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COVERED CALIFORNIA™

News Release

Media line: (916) 206-7777 Email: media@covered.ca.gov

FOR IMMEDIATE RELEASE
April 27, 2017

New Analysis Shows Potentially Significant Health Care Premium Increases and Drops in Coverage If Federal Policies Change

- *California's premiums could rise by 28 to 49 percent in 2018, and up to 340,000 consumers could lose individual market coverage if changes are made to existing federal policies.*
- *The potential rate increase would mean billions of dollars in additional federal spending. The 1.2 million consumers who do not receive subsidies would bear the entire brunt of these increases.*
- *The potential decrease of 340,000 insured consumers would not only represent many individuals losing access to potentially life-saving care, but it would result in a sicker risk mix in the individual market and higher premiums for everyone.*

SACRAMENTO, Calif. — A new analysis shows the dramatic consequences facing Californians if federal policies are changed from the current structure and there is no longer direct federal funding of cost-sharing reduction (CSR) reimbursements and the individual shared responsibility payment is not enforced when a consumer chooses not to purchase coverage.

The analysis found that Covered California health plan premiums could rise up to 49 percent if two key elements that have been in place for the past four years are changed: Cost-sharing reduction reimbursements are no longer directly funded as reimbursements to carriers, and the shared individual responsibility payment is not enforced.

(more)

"California and the majority of markets across the nation are stable and working right now, but the possibility of changing the rules of the industry is threatening to upend markets and put consumers at risk," said Peter V. Lee, executive director of Covered California. "This specter of uncertainty could lead to dramatically higher rates, but there is still time to take the concrete steps necessary to keep the marketplaces stable and preserve coverage for millions of people."

The analysis, commissioned by Covered California and conducted by PricewaterhouseCoopers (PwC), also found that without CSR reimbursements and enforcement of the individual responsibility payment (sometimes called the individual mandate or individual penalty), up to 340,000 Californians would drop from coverage in the individual market in 2018.

"Failure to support cost-sharing reduction subsidies results in significant increases in premiums, in particular for unsubsidized Silver plans. Fewer people would participate with these higher premiums, which would lead to a drop in coverage in the unsubsidized market," said Sandra Hunt, principal at PwC.

"Our analysis also highlights the critical importance of enforcing the individual mandate," continued Hunt. "If federal policy were to change and the individual mandate were not enforced, not only would premiums rise significantly, but up to 340,000 could lose health coverage."

In addition, a previous analysis conducted by Covered California found that due to a requirement for carriers to build cost-sharing reduction payments into premiums, discontinuing funding directly to carriers would result in increased federal spending. Costs would rise by more than $4 billion in 2018 alone, and tens of billions of dollars would be added to the federal budget over 10 years.

"Because of the interplay between rising premiums and premium subsidies, the federal government would end up paying tens of billions of additional dollars if they do not fund the cost-sharing reduction subsidies," said Lee. "There is no logic to not funding cost-sharing reductions. They achieve two important goals: They help low-income consumers afford health care, and they allow the federal government to spend less."

Lee urged the federal government to provide clarity on these issues as soon as possible, since health plans are finalizing rates that need to be locked down by June 15, 2017.

"Stopping the funding of CSR reimbursements, or even leaving the payments up in the air, would mean carriers would raise their prices to account for the uncertainty — costing the federal government billions in higher subsidy payments," Lee said. "Even more important is the enforcement of the penalty, which boosts enrollment, builds a healthier pool of consumers and lowers premiums for everyone."

(more)

The high potential rate increases would lead to hundreds of thousands of subsidized individuals deciding to go without insurance. For those who decide to keep their coverage, they would likely face relatively little impact, since their federal subsidies would also increase. The 1.2 million Californians on the individual market who do not receive subsidies, both in Covered California and off exchange, would pay the full cost of any premium increases.

The full analysis can be found here: http://hbex.coveredca.com/data-research/library/CoveredCA_Impact_to_CA_ind_market_4-27-17%20(1).pdf.

"While Californians face significant uncertainty, in many other parts of the nation the premium increases would be far larger, and it is possible that many areas would have no health plan offering coverage in the individual market," Lee said. "The cost of inaction or indecision is high and consumers, particularly those who do not get any financial help, will end up bearing the cost."

About Covered California
Covered California is the state's health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the legislature. For more information about Covered California, please visit www.CoveredCA.com.

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Analysis of Impact to California's Individual Market If Federal Policy Changes Are Implemented

Effect on Premiums, Enrollment and Coverage in 2018

This analysis was prepared by John Bertko, chief actuary for Covered California and Sandra Hunt, principal for PricewaterhouseCoopers for Covered California's ongoing planning and to inform policy making in California and nationally.

April 27, 2017

Summary

- Urgent clarity is needed on federal policies related to the enforcement of the individual mandate and the funding for financial assistance to consumers in the form of cost-sharing reductions (CSR). Health plans must set their rates for 2018 by June 2017 and these potential changes in existing federal policies have significant impacts.
- Under current trends, assuming continued direct federal funding of cost-sharing reductions and enforcement of the individual mandate, enrollment in California's market for individual coverage is projected to stay strong and stable in 2018, maintaining or even decreasing the historically low rate of uninsured achieved over the past four years.
- Failure to directly fund cost-sharing reductions and enforce the mandate could result in an estimated premium rate increase of 42 percent on average in California for 2018, and as high as 49 percent for enrollees in Silver plans, with over 1.2 million on and off the exchange receiving no federal subsidy to soften the impact of the large increase.
- Failure to enforce the penalty for not having health insurance could result in total premium increases of more than 28 percent, and up to 350,000 consumers who would otherwise get coverage likely going uninsured in 2018.

Analyzing Impacts of Changes to Federal Policies on 2018 Premiums, Enrollment, and Coverage

Millions Affected by Uncertainty: There is great uncertainty about the federal policies that have been in place for the past four years and are critical to the stability of the nation's health care markets. Health plans across the country are making business decisions for 2018 that will affect the coverage of approximately 19 million Americans who get their insurance through these non-group markets.[1] California has about 2.4 million individuals in this market, with 1.3 million getting their insurance through Covered California and 1.1 million purchasing directly from insurers "off exchange."[2]

To assist health plans in developing initial premiums and to help policy makers understand the potential outcomes of changing federal policies without clearly articulating the approach for ongoing enforcement of the penalty, Covered California commissioned PricewaterhouseCoopers (PwC) to develop initial 2018 enrollment, premium and coverage estimates for California's individual market for the following scenarios:

1. Base estimate assuming no federal policy changes;
2. No direct federal funding for CSRs and non-enforcement of the individual mandate; and
3. Continued direct federal funding for CSRs but non-enforcement of the individual mandate.

Urgent Need for Clear Policy: Covered California health insurance carriers are actively developing their 2018 rate submissions and will submit preliminary proposals on May 1. Across the nation, carriers are also submitting initial premiums and in most cases those rates must be totally finalized by June. Carriers will ultimately propose rates that each believes are sufficient to cover the anticipated medical cost trend and changes to the risk mix of those they are covering:

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[1] https://aspe.hhs.gov/system/files/pdf/208306/OffMarketplaceSubsidyeligible.pdf and https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html

[2] Using the most recent publicly available administrative data (December 2015), we estimate that 800,000 off-exchange consumers are in Affordable Care Act-compliant plans and the remaining 300,000 are enrolled in grandfathered plans that are not available for purchase.

With a worse risk mix, the health plan will need to increase premiums. The scenarios that follow illustrate the importance of the individual mandate and of continued direct funding of CSRs to ensure a healthy risk mix for carriers and to keep premiums low.

All Individual Market Consumers Are Affected: All consumers in the individual market will be affected by these decisions. Many consumers in the market receive premium tax credits under the Patient Protection and Affordable Care Act that are based on their income. To a large extent, these credits will adapt to provide some financial relief from these increases. Those credits, however, phase out as income increases and are not available to consumers making more than 400 percent of the federal poverty level (about $48,000 annual income for an individual in 2018). Still, increases in tax credits due to premium increases will also result in unnecessary increased federal spending because the higher premiums will directly result in higher tax credits. The 1.1 million Californians in the non-group market who do not receive federal tax credits to help make their coverage more affordable must bear the full amount of any annual rate increase. They will be more negatively affected.

While this analysis assesses potential changes to premiums, enrollment and the number of uninsured, the broader implications of significant increases in the number of the uninsured are beyond the scope of this research (such as personal bankruptcies, the health care impacts of uninsured individuals not getting needed care and increases in uncompensated care by hospitals).

Summary of Potential Impacts[3]

The following are descriptions of each scenario's assumptions and modeling results, which are summarized in Table 1 below.

Scenario One: Covered California Base Estimate

California currently has a stable and actively competitive market of roughly 2.4 million consumers in the individual market. The state has seen an average three-year premium trend of approximately 7 percent since 2014. Under the base estimate for 2018, the premium rate increase is anticipated to be 9 percent, which reflects an increase in medical costs of 7 percent, based on current national averages, plus an additional one-time 2 percent increase reflecting the expiration of the health insurer tax "holiday."[4] Premium increases will naturally vary by issuer depending on their enrollee risk mix, their medical trend and related experience.

Based on the past four years' experience and the base premium increase, PwC projects stable enrollment both on- and off-Covered California. Enrollment in the individual market is projected to be about 2.4 million at the end of 2018, with about half receiving subsidies and the other half benefiting from the competitive market forces, but not directly receiving a subsidy. This estimate assumes no major changes in federal policy or funding, and is based on Covered California's "medium" 2018 projection of 1.3 million enrollees, informed by four years of enrollment, renewal and sign-ups during both the open-enrollment and special-enrollment periods. Given the natural

[3] All estimates are presented as rounded point estimates: there is considerable uncertainty about various drivers in the premium and take-up modeling, so these estimates should be taken as the mid-point in a range of possible impacts identified in the course of the modeling.

[4] The health insurer tax ("Health Insurance Providers Fee") is scheduled to total $14.3 billion nationally in 2018. It is allocated based on each insurer's share of aggregate net premiums (among other factors), and is estimated by the CBO to increase premiums by 2 to 2.5 percent. See summary from Internal Revenue Service at https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010. See also the Congressional Budget Office and Joint Committee on Taxation discussion on page 17 of "Private Health Insurance Premiums and Federal Policy" (February 2016): https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.

substantial movement of consumers into and out of the individual market — with consumers leaving to get job-based or other coverage and joining the market as they lose other coverage — and maintaining the "same" total enrollment still reflects large new enrollment through the year. Under the base estimate, across the open-enrollment and special-enrollment periods, approximately 600,000 Californians would newly enroll in coverage through Covered California in 2018 as a result of extensive marketing and outreach efforts.

One key factor in developing the base estimate is California's relative success at expanding coverage and reducing the uninsured, both through Covered California and the expansion of the state's Medicaid program ("Medi-Cal"). As of fall 2016, the uninsured rate in California had fallen to a historic low of 7.1 percent. The "eligible uninsured" rate, however, is only about 3.6 percent when those not eligible for subsidized coverage are excluded.[5] This means the opportunity for dramatic expansions in coverage is limited.

Scenario Two: No Direct Cost-Sharing Reduction Funding and Non-Enforcement of the Individual Mandate

In the event that CSRs are not directly funded and the penalty for not purchasing affordable coverage is not enforced, the number of Californians with insurance coverage in the individual market would fall from 2.4 million to 2.07 million, or a drop of around 14 percent, leading to an estimated increase in the uninsured of approximately 330,000. For Californians receiving help purchasing coverage with a federal premium tax credit through Covered California, enrollment in 2018 would fall by approximately 260,000, or 22 percent compared to the base estimate. For Californians who do not receive a subsidy, enrollment would fall by approximately 70,000 individuals. Under this scenario, premiums would rise by an estimated 30 percent over the base premium assumption of 9 percent, for a total potential premium increase of 42 percent. Covered California and PwC project potential premium increases of 17.5 percent due to adverse selection associated with non-enforcement of the individual mandate.[6]

Additionally, because health plans must provide enhanced benefits of cost-sharing reduction subsidies to low-income consumers enrolled in Silver plan by law, if the CSR payment are not funded by the federal government, health plans would be forced to raise premiums on Silver-tier consumers to cover the value of the richer coverage consumers receive with CSR. We estimate that the Silver premiums would need to increase by 16.6 percent to account for the loss of CSR funding.[7] On average, across all enrollees in all metal tiers, the loss of CSR funding would represent an additional 11 percent premium increase required for health plans to fund CSR absent direct federal funding.

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[5] Based on Covered California's analysis of the American Communities Survey 2015 data on the source of coverage for Californians, and estimates of eligibility for coverage among the uninsured by CalSIM and the Kaiser Family Foundation: http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/ http://laborcenter.berkeley.edu/pdf/2016/Preliminary-CalSIM-20-Regional-Remaining-Uninsured-2017.pdf.

[6] Using Congressional Budget Office estimate of the impact on non-enforcement of the mandate in 2018, from "Cost Estimate of the American Health Care Act" (March 13, 2017), on page three: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

[7] For impacts of not funding CSRs, see Yin and Domurat (2017): http://www.coveredca.com/news/pdfs/CoveredCA_Consequences_of_Terminating_CSR.pdf and technical appendix at http://www.coveredca.com/news/pdfs/Appendix-Consequences_of_Terminating_CSR.pdf
Note that the Yin and Domurat analysis assumed that health plans loaded the entire cost of funding the CSRs on the Silver Tier plans, for an increase of 16.6 percent to Silver plans and no change to Bronze, Gold or Platinum. Based on Silver tier's share of total enrollment, PwC and Covered California use an estimated premium impact of 11 percent after averaging across all tiers. However, as noted in Yin and Domurat, the impact to consumers will vary depending on whether the value of CSR premium impact is concentrated only on Silver tier or spread across all metal tiers evenly.

Taken together, compounding the existing medical trend and health insurance tax impacts from Scenario 1 with the combination of non-enforcement of the individual mandate and the loss of CSR funding would increase premiums in 2018 by an average of 42 percent, with Silver enrollees facing a total premium increase of roughly 49 percent, while non-silver enrollees would face increases of roughly 28 percent. The premium increase caused by these policy changes would result in a worse risk mix and higher premiums for those not receiving subsidies as healthier, lower-risk consumers are "priced out" of coverage. See "Related Research" for analysis of the impact of requiring health plans to pay for CSR by raising premiums and the likely significant increases in federal spending.

Scenario Three: Non-Enforcement of the Individual Mandate

In the event that the federal penalty for not purchasing affordable coverage is not enforced, the number of Californians with insurance coverage in the individual market would fall from 2.4 million to approximately 2.06 million, a 14 percent drop, leading to an increase in the uninsured of approximately 340,000. For Californians receiving help purchasing coverage with a federal premium tax credit through Covered California, enrollment in 2018 would fall approximately 280,000, or 24 percent, compared to the base estimate. For Californians who do not receive a subsidy, enrollment would fall by approximately 60,000 individuals.

Covered California and PwC project potential premium increases of 28 percent, with an increase of 17.5 percent over the Covered California base premium estimate due to adverse selection associated with non-enforcement of the individual mandate. Similar to Scenario Two, this would result in a worse risk mix and higher premiums for those not receiving subsidies, as healthier, lower-risk consumers drop coverage.

Table 1. **Summary of Potential 2018 Premium and Enrollment in California Based on Key Federal Policies**

	Scenario 1: Covered California Base Estimate	**Scenario 2:** No CSR Funding, Non-Enforcement of the Individual Mandate	**Scenario 3:** Non-Enforcement of the Individual Mandate
Estimated Premium Increase for 2018	9%	42%*	28%
Change From Base Estimate		*30%*	*17.5%*
Projected Enrollment			
On Exchange (Covered California)	1,300,000	1,020,000	1,000,000
Exchange Subsidized	*1,170,000*	*910,000*	*890,000*
Exchange Unsubsidized	*130,000*	*110,000*	*110,000*
Off Exchange	1,100,000	1,050,000	1,060,000
California Total Enrollment	**2,400,000**	**2,070,000**	**2,060,000**
Projected Enrollment, by Subsidy Status			
Total Subsidized	*1,170,000*	*910,000*	*890,000*
Total Unsubsidized	*1,230,000*	*1,160,000*	*1,170,000*
California Total Enrollment	**2,400,000**	**2,070,000**	**2,060,000**

* Premium increase for 2018 for Silver enrollees estimated to be 49 percent total under Scenario 2, or 40 percent higher than base estimate.

Notes:

1. *The values in the table above include rounded "mid-point" of potential enrollment impact. See the technical appendix for more details.*
2. *Covered California base estimate is the average effectuated enrollment for 2018. At the close of the open-enrollment period for 2017, the total exchange population is 1.4 million.*
3. *The total population of consumers with unsubsidized coverage includes those enrolling both through Covered California and "off exchange." Roughly 10 percent of exchange enrollment is unsubsidized. Off-exchange enrollment primarily means those enrolled in Covered California mirrored products, which reflect the prices negotiated by Covered California and have identical benefit designs, provider networks and other features.*
4. *The figures here reflect changes in coverage: decreases in coverage that are very likely to mean individuals become uninsured. Some may maintain insurance from other sources, such as COBRA. The scenarios analyzed suggest that failing to enforce the mandate, or failure to fund financial help for consumers in the form of CSRs, would lead to an increase in the uninsured. This could lead the ranks of the uninsured (yet eligible for coverage) to grow by 25 percent or more in California in 2018 alone (based on Covered California's estimate of approximately 1.2 million uninsured yet eligible for coverage).*

Similar or Worse Impacts Are Likely in Markets Across the Nation

The modeling results summarized here focus on California's individual insurance market, but similar or worse results should be expected nationwide. Because health care is local, the magnitude of the impacts in other states is likely to vary significantly, but the *directional* effects should be consistent with the analysis for California.

Basic dynamics are the same across the country: The subsidy structure for premium tax credits, cost-sharing reductions, and the rules relating to health plan ratings are spelled out in federal law and are the same across the nation. Thus, it is reasonable to expect impacts in other states that are *directionally* similar to the analysis about California provided here.

California has a stable market — impacts could be more severe in other states: California has established a robust and competitive insurance market, with a three-year average rate increase from 2014 to 2017 of about 7 percent. It is likely that in most other states the impacts would be far more significant — with larger premium increases that would drive even more substantial reductions in the number of people covered by insurance.

For example, California has robust competition, with 11 health plans competing across the state as of 2017 and 92 percent of consumers having the choice of at least three carriers. Two out of three consumers in California have more than five carriers on their local market, and no consumer has fewer than two carriers to choose from. This is not the reality in many other health care markets, where over 30 percent of counties in the U.S. have only one carrier available.[8] In those areas, the potential implication of near-term federal policy decisions is not just one of changes in premiums and enrollment, but the danger that if the single carrier leaves, there could be broad areas of the country with no carriers participating in the individual market.

A critical ingredient of success for California is the intensity of the marketing and outreach used to promote enrollment, and the steps taken to improve consumer choice that drives value in health coverage (such as the use of patient-centered benefit designs). The intensity of marketing and outreach varies widely for other state marketplaces and for those states whose exchanges are run by the federal government (known as "federally facilitated marketplaces").

Differences in these aspects of marketplace implementation have created variation around the nation in the mix of health plans' participation in marketplaces and the health status of those who are enrolled in coverage. These variations in turn would impact the magnitude of premium increases observed under these same federal policy scenarios.

Related Research

The premium and enrollment estimates above build on and complement recent Covered California analyses of the potential premium, enrollment, coverage and federal budget impacts of key policy decisions which are highlighted below.

1. **Funding for Cost-Sharing Reductions** — Health plans are required by federal law to offer CSRs. Analyses developed by Covered California, and updated on April 26, show that not only will federal spending on premium tax credits increase if CSRs are not funded, but consumers purchasing unsubsidized coverage would be less likely to enroll or maintain coverage due to the significant premium increases that would be required to fund

[8] See http://www.vox.com/science-and-health/2016/10/26/13407610/obamacare-counties-one-insurer and http://healthaffairs.org/blog/2017/03/30/aca-round-up-bill-would-allow-use-of-tax-credits-for-off-marketplace-plans-and-more/

CSRs absent federal funding.[9] In particular, the analyses find that not directly funding CSRs would cost the federal government $4 billion more in 2018 due to the increased tax credit spending that far exceeds the reduction in direct CSR payments. The estimated increased cost over 10 years is $80 billion.

2. **Enforcement of the Individual Mandate** — This element of the current law helps ensure a healthy pool of consumers and lower premiums, particularly for those who do not receive subsidies. Without enforcement of the penalty, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that average premiums in 2018 and 2019 would be 15 to 20 percent higher than they would be otherwise.[10] Covered California commissioned an analysis by PwC in 2016 to quantify the enrollment impact of non-enforcement of the individual mandate.

3. **Establishing Stability Funding for 2018 and 2019** — The American Health Care Act (AHCA) recognized the need to help stabilize the health insurance market, mitigate rate increases and encourage enrollment. An estimate by Covered California showed that a $15 billion appropriation, if used for reinsurance, would reduce 2018 premiums by 12 to 18 percent depending on the market, but the cost to the federal government would be less than $4 billion because the funds would lead to a reduction in tax credit payments.[11]

[9] http://hbex.coveredca.com/data-research/library/Federal Budget Impact of Not Funding CSRs-04-14-17 Final_.pdf and http://www.coveredca.com/news/pdfs/CoveredCA_Consequences_of_Terminating_CSR.pdf

[10] https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf

[11] http://hbex.coveredca.com/data-research/library/RiskStabilization-FederalSpendingImpact-04-14-17-Final.pdf

TECHNICAL APPENDIX

This appendix summarizes the assumptions and enrollment outputs from modeling in two scenarios (Scenarios 2 and 3) of federal policy related to the individual market for 2018.

Scenario 2: No Direct CSR Funding and Non-Enforcement of the Individual Mandate

Impact	Assumptions	Additional Rationale/Notes
Premiums + 42 percent	+7% base net premium increase	• Assuming average Coverage California premium growth 2014-17 for following years
	+2% increase from Health Insurance Fee	• One-time effect in 2018 only
	+11% increase from not funding CSR credits	• Premium increase due to CSR elimination is anticipated to be 16.6% for Silver and 0% for all other tiers, resulting in an estimated 11% increase on average. • Approximately 50% of individuals choose Silver CSR plans, and 65% overall choose Silver plans.
	+17.5% increase from non-enforcement of Individual mandate	• CBO estimates 15 to 20% (mid-point: 17.5%) increase in premiums due to rollback/non-enforcement of individual mandate penalty • Approximately 50% of the enrollees in the individual market are eligible for CSR credits, and are likely to be affected by both the individual mandate and CSR credit repeals.
Enrollment On Exchange: (265K to 300K) decrease	(270K to 300K) decrease in subsidized individuals from individual mandate	• CalSIM/PwC analysis presented at May 2016 board meeting
	(15K to 20K) decrease in unsubsidized individuals from individual mandate	• Based on elasticity estimates for unsubsidized population due to a 17.5% increase in premiums
	+20K increase in subsidized individuals from CSR credits	• Per Covered CA/UCLA analysis, payors will make up reduction in CSR largely through premium increases, raising the levels of Advanced Premium Tac Credits (APTC) across all plans
	(1K) decrease in unsubsidized individuals from CSR credits	
On Exchange: Projected 2017 Enrollment		**On Exchange: Projected 2017 Enrollment**
On Exchange: Enrollment Decrease		**On Exchange: Enrollment Decrease**
On Exchange: Projected 2017 Scenario Enrollment		**On Exchange: Projected 2017 Scenario Enrollment**
Enrollment Off Exchange: (45K to 55K) decrease	(40K to 50K) decrease in unsubsidized individuals from individual mandate	• Based on elasticity estimates for unsubsidized population due to a 17.5% increase in premiums
	(6K) decrease in unsubsidized individuals from CSR credits	• Increase in premiums will lead to a moderate decrease in Individuals off exchange
Total Enrollment Decrease (On and Off Exchange)		**(310K to 355K)**

Scenario 3: Non-Enforcement of the Individual Mandate Only

Impact	Assumptions	Additional Rationale/Notes
Premiums +28% increase in premiums	+7% baseline net premium increase	• Assuming average Covered California premium growth 2014-17 for following years
	+2% increase from Health Insurance Fee	• One-time effect in 2018 only
	+17.5% increase from non-enforcement of individual mandate	• CBO estimates 15% to 20% (mid-point: 17.5%) increase in premiums due to rollback/non-enforcement of individual mandate penalty
Enrollment On-Exchange: (285K to 320K) decrease	(270K to 300K) Subsidized impact	• CalSIM/PwC analysis presented at May 2016 board meeting
	+7% baseline net premium increase	• Assuming average Covered California premium growth 2014-17 for following years
On Exchange: Projected 2017 Enrollment		**1.29M**
On Exchange: Enrollment Decrease		**(285K to 320K)** *(22% to 25%)*
On Exchange: Projected 2017 Scenario Enrollment		**0.97M to 1.00M**
Enrollment Off-Exchange: (40K to 50K) decrease	(40K to 50K) from repeal of mandate	• Based on elasticity estimates for unsubsidized population due to a 17.5% increase in premiums
Total Enrollment Decrease (On and Off Exchange)		**(325K to 370K)**

Potential Impact to the Federal Budget of Not Directly Funding Cost-Sharing Reduction Subsidies

Updated April 26, 2017

Under current law, qualified health plans are required to offer cost-sharing reduction (CSR) subsidies to eligible individuals. Removing direct federal funding — received by carriers for the past three years and budgeted for 2017 — without changing the requirement that health plans in exchanges must offer the CSR Silver-variant plans would have significant negative effects on the federal budget. This projection details the rationale and potential size of those impacts.

Several analysts (including the Office of the Assistant Secretary for Planning and Evaluation) have concluded that the 2018 premium for Silver plans would need to be raised to ensure that premiums adequately cover the cost of coverage for the richer benefits required by the Patient Protection and Affordable Care Act for lower-income enrollees.[1]

Since the direct federal funding of subsidies is linked to the cost of the second-lowest Silver plan, if Silver premiums must be increased by 15 to 20 percent to cover the cost of CSRs, then the Advanced Premium Tax Credit (APTC) will rise by comparable amounts.[2] A recent study conducted by the Kaiser Family Foundation estimated there would be a 19 percent increase in premiums across all states due to the loss of direct federal support for CSRs. An analysis of the impact on California found a similar result (16.6 percent increase), concluding that, compared to the status quo (with direct federal funding of CSR), federal spending on health subsidies would increase by approximately 30 percent if CSRs were defunded.[3]

Currently the funding for CSRs is budgeted into the "baseline" federal spending for health insurance subsidies, which also includes federal spending on APTC. The analysis in Table 1 below applies Yin and Domurat's (2017) estimates that APTC outlays would increase by 30 percent if CSRs were defunded to the Congressional Budget Office's 10-year (2018–2027) estimates of APTC and CSR outlays in order to project the budgetary effects of ending CSR funding.[4] [5]

The additional costs of not directly funding CSRs would amount to approximately $851 billion.[6] Based on this projection, in the absence of direct CSR funding, the 10-year outlays to the federal government would amount to $931 billion, representing an increase in total federal spending of $80 billion, or $4 to $10 billion per year over the 10-year period.[7]

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[1] https://aspe.hhs.gov/pdf-report/potential-fiscal-consequences-not-providing-csr-reimbursements

[2] http://kff.org/health-reform/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/

[3] Yin and Domurat (2017): http://www.coveredca.com/news/pdfs/CoveredCA_Consequences_of_Terminating_CSR.pdf

[4] https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf

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TABLE 1 – PROJECTED FEDERAL SPENDING IMPACTS IF COST SHARE REDUCTIONS (CSR) ARE DEFUNDED

($ in billions)

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Total 2018-2027
CBO's January 2017 baseline											
APTC outlays and revenue reductions[8]	48	56	65	69	73	76	79	81	83	85	**716**
CSR	10	11	12	13	14	14	15	15	15	16	**135**
If CSR Defunded — using Yin and Domurat (2017) analysis											
APTC outlays and revenue reductions	62	73	85	90	95	99	103	105	108	111	**931**
CSR	0	0	0	0	0	0	0	0	0	0	**0**
Difference in Federal Outlays Between CBO Baseline and CSR Defunded											
	4	6	8	8	8	8	9	9	10	10	**80**

This analysis was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally. The analysis relies on research commissioned from independent economists at the University of California, Los Angeles. For more information, contact john.bertko@covered.ca.gov.

estimating that premium increases would cause spending on tax credits to go by 23% (compared to the 30% increase found by Yin and Domurat) which drawn out over the 10 year CBO window resulted in a total additional federal spending of $31 billion. See http://kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/.

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COVERED CALIFORNIA

News Release

Media line: (916) 206-7777 Email: media@covered.ca.gov

FOR IMMEDIATE RELEASE
April 14, 2017

Options to Stabilize the Individual Market Can Reduce Federal Spending and Lower Premiums

Analysis Shows Failure to Fund Cost-Sharing Reduction Subsidies Would Raise Rates and Cost the Federal Government at Least $47 Billion Over the Next 10 Years

- *Without direct federal funding of cost-sharing reduction (CSR) payments, premiums would rise 15–20 percent, leading to higher federal premium subsidy payments.*
- *Due to a requirement for carriers to build these payments into premiums, federal spending would increase by more than $47 billion over 10 years, while non-subsidized individuals would also face far higher premiums.*
- *Providing a temporary risk stabilization fund for 2018 and 2019 of $15 billion per year would promote carrier participation, lower premiums by 15 percent and only incur federal spending of $3–5 billion per year due to decreased subsidy spending.*

SACRAMENTO, Calif. — Covered California on Friday shared with the Congressional Budget Office (CBO) an analysis that shows that a decision not to provide ongoing direct federal funding for cost-sharing reductions would have immediate and dramatic effects on rates, federal spending and the viability of exchanges across the nation.

“The impact of not providing direct federal funding of cost-sharing reductions is enormous, and not only puts the viability of the individual market in many states in peril, but would be a bad deal for the federal budget — costing more than $47 billion over the next 10 years,” said Peter V. Lee, executive director of Covered California.

(more)

"Without the direct federal support for cost-sharing reductions, some health plans will leave the individual market entirely, and those who stay will raise rates significantly," Lee said. "While the market in California is likely to be relatively stable, for other states there is grave uncertainty. But what is certain is that not funding cost-sharing reductions would actually cost the federal government billions more because of the interplay between rising premiums and subsidies."

Covered California's analysis was conducted by Covered California Actuary John Bertko with assistance from UCLA economist Wes Yin. The analysis shows that the federal government would see increased costs of more than $47 billion over the next decade if funding for cost-sharing reductions were discontinued. The $47 billion is the net cost to the federal government after accounting for the $135 billion in savings from defunding funding CSRs. It reflects the difference between premium costs over 10 years of $788 billion if no CSRs are provided vs. $606 billion if CSRs remain in place.

Cost-sharing reductions are provided to help lower the cost of accessing health care for consumers with incomes below 250 percent of the federal poverty level for Silver Tier plans. The funding is provided directly to health insurers. If federal support for the program is discontinued, health plans would still be required to lower those costs at point of care, but they would take steps to make up for the lost funding by increasing premiums across the individual market.

"Without the direct funding of cost-sharing reductions, we estimate that health plans would increase premiums by 15 to 20 percent, which in turn would increase federal spending on premium subsidies by 30 percent," Bertko said.

The communication to the Congressional Budget Office also included analysis showing that spending $15 billion to stabilize insurance markets now, in the form of reinsurance, would reduce premiums and thus reduce federal premium subsidies, meaning a net cost to the federal government of just $3–5 billion per year.

"Providing $15 billion in risk stabilization funding in the form of reinsurance would not only stabilize markets by keeping plans in markets they would otherwise exit, it would mean lower rates for all consumers in the individual market," Lee said. "The impact of temporary risk stabilization funding would be to lower premiums in 2018 by about 15 percent. The actual cost in federal spending would be far lower than the benefit because of the reduced subsidy payments."

"While the political debate continues over the future of health care in America, the sensible step in the short term — for both consumers and the federal budget — is to directly fund the cost-sharing reductions as complements to the tax subsidies and to provide funding to stabilize markets."

Lee said that exchanges now have five years of operational experience, so they have unique insights into the interplay between rates and federal costs.

