.**

OMB Counsel. **She has discussed that she has had conversations with Mr. Schultz about this topic, and, you know, the particulars or the specific conversations and when those might have occurred is not something we're going to discuss today.**

Committee Counsel. I'm sorry. **There is absolutely nothing deliberative about the date in which a conversation took place.** We're asking very high-level process questions about the development of one issue. We are not asking about the substance of the interagency deliberations or even at the point about the internal deliberations that would have happened at OMB.

The factual existence of a conversation is not protected by any legal privilege and never has been. We're just asking for facts.

OMB Counsel. **So we're not asserting a legal privilege, to be clear, but we are saying that there are heightened sensitivities and confidentiality interests in particular conversations that Ms. Washington may have had.** If you'd like to speak generally and ask her, you know, was it in 2013, then I think that's something we could discuss, but in terms of zeroing in on a particular conversation that she may have had with a particular person on a particular topic, that, we believe has a heightened sensitivity.[291]

Committee counsel asked OMB counsel to explain these "heightened sensitivities." OMB counsel, however, could not do so. The interview continued:

Committee Counsel. **Could you explain the heightened sensitivity?** I hope that we can have a fruitful interview and that this can continue, but I'm very nervous based on the statements that you're making right now that we'll be able to make any actual progress.

OMB Counsel. Well, it seems like you're trying to zero in on a particular meeting that she may have had or may not have had, depending on the nature of the answer. **Particular specific conversations that she had with respect to this topic and the interagency deliberations that she may have had on this topic have a heightened sensitivity.**

Committee Counsel. **Can you articulate what that heightened sensitivity is?** You articulated when we began that she was aware of the January meeting that we were going to ask questions about and was prepared to talk about it.

OMB Counsel. I mentioned that we would talk about the January meeting in particular because I knew that the committee had an expressed interest and has articulated an interest in that meeting. So as a result, we are willing to be **extra accommodating** to the committee and to allow Ms. Washington to discuss that general meeting given what we understand to be a significant interest to the committee; however, **as you know, conversations between attorneys on a particular matter is an institutional interest of the Executive Branch and, as a result, that is why she will not be discussing particular conversations that she had with those attorneys.**

Committee Counsel. **The committee does not recognize that heighten sensitivity, and I do not, frankly, fully understand the heightened sensitivity that you are trying to articulate; but,**

[291] *Id.* at 24–27 (emphasis added).

again, we are not asking about the substance or interagency deliberations between Ms. Washington or any of the people that we have named so far. We are merely asking for when, for dates and times and facts, which are absolutely not deliberative.

So I think we'll just continue with the questions.

Q. Ms. Washington, did you speak with Mr. Schultz in 2013?

A. Yes, about cost-sharing reductions.

Q. About cost-sharing reductions. What timeframe in 2013 did these conversations or conversation happen?

OMB Counsel. Again, I think we just went over that **we're not going to get into particular conversations and particular dates and particular conversations between attorneys of the Executive Branch to address this specific issue.**[292]

Shortly thereafter, OMB counsel refused to allow Ms. Washington to answer if she met Mr. Schultz in person:

Committee Counsel. Ms. Washington, did you ever meet in a face-to-face meeting with Mr. Schultz to discuss cost-sharing reduction payments?

OMB Counsel. As I said, because you're asking her a specific question about a particular meeting on a particular topic, we think that that is something that she should – that she will not discuss today. She already acknowledged that she discussed cost-sharing reductions with him.

Committee Counsel. I asked if she had met with him face to face.

OMB Counsel. So you're asking her about a particular meeting on a particular topic.[293]

OMB counsel did, however, allow Ms. Washington to answer whether she talked with him on the telephone.

Q. Did you ever speak with him on the phone about the Cost-Sharing Reduction Program?

[292] *Id.* at 27–29 (emphasis added).
[293] *Id.* at 34.

A. Yes.[294]

When confronted with this inconsistency, OMB counsel could not articulate why she permitted Ms. Washington to answer questions about whether and when she spoke with Mr. Schultz on the phone, but not in person. Instead, OMB counsel stated that she could have prevented the witness from answering questions about the telephone calls if she so desired. Counsel stated:

> Q. Did he ever come to OMB to meet with you about the Cost-Sharing Reduction Program?
>
> OMB Counsel. Again, Ms. Washington is not going to talk about particular meetings that she had with –
>
> Committee Counsel. So you will let her answer questions about telephone conversations because those don't count as meetings, but you will not let her answer conversations about face-to-face meetings?
>
> OMB Counsel. Well, Ms. Washington will not talk about particular meetings that she had with respect to cost-sharing reductions, and I was –
>
> Committee Counsel. The line seems to be a little bit inconsistent here.
>
> OMB Counsel. **Well, we could have easily cut it off with respect to those calls as well, but in an effort to be accommodating, she answered those questions.**[295]

Throughout the interview, OMB counsel could not articulate why she permitted Ms. Washington to answer questions about conversations or meetings with some individuals, but not others. She further could not articulate why she did not allow Ms. Washington to answer questions about the dates or times on which various meetings occurred. At no time during the interview did OMB counsel provide a legally-cognizable reason for the extreme limitations placed on Ms. Washington's testimony.

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[294] *Id.* at 34.
[295] *Id.* at 35–36 (emphasis added).

d. The Administration Failed to Provide Any Valid Legal Grounds for Instructing Witnesses Not to Answer Substantive Questions Posed by the Committees

FINDING: The Administration sought to withhold information from Congress by effectively claiming the deliberative process privilege. That privilege does not apply in this instance.

Throughout the interviews, the Administration repeatedly instructed witnesses not to answer substantive questions about the source of funding for the CSR program. At no time during the course of the investigation did any lawyer for the Administration invoke or otherwise provide any legally-recognized basis upon which the information was withheld. Instead, Administration lawyers provided excuses such as the need to protect internal deliberations—including interagency communications—and unspecified "Executive branch confidentiality interests." That position allows the Administration absolute discretion over what it will and will not provide to Congress and fundamentally undermines the principles of congressional oversight.

The Administration effectively sought to cloak itself in the deliberative process privilege without actually invoking the privilege—because it was not applicable. Even if one were to assume that the Executive branch could use this privilege to withhold information from Congress, the nature of the information sought by the committees and the Executive branch's actions would make it inapplicable in this situation.

Even if it were applicable here, the deliberative process privilege is a privilege that may be invoked by the Executive in response to a request for internal, or deliberative, documents or testimony. A proper invocation of the privilege involves two prongs: (1) the documents and communications must be predecisional, or created prior to the agency or department reaching a final decision, and (2) they must be deliberative.[296] To be deliberative, a document or communication must relate to the thought processes or opinions of relevant officials—the information cannot be purely factual.[297] The Executive branch is required to disclose factual information that can be segregated from other material potentially protected by the deliberative process privilege.[298]

Because factual information is expressly not protected by the deliberative process privilege, the Administration cannot withhold information such as the names of persons involved in decisions or the dates and times of meetings. Further, no other legal privilege would protect purely factual information of this sort.

Additionally, the deliberative process privilege is not absolute; it can be overcome by a showing of need.[299] Moreover, the privilege "disappears altogether when there is any reason to believe government misconduct [has] occurred."[300] Overcoming the privilege carries such a low

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[296] *In re Sealed Case (Espy)*, 121 F.3d. 729 (D.C. Cir. 1997).
[297] *Id.*
[298] *Id.*
[299] *Id.*
[300] *Id.*

bar because, otherwise, agencies could withhold internal or deliberative material from Congress for any reason imaginable. The Administration could use the privilege to protect discovery of actual misconduct, shield information that shows flaws or limitations in an agency's position, or simply hide an embarrassing comment.

Finally, the deliberative process privilege cannot be used to withhold information about a final decision, including the rationale for that decision. The Supreme Court made this clear in *NLRB v. Sears, Roebuck & Co.*, dismissing the Administration's argument that such rationales cannot be provided to the committees.[301]

Given the Administration's illegal actions to fund the CSR program without a congressional appropriation, it cannot now withhold key testimony from Congress by effectively claiming that the information is protected by the deliberative process privilege. Thus, the Administration, without any legal grounds to do so, instructed witnesses not to answer substantive and other factual questions.

6. Lawyers for the Department of the Treasury Pressured at Least One Witness into Following Restrictions Set Forth in his Testimony Authorization

FINDING: The Department of the Treasury pressured at least one witness into following the restrictions set forth in his Testimony Authorization after the witness questioned Treasury's ability to limit his testimony.

The Administration successfully limited the testimony of most of their current and former employees by sending Administration counsels to attend the interviews. These counsels instructed witnesses not to provide full and complete answers to the Committees' questions. The counsels who attended—from Treasury, HHS, and OMB—all represented their Department or Office. At no point in time did they represent the interests of the individuals appearing before the Committee.

One witness, however, did not want agency counsel to accompany him. Former IRS Chief Risk Officer David Fisher spoke by telephone with Ways and Means Committee staff at approximately 4:00 p.m. on April 28, 2016 to confirm the date, time, and location of his transcribed interview, as well as discuss logistics of the interview process.[302] During that call, staff informed Mr. Fisher that he had the right to invite counsel—either agency counsel or personal counsel—to attend the interview with him.[303] Mr. Fisher told Committee staff that he did not believe that Treasury counsel represented his interests and did not wish for them to attend the interview.[304] Mr. Fisher also stated that he had already spoken to Treasury counsel and told them he did not want representatives from that office to attend his interview.[305]

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[301] *NLRB v. Sears, Roebuck & Co.*, 421 U.S. 132, 161 (1975).
[302] Fisher Tr. at 23.
[303] Phone call between David Fisher and Maj. Staff, H. Comm. on Ways & Means (Apr. 28, 2016).
[304] *Id.*
[305] *Id.*

After Mr. Fisher's conversation with Ways and Means counsel, Mr. Fisher received an email from IRS Counsel John McDougal. Mr. Fisher testified:

> Q. Mr. Fisher, when did you first see this testimony authorization?
>
> A. Thursday, again, late afternoon or early evening
>
> Q. Was that before or after the telephone call that you had with Machalagh Carr and myself?
>
> A. After. In fact, almost immediately after, as I recall.
>
> Q. Who sent this testimony authorization to you?
>
> A. John McDougal, counsel for IRS.[306]

The Testimony Authorization was one of four documents Mr. Fisher received from Mr. McDougal "almost immediately after" his phone call with Ways and Means staff. Mr. Fisher testified:

> Q. Other than the testimony authorization form, did you receive any other documents from the Department of the Treasury?
>
> A. Yes.
>
> Q. What were they?
>
> A. So most explicitly, I received a cover letter that came along with the authorization and I received copies of two regulations, Treasury Department regulations, covering this topic of deliberative process.
>
> Q. Who sent you the documents?
>
> A. All four documents came in the E-mail from Mr. McDougal on Thursday.
>
> Q. Who had written the cover letter or who signed it?
>
> A. Drita Tonuzi, Associate Chief Counsel, Procedure and Administration, which I believe is at the IRS. It could have been at Treasury. The letterhead is Office of Chief Counsel, Internal Revenue Service.[307]

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[306] Fisher Tr. at 14–15.
[307] *Id.* at 19.

The cover letter states:[308]

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

OFFICE OF
CHIEF COUNSEL

April 23, 2016

David M. Fisher

Dear Mr. Fisher:

I write regarding the request of the House Committee on Ways and Means and the House Committee on Energy and Commerce to interview you regarding your employment as an official of the Internal Revenue Service (IRS). I understand that you have scheduled a voluntary transcribed interview with the Committees on May 3, 2016, to discuss facts relating to cost-sharing reduction payments made under the Affordable Care Act. This letter provides information in response to questions that you have raised with IRS counsel.

As we have described to you, when current or former IRS employees are scheduled to appear for interviews related to their agency employment, the IRS's standard practice, consistent with that of other Executive Branch departments and agencies, is to assist them in preparing for their interviews. Similarly, agency counsel are available to accompany current and former employees to the interviews to support them in any way they can. IRS and Treasury counsel remain willing to provide this type of assistance to you directly, or through your private counsel, if you are interested in their assistance.

In conversations with IRS officials, you have asked about the policies and regulations IRS follows when former officials and employees are asked to testify about matters related to their IRS employment. Under the General Housekeeping Statute, 5 U.S.C. § 301, heads of executive agencies may prescribe regulations governing the custody, use, and preservation of their records and information. These regulations, usually referred to as "Touhy regulations" after the Supreme Court's decision in United States ex rel. Touhy v. Ragen, 340 U.S. 462 (1951), govern the conditions and procedures by which agency employees may testify about work-related issues. The IRS, like other Executive Branch agencies, has promulgated Touhy regulations applicable to your interview with the Committees. These regulations provide that IRS employees, including former employees, shall not "testify or disclose IRS records or information to any court, administrative agency or other authority, or to the Congress, or to a

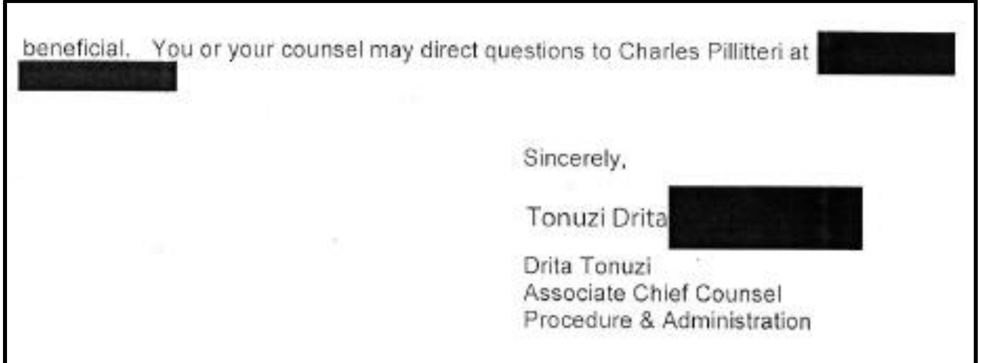
[308] Letter from Drita Tonuzu, Associate Chief Counsel, Procedure and Admin., Internal Rev. Serv., U.S. Dep't of the Treasury, to David Fisher (Apr. 23, 2016).

committee or subcommittee of the Congress without a testimony authorization." 26 C.F.R. §§ 301.9000-3(a); 301.9000-1(b). The regulations define "IRS information" to include "any information acquired by an IRS officer or employee, while an IRS officer or employee, as part of the performance of official duties." 26 C.F.R. § 301.9000-1(a). Thus, as the Internal Revenue Manual describes this regulation, "former employees and contractors who receive a request or demand for IRS records or information . . . must receive authorization to disclose such information." Internal Revenue Manual 34.9.1.3(4). For your convenience, we have enclosed a copy of these materials.

So that you may discuss IRS information with the Committees in your upcoming interview consistently with the IRS's Touhy regulations, we have also enclosed a testimony authorization. This document identifies the IRS information you are authorized to discuss with the Committees and is identical in substance to those received by the other current and former IRS employees who have been interviewed by the Committees in this matter. In particular, the testimony authorization clarifies that you are not authorized to disclose information about internal IRS deliberations, or deliberations between IRS and Treasury or other Executive Branch agencies or offices, regarding the cost-sharing reduction payments under the Affordable Care Act. Consistent with longstanding practices across administrations, the Executive Branch has significant confidentiality interests in such deliberations, based on the chilling effect on future deliberations that would inevitably result from their disclosure.

You have also asked about executive privilege. The Supreme Court has emphasized, in Cheney v. U.S. District Court for the District of Columbia, 542 U.S. 367 (2004), that executive privilege is "an extraordinary assertion of power 'not to be lightly invoked'" and that it should be "avoided whenever possible." As recognized by President Reagan's 1982 Memorandum on Procedures Governing Responses to Congressional Requests for Information (which continues to govern the Executive Branch's responses to congressional oversight), "[h]istorically, good faith negotiations between Congress and the Executive Branch have minimized the need for invoking executive privilege, and this tradition of accommodation should continue as the primary means of resolving conflicts between the Branches." Treasury and the IRS are engaged in an ongoing accommodation process with the Committees with respect to the matter that is the subject of your interview.

Please let us know if you or your counsel has any questions regarding the policies and regulations of the IRS described above, including the enclosed testimony authorization, or questions about your upcoming interview. As noted above, IRS and Treasury counsel remain available to assist you in this process. They would be happy to meet with you in advance of the interview to answer your questions or assist you in any way they can, and they are willing to accompany you to the interview if you feel it would be



beneficial. You or your counsel may direct questions to Charles Pillitteri at [redacted]

Sincerely,

Tonuzi Drita [redacted]

Drita Tonuzi
Associate Chief Counsel
Procedure & Administration

What the IRS' letter did not state is that 5 U.S.C. § 7211 specifically provides that no one may interfere with a federal employee's right to speak to Congress. Although the IRS claims here that its restrictions are just like other agencies that have issued *Touhy* regulations, other agencies specifically exempt congressional information requests from their regulations' restrictions like

HHS' regulations, or make clear that the regulations apply only in litigation, as OMB's do. Here, however, the IRS makes plain that it forbids its employees and former employees from speaking to Congress without explicit permission from the IRS.

Further, while Treasury lawyers told Mr. Fisher over the telephone that a "deliberative interest" protected the information Mr. Fisher had to share about the CSR program, Treasury suggested in its letter to him that they were in fact not asserting a legal privilege. Once again, the Department sought to avail itself of a legal privilege without explicitly claiming it.

In addition to the cover letter and Testimony Authorization, Mr. McDougal had previously provided Mr. Fisher with a White House Office of Legal Counsel opinion and other regulations and opinions about restrictions on agency employees sharing information with Congress.[309]

Three days after Mr. Fisher asserted to Committee staff that he did not wish for Treasury counsel to accompany him because they did not represent his interests and Treasury sent him the cover letter and Testimony Authorization, on Monday, May 2, a Deputy Assistant Secretary for Legislative Affairs at the Department of the Treasury emailed Committee staff about Mr. Fisher's interview. Attaching a Testimony Authorization for Mr. Fisher, she wrote, "In addition, Mr. Fisher has asked Treasury counsel to attend the interview tomorrow to provide advice regarding the scope of the authorization."[310]

Between April 28 and May 2, Mr. Fisher had two telephone conversations with Treasury counsel regarding his interview. In those calls, Treasury counsel provided instructions on the upcoming interview, including about how to respond to questions that asked about deliberative discussions. Mr. Fisher testified:

> Q. Did you receive any oral instructions from Treasury or the IRS about what you were or were not allowed to say today?
>
> A. Yes.
>
> Q. What were they?
>
> A. It was guidance on how to conform to the restrictions in the authorization, and so we had a little role play yesterday on the type of questions that could be answered and the type of questions that could not be answered per the authorization.
>
> Q. What are some examples of the questions that could not be answered?

[309] Fisher Tr. at 20.
[310] Email from Deputy Assistant Sec'y, Legis. Affairs, U.S. Dep't of the Treasury, to Maj. Oversight Staff Dir., H. Comm. on Ways & Means (May 2, 2016, 12:08 p.m.).

A. So in addition to, again, the list of items here, **the one that we spent the most time discussing was Bullet 6, which was on disclosing information about internal IRS deliberations or deliberations between IRS and Treasury or other Executive Branch agencies or offices regarding cost-sharing reduction payments under the Affordable Care Act.** So the deliberative process portion was the main portion of our discussion about what I could or could not talk about.

Q. How were the limitations on what you could disclose about the deliberative process described to you?

A. Could you be more specific?

Q. What was said to you about deliberative process?

A. So, fundamentally, that it's the Executive Branch's position that communication that is delivered in a deliberative fashion that ultimately leads to some decision is, in essence, not authorized for discussion at this particular hearing, and that includes my recollections of who said what to whom as well as my own recollections of what I might have said during those discussions that ultimately led up to a decision.

Q. Who gave you these instructions?

A. The Treasury counsel to my right.

Q. Mr. Crimmins?

A. And – both.

Q. When did they give you these instructions?

A. Yesterday.[311]

As part of his conversations with Treasury, Mr. Fisher also discussed the constitutionality of Treasury restricting his statements to Congress. He testified:

Q. Was that the only conversation that you had about deliberative process with Treasury or IRS counsel?

A. No.

Q. What were the other discussions?

[311] Fisher Tr. at 15–17 (emphasis added).

A. We had discussions about the – we had discussions about the constitutionality of the authorization.

Q. What did you say about the constitutionally of the authorization?

A. **I expressed some doubt as to whether or not these restrictions were not an infringement upon my own constitutional rights.**

Q. What was their response?

A. They gave a reasoned explanation as to why and some history about why the Executive Branch has historically at times served to protect its own deliberative interest to allow people to have free and open discussion without fear of being pointed out later on down the road and has embraced this – again, I'm reluctant to use the word "privilege", but to me, privilege of not allowing its employees, former employees, or contractors to sort of breach that, which is the essence of what I see in the authorization.[312]

During the course of the phone conversations, Treasury counsel also implied that there would be repercussions if Mr. Fisher did not follow the Testimony Authorization instructions. He testified:

Q. To your understanding, are there any repercussions if you do not abide by the authorization?

A. There certainly would be repercussions or could be repercussions if I was still an employee. It's unclear to me what, if any, repercussions would occur for a former employee.

Q. **Did anyone articulate any repercussions that could be imposed?**

A. **Not explicitly.**

Q. – if you did not abide –

A. I apologize. Go ahead and finish.

Q. If you did not abide by the instructions.

A. No explicitly.

Q. **Did they implicitly articulate any repercussions?**

[312] *Id.* at 17–18 (emphasis added).

A. **They represented the Executive Branch's position that the regulations that were in effect when I was an employee still cover me and, therefore, if nothing else, I would be violating those regulations, which in and of itself is a repercussion to be perhaps breaking a rule that I was under, constitutional objections aside.**[313]

Concerned by the pressure Treasury exerted on Mr. Fisher, and heightened by the discussion between Mr. Fisher and Treasury counsel about the implications of not following the Department's instructions, Committee counsel asked him to explain what happened between Thursday, April 28, when he told Committee staff that he did not believe Treasury represented his interests, and Monday, May 2 when Treasury staff informed the Committee that Treasury counsel would appear with Mr. Fisher. Mr. Fisher testified:

Q. Will you tell this committee what changed between 5:00 on Thursday and 12:08 on Monday when Treasury informed the committee that you had asked them to attend?

A. What changed was shortly after our phone call, I received the four documents that I've mentioned, the cover letter, the two regulations, and the testimony authorization, and I needed to decide the degree to which that authorization would impact my ability to answer some or all of your questions.

I spoke with Treasury about this, as I mentioned on Friday. I spoke with additional counsel. I weighed the different equities involved between the two branches of government and the two very different opinions that I had received in my more informal conversations with you all as well as with the Treasury counsel.

I weighed the responsibilities associated with the regulations which were in effect when I was an employee, even though I, honestly, was not aware of them, against the First Amendment Constitutional protections, I think that Amanda just alluded to, and my conclusion was while I may have an opinion on the merits of those arguments, I am not in a position to be the arbiter of that dispute.

If at some point in the future that the accommodation process comes to some sort of different conclusion, if there is a third-party finding of some sort that would provide some other definitive interpretation of which of these conflicting pieces of guidance actually trumps the other, then I would be in the position again to take a look at that additional information and I'd always weigh new information if it came along to see if that would change my

[313] *Id.* at 18-19 (emphasis added).

> position; but right now, I'm not in a position to be the arbiter of that dispute. So I need to be conservative in my approach, which is to abide by the authorization I've been provided.[314]

Mr. Fisher was put in an untenable situation: Congress requested information from him, and he was willing to provide it, but Treasury threatened him with an overly broad, inapplicable regulation.

Ultimately, the Ways and Means Committee subpoenaed Mr. Fisher to testify at a deposition the following week. Under the Procedures for Staff Deposition Authority issued by the House of Representatives Committee on Rules, Treasury counsel would not be allowed to attend. At that deposition, Mr. Fisher spoke freely and provided detailed information regarding his and Mr. Kane's concerns about paying for the CSR program from the § 1324 permanent appropriation. In the time between the transcribed interview and the deposition, Mr. Fisher asked Treasury if it planned to invoke a specific privilege to protect the information. He received no reply. Mr. Fisher testified:

> So I followed, as we all recall, the Treasury's guidance last week based on this testimony authorization, which had clear limitations associated with it, and was unable to answer questions consistent with that and the administration's guidance at the transcribed interview.
>
> The purpose of the phone call that I initiated last week with Treasury was to inquire, after reading the House rules, receiving the subpoena, and being aware that the only restriction – or the only reason to restrict answering questions under the subpoena would be privilege, and posed that to the administration, of whether or not they were planning to go to court and assert executive privilege around the deliberative process.
>
> I posed that. I did not receive an answer. I still have not gotten any answer back. I sent Treasury a note yesterday, so we didn't talk, but I sent them a note simply identifying that I had not heard from them. I'm assuming or deducing that no privilege is being asserted and have no further guidance from them regarding this.
>
> So I'm here under subpoena. It would have been far preferable to me for the executive branch and legislative branch to resolve this dispute independently and not sort of put me in the middle of being the arbiter of what to say or what questions to answer and what not to answer.
>
> But we are here under subpoena. I have no privilege assertion from the executive branch, which is the reason why I'm here to answer any of your questions without limitation.

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[314] *Id.* at 24–25.

> I wanted to walk through my thought process in trying to balance the equities here on the backs of an individual who should not be balancing those equities. Yet the administration had an opportunity to try to move forward on some other step along the lines of privilege. They clearly have chosen not to do that. I'm in no position to do that. I'm here to answer your questions.[315]

Treasury went to great lengths to prevent Mr. Fisher from providing full and complete answers to the committees' questions about the CSR program—and the reasons for the Administration's obstruction became clear during his deposition. The answers he gave in provided more insight into the Administration's decision-making processes than those of any other individual the committees interviewed with agency counsel present. His answers also shed light onto why the Administration has restricted the testimony of every other witness—going so far as to not letting witnesses answer questions about the names of individuals involved in the decision-making process—and why the Administration has failed to comply with the committees' document subpoenas.

In summary, the Administration has undertaken numerous specific actions to obstruct the committees' investigation. The Administration has:

- Failed to comply with the committees' subpoenas;

- Failed to timely deliver subpoenas issued by the Committee on Ways and Means to Administration employees;

- Relied on an overbroad regulation inconsistent with federal law to limit information provided to Congress;

- Unilaterally restricted the scope of the testimony that current and former employees provided to Congress;

- Instructed witnesses who appeared before the committees to not fully answer questions posed by Congress; and

- Pressured at least one witness who questioned the Administration's testimonial restrictions.

The Administration took the position that all information—be it in the form of documents or testimony—not already publicly available are somehow shielded from congressional oversight without any basis in law, precedent, or fact. The Administration did so while refusing to assert any claim of privilege—to the extent any even apply—over the documents sought by the committees. Yet, despite refusing to assert a privilege, the Administration effectively

[315] Fisher Depo. at 14–15.

asserted the deliberative process privilege in withholding documents and restricting witness testimony implicating, in the Administration's opinion, "internal Executive branch deliberations," among other purported justifications.

Congress' oversight prerogatives would be severely undermined if an agency could unilaterally decide to block disclosure of internal deliberations to Congress. This practice encourages agencies to withhold any documents that show flaws or limitations in the agency's position. Under the position advanced by the Administration here, agencies could withhold internal or deliberative documents from Congress for any reason imaginable—even if they simply included an embarrassing comment. It is for this precise reason that the deliberative process privilege can be so easily overcome. And the privilege is clearly overcome here, where a federal district court has already ruled the actions of the Administration to be unconstitutional.

The actions of the Administration—the self-styled most transparent administration in history—to conceal information about the CSR program from Congress and the American people are unacceptable. They may also be illegal. Obstructing a congressional investigation is a crime:

> Whoever corruptly . . . or by any threatening letter or communication influences, obstructs, or impedes or endeavors to influence, obstruct, or impede . . . the due and proper exercise of the power of inquiry under which any inquiry or investigation is being had by either House, or any committee of either House or any joint committee of the Congress, shall be fined under this title, imprisoned not more than 5 years or . . . both.[316]

It is also against the law to hinder federal employees in providing information to Congress.[317] Taxpayer dollars may not be used to pay the salaries of federal officials who deny or interfere with federal employees' rights to furnish information to Congress in connection with any matter pertaining to their employment.[318]

The federal obstruction laws reflect the fact that Congress' constitutionally based right of access to information is critical to the integrity and efficacy of its oversight and investigative

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[316] 18 U.S.C. § 1505.
[317] 5 U.S.C. § 7211.
[318] Div. E, § 713 of P.L. 113-235 ("No part of any appropriation contained in this or any other Act shall be available for the payment of the salary of any officer or employee of the Federal Government, who—
(1) prohibits or prevents, or attempts or threatens to prohibit or prevent, any other officer or employee of the Federal Government from having any direct oral or written communication or contact with any Member, committee, or subcommittee of the Congress in connection with any matter pertaining to the employment of such other officer or employee or pertaining to the department or agency of such other officer or employee in any way, irrespective of whether such communication or contact is at the initiative of such other officer or employee or in response to the request or inquiry of such Member, committee, or subcommittee; or, (2) removes, suspends from duty without pay, demotes, reduces in rank, seniority, status, pay, or performance or efficiency rating, denies promotion to, relocates, reassigns, transfers, disciplines or discriminates in regard to any employment right, entitlement, or benefit, or any term or condition of employment of, any other officer or employee of the Federal Government, or attempts or threatens to commit any of the foregoing actions with respect to such other officer or employee, by reason of any communication or contact of such other officer or employee with any Member, committee, or subcommittee of the Congress as described in paragraph (1).").

activities. Without effective oversight, Congress cannot be an effective steward of the taxpayers' dollars.

VIII. Conclusion

The Patient Protection and Affordable Care Act did not—and still does not—provide funding for the cost sharing reduction program. The Administration knew that. Internal Administration memoranda acknowledged that fact. Actions taken by the Administration in 2012 and 2013 demonstrated that fact. And indeed, the Administration initially requested an annual appropriation to fund the CSR program, knowing that the ACA did not provide a source of funding for the program and thus necessitated further Congressional action.

Yet, for reasons still unclear, the Administration informally withdrew that request by surreptitiously calling the Senate Committee on Appropriations, leaving no paper trail and hiding its actions from the public, before Congress denied it. The Administration then concocted a *post hoc* justification to raid the premium tax credit account—which was lawfully funded through the 31 U.S.C. § 1324 permanent appropriation—to pay for the CSR program. It memorialized this legal justification in an OMB memorandum reviewed by very senior Administration officials at multiple departments, including the Attorney General himself. IRS officials expressed concerns about funding the CSR program through this permanent appropriation. How could the Administration fund the CSR program this way without violating appropriations law? But when they expressed those concerns, they were essentially told that the decision had been made. Like it or not, the Administration was going forward with funding the CSR payments through the 31 U.S.C. § 1324 permanent appropriation. And it did so knowing that it would violate appropriations law, the Antideficiency Act, and ultimately, the United States Constitution.

The committees persistently pursued the facts underlying the Administration's decision to illegally fund the CSR program through a permanent appropriation. Because of the Administration's obstruction, however, many questions remain unanswered. When exactly did the Administration decide to pull its request for the annual appropriation? Did OMB's April 10, 2013 sequestration report affect that decision? Who decided that the Administration should pull the appropriation request and find a different source of funding, and why that was deemed necessary? Who instructed HHS Assistant Secretary for Financial Resources Ellen Murray to call the Senate Committee on Appropriations to withdraw the request? What does OMB's memorandum say? What did the Treasury Department redact from the final Action Memorandum that Secretary Lew signed?

These questions and others remain because the Administration has refused to cooperate, going to great lengths to obstruct the committees' investigation at every step. The Administration has refused to produce documents, despite lawfully-issued congressional subpoenas. The Administration has refused to allow witnesses to answer questions—even factual questions such as who and when. It has attempted to cloak its obstruction by essentially claiming an inapplicable legal privilege, yet insisting at every turn that it has not, in fact, claimed such a privilege. And in at least one instance, the Administration has intimidated a witness to chill his willingness to answer Congress' questions.

This is unacceptable. The Executive branch should not be permitted to shield how, when, and why it makes decisions from the American public—especially in this instance, in which the Administration decided to *unconstitutionally* spend taxpayer dollars that Congress did not appropriate. Congress is a co-equal branch of government and the branch most accountable to and representative of the American people. As such, the Executive branch must respect the constitutional powers and duties assigned to Congress, including the power to appropriate funds and the duty to conduct oversight over the laws it enacts. Unfortunately, the Administration has failed to do so here. The American people need and deserve better from their representative government.

Data Brief: 2016 Median Marketplace Deductible $850, with Seven Health Services Covered Before the Deductible on Average

Date	2016-07-12
Title	Data Brief: 2016 Median Marketplace Deductible $850, with Seven Health Services Covered Before the Deductible on Average
Contact	press@cms.hhs.gov

Data Brief: 2016 Median Marketplace Deductible $850, with Seven Health Services Covered Before the Deductible on Average

In the more than six years since the enactment of the Affordable Care Act, our country has made tremendous progress in improving access to health coverage and health care. The data show this: 20 million people have health coverage thanks to the Affordable Care Act, and for the first time in our nation's history, the uninsured rate last year fell below 10 percent.

Part of this success is thanks to the Health Insurance Marketplace, where 11.1 million individuals had coverage as of March 2016. This issue brief provides new information about the coverage selected by Marketplace consumers in states using the HealthCare.gov platform for the 2016 coverage year. Specifically, the data show:

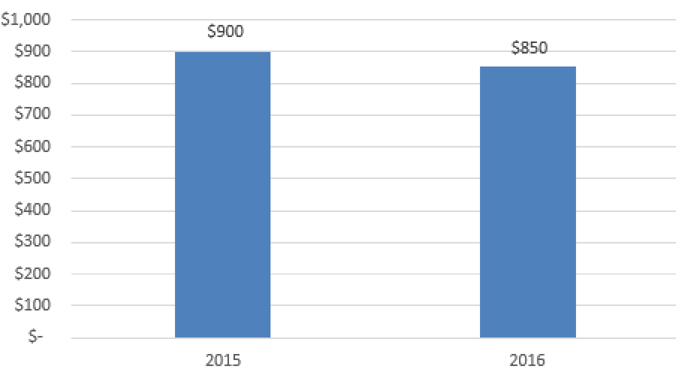
- The median individual deductible for HealthCare.gov Marketplace policies in 2016 is $850, down from $900 in 2015. Importantly, these figures account for the fact that many consumers qualify for financial assistance that lowers their deductibles based on their income. As with Marketplace premiums, many consumers' deductibles are well below the deductible that would apply without financial assistance, so ignoring financial assistance gives a misleading picture of what consumers actually pay.[1]
- On average, Healthcare.gov Marketplace policies cover seven common health care services (most often generic drugs and primary care visits), in addition to preventive services, with no or low cost-sharing before consumers meet their deductibles. This means that even accurately-measured deductibles present an incomplete picture of consumers' actual cost-sharing obligations, since deductibles do not apply to most consumers' most frequent health care needs.

Meanwhile, unlike many insurance policies sold before the Affordable Care Act was enacted, all Marketplace plans have out-of-pocket limits that protect consumers from catastrophic costs.

These findings on the moderate cost-sharing levels in Marketplace plans are consistent with other data showing that Marketplace policies are providing consumers with access to care and financial protection. For example, Marketplace consumers report accessing health services, including check-ups, physician services, and prescription drugs, at rates similar to consumers with employer-sponsored coverage, according to an Urban Institute survey .

Marketplace Plan Deductibles

A health plan's deductible is the amount the consumer needs to pay for certain health care services before the health insurance plan begins to pay. Deductibles can be an important factor in an individual's plan choice. In 2016, among all consumers purchasing HealthCare.gov Marketplace coverage, the median individual deductible is $850. This is lower than the $900 median deductible for 2015. (See Figure 1.)



These facts may seem surprising given anecdotes about Marketplace policies with very high cost sharing. However, those reports, which often focus on the highest-deductible plans in a market, ignore two important factors.

- Financial assistance. The figures in this analysis account for the fact that about 60 percent of 2016 HealthCare.gov Marketplace consumers qualify for financial assistance that reduces their deductibles, out-of-pocket maximums, and other cost-sharing obligations. For example, among consumers in silver plans who do not qualify for reduced cost sharing, the median deductible is $3,000, whereas the median deductible for groups of silver plan enrollees who do receive assistances ranges anywhere from $0 to $2,500, depending on the consumers' household income. (See Table 1.) Just as examining Marketplace premiums without accounting for advance payment of premium tax credits gives a highly misleading picture of what consumers actually pay, examining cost sharing without taking into account cost-sharing reductions substantially exaggerates consumers' actual deductibles.
- Consumer choice. Rather than choosing bronze plans, which generally offer the lowest premiums, Marketplace consumers are overwhelmingly choosing silver plans, which generally have higher premiums, but lower cost sharing. Last year, HealthCare.gov rolled out new shopping tools that help consumers estimate their total cost of care across different policies (taking into account both premiums and cost sharing). These tools let consumers make informed tradeoffs between up-front costs and more comprehensive coverage.

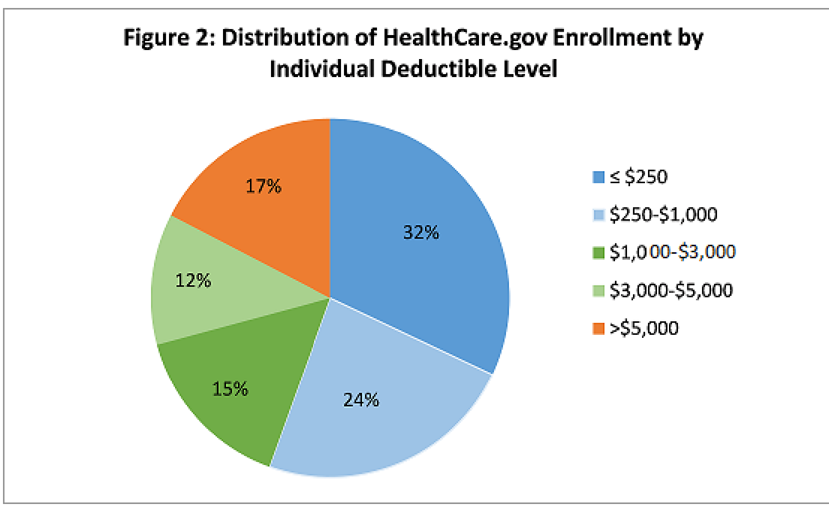
The net result of these factors is that about a third of HealthCare.gov Marketplace enrollees have deductibles less than or equal to $250, and over half have deductibles below $1000 in 2016. (Table 1.)

Table 1: Median Deductible and Enrollment by Metal Level

	Median Enrollment Weighted Deductible ($)		Share of Enrollment
	2015	2016	
Zero Cost Sharing*	0	0	0%
Silver - high cost-sharing assistance	100	0	33%
Platinum	250	0	1%
Silver - medium cost-sharing assistance	500	500	19%
Gold	1,000	1,000	6%
Silver - moderate cost-sharing assistance	2,500	2,500	9%
Silver - no cost-sharing assistance	3,000	3,000	12%
Bronze	5,750	6,300	21%
Catastrophic	6,600	6,850	1%
Total	**900**	**850**	**100%****

* Enrollees in zero-cost sharing plans are included in this analysis, but comprise less than half a percent of total Healthcare.gov Marketplace enrollment.

**Totals do not add up to 100% due to rounding.



Covered Services Before the Deductible

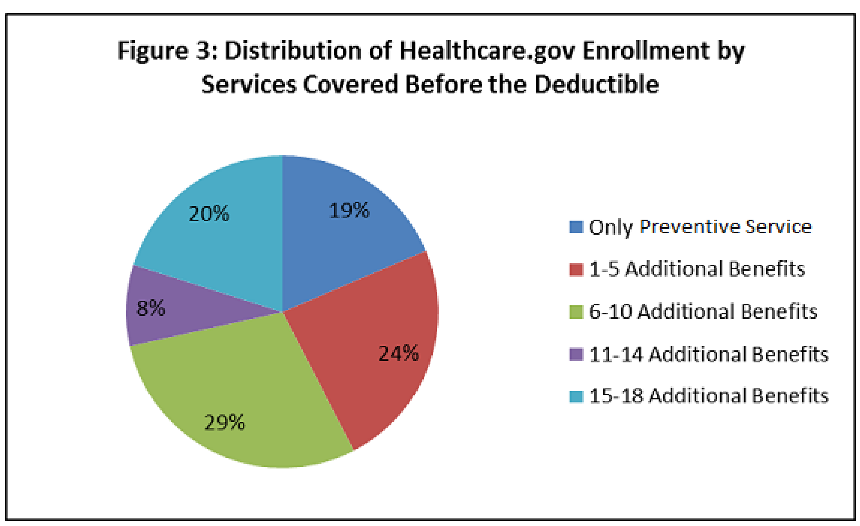
As we noted last year, unlike other kinds of insurance, like automobile or homeowner's insurance, many health insurance plans cover the costs of certain key services before someone meets their deductible. Not only do all plans cover preventive services such as cancer screenings, immunizations and well-child visits without cost-sharing, but most also cover commonly used health services either without cost-sharing or with low copayments, even if a consumer has not met the deductible. This means that even though a health plan has a deductible, it might not matter for the services used most frequently, like primary care visits or prescription drugs. In other words, just looking at the deductible – even after accounting for cost-sharing reductions – does not provide an accurate picture of Marketplace consumers' access to care.

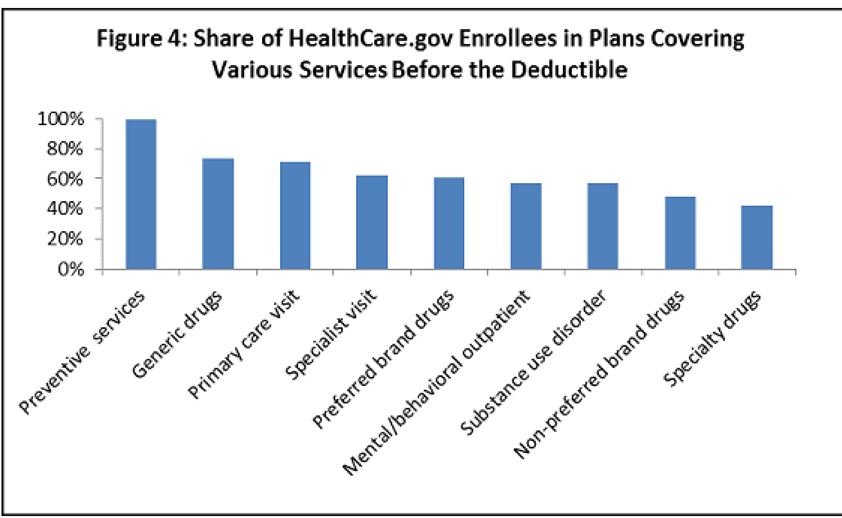
Similar to 2015, in 2016, on average, HealthCare.gov Marketplace policies cover seven services before the deductible, and approximately a third of HealthCare.gov Marketplace enrollees have policies that cover at least ten services before the deductible. (See Table 2 and Figure 3.) And the services most commonly covered before the deductible include the services typical consumers rely on most. (See Figure 4.)[2]

Table 2: Number of Additional (Non-Preventive) Services Covered Before the Deductible

	Services	Share of Enrollment
Platinum	13.2	1%
Silver - high cost-sharing assistance	10.6	33%
Silver - medium cost-sharing assistance	8.9	6%
Gold	8.2	19%
Silver - moderate cost-sharing assistance	6.9	9%
Silver - no cost-sharing assistance	6.7	12%
Bronze	1.4	21%
Total	7.3	**100%***

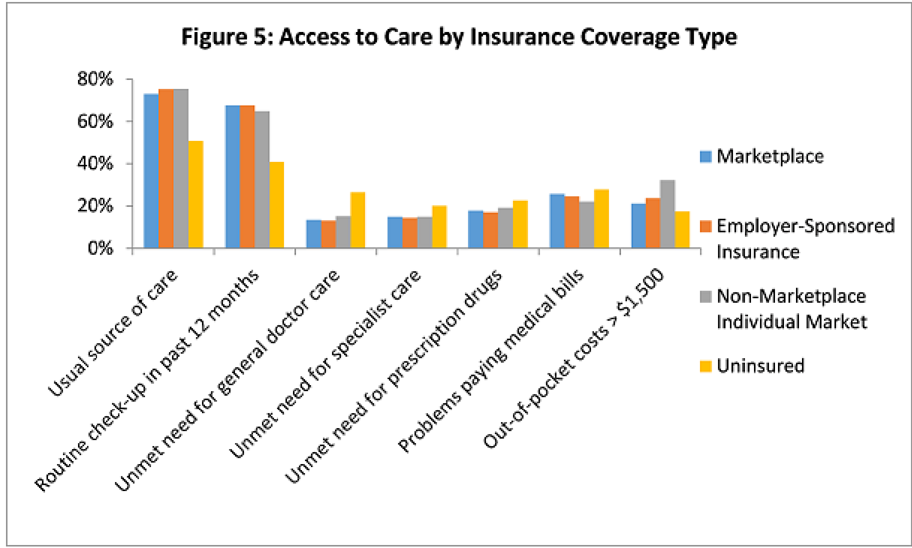
*Totals do not add up to 100% due to rounding.





Access to care and financial protection

The HealthCare.gov Marketplace plan data presented above help explain another important finding about Marketplace consumers: they appear to be using their coverage to access care at rates similar to consumers with coverage through their jobs. An Urban Institute survey found that across a range of measures of access to care and health-care related financial security, Marketplace consumers' experiences were generally not statistically distinguishable from those of consumers with employer coverage, while both groups reported far better access to care than those without health insurance in 2015. (See Figure 5.) In addition, Census data show that median total out-of-pocket costs (taking into account premiums, deductibles, and other cost sharing) for consumers purchasing health coverage through the individual market fell by 25 percent between 2013 and 2014, when the Health Insurance Marketplace and other individual market reforms in the Affordable Care Act took effect.



These data show that the promise of the Affordable Care Act is being realized for millions of Americans. It wasn't that long ago when too many of our friends and neighbors were locked out of health coverage because it was too costly or because of a preexisting condition. The Affordable Care Act changed that. It limited out-of-pocket costs, banned annual and lifetime dollar limits on essential health benefits, and guaranteed coverage of a set of core health services. This has given every American the peace of mind that their health coverage will be there when they need it.

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[1]All median deductible figures in this report are enrollment weighted.

[2]All plans are required to cover preventive services.

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: **August 11, 2016**

Subject: **Changes in ACA Individual Market Costs from 2014-2015: Near-Zero Growth Suggests an Improving Risk Pool**

Key Findings

- Per-enrollee costs in the ACA individual market were essentially unchanged between 2014 and 2015. Specifically, after making comparability adjustments described below, per-member-per-month (PMPM) paid claims in the ACA individual market fell by 0.1 percent from 2014 to 2015. For comparison, per-enrollee costs in the broader health insurance market grew by at least 3 percent

- Available evidence indicates that the slow ACA individual market cost growth resulted at least in part from a broader, healthier risk pool. In particular, states that saw stronger-than-average enrollment growth in 2015 saw greater-than-average reductions in PMPM costs. For example, in the 10 states with the highest 2015 growth in ACA individual market member months, PMPM claims costs fell by an average of 5 percent.

- Nearly all states saw continued growth in Marketplace enrollment in 2016, suggesting continued risk pool improvement. Moreover, the 2015 claims data also predate important steps CMS has taken over the six months to further strengthen the Marketplace risk pool. These steps include implementing new processes to prevent misuse of Special Enrollment Periods, reducing the number of consumers losing coverage or financial assistance due to data-matching issues, helping consumers who turn 65 move from the Marketplace onto Medicare, and proposing to curb abuses of short-term plans.

Analysis

On June 30th, the Centers for Medicare & Medicaid Services (CMS) released data on reinsurance payments for 2015.[1] Reinsurance payments are based on issuers' claims paid amounts for the full individual market, excluding grandfathered and transitional plans; the data include all plans sold on the Health Insurance Marketplace, including the federal HealthCare.gov Marketplace and the individual

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf

State-based Marketplaces, as well as off-Marketplace plans that are subject to the same pricing and coverage rules. Therefore, these data provide the first snapshot of how costs in the ACA individual market evolved from 2014 to 2015.

In the broader health insurance market, such as employer coverage and Medicare, per-enrollee costs grew 3 to 6 percent from 2014 to 2015. For example, the CMS Office of the Actuary estimates that per-enrollee growth in employer sponsored insurance (ESI) grew 3 percent[2]; the Kaiser Family Foundation's annual survey[3] and the Medical Expenditure Panel Survey[4] both estimate that average premiums for employer-based family coverage grew 4 percent; and insurers' projections of medical cost trend for 2015 averaged 6 percent.[5]

In contrast, in the ACA individual market, per-enrollee costs were essentially unchanged from 2014 to 2015. Specifically, after making comparability adjustments described below, per-member-per-month (PMPM) paid claims in the ACA individual market fell by 0.1 percent from 2014 to 2015. Moreover, this estimate likely overstates the true growth in per-enrollee costs, since it does not account for improvements in data reporting which likely increased measured PMPM costs.

Available evidence implies that the slow ACA individual market cost growth results at least in part from a broader, healthier risk pool. Supporting that interpretation, states that saw stronger enrollment growth in 2015 saw larger reductions in costs. For example, in the 10 states with the highest 2015 growth in ACA individual market member months, PMPM claims costs fell by an average of 5 percent. Likewise, states with higher enrollment growth saw larger improvements in risk adjustment program risk scores.[6] These data are encouraging for the future, since the Marketplace and the broader ACA individual market continue to grow.

Data and Methodology

This analysis draws on data collected by CMS to administer the ACA's transitional reinsurance and risk adjustment programs. To operationalize these programs, CMS implemented a distributed data approach through External Data Gathering Environment or "EDGE" servers. Issuers upload enrollee, pharmaceutical claim, medical claim, and supplemental diagnosis information from their systems to an

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[2] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

[3] http://kff.org/health-costs/report/2015-employer-health-benefits-survey/

[4] https://meps.ahrq.gov/data_stats/summ_tables/hc/hlth_insr/2014/alltablesfy.pdf

[5] 6 percent is the average medical cost trend insurers reported on the Uniform Rate Review templates filed for the 2015 plan year.

[6] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf

issuer-owned and controlled EDGE server.[7] Our analysis is based on claims data submitted to EDGE servers for calendar years 2014 and 2015.[8]

In order to accurately capture year-over-year changes in claims costs, we make two comparability adjustments to the EDGE data. First, we exclude from this analysis a small number of issuers who had self-admitted material errors in their EDGE submissions for either 2014 or 2015. In 2014 in particular, a small minority of issuers experienced difficulties with their EDGE submissions and failed to submit a material fraction of their claims; this would naturally distort year-over-year comparisons. (Issuers with errors in either year are excluded from the data in both years.)[9]

Second, we adjust the 2015 data to remove the estimated effect of cross-year claims. For the first time in 2015, issuers could submit cross-year claims, or claims that began in the year before the benefit year. In contrast, cross-year claims were not allowed in 2014 since the ACA individual market did not exist in 2013. The inclusion of cross-year claims in 2015 but not 2014 distorts any comparison of 2015 and 2014 claims costs. Unfortunately, it is not possibly to directly identify cross-year claims in the EDGE data. Instead, we used two different data sets from similar markets to estimate the magnitude of cross-year claims relative to total claims. The analysis of indicates that cross-year claims comprise about 4 percent of total claims costs.[10] This estimate is also consistent with issuer estimates of incurred but not received claims costs in the past year's MLR filings, which measure a different but related set of claims.

Even with the comparability adjustments described above, our estimates likely overstate 2015 claims growth. In particular, by 2015, most issuers had a year of experience submitting claims to the EDGE servers, meaning that the 2015 claims data are probably more complete than the 2014 data (even excluding those issuers who had self-admitted material errors).

Key Findings

With comparability adjustments, PMPM claims cost in the ACA individual market were essentially unchanged from 2014 to 2015, falling by 0.1 percent. As noted above, estimates of 2015 cost growth in the broader private insurance market range from 3-4 percent, while projected estimates of 2015

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[7] EDGE data requirements differ from other data submission requirements (e.g., MLR). Unlike the MLR data, the EDGE data include only ACA risk pool plans (both individual and small group) and thus provide the best available information on the ACA individual market.

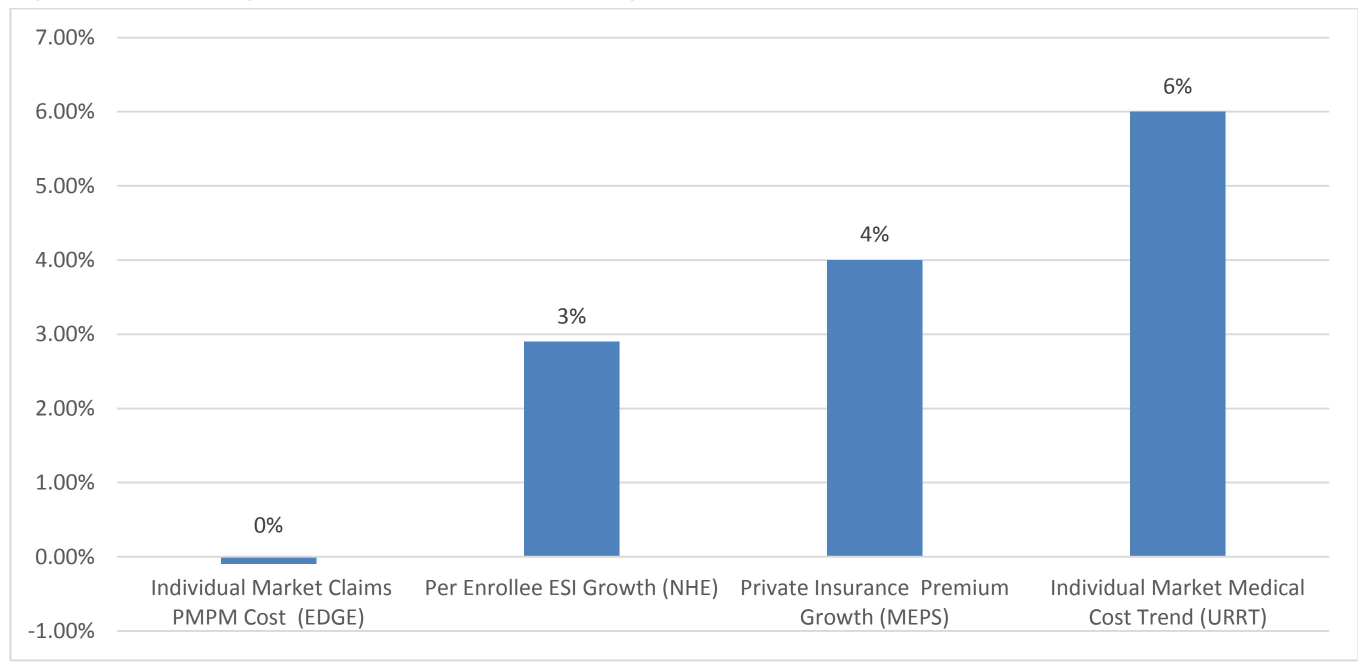
[8] The data exclude Massachusetts, which operated its own risk adjustment program for 2014 and 2015 and therefore did not provide CMS with some of the data needed for this analysis.

[9] We excluded approximately 6 percent of member months in 2014 and 4 percent of member months in 2015. The impact on overall per-enrollee claims growth of these exclusions is about 1 percentage point.

[10] Cross-year claims comprise about 4 percent of total claims costs, even though they comprise a smaller share of claims, because they are disproportionately expensive claims. CMS estimated the additional cost of cross-year claims using data from the California Office of Statewide Health Planning and Development (OSHPD) files. Claims costs were categorized by the admission and discharge date with claims that started in the preceding year but were completed in the following year were categorized as cross year claims. Special thanks to Jim Watkins for the OSHPD analysis. The estimate was cross-validated using the same specifications w Truven Marketscan data.

medical trend averaged 6 percent. This implies that per-enrollee costs for the ACA individual market, adjusted for underlying medical cost growth, fell from 2014 to 2015.

Figure 1. Cost Changes 2014 to 2015 (Percent Change)



In principle, the below-trend growth in claims costs in the ACA compliant market could reflect multiple factors. For example, changes in plan designs, such as greater enrollment in plans with higher cost sharing or increased utilization management by insurers, could have contributed to lower costs. In practice, however, average plan actuarial value, a measure of the overall level of cost sharing plans include, was roughly constant between 2014 and 2015.[11] Likewise, an independent analysis concluded that network breadth also remained roughly constant from 2014 to 2015.[12] Plan costs could also have gone down as pent-up demand effects faded for 2014 newly-ensured enrollees, but many new 2015 enrollees were themselves recently uninsured. Meanwhile, changes in average enrollment duration likely put upward pressure on costs from 2014 to 2015 since the average plan participant was enrolled for a longer period in 2015 than in 2014.[13] Typically, PMPM claims costs increase the longer a member is enrolled because people who are enrolled longer are more likely to meet their deductibles and then be enrolled for some period in which they face low or no cost sharing.

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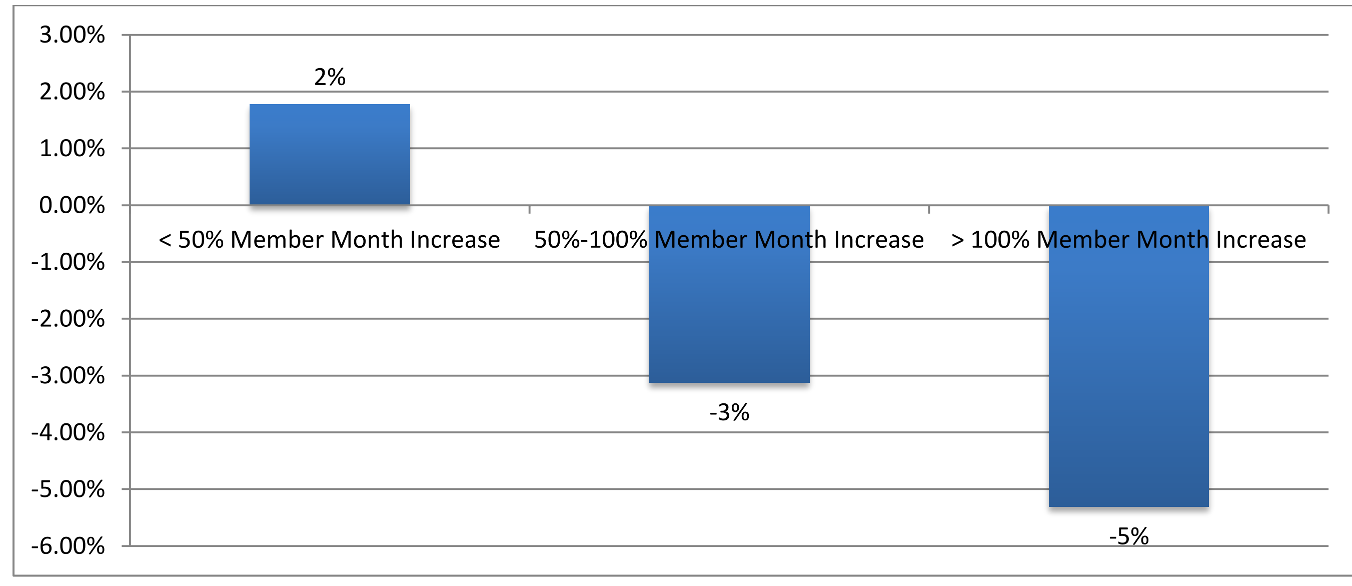
[11] The ACA individual market member month weighted actuarial value level, excluding effects of cost-sharing reductions, was approximately 1 percent lower in 2015 than it was in 2014 (June 30th report for 2014 and 2015 Appendix A). The proportion of enrollees with cost sharing reductions was also similar in 2014 and 2015.
[12] http://healthcare.mckinsey.com/sites/default/files/McKinsey%20Reform%20Center_2016%20Exchange%20Networks_FINAL.pdf
[13] The average number of member months per enrollee increased approximately 8% between 2014 and 2015 in the ACA individual market according to EDGE data.

Rather, it seems likely that the below trend growth in ACA individual market claims costs reflects at least in part an improving risk pool. Supporting that interpretation, cost growth was lower, and often negative, in states that saw the most growth in Marketplace enrollment – growth that would have been expected to broaden their risk pools. Overall, total ACA individual market member months increased 66 percent in 2015, reflecting higher Marketplace enrollment, increased enrollment duration, and shifts from grandfathered and transitional plans into the ACA individual market. On average across states, stronger growth in individual market enrollment translated into larger improvement in PMPM claims costs. In the 13 states with member-month growth of less than 50 percent, PMPM claims increased by an average of 2 percent. Meanwhile, in the 27 states with member-month growth between 50 and 100 percent, PMPM claims fell by an average of 3 percent, and in the 10 states with member-month growth exceeding 100 percent, PMPM claims fell by an average of 5 percent. (See Figure 2 and appendix maps.)

Also consistent with the interpretation that slow cost growth reflects an improving risk pool, risk adjustment program risk scores fell in states experiencing higher enrollment growth relative to those that experience lower enrollment growth.

Figure 2. Average Claims Cost PMPM Change by Member-Month Growth Group



Of note, states in the Federally-Facilitated Marketplace saw higher than average growth, an 81 percent increase in total member months. Consistent with that, they also saw a larger than average reduction in their PMPM claims, a 3.5 percent decline on average.

Conclusion and Implications

These data are very encouraging for the long-term health and stability of the Marketplace. They suggest that the individual market evolved as would have been expected in 2015: with moderate but real progress toward a broader risk pool as Marketplace enrollment grew.

Nearly all states saw continued growth in Marketplace enrollment in 2016, suggesting continued improvement in their risk pools.[14] Moreover, the 2015 claims data also predate important steps CMS has taken over the past six months to further strengthen the Marketplace risk pool. These steps include implementing new processes to prevent misuse of Special Enrollment Periods, reducing the number of consumers losing coverage or financial assistance due to data-matching issues, helping consumers who turn 65 move from the Marketplace onto Medicare, and proposing to curb abuses of short-term plans that are keeping some of the healthiest customers out of the ACA risk pool. Going into the next Open Enrollment, CMS will also be strengthening outreach, especially to young adults, by communicating with people who paid the individual responsibility penalty, facilitating 26-year-olds' transitions from their parents' plans to Marketplace coverage, and undertaking even more timely and targeted email and other campaigns. With these new actions in 2016, as well as the expiration of remaining transitional policies by the end of 2017, we expect the Marketplace risk pool will continue to grow and improve going forward.

Importantly, an improving risk pool does not assure issuer profitability in any given year, since profitably depends on both costs and pricing decisions. Evidence suggests that many issuers priced below cost for 2014, for reasons that included difficulty predicting cost in a new market and a desire to offer strongly competitive rates to gain share in a new market.[15] Meanwhile, the EDGE data show that premiums increased an average of just 2 percent in 2015. This increase would have been sufficient, on average, to keep pace with claims costs, because of the exceptionally slow growth in per-enrollee claims. However, it would not have been sufficient to make up for 2014 gaps between prices and costs or to accommodate the partial phasedown of the transitional reinsurance program.

But a risk pool that is getting stronger over time does assure that the Marketplace is well positioned for the long run. As the Marketplace continues to mature and grow, it will continue to be a place where insurers want to do business and where consumers are able to find affordable coverage that meets their needs.

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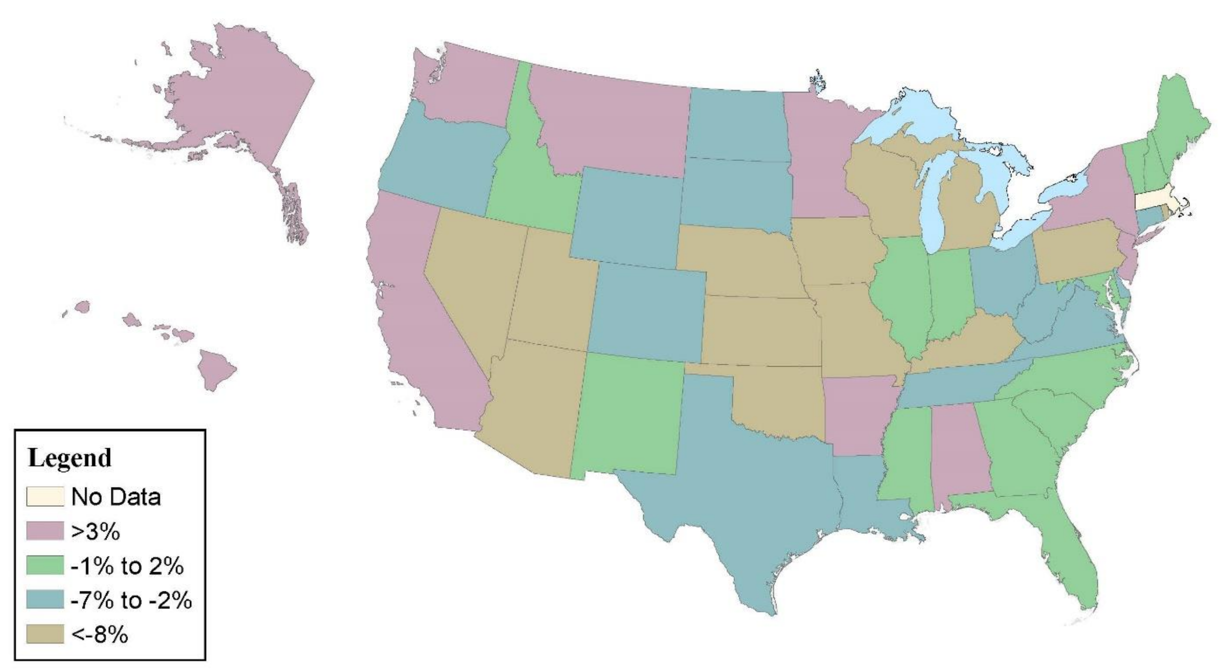
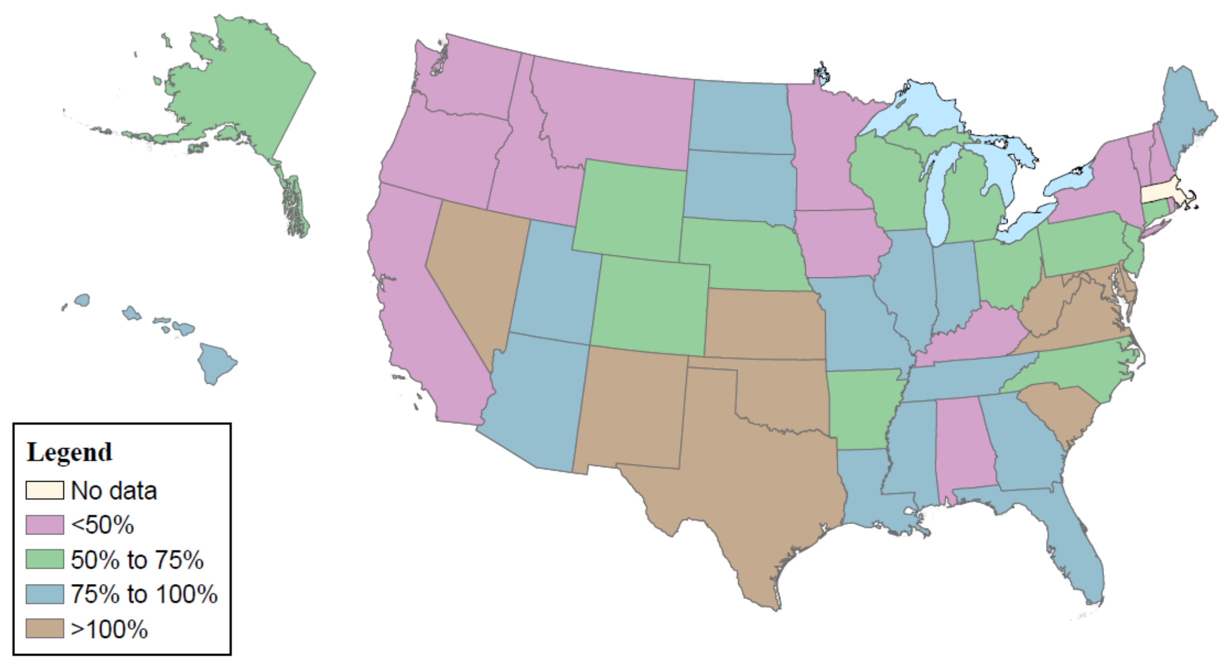
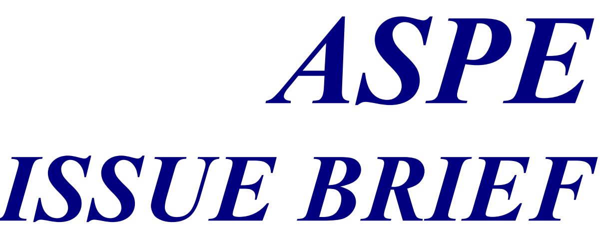
[14] Pennsylvania and Indiana implemented their Medicaid expansion over this period, shifting consumers with incomes 100-138 percent of the federal poverty line out of the Marketplace, and New York introduced a Basic Health Program, shifting most consumers with incomes up to 200 percent FPL out of the Marketplace. Other than these states, all but three states saw growth in Marketplace plan selections, and most states saw growth exceeding 10 percent.

[15] http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/the-affordable-care-act-and-health-insurers-financial-performance

Appendix: State Growth in ACA Individual Market Member Months and Per-Enrollee Claims







Impact of the Affordable Care Act Coverage Expansion on Rural and Urban Populations

June 10, 2016

By Kelsey Avery, Kenneth Finegold, and Xiao Xiao*

Provisions of the Affordable Care Act (ACA) have increased health insurance coverage rates in the U.S; we estimate that 20.0 million non-elderly adults gained health insurance coverage through early 2016.[1] At 9.1 percent, the uninsured rate for Americans of all ages is the lowest it has been on record.[2] These gains have been experienced across demographic and geographic groups. This brief examines health insurance coverage gains, Marketplace coverage and premium tax credits, and access to health care, with a special focus on individuals living in rural areas.[3]

Key Highlights

- **Coverage:** Rural individuals, like those living in urban and suburban areas, have seen large coverage gains under the ACA – about an 8 percentage point increase from before the first open enrollment period through early 2015.
- **Premium tax credits:** Among the 88 percent of rural HealthCare.gov consumers with premium tax credits, the average net monthly premium increased by $5, or 4 percent, between 2015 and 2016.
- **Access to care:** Individuals in rural areas have seen improvements in access to care; the share who report being unable to afford needed care declined by nearly 6 percentage points from before the first open enrollment period through early 2015.

*Affiliations: Office of the Assistant Secretary for Planning and Evaluation (Avery, Finegold); Acumen LLC (Xiao)

[1] Uberoi, N., Finegold, K., & Gee, E. (3 March 2016). "Health Insurance Coverage and the Affordable Care Act." *Issue Brief.* Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf.

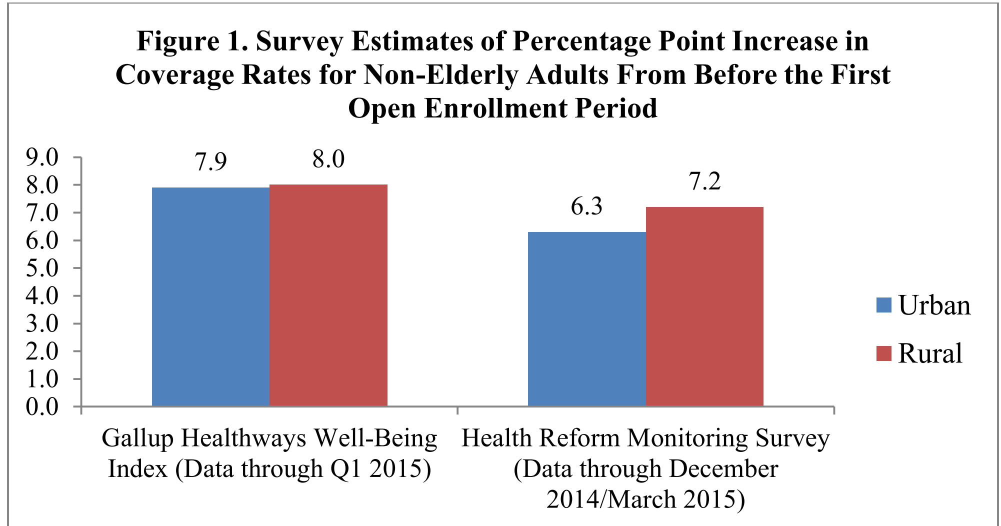
[2] Cohen, R.A., Martinez, M.E., & Zammitti, E.P. (17 May, 2016). "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2015." National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf.

[3] Throughout this brief, "rural" refers to residence in a zip code classified as rural by the Federal Office of Rural Health Policy in the U.S. Department of Health and Human Services (Gallup Healthways Well-Being Index and Health Insurance Marketplace analyses) or residence in an area that is not part of a metropolitan statistical area (Health Reform Monitoring Survey and National Health Interview Survey analyses). "Urban" refers to residence in a zip code not classified as rural by the FORHP or residence in an area that is part of a metropolitan statistical area.

I. Change in Health Insurance Coverage

The Health Insurance Marketplace and Medicaid expansion provisions of the Affordable Care Act have contributed to large reductions in the uninsured rate in both rural and urban areas. According to an analysis of data from 2012 through the first quarter of 2015 from the Gallup Healthways Well-Being Index, coverage rates among non-elderly adult increased similarly in urban and rural areas, rising by 8.0 percentage points in rural areas and 7.9 percentage points in urban areas.[4] Similarly, an analysis of data from the Urban Institute's Health Reform Monitoring Survey (HRMS) found that rural individuals saw a 7.2 percentage point increase in coverage between mid-2013 and a period including late 2014 and early 2015 (a 33 percent decrease in the uninsured rate, from 21.6 percent in 2013 to 14.4 percent in 2015). This compares with a 6.3 percentage point increase in coverage for urban individuals (reducing the uninsured rate from 17.2 percent in 2013 to 10.9 percent in 2015) (See Figure 1).[5] Since early 2015, the national uninsured rate for non-elderly adults has continued to fall; both urban and rural individuals have shared in this additional progress.[6]

Figure 1. Survey Estimates of Percentage Point Increase in Coverage Rates for Non-Elderly Adults From Before the First Open Enrollment Period



Sources: Sommers, B., Gunja, M., Finegold, K., & Musco, T. (28 July, 2015). "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act." Journal of the American Medicaid Association, 314(4): 366-374. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2411283. Data are from 2012 through the first quarter of 2015. Models are adjusted for age, sex, race/ethnicity, marital status, employment, income, urban vs. rural residence, state-year specific unemployment rate, calendar month (to adjust for seasonality), and state of residence.
Karpman, M., Zuckerman, S., Kenney, G.M., & Odu, Y. (16 April, 2015). "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas." Urban Institute. Retrieved from http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html. Data are from June/September 2013 and December 2014/March 2015.

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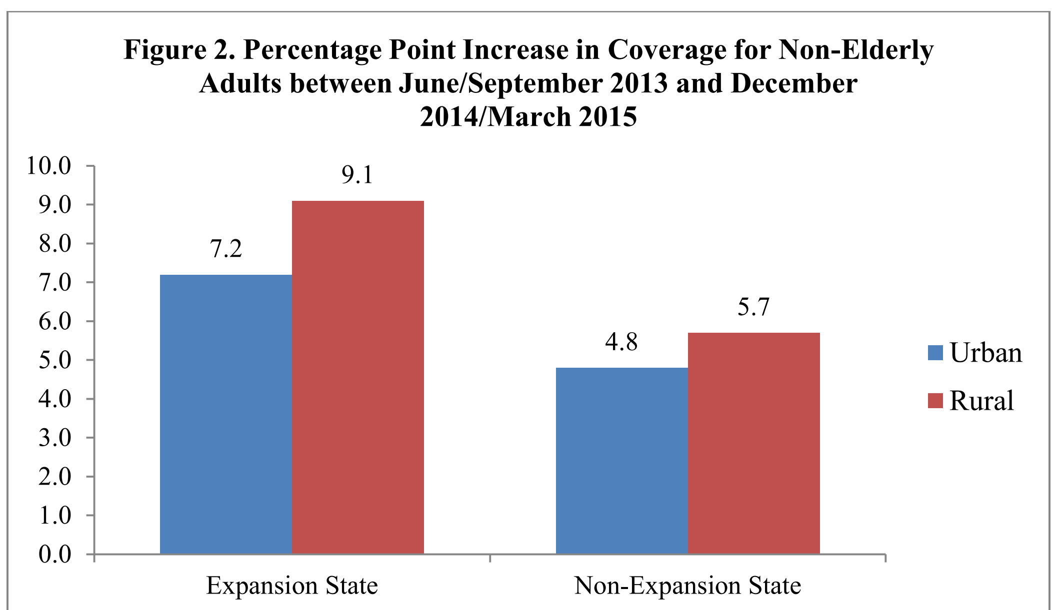
[4] Sommers, B., Gunja, M., Finegold, K., & Musco, T. (28 July, 2015). "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act." Journal of the American Medicaid Association, 314(4): 366-374. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2411283.
[5] Karpman, M., Zuckerman, S., Kenney, G.M., & Odu, Y. (16 April, 2015). "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas." Urban Institute. Retrieved from http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html.
[6] ASPE analysis of Gallup Healthways Well-Being Index from 2012 to February 22, 2016.

Unsurprisingly, the HRMS, like many other surveys, shows that coverage gains were larger for individuals in states that took up the ACA Medicaid expansion. But within both expansion and non-expansion states, gains in coverage were modestly larger for rural than urban individuals (See Figure 2).[7]



Sources: Karpman, M., Zuckerman, S., Kenney, G.M., & Odu, Y. (16 April, 2015). "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas." Urban Institute. Retrieved from http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html.

The overall coverage gains for rural individuals are particularly striking in light of the fact that uninsured rural individuals are disproportionately concentrated in states that have not expanded Medicaid. ASPE analysis of 2015 data from the National Health Interview Survey (NHIS) found that 65 percent of the 4.5 million rural nonelderly uninsured lived in states that had not expanded Medicaid. In comparison, 51 percent of the nonelderly uninsured in urban areas lived in states that had not expanded Medicaid.[8] Medicaid expansion in additional states would thus be of particular benefit to rural Americans.

II. Marketplace Enrollment and Premium Tax Credits among Rural Individuals

Health Insurance Marketplace administrative data show that individuals in rural ZIP Codes comprise nearly 1 in 5 Marketplace plan selections. In the third open enrollment period for 2016

[7] Karpman, M., Zuckerman, S., Kenney, G.M., & Odu, Y. (16 April, 2015). "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas." Urban Institute. Retrieved from http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html.

[8] ASPE analysis of National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files for all 50 states and the District of Columbia, January-December 2015. For these estimates, states are classified as expanding or not expanding based on their status at the beginning of 2015. Alaska (expanded September 2015), Montana (expanded January 2016), and Louisiana (expanding July 2016) are thus counted as not expanding. See Appendix for analysis of the characteristics of the rural and urban uninsured.

coverage, 1.71 million consumers living in rural areas signed up for or had their coverage automatically renewed through the HealthCare.gov platform. This was an increase of 11 percent over 2015 for rural consumers, compared with 8 percent for other consumers (See Table 1).

Table 1. Selected Characteristics of Plan Selections through the Marketplaces in HealthCare.gov States

	2015 Total Plan Selections	2016 Total Plan Selections	Percent Growth from 2015 to 2016
Total Number of Individuals Who Have Selected a 2016 Plan Through the Marketplaces in the HealthCare.gov States	8.84 million	9.63 million	9%
Individuals in ZIP Codes designated as rural who have selected a Marketplace plan	1.54 million	1.71 million	11%
Individuals in ZIP Codes designated as urban who have selected a Marketplace plan	7.30 million	7.92 million	8%

Source: Office of the Assistant Secretary for Planning and Evaluation. (11 March, 2016). "Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report For the period: November 1, 2015 – February 1, 2016." *Issue Brief*. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.

Of the 1.71 million rural individuals who selected a Marketplace plan in the third Open Enrollment Period, 88 percent were eligible for premium tax credits (See Table 2).

Table 2. Percentage of Urban and Rural Plan Selections with Tax Credits through the Marketplaces in HealthCare.gov States, 2016

2016	Total Plan Selections	Plan Selections With Tax Credits	Percent with Tax Credits
All	**9.63 million**	**8.15 million**	**85%**
Rural	1.71 million	1.51 million	88%
Urban	7.92 million	6.64 million	84%

Numbers may not sum due to rounding. Information is for enrollees in the 37 states that used the HealthCare.gov platform for 2015 and in the 38 states that used the HealthCare.gov platform for 2016. 2015 enrollees are those who selected plans during the second Open Enrollment Period. 2016 enrollees include those who had an active Marketplace plan selection as of 2/1/2016 but exclude those whose plans were terminated prior to that date.

The premium tax credit is based on the premium of the second-lowest cost silver plan (also known as the benchmark plan) available to an eligible consumer and the tax credit amount a consumer is eligible for adjusts if the benchmark plan's premium changes. Thus, if premiums for all plans in an area rise similarly, the increase is essentially fully offset for eligible consumers by a higher premium tax credit. As previous ASPE analysis has shown, because tax credits are designed to ensure that affordable options are available to consumers, the average out-of-pocket premium obligation consumers with tax credits paid rose just 4 percent, or $4 a month, between 2015 and 2016.[9] Rural and urban consumers alike benefit from the design of tax credits; the increase in average net monthly premium among rural individuals with tax credits was $5 a month between 2015 and 2016 (See Table 3).

[9] Office of the Assistant Secretary for Planning and Evaluation. (12 April, 2016). "Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016." *Issue Brief*. Retrieved from https://aspe.hhs.gov/pdf-report/marketplace-premiums-after-shopping-switching-and-premium-tax-credits-2015-2016.

Table 3. Health Insurance Marketplace Monthly Premium Changes for 2015 – 2016 in HealthCare.gov States

	2015 Average Monthly Premium	2016 Average Monthly Premium	Increase in Average Monthly Premium	
			Dollars	% Change
Net **monthly premium among plan selections with premium tax credits**	**$102**	**$106**	**$4**	**4%**
in rural areas	$108	$113	$5	4%
in urban areas	$100	$105	$4	4%

Numbers may not sum due to rounding. Information is for enrollees in the 37 states that used the HealthCare.gov platform for 2015 and in the 38 states that used the HealthCare.gov platform for 2016. 2015 enrollees are those who selected plans during the second Open Enrollment Period. 2016 enrollees include those who had an active Marketplace plan selection as of 2/1/2016 but exclude those whose plans were terminated prior to that date.

III. Access to Care

Previous analyses of Gallup Healthways Well-Being Index data show improved access to care since the ACA's major coverage provisions took effect. Like the coverage gains discussed above, these gains have been seen by both urban and rural Americans. For example, among rural individuals, the share without access to a personal physician dropped 3.4 percentage points and the share unable to afford needed care dropped 5.9 percentage points (See Figure 4). ASPE analysis of NHIS data also indicates that rural and urban individuals have comparable access to care (See Appendix Table 1).

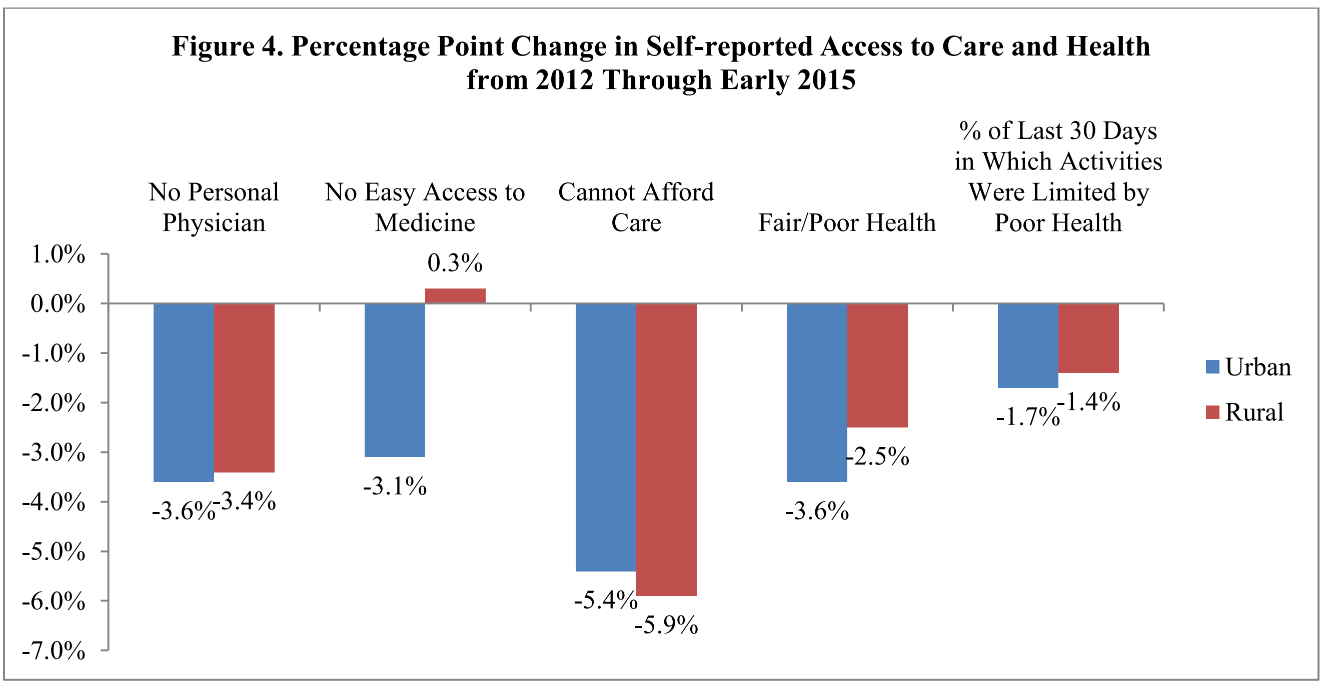


Figure 4. Percentage Point Change in Self-reported Access to Care and Health from 2012 Through Early 2015

Source: Sommers, B., Gunja, M., Finegold, K., & Musco, T. (28 July, 2015). "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act." Journal of the American Medicaid Association, 314(4): 366-374. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2411283. Models are adjusted for age, sex, race/ethnicity, marital status, employment, income, urban vs. rural residence, state-year specific unemployment rate, calendar month (to adjust for seasonality), and state of residence.

IV. Conclusion

Provisions of the Affordable Care Act have helped improve health insurance coverage and access to care across rural and urban areas. Rural individuals comprise nearly 1 in 5 Marketplace plan selections and, due to the design of premium tax credits, the increase in average net monthly premium among rural individuals with tax credits was $5 a month between 2015 and 2016. Despite being disproportionately likely to live in states that have not expanded Medicaid, rural individuals have seen similar coverage gains under the ACA as other individuals, because they have been major beneficiaries from access to the Health Insurance Marketplace, from the ACA's other coverage reforms, and from Medicaid expansion in states that chose to expand. Rural individuals would be expected to benefit disproportionately if the remaining 19 states chose to take up the ACA's Medicaid expansion.

Acknowledgements

ASPE appreciates the assistance of the Centers for Disease Control and Prevention National Center for Health Statistics Research Data Center in facilitating our access to and analysis of the restricted NHIS Preliminary Quarterly Microdata Files. The findings and conclusions in this brief are those of the authors and do not necessarily represent the views of the Research Data Center, the National Center for Health Statistics, or the Centers for Disease Control and Prevention.

Appendix: Characteristics of the Rural and Urban Uninsured

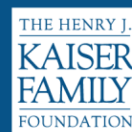
Uninsured rural individuals share some similarities with their uninsured urban counterparts. Urban and rural areas have similar distributions of nonelderly uninsured individuals across income, age and gender, with uninsured individuals in rural areas somewhat more likely to be age 55 to 64 and somewhat less likely to be age 18 to 25. Uninsured individuals living in rural areas are much less likely to be Hispanic and much more likely to be White than those living in urban areas. While uninsured rural individuals are somewhat less likely to report being in excellent health than urban individuals, more uninsured rural individuals report having access to a usual source of care than uninsured urban individuals, and uninsured rural and urban individuals report similar rates of delaying or forgoing care due to cost.

Appendix Table 1. Characteristics of Rural and Urban Nonelderly (0-64) Uninsured, National Health Interview Survey, 2015

	Rural	**Urban**
Income		
<100% FPL	23.5%	24.8%
100-138% FPL	15.5%	14.3%
139-250%FPL	33.5%	32.2%
250-399% FPL	17.0%	17.5%
>400% FPL	10.5%	11.2%
Total	100.0%	100.0%
Age		
0-17	14.0%	11.2%
18-25	14.6%	18.9%
26-34	22.9%	24.1%
35-54	34.6%	35.6%
55-64	13.9%	10.3%
Total	100.0%	100.0%
Gender		
Male	54.9%	56.3%
Female	45.1%	43.7%
Total	100.0%	100.0%
Race/Ethnicity		
Hispanic/Latino (all races)	20.6%	41.5%
White (non-Latino)	60.7%	38.2%
Black (non-Latino)	12.6%	13.6%
Asian (non-Latino)	0.5%	4.2%
Other (non-Latino)*	5.6%	2.6%
Total	100.0%	100.0%

Health Status		
Excellent	28.6%	32.0%
Very Good	29.9%	28.9%
Good	27.9%	29.3%
Fair/Poor	13.7%	9.9%
Total	100.0%	100.0%
Usual Source of Care		
Has Usual Source of Care	56.6%	47.4%
No Usual Source of Care	43.4%	52.6%
Total	100.0%	100.0%
Delayed or Did Not Receive Care Due to Cost (Last 12 Months)		
Yes	26.5%	27.2%
No	73.5%	72.8%
Total	100.0%	100.0%
Education (18-64 only)		
Less than High School	26.5%	28.2%
High School/GED	39.7%	33.0%
Post-High School	33.8%	38.9%
Total	100.0%	100.0%
Employment Status (18-64 only)		
Employed	63.4%	68.7%
Unemployed	10.8%	11.1%
Not in Workforce	25.8%	20.2%
Total	100.0%	100.0%
Marital Status (18-64 only)		
Married	44.3%	39.0%
Not Married	55.7%	61.0%
Total	100.0%	100.0%

Source: ASPE analysis of National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files for all 50 states and the District of Columbia, January-December 2015.
*Estimates for non-Hispanic personas of races other than white only, black only, and Asian only (such as American Indian or Alaskan Native, or Native Hawaiian or Pacific Islander), or of multiple races, are combined to the "Other" category.



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June 2016 | Issue Brief

Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces

Cynthia Cox, Gary Claxton, Larry Levitt, Michelle Long, Selena Gonzales, Nolan Sroczynski

Marketplace premiums under the Affordable Care Act (ACA), already a subject of perennial interest, have gained even more attention amid unfavorable financial results from some insurers, as well as initial reports of steep premium increases requested for 2017. Several factors will influence how premiums will change in 2017, and there is reason to believe that increases will be higher than in recent years.

Many of the initial reports of premium increases for 2017 have been based on anecdotal examples or averages across insurers. This brief takes a different approach, presenting an early analysis of changes in insurer participation and premiums for the lowest-cost and second-lowest silver marketplace plans in major cities in 13 states plus the District of Columbia where complete data on rates is publicly available for all insurers. Using this information, we are able to calculate the premium a specific person might pay without a premium tax credit, and take into account new plans entering the market. It follows a similar approach to our analyses of 2014, 2015, and 2016 marketplace premiums. The two lowest-cost silver plans are significant because they are the most common plan choices in the marketplaces, and the second lowest-cost plan is the benchmark used to calculate government premium subsidies.

While we cannot generalize to all states until more data become available later this year, in most of these population centers, the costs for the lowest and second-lowest silver plans are, in fact, increasing faster in 2017 than they have in previous years. Based on insurer rate requests, the cost of the second-lowest silver plan in these cities will increase by a weighted average of 10% in 2017. Last year, premiums for the second-lowest silver plans in these areas increased 5% following review by state insurance departments. There is substantial variation across markets, with premium changes for second-lowest silver plans ranging from a drop of 13% to an increase of 18%. Premiums for 2017 are still preliminary and could be raised or lowered through these states' rate review processes.

We also find that some states will have fewer insurers participating in 2017 than participated in 2016. On average across these 14 marketplaces, participation is down slightly from 2016 but similar to that of 2014. In the 14 marketplaces included in this analysis, half (7) will see insurer participation remain steady or increase, while the other 7 states will see a drop in the number of issuers, in many cases due to the withdrawal of UnitedHealth.

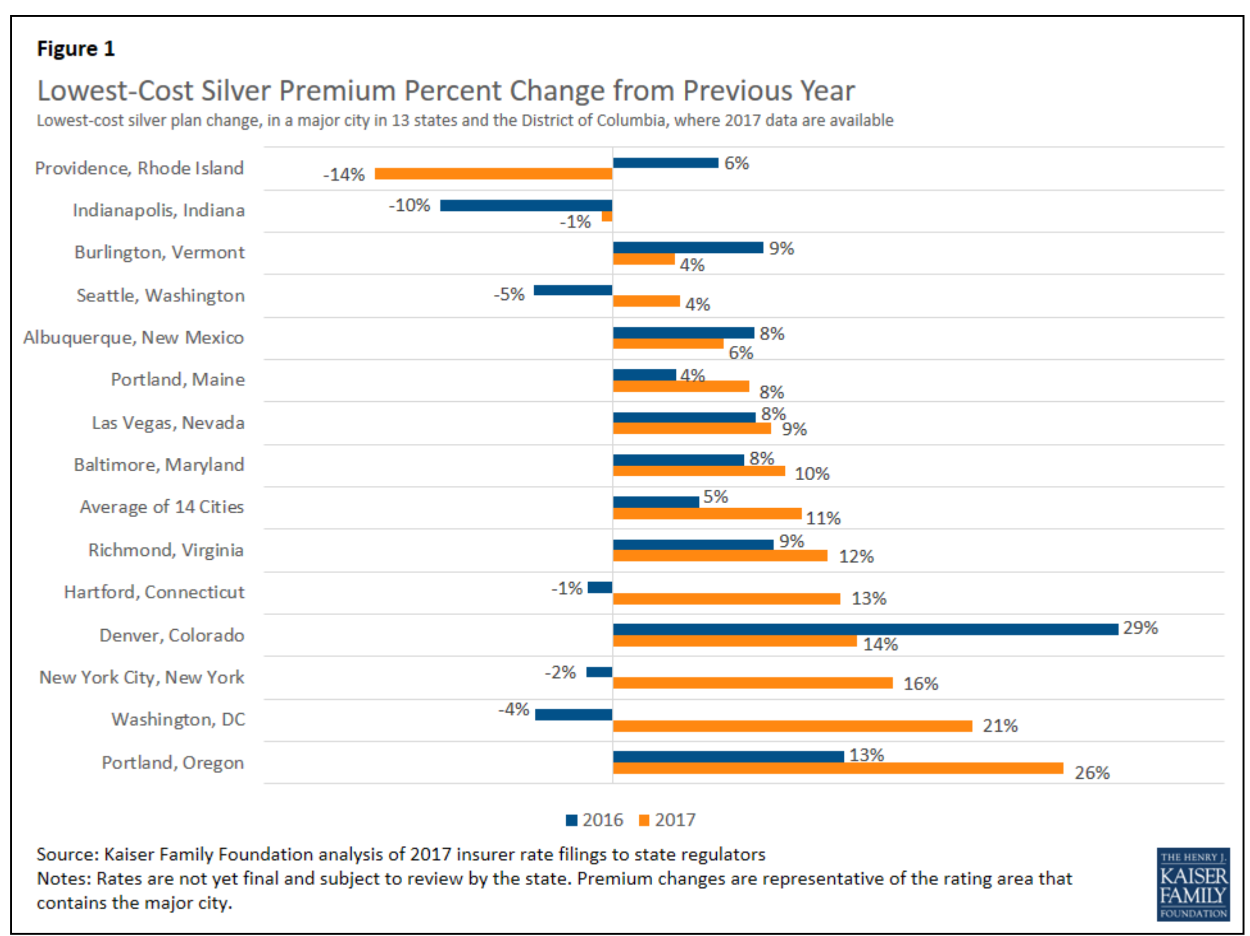
Analyzing Marketplace Premium Changes

In preparation for open enrollment in 2017, insurers have filed premium requests with state insurance departments. States vary in whether and when they release those filings. In this analysis, we analyze premium data from all 13 states and the District of Columbia where either public insurer filings include all of the information necessary to calculate the premium for a 40-year-old living in specific part of the state, or, where the state has made similar information public in some other format such as rate tables or search tools. Other states have released summary information, but not sufficient detail to identify the two lowest-cost silver plans.

We examine premiums in a rating area that includes a major city in each state. Premiums vary significantly within states, with the rating area being the smallest geographic unit by which insurers are allowed to vary rates. For each rating area, we look at premiums for the two lowest-cost silver plans. We focus on silver plans because they are the basis for federal premium subsidies[1] and because these are the plans that most marketplace enrollees (68%) tend to choose. These cities represent major population centers in each state; premiums and insurer participation may be different in rural areas. These premiums are still preliminary and subject to review by the state or federal government.

Changes in the Lowest-Cost Silver Plans

Across the 14 cities we examined, the premium for the lowest-cost silver plan is increasing by a weighted average of 11% in 2017, though changes vary geographically ranging from a decrease of 14% in Providence, Rhode Island, to an increase of 26% in Portland, Oregon.



From the creation of the exchange markets in 2014 to 2017, the lowest-cost silver premium will have increased an average of 5% per year across these 14 areas, if 2017 proposed rates are not changed through the review process. Average annual growth in the lowest-cost silver plan in these cities ranges from a decrease of 6% per year in Indianapolis, Providence, and Seattle, to an increase of 16% in Portland, Oregon.

Table 1: Monthly Lowest-Cost Silver Premiums for a 40 Year Old Non-Smoker (Before Tax Credits)

State	Major City (Rating Area #)	2017	2016	2016-2017 % Change	2015-2016 % Change	Average Annual Change 2014-2017
Colorado	Denver (3)	**$304**	$266	**14%**	29%	7%
Connecticut	Hartford (2)	**$358**	$316	**13%**	-1%	4%
DC	Washington (1)	**$275**	$228	**21%**	-4%	5%
Indiana	Indianapolis (10)	**$284**	$286	**-1%**	-10%	-6%
Maine	Portland (1)	**$307**	$285	**8%**	4%	3%
Maryland	Baltimore (1)	**$267**	$243	**10%**	8%	8%
Nevada	Las Vegas (1)	**$279**	$256	**9%**	8%	6%
New Mexico	Albuquerque (1)	**$192**	$181	**6%**	8%	1%
New York	New York City (4)	**$425**	$366	**16%**	-2%	6%
Oregon	Portland (1)	**$302**	$240	**26%**	13%	16%
Rhode Island	Providence (1)	**$224**	$259	**-14%**	6%	-6%
Vermont	Burlington (1)	**$482**	$465	**4%**	9%	7%
Virginia	Richmond (7)	**$296**	$264	**12%**	9%	9%
Washington	Seattle (1)	**$232**	$224	**4%**	-5%	-6%
Weighted Average		**$307**	$277	**11%**	5%	5%

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Note: Rates are not yet final and subject to review by the state. Premium changes are representative of the rating area that contains the major city.

Changes in the Second-Lowest Silver Plans

Similar patterns can be seen for the second-lowest silver plan in each city. Before accounting for any tax credit that subsidizes premiums for low and middle income people, the premium for the second-lowest silver plan is increasing by a weighted average of 10% from 2016. By contrast, the average change in the second-lowest silver plan in these cities was 5% from 2015 to 2016.

Second-lowest silver plan premium changes in 2017 vary significantly across these cities, ranging from a decrease of 13% in Providence, Rhode Island, to an increase of 18% in Portland, Oregon. Since 2014, premiums in these cities have increased an average of 4% per year, ranging from an average annual decrease of 8% in Providence, Rhode Island, to an average annual increase of 15% in Portland, Oregon. Although Portland, Oregon's increases have been relatively high, it is worth noting that the benchmark premium started out quite low in 2014 ($201 for a 40 year old, compared to an average of $273 nationally).

These premium changes do not reflect what marketplace enrollees receiving premium tax credits will actually pay. Most marketplace enrollees receive premium tax credits, which means that they do not actually pay the entire premium but make a contribution based on a percentage of their incomes and family sizes to enroll in the second-lowest silver plan.

In 2016, a 40-year-old single enrollee making $30,000 per year would have paid about $208 per month in most areas of the country, and a similar person would pay approximately the same in 2017. (Although premium caps are increasing for 2017, the poverty guidelines are also changing such that a single person making $30,000 will be at a slightly lower percent of poverty than he or she would be this year. These two changes in effect cancel each other out, leaving monthly payments for the benchmark plan very similar from year-to-year.) However, in order to take advantage of this stability in premium payments, enrollees may need to switch plans to the new benchmark silver plan.

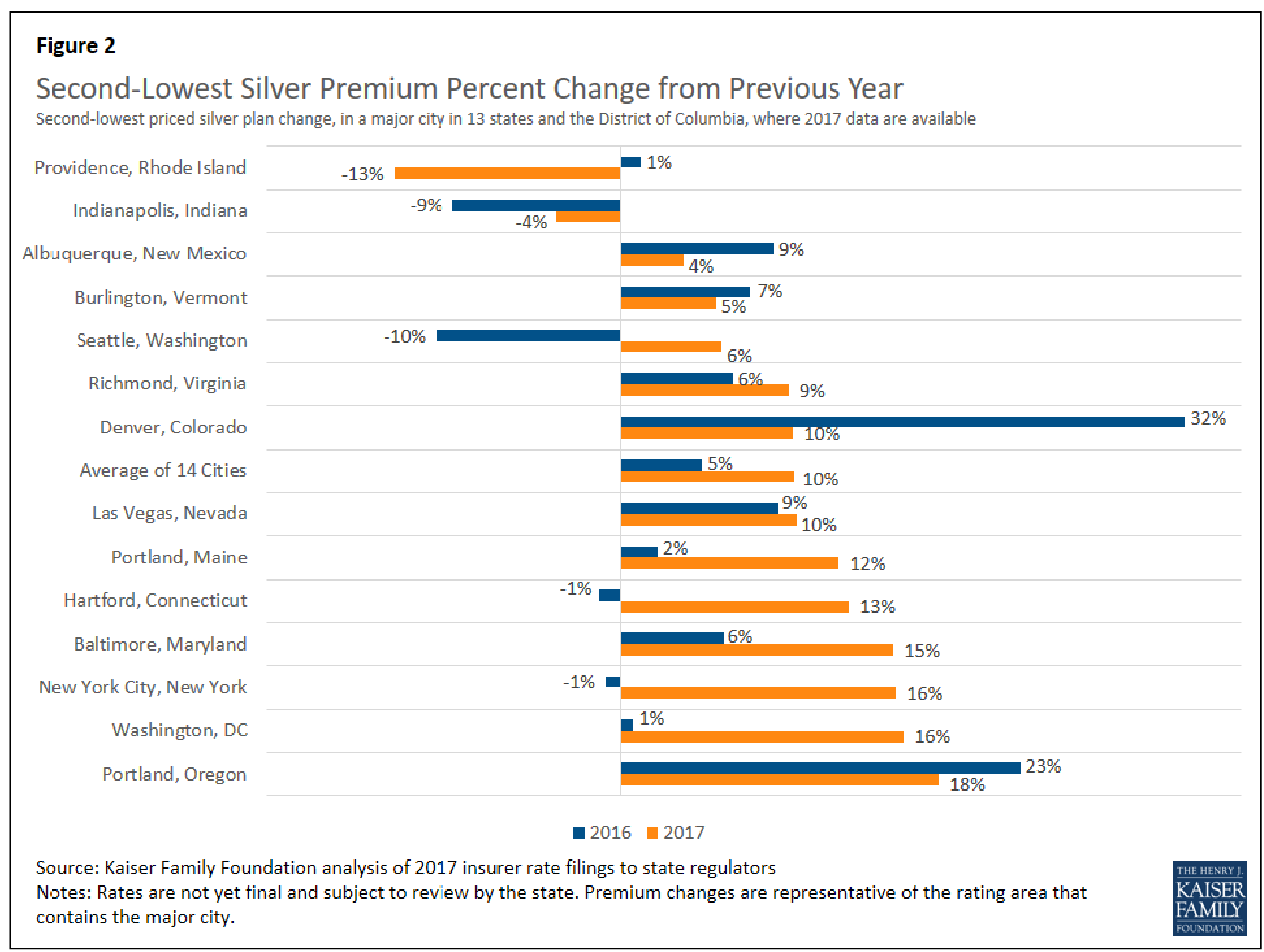


Table 2: Monthly Second-Lowest Silver Premiums for a 40-Year-Old Non-Smoker (Before Tax Credits)						
State	Major City (Rating Area #)	2017	2016	2016-2017 % Change	2015-2016 % Change	Average Annual Change 2014-2017
Colorado	Denver (3)	**$305**	$278	**10%**	32%	7%
Connecticut	Hartford (2)	**$359**	$318	**13%**	-1%	3%
DC	Washington (1)	**$282**	$243	**16%**	1%	5%
Indiana	Indianapolis (10)	**$287**	$298	**-4%**	-9%	-6%
Maine	Portland (1)	**$323**	$288	**12%**	2%	3%
Maryland	Baltimore (1)	**$287**	$249	**15%**	6%	8%
Nevada	Las Vegas (1)	**$287**	$261	**10%**	9%	6%
New Mexico	Albuquerque (1)	**$193**	$186	**4%**	9%	0%
New York	New York City (4)	**$426**	$369	**16%**	-1%	3%
Oregon	Portland (1)	**$308**	$261	**18%**	23%	15%
Rhode Island	Providence (1)	**$229**	$263	**-13%**	1%	-8%
Vermont	Burlington (1)	**$493**	$468	**5%**	7%	6%
Virginia	Richmond (7)	**$302**	$276	**9%**	6%	6%
Washington	Seattle (1)	**$240**	$227	**6%**	-10%	-5%
Weighted Average		**$313**	$285	**10%**	5%	4%

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Note: Rates are not yet final and subject to review by the state. Premium changes are representative of the rating area that contains the major city.

Active Renewal and Premium Changes

As was the case last year, the insurers that had the lowest premiums in 2016 are often no longer one of the two lowest-cost silver plans in 2017. This underscores the importance of enrollees actively shopping each open enrollment period. For example, in Providence, Rhode Island, Blue Cross Blue Shield (BCBS) of Rhode Island offered the second-lowest silver plan in 2016 at a premium of $263 per month for a single 40 year-old before taking a tax credit into account. BCBS is increasing this plan's rate to $272 per month for 2017, but another insurer, Neighborhood Health Plan, is offering a few lower-cost silver options – the lowest for $224 per month and the second-lowest for $229. An unsubsidized person enrolled in the 2016 second-lowest silver plan offered by BCBS would see a premium increase of about 4% if she stayed in the same plan. Conversely, if she switched to the new second-lowest silver plan offered by Neighborhood, her premium would drop 13% (before accounting for the relatively small effect aging up a year would have on her premiums).

The effect of changes in the benchmark premium relative to other plans is magnified for subsidized enrollees because the tax credit is tied to the premium for the second-lowest silver plan in a given year. If the same 40 year-old in the example above makes $30,000, she would be paying $208 per month in 2016 for the benchmark plan (offered by BCBS) and the federal government covers the rest through a tax credit. In 2017, if she switches to the new benchmark (offered by Neighborhood), she would continue to pay about $208 per month (assuming she continues to have the same income and family size in 2016). However, if she stayed in the BCBS plan, she would have to pay that amount plus the premium difference between the Neighborhood and

BCBS plans, or a total of approximately $250 (an increase of about 20%, before accounting for a relatively small effect of aging one year and before accounting for any amount attributable to non-essential health benefits that may be covered by either plan). To keep her lower premium, she has to be willing to switch plans.

Experience in this market suggests that a sizable share of people enrolling in 2017 will actively shop for coverage. A research brief by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that about two-thirds of Healthcare.gov enrollees actively shopped in 2016, including 43% of renewing enrollees and all new shoppers. While several reports of premium increases had suggested that premiums would increase in the double digits in 2016, the ASPE analysis found that, after accounting for shopping, marketplace premiums increased 8% before subsidies. For enrollees receiving a subsidy, the increase in the amount they paid was 4% on average.

In addition to switching plans, enrollees may also have to switch insurance companies in order to avoid a significant premium increase, which could involve changing doctors as well. In 6 out of 14 cities we examined, an insurer offering the lowest-cost silver plan in 2016 is no longer offering one of the two lowest-cost silver plans in 2017. Similarly, in 6 out of the 14 cities we examined, an insurer offering the second-lowest silver plan in 2016 is no longer offering one of the two lowest-cost silver plans in 2017. All in all, at least one of the low-cost insurers from 2016 will no longer be a low-cost insurer in 2017 in 9 out of the 14 marketplaces.

Table 3: Changes in Insurers Offering the Lowest-Cost Silver Products

State	Major City (Rating Area #)	Is the insurer that offered the **lowest-cost silver plan in 2016** still offering one of the two lowest-cost silver plans in 2017?	Is the insurer that offered the **2nd lowest-cost silver plan in 2016** still offering one of the two lowest-cost silver plans in 2017?
Colorado	Denver (3)	Yes	No
Connecticut	Hartford (2)	Yes	Yes
DC	Washington (1)	Yes	Yes
Indiana	Indianapolis (10)	No	Yes
Maine	Portland (1)	No	Yes
Maryland	Baltimore (1)	No	No
Nevada	Las Vegas (1)	Yes	Yes
New Mexico	Albuquerque (1)	Yes	No
New York	New York City (4)	No	No
Oregon	Portland (1)	No	Yes
Rhode Island	Providence (1)	Yes	No
Vermont	Burlington (1)	Yes	Yes
Virginia	Richmond (7)	No	No
Washington	Seattle (1)	Yes	Yes
Total		**8 Yes, 6 No**	**8 Yes, 6 No**

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Note: Rates are not yet final and subject to review by the state. Premium changes are representative of the rating area that contains the major city.

Changes in Insurer Participation

The number of insurers participating in these states' marketplaces ranges from 2 in Vermont, DC, and Rhode Island, to 15 in New York. On average, 5.5 insurers (grouped by parent company) will offer coverage in these 14 states in 2017, which is slightly less than the average participation in 2015 and 2016 (an average of 6.4 and 5.9, respectively), and equal to the number that participated in 2014 (5.5 on average).

Seven states will see a drop in insurer participation, most often resulting at least in part from UnitedHealth's broad exit from the individual market in most states. Three states (Maine, New Mexico, and Virginia) will see an increase in insurer participation, and the remaining three states plus the District of Columbia will have the same number of insurers participating in 2017 as in 2016. All insurers may not participate statewide, and rural areas in particular tend to have fewer insurers.

Connecticut	3	4	4	**3**
Indiana	4	8	7	**6**
Maryland	4	5	5	**4**
New Mexico	4	5	4	**5**
Oregon	11	10	10	**8**
Vermont	2	2	2	**2**
Washington	7	10	10	**8**
Average	5.5	6.4	5.9	**5.5**

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Note: Filings are not yet final and subject to review by the state.

In some marketplaces, there will be both entrants and exits. In Colorado, for example, UnitedHealth and Humana are exiting, while a new insurer, Bright Health Plan, is entering. Similarly, in Indiana, UnitedHealth and a local insurer are exiting, while Aetna is entering in 2017. In total, 6 of the 14 marketplaces will have new entrants in 2017. Oregon and Washington will experience the largest drops in insurer participation – both losing 2 on net. Even so, these two states will have 8 insurers, which is higher than average.

Discussion

Recent reports of substantial increases from some insurers have led to concerns regarding the stability of the ACA's marketplaces. There is reason to believe that premium increases in the ACA's marketplaces will be higher in 2017 than in recent years. However, anecdotal examples of premium hikes or averages across insurers

can provide a skewed picture of the increases marketplace enrollees will actually face. As noted above, about 8 in 10 marketplace enrollees are receiving government premium subsidies, and these enrollees are protected from an increase in premiums if they continue to be enrolled in a low-cost plan. Regardless of tax credit eligibility, most enrollees have multiple plans from which to choose and can often save money on their premium by switching to a lower-cost plan. Experience has shown that many enrollees are willing to switch plans to avoid a premium increase, even though this might mean changing insurers and potentially doctors as well.

Given this high rate of plan switching – and the jockeying by insurers to be one of the lower-cost options – it is instructive to look at how premiums for the two lowest-cost silver plans are changing. Our analysis of premiums in major cities in the 13 states and DC where more complete information is available finds that the premium changes for the two lowest-cost silver plans – which the bulk of enrollees tend to purchase – vary substantially across the country, ranging from a decrease of 14% to an increase of 26% for the lowest-cost silver plan. On average, proposed premiums for the second-lowest silver plan in these cities are increasing by 10%, up from 5% in 2016.

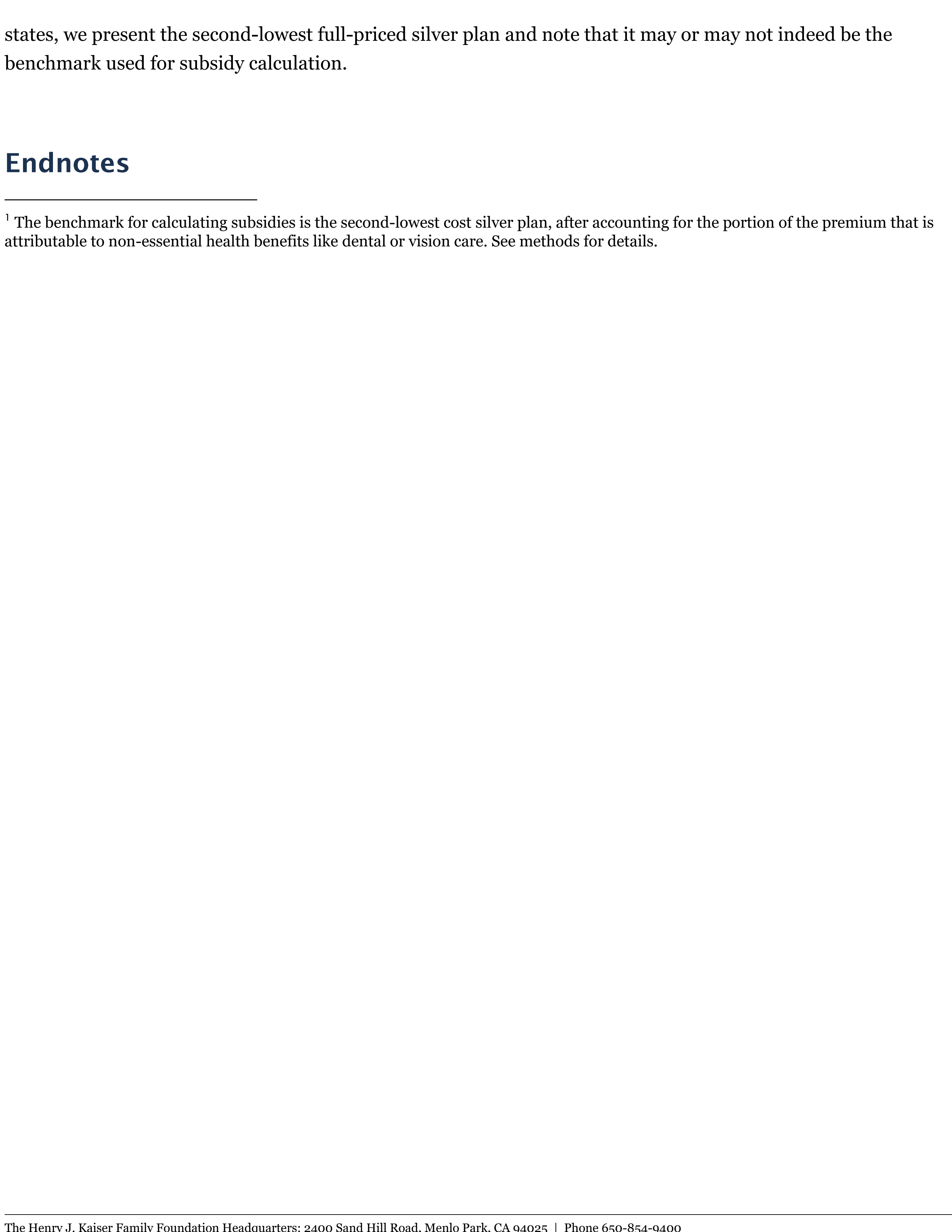
Another recent concern over the viability of the exchange market has stemmed from the news that UnitedHealth would exit all but a handful of the 34 states where it had participated. However, in earnings calls, other large insurers have expressed more confidence in the exchange markets, with some planning expansion into new markets. On average, across the 14 marketplaces where we analyzed premium data, insurer participation in 2017 will be slightly lower than in 2016. Often the decrease in insurer participation in 2017 is resulting from the exit of UnitedHealth. In all of these states, there are multiple insurers continuing to offer coverage. A remaining question, though, is how insurer participation will vary geographically, and particularly in rural areas where a number of counties may be at risk of having just one insurer.

Premiums that are reviewed by states or the federal government and made final for 2017 marketplace plans will become available for these and other states over the next few months, with complete information for all 50 states and the District of Columbia typically becoming public shortly before open enrollment, which begins November 1, 2016.

Methods

Data were collected from health insurer rate filings submitted to state regulators. These submissions are publicly available for the states we analyzed. Most rate information is available in the form of a SERFF (System for Electronic Rate and Form Filing) filing, which includes a base rate and other factors that build up to an individual rate. In states where filings were unavailable, we gathered data from tables released by state insurance departments. Filings are still preliminary. All premiums in this analysis are at the rating area level, and some plans may not be available in all cities or counties within the rating area. Rating areas are typically groups of neighboring counties, so a major city in the area was chosen for identification purposes. Weighted averages are weighted by marketplace enrollment in the state in 2016.

In some cases, the plan that has the second-lowest full-priced silver premium is not the benchmark because two or more other plans may have lower premiums when accounting for the portion of the premium that is attributable to non-essential health benefits. Because this information is not consistently available in these



states, we present the second-lowest full-priced silver plan and note that it may or may not indeed be the benchmark used for subsidy calculation.

Endnotes

[1] The benchmark for calculating subsidies is the second-lowest cost silver plan, after accounting for the portion of the premium that is attributable to non-essential health benefits like dental or vision care. See methods for details.

The Cost of ACA Repeal

Matthew Buettgens, Linda J. Blumberg, John Holahan, and Siyabonga Ndwandwe

JUNE 2016

In-Brief

Six years after its enactment, many are still calling for the repeal of the Affordable Care Act (ACA). In January 2016, Congress passed a bill for the rst time, repealing the ACA without a replacement, but this was vetoed by the president. Because considerable controversy exists among ACA opponents on what should replace the ACA, the prospect of repeal without replacement is real and merits analysis. In this brief, we compare future health care coverage and costs with the ACA in place and with the law repealed.

We nd that ACA repeal would reduce federal government spending on health care for the nonelderly, which appears to be one of the goals of those advocating repeal, by $90.9 billion in 2021 and $927 billion between 2017 and 2026. That represents a decrease of 21.1 percent. However, that reduction comes at a cost in other areas:

- The number of uninsured people would rise by 24 million by 2021, an increase of 81 percent.
- 81 percent of those losing coverage would be in working families, around 66 percent would have a high school education or less, 40 percent would be young adults, and about 50 percent would be non-Hispanic whites.
- There would be 14.5 million fewer people with Medicaid coverage in 2021.
- Approximately 9.4 million people who would have received tax credits for private health coverage would no longer receive assistance.
- State spending would increase by $68.5 billion between 2017 and 2026 as reductions in Medicaid spending would be more than offset by increases in uncompensated care.
- Many states have reported net budget savings as a result of expanding Medicaid and would experience budget shortfalls if the ACA were repealed.
- Signi cantly less health care would be provided to modest- and low- income families.

WHAT HAPPENS to Health Coverage if the Affordable Care Act is REPEALED?

24M MORE people would be **UNINSURED**

14.5M FEWER people would have **MEDICAID/CHIP**

8.8M FEWER people would have **PRIVATE NONGROUP COVERAGE** (e.g., through the marketplaces)

700K FEWER people would have **INSURANCE THROUGH THEIR JOBS**

Introduction

Frequent attempts have been made by Congress to repeal the Patient Protection and Affordable Care Act (ACA) in the six years since its enactment. In January 2016, a repeal bill passed both houses of Congress for the time and was vetoed by the president.[1] The bill did not any replacement for the ACA because there was no general agreement among congressional Republicans on what should replace it. Every Republican presidential candidate for 2016 has called for the repeal of the ACA. Some, but not all, Republican candidates have proposed health policies that they would like to put in place after repeal, but there is no broad agreement on a replacement for the ACA.[2]

The US Department of Health and Human Services recently released an estimate that 20 million people have thus far gained health coverage because of the ACA.[3] Our own analysis, based on Medicaid and marketplace enrollment data for 2015, produced a similar estimate. Given the magnitude of this gain in coverage and the congressional interest (and possible presidential candidate interest) in repeal without necessity of replacement, the consequences of repealing the ACA deserve scrutiny.

In this report, we project health care coverage and costs for the nonelderly from 2017 to 2026 under two scenarios, the in which the ACA continues as currently enacted and the second in which the ACA is fully repealed. Repeal of the ACA would reverse the expansion of Medicaid eligibility and eliminate the health insurance marketplaces and the assistance available through them to modest-income families, the individual and employer mandates, insurance market reforms,[4] and the extension of dependent coverage to children up to age 26. We analyze the effects of repealing the ACA on health coverage, Medicaid spending, uncompensated care for the uninsured, private health care spending, and marketplace tax credits and cost-sharing reductions.

Methods

Our primary source of data for the demographic and economic characteristics of Americans is the American Community Survey (ACS). Our estimates of pre-ACA health coverage come from the 2013 ACS. We apply edits to the ACS coverage variables; the edits have been developed over many years and have made the resulting coverage estimates agree well with sources of health coverage data considered most reliable, particularly the National Health Interview Survey (NHIS).[5] The ACS has a much larger sample size than the NHIS, enabling state-level analysis. We estimate eligibility for Medicaid on the 2013 ACS using the Urban Institute's pre-ACA Medicaid eligibility model for 2013.[6]

We estimate health coverage in 2021 using the Health Insurance Policy Simulation Model (HIPSM). We use the latest available enrollment data from the marketplaces and Medicaid to impute new coverage and ensure that our 2015 and 2016 estimates of the resulting number of enrollees in each state match actual enrollment. Most of the new enrollees in our model were previously uninsured, but some who had private coverage were also simulated to switch to Medicaid and the marketplaces. After calibrating HIPSM to reproduce 2015 Medicaid and marketplace enrollment, the resulting number of uninsured people is 28.4 million. This is extremely close to the NHIS estimate for June 2015 of 28.2 million uninsured.

For estimates of coverage under the ACA after 2016, we do not assume notably higher take-up of Medicaid or marketplace coverage than in 2016. For example, some have suggested that the individual mandate could have a stronger effect on people's behavior in the future as people have more direct experience with the full penalty amounts when they out their taxes. Such increases are possible, but we chose to use a conservative estimate of ACA impact based on what has already happened. As premiums increase faster than health costs, some attrition of private coverage will occur over time, leading to small increases in Medicaid and the number of uninsured. However, the ACA's individual and employer mandates limit this effect (though the latter to a much smaller extent).

Some studies have found evidence that the ACA contributed to the slowing growth of health care costs in recent years, but there is no generally accepted estimate of how large that contribution was.[7] We assume that the underlying growth rate of health care costs would be the same with or without the ACA. In this, as in other areas, we avoid assumptions that would further increase health coverage under the ACA beyond what has been observed by 2016, making our estimates conservative.

Under the ACA, beginning in September 2010, children up to age 26 could enroll in a parent's private insurance family plan. ACA repeal would eliminate this provision as well. Thus, we need to impute which young adults in the 2013 ACS data would have been uninsured without the ACA dependent-coverage expansion. Our simulation that almost a million additional young adults who gained coverage before 2014 would be uninsured without the ACA, consistent with other estimates in the literature.[8]

Additional details about our methodology are available in appendix B.

Results

We begin by estimating the change in the distribution of health coverage from 2013 to 2021 under the ACA and the change that would exist in 2021 from repealing the ACA. We then examine the share of the uninsured that would be eligible for assistance and the characteristics of those who would lose health coverage if the ACA were repealed. The rest of the results concern health care costs: differences in federal and state government spending on health care for the nonelderly and total health care spending by payer. State-level results are available in appendix A.

Changes in Health Coverage

Millions more would be uninsured. We estimate that 47.5 million nonelderly people were uninsured in 2013, representing 17.6 percent of the population (Table 1). Based on the latest available Medicaid

and marketplace enrollment data, we estimate that 29.6 million people would be uninsured in 2021 if the ACA and state Medicaid expansion decisions continue unchanged, or 10.7 percent of the population.[9] If the ACA were repealed, we estimate 24.0 million more people would be uninsured in 2021, totaling 53.5 million people or 19.4 percent of the population (Figure 1). Thus, the uninsurance rate would be higher in 2021 without the ACA than it was in 2013. There are two main reasons for this. First, health care cost growth over those years would erode some private health coverage. Second, we estimate that roughly a million young adults in 2013 gained health coverage because of the ACA's dependent coverage provision, which took effect in 2010. ACA repeal would reverse this gain in coverage.

Medicaid enrollment would drop. Gains in health coverage under the ACA are caused mainly by new enrollment in Medicaid and the marketplaces, so these types of coverage would change the most if the ACA were repealed. We estimate that 52.6 million nonelderly people were enrolled in Medicaid or the Children's Health Insurance Program in 2013. Under the ACA, Medicaid and CHIP enrollment will reach 69.3 million in 2021. If the ACA were repealed, 14.5 million fewer people would be enrolled.

Private nongroup health insurance would fall to pre-ACA levels. Altogether, 20.3 million people will be enrolled in nongroup coverage under the ACA in 2021, compared with 11.5 million if the ACA were repealed. Thus, the private nongroup market would contract to pre-ACA enrollment levels. We estimate that 9.4 million people would be enrolled in marketplace nongroup coverage with premium tax credits in 2021. This program would be discontinued under ACA repeal.

As we have pointed out in earlier analysis, less than half of those eligible for marketplace tax credits enrolled in 2015.[10] Marketplace enrollment was modestly higher in 2016. Thus, it is possible that marketplace take-up rates could continue to rise, but we do not assume that they would. In the absence of a policy change, factors that could

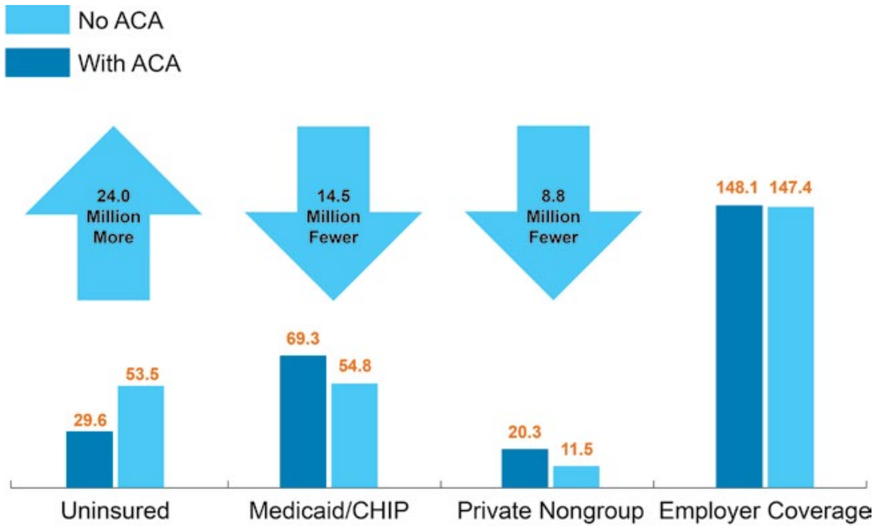
Table 1. Health Insurance Coverage Distribution of the Nonelderly with and without the ACA, 2013 and 2021 (Millions)

	No ACA		ACA		Difference
2013					
Insured	**221.9**	**82.4%**			
Employer	149.9	55.7%			
Nongroup (eligible for tax credit)	0.0	0.0%			
Nongroup (other)	11.1	4.1%			
Medicaid/CHIP	52.6	19.5%			
Other (including Medicare)	8.2	3.1%			
Uninsured	47.5	17.6%			
Total	**269.4**	**100.0%**			
2021					
Insured	**222.4**	**80.6%**	**246.1**	**89.2%**	**-23.8**
Employer	147.4	53.4%	148.1	53.7%	-0.7
Nongroup (eligible for tax credit)	0.0	0.0%	9.4	3.4%	-9.4
Nongroup (other)	11.5	4.2%	10.9	4.0%	0.6
Medicaid/CHIP	54.8	19.9%	69.3	25.1%	-14.5
Other (including Medicare)	8.6	3.1%	8.6	3.1%	0.0
Uninsured	**53.5**	**19.4%**	**29.6**	**10.7%**	**24.0**
Total	**275.9**	**100.0%**	**275.9**	**100.0%**	**0.0**

Source: Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act; CHIP = the Children's Health Insurance Program.

Figure 1: Health Coverage of the Nonelderly in 2021 (Millions)

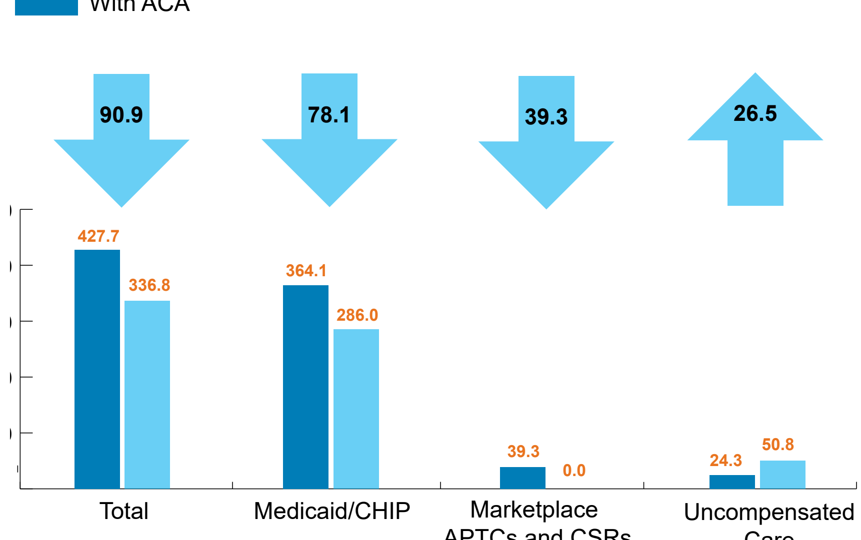


raise take-up rates noticeably are (1) the individual mandate having a greater effect on people's choices as they become more familiar with it and the resulting penalties or (2) information about insurance options continuing to spread further through word of mouth and private and public efforts.

Employer-sponsored insurance (ESI) would change little. We estimate that 149.9 million people, or 55.7 percent of the population, were enrolled in ESI in 2013,. In 2021 under the ACA, we estimate that 148.1 million will be enrolled in ESI or 53.7 percent of the population. If the ACA were repealed, ESI enrollment would be lower by 700,000 people. ESI has remained stable after implementation of the ACA, so the total number of people with ESI would not change much if the ACA were repealed.

Although health care cost growth has slowed in recent years, these costs still grow faster than income. This long-term trend has led to gradual erosion in ESI coverage over time.[11] Because of that, the number of people with ESI is projected to be lower in 2021 than in 2013, with or without the ACA.

Figure 2: Federal Government Spending in 2021 (Billions $)



The Uninsured and Eligibility for Medicaid, CHIP, and Tax Credits

Medicaid expansion states would lose the most health coverage. As discussed, repealing the ACA would lead to 24.0 million more uninsured people in 2021. Not surprisingly, states that have expanded Medicaid eligibility would see much larger increases in the number of uninsured than states that did not expand Medicaid. Among expansion states, the number of uninsured people would increase by 15.2 million or 107.0 percent (Table 2). The number of uninsured people in nonexpansion states would increase by 8.7 million or 56.9 percent.

Many uninsured people are eligible for assistance under the ACA. Not only are there fewer uninsured people under the ACA than would have been without it, but also a substantial share of the remaining uninsured are eligible for assistance to obtain health coverage but have not yet enrolled. We that 41.6 percent of the uninsured in 2021 under the ACA will be eligible for Medicaid, CHIP, or marketplace tax credits (Table 2). These 12.3 million eligible-but-uninsured people could potentially be enrolled through future outreach and application assistance efforts.[12]

In states that have expanded Medicaid, 50.9 percent of the uninsured in 2021 are eligible for some form of assistance. By contrast, in nonexpansion states only 33.0 percent of the uninsured are eligible for marketplace tax credits.

Table 2. Uninsured, National Total and by State Medicaid Expansion Status, 2021 (Millions)

State	2021 ACA				2021 Without ACA			Difference	
	Number of Uninsured	Uninsured and eligible for Medicaid/ CHIP	Uninsured and eligible for tax credits	Percentage of uninsured eligible for any assistance	Number of uninsured	Uninsured and eligible for Medicaid/ CHIP	Percentage of uninsured eligible for assistance	Number of uninsured	Percent change
National	**29.6**	**6.2**	**6.1**	**41.6%**	**53.5**	**8.6**	**16.0%**	**24.0**	**81.0%**
Expansion states	**14.2**	**4.2**	**3.1**	**50.9%**	**29.5**	**5.1**	**17.4%**	**15.2**	**107.0%**
Nonexpansion states	**15.4**	**2.1**	**3.0**	**33.0%**	**24.1**	**3.5**	**14.4%**	**8.7**	**56.9%**

Source:Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act; CHIP = the Children's Health Insurance Program. Estimates assume that increased participation rates by those newly enrolling under the ACA but eligible under pre-ACA

Medicaid eligibility rules would remain at ACA levels in 2017, with the higher participation rates eroding by 2021.

If the ACA were repealed, 16.0 percent of the uninsured—8.6 million people—would still be eligible for Medicaid or CHIP under the rules in place before the ACA (Table 2). Marketplace tax credits would no longer be available. Thus, without replacements for the ACA's marketplace tax credits and Medicaid expansion, it would be to increase coverage for more than a small fraction of the uninsured above what we have estimated.

Those Losing Health Coverage

Among the 24 million people who would lose coverage in 2021 if the ACA were repealed, 63.3 percent would have incomes below 200 percent of the federal poverty level, or FPL (Table 3). About 81 percent of those losing coverage would be in working families, and about 66 percent would be in families with at least one full-time worker. Nearly two-thirds of those losing coverage would have a high school education or less. About 40 percent of those losing coverage would be young adults ages 18 to 34. Nearly 50 percent of those losing coverage would be white non-Hispanic, just over 26 percent would be Hispanic, and 14 percent would be black non-Hispanic.