(more)

Covered California and other state exchanges will soon enter into rate negotiations for 2018. “Health plans need far more certainty than they have today to determine whether to participate and how to set their prices for 2018,” said Lee. “The window for action is closing, and if plans do not have a clear path forward by June of this year, next year could be a bad year for consumers and the federal budget.”

The analysis was shared in a letter sent Friday to Keith Hall, director of the Congressional Budget Office.

“We’re sharing this analysis with the CBO today and urging them to take an in-depth look at the way curtailing federal spending around the ACA in some areas could actually cost the federal government more,” Lee said. “It’s important for federal policy makers to understand the impact of short-term decisions, even as they weigh longer-term change.”

About Covered California
Covered California is the state’s health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California’s consumers. It is overseen by a five-member board appointed by the governor and the legislature. For more information about Covered California, please visit www.CoveredCA.com.

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Potential Impact to the Federal Budget of Not Directly Funding Cost-Sharing Reduction Subsidies

Updated April 26, 2017

Under current law, qualified health plans are required to offer cost-sharing reduction (CSR) subsidies to eligible individuals. Removing direct federal funding — received by carriers for the past three years and budgeted for 2017 — without changing the requirement that health plans in exchanges must offer the CSR Silver-variant plans would have significant negative effects on the federal budget. This projection details the rationale and potential size of those impacts.

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April 14, 2017

Keith Hall
Director, Congressional Budget Office
D St. SW & 2nd St SW
Washington D.C., 20515

Director Hall,

As a follow-up to our recent letter on the budget impact of not funding Cost-Sharing Reduction (CSR) subsidies, Covered California would like to provide two additional analyses for your consideration. Attached please find:

- **Potential Impact to the Federal Budget of Not Directly Funding Cost Sharing Reduction Subsidies.** This analysis expands on our previous research, and examines the nationwide impact to the federal budget in the event that CSR subsidies are not funded directly. As a result of defunding CSRs, health plans would implement rate increases to pay for the CSR subsidies, which would increase federal spending for Advanced Premium Tax Credits (APTC). Our analysis finds that total federal spending would increase by approximately $47 billion to $80 billion in a ten-year period because the increased APTC spending would far exceed the cost of funding CSRs directly.

- **Supporting Risk Stabilization and Potential Positive Impact on Reducing Federal Spending for Advanced Premium Tax Credits by Funding Reinsurance**. This analysis examines the potential impact of funding a $15 billion Stability Fund for 2018 and 2019 as introduced in the American Health Care Act. Our analysis shows that such a fund, if used to operate a national reinsurance program, would reduce 2018 premiums by about 15 percent for 2018. In addition, the cost to the federal government would be less than $5 billion, as the fund would lead to a reduction of APTC payments.

Thank you for your consideration. If you have any questions, feel free to reach out to me at (916) 228-8699 or my staff.

Sincerely,

Peter V. Lee
Executive Director

cc: Jessica Banthin, Deputy Assistant Director, Congressional Budget Office
Attachments:

- Supporting Risk Stabilization and Potential Positive Impact on Reducing Federal Spending for Advanced Premium Tax Credits by Funding Reinsurance; April 14, 2017
- Potential Impact to the Federal Budget of Not Directly Funding Cost Sharing Reduction Subsidies; April 14, 2017

COVERED CALIFORNIA

News Release

Media line: (916) 206-7777 Email: media@covered.ca.gov

FOR IMMEDIATE RELEASE

March 20, 2017

Covered California Releases Regional Analysis of Support Provided to Consumers Under the Affordable Care Act Compared to Changes Proposed in the American Health Care Act

- *Analysis shows lower-income Californians, particularly those who are older and live in high-cost areas, would be negatively impacted by the proposed changes.*
- *Updated analysis using Congressional Budget Office findings and historic trends finds that premiums are likely to be 15 to 20 percent higher under the American Health Care Act.*
- *Under the American Health Care Act, many Californians would need to spend more than a quarter of their income on health insurance premiums.*

SACRAMENTO, Calif. — Covered California released a new analysis on Monday that goes into greater detail regarding how consumers could be impacted by the changes in financial assistance proposed under the American Health Care Act (AHCA).

The latest figures take into account the recent Congressional Budget Office (CBO) analysis and detail how consumers would be affected in all 19 of California's rating regions for non-group coverage.

"We have made great progress in reducing California's uninsured rate to a historic low of 7.1 percent," said Covered California Executive Director Peter V. Lee. "The main reasons for that are that the financial assistance currently available helps many afford coverage, and for those not receiving subsidies we have kept premium increases to historically low levels. The current AHCA proposal would dramatically reduce financial assistance for most Californians while increasing costs for those who do not get help."

The CBO examined the AHCA and determined that health insurance premiums would be 15 to 20 percent higher in 2018 and 2019 than they would have been under

(more)

existing law. The amount of tax credits under the proposed legislation would be 60 percent of what is provided under the current law.

The result would be that some older Californians, particularly those who are lower-income and live in higher-cost areas, would see large increases in their costs, requiring them to spend a significant amount — or even their entire income — to maintain their health insurance coverage.

"The proposed changes to the subsidy structure would put coverage out of reach of many," Lee said.

The examples below compare the financial help that consumers would receive in 2020 based on the current Patient Protection and Affordable Care Act (ACA) subsidies — which consider a consumer's age, income, family size and where they live — to the proposed age-based-only subsidies of the AHCA.

For example, under the age-based subsidy structure, consumers purchasing the second-lowest-cost Silver plan would fare very differently depending on their income and where they live:

- In Sacramento under the ACA, a 27-year-old earning $17,000 would pay 3.7 percent of her income toward health insurance premiums ($622 per year or $52 per month). By contrast, under the AHCA that individual would be asked to spend nearly 25 percent of her income on her health insurance premium, paying $4,036 per year or $336 per month.
- In Kern County, a 62-year-old earning $30,000 a year would pay 8.3 percent of his income toward health insurance premiums ($2,494 per year or $208 per month under the ACA). If the AHCA were in effect, he would be asked to allocate more than 30 percent of his income to health insurance, paying $9,182 a year or $765 per month.
- Finally, in Monterey County, a 62-year-old earning $17,000 would receive support under the ACA to limit her premium to 3.7 percent of her income ($622 per year or $52 per month). Yet under the AHCA, this consumer would have to spend 100 percent of her income on her premium and would still fall short of what it would take to purchase a plan that costs $17,873 per year, or $1,489 per month.

Covered California provided data for consumers aged 27, 40 and 62 years old who earn $17,000; $30,000; or $75,000 per year in each of California's 19 rating regions. The premium projections estimated premiums and tax credits in 2020 under both the AHCA and ACA, using Covered California's trend of a 7 percent average rate change during its first three years of operation to establish a "baseline" of what ACA coverage would cost.

(more)

Lee says the AHCA does address some of the gaps in our current health care system, such as providing needed financial assistance to those above 400 percent of the federal poverty level.

"The proposal addresses the real challenges for some Californians on the 'cliff,' of being at 400 percent of the federal poverty level. However, the proposal does not take into account what people earn or the cost of where they live. As a result, many of the most vulnerable Californians will be priced out of coverage under the proposed system," Lee said. "The likely result is a smaller and less healthy risk pool, which would mean higher premiums for everyone in the individual market."

The data for all scenarios, in each of Covered California's rating regions, can be found here: http://coveredca.com/news/pdfs/AHCA_ACA_comparison_chart.pdf.

Now that open enrollment has ended, Covered California is focused on its special-enrollment period. Consumers are eligible to sign up now if they experience changes in their life circumstances, such as losing their health care coverage, getting married, having a child or moving.

For more information on special-enrollment rules, visit: www.CoveredCA.com/individuals-and-families/getting-covered/special-enrollment.

Consumers who qualify for Medi-Cal may enroll through Covered California year round.

For more information, consumers should visit CoveredCA.com, where they can enroll online or get information about obtaining free, confidential in-person assistance in a variety of languages. They can find a certified enroller at a storefront in their area or have a certified enroller contact them through the "Help on Demand" feature.

Consumers can also enroll over the phone by calling Covered California at (800) 300-1506.

About Covered California
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Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the legislature. For more information about Covered California, please visit www.CoveredCA.com.

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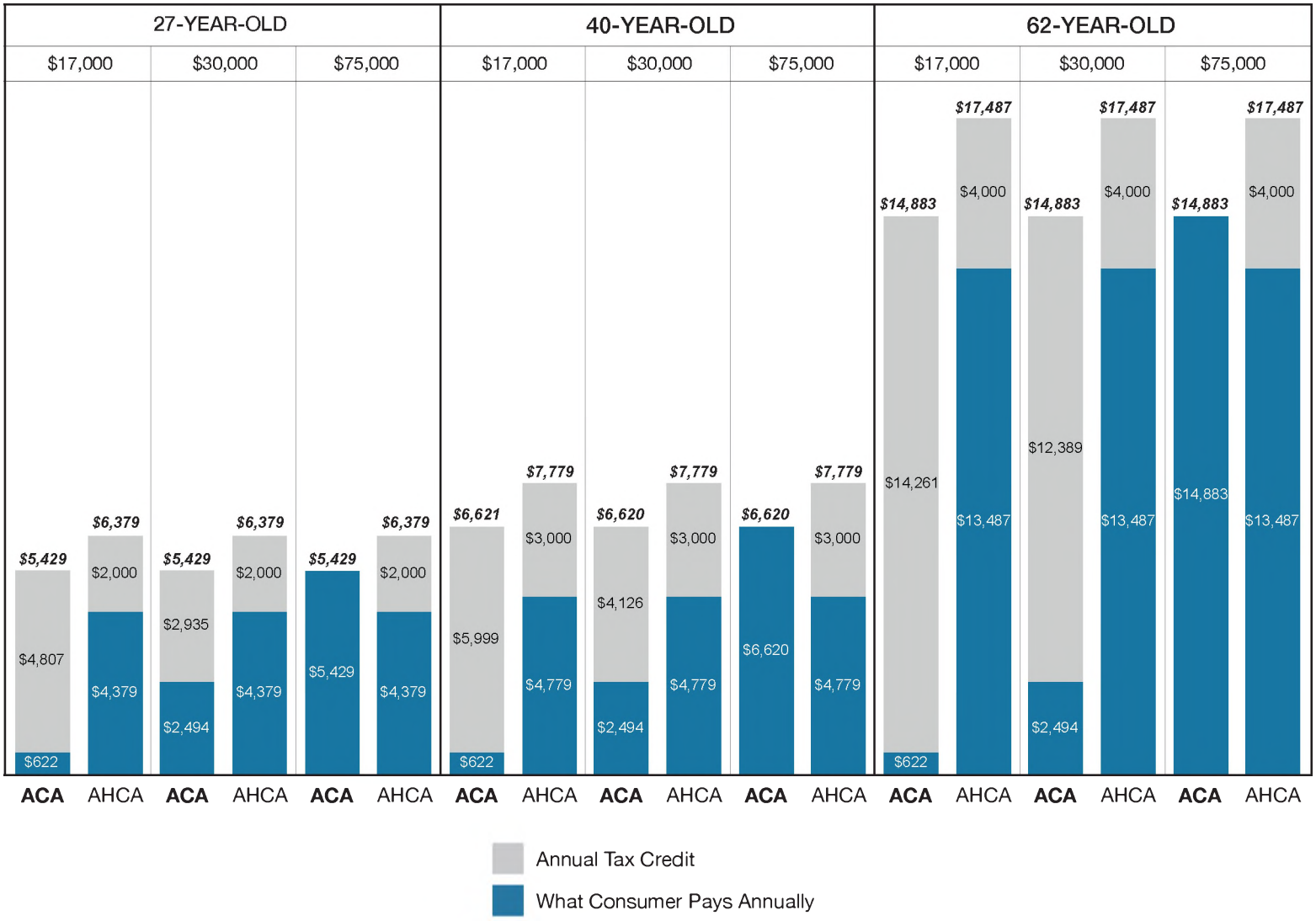
Region 1

Northern California

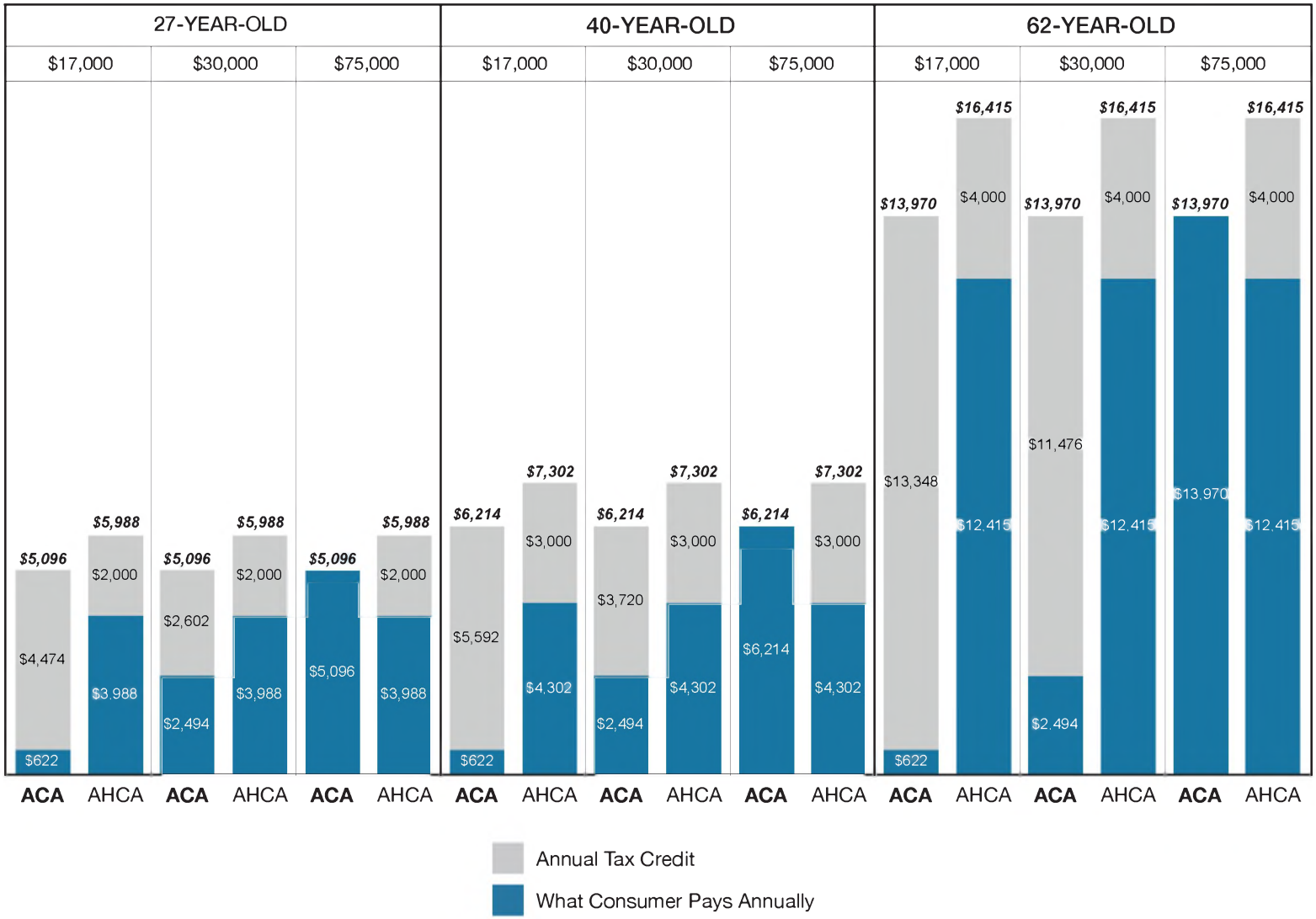
Region 1 counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yuba, Tuolumne



Note: Values at top of bars reflect total cost of premium, which is based on the second-lowest-cost Silver plan in this region. Analysis is based on estimates of 2020 California premiums and tax credits, comparing typical consumer scenarios under the existing Patient Protection and Affordable Care Act (ACA) rules to the proposed American Health Care Act (AHCA). Premium estimates for the scenarios are based on 2017 Covered California second-lowest-cost Silver products, and use Covered California's three-year average premium trend of 7 percent annual increases to estimate a 2020 baseline; AHCA premiums are based on the Congressional Budget Office (CBO) assessment that premiums under AHCA passage would be 15 to 20 percent higher by 2020 than the ACA baseline. For more information, view the CBO's Cost Estimate of the American Health Care Act: http://bit.ly/2n0WeaT.

Region 2

Marin, Napa, Solano and Sonoma counties



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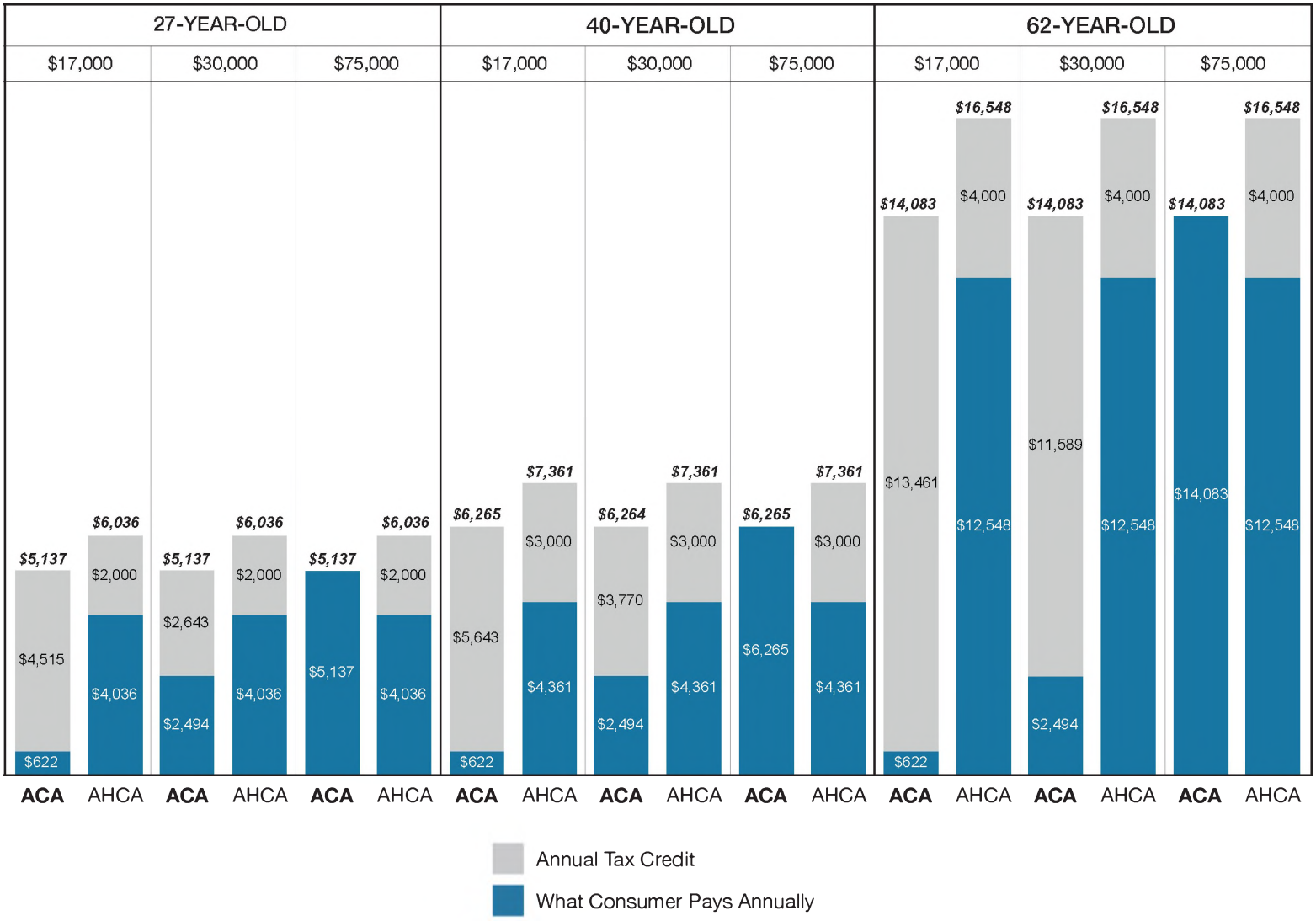
Region 3

El Dorado, Placer, Sacramento and Yolo counties



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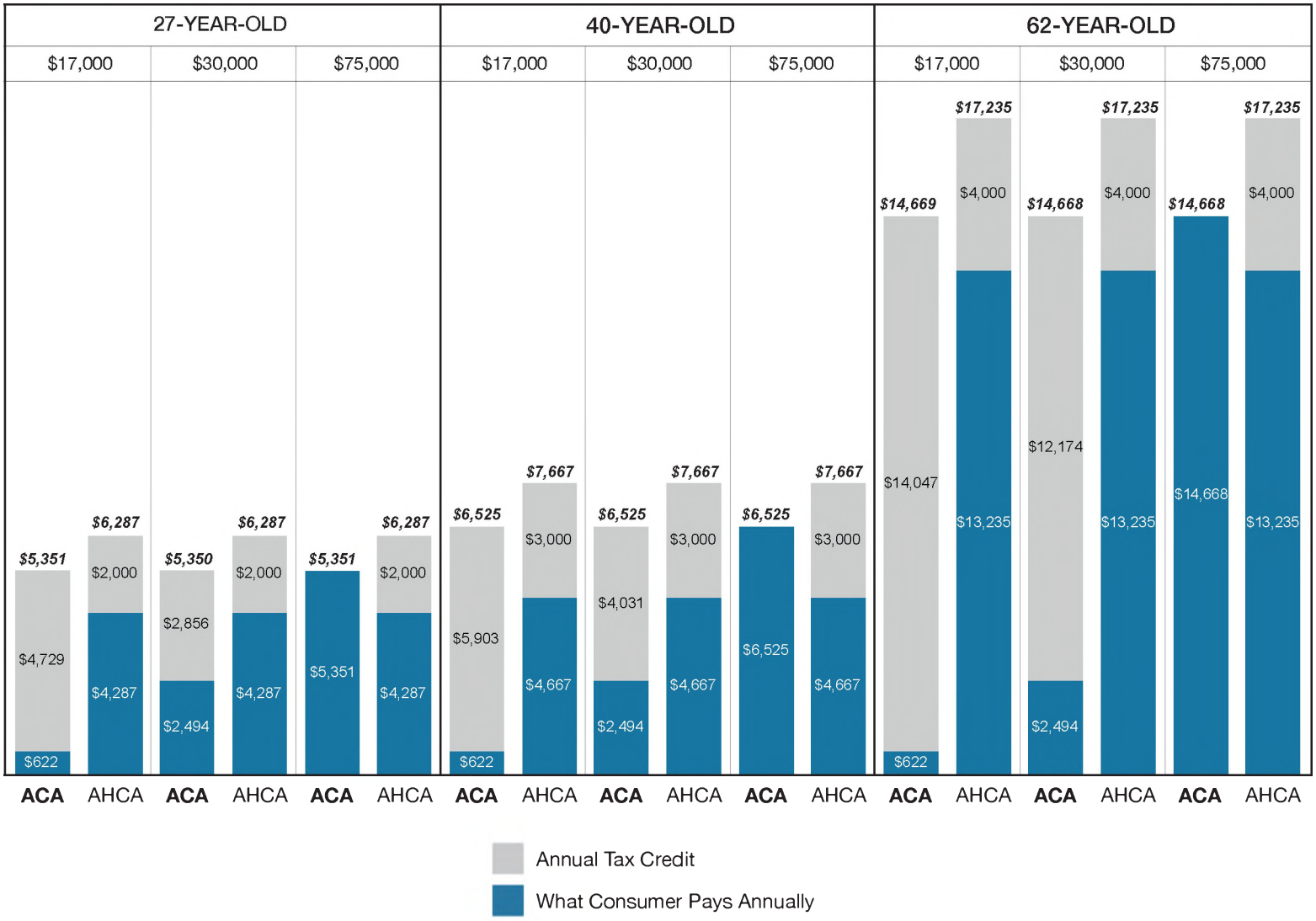
Region 4

San Francisco County



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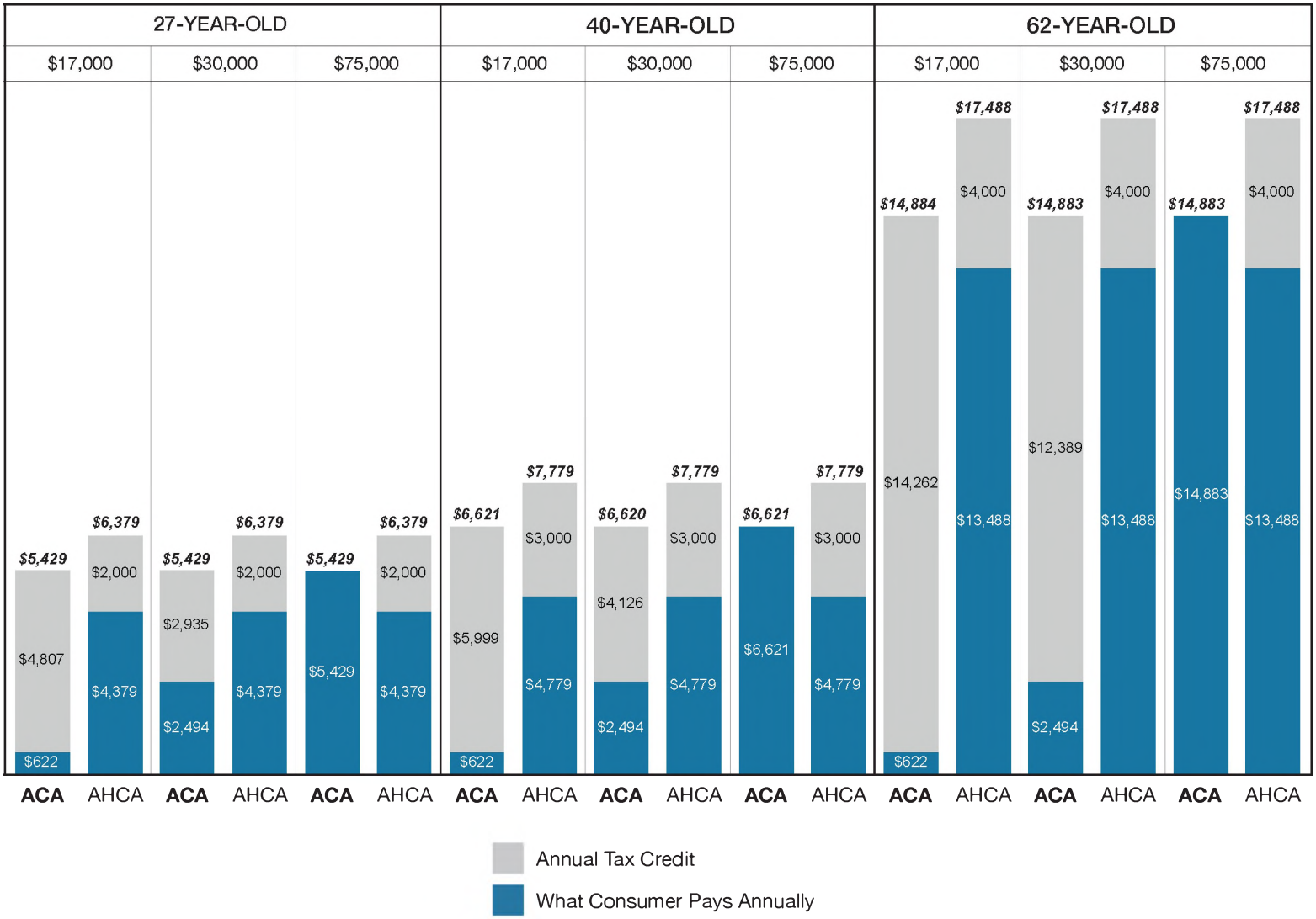
Region 5

Contra Costa County



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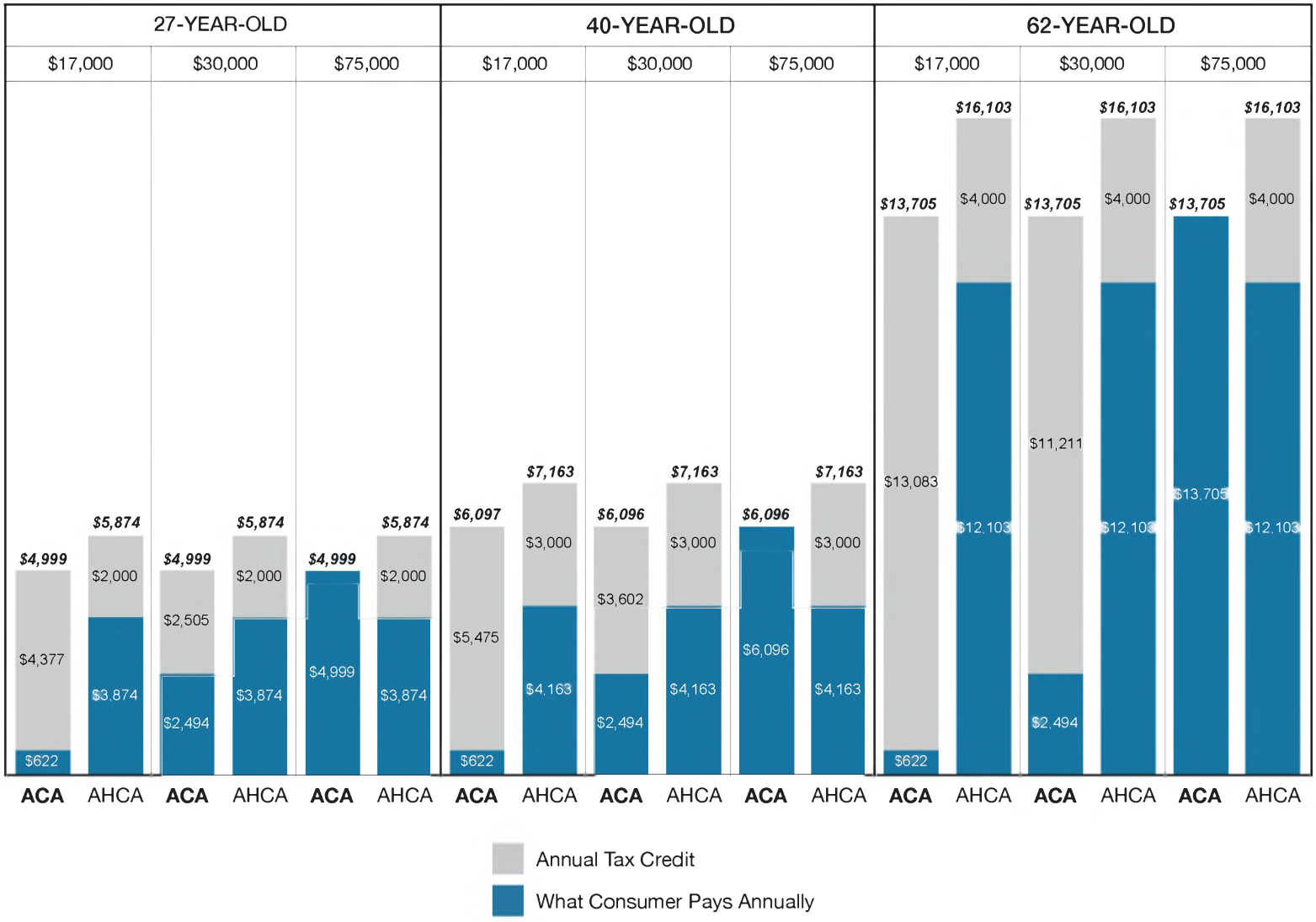
Region 6