Government Spending

The federal government would spend $90.9 billion less on health care for the nonelderly in 2021 if the ACA were repealed (Table 4 and Figure 2). This includes $78.1 billion less in Medicaid and CHIP spending and $39.3 billion in marketplace premium tax credits and cost-sharing reductions that would be eliminated. About $26.5 billion in additional federal spending on uncompensated care for the uninsured would partially offset these decreases in spending. The federal government funds uncompensated care through several different programs, such as Medicaid Disproportionate Share Hospital, Medicare Disproportionate Share Hospital, and the Veterans Administration.[13]

State governments as a whole would spend $5.2 billion more on health care for the nonelderly in 2021 if the ACA were repealed (Table 4 and Figure 3). An $11.3 billion decrease in their Medicaid and CHIP spending would be more than offset by $16.6 billion in new spending on uncompensated care. We

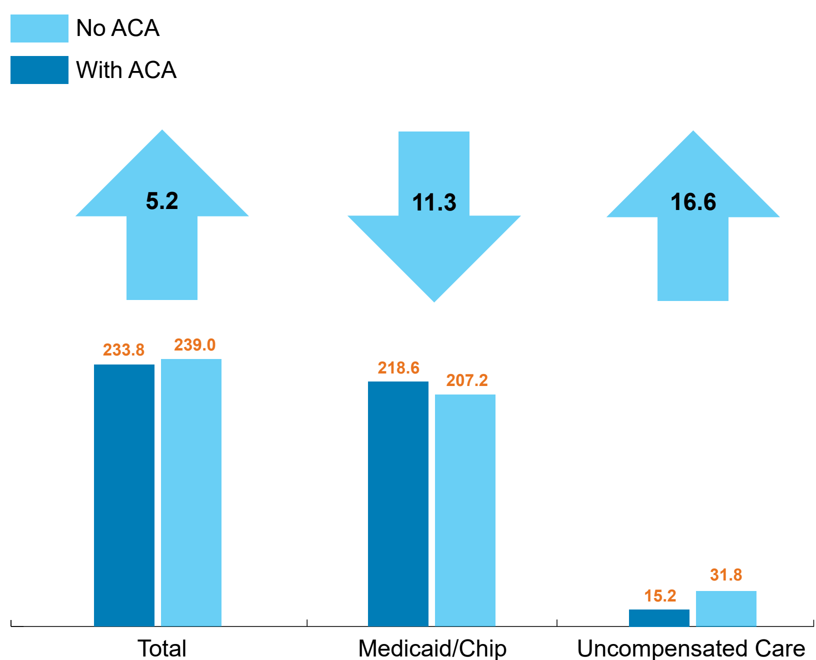
Table 3. Characteristics of Those Losing Coverage Without the ACA, 2021 (Millions)

	2021 Without ACA	
Income Level		
< 100% FPL	7.1	29.7%
100%–150% FPL	4.8	19.9%
150%–200% FPL	3.3	13.7%
200%–300% FPL	3.0	12.4%
300%–400% FPL	1.9	7.7%
> 400% FPL	4.0	16.5%
Total	**24.0**	**100.0%**
Age group (years)		
< 18	3.0	12.6%
18–24	4.2	17.5%
25–34	5.5	22.9%
35–44	4.1	17.1%
45–54	4.0	16.7%
55–64	3.2	13.2%
Total	**24.0**	**100.0%**
Family employment status		
No worker	4.5	18.7%
Part-time only	3.7	15.5%
At least one full-time worker	15.8	65.7%
Total	**24.0**	**100.0%**
Race/Ethnicity		
White, non-Hispanic	11.8	49.2%
Black, non-Hispanic	3.3	14.0%
Hispanic	6.3	26.4%
Asian	1.5	6.2%
American Indian/Alaska Native	0.6	2.7%
Other, non-Hispanic	0.4	1.6%
Total	**24.0**	**100.0%**
Education attainment		
Less than high school	6.4	26.8%
High school	9.0	37.6%
Some college	5.5	23.1%
College	2.2	9.2%
Graduate school	0.8	3.2%
Total	**24.0**	**100.0%**

Source:Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act.

Figure 3: State & Local Government Spending in 2021 (Billions $)



assume that federal, state, and local governments would fund uncompensated care at pre-ACA levels. If they spend less after repeal, more people would not receive necessary care and more uncompensated care would be paid for by health care providers.

If the ACA were repealed, the federal government would spend $66.1 billion less on health care for the nonelderly in states that have expanded Medicaid; expansion states in total would spend $5.4 billion more. Not counting increases in uncompensated care, expansion states as a whole would spend $5.3 billion less on Medicaid and CHIP without the ACA. But some states, such as New York, Minnesota, and Vermont would spend more if the ACA were repealed than with the ACA in place if, as we assume here, they continued the expanded Medicaid eligibility that they implemented before the ACA (Appendix B). Under the ACA, the federal government would pay a higher share of the costs of some existing enrollees in these states. States that expanded Medicaid under the ACA reported other cost savings caused by expansion that would be lost without the ACA, so the cost of repeal to these state budgets would be higher than what is shown.[14]

If the ACA were repealed, the federal government would spend $24.8 billion less on health care for the nonelderly in states that have not expanded Medicaid. In contrast with expansion states, nonexpansion states would spend slightly less on health care for the nonelderly without the ACA.

If the ACA were repealed, federal spending on health care for the nonelderly would be $926.6 billion lower over the 10-year budget window from 2017 to 2026, going from $4.4 trillion with the ACA to $3.5 trillion without it (Table 5 and Figure 4). The federal government would spend $789.8 billion less for Medicaid and CHIP. The ACA's marketplace tax credits and cost-sharing reductions will cost the federal government $394.1 billion over

Table 4. Government Cost Estimates, 2021 ($ Billions)

	All states			Medicaid expansion states			Nonexpansion states		
	ACA	No ACA	Difference	ACA	No ACA	Difference	ACA	No ACA	Difference
Medicaid/CHIP spending	**$582.7**	**$493.2**	**-$89.5**	**$392.3**	**$319.7**	**-$72.5**	**$190.5**	**$173.5**	**-$16.9**
Federal	$364.1	$286.0	-$78.1	$245.2	$178.0	-$67.3	$118.9	$108.0	-$10.9
State/Local	$218.6	$207.2	-$11.3	$147.0	$141.7	-$5.3	$71.6	$65.5	-$6.1
Federal marketplace financial assistance	**$39.3**	**$0.0**	**-$39.3**	**$15.8**	**$0.0**	**-$15.8**	**$23.5**	**$0.0**	**-$23.5**
Spending on uncompensated care	**$39.5**	**$82.6**	**$43.1**	**$20.5**	**$48.2**	**$27.7**	**$19.0**	**$34.4**	**$15.5**
Federal	$24.3	$50.8	$26.5	$12.6	$29.7	$17.0	$11.7	$21.2	$9.5
State/Local	$15.2	$31.8	$16.6	$7.9	$18.5	$10.6	$7.3	$13.2	$5.9
Total federal spending	**$427.7**	**$336.8**	**-$90.9**	**$273.7**	**$207.6**	**-$66.1**	**$154.0**	**$129.2**	**-$24.8**
Total state/local spending	**$233.8**	**$239.0**	**$5.2**	**$154.9**	**$160.3**	**$5.4**	**$78.9**	**$78.7**	**-$0.1**
Total federal and state spending	**$661.5**	**$575.8**	**-$85.7**	**$428.6**	**$367.9**	**-$60.7**	**$232.9**	**$207.9**	**-$25.0**

Source:Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act.

Figure 4: Federal Government Spending, 2017–2026 (Billions $)

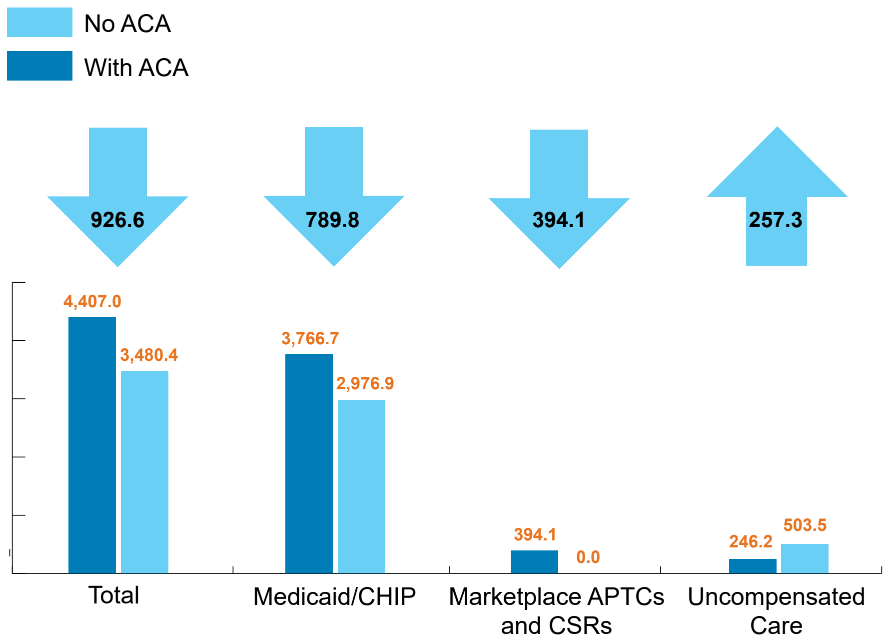


Table 5. Government Cost Estimates, 10-Year Budget Window of 2017–2026 ($ Billions)

	2017–2026		
	ACA	No ACA	Difference
Medicaid/CHIP spending	**$6,016.7**	**$5,134.7**	**-$882.0**
Federal	$3,766.7	$2,976.9	-$789.8
State/Local	$2,250.0	$2,157.8	-$92.2
Federal marketplace financial assistance	**$394.1**	**$0.0**	**-$394.1**
Spending on uncompensated care	**$400.1**	**$818.1**	**$418.0**
Federal	$246.2	$503.5	$257.3
State/Local	$153.9	$314.6	$160.7
Total federal spending	**$4,407.0**	**$3,480.4**	**-$926.6**
Total state/local spending	**$2,403.9**	**$2,472.4**	**$68.5**
Total federal and state spending	**$6,810.9**	**$5,952.8**	**-$858.1**

Source:Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act.

this 10-year period. However, absent the ACA, the federal government would spend $257.3 billion more on uncompensated care for the uninsured over this period, assuming that federal and state governments are willing to fund uncompensated care at pre-ACA levels after repeal.

Note that we have not assessed the full impact of repeal on the federal
For example, several important revenue provisions in the ACA would also be eliminated; we do not estimate the revenue effects of repeal here.

State governments would spend $92.2 billion less on Medicaid/CHIP without the ACA from 2017 to 2026; states' shares of expenditures with the ACA are small by design (Table 5 and Figure 5). However, state and local governments would spend $160.7 billion more on uncompensated care if they funded it at pre-ACA levels after repeal. Thus, state and local governments as a whole would spend $68.5 billion more over this 10-year period without the ACA. As we discussed above for the 2021 cost estimates, the actual effect would vary by state.

Total Health Care Spending

People would receive less health care if the ACA were repealed. Finally, we look at total spending on health care for the nonelderly by type of payer in 2021. Total health care spending would be $88.1 billion lower without the ACA, falling from $2.2 trillion to $2.1 trillion (Table 6). We do not assume that ACA repeal would reduce the unit price of health care. On the contrary, some evidence suggests that part of the recent slowdown in health care cost growth is partially because of the ACA, so people would receive less health care without the ACA. More than two-thirds of the reduction in health care spending would come from reducing care delivered to those in families with incomes below 200 percent of FPL. Almost all of the rest of the reduction is from the health care of those with incomes between 200 and 400 percent of FPL. If governments and health care providers did not return to pre-ACA rates of spending on uncompensated care under repeal, then the reductions in total

health care spending would be larger than the $88.1 billion estimated here and unmet need would be higher.

Changes in household health care spending would vary by income. Households would spend $28.9 billion less on their own health care without the ACA, a decrease of 4.9 percent. Spending is lower because fewer people would have health coverage. However, the effect varies by income. Households below 100 percent of FPL would see their spending on health care increase 5.9 percent without the ACA, households with incomes between 100 and 200 percent of FPL would see their spending on health care decrease 0.8 percent without the ACA, and those with higher incomes would see larger reductions in health care spending. These reductions in health care spending occur because more people enroll in health coverage under the ACA and many contribute to insurance premiums and pay directly out-of-pocket for some portion of the care they receive, and they use more care when insured.

Providers would pay for more uncompensated care if the ACA were repealed. Uncompensated care that is not funded by federal, state, or local governments is ultimately absorbed by health care providers. We estimate that the providers' share of uncompensated care would increase 109.2 percent in 2021 if the ACA were repealed, from $21.3 billion to $44.5 billion (Figure 6). That assumes that governments would be willing to fund uncompensated care at pre-ACA levels. If governments did not return to pre-ACA levels of uncompensated care funding, the increase in the burden on providers would be higher than shown here, and the unmet need for care would also be higher.

Discussion

This is not a complete picture of the effect of ACA repeal on the federal budget. Most importantly, revenue-raising provisions of the ACA would also be repealed. Similarly, the difference in direct Medicaid spending is not the only effect on state budgets. In particular, the loss of federal and state spending on health

Figure 5: State & Local Government Spending, 2017–2026 (Billions $)

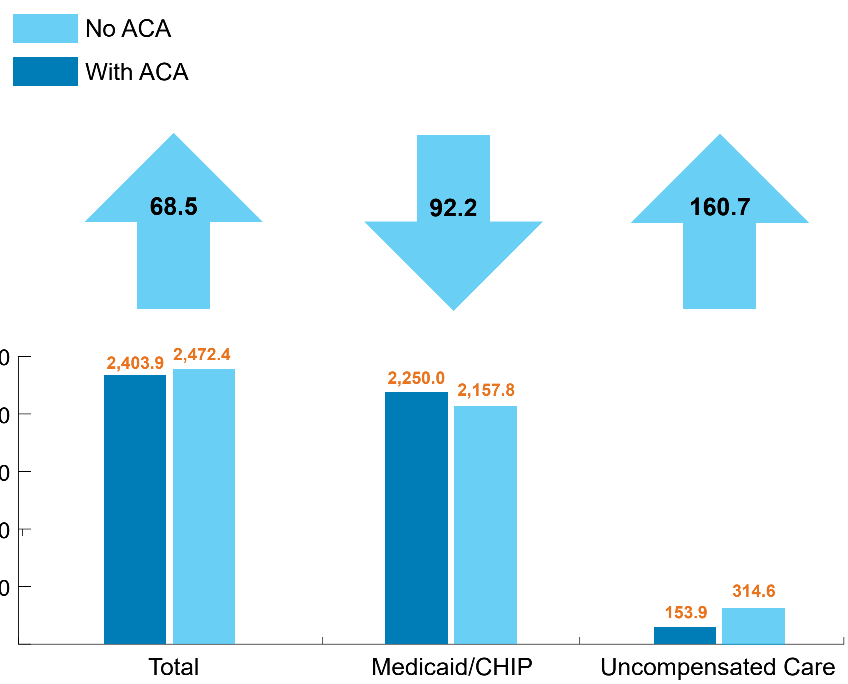


Table 6. Total Health Care Spending for the Nonelderly by Payer and Income Level, 2021 ($ Billions)

	ACA	No ACA	Difference	% Difference
Health care costs paid directly by households, including premiums and out-of-pocket costs				
< 100% FPL	$39.8	$42.2	$2.3	5.9%
100%–200% FPL	$76.1	$75.5	-$0.6	-0.8%
200%–300% FPL	$98.4	$91.8	-$6.6	-6.7%
300%–400% FPL	$94.0	$86.0	-$8.0	-8.5%
> 400% FPL	$282.5	$266.4	-$16.1	-5.7%
Total	**$590.8**	**$561.9**	**-$28.9**	**-4.9%**
Total spending on health care by all payers on behalf of households in each income group				
< 100% FPL	$466.1	$438.2	-$27.9	-6.0%
100–200% FPL	$362.0	$329.8	-$32.2	-8.9%
200–300% FPL	$323.4	$309.0	-$14.4	-4.5%
300–400% FPL	$277.9	$268.9	-$9.0	-3.2%
400%+ FPL	$779.3	$774.7	-$4.6	-0.6%
Total	**$2,208.7**	**$2,120.6**	**-$88.0**	**-4.0%**

Source: Urban Institute analysis, HIPSM 2016.

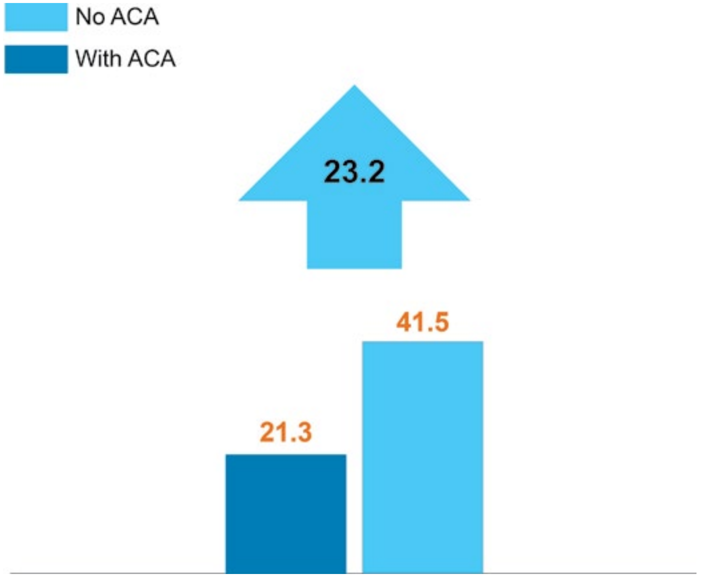
Note: ACA = the Affordable Care Act.

care would have important economic consequences for states. For example, Arkansas Governor Asa Hutchinson and Arkansas House Speaker Jeremy Gillam recently warned that if the state legislature failed to approve continuing Medicaid expansion, the state would face a substantial budget gap.[15] Arkansas is not alone in reporting savings resulting from Medicaid expansion.[16]

Our estimates of the effect of ACA repeal are conservative. Several factors could lead to higher enrollment in the future under the ACA than we simulated, and thus a greater loss of coverage with repeal:

- More states could choose to expand Medicaid. In an earlier report, we estimated that if all states were to expand Medicaid, the number of uninsured people would decrease by 4.3 million in 2016.[17] Thus, if the remaining states would have expanded Medicaid eligibility in the coming years, the effect of repeal would be larger, increasing the number of uninsured by over 28.0 million people in 2021. According to our earlier report, all states expanding Medicaid would lead to $472 billion more in federal Medicaid spending and $38 billion more in state Medicaid spending from 2015 to 2024.
- The individual mandate could have a larger effect on people's behavior than it has so far. This would lead to more private coverage under the ACA than we simulated and a correspondingly larger loss of coverage under repeal.
- It is unclear how much of the slowdown in per-capita health care cost growth in recent years is directly attributable to the ACA.[18] Our estimates make the same cost-growth assumptions both with and without the ACA. If, as we suspect, at least a portion of the slowdown in spending is attributable to the ACA, repealing it would increase both government and private spending over time more than shown here.
- We nd that 41.6 percent of the remaining uninsured under the ACA are eligible for Medicaid or subsidized private marketplace coverage. Additional targeted outreach and assistance efforts could potentially increase health coverage further under the ACA.[19] If such an effort succeeds, a greater loss of coverage under repeal would occur than shown here.
- Repeal may be more disruptive of health coverage than we simulate. Before the ACA, many states used Medicaid waivers to expand eligibility. We assume that those states would revert back to pre-ACA eligibility levels if the ACA were repealed. However, pre-ACA waivers have been renegotiated to accommodate the ACA, so going backwards would likely require the Centers for Medicare and Medicaid Services to approve new waivers. A new presidential administration that favors ACA repeal may not necessarily grant such waivers or may require substantial changes to them. In that case, some people who were covered by Medicaid before the ACA would become ineligible after the ACA's repeal. We do not attempt to predict what waiver changes would occur in various states under repeal, but we estimate that this could affect the coverage of up to an additional 3.6 million childless adults (data not shown).

Figure 6: Uncompensated Care Paid for by Providers in 2021 (Billions $)



We that total health care spending on the nonelderly would be $88.0 billion lower in 2021 if the ACA were repealed, a decrease of 4 percent. No evidence suggests that ACA repeal would lower the unit cost of health care—in fact, the opposite may be true[20]—so this reduction in total spending means that people would receive less health care without the ACA. This gap in health spending is largest for families with incomes below 200 percent of FPL, but those with incomes between 200 and 400 percent of FPL would also see noticeable reductions. These reductions in spending would be concentrated on those made uninsured under repeal. For them, the decreases in health care use would be substantially larger.

In addition to reductions in total health care, those with incomes below 100 percent of FPL would pay more health costs out-of-pocket without the ACA. Those with higher incomes would pay less out-of -pocket for health care because more have purchased private health coverage under the ACA, and, without it, they will receive less care.

In 2021, repeal would lower the amount of health care spending funded by the federal government by $90.9 billion, a 21.3 percent increase. State and local governments as a whole would spend $5.2 billion more on health care without the ACA—a 2.2 percent increase—

because their increase in spending on uncompensated care would outweigh their reduction in Medicaid spending. ACA repeal would have very little effect on the amount that employers pay in health insurance premium contributions. By contrast, the amount of uncompensated care that providers would have to absorb would more than double. And that assumes that federal, state, and local governments would be willing to restore uncompensated care funding to pre-ACA levels. If they do not, the decline in health care spending overall would be greater.

Thus, ACA repeal would reduce federal government spending, which appears to be one of the goals of those advocating repeal. However, that reduction in spending comes at a cost in other areas. The number of uninsured people would increase by 24 million or more. Many states that have expanded Medicaid would actually see their health care spending increase without the ACA, and states that have seen savings because of Medicaid expansion in their budgets would face budget shortfalls if the ACA were repealed. Modest- and low-income families would forgo health care because of cost and lack of coverage, and health care providers would end up paying for more uncompensated care.

Appendix A. State-Level Estimates

In this appendix, we present state-level estimates supplementing the estimates presented in the report.

The Uninsured by State, 2021

Looking at the difference in the number of uninsured people by state, we that ACA repeal would increase the number of uninsured people in Medicaid expansion states, in aggregate, 107.0 percent in 2021 and would increase the number of uninsured in nonexpansion states in aggregate 56.9 percent (Table A.1). Every state would have at least 40 percent more uninsured people, and the number of uninsured people would more than double in 19 states: Arkansas, California, Illinois, Iowa, Kentucky, Louisiana, Massachusetts, Michigan, Montana, New Hampshire, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, West Virginia, and Wisconsin. States that had already expanded Medicaid eligibility before the ACA was enacted, such as New York, Minnesota, and Vermont, would see lower increases in the number of uninsured because we assume they would maintain those earlier expansions. But even in these states the number of uninsured would increase somewhere in the range of 57.7 percent to 81.0 percent.

Wisconsin stands out among the other Medicaid nonexpansion states; it would see a 104.7 percent increase in the number of uninsured without the ACA. This is because the state changed eligibility rules in 2014 to make all adults up to 100 percent of FPL eligible for Medicaid; that change was related to the ACA but did not meet the ACA's expansion rule of eligibility up to 138 percent of FPL. Because Wisconsin's change was made in response to the ACA, we assume that the state would revert to its pre-ACA eligibility level after repeal.

It may come as a surprise that Massachusetts would see its number of uninsured more than double if the ACA were repealed. That large rate of increase occurs because the change in the number of uninsured under the ACA, based on published enrollment data, is compared with an extremely small number of uninsured people before the ACA because of that state's landmark health reform law (i.e., we estimate a large rate of increase off of a small base). If Massachusetts is not able to re-create its pre-ACA health reform institutions after the ACA's repeal, the increase in the uninsured would be far larger than we estimate.

The share of the remaining uninsured eligible for Medicaid or marketplace tax credits varies considerably across expansion states (table A.1). The number of people newly enrolling in these programs in each state was based on reported 2015 data, so such shares vary depending on each state's 2015 marketplace participation. The lowest share of uninsured eligible for assistance is in California (33.2%), a state with notably high enrollment among both those eligible for Medicaid and those eligible for marketplace tax credits according to 2015 administrative data. Alaska has the highest share of uninsured eligible for assistance, but that state expanded Medicaid in the middle of 2015, so Medicaid enrollment is likely to end up higher in the coming years under the ACA.

Among states that did not expand Medicaid, the share of the uninsured eligible for marketplace tax credits under the ACA is largely driven by the marketplace participation rates observed in 2015. Florida saw the highest share of those eligible for tax credits enrolling in coverage; consequently, only 25.4 percent of the remaining uninsured in that state are eligible for tax credits.[21] States with lower marketplace participation, such as South Dakota, have notably higher shares of the uninsured eligible for assistance. Wisconsin is a special case because adults with incomes up to 100 percent of FPL are eligible for Medicaid, raising its share of uninsured eligible for assistance to a level similar to that of a Medicaid expansion state.

Medicaid/CHIP Costs by State

We provide state-level estimates of Medicaid and CHIP spending for 2021 (Table A.2). Under the ACA, the federal government will spend $364.1 billion on acute care for the nonelderly under Medicaid in 2021; the corresponding state share will be $218.6 billion. If the ACA were repealed, federal Medicaid spending would decrease by $78.1 billion, or 21.5 percent, while overall state Medicaid spending would decrease by $11.3 billion, or 5 percent.

ACA repeal would lead to a 3.5 percent decline in state Medicaid spending, in aggregate, among expansion states in 2021 ($147.0 billion to $141.7 billion). However, some states, such as New York, Minnesota, and Vermont would spend more if the ACA were repealed than with the ACA in place, if, as we assume here, those states continued the expanded

Medicaid eligibility that they implemented before the ACA. States that expanded Medicaid under the ACA reported other cost savings caused by expansion that would be lost without the ACA, so the cost to of repeal to these state budgets would be higher than shown in here (i.e., state spending in 2021 would not decrease to the extent shown).[22]

Among nonexpansion states, state Medicaid spending in 2021 would be 8.5 percent lower without the ACA than with it ($65.5 billion versus $71.6 billion). Therefore, the lower spending r ects fewer Medicaid enrollees.

Marketplace Subsidy Costs by State

We provide state-level estimates of spending on marketplace tax credits and cost-sharing reductions for 2021 in Table A.3. We estimate that the federal government will spend $32.4 billion on tax credits and $6.9 billion on cost-sharing reductions for marketplace coverage in 2021 under the ACA. Just ve states, California, Florida, Texas, North Carolina, and Georgia, account for more than half of the amount spent to make marketplace coverage more affordable. If the ACA were repealed, this spending would be eliminated.

Uncompensated Care Costs by State

We provide state-level estimates of uncompensated care by payer for 2021 (Table A.4). The most populous state that has expanded Medicaid, California, would see total uncompensated care increase 148 percent if the ACA were repealed; that is larger in relative terms than the 134 percent increase that Medicaid expansion states as a whole would experience. The four nonexpansion states with the largest uncompensated care costs, Florida, Georgia, Texas and North Carolina, account for more than half of the total uncompensated care in all 19 states that have not expanded Medicaid.

Appendix B. Data and Methods

Our primary source of data for the demographic and economic characteristics of Americans is the ACS. Our estimates of pre-ACA health coverage come from the 2013 ACS. We apply edits to the ACS coverage variables; these edits have been developed over many years and have made our resulting coverage estimates agree well with sources of health coverage data considered most reliable, particularly the NHIS.[23] The ACS has a much larger sample size than the NHIS, making state-level analysis possible. We estimate eligibility for Medicaid on the 2013 ACS using the Urban Institute's pre-ACA Medicaid eligibility model for 2013.[24]

We estimate health coverage in 2015 using HIPSM because ACS data for that year have not been released yet. HIPSM uses a microsimulation approach based on the relative desirability of the health insurance options available to each individual and family under reform. The health insurance coverage decisions of individuals and families in the model account for several factors, such as premiums and out-of-pocket health care costs for available insurance products, health care risk, whether or not the individual mandate would apply to them and the size of the applicable penalties, and family disposable income. Our utility model accounts for people's current choices as reported on the survey data. We use such preferences to customize individual utility functions so their current choices score the highest, and this in turn affects behavior under the ACA. The resulting health insurance decisions made by individuals, families, and employers are calibrated to in the empirical economics literature, such as price elasticities for employer-sponsored insurance and nongroup coverage.[25]

We use June 2015 enrollment data from the marketplaces and Medicaid to ensure that the resulting number of enrollees in each state match actual enrollment. The US Department of Health and Human Services published income and age distributions for 2015 Marketplace enrollees, so we calibrate HIPSM to replicate those as well. Although the total number of enrollees in a state is controlled to match actual experience, HIPSM is used to determine which eligible people actually enroll under the ACA, based on their characteristics and estimated health care costs. HIPSM computes the difference in the expected utility of each family's best coverage option under the ACA, given eligibility for Medicaid or subsidized marketplace coverage and the type of coverage they had before the ACA (uninsured or private). The individual mandate reduces the value of remaining uninsured. Those with the most to gain from being insured are the most likely to enroll. Those with the strongest preferences for Medicaid or marketplace coverage are enrolled until the target total number (based on actual enrollment data) is reached.

Many relevant characteristics about Medicaid and marketplace enrollees were not available from administrative data. For example, we do not know what type of coverage marketplace or Medicaid enrollees had before they signed up. Most of the new enrollees in our model were previously uninsured, but some who had private coverage were also simulated to switch to Medicaid and the marketplaces. Also, Medicaid enrollment in 2015 was only reported in aggregate. We have no information about basic distinctions, such as how many of them gained eligibility under the ACA Medicaid expansion and how many were eligible under pre-ACA rules. After calibrating HIPSM to reproduce 2015 Medicaid and marketplace enrollment, the resulting number of uninsured people is 28.4 million. This is extremely close to the NHIS estimate for June 2015 of 28.2 million uninsured people.

Our 2016 estimates use the same methodology as for 2015 but with more-recent enrollment data. The US Department of Health and Human Services released marketplace plan selections at the end of the 2016 open enrollment period. We simulate actual, or effectuated, enrollment, which is lower than the number of plan selections because some people will fail to pay

their month's premium or supply required documentation. We estimate actual enrollment for 2016 by applying the percent change in plan selections for each state to the 2015 effectuated enrollment. We also assume that the attrition between plan selections and effectuated enrollment is 25 percent lower in 2016 than in 2015 because of improvements in data coordination between Healthcare.gov and insurers.

For future estimates of coverage under the ACA, we do not assume notably higher take-up of Medicaid or marketplace coverage than in 2016. For example, some have suggested that the individual mandate could have a stronger effect on people's behavior in the future as people see the full penalty amounts when they out their taxes. Such increases are possible, but we chose to use a conservative estimate of ACA effect based on experience so far. As premiums increase faster than health costs, some attrition of private coverage will occur over time, leading to small increases in Medicaid and the number of uninsured. However, the ACA's individual and employer mandates limit this effect (the latter to a smaller extent).

Data show that Medicaid enrollment increased under the ACA for those who were already eligible before enactment of the law. If the ACA were repealed, we assume that those enrolled in 2016 who were eligible under 2013 rules would maintain coverage into 2017 but that this additional enrollment caused by the ACA would phase out over time because ACA-related outreach and enrollment activities that likely led to this increase would cease with repeal. Also, with repeal, growth in premiums and health care costs would lead to a greater decline in private health coverage because the ACA's mandates would be eliminated.

Some studies have found evidence that the ACA contributed to the slowing growth of health care costs in recent years, but there is no generally accepted estimate of how large that contribution was.[26] We assume that the underlying growth rate of health care costs would be the same with or without the ACA. In this, as in other areas, we avoid assumptions that would further increase health coverage under the ACA beyond what has been observed by 2016.

Although Wisconsin did not accept the ACA's Medicaid expansion, the state made major changes to its eligibility rules in 2014. Previously, parents with incomes up to 200 percent of FPL were eligible and income-based eligibility did not exist for adult nonparents. Beginning in 2014, both parents and nonparents with incomes up to 100 percent of FPL were eligible; that was the lowest income level for which people could qualify for marketplace tax credits under the ACA. We assume that Wisconsin would revert to 2013 Medicaid eligibility rules if the ACA were repealed. That state's change in rules for 2014 was clearly a response to the ACA, though it was not technically an acceptance of Medicaid expansion.

Also, some states, such as California, expanded Medicaid eligibility beginning in 2011 or later in anticipation of the ACA expansion in 2014. We assume that these early expansions would be revoked under ACA repeal because they were intended as a temporary transition between the law's enactment and its implementation. In contrast, we assume that Medicaid expansions that occurred before the ACA was enacted would continue. We also assume that Massachusetts would revert to its 2006 state coverage expansion. Given that pre-ACA Medicaid expansions were dependent on federal waivers that would have to be approved once again, this assumption may not be realistic.

Under the ACA, beginning in September 2010, children up to age 26 could enroll in a parent's private insurance family plan. Repealing the ACA would eliminate this provision as well. Thus, we need to impute which young adults in the 2013 ACS data would have been uninsured without the ACA dependent-coverage expansion. To do this, we analyze Survey of Income and Program Participation data from 2010 to 2013 to estimate the probability that privately insured young adults in 2013 would have been uninsured without access to a parent's policy. Our simulations consistent with other estimates in the literature, that almost a million additional young adults who gained coverage before 2014 would be uninsured without the ACA.[27]

Comparison with estimates from the Congressional Budget Office (CBO). The CBO released its latest projections of health coverage under the ACA in March.[28] Their Medicaid and CHIP enrollment forecasts are very close to ours, with 67 million enrolled in 2016 and 69 million enrolled in 2021. Their estimates of the number of people uninsured are a somewhat lower than our projections: 26 million in 2017 and 27 million in 2021.

The biggest difference between their projections and ours is in marketplace enrollment. The US Department of Health and Human Services reported that about 8.3 million people were enrolled in subsidized marketplace coverage in June 2015. Based on 2016 open enrollment period data, we estimate that enrollment has increased to just over 9 million, a little lower than the CBO's estimate of 10 million in subsidized marketplace coverage. However, the CBO predicts substantial future increases in marketplace enrollment; 12 million people would be enrolled in subsidized marketplace coverage in 2017, rising to 19 million by 2021. We project little growth in subsidized marketplace coverage after 2016.

Table A1. Uninsured by State

State	2021 ACA				2021 Without ACA, pre-ACA Medicaid enrollment rates			Difference	
	Number of Uninsured	Uninsured and eligible for Medicaid/ CHIP	Uninsured and eligible for tax credits	Percentage of uninsured eligible for any assistance	Number of Uninsured	Uninsured and eligible for Medicaid/ CHIP	Percentage of uninsured eligible for any assistance	Number of Uninsured	Percent change
National	*29,588,000*	*6,210,000*	*6,098,000*	*41.6%*	*53,542,000*	*8,585,000*	*16.0%*	*23,954,000*	*81.0%*
Expansion states									
Alaska	119,000	59,326.10	33,000	**77.7%**	175,000	22,000	**12.4%**	57,000	**47.7%**
Arizona	771,000	219,000	190,000	**53.0%**	1,367,000	270,000	**19.7%**	596,000	**77.2%**
Arkansas	218,000	65,000	60,000	**57.3%**	546,000	70,000	**12.8%**	328,000	**150.5%**
California	3,383,000	603,000	506,000	**32.8%**	7,531,000	1,172,000	**15.6%**	4,148,000	**122.6%**
Colorado	447,000	85,000	155,000	**53.6%**	888,000	139,000	**15.7%**	441,000	**98.6%**
Connecticut	203,000	56,000	38,000	**46.6%**	390,000	108,000	**27.8%**	187,000	**92.3%**
Delaware	62,000	23,000	12,000	**57.2%**	104,000	36,000	**35.0%**	42,000	**67.3%**
District of Columbia	32,000	13,000	5,000	**54.9%**	49,000	20,000	**41.5%**	17,000	**53.1%**
Hawaii	88,000	22,000	39,000	**69.3%**	154,000	21,000	**13.5%**	67,000	**76.0%**
Illinois	907,000	272,000	164,000	**48.0%**	1,849,000	278,000	**15.1%**	942,000	**103.8%**
Indiana	567,000	273,000	119,000	**69.2%**	1,061,000	177,000	**16.7%**	493,000	**87.0%**
Iowa	160,000	51,000	48,000	**61.8%**	326,000	51,000	**15.7%**	166,000	**103.6%**
Kentucky	250,000	78,000	84,000	**65.0%**	686,000	118,000	**17.3%**	436,000	**174.5%**
Louisiana	368,000	123,000	104,000	**61.6%**	825,000	107,000	**13.0%**	457,000	**124.0%**
Maryland	403,000	67,000	77,000	**35.7%**	779,000	88,000	**11.2%**	377,000	**93.6%**
Massachusetts	137,000	21,000	37,000	**42.7%**	376,000	36,000	**9.6%**	238,000	**173.3%**
Michigan	508,000	238,000	117,000	**69.9%**	1,226,000	174,000	**14.2%**	718,000	**141.3%**
Minnesota	318,000	141,000	69,000	**66.1%**	562,000	204,000	**36.3%**	244,000	**76.6%**
Montana	86,000	37,000	30,000	**78.6%**	196,000	34,000	**17.4%**	110,000	**127.4%**
Nevada	408,000	119,000	86,000	**50.3%**	748,000	143,000	**19.0%**	340,000	**83.3%**
New Hampshire	62,000	16,000	23,000	**62.7%**	155,000	16,000	**10.2%**	92,000	**147.7%**
New Jersey	654,000	136,000	107,000	**37.1%**	1,355,000	203,000	**15.0%**	701,000	**107.2%**
New Mexico	197,000	44,000	54,000	**49.7%**	443,000	71,000	**16.0%**	246,000	**124.8%**
New York	1,532,000	554,000	286,000	**54.8%**	2,416,000	792,000	**32.8%**	884,000	**57.7%**
North Dakota	46,000	13,000	19,000	**68.8%**	91,000	11,000	**12.3%**	45,000	**98.7%**
Ohio	625,000	235,000	202,000	**69.9%**	1,432,000	224,000	**15.6%**	807,000	**129.1%**
Oregon	261,000	71,000	58,000	**49.3%**	658,000	83,000	**12.6%**	397,000	**151.8%**
Pennsylvania	724,000	357,000	163,000	**71.9%**	1,452,000	208,000	**14.3%**	728,000	**100.6%**
Rhode Island	58,000	11,000	14,000	**43.5%**	137,000	22,000	**16.3%**	79,000	**136.5%**
Vermont	27,000	9,000	10,000	**68.3%**	49,000	19,000	**39.5%**	22,000	**81.0%**
Washington	522,000	111,000	149,000	**49.9%**	1,169,000	158,000	**13.5%**	648,000	**124.2%**
West Virginia	88,000	35,000	28,000	**70.6%**	261,000	36,000	**13.9%**	172,000	**194.8%**
Total	**14,233,000**	**4,158,000**	**3,087,000**	**50.9%**	**29,456,000**	**5,113,000**	**17.4%**	**15,223,000**	**107.0%**

Table A1. Uninsured by State (continued)

State	2021 ACA				2021 Without ACA, pre-ACA Medicaid enrollment rates			Difference	
	Number of Uninsured	Uninsured and eligible for Medicaid/ CHIP	Uninsured and eligible for tax credits	Percentage of uninsured eligible for any assistance	Number of Uninsured	Uninsured and eligible for Medicaid/ CHIP	Percentage of uninsured eligible for any assistance	Number of Uninsured	Percent change
National	*29,588,000*	*6,210,000*	*6,098,000*	*41.6%*	*53,542,000*	*8,585,000*	*16.0%*	*23,954,000*	*81.0%*
Nonexpansion states									
Alabama	496,000	64,000	92,000	**31.3%**	758,000	116,000	**15.3%**	262,000	**52.7%**
Florida	2,532,000	248,000	395,000	**25.4%**	4,310,000	558,000	**12.9%**	1,778,000	**70.2%**
Georgia	1,496,000	208,000	252,000	**30.7%**	2,328,000	384,000	**16.5%**	833,000	**55.7%**
Idaho	189,000	21,000	45,000	**35.3%**	316,000	40,000	**12.7%**	127,000	**67.1%**
Kansas	294,000	40,000	72,000	**38.2%**	438,000	61,000	**13.9%**	144,000	**48.8%**
Maine	77,000	10,000	21,000	**40.1%**	147,000	19,000	**13.1%**	70,000	**90.3%**
Mississippi	353,000	52,000	87,000	**39.2%**	544,000	95,000	**17.4%**	191,000	**54.2%**
Missouri	551,000	88,000	120,000	**37.8%**	921,000	156,000	**17.0%**	370,000	**67.2%**
Nebraska	154,000	29,000	25,000	**35.1%**	248,000	37,000	**14.9%**	94,000	**61.1%**
North Carolina	1,190,000	98,000	219,000	**26.7%**	1,981,000	267,000	**13.5%**	791,000	**66.5%**
Oklahoma	543,000	101,000	129,000	**42.3%**	790,000	136,000	**17.2%**	247,000	**45.6%**
South Carolina	624,000	124,000	135,000	**41.5%**	897,000	164,000	**18.3%**	273,000	**43.8%**
South Dakota	83,000	13,000	32,000	**54.8%**	118,000	19,000	**16.3%**	36,000	**43.4%**
Tennessee	686,000	72,000	180,000	**36.7%**	1,057,000	176,000	**16.7%**	372,000	**54.2%**
Texas	4,478,000	580,000	827,000	**31.4%**	6,602,000	890,000	**13.5%**	2,124,000	**47.4%**
Utah	341,000	71,000	81,000	**44.4%**	520,000	89,000	**17.2%**	179,000	**52.4%**
Virginia	900,000	99,000	214,000	**34.7%**	1,387,000	134,000	**9.7%**	487,000	**54.1%**
Wisconsin	306,000	126,000	64,000	**61.8%**	627,000	120,000	**19.1%**	321,000	**104.7%**
Wyoming	62,000	10,000	21,000	**48.7%**	95,000	11,000	**11.3%**	33,000	**53.2%**
Total	**15,355,000**	**2,052,000**	**3,011,000**	**33.0%**	**24,086,000**	**3,472,000**	**14.4%**	**8,731,000**	**56.9%**

Source:Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act.

Table A2. Medicaid/CHIP Costs by State in 2021 ($ Millions)

State	2021 ACA			2021 Without ACA, pre-ACA Medicaid enrollment rates		
	Federal	State	Total	Federal	State	Total
National	*$364,117*	*$218,591*	*$582,708*	*$285,972*	*$207,249*	*$493,221*
Medicaid Expansion States						
Alaska	$1,010	$858	$1,868	$889	$889	$1,778
Arizona	$12,500	$5,250	$17,750	$9,350	$4,560	$13,910
Arkansas	$3,670	$1,370	$5,040	$2,940	$1,250	$4,190
California	$31,900	$25,900	$57,800	$22,700	$22,700	$45,400
Colorado	$6,520	$3,890	$10,410	$3,630	$3,470	$7,100
Connecticut	$4,540	$3,480	$8,020	$3,560	$3,480	$7,040
Delaware	$1,310	$775	$2,085	$1,060	$837	$1,897
District of Columbia	$1,600	$586	$2,186	$1,420	$608	$2,028
Hawaii	$1,340	$923	$2,263	$984	$914	$1,898
Illinois	$13,800	$9,990	$23,790	$10,200	$9,680	$19,880
Indiana	$7,120	$2,770	$9,890	$5,760	$2,800	$8,560
Iowa	$3,020	$1,710	$4,730	$2,480	$1,730	$4,210
Kentucky	$9,230	$2,620	$11,850	$4,960	$2,120	$7,080
Louisiana	$6,510	$3,160	$9,670	$4,510	$2,860	$7,370
Maryland	$7,020	$5,030	$12,050	$4,810	$4,810	$9,620
Massachusetts	$8,330	$6,840	$15,170	$6,680	$6,460	$13,140
Michigan	$13,000	$5,070	$18,070	$10,100	$5,080	$15,180
Minnesota	$7,220	$5,580	$12,800	$5,740	$5,740	$11,480
Montana	$1,970	$713	$2,683	$1,210	$591	$1,801
Nevada	$3,090	$1,240	$4,330	$1,900	$1,090	$2,990
New Hampshire	$1,240	$866	$2,106	$864	$864	$1,728
New Jersey	$11,800	$6,690	$18,490	$6,980	$6,670	$13,650
New Mexico	$6,340	$2,000	$8,340	$3,910	$1,740	$5,650
New York	$30,500	$23,500	$54,000	$25,900	$25,200	$51,100
North Dakota	$617	$383	$1,000	$405	$400	$805
Ohio	$15,500	$6,910	$22,410	$11,500	$6,740	$18,240
Oregon	$7,220	$2,460	$9,680	$3,950	$2,220	$6,170
Pennsylvania	$13,500	$8,880	$22,380	$11,200	$9,300	$20,500
Rhode Island	$1,840	$1,370	$3,210	$1,210	$1,210	$2,420
Vermont	$986	$609	$1,595	$804	$655	$1,459
Washington	$7,910	$4,710	$12,620	$4,380	$4,300	$8,680
West Virginia	$3,080	$888	$3,968	$1,980	$777	$2,757
Total	**$245,233**	**$147,021**	**$392,254**	**$177,966**	**$141,745**	**$319,711**

Table A2. Medicaid/CHIP Costs by State in 2021 ($ Millions) (continued)

State	2021 ACA			2021 Without ACA, pre-ACA Medicaid enrollment rates		
	Federal	State	Total	Federal	State	Total
National	*$364,117*	*$218,591*	*$582,708*	*$285,972*	*$207,249*	*$493,221*
Nonexpansion states						
Alabama	$4,100	$1,810	$5,910	$3,770	$1,670	$5,440
Florida	$15,900	$10,800	$26,700	$14,000	$9,640	$23,640
Georgia	$8,850	$4,440	$13,290	$7,700	$3,870	$11,570
Idaho	$2,250	$873	$3,123	$1,990	$773	$2,763
Kansas	$2,090	$1,510	$3,600	$1,910	$1,380	$3,290
Maine	$1,490	$911	$2,401	$1,440	$888	$2,328
Mississippi	$3,840	$1,390	$5,230	$3,470	$1,250	$4,720
Missouri	$7,060	$4,180	$11,240	$6,530	$3,880	$10,410
Nebraska	$1,290	$1,070	$2,360	$1,270	$1,050	$2,320
North Carolina	$12,800	$6,500	$19,300	$10,800	$5,520	$16,320
Oklahoma	$4,240	$2,380	$6,620	$4,070	$2,290	$6,360
South Carolina	$4,740	$1,980	$6,720	$4,630	$1,930	$6,560
South Dakota	$724	$624	$1,348	$689	$593	$1,282
Tennessee	$8,560	$4,390	$12,950	$7,090	$3,670	$10,760
Texas	$28,400	$19,400	$47,800	$26,800	$18,300	$45,100
Utah	$2,880	$1,180	$4,060	$2,720	$1,120	$3,840
Virginia	$4,940	$4,810	$9,750	$4,660	$4,540	$9,200
Wisconsin	$4,330	$2,930	$7,260	$4,080	$2,760	$6,840
Wyoming	$400	$392	$792	$387	$380	$767
Total	**$118,884**	**$71,570**	**$190,454**	**$108,006**	**$65,504**	**$173,510**

Source:Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act.

Table A3. Marketplace Subsidy Costs by State ($ Millions)

State	2021 ACA		
	PTCs	CSRs	Total
National	*$32,392.1*	*$6,898.8*	*$39,291.0*
Medicaid expansion states			
Alaska	$130.0	$22.2	$152.2
Arizona	$230.0	$53.4	$283.4
Arkansas	$193.0	$37.5	$230.5
California	$5,240.0	$802.0	$6,042.0
Colorado	$171.0	$35.0	$206.0
Connecticut	$280.0	$45.1	$325.1
Delaware	$63.2	$11.0	$74.2
District of Columbia	$5.3	$0.2	$5.5
Hawaii	$28.0	$6.0	$34.0
Illinois	$631.0	$129.0	$760.0
Indiana	$452.0	$82.8	$534.8
Iowa	$140.0	$25.8	$165.8
Kentucky	$221.0	$48.8	$269.8
Louisiana	$290.0	$53.5	$343.5
Maryland	$273.0	$57.2	$330.2
Massachusetts	$534.0	$79.6	$613.6
Michigan	$671.0	$124.0	$795.0
Minnesota	$48.5	$2.0	$50.5
Montana	$62.2	$12.5	$74.7
Nevada	$282.0	$54.9	$336.9
New Hampshire	$81.6	$16.4	$98.0
New Jersey	$578.0	$101.0	$679.0
New Mexico	$72.4	$16.9	$89.3
New York	$692.0	$128.0	$820.0
North Dakota	$50.7	$7.8	$58.5
Ohio	$507.0	$102.0	$609.0
Oregon	$210.0	$43.6	$253.6
Pennsylvania	$650.0	$129.0	$779.0
Rhode Island	$61.9	$10.5	$72.4
Vermont	$90.6	$9.1	$99.7
Washington	$424.0	$78.0	$502.0
West Virginia	$107.0	$22.2	$129.2
Total	**$13,470.4**	**$2,347.0**	**$15,817.5**

Table A3. Marketplace Subsidy Costs by State ($ Millions) (continued)

State	2021 ACA		
	PTCs	CSRs	Total
National	*$32,392.1*	*$6,898.8*	*$39,291.0*
Nonexpansion states			
Alabama	$590.0	$156.0	$746.0
Florida	$5,070.0	$1,090.0	$6,160.0
Georgia	$1,670.0	$418.0	$2,088.0
Idaho	$234.0	$60.3	$294.3
Kansas	$222.0	$63.6	$285.6
Maine	$287.0	$59.2	$346.2
Mississippi	$342.0	$90.0	$432.0
Missouri	$908.0	$225.0	$1,133.0
Nebraska	$237.0	$55.6	$292.6
North Carolina	$2,170.0	$511.0	$2,681.0
Oklahoma	$339.0	$93.4	$432.4
South Carolina	$661.0	$176.0	$837.0
South Dakota	$71.7	$16.3	$88.0
Tennessee	$482.0	$141.0	$623.0
Texas	$3,340.0	$894.0	$4,234.0
Utah	$220.0	$50.5	$270.5
Virginia	$1,190.0	$273.0	$1,463.0
Wisconsin	$763.0	$147.0	$910.0
Wyoming	$125.0	$31.9	$156.9
Total	**$18,921.7**	**$4,551.8**	**$23,473.5**

Source:Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act; CSRs = cost-sharing reductions; PTCs = premium tax credits.

Table A4. Uncompensated Care Costs by State in 2021 ($ Millions)

State	2021 ACA				2021 Without ACA, Medicaid Enrollment Rates Maintained			
	Total	Federal	State/Local	Providers	Total	Federal	State/Local	Providers
National	*$60,758.9*	*$24,297.4*	*$15,191.5*	*$21,270.0*	*$127,083.6*	*$50,837.2*	*$31,771.4*	*$44,475.0*
Medicaid expansion states								
Alaska	$342.6	$137.0	$85.6	$120.0	$468.0	$187.0	$117.0	$164.0
Arizona	$1,840.0	$736.0	$460.0	$644.0	$3,253.0	$1,300.0	$813.0	$1,140.0
Arkansas	$705.0	$282.0	$176.0	$247.0	$1,605.0	$642.0	$401.0	$562.0
California	$6,370.0	$2,550.0	$1,590.0	$2,230.0	$15,770.0	$6,310.0	$3,940.0	$5,520.0
Colorado	$1,200.0	$480.0	$300.0	$420.0	$2,544.0	$1,020.0	$635.0	$889.0
Connecticut	$473.0	$189.0	$118.0	$166.0	$1,365.0	$546.0	$341.0	$478.0
Delaware	$126.5	$50.6	$31.6	$44.3	$322.6	$129.0	$80.6	$113.0
District of Columbia	$80.1	$32.1	$20.0	$28.0	$155.9	$62.3	$39.0	$54.6
Hawaii	$147.3	$58.9	$36.8	$51.6	$302.4	$121.0	$75.4	$106.0
Illinois	$2,167.0	$867.0	$542.0	$758.0	$5,230.0	$2,090.0	$1,310.0	$1,830.0
Indiana	$1,280.0	$512.0	$320.0	$448.0	$2,975.0	$1,190.0	$745.0	$1,040.0
Iowa	$377.2	$151.0	$94.2	$132.0	$875.0	$350.0	$219.0	$306.0
Kentucky	$617.0	$247.0	$154.0	$216.0	$1,685.0	$674.0	$421.0	$590.0
Louisiana	$885.0	$354.0	$221.0	$310.0	$2,020.0	$808.0	$505.0	$707.0
Maryland	$725.0	$290.0	$181.0	$254.0	$1,652.0	$661.0	$413.0	$578.0
Massachusetts	$387.9	$155.0	$96.9	$136.0	$1,177.0	$471.0	$294.0	$412.0
Michigan	$1,503.0	$601.0	$376.0	$526.0	$3,771.0	$1,510.0	$941.0	$1,320.0
Minnesota	$988.0	$395.0	$247.0	$346.0	$2,264.0	$906.0	$566.0	$792.0
Montana	$344.0	$138.0	$86.0	$120.0	$635.0	$254.0	$159.0	$222.0
Nevada	$636.0	$254.0	$159.0	$223.0	$1,621.0	$649.0	$405.0	$567.0
New Hampshire	$139.7	$55.9	$34.9	$48.9	$468.0	$187.0	$117.0	$164.0
New Jersey	$1,156.0	$462.0	$289.0	$405.0	$3,055.0	$1,220.0	$765.0	$1,070.0
New Mexico	$373.4	$149.0	$93.4	$131.0	$903.0	$361.0	$226.0	$316.0
New York	$2,907.0	$1,160.0	$727.0	$1,020.0	$5,800.0	$2,320.0	$1,450.0	$2,030.0
North Dakota	$90.0	$36.0	$22.5	$31.5	$276.9	$111.0	$69.1	$96.8
Ohio	$1,489.0	$596.0	$372.0	$521.0	$3,894.0	$1,560.0	$974.0	$1,360.0
Oregon	$705.0	$282.0	$176.0	$247.0	$1,792.0	$717.0	$448.0	$627.0
Pennsylvania	$1,772.0	$709.0	$443.0	$620.0	$3,628.0	$1,450.0	$908.0	$1,270.0
Rhode Island	$84.5	$33.8	$21.1	$29.6	$270.5	$108.0	$67.7	$94.8
Vermont	$105.5	$42.2	$26.4	$36.9	$214.5	$85.8	$53.6	$75.1
Washington	$1,297.0	$519.0	$324.0	$454.0	$3,374.0	$1,350.0	$844.0	$1,180.0
West Virginia	$277.1	$111.0	$69.2	$96.9	$769.0	$308.0	$192.0	$269.0
Total	**$31,590.8**	**$12,635.5**	**$7,893.6**	**$11,061.7**	**$74,135.8**	**$29,658.1**	**$18,534.4**	**$25,943.3**

Table A4. Uncompensated Care Costs by State in 2021 ($ Millions) (continued)

State	2021 ACA				2021 Without ACA, Medicaid Enrollment Rates Maintained			
	Total	Federal	State/Local	Providers	Total	Federal	State/Local	Providers
National	*$60,758.9*	*$24,297.4*	*$15,191.5*	*$21,270.0*	*$127,083.6*	*$50,837.2*	*$31,771.4*	*$44,475.0*
Nonexpansion states								
Alabama	$940.0	$376.0	$235.0	$329.0	$1,669.0	$668.0	$417.0	$584.0
Florida	$5,350.0	$2,140.0	$1,340.0	$1,870.0	$10,080.0	$4,030.0	$2,520.0	$3,530.0
Georgia	$2,495.0	$998.0	$624.0	$873.0	$4,480.0	$1,790.0	$1,120.0	$1,570.0
Idaho	$463.0	$185.0	$116.0	$162.0	$812.0	$325.0	$203.0	$284.0
Kansas	$671.0	$268.0	$168.0	$235.0	$1,300.0	$520.0	$325.0	$455.0
Maine	$238.9	$95.6	$59.7	$83.6	$580.0	$232.0	$145.0	$203.0
Mississippi	$905.0	$362.0	$226.0	$317.0	$1,449.0	$580.0	$362.0	$507.0
Missouri	$1,480.0	$592.0	$370.0	$518.0	$2,998.0	$1,200.0	$748.0	$1,050.0
Nebraska	$374.9	$150.0	$93.9	$131.0	$666.0	$266.0	$167.0	$233.0
North Carolina	$1,860.0	$744.0	$465.0	$651.0	$3,922.0	$1,570.0	$982.0	$1,370.0
Oklahoma	$1,531.0	$612.0	$383.0	$536.0	$2,425.0	$970.0	$606.0	$849.0
South Carolina	$1,108.0	$443.0	$277.0	$388.0	$1,763.0	$705.0	$441.0	$617.0
South Dakota	$207.3	$82.9	$51.8	$72.6	$337.3	$135.0	$84.3	$118.0
Tennessee	$1,368.0	$547.0	$342.0	$479.0	$2,317.0	$927.0	$579.0	$811.0
Texas	$6,310.0	$2,520.0	$1,580.0	$2,210.0	$10,930.0	$4,370.0	$2,730.0	$3,830.0
Utah	$829.0	$332.0	$207.0	$290.0	$1,374.0	$550.0	$343.0	$481.0
Virginia	$2,013.0	$805.0	$503.0	$705.0	$3,602.0	$1,440.0	$902.0	$1,260.0
Wisconsin	$818.0	$327.0	$205.0	$286.0	$1,869.0	$748.0	$467.0	$654.0
Wyoming	$206.0	$82.4	$51.5	$72.1	$374.5	$150.0	$93.5	$131.0
Total	**$29,168.1**	**$11,661.9**	**$7,297.9**	**$10,208.3**	**$52,947.8**	**$21,176.0**	**$13,234.8**	**$18,537.0**

Source:Urban Institute analysis, HIPSM 2016.

Note: ACA = the Affordable Care Act.

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

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Matt Buettgens is a senior research associate, Linda J. Blumberg is a senior fellow, John Holahan is an Institute fellow, and Siyabonga Ndwandwe is a research assistant, all in the Urban Institute's Health Policy Center. The authors appreciate the comments and suggestions of Bowen Garrett and Genevieve Kenney.

ABOUT THE URBAN INSTITUTE

te on social and economic policy
scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector s Health Policy Center, its staff, and its recent research, visit http://www.urban.org/policy-centers/health-policy-center.

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Notes

1 An act to provide for reconciliation pursuant to section 2002 of the concurrent resolution on the budget for year 2016, H.R. 3762, 114th Cong. (2015–2016). https://www.congress.gov/bill/114th-congress/house-bill/3762. Accessed May 24, 2016.

2 2016 presidential candidates on healthcare. Ballotpedia. https://ballotpedia.org/2016_presidential_candidates_on_healthcare. Accessed May 24, 2016.

3 Uberoi N, Finegold K, and Gee E. *Health Insurance Coverage and the Affordable Care Act, 2010–2016*. Washington: US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/ les/pdf/187551/ACA2010-2016.pdf. Accessed May 24, 2016.

4 The insurance market reforms include such provisions as guaranteed issue of coverage, prohibitions on pre-existing conditions, prohibitions of rescissions, community rating, coverage of essential health preventive care coverage without cost sharing, actuarial value standards, limits on waiting periods, uniform

5 Lynch V, Boudreaux M, and Davern M. *Applying and Evaluating Logical Coverage Edits to Health Insurance Coverage in the American Community Survey*. Suitland, MD: US Census Bureau, Housing and Household Economic Statistics Division, 2010.

6 Haley JM, Lynch V, and Kenney GM. *The Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model.* Washington: Urban Institute, 2014. http://www.urban.org/research/publication/urban-institute-health-policy-centers-medicaidchip-eligibility-simulation-model. Accessed May 24, 2016.

7 Holahan J and McMorrow S. *The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act.* Washington: Urban Institute, 2015. http://www.urban.org/research/publication/widespread-slowdown-health-spending-growth. Accessed May 24, 2016.

8 Blumberg LJ, Garrett B, and Holahan J. Estimating the counterfactual: How many uninsured adults would there be today without the ACA? *Inquiry* 2016;53: 1–13. http://inq.sagepub.com/content/53/0046958016634991.full.pdf+html. Accessed May 24, 2016.

9 Note that the total nonelderly population would grow by 6.5 million people between 2013 and 2021, so care should be taken when comparing numbers of people with various types of coverage across those years.

10 Buettgens M, Kenney GM, and Pan CW. *Variation in Marketplace Enrollment Rates in 2015 by State and Income.* Washington: Urban Institute, 2015. http://www.urban.org/research/publication/variation-marketplace-enrollment-rates-2015-state-and-income. Accessed May 24, 2016.

11 Blavin F, Garrett B, Blumberg LJ, Buettgens M, Gadsden SM, and Rifkin S. *Monitoring the Impact of the Affordable Care Act on Employers*. Washington: Urban Institute, 2014. http://www.urban.org/research/publication/monitoring-impact-affordable-care-act-employers. Accessed May 24, 2016.

12 Recent Urban Institute analysis of the 2015 Current Population Survey (CPS) also found that about 21 percent of the remaining uninsured were eligible for marketplace tax credits. However, that analysis found that 27.7 percent of the uninsured were eligible for Medicaid. That share is higher than the 21 percent that we estimate here because the current analysis matches the Medicaid enrollment from administrative data; the CPS analysis used reported health coverage. Type of health coverage is not available on the 2015 CPS, but other surveys, such as the National Health Interview Survey and the ACS, reported lower Medicaid enrollment than the administrative data. Medicaid has been underreported on the CPS in the past, so that is likely to have been the case in 2015 as well. See Blumberg LJ, Karpman M, Buettgens M, and Solleveld P. *Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us About How to Reach Them?* Washington: Urban Institute, 2016. http://www.urban.org/research/publication/who-are-remaining-uninsured-and-what-do-their-characteristics-tell-us-about-how-reach-them. Accessed May 24, 2016.

13 Coughlin TA, Holahan J, Caswell KJ, and McGrath M. *Uncompensated Care for the Uninsured in 2013: A Detailed Examination.* Washington: Urban Institute, 2014. http://www.urban.org/research/publication/uncompensated-care-uninsured-2013. Accessed May 24, 2016.

14 Dorn S, Francis N, Snyder L, and Rudowitz R. *The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States.* Washington: Urban Institute, 2015. http://www.urban.org/research/publication/effects-medicaid-expansion-state-budgets. Accessed May 24, 2016.

15 See Fanney B. Arkansas house speaker details cuts if Medicaid plan fails. *Arkansas Online.* April 12, 2016. http://www.arkansasonline.com/news/2016/apr/12/plan-wields-ax-to-anticipate-a-medicaid/?news-arkansas. Accessed May 24, 2016. Medicaid expansion in Arkansas was extended on April 21, 2016. See Ramsey D. Using novel line-item veto, Ark. governor extends Medicaid expansion. *Kaiser Health News.* April 21, 2016. http://khn.org/news/using-novel-line-item-veto-ark-governor-extends-medicaid-expansion/. Accessed May 24, 2016.

16 Dorn S et al, 2015.

17 These published estimates include Montana and Louisiana, which have since approved Medicaid expansion. See Buettgens M, Holahan J, and Recht H. *Medicaid Expansion, Health Coverage, and Spending: An Update for the 21 States that have not Expanded Eligibility*. Washington: Urban Institute, 2015. http://www.urban.org/research/publication/medicaid-expansion-health-coverage-and-spending. Accessed May 24, 2016.

18 Holahan and McMorrow, 2015.

19 Blumberg et al., *Who Are the Remaining Uninsured?*

20 Holahan and McMorrow, 2015.

21 Buettgens, Kenney, and Pan, 2015.

22 Dorn et al., 2015.

23 Lynch V, Boudreaux M, and Davern M. *Applying and Evaluating Logical Coverage Edits to Health Insurance Coverage in the American Community Survey*. Suitland, MD: US Census Bureau, Housing and Household Economic Statistics Division, 2010.

24 Haley, Lynch, and Kenney, 2014.

25 More detailed methodology is available at Buettgens M. *Health Insurance Policy Simulation Model (HIPSM) Methodology Documentation*. Washington: Urban Institute, 2011. http://www.urban.org/research/publication/health-insurance-policy-simulation-model-hipsm-methodology-documentation. Accessed May 24, 2016.

26 Holahan and McMorrow 2015.

27 Blumberg, Garrett, and Holahan, Estimating the counterfactual.

28 Congressional Budget *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*. Washington: Congressional Budget https://www.cbo.gov/sites/default les/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf. Accessed May 24, 2016.

ACA Implementation—Monitoring and Tracking

The Widespread Slowdown in Health Spending Growth Implications for Future Spending Projections and the Cost of the Affordable Care Act

An Update

June 2016

Stacey McMorrow and John Holahan

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

In April 2015, we published a report that analyzed the widespread slowdown in health care spending growth leading up to 2014 and the implications for national health expenditure projections and the cost of the Affordable Care Act (ACA).[1] We examined six consecutive Centers for Medicare and Medicaid Services (CMS) forecasts of national health expenditures, focusing on the pre-ACA forecast made in February 2010, the ACA baseline forecast made in September 2010, and the 2014 forecast.[2] In 2010, CMS estimated that national health expenditures for the years 2014 to 2019 would increase by $577 billion under the ACA. This reflected the increased costs of coverage expansion offset by reductions in Medicare and Medicaid payments.

Over the next four years, however, CMS repeatedly reduced its annual forecasts of 2014 to 2019 expenditures. Ultimately, the 2014 forecast suggested that national health expenditures for 2014 to 2019 would be about $2.5 trillion less than the ACA baseline forecast from September 2010. Projections were lower overall and for Medicare, Medicaid, and private health insurance, with some of the reductions explained by policy changes over time, such as the 2012 Supreme Court decision on Medicaid expansion and the Budget Control Act of 2011 (i.e., sequestration).

A critical factor in the reduced spending projections over time, however, was the historic slowdown in health spending growth that began in 2008. At the time of the 2014 forecast, the average annual growth rate from 2010 to 2013 was about 3.6 percent compared with the 5.4 percent that had been projected in 2010. This slower growth clearly lowered the level of spending on which later forecasts were based and therefore contributed to reduced spending projections for 2014 to 2019. Unclear, however, is how much slower growth leading up to 2014 informed assumptions about the projected future rate of growth. Although the CMS actuaries did acknowledge the proliferation of high-deductible private health plans and cost-containment efforts in state Medicaid programs as contributors, they mainly attributed the slowdown to the Great Recession and sluggish economic recovery. Consequently, those actuaries assumed that a robust recovery would ultimately lead to returns to higher growth rates in the later years of the forecast.

In our earlier report, we discussed several factors beyond the recession, including several ACA provisions, that may have contributed to the health spending slowdown. We also suggested that if these other factors kept spending growth low following economic recovery, then CMS spending projections may continue to fall. Since that report, CMS has released another round of national health spending projections for 2014 to 2024, and additional estimates of health spending growth in 2014 and 2015 have become available through CMS and the Altarum Institute. This brief uses the CMS projections released in July 2015 to update our previous analysis and considers the implications of other recent data for interpreting future spending projections.

DATA & METHODS

This paper compares the most recent CMS forecast released in July 2015 to the 2010 ACA baseline forecast. The 2015 forecast incorporates actual spending data from 2013 and projects spending for 2014 through 2024.[3] Importantly, the 2015 forecast also incorporates the Medicare Access and CHIP Reauthorization Act (MACRA), passed in April 2015, that permanently eliminated the sustainable growth rate (SGR) system for setting physician payment rates in Medicare.[4] Our earlier work used the “current-law” forecasts for Medicare spending, which included the projected effects of large cuts to Medicare physician payments that were required by the SGR system at the time of each forecast.

To be consistent with the new law reflected in the 2015 forecast, we have adjusted the ACA baseline Medicare forecast to assume that the cuts to physician payments under the SGR system would be replaced with a rate freeze.[5] We made a similar adjustment to the 2014 forecast used in our earlier report, and these adjustments change two main findings from that report.[6] First, when comparing the adjusted 2014 forecast to the adjusted ACA baseline forecast, we now find a decline in projected Medicare spending for 2014 to 2019 of $518 billion compared with our earlier finding of $384 billion (table 1).[7] Second, this additional $134 billion decline in Medicare spending is directly reflected in the additional decline in total national health expenditures for 2014 to 2019 when comparing the adjusted forecasts (-$2,672 billion) versus the original forecasts (-$2,538 billion). For simplicity, we omit “adjusted” from future references to the forecasts, but all estimates hereafter use the adjusted forecasts that assume SGR-related cuts to physician payments are replaced with rate freezes or modest increases.

Table 1. Cumulative Spending Projections for 2014 to 2019

	Original 2014 forecast (2014–2019) relative to original ACA baseline		Adjusted 2014 forecast (2014–2019) relative to adjusted ACA baseline		2015 forecast (2014–2019) relative to adjusted 2014 forecast		2015 forecast (2014–2019) relative to adjusted ACA baseline	
	$	% change	$	% change	$	% change	$	% change
NHE	-2538	-10.8%	-2672	-11.3%	49	0.2%	-2623	-11.0%
Medicare	-384	-8.4%	-518	-10.9%	63	1.5%	-455	-9.6%
Medicaid	-927	-20.3%	-927	-20.3%	-123	-3.4%	-1050	-23.0%
Private	-688	-8.9%	-688	-8.9%	24	0.3%	-664	-8.6%
OOP	-20	-0.9%	-20	-0.9%	22	1.0%	2	0.1%
Other	-519	-11.5%	-519	-11.5%	63	1.6%	-456	-10.1%

Source: Authors’ analysis of Centers for Medicare and Medicaid Services national health expenditure projections.