Alameda County



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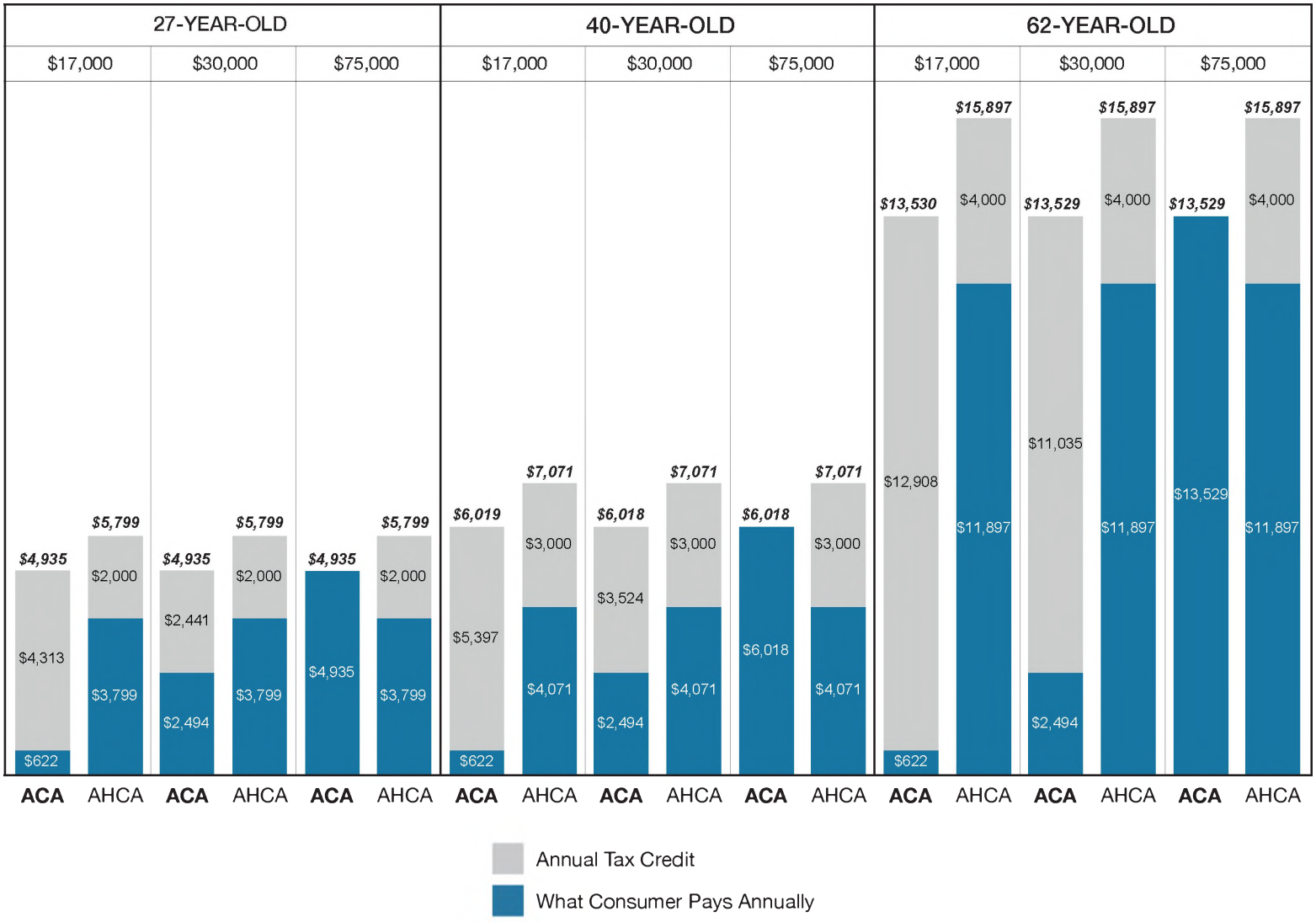
Region 7

Santa Clara County



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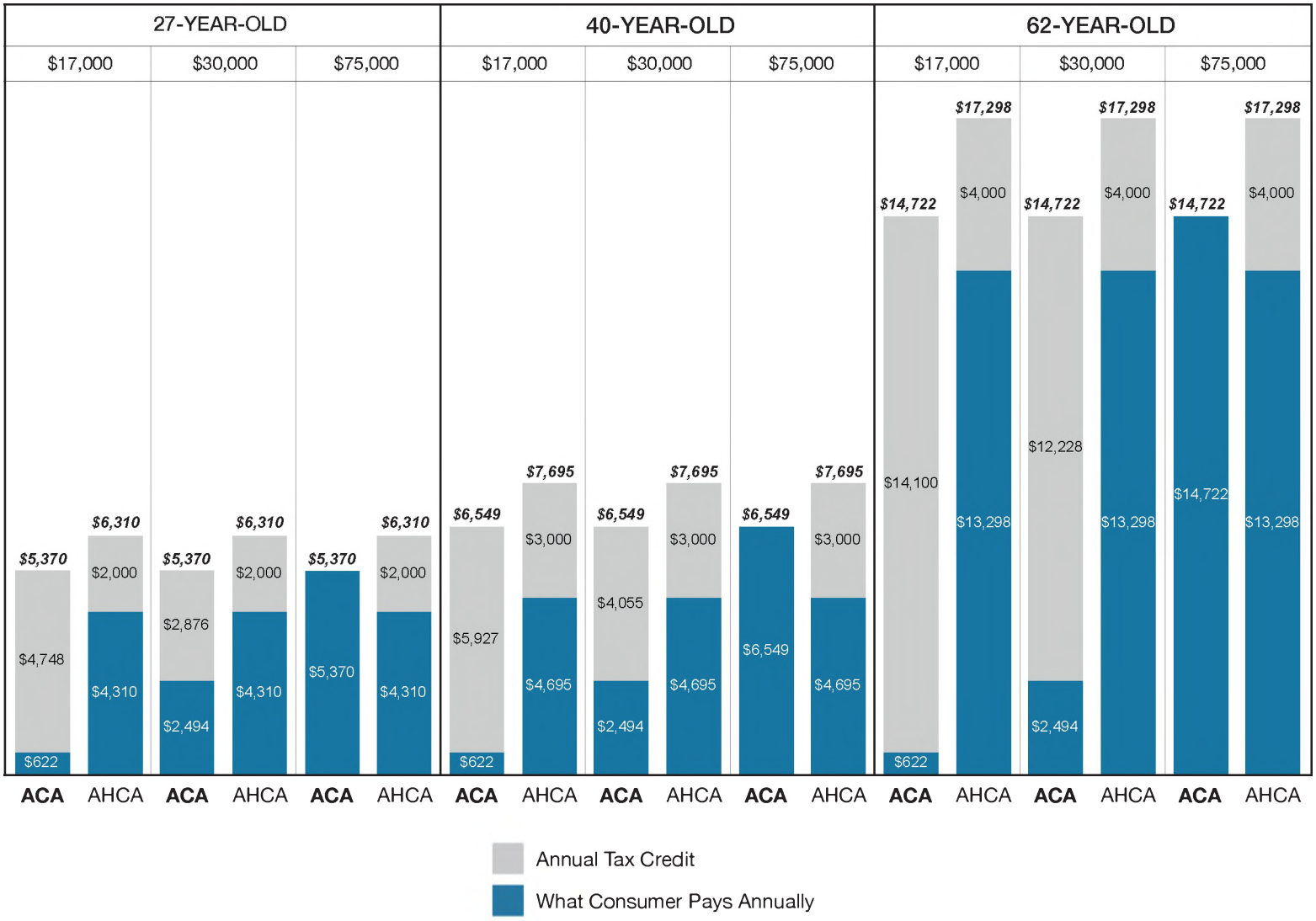
Region 8

San Mateo County



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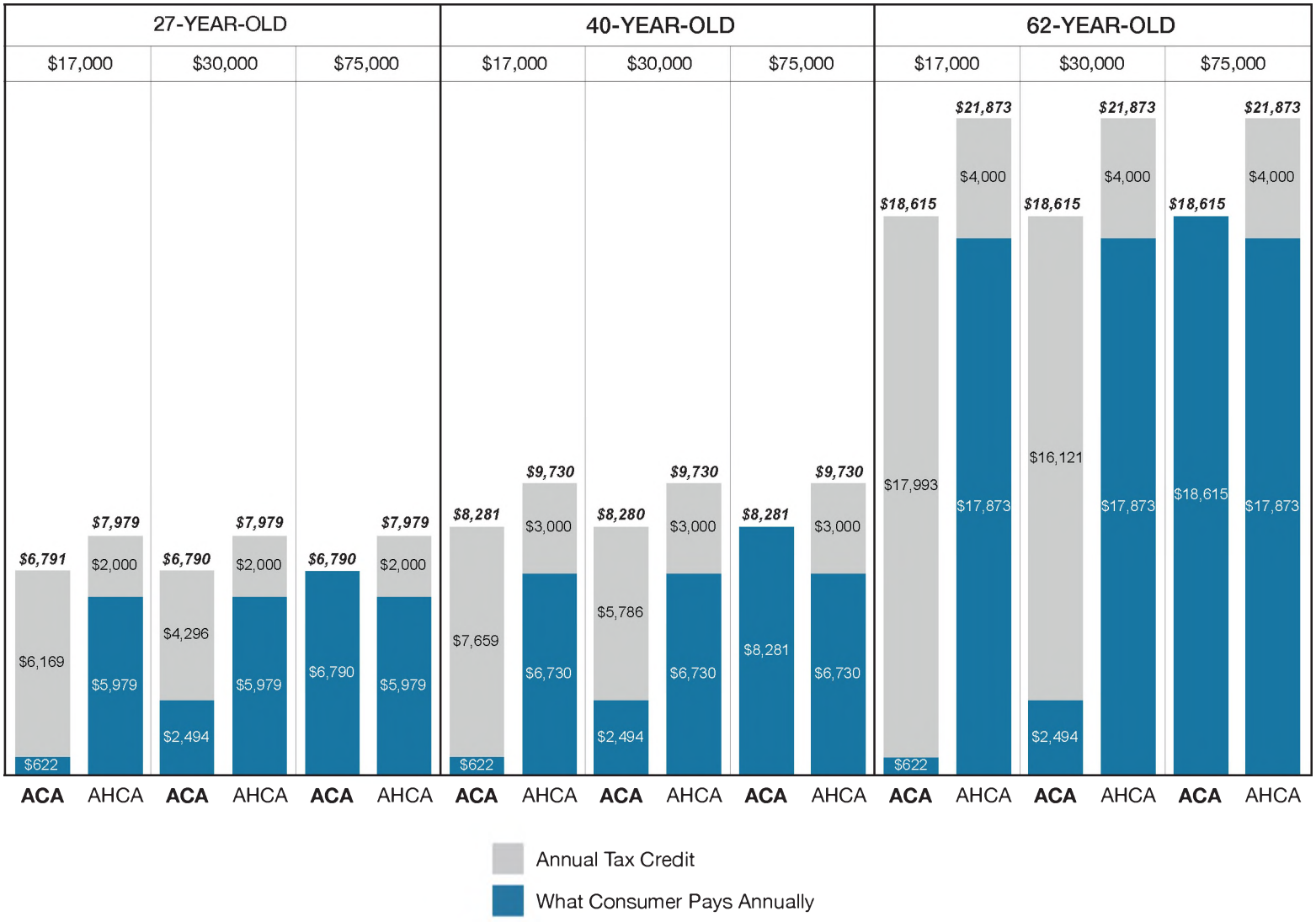
Region 9

Monterey, San Benito and Santa Cruz counties



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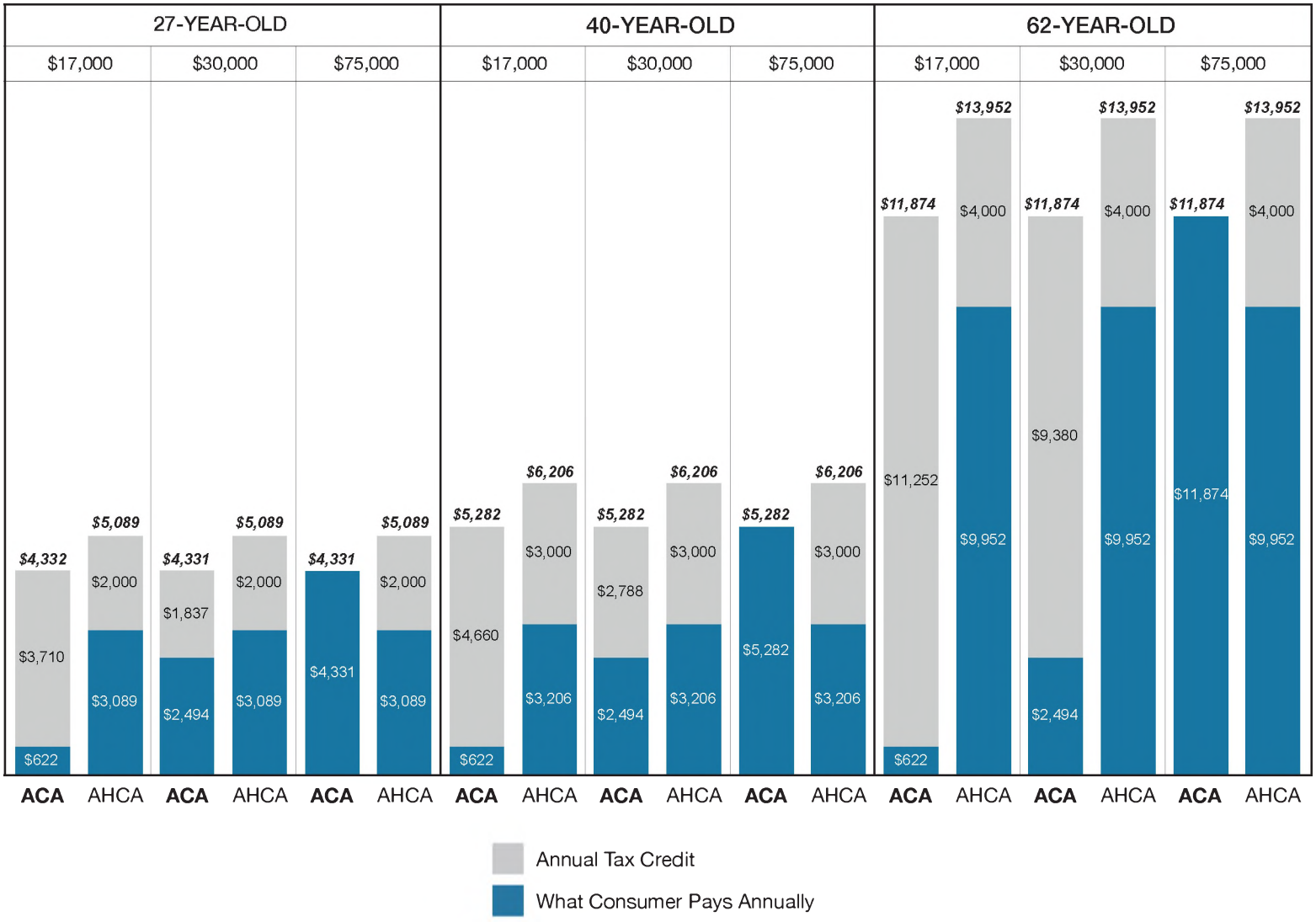
Region 10

Mariposa, Merced, San Joaquin, Stanislaus and Tulare counties



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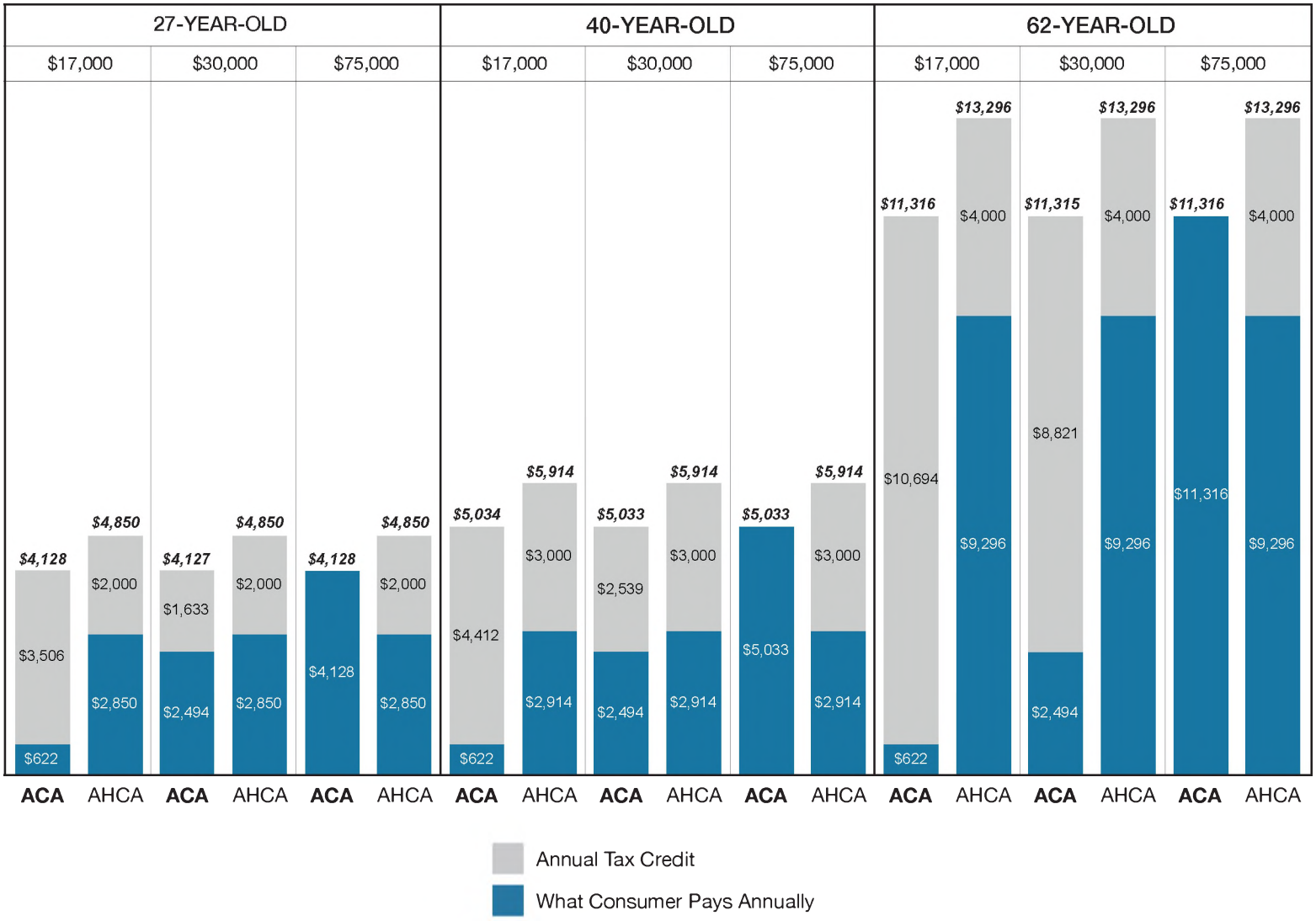
Region 11

Fresno, Kings and Madera counties



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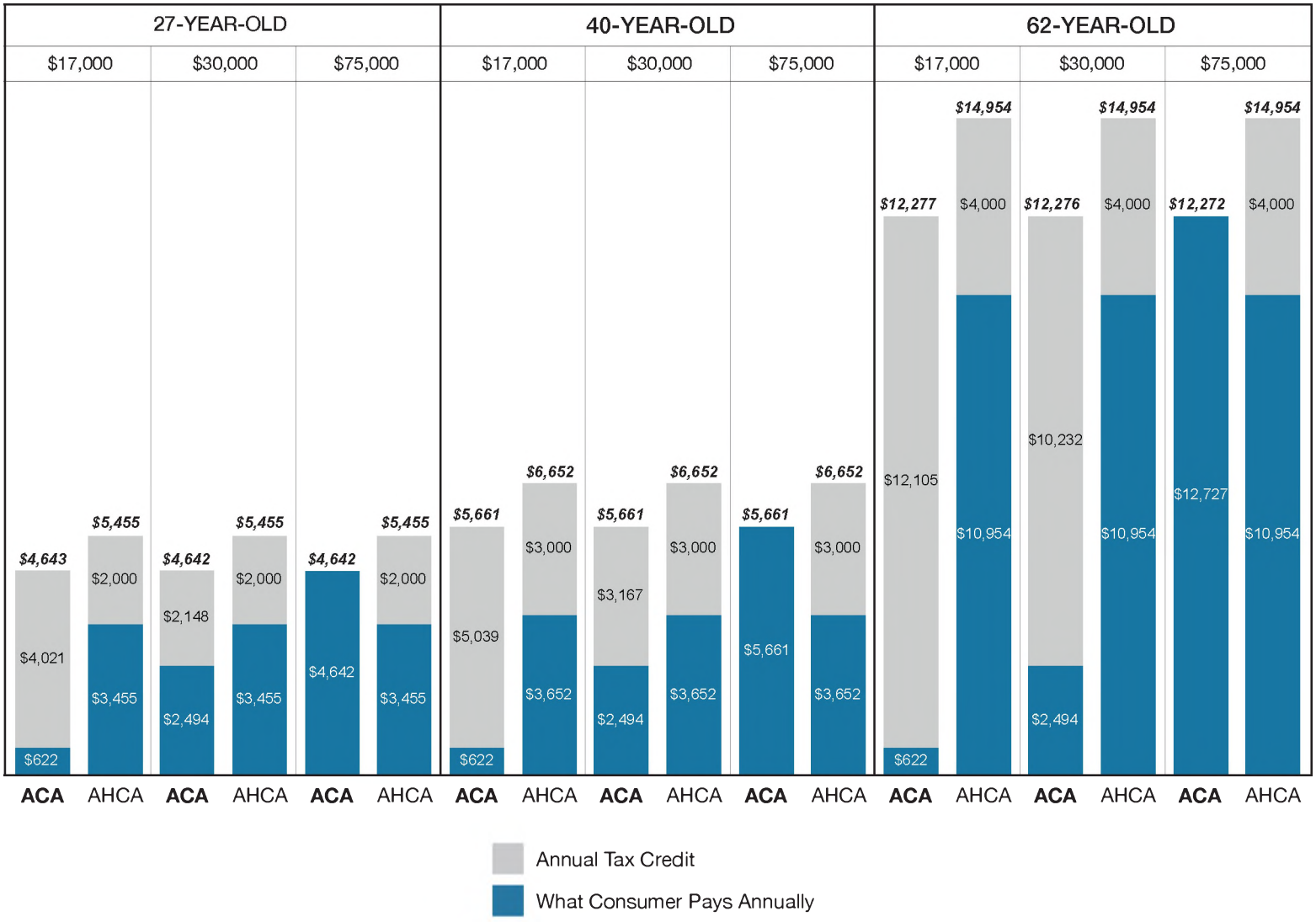
Region 12

San Luis Obispo, Santa Barbara and Ventura counties



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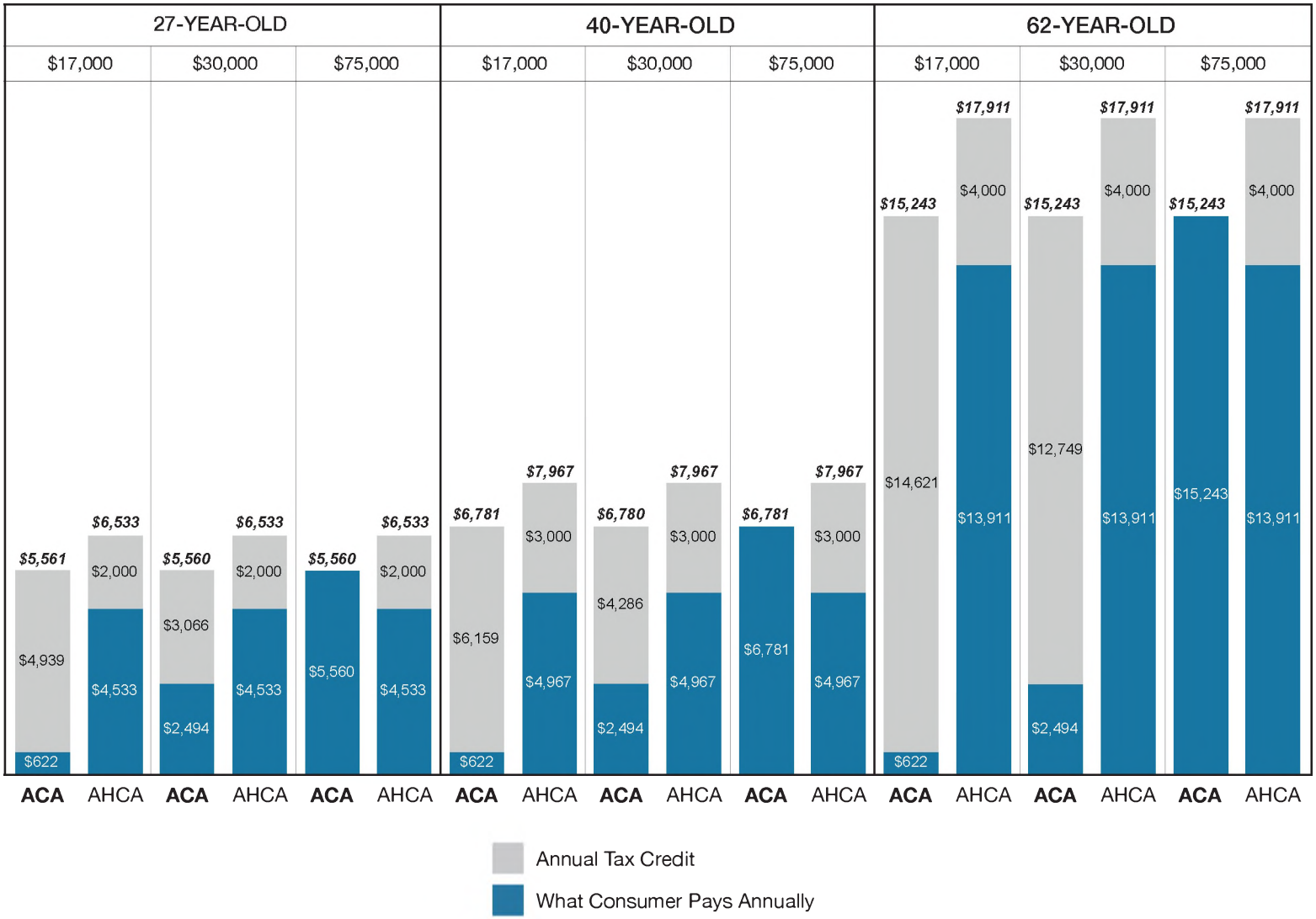
Region 13

Imperial, Inyo and Mono counties



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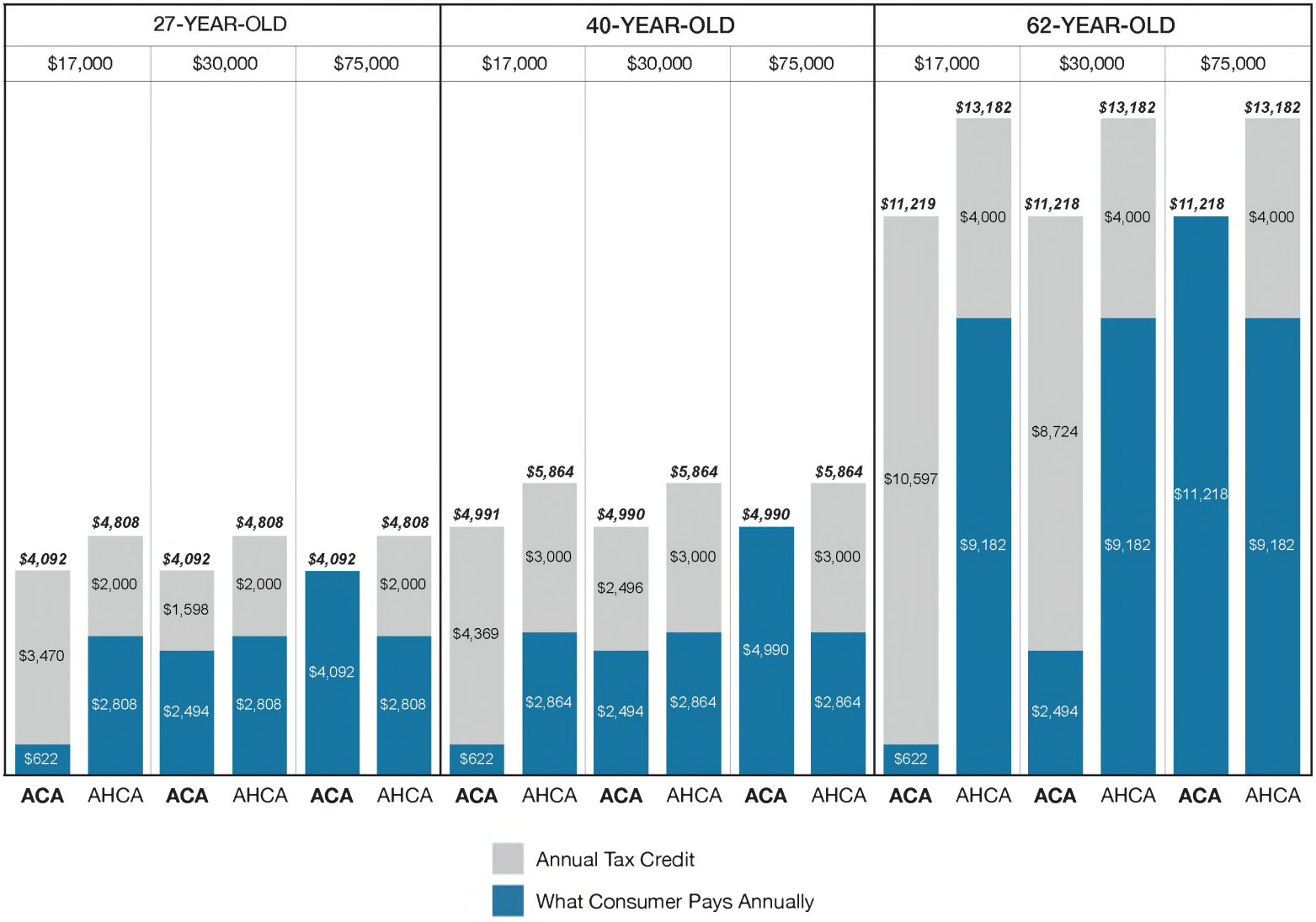
Region 14

Kern County



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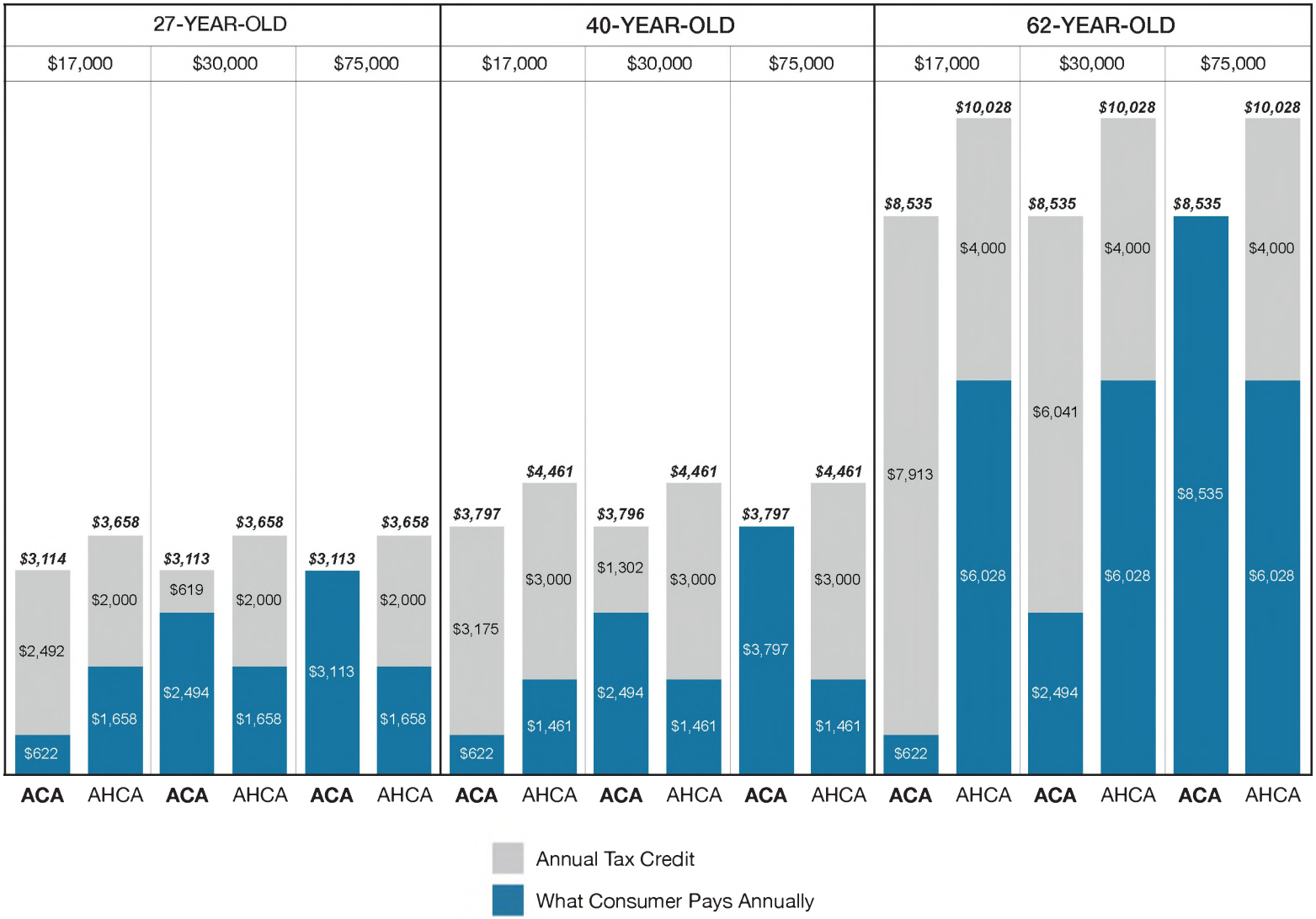
Region 15

Los Angeles County (partial)



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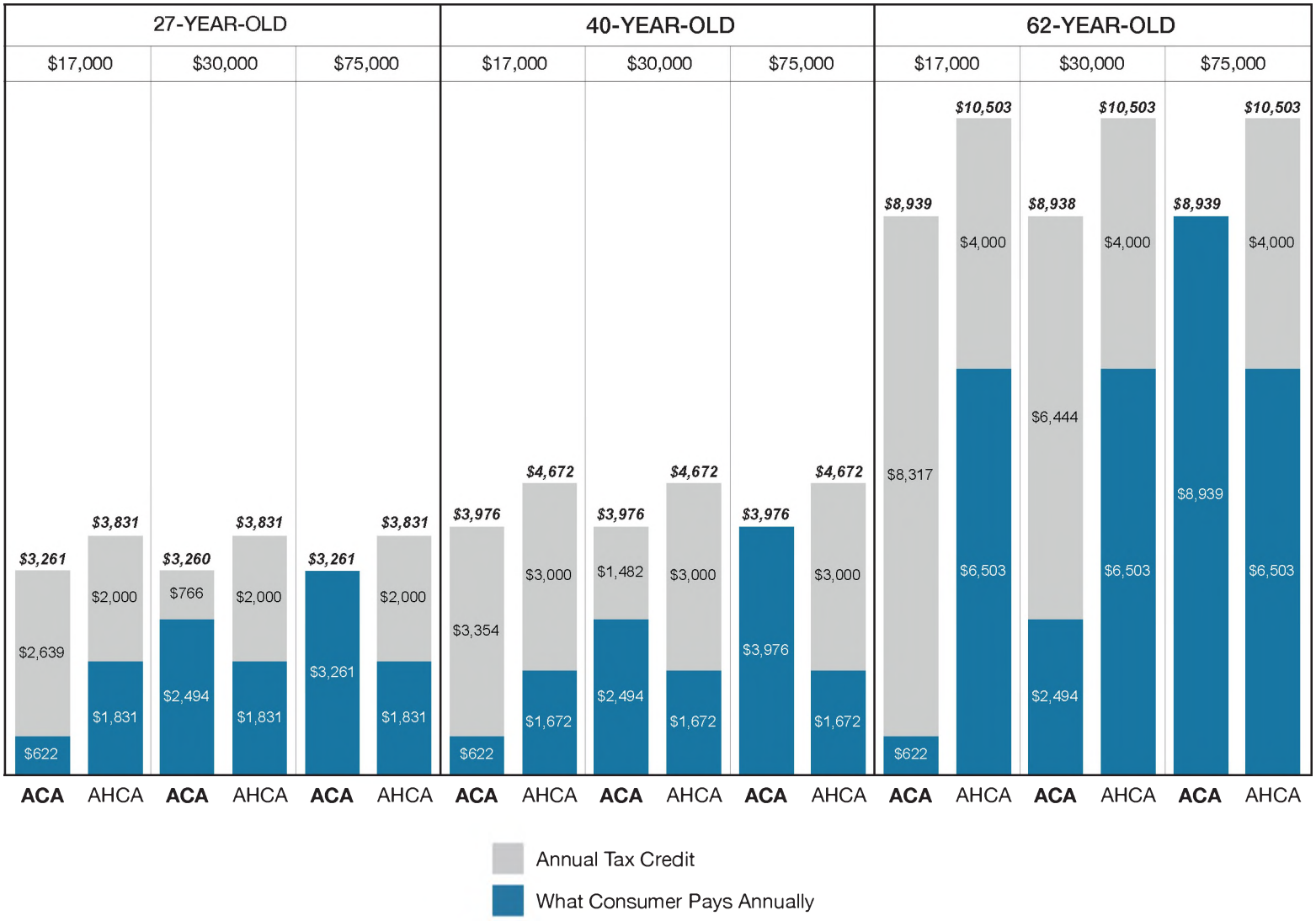
Region 16

Los Angeles County (partial)



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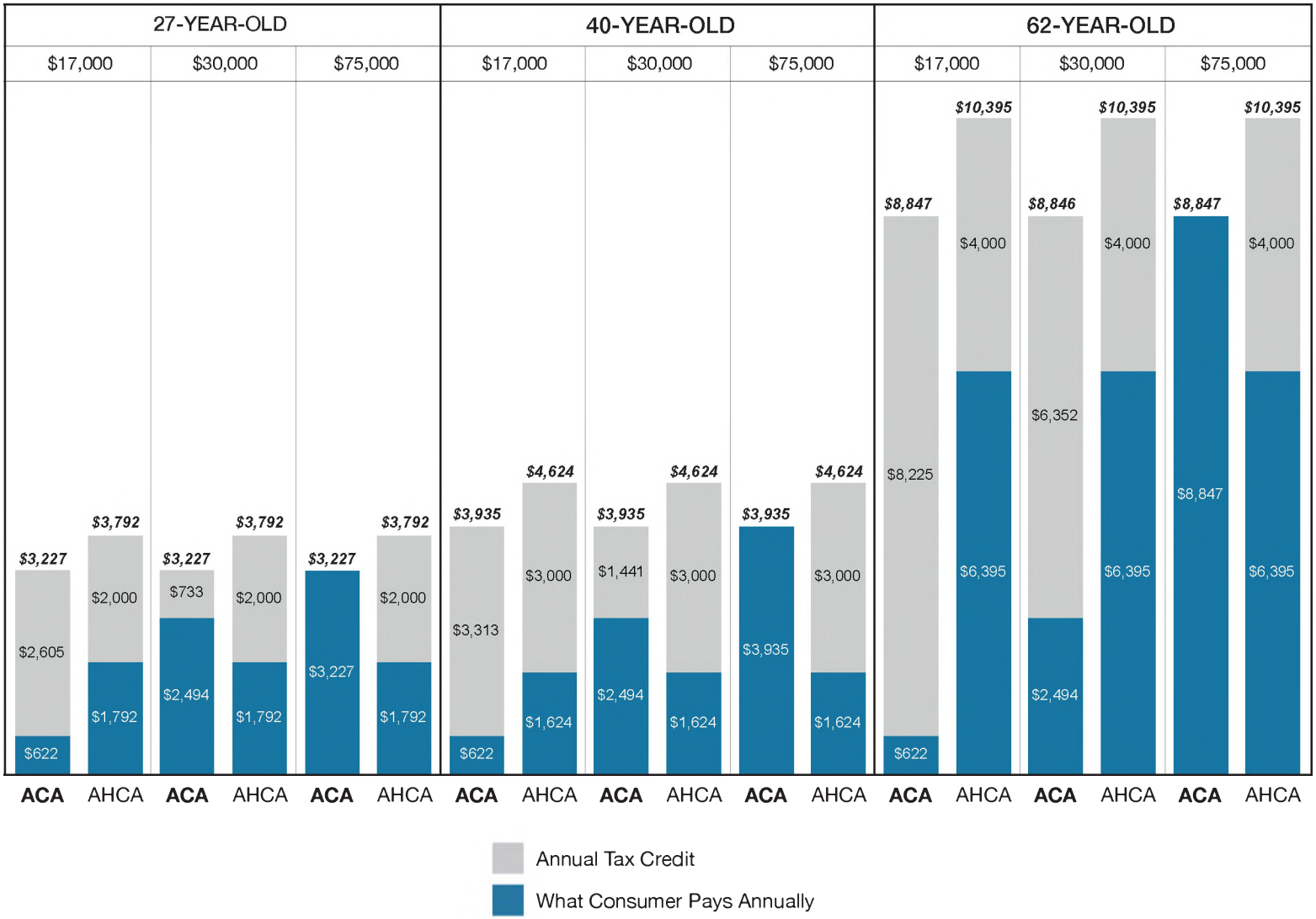
Region 17

Riverside and San Bernardino counties



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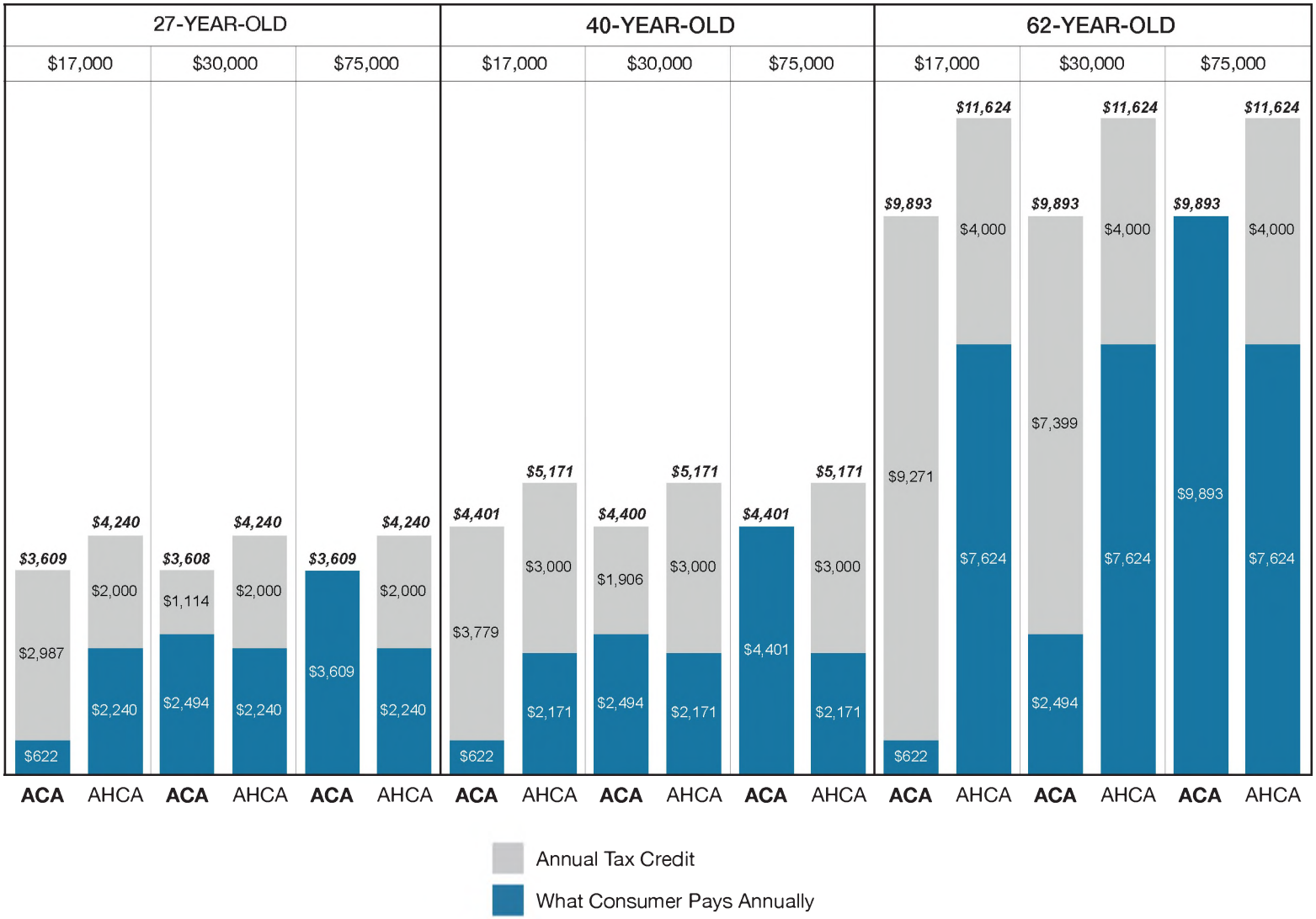
Region 18

Orange County



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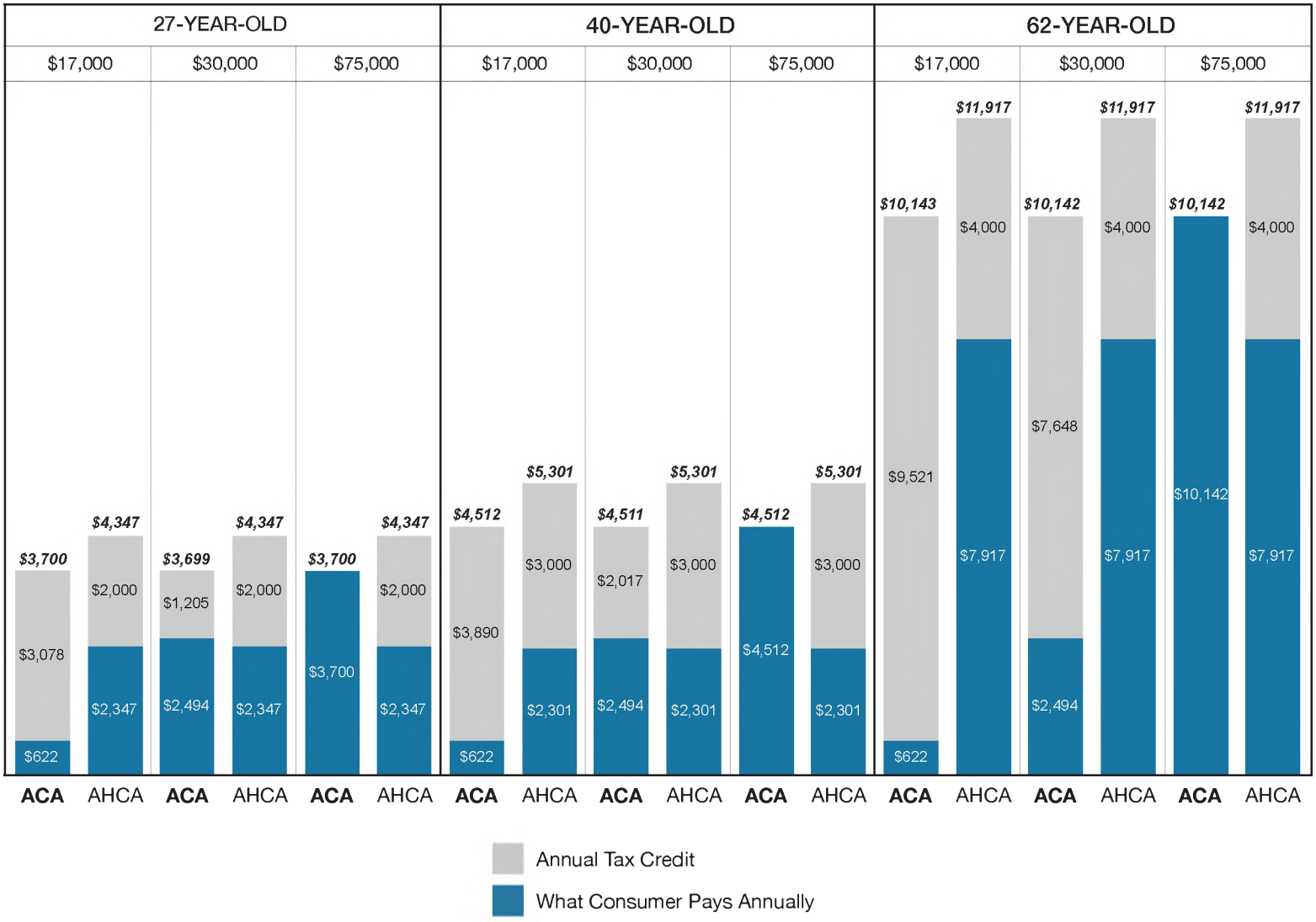
Region 19

San Diego County



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COVERED CALIFORNIA

News Release

Media line: (916) 206-7777 Email: media@covered.ca.gov

FOR IMMEDIATE RELEASE

March 14, 2017

Covered California Releases Analysis of Support Provided to Consumers Under the Affordable Care Act and an Early Look at Consumer Impact of Changes Proposed in the American Health Care Act

- *Covered California enrollees benefited from $4.2 billion in subsidies to help them purchase health coverage and get care in 2016.*
- *County data shows how tax credits help individuals throughout California purchase health insurance.*
- *The average subsidy in 2016 was worth $5,300 per household and $3,500 per individual, but sizeable numbers of enrollees received more — with 12 percent of households receiving more than $10,000 per year to help them pay for coverage.*
- *Initial review of proposed changes under the current American Health Care Act indicates big impacts, especially to older Californians and those who live in higher-cost areas.*

SACRAMENTO, Calif. — Covered California released a new comprehensive analysis on Tuesday detailing the financial assistance available through the Affordable Care Act as well as a preliminary analysis of how changes proposed in federal law would affect enrollees.

The studies come one day after the Congressional Budget Office (CBO) reported that 24 million consumers could lose coverage under the proposed American Health Care Act (AHCA), which was introduced in the U.S. House of Representatives on March 6.

(more)

"We are deeply troubled by the CBO's finding that the amount of support provided for consumers to buy health insurance in 2020 under proposed legislation would be only 60 percent of what is provided under current law," said Covered California Executive Director Peter V. Lee. "While we are still doing an analysis of the aggregate effects of this law on our consumers, the likely effect of basing subsidies on age alone — rather than considering income and where an individual lives — is that it will make coverage unaffordable and in many cases, put coverage out of reach."

Covered California released two documents on Tuesday: "Bringing Health Care Coverage Within Reach," an in-depth analysis of Covered California enrollees and the subsidies they receive in 2016; and "Preliminary Analysis of Impacts to Consumers from Changes in Premium Subsidies and Cost Sharing Reductions Available Under the Proposed American Health Care Act."

The first analysis shows Covered California households received an average of $5,300 per year in tax credits to help pay for the cost of their coverage in 2016. Additionally, 12 percent of Covered California households receive more than $10,000 per year and 16 percent of individuals receive more than $6,000 per year to help bring health care coverage within reach.

Approximately half of Covered California consumers are enrolled in "Enhanced Silver" plans, which give them the additional benefit of cost-sharing reductions that reduce their out-of-pocket expenses by an average of $1,500 per year.

"Health insurance can be expensive, and the financial assistance provided through Covered California helps consumers save money and brings that coverage within reach of millions," Lee said. "As policy makers in Washington consider changes to our health care system, it is important that the impact on real individuals informs the debate in Washington, D.C. because we are seeing that many will be priced out of needed coverage."

While the average effects are relatively clear and consistent with the CBO's assessment that "the average subsidy under the legislation would be about 60 percent of the average subsidy under current law," the effect on individuals in California and nationally will vary greatly.

The examples below compare the financial help that consumers receive now through the Affordable Care Act — which considers a consumer's age, income, family size and where they live — to the newly proposed age-based-only subsidies of the AHCA. For example, under the age-based subsidy structure, consumers purchasing the second-lowest Silver plan would fare very differently depending on whether they live in Los Angeles or San Francisco:

(more)

- In Los Angeles, a 27-year-old earning $17,000 a year would see similar net premiums: $55 per month under the proposed law compared to $52 per month under the current law. However, if that same individual lived in San Francisco, his or her new net premium would be four times higher — $199 per month — compared to $52 per month under the current law.

- In Los Angeles, a 62-year-old earning $30,000 a year would see his or her net premium increase from $207 per month under the current law to $275 per month under the proposed law. If that person lived in San Francisco, his or her net premium would jump threefold from $209 per month to $668 per month.

"As many independent studies have shown, moving to age-based tax credits will hurt many of our consumers, particularly those older and lower- to middle-income consumers, and price them out of the market," Lee said. "This would damage our risk mix and lead to higher premiums for everyone in the individual market, even those who do not purchase their insurance through Covered California."

Covered California plans to conduct further analysis of the overall impact of proposed changes including all provisions contained in the American Health Care Act.

The county data used to prepare today's analysis can be found here: http://hbex.coveredca.com/data-research/library/County_APTC_CSR_data.pdf.

This is the latest analysis performed by Covered California that details how consumers are benefitting from the Affordable Care Act. Previous analyses include "Consumer and Market Implications of Affordable Care Act Repeal Without a Viable Replacement" and "Covered California Brings Health Care Within Reach and Shows How Consumers Can Save by Shopping."

Now that open enrollment has ended, Covered California is focused on its special-enrollment period. Consumers are eligible to sign up now if they experience changes in their life circumstances, such as losing their health care coverage, getting married, having a child or moving.

For more information on special-enrollment rules, visit: www.CoveredCA.com/individuals-and-families/getting-covered/special-enrollment.

Consumers who qualify for Medi-Cal may enroll through Covered California year round.

(more)

For more information, consumers should visit CoveredCA.com, where they can enroll online or get information about obtaining free, confidential in-person assistance in a variety of languages. They can find a certified enroller at a storefront in their area or have a certified enroller contact them through the "Help on Demand" feature.

Consumers can also enroll over the phone by calling Covered California at (800) 300-1506.

About Covered California
Covered California is the state's health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the legislature. For more information about Covered California, please visit www.CoveredCA.com.

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Bringing Health Care Coverage Within Reach

Measuring the Financial Assistance Available Through Covered California That Is Lowering the Cost of Coverage and Care

Introduction

The Patient Protection and Affordable Care Act helped cut the rate of the uninsured by more than half in California, by 17 percent in 2013 to 7.1 percent in 2016, according to the latest survey by the U.S. Centers for Disease Control and Prevention (CDC).

Under the Affordable Care Act, nearly 3.7 million adults now have Medi-Cal as a result of California's expansion of the insurance program. In addition, Covered California has served 2.9 million consumers since it opened its doors in 2014.

The following report examines how Covered California enrollees, and to a degree those who purchase their health care coverage off exchange, benefit from lower costs through Advanced Premium Tax Credits (APTC), cost-sharing reductions (CSR) and a healthy mix of consumers.

The data within the report examines the 2016 coverage year, in which a total of approximately 1.7 million consumers obtained health care coverage, for at least one month, through Covered California. The report details how much financial help consumers received through tax credits, which are adjusted based on age, income, region and household size.

An overview of APTC and CSR data by county is available here: http://bit.ly/2moBJD0. A preliminary analysis of how the current structure of financial help from APTC and CSR would change under the proposed age-based system in the American Health Care Act (AHCA) can be found here: http://hbex.coveredca.com/pdfs/Preliminary_Analysis_of_AHCA.pdf

Bringing Coverage Within Reach

As a state-based marketplace set up under the Affordable Care Act, Covered California helps consumers get federal financial assistance to make health insurance and health care at the point of service more affordable. This report summarizes the financial assistance received by Covered California's consumers in 2016.

Highlights:

- Covered California enrollees benefited from $4.2 billion in tax credits and over $700 million in subsidies to reduce costs at the point of care (cost-sharing reductions) in 2016.
- Covered California enrollees receive an average of $5,300 per household and more than $3,500 per individual, per year in tax credits to help them pay for the cost of coverage (respectively, $442 and $318 per month).
- Twelve percent of enrollees receive more than $10,000 per household, and 16 percent of individuals receive more than $6,000 per year in tax credits. Financial assistance plays a critical role in bringing health care coverage within reach of those who need it most (respectively, more than $833 and $500 per month).
- In addition to tax credits, half of Covered California enrollees receive cost-sharing reductions that on average reduce out-of-pocket expenses by more than $1,500 per household per year or more than $1,000 for an individual.
- The vast majority of consumers who were eligible for cost-sharing reductions through Covered California chose Silver plans and received the enhanced coverage to lower their out-of-pocket costs.

This analysis was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally.

The financial help offered under the Affordable Care Act (often referred to as "subsidies") includes three forms of financial assistance for those receiving subsidies and those who are not:

1. **Advance Premium Tax Credits** — These allow consumers to buy health coverage at a reduced monthly premium throughout the year, based on their projected final income at year's end.

2. **Cost-Sharing Reductions** — This additional coverage is included automatically in Silver-level plans for lower-income enrollees, and reduces deductibles and out-of-pocket costs when care is used. These "Enhanced Silver" plans often match or exceed the coverage of a Gold or Platinum plan, yet have a Silver-level premium.

3. **Reducing costs for those with no subsidies** — While it is not the subject of this report, the 10 percent of consumers who purchase health care coverage through Covered California and the more than one million who buy coverage off exchange also benefit from lower costs achieved through a good risk mix that enrolls because of the subsidies, which lower premiums for everyone in the individual market.

The data that follows illustrates the vital role this financial assistance plays in making coverage more affordable.[1] The data in this report is complemented by a detailed set of data tables showing many of the statistics cited in this brief broken out by demographic and geographic characteristics, available at http://hbex.coveredca.com/data-research/library/Bringing_Health_Care_Coverage_Within_Reach_Data_Sheet_2016.xlsx.

Advance Premium Tax Credits

Advance Premium Tax Credits are the primary form of financial help administered by Covered California to make coverage affordable for lower- and middle-income consumers shopping through the marketplace. The credit adjusts to account for age, income, family size and the cost of health care where they live, which are all factors that make it so eligible consumers' health care expenses are capped as percentage of income.

Important features of the current tax credit design include:

1. **Advanced** — Making the tax credits available at the point of enrollment, rather than only at tax filing after year's end, helps defray the cost of health insurance throughout the year and promotes broad participation of consumers. If the tax credit were not advanced, consumers would have to bear the full cost of the premiums throughout the year and wait for a refund after filing taxes the following spring.

2. **Adjusted by income** — By defining the amount of the tax credit in relation to the consumer's income, the tax credit gets more "bang per buck" by giving the most financial support to those with the greatest need.

3. **Adjusted by household size** — The amount of the tax credit is adjusted based on consumers' household size, which could impact their household income total.

4. **Adjusted by age** — The ages of those enrolling in the household are a key determinant in the price of insurance.

[1] Data note: The analysis that follows uses data from Covered California's eligibility and enrollment system. Both the APTC and CSR financial data are necessarily estimates — the final, actual amount of both forms of financial assistance is subject to reconciliation and the results of that reconciliation are not known to Covered California.

5. **Adjusted by regional costs** — By indexing the amount of the tax credit to a benchmark plan (the second-lowest-cost Silver plan) available to the consumer, the tax credit adjusts the definition of "affordable" for consumers' unique circumstances and the products available to them. This means the tax credit adjusts for regional variations in the cost of insurance.

6. **Allows choice** — Because consumers apply a fixed tax credit amount (benchmarked to the second-lowest-cost Silver plan) to reduce the cost of any available plan, the tax credit encourages choice and competition in the marketplace. Even those who see a large share of their premium paid by the tax credit have an incentive to shop for the best value among metal tiers, driving health plans to compete for all consumers based on price and networks. The following scenarios illustrate the impact of the Advanced Premium Tax Credit for California consumers, and describe the data summarizing the aggregate impact on consumers and the state.

An Example of How the Advanced Premium Tax Credits Help Make Coverage More Affordable

Take Isaac, a 40-year-old in Los Angeles, with an income of $17,000 per year. Because Isaac's income is between 150 and 200 percent of the federal poverty level, he is expected to contribute around 5 percent of his income toward the cost of the benchmark plan available to him (the second-lowest-cost Silver plan).

While reviewing the plan choices available in his ZIP code for a 40-year-old, Isaac would see that the benchmark Silver plan would normally cost about $270 per month, or $3,246 per year. Under the current Advanced Premium Tax Credit factors, Isaac is eligible for a credit large enough to bring that $270 premium down to the cost of his expected contribution of $83 per month, or about $990 per year. Based on a $270 benchmark plan, then, Isaac is eligible for a tax credit of $188 per month, or $2,256 per year.

FIGURE 1

Gross and Net Premiums, and Tax Credits, for a Single 40-year-old in Los Angeles Who Makes $17,000 Per Year

Isaac can also use that tax credit to buy a different plan, such as the lowest-cost Silver, or even a Bronze plan. For example, in Los Angeles, the lowest-priced Silver plan costs nearly $15 less per month — $256 per month, or $3,072 per year. By applying the tax credit to this plan, Isaac can further reduce his costs, down from $83 to $68 per month, or from $996 to $816 per year.

Isaac could also choose a Bronze plan, which would lower his monthly premiums even further and maintain his access to care, but he would lose the benefits of the cost-sharing reductions in his Silver plan. Even though a bigger share of his premium would be covered by the tax credit, he would spend more out-of-pocket if he needed care. Isaac is able to make that decision and shop for the right plan for him. The fact that consumers in California benefit from this competition has been the subject of independent academic research.[3]

[2] Because CalHEERS is now programmed for 2017 benefit year, the example scenarios will use 2017 premium availability and APTC calculations for convenience.

[3] http://news.coveredca.com/2016/02/new-data-show-how-covered-california.html.

Covered California Households That Are Eligible for Tax Credits Receive an Average of $5,300 per Year in Assistance, or $3,500 for an Individual, to Help Them Pay Their Health Insurance Premiums

In 2016, Covered California enrollees received on average $299 per enrollee per month — or $442 per household per month — of advanced tax credits to help them purchase insurance coverage. On an annualized basis, this assistance represents on average more than $3,500 per individual, or $5,300 per household, per year.

In addition, 12 percent of enrollees received more than $10,000 per household per year ($833 per month), and 16 percent of individuals receive more than $6,000 per year ($500 per month) in tax credits to bring health care coverage within reach. This shows how expensive health care can be and how much financial help is needed to help consumers get the coverage they need.

See Figure 2 below for summary data on enrollment, premiums and tax credits in 2016, and Figure 3 for statistics on key financial data (gross premiums, net premiums, tax credits and cost-sharing reductions) at the individual and household level for 2016.[4]

FIGURE 2

Summary Enrollment and Financial Data for Covered California 2016 Enrollees

Unique Enrollees	Total	1,698,326
Not subsidy eligible	*Not subsidy eligible*	213,789
Subsidy eligible	*Subsidy eligible*	1,484,537
Subsidy eligible (subset)	*No CSR*	654,539
Subsidy eligible (subset)	*Enrolled in CSR*	829,998
Members Months	Total	15,817,927
Not subsidy eligible	*Not subsidy eligible*	1,784,169
Subsidy eligible	*Subsidy eligible*	14,033,758
Subsidy eligible (subset)	*No CSR*	6,082,433
Subsidy eligible (subset)	*Enrolled in CSR*	7,951,325
Household/Policy Months	Total	10,710,754
Not subsidy eligible	*Not subsidy eligible*	1,216,532
Subsidy eligible	*Subsidy eligible*	9,494,222
Subsidy eligible (subset)	*No CSR*	3,932,812
Subsidy eligible (subset)	*Enrolled in CSR*	5,561,410
Financials ($)		
Gross Premiums	*Total*	6,490,691,272
Gross Premiums (subset)	*Subsidy eligible*	5,839,111,473
Advanced Premium Tax Credits	*Subsidy eligible*	4,200,597,579
Net Premiums	*Subsidy eligible*	1,638,535,997
Cost Sharing Reductions	*Enrolled in CSR*	723,799,157
Aggregate Financial Assistance	*Subsidy eligible*	4,924,396,736

[4] A complete reporting of similar metrics is available at hbex.coveredca.com\data-research, including breakdowns by demographics and geography.