Table Notes: OOP = out-of-pocket. NHE = national health expenditures. Dollar estimates in billions. Original 2014 forecast and ACA baseline included the projected effects of required cuts to physician payment rates under the sustainable growth rate system. Adjusted forecasts reflect alternative scenarios that assume the cuts to physician payments under the sustainable growth rate system will be replaced with rate freezes or small increases.

RESULTS

On the whole, cumulative 2014 to 2019 national health spending in the 2015 forecast is $49 billion higher than in the 2014 forecast (table 1). The 2015 forecasts for Medicare, private health insurance, out-of–pocket spending, and other health spending are also slightly higher for the 2014 to 2019 period than in the 2014 forecast. Medicaid spending for 2014 to 2019, however, is now projected to be $123 billion lower than in the 2014 forecast. Despite the modest increase in projected national health spending since the 2014 forecast, however, the 2015 forecast still reflects a decline of $2.6 trillion from 2014 to 2019 compared with the 2010 ACA baseline forecast (figure 1). In the sections that follow, we compare the 2015 forecast to the ACA baseline forecast for each major component of national health spending.

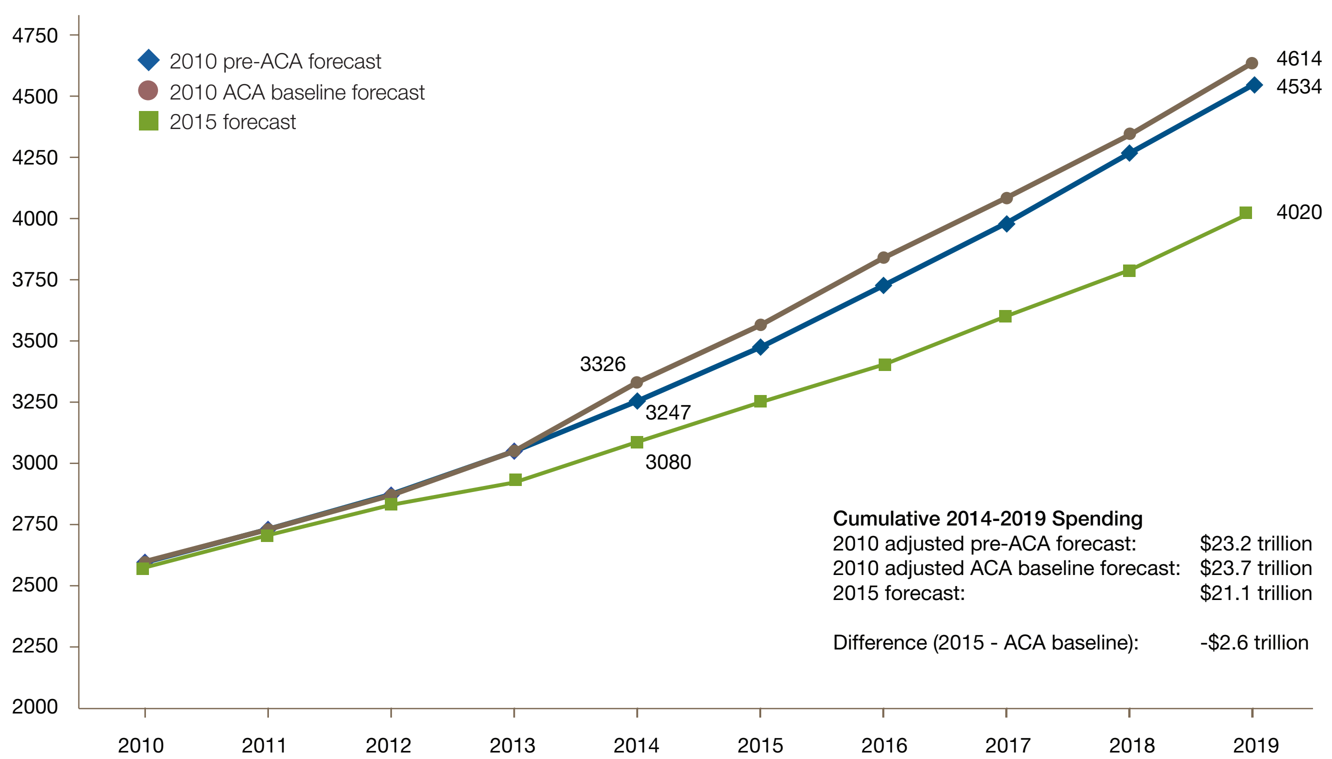
Medicare

Medicare spending was reduced in the 2010 ACA baseline forecast compared with the pre-ACA forecast because of reductions in payments to Medicare Advantage plans and the reductions in annual payment updates for most institutional providers (figure 2). By 2015, the CMS actuaries predicted that total Medicare spending for 2014 to 2019 would be $455 billion lower than in the ACA baseline forecast. One reason is the Budget Control Act of 2011 (i.e., sequestration), which required Medicare payments for all types of services be reduced 2 percent beginning in April 2013; another reason is the slower-than-expected spending growth between 2010 and 2014. CMS currently assumes spending growth would increase to an average annual rate of 6.3 percent from 2014 to 2019 compared with 4.4 percent from 2010 to 2014 (table 2). This faster growth from 2014 to 2019 is driven by spending per enrollee, which is expected to grow at an average annual rate of 3.1 percent for 2014 to 2019 compared with 1.3 percent for 2010 to 2014 while projected enrollment growth remains stable.

Medicaid

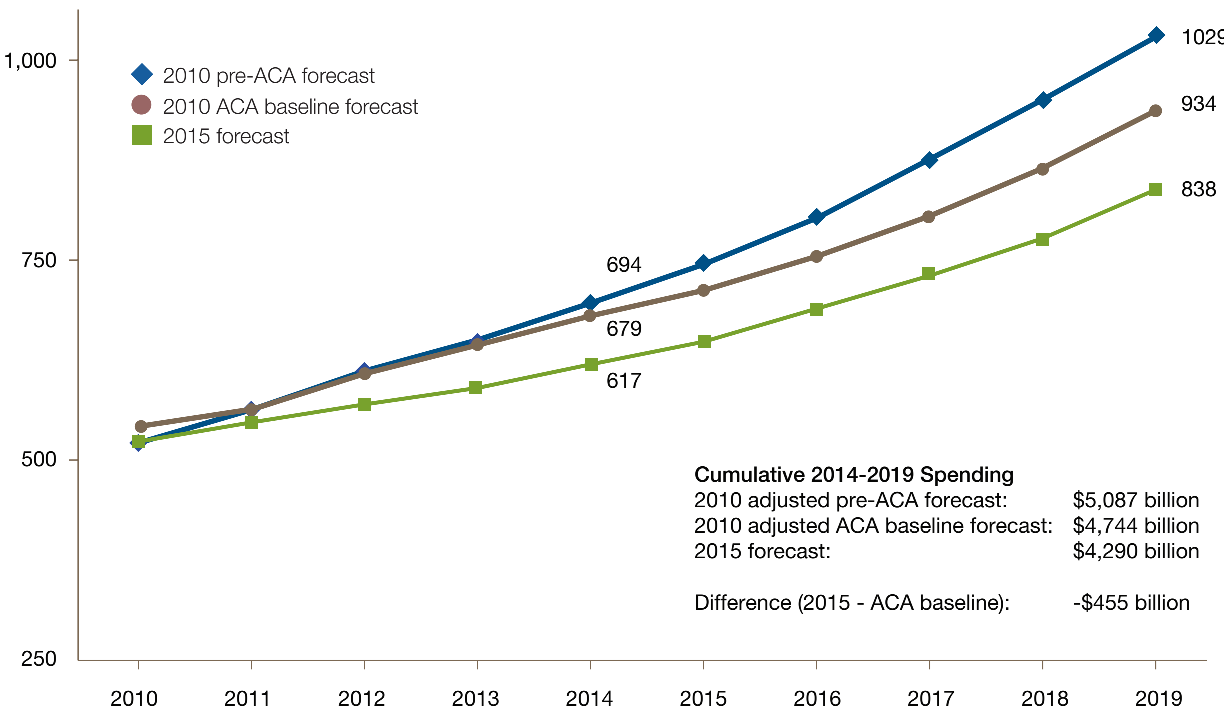
Medicaid spending under the 2010 ACA baseline forecast was higher than the pre-ACA forecast because of the eligibility expansion (figure 3). Compared with the ACA

Figure 1. National Health Expenditure Projects ($ billions)



Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections. Adjusted forecasts reflect alternative scenarios that assume the cuts to physician payments under the sustainable growth rate system are replaced with a rate freeze. 2015 forecast reflects permanent fix under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Figure 2. Medicare Expenditure Projections ($ billions)



Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections. Adjusted forecasts reflect alternative scenarios that assume the cuts to physician payments under the sustainable growth rate system are replaced with a rate freeze. 2015 forecast reflects permanent fix under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

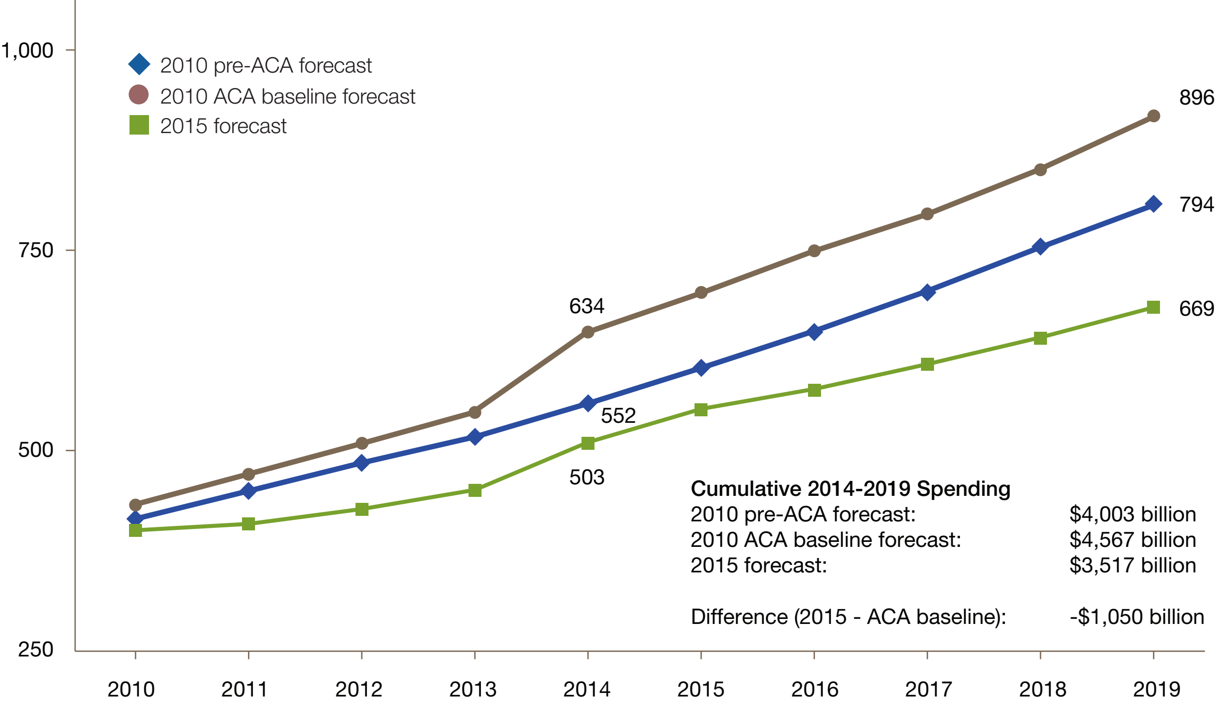
Table 2. Medicare Spending, Enrollment and Spending per Enrollee Projections, 2014 to 2019

	2010	2014	2019	2010–2014	2014–2019
Medicare spending	$ billions			Cumulative spending	
Adjusted ACA baseline	537	679	934	3,025	4,744
Average annual growth rate				*6.0%*	*6.6%*
2015 forecast	520	617	838	2,834	4,290
Average annual growth rate				*4.4%*	*6.3%*
Medicare enrollment	millions			Average enrollment	
ACA baseline	46.8	52.4	60.5	49	56
Average annual growth rate				*2.9%*	*2.9%*
2015 forecast	46.6	52.6	61.2	50	57
Average annual growth rate				*3.1%*	*3.1%*
Medicare spending per enrollee	$			Average spending per enrollee	
Adjusted ACA baseline	11,479	12,961	15,440	12,211	13,990
Average annual growth rate				*3.1%*	*3.6%*
2015 forecast	11,157	11,726	13,686	11,424	12,527
Average annual growth rate				*1.3%*	*3.1%*

Source: Authors' analysis of CMS national health expenditure projections.

Table Notes: Adjusted forecasts reflect alternative scenarios that assume the cuts to physician payments under the sustainable growth rate system are replaced with rate freezes or small increases. 2015 forecast reflects permanent fix under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Figure 3. Medicaid Expenditure Projections ($ billions)



Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections.

baseline forecast, projected Medicaid spending for 2014 to 2019 fell by $1,050 billion in the 2015 forecast. This was partly because of the Supreme Court decision in 2012 that made the ACA Medicaid expansion optional for states and significantly reduced enrollment projections. For example, the ACA baseline forecast predicted 2014 Medicaid enrollment of 78.8 million enrollees, but this fell to 66.5 million enrollees in the 2015 forecast after accounting for the Supreme Court decision (table 3). Projected average annual growth in spending per enrollee for 2014 to 2019 also fell between the ACA baseline forecast and the 2015 forecast, from 6.8 percent to 3.3 percent.

Private Health Insurance

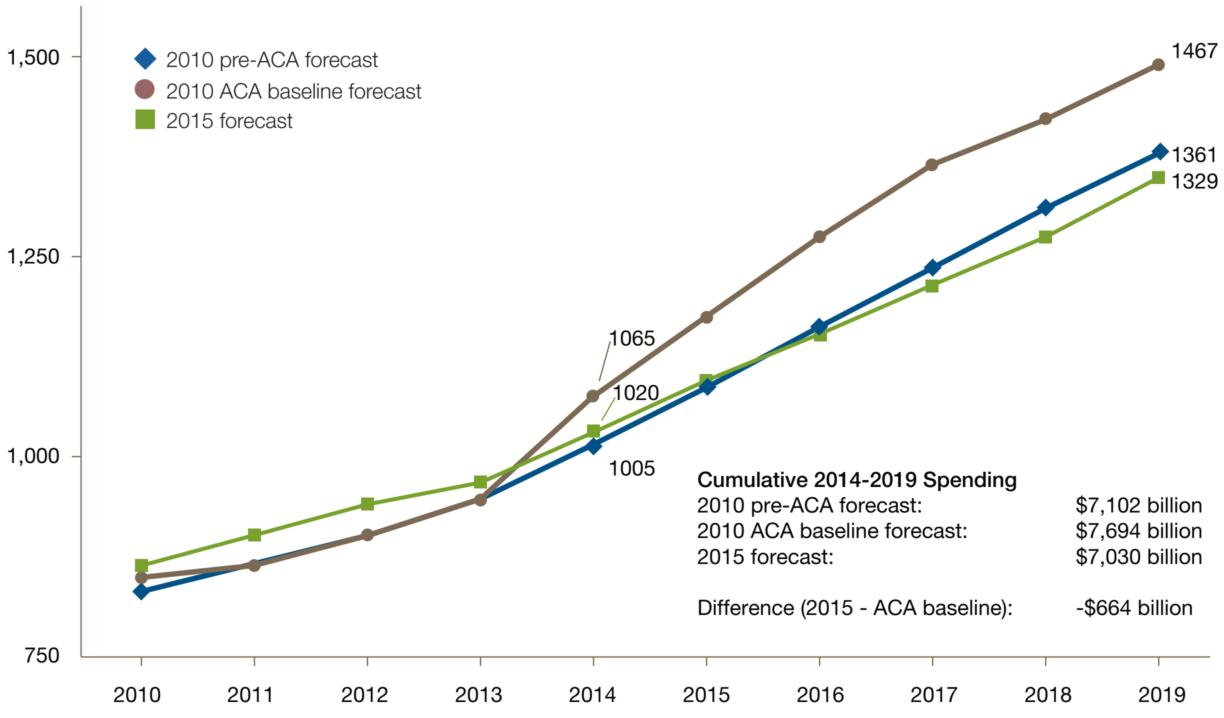
Like Medicaid spending, private health insurance spending projections were higher in the 2010 ACA baseline forecast than in the pre-ACA forecast mainly because of the marketplace expansion (figure 4). But private spending projections for 2014 to 2019 were lower in the 2015 forecast by $664 billion than in the ACA baseline forecast. Much of this decline was driven by slower spending growth between 2010 and 2014 than had been expected in 2010. Contributors to slower growth likely included the sluggish economic recovery as well as lower-than-expected prescription drug spending because of patent expirations and increases in generic drug prescribing. Another likely contributor was a substantial shift toward higher deductibles and cost sharing in private plans, some of which may have been adopted in anticipation of the ACA excise tax on high-cost plans. The average annual growth rate for 2014 to 2019 is currently projected to be 5.4 percent, which is somewhat faster than estimated growth from 2010 to 2014 of 4.3 percent. This uptick in spending growth in the later period is driven primarily by higher projected enrollment growth (table 4).

Table 3. Medicaid Spending, Enrollment and Spending per Enrollee Projections, 2014 to 2019

	2010	2014	2019	2010–2014	2014–2019
Medicaid spending		$ billions		Cumulative spending	
ACA baseline	427	634	896	2,569	4,567
Average annual growth rate				*10.4%*	*7.2%*
2015 forecast	398	503	669	2,182	3,517
Average annual growth rate				*6.1%*	*5.9%*
Medicaid enrollment		millions		Average enrollment	
ACA baseline	54.9	78.8	80.2	61	79
Average annual growth rate				*9.5%*	*0.4%*
2015 forecast	54.3	66.5	75.3	59	72
Average annual growth rate				*5.2%*	*2.5%*
Medicaid spending per enrollee		$		Average spending per enrollee	
ACA baseline	7,783	8,047	11,175	8,491	9,647
Average annual growth rate				*0.8%*	*6.8%*
2015 forecast	7,322	7,568	8,888	7,413	8,111
Average annual growth rate				*0.8%*	*3.3%*

Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections.

Figure 4. Private Health Insurance Expenditure Projections ($ billions)



Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections.

Table 4. Private Health Insurance Spending, Enrollment and Spending per Enrollee Projections, 2014 to 2019

	2010	2014	2019	2010–2014	2014–2019
Private health insurance spending	$ billions			Cumulative spending	
ACA baseline	845	1,065	1,467	4,613	7,694
Average annual growth rate				*6.0%*	*6.6%*
2015 forecast	862	1,020	1,329	4,679	7,030
Average annual growth rate				*4.3%*	*5.4%*
Private health insurance enrollment	millions			Average enrollment	
ACA baseline	189.2	198.1	207.1	191	204
Average annual growth rate				*1.2%*	*0.9%*
2015 forecast	186.3	190.6	204.1	188	199
Average annual growth rate				*0.6%*	*1.4%*
Private spending per enrollee	$			Average spending per enrollee	
ACA baseline	4,466	5,375	7,085	4,832	6,285
Average annual growth rate				*4.7%*	*5.7%*
2015 forecast	4,628	5,353	6,512	4,968	5,873
Average annual growth rate				*3.7%*	*4.0%*

Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections.

Out-of-Pocket Spending and Other Health Spending

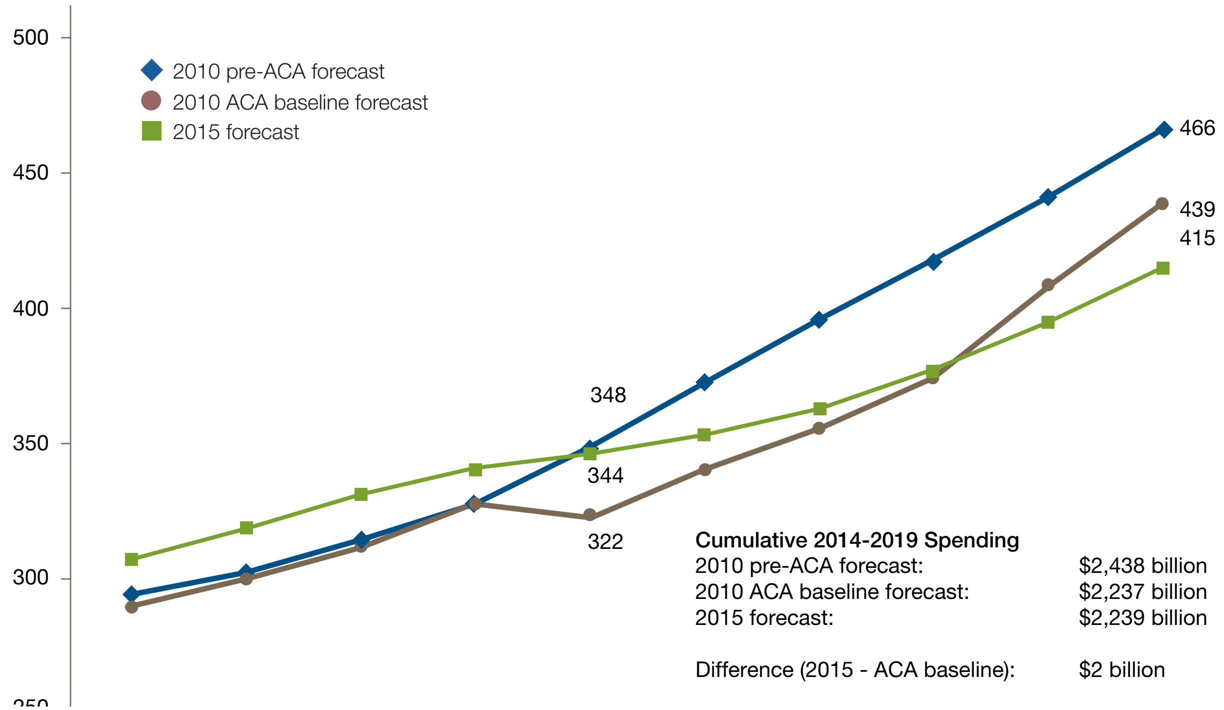
In the 2010 ACA baseline forecast, the CMS actuaries predicted a significant reduction in out-of-pocket expenditures caused by the ACA coverage expansions (figure 5). Subsequent forecasts have varied slightly, most notably because of reductions in the projected effects of the ACA excise tax on high-cost plans. But by 2015, projected out-of-pocket spending for 2014 to 2019 was just $2 billion more than in the 2010 ACA baseline forecast.

Finally, CMS estimates a residual category of "other health spending" that includes spending on the Children's Health Insurance Program, the US Department of Defense and US Department of Veterans Affairs health programs, public health activity, and investments such as new construction and capital equipment. The 2010 ACA baseline forecast projected a small decline in other spending under the ACA (figure 6). By 2015, however, projected spending in the other category fell by $456 billion for 2014 to 2019 compared with the ACA baseline forecast. Most of the reduction was driven by declines in investment spending, perhaps related to the slow economic recovery and anticipation of less demand for new construction and medical devices because of payment constraints in the ACA.

Congressional Budget Office (CBO) Projections of Federal Spending

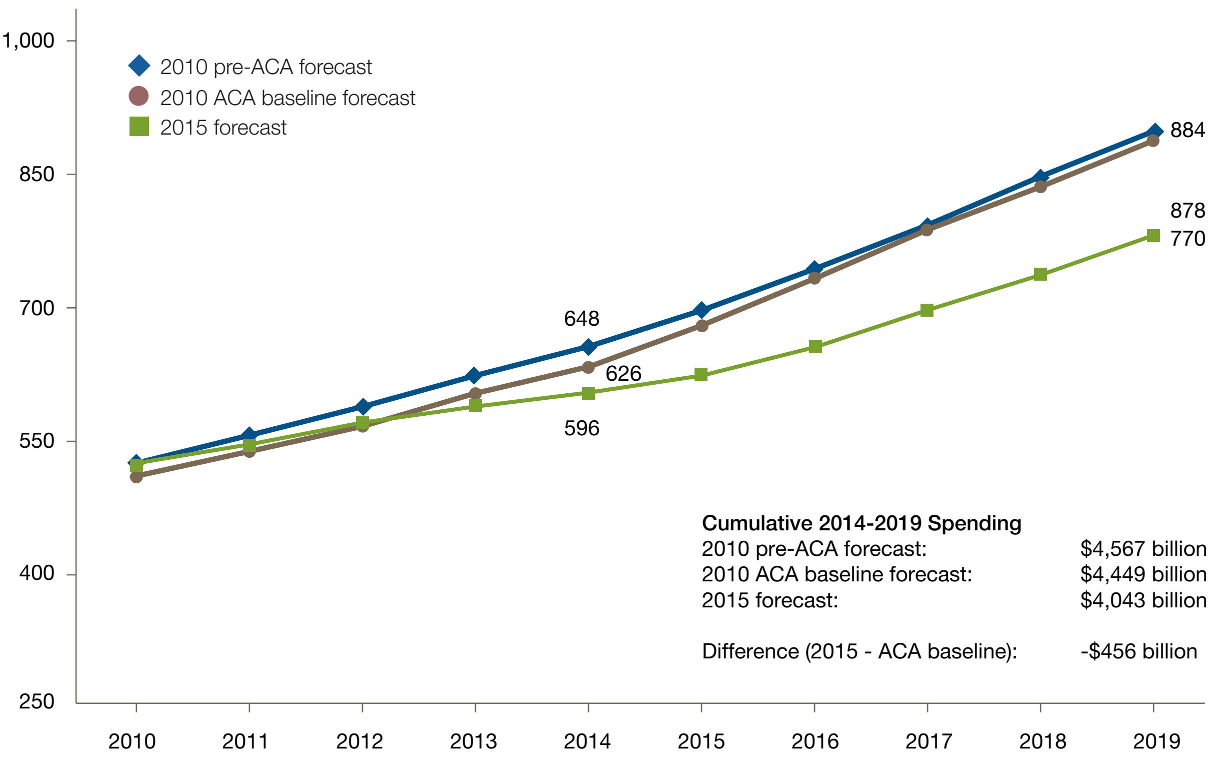
Although CMS projects health expenditures by all payers, CBO makes independent projections of ACA-related federal spending as well as federal spending on Medicare and Medicaid (table 5). In 2010, after the passage of the ACA, CBO estimated that exchange subsidies would amount to $464 billion from 2014 to 2019. In its most recent forecast, CBO projects $313 billion, a reduction of 32.5 percent. In its 2010 forecast, CBO projected federal Medicaid and CHIP outlays for the expansion population would be $434 billion from 2014 to 2019 compared with $366 billion in its current forecast, a reduction of 15.7 percent. Small-employer tax credits are also 85 percent smaller than originally projected because of limited use. Consequently, CBO's projected gross cost of all ACA coverage provisions for 2014 to 2019 has fallen from $938 billion in the 2010 forecast to $686 billion in the 2015 forecast, a reduction of 26.9 percent.

Figure 5. Out-of-Pocket Expenditure Projections ($ billions)



Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections.

Figure 6. Other Health Expenditure Projections ($ billions)



Source: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections.

Table 5. Congressional Budget Office Projections, 2014 to 2019

	Cumulative Federal Spending 2014-2019			
	2010 ACA baseline	2016 forecast	2016 forecast relative to ACA baseline	
	$ billions	$ billions	Difference	% Change
ACA insurance coverage provisions				
Medicaid and CHIP outlays	434	366	-68	-15.7%
Exchange subsidies and related spending	464	313	-151	-32.5%
Small-employer tax credits	40	6	-34	-85.0%
Gross cost of provisions	938	686	-252	-26.9%
Medicare				
Gross outlays	4,713	4,185	-528	-11.2%
Net outlays	4,044	3,527	-517	-12.8%
Medicaid				
Total federal outlays, excluding ACA expansion population	2,188	1,901	-287	-13.1%
Total gross outlays	7,170	6,114	-1,056	-14.7%

Source: Authors' analysis of Congressional Budget Office federal spending projections.

Table Notes: In order to compare like budget windows, the 2016 forecast incorporates historical data from previous years projections. The Medicare and Medicaid projections are from their respective 2015 and 2016 baselines. The ACA insurance coverage provision projections are from 2014, 2015, and 2016 since no historical data is included.

CBO also currently forecasts a reduction of $528 billion in Medicare mandatory outlays from 2014 to 2019, or 11.2 percent relative to their 2010 forecast. Finally, federal Medicaid outlays for 2014 to 2019 for those not newly eligible under the ACA Medicaid expansion are now projected to be $287 billion lower than in their 2010 forecast, a reduction of 13.1 percent. Thus, although we cannot compare CBO's specific estimates to those produced by CMS because of differences in the spending categories and other methodological inconsistencies, the patterns generally parallel those in the CMS forecasts over time. That is, current CBO projections are far below those made when the ACA was enacted in 2010. Altogether, federal spending for Medicare, Medicaid, and ACA coverage provisions for 2014 to 2019 are now projected to be $1.1 trillion, or 14.7 percent, below CBO's 2010 ACA forecasts.

CONCLUSIONS

Relative to the 2014 forecast, the 2015 CMS forecast includes a relatively modest increase in projected national health spending for 2014 to 2019 of $49 billion. Despite this increase, comparing the 2015 forecast to the 2010 ACA baseline forecast still reveals dramatic declines in spending projections for 2014 to 2019. National health spending is projected to be $2.6 trillion lower than in the 2010 ACA baseline forecast for the same period. Declines in projected 2014 to 2019 spending on Medicare ($455 billion), Medicaid ($1050 billion), private health insurance ($664 billion) and other health spending ($456 billion) since the 2010 ACA baseline forecast continue to be quite large as well.

CMS did not attribute any of the reductions in their projections over time for 2014 to 2019 to the ACA.[9] They had of course incorporated the law's significant cost containment provisions in their 2010 ACA baseline forecast. But the ACA could have contributed to the lower 2015 projections in several ways. First, the ACA payment adjustments that began in 2011 seemed to have had a greater effect on utilization than anticipated. Unexpected reductions occurred in Medicare hospital days, outpatient visits, skilled nursing facility days, and advanced imaging between 2010 and 2014.[10] Second, lower payment rates in Medicare may have affected payment rates by other payers, with commercial insurers following

Medicare in their negotiations with hospitals and physicians.[11] Third, Medicare policies, such as financial penalties for hospital readmissions, may have spilled over to other payers. Fourth, premiums in marketplaces are below expectations because of strong competition, intense negotiations over provider payment rates, and narrow networks.[12]

In addition, CMS has thus far not attributed any cost savings to accountable care organizations, medical homes, or other delivery system reforms that have been proliferating over the past several years. But the presence of such reforms, together with payment reductions in Medicare and dramatically increased cost sharing in private plans, may have heightened uncertainty among providers over the flow of revenues. All of this could have caused providers to make substantial structural changes to adapt to the new environment.

If the ACA and other factors discussed above have contributed to slower spending growth in unmeasured ways, then slower growth may persist beyond current projections.[13] But if the economy was the primary driver of slower growth, then we should expect a return to faster growth with a robust recovery.[14] Researchers at the Altarum Institute have been tracking health spending growth ahead of the official CMS estimates, and they reported increases in spending growth throughout 2014, peaking at 6.2 percent in the fourth quarter; compare this with the average growth of under 4 percent from 2008 to 2013.[15] Some interpreted this as a sign that the slowdown in health spending growth had ended, but evidence is growing that this spike was largely caused by the ACA coverage expansion and has already begun to dissipate.[16]

More recent evidence from the Altarum Institute seems to confirm the temporary nature of the 2014 spike; their researchers reported that spending growth continued to increase through the first quarter of 2015, but by the last quarter of 2015, spending growth had again slowed to below 5 percent. If this persists, even the current CMS forecast could prove too high. CMS projects returns to national health expenditure growth rates of at least 6 percent from 2019 to 2024, but the Altarum Institute's estimates seem to support the notion that factors beyond the economy have contributed to persistently slower spending growth. If current CMS projections do not fully reflect this pattern, spending projections will continue to fall and it will become harder not to attribute at least some of the sustained cost containment to the ACA.

ENDNOTES

1. Holahan J and McMorrow S. *The Widespread Slowdown in Health Spending Growth*. Washington: Urban Institute, 2015. http://www.urban.org/research/publication/widespread-slowdown-health-spending-growth. Accessed May 26, 2016.

2. Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2009–2019, 2010; Truffer CJ, Keehan S, Smith S, Cylus J, Sisko A, Poisal JA, et al. Health Spending Projections Through 2019: The Recession's Impact Continues. *Health Affairs* 2010;29(3):522-29; Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2009–2019 (September 2010), 2010; Sisko AM, Truffer CJ, Keehan SP, Poisal JA, Clemens MK, and Madison AJ. National Health Spending Projections: The Estimated Impact of Reform Through 2019. *Health Affairs* 2010;29(10):1933-41; Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2013-2023, 2014; Sisko AM, Keehan SP, Cuckler GA, Madison AJ, Smith SD, Wolfe CJ, et al. National Health Expenditure Projections, 2013-23: Faster Growth Expected with Expanded Coverage and Improving Economy. *Health Affairs*. 2014;33(10):1-10.

3. Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2014–2024, July 2015. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html. Updated July 30, 2015.Accessed May 26, 2016; and Keehan SP, Cuckler GA, Sisko AM, Madison AJ, Smith SD, et al. National Health Expenditure Projections, 2014-24: Spending Growth Faster Than Recent Trends. *Health Affairs*. 2015;34(8):1407–1417.

4. In practice, the Medicare Access and CHIP Reauthorization Act of 2015 included a payment rate freeze for the first six months of 2015, a 0.5 percent increase for the rest of that year, and a 0.5 percent increase for each year from 2016 to 2019.

5. We adjusted both the pre-ACA baseline and ACA baseline forecasts using information provided by CBO on the increase in Part B spending projections that would occur assuming a physician payment rate freeze rather than the required SGR cuts (https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/dataandtechnicalinformation/health2.pdf and https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/dataandtechnicalinformation/SGR-Menu.pdf). We calculated this spending adjustment as a share of Medicare Part B spending in each year using the CBO forecasts (March 2009 Medicare Baseline https://www.cbo.gov/sites/default/files/51302-2009-03-Medicare.pdf and August 2010 Baseline https://www.cbo.gov/sites/default/files/51302-2010-08-Medicare.pdf), and applied the equivalent adjustment to CMS forecasts of Medicare Part B spending (CMS Projected Medicare Part B Expenditures under Two Illustrative Scenarios with Alternative Payment Updates, May 12, 2009; and CMS Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers, August 5, 2010).

6. For the 2014 CMS forecast, we used the "projected baseline" provided by CMS, which used assumptions that were very close to the actual provisions implemented under the Medicaid Access and CHIP Reauthorization Act of 2015 (CMS Projected Medicare Expenditures under Current Law, the Projected Baseline and an Illustrative Alternative Scenario, August 28, 2014, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2014TRAlternativeScenario.pdf). In 2014, the alternative scenario assumed a freeze in 2015 and a 0.6 percent increase for 2016 to 2019. We did not use the CMS illustrative alternative scenarios in earlier years because they generally assumed more generous physician updates than those that were actually implemented in later "doc fix" bills.

7. The additional decline in projected spending reflects the fact that the ACA baseline forecast assumed the effects of adherence to the sustainable growth rate system over a longer period, leading to a more substantial underestimate of Medicare spending than in the 2014 forecast.

8. To compare like budget windows, we have combined data from several reports to get the 2016 forecast because those reports do not include historical projections. The Medicare and Medicaid outlays use the March 2015 baselines combined with the March 2016 to get the full 2014 to 2019 budget window. The cost of ACA insurance coverage provisions use three years of baseline projections because no historical data are included. For 2016 estimates, see Congressional Budget Office's March 2015 Medicare Baseline: By Fiscal Year. Congressional Budget Office. https://www.cbo.gov/sites/default/files/51302-2015-03-Medicare.pdf. Accessed May 26, 2016; Congressional Budget Office's March 2016 Medicare Baseline: By Fiscal Year. Congressional Budget Office. https://www.cbo.gov/sites/default/files/51302-2016-03-Medicare.pdf. Accessed May 26, 2016; Detail of Spending and Enrollment for Medicaid—CBO's March 2015 Baseline (By Fiscal Year). Congressional Budget Office. https://www.cbo.gov/sites/default/files/51301-2015-03-Medicaid.pdf. Accessed May 26, 2016; Detail of Spending and Enrollment for Medicaid for CBO's March 2016 Baseline (By Fiscal Year). Congressional Budget Office. https://www.cbo.gov/sites/default/files/51301-2016-03-Medicaid.pdf. Accessed May 26, 2016; Federal Subsidies for Health Insurance Coverage for People under Age 65: Tables From CBO's March 2016 Baseline. Congressional Budget Office. https://www.cbo.gov/sites/default/files/51298-2016-03-HealthInsurance.pdf. Accessed May 26, 2016; Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline. Congressional Budget Office. https://www.cbo.gov/sites/default/files/51298-2015-03-ACA.pdf. Accessed May 26, 2016; Insurance Coverage Provisions of the Affordable Care Act—CBO's April 2014 Baseline. Congressional Budget Office. https://www.cbo.gov/sites/default/files/51298-2014-04-ACA.pdf. Accessed May 26, 2016. For 2010, see CBO's August 2010 Baseline: Medicare. Congressional Budget Office. https://www.cbo.gov/sites/default/files/51302-2010-08-Medicare.pdf. Accessed May 26, 2016; Douglas W. Elmendorf. Congressional Budget Office Letter to Speaker Nancy Pelosi, March 20, 2010. https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf. Accessed May 26, 2016; Spending and Enrollment Detail for CBO's March 2010 Baseline: Medicaid. Congressional Budget Office. https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/dataandtechnicalinformation/MedicaidBaseline.pdf. Accessed May 26, 2016.

9. Centers for Medicare and Medicaid Services. Analysis of Factors Leading to Changes in Projected 2019 National Health Expenditure Estimates: A Comparison of April 2010 and September 2013 Projections. Baltimore: Centers for Medicare and Medicaid Services, 2013.

10. White C, Cubanski J, and Neuman T. *How Much of the Medicare Spending Slowdown Can Be Explained? Insights and Analysis from 2014.* Menlo Park, CA: Kaiser Family Foundation, 2014.

11. Clemens J and Gottlieb JD. Bargaining in the Shadow of a Giant: Medicare's Influence on Private Payment Systems. Working Paper No. 19503. Cambridge, MA: National Bureau of Economic Research, 2013.; White C, Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates. *Health Affairs.* 2013;32(5):935–943; White C and Wu VY. How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices? *Health Services Research.* 2014;49(1):11–31.

12. Holahan J, Blumberg LJ, and Wengle E. *Marketplace Premium Changes throughout the United States*, 2014-2015. Washington: Urban Institute, 2015

13. Chandra A, Holmes J, and Skinner J. *Is This Time Different? The Slowdown in Healthcare Spending.* Working Paper No. 19700. Cambridge, MA: National Bureau of Economic Research, 2013; Cutler D and Sahni NR. If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off by $770 Billion. *Health Affairs.* 2013;32(5):841–850; Ryu AJ, Gibson TB, McKellar MR, and Chernew ME. The Slowdown in Health Care Spending in 2009-11 Reflected Factors Other Than the Weak Economy and Thus May Persist. *Health Affairs.* 2013;32(5): 835–840; Holahan J and McMorrow S. *What Drove the Recent Slowdown in Health Spending Growth and Can It Continue?* Washington: Urban Institute, 2013.

14. Dranove D, Garthwaite C, and Ody C. Health Spending Slowdown Is Mostly Due to Economic Factors, not Structural Change in the Health Care Sector. *Health Affairs*. 2014;33(8):1399–1406; Kaiser Family Foundation. Assessing the Effects of the Economy on the Recent Slowdown in Health Spending. Menlo Park, CA: Kaiser Family Foundation, 2013. http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/. Accessed May 26, 2016.

15. Roehrig C, Turner A, Hughes-Cromwick P, and Miller G. *Health Sector Trend Report: March 2015- Expanded Report Covering All of 2014.* Washington: Altarum Institute, 2015. http://altarum.org/sites/default/files/uploaded-publication-files/ltarumpercent20RWJFpercent20Trendpercent20Reportpercent20Marchpercent202015percent20FINAL_0_0.pdf. Accessed May 26, 2016.

16. Holahan J and McMorrow S. *Has Faster Health Care Spending Growth Returned?* Washington: Urban Institute, 2015. http://www.urban.org/research/publication/has-faster-health-care-spending-growth-returned. Accessed May 26, 2016; Larner L. Health Affairs Web First: National Health Spending Growth Accelerates in 2014. *Health Affairs.* December 2, 2015 http://healthaffairs.org/blog/2015/12/02/health-affairs-web-first-national-health-spending-growth-accelerates-in-2014/. Accessed May 26, 2016; Martin AB, Hartman M, Benson J, Catlin A, and the National Health Expenditure Accounts Team. National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending. *Health Affairs.* 2015;35(1):150-160.

17. Roehrig C, Turner A, Hughes-Cromwick P, Miller G, and Rhyan C. *Health Sector Trend Report: March 2016- Expanded Report Covering Fourth Quarter of 2015.* Washington: Altarum Institute, 2016. http://altarum.org/sites/default/files/uploaded-publication-files/Altarum%20RWJF%20Trend%20Report%20March%202016_1.pdf. Accessed May 26, 2016.

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June 2016 | Issue Brief

ACA Coverage Expansions and Low-Income Workers

Alanna Williamson, Larisa Antonisse, Jennifer Tolbert, Rachel Garfield, and Anthony Damico

Executive Summary

This brief highlights low-income workers and the impact of ACA coverage expansions on this population. While low-income workers are a diverse group, unique characteristics and challenges differentiate them from their higher income counterparts. Key findings of this analysis include the following:

- **Low-income workers are more likely to be young, people of color, and female than higher income workers.** Low-income workers also tend to have lower levels of education and more limited access to health insurance than workers with higher incomes. Addressing the challenges that many low-income workers face could help to reduce existing economic and health disparities between demographic groups.
- **Low-income workers may not have access to jobs that provide full-time, full year employment or jobs with comprehensive benefit packages, including health insurance.** Low-income workers work nearly as many hours per week and weeks per year as higher income workers and are more likely to work in the agriculture and service industries and for small firms that are typically less likely to provide comprehensive benefit packages (including health insurance) as consistently as other employers.
- **Medicaid plays an important role in providing health coverage for low-income workers, particularly those in families living below poverty.** More than one in five low-income workers received Medicaid or other public coverage in 2014. Furthermore, one in three low-income workers in families living below poverty relied on Medicaid or other public coverage in 2014. Compared to higher income workers, low-income workers are less likely to have coverage through their employer and are more likely to be uninsured.
- **Coverage expansions implemented under the ACA have produced substantial coverage gains for low-income workers and a corresponding reduction in the uninsured**. From 2013 to 2014, low-income workers experienced large gains in coverage as a result of the Medicaid expansion and the availability of subsidies in the health insurance Marketplaces under the ACA. Low-income workers in expansion states were more likely to have coverage than those in non-expansion states.
- **Nearly a quarter of uninsured low-income workers in non-expansion states fall into the coverage gap.** Low-income workers in non-expansion states with incomes too high for Medicaid but too low for subsidies in the Marketplace do not have an affordable coverage option and will likely remain uninsured.

Introduction

Approximately 145 million nonelderly adults ages 19 to 64 in the United States worked in 2014. Nearly one in three of these workers (30%) were in families that earned less than 250% of the Federal Poverty Level (FPL), or $30,790 for an individual in 2014. Since the end of the Great Recession in 2009, real (inflation-adjusted) hourly wages have largely stagnated or fallen for low-income workers.[1] Furthermore, the wage gap between the highest income workers and low-income workers has been widening over the past three decades.[2] Prior to 2014, health insurance coverage rates for low-income workers had been falling, largely due to reductions in employer-based health coverage.[3]

The implementation of the Affordable Care Act (ACA) in 2014 created new coverage opportunities for workers who were not offered insurance by their employer. The expansion of Medicaid to nearly all adults with incomes up to 138% FPL in Medicaid expansion states and the availability of premium tax credits through the Marketplaces led to large gains in coverage, particularly among low-income adults.[4] Medicaid has always been an important source of coverage for low-income families and children; however, eligibility rules in place prior to the ACA excluded childless adults from coverage. The elimination of these rules in states that chose to adopt the expansion increased Medicaid eligibility for low-income working adults.

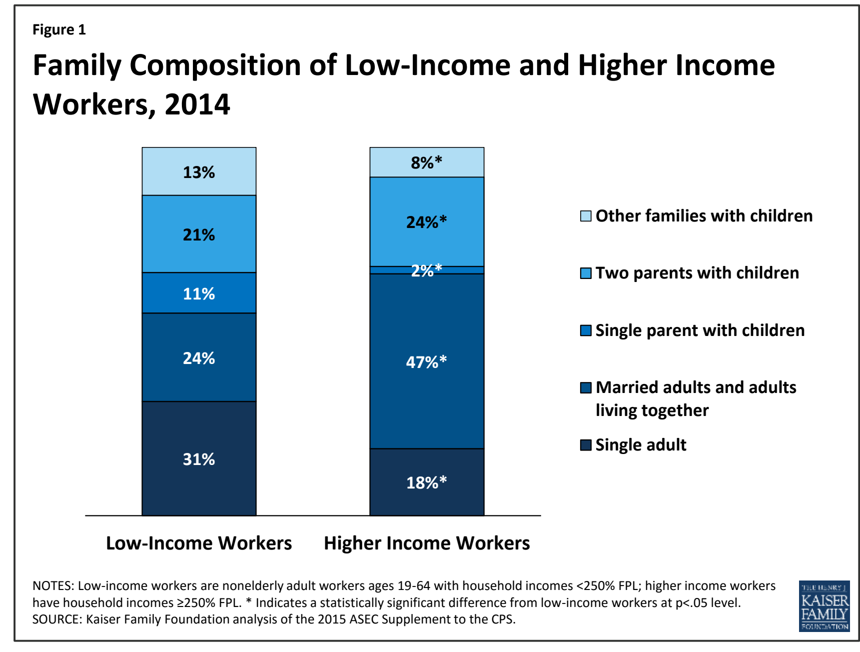
Although low-income workers are a diverse population, distinct characteristics and challenges differentiate low-income workers from their higher income counterparts, especially when it comes to health insurance coverage. Using data from the Census Bureau's 2014 and 2015 Annual Social and Economic Supplement to the Current Population Survey (CPS ASEC), this brief compares the demographic and employment characteristics and health coverage status of nonelderly adult low-income workers with those of higher income workers. We define low-income workers as non-elderly adult workers (ages 19-64) in families that earned less than 250% FPL. Higher income workers are non-elderly adult workers in families that earned 250% FPL or more. This brief also examines the change in health coverage among low-income workers following implementation of the ACA and provides estimates of eligibility for ACA coverage options among low-income workers who remain uninsured.

Who are low-income workers?

Low-income workers are more likely to be young, people of color, and female and to have lower levels of educational attainment compared to higher-income workers, Nearly half (47%) of low-income workers are between the ages of 19 and 34, compared to just one third of higher income workers (31%) (Appendix Table 1). More than half (51%) of low-income workers are people of color compared to less than one third of higher income workers (30%) Female workers are also overrepresented at lower income levels. Women make up 47% of the workforce overall, but comprise half of low-income workers. Eighty-five percent of low-income workers lack a college degree, and nearly one in five (17%) has not graduated from high school.

These differences are even more pronounced for workers living below poverty. Very low income workers living below 100% FPL are even more likely to be young (53%), people of color (56%), and female (56%) than workers of any other income group (Appendix Table 1). This trend persists across all measures.

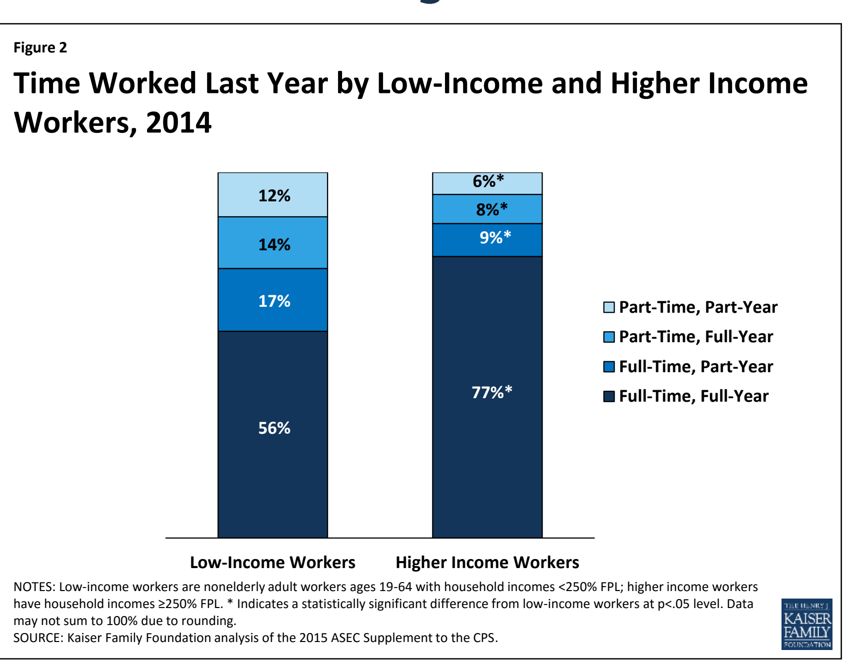
A larger share of low-income workers are members of families with dependent children than higher income workers; however, over half of low-income workers are adults without dependent children. Over four in ten (45%) low-income workers are members of families with dependent children, compared to one third (34%) of higher income workers (Figure 1). Low-income workers are also more likely to be single parents compared to higher income workers (11% versus 2%). At the same time, more than half (55%) of low-income workers are adults without dependent children, including 31% who are single adults. This group is particularly noteworthy because prior to the ACA, these low-income individuals were largely ineligible for Medicaid due to categorical eligibility limits.



Low-income workers are more likely to be non-citizens than their higher income counterparts. Sixteen percent of low-income workers are non-citizens, compared to just 6% of higher income workers (Appendix Table 1). Immigrants, particularly recent immigrants, may face language and other barriers that limit their employment options which may lead to lower paying jobs that lack comprehensive benefits, including health insurance. Immigrants, particularly those who are not citizens, also face disproportionate barriers to accessing health coverage and care.[5]

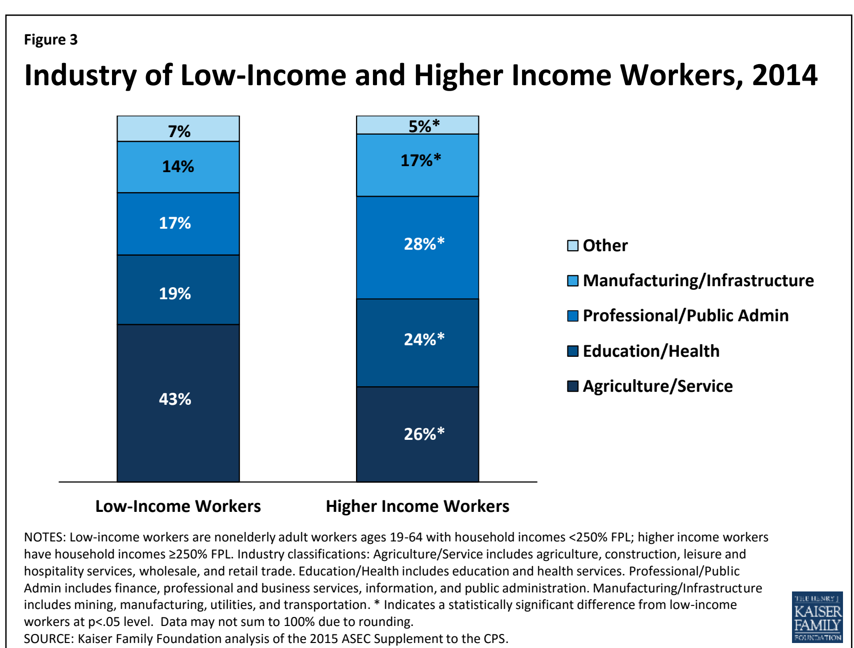
How much are low-income workers working?

Low-income workers are more likely to work part-time or part-year and to report doing so for job-related reasons compared to higher income workers. Although the majority of low-income workers work both full-time (defined as 35 hours or more per week) and full-year (defined as 50 weeks or more per year), the share of full-time, full-year workers is significantly lower among low-income workers than among higher income workers (56% versus 77%) (Figure 2). While low and higher income workers worked similar numbers of hours per week (37 versus 40) in 2014, some low-income



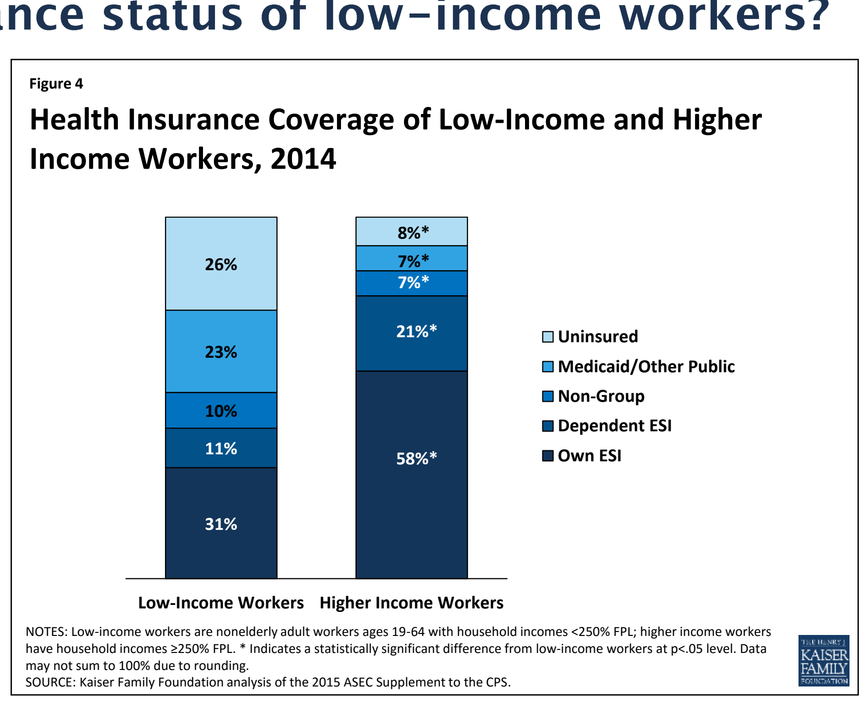
workers may be acquiring those hours through multiple part-time jobs rather than a single full-time job (Appendix Table 2). This distinction is important to note because part-time positions may pay lower wages and may provide more limited benefit packages than full-time positions. Furthermore, part-time positions may not be subject to the employer shared responsibility provision under the ACA. This provision requires that employers with 50 or more full-time equivalent employees provide affordable health coverage options to their employees or face a penalty.[6]

Low-income workers are more likely to work in the agriculture and service industries and for smaller firms compared to higher income workers. The share of low-income workers in the agriculture and service industries is far greater than the share of higher income workers employed in these fields (43% versus 26%) (Figure 3). This difference is important given that the agriculture and service industries are typically less likely to offer benefits like health insurance to employees.[7] More than four in ten low-income workers work for firms with fewer than 50 employees, compared with just three in ten higher income workers (42% versus 30%). Firms with fewer than 50 workers are exempt from employer responsibility requirements for health coverage under the Affordable Care Act (ACA).[8] Therefore, low-income workers may be less likely to receive health coverage through their employer if they work for a small firm.



What is the health insurance status of low-income workers?

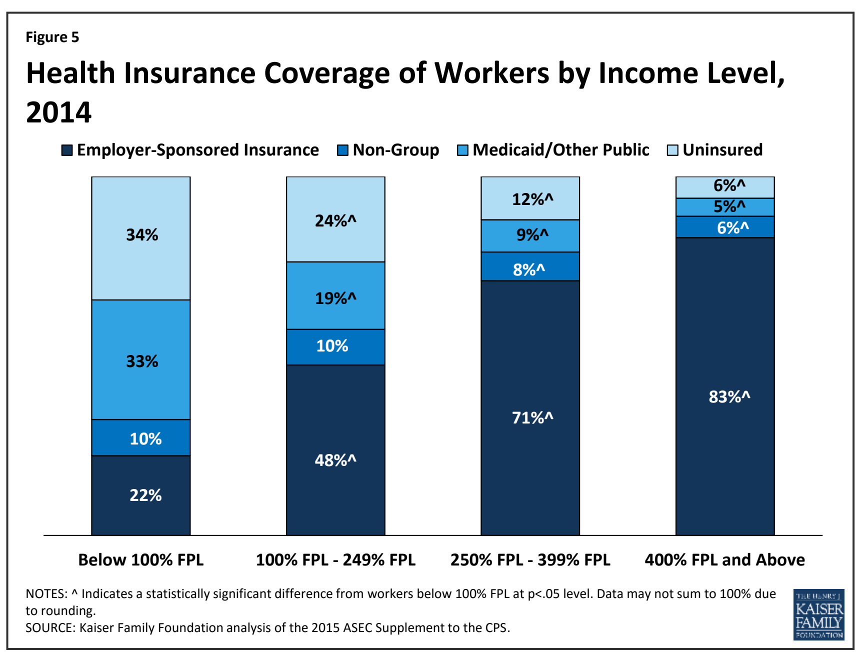
The share of low-income workers who have health coverage through their employers is lower than that of higher income workers. Less than one third (31%) of low-income workers had employer-sponsored insurance through their own job in 2014 compared to half (58%) of higher income workers (Figure 4). Low-income workers were also half as likely to have employer-sponsored insurance coverage as a dependent compared to higher income workers (11% versus 21%). As previously mentioned, low-income workers are more likely to be



employed by smaller firms that are less likely to offer health benefits and are more likely to work in industries with lower levels of health coverage on average, such as the agriculture and service industries. Furthermore, low-income workers are more likely to work part-time than their higher income counterparts and may not be offered health benefits through their employers for this reason.

Under the ACA, employers with 50 or more full-time equivalent employees are required to offer health insurance coverage that meets minimum value and affordability standards to their full-time workers or pay a fine. These requirements were not in effect in 2014, but have been fully implemented in 2016. Coverage is deemed affordable under the ACA if the employee contribution for individual coverage for the lowest-priced plan offered is no more than 9.66% of the employee's household income in 2016. Employees offered coverage that does not meet the affordability standard may qualify for premium tax credits to purchase coverage in the Marketplaces. However, if coverage offered by their employer meets these affordability standards, low-income workers are ineligible for premium tax credits to help pay for coverage in the Marketplace even if they perceive the employer coverage to be unaffordable to them.

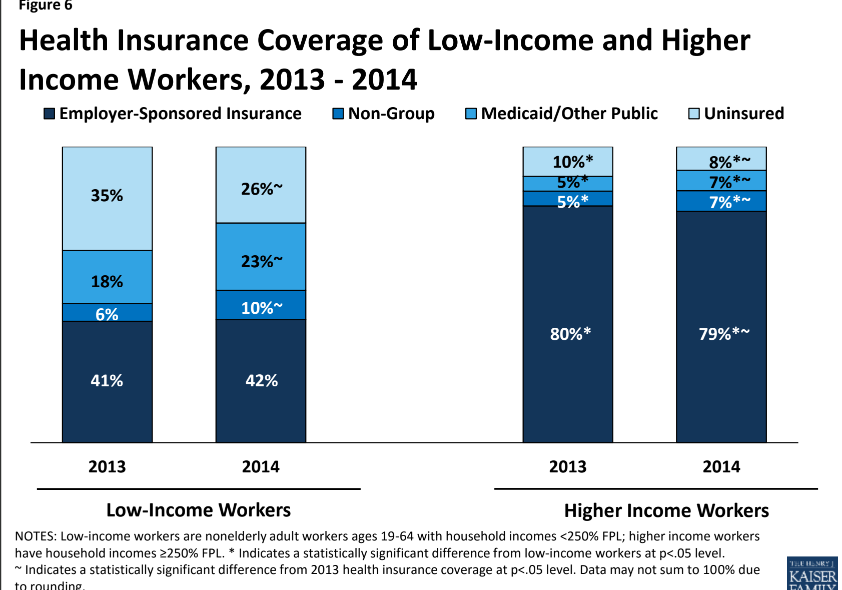
Medicaid plays an important role in providing health coverage for low-income workers, particularly those who make less than 100% FPL. In 2014, more than one-fifth (23%) of low-income workers received Medicaid or other public coverage, compared to just 7% of higher income workers (Figure 4). Medicaid is even more important as a source of health coverage for workers with very low incomes. One in three (33%) low-income workers below poverty relied on Medicaid or other public coverage in 2014 (Figure 5). Without Medicaid, many vulnerable workers living below poverty would likely remain uninsured.



Following implementation of the ACA's coverage expansions in January 2014, low-income workers experienced large gains in coverage. Under the ACA, health coverage was extended to individuals who did not previously have access to affordable coverage through an expansion of Medicaid to low-income individuals under 138% FPL ($27,310 for a family of three in 2014) and through premium tax credits available to individuals with incomes 100%-400% FPL who purchase coverage in the Marketplaces. While the Medicaid expansion was intended to be implemented nationwide, a June 2012 Supreme Court ruling essentially made it optional for states. As of 2014, 27 states (including DC) had adopted the Medicaid expansion.[9] [10]

From 2013 to 2014, the share of low-income workers enrolled in Medicaid and other public coverage grew from 18% to 23%, and the share of low-income workers who purchased health insurance in the individual or non-

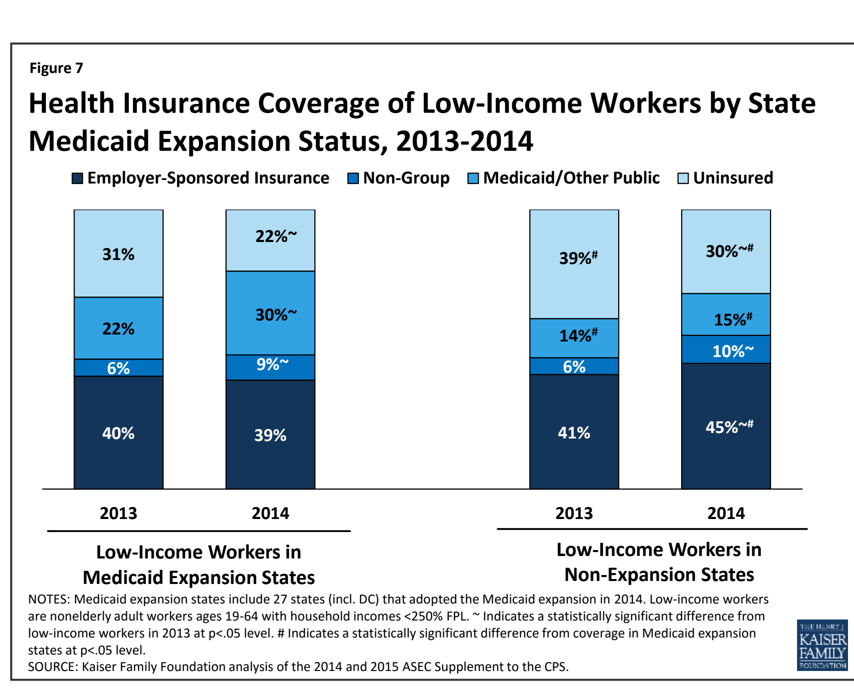
group market (a category that includes coverage through the health insurance Marketplaces in 2014) rose from 6% to 10% (Figure 6). Over the same period, the share of low-income workers who were uninsured dropped from 35% in 2013 to 26% in 2014. The share of low-income workers with employer-sponsored insurance remained relatively constant over this period. Even with these gains in coverage, over a quarter (26%) of low-income workers (more than 11 million) remained uninsured in 2014.



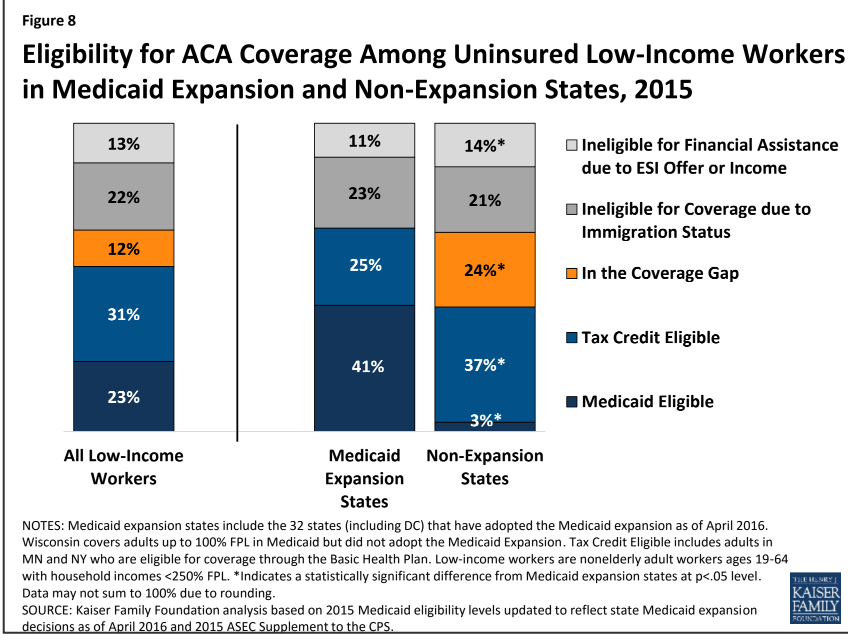
Higher income workers experienced coverage gains from 2013 to 2014 as well, resulting in a two-percentage-point reduction in the share who were uninsured (10% to 8%). However, since the ACA coverage provisions primarily targeted people in the low-income range, coverage gains among the higher income worker population were more limited than those observed among low-income workers.

Low-income workers who live in states that have expanded Medicaid under the ACA are more likely to have health coverage than in than those who live in states that have not expanded Medicaid. In states that adopted the Medicaid expansion in 2014, the share of low-income workers covered by Medicaid or other public coverage increased from 22% in 2013 to 30% in 2014 (Figure 7). The percentage of individuals covered in the non-group market also increased from 6% in 2013 to 9% in 2014. These coverage expansions contributed to a decline in the uninsured rate in Medicaid expansion states from 31% in 2013 to 22% in 2014.

In states that did not adopt the Medicaid expansion, Medicaid and other public coverage covered just 15% of the low-income working population in 2014. While coverage of low-income workers did increase in non-expansion states, these coverage gains were seen in the non-group and employer-sponsored insurance markets. Without the coverage gains in Medicaid, low-income workers in non-expansion states were more likely to remain uninsured in 2014 than those in Medicaid expansion states—30% of low-income workers were uninsured in non-expansion states in 2014, compared to 22% in expansion states (Figure 7).



Over half of uninsured low-income workers are eligible for coverage either through Medicaid or subsidized Marketplace coverage. Among uninsured low-income workers, nearly one quarter (23%) are estimated to be eligible for Medicaid and three in ten (31%) are estimated to be eligible for tax credits in the Marketplace (Figure 8). For low-income workers in particular, outreach and education about available coverage options is important to build upon the coverage gains experienced by this population in 2014. Misperceptions about cost, lack of awareness of financial assistance, and confusion about eligibility rules were cited as barriers to some eligible uninsured individuals gaining coverage.[11] Others reported that coverage was still too costly, even with the availability of financial assistance.[12]



Over one in ten low-income workers fall into the coverage gap. Because the ACA envisioned all people below 138% FPL receiving coverage through Medicaid, it does not provide financial assistance to people below 100% FPL for coverage in the Marketplace. Consequently, 12% of all low-income workers (24% of low-income workers in non-expansion states) have incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits and fall into the "coverage gap."[13] Workers with incomes less than 100% FPL are even more vulnerable; 61% of workers with incomes below poverty fall into the coverage gap in non-expansion states (data not shown).

Another 22% of uninsured low-income workers are undocumented immigrants who are ineligible for ACA coverage under federal low. The remaining 13% are ineligible for financial assistance in the Marketplaces due to an offer of employer-sponsored coverage or due to income. These workers could purchase unsubsidized coverage in the Marketplaces; however, that coverage is likely unaffordable to them.