FIGURE 3

Mean Premiums and Financial Assistance for Covered California 2016 Enrollees

Gross Premiums ($)		
Individual - mean (monthly)	*Subsidy eligible*	416
Individual - annualized mean	*Subsidy eligible*	4,993
Household - mean (monthly)	*Subsidy eligible*	615
Household - annualized mean	*Subsidy eligible*	7,380
Advance Premium Tax Credits ($)		
Individual - mean (monthly)	*Subsidy eligible*	299
Individual - annualized mean	*Subsidy eligible*	3,592
Household - mean (monthly)	*Subsidy eligible*	442
Household - annualized mean	*Subsidy eligible*	5,309
Aggregate Net Premiums ($)		
Individual - mean (monthly)	*Subsidy eligible*	117
Individual - annualized mean	*Subsidy eligible*	1,401
Household - mean (monthly)	*Subsidy eligible*	173
Household - annualized mean	*Subsidy eligible*	2,071
Cost Sharing Reductions ($)		
Individual - mean (monthly)	*Enrolled in CSR*	91
Individual - annualized mean	*Enrolled in CSR*	1,092
Household - mean (monthly)	*Enrolled in CSR*	130
Household - annualized mean	*Enrolled in CSR*	1,562
Total Financial Assistance per Subsidy-eligible Enrollee ($)		
Individual - mean (monthly)	*Subsidy eligible*	519
Individual - annualized mean	*Subsidy eligible*	6,224
Household - mean (monthly)	*Subsidy eligible*	519
Household - annualized mean	*Subsidy eligible*	6,224

These average figures only partially describe the impact of the assistance provided by the Advanced Premium Tax Credits, since there is a considerable range in the amount of assistance received. As Figure 4 shows, over half of all households receiving tax credits received assistance worth $5,000 per year or more ($417 per month or more), and one-third of households received $7,000 or more per year ($583 per month or more) in tax credits. Figure 5 provides the distribution at the individual level, showing over half of all individuals receiving a credit worth $3,000 or more per year ($250 per month or more), and one-third of all individuals receiving more than $3,000 per year ($333 per month or more).

FIGURE 4

Distribution of 2016 Advance Premium Tax Credits per Household, Annualized

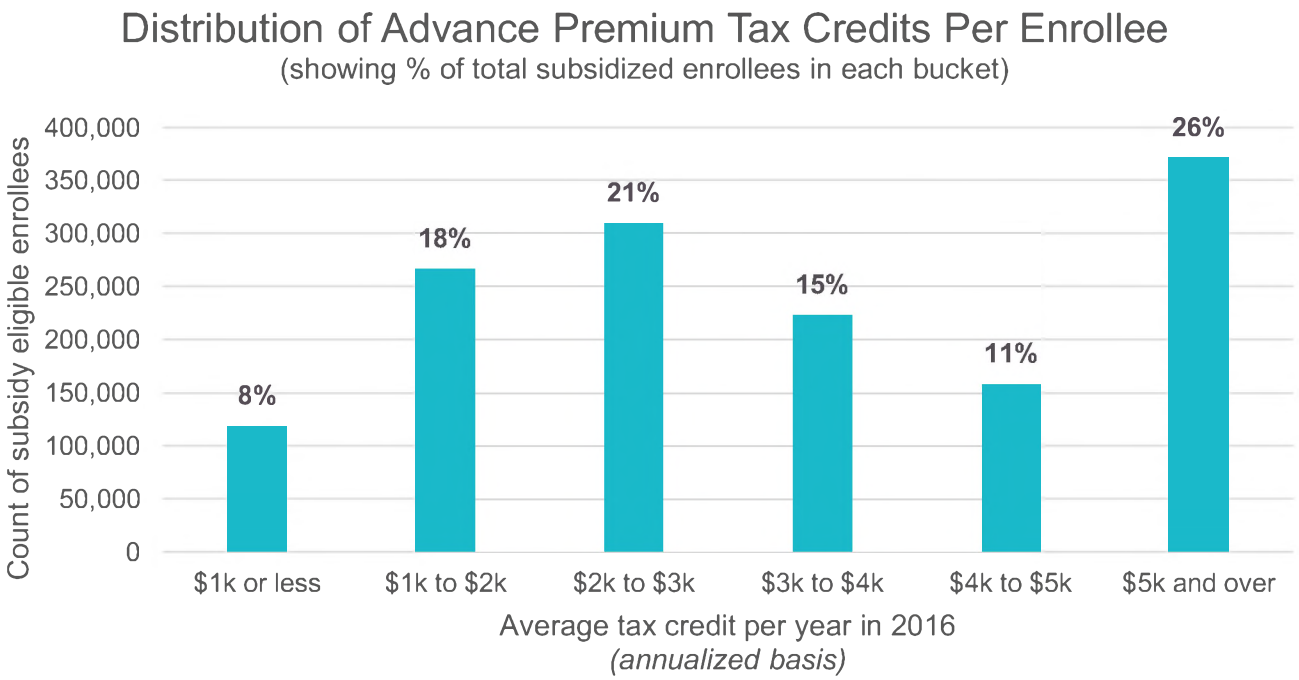
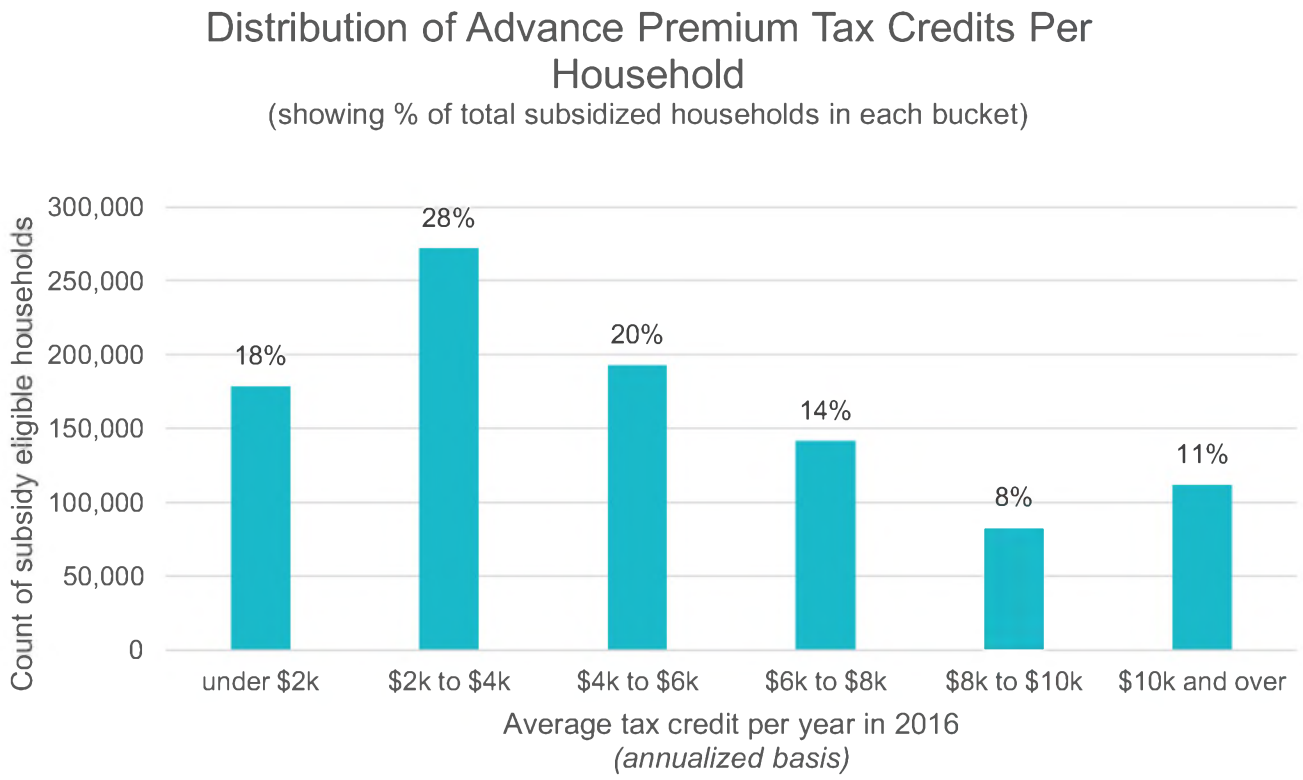


FIGURE 5
Distribution of 2016 Advance Premium Tax Credits per Individual, Annualized



Examples: Different Levels of Assistance for Different Situations

To illustrate key design principles of the Advanced Premium Tax Credit, the chart below lays out a series of variations on affordability scenarios by age, income, family size and geography, listing the gross premiums, tax credits, net premium after tax credit, as well as the estimated value of cost-sharing reductions received by each scenario. The scenarios describe the costs to the consumer or family of the second-lowest Silver plan available to them and also the cost of the lowest Bronze plan available, after taking into account the tax credit. Key features of each scenario will be explored in the following sections.

Bringing Health Care Coverage Within Reach

Income of $17,000 per year ($35,000 for family of four) ~ 143 percent FPL

Income of $20,000 per year ($41,000 for family of four) ~ 170 percent FPL

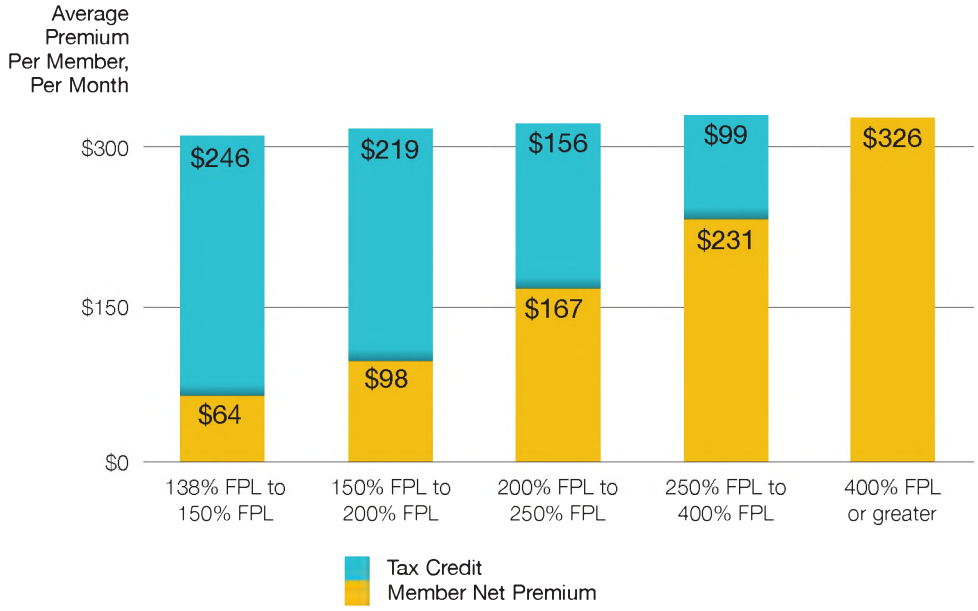
Income of $30,000 per year ($61,000 for family of four) ~ 253 percent FPL

Income of $50,000 per year ($102,500 for family of four) ~ 420 percent FPL

		Covered California 2017 Actuals			
	Gross Premium for Silver (2nd lowest cost)	Advanced Premium Tax Credit	Net Premium for Silver (2nd lowest cost)	Cost Sharing Reductions (estimated value)	Net Premium for Bronze (lowest cost)
Los Angeles					
Age 27	222	170	52	117	1
Age 40	270	218	52	117	1
Age 62	608	556	52	117	1
Family (42, 40, 16, 12)	820	711	109	234	4
San Francisco					
Age 27	365	313	52	157	1
Age 40	446	393	53	157	1
Age 62	1,002	948	54	157	2
Family (42, 40, 16, 12)	1,350	1,239	111	314	4
Los Angeles					
Age 27	222	140	82	83	24
Age 40	270	188	82	83	13
Age 62	608	526	82	83	1
Family (42, 40, 16, 12)	820	651	169	166	4
San Francisco					
Age 27	365	283	82	115	1
Age 40	446	363	83	115	1
Age 62	1,002	918	84	115	2
Family (42, 40, 16, 12)	1,350	1,179	171	230	4
Los Angeles					
Age 27	222	15	207	-	149
Age 40	270	63	207	-	138
Age 62	608	401	207	-	142
Family (42, 40, 16, 12)	820	398	422	-	210
San Francisco					
Age 27	365	158	207	-	106
Age 40	446	238	208	-	84
Age 62	1,002	793	209	-	2
Family (42, 40, 16, 12)	1,350	926	424	-	50
Los Angeles					
Age 27	222	-	222	-	164
Age 40	270	-	270	-	201
Age 62	608	-	608	-	451
Family (42, 40, 16, 12)	820	-	820	-	608
San Francisco					
Age 27	365	-	365	-	264
Age 40	446	-	446	-	325
Age 62	1,002	-	1,002	-	724
Family (42, 40, 16, 12)	1,350	-	1,350	-	976

FIGURE 6

Statewide Average Premiums for Subsidy-Eligible 40-Year-Old Silver Plan Enrollees, by Income, as Indicated by Percentage of Federal Poverty Level (FPL) Bucket



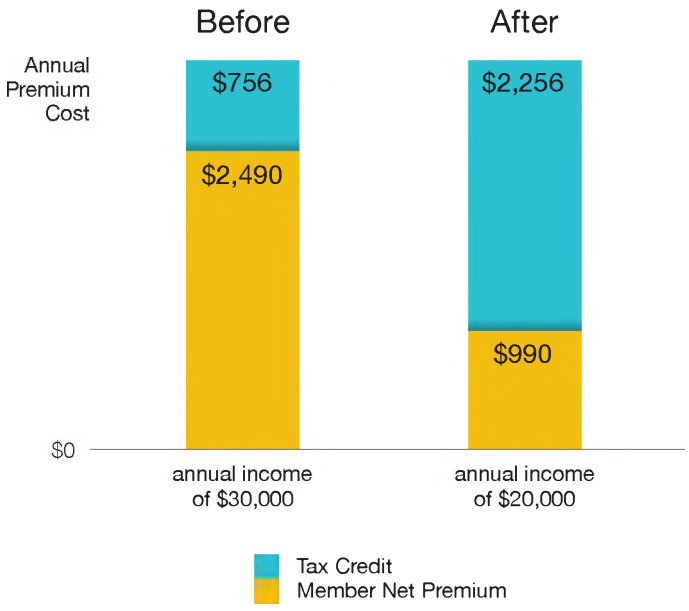
Tax Credits Are Income-Based, Helping Consumers Afford Coverage

The Advance Premium Tax Credit adjusts the amount of financial assistance based on a consumer's projected household income. For example, Figure 6 above illustrates the variation in member net premium and tax credit for a 40-year-old purchasing a Silver plan, with various levels of income (defined as percentage of the federal poverty level). The average gross premium for a 40-year-old, whether he or she enrolled through Covered California or off exchange, was $327 per month in 2016, or $3,924 per year.[5] Because financial assistance caps at 400 percent of the federal poverty level, a single consumer earning over approximately $47,000 per year was responsible for the entire $327.

As observed in the scenario of Isaac, above, 40-year-old Covered California enrollees in the 150 to 200 percent FPL range (with an income of approximately $18,000 to $24,000 for a single tax filer) paid just under $100 per month for their Silver plan, while the tax credit covered the remaining $200 or more.

FIGURE 7

Example: Tax Credits Adapt to Maintain Affordability During Income Change Due to Reduction in Income (40-Year-Old, Los Angeles)



[5] All references to income data in this brief refer to the consumer's projected Modified Adjusted Gross Income (MAGI). Covered California does not receive final filed income data for consumers from the IRS.

By adjusting to a consumer's income, the Advance Premium Tax Credit seeks to maximize affordability for the greatest number of consumers. All consumers are still responsible for paying their "fair share" towards the cost of coverage, but the amount they must contribute is based on their ability to pay.

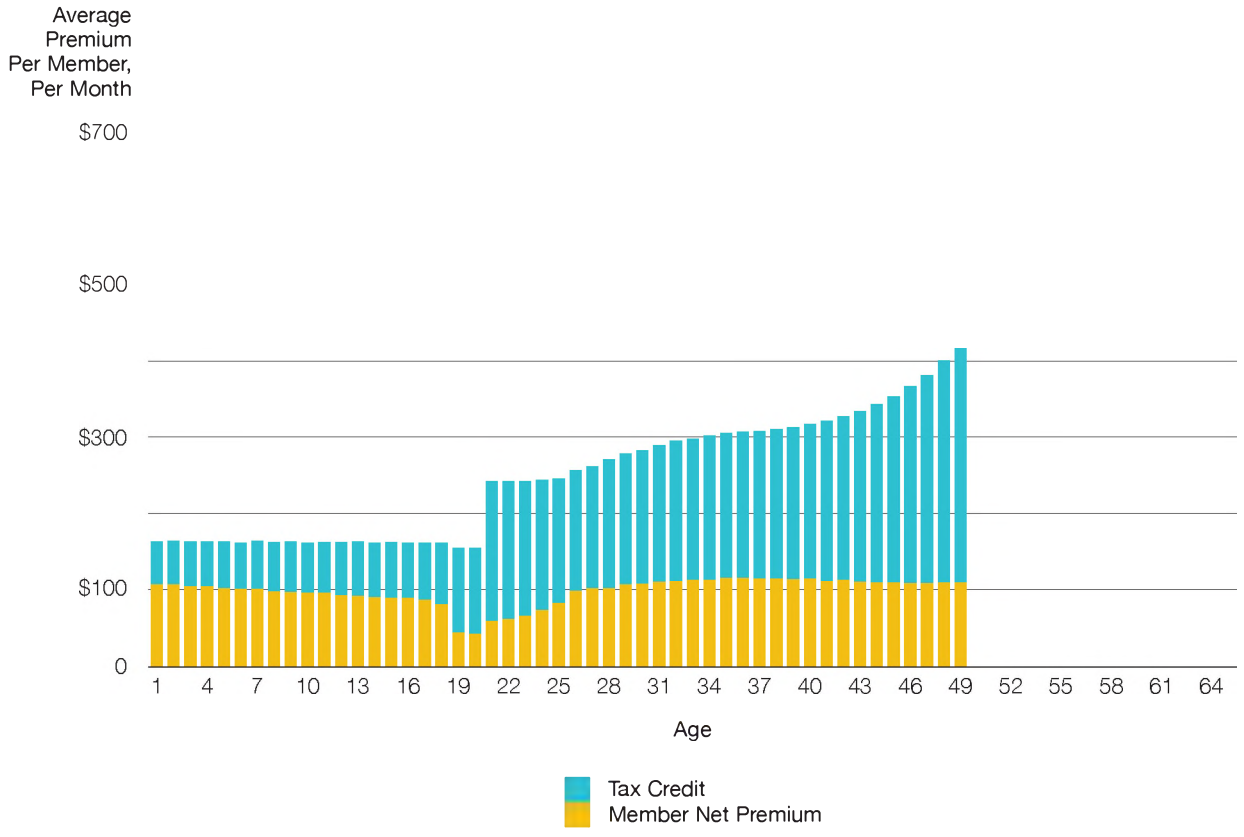
Consider the scenario if Isaac had enrolled in January at an income of $30,000 per year equivalent. As seen in Figure 7, Isaac would have been eligible for a modest tax credit of $63 per month. Yet if his income had slowly fallen off, (e.g., as a result of getting fewer shifts each month), Isaac's new expected income at year end would now be $20,000, placing him in the 150 to 200 percent FPL range (for a single tax filer). At this point, the tax credit would kick in to make up the difference, providing nearly two-thirds of the cost of the premium and making the consumer responsible for less than one-third of the total cost of the premium.

Tax Credits Help Keep Coverage Affordable as Consumers Age

The tax credits under the Affordable Care Act adjust to ensure that consumers only pay a share of their income toward their premium, which means that the "fair share" paid by a consumer is the same, regardless of age. As shown in Figure 8 below, among Covered California subsidized members enrolled in Silver plans in 2016, older adults faced much higher average gross premium costs, but also in turn received proportionally more tax credits to defray the cost of coverage than their younger counterparts. While younger adults do pay a larger share of member net premium, their average premium is far below the average premium for older adults. The Affordable Care Act implemented a 3-to-1 age rating curve, meaning that the older adults can be charged no more than three times what younger adult consumers are charged.

FIGURE 8

Statewide Average Premiums for Subsidy-Eligible Silver Plan Enrollees in 2016, by Age, Showing Portion of Premium Paid by Enrollee and Portion Covered by APTC

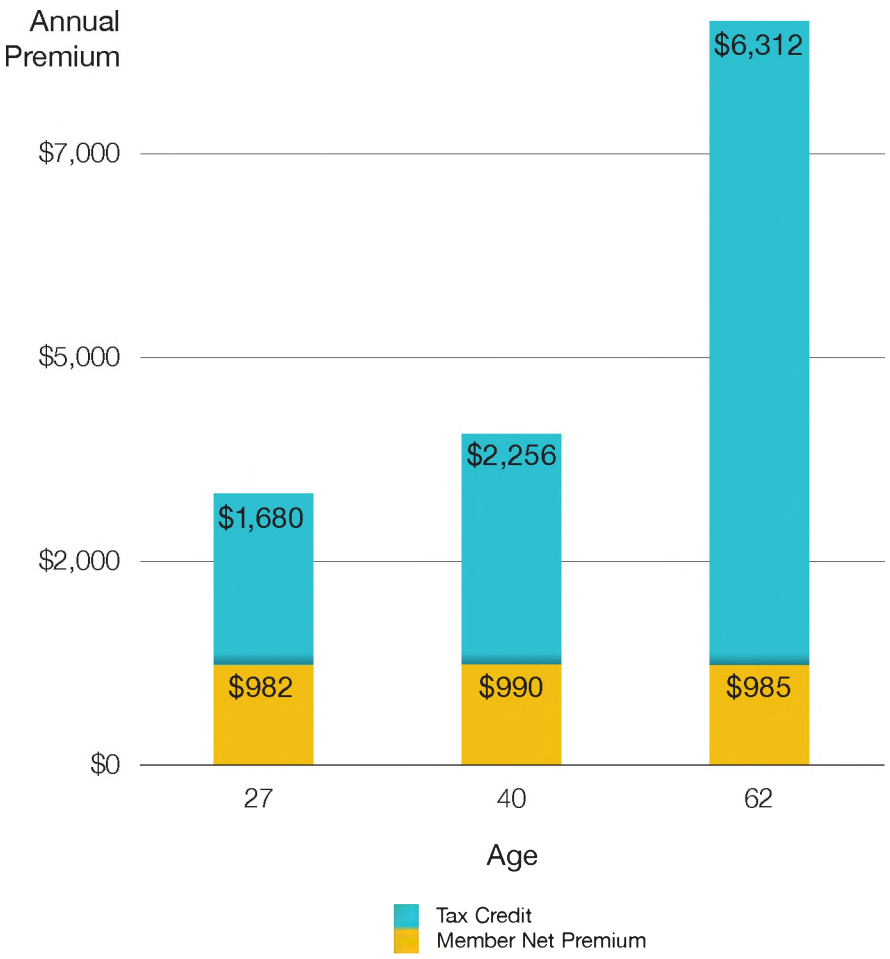


Returning to the hypothetical example of Isaac, a person earning $20,000 in Los Angeles, consider the way the tax credit would adapt for Isaac as he ages. Due to the actuarial age curve used in health plan premium rating, health premiums generally increase much more rapidly each year over one's lifetime than wages do. Thus, even supposing Isaac keeps steady work at $20,000 per year, the relative cost of his insurance would climb, such that by age 62 he is being charged more than double what he was being charged at age 62 — even if the cost of care is the same (i.e., no medical inflation).

However, as indicated in Figure 9 below, under the Advanced Premium Tax Credit Isaac's net premium remains constant, thanks to a tax credit that grows to meet the rising cost of coverage for an older consumer. Isaac's tax credit as a 62-year-old would be nearly three times the credit he would receive as a 40-year-old, rising from $2,256 per year ($188 per month) to $6,312 per year ($526 per month).

FIGURE 9

Example: Tax Credits Adjust to Keep Coverage Affordable, Despite Higher Premium for Older Consumers (Los Angeles Resident Earning $20,000 per Year)



By ensuring that net premiums are determined based on income, the Advance Premium Tax Credit preserves affordability across all ages — even as premiums change dramatically across the rating curve.

Keeping Coverage Affordable Despite Wide Regional Variation in the Cost of Coverage

The cost of coverage — and the cost of health care — varies substantially in California due to differences in market conditions, such as the availability of hospitals and provider networks.

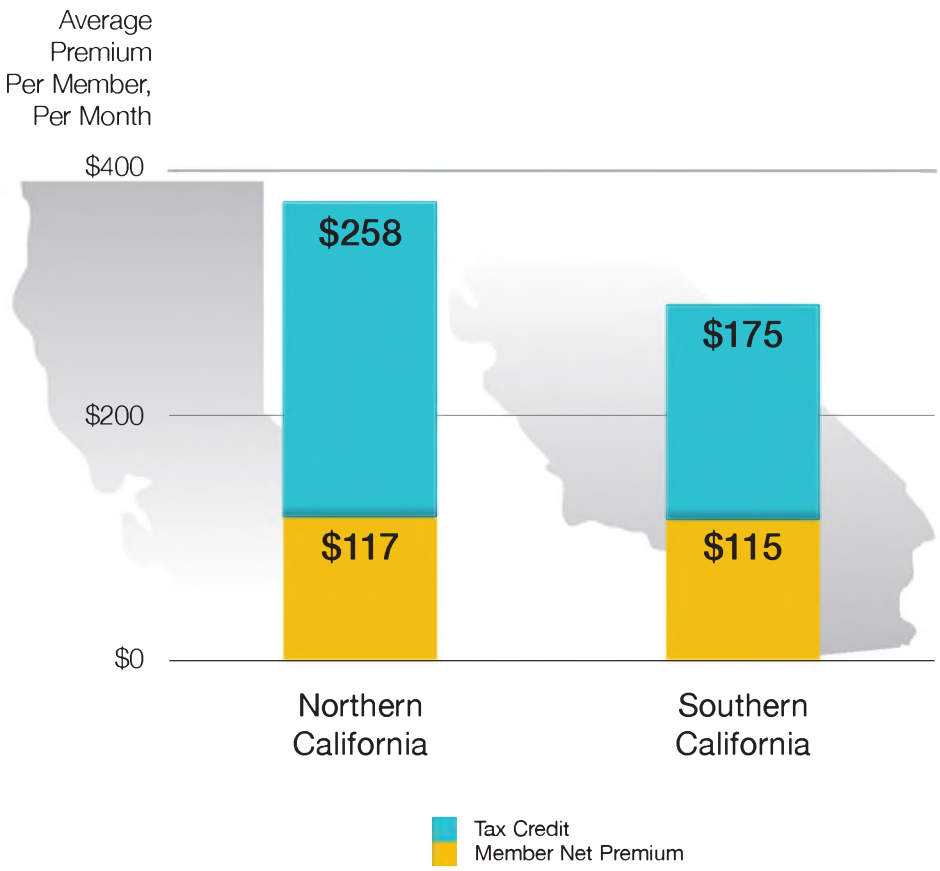
For example, a recent analysis by the Integrated Healthcare Association (IHA), using the California Regional Health Care Cost and Quality Atlas, documented substantial disparities in the cost of providing care for individuals with commercial insurance (including many of the health plans available through Covered California) between northern and southern California, in which all northern California regions had a cost above the statewide average, while all southern California regions had costs below the statewide average. For example, IHA found that the average cost to provide care per enrollee was $5,400 in San Francisco, but only $3,600 in Los Angeles, meaning costs of care varied by 50 percent.[6]

Due to these extensive variations in the cost to provide care, the cost of coverage varies accordingly. Thus, even after negotiations with insurers to get the best deal possible for consumers, gross premiums offered through Covered California reflect these differences. Indeed, as indicated in Figure 10 below, the average gross premium in 2016 for 40-year-olds in Silver plans was 30 percent higher in northern California than in southern California.

However, because the Advance Premium Tax Credit adjusts for the cost of care where the consumer lives, the financial assistance makes coverage relatively affordable regardless of whether a consumer happens to live in an area of unusually high-priced health care (such as Region 4, San Francisco, or Region 9 on the Central Coast) or an area of abundant competition that has lower prices (such as Regions 15 and 16, Los Angeles County).

FIGURE 10

Tax Credits Account for Wide Differences in the Underlying Cost of Care Between Northern and Southern California



[6] Benchmarking California Health Care Quality and Cost Performance. http://www.iha.org/sites/default/files/resources/issue-brief-cost-atlas-2016.pdf.

Consider the example of two families of four earning $61,000, one living in Los Angeles and the other in San Francisco. Both families have two middle-aged parents (ages 42 and 40) and two kids (ages 16 and 12). In both locations, the children are eligible for Medi-Cal. Without a tax credit, the parents face very different costs, with the coverage for the family in San Francisco costing $1,350 per month while the parents in Los Angeles face a gross premium of $820. However, because the tax credit calculation ensures that families with the same income should pay the same amount for their coverage, the credits adjust for regional differences in the cost of care, making the family in San Francisco eligible for over twice the tax credit ($926 per month) as the Los Angeles family ($398). As a result of the credits, both families can purchase the second-lowest Silver policy for an identical price: $422 in Los Angeles compared to $424 in San Francisco.

Cost-Sharing Reductions

The Affordable Care Act recognizes that low-income consumers face challenges not only with monthly premium costs to purchase coverage, but also in affording the price of health care when services are used — even when covered under an insurance plan. As a result, the Affordable Care Act requires that low-income enrollees be eligible for special Silver plans, called Enhanced Silver 73, 87 and 94 in California.

Reducing the cost to the consumer at the point of care is a critical component of ensuring that consumers not only have affordable coverage, but that they can get affordable care.

Even without the benefit of additional cost-sharing reductions, Covered California takes careful steps to ensure that copays are not a deterrent to care by requiring all of its health plans to offer their Bronze, Silver, Gold, Platinum and minimum-coverage plans in patient-centered benefit designs. These benefit designs ensure that consumers can access primary care without first having to meet deductibles. They also limit the use of coinsurance and take other steps to incentivize high-value care.

Because coverage alone does not ensure that care is affordable, the Affordable Care Act's cost-sharing reductions ensure that the lower-income consumers enrolled through Covered California receive additional financial protection in the form of richer coverage. By being available at 250 percent of the federal poverty level and below (approximately $29,000 for a single person), this assistance is targeted precisely at those who are most likely to be deterred from seeking care due to the up-front cost of copays and deductibles.

Effectively, cost-sharing reductions increase the actuarial value of Silver plans for consumers below 250 percent of the federal poverty level as follows:

- 100 to 150 percent FPL: 94 percent actuarial value.
- 150 to 200 percent FPL: 87 percent actuarial value.
- 200 to 250 percent FPL: 73 percent actuarial value.
- All other incomes: 70 percent actuarial value.

Additionally, American Indian and Alaska Native (AI/AN) consumers may be eligible for certain reduced services and no cost-sharing at any metal level.

Consumers who are below 250 percent of the federal poverty line and choose a Silver plan are automatically placed into an Enhanced Silver plan according to their eligibility.

In addition to cost-sharing reductions, Covered California's patient-centered benefit designs put the consumer first by removing the financial hurdles to getting care. Most outpatient services in Silver, Gold and Platinum plans are not subject to a deductible, including primary care visits, specialist visits, lab tests, X-rays and imaging. Even consumers in Covered California's most affordable Bronze plans are able to see their doctor or a specialist three times before the visits are subject to the deductible. In 2017, most consumers saw a lower copay for their primary care visits, and urgent care costs in every plan are now the same as the primary care visit, helping consumers save up to $55 per visit. Consumers in Silver, Gold and Platinum plans will also pay a flat copay for emergency room visits in 2017, without having to satisfy a deductible, which could help them save thousands of dollars.

Enhanced Silver Plans Provide Better Coverage for the Same Premium

Enhanced Silver plans include much richer coverage for the price of the same Silver premium. These plans include lower copays, coinsurance and deductibles than normal silver plans. For consumers in Enhanced Silver 87 and 94 plans, the coverage is richer than that of Gold plans and Platinum plans, respectively.