Conclusion

Low-income workers make up almost one third of the American workforce, yet distinct characteristics and challenges differentiate this population from their higher income counterparts. Low-income workers are more likely to be young, people of color, female, and to have lower levels of education than those with higher incomes. They also may not have access to jobs that provide full-time, full-year employment. Low-income workers are more likely than higher income workers to work in the agriculture and service industries and to work for small firms that are typically less likely to provide comprehensive benefit packages (including health insurance) as consistently as other employers.

Coverage expansions implemented under the ACA have produced large health coverage gains for low-income workers and a corresponding reduction in the uninsured. These coverage gains have been particularly large in

states that have expanded their Medicaid programs. Low-income workers who live in states that have expanded their Medicaid programs are more likely to have health coverage than those who live in states that have not expanded Medicaid. Even with these promising improvements in health coverage rates under the ACA, coverage rates among the low-income worker population continue to lag behind the rates among higher income workers. Despite the fact that they are working nearly as many hours per week and weeks per year as higher income workers, low-income workers are far less likely to receive health insurance through their employers and far more likely to be uninsured than higher income workers. While Medicaid provides coverage to nine million low-income workers without other affordable coverage options, not all low-income workers are eligible for coverage. Nearly one quarter of uninsured workers in non-expansion states fall into the coverage gap, with incomes too high for Medicaid but too low for subsidies in the Marketplace. Although these individuals are working, they do not have access to an affordable coverage option and will likely remain uninsured.

Given the differences between low and higher income workers in a range of demographic characteristics (including race, age, and gender), addressing the challenges that many low-income workers face in accessing health insurance could help to reduce existing economic and health disparities between demographic groups. Broadening coverage through the Medicaid expansion, combined with additional outreach and enrollment efforts targeted at this population and efforts to improve the affordability of existing coverage options, could help to connect the remaining uninsured to affordable health coverage throughout the country.

Appendix Table 1: Characteristics of Adult Workers (Ages 19–64) by Income Level, 2014							
	All Workers	Workers Above and Below 250% FPL		Workers by Income Level			
		Low-Income Workers <250% FPL	Higher Income Workers ≥250% FPL	Very Low Income Workers <100% FPL	Low Income Workers 100% FPL – 249% FPL	Higher Income Workers 250% FPL – 399% FPL	Highest Income Workers ≥400% FPL
Total Number of Workers (in thousands)	145,008	43,044	101,965	9,714	33,329	32,693	69,271
Age							
19 – 34	36%	47%	31% *	53%	45% ^	37% ^	28% ^
35 – 54	46%	41%	48% *	38%	42% ^	47% ^	48% ^
55 – 64	19%	12%	21% *	9%	13% ^	17% ^	24% ^
Gender							
Male	53%	50%	54% *	44%	52% ^	53% ^	54% ^
Female	47%	50%	46% *	56%	48% ^	47% ^	46% ^
Race/Ethnicity							
White	64%	49%	70% *	44%	51% ^	62% ^	74% ^
Hispanic	17%	27%	12% *	30%	27% ^	18% ^	9% ^
Black	11%	16%	9% *	19%	15% ^	12% ^	8% ^
Other	8%	8%	8% *	7%	8%	7%	9% ^
Education							
Less than high school	8%	17%	4% *	24%	15% ^	7% ^	2% ^
High school graduate	27%	36%	23% *	35%	36%	32% ^	19% ^
Some college	30%	32%	29% *	30%	33% ^	33% ^	27% ^
Bachelor's or higher	35%	15%	44% *	12%	16% ^	28% ^	51% ^
Citizenship Status							
Native born	83%	76%	86% *	73%	76% ^	83% ^	87% ^
Naturalized	8%	8%	8%	7%	8% ^	8% ^	8% ^
Non-citizen	9%	16%	6% *	20%	15% ^	8% ^	5% ^
Health Status							
Excellent/very good	69%	62%	72% *	59%	63% ^	68% ^	74% ^
Good	25%	29%	23% *	30%	29%	26% ^	21% ^
Fair/poor	6%	9%	5% *	10%	8% ^	6% ^	4% ^
Average Household Size	3.1	3.4	3.0 *	3.5	3.4 ^	3.2 ^	2.9 ^
Family Composition							
Single adult	22%	31%	18% *	34%	30% ^	23% ^	16% ^
Married adults and adults living together	40%	24%	47% *	15%	26% ^	39% ^	51% ^
Single parent with children	5%	11%	2% *	18%	9% ^	4% ^	1% ^
Two parents with children	23%	21%	24% *	18%	22% ^	24% ^	25% ^
Other families with children	9%	13%	8% *	15%	13% ^	11% ^	7% ^
No. of Workers in Family							
Multiple full-time workers in family	42%	17%	53% *	6%	20% ^	41% ^	58% ^
One full-time worker in family	50%	64%	44% *	56%	66% ^	55%	40% ^
Part-time workers only in family	8%	19%	3% *	38%	13% ^	4% ^	2% ^

* Indicates a statistically significant difference from low-income workers <250% FPL at p<.05 level.
^ Indicates a statistically significant difference from very low income workers <100% FPL at p<.05 level.
NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2015 ASEC Supplement to the CPS.

Appendix Table 2: Employment Characteristics of Adult Workers (Ages 19-64) by Income Level, 2014

	All Workers	Workers Above and Below 250% FPL		Workers by Income Level			
		Low-Income Workers <250% FPL	Higher Income Workers ≥250% FPL	Very Low Income Workers <100% FPL	Low Income Workers 100% FPL – 249% FPL	Higher Income Workers 250% FPL – 399% FPL	Highest Income Workers ≥400% FPL
Avg. Annual Income of Worker	$51,802	$20,593	$64,977 *	$10,091	$23,654 ^	$36,262 ^	$78,529 ^
Average Hourly Wage (among those paid hourly)	$16.65	$12.86	$18.75 *	$11.57	$13.16 ^	$15.99 ^	$20.59 ^
Weeks Worked per Year							
Average	47.6	44.7	48.8 *	38.0	46.7 ^	48.3 ^	49.1 ^
Median	52.0	52.0	52.0	50.0	52.0 ^	52.0 ^	52.0 ^
Hours Worked per Week							
Average	39.5	37.0	40.4 *	34.0	37.8 ^	39.3 ^	41.0 ^
Median	40.0	40.0	40.0	40.0	40.0	40.0	40.0
Work Status							
Full-Time, Full-Year	71%	56%	77% *	32%	64% ^	74% ^	79% ^
Full-Time, Part Year	12%	17%	9% *	27%	14% ^	11% ^	9% ^
Part-Time, Full-Year	10%	14%	8% *	19%	13% ^	9% ^	7% ^
Part-Time, Part-Year	8%	12%	6% *	23%	9% ^	7% ^	5% ^
Reasons for Working Part-Time (Among Part-Time Workers)							
Job Related	36%	45%	31% *	51%	42% ^	33% ^	29% ^
Child Care/Family	20%	18%	22% *	16%	19% ^	21% ^	23% ^
School/Training	15%	15%	15%	16%	15%	15%	14%
Health/Medical	10%	9%	10% *	7%	10% ^	11% ^	10% ^
Vacation/Pers. Day or Holiday	10%	6%	12% *	4%	7% ^	10% ^	13% ^
Other	9%	7%	10% *	7%	7%	9% ^	10% ^
Employer Firm Size							
Under 10	19%	25%	17% *	30%	24% ^	18% ^	16% ^
10-49	14%	17%	13% *	17%	17%	15% ^	12% ^
50-99	7%	8%	7%	6%	8% ^	8% ^	7%
100-999	18%	16%	19% *	14%	17% ^	19% ^	19% ^
1,000+	41%	34%	44% *	33%	34% ^	40% ^	46% ^
Industry							
Agriculture/Service	31%	43%	26% *	50%	41% ^	32% ^	24% ^
Professional/Public Admin	25%	17%	28% *	16%	18% ^	22% ^	31% ^
Education/Health	23%	19%	24% *	17%	19% ^	23% ^	25% ^
Manufacturing/Infrastructure	16%	14%	17% *	10%	15% ^	17% ^	17% ^
Other	5%	7%	5% *	7%	7%	6% ^	4% ^

* Indicates a statistically significant difference from low-income workers <250% FPL at p<.05 level.

^ Indicates a statistically significant difference from very low income workers <100% FPL at p<.05 level.

NOTE: Industry classifications: Agriculture/Service includes agriculture, construction, leisure and hospitality services, wholesale and retail trade. Education/Health includes education and health services. Professional/Public Admin includes finance, professional and business services, information and public administration. Manufacturing/Infrastructure includes mining, manufacturing, utilities, and transportation. Data may not sum to 100% due to rounding.

SOURCE: Kaiser Family Foundation analysis of the 2015 ASEC Supplement to the CPS.

Appendix Table 3: Health Coverage of Adult Workers (Ages 19-64) by Income Level, 2013-2014						
	2013			2014		
	All Workers	Low-Income Workers <250% FPL	Higher Income Workers ≥250% FPL	All Workers	Low-Income Workers <250% FPL	Higher Income Workers ≥250% FPL
Health Coverage						
Employer-Sponsored Insurance	68%	41%	80% *	68%	42%	79% *~
Own ESI	50%	30%	58% *	50%	31%	58% *~
Dependent ESI	18%	11%	22% *	18%	11%	21% *
Non-Group	5%	6%	5% *	7% ~	10% ~	7% *~
Medicaid/Other Public	9%	18%	5% *	11% ~	23% ~	7% *~
Uninsured	17%	35%	10% *	13% ~	26% ~	8% *~
Expansion States						
Employer-Sponsored Insurance	69%	40%	81% *	68% ~	39%	79% *~
Own ESI	50%	29%	58% *	49% ~	28% ~	57% *~
Dependent ESI	19%	11%	23% *	19%	11%	22% *
Non-Group	5%	6%	5% *	7% ~	9% ~	6% *~
Medicaid/Other Public	10%	22%	6% *	14% ~	30% ~	7% *~
Uninsured	15%	31%	9% *	11% ~	22% ~	7% *~
Non-Expansion States						
Employer-Sponsored Insurance	67% #	41%	79% *#	68%	45% ~#	78% *#
Own ESI	50%	31% #	59% *	50% #	34% ~#	58% *#
Dependent ESI	17% #	10%	20% *#	17% #	11%	20% *#
Non-Group	5%	6%	5% *	8% ~#	10% ~	7% *~
Medicaid/Other Public	8% #	14% #	5% *	8% #	15% #	6% *#
Uninsured	19% #	39% #	11% *#	16% ~#	30% ~#	9% *~#

* Indicates a statistically significant difference from low-income workers <250% FPL within the same year at p<.05 level.
~ Indicates a statistically significant difference from 2013 health insurance coverage at p<.05 level.
# Indicates a statistically significant difference from coverage in Medicaid expansion states within the same year at p<.05 level.
NOTE: In this table, Medicaid expansion states include the 27 states (including DC) that adopted the Medicaid expansion in 2014. Five additional states have adopted the Medicaid expansion since 2014, including Pennsylvania, Indiana, Alaska, Montana, and Louisiana. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the Medicaid Expansion. Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2014 and 2015 ASEC Supplements to the CPS.

Appendix Table 4: Eligibility for ACA Health Coverage Among Uninsured Adult Workers (Ages 19-64), 2015			
	Total Uninsured Workers	Uninsured Low-Income Workers <250% FPL	Uninsured Higher Income Workers ≥250 % FPL
Uninsured Workers			
Medicaid Eligible	16%	23%	5% *
Tax Credit Eligible	27%	31%	22% *
In the Coverage Gap	7%	12%	2% *
Ineligible for Coverage due to Immigration Status	17%	22%	10% *
Ineligible for Financial Assistance due to ESI Offer	19%	11%	30% *
Ineligible for Financial Assistance due to Income	14%	2%	31% *
Uninsured Workers in Medicaid Expansion States			
Medicaid Eligible	27%	41%	9% *
Tax Credit Eligible	23%	25%	21% *
In the Coverage Gap	N/A	N/A	N/A
Ineligible for Coverage due to Immigration Status	18%	23%	11% *
Ineligible for Financial Assistance due to ESI Offer	18%	9%	29% *
Ineligible for Financial Assistance due to Income	14%	2%	31% *
Uninsured Workers in Non-Expansion States			
Medicaid Eligible	2% ~	3% ~	0% *~
Tax Credit Eligible	32% ~	37% ~	25% *~
In the Coverage Gap	16% ~	24% ~	4% *~
Ineligible for Coverage due to Immigration Status	16%	21%	10% *
Ineligible for Financial Assistance due to ESI Offer	20% ~	13% ~	31% *
Ineligible for Financial Assistance due to Income	13%	2%	30% *

* Indicates a statistically significant difference from uninsured low-income workers <250% FPL at p<.05 level.

~ Indicates a statistically significant difference from eligibility for coverage in Medicaid expansion states at p<.05 level.

NOTES: In this table, Medicaid expansion states include the 32 states (including DC) that have adopted the Medicaid expansion as of April 2016. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the Medicaid Expansion. Tax credit eligible includes individuals eligible for the Basic Health Plan. Income eligibility for both Medicaid and Marketplace subsidies is assessed by grouping people into "health insurance units" (HIUs) and calculating HIU income according to Medicaid and Marketplace program rules. HIUs differ from Census families, which are used to determine household income. This distinction results in a small number of workers that reside in higher income households falling into the coverage gap. Data may not sum to 100% due to rounding.

SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of April 2016 and 2015 ASEC Supplement to the CPS.

Endnotes

[1] Elise Gould, *2014 Continues a 35-Year Trend of Broad-Based Wage Stagnation*, (Washington, DC: Economic Policy Institute, February 2015). Available at: http://www.epi.org/publication/stagnant-wages-in-2014.

[2] Josh Bivens, Elise Gould, Lawrence Mishel and Heidi Shierholz, *Raising America's Pay: Why It's Our Central Economic Policy Challenge,* (Washington, DC, Economic Policy Institute, June 2014). Available at: http://www.epi.org/publication/raising-americas-pay.

[3] John Schmitt, *Health-insurance Coverage for Low-wage Workers, 1979-2010 and Beyond,* (February 2012). Available at: http://cepr.net/documents/publications/health-low-wage-2012-02.pdf.

[4] Kaiser Family Foundation, *Key Facts about the Uninsured Population,* (October 5, 2015). Available at: http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[5] Samantha Artiga, Anthony Damico, Katherine Young, Elizabeth Cornachione, and Rachel Garfield. *Health Coverage and Care for Immigrants*. (Washington, DC: Kaiser Family Foundation, January 20, 2016). Available at: http://kff.org/report-section/health-coverage-and-care-for-immigrants-issue-brief/.

[6] Kaiser Family Foundation, *Employer Responsibility Under the Affordable Care Act*, (October 5, 2015). Available at: http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/.

[7] Kaiser Family Foundation, *2015 Employer Health Benefit Survey*, (September 22, 2015). Available at: http://kff.org/health-costs/report/2015-employer-health-benefits-survey/.

[8] Internal Revenue Service, *Employer Shared Responsibility Provisions*, accessed December 15, 2015. Available at: https://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions/.

[9] Five additional states have adopted the ACA Medicaid expansion since 2014, including Pennsylvania, Indiana, Alaska, Montana, and Louisiana. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the ACA expansion.

[10] The Kaiser Family Foundation, State Health Facts. *Status of State Action on the Medicaid Expansion Decision*, as of February 24, 2016. Available at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[11] Rachel Garfield and Katherine Young. *Adults who Remained Uninsured at the End of 2014.* (Washington, DC: Kaiser Family Foundation, January 2015). Available at: http://kff.org/health-reform/issue-brief/adults-who-remained-uninsured-at-the-end-of-2014/.

[12] *Ibid.*

[13] In our analysis of eligibility for coverage for low-income workers, we define Medicaid expansion states as all states that have adopted the Medicaid expansion as of April 2016, including Louisiana.

Tracking Trends in Health System Performance

July 2016

Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction

Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016

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

Abstract For people with low and moderate incomes, the Affordable Care Act's tax credits have made premium costs roughly comparable to those paid by people with job-based health insurance. For those with higher incomes, the tax credits phase out, meaning that adults in marketplace plans on average have higher premium costs than those in employer plans. The law's cost-sharing reductions are reducing deductibles. Lower-income adults in marketplace plans were less likely than higher-income adults to report having deductibles of $1,000 or more. Majorities of new marketplace enrollees and those who have changed plans since they initially obtained marketplace coverage are satisfied with the doctors participating in their plans. Overall, the majority of marketplace enrollees expressed confidence in their ability to afford care if they were to become seriously ill. This issue brief explores these and other findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

BACKGROUND

About 26 million Americans have health insurance through the Affordable Care Act's coverage expansions, either through the state or federal marketplaces or through expanded eligibility for Medicaid.[1] Estimates from a recent survey (The Commonwealth Fund's Affordable Care Act Tracking Survey, conducted between February and April 2016) indicate this coverage is improving people's ability to get health care. Sixty-one percent of respondents who were enrolled in marketplace plans or Medicaid said they would not have been able to access or afford their care before they got their new insurance.[2]

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this brief, please contact:

Sara R. Collins, Ph.D.
Vice President, Health Care Coverage and Access
The Commonwealth Fund
src@cmwf.org

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Using these survey data, this brief examines the costs of marketplace plans and how consumers view the affordability of their health insurance. We compare premiums and deductibles reported by marketplace enrollees with those reported by adults in employer plans and examine whether these costs have increased over time. We also investigate if enrollees are choosing plans that limit the number of providers offered ("narrow network" plans) and the level of consumers' satisfaction with the doctors participating in their plans.

AFFORDABILITY OF MARKETPLACE PLANS

Premium Costs Are Similar in Marketplace Plans and Employer Plans

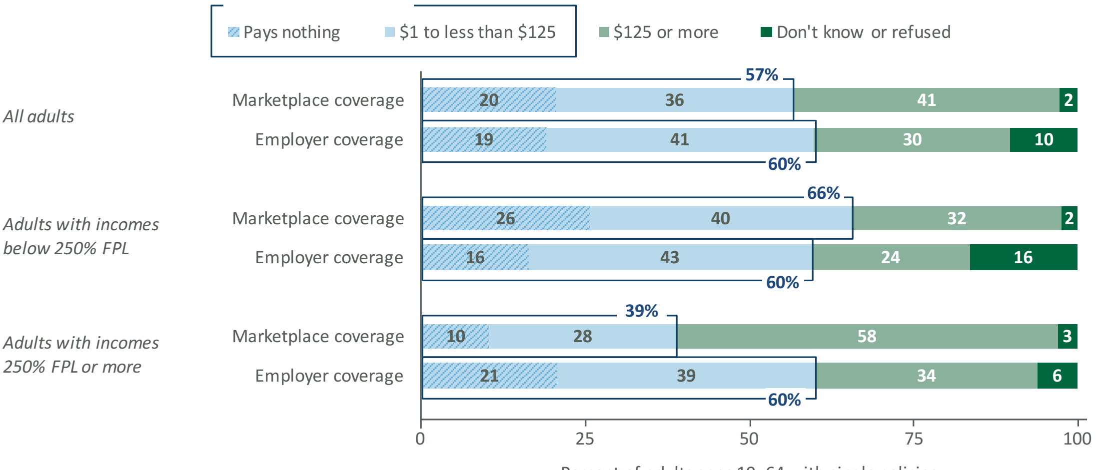
Of the 11.1 million people enrolled in marketplace plans in 2016, more than eight of 10 are paying for their premiums with the help of federal tax credits.[3] The effect of these tax credits on consumers' costs is reflected in this brief's findings.

Among adults with single policies (i.e., those covering only themselves), those enrolled in marketplace plans reported that the amount they pay for their premiums is similar to what people with employer-based coverage pay. Fifty-seven percent of adults in marketplace plans and 60 percent in employer plans spent less than $125 per month on insurance premiums. These figures include the one of five people with either type of insurance who paid nothing (Exhibit 1).[4]

Most people who purchased marketplace plans were eligible for premium tax credits. Fifty-nine percent of people with marketplace coverage had incomes under 250 percent of the federal poverty level ($29,425 for an individual and $60,625 for a family of four), making them eligible for the most generous premium subsidies (Table 1). As a result, 66 percent of these adults paid less than $125 a month toward their premium, including 26 percent who paid nothing. Among people with

Exhibit 1

Low-Income Adults with Marketplace Coverage Paid Monthly Premiums Comparable to Low-Income Adults with Employer Coverage



Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four. Segments may not sum to subtotals because of rounding. Bars may not sum to 100 percent because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

employer coverage in this income range, 60 percent paid less than $125 per month, including 16 percent who paid nothing.

Under the ACA, adults with incomes between 250 percent and 400 percent of poverty ($29,425 to $47,080 for a single person) receive smaller tax credits for marketplace coverage, while those with incomes above 400 percent of poverty receive no tax credit and pay the full premium. In contrast, most people in employer plans, regardless of income level, receive premium contributions from their employers. Thus, among adults at 250 percent of poverty or higher, 58 percent of those with marketplace coverage spent $125 a month or more on premiums compared with only 34 percent of those in employer plans.

Half of Adults in Marketplace Plans Say Their Premiums Are Affordable

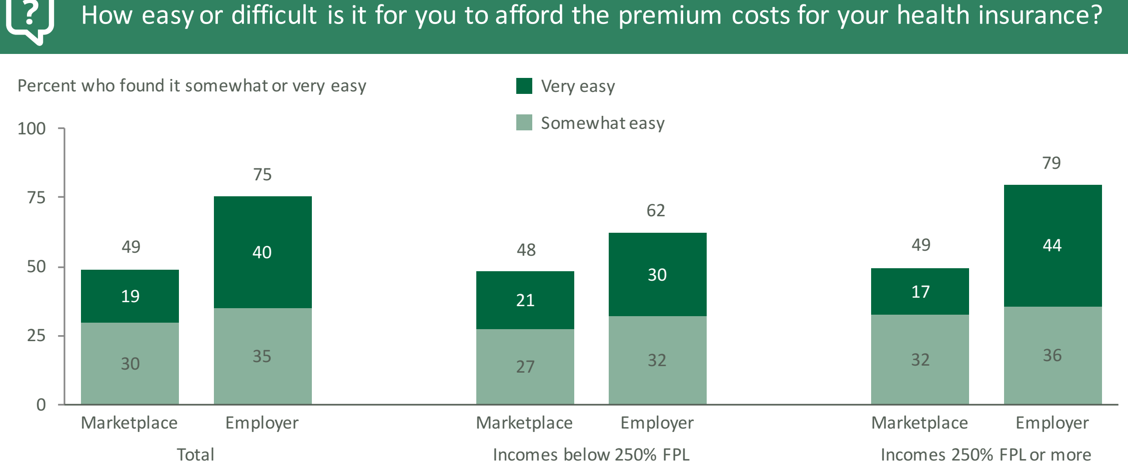
When we asked people their views on affordability, we limited the survey sample to respondents who paid all or part of their premium and knew the amount they paid.

Half (49%) of adults with marketplace coverage found it somewhat or very easy to afford their premium (Exhibit 2). This rate is statistically unchanged from April–June 2014, after the ACA's first open enrollment season (data not shown).[5] People with marketplace coverage—those with low as well as higher incomes—found it more difficult to afford their premiums than did people with employer coverage. Compared to other survey respondents, employer plan enrollees with higher incomes reported the easiest time affording their premiums.

Views of affordability diverge at higher income levels. This reflects the phase out of premium tax credits in marketplace plans at higher incomes and the fact that people in employer plans are much more likely to have higher incomes than are marketplace enrollees. Half (51%) of 19-to-64-year-old adults in employer plans had incomes of 400 percent of poverty or higher, compared with only 19 percent of those in marketplace plans (Table 1).

Exhibit 2

Half of Adults in Marketplace Plans View Their Premiums as Affordable



Adults ages 19–64 who pay all or some of premium and are aware of their premium amount

Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four. Segments may not sum to subtotals because of rounding.

Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Lower-Income Adults with Marketplace Coverage Less Likely to Have High Deductibles

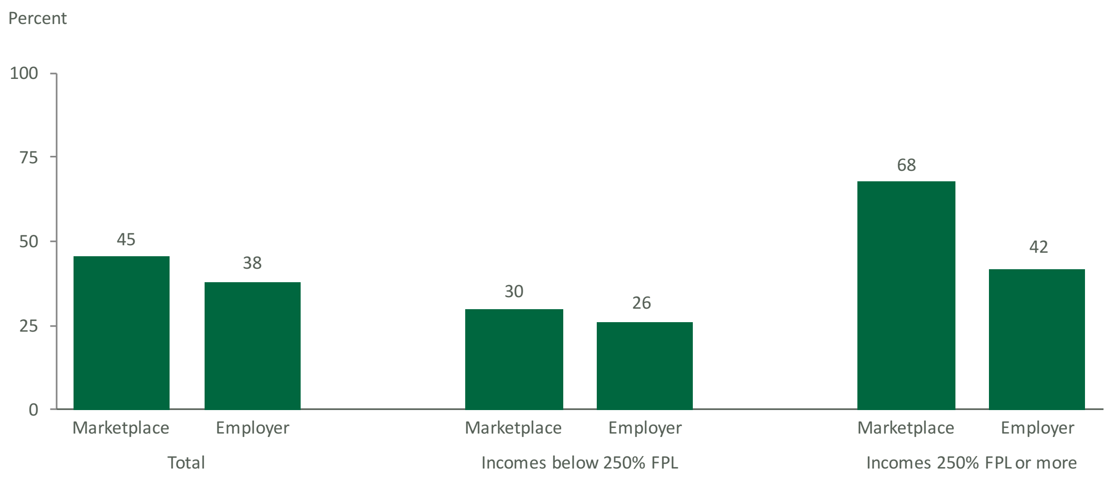
The ACA requires insurers that sell plans in the marketplaces to offer silver-level plans that come with cost-sharing reductions for adults earning between 100 percent and 250 percent of the federal poverty level. These reductions lower an individual's deductible amount, copayments, and coinsurance, substantially so for enrollees with the lowest incomes.[6] In 2016, 57 percent of marketplace enrollees are estimated to be covered by plans with these reductions.[7]

The effect is clear: among marketplace enrollees living under 250 percent of poverty, 30 percent said they had deductibles of $1,000 or more (Exhibit 3). But more than two-thirds (68%) of marketplace enrollees at 250 percent of poverty or more reported deductibles of $1,000 or greater. Cost-sharing reductions become less generous as income rises and are phased out completely at 250 percent of poverty. The share of adults with incomes between 138 percent and 250 percent of poverty with deductibles of $1,000 or greater was also significantly smaller than the share of adults with incomes of 250 percent of poverty or higher (45% vs. 68%) (data not shown).

Cost-sharing reductions have made deductibles similar to those incurred in employer plans for adults with lower incomes. The share of lower-income adults with high deductibles is similar in marketplace plans and in employer plans. At higher incomes, however, marketplace enrollees were significantly more likely than employer plan enrollees to have a high-deductible plan.

Exhibit 3

Low-Income Adults with Marketplace Coverage Less Likely to Have High Deductibles Than Adults with Higher Incomes



Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Lower-Income Adults with Marketplace Coverage Less Likely to Report Premium Increase

The survey finds evidence that the tax credits are protecting many enrollees from premium increases. Higher-income adults were much more likely to report premium increases than lower-income adults were (Exhibit 4). About two-thirds (64%) of people in marketplace plans with incomes of 250 percent of poverty or more reported their premiums had increased over the time they had their plan, compared to 45 percent of adults with lower incomes who receive the largest tax credits.

Exhibit 4

Low-Income Adults with Marketplace Coverage Less Likely to Have Premium Increases Than Adults with Higher Incomes

Over the time you have had a health plan through the marketplace, has the amount you have had to pay in premiums increased, decreased, or stayed about the same?

Adults ages 19–64 who have had marketplace coverage since before January 2016

Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

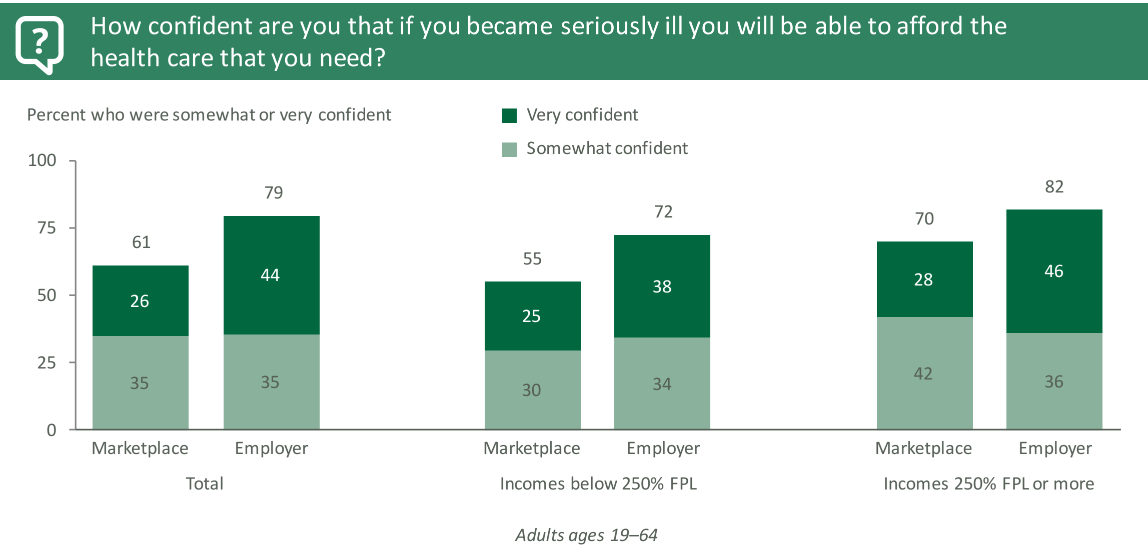
In contrast to premiums, deductibles and copayments on average were more likely to have stayed the same over the course of people's enrollment in the marketplaces. Half (51%) of adults who had marketplace coverage since before January 2016 and whose plans had a deductible reported that their deductible amounts stayed the same, while 36 percent reported an increase and 10 percent reported a decrease (data not shown).[8] These results were similar across income categories. Similarly, nearly half of adults with marketplace coverage since before January 2016 reported the amount they pay in either copayments or coinsurance for doctor visits (48%) and prescription drugs (45%) has stayed the same (data not shown). One-third (34%) of enrollees reported their copayments or coinsurance increased for doctor visits, while 29 percent reported an increase for prescription drugs.

Most Marketplace Enrollees Were Confident They Could Afford Health Care If Sick

We asked people about their confidence in their ability to afford care if they were to become seriously ill. Majorities of people with marketplace plans (61%) and employer plans (79%) were very or somewhat confident they could afford needed care if they became sick, but larger shares of those with employer plans expressed confidence (Exhibit 5).

Exhibit 5

Majority of Adults with Marketplace Coverage Confident They Could Afford Needed Care



Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

PROVIDER NETWORKS

Four of 10 Adults Chose a Narrow Network Plan

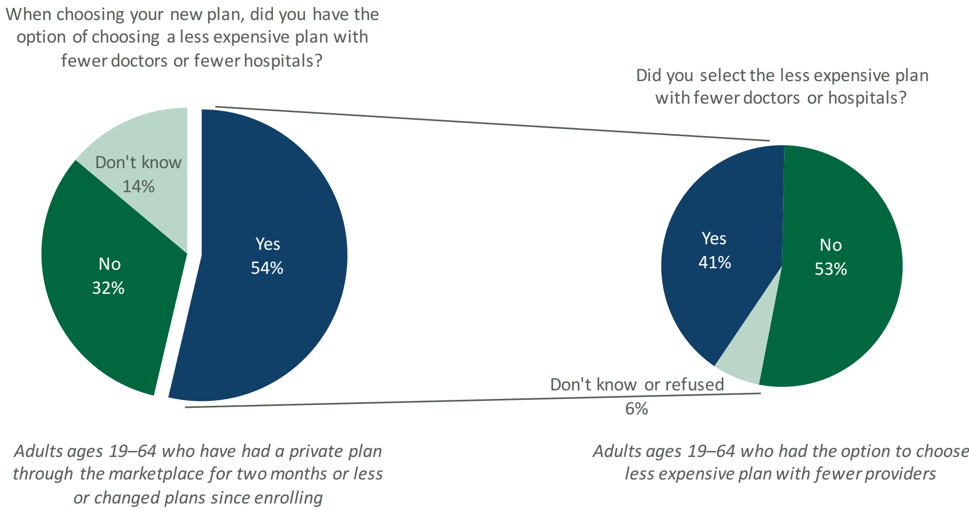
Insurer competition in the marketplaces has led to the proliferation of health plans that offer a narrow, or limited, network of health care providers at a lower price than plans with broader networks. This has led to concerns over access to care.

In the survey, more than half (54%) of people who were enrolled in a marketplace plan for the first time or who had changed plans said they had the option of choosing a less expensive plan featuring fewer doctors or hospitals (Exhibit 6). Of those, 41 percent selected the limited network plan.

Across all marketplace plans, more than three-quarters (78%) of enrollees who either recently enrolled or had changed plans reported being very or somewhat satisfied with the doctors covered by their insurance (Exhibit 7). Among these adults, 64 percent reported their plans have some or all of the doctors they want. Sample size limitations prevented us from examining differences between people enrolled in narrow vs. broader network plans.

Exhibit 6

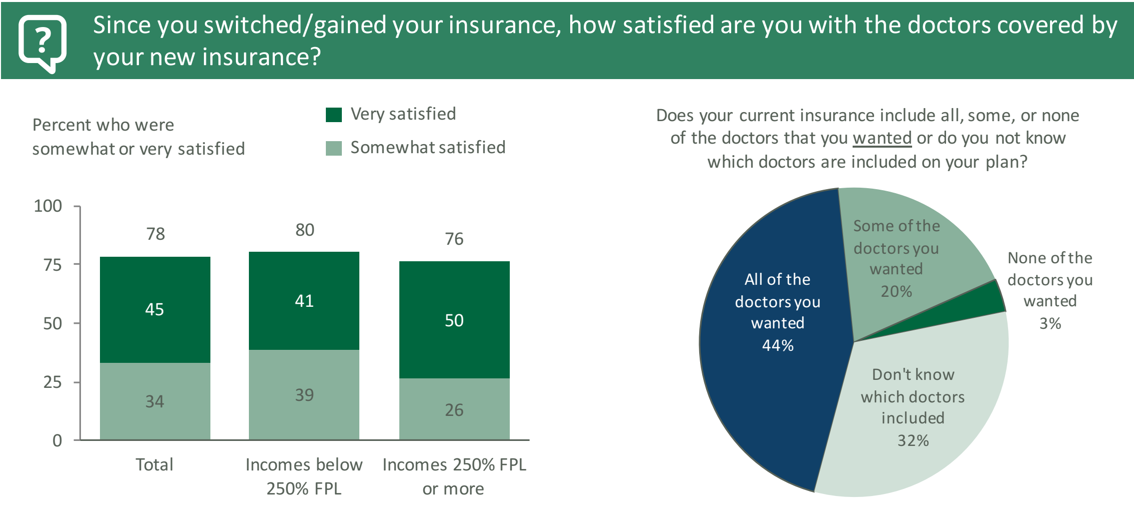
Four of Ten Adults Chose a Less Expensive Plan with Fewer Providers When Given the Option



Note: Segments may not sum to 100 percent because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Exhibit 7

Four of Five Adults with New Marketplace Coverage Are Satisfied with the Doctors in Their Plans



Adults ages 19–64 who have had a private plan through the marketplace for two months or less or changed plans since enrolling or switched from Medicaid to marketplace

Note: Segments may not sum to 100 percent because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

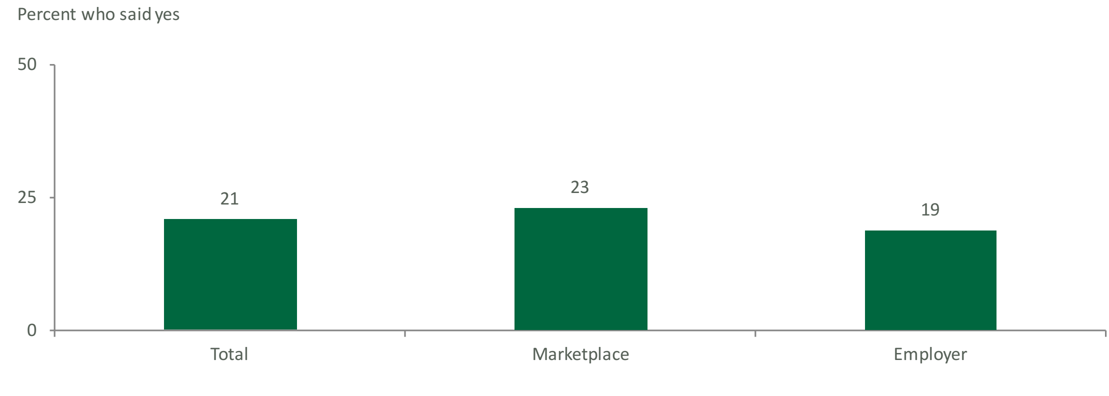
Rate of "Surprise Medical Bills" Similar in Employer and Marketplace Plans

The proliferation of narrow network plans does not appear to be creating more problems with so-called surprise medical bills. Such bills arrive unexpectedly from an out-of-network provider, as when, for example, a patient is operated on by an in-network surgeon at an in-network hospital but is billed by an out-of-network anesthesiologist.[9] We found no difference in the rate of reports of surprise bills between adults with employer coverage and adults with marketplace coverage: about one of five in both groups reported they had experienced a surprise medical bill (Exhibit 8).

Exhibit 8

Rate of "Surprise Medical Bills" Similar for Adults Insured with Employer and Marketplace Coverage

Have you or a family member ever received care at a hospital that you thought was covered by your insurance, but you received a bill from a doctor who was not covered by your plan?



Adults ages 19–64 who are insured

Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

SHOPPING FOR MARKETPLACE PLANS

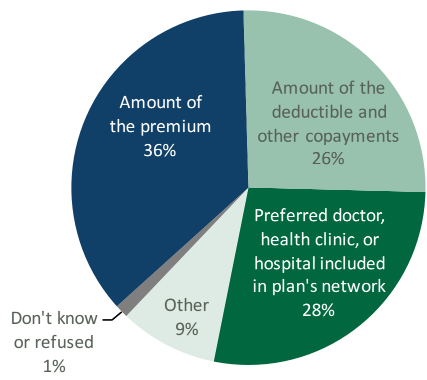
Cost Was Most Important Factor in Selecting a Plan

Premiums and cost-sharing figured most prominently in people's decisions regarding choice of marketplace plan (Exhibit 9). Six of 10 (62%) adults who either had enrolled in private plans through the marketplace for the first time or switched health plans said the premium amount (36%) or the amount of the deductible and copayments (26%) was the most important factor in their decision. Choice of doctors and hospitals was also important. More than one-quarter (28%) said the inclusion of their preferred provider (doctor, health clinic, or hospital) in their plan's network was the most important factor in choosing a plan.

Exhibit 9

Cost Is the Most Important Factor in Plan Selection Among Marketplace Enrollees

What was the most important factor in your decision about which plan to select?



Adults ages 19–64 who have had a private plan through the marketplace for two months or less or changed plans since

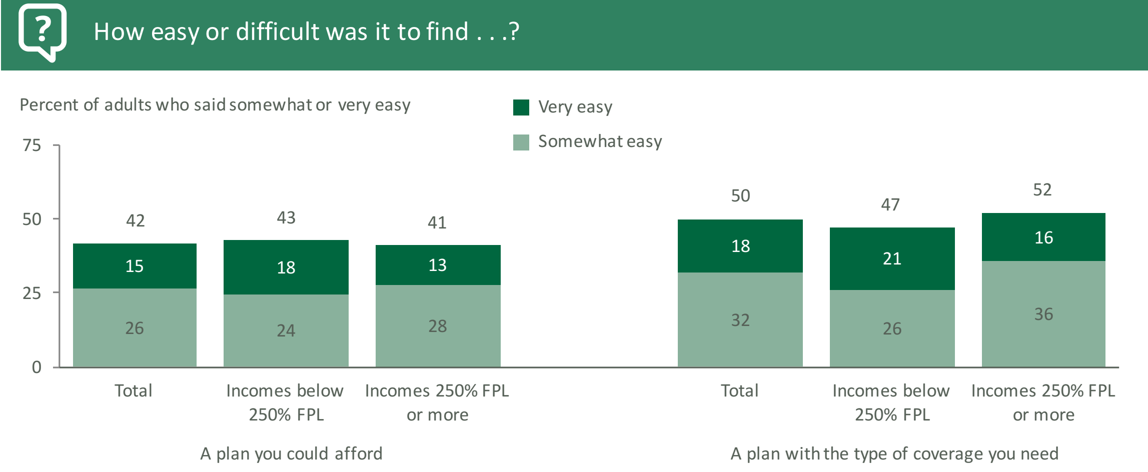
Note: Segments may not sum to 100 percent because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Fewer Than Half of Adults Found It Easy to Find an Affordable Plan

When asked about their experiences finding affordable plans and adequate coverage, adults' views were the same as they were in April-to-June 2014 and March-to-May 2015 (see the Affordable Care Act Tracking Survey interactive). Low- and higher-income adults alike found it difficult to find affordable plans. This year, 42 percent of adults who visited the marketplace and whose incomes make them eligible for coverage said it was somewhat or very easy to find an affordable plan (Exhibit 10).[10]

Exhibit 10

Fewer Than Half of Adults Said It Was Easy to Find an Affordable Plan



* Marketplace eligible includes adults in expansion states with incomes >138% FPL and adults in nonexpansion states with incomes >100% FPL.
Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four. Segments may not sum to subtotals because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Why Do Marketplace Enrollees Switch Plans or Keep Them?

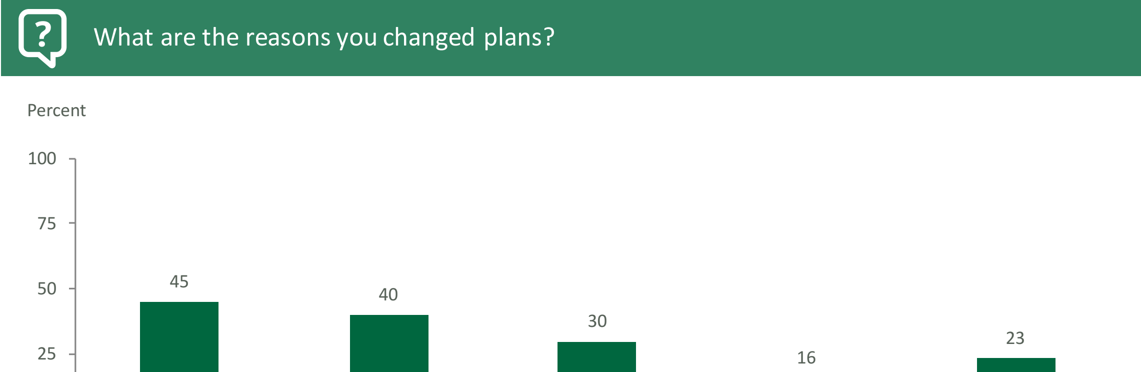
Nearly half (46%) of adults with marketplace coverage since before the most recent open enrollment period said they have changed plans over the time they have had coverage.[11] We asked why people had either changed or kept their plans.

Switching plans. Among adults who had changed their marketplace plans, 45 percent did so because their old plan was no longer being offered (Exhibit 11). Similar to their priorities in selecting a plan, 40 percent reported they switched plans for a lower premium, 30 percent did so for more of the doctors or hospitals they want, and 16 percent did so to obtain a lower deductible.

Keeping the same plan. Most adults (87%) reported they kept the same plan simply because it was easier to do so (Exhibit 12). About three-quarters (77%) of adults said they kept the same plan because they were satisfied with their coverage, and 64 percent did so because they liked the doctors in their network.

Exhibit 11

Consumers Cite Costs, Choice of Providers as Factors When Switching Plans

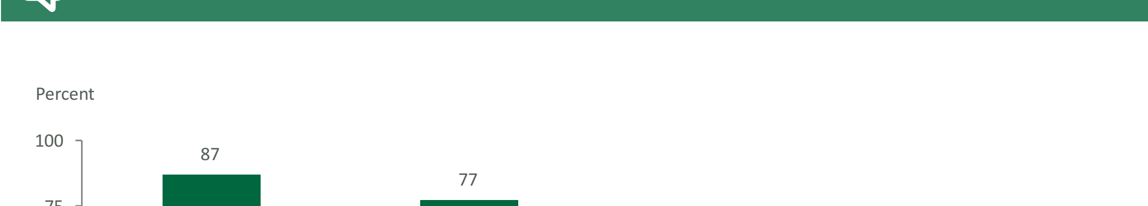


*Adults ages 19–64 who changed marketplace plans**

* 46 percent of adults ages 19–64 who have had marketplace coverage since before January 2016 switched plans since enrolling.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Exhibit 12

Adults Said Staying in Same Marketplace Plan Was Easier



*Adults ages 19–64 who stayed in the same plan marketplace plan**

* 50 percent of adults ages 19–64 who have had marketplace coverage since before January 2016 stayed in the same plan since enrolling.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

CONCLUSION

The affordability of marketplace plans continues to be the subject of considerable debate. A recent analysis of insurers' 2017 rate requests in 14 large cities by the Kaiser Family Foundation finds a weighted average increase of 10 percent.[12] While these preliminary requests are subject to state rate review, it is likely that premium increases will be higher in 2017 than in 2016.[13]

However, most consumers will be shielded from the full premium increase. More than eight of 10 marketplace enrollees have tax credits to help pay their premiums. The tax credit is calculated as the difference between what enrollees are required to pay as a share of their income and the premium of the benchmark silver plan in their market. This means that most of the premium increases next year will be absorbed by enrollees' tax credits, particularly if they select the benchmark plan. An analysis by the U.S. Department of Health and Human Services (HHS) of 2016 premiums found that among people eligible for tax credits in marketplace plans, premiums rose by just 4 percent on average, or $4 per month, despite earlier predictions of much larger increases across plans offered in 2015.[14] The large amount of plan switching found in this survey, as well as in HHS marketplace data, indicates that many people will likely shop for the best deal.

The findings present cautionary notes for policymakers. People with higher incomes with marketplace coverage who receive little to no subsidy are more likely to pay more for their premiums and have a high deductible than those in employer plans. Overall, people in marketplace plans are less likely than those in employer plans to view their plans as affordable; fewer than half of those who had shopped for a plan said it was easy to find a plan they could afford. Adjustments to the marketplaces will likely be needed to ensure that consumers can afford both the insurance and the health care they need. These could include changes to the marketplace subsidies and to the law's premium stabilization programs—in particular, the reinsurance program—that have helped moderate premium growth in the marketplace's first three years. However, the fundamental driver of premiums across all health insurance markets is the underlying rate of growth in medical costs. Therefore, ongoing systemwide efforts to slow the rate of increase in medical expenditures will be critical.

Table 1. Demographics of Overall Sample, Adults Enrolled in the Marketplace, and Adults Enrolled in Employer-Sponsored Insurance

	Total adults (% ages 19–64)	Enrolled in a private health plan through the marketplace (%)	Enrolled in employer-sponsored insurance (%)
Unweighted n	4,802	432	2,237
Age			
19–34	34	32	29
35–49	32	28	35
50–64	32	37	33
Race/Ethnicity			
Non-Hispanic White	61	60	70
Black	13	14	9
Latino	17	21	11
Asian/Pacific Islander	5	2	5
Other/Mixed	2	1	2
Poverty status			
Below 138% poverty	30	27	9
138%–249% poverty	20	32	17
250%–399% poverty	18	22	23
400% poverty or more	32	19	51
Health status			
Fair/Poor health status, or any chronic condition or disability[a]	52	48	45
No health problem	48	52	55
Political affiliation			
Democrat	29	34	28
Republican	19	20	22
Independent	24	23	25
Something else	17	14	16
Adult work status			
Full-time	53	43	73
Part-time	14	25	10
Not working	33	32	17
Employer size[b]			
1–24 employees	26	49	15
25–99 employees	14	18	12
100–499 employees	14	11	16
500 or more employees	43	18	54

[a] At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

[b] Base: full- and part-time employed adults ages 19–64.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Notes

[1] By the end of The Affordable Care Act's third open enrollment period, marketplace plan enrollment had climbed to 11.1 million people and 15 million more people were enrolled in Medicaid compared to three years earlier. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot* (CMS, June 30, 2016); U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid & CHIP: April 2016 Monthly Applications, Eligibility Determinations and Enrollment Report* (CMS, June 30, 2016).

[2] S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction* (The Commonwealth Fund, May 2016).

[3] The tax credits cap what people pay in premiums as a share of their income, and range from 2.03 percent to 9.66 percent for adults earning between 100 percent and 400 percent of poverty. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot* (CMS, June 30, 2016).

[4] A larger share of adults with employer plans (10%) did not know the amount of their premium costs than did those with marketplace plans (2%). This is likely because most people with employer health benefits receive and make premium contributions through their paychecks while those with marketplace plans shop for insurance and pay their premiums directly. Included in this response are some people who refused to answer the question.

[5] In the Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014, 49 percent of adults ages 19 to 64 who paid all or some of their premiums and were aware of their premium amount found it somewhat or very easy to afford their premium costs for their health insurance.

[6] 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).

[7] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot* (CMS, June 30, 2016).

[8] Seventy-six percent of adults ages 19 to 64 who have had marketplace coverage since before January 2016 reported their health plan has a deductible. We include adults who reported they currently do not have a deductible but have had a marketplace plan with a deductible in the past. These adults are considered to have deductibles that have decreased over the time they had marketplace coverage.

[9] A 2011 survey found that 40 percent of the respondents that had used out-of-network care did so involuntarily, and a 2015 Consumers Union survey found that 30 percent of privately insured Americans received a surprise medical bill in the prior two years. K. A. Kyanko, L. A. Curry, and S. H. Busch, "Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?" *Health Services Research,* June 2013 48(3):1154–72; and *Surprise Medical Bills Survey, 2015 Nationally Representative Online Survey* (Consumer Reports National Research Center, May 5, 2015). Recently some states have put in place measures to prevent consumers from receiving these bills. New York's "Emergency Medical Services and Surprise Bills Law" went into effect in March 2015 and prohibits consumers in state-regulated health plans from being charged more than in-network cost-sharing for out-of-network services in both emergency and non-emergency situations. A number of other states also have limited regulations aimed at addressing surprise medical bills. See K. Pollitz, *Surprise Medical Bills* (Henry J. Kaiser Family Foundation, March 17, 2016); and J. Hoadley, S. Ahn, and K. Lucia, *Balance Billing: How Are States Protecting Consumers from Unexpected Charges?* (Robert Wood Johnson Foundation, June 2015).

[10] Marketplace-eligible adults are those in Medicaid expansion states who have incomes above 138 percent of the federal poverty level and those in nonexpansion states who have incomes above 100 percent of poverty.

[11] This switching rate is much higher than that in employer plans, the Federal Employees Health Benefits Program, and Medicare Part D. T. DeLeire and C. Marks, *Consumer Decisions Regarding Health Plan Choices in the 2014 and 2015 Marketplaces,* ASPE Issue Brief (U.S. Department of Health and Human Services, Oct. 28, 2015).

[12] C. Cox, G. Claxton, L. Levitt et al., *Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces* (Henry J. Kaiser Family Foundation, June 15, 2016).

[13] S. R. Collins, *Consumer Experiences in the ACA Marketplaces, Marketplace Stability, and Remaining Challenges to Covering the Uninsured,* Invited testimony, U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Hearing on "Advancing Patient Solutions of Lower Costs and Better Care," June 10, 2016.

[14] Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015–2016,* ASPE Issue Brief (U.S. Department of Health and Human Services, April 12, 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.

About the Authors

Munira Z. Gunja, M.P.H., is senior research associate in the Health Care Coverage and Access program at The Commonwealth Fund. Ms. Gunja joined the Fund from the U.S. Department of Health and Human Services in the office of the Assistant Secretary for Planning and Evaluation (ASPE), Division of Health Care Access and Coverage, where she received the Secretary's Award for Distinguished Service. Before joining ASPE, Ms. Gunja worked for the National Cancer Institute where she conducted data analysis for numerous studies featured in scientific journals. She graduated from Tulane University with a B.S. in public health and international development and an M.P.H. in epidemiology.

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

Michelle McEvoy Doty, Ph.D., is vice president of survey research and evaluation for The Commonwealth Fund. She has authored numerous publications on cross-national comparisons of health system performance, access to quality health care among vulnerable populations, and the extent to which lack of health insurance contributes to inequities in quality of care. Dr. Doty holds an M.P.H. and a Ph.D. in public health from the University of California, Los Angeles.

Sophie Beutel is program associate in the Health Care Coverage and Access program. In this role, she is responsible for providing daily support for the program with responsibilities ranging from daily administrative and grants management tasks to writing and research responsibilities, including tracking developments in the implementation of the Affordable Care Act. Prior to joining the Fund, she was a summer intern with the State of Rhode Island Department of Health. Ms. Beutel graduated from Brown University with a B.A. in Science and Society, on the Health and Medicine track.

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By Paul D. Jacobs, Noelia Duchovny, and Brandy J. Lipton

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DATAWATCH

Changes In Health Status And Care Use After ACA Expansions Among The Insured And Uninsured

Following the Affordable Care Act's insurance expansion provisions in 2014, the average health status and use of health care within coverage groups has likely changed. Medicaid enrollees and the uninsured were both healthier in 2014 than those respective groups were in 2013. By contrast, those with individual private insurance coverage appeared less healthy as a group.

Paul D. Jacobs (paul.jacobs@ahrq.hhs.gov) is a service fellow in the Center for Financing, Access, and Cost Trends at the Agency for Healthcare Research and Quality, in Rockville, Maryland.

Noelia Duchovny is a principal analyst in the Health, Retirement, and Long-Term Analysis Division of the Congressional Budget Office, in Washington, D.C.

Brandy J. Lipton is a research scientist at Social and Scientific Systems, in Rockville.

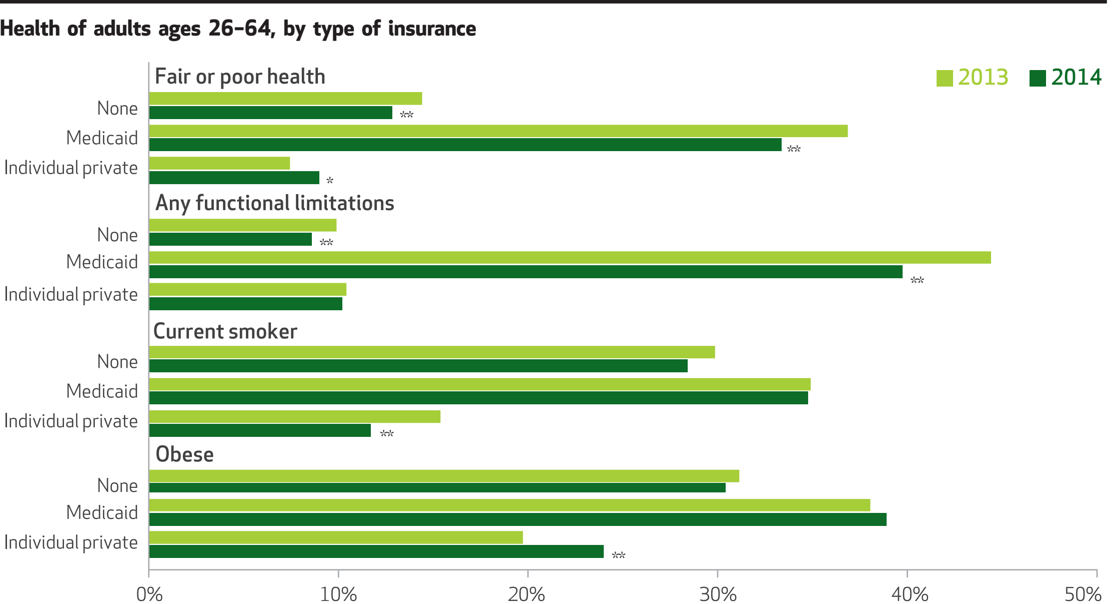
The Affordable Care Act (ACA) made significant changes to the availability and financing of health insurance in the United States in 2014, including the expansion of Medicaid eligibility and tax credits for Marketplace coverage. Stemming from these changes, the number of adults ages 26–64 without coverage fell by 5.7 million (18 percent) from 2013 to 2014, while the number with Medicaid increased by 3.1 million (25 percent) and the number with individual private insurance increased by 3.6 million (49 percent).[1]

The health status and rates of health care utilization of uninsured and insured groups may have changed as a result of these changes in insurance coverage. As shown in Exhibit 1, we found that in 2014 the uninsured and Medicaid enrollees as groups described themselves as healthier, while those with individual private health insurance described themselves as less healthy, relative to individuals in the same groups in 2013.

We hypothesized that relatively sicker unin-

EXHIBIT 1

Health of adults ages 26–64, by type of insurance



SOURCE Authors' analysis of data for 2013–14 from the National Health Interview Survey (Note 1 in text). **NOTES** Insurance is at the time of the survey. Significance refers to difference from 2013. All results shown as significant are also different from the trend in the period 2008–14 ($p < 0.10$) except for the percentage of current smokers with individual private insurance. *$p < 0.10$ **$p < 0.05$

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sured people may have been more likely to take up coverage in 2014, compared to the broader pool of people who were without coverage in 2013. Furthermore, people newly eligible for Medicaid may have been healthier, on average, than those previously eligible for Medicaid because of disability or very low income.

Study Data And Methods

We used data from the National Health Interview Survey (NHIS), a continuous cross-sectional survey of the civilian noninstitutionalized population, to compare measures of health status and health care use in 2014 to those same measures in 2013 for the following three coverage categories: uninsured people, Medicaid enrollees, and people with individual (nongroup) coverage.[1] Because a two-year comparison would be misleading if there was a prior trend in the data, we note below the few instances where unadjusted differences between 2013 and 2014 were significant but where those differences were not significant after adjustment for a linear trend in the period 2008–14. (Additional details about our methodology can be found in online Appendix Exhibits A.1 and A.4.)[2] All estimates accounted for the complex design of the NHIS and incorporated sampling weights to produce nationally representative estimates.

We analyzed outcomes for each of the three insurance categories. Insurance status was measured at the time of the NHIS interview. Because people might not be aware of the source of their coverage, we defined *individual private insurance* as coverage reported as obtained either directly or through a Marketplace.

The sample was restricted to adults ages 26–64 because the 2010 implementation of the ACA's dependent coverage provision increased insurance coverage and may have affected related outcomes for people ages 19–25.[3]

Because most of the utilization measures we studied had a one-year recall period, individuals interviewed earlier in 2014 would have reported utilization corresponding to insurance coverage in 2013. Thus, we used the entire calendar year for four exhibits in this article, while for one exhibit we limited our analysis of utilization to respondents in the fourth quarter of each calendar year.

There were some limitations to our study. First, the NHIS does not interview the same individuals over time. As a result, we focused on changes in average group characteristics instead of attempting to identify specific individuals who changed their type of coverage. Second, individuals may misreport their type of coverage, especially those newly obtaining coverage or changing the source of their coverage.

Third, changes in health status and utilization within each insurance group could be attributed to compositional changes within the groups or to the effects of gaining coverage or switching sources of coverage (for example, uninsured people who gained coverage in 2014 may have been more likely to visit a health care provider and to be subsequently diagnosed with a condition, compared to those who remained uninsured throughout 2013 and 2014). Our analysis suggests that compositional shifts are likely the primary explanation of these changes.[4]

Finally, because we limited our analysis of health care utilization measures to NHIS interviews during the fourth quarter of each year, our sample for these measures is smaller than the samples for health outcome measures, which limits the precision of these results. (Appendix Exhibit A.6 presents unweighted sample sizes for the subpopulations we examined.)[2]

Study Results

We observed differences in health status in 2014 compared with 2013 for all three insurance groups, though the specific measures that changed varied by group. Between 2013 and 2014, the likelihood of reporting fair or poor health and the likelihood of having any functional limitations declined by 1.6 and 1.3 percentage points, respectively, among the uninsured and by 3.5 and 4.7 percentage points, respectively, among Medicaid enrollees (Exhibit 1).

However, among those with individual private coverage, the likelihood of reporting fair or poor health and the likelihood of being obese increased by 1.5 and 4.2 percentage points, respectively (Exhibit 1). We also found that the likelihood of having at least one of ten specific chronic conditions[5] increased by 6.7 percentage points for this group—a change that was driven by increases in the likelihood of having hypertension (a 4.0-percentage-point increase) and diabetes (a 2.9-percentage-point increase) (Exhibit 2). In contrast, we found that among Medicaid enrollees with at least one chronic condition, the average number of conditions in 2014 (2.1) was smaller than in 2013 (2.3) (Exhibit 3).

Compared with the measures of health status we analyzed, relatively few of the measures of health care utilization were different in 2014 compared with 2013 (Exhibit 4). We found a reduction in the percentage of uninsured people who had an emergency department visit (a 3.3-percentage-point decrease) and a small but significant reduction in the average number of times uninsured people who sought care visited a health care professional in the two weeks be-

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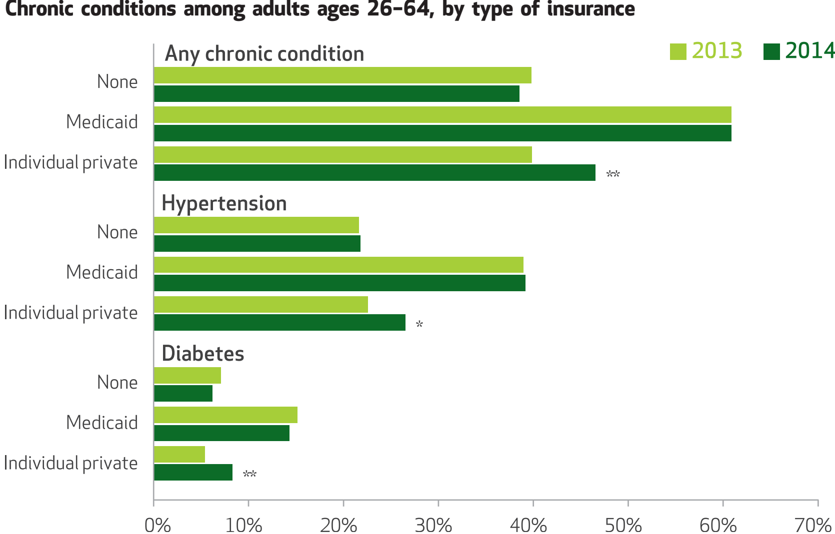
Chronic conditions among adults ages 26–64, by type of insurance

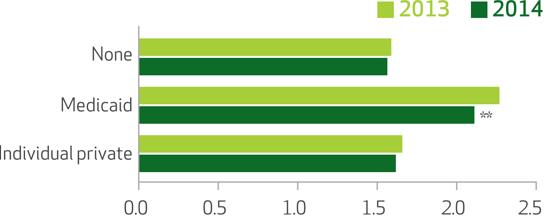


SOURCE Authors' analysis of data for 2013–14 from the National Health Interview Survey (Note 1 in text). **NOTES** Insurance is at the time of the survey. For definitions of the ten chronic conditions analyzed, see Note 5 in text. Significance refers to difference from 2013. All results shown as significant are also different from the trend in the period 2008–14 ($p < 0.10$). A more detailed version of the exhibit is available in Appendix Exhibit A.2 (see Note 2 in text). $^{*}p < 0.10$ $^{**}p < 0.05$

fore the survey (from 1.6 to 1.3 visits), although this latter estimate was not significantly different from the preexisting trend. For Medicaid enrollees, we found a 5.5-percentage-point reduction in the likelihood of obtaining care ten or more times in the same time period. And among people with individual private insurance, we found a 13.5-percentage-point increase in the percentage who saw a general practitioner.

When we compared states that did and did not expand Medicaid, we observed no significant differences in the change in the percentages of uninsured people reporting better health and

Number of chronic conditions among adults ages 26–64 with at least one chronic condition, by type of insurance



SOURCE Authors' analysis of data for 2013–14 from the National Health Interview Survey (Note 1 in text). **NOTES** Insurance is at the time of the survey. For definitions of the ten chronic conditions analyzed, see Note 5 in text. Significance refers to difference from 2013. All results shown as significant are also different from the trend in the period 2008–14 ($p < 0.05$). $^{**}p < 0.05$

fewer functional limitations in 2014 compared with the previous year (Exhibit 5). Likewise, Medicaid enrollees in all states appeared healthier in 2014 than in 2013 across these same measures, with no significant differences between expansion and nonexpansion states—which might reflect the fact that Medicaid enrollment increased in both groups of states. (Appendix Exhibit A.5 contains a list of the states that opted to expand eligibility for Medicaid under the ACA.)[2]

We found notably large increases between 2013 and 2014 in the prevalence of diabetes, hypertension, and obesity among people with individual private insurance in nonexpansion states. For example, the likelihood of having hypertension increased by 5.8 percentage points during this time in nonexpansion states. The corresponding increase (not significant) in expansion states was 2.3 percentage points. Out of the twenty-one comparisons of health measures in Exhibit 5 across expansion and nonexpansion states, only one result (for smoking among the uninsured) was significantly different.

Discussion

We observed better health status among the uninsured in 2014 compared to that group in 2013, which suggests that people who were uninsured in 2013 and took up coverage in 2014 were somewhat less healthy than the average uninsured person in 2013.[6] In turn, this suggests that people who took up coverage in 2015 and take it up in subsequent years after being uninsured the prior year will likely be healthier and possibly have lower average health expenditures than those who became newly insured in 2014.

Like the uninsured, Medicaid enrollees in 2014 appeared healthier, on average, across several measures compared with 2013. We also found that fewer Medicaid enrollees in 2014 than in 2013 used care ten or more times, which is consistent with our findings on self-reported health and disease prevalence. Our results are also consistent with predictions that people newly eligible for Medicaid would be healthier, on average, than existing Medicaid enrollees, many of whom had previously been eligible because of disability or very low income.[7]

Our findings demonstrate that people with individual private insurance were more likely to have a chronic condition in 2014 than in 2013. One explanation is that previously uninsured people could have been newly diagnosed with conditions after taking up individual coverage in 2014.

An alternative explanation is that before 2014, insurers in most states were not required to offer

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EXHIBIT 4

Health care use by adults ages 26–64, by type of insurance

	No insurance		Medicaid		Individual private	
	2013	2014	2013	2014	2013	2014
PERCENT OF ADULTS WHO:						
Saw a generalist	39.0%	36.6%	74.7%	73.6%	60.4%	73.9%**
Saw a specialist	9.2	6.9	30.8	30.0	30.3	22.8
Saw any health professional[a]	7.0	5.9	25.7	25.7	16.8	16.6
Got care more than 10 times	4.4	4.6	24.9	19.4**	9.6	11.9
Had an ED visit	18.0	14.7*	38.8	33.0	13.4	17.3
Had an overnight hospital stay	5.2	4.4	16.4	15.2	6.3	7.3
AVERAGE NUMBER OF TIMES:						
Saw a health professional, if seen at least once[a]	1.6	1.3**	1.5	1.6	1.4	1.4

SOURCE Authors' analysis of data for the fourth quarter of 2013 and 2014 from the National Health Interview Survey (see Note 1 in text). **NOTES** Insurance is at the time of the survey. Respondents who were surveyed in the first three quarters of either year are excluded. All measures refer to within the past twelve months except where noted. Significance refers to difference from 2013. All results shown as significant are also different from the trend in the period 2008–14 ($p < 0.10$) except for the number of times the uninsured saw a health professional. ED is emergency department. [a]In the past two weeks. *$p < 0.10$ **$p < 0.05$

EXHIBIT 5

Health and chronic conditions among adults ages 26–64, by type of insurance and state Medicaid expansion status

	All (%)		Nonexpansion states (%)		Expansion states (%)	
	2013	2014	2013	2014	2013	2014
FAIR OR POOR HEALTH						
No insurance	14.4	12.8**	15.5	14.3	13.3	11.0**
Medicaid	37.3	33.2**	46.8	42.7*	31.5	28.9*
Individual private	7.4	9.0**	8.7	9.2	6.3	8.7**
ANY FUNCTIONAL LIMITATIONS						
No insurance	9.9	8.6**	10.7	9.2**	9.1	7.8*
Medicaid	44.8	40.0**	54.8	51.0**	38.9	34.5**
Individual private	10.4	10.2	12.0	10.3	9.0	10.1
CURRENT SMOKER						
No insurance[a]	29.9	28.4	33.2	29.7**	26.4	26.9
Medicaid	34.7	34.4	39.5	38.9	32.3	32.7
Individual private	15.4	11.7**	16.9	10.5**	13.9	12.7
OBESE						
No insurance	31.1	30.4	31.9	33.0	30.4	27.3
Medicaid	37.9	39.5	40.0	41.7	37.0	37.5
Individual private	19.7	24.0**	21.9	28.1**	17.8	20.3
ANY CHRONIC CONDITION						
No insurance	39.8	38.5	42.6	40.9	37.8	36.9
Medicaid	61.0	61.1	66.0	68.2	59.5	58.6
Individual private	39.9	46.5**	38.2	48.2**	42.4	46.9
HYPERTENSION						
No insurance	21.6	21.8	23.6	23.2	19.5	20.1
Medicaid	38.9	39.5	42.6	45.3	37.0	36.1
Individual private	22.6	26.5*	22.7	28.5*	22.5	24.8
DIABETES						
No insurance	7.1	6.2	7.4	5.7*	6.8	6.7
Medicaid	15.2	14.4	15.3	15.1	15.0	13.9
Individual private	5.4	8.3**	4.7	8.8**	6.1	7.8

SOURCE Authors' analysis of data for 2013–14 from the National Health Interview Survey (Note 1 in text). **NOTES** Insurance is at the time of the survey. For definitions of the ten chronic conditions analyzed, see Note 5 in text. Significance refers to difference from 2013. All results shown as significant are also different from the trend in the period 2008–14 ($p < 0.10$) except for the percentage of current smokers with individual private insurance, with diabetes who have no insurance, and with fair or poor health in expansion states who have Medicaid. [a]Change in 2014 relative to 2013 was significantly different for non-expansion and expansion states ($p < 0.10$). *$p < 0.10$ **$p < 0.05$

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coverage to all applicants, and they were allowed to exclude coverage of preexisting conditions for those who were offered a policy. The ACA prohibits these practices, and thus it may not be surprising that new enrollees in 2014 appear to have increased the average morbidity of the individual market since 2013.