FIGURE 11

Covered California Patient-Centered Benefit Designs for 2017 Show How Cost-Sharing Reductions Improve Benefits and the Lower Cost of Using Care

Coverage Category	Enhanced **Silver 94**	Enhanced **Silver 87**	Enhanced **Silver 73**	**Silver**
Cost-Sharing Reduction Single Income Range	**up to $17,820** (100% to ≤150% FPL)	**$17,820 to $23,760** (>150% to ≤200% FPL)	**$23,760 to $29,700** (>200% to ≤250% FPL)	N/A
Primary Care Vist	$5	$10	$30	$35
Specialist Visit	$8	$25	$55	$70
Tier 1 (Generic Drugs)	$3	$5	$15	$15
Tier 2 (Preferred Drugs)	$10	$20**	$50**	$55**
Tier 3 (Non-preferred Drugs)	$15	$35**	$75**	$80**
Tier 4 (Specialty Drugs)	10% up to $150 per script	15% up to $150** per script	20% up to $250** per script	20% up to $250** per script
Medical Deductible	Individual: $75 Family: $150	Individual: $650 Family: $1,300	Individual: $2,200 Family: $4,400	Individual: $2,500 Family: $5,000
Pharmacy Deductible	N/A	Individual: $50 Family: $100	Individual: $250 Family: $500	Individual: $250 Family: $500
Annual Out-of-Pocket Maximum	$2,350 individual $4,700 family	$2,350 individual $4,700 family	$5,700 individual $11,400 family	$6,800 individual $13,600 family

Items in blue are not subject to any deductible.
Drug prices are for a 30-day supply.

* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

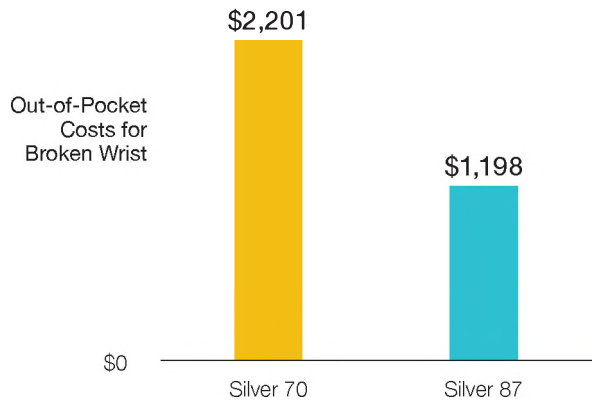
** Price is after pharmacy deductible amount is met.

Cost-Sharing Reductions Significantly Lower the Out-of-Pocket Costs of Medical Care

Cost-sharing reductions are an important component of affordability because they significantly reduce a consumer's out-of-pocket expenses. Using publicly available cost data on a moderate injury, a broken wrist, Figure 12 shows how the Enhanced Silver 87 plan saves the consumer $1,000.

FIGURE 12

Cost-Sharing Reductions (CSR) Cut by Half the Out of Pocket Costs for a Typical Broken Wrist



The scenario used to derive these out-of-pocket estimates is based on one emergency room visit, two-view X-ray, a specialist procedure to treat the broken wrist and a single follow-up visit. Cost data uses FAIR (fairhealthconsumer.org) commercial pricing for ZIP code 90017 (discounted to reflect Covered California's lower, negotiated rates).

In this example, the consumer had not yet used any services in the plan year. The total cost of the care to treat the broken wrist was estimated to be $2,201 — less than the $2,500 deductible in the Silver 70, but more than the more modest $650 deductible in the Enhanced Silver 87 plan. Because of cost-sharing reductions, consumers in the Silver 87 see the benefits of their coverage "kick in" much earlier. As a result, thanks to the Enhanced Silver 87 coverage, the consumer will save over $1,000 in the month of the accident, and will also have met his or her deductible for any future follow-ups or other medical treatments needed in the year.

The average Covered California enrollee eligible for Silver 87 has a mean monthly income of just over $2,200, based on his or her projected income. Thus, for the more than half of Covered California's consumers who receive cost-sharing reductions, this assistance is a critical support without which consumers would be forced to choose between health care and basic necessities like food or rent, or to go without care entirely.

Covered California enrollees with cost-sharing reductions pay on average $1,000 less per year out of pocket when they use care.

For the half of Covered California enrollees who benefit from cost-sharing reductions in Enhanced Silver plans, the average reduction in out-of-pocket costs when they use care is estimated to be $90 per month, or $1,000 per year (see Figure 13).[7] Because there are multiple levels of cost-sharing reductions, and because use of services is uneven across the population, the actual specific savings will vary greatly from enrollee to enrollee. At a household level, cost-sharing reductions represented over $1,500 in financial assistance in 2016.

[7] All cost-sharing reduction financial data cited in this brief is based on the estimate of the value of the cost-sharing reductions, following the prescribed methodology from the Centers for Medicare and Medicaid Services (CMS) for estimating the amount of cost-sharing reductions. The actual amount of out-of-pocket costs that have been reduced depends on the services incurred by the enrollees, and Covered California is not part of the final reconciliation that occurs between qualified health plans and CMS.

FIGURE 13

Member Months and Total Estimated Value of Cost-Sharing Reductions, by Metal Tier Cost-Share Variant

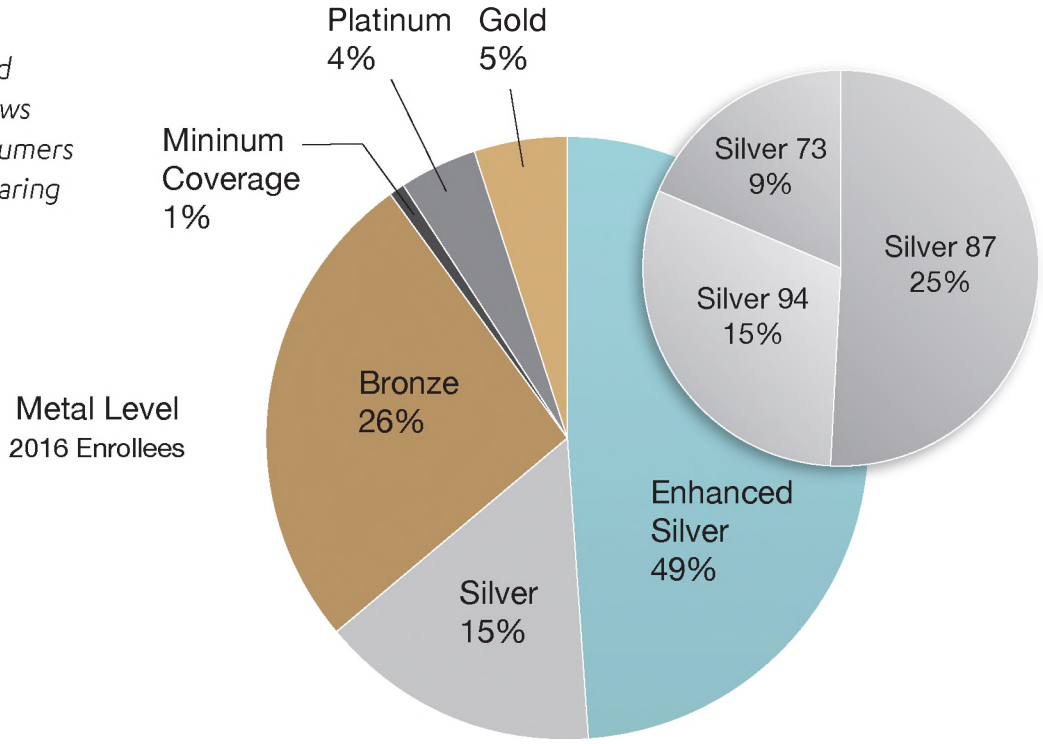
Cost-Sharing Reduction Category	Members Months Enrollment in 2016	Household Months Enrollment in 2016	Aggregate Estimated Value of Cost Sharing Reductions
Silver 73 Cost Sharing Reduction	1,455,692	1,004,394	$ 20,272,252
Silver 87 Cost Sharing Reduction	4,035,157	2,838,566	$ 386,769,039
Silver 94 Cost Sharing Reduction	2,422,932	1,686,863	$ 310,567,614
AI/AN Cost Sharing Reduction - Zero Cost Share	37,572	31,590	$ 6,521,981
Total	**7,951,353**	**5,561,413**	**$ 724,130,886**

Cost-Sharing Reduction Category	Individual - Mean Estimated Monthly Value of Cost Sharing Reductions	Individual - Mean Estimated Annualized Value of Cost Sharing Reductions	Household - Mean Estimated Monthly Value of Cost Sharing Reductions	Household - Mean Estimated Annualized Value of Cost Sharing Reductions
Silver 73 Cost Sharing Reduction	$ 14	$ 167	$ 20	$ 242
Silver 87 Cost Sharing Reduction	$ 96	$ 1,150	$ 136	$ 1,635
Silver 94 Cost Sharing Reduction	$ 128	$ 1,538	$ 184	$ 2,209
AI/AN Cost Sharing Reduction - Zero Cost Share	$ 174	$ 2,083.03	$ 206	$ 2,477.49
Total	**$ 91**	**$ 1,093**	**$ 130**	**$ 1,562**

Half of Covered California Enrollees Benefit From Cost-Sharing Reductions in Enhanced Silver Plans
Half of all Covered California enrollees benefit from cost-sharing reductions in Enhanced Silver plans, of which over three-quarters receive benefits well above Gold-level coverage (i.e., those enrolled in Silver 87 or Silver 94).

Additionally, American Indian and Alaska Native consumers are eligible for additional cost-sharing reductions, with limited cost-sharing for those above 300 percent FPL and no cost-sharing for those below 300 percent FPL. Over 3,000 American Indian or Alaskan Native consumers in Covered California benefited from these reductions to cost sharing in 2016.

FIGURE 14
Metal Tier Choice by Covered California 2016 Enrollees Shows That the Majority of All Consumers Are Benefiting From Cost-Sharing Reductions



Conclusion
The observations and findings presented in this Covered California analysis document how California consumers receiving tax credits or cost-sharing reductions, or both, have been made better off through more affordable coverage and financial protection for routine and unexpected medical expenses. As federal policy makers evaluate proposals that may repeal and replace the Affordable Care Act, it will be important to measure the impact of such proposals on coverage in the individual market and affordability for consumers for both premiums and out-of-pocket costs. This should involve careful consideration of policy changes to the financial assistance that is currently provided on an advanced basis and adjusted by income, age, family size and region to take into account a consumer's unique circumstances and local market conditions.

About Covered California

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit CoveredCA.com.

COVERED CALIFORNIA

Preliminary Analysis of Impacts to Consumers From Changes in Premium Subsidies and Cost-Sharing Reductions Available Under the Proposed American Health Care Act

Background

Under the Patient Protection and Affordable Care Act (ACA), individuals with incomes between 138 and 400 percent of the federal poverty level ($16,000 to $47,000) qualify for financial assistance to purchase health insurance through an Advance Premium Tax Credit, or APTC, based on age, income, family size and the region where an individual lives. In addition, depending on their income, consumers may qualify for cost-sharing reductions (CSR), which limit what they pay when they access health care.

On Monday, March 6, the American Health Care Act (AHCA) was introduced in the U.S. House of Representatives and is currently under consideration in Congress. The bill would alter the way financial assistance is provided to help consumers afford health insurance on the individual market.

This preliminary analysis uses actual data on the size, nature and structure of financial support for consumers in California. The analysis, prepared by Covered California, can be found at URL. It shows how the current structure of financial support, using APTC and CSR, assists Covered California enrollees. The analysis uses that data to better understand the potential impact of the AHCA.

This preliminary analysis is based on the version of the AHCA that was reported out of the House of Representatives, two main committees of jurisdiction, the Energy and Commerce Committee and the Ways and Means Committee, in early March.

Key Changes Proposed Under the AHCA

Instead of receiving financial assistance based on age, income, family size and where the consumer lives — as provided in current law — consumers would receive an advanceable tax credit based on age if the AHCA were to become law, with income considered as a factor only for the phasing out of the availability of the tax credit for individuals making more than

Key Findings:

- While the average effects are relatively clear, with analysis by the Congressional Budget Office's assessment that, "the average subsidy under the legislation would be about 60 percent of the average subsidy under current law," the effect on individuals in California varies greatly.
- In particular, for older Californians, the effect of the proposed tax credit structure is a dramatic increase in the out-of-pocket costs for coverage, meaning they are likely to drop coverage
- Eliminating the adjustment of subsidy based on the region where an individual lives has a major impact on those who live in higher-cost areas, who will likely find coverage unaffordable.
- Further analysis is needed to model the overall impact of proposed changes, including all provisions contained in the American Health Care Act.

This analysis was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally.

$75,000 per year. The tax credits proposed in the AHCA would range from $2,000 to $4,000 and would be based on age alone. The legislation would not include cost-sharing reductions the financial assistance provided to lower-income individuals (between 138 and 250 percent of the federal poverty level) when they access care.

The AHCA also allows for states to apply for and receive funds from a Patient and State Stability Fund, which could be used to fund a variety of activities that promote market stability, such as stabilizing premiums or lowering lower health care expenses for consumers. The AHCA provides for up to $15 billion per year available to states for 2018 and 2019, and then $10 billion per year for 2020 through 2026. After 2019, there would be a requirement on states to provide "matching funds" to receive these resources – starting at 7 percent "match" in 2020 and increasing to 50 percent in 2026. Additional analysis is needed to estimate California's potential share of these funds.

The following tables show financial assistance provided under current law for a variety of hypothetical individuals or a family, with various ages, incomes and locations of residence compared to the proposed changes under the AHCA. In all cases, the financial estimates are based on 2017 premiums and costs.*

*Analysts including CBO anticipate that premiums and, accordingly, APTC available under current law would increase by 15-20% by the time the AHCA tax credits would take effect in 2020. The estimates here do not rescale Covered California premiums for this increase, and thus likely understand the size of tax credits under the ACA."

Income of $17,000 per year ($35,000 for family of four) ~ 143 percent FPL

	Gross Premium for Silver (2nd lowest cost)	Advanced Premium Tax Credit	Net Premium for Silver (2nd lowest cost)	Cost Sharing Reductions (estimated value)	Net Premium for Bronze (lowest cost)	AHCA Premium Tax Credit	AHCA Net Premium for Silver (2nd lowest cost)	AHCA Cost Sharing Reductions	Change in Tax Credit	Change in Net Premium
Los Angeles										
Age 27	222	170	52	117	1	167	55	?	(3)	3
Age 40	270	218	52	117	1	250	20	?	32	(32)
Age 62	608	556	52	117	1	333	275	?	(223)	223
Family (42, 40, 16, 12)	820	711	109	234	4	833	-	?	122	(109)
San Francisco										
Age 27	365	313	52	157	1	167	199	?	(146)	146
Age 40	446	393	53	157	1	250	196	?	(143)	143
Age 62	1,002	948	54	157	2	333	668	?	(615)	615
Family (42, 40, 16, 12)	1,350	1,239	111	314	4	833	517	?	(406)	406

Income of $20,000 per year ($41,000 for family of four) ~ 170 percent FPL

Los Angeles										
Age 27	222	140	82	83	24	167	55	?	27	(27)
Age 40	270	188	82	83	13	250	20	?	62	(62)
Age 62	608	526	82	83	1	333	275	?	(193)	193
Family (42, 40, 16, 12)	820	651	169	166	4	833	-	?	182	(169)
San Francisco										
Age 27	365	283	82	115	1	167	199	?	(116)	116
Age 40	446	363	83	115	1	250	196	?	(113)	113
Age 62	1,002	918	84	115	2	333	668	?	(585)	585
Family (42, 40, 16, 12)	1,350	1,179	171	230	4	833	517	?	(346)	346

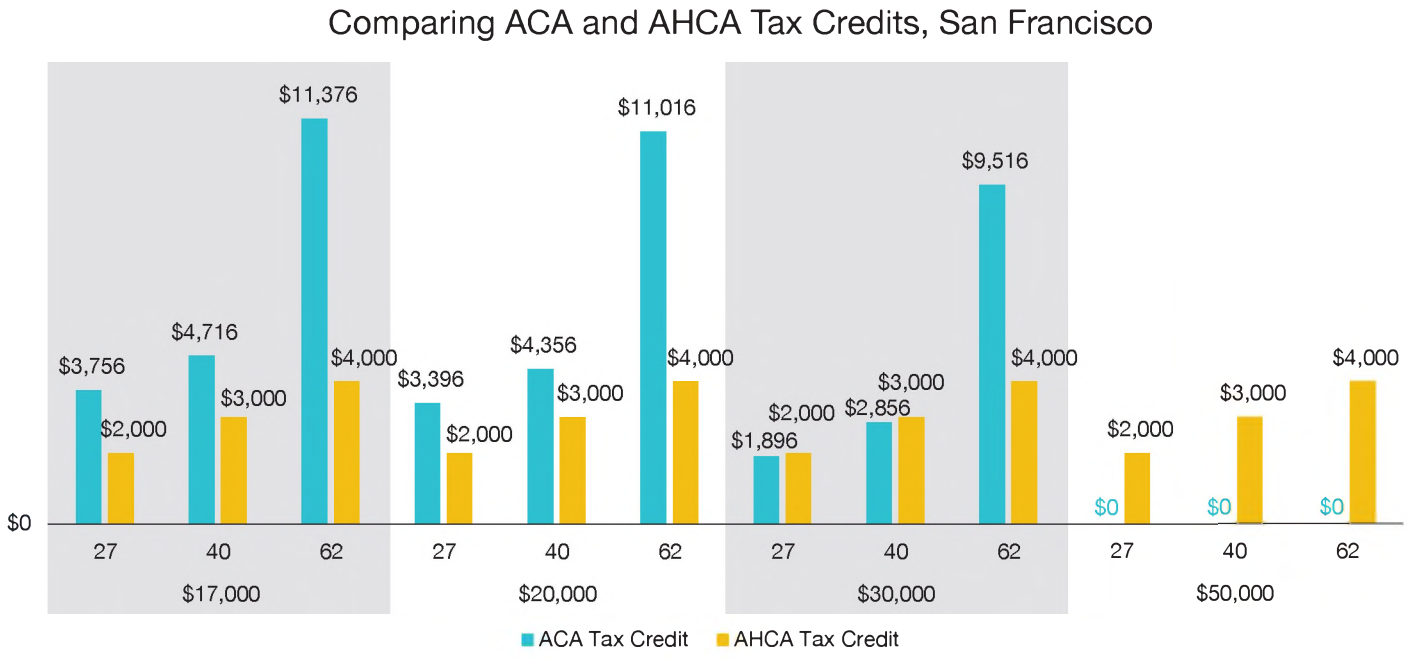
Income of $30,000 per year ($61,000 for family of four) ~ 253 percent FPL

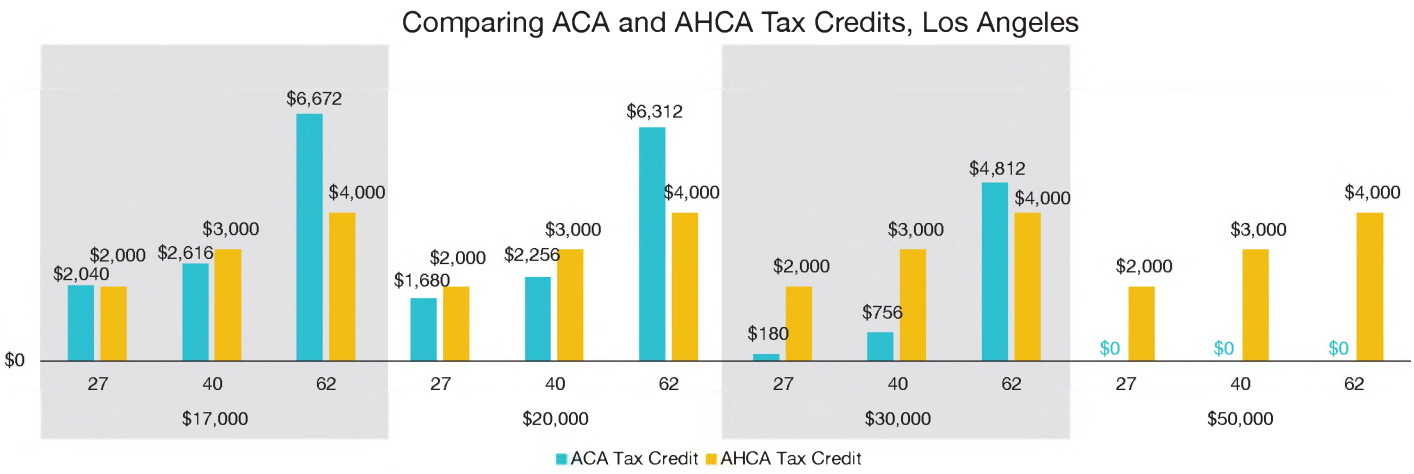
Los Angeles										
Age 27	222	15	207	-	149	167	55	?	152	(152)
Age 40	270	63	207	-	138	250	20	?	187	(187)
Age 62	608	401	207	-	142	333	275	?	(68)	68
Family (42, 40, 16, 12)	820	398	422	-	210	833	-	?	435	(422)
San Francisco										
Age 27	365	158	207	-	106	167	199	?	9	(9)
Age 40	446	238	208	-	84	250	196	?	12	(12)
Age 62	1,002	793	209	-	2	333	668	?	(460)	460
Family (42, 40, 16, 12)	1,350	926	424	-	50	833	517	?	(93)	93

Income of $50,000 per year ($102,500 for family of four) ~ 420 percent FPL

Los Angeles										
Age 27	222	-	222	-	164	167	55	?	167	(167)
Age 40	270	-	270	-	201	250	20	?	250	(250)
Age 62	608	-	608	-	451	333	275	?	333	(333)
Family (42, 40, 16, 12)	820	-	820	-	608	833	-	?	833	(820)
San Francisco										
Age 27	365	-	365	-	264	167	199	?	167	(167)
Age 40	446	-	446	-	325	250	196	?	250	(250)
Age 62	1,002	-	1,002	-	724	333	668	?	333	(333)
Family (42, 40, 16, 12)	1,350	-	1,350	-	976	833	517	?	833	(833)

The following tables provide additional side-by-side comparisons of the tax credit at a range of income levels the financial assistance provided by the Affordable Care Act (ACA), and the American Health Care Act (AHCA).





Going forward, Covered California will conduct modeling of how enrollees would be affected under changes proposed to federal law. The results of that modeling, which requires complex assumptions about rates, risk mix and consumer behavior, will be shared publicly to inform policy and plan for any changes that could affect Covered California enrollees.

This analysis will be updated as proposed policies are considered at the national level.

About Covered California

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the legislature. For more information about Covered California, please visit CoveredCA.com.

California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Californians in Individual Market Spent $2,500 Less on Care in 2015 Than Before the ACA

Amy Adams, Senior Program Officer, Improving Access

April 17, 2017

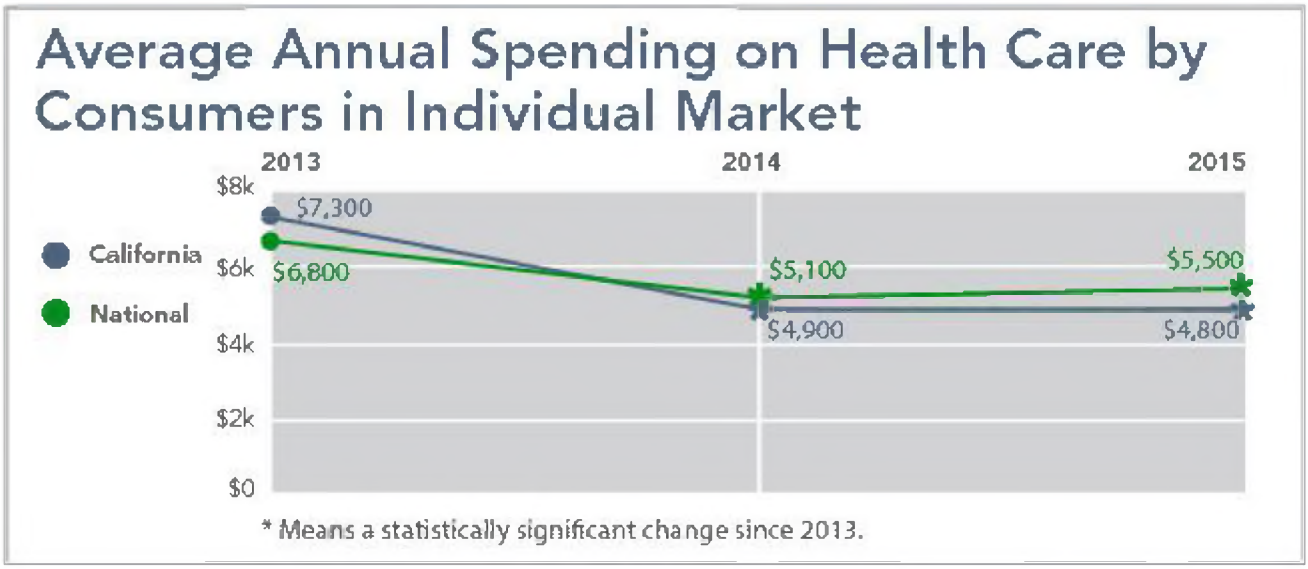

Amy Adams

Two years into the Affordable Care Act (ACA), Californians who bought health insurance on the individual market spent $2,500 less on health care compared to 2013, the year before the ACA was fully implemented, according to data from the US Census Bureau's Current Population Survey (CPS) available on ACA 411. This decline was likely driven primarily by the premium tax credits and cost-sharing reductions provided through the ACA's health insurance marketplaces. This progress toward making health care more affordable is at risk as federal lawmakers debate repealing or radically changing the ACA.

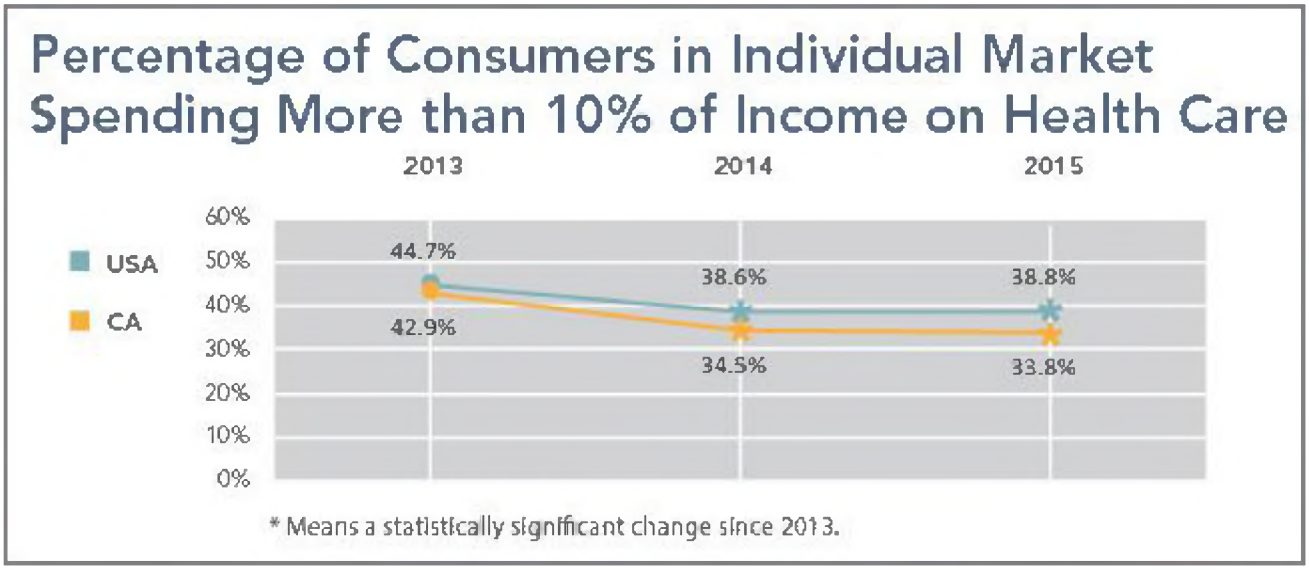
Californians' Spending Decline Beats National Trends

In 2013, Californians with individual coverage spent, on average, $7,300 out of pocket on health care (defined as spending on health insurance premiums, copays, deductibles, coinsurance for services and prescription drugs). That amount fell to $4,900 in 2014, the first year the ACA health insurance marketplaces (called Covered California in California) were open for business. In 2015 average spending for those covered through the individual market continued declining to $4,800 for a total drop of $2,500 over the two-year period.

Nationally, the amount spent on health care by consumers with individual coverage dropped from $6,800 in 2013 to $5,500 in 2015, a $1,300 decline.



Similarly, the percentage of consumers with individual coverage reporting "high-burden spending" (defined as spending more than 10% of total income on health care) fell nationally, with California seeing a steeper decline, from 42.9% in 2013 to 33.8% in 2015. Nationally, it dropped from 44.7% to 38.8% during the same period.



For more information on national trends in high-burden spending, read this new analysis of the CPS data by the State Health Access Data Assistance Center (SHADAC). There was a small but statistically significant decline in the overall US rate of high-burden spending, with improvements also among those on Medicare and those earning less than 400% of the federal poverty level (about $47,000 a year for a single person). The brief also highlights which states saw statistically significant changes in high-burden spending among various coverage types and income levels.

ACA Subsidies Caused Most of the Spending Declines

Spending by those with individual coverage was likely driven down primarily by the premium tax credits and cost-sharing reductions available to eligible low-income consumers through the ACA's health insurance marketplaces.

In 2015, 2.3 million Californians had individual health coverage — and 53% of them purchased it through Covered California. Nearly 90% of Covered California enrollees, about 1.2 million people, in 2015 received premium tax credits to bring down the cost of premiums (worth, on average, $445 a month per household). About half of Covered California enrollees, or approximately 645,000 people, were in plans with additional cost-sharing reductions (worth, on average, $125 a month per household) to defray the cost of deductibles and copays.

Californians with Individual Coverage Have a Lot Riding on ACA Debate

Lawmakers in Congress continue to debate whether and how to dismantle the ACA, and the reduced financial burden experienced by many consumers hangs in the balance. For example, provisions in the American Health Care Act (AHCA) under discussion earlier this year would have reduced financial assistance to poorer and older consumers, and it is still unclear whether the Trump Administration will end the marketplace cost-sharing reductions that reduce out-of-pocket costs for low-income consumers. Elimination of these would potentially have profound impacts on both the affordability and availability of marketplace coverage.

The financial consequences for consumers with individual coverage are huge — and Californians are among those with the most to lose.

Supporting Informed Decision-Making in the Health Insurance Marketplace: A Progress Report for 2017

APRIL 2017

national partnership for women & families

Contents

About the National Partnership for Women & Families

At the National Partnership for Women & Families, we believe that actions speak louder than words, and for 45 years we have fought for every major policy advance that has helped women and families.

Today, we promote fairness in the workplace, reproductive health and rights, access to quality, affordable health care, and policies that help women and men meet the dual demands of their jobs and families. Our goal is to create a society that is fair and just, where nobody has to experience discrimination, all workplaces are family friendly, and no family is without quality, affordable health care and real economic security.

Founded in 1971 as the Women s Legal Defense Fund, the National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)3 organization located in Washington, D.C.

Supporting Informed Decision-Making in the Health Insurance Marketplace: A Progress Report for 2017

APRIL 2017

Executive Summary

The National Partnership for Women & Families has been actively tracking the progress of the health care marketplaces established by the Affordable Care Act (ACA) since the first open enrollment period began in 2013. Beginning in 2015, we have released an analysis of each annual open enrollment period entitled *Supporting Informed Decision-Making in the Health Insurance Marketplace: A Progress Report*. In these reports, we examine how the federal and state-based marketplaces are equipping consumers with the tools and information they need to choose and enroll in health insurance. This year's report assesses marketplace support during open enrollment for the 2017 coverage year (November 1, 2016 through January 31, 2017).

For the 2017 open enrollment period, we assessed the marketplaces on metrics that are important to consumers, such as the availability of transparent, accessible information on cost, quality ratings and the inclusion of providers and prescription drugs in specific plans. In this report, we describe common marketplace website features and highlight best practices for the federally facilitated marketplace (FFM, also called HealthCare.gov) and for the 12 state-based marketplaces (SBMs).

Overall, we found that the marketplaces continue to improve and are becoming more adept at meeting consumers' needs. Below, we summarize our recommendations for how administrators can continue to support informed decision-making in the health insurance marketplace.

Recommendations

Supporting Enrollment and Website Navigation: Consumer Outreach and Assistance

RECOMMENDATION 1: OFFER MOBILE APPS.