While enrollees in individual private insurance appeared less healthy, on average, in 2014 than in 2013, we did not observe many significant changes in health care utilization for this group. This may result from the relatively small sample sizes in the NHIS for some of the utilization measures we studied. It is also possible that the relatively high levels of cost sharing in many individual-market plans inhibited changes in utilization.[8]

Many of our key findings were similar across states that expanded Medicaid in 2014 and states that did not, and we could not rule out smaller sample sizes as a cause of these null findings. However, the relative magnitude of some of our findings appeared larger in nonexpansion states. This could stem from the different composition of insurance groups in expansion and nonexpansion states before 2014—in particular, the potentially different characteristics of newly and previously eligible Medicaid enrollees. Additionally, people with individual private insurance reported higher rates of disease prevalence in 2014 compared with the previous year in nonexpansion states, which might reflect different rules in the individual private markets in those states before the ACA reforms, compared to the rules in the individual markets in expansion states.

Conclusion

Overall, our analysis suggests that people newly taking up coverage in 2014 were less healthy than the broader uninsured population in the previous year, before the implementation of the ACA's insurance expansion provisions. But the expansion had different net effects on the average health of Medicaid and individual-market enrollees in 2014. As the landscape of coverage continues to shift, our analysis will be useful for understanding whether and where people with greater-than-average health care needs are obtaining insurance. And because the incremental cost of further gains in coverage will depend on the health status and needs of the people who remain uninsured, our findings may have implications for future spending in Medicaid and the ACA Marketplaces. ■

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NOTES

1. National Center for Health Statistics. National Health Interview Survey: NHIS data, questionnaires, and related documentation [Internet]. Hyattsville (MD); NCHS; [last updated 2016 May 5; cited 2016 May 20]. Available from: http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm
2. To access the Appendix, click on the Appendix link in the box to the right of the article online.
3. Chua KP, Sommers BD. Changes in health and medical spending among young adults under health reform. JAMA. 2014;311(23):2437–9.
4. We assessed whether our findings might be a result of gaining or switching coverage by comparing outcomes for the broader NHIS sample of adults (instead of by coverage status) in 2013 and 2014. Nearly half of the results that were significant within coverage categories were not significant overall, and the results that were significant overall were typically small in magnitude. In addition, Appendix Exhibit A.3 shows significant changes in race/ethnicity and educational status by coverage type between 2013 and 2014 (see Note 2).
5. The ten chronic conditions were as follows: hypertension, heart disease, stroke, diabetes, cancer, arthritis, and hepatitis (meaning that the respondent had ever been told by a health care provider that he or she had the condition); kidney disease (meaning that the respondent had experienced weak or failing kidneys during the past twelve months); asthma; or chronic obstructive pulmonary disease. The Appendix provides more details (see Note 2). The chronic conditions are based on Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. Prev Chronic Dis. 2014;11:E62.
6. In 2014, 5.7 million people became newly insured, which supports the notion that our findings were driven mostly by compositional changes among the uninsured from 2013 to 2014 (see Note 4).
7. Hill SC, Abdus S, Hudson JL, Selden TM. Adults in the income range for the Affordable Care Act's Medicaid expansion are healthier than pre-ACA enrollees. Health Aff (Millwood). 2014;33(4):691–9.
8. Thorpe KE, Allen L, Joski P. Out-of-pocket prescription costs under a typical silver plan are twice as high as they are in the average employer plan. Health Aff (Millwood). 2015;34(10):1695–703.

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ACA SPOTLIGHT

FEATURE ARTICLE ABOUT | CONTACT ARCHIVES

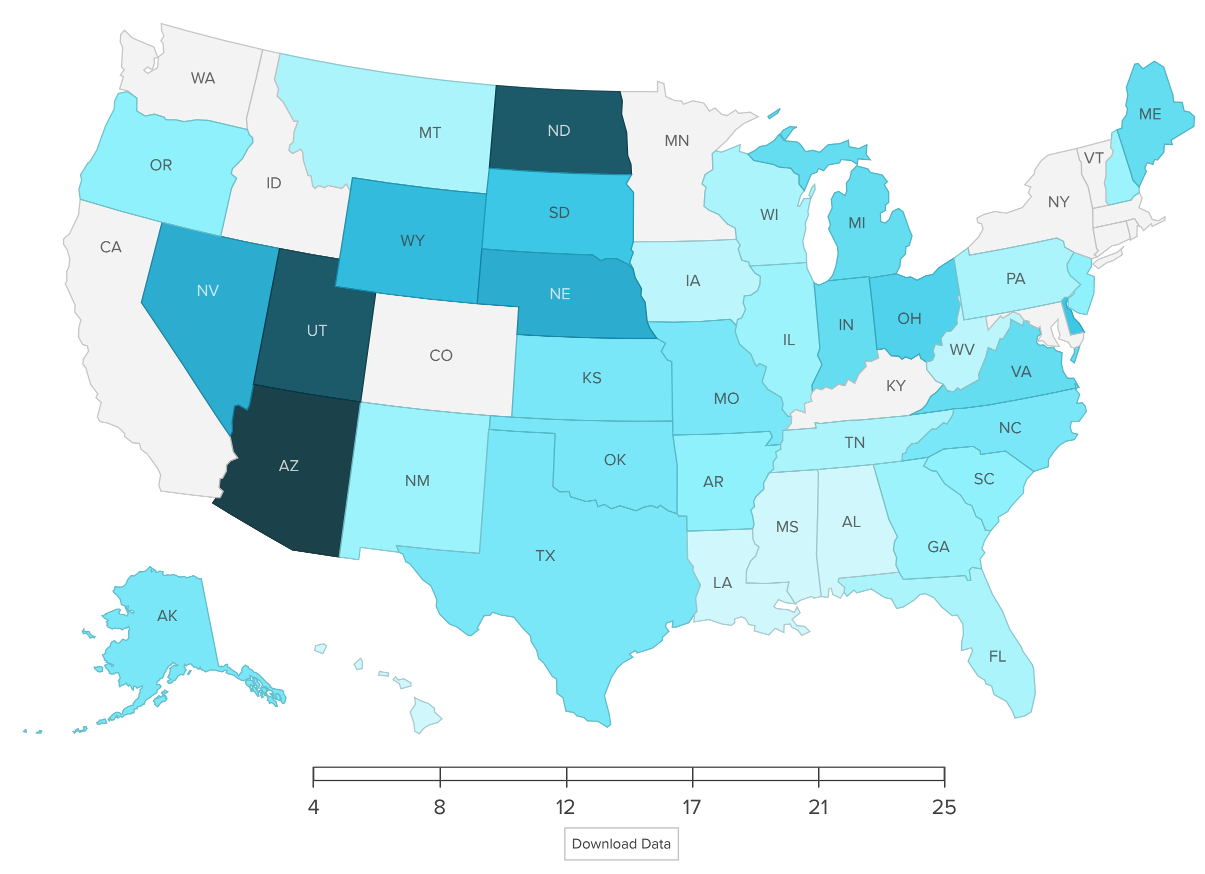
SPOTLIGHT 6, LAST UPDATED- JULY 2016:

Consumers' Enrollment Patterns in the ACA Marketplaces

How did consumers' enrollment choices vary across states by plan category, age, and financial assistance in the latest open enrollment period?

FOR ▶ SILVER SHOW ▶ 0-17 SEE RESULT

Percent of Enrollees in a Silver Plan Who Are Ages 0-17
(Only for Healthcare.gov states)



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Percent of Enrollees in a Silver Plan Who Are Ages 0-17

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Realizing Health Reform's Potential

JULY 2016

Factors Affecting Health Insurance Enrollment Through the State Marketplaces: Observations on the ACA's Third Open Enrollment Period

Justin Giovannelli and Emily Curran

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For more information about this brief, please contact:

Justin Giovannelli, J.D., M.P.P.
Associate Research Professor
Center on Health Insurance Reforms
Georgetown University Health Policy Institute
jmg298@georgetown.edu

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ABSTRACT

Issue: Nearly 12.7 million individuals signed up for coverage in the Affordable Care Act's (ACA) health insurance marketplaces during the third open enrollment period, and by the end of March there were 11.1 million consumers with active coverage. States that operate their own marketplaces posted a year-to-year enrollment gain of 8.8 percent. To maintain membership and attract new consumers, the state-based marketplaces must sponsor enrollment assistance programs and conduct consumer outreach. These marketplaces relied heavily on such efforts during the third enrollment period, despite declining funding. **Goal:** To learn which outreach strategies, assistance programs, and other factors marketplace officials viewed as having exerted the greatest influence on enrollment. **Methods:** Survey of officials representing each of the 17 state-based marketplaces (15 responses). **Key findings and conclusions:** The cost of coverage and low health insurance literacy pose significant barriers to enrollment for many consumers. Marketplaces sought to overcome them by encouraging consumers to obtain in-person enrollment assistance from ACA-created assistance programs and from insurance brokers, and by partnering with community organizations for outreach activities. Many marketplaces also enhanced their web portals to make them easier to navigate and to give consumers better tools with which to evaluate their coverage options.

BACKGROUND

By the close of the third open enrollment period for the Affordable Care Act's (ACA) health insurance marketplaces, approximately 12.7 million individuals had signed up for or been reenrolled in a marketplace health plan.[1] This result fits comfortably within the range projected by the U.S. Department of Health and Human Services (HHS), which estimated enrollment of between 11.0 million and 14.1 million.[2] Nationwide, plan selections in the third open enrollment season surpassed those in the second by 8.5 percent.[3] Year-to-year gains by the states that manage their own

marketplaces (8.8 percent) slightly exceeded those experienced by the states that do not (8.3 percent), though these averages mask significant variation among states (Exhibit 1).

Exhibit 1

State-Based Marketplace Enrollment in the Third Open Enrollment Period

State	Individuals who selected a marketplace plan	Percent of plan selections by new enrollees	Percent of active renewals (as a share of total renewals)*	Percent of consumers receiving financial assistance	Percent change in enrollment from OEP2
California	1,575,340	27.0%	37.3%	87.0%	11.6%
Colorado	150,769	48.0%	75.9%	61.0%	7.4%
Connecticut	116,019	32.0%	19.7%	78.0%	5.6%
District of Columbia	22,693	26.0%	17.9%	6.0%	22.9%
Hawaii	14,564	99.0%**	100.0%	82.0%	15.4%
Idaho	101,073	33.0%	31.1%	83.0%	4.1%
Kentucky	93,666	20.0%	73.1%	67.0%	–11.9%
Maryland	162,177	30.0%	14.0%	70.0%	35.0%
Massachusetts	213,883	22.0%	N/A	78.0%	52.2%
Minnesota	83,507	45.0%	N/A	N/A	39.9%
Nevada	88,145	47.0%	76.5%	88.0%	19.8%
New Mexico	54,865	45.0%	70.6%	70.0%	4.8%
New York	271,964	19.0%	N/A	54.0%	–33.5%***
Oregon	147,109	45.0%	78.4%	72.0%	31.3%
Rhode Island	34,670	22.0%	21.0%	87.0%	10.6%
Vermont	29,440	6.0%	10.0%	69.0%	–6.9%
Washington	200,691	37.0%	37.8%	70.0%	24.9%
State-based marketplaces using state platforms (12 states and DC)	3,055,892	28.1%	37.2%†	78.0%	7.7%
State-based marketplaces using the HealthCare.gov platform (HI, NV, NM, OR)	304,683	48.1%	76.3%	76.7%	21.5%**
All state-based marketplaces (16 states and DC)	3,360,575	29.9%	40.4%†	77.9%‡	8.8%
All federally facilitated marketplaces (34 states)	9,321,299	41.7%	69.7%	85.2%	8.3%
Nationwide	12,681,874	38.6%	62.1%	83.3%	8.5%

Note: Data reflect a reporting period of November 1, 2015, to February 1, 2016, with the exception of data for nine marketplaces–CA, DC, ID, KY, MD, NY, RI, VT, and WA–which reflect a reporting period of November 1, 2015, to January 31, 2016.

* An "active renewal" refers to an individual with existing marketplace coverage during the third open enrollment period who returned to the marketplace to choose a health plan for 2016, whether renewing the same coverage or switching to a new plan. This renewal method contrasts with a "passive renewal": the process by which an enrollee who did not return to the marketplace to select a plan by December 15, 2015, was automatically reenrolled in coverage. This column shows the percentage of total renewals that were active renewals.

** Hawaii moved from a state enrollment and eligibility platform to HealthCare.gov for the third open enrollment period. As part of this transition, nearly all existing enrollees were required to reenroll with the marketplace and are classified for reporting purposes as new enrollees.

*** New York is one of two states (including Minnesota) to launch a Basic Health Program (BHP), a low-cost coverage option created by the ACA for consumers with limited incomes (less than 200 percent of the federal poverty level). New York's BHP enrolled approximately 380,000 individuals, many of whom had marketplace coverage during the second open enrollment period and would have been eligible to remain in a marketplace plan in 2016, absent the new program.

† Excludes Massachusetts, Minnesota, and New York (no data reported).

‡ Excludes Minnesota (no data reported).

Sources: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE); authors' analysis.

The final enrollment tally suggests the marketplaces are on track to meet another HHS target, of 10 million enrollments by the close of 2016.[4] (The projection for the end of the calendar year is lower because it reflects attrition; some people who select a plan during open enrollment never take up coverage, while others move from their marketplace plan to other coverage sources as the year unfolds.[5]) Still, the total is notably less than what some observers had anticipated.[6] Researchers have attributed this divergence to the stability of employer-sponsored health insurance (the availability of employer coverage has not declined since the ACA's enactment, contrary to some expectations); the fact that many people have purchased individual insurance outside of the marketplaces; and ongoing concerns about the cost of coverage, among other factors.[7]

Studies of marketplace policies and enrollment assistance practices during the first and second open enrollment periods have identified a number of additional factors that likely influenced enrollment. For example, researchers at the Urban Institute found that marketplaces with comparatively strong enrollment during the second open season had highly collaborative outreach and enrollment assistance activities that leveraged the contributions of trusted messengers.[8] In marketplaces with lower enrollment, relatively high premiums for those at higher income levels made the problem of coverage affordability more acute. Meanwhile, difficulties with technology platforms and shortages of assistance personnel—the latter in part the result of funding limitations—soured public perceptions and made the enrollment process more burdensome.[9]

We sought to build on these analyses by examining the actions taken by state-based marketplaces to maximize enrollment and consumer assistance during the most recent open enrollment season. To do so, we asked marketplace officials to complete a confidential questionnaire that sought to identify what assistance and outreach strategies they viewed as most effective and what factors they identified as exerting important influence on sign-ups, positively and negatively. Fifteen of 17 marketplaces responded.[10] This brief explores key themes that emerged from those responses.

KEY FINDINGS

Personal Connections Forged by ACA Assisters, Community Partners, and Agents and Brokers Drive Enrollment

The state-based marketplace respondents were unanimous in suggesting that in-person outreach and enrollment assistance were critical to facilitating sign-ups during the third open enrollment period. One respondent conveyed the group's experience succinctly: "consumers like to talk to someone person to person. The easier it is for an individual to make a connection and get help, the higher your enrollment and the better the consumer feels." Marketplaces thus devoted considerable effort to fostering in-person connections—to educate consumers about health insurance and the existence and role of the marketplace, as well as to help those interested in enrolling in coverage navigate the sometimes complex decisions involved in doing so.

To these ends, several marketplaces established physical locations, often retail storefronts located in urban areas, staffed by trained enrollment assisters, marketplace customer support workers, and, sometimes, agents and brokers. Others created partnerships with well-regarded organizations—children's hospitals and clinics in one state, churches and civic groups in others—and with respected individuals whose long-standing relationships within their communities made them trusted voices for outreach and education.

While nearly all respondents noted the efforts of marketplace-certified enrollment assisters in helping to connect consumers—especially hard-to-reach populations—with coverage, most also emphasized the contributions of their state's agent and broker communities. Several marketplaces described broker-led enrollment centers and advertising support, while one touted a pilot program that enabled authorized agents to receive, at a consumer's request, a "warm transfer" from the marketplace's call center so they could assist with enrollment. We did not survey brokers themselves and so cannot shed light on whether they shared this perception of fruitful coordination. Still, the responses suggest that marketplaces are giving increased attention to the services brokers can provide and are doing more to engage them in the enrollment process than what most observers and stakeholders reported in the first two sign-up periods.[11]

> "We established walk-in centers in high-priority locations. We opened new full-service centers in four communities, three of them in community health centers. These were very successful."

Frequently, marketplaces also leveraged their connections with community leaders and stakeholders to publicize and execute outreach and enrollment events. For example, two marketplaces highlighted their work with faith-based leaders, with whom they partnered to hold events at area churches, mosques, and synagogues, while another reported successful enrollment events jointly staffed by agents and assisters. One marketplace viewed enrollment fairs and outreach events as "pivotal" to its enrollment strategy in the wake of budget cuts that forced the closure of its walk-in center. Still another launched a statewide bus tour to promote enrollment at stops along the way and generate wider media coverage.

> "I can't stress enough the importance of agents and brokers. . . . They are a trusted resource throughout the state and they can help educate consumers as well as build a long-term relationship that will help build enrollment stability."

States Grapple with Affordability Concerns

Though personal assistance made signing up for coverage an easier task, most marketplaces reported that consumer decisions about whether to enroll and which plan to choose revolved to a large degree around perceptions of health plan cost. As one respondent stated: "affordability and the availability of premium tax credits continue to drive enrollment on the exchange."

Two states that experienced double-digit increases in premium rates stressed the value of the ACA's tax credits in insulating eligible consumers from the cost spike. Yet, particularly for those unaware of the subsidies or unclear about what they cover, worries about costs loomed large. And respondents acknowledged that consumers who are not eligible for financial assistance were less interested in enrolling through the marketplace.[12]

To grapple with the issue of affordability—what one respondent called "the major challenge"—many marketplaces sought to raise awareness of the availability of financial assistance, craft messages explaining how the subsidies work, and convey "a realistic expectation" of premiums. While

some states viewed such efforts as successful, others found it a "continual" challenge, made more difficult by what one marketplace argued was confusing coverage of premium rates by the media.

> "We find that consumers who enroll state the premium tax credits and price were key factors in their decision. Consumers who do *not* enroll cite the tax credits and affordability as the reason."

One marketplace, acknowledging the salience of concerns about cost, suggested it had helped its consumers by negotiating with prospective marketplace insurers to limit the size of their rate increases.[13] Though only one respondent highlighted this "active purchasing" approach, its mention is notable given that HHS officials have signaled a willingness to pursue a similar strategy for the federal marketplace in future years.[14]

Improvements in Technology Systems Ease Consumer Frustration

By the third open enrollment period, the state-based marketplaces had moved beyond the early technological failures that plagued their enrollment systems at their launch in 2013. No states encountered prolonged technical issues during the sign-up window and several claimed notable strides in improving the functionality and experience of their online portals. While many respondents said that their websites and back-end technology played a positive role in influencing enrollment, several noted areas for continued improvement.

Among the states that reported a significant positive impact from their technology, three described adding consumer decision-support tools, such as a searchable provider directory and an out-of-pocket cost calculator to facilitate plan comparisons, and two said they had simplified the online application to create faster, easier-to-use services. Still another suggested its systems training program, held prior to open enrollment for agents, brokers, and assisters, was critical to avoiding consumer frustration. The same state also highlighted its capacity to identify unfinished applications, enabling it to issue targeted reminders to consumers to complete the process.

At the same time, several states identified a need for improvements to their platforms. A respondent from one marketplace, which uses the federal platform for eligibility and enrollment, reported that navigation of HealthCare.gov remained a challenge. Another official expressed similar concerns about their state-run platform, wishing for upgrades to the front-end of the marketplace website, which might, in turn, help alleviate "intense volume" at its call center.

> "The marketplace listened to its customers, redesigned the site and dropped the application process for the individual market from 28 screens to 11."

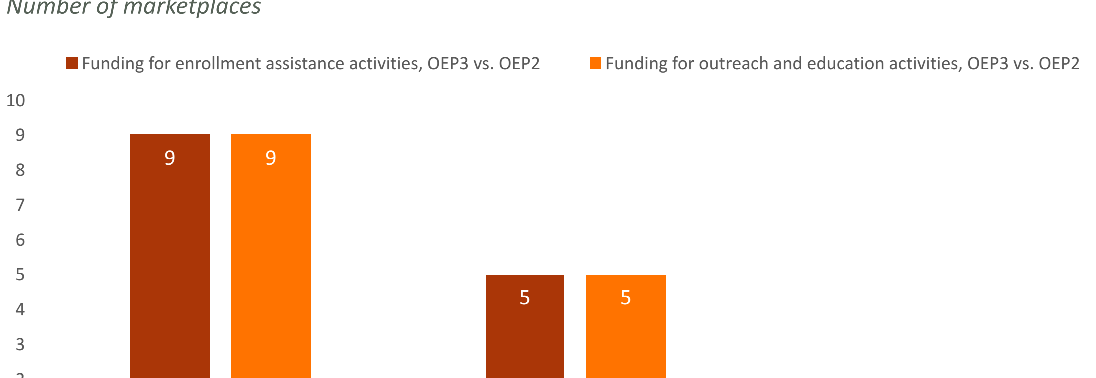
Funding for Outreach and Assistance Has Declined

Development of the state-based marketplaces was financed largely through federal start-up grants authorized by the ACA.[15] These funding opportunities were time-limited, however.[16] As implementation has progressed and federal dollars have diminished, the marketplaces have had to tighten their budgets to compete with other state priorities. Two-thirds of respondents indicated that funding for enrollment assistance and outreach/education activities was lower for the third open enrollment

period than it had been for the second—most of this group said “much lower”—despite it being “harder to find and reach the remaining eligible uninsured” (Exhibit 2).

Exhibit 2

State-Based Marketplace Survey: Funding for Enrollment and Outreach, Open Enrollment Period Year 3 vs. Year 2



Data: Authors’ analysis.

Low Health Insurance Literacy Poses a Barrier

Health insurance is complicated, and people face well-documented difficulties understanding how coverage works both when shopping for a plan and, later, when attempting to use it.[17] While these challenges are one reason why the state marketplace sought to promote one-on-one help with the enrollment process, nearly half of respondents separately stressed the need to improve consumer understanding of the value and mechanics of health insurance or emphasized their ongoing efforts to do so. Several states saw consumer confusion about premiums, cost-sharing terms, and the ACA’s tax credits as inhibiting enrollment and lamented the spread of misinformation on these topics. Another noted the challenge of ensuring that consumers have accurate information about plan quality and provider networks so they could make informed decisions when choosing plans.

DISCUSSION

Marketplace enrollment continues to rise; along with other ACA reforms, these coverage gains have helped to reduce the uninsured rate by more than a third over the past two years.[18] At the same time, the rate of enrollment growth has not matched initial expectations. There is good reason to view marketplace enrollment levels in the context of broader coverage data: for example, when it comes to risk assessment and plan pricing, insurers must lump together all those who enrolled through the marketplaces with everyone who purchased an ACA-compliant plan outside of them.[19] This latter group, while difficult to quantify, may contribute an additional 4 million to the risk pool.[20]

Yet marketplace enrollment is, without doubt, important in its own right. If the first wave of marketplace enrollees has been relatively sicker and more expensive to treat than those with nongroup coverage prior to the ACA—when insurance companies regularly restricted benefits or denied coverage based on health status—there is some reason to expect that subsequent enrollments, including by people moving from plans that are not compliant with the ACA, could include a greater share of healthy individuals.[21] Steady growth of this sort could help blunt future premium increases and promote insurer participation in the marketplaces, ensuring consumers have a range of plans from which to choose.[22]

Accordingly, there is value in understanding the actions of, and obstacles faced by, marketplaces as they sought to facilitate enrollment during the most recent sign-up period. Our survey of the state-based marketplaces reveals several common strategies and experiences. Most common—in fact, universal—was the value respondents attached to in-person outreach and assistance. Though marketplaces described numerous barriers to enrollment, including consumers' lack of awareness about their insurance options and financial assistance and the complexities of choosing suitable coverage, they viewed efforts by assisters and other outreach partners to forge personal connections with consumers as crucial to overcoming those barriers.[23]

Notable too among the responses, if not altogether surprising, was the emphasis given by many marketplaces to technology improvements. These included advances in website functionality and the addition of features to support consumer decision-making. Such efforts, still a work in progress, demonstrate awareness of the need to simplify the enrollment process and provide consumers better tools with which to evaluate their coverage choices and costs. To the extent investment in these areas raises the value proposition of the marketplaces for consumers who are not eligible for subsidies, it also may spur enrollment by a group that so far has largely avoided the marketplaces.

If in-person assistance and technology upgrades were critical, so too was the funding that supported them. Yet most marketplaces reported that budget dollars for outreach and enrollment assistance have declined. Marketplaces have responded to decreased funding by employing strategies that were more targeted, and in some instances more reliant on promotional efforts and social media, than in the past.[24] Having less money for enrollment assistance may partially explain marketplaces' efforts to strengthen partnerships with agents and brokers (though their desire to compensate for perceived shortcomings in broker engagement during prior years likely also drove these initiatives). Should funding continue to diminish, marketplaces may find value in still greater collaboration with these and other stakeholders.

Yet, funding shortages cannot be offset by stronger stakeholder engagement alone. Findings from this survey and others suggest that brokers and assistance personnel tend to serve somewhat different constituencies, with assisters more likely to engage and enroll lower-income and vulnerable populations.[25] Given that many of the remaining uninsured fall into these categories, there is danger that further reductions in funding for outreach and enrollment assistance could materially weaken future enrollment growth.[26]

About This Study

We proffered an eight-question questionnaire to marketplace officials in all 17 state-based marketplaces: California, Colorado, Connecticut, the District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. The questionnaire sought to identify: 1) marketplace practices or strategies related to enrollment assistance that were the most effective in facilitating enrollment during the third open enrollment period; 2) marketplace practices or strategies related to consumer outreach and education that were the most effective in facilitating enrollment; 3) other state- or market-specific factors that the marketplaces believed exerted the largest positive and negative effect on enrollment; and 4) the relative funding level for enrollment assistance and consumer outreach and education in the third open enrollment period compared with the second. The questionnaire was administered electronically and included six open-ended questions and two rating-scale questions, the responses to which have been anonymized for this publication. Fifteen state-based marketplaces responded; two marketplaces, Hawaii and New York, did not.

This brief occasionally quotes from states' questionnaire responses. These excerpts have been lightly edited for clarity and to preserve anonymity.

Notes

1. U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report* (ASPE, March 2016).

2. U.S. Department of Health and Human Services, *10 Million People Expected to Have Marketplace Coverage at End of 2016* (HHS, Oct. 15, 2015).

3. In fact, the true growth in plan selection is at least marginally higher, owing to a change in how HHS reports 2016 data. For 2016, data for the third open enrollment period reflect the total number of plan selections for all marketplaces (except DC and MN), excluding any cancellations or terminations that occurred during the open enrollment period. Last year, these cancellations were reflected only in subsequent reports. This means a larger number of cancellations because of the nonpayment of premiums have already been accounted for. One observer has estimated that the purge amounted to approximately 300,000 cancellations. See C. Gaba, "Final OE3 ASPE Report Released," ACASignups.net, March 11, 2016.

4. U.S. Department of Health and Human Services, *10 Million People Expected to Have Marketplace Coverage at End of 2016* (HHS, Oct. 15, 2015).

5. By March 31, 2016, there were about 11.1 million consumers with active coverage through the marketplaces. Measured against the number of plan selections at the close of open enrollment (12.7 million), the March effectuated enrollment total represents a retention rate of about 87 percent. This figure is in line with the expectations of HHS officials, who continue to project that the marketplaces will have about 10 million active enrollments at the close of 2016. U.S. Department of Health and Human Services, "March 31, 2016 Effectuated Enrollment Snapshot," June 30, 2016.

[6] In March 2015, the Congressional Budget Office estimated that an average of about 21 million people would have marketplace coverage in any given month in 2016. See Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline" (CBO, March 2015). Projections from other researchers, offered around the time of the marketplaces' launch in 2014, also have proved to be high. See, e.g., L. Blumberg, J. Holahan, G. Kenney et al., *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update* (Urban Institute, May 2014).

[7] See generally L. Levitt, G. Claxton, A. Damico et al., *Assessing ACA Marketplace Enrollment* (Henry J. Kaiser Family Foundation, March 2016). A leading reason why uninsured adults who have heard of the marketplaces choose not to visit them is that they do not think their health insurance options will be affordable. S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Americans' Experiences with Marketplace and Medicaid Coverage—Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015* (The Commonwealth Fund, June 2015); see also S. R. Collins, M. Gunja, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Are Marketplace Plans Affordable? Consumer Perspectives from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015* (The Commonwealth Fund, Sept. 2015).

[8] J. Wishner, I. Hill, S. Benatar et al., *Factors that Contributed to High Marketplace Enrollment Rates in Five States in 2015* (Urban Institute, Oct. 2015). See also S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not* (The Commonwealth Fund, Sept. 2015); and J. Tolbert, M. Perry, S. Dryden et al., *Connecting Consumers to Coverage: Lessons Learned from Assisters for Successful Outreach and Enrollment* (Henry J. Kaiser Family Foundation, Sept. 2014).

[9] J. Holahan, L. Blumberg, E. Wengle et al., *Factors that Contributed to Low Marketplace Enrollment Rates in Five States in 2015* (Urban Institute, Oct. 2015).

[10] For more information regarding the questionnaire, see "About This Study."

[11] S. Corlette, L. Blumberg, and E. Wengle, *Insurance Brokers and the ACA: Early Barriers and Options for Expanding Their Role* (Robert Wood Johnson Foundation, Feb. 2015). See also J. Tolbert, M. Perry, S. Dryden et al., *Connecting Consumers to Coverage: Lessons Learned from Assisters for Successful Outreach and Enrollment* (Henry J. Kaiser Family Foundation, Sept. 2014); and S. Goodell, "Health Policy Brief: Navigators and Assisters," *Health Affairs*, Oct. 31, 2013.

[12] Overall, state-based marketplace enrollees were more than three times as likely to be receiving financial assistance as not. See Exhibit 1.

[13] When a marketplace conditions insurer participation on the results of negotiations over rates or other criteria, it is often said to be behaving as an "active purchaser." See S. Corlette and J. Volk, *Active Purchasing for Health Insurance Exchanges: An Analysis of Options* (Georgetown University/ National Academy of Social Insurance, June 2011).

[14] Center for Consumer Information and Insurance Oversight, "2017 Letter to Issuers in the Federally-Facilitated Marketplaces" (CCIIO, Feb. 29. 2016).

[15] From 2010 to 2014, the state-based marketplace states received approximately $4.8 billion in exchange planning, establishment, and early innovator grants. See A. Mach and C. Redhead, *Federal Funding for Health Insurance Exchanges* (Congressional Research Service, Oct. 2014).

[16] The ACA prohibited the award of new exchange grants after January 1, 2015, and required marketplaces to be self-sustaining after that date, though states had limited flexibility to wind down open projects and seek extensions for certain types of funded work. See Pub. L. 111–148, 124 Stat. 782 (2010) §§1311(a)(4), 1311(d)(5) (codified at 42 U.S.C. §§ 18031(a)(4), 18031(d)

(5)). For guidance on marketplace flexibility to seek extensions of funded projects, see Centers for Medicare and Medicaid Services, "FAQ on the Use of 1311 Funds and No Cost Extensions" (CMS, March 14, 2014).

[17] For a helpful overview, which includes a scan of recent literature on the topic, see Z. Parragh and D. Okrent, *Health Literacy and Health Insurance Literacy: Do Consumers Know What They Are Buying?* (Alliance for Health Reform, Jan. 2015).

[18] According to the Gallup-Healthways Well-Being Index, the uninsured rate in the United States declined 6.1 percentage points between the fourth quarter of 2013, immediately before the ACA's largest reforms to the insurance markets took effect, and the first quarter of 2016. See S. Marken, "U.S. Uninsured Rate at 11.0%, Lowest in Eight-Year Trend," *Gallup*, April 7, 2016. Other surveys have measured similar reductions. See, for example, S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction* (The Commonwealth Fund, May 2016); R. Cohen, M. Martinez, and E. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2015* (Centers for Disease Control and Prevention, May 2016); and M. Karpman, S. Long, and S. Zuckerman, *Taking Stock: Health Insurance Coverage under the ACA as of March 2016* (Urban Institute, May 2016).

[19] Pub. L. 111-148, 124 Stat. 782 (2010) § 1312(c) (codified at 42 U.S.C. § 18032(c)).

[20] A Kaiser Family Foundation survey of nongroup market health insurance enrollees, conducted in February and March 2016, found that about 64 percent of enrollees had coverage through the marketplaces, while at least 19 percent were enrolled in ACA-compliant plans purchased outside of the marketplaces. L. Hamel, J. Firth, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 3* (Henry J. Kaiser Family Foundation, May 2016). Extrapolating from these market shares and the reported total number of marketplace plan selections at the end of the third open enrollment period (12.7 million), we can estimate that approximately 3.8 million individuals were enrolled in ACA-compliant plans outside of the marketplaces in the spring of 2016. Projections of this market's size have varied substantially, however. One close observer has estimated that, of all nongroup plans purchased outside the marketplaces, the volume of ACA-compliant plans equals about 6 million. C. Gaba, "Show Your Work: Healthcare Coverage Breakout for the Entire U.S. Population in 1 Chart," ACASignups.net, March 28, 2016. McCue and Hall suggest that this market is in fact smaller—perhaps less than 3 million—though their market estimates are likely low, as they do not account for all sources of off-marketplace enrollment in ACA-compliant coverage. 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). For overall projections of nongroup coverage purchased outside the marketplaces, including ACA-compliant, grandfathered, and "grandmothered" or transitional plans, see also Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (Washington D.C.: CBO, March 2016).

[21] Blue Cross Blue Shield Association, *Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015* (BCBSA, March 2016). See also M. Sanger-Katz, "New Health Insurance Customers Are Sicker. Should We Be Surprised?" *New York Times*, March 31, 2016.

[22] L. Levitt, G. Claxton, A. Damico et al., *Assessing ACA Marketplace Enrollment* (Henry J. Kaiser Family Foundation, March 2016).

[23] The perceived value of personal assistance is substantiated by surveys seeking to understand the experiences of consumers who shopped for coverage through the marketplaces. Findings from the Commonwealth Fund's ACA tracking survey reveal, for example, that marketplace shoppers who

received personal assistance were significantly more likely to obtain coverage than those who did not (78 percent vs. 56 percent, respectively). S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not* (The Commonwealth Fund, Sept. 2015). Other researchers have found that nearly 80 percent of consumers who sought help from an in-person assister program did so because they lacked confidence to apply for coverage on their own. K. Pollitz, J. Tolbert, and A. Semanskee, *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Henry J. Kaiser Family Foundation, June 2016).

[24] Targeted outreach is not intrinsically problematic. In the view of many marketplaces, a focused, tailored approach enabled them to maximize their impact with the uninsured or other special populations.

[25] See, e.g., K. Pollitz, J. Tolbert, and A. Semanskee, *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Henry J. Kaiser Family Foundation, June 2016); K. Pollitz, J. Tolbert, and R. Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Henry J. Kaiser Family Foundation, Aug. 2015).

[26] L. Blumberg, M. Karpman, M. Buettgens et al., *Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us About How to Reach Them?* (Urban Institute, March 2016); and T. Schmidt, "Enrolling Hard-to-Reach Populations in Health Coverage Calls for Creative Outreach," *Families USA Blog*, Jan. 21, 2016.

About the Authors

Justin Giovannelli, J.D., M.P.P., is an associate research professor at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. His research focuses primarily on the implementation of the Affordable Care Act's market reforms and health insurance exchanges the federal and state levels. Mr. Giovannelli received his law degree from the New York University School of Law and his master's degree in public policy from Georgetown's Public Policy Institute.

Emily Curran, M.P.H., is a research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. Her research focuses on private health insurance and the effects of the Affordable Care Act, with emphasis on the implementation of the federal and state health insurance marketplaces. Curran received her M.P.H. in health policy from George Washington University's Milken Institute School of Public Health.

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Report Card

Report Card on State Price Transparency Laws – July 2016

François de Brantes, MS, MBA | Suzanne Delbanco, PhD

Dear Colleagues,

We are happy to announce the fourth installment of the Health Care Incentives Improvement Institute (HCI³) – Catalyst for Payment Reform (CPR) Report Card on State Price Transparency Laws. The health care leaders who have been following our report card since it was first released in 2013 will not be surprised by some of the states earning the highest grades in this 2016 edition. Colorado, Maine, New Hampshire, Vermont, and Virginia again stand atop the rankings, with Colorado and Maine moving from Bs in 2015 to As this year. Joining the leading states for the first time is Oregon, whose new transparency law and consumer-facing transparency website earned the state a B this year after receiving an F last year.

The quality of their transparency websites drove up Colorado's and Maine's grades (and contributed to Oregon's new grade), underscoring that how states *present* price information—in addition to how they *collect* it—is essential for making price information accessible and usable for consumers. As such, this year's report card contains a special feature focusing on the best practices for displaying price information as identified by Dr. Judith Hibbard, of the University of Oregon, an expert in how consumers and patients experience, absorb, and act on information about their health care.

In addition, this year's report card offers low-performing states specific recommendations for how they can improve their grade. As in previous years, our scoring methodology rewards states with all-payer claims databases (APCDs) and that publish those data on a well-designed, state-mandated website. That level of commitment remains the model for truly robust price transparency laws. However, our recommended improvements (reflected in Table C) tackle incremental change as well, encouraging states that already collect data to make it more accessible to consumers. Furthermore, not every F is created equal. For instance Louisiana and Washington have new APCD legislation that calls for publishing price information online, but have not yet launched those websites. If such websites are well designed and online by next year, these states can expect to see their grades rise markedly.

Another new aspect of this 2016 report card is the acknowledgement of not just adopted price transparency laws, but also proposed transparency legislation. We recognized a trend in proposed legislation focusing on directing providers or insurers to disclose prices to patients prior to a procedure or service. While this approach is rooted in common sense, it is not a substitute for state laws that require the collection and publication of a wide range of price information. Moreover, although the private sector has made great strides in enhancing price transparency, access to price information often is dependent on the employer or insurer a consumer has and, of course, some have neither. Therefore, there is still an important role for states to play in ensuring that their citizens have access to the information they need to make informed health care choices.

The 2016 Report Card on State Price Transparency Laws is a product of collaboration among valued partners. Analysts at The Source on Healthcare Price and Competition—a program of the University of California, Hastings College of the Law and the University of California, San Francisco—conducted legislative research and summarized each state's enacted and proposed legislation on health care price transparency. Dr. Hibbard provided her valuable insights on how to make price and quality information accessible and actionable to consumers, one of the several ways the report offers a path forward for states willing to improve transparency.

These combined contributions make this document a roadmap for improved transparency at the state level, in addition to a report card with grades. Now, it's up to states to act. When they do, we will recognize their improvements in subsequent report cards.

Sincerely,

Suzanne Delbanco
François de Brantes

Special thanks to Elizabeth Cronen and Elizabeth Bailey, HCI[3]; Lea Tessitore, Andréa Caballero, and Spencer Sherman, CPR; and Anne Marie Helm and Becky Wildman-Tobriner of The Source on Healthcare Price and Competition for their contributions to researching, writing, and editing this project.

Introduction

The question "how much does it cost?" is integrated so deeply into the act of buying that consumers often don't have to ask – prices are printed on menus, stamped on tags, and posted online, among other places. There are services—like car repairs or home improvement—that aren't easily distilled into standardized, published prices. But rarely do successful professionals get away with answering, "Hard to say; you'll know when you get the bill" in response to consumer inquiries about costs.

Despite the full integration of price information into almost every other retail experience, it's typical in American health care for consumers to go into an appointment or procedure knowing nothing about what it will cost until long afterward. State laws mandating health care price transparency for consumers can help fix the mystery surrounding health care prices, unbolting the door between consumers and the information they need to shop for and buy high-quality, affordable health care.

That's why we launched the Report Card on State Price Transparency Laws in 2013. For purchasers, advocates, legislators and other leaders who believe consumers deserve to know what health care will cost them, it's essential to know how far states have moved toward adopting strong transparency legislation and to understand what a strong transparency resource looks like.

In this year's report card we find that too many states still fall far short of requiring and implementing thorough, useable transparency resources. Dozens of states have laws that refer to price transparency, but provide little to help consumers shop for and choose care, and offer little potential to move the health care delivery system toward quality and affordability.

Beyond offering a letter grade for each state, we outline the shortcomings that are holding back transparency in a given state, including the scope of providers whose cost information is available to consumers, the type of cost included, and the accessibility of the information. Addressing these components can send low-scoring states on a path toward robust transparency.

The Need for Transparency

The simple fact that patients often do not have the tools to comparison-shop for health care is remarkable, but how much does it matter? Dozens of studies published in just the past 12 months have addressed this question conclusively, including a recent study in Health Affairs,[1] another one in the American Journal of Managed Care,[2] and a narrative in the Annals of Internal Medicine.[3] More comprehensively, researchers at Yale University launched an ambitious project, called the Health Care Pricing Project, on the heels of a study showing significant variation in the price of common health care procedures and services both between and within states.[4] Their research showed, for example, that knee replacements were priced more than double at one hospital compared to another *within* the Dallas area.[5] And in the Atlanta area, the most expensive colonoscopy was more than five times the price of the least expensive one.[6]

Without price transparency, a consumer can't predict whether their bill will be on the high or low end of the spectrum, or anywhere in between. The impact of unexpected high cost bills is clear for uninsured patients who bear the entire financial burden. However, these expenses can be significant and burdensome for insured consumers as well; this is especially true with the rise in high-deductible health plans.

The average deductible for an individual "silver" plan—the most commonly purchased[7] type of plan sold in health insurance marketplaces—is $3,065.[8] On average, silver plans cover 70 percent[9] of eligible costs. According to an HCI³ analysis of one state's hospital prices for vaginal deliveries, a woman with a silver plan could pay $600 more out of pocket if she delivered her baby at the highest-priced hospital compared to an average priced one. That number jumps to $1,600 when comparing the highest and lowest priced hospitals. In the figure on the following page, hospitals are arrayed from most affordable to least affordable, with average prices for a routine vaginal delivery ranging from $4,500 to close to $10,000, with no measurable differences in the quality of care received. The impact on a plan member enrolled in a silver plan is depicted by two red shaded areas. The darker red represents

1 Newman D, Parente S, Barrette E, and Kennedy K. DATAWATCH: Prices For Common Medical Services Vary Substantially Among The Commercially Insured. *Health Aff*. 2016;35:5923-927. doi:10.1377/hlthaff.2015.1379

2 Higgins A, Veselovskiy G, Schinkel J. National Estimates of Price Variation by Site of Care. The American Journal of Managed Care. 2016;3:e116-e121.

3 Grande D. Sticker Shock: The Experience of a Health Care Consumer. *Ann Fam Med*. May/June 2016;14:270-272. doi:10.1370/afm.1921

4 Zack Cooper, et. al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. December 2015.

5 Hospital Prices for Knee Replacement Dallas, TX HRR, 2008-2011. A graph by the Health Care Pricing Project. http://www.healthcarepricingproject.org/sites/default/files/papers/within_market_graphs.zip

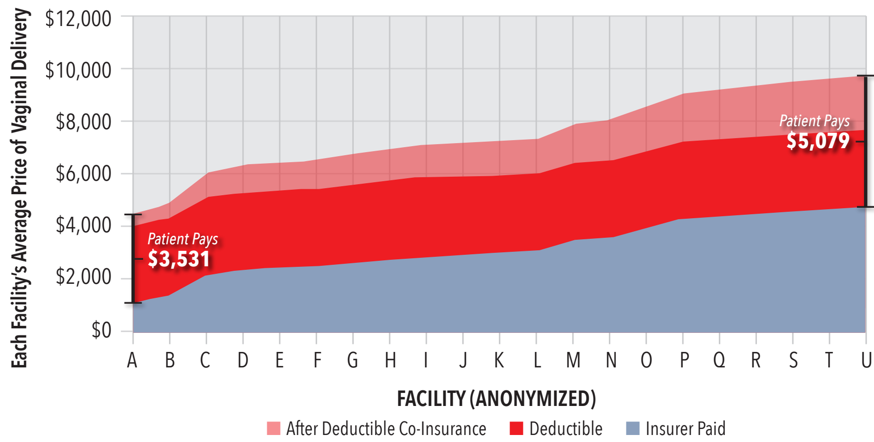
6 Hospital Prices for Colonoscopy Atlanta, GA HRR, 2008-2011. A graph by the Health Care Pricing Project. http://www.healthcarepricingproject.org/sites/default/files/papers/within_market_graphs.zip

7 Total Effectuated Enrollment Data by Metal Level by State. Centers for Medicare and Medicaid Services. December 31, 2015.https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html

8 Patient Cost-Sharing in Marketplace Plans, 2016. Kaiser Family Foundation. November 13, 2015. http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/

9 What the Actuarial Values in the Affordable Care Act Mean. Kaiser Family Foundation. April 2011. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf

the $3,065 deductible and the lighter red represents the co-insurance payment. For the most affordable hospital, the total out-of-pocket expenses would be $3,531. For the average priced hospital, the out-of-pocket expenses jump to $4,393. And for the most expensive hospital, the out-of-pocket expenses grow to close to $5,100. This shows starkly why price transparency matters; because the lack of information on the price of care hurts the pocket books of Americans every day.



Even an insured patient may have to pay $5,079, out-of-pocket, at the highest-priced facility compared to $3,531 out-of-pocket at the lowest-priced facility

Components of High-Quality State Price Transparency Resources

The cost insights from all these analyses underscore how much is at stake as states seek to address price transparency. Real health care price transparency relies on a rich data source and supplies meaningful price information on a wide range of procedures and services, and is presented on an accessible, publicly available web site. Most states *have* approached the subject of price transparency at the legislative level, as only seven states have no statutes addressing it. But in 37 other states, the lack of transparency comes from weaknesses in the design and implementation of their laws, earning them each a D or F in our report card.

Rich data source: To procure health care price data, states can either compel providers and/or health plans to report prices, or mandate an all-payer claims database (APCD). APCDs collect data from multiple sources including private health insurers, Medicaid, children's health insurance and state employee health benefit programs, prescription drug plans, dental insurers, self-insured employer plans, and Medicare (if available to a state). APCDs are widely considered to be superior data sources because they include actual paid amounts—not *charged* amounts—which often are significantly lower due to contracted or negotiated rates from providers. When there is no APCD, typically only charged amounts are available in the data turned over from providers to states or consumers, making the price information significantly less useful for comparisons.

A transparency law may also direct health care providers or insurers to divulge price information to consumers prior to a procedure or other service, which is the very minimum amount of information a consumer would expect in any other transaction. This does not meet high standards for transparency because providers and insurers usually differ in how they calculate and present pricing information, making it very difficult to comparison shop.

Meaningful price information: For a consumer, a paid amount is a more consequential price than a charged amount (called "scope of prices" in our scoring). In addition, it is more meaningful to see the entire price for a health care event than to see only a hospital or facility price, or only a physician price for a specific service (called "scope of provider" in our scoring). A transparency resource that collects and displays only one or the other isn't giving a health care consumer real transparency or full enough data to make an informed decision.

Scope of procedures and services: A robust set of price data will include information on in-patient and out-patient procedures and services, instead of just one category, or only a limited list of procedures and services.

Accessible, mandated website: Having high-quality, comprehensive price information is vital, but it cannot serve health care consumers if that information is not easily obtainable or is not presented in a consumer friendly format. Some transparency laws require only that a state prepare a report using collected price data, or that the data be turned over to consumers only upon request. On the other hand, good legally mandated transparency resources will make the collected data available on a website, and great ones will ensure that the website's content is current and online tools are easy to use. In addition, the website will be mandated in legislation, making it permanent and not subject to the varying priorities or funding of the agency publishing it.

Scoring Methodology

To evaluate state price transparency laws and their implementation, we distilled the best practices described above into scoring guidelines. The detailed scoring rubric appears in the Appendix that begins on page 17. The key features are summarized below.

TABLE A – SUMMARY OF SCORING CRITERIA

	DATA SOURCE	SCOPE OF PROVIDER	SCOPE OF PRICES	SCOPE OF SERVICES	PRESENTATION OF DATA
LOW SCORING	Providers	Only hospitals/ facilities or only clinicians	Charges	Only in-patient, only out-patient, or a limited list of services	Prepared report or by request
HIGHEST SCORING	APCD	Hospitals/facilities and clinicians	Paid amounts	All in-patient and out-patient services	On a public, legislated website, with additional credit for quality of the site

Researchers at The Source on Healthcare Price and Competition, a project of the UCSF/UC Hastings Consortium on Law, Science & Health Policy, conducted a census of health care price transparency laws in all 50 states. For each state that has mandated price transparency, The Source compiled relevant excerpts from the legislation and details on the scope of the laws. HCI[3] analyzed the legislation, scored it on the parameters summarized above and assigned a corresponding letter grade, A through F. The transparency laws that were scored are summarized and excerpted in a table available online at *http://bit.ly/transparency-research*.

The Grades

Consistent with best practices, the highest-scoring state transparency resources incorporate many of the characteristics listed in the "highest scoring" row of Table A. In several of the low-scoring states, meaningful price transparency is not out of reach. That's why our report card lists not just the letter grades, but also practices for states to emulate, and improvements low-performing states can make.

TABLE B – REPORT CARD: HIGHER-PERFORMING STATES

STATE	GRADE	PRACTICES FOR OTHER STATES TO EMULATE	LEGISLATED WEBSITE
CO	A	Collects data in an APCD, including full scope of providers, and paid amounts. Has an excellent website for consumers.	https://www.comedprice.org
ME	A	Collects data in an APCD, including full scope of providers, and paid amounts. Has an excellent website for consumers.	http://www.comparemaine.org
NH	A	Collects data in an APCD, including paid amounts. Has an excellent website for consumers.	http://www.nhhealthcost.org
OR	B	Collects data in an APCD, including paid amounts, and publishes the data on a good website for consumers. Oregon can earn an even higher score if the state collects practitioner prices in addition to facility prices and does so for a greater number of services and procedures.	http://oregonhospitalguide.org
VA	C	Collects data in an APCD, including full scope of providers, and paid amounts. However, a poor website keeps Virginia from earning an even higher score.	http://www.vhi.org
VT	C	Collects data in an APCD, including full scope of providers, and paid amounts. However, a poor website keeps Vermont from earning an even higher score.	http://www.dfr.vermont.gov/insurance/insurance-consumer/2012-pricing-financial-reports

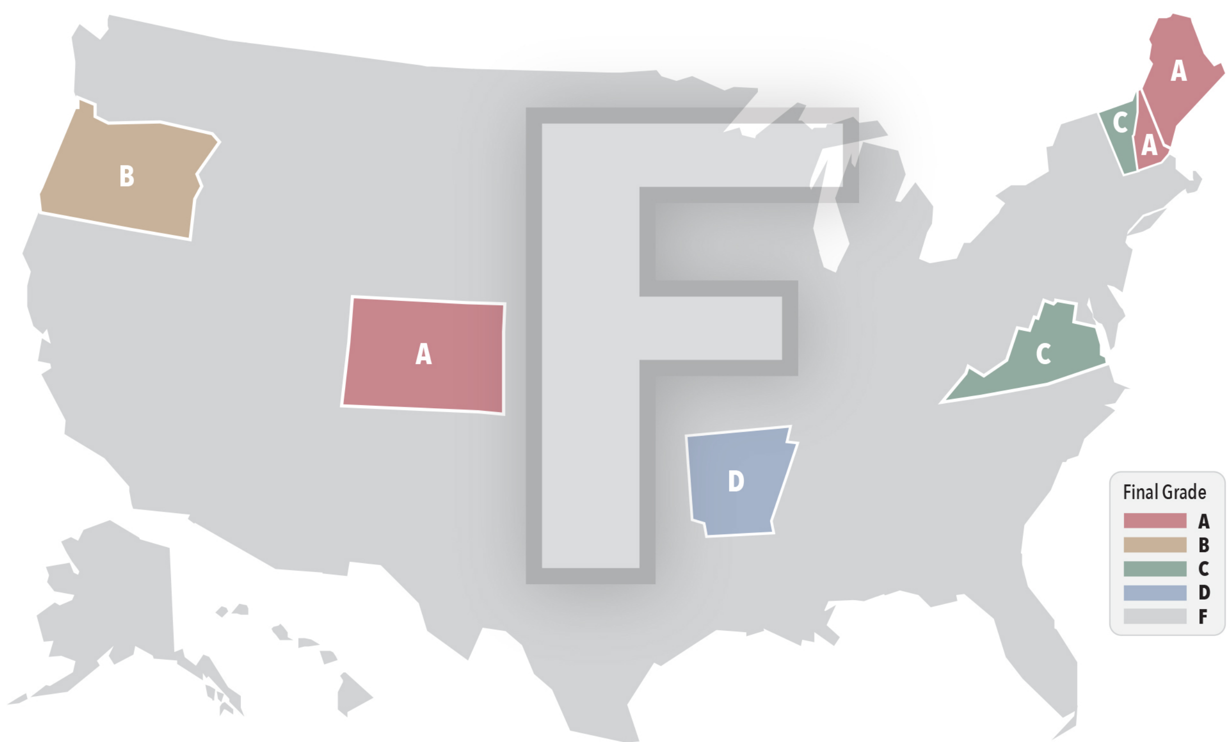


TABLE C – REPORT CARD: LOW-PERFORMING STATES

STATE	GRADE	IMPROVEMENTS NEEDED
AK	F	Commit to price transparency; Alaska has no transparency law.
AL	F	Commit to price transparency; Alabama has no transparency law.
AR	D	Take the data from the state's newly established APCD and post it on a publicly accessible website. Arkansas' law is unclear on how the data must be shared.
AZ	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
CA	F	Legislate submission of price data to a true APCD and post the data on a publicly accessible website. California's current APCD is only voluntary.
CT	F	Take the data from the state's established APCD and post it on a publicly accessible website.
DE	F	Commit to price transparency. At the very least, post to a website the data Delaware is already collecting. Currently, limited information is available, and only in a report.
FL	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
GA	F	Commit to price transparency. At the very least, post to a website the data the state is collecting. Currently, limited information is available, and the law is not clear on how it must be shared.
HI	F	Commit to price transparency; Hawaii has no transparency law.
IA	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
ID	F	Commit to price transparency; Idaho has no transparency law.
IL	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
IN	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
KS	F	Take the data from the state's established APCD and post it on a publicly accessible website. The current law is not clear on how the data must be shared.
KY	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
LA	F	Take the data from the state's newly established APCD and post it on a publicly accessible website. The Louisiana APCD law calls for a website for consumer use "pending the availability of funds," and a consumer website is not now available.

Continued on page 9

TABLE C – REPORT CARD: LOW-PERFORMING STATES, *continued from page 8*

STATE	GRADE	IMPROVEMENTS NEEDED
MA	F	Take the data from the state's established APCD and post it on a publicly accessible website.
MD	F	Take the data from the state's established APCD and post it on a publicly accessible website. That data is now available only in annual reports.
MI	F	Commit to price transparency; Michigan's price transparency law calls only for studying the potential for a price and quality database.
MN	F	Take the data from the state's established APCD and post it on a publicly accessible website.
MO	F	Commit to price transparency. At the very least, post to a website the data Missouri is already collecting. Currently, limited information is available, and only in a report.
MS	F	Commit to price transparency; Mississippi has no transparency law.
MT	F	Commit to price transparency; Montana law calls for considering an APCD, but has not established one.
NC	F	Shift from collecting data only from providers; establish an APCD and post the data on a publicly accessible website.
ND	F	Commit to price transparency. In recent years, North Dakota has eliminated a law requiring the state to produce a report on health care prices.
NE	F	Nebraska recently enacted a law that establishes a committee to evaluate developing an APCD. As a next step, establish the APCD and post the data on a publicly accessible website.
NJ	F	Commit to price transparency. At the very least, post to a website the data New Jersey is already collecting. Currently, limited information is available, and only in a report.
NM	F	Commit to price transparency. At the very least, post to a website the data New Mexico is already collecting. Currently, limited information is available, and only in a report.
NV	F	Shift from collecting and posting data from providers; establish an APCD and post the data on a publicly accessible website.
NY	F	Mandate that data from the state's established APCD be posted on a publicly accessible website. The current APCD law says nothing about how the data must be shared.
OH	F	Shift from collecting and posting data from providers; establish an APCD and post the data on a publicly accessible website.
OK	F	Commit to price transparency; Oklahoma has no transparency law.
PA	F	Commit to price transparency. At the very least, post to a website the data Pennsylvania is already collecting. Currently, limited information is available, and only in a report.
RI	F	Take the data from the state's established APCD and post it on a publicly accessible website. The current APCD law is not clear on how, or how much, data must be shared with consumers.
SC	F	Commit to price transparency. Currently South Carolina collects and publishes revenue and utilization data, not prices for consumers.
SD	F	Shift from collecting and posting data from providers; establish an APCD and post the data on a publicly accessible website.
TN	F	Shift from collecting and posting price data from providers, and make price data from the already-established APCD available on public website. Currently, only quality information from the state's APCD is available to the public online.
TX	F	Commit to price transparency. Currently, Texas law mainly directs facilities and insurance companies individually to provide price information upon request.
UT	F	Take the data from the state's established APCD and post it on a publicly accessible website. It is now available only in a report or by written request.
WA	F	Take the data from the state's newly expanded APCD and post it on a publicly accessible website. Washington has not yet launched a consumer website with price information.
WI	F	Legislate submission of price data to a true APCD and post specific data on a state-mandated, publicly accessible website. Wisconsin's current APCD is only voluntary, and a voluntary website has quality and price information only as general categories, without specifics.
WV	F	Take the data from the state's established APCD and post it on a publicly accessible website. West Virginia's APCD law does not specify how the data will be shared with the public.
WY	F	Commit to price transparency; Wyoming has no transparency law.

Additional Proposals

There also is pending transparency legislation in some states. Informed by our criteria for high-quality transparency laws, we recommend many states take a second look at their proposals.

Most state legislatures addressing transparency in 2016 have prepared bills directing hospitals and clinicians to give consumers price information prior to care, whether by request, or posted on a website. Such mandates are a step toward meeting consumers' needs, but they are not a substitute for a robust state price transparency resource. Under our scoring system for existing transparency resources, a law only requiring providers to disclose prices upon request or on a website would receive an F grade. The best way to allow consumers to compare prices is—as our scoring criteria reflect—with a searchable website, containing paid amounts for all providers for a wide range of services, from an APCD. Price disclosure laws can be a useful add-on to an existing transparency resource.

However, some of the states considering such legislation have either not yet begun collecting price data, or are not sharing publicly the information they do collect. In addition to the disclosure laws they are pursuing, these states should more fully address the transparency needs of consumers:

- Alabama
- Georgia
- Michigan
- Missouri
- Oklahoma
- Pennsylvania
- Texas
- West Virginia

A few other pieces of proposed legislation show progress, but also have room for improvement:

STATE	WAYS TO IMPROVE
HI	Proposed legislation that will greatly expand Hawaii's collection of price data should specify how the information will be shared with the public.
NJ	Proposed legislation would establish an APCD. The law will be strongest if it mandates sharing price and quality information on a publicly accessible website.
OK	Proposed legislation would direct the state to collect and publish prices, but only charges, for only 100 procedures, to be made available only by request. The best transparency resources collect and publish online paid amounts.

Price Transparency Resources Consumers Can Use

Price information has no power to improve the affordability of care if consumers can't access it, understand it, or apply it to their own situations. That's why our grading rewards states that bring data together in one place for consumers, as opposed to having them seek it from many different sources. It's also why we measure the *quality* of a state's transparency website, in addition to crediting states for having such websites at all.

Our scoring standards were informed greatly by the consumer-engagement research of Dr. Judith Hibbard, of the University of Oregon. In the past 15 years alone, she has published more than 100 papers on how consumers and patients experience, absorb, and act on information about their health care. Recent published studies by others have cast some doubt on the effectiveness of price transparency when, in fact, thorough and comprehensive research by Dr. Hibbard and her colleagues throughout the last decade shows the influence of such tools on consumer choices. Moreover, those studies concluding that consumers do not use price information have looked at transparency tools that were either badly constructed or incomplete and missing the key ingredients that make price and quality information useful and actionable for consumers. Below are the best practices for displaying price information as identified by Dr. Hibbard.

SPECIAL FEATURE

Best Practices to Maximize Consumer Use

By Judith Hibbard, University of Oregon

Price transparency is a new and important trend in health care. Transparency efforts can help consumers to become aware of the variation in prices and also enable choices that will lessen the financial burden of obtaining care. Price transparency may also influence the pricing behavior of providers, particularly if they believe that consumers are using the information to make choices. The benefits of transparency are only realized, however, if consumers attend to and use the information in making choices. We know from years of experience and decades of research with health care quality transparency efforts, that the way in which information is displayed and presented can make a difference in whether it is understood and used.

A key consideration in price transparency is the difficulty that many people have with numbers. Data from the National Literacy Survey indicate that about half of Americans lack the minimal mathematical skills needed to use numbers embedded in printed materials.[i] Less numerate individuals find it harder to derive meaning from numbers.

Some data presentation approaches that may help consumers understand and use the information in making choices are discussed below, they include: reducing the burden of information processing; interpreting the meaning of the data for the user; and, highlighting best options. Overall these presentation strategies make it easier for consumers to comprehend and use information. People's attention is pulled in many directions; the key is to provide information that is quickly and easily understood, before you lose their attention. The longer it takes, the more effort that is required, the more likely it is that fewer consumers will end up using the information. To make your transparency efforts pay off, make it as easy and simple as possible for consumers to use the information to inform their choices.

Reducing the Burden of Processing Information

Research shows that processing lots of information and bringing it together into a choice are burdensome cognitive tasks. When faced with this type of burden, consumers often make short cuts in decision-making—they choose on only one factor, ignoring other factors. Often this one factor is something they understand and are familiar with. This "short cut" in decision-making often undermines the individual's own self-interest. If we lessen the burden of using information, fewer people will take these short cuts.[ii,iii] What we know is that "less is more:" providing less information can be more effective. One example of providing fewer data points: simply allowing consumers to narrow their range of options before choosing. Similarly, limiting the parameters of options being compared also helps, as it requires fewer bits of information to be processed. Sometimes this is done by using web-based tools that can narrow options on user-defined preference, such as distance from home, or whether a provider is in a network. Even though we want to give consumers as much information as possible, it is not always an effective approach. Removing comparative information that is less important (nonessential to the decision) also helps make the task easier[iv,iii] When less numerate consumers see a "sea" of numbers it feels overwhelming. Showing one column of numbers, or no more than two columns, will be less intimidating to low numerate consumers.

Another way to reduce the information-processing burden is to remove all technical terms and jargon and replace them with plain language translations. Reducing the need to have to look up unfamiliar words is a further way to reduce the burden of using the information. It also increases the chances that the information will be understood and used. We like to believe that users will "click here" to find out what a word means, but the reality is that they will more likely just ignore information they do not understand. Translating technical terms and insider jargon into plain language means that your efforts will be more effective.

Interpret the Data

One of the most helpful strategies for supporting consumer choice is to interpret the data for the user. One of the most effective interpretation approaches is to add an "affective label."[v] An affective label indicates what is good or bad—interpreting the information for the user. In the case of price transparency, this might be indicating what is a good price and what is not. In health care this is not a straightforward proposition. Research shows that some consumers may use price as a proxy for quality. That is, a significant minority of consumers will assume that higher priced providers or services are also the higher quality options. This consumer belief could undermine one of the goals of price transparency. What is the solution?

The best solution is to always pair price information with quality information. Consumers need to see that they don't have to pay top dollar to get good quality. The way the data is presented can highlight this important point for consumers. For example, by presenting price information within quality tiers or presenting quality information within cost tiers, either way will show consumers that there is variation in both cost and quality and that higher quality and price are not necessarily linked. Simply showing price and quality side by side is also a good solution.

If you have no quality information to show along with price, you run the risk that many consumers will use price as a proxy for quality. When this happens, not only will it push some consumers to choose the high cost options, *but it will also reduce consumers' willingness to choose the lowest cost options.* Research shows that absent quality information, consumers are reluctant to go to the lowest cost options.[vi] This may reflect a belief that lower cost providers are "cutting corners" and providing a lower quality service.

Best Practices to Maximize Consumer Use

Highlight Best Options

If quality information is paired with price information it is possible to 'call out' best value options for consumers (see example below). This is a strong 'nudge' that will influence choices by allowing consumers to quickly and easily identify best options.[vi] It is best operationalized by actually showing the price and quality information along with the high value designation, so that consumers can see the reason for the designation.

INTERPRET THE DATA: CALL OUT VALUE KNEE REPLACEMENT

HOSPITAL	IMPROVED FUNCTIONING	PREVENTION OF COMPLICATIONS	AVERAGE COSTS	HIGH VALUE (high quality and low cost)
EVERGREEN HOSPITAL	Average	Below	$32,685	
LAKEVIEW HOSPITAL	Better	Better	$23,815	✔
WOODLAND HOSPITAL	Below	Below	$44,686	
SIERRA VISTA HOSPITAL	Better	Better	$25,652	✔
PARKDALE HOSPITAL	Average	Average	$38,789	

All consumers are helped by these strategies, but those who have less skill are helped the most. Improving consumer choice is a key goal of price transparency. Taking steps to make a report more understandable and useable to a wide consumer audience will mean your transparency efforts will pay off with a greater overall impact. ■

i Kirsch I, Jungeblut A, Jenkins L, Kolstad A. Adult literacy in America: A first look at tbe findings of the National Adult Literacy Survey. 2002.

ii Hibbard JH, Peters EM. Supporting informed consumer health care decisions: data presentation approaches that facilitate the use of information in choice. *Annu Rev Public Health.* 2003;24:413-433.

iii Peters E, Dieckmann N, Dixon A, Hibbard JH, Mertz CK. Less is more in presenting quality information to consumers. *Med Care Res Rev.* 2007;64:169-190.

iv Damman OC, De Jong A, Hibbard JH, Timmermans DRM. Making comparative performance information more comprehensible: an experimental evaluation of the impact of formats on consumer understanding. *BMJ Qual Saf.* November 2015. doi:10.1136/bmjqs-2015-004120.

v Peters E, Dieckmann NF, Västfjäll D, Mertz CK, Slovic P, Hibbard JH. Bringing meaning to numbers: the impact of evaluative categories on decisions. *J Exp Psychol Appl.* 2009;15(3):213-227. doi:10.1037/a0016978.

vi Hibbard JH, Greene J, Sofaer S, Firminger K, Hirsh J. An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care. *Health Aff.* 2012;31:560-568. doi:10.1377/hlthaff.2011.1168.