- Marketplaces should offer and promote mobile apps. Mobile apps are a great tool to educate and encourage enrollment, particularly among younger consumers.
- Mobile apps also may allow consumers to more easily locate information that requires more searching on the full site. This includes the submission of verification information, FAQs and definitions, and broker or other live consumer assistance resources.

RECOMMENDATION 2: INCLUDE MORE KEY TERMS OFFERED AS HOVER DEFINITIONS AND IN THE GLOSSARY.

- The hover definition feature helps consumers easily access definitions of key terms and should be an option for these terms.
- All terms that have a hover definition feature should also be defined in the glossary because the glossary provides quick access, usually one click from the homepage. To access definitions via the hover feature, consumers must either be logged in to a marketplace account or use the anonymous browsing feature.

RECOMMENDATION 3: INCORPORATE A LIVE CHAT FEATURE.

- Marketplaces should incorporate a live chat feature into their websites. Live chat allows tech savvy consumers to access help efficiently.
- This feature also allows call centers to focus on more complicated consumer assistance, while the chat operators can focus on easier-to-resolve quick fixes, such as forgotten or lost passwords.

Helping Consumers Differentiate Among Plan Choices: Plan Display and Sort and Filter Options

RECOMMENDATION 1: HELP CONSUMERS EASILY FIND THE MOST BENEFICIAL PLAN OPTIONS.

- Websites should clearly explain potential cost-sharing reduction (CSR) eligibility and display silver plans first for individuals potentially eligible for CSRs to ensure that consumers consider their CSR plan options. However, websites should make it clear how a consumer can view all plan options.
- Marketplace websites should display distinctly marked standardized plan options and offer clear explanations of what they are and how they can help consumers more easily compare non-obvious plan features.

- All marketplaces should have a consumer-friendly provider and formulary search tool built into the plan shopping portal. The shopping process would be easier and more transparent if consumers could avoid comparing across many issuer webpages and instead, sort and filter plans based on network or formulary inclusion. At the very least, to limit confusion, a marketplace should include the link to the exact formulary search page specific to the plan a consumer is exploring.
- Marketplaces should use indicators to show which providers and drugs are covered by each plan, rather than using a filter that removes plans not meeting the criteria. An indicator can provide similar transparency but will not prevent consumers from seeing plans that also may fit their needs.
- As marketplace plans move toward more tightly managed networks, marketplace websites should continue to build and display measures of network breadth, and clearly explain what these measures mean.

RECOMMENDATION 2: ALLOW CONSUMERS TO SORT PLAN OPTIONS.

- Marketplace websites should clearly explain sorting options and how activating a specific type of sort will affect the plans that appear on the plan selection page.
- All marketplaces should, if possible, display an estimated total annual cost with personalized information for each plan. This feature helps consumers understand the potential impact of cost sharing on access and ultimate plan affordability. This is especially important given the high number of consumers who select plans based on the premiums, but whose access or affordability may be diminished by choosing a lower level, cheaper plan. However, it is important that all plans also display monthly premium and deductible information separately on the initial page to mitigate perceived unaffordability.
- Marketplaces should provide the option to sort by many different features, including by both cost and non-cost features such as quality rating or network breadth.

RECOMMENDATION 3: ENHANCE FILTERING OPTIONS WHILE ALLOWING CONSUMERS TO COMPARE ALL PLANS.

- Marketplaces should offer filtering tools that allow more customization; for example, sliding scales, currently utilized in the FFM, which provide more personalized results.
- Marketplaces should provide the option to filter by many features, including by both cost and non-cost features such as quality rating, issuer, standardized plan option or network breadth.
- Marketplaces should make clear that not all plans are being shown when a filter is engaged and should provide a clear and easy way for consumers to remove the filter to see all plans.

Making Key Plan Information Accessible: Marketplace Transparency

RECOMMENDATION 1: AT A MINIMUM, PLACE PRIMARY CARE PROVIDER, SPECIALIST AND ALL PRESCRIPTION DRUG TIERS' COST-SHARING INFORMATION ON INITIAL DISPLAY PAGES, IN ADDITION TO PREMIUM AND DEDUCTIBLE COSTS.

- Cost-sharing amounts for common services are crucial information for consumers to consider when choosing a health plan. Requiring consumers to click to details pages can increase confusion and may give the impression that these details are not important to consider in selecting a plan.
- When details are displayed on the initial page, marketplaces should clearly note where benefits are subject to a combined or separate drug deductible. Consumer confusion can result when that information appears only on the details pages.

RECOMMENDATION 2: EMBED BOTH THE SUMMARY OF BENEFITS AND COVERAGE (SBC) AND SCHEDULE OF BENEFITS (SOB) INTO MARKETPLACE WEBSITES TO ENSURE THESE DOCUMENTS ARE EASILY ACCESSIBLE.

- Consumers need information on covered services and the associated cost sharing for each service. This information is essential to making informed decisions when selecting health coverage. Embedding the SBC and SOB, both important consumer materials, would ensure this information is accessible.

RECOMMENDATION 3: EMBED PROVIDER AND DRUG SEARCH TOOLS IN MARKETPLACE WEBSITES.

- Consumers may prefer receiving care from particular providers or need coverage of specific medications. All marketplace websites should have embedded provider and drug search tools, and existing tools should be enhanced, so consumers can more easily select plans that include their preferred providers and/or medications.

RECOMMENDATION 4: INCREASE THE ACCURACY OF OUT-OF-POCKET (OOP) COST CALCULATORS AND MAKE THE RESULTS EASY TO UNDERSTAND.

- OOP cost calculators are important tools for consumers that give a personal context to the many coverage and cost-sharing details. However, OOP cost calculators vary widely in their precision.
- Marketplaces should improve the accuracy of these tools by offering additional inputs and using more personalized data in the calculation, such as specific medications a patient takes and the corresponding cost sharing, in order to deliver results that are as meaningful as possible to consumers.

Introduction

The Affordable Care Act (ACA) marketplaces have played a pivotal role in providing health care to millions of people across the country. Indeed, by connecting more people with health insurance sold on the individual market, marketplaces have helped drive the national uninsured rate to a record low of 8.8 percent in 2016.[1]

The National Partnership for Women & Families has been actively tracking the progress of the health care marketplaces established by the ACA since the first open enrollment period began in 2013. Beginning in 2015, we have released an analysis of each annual open enrollment period entitled *Supporting Informed Decision-Making in the Health Insurance Marketplace: A Progress Report*. In these reports, we examine how well the federal and state-based marketplaces are equipping consumers with the tools and information they need to choose and enroll in health insurance. Prior to the ACA, there was no clear or easy way to compare health care plans sold in the individual market. Over the past four open enrollment periods, the marketplaces have changed that, allowing consumers to shop and compare health plans and to find the best plan for themselves and their families. Marketplace administrators have rapidly increased the websites' capabilities and tools to serve consumers.

This year's report assesses marketplace support during open enrollment for the 2017 coverage year, which ran from November 1, 2016 to January 31, 2017. For the fourth open enrollment period, we assessed the marketplaces on metrics that are important to consumers, such as the availability of transparent, accessible information on cost, quality ratings and the inclusion of providers and prescription drugs in specific plans. In this report, we describe common marketplace website features and highlight best practices for the federally facilitated marketplace (FFM, also called HealthCare.gov) and for the 12 state-based marketplaces (SBMs). Despite recent uncertainty surrounding the future of the marketplaces, the lessons learned from the ACA's health insurance online marketplaces can inform future efforts to help consumers shop for health insurance in online settings.

We found that during the open enrollment period for plan year 2017, the marketplaces continued to improve, offering increased transparency and an even better consumer experience than in years past. Both the federal platform, HealthCare.gov, and the websites developed by specific SBMs have all continued to expand and improve tools that help consumers sort through many plan choices. Marketplace websites showed increased transparency, meaning it has become easier for consumers to compare plans across a number of features. We also found that administrators have stepped up public outreach and engagement to educate and attract enrollees, such as by partnering with civic and community health centers and directly with potential and current enrollees.[2]

We did find that some marketplaces provide better experiences than others, suggesting an opportunity for administrators to learn from one another as they continue to improve tools and services. A comprehensive set of recommendations is included in the report that follows.

Methodology

To develop this report, the National Partnership partnered with Avalere to assess the FFM and each SBM. Avalere conducted a review of historical marketplace improvements and a baseline review to highlight where marketplaces differed in approach and content. Three topical areas – consumer outreach, plan display and sort and filter functions, and transparency of information on the marketplace – were identified as elements that significantly affect the consumer enrollment experience. Marketplace websites were then evaluated for their performance on these three core metrics. Table 2 on the next page lists the marketplace websites reviewed as part of this analysis.

To assess what information is available on marketplace websites, Avalere simulated a real consumer. Table 1 details the two profiles Avalere used to shop on each marketplace's window-shopping platform.

Avalere used the ZIP code from the most populous city in each state. For HealthCare.gov, Avalere chose the most populous ZIP codes for Texas and Virginia, as they each take part in a HealthCare.gov pilot – network breadth and plan quality indicators, respectively. The reviewers of each marketplace website only looked at information and plan options that are available to the general public through the site's window-shopping feature. Avalere catalogued important details that were or were not available as part of each marketplace website's window-shopping feature to assess the robustness of available decision-making support tools. The National Partnership maintained editorial control over the content of this report.

Table 1: Consumer Profiles

Demographic Variable	Profile 1	Profile 2
Age	28	28
Sex	Female	Female
Annual Income	$30,000	$100,000
Household Size	1	3

Table 2: Marketplace Websites Included in Review

State	Marketplace Name	Marketplace Website	Shopping Tool Website
Federally Facilitated Marketplace	HealthCare.gov/FFM	HealthCare.gov	https://www.healthcare.gov/see-plans/#/buying
California	Covered California	http://www.coveredca.com/	https://apply.coveredca.com/apspahbx/ahbxanonym.portal?_nfpb=true&_st=&_nfls=false&_pageLabel=previewPlanPage#1
Colorado[3]	Connect for Health CO	http://connectforhealthco.com/	http://planfinder.connectforhealthco.com/ and https://prd.connectforhealthco.com/individual
Connecticut	Access Health CT	https://www.accesshealthct.com/AHCT/LandingPageCTHIX	https://www.accesshealthct.com/AHCT/IndividualInformation.action
District of Columbia	DC Health Link	https://www.dchealthlink.com/	https://dc.checkbookhealth.org/hie/dc/2017/
Idaho	Your Health Idaho	https://www.yourhealthidaho.org/	https://idahohix.yourhealthidaho.org/hix/preeligibility#/
Maryland	Maryland Health Connection	https://www.marylandhealthconnection.gov/	https://secure.marylandhealthconnection.gov/AHCT/FamilyInformation.action
Massachusetts	Massachusetts Health Connector	https://www.mahealthconnector.org	https://mahealthconnector.optum.com/individual/
Minnesota	MNsure	https://www.mnsure.org/	https://mn.checkbookhealth.org/hie/MN/2017/index.cfm?data=eyJGT1JNIjp7fSwiVVJMIjp7IkNPVkVSQUdFIjoiSW5kaXZpZHVhbCIsIkxBTkciOiJFTiJ9fQ%3D%3D
New York State	NY State of Health	https://nystateofhealth.ny.gov/	https://nystateofhealth.ny.gov/individual/searchAnonymousPlan/search
Rhode Island[4]	Health Source RI	http://healthsourceri.com/	https://healthyrhode.ri.gov/HIXWebI3/DisplayGetStarted.action and http://healthsourceri.com/calculator/
Vermont	Vermont Health Connect	https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action	https://vt.checkbookhealth.org/hie/vt/2017/index.cfm?data=eyJGT1JNIjp7fSwiVVJMIjp7IkNPVkVSQUdFIjoiSW5kaXZpZHVhbCJ9fQ%3D%3D
Washington	Washington Healthplanfinder	https://www.wahealthplanfinder.org/_content/Homepage.html	https://www.wahealthplanfinder.org/HBEWeb/Annon_ViewIndividualPlans?request_locale=en

Supporting Enrollment and Website Navigation: Consumer Outreach and Assistance

A core mission of the FFM and SBMs is to educate consumers about coverage choices and encourage enrollment through consumer outreach and assistance. Marketplaces help consumers stay informed about important dates and events, such as open enrollment deadlines. Social media and advertising have allowed marketplaces to reach a wider, often younger, population. Other outreach includes phone calls, in-person enrollment events and live online support.

Social Media and Outreach Events

FFM and SBM administrators have recognized that social media is effective to promote and convey important health coverage and enrollment information. It has a broad reach and requires relatively low set-up and maintenance efforts. Table 3 and Figure 1 illustrate how marketplaces have used social media.

Table 3: Social Media Followers (as of January 2017)

Marketplace	Facebook Likes	Twitter Followers
HealthCare.gov	527,251	272,000
California	229,887	50,100
Colorado	7,468	2,342
Connecticut	40,234	3,503
District of Columbia	500	2,387
Idaho	2,871	495
Massachusetts	20,924	4,371
Maryland	6,663	5,232
Minnesota	4,372	3,508
New York	21,293	9,194
Rhode Island	5,306	2,092
Vermont	2,536	2,259
Washington	17,935	3,231

Figure 1: Tweet from the Federally Facilitated Marketplace on January 25, 2017

All marketplaces have an extensive Facebook and Twitter presence, but some use additional social media platforms like YouTube, LinkedIn and Instagram (see Table 4). These social media platforms provide valuable outlets for marketplaces to promote events, share information about important dates and convey helpful information about how people can access coverage and care.

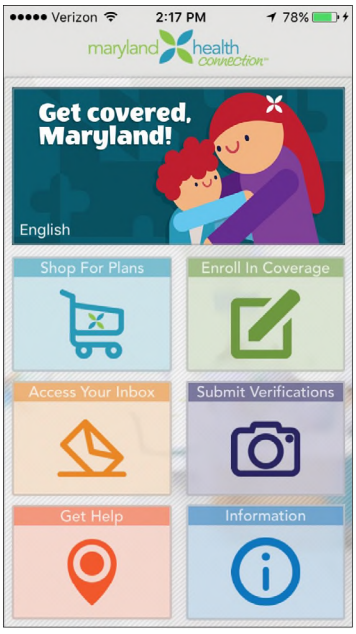
Table 4: Additional Social Media Platforms Used by Each Marketplace

Marketplace	YouTube	LinkedIn	Instagram
HealthCare.gov	✔		
California	✔		✔
Colorado	✔	✔	✔
Connecticut	✔	✔	✔
District of Columbia	✔		✔
Idaho	✔		
Massachusetts	✔		✔
Maryland	✔		✔
Minnesota	✔		
New York	✔		✔
Rhode Island	✔	✔	
Vermont	✔		
Washington	✔		

Because more and more consumers use mobile devices (including phones and tablets) for shopping and everyday activities, Connecticut, D.C. and Maryland developed mobile applications ("apps") for their SBMs (see Figure 2). Apps provide information about the marketplace and a mechanism to stay engaged with it. Some also allow consumers to take and upload photos of enrollment eligibility verification materials.

Marketplaces with similar platforms could partner to co-develop and implement mobile platforms to make the enrollment process easier. This approach could ease the eligibility verification process, which causes considerable issues and backlog, by supplementing the existing process by which consumers submit verification information. Allowing consumers to submit information via the cameras on their phones may lead to greater compliance, as compared to requiring consumers to print out and mail in such information. It also makes it significantly easier to process the information received by eliminating the sorting and scanning requirements of paper submissions. SBMs and the FFM should consider integrating a mobile app into future consumer outreach.

Figure 2: Maryland Health Connection App Screen Shot



Most marketplaces (Calif., Colo., Conn., D.C., Mass., Md., Minn., N.Y., R.I.) also offer outreach events, such as those noted in Figure 3. HealthCare.gov, on the other hand, works with consumer outreach partners – such as navigators and in-person assisters – to sponsor and facilitate such outreach. HealthCare.gov has a search feature to identify partners that offer assistance.

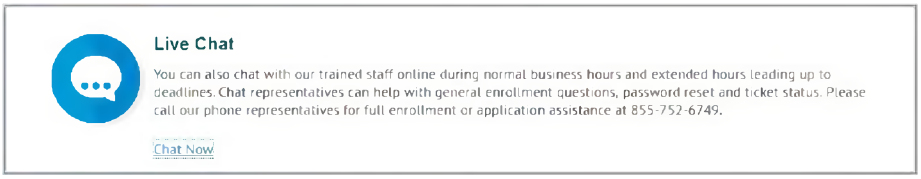
Figure 3: Outreach Events

California	Massachusetts	New York
The Clinica Sierra Vista Open Enrollment Event located at a community health center helped consumers determine whether they qualified for Medi-Cal or financial assistance.	The MA Community Action Committee of Cape Cod & Islands hosted navigators and insurance counselors at an open enrollment event. The event offered answers to questions and application and enrollment assistance to the uninsured and to those who needed to shop for plans or renew marketplace or Medicaid plans.	The Buffalo Employment and Training Center held a Career Center Marketplace Information Session at which marketplace representatives answered questions about enrollment in the marketplace.

Live Chat Feature

Select marketplace websites have non-traditional enrollment aids, including a live chat function. While HealthCare.gov does not include this feature, California, Colorado and New York do (see Figure 4). Live chat features appeal to consumers who prefer to receive help online rather than in person or by phone. Live chats also provide immediate assistance, often with minimal wait times. However, it may be harder for consumers and chat administrators to discuss more complex topics and challenges in this digital setting than via phone or in person.

Figure 4: Colorado Live Chat Feature



Consumer Education and Marketplace Glossary

For some consumers, the marketplace shopping experience means confronting unfamiliar vocabulary. Marketplaces have tried to increase consumer health insurance literacy by defining terminology through web features. In fact, all of the marketplaces offer definitions of important or potentially confusing insurance terms using a "hover" functionality (definitions appear when the consumer holds a mouse over the word). Additionally, all marketplaces offer a glossary of terms. However, the terms featured in glossaries – and how comprehensive the definitions for those terms are – vary. Unfortunately, some terms are not defined in both the glossary and a hover box.

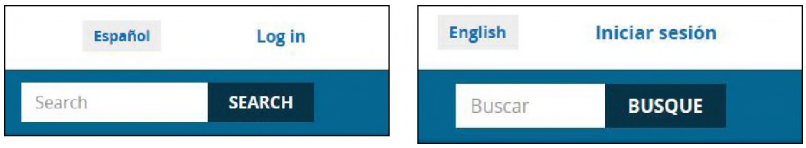
Table 5 reviews how marketplace glossaries define five key terms: deductible, maximum out-of-pocket (MOOP)/out-of-pocket (OOP) limit, quality/quality rating, cost-sharing reductions (CSRs) and special enrollment period (SEP). It illustrates the inconsistency of definitions.

Table 5: Availability of Definitions for Five Key Terms

Marketplace	CSRs	Deductible	MOOP	Quality or Quality Rating	SEP
HealthCare.gov	✔	✔	✔	✔	✔
California		✔	✔		✔
Colorado		✔	✔		✔
Connecticut	✔	✔	✔		✔
District of Columbia	✔	✔	✔		✔
Idaho	✔	✔	✔		✔
Massachusetts	✔	✔	✔		✔
Maryland	✔	✔	✔		✔
Minnesota	✔	✔	✔		
New York	✔	✔	✔	✔	✔
Rhode Island		✔	✔	✔	✔
Vermont	✔	✔	✔		
Washington	✔	✔	✔		✔

Marketplace websites must provide assistance in other languages and include "taglines" in at least the top 15 languages in a state on their websites and any document "that is critical for obtaining health insurance coverage or access to health care services through a QHP [qualified health plan] for qualified individuals, applicants, qualified employers, qualified employees, or enrollees."[5] Further, call centers must provide interpretation in at least 150 languages.[6] Figure 5 shows how consumers can select to navigate HealthCare.gov in Spanish or English.

Figure 5: HealthCare.gov English and Spanish Language Option Button on Homepage



Recommendations to Support Enrollment and Website Navigation

RECOMMENDATION 1: OFFER MOBILE APPS.

- Marketplaces should offer and promote mobile apps. Mobile apps are a great tool to educate and encourage enrollment, particularly among younger consumers.
- Mobile apps also may allow consumers to more easily locate information that requires more searching on the full site. This includes the submission of verification information, FAQs and definitions, and broker or other live consumer assistance resources.

RECOMMENDATION 2: INCLUDE MORE KEY TERMS OFFERED AS HOVER DEFINITIONS AND IN THE GLOSSARY.

- The hover definition feature helps consumers easily access definitions of key terms and should be an option for these terms.
- All terms that have a hover definition feature should also be defined in the glossary because the glossary provides quick access, usually one click from the homepage. To access definitions via the hover feature, consumers must either be logged in to a marketplace account or use the anonymous browsing feature.

RECOMMENDATION 3: INCORPORATE A LIVE CHAT FEATURE.

- Marketplaces should incorporate a live chat feature into their websites. Live chat allows tech savvy consumers to access help efficiently.
- This feature also likely allows call centers to focus on more complicated consumer assistance, while the chat operators can focus on easier-to-resolve quick fixes, such as forgotten or lost passwords.

Helping Consumers Differentiate Among Plan Choices: Plan Display and Sort and Filter Options

A marketplace website's plan shopping page is likely the most important element of a consumer's marketplace experience. The structure and functions of this page – such as the organization of information and the available filtering and sorting options – can substantially affect a consumer's ability to find the plan that best meets her or his needs.

For most consumers, the plan shopping page displays dozens of plan options across different coverage levels – bronze, silver, gold and platinum. Additionally, plans typically have unique networks, prescription drug formularies, covered benefits, coverage limitations, cost sharing and coverage of out-of-network providers. While diverse options often make it possible for consumers to find a plan that meets their particular needs, the wide variety of choices mean consumers need tools that help them quickly and easily distinguish among plans.

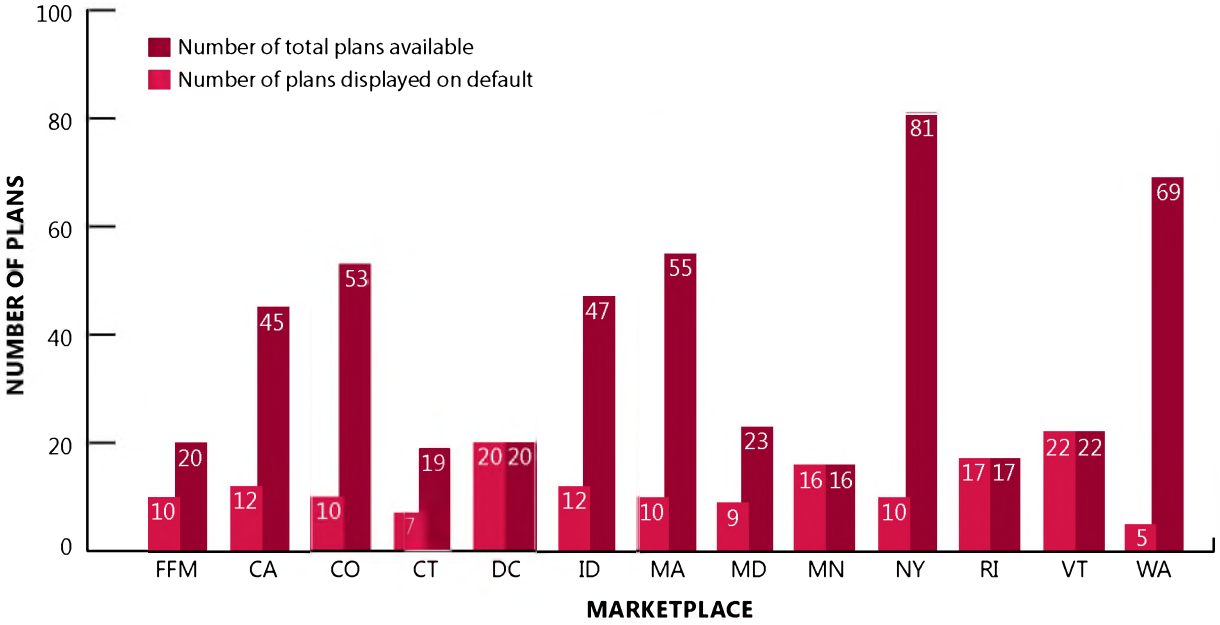
This chapter reviews some of the tools and many display options that marketplaces are using to help consumers identify the plans that best match their needs.

Default Plan Display

NUMBER OF PLANS

Limiting the number of options presented to the consumer can help make the process more manageable, but it also can influence the consumer's ultimate choice. Some marketplaces only display a limited set of plans on the initial window-shopping page, while other marketplaces include all available plans. While the number of available plans per marketplace varies, more than two-thirds of marketplaces do not display all available plans on that initial selection page (see Figure 6).

Figure 6: Number of Plans Initially Displayed on Each Marketplace's Window-Shopping Page



DEFAULT SORT ORDER

The order in which plans are sorted on the plan window-shopping page can influence consumer decision-making. Studies have shown that order affects choice and that consumers may rely on the default sort order, particularly when making complex decisions such as selecting a plan from a marketplace.[7] In fact, an article regarding the behavioral economics at play in the insurance marketplaces noted that people "often settle for options at the top of a menu, regardless of whether that choice is best for them," explaining that the order of plans may be influencing consumers' decisions.[8] For this reason, the default plan sort order is an influential aspect of the shopping experience.

The default sort order on window-shopping pages has evolved. At first, all marketplaces, including the FFM, sorted plans from lowest monthly premium to highest. The following year, all but one marketplace sorted this way. In the third open enrollment period, five of the 13 SBMs (Calif., D.C., Ky., Minn. and Vt.) switched to sorting plans by total estimated costs, including premiums and cost sharing. For the 2017 open enrollment period, five SBMs used a feature other than the monthly premium as the default sort order; the rest, including the FFM, default sorted by premium (see Table 6).

Table 6: Marketplace Portal Default Sort Order, 2017

Marketplace	Default Plan Sort Order
HealthCare.gov	Premium
California	Yearly cost estimate
Colorado	Premium
Connecticut	Premium
District of Columbia	Yearly cost estimate
Idaho	Premium
Maryland	Premium
Massachusetts	Premium
Minnesota	Yearly cost estimate
New York	Premium
Rhode Island[9]	Premium, metal level
Vermont	Yearly cost estimate
Washington	Premium

Sorting plans based on an estimate of annual health care costs may provide a helpful glimpse of the possible total costs associated with choosing a particular plan. This is important given that many consumers may not be fully aware of the role that premiums and cost sharing may play in the total cost of health care. Health plan costs, particularly OOP spending, can be confusing for consumers and difficult to estimate.[10] It is important to note, however, that using a yearly cost estimate as the default sort may lead to concerns about affordability. Consumers may be used to thinking about the cost of health care in terms of monthly premiums, and since yearly cost estimates show higher costs than monthly premiums alone (as they include both the premiums and projected cost sharing for the full plan year), consumers may be deterred from buying coverage when they see such high costs. To address this, marketplaces could also display premiums separately. Indeed, all four SBMs with a yearly cost default sort order also separately display premiums on the initial page. Informed consumers can therefore separate out the premium versus the expected utilization costs and decide if these estimates are likely to be accurate for them.

Figure 7: Comparison of Plans Using Default Sort and Sort by Premium for DC Health Link

Default Sort by Yearly Cost Estimate

Plan Select the plan name for DETAILS. Select checkboxes to compare plans.	Yearly Cost Estimate	Cost in a Bad Year (3% chance)	Doctors
KP DC STANDARD Bronze 5000/50/Dental/Ped Dental Kaiser - HMO - Bronze MONTHLY PREMIUM: **$111** after $72 subsidy ANNUAL PREMIUM: **$1,332** after $864 subsidy DEDUCTIBLE: Medical: **$5,000** / Drug: **$300**	$2,962	$8,482	
KP DC Bronze 6400/55/Dental/Ped Dental Kaiser - HMO - Bronze MONTHLY PREMIUM: **$97** after $72 subsidy ANNUAL PREMIUM: **$1,164** after $864 subsidy DEDUCTIBLE: Medical: **$6,400** / Drug: **$750**	$2,994	$8,314	
BlueChoice HMO Standard Bronze $5,000 CareFirst - HMO - Bronze MONTHLY PREMIUM: **$115** after $72 subsidy ANNUAL PREMIUM: **$1,380** after $864 subsidy DEDUCTIBLE: Medical: **$5,000** / Drug: **$300**	$3,010	$8,530	
KP DC Silver 1700/20%/CSR/HDHP/Dental/Ped Dental Kaiser - HMO - Silver MONTHLY PREMIUM: **$139** after $72 subsidy ANNUAL PREMIUM: **$1,668** after $864 subsidy DEDUCTIBLE: **$1,700**	$3,048	$6,668	
BlueChoice HMO Standard Silver $2,000 A CareFirst - HMO - Silver MONTHLY PREMIUM: **$156** after $72 subsidy ANNUAL PREMIUM: **$1,872** after $864 subsidy DEDUCTIBLE: Medical: **$1,300** / Drug: **$250**	$3,052	$7,572	
KP DC Bronze 6200/20%/HSA/Dental/Ped Dental Kaiser - HMO - Bronze MONTHLY PREMIUM: **$101** after $72 subsidy ANNUAL PREMIUM: **$1,212** after $864 subsidy DEDUCTIBLE: **$6,200**	$3,112	$7,762	

Optional Sort by Premium

Plan Select the plan name for DETAILS. Select checkboxes to compare plans.	Yearly Cost Estimate	Cost in a Bad Year (3% chance)	Doctors
KP DC STANDARD Bronze 5000/50/Dental/Ped Dental Kaiser - HMO - Bronze MONTHLY PREMIUM: **$111** after $72 subsidy ANNUAL PREMIUM: **$1,332** after $864 subsidy DEDUCTIBLE: Medical: **$5,000** / Drug: **$300**	$2,962	$8,482	
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PLANS FOR CSR-ELIGIBLE CONSUMERS

For many, CSRs are critical to preserving coverage affordability. To take advantage of the benefits of CSRs, however, eligible consumers must have household incomes between 100 and 250 percent of the Federal Poverty Level (FPL) and enroll in a silver plan – the only plan metal level for which consumers can receive CSRs.

Despite consumer interest in easily being able to discern plans for which CSRs may be applied, many marketplaces continue to sort plans by premium, causing consumers to see bronze plans first. This may tempt CSR-eligible consumers to choose a bronze plan (with the lowest premium) even though a silver plan would, in fact, provide more robust health coverage and better match their health care needs and financial circumstances. A CSR plan – with its lower cost sharing – may offer more coverage at a lower yearly cost than a bronze plan (even accounting for premiums that are often higher for silver plans than for bronze plans).

To help eligible consumers consider CSR options, some marketplaces (Conn., Md., R.I. and Wash.) list CSR plans first on the default plan window-shopping page. Unfortunately, the FFM does not highlight CSR plans in this way. While many consumers are enrolled in CSR plans (60 percent via HealthCare.gov and 58 percent across all marketplaces[11]), states that promote CSRs in the default sort have more eligible enrollees in CSR plans. Data from Connecticut's 2016 open enrollment period shows that only 12.5 percent of CSR-eligible enrollees chose a bronze or catastrophic plan, while 82 percent enrolled in a CSR plan.[12] By contrast, a 2015 Avalere Health assessment found that, across all marketplaces, only about 70 percent of CSR-eligible consumers actually enrolled in a silver plan in 2015.[13]

STANDARDIZED PLANS

Standardized plans require the same cost sharing for each service and have the same deductibles and OOP maximums for a particular metal level in a state. Some marketplaces require issuers to offer standardized plans to participate in the state's marketplace, while others allow it as an option.

Currently, the marketplaces in seven SBMs (Calif., Conn., D.C., Mass., N.Y., Ore. and Vt.) and the FFM have standard benefit designs. In California, issuers are only allowed to offer the marketplace-created standardized plans.[14] For the FFM, the Centers for Medicare & Medicaid Services (CMS) first established optional standardized benefit designs – known as "Simple Choice" – for the 2017 plan year.[15]

Marketplaces with standardized plans identify these plans through window-shopping in different ways. Of the SBMs, only Connecticut and Massachusetts require special naming conventions – they both require the word "Standard" in the plan name. The FFM uses a banner (see Figure 8) to introduce the Simple Choice plan options, with a description of the features of standardized plans. However, for the FFM, these plans are only highlighted with a blue box in the top left corner of the plan on the plan window-shopping page, as shown in Figure 9 below.