Going Further with Transparency: Leveraging an APCD to Expose Price and Quality of Care for Hysterectomy Procedures

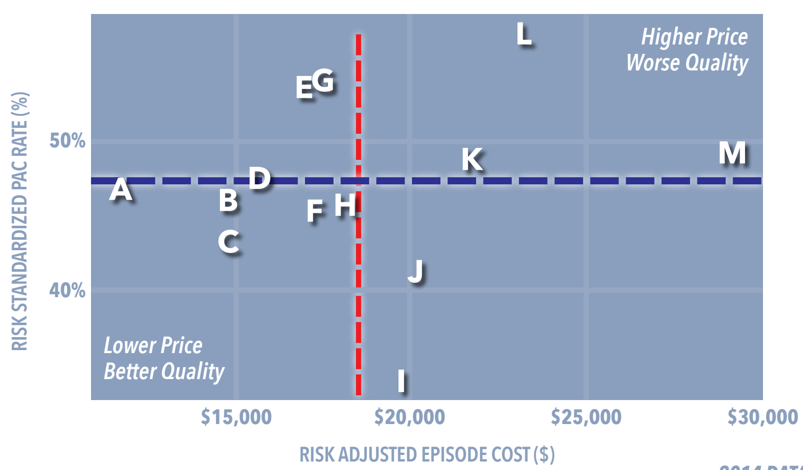
It's clear from the report card grades and descriptions that APCDs are crucial to state success with price transparency. A state that publishes straightforward price and quality information from its APCD is meeting its responsibilities under our grading criteria. However, a state that opens its data for exploration creates opportunities for even richer insights.

One such state is New Hampshire. Unlike most states with APCDs, which provide their databases to researchers for analyses, New Hampshire also authorizes the publication of the results of those analyses as long as they are shared with the state prior to publication.

HCI³ analyzed New Hampshire's 2014 data on hysterectomies to demonstrate the kinds of findings that are possible with access to an APCD. Advanced analytic techniques were used to:

- Identify services and procedures listed in the database that may have been tied to potentially avoidable complications, a possible signal of low quality
- Account for the severity of a patient's condition when considering these potentially avoidable complications
- Account for the severity of a patient's condition when measuring the costs of treatment

In the resulting chart, each facility is plotted on two axes, one that shows the average, severity-adjusted price for a hysterectomy, and the other shows the severity-adjusted rate of complications.



A CHESHIRE MEDICAL CENTER
B ELLIOT HOSPITAL
C EXETER HOSPITAL INC
D CATHOLIC MEDICAL CENTER
E PORTSMOUTH REGIONAL HOSPITAL
F WENTWORTH-DOUGLASS HOSPITAL
H SOUTHERN NH MEDICAL CENTER
I ST. JOSEPH HOSPITAL OF NASHUA
J CONCORD HOSPITAL
K LITTLETON REGIONAL HOSPITAL
L DARTMOUTH-HITCHCOCK MEDICAL CENTER
M LAKES REGION GENERAL HOSPITAL

If the state of New Hampshire were to package these data following Dr. Hibbard's recommendations, there's little doubt that most consumers would avoid facilities L and M, which would likely have the result of driving down excessive prices. In addition, further scrutiny on the observed rates of complications for this and other episodes of care by state medical specialty groups and regulators may drive better quality, which is especially needed in hysterectomy surgery.[vii]

The sophisticated analysis performed by HCI³ helps ensure that these comparisons among facilities are fair. Risk standardizing[viii] the potentially avoidable complication rates and severity adjusting the prices mean that receiving sicker, more-expensive-to-treat patients won't obscure the quality and affordability achievements of the facilities where they are treated.

Not every state will have the resources necessary to risk standardize and severity adjust data; they may be able only to publish the data. That's why opening the data to outside analysts, as New Hampshire does, is a potentially powerful step in furthering the impact of price and quality transparency.

vii de Brantes F, Rastogi A, Wilson A. When is the Most Popular Procedure the One with the Worst Outcomes? Health Care Incentives Improvement Institute. 2016. http://www.hci3.org/wp-content/uploads/2016/07/hysterectomy-issue-brief.pdf

viii de Brantes F, Wilson A, Rastogi A. Piercing The Darkness: A Generalizable Approach To Reliably Measuring Quality Of Care. Health Care Incentives Improvement Institute. 2015. http://www.hci3.org/wp-content/uploads/2015/11/Transparency_Scrcrd_WhitePaper_HCI15026-11.13.15-R1.pdf

Conclusion

Our 2016 Report Card on State Price Transparency Laws shows that price transparency—an obvious expectation integrated into every other consumer experience—is on the minds of state legislators and other health care leaders throughout the U.S. It also highlights why this information is so critical to every health care consumer in every state; prices for routine and very common procedures can vary by more than 50 percent, even in the same geographical area, placing a potentially significant financial burden on individual consumers, a burden that can be avoided with robust health care price transparency.

Thus, design and implementation of the legislation matter. In fact, the potential for transparency to empower consumers, shift costs down, and raise quality rests entirely on the strength and comprehensiveness of each state law's implementation. This is a perspective that is often lost in some of the research on the effectiveness of price transparency, even though no one should be surprised that weak resources yield poor results. Importantly, a very strong and thorough body of research demonstrates that consumers *will* seek lower-priced, high-quality providers when given the right information in the right format.

Many states may see low grades for themselves. However, in this report card, they also have a roadmap for improvement. It's up to states to apply that roadmap to benefit from the desired and proven positive effects of price and quality transparency. ■

Appendix

Each state's price transparency legislation was analyzed according to the Legislation Scoring Rubric, at right, with 100 total points possible for excellent legislation.

Legislated websites were scored out of 50 points. Out of the total 150 points (legislation and website combined), each state's number of points was converted to a percent.

90-100% = A
80-89% = B
70-79% = C
60-69% = D
59% and below = F

Data Source	LEGISLATION SCORING RUBRIC				Level Subtotal	Data Source Subtotal	Total
DATA SOURCE PROVIDER	**Ability for patient to request pricing information prior to rendering of services**			**1**	10	50	100
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	4			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	3			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
		All hospitals or providers	2				
		Subset of hospitals/providers	1				
	Provision for publishing a public report on pricing information			**1**	10		
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	4			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	3			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
		All hospitals or providers	2				
		Subset of hospitals/providers	1				
	Provision for posting pricing information on a public website			**3**	30		
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	12			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	9			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	9			
		All hospitals or providers	2				
		Subset of hospitals/providers	1				
DATA SOURCE APCD	**Ability for patient to request pricing information prior to rendering of services**			**1**	10	50	
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	4			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	3			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
		All hospitals or providers	2				
		Subset of hospitals/providers	1				

Continued on page 18

LEGISLATION SCORING RUBRIC, *continued from page 17*

Data Source	Provision / Scope	Level	Points	Score	LEVEL SUBTOTAL	DATA SOURCE SUBTOTAL	TOTAL
DATA SOURCE APCD	**Provision for publishing a public report on pricing information**			**1**	10	50	100
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	4			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	3			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
		All hospitals or providers	2				
		Susbet of hospitals/providers	1				
	Provision for posting pricing information on a public website			**3**	30		
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	12			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	9			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	9			
		All hospitals or providers	2				
		Susbet of hospitals/providers	1				

LEGISLATED WEBSITE SCORING RUBRIC

Ease of Use	User interface, intuitive design	12.5	50
Utility	Faciliation of provider selection	12.5	
Timeliness/Accuracy	Reliability and currency of data	12.5	

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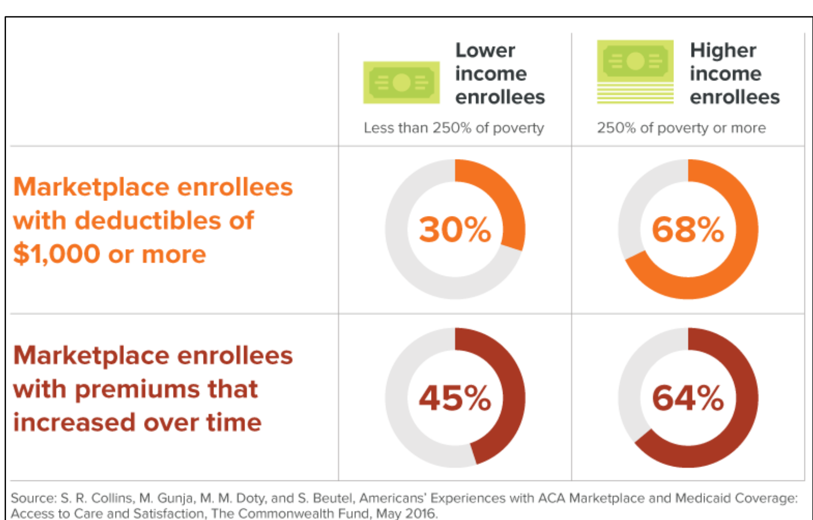
For further information, contact:
Mary Mahon: (212) 606-3853, mm@cmwf.org
Bethanne Fox: (301) 448-7411, bf@cmwf.org
Twitter: @commonwealthfnd

NEW ACA MARKETPLACE FINDINGS: SUBSIDIES FOR LOWER-INCOME ENROLLEES MAKE INSURANCE PREMIUM AND DEDUCTIBLE COSTS COMPARABLE TO EMPLOYER COVERAGE

Large Majority of Marketplace Enrollees Satisfied with Doctors Covered by Their Insurance

New York, NY, July 7, 2016—The Affordable Care Act's subsidies have made health insurance premium costs in the marketplaces more affordable for lower-income enrollees and nearly comparable to costs in employer-sponsored health plans, according to a new report from The Commonwealth Fund. Sixty-six percent of marketplace enrollees with annual incomes under $30,000 reported paying either nothing or less than $125 a month for individual coverage, compared to 60 percent of people in employer plans.

However, for enrollees with higher incomes, the phaseout of the marketplace tax credits means health care costs are greater compared to those in employer plans. Fifty-eight percent of marketplace enrollees with incomes above $30,000 paid more than $125 in monthly premiums compared to 34 percent of people with employer coverage, most of whom receive premium contributions from their companies regardless of income level.



Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction, a new brief based on The Commonwealth Fund Affordable Care Act (ACA) Tracking Survey, February – April 2016, finds differences in the cost and cost protection that marketplace plans provide, depending on enrollees' incomes. Under the health care law, marketplace enrollees living under 250

percent of the federal poverty level (just under $30,000 for a single person) are eligible for the most generous subsidies. But enrollees earning above that level, up to $47,000 annually, qualify for smaller tax credits and may face higher cost-sharing. Those with higher incomes pay the full premium for their coverage.

Because of the phaseout of subsidies as incomes climb, marketplace enrollees with lower incomes are less likely to have per-person deductibles of $1,000 or more compared to higher-income enrollees (30% vs. 68%). And while less than half (45%) of lower-income adults with marketplace coverage reported their premiums had grown over time, about two-thirds (64%) of higher-income adults reported paying increasing premiums.

"Affording health care remains a top concern for consumers," said Sara R. Collins, Vice President for Health Care Coverage and Access at The Commonwealth Fund and one of the study's coauthors. "The survey findings suggest that the law's premium subsidies have been effective for people with lower and moderate incomes, who have been most at risk of being uninsured. We know from prior surveys that people are also getting the health care they need and using their insurance to get care they wouldn't have been able to get before."

Other key findings from the report:

- **Cost continues to be the primary factor in plan selection among marketplace enrollees.** Premiums and cost-sharing figured most prominently in people's decisions regarding choice of marketplace plan. Six of 10 (62%) adults who either had enrolled in private plans through the marketplace for the first time or had switched health plans said that the amount of the premium (36%) or the amount of the deductible and copays (26%) was the most important factor in their decision. Additionally, more than one-quarter (28%) said the inclusion of their preferred doctors and hospitals in their plan's network was the most important factor in choosing a plan.

- **Half of people in marketplace plans view their premiums as affordable.** Nearly half (49%) of marketplace enrollees said their premiums were very easy or somewhat easy to afford, compared with 75 percent of people with employer plans. This difference is partially due to income differences between those with employer and marketplace coverage. While about half (51%) of individuals with employer coverage had incomes above $47,000 ($97,000 for a family of four), only 19 percent of those in marketplace plans did. This means that higher-income consumers in marketplace plans are spending more on premiums, as a share of their income, than people with employer health benefits.

- **Four of 10 adults chose a "narrow network" plan when given the option.** Consumers were not averse to selecting a plan with a narrow provider network if it offered a lower price. More than half (54%) of people who switched plans or bought marketplace coverage for the first time had the option to pay less for a plan with fewer participating doctors or hospitals. Of those, 41 percent selected the limited network plan.

- **Most marketplace enrollees are satisfied with the doctors covered by their insurance.** Of people who had new marketplace coverage or switched plans, more than three-quarters (78%) reported they are very or somewhat satisfied with the doctors included in their plan's network. Nearly two-thirds (64%) said their plans included some or all of the doctors they wanted.

Moving Forward

The authors note that for next year's marketplace open enrollment period, it is likely that marketplace premium increases on average will be higher in 2017 than in 2016. The majority of enrollees have subsidies that will help shield them from paying the full premium increase. And consumers are also likely to shop for better deals, as they did in 2016. Still, efforts are needed to ensure that marketplace plans and health care are affordable over time.

"The Affordable Care Act was designed to ensure all Americans have access to affordable and comprehensive health insurance so they can get the health care they need," said Commonwealth Fund President David Blumenthal, M.D. "This survey shows that we will need to continue to monitor the affordability of marketplaces, especially as health care costs continue to rise and incomes remain flat."

When the embargo lifts, the study will be available at http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/Affordability-and-Network-Satisfaction.

Methodology

The Commonwealth Fund Affordable Care Act Tracking Survey, February-April 2016, was conducted by SSRS from February 2-April 5, 2016. The survey consisted of 15-minute telephone interviews in English or Spanish and was 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 cellular phones.

This survey is the fourth in a series of Commonwealth Fund surveys to track the implementation and impact of the Affordable Care Act. Like the prior waves of the survey, the February-April 2016 sample 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: (1) stratified RDD sample; and (2) households reached through the SSRS Omnibus 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.

The data are weighted to correct for the stratified sample design, the use of recontacted respondents from the omnibus survey, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The resulting weighted sample is representative of the approximately 189 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 2.0 percentage points at the 95 percent confidence level.

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By Sean P. Keehan, John A. Poisal, Gigi A. Cuckler, Andrea M. Sisko, Sheila D. Smith, Andrew J. Madison, Devin A. Stone, Christian J. Wolfe, and Joseph M. Lizonitz

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National Health Expenditure Projections, 2015–25: Economy, Prices, And Aging Expected To Shape Spending And Enrollment

ABSTRACT Health spending growth in the United States for 2015–25 is projected to average 5.8 percent—1.3 percentage points faster than growth in the gross domestic product—and to represent 20.1 percent of the total economy by 2025. As the initial impacts associated with the Affordable Care Act's coverage expansions fade, growth in health spending is expected to be influenced by changes in economic growth, faster growth in medical prices, and population aging. Projected national health spending growth, though faster than observed in the recent history, is slower than in the two decades before the recent Great Recession, in part because of trends such as increasing cost sharing in private health insurance plans and various Medicare payment update provisions. In addition, the share of total health expenditures paid for by federal, state, and local governments is projected to increase to 47 percent by 2025.

Sean P. Keehan (sean .keehan@cms.hhs.gov) is an economist in the Office of the Actuary, Centers for Medicare and Medicaid Services (CMS), in Baltimore, Maryland.

John A. Poisal is deputy director of the National Health Statistics Group, CMS Office of the Actuary.

Gigi A. Cuckler is an economist in the CMS Office of the Actuary.

Andrea M. Sisko is an economist in the CMS Office of the Actuary.

Sheila D. Smith is an economist in the CMS Office of the Actuary.

Andrew J. Madison is an actuary in the CMS Office of the Actuary.

Devin A. Stone is an economist in the CMS Office of the Actuary.

Christian J. Wolfe is an actuary in the CMS Office of the Actuary.

Joseph M. Lizonitz is an actuary in the CMS Office of the Actuary.

Following the initial effects of the Affordable Care Act (ACA) on health care spending and insurance coverage, increases in economic growth, faster growth in medical prices, and population aging are expected to be the primary drivers of national health spending and coverage trends over the next decade. Growth in nominal (not inflation adjusted) national health expenditures is projected to average 5.8 percent for the period 2015–25, outpacing growth in the gross domestic product (GDP) by 1.3 percentage points. As a result, the health share of the economy is expected to climb from 17.5 percent in 2014 to 20.1 percent in 2025.

Millions of Americans gained health insurance coverage in 2014 as a result of the ACA, which expanded Medicaid eligibility and made subsidized Marketplace plans available. Health spending growth reflected this change, increasing from 2.9 percent in 2013 to 5.3 percent in 2014. These coverage expansions are anticipated to continue influencing health spending growth during the first two years of the 2015–25 projection period. For 2015, continued enrollment growth in Medicaid and the Marketplaces, as well as projected enrollment increases in employer-sponsored plans, is expected to have resulted in a slight acceleration in spending growth (5.5 percent) and a further substantial reduction in the number of uninsured people (7.2 million). By 2016 the transition of consumers into Medicaid and Marketplace plans and the associated declines in the number of uninsured people are expected to slow significantly, contributing to a lower rate of growth in health spending (4.8 percent).

The expectation for 2017–19 is for health spending growth to accelerate somewhat (averaging 5.7 percent), in part as a result of the effect of faster growth in health care prices. In addition, growth in Medicare spending is also projected to accelerate (averaging 6.7 percent), because members of the baby-boom generation will continue to age into that federal program and because existing beneficiaries are expected to use services more often than in the recent past. Over the same three-year time frame, Medicaid

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spending growth is expected to average 5.6 percent, as aged and disabled beneficiaries, who tend to require relatively more expensive care than those who are younger and nondisabled, represent an increasingly higher share of total beneficiaries.[1] Lastly, private health insurance spending growth is expected to average 5.6 percent—its fastest rate for any subperiod examined in the projection period. That growth rate is largely related to rising disposable personal incomes, as well as the continued use of high-cost specialty drugs and faster growth in drug prices.

During the latter half of the projection period (2020–25), average annual national health spending growth is expected to be at its highest rate for the period (6.0 percent) but to remain below the average annual growth observed over the twenty-year period preceding the 2007–09 recession (nearly 8 percent). Influenced largely by the aging of the population, spending growth is expected to be the highest for Medicare among the major payers of health care, as one in five Americans are expected to be covered by the program by 2025. In addition to Medicare's enrollment gains, its projected per enrollee spending is expected to reach nearly $18,000 in 2025, as the use of Medicare-covered goods and services increases to rates almost as high as its long-term average—which will result in more physician visits and hospital admissions.[2] Projected growth in per enrollee private health insurance spending to nearly $8,600 in 2025 reflects expected additional use of health care goods and services as consumer incomes grow, with improved economic conditions expected throughout most of the projection period.

Model And Assumptions

The national health expenditure projections are developed using actuarial and econometric modeling methods, as well as judgments about future events and trends that influence health spending.[3] The projections are based on current law for Medicare and use the economic and demographic assumptions from the 2016 *Medicare Trustees Report*, updated to reflect the latest macroeconomic data.[2] They are also consistent with assumptions from the 2015 *Medicaid Actuarial Report*.[1]

These projections are inherently subject to substantial uncertainty related to variable macroeconomic conditions. Additionally, although the initial impacts of the ACA have already occurred, longer-term indirect effects of the legislation on the market for health care remain uncertain, including the behavioral response to reform on the part of consumers, insurers, employers, and providers throughout the projection period.

The projection approach of the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary is based on analysis of more than fifty years of National Health Expenditure Accounts data that show a lagged, long-term relationship to economic (income) growth. Recent health spending trends through 2013, or the year before the occurrence of the major coverage expansions, while low by historical standards, were consistent with expectations inferred from economic trends. Thus, health spending growth is likely to accelerate in response to improvements in economic conditions that are projected over the coming decade.[4]

Chronological Outlook Of Yearly Trends

2015 Driven in part by increased health care utilization among the newly insured, national health spending is projected to have grown 5.5 percent in 2015, compared to 5.3 percent in 2014, and to have reached $3.2 trillion (Exhibit 1). Both the hospital sector and the physician and clinical services sector are projected to have experienced accelerations related to the projected decrease of 7.2 million people in the uninsured population (to 28.4 million), as consumers acquired coverage through either Medicaid or private health insurance plans (which include the federal and state-based Marketplaces) (Exhibit 2). For hospitals, spending growth is projected at 4.9 percent in 2015, up from 4.1 percent in 2014 (Exhibit 1), reflecting an expected second year of faster growth in the use of services following the coverage expansions.[5] The use of physician and clinical services also accelerated, with fewer people reporting that they had skipped needed medical care because of cost concerns.[6] Physician and clinical services spending growth is projected to have accelerated 0.8 percentage point, to 5.4 percent.

On the heels of slow growth in 2014 related to the health insurance expansions, growth in out-of-pocket spending is projected to have accelerated 1.3 percentage points in 2015, to 2.6 percent (Exhibit 3)—which is still well below 4.3 percent, the annual average for the previous twenty years. This represents the first year of an expected four-year trend of gradually increasing growth in this category after the initial impacts of coverage gains under the ACA fades, and as the number of people covered by high-deductible health plans—with their associated higher cost-sharing requirements—continues to grow.[7]

Medical price inflation continued to slow in 2015, growing at a historically low rate of 0.8 per-

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EXHIBIT 1

National health expenditures (NHE), amounts and annual growth from previous year shown, by spending category, selected calendar years 2007–25

Spending category	2007[a]	2013	2014	2015[b]	2016[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$2,296.2	$2,879.9	$3,031.3	$3,197.2	$3,350.7	$3,958.6	$5,631.0
Health consumption expenditures	2,157.8	2,727.4	2,877.4	3,037.8	3,185.5	3,766.0	5,361.6
Personal health care	1,919.3	2,441.3	2,563.6	2,700.3	2,830.4	3,341.1	4,743.8
Hospital care	692.0	933.9	971.8	1,019.2	1,067.3	1,259.0	1,800.5
Professional services	614.8	767.5	801.6	844.0	881.8	1,033.6	1,446.6
Physician and clinical services	458.7	576.8	603.7	636.3	664.9	779.9	1,092.8
Other professional services	59.0	80.3	84.4	89.1	93.3	110.0	154.9
Dental services	97.0	110.4	113.5	118.6	123.6	143.7	198.9
Other health, residential, and personal care	108.3	144.5	150.4	158.1	166.0	193.2	264.5
Long-term care services	183.8	229.6	238.8	249.8	261.7	307.4	435.9
Home health care	57.5	79.4	83.2	88.2	92.2	109.2	159.5
Nursing care facilities and continuing care retirement communities	126.3	150.2	155.6	161.6	169.5	198.2	276.4
Retail outlet sales of medical products	320.5	365.8	401.0	429.2	453.6	547.8	796.2
Prescription drugs	235.6	265.3	297.7	321.9	342.1	418.6	614.5
Durable medical equipment	37.1	44.9	46.4	48.4	50.4	58.9	85.5
Other nondurable medical products	47.8	55.6	56.9	59.0	61.1	70.3	96.3
Government administration	29.1	36.3	40.2	44.4	47.3	57.7	87.3
Net cost of health insurance	143.5	173.2	194.6	209.7	220.4	263.7	382.6
Government public health activities	65.9	76.6	79.0	83.3	87.4	103.5	147.8
Investment	138.4	152.5	153.9	159.4	165.2	192.6	269.4
Noncommercial research	42.6	46.5	45.5	46.2	47.3	53.8	71.4
Structures and equipment	95.8	106.0	108.3	113.3	117.8	138.9	198.0
ANNUAL GROWTH							
NHE	7.3%	3.8%	5.3%	5.5%	4.8%	5.7%	6.0%
Health consumption expenditures	7.3	4.0	5.5	5.6	4.9	5.7	6.1
Personal health care	7.2	4.1	5.0	5.3	4.8	5.7	6.0
Hospital care	6.4	5.1	4.1	4.9	4.7	5.7	6.1
Professional services	6.8	3.8	4.4	5.3	4.5	5.4	5.8
Physician and clinical services	6.7	3.9	4.6	5.4	4.5	5.5	5.8
Other professional services	8.1	5.2	5.2	5.6	4.7	5.6	5.9
Dental services	6.9	2.2	2.8	4.4	4.2	5.2	5.6
Other health, residential, and personal care	9.4	4.9	4.1	5.2	4.9	5.2	5.4
Long-term care services	7.6	3.8	4.0	4.6	4.8	5.5	6.0
Home health care	10.1	5.5	4.8	6.0	4.5	5.8	6.5
Nursing care facilities and continuing care retirement communities	6.8	2.9	3.6	3.9	4.9	5.3	5.7
Retail outlet sales of medical products	9.0	2.2	9.6	7.0	5.7	6.5	6.4
Prescription drugs	11.2	2.0	12.2	8.1	6.3	7.0	6.6
Durable medical equipment	6.5	3.2	3.2	4.3	4.2	5.3	6.4
Other nondurable medical products	4.7	2.6	2.4	3.6	3.6	4.8	5.4
Government administration	8.6	3.8	10.7	10.5	6.6	6.8	7.2
Net cost of health insurance	9.6	3.2	12.4	7.8	5.1	6.2	6.4
Government public health activities	7.6	2.5	3.1	5.4	4.9	5.8	6.1
Investment	6.8	1.6	0.9	3.6	3.6	5.3	5.8
Noncommercial research	7.4	1.5	–2.0	1.4	2.6	4.3	4.9
Structures and equipment	6.5	1.7	2.2	4.6	4.0	5.6	6.1

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found at CMS.gov. National Health Expenditure Accounts methodology paper, 2014: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2015 [cited 2016 Jun 7]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-14.pdf. Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

cent (down from 1.4 percent in 2014) (Exhibit 3), despite the increase in the use of health care goods and services driven by the gains in health insurance coverage. Hospital price growth slowed slightly in 2015, going from 1.3 percent in 2014 to 0.9 percent, and growth in physician prices declined, going from 0.5 percent in 2014 to –1.1 percent in 2015.[8] Underlying the change in physician price growth in 2015 was a significant decline in payment rates for Medicaid pro-

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EXHIBIT 2

National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and average annual growth from previous year shown, by source of funds, selected calendar years 2007–25

Source of funds	2007[a]	2013	2014	2015[b]	2016[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
Private health insurance	$776.4	$949.2	$991.0	$1,042.0	$1,092.7	$1,286.3	$1,756.2
Medicare	432.7	586.3	618.7	647.3	681.3	827.6	1,282.4
Medicaid	325.8	446.7	495.8	548.8	577.7	680.8	973.8
ANNUAL GROWTH IN EXPENDITURE							
Private health insurance	7.7%	3.4%	4.4%	5.1%	4.9%	5.6%	5.3%
Medicare	8.4	5.2	5.5	4.6	5.2	6.7	7.6
Medicaid	9.7	5.4	11.0	10.7	5.3	5.6	6.1
PER ENROLLEE EXPENDITURE							
Private health insurance	$3,932	$5,056	$5,218	$5,380	$5,605	$6,475	$8,591
Medicare	10,003	11,434	11,707	11,986	12,206	13,611	17,911
Medicaid	7,142	7,676	7,523	7,954	8,191	9,215	12,472
ANNUAL GROWTH IN PER ENROLLEE EXPENDITURE							
Private health insurance	7.1%	4.3%	3.2%	3.1%	4.2%	4.9%	4.8%
Medicare	6.8	2.3	2.4	2.4	1.8	3.7	4.7
Medicaid	5.0	1.2	−2.0	5.7	3.0	4.0	5.2
ENROLLMENT, MILLIONS							
Private health insurance	197.5	187.7	189.9	193.7	195.0	198.6	204.4
Medicare	43.3	51.3	52.8	54.0	55.8	60.8	71.6
Medicaid	45.6	58.2	65.9	69.0	70.5	73.9	78.1
Uninsured	41.1	44.2	35.5	28.4	26.8	25.7	28.4
Population	301.0	315.9	318.3	321.0	323.9	333.0	351.2
Insured share of total population	86.4%	86.0%	88.8%	91.2%	91.7%	92.3%	91.9%
ANNUAL GROWTH IN ENROLLMENT							
Private health insurance	0.5%	−0.8%	1.2%	2.0%	0.7%	0.6%	0.5%
Medicare	1.5	2.9	3.1	2.2	3.3	2.9	2.8
Medicaid	4.5	4.1	13.2	4.7	2.2	1.6	0.9
Uninsured	1.7	1.2	−19.5	−20.2	−5.5	−1.4	1.7
Population	1.0	0.8	0.7	0.8	0.9	0.9	0.9

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, source, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2014 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

viders,[9] which coincided with the expiration of the temporary increase in payments to Medicaid primary care physicians. Medicaid spending growth on physician and clinical services is projected to have slowed from 22.8 percent in 2014 to 11.4 percent in 2015.

2016 Although national health spending per capita is projected to exceed $10,000 for the first time in 2016 (Exhibit 3), aggregate national health spending growth (4.8 percent) is projected to slow temporarily, in large part because of slower growth in Medicaid spending (Exhibit 3) after two years of rapid enrollment growth. The uninsured population is projected to decrease again, but by just 1.6 million, to 26.8 million people—with smaller increases in coverage in private health insurance and Medicaid than in 2014 and 2015 (Exhibit 2). From a sponsor perspective, growth in health care expenditures paid for by federal, state, and local governments is projected to fall to 5.5 percent in 2016 (compared to 7.0 percent in 2015) (Exhibit 4), reflecting smaller enrollment gains in Medicaid and its associated costs to government payers.

From a payer perspective, Medicaid spending growth is projected to slow to 5.3 percent in 2016 (from an average of 10.8 percent in 2014–15), following the program's initial expansion-related enrollment growth in 2014–15 (Exhibit 2). Growth in enrollment is projected to slow to 2.2 percent in 2016 (from an average of 8.9 percent in 2014–15). With fewer enrollment gains and continuing efforts by Medicaid managed care plans to ensure appropriate use of services, growth rates of nearly all service categories are expected to slow sharply.[1] As a result, Medicaid hospital spending growth is expected to be 6.5 percent in 2016 (down from 12.4 percent in 2015), Medicaid physician and clinical services spending growth is projected to be 5.1 percent (down from 11.4 percent in 2015), and Medicaid prescription drug spending growth is

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EXHIBIT 3

National health expenditures (NHE), aggregate and per capita amounts, share of gross domestic product (GDP), and average annual growth from previous year shown, by source of funds, selected calendar years 2007–25

Source of funds	2007[a]	2013	2014	2015[b]	2016[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$ 2,296.2	$ 2,879.9	$ 3,031.3	$ 3,197.2	$ 3,350.7	$ 3,958.6	$ 5,631.0
Health consumption expenditures	2,157.8	2,727.4	2,877.4	3,037.8	3,185.5	3,766.0	5,361.6
Out of pocket	290.6	325.5	329.8	338.4	350.1	402.9	555.8
Health insurance	1,609.5	2,087.9	2,216.9	2,353.7	2,473.7	2,939.8	4,216.1
Private health insurance	776.4	949.2	991.0	1,042.0	1,092.7	1,286.3	1,756.2
Medicare	432.7	586.3	618.7	647.3	681.3	827.6	1,282.4
Medicaid	325.8	446.7	495.8	548.8	577.7	680.8	973.8
Federal	185.5	257.7	305.1	350.1	367.2	427.1	607.2
State and local	140.3	189.0	190.6	198.7	210.5	253.7	366.5
Other health insurance programs[c]	74.6	105.6	111.4	115.6	122.0	145.1	203.7
Other third-party payers and programs and public health activity	257.7	314.0	330.7	345.6	361.7	423.2	589.7
Investment	138.4	152.5	153.9	159.4	165.2	192.6	269.4
Population (millions)	301.0	315.9	318.3	321.0	323.9	333.0	351.2
GDP, billions of dollars	$14,477.6	$16,663.2	$17,348.1	$17,947.0	$18,521.3	$21,348.0	$27,987.0
NHE per capita	7,629.7	9,115.1	9,523.4	9,960.2	10,345.5	11,887.5	16,031.9
GDP per capita	48,106.0	52,740.8	54,502.2	55,910.2	57,185.4	64,107.1	79,680.7
Prices[d]							
GDP Implicit Price Deflator, chain weighted	0.973	1.069	1.087	1.098	1.113	1.187	1.352
Personal Health Care Price Index	0.949	1.084	1.099	1.108	1.124	1.209	1.424
NHE as percent of GDP	15.9%	17.3%	17.5%	17.8%	18.1%	18.5%	20.1%
ANNUAL GROWTH							
NHE	7.3%	3.8%	5.3%	5.5%	4.8%	5.7%	6.0%
Health consumption expenditures	7.3	4.0	5.5	5.6	4.9	5.7	6.1
Out of pocket	4.7	1.9	1.3	2.6	3.5	4.8	5.5
Health insurance	8.2	4.4	6.2	6.2	5.1	5.9	6.2
Private health insurance	7.7	3.4	4.4	5.1	4.9	5.6	5.3
Medicare	8.4	5.2	5.5	4.6	5.2	6.7	7.6
Medicaid	9.7	5.4	11.0	10.7	5.3	5.6	6.1
Federal	9.7	5.6	18.4	14.7	4.9	5.2	6.0
State and local	9.6	5.1	0.9	4.2	5.9	6.4	6.3
Other health insurance programs[c]	7.8	6.0	5.5	3.7	5.6	6.0	5.8
Other third-party payers and programs and public health activity	6.1	3.3	5.3	4.5	4.7	5.4	5.7
Investment	6.8	1.6	0.9	3.6	3.6	5.3	5.8
Population[e]	1.0	0.8	0.7	0.8	0.9	0.9	0.9
GDP	5.4	2.4	4.1	3.5	3.2	4.8	4.6
NHE per capita	6.2	3.0	4.5	4.6	3.9	4.7	5.1
GDP per capita	4.3	1.5	3.3	2.6	2.3	3.9	3.7
Prices							
GDP Implicit Price Deflator, chain weighted	2.3	1.6	1.6	1.0	1.4	2.1	2.2
Personal Health Care Price Index	3.3	2.2	1.4	0.8	1.5	2.4	2.8

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** For definitions, source, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2014 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected. [c]Includes health-related spending for Children's Health Insurance Program, Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [d]Both price indexes have a 2009 base year (2009 = 100.0). [e]Estimates reflect the Bureau of the Census's definition of *resident-based population*, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, and US Armed Forces overseas and US citizens whose usual place of residence is outside of the United States. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts. Projected estimates reflect the area population growth assumptions found in the 2016 *Medicare Trustees Report* (see Note 2 in text).

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EXHIBIT 4

National health expenditures (NHE) amounts, average annual growth from previous year shown, and percent distribution, by type of sponsor, selected calendar years 2007–25

Type of sponsor	2007[a]	2013	2014	2015[b]	2016[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$2,296.2	$2,879.9	$3,031.3	$3,197.2	$3,350.7	$3,958.6	$5,631.0
Businesses, households, and other private revenues	1,371.1	1,618.3	1,672.6	1,742.8	1,816.2	2,139.7	2,958.3
Private businesses	507.1	581.9	606.4	627.6	655.2	764.0	1,021.5
Households	693.8	827.4	844.0	879.1	913.3	1,085.0	1,530.4
Other private revenues	170.2	209.1	222.2	236.0	247.6	290.7	406.3
Government	925.1	1,261.6	1,358.7	1,454.4	1,534.5	1,818.9	2,672.7
Federal government	528.1	755.5	843.7	919.9	974.5	1,153.2	1,710.9
State and local governments	396.9	506.0	515.0	534.6	560.0	665.7	961.8
ANNUAL GROWTH							
NHE	7.3%	3.8%	5.3%	5.5%	4.8%	5.7%	6.0%
Businesses, households, and other private revenues	6.5	2.8	3.4	4.2	4.2	5.6	5.5
Private businesses	6.9	2.3	4.2	3.5	4.4	5.3	5.0
Households	6.1	3.0	2.0	4.2	3.9	5.9	5.9
Other private revenues	6.8	3.5	6.3	6.2	4.9	5.5	5.7
Government	8.9	5.3	7.7	7.0	5.5	5.8	6.6
Federal government	9.4	6.2	11.7	9.0	5.9	5.8	6.8
State and local governments	8.2	4.1	1.8	3.8	4.8	5.9	6.3
DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, households, and other private revenues	60	56	55	55	54	54	53
Private businesses	22	20	20	20	20	19	18
Households	30	29	28	27	27	27	27
Other private revenues	7	7	7	7	7	7	7
Government	40	44	45	45	46	46	47
Federal government	23	26	28	29	29	29	30
State and local governments	17	18	17	17	17	17	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, source, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2014 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

expected to be 4.9 percent (down from 17.7 percent in 2015) (data not shown).

As seen in Exhibit 2, growth in private health insurance spending in 2016 is projected to remain low, at 4.9 percent (the projected growth in 2015 is 5.1 percent). This similar rate reflects the net result of two offsetting trends. Slower growth in projected private health insurance enrollment of 0.7 percent (compared to 2.0 percent in 2015), primarily for employer-sponsored plans, is expected to exert downward pressure on spending growth. However, an uptick in projected medical price growth offsets that slowdown. Growth in the Personal Health Care Price Index is expected to remain low in 2016, at 1.5 percent, but to increase from the historically low rate of 0.8 percent in 2015 (Exhibit 3). The expansion of narrow networks in some health plans is expected to help prevent sharp increases in health prices.[10]

Unlike the other two major payers, Medicare is projected to have accelerated spending growth in 2016, to 5.2 percent from 4.6 percent in 2015 (Exhibit 2). Underlying this trend is spending associated with Medicare hospital services, whose growth rate is expected to increase from 2.0 percent in 2015 to 4.4 percent in 2016 (data not shown). The acceleration is driven in part by an expected rebound in use of inpatient hospital services, which declined in 2015.[2]

Finally, slowdowns are expected for two major health sectors in 2016. Physician and clinical services spending growth is projected to slow 0.9 percentage point, falling to 4.5 percent in 2016 (Exhibit 1), in line with a moderation of the effects of the coverage expansions—particularly in Medicaid. Growth in prescription drug spending is also expected to slow, from 8.1 percent in 2015 to 6.3 percent in 2016, as the influence on spending from newly approved drugs is expected to fade after two years of above-average impacts.[11]

2017–19 In the period 2017–19, rates of

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Unlike the other two major payers, Medicare is projected to have accelerated spending growth in 2016.

spending growth are expected to rise across most sectors and payers. As a result, national health spending growth is projected to average 5.7 percent over this period, compared to 4.8 percent in 2016. This faster trend is primarily the result of a projected gradual acceleration in medical price growth and the impact of increased demand for care in response, on a lagged basis, to accelerating growth in disposable personal income.

Medical prices are projected to continue rising, and at a faster rate, in 2017–19, averaging 2.4 percent—compared with projected growth of 1.5 percent in 2016 (Exhibit 3). The acceleration in medical prices is mostly driven by expected faster growth in economywide price inflation, as the two have exhibited similar patterns since 2012.[12] In 2017–19, medical price inflation is anticipated to grow faster than in 2016, in part because of rising prices for the inputs required to provide health care—specifically, growth in health care wages.

Private health insurance spending growth is projected to average 5.6 percent during this period, compared to an expected growth rate of 4.9 percent in 2016 (Exhibit 2), partly as demand for care, and thus spending, responds to faster income growth on a lagged basis. For prescription drugs, it is expected that there will be significantly fewer top-selling brand-name drugs losing patent protection in 2017 and 2018, compared to the period 2011–16.[13] As a result, a smaller number of new generic drugs (whose lower prices have typically helped offset annual increases in brand-name drug prices) is expected in these years, and therefore higher drug price growth is anticipated. However, the overall medical price acceleration is expected to be mitigated as a result of insurers' continuing to experiment with different benefit design structures to limit the amount of premium increases each year.[14]

Medicare spending growth is projected to continue to accelerate and to average 6.7 percent in 2017–19, compared to 5.2 percent in 2016. Strong projected annual enrollment gains of nearly 3 percent play an important role, as more baby boomers reach the age of entitlement (Exhibit 2). Although somewhat mitigated by the continuing influx of younger beneficiaries, per beneficiary expenditures are expected to rise from 1.8 percent in 2016 to an average of 3.7 percent in 2017–19 (Exhibit 2). The change reflects expectations that growth in the use and intensity of Medicare services will rise from recent historic low rates and become closer to longer-term averages. This is particularly true for hospital services—for which projected growth is an average of 5.9 percent per year over the period, relative to 4.4 percent in 2016 (data not shown).

Medicaid spending is projected to grow 5.6 percent on average in 2017–19—considerably slower than in 2014–15 but somewhat faster than in 2016. Underlying this overall expectation is slower, more stable average enrollment growth of 1.6 percent, following the mostly one-time transition impacts of people newly eligible for Medicaid. Offsetting slowing enrollment growth is faster growth in spending per enrollee, which is projected to average 4.0 percent, compared to 3.0 percent in 2016 (Exhibit 2), as comparatively more expensive dually eligible beneficiaries (those enrolled in both Medicare and Medicaid) and disabled beneficiaries make up a growing proportion of the program's population.

2020–25 In the second half of the projection period (2020–25), the increasing use of services in response to rising income growth and population aging is projected to increase growth in national health expenditures to an average of 6.0 percent per year—the highest for any of the subperiods examined. Medicare spending is projected to grow an average of 7.6 percent in 2020–25—faster than the spending of other major payers. This reflects the baby boomers' continuing to age into the program. It also reflects existing Medicare beneficiaries increasing their use of hospital and physician services to rates that do not reach as high as the program's long-term averages but that are above the program's recent historical experience. Similarly, the aging of the Medicaid population is expected to lead to increased Medicaid spending growth (6.1 percent growth over the period on average), particularly for physician and clinical services and for prescription drugs. Average Medicaid spending per beneficiary in 2020–25 is expected to grow more rapidly (5.2 percent) than in 2017–19 (4.0 percent).

Growth in private health insurance spending is projected to remain at or above 5 percent, on average, throughout the latter half of the projection period but to generally slow in the final few years of the period in lagged response to slower

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growth in income. Notably, growth in private health insurance spending is expected to be outpaced by faster overall Medicare spending growth during this time, in part because of the continued shift of baby boomers out of private health insurance and into Medicare. Thus, private health insurance enrollment is projected to increase at an average rate of 0.5 percent per year, or 2.3 percentage points slower than Medicare enrollment.

Contributing to slower growth in private health insurance spending is the excise tax on high-cost employer-based insurance plans, which begins in 2020. As a result of the tax, some employers are expected to reduce benefits so they are not subject to the tax. Accordingly, this reduction in benefits is also expected to contribute to faster growth in out-of-pocket spending, which is projected to average 5.5 percent in 2020–25 (compared to 4.8 percent in 2017–19).

By 2025, changes are projected with respect to who ultimately pays for the nation's health care. The proportion of health spending sponsored by federal, state, and local governments is expected to be 47 percent—almost 3 percentage points higher than it was in 2014—and to reach nearly $2.7 trillion. The proportion of spending by businesses and households is expected to be 53 percent in 2025—approximately 3 percentage points lower than it was in 2014—and to reach nearly $3.0 trillion. This expected higher share of spending by governments reflects the full impacts from the ACA's coverage expansions, the continued transition of the baby-boom generation into Medicare, and a growing gap between dedicated Medicare financing and program outlays.[2]

By the end of the projection period, medical price inflation is expected to be at its highest for the period, averaging 2.8 percent for 2020–25. Expectations for rising economywide inflation, together with higher input prices for providers, contribute to this faster increase in projected medical prices. However, the upward pressure is expected to be slightly offset by the continued effects of the ACA-mandated productivity adjustments and implementation of the Independent Payment Advisory Board,[2] as well as the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which specified payment reductions to inpatient hospitals and postacute care providers (skilled nursing facilities, home health care, and hospice care).

Collectively, reductions in the number of uninsured people are expected as well as changes in the distribution of spending by payer and sector over the next decade. The insured share of the population is projected to be approximately 92 percent in 2025, up from 89 percent in 2014 (Exhibit 2). The shares of spending by Medicare and Medicaid are projected to increase from 2014 (20.4 percent and 16.4 percent, respectively) to 2025 (22.8 percent and 17.3 percent, respectively), while shares of private health insurance and out-of-pocket spending decline from 2014 (32.7 percent and 10.9 percent, respectively) to 2025 (31.2 percent and 9.9 percent, respectively) (data not shown). By sector, the share of spending accounted for by prescription drugs is projected to increase (from 9.8 percent in 2014 to 10.9 percent in 2025), while the share of spending for physician and clinical services is projected to decline slightly (from 19.9 percent to 19.4 percent in the same period).

One area of uncertainty in projections of Medicaid spending and enrollment concerns the prospect of states' expanding Medicaid eligibility.

Major Topics In The Outlook For Medical Goods And Services

HOSPITAL SERVICES: OUTLOOK FOR HOSPITAL PRICES Growth in hospital prices, one of the key underlying drivers of overall hospital spending growth, decelerated from 1.3 percent in 2014 to just 0.9 percent in 2015, which is the slowest rate of price growth since 1998.[8] This deceleration was driven primarily by slower growth in payments by Medicare and Medicaid.[9] After 2015, hospital price growth is projected to accelerate, reaching 2.8 percent by 2019, because of an expectation of higher growth in input costs for hospital services—especially labor compensation, reflecting both expected increases in economywide wages and increasing competition for hospital employees.[15] In the second half of the projection period, hospital prices are anticipated to continue to grow at about 3 percent per year.

PHYSICIAN AND CLINICAL SERVICES: IMPACT OF INCREASED COST SHARING ON USE Despite expanded insurance coverage provided by the Mar-

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The health sector is in the midst of a unique period, in which various forces are exerting differential pressures on health spending growth.

ketplaces, growth in private health insurance spending on physician and clinical services is tempered somewhat over the projection period (averaging 4.9 percent in 2015–25) by the continued growth of high-deductible health plans, which are estimated to account for nearly one in four employer health plans in 2015, up from one in five in 2014.[7] Research has found that moving into high-deductible health plans or being subject to other increases in cost sharing tends to have a disproportionate impact on the use of physician and clinical services, such as preventive care.[16,17] Increases in multiple types of cost sharing (including benefit-design changes, higher copayments, and higher deductibles) are expected to continue throughout the projection period and will act to limit the growth in the use of physician and clinical services. These increases in cost sharing are anticipated to contribute to an acceleration in the growth of out-of-pocket spending in this category, with projected average annual growth of 5.4 percent for 2020–25 (data not shown).

PRESCRIPTION DRUGS: IMPACT OF NEW DRUGS In 2015 there were forty-five new drug approvals in the United States, up from forty-one in 2014 and twenty-seven in 2013.[18] Many of these drugs have small target patient populations. Thus, the impact of new drugs approved in 2015 is likely to be smaller than in the previous two years—when fewer new drugs were approved, but several of them were intended for wide use.

Over the projection period, the impact on spending growth from newly approved drugs each year is expected to be lower than that observed in 2014 and 2015. The number of new drugs approved annually is anticipated to decrease. Moreover, a few of these new drugs are expected to be biosimilars, which are typically priced lower than the originator drug.[19]

Selected Topics In The Outlook For Payers

MEDICARE: UPWARD LEGISLATIVE PRESSURE ON GROWTH Certain legislative changes, as well as growth in economywide prices, are projected to exert upward pressure on spending growth in the Medicare program over the next decade. For example, an annual 0.5-percentage-point increase in hospital payments is legislated for fiscal year 2018 through fiscal year 2023, related to documentation and coding requirements in MACRA. Because of the same legislation, an increase in physician bonus payments is expected to begin in 2019, as doctors participate in Medicare's transition to alternative payment models or the merit-based incentive payment systems. In addition, prices associated with the inputs required to furnish care to Medicare beneficiaries are expected to grow more rapidly in the coming years than in the recent past, including faster growth in health-sector wages and salaries associated with the expected tightening of labor markets.

MEDICAID: IMPACT OF STATES EXPANDING ELIGIBILITY Currently, thirty-one states and the District of Columbia have expanded their Medicaid eligibility under the ACA, while nineteen states have elected not to do so.[20] One area of uncertainty in projections of Medicaid spending and enrollment concerns the prospect of additional states' expanding Medicaid eligibility. These projections assume that there will be a small increase in Medicaid expansion going forward. Specifically, in 2016, it is assumed that 50 percent of the people who were potentially newly eligible to enroll in Medicaid resided in states that elected to expand Medicaid eligibility. In 2017 and beyond, this share is assumed to rise to 55 percent.[1] As a result, Medicaid spending as a share of overall national health spending is expected to rise to 17.3 percent by 2025, up from 15.5 percent in 2013, before the major coverage expansion of Medicaid in 2014 (data not shown).

Conclusion

The health sector is in the midst of a unique period, in which various forces are exerting differential pressures on health spending growth. Economywide and medical-specific price growth have been very low, helping restrain inflation's impact on health spending, and the Medicare program is experimenting with various alternative payment approaches. Meanwhile, many Americans are gaining access to health coverage for the first time, aging into Medicare, or finding that a greater share of their health expenses needs to be paid out of pocket. And the Medicaid program is evolving: Its population mix is in-

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creasingly likely to be covered through private plans.

For the period 2015–25, growth in health spending is projected to average 5.8 percent, influenced in part by an expectation of higher economywide and medical prices. By 2025, as economic, legislative, and demographic influences play out, the health spending share of the economy is projected to reach 20.1 percent, up from 17.5 percent in 2014, and governments are anticipated to sponsor 47 percent of health spending, up from 45 percent in 2014. The percentage of the US population that is uninsured is expected to be 8 percent in 2025, down from about 11 percent in 2014. ■

The opinions expressed here are the authors' and not necessarily those of the Centers for Medicare and Medicaid Services. The authors thank Paul Spitalnic, Stephen Heffler, John Shatto, Chris Truffer, and Aaron Catlin. [*Published online July 13, 2016.*]

NOTES

1. Medicaid.gov. 2015 actuarial report on the financial outlook for Medicaid [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; forthcoming 2016. Available from: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2015.pdf
2. Boards of Trustees. 2016 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2016 [cited 2016 Jun 22]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf
3. Centers for Medicare and Medicaid Services. Projections of national health expenditures: methodology and model specification [Internet]. Baltimore (MD): CMS; 2015 July 28 [cited 2016 Jun 15]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf
4. Nominal GDP averaged 2.6 percent for the period 2008–14 and is projected to grow at an average annual rate of 4.4 percent for the period 2015–25.
5. Kim J, LeBuhn J. 2016 outlook: U.S. nonprofit hospitals and healthcare systems [Internet]. New York (NY): Fitch Ratings; 2015 Dec 2 [cited 2016 Jun 7]. Available from: http://www.modernhealthcare.com/assets/pdf/CH102767122.pdf
6. Goldstein A. Fewer Americans skipping medical care for cost reasons. Washington Post. 2015 Sep 1.
7. Claxton G, Rae M, Panchal N, Whitmore H, Damico A, Kenward K, et al. Health benefits in 2015: stable trends in the employer market. Health Aff (Millwood). 2015;23(10):1779–88.
8. Bureau of Labor Statistics. Producer Price Indexes [Internet]. Washington (DC): BLS; [cited 2016 May 26]. Available from: http://www.bls.gov/ppi/
9. Based on the authors' analysis of Producer Price Index data by specialty and payer.
10. Polsky D, Weiner J. The skinny on narrow networks in health insurance marketplace plans [Internet]. Philadelphia (PA): University of Pennsylvania, Leonard Davis Institute of Health Economics; 2015 Jun [cited 2016 Jun 7]. Available from: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027
11. Tharaldson A. 2016 drug pipeline full of blockbuster potential [Internet]. St. Louis (MO): Express Scripts; 2016 Mar 24 [cited 2016 Jun 7]. Available from: http://lab.express-scripts.com/lab/insights/drug%20options/2016%20drug%20pipeline%20full%20of%20blockbuster%20potential
12. Economywide price inflation, measured by growth in the GDP Implicit Price Deflator, is expected to average 2.1 percent during this period, compared to projected growth of 1.4 percent in 2016.
13. Therapeutic Research Center. Anticipated availability of first-time generics [Internet]. Stockton (CA): The Center; 2016 May [cited 2016 May 26]. Available for download from: http://pharmacistsletter.therapeuticresearch.com/pl/ArticlePDF.aspx?s=PL&DetailID=280401
14. Livingston S. Continued health plan design changes keep down group plan costs. Business Insurance [serial on the Internet]. 2015 Nov 19 [cited 2016 Jun 7]. Available from: http://www.businessinsurance.com/article/20151119/NEWS03/151119782
15. Raskin JR, Fellinger R, Shah N, Galitz H, Shang M. U.S. health care facilities: 2016 outlook: laboring through post-ACA period. New York (NY): Barclays Bank; 2016 Jan 6.
16. Fronstin P, Roebuck MC. Quality of health care after adopting a full-replacement, high-deductible health plan with a health savings account: a five-year study [Internet]. Washington (DC): Employee Benefit Research Institute; 2014 Sep [cited 2016 Jun 8]. (Issue Brief No. 404). Available from: https://www.ebri.org/pdf/briefspdf/EBRI_IB_404_Sept14.HSA-Qual.pdf
17. Brot-Goldberg ZC, Chandra A, Handel BR, Kolstad JT. What does a deductible do? The impact of cost-sharing on health care prices, quantities, and spending dynamics [Internet]. Cambridge (MA): National Bureau of Economic Research; 2015 Oct [cited 2016 Jun 8]. (Working Paper No. 21632). Available for download (fee required) from: http://www.nber.org/papers/w21632
18. Food and Drug Administration. Novel Drugs 2015 summary [Internet]. Silver Spring (MD): FDA; 2016 Jan [cited 2016 Jun 8]. Available from: http://www.fda.gov/downloads/Drugs/DevelopmentApprovalProcess/DrugInnovation/UCM485053.pdf
19. Aitken M. Delivering on the potential of biosimilar medicines: the role of functioning competitive markets [Internet]. Parsippany (NJ): IMS Institute for Healthcare Informatics, 2016 Mar [cited 2016 Jun 8]. Available from: http://www.imshealth.com/files/web/IMSH%20Institute/Healthcare%20Briefs/Documents/IMS_Institute_Biosimilar_Brief_March_2016.pdf
20. Henry J. Kaiser Family Foundation. Status of state action on the Medicaid expansion decision [Internet]. Menlo Park (CA): KFF; 2016 Mar 14 [cited 2016 Jun 8]. Available from: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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UPDATE: Early Analysis Finds 2017 Proposed Exchange Premiums for Low Cost Silver Plans Increasing 8 Percent on Average

Rates Vary Widely by State; Popular Low Cost Options See Smaller Increases

An updated analysis from Avalere finds 2017 premium increases continue to vary significantly by geography as more states publish their proposed rates for individual market exchange plans. Requested premium increases for average silver plans is 11 percent, but consumers can limit cost increases by selecting lower cost silver plans, which are set to increase only 8 percent. The analysis has been updated to include 14 states where complete data are available. Avalere's previous analysis of proposed rates in nine states found similar results.

Consistent with the previous analysis, changes in premiums vary widely across states. Average proposed premiums for the lowest cost silver plans are decreasing in Washington and Rhode Island, while those lowest cost silver plans in Connecticut, DC, and Oregon will increase more than 15 percent. Notably, Rhode Island is the only state experiencing a decrease in the average proposed silver premiums. That decrease is primarily a result of one of the state's highest cost issuers exiting the market for 2017, and one of its remaining issuers offering lower cost options. 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.

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.

"Exchange consumers have been active shoppers who tend to re-shop each year and gravitate toward lower premium plans," said Caroline Pearson, senior vice president at Avalere. "As in previous years, many enrollees will limit their premium increases by selecting plans with smaller premium increases and taking advantage of premium subsidies available in the market."

Proposed Premiums for 2017 Compared to Final Premiums for 2016 in 14 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**
CO	$523	$588	**12%**	$415	$475	**14%**	$434	$495	**14%**
CT	$523	$593	**13%**	$480	$556	**16%**	$487	$559	**15%**
DC	$400	$434	**9%**	$336	$404	**20%**	$358	$414	**16%**
IN	$466	$493	**6%**	$365	$366	<1%	$383	$379	**-1%**

Avalere Health
An Inovalon Company
1350 Connecticut Ave, NW
Washington, DC 20036
P | 202.207.1300
F | 202.467.4455
avalere.com

MD	$412	$474	**15%**	$348	$383	**10%**	$361	$405	**12%**
ME	$495	$583	**18%**	$449	$511	**14%**	$458	$532	**16%**
MI	$424	$477	**12%**	$368	$403	**10%**	$382	$414	**9%**
NV	$488	$539	**10%**	$460	$492	**7%**	$486	$514	**6%**
NY	$458	$525	**15%**	$372	$396	**6%**	$401	$430	**7%**
OR	$441	$517	**17%**	$366	$429	**17%**	$380	$442	**16%**
RI	$405	$387	**-5%**	$362	$313	**-14%**	$367	$320	**-13%**
VA	$451	$538	**19%**	$404	$450	**11%**	$417	$472	**13%**
VT	$476	$513	**8%**	$465	$482	**4%**	$468	$493	**5%**
WA	$429	$449	**5%**	$366	$335	**-8%**	$377	$350	**-7%**
Average	**$456**	**$508**	**11%**	**$397**	**$428**	**8%**	**$411**	**$444**	**8%**

Methodology

Analysis includes final 2016 premiums and proposed 2017 premiums in Colorado, Connecticut, the District of Columbia, Indiana, Maryland, Maine, Michigan, Nevada, New York, Oregon, Rhode Island, 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 July 8, 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 Colorado, Connecticut, the District of Columbia, Maryland, New York, Oregon, Rhode Island, Vermont, and Washington 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 July 8, 2016. Per HHS requirements, issuers in each state must uniformly use a set number of geographic rating areas as part of their premium setting. Each state's market rating areas and methodology for dividing the state into rating areas are subject to variation based on Metropolitan Statistical Areas (MSAs), counties, three-digit zip codes, or MSA/non-MSAs. 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.

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Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces

Cynthia Cox, Gary Claxton, Larry Levitt, Michelle Long, Selena Gonzales, Nolan Sroczynski

Marketplace premiums under the Affordable Care Act (ACA), already a subject of perennial interest, have gained even more attention amid unfavorable financial results from some insurers, as well as initial reports of steep premium increases requested for 2017. Several factors will influence how premiums will change in 2017, and there is reason to believe that increases will be higher than in recent years.

Many of the initial reports of premium increases for 2017 have been based on anecdotal examples or averages across insurers. This brief takes a different approach, presenting an early analysis of changes in insurer participation and premiums for the lowest-cost and second-lowest silver marketplace plans in major cities in 13 states plus the District of Columbia where complete data on rates is publicly available for all insurers. Using this information, we are able to calculate the premium a specific person might pay without a premium tax credit, and take into account new plans entering the market. It follows a similar approach to our analyses of 2014, 2015, and 2016 marketplace premiums. The two lowest-cost silver plans are significant because they are the most common plan choices in the marketplaces, and the second lowest-cost plan is the benchmark used to calculate government premium subsidies.

While we cannot generalize to all states until more data become available later this year, in most of these population centers, the costs for the lowest and second-lowest silver plans are, in fact, increasing faster in 2017 than they have in previous years. Based on insurer rate requests, the cost of the second-lowest silver plan in these cities will increase by a weighted average of 10% in 2017. Last year, premiums for the second-lowest silver plans in these areas increased 5% following review by state insurance departments. There is substantial variation across markets, with premium changes for second-lowest silver plans ranging from a drop of 13% to an increase of 18%. Premiums for 2017 are still preliminary and could be raised or lowered through these states' rate review processes.

We also find that some states will have fewer insurers participating in 2017 than participated in 2016. On average across these 14 marketplaces, participation is down slightly from 2016 but similar to that of 2014. In the 14 marketplaces included in this analysis, half (7) will see insurer participation remain steady or increase, while the other 7 states will see a drop in the number of issuers, in many cases due to the withdrawal of UnitedHealth.

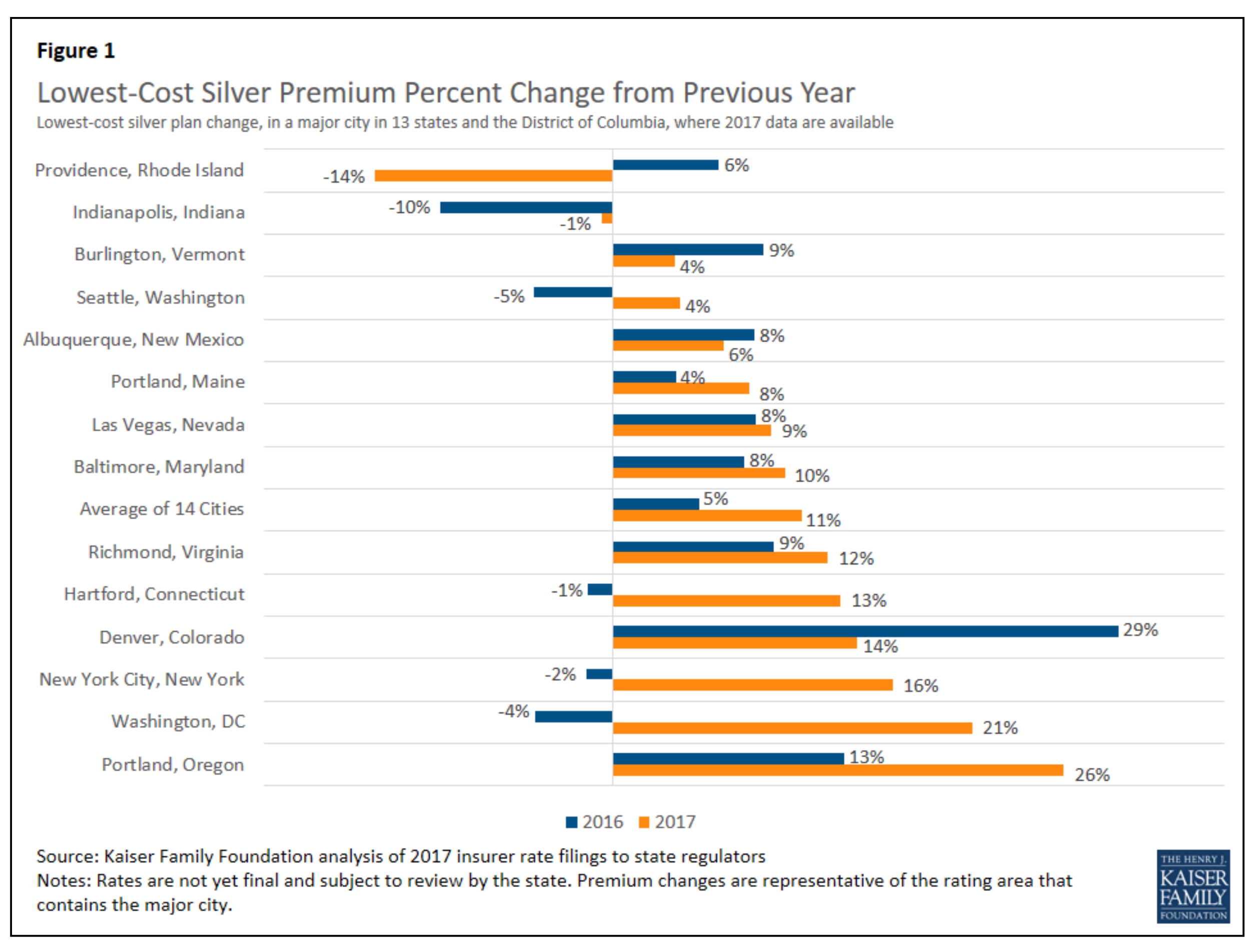
Analyzing Marketplace Premium Changes

In preparation for open enrollment in 2017, insurers have filed premium requests with state insurance departments. States vary in whether and when they release those filings. In this analysis, we analyze premium data from all 13 states and the District of Columbia where either public insurer filings include all of the information necessary to calculate the premium for a 40-year-old living in specific part of the state, or, where the state has made similar information public in some other format such as rate tables or search tools. Other states have released summary information, but not sufficient detail to identify the two lowest-cost silver plans.

We examine premiums in a rating area that includes a major city in each state. Premiums vary significantly within states, with the rating area being the smallest geographic unit by which insurers are allowed to vary rates. For each rating area, we look at premiums for the two lowest-cost silver plans. We focus on silver plans because they are the basis for federal premium subsidies[1] and because these are the plans that most marketplace enrollees (68%) tend to choose. These cities represent major population centers in each state; premiums and insurer participation may be different in rural areas. These premiums are still preliminary and subject to review by the state or federal government.

Changes in the Lowest-Cost Silver Plans

Across the 14 cities we examined, the premium for the lowest-cost silver plan is increasing by a weighted average of 11% in 2017, though changes vary geographically ranging from a decrease of 14% in Providence, Rhode Island, to an increase of 26% in Portland, Oregon.



From the creation of the exchange markets in 2014 to 2017, the lowest-cost silver premium will have increased an average of 5% per year across these 14 areas, if 2017 proposed rates are not changed through the review process. Average annual growth in the lowest-cost silver plan in these cities ranges from a decrease of 6% per year in Indianapolis, Providence, and Seattle, to an increase of 16% in Portland, Oregon.

Table 1: Monthly Lowest-Cost Silver Premiums for a 40 Year Old Non-Smoker (Before Tax Credits)

State	Major City (Rating Area #)	2017	2016	2016-2017 % Change	2015-2016 % Change	Average Annual Change 2014-2017
Colorado	Denver (3)	**$304**	$266	**14%**	29%	7%
Connecticut	Hartford (2)	**$358**	$316	**13%**	-1%	4%
DC	Washington (1)	**$275**	$228	**21%**	-4%	5%
Indiana	Indianapolis (10)	**$284**	$286	**-1%**	-10%	-6%
Maine	Portland (1)	**$307**	$285	**8%**	4%	3%
Maryland	Baltimore (1)	**$267**	$243	**10%**	8%	8%
Nevada	Las Vegas (1)	**$279**	$256	**9%**	8%	6%
New Mexico	Albuquerque (1)	**$192**	$181	**6%**	8%	1%
New York	New York City (4)	**$425**	$366	**16%**	-2%	6%
Oregon	Portland (1)	**$302**	$240	**26%**	13%	16%
Rhode Island	Providence (1)	**$224**	$259	**-14%**	6%	-6%
Vermont	Burlington (1)	**$482**	$465	**4%**	9%	7%
Virginia	Richmond (7)	**$296**	$264	**12%**	9%	9%
Washington	Seattle (1)	**$232**	$224	**4%**	-5%	-6%
Weighted Average		**$307**	$277	**11%**	5%	5%

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Note: Rates are not yet final and subject to review by the state. Premium changes are representative of the rating area that contains the major city.

Changes in the Second-Lowest Silver Plans

Similar patterns can be seen for the second-lowest silver plan in each city. Before accounting for any tax credit that subsidizes premiums for low and middle income people, the premium for the second-lowest silver plan is increasing by a weighted average of 10% from 2016. By contrast, the average change in the second-lowest silver plan in these cities was 5% from 2015 to 2016.

Second-lowest silver plan premium changes in 2017 vary significantly across these cities, ranging from a decrease of 13% in Providence, Rhode Island, to an increase of 18% in Portland, Oregon. Since 2014, premiums in these cities have increased an average of 4% per year, ranging from an average annual decrease of 8% in Providence, Rhode Island, to an average annual increase of 15% in Portland, Oregon. Although Portland, Oregon's increases have been relatively high, it is worth noting that the benchmark premium started out quite low in 2014 ($201 for a 40 year old, compared to an average of $273 nationally).

These premium changes do not reflect what marketplace enrollees receiving premium tax credits will actually pay. Most marketplace enrollees receive premium tax credits, which means that they do not actually pay the entire premium but make a contribution based on a percentage of their incomes and family sizes to enroll in the second-lowest silver plan.

In 2016, a 40-year-old single enrollee making $30,000 per year would have paid about $208 per month in most areas of the country, and a similar person would pay approximately the same in 2017. (Although premium caps are increasing for 2017, the poverty guidelines are also changing such that a single person making $30,000 will be at a slightly lower percent of poverty than he or she would be this year. These two changes in effect cancel each other out, leaving monthly payments for the benchmark plan very similar from year-to-year.) However, in order to take advantage of this stability in premium payments, enrollees may need to switch plans to the new benchmark silver plan.

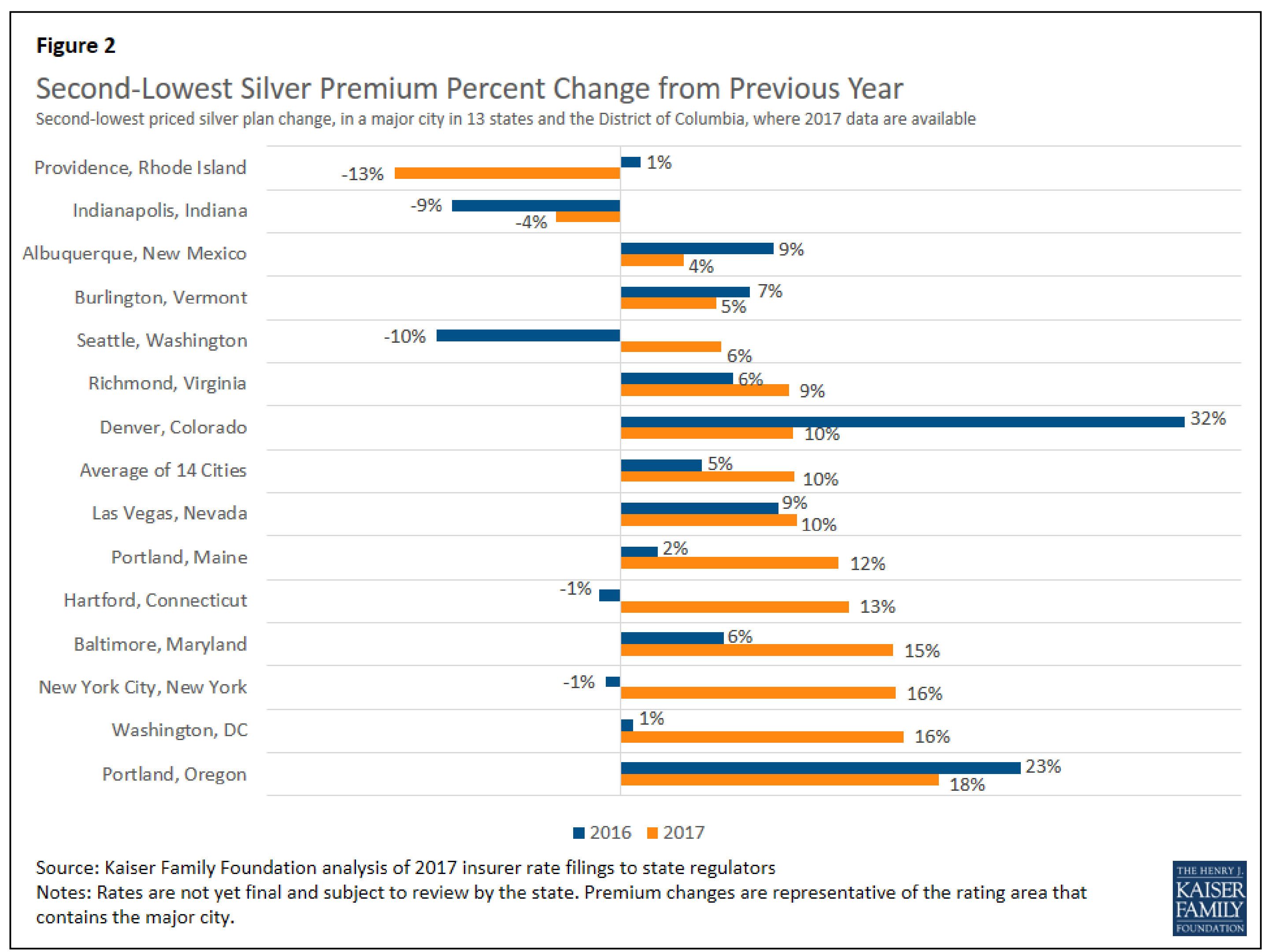


Table 2: Monthly Second-Lowest Silver Premiums for a 40-Year-Old Non-Smoker (Before Tax Credits)						
State	Major City (Rating Area #)	2017	2016	2016-2017 % Change	2015-2016 % Change	Average Annual Change 2014-2017
Colorado	Denver (3)	**$305**	$278	**10%**	32%	7%
Connecticut	Hartford (2)	**$359**	$318	**13%**	-1%	3%
DC	Washington (1)	**$282**	$243	**16%**	1%	5%
Indiana	Indianapolis (10)	**$287**	$298	**-4%**	-9%	-6%
Maine	Portland (1)	**$323**	$288	**12%**	2%	3%
Maryland	Baltimore (1)	**$287**	$249	**15%**	6%	8%
Nevada	Las Vegas (1)	**$287**	$261	**10%**	9%	6%
New Mexico	Albuquerque (1)	**$193**	$186	**4%**	9%	0%
New York	New York City (4)	**$426**	$369	**16%**	-1%	3%
Oregon	Portland (1)	**$308**	$261	**18%**	23%	15%
Rhode Island	Providence (1)	**$229**	$263	**-13%**	1%	-8%
Vermont	Burlington (1)	**$493**	$468	**5%**	7%	6%
Virginia	Richmond (7)	**$302**	$276	**9%**	6%	6%
Washington	Seattle (1)	**$240**	$227	**6%**	-10%	-5%
Weighted Average		**$313**	$285	**10%**	5%	4%

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Note: Rates are not yet final and subject to review by the state. Premium changes are representative of the rating area that contains the major city.

Active Renewal and Premium Changes

As was the case last year, the insurers that had the lowest premiums in 2016 are often no longer one of the two lowest-cost silver plans in 2017. This underscores the importance of enrollees actively shopping each open enrollment period. For example, in Providence, Rhode Island, Blue Cross Blue Shield (BCBS) of Rhode Island offered the second-lowest silver plan in 2016 at a premium of $263 per month for a single 40 year-old before taking a tax credit into account. BCBS is increasing this plan's rate to $272 per month for 2017, but another insurer, Neighborhood Health Plan, is offering a few lower-cost silver options – the lowest for $224 per month and the second-lowest for $229. An unsubsidized person enrolled in the 2016 second-lowest silver plan offered by BCBS would see a premium increase of about 4% if she stayed in the same plan. Conversely, if she switched to the new second-lowest silver plan offered by Neighborhood, her premium would drop 13% (before accounting for the relatively small effect aging up a year would have on her premiums).

The effect of changes in the benchmark premium relative to other plans is magnified for subsidized enrollees because the tax credit is tied to the premium for the second-lowest silver plan in a given year. If the same 40 year-old in the example above makes $30,000, she would be paying $208 per month in 2016 for the benchmark plan (offered by BCBS) and the federal government covers the rest through a tax credit. In 2017, if she switches to the new benchmark (offered by Neighborhood), she would continue to pay about $208 per month (assuming she continues to have the same income and family size in 2016). However, if she stayed in the BCBS plan, she would have to pay that amount plus the premium difference between the Neighborhood and

BCBS plans, or a total of approximately $250 (an increase of about 20%, before accounting for a relatively small effect of aging one year and before accounting for any amount attributable to non-essential health benefits that may be covered by either plan). To keep her lower premium, she has to be willing to switch plans.

Experience in this market suggests that a sizable share of people enrolling in 2017 will actively shop for coverage. A research brief by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that about two-thirds of Healthcare.gov enrollees actively shopped in 2016, including 43% of renewing enrollees and all new shoppers. While several reports of premium increases had suggested that premiums would increase in the double digits in 2016, the ASPE analysis found that, after accounting for shopping, marketplace premiums increased 8% before subsidies. For enrollees receiving a subsidy, the increase in the amount they paid was 4% on average.

In addition to switching plans, enrollees may also have to switch insurance companies in order to avoid a significant premium increase, which could involve changing doctors as well. In 6 out of 14 cities we examined, an insurer offering the lowest-cost silver plan in 2016 is no longer offering one of the two lowest-cost silver plans in 2017. Similarly, in 6 out of the 14 cities we examined, an insurer offering the second-lowest silver plan in 2016 is no longer offering one of the two lowest-cost silver plans in 2017. All in all, at least one of the low-cost insurers from 2016 will no longer be a low-cost insurer in 2017 in 9 out of the 14 marketplaces.

Table 3: Changes in Insurers Offering the Lowest-Cost Silver Products

State	Major City (Rating Area #)	Is the insurer that offered the **lowest-cost silver plan in 2016** still offering one of the two lowest-cost silver plans in 2017?	Is the insurer that offered the **2nd lowest-cost silver plan in 2016** still offering one of the two lowest-cost silver plans in 2017?
Colorado	Denver (3)	Yes	No
Connecticut	Hartford (2)	Yes	Yes
DC	Washington (1)	Yes	Yes
Indiana	Indianapolis (10)	No	Yes
Maine	Portland (1)	No	Yes
Maryland	Baltimore (1)	No	No
Nevada	Las Vegas (1)	Yes	Yes
New Mexico	Albuquerque (1)	Yes	No
New York	New York City (4)	No	No
Oregon	Portland (1)	No	Yes
Rhode Island	Providence (1)	Yes	No
Vermont	Burlington (1)	Yes	Yes
Virginia	Richmond (7)	No	No
Washington	Seattle (1)	Yes	Yes
Total		**8 Yes, 6 No**	**8 Yes, 6 No**

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Note: Rates are not yet final and subject to review by the state. Premium changes are representative of the rating area that contains the major city.

Changes in Insurer Participation

The number of insurers participating in these states' marketplaces ranges from 2 in Vermont, DC, and Rhode Island, to 15 in New York. On average, 5.5 insurers (grouped by parent company) will offer coverage in these 14 states in 2017, which is slightly less than the average participation in 2015 and 2016 (an average of 6.4 and 5.9, respectively), and equal to the number that participated in 2014 (5.5 on average).

Seven states will see a drop in insurer participation, most often resulting at least in part from UnitedHealth's broad exit from the individual market in most states. Three states (Maine, New Mexico, and Virginia) will see an increase in insurer participation, and the remaining three states plus the District of Columbia will have the same number of insurers participating in 2017 as in 2016. All insurers may not participate statewide, and rural areas in particular tend to have fewer insurers.

Connecticut	3	4	4	**3**
Indiana	4	8	7	**6**
Maryland	4	5	5	**4**
New Mexico	4	5	4	**5**
Oregon	11	10	10	**8**
Vermont	2	2	2	**2**
Washington	7	10	10	**8**
Average	5.5	6.4	5.9	**5.5**

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Note: Filings are not yet final and subject to review by the state.

In some marketplaces, there will be both entrants and exits. In Colorado, for example, UnitedHealth and Humana are exiting, while a new insurer, Bright Health Plan, is entering. Similarly, in Indiana, UnitedHealth and a local insurer are exiting, while Aetna is entering in 2017. In total, 6 of the 14 marketplaces will have new entrants in 2017. Oregon and Washington will experience the largest drops in insurer participation – both losing 2 on net. Even so, these two states will have 8 insurers, which is higher than average.

Discussion

Recent reports of substantial increases from some insurers have led to concerns regarding the stability of the ACA's marketplaces. There is reason to believe that premium increases in the ACA's marketplaces will be higher in 2017 than in recent years. However, anecdotal examples of premium hikes or averages across insurers

can provide a skewed picture of the increases marketplace enrollees will actually face. As noted above, about 8 in 10 marketplace enrollees are receiving government premium subsidies, and these enrollees are protected from an increase in premiums if they continue to be enrolled in a low-cost plan. Regardless of tax credit eligibility, most enrollees have multiple plans from which to choose and can often save money on their premium by switching to a lower-cost plan. Experience has shown that many enrollees are willing to switch plans to avoid a premium increase, even though this might mean changing insurers and potentially doctors as well.

Given this high rate of plan switching – and the jockeying by insurers to be one of the lower-cost options – it is instructive to look at how premiums for the two lowest-cost silver plans are changing. Our analysis of premiums in major cities in the 13 states and DC where more complete information is available finds that the premium changes for the two lowest-cost silver plans – which the bulk of enrollees tend to purchase – vary substantially across the country, ranging from a decrease of 14% to an increase of 26% for the lowest-cost silver plan. On average, proposed premiums for the second-lowest silver plan in these cities are increasing by 10%, up from 5% in 2016.

Another recent concern over the viability of the exchange market has stemmed from the news that UnitedHealth would exit all but a handful of the 34 states where it had participated. However, in earnings calls, other large insurers have expressed more confidence in the exchange markets, with some planning expansion into new markets. On average, across the 14 marketplaces where we analyzed premium data, insurer participation in 2017 will be slightly lower than in 2016. Often the decrease in insurer participation in 2017 is resulting from the exit of UnitedHealth. In all of these states, there are multiple insurers continuing to offer coverage. A remaining question, though, is how insurer participation will vary geographically, and particularly in rural areas where a number of counties may be at risk of having just one insurer.

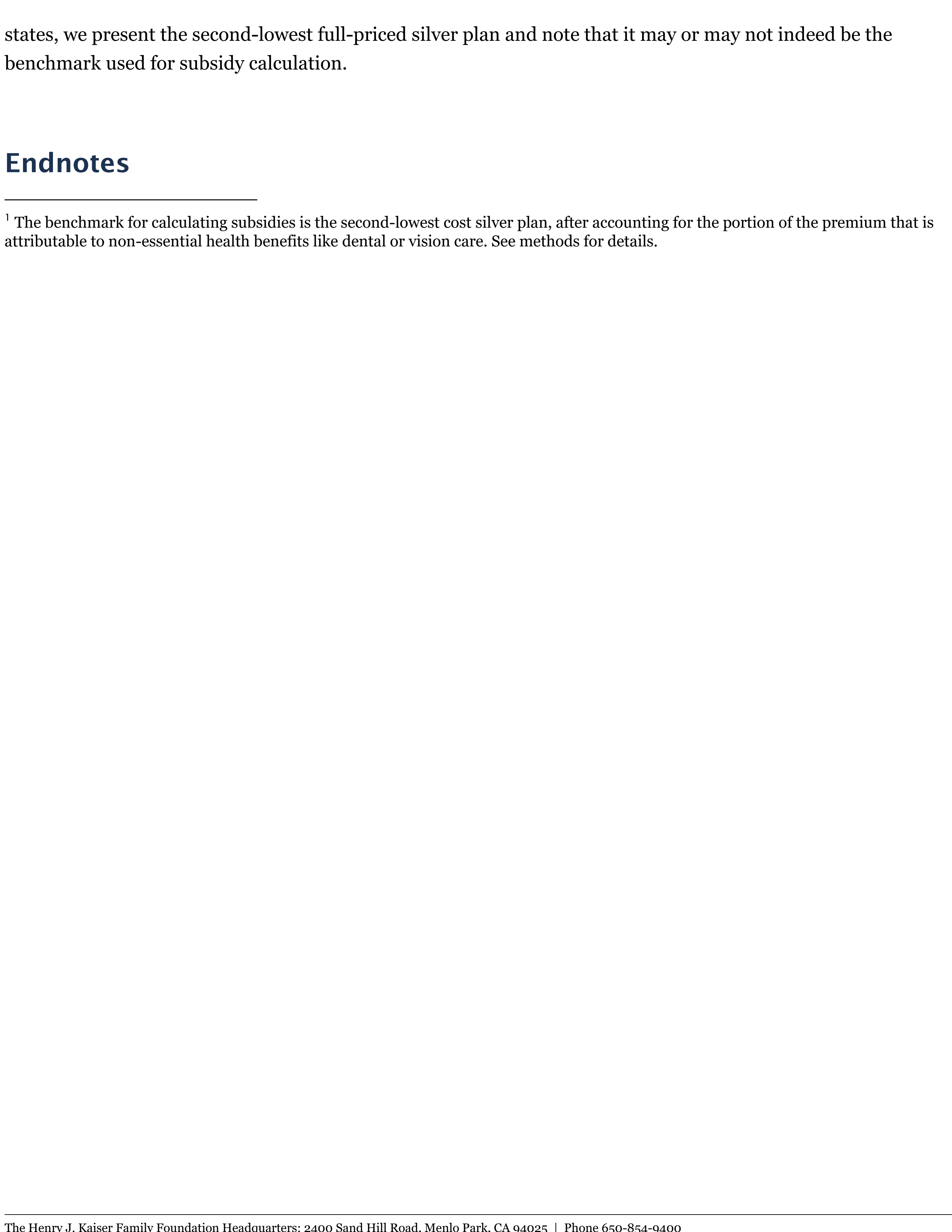
Premiums that are reviewed by states or the federal government and made final for 2017 marketplace plans will become available for these and other states over the next few months, with complete information for all 50 states and the District of Columbia typically becoming public shortly before open enrollment, which begins November 1, 2016.

Methods

Data were collected from health insurer rate filings submitted to state regulators. These submissions are publicly available for the states we analyzed. Most rate information is available in the form of a SERFF (System for Electronic Rate and Form Filing) filing, which includes a base rate and other factors that build up to an individual rate. In states where filings were unavailable, we gathered data from tables released by state insurance departments. Filings are still preliminary. All premiums in this analysis are at the rating area level, and some plans may not be available in all cities or counties within the rating area. Rating areas are typically groups of neighboring counties, so a major city in the area was chosen for identification purposes. Weighted averages are weighted by marketplace enrollment in the state in 2016.

In some cases, the plan that has the second-lowest full-priced silver premium is not the benchmark because two or more other plans may have lower premiums when accounting for the portion of the premium that is attributable to non-essential health benefits. Because this information is not consistently available in these

states, we present the second-lowest full-priced silver plan and note that it may or may not indeed be the benchmark used for subsidy calculation.



Endnotes

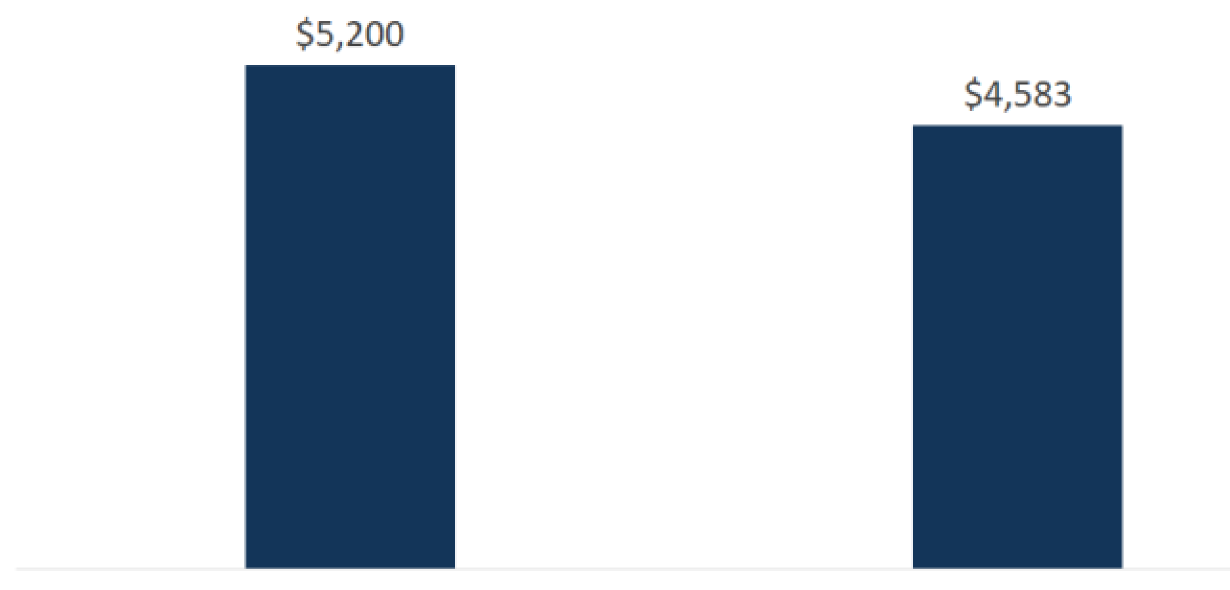
[1] The benchmark for calculating subsidies is the second-lowest cost silver plan, after accounting for the portion of the premium that is attributable to non-essential health benefits like dental or vision care. See methods for details.

How ACA Marketplace Premiums Measure Up to Expectations

Aug 01, 2016 | **Larry Levitt** (http://kff.org/person/larry-levitt/) (https://twitter.com/larry_levitt), **Cynthia Cox** (http://kff.org/person/cynthia-cox/) (https://twitter.com/cynthiaccox), and **Gary Claxton** (http://kff.org/person/gary-claxton/)

Premium increases in the health insurance marketplaces created under the Affordable Care Act (ACA) will likely be higher in 2017 than in recent years. While premiums generally go up every year as the underlying cost of care rises, there are a number of reasons (http://kff.org/private-insurance/perspective/what-to-look-for-in-2017-aca-marketplace-premium-changes/) to expect faster growth this coming year, including the expiration of the ACA's temporary reinsurance program at the end of 2016 and miscalculations by many insurers about how much health care enrollees would use.

Kaiser Family Foundation analysis (http://kff.org/health-reform/issue-brief/analysis-of-2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/) of proposed rates in states that make the information publicly-available shows an average premium increase in the benchmark second-lowest-cost Silver plan in 17 major cities of 9% in 2017, compared to an average increase of 2% in these cities in 2016. The second-lowest-cost Silver plan is a popular choice in this market, and is particularly significant because it is the benchmark for federal subsidies provided to low- and middle-income enrollees. It therefore helps determine how much these subsidies cost the government.



Source: Kaiser Family Foundation analysis using federal marketplace premiums by county, insurer rate filings and state-based marketplace shopping tools, and marketplace enrollment data from HHS. CBO projection from a letter to Senator Evan Bayh, November 30, 2009.

Actual ACA Benchmark Premiums in 2016 vs. CBO Projections

Bigger rate hikes coming in 2017 raise the question of how premiums compare to what was expected when the ACA was considered by Congress. At the time, the Congressional Budget Office (CBO) projected (https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf) that the law would modestly reduce the budget deficit over a ten-year period, taking into account new expenses, new taxes, and savings in existin government health programs. How actual marketplace premiums compare to what CBO expected in doing those budget projections is an important factor in determining whether the ACA continues to be on track to reducing the deficit.

In late 2009, as the debate over the ACA began before the U.S. Senate, CBO (along with the Joint Committee on Taxation) released an analysis (https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/reports/11-30-premiums.pdf) of how premiums in the individual insurance market would change under the law. CBO projected that the average nationwide premium for a benchmark plan (i.e., the second-lowest-cost Silver plan) would be about $5,200 for single coverage in 2016 (the only year for which CBO provided projections).

We estimate that the actual average benchmark premium in the ACA marketplaces in 2016 is $4,583, or 12% below what CBO originally projected. Even if benchmark premiums rise b 9% in 2017, as suggested by our analysis of major metropolitan areas, they would on average remain below what CBO estimated in its projections of the cost of expanding coverage under the ACA.

There are a variety of factors that may explain why premiums are lower than projected, including the persistent slowdown (http://www.healthsystemtracker.org/chart-collection/what-is-behind-the-recent-slowdown-in-health-spending/) in health cost growth and strong competition (http://kff.org/health-reform/issue-brief/analysis-of-insurer-participation-in-2016-marketplaces/) in the marketplaces in much of the country. Even in areas with a handful of plans, insurers face competitive pressure to offer low-cost options as the ACA's market rules allow enrollees to more easily shop for coverage and the subsidy calculation adds financial incentive to do so. These incentives have led some insurers participating in the marketplaces to narrow their provider networks to enable lower premiums.

Lower-than-expected premiums are also the result of underpricing by many insurers, whic led to them taking larger premium increases in 2016 and 2017. There are good reasons to believe that these bigger premium increases are a one-time market correction rather than a trend, as insurers are now able to make use of better data on the claims experience of their enrollees to adjust their premiums to the proper level and as the temporary reinsurance program sunsets. However, there is no guarantee that insurers currently losing money on marketplace business will be able to stem those losses with premium increases. Also, recen exits from the marketplaces and the individual insurance market by some insurers could diminish competition.

While subsidies cushion premium increases for the 82% of marketplace enrollees (http://kff.org/health-reform/state-indicator/marketplace-plan-selections-by-financial-assistance-status/) who receive them, consumers may have to switch plans to obtain the full extent of that protection. During open enrollment for 2016, 43% of returning enrollees switched plans (https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf). If that high degree of plan switching does not persist, though, premium increases could lead healthier enrollees – including those who are not eligible for subsidies – to drop coverage, in turn leading to the need for additional premium increases in coming years. Since insurance pools operate at the state level, experience could vary from state to state.

So far, however, the fact that premiums are coming in lower than expected when the ACA passed suggests some cause for optimism.

METHODS

To estimate the average benchmark premium in 2016, we did the following:

- Determined the premium for the second-lowest-cost Silver plan for a 40 year-old in each county nationwide using the QHP landscape dataset (https://www.healthcare.gov/health-plan-

information-2016/) for the federal marketplace and in each rating area using rate filings or shopping tools for state-based marketplaces.

- Calculated a national average benchmark premium for a 40 year-old weighted by core-based statistical area (CBSA) population.
- Estimated the average benchmark premium across all ages using the standard factors for how premiums vary by age and the national distribution of marketplace plan selections by designated age categories (https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf) (including the small number of enrollees under age 18). We assumed that enrollees were distributed equally within age categories. Six states do not use (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html) the standard age factors, but that should not materially affect the national average premium calculation.

The Office of the Assistant Secretary for Planning and Evaluation within U.S. Department of Health and Human Services reported (https://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue that the average benchmark premium in 2016 for a 27 year-old in states participating in the federal marketplace is $240 per month. Our method produces a similar estimate for the average benchmark premium for a 27 year-old nationwide (including state-based marketplaces) at $245 per month. A recent blog post (http://healthaffairs.org/blog/2016/07/21/obamacare-premiums-are-lower-than-you-think/) in Health Affair by researchers at the Brookings Institution also examined how CBO's premium estimates (http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf) have been lowered since 2009.

The Henry J. Kaiser Family Foundation Headquarters: 2400 Sand Hill Road, Menlo Park, CA 94025 | Phone 650-854-9400

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW, Washington, DC 20005 | Phone 202-347-5270

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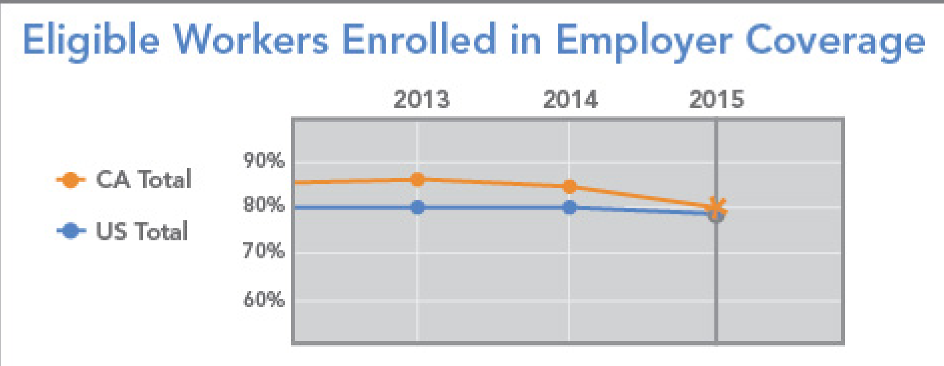
California Employers Continue Offering Insurance, but Fewer Workers Enroll

Lacey Hartman, State Health Access and Data Assistance Center (SHADAC)

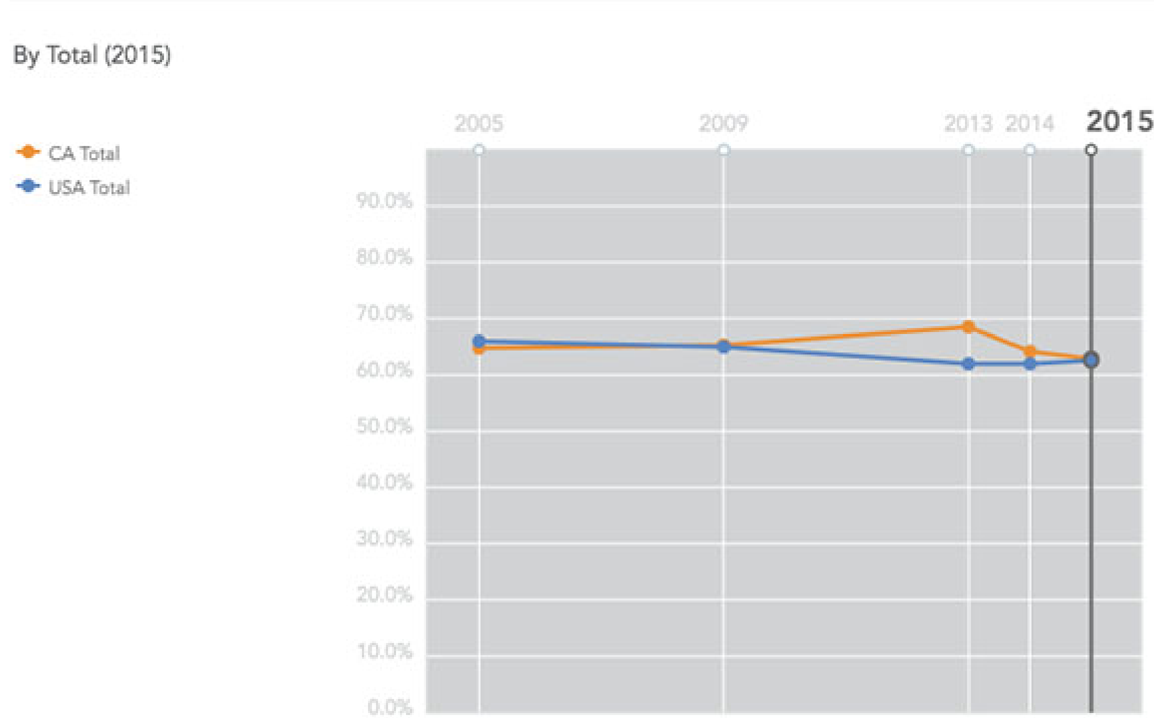
The share of employers who offer insurance to their employees remained stable in California between 2013 and 2015. But the share of eligible employees who chose to enroll dropped from 86.4% to 80.2%.

August 2016



Most Californians under age 65 with health insurance receive it through an employer, but since 2009 the availability of employer-sponsored insurance (ESI) in the state has been on the decline. A key question around the Affordable Care Act (ACA) was whether the reforms would further erode ESI coverage.

Recent results from the 2015 California Employer Health Benefits Survey, now available on ACA 411, show that the availability of ESI remained stable in the state following implementation of the law. There was no significant change in the share of firms that offered coverage between 2013 and 2015, and the share of employees who work at firms that offer coverage also remained stable. (The declines in both measures between 2013 and 2015 in the graphs below are not statistically significant.)

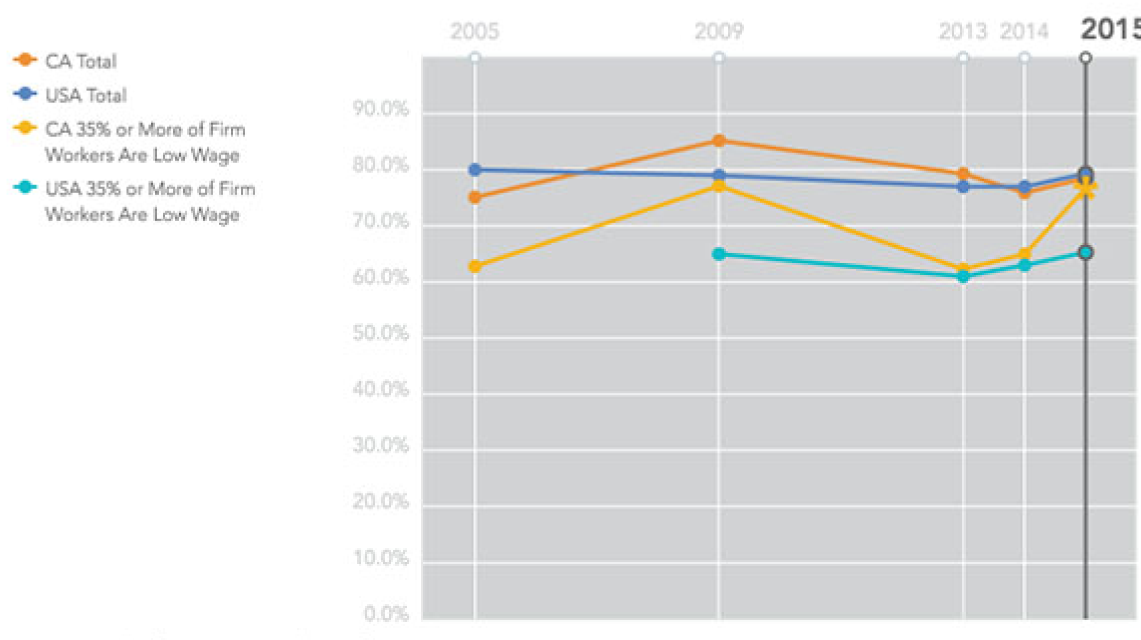


Worker Eligibility for ESI Remained Stable Overall, Increased Among Some Groups

Another issue of potential concern with ACA was whether firms would reduce employees' eligibility for ESI by taking such steps as shifting full-time workers to part-time. This does not appear to be the case in California, where the share of eligible workers at firms that offer coverage remained stable at about 79% between 2013 and 2015. At firms with a

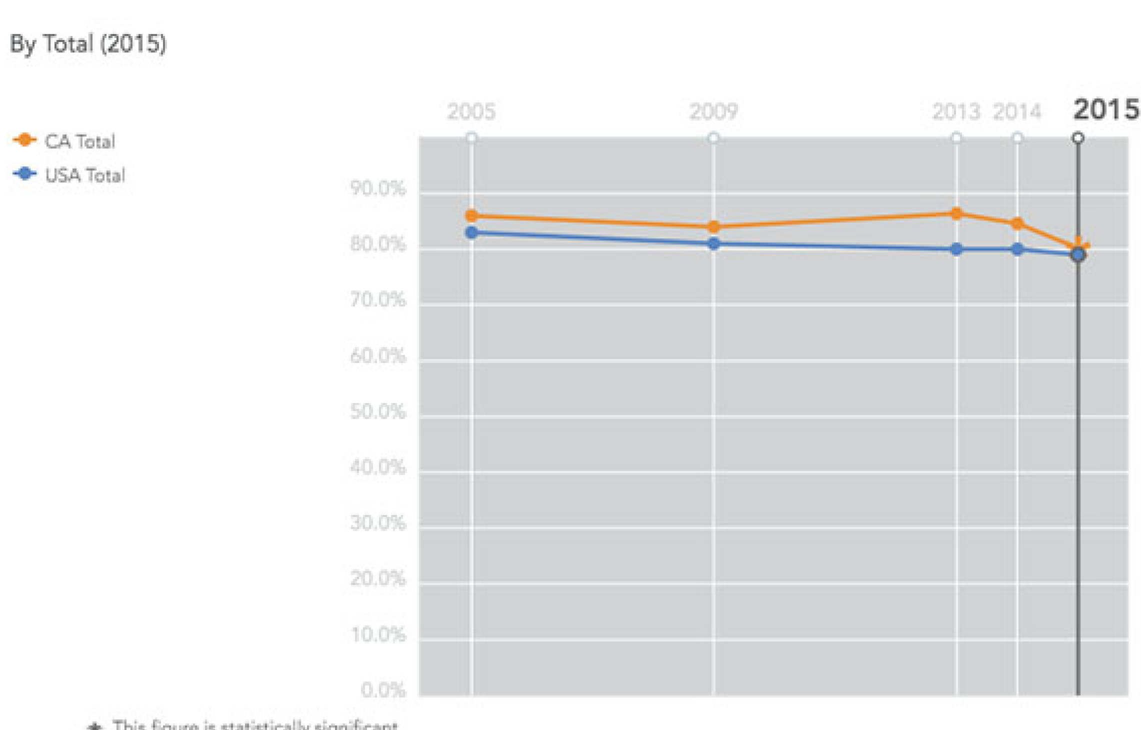
larger share of low-wage employees (more than 35% of workers earning less than $23,000 per year), the proportion of workers who were eligible for coverage actually increased significantly from 62.3% to 76.7% between 2013 and 2015 (yellow line below).

Workers Eligible for Employer Coverage



Fewer Eligible Workers Enroll in ESI

The share of eligible workers who *actually enrolled* in ESI coverage did decline between 2013 and 2015 in California. Also known as the "take-up" rate, this figure declined from 86.4% in 2013 to 80.2% in 2015, a statistically significant change. This decline brings California closer to the national average take-up rate of 79%, which was statistically unchanged between 2013 and 2015.

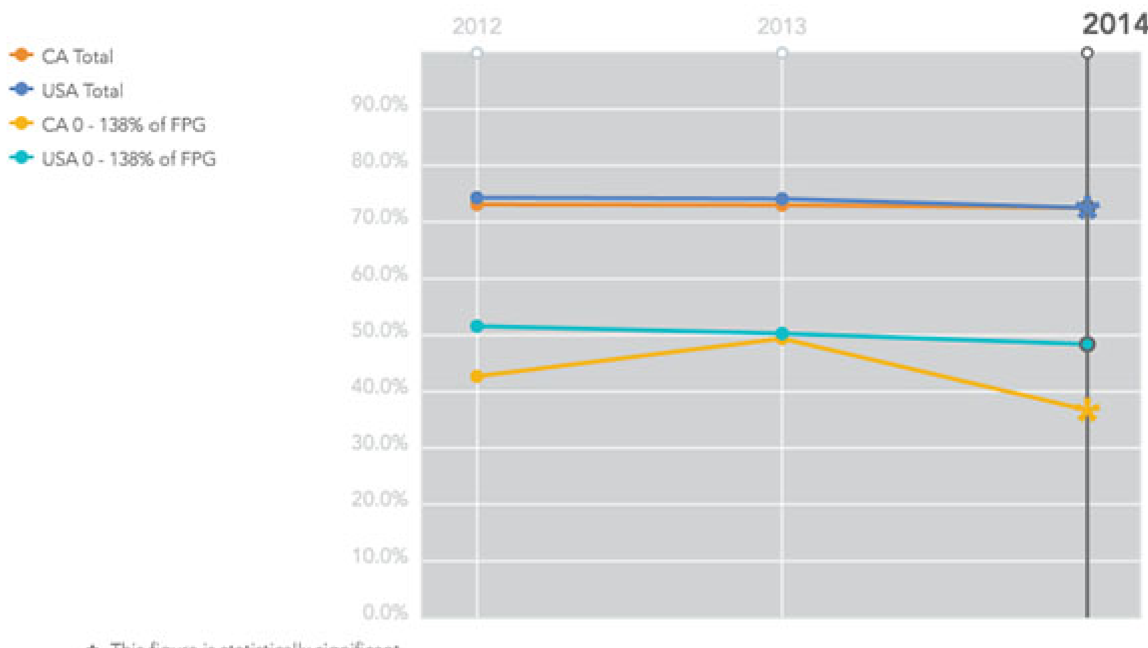


Availability of ESI for Workers' Family Members Remained Stable, While Enrollment Dropped Among Low-Income Family Members

Many individuals obtain ESI as a spouse or dependent of another worker, so it is helpful to track trends in the availability and take-up of ESI at the family level. Between 2013 and 2014 (the latest year for which data are available) the share of families in California with *any* offer of ESI was statistically unchanged, as was the share of families with any ESI offer who enrolled all eligible family members. However, there was a significant decline in enrollment in ESI among low-income families. The share of families with incomes below 138% of the federal poverty level who were offered ESI and enrolled all eligible family members declined by nearly 13 percentage points from 49.4% to 36.7% (yellow line below).

Families Offered ESI with All Family Members Enrolled

By % of Federal Poverty Guidelines (3 Categories) (2014)



The reduction in the share of employees and low-income family members deciding to enroll in ESI when eligible could be driven by multiple factors, including cost and the availability of alternative coverage options, such as Medi-Cal and subsidized coverage through Covered California.

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Women's Health Coverage Since the ACA: Improvements for Most, But Insurer Exclusions Put Many at Risk

August 2, 2016

Authors

Dania Palanker, Karen Davenport

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D. Palanker and K. Davenport, W*omen's Health Coverage Since the ACA: Improvements for Most, But Insurer Exclusions Put Many at Risk,* The Commonwealth Fund, August 2016.

Abstract

Issue: Since enactment of the Affordable Care Act (ACA), many more women have health insurance than before the law, in part because it prohibits insurer practices that discriminate against women. However, gaps in women's health coverage persist. Insurers often exclude health services that women are likely to need, leaving women vulnerable to higher costs and denied claims that threaten their economic security and physical health. Goal: To uncover the types and incidence of insurer exclusions that may disproportionately affect women's coverage. Method: The authors examined qualified health plans from 109 insurers across 16 states for 2014, 2015, or both years. **Key findings and conclusions:** Six types of services are frequently excluded from insurance coverage: treatment of conditions resulting from noncovered services, maintenance therapy, genetic testing, fetal reduction surgery, treatment of self-inflicted conditions, and preventive services not covered by law. Policy change recommendations include prohibiting variations within states' "essential health benefits" benchmark plans and requiring transparency and simplified language in plan documents.

BACKGROUND

The Affordable Care Act (ACA) changed the landscape of the individual health insurance market for women. Before its full implementation, women were routinely charged higher premiums than men, prevented from purchasing coverage for services they needed, or denied coverage altogether. Insurers regularly denied coverage for a range of "preexisting conditions": being pregnant, having undergone a Cesarean section, and even receiving health services after sexual assault.[1 (#/#1)] Women commonly paid more than men for their insurance, at an additional cost of approximately $1 billion per year, and many plans excluded maternity coverage.[2,3 (#/#2)] Such discriminatory practices led women to bear significant costs for health insurance or to forgo care altogether.[4 (#/#4)]

Because of the ACA's rules, insurers can no longer deny coverage or charge higher premiums because of gender or because of current or prior health conditions (Exhibit 1). All individual market plans must cover essential health benefits that include maternity services, birth control, mammograms and other preventive care, and mental health services.

Exhibit 1.
Impr **ovements in Individual Market Health Insurance That Benefit** Women

Plans cannot:	Plans must:
• Base premiums on gender • Vary premiums based on health conditions • Discriminate based on sex • Deny coverage because of a preexisting condition or exclude services to treat a preexisting condition	• Provide preventive services, including birth control, breastfeeding support and supplies, and mammograms, without cost-sharing to eligible women • Cover essential health benefits, including maternity services, mental health, and prescription drugs • Cover any eligible enrollee

However, there are still insurance practices that can leave women without adequate coverage. One such practice is the exclusion of certain services from plan coverage.

In this brief, we present results from our analysis of exclusions in qualified health plans (QHPs) from 109 insurers in 16 states. We identify six categories, and numerous examples, of exclusions that may prevent women from being covered for conditions that disproportionately affect them, or for services they access—even those that are also available to men. Such exclusions can undermine a primary goal of the ACA: to improve women's health and eliminate gender discrimination in health insurance markets.

The service exclusions we identify are often described in health plan materials for consumers in language that is difficult to understand for somebody with limited health literacy, and often they appear only in detailed plan documents that many consumers do not read. As a result, women purchasing insurance may be unaware of this practice and the effect it may have on their coverage.

We review only exclusions described in QHPs' evidence of coverage, or similar documents; we do not address services excluded based on medical necessity determinations, medical policies, or other guidelines. Readers also should note that an insurer that excludes a particular service generally also excludes that service in all or most of the QHPs it offers within a state.

INSURER PLAN EXCLUSIONS THAT AFFECT **WOMEN'S HEAL**TH

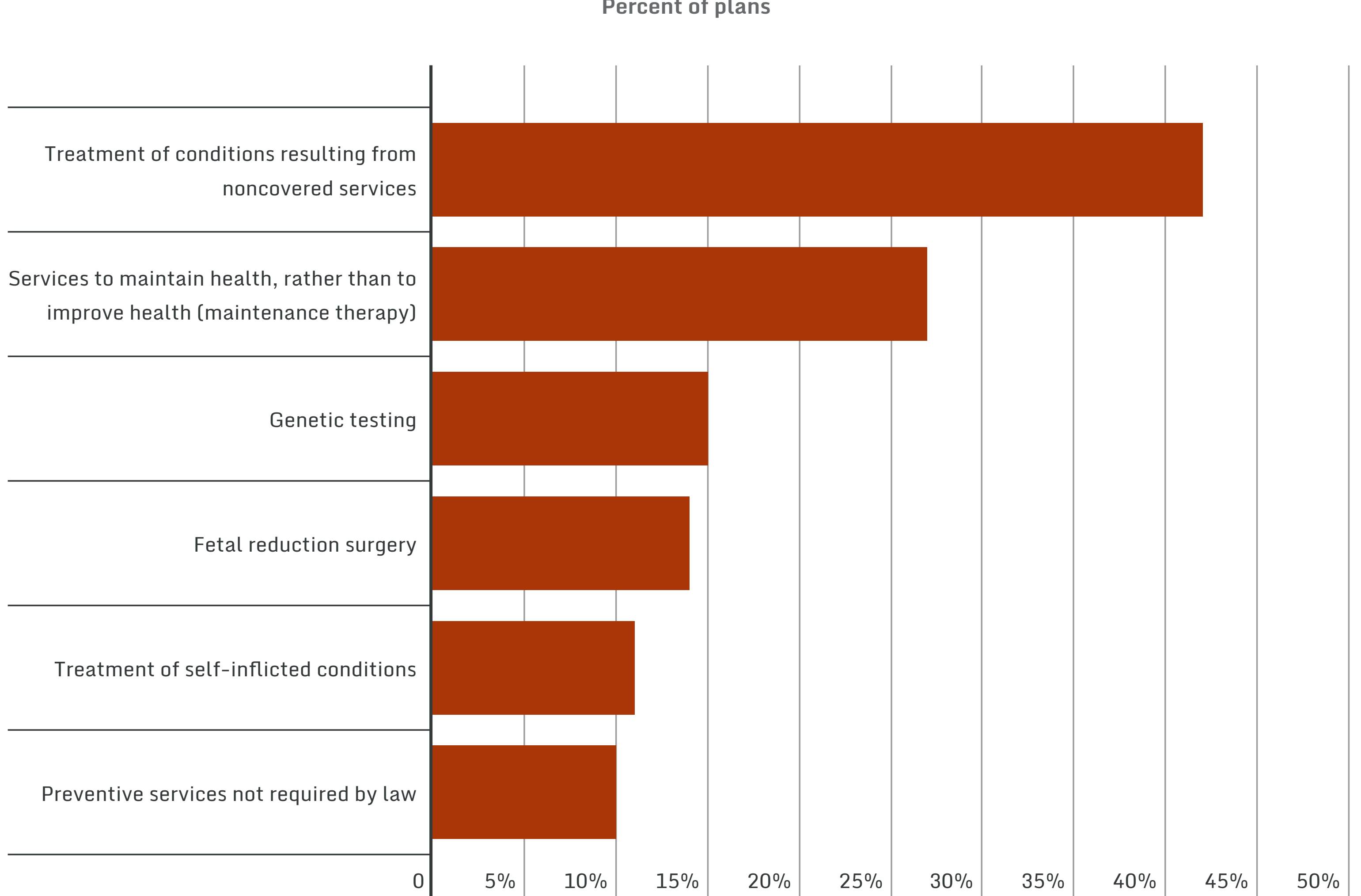
Conditions Resulting from Noncovered Services

Health insurers make determinations of medical necessity and formulate guidelines based in part on medical research—an area that tends to underrepresent women and their particular health needs.[5 (#/#5)] As a result, women's health needs are not always incorporated into medical policies and guidelines informed by such research. Insurers also may deny a claim for needed medical care following the

provision of an excluded service, such as treatment of an infection arising from a prophylactic mastectomy. In our study, 46 of the 109 insurers examined exclude coverage of services that are related to, or arise from, other noncovered services (Exhibit 2 and Exhibit 3 (~/media/dac9dd9e6f244639b5bbc279d7630ff6.ashx)).

Exhibit 2

Incidence of Selected Exclusions in Plans Reviewed



Source: Authors' analysis.

Share

Maintenance Therapy

Twenty-nine of the 109 insurers exclude coverage of maintenance therapy—treatments that maintain health but generally are not expected to lead to improvements—or exclude other ongoing medical treatments that "prevent regression of functions in conditions that are resolved or stable."[6 (#/#6)] Nine of the 29 insurers omit both types of treatment. Women are more likely than men to have lupus, depression, chronic pain, and other chronic health conditions that require maintenance therapy.[7,8 (#/#7)] They are also more likely to have breast and lung cancers, the two most common forms of cancer in women; these conditions also require maintenance therapy to prevent or slow their progression.[9,10 (#/#9)]

Genetic Testing

Sixteen of the 109 insurers exclude coverage of genetic testing not expressly required by law. Women often rely on genetic testing to determine the need for prophylactic, or preventive, services. For example, genetic testing can reveal increased risk for breast or gynecological cancers; although many genetic mutations are connected with this greater risk, insurance plans are required to cover the testing of only two genes.[11 (#/#11)]

For men and women who risk passing on serious genetic conditions, such as sickle cell disease or Tay-Sachs disease, to their child, preconception genetic counseling and testing are also common medical practice.[12 (#/#12)] And women with various risk factors commonly receive prenatal genetic testing to help them make informed decisions about pregnancy and prepare for a child with health needs.[13 (#/#13)]

Fetal Reduction Surgery

Fifteen of the 109 insurers exclude coverage for fetal reduction surgery, a service that may be recommended for a pregnant woman's health or to increase the chances of a successful pregnancy. Multifetal pregnancies carry numerous risks, including hypertension, preeclampsia, and postpartum hemorrhage,[14 (#/#14)] and risks increase with the number of fetuses.[15 (#/#15)] Only one insurer's exclusion for fetal reduction surgery contains an exception for medical necessity.[16 (#/#16)]

Tr**eatment for Self-Inflicted Injuries or Illnesses**

Twelve of the 109 insurers exclude services for self-inflicted injuries or conditions. Because women are more likely than men to both attempt suicide and survive a suicide attempt, for example, such exclusions have a disproportionately harmful impact.[17 (#/#17)] Women and their families often face the financial burden of large medical bills as a result. Moreover, plans do not define "self-inflicted," leaving the scope of the exclusions uncertain. An insurer might rely on this exclusion to, as an example, deny coverage of services to treat malnourishment resulting from an eating disorder, claiming that malnourishment is a self-inflicted condition. Four of the 12 insurers with self-inflicted exclusions have exceptions for injuries or conditions resulting from a physical or mental health condition such as anorexia or depression.[18 (#/#18)] However, insurers may still deny claims for treatment if the provider does not list a diagnostic code for the underlying condition. This can be problematic for women with undiagnosed conditions, such as postpartum depression.[19 (#/#19)]

Pr**eventive Services Not Currently Required by Law**

Eleven of the 109 insurers apply exclusions to prophylactic services. Prophylactic mastectomies and the removal of ovaries and fallopian tubes are widely considered appropriate procedures for women who have inherited particular genetic mutations or have a certain family or personal health history.[20 (#/#20)] Antiretroviral prophylaxis is available for individuals exposed to HIV or other sexually transmitted diseases—particularly significant in the case of sexual assault.[21 (#/#21)] The ACA requires coverage of a broad array of preventive services, but the list of services covered is based on those recommended for the general population, leaving out additional preventive services needed by many women (or other individuals with higher risk profiles).[22 (#/#22)]

PROBLEMS FROM LACK OF TRANSPARENCY

There is little transparency in plan documents regarding health insurance exclusions. As a result, women may unwittingly enroll in plans containing exclusions that impact their coverage, and remain unaware of the exclusions until they seek services or have a claim denied. The short overview of coverage provided for each plan on the marketplace—called the "Summary of Benefits and Coverage"—includes space for information on exclusions. However, only 13 exclusions are required to be listed, and none of the exclusions described in this brief are in that group. Identifying all exclusions requires reading the underlying plan document, such as the evidence of coverage; yet some plan documents are over 100 pages long and exclusions appear in various sections. Terminology also varies among insurers; for example, some plans exclude "maintenance therapy" and others exclude "maintenance care." In addition, some exclusions appear among only a small number of insurers, so women cannot know all the exclusions to look for in

their plans. For example, six insurers exclude services resulting from an enrollee's failure to comply with or accept recommended treatment, which is problematic for women who are less likely than men to adhere to prescription protocols.[23 (#/#23)] These factors make it difficult for women to identify and compare exclusions across plans.

POLICY **RECOMMEND**ATIONS

The ACA has vastly improved health insurance coverage on the individual market for women. But coverage exclusions still impact women's access to health care and continue to impede federal efforts to improve women's health and eliminate gender discrimination in health insurance markets.[24 (#/#24)] As discussed above, exclusions on maintenance therapy to manage chronic conditions, for example, can have the same effect as denying women coverage because of preexisting conditions, by excluding care for preexisting chronic conditions that are disproportionately prevalent in women. Regulators can address these problems through two approaches: prohibiting exclusions that undermine protections in the ACA and increasing transparency in their plans, so that women are aware of exclusions when choosing coverage.

Reduce Variability in State Requirements for Essential Health Benefits

ACA regulations require states to select a plan to use as a benchmark for the law's essential health benefits (EHB) requirements;[25 (#/#25)] states that did not choose a benchmark plan were assigned a state-specific default plan that became the benchmark. However, insurers are allowed to offer benefit packages that substitute some benefits included in the benchmark plan for others, as long as the benefits are in the same category—such as hospitalization—and actuarially equivalent (meaning they provide the same level of coverage).[26 (#/#26)] On the other hand, states may prohibit benefit substitution, which means that those states' QHPs must offer the same benefits as the benchmark.[27 (#/#27)]

Both federal and state regulators can improve the EHB process to ensure that exclusions, like those identified in this brief, do not impede women's access to health care and coverage. Federal regulators could limit or prohibit exclusions through a number of regulatory strategies. For example, they could:

- prohibit benefit substitution in the EHB so that QHPs cannot contain any exclusions that do not exist in a state's benchmark plan
- ban specific exclusions in QHPs or plans offering the EHB
- clarify that an insurer is violating the EHB requirements if it selectively uses exclusions to prevent high-cost claims or encourage high-cost enrollees to drop coverage.

State regulators can limit exclusions through the following actions:

- prohibit substitutions in the EHB, allowing only those exclusions contained in the state's EHB benchmark plan, and reviewing compliance when approving plans
- require insurers whose plans contain exclusions that are not in the EHB benchmark to demonstrate that benefits are substantially similar to the benchmark, in compliance with federal regulations
- review plans for discriminatory exclusions and require insurers to revise these plans.

Ensur **e** Transpar **ency in Plan Documents**

Plan summaries of benefits and coverage provide clear information to enrollees and potential enrollees about cost-sharing for certain services. However, because of a statutory page limit, they cannot describe all excluded services.[28 (#/#28)] While summaries for QHPs must now include information about how enrollees can receive the evidence of coverage or contract, more can be done to improve transparency regarding plan exclusions.[29 (#/#29)]

Online marketplaces can increase transparency using these strategies:

- require QHPs to provide a detailed list of exclusions
- post the complete list of exclusions on the marketplace website in a searchable format
- remind enrollees to review exclusions before completing enrollment.

The ACA has improved women's access to health coverage and care, yet exclusions create gaps in coverage that threaten their full access to health care and economic security. Regulators and insurers must take concrete steps to eliminate exclusions that disproportionately affect women, improve transparency in plan documents, and achieve the law's goal of ensuring that women can obtain the coverage and care they need.

ABOUT **THIS STUDY**

The authors analyzed plan documents from 109 insurers offering qualified health plans in 16 states for 2014, 2015, or both years. They identified language regarding excluded health services (exclusions) that leave gaps in coverage for women's health care needs. This brief builds on a prior analysis of plan language that explicitly violates key requirements of the ACA, such as charging cost-sharing for preventive services.[i]

The analysis includes exclusions that could be used in a manner prohibited under the law, for example, as a subterfuge for a preexisting condition exclusion or as a means of discriminating against women with chronic conditions.[ii] The analysis does not indicate whether medical claims were approved or denied but rather highlights the potential for denial under the plan language.

For most states, the analysis covers one plan year; for eight states, the authors looked at plans from both 2014 and 2015.[iii] Insurers are counted separately for each state and for each product type (i.e., HMO or PPO). In addition, multistate plans are listed separately from other products offered by the same insurer in a state. Insurers whose plan documents for both 2014 and 2015 were reviewed appear only once. Note that insurers may no longer offer some plans, or they may have changed plan language.

[i] See National Women's Law Center, State of Women's Coverage: Health Plan Violations of the Affordable Care Act (http://nwlc.org/wp-content/uploads/2015/04/stateofwomenscoverage2015final.pdf) (NWLC, 2015). Previous analysis by the National Women's Law Center found violations of the ACA by at least one insurer in every state included in the analysis, across a wide range of women's health concerns.

[ii] See 45 C.F.R. Part 107.

[iii] See Exhibit 2 and Exhibit 3 (/~/media/files/publications/issue-brief/2016/aug/palanker_exhibit_03_v2.pdf?la=en) listing all plans reviewed and the category of exclusions in each plan. State plans reviewed for both years: California, Colorado, Connecticut, Maine, Nevada, Ohio, Rhode Island, and Washington. State plans reviewed only for 2014: Maryland, Minnesota, South Dakota, Tennessee, and Wisconsin. State plans reviewed only for 2015: Alabama, Florida, and South Carolina.

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Notes

[1] L. Codispoti, B. Courtot, J. Swedish et al., Nowhere to Turn: How the Individual Health Insurance Market Fails Women (http://nwlc.org/wp-content/uploads/2015/08/NWLCReport-NowhereToTurn-81309w.pdf) (National Women's Law Center, 2008); C. Turner, Rape Is Not a Pre-Existing Condition (https://nwlc.org/blog/rape-not-pre-existing-condition/) (National Women's Law Center, Oct. 22, 2009).

[2] D. Garret, Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act

(http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf) (National Women's Law Center, 2012).

3 B. Courtot and J. Kaye, Still *Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* (http://nwlc.org/wp-content/uploads/2015/08/stillnowheretoturn.pdf) (National Women's Law Center, 2009). Only 13% of individual market plans available to a 30-year-old woman in 2009 provided maternity coverage.

4 See, e.g., R. Robertson, D. Squires, T. Garber, S. R. Collins, and M. M. Doty, Oceans Apart*: The Higher Health Costs of Women in the U.S. Compared to Other Nations, and How Reform Is Helping* (/publications/issue-briefs/2012/jul/oceans-apart-women) (The Commonwealth Fund, July 2012); and S. Rustgi, M. M. Doty, and S. R. Collins, Women *at* Risk*: Why Many Women Are Forgoing Needed Health Care* (/publications/issue-briefs/2009/may/women-at-risk) (The Commonwealth Fund, May 2009).

5 P. Johnson, T. Fitzgerald, A. Salganicoff et al., Sex-Specific *Medical Research: Why Women's Health Can't Wait* (http://www.brighamandwomens.org/Departments_and_Services/womenshealth/ConnorsCenter/Policy/ConnorsReportFINAL.pdf) (Mary Horrigan Connors Center for Women's Health & Gender Biology at Brigham and Women's Hospital, 2014).

6 See 45 C.F.R. Part 156. While the ACA explicitly requires that QHPs cover habilitative services, which help an enrollee keep, learn, or improve skills and functioning for daily living, there is no parallel requirement to cover other medical services specifically meant to maintain or keep a specific level of health.

7 "Women were more likely than men to report multiple chronic conditions," J. Gerteis, D. Izrael, D. Deitz et al., Multiple *Chronic Conditions Chartbook: 2010 Medical Expenditure Panel Survey Data* (http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf) (Agency for Healthcare Research and Quality, April 2014). "Women consistently report a higher prevalence of chronic pain than men . . . and are at greater risk for many pain conditions," Institute of Medicine, Relieving *Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (http://www.nationalacademies.org/hmd/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx) (National Academies Press, 2011). "Females had higher rates of depression than males in every age group," L. Pratt and D. Brody, *Depression in the U.S. Household Population, 2009–2012*, (http://www.cdc.gov/nchs/products/databriefs/db172.htm) NCHS Data Brief, No. 172 (National Center for Health Statistics, Dec. 2014). "More than 90 percent of people with lupus are women between the ages of 15 and 45," Office on Women's Health, "Lupus Fact Sheet (http://www.womenshealth.gov/publications/our-publications/fact-sheet/lupus.html)" (U.S. Department of Health and Human Services, July 16, 2012).

8 "In many cases, there is no cure for chronic pain. Therefore, treatment goals and clinical focus include pharmacologic and non-pharmacologic methods to improve the management of pain, improve quality of life, and decrease suffering," American Academy of Pain Medicine, "Use of Opioids for the Treatment of Chronic Pain (http://www.painmed.org/files/use-of-opioids-for-the-treatment-of-chronic-pain.pdf)" (American Academy of Pain Medicine, Feb. 2013). Recommendations and guidelines for maintenance therapy for depression: American Psychiatric Association, *Practice Guideline for the Treatment of Patients with Major Depressive Disorder* (https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf), 3rd ed. (American Psychiatric Association, 2010). Recommendations and guidelines for maintenance treatment for lupus nephritis: B. H. Hahn, M. A. McMahon, A. Wilkinson et al., "American College of Rheumatology Guidelines for Screening, Treatment, and Management of Lupus Nephritis (http://onlinelibrary.wiley.com/doi/10.1002/acr.21664/abstract)," Arthritis *Care & Research*, June 2012, 64(6):797–808.

9 A health insurance company that excludes coverage for maintenance therapy in QHPs in five states has a medical policy that describes an expensive medication often used for treatment for terminal lung cancers as "medically necessary" and "maintenance therapy." Anthem, "Bevacizumab (Avastin®) for Non-Ophthalmologic Indications (https://www.anthem.com/medicalpolicies/policies/mp_pw_b078445.htm)," Medical Policy (Nov. 2015); see also National Cancer Institute, "Maintenance Therapy (http://www.cancer.gov/publications/dictionaries/cancer-terms?cdrid=45768)," NCI Dictionary of Cancer Terms (National Institutes of Health).

10 Cancer Prevention and Control, "Cancer Among Women (http://www.cdc.gov/cancer/dcpc/data/women.htm)" (Centers for Disease Control and Prevention, June 16, 2016).

11 Marketplace plans must cover screening for harmful mutations related to the BRCA1 and BRCA2 genes for women with a family history of certain cancers, because such screening receives a B grade from the United States Preventive Services Task Force. See http://www.cancer.gov/types/breast/hp/breast-ovarian-genetics-pdq (http://www.cancer.gov/types/breast/hp/breast-ovarian-genetics-pdq).

12 American Congress of Obstetricians and Gynecologists, "Identification and Referral of Maternal Genetic Conditions in Pregnancy (http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Genetics/Identification-and-Referral-of-Maternal-Genetic-Conditions-in-Pregnancy)," Committee Opinion (Oct. 2015); American Congress of Obstetricians and Gynecologists, "Screening for Tay-Sachs Disease (http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Genetics/Screening-for-Tay-Sachs-Disease)," Committee Opinion (Oct. 2005, reaffirmed 2014).

13 American Congress of Obstetricians and Gynecologists, "Prenatal Diagnostic Testing for Genetic Disorders," Practice Bulletin (May 2016); and American Congress of Obstetricians and Gynecologists, "Screening for Fetal Anauploidy," Practice Bulletin (May 2016).

14 B. Luke and M. B. Brown, "Contemporary Risks of Maternal Morbidity and Adverse Outcomes with Increasing Maternal Age and Plurality (http://www.fertstert.org/article/S0015-0282(06)04409-8/fulltext)," Fertility *and Sterility*, Aug. 2007 88(2):283–93.

15 Ibid.

16 Community Health Plan of Washington, "2015 Community HealthEssentials Plus," in Health Care Coverage Agreement for Individuals and Families (Community Health Plan, 2015).

[17] Unpublished National Women's Law Center analysis of data from Injury Prevention & Control: Data & Statistics (WISQARSTM), "Nonfatal Injury Reports, 2001–2013" (Centers for Disease Control and Prevention, 2010–2013). Between 2010 and 2013 women ages 18–65 were 22.6% more likely to have a nonfatal injury from self-harm, including suicide attempts and other self-harm, than were men in the same age range.

[18] See 45 C.F.R. Part 156. The EHB requires that QHPs provide mental health coverage in parity with other health services, but there is a lack of clarity on how this applies if an individual has not been diagnosed with a condition, or if the issuer excludes all self-inflicted injuries or conditions, regardless of physical or mental health diagnoses.

[19] D. Brauser, "Postpartum Depression Underidentified, Undertreated," Medscape, March 21, 2013; S. Thurgood, D. M. Avery, and L. Williamson, "Postpartum Depression (PPD) (http://www.aapsus.org/articles/11.pdf)," American Journal of Clinical Medicine, Spring 2009 6(2):17–22. Postpartum depression is undiagnosed more often than many other health conditions because many providers do not screen for it, and because of social stigma that prevents mothers from reporting symptoms.

[20] National Comprehensive Cancer Network, "Breast Cancer Risk Reduction," in NCCN Guidelines Version 2 2015 (NCCN, 2015). Evidence-based, consensus guidelines recommend these procedures to reduce cancer risk for women with these genetic mutations and for women with a compelling family history or a history of radiation therapy to the chest early in life.

[21] Centers for Disease Control and Prevention, "Sexual Assault and Abuse and STDs (http://www.cdc.gov/std/tg2015/sexual-assault.htm)," in 2015 Sexually Transmitted Diseases Treatment Guidelines (CDC, 2015). Many women need access to prophylactic antiretroviral medications. Excluding such services raises a particular concern for survivors of sexual assault who may not know if they were exposed to STDs.

[22] American Cancer Society, "American Cancer Society Recommendations for Early Breast Cancer Detection in Women Without Breast Symptoms (http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-acs-recs)," in Breast Cancer and Early Detection (Oct. 20, 2015). Providers may recommend an MRI for women with higher than average risk for breast cancer, but MRIs are not included in the ACA's required preventive services.

[23] See, e.g., C. M. Puskas, J. I. Forrest, S. Parashar et al., "Women and Vulnerability to HAART Non-Adherence: A Literature Review of Treatment Adherence by Gender from 2000 to 2011 (http://link.springer.com/article/10.1007%2Fs11904-011-0098-0)," Current *H*IV/AID*S R*eports, Dec. 2011 8(4):277–87; M. Manteuffel, S. Williams, W. Chen et al., "Influence of Patient Sex and Gender on Medication Use, Adherence, and Prescribing Alignment with Guidelines (http://online.liebertpub.com/doi/abs/10.1089/jwh.2012.3972)," Journal *of W*omen's *H*ealth, Feb. 2014 23(2):112–19.

[24] See, e.g., these statements on H.R. 4872. Representative Barbara Lee: "While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children," 111 Cong. Rec. 156, H1632 (March 18, 2010). Representative Nancy Pelosi: "It's personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition," 111 Cong. Rec. 156, H1896 (March 21, 2010). Senator Barbara Boxer: "Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform," 111 Cong. Rec. 155, S10263 (Oct. 8, 2009). Senator Barbara Mikulski: "Health care is a women's issue, health care reform is a must-do women's issue, and health insurance reform is a must-change women's issue because . . . when it comes to health insurance, we women pay more and get less," 111 Cong. Rec., S10265 (Oct. 8, 2009).

[25] 45 C.F.R. Part 156.

[26] 45 C.F.R. Part 156.

[27] J. Giovannelli, K. Lucia, and S. Corlette, Implementi*ng t*he Affordable *Car*e Act*: R*evisiti*ng t*he ACA's *E*ssential *H*ealt*h B*enefits *R*equirements *(/*publications/issue-briefs/2014/oct/revisiting-aca-essential-health-benefits-requirements) (The Commonwealth Fund, Oct. 2014). Only nine states and the District of Columbia ban substitutions.

[28] 42 U.S. Code § 300gg–15.

[29] 45 C.F.R. Part 147.