Figure 8: Federally Facilitated Marketplace Simple Choice Banner

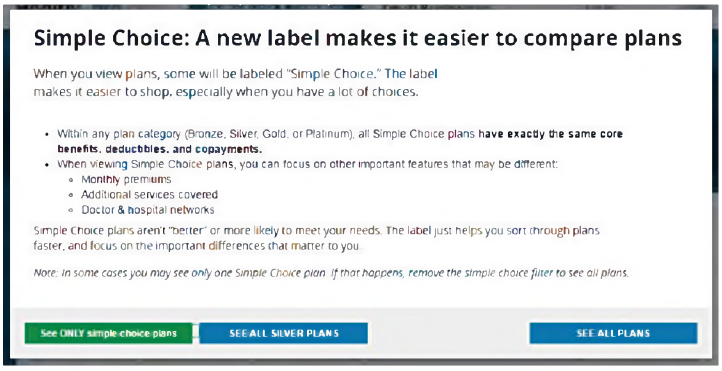
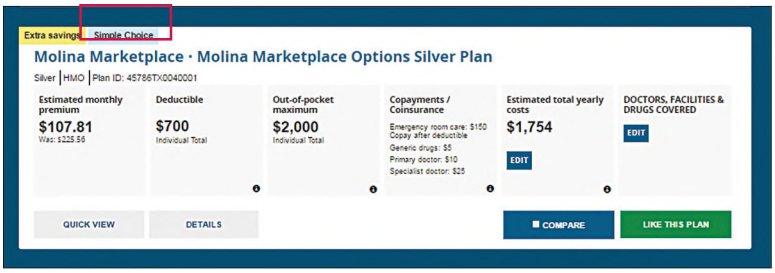


Figure 9: Federally Facilitated Marketplace Simple Choice Label



Consumer-Driven Sort and Filter Options

Marketplaces provide two important tools – sorting and filtering – to help consumers choose plans based on the factors that are most important to them. Consumer-driven sorting allows consumers to determine the order of plan display. For example, if a consumer chooses to sort plans by premium, they will see the plan options with the lowest premiums listed first, followed by plans with higher premiums. All marketplace websites offer sort options of various types, but sorting by premium is the only feature offered on all marketplaces. The only other commonly offered sort option in window-shopping is by deductible (low to high), which is offered by nine SBMs (Calif., Colo., Conn., Idaho, Md., Mass., N.Y., R.I. and Wash.) and the FFM.

Consumer-driven filtering, on the other hand, allows consumers to limit the plan choices shown in window-shopping by focusing filter results only on the plan options that meet one or more criteria. This option can be helpful for consumers looking for a specific feature. Currently, the only filtering option offered by all marketplaces is insurance issuer. Filtering by premium (offered in Calif., Colo., Conn.,

D.C., Md., Mass., Minn., R.I., Vt., Wash. and the FFM), metal level (offered in Calif., Colo., Conn., D.C., Idaho, Mass., Minn., N.Y., R.I., Vt., Wash. and the FFM) and deductible (offered in Calif., Colo., Conn., D.C., Idaho, Mass., Md., Minn., R.I., Vt., Wash. and the FFM) are the other most commonly offered options. Filtering by plan type is also frequently offered, appearing in California, D.C., Idaho, Maryland, Minnesota, Rhode Island, Vermont, Washington and the FFM. Sliding scales, offered by some marketplaces, are particularly effective filtering tools; they allow consumers to identify plans with premiums, deductibles and/or maximum OOP costs that fall within a specific range. See Table 7 for a summary of the filtering and sorting options available in each marketplace.

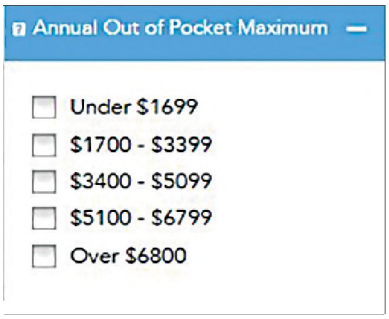
One drawback of filtering, however, is that it may prevent consumers from effectively comparing all their plan options. For example, consumers may filter to see only bronze plans, thinking they are the most affordable options, when a silver CSR plan may actually be a more cost-effective option.

SELECT SORT AND FILTER OPTIONS

Out-of-Pocket Maximum. For some consumers with greater health care needs, sorting or filtering by OOP maximum can be useful. (The OOP maximum represents the maximum amount of cost sharing that a consumer can spend for covered health care services during a plan year.) Sorting by OOP maximum shows plans in order from lowest to highest OOP maximum. Filtering by OOP maximum allows consumers to see only plans that have OOP maximums that fall within a spending range.

Currently, only the Maryland, Massachusetts and Washington marketplaces have a window-shopping tool to filter by the OOP maximum (see Figure 10), while the Idaho, Maryland and Washington marketplaces include a similar sorting option.

Figure 10: Maryland's Out-of-Pocket Maximum Filter



Health Savings Account (HSA) Eligibility. HSA window-shopping filtering tools are becoming more common as more issuers offer HSAs. These medical savings accounts allow consumers to use tax-advantaged income deferrals to help pay for certain approved medical expenses, such as cost sharing. For the 2017 plan year, the FFM and the California, Idaho and Washington marketplaces offered an HSA filtering function.

Quality Rating. Another emerging trend is use of issuer quality ratings. For 2017, the FFM piloted the display of quality ratings in two states – Virginia and Wisconsin (see Figure 11).[16] Some SBMs display quality ratings, and some even allow consumers to filter in window-shopping for the quality rating they are seeking (Calif., Conn., Md., N.Y. and Wash.). By hovering their mouse over the star rating next to each plan, consumers can read more about the quality ratings, as shown in Figure 12.

Table 7: Marketplace Portal Sorting and Filtering Functions by Feature

Marketplace	Premium	Deductible	Yearly Cost Estimate	Expense Estimate Ranking*	Metal Level	Insurance Issuer	Cost in a Bad Year	Medical Management Program	Maximum OOP Limit
HealthCare.gov	F, S	F, S	F		F	F		F	
California	F, S	F, S		S	F	F			
Colorado	F, S	F, S	S		F	F			
Connecticut	F, S	F, S			F, S	F, S			
District of Columbia	F, S	F	F, S		F	F	F, S		
Idaho	S	F, S		S	F	F			S
Maryland	F, S	F, S			S	F, S			F, S
Massachusetts	F, S	F, S			F	F			F
Minnesota	F, S	F	F, S		F	F	F, S		
New York	S				F	F			
Rhode Island	F, S	F, S			F, S	F			F
Vermont	F, S	F	F, S		F	F	S		
Washington	F, S	F, S			F	F			F, S

Table 7 (continued)

Marketplace	Plan Type	Quality Rating	Consumer Specified Provider	Consumer Specified Prescription Drug	HSA Eligible	Plan ID or Plan Name	Has Separate Drug Deductible
HealthCare.gov	F		F	F	F	F	
California	F	F			F		
Colorado			F	F			
Connecticut		F, S					
District of Columbia	F		F	F		S	F
Idaho	F				F		
Maryland	F	F, S					
Massachusetts			F				
Minnesota	F					S	
New York		F				F	
Rhode Island	F	S	F				
Vermont	F					S	
Washington	F	F, S	F		F		

F = Filtering functionality, S = Sorting functionality

* Expense Estimate Ranking offers a descriptor of expenses, such as high, medium or low, rather than a numerical estimate.

Figure 11: Federally Facilitated Marketplace Quality Rating Display

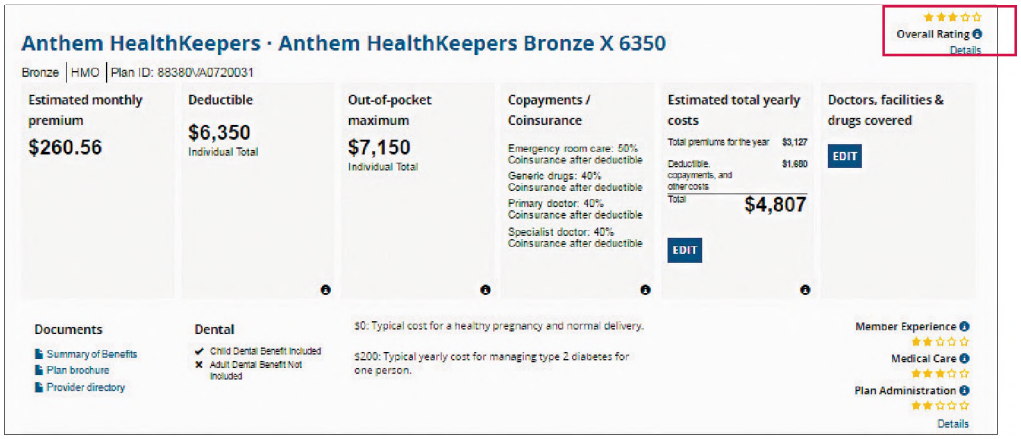
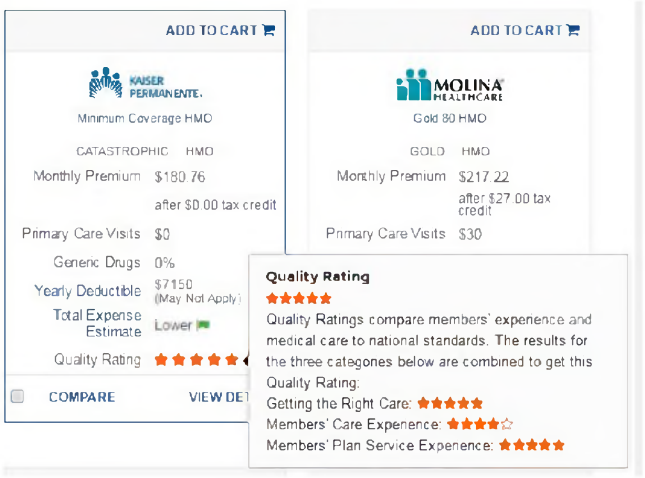


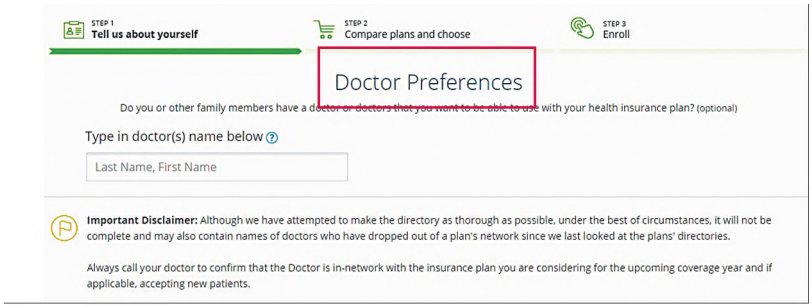
Figure 12: California Quality Rating Display and Explanation



NETWORK AND FORMULARY INCLUSION

Some consumers prefer to use specific physicians and hospitals when seeking care and/or require certain prescription drugs. Marketplaces have created tools to help consumers identify plans that include preferred providers in their networks and that include specific prescription drugs in their formularies. Currently, only the FFM and the Colorado, D.C., Massachusetts and Washington marketplaces allow consumers to filter plans based on whether specific physicians are in-network (see Figures 13 and 14). The FFM and marketplaces in Colorado and D.C. also allow consumers to filter plans based on whether specific prescription drugs are covered by the plan (see Figures 13 and 14). The emergence of machine-readable drug formularies and provider networks should help more marketplaces provide sorting and filtering for medications and providers, and marketplaces should leverage these tools to give consumers the most complete and accurate information possible.

Figure 13: Doctor and Drug Preferences Option for DC Health Link



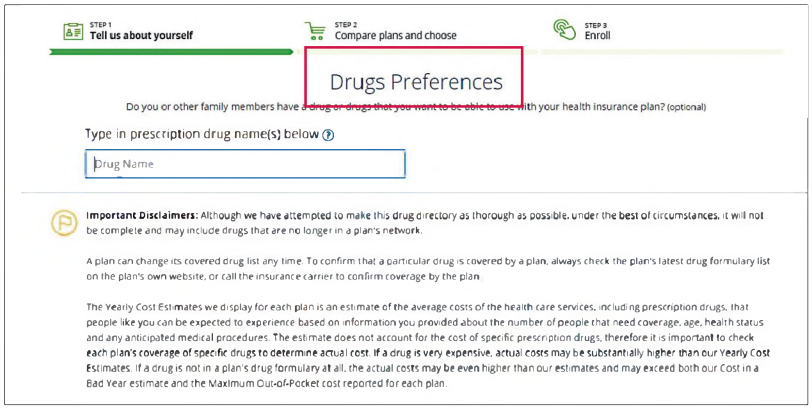
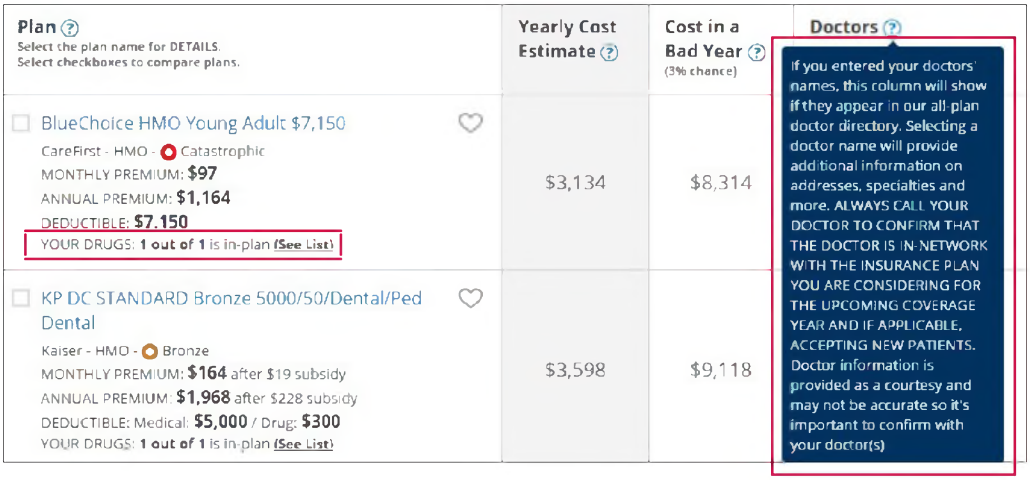


Figure 14: Doctor and Drug Preferences on Default Display Page for DC Health Link



NETWORK BREADTH

In 2017, CMS piloted a network breadth tool in Maine, Ohio, Tennessee and Texas[17] that helps consumers understand how broad a plan's provider network is compared with other plans offered in the same coverage area (see Figure 15). Across the SBMs, only the D.C. (see Figure 16) and Rhode Island marketplaces have filter options that allow consumers to select only from plans with a national network. Given concerns about plans' network breadth, more marketplaces should offer these tools in window-shopping.

Figure 15: Federally Facilitated Marketplace Network Breadth Indicator for a Houston, Texas Insurance Plan

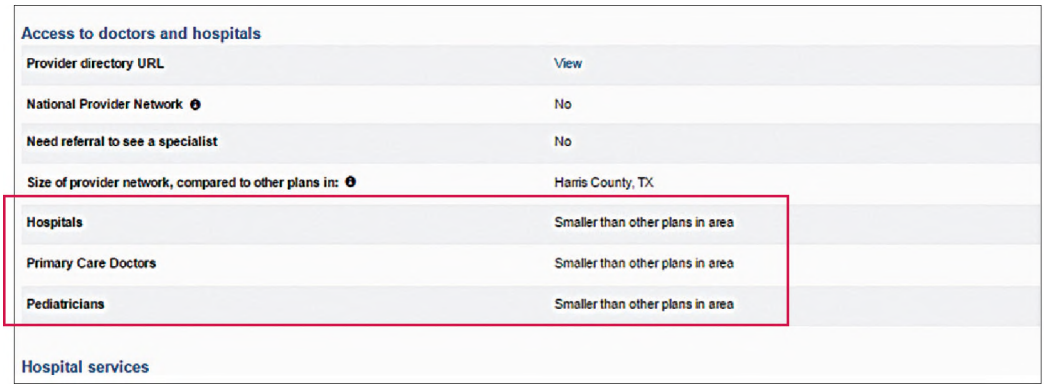


Figure 16: National Network Indicator for DC Health Link

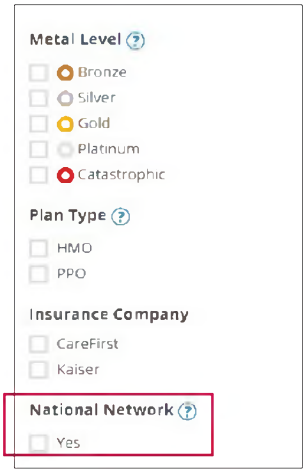


Figure 17: Plan Type Filter Option for California

PLAN TYPE

The FFM and eight SBMs (Calif., D.C., Idaho, Md., Minn., R.I., Vt. and Wash.) allow consumers to filter their searches by specific plan type (e.g., HMO or PPO) in window-shopping (see Figure 17). Plan types are indicative of the network design of the plan, with PPO plans having the broadest networks and HMOs often having the most limited ones.

Recommendations to Help Consumers Differentiate Among Plan Choices

RECOMMENDATION 1: HELP CONSUMERS EASILY FIND THE MOST BENEFICIAL PLAN OPTIONS.

- Websites should clearly explain potential CSR eligibility and display silver plans first for individuals potentially eligible for CSRs to ensure that consumers consider their CSR plan options. However, websites should make it clear how a consumer can view all plan options.
- Marketplace websites should display distinctly marked standardized plan options and offer clear explanations of what they are and how they can help consumers more easily compare non-obvious plan features.
- All marketplaces should have a consumer-friendly provider and formulary search tool built into the plan shopping portal. The shopping process would be easier and more transparent if consumers could avoid comparing across many issuer webpages and instead, sort and filter plans based on network or formulary inclusion. At the very least, to limit confusion, a marketplace should include the link to the exact formulary search page specific to the plan a consumer is exploring.
- Marketplaces should use indicators to show which providers and drugs are covered by each plan, rather than using a filter that removes plans not meeting the criteria. An indicator can provide similar transparency but will not prevent consumers from seeing plans that also may fit their needs.
- As marketplace plans move toward more tightly managed networks, marketplace websites should continue to build and display measures of network breadth, and clearly explain what these measures mean.

RECOMMENDATION 2: ALLOW CONSUMERS TO SORT PLAN OPTIONS.

- Marketplace websites should clearly explain sorting options and how activating a specific type of sort will affect the plans that appear on the plan selection page.
- All marketplaces should, if possible, display an estimated total annual cost with personalized information for each plan. This feature allows consumers to understand more clearly the possible impact of cost sharing on access and ultimate plan affordability. This is especially important given the high numbers of consumers who select plans based on the premiums, but whose access or affordability may be diminished by choosing a lower level, cheaper plan. However, it is important that all plans also display monthly premium and deductible information separately on the initial page to mitigate perceived unaffordability.
- Marketplaces should provide the option to sort by many different features, including by both cost and non-cost features such as quality rating or network breadth.

RECOMMENDATION 3: ENHANCE FILTERING OPTIONS WHILE ALLOWING CONSUMERS TO COMPARE ALL PLANS.

- Marketplaces should offer filtering tools that allow more customization; for example, sliding scales, currently utilized in the FFM, which provide more personalized results.
- Marketplaces should provide the option to filter by many features, including by both cost and non-cost features such as quality rating, issuer, standardized plan option or network breadth.
- Marketplaces should make clear that not all plans are being shown when a filter is engaged and should provide a clear and easy way for consumers to remove the filter to see all plans.

Making Key Plan Information Accessible: Marketplace Transparency

Consumers must be able to easily and quickly find information that helps them compare plans. Marketplace administrators should keep working to reduce the amount of time and number of clicks consumers must use to gather the most important plan details. Consumers will face fewer surprises related to coverage and cost if information on access, quality and benefits is readily available. Further, marketplaces can improve the shopping experience for consumers by including information directly on the marketplace website, rather than requiring consumers to click through to each insurer's separate website.

Consumers often look for information on premiums, deductibles, cost sharing, provider networks and formularies when making decisions about coverage. Marketplaces that make this information easy to find and easy to understand give consumers the best chance to enroll in a plan that meets their needs. This chapter reviews how and where marketplace websites display key coverage and cost-sharing information.

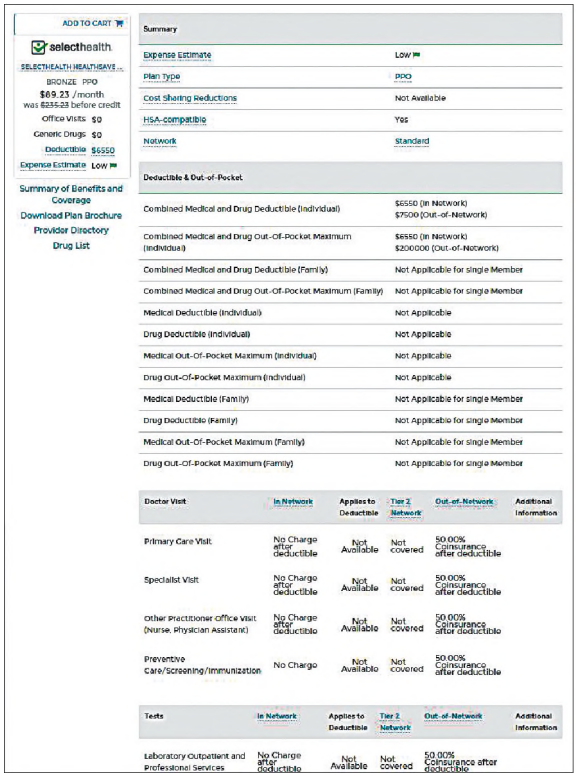
Location of Key Plan Details

Marketplaces primarily display coverage information in two locations: the initial plan display page (the first page of plan information provided after the consumer enters personal information and receives an eligibility decision) and the "more details" or "compare plan" pages that are accessed by clicking from the initial display page. The plan details that appear on the initial page, the details page, or both vary greatly among the marketplaces, as shown in Figures 18–20. When important plan information is hidden on the plan details page, it is more difficult for consumers to find and use this data. And, while it is not possible to include all details on an initial page, marketplaces could more clearly indicate that more detailed information is available.

For the 2017 open enrollment period, all SBMs and the FFM showed premiums on the initial window-shopping page. Only the New York marketplace did not show deductibles on the initial page. The FFM is particularly strong at including key plan details on its initial plan display page, offering details on premiums, deductibles, maximum out-of-pocket costs and cost sharing associated with primary care, specialist, emergency room and in-patient hospital visits and cost sharing associated with accessing generic prescription drugs.

Figure 18: Sample Initial Plan Display for Idaho

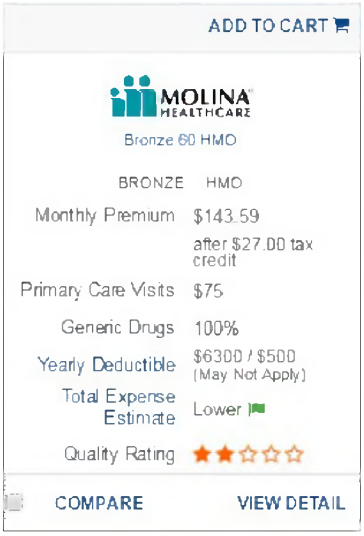
Figure 19: Sample Plan Details Page for Idaho



States also commonly show MOOP and estimated OOP cost (sometimes referred to as "estimated total yearly costs") on the initial page. Both of these amounts are important for consumers to understand since they may more accurately represent the potential full cost of coverage than premium alone, especially for consumers with significant health needs.

Other important cost-sharing information is commonly displayed only on the details page, including cost sharing for a primary care physician (PCP) visit, specialist visit and an emergency room (ER) visit. Hospital cost sharing does not appear on the initial page of any marketplace portal, though it does appear on the details page for all.

Figure 20: Sample Initial Plan Display for California



Access to prescription drugs is an important coverage feature for many consumers, but drug cost-sharing information mostly appears only on details pages. Only the FFM and the California, Idaho and Rhode Island marketplaces display any drug tier cost sharing information on the initial page (see Figure 21), and only Rhode Island shows cost-sharing information for all drug tiers. (The other three show generic tier cost-sharing information only.) All other marketplaces feature drug cost-sharing information only on the details pages. However, even when generic tier cost-sharing information is

displayed on the initial page, most marketplaces do not indicate whether the plan requires an enrollee to meet a deductible before accessing such benefits. In addition, a number of plans apply separate drug and pharmaceutical deductibles. Only eight SBMs (Calif., D.C., Idaho, Md., Mass., R.I., Vt. and Wash.) show separate medical and pharmaceutical deductibles when applicable. Consumers need to know whether drug spending is subject to a plan's deductible. Table 8 shows if and where consumers can find this information on initial pages, detail pages, or both for each SBM and the FFM.

Table 8: Location of Key Plan Details on Marketplace Websites

Marketplace	Premium	Deductible	MOOP	Estimated OOP	PCP Visit (in network)	Specialist Visit (in network)	ER Visit (in network)
HealthCare.gov	Yes	Yes	Yes	Yes	Yes	Yes	Yes
California	Yes	Yes	D	Yes	Yes	D	D
Colorado	Yes	Yes	Yes	Yes	D	D	D
Connecticut	Yes	Yes	Yes	No	Yes	D	Yes
District of Columbia	Yes	I	D	Yes	D	D	D
Idaho	Yes	Yes	Yes	No	D	D	D
Maryland	Yes	Yes	Yes	No	Yes	D	Yes
Massachusetts	Yes	Yes	No	Yes	No	No	D
Minnesota	Yes	Yes	D	Yes	D	D	D
New York	Yes	D	D	No	D	D	D
Rhode Island	Yes	Yes	Yes	I	Yes	D	D
Vermont	Yes	Yes	I	Yes	D	D	D
Washington	Yes	Yes	Yes	No	Yes	D	Yes

Table 8 (continued)

Marketplace	Inpatient Hospital	Preventive Care (in network)	Generic Drug Tier (Tier 1)	Brand Drug Tiers (Tiers 2-4)
HealthCare.gov	D	No	Yes	D
California	D	D	Yes	D
Colorado	D	D	D	D
Connecticut	D	D	D	D
District of Columbia	D	No	D	D
Idaho	D	D	Yes	D
Maryland	D	D	D	D
Massachusetts	D	D	D	D
Minnesota	D	D	D	D
New York	D	D	D	D
Rhode Island	D	D	Yes	Yes
Vermont	D	D	D	D
Washington	D	Yes	D	D

Yes = The information appears on both the initial page and the details page
I = The information only appears on the initial page
D = The information only appears on the details page
No = The information appears on neither the initial page nor the details page

Figure 21: Plan Details Included on the Federally Facilitated Marketplace's Initial Plan Display Page

Accessibility of Key Documents

Issuer-generated coverage documents such as the Summary of Benefits and Coverage (SBC) and the Schedule of Benefits (SOB) can offer a more comprehensive picture of coverage than the details offered on marketplace websites.

The SBC is a standardized template summarizing the services a plan covers and associated cost sharing for each service. SBCs also include coverage examples that show the potential cost sharing a consumer could pay if she or he suffers from a certain condition or requires a certain treatment. The SOB provides much more detailed coverage and cost-sharing information than the SBC, outlining each covered service and any utilization management, provider or coverage restrictions. While some consumers may not regularly need the level of detail offered in a plan's SOB, it is an invaluable tool for individuals with specific health care needs.

Marketplace websites either embed these documents or provide links to them on issuers' websites, as detailed in Table 9. While all but one marketplace offers access to the SBC in window-shopping, only Connecticut, New York and Rhode Island provide direct access to the SOB.

Table 9: Access to SBC and SOB Documents for Each Marketplace

Marketplace	SBC Embedded or Linked	SOB Embedded or Linked
HealthCare.gov	Linked	N/A
California	Embedded	N/A
Colorado	N/A	N/A
Connecticut	Embedded	Embedded
District of Columbia	Embedded	N/A
Idaho	Linked	N/A
Maryland	Embedded and Linked	N/A
Massachusetts	Linked	N/A
Minnesota	Embedded	N/A
New York	Embedded and Linked	Embedded
Rhode Island	Linked	Linked
Vermont	Embedded	N/A
Washington	Embedded	N/A

Generally, embedding the SOB and SBC on the marketplace page offers easier access to information and allows the consumer to stay within the same webpage. Linking to another website can disrupt the enrollment process when the document opens in the same window rather than a new tab or window.

Provider and Drug Formulary Search Tools

Search tools are an important feature for consumers to ensure their providers or medications are covered by the plan they purchase. Marketplaces can embed these search tools within their websites or link to issuer search tools. Currently, the majority of marketplace websites link to issuer search tools, as shown in Table 10.

Table 10: Marketplace Access to Provider and Drug Search Tools

Marketplace	Provider Search	Drug Search
HealthCare.gov	**E**	**E**
California	**L**	N/A
Colorado*	**E**	**E**
Connecticut	**L**	E
District of Columbia	**E**	**E**
Idaho†	**L**	**L** / E
Maryland	E	**L**
Massachusetts	E	**L**
Minnesota	**L**	**L**
New York	**L**	**L**
Rhode Island‡	**E**	**L**
Vermont	**L**	L
Washington	**E**	N/A

E = Search tool is embedded into the marketplace infrastructure and consumers are able to search for provider or formulary inclusion on the shopping page

E = Search tool is embedded into the marketplace, but separate from the plan shopping page

E = Information is available as a PDF or discrete document on marketplace site, but not via a search tool

L = Search tool is linked to a specific page on issuer/external website that contains a provider or formulary search function

L = Search tool is linked to non-specific page on issuer website that requires the consumer to search the site to locate the provider/formulary search function

N/A = No search is embedded or linked to

* Colorado has two anonymous browsing portals. While we have elected to show one representation of provider/drug search for Colorado, the **E** is associated with the portal assessed at http://planfinder.connectforhealthco.com/. However, interested customers are not able to enroll in coverage through this link. The portal accessed at https://prd.connectforhealthco.com/individual would receive a **L** rating, but does allow for customers to continue to enroll in coverage.

† For some plans, such as those offered by Blue Cross of Idaho, clicking on "drug list" takes the consumer to a PDF of the drug list. However, for all other issuers, clicking on "drug list" only links the consumer to the issuer's formulary search page.

‡ Rhode Island has two anonymous browsing portals. While we have elected to show one representation of provider/drug search for Rhode Island, the **E** and **L** is associated with the portal assessed at https://healthyrhode.ri.gov/HIXWebI3/DisplayGetStarted.action. However, such portal is only accessible by clicking on "enroll in coverage," agreeing to be redirected, not creating an account but navigating to the home page, and then selecting "anonymous browsing." The anonymous shopping portal available

The search options vary by marketplace. In the provider search option, consumers may be presented with the option to search for a provider by location, specialty or issuer. In the FFM and the Colorado marketplace, consumers can search for multiple providers at once. The Washington marketplace only has the option to search for providers by distance. Consumers in the Massachusetts marketplace can search by ZIP code, specialty and issuer.

Currently, the only available formulary search function uses a drug's name. This option is provided to consumers in the FFM and the Colorado and D.C. marketplaces. In addition, the FFM and the D.C. marketplace allow consumers to search for coverage of multiple drugs at once. As drug names can be hard for some consumers to spell correctly, Colorado and D.C. help consumers by auto-populating prescription drug options once the consumer inputs the first few letters of the drug's name. The FFM, however, requires the consumer to spell out the whole name and spell it correctly; a single letter off will yield no results. When an embedded search is not offered, marketplaces can provide direct links to the formulary information specific to the plans consumers are comparing to improve transparency. With the exception of Vermont, all marketplaces without an embedded search function provide direct links to such formulary information.

For the 2017 open enrollment period, D.C. introduced a feature that helps consumers determine specific prescription drug costs and health coverage information, shown in Figures 22 and 23. Consumers can enter up to 10 prescription drugs, see which plans cover each drug, and view the cost sharing and tier placement of those drugs.[18] Consumers also can see whether the drugs they entered require step therapy (trying lower priced medications first) or prior authorization (permission from the insurance company to qualify for coverage).[19]

Figure 22: DC Health Link Shopping Page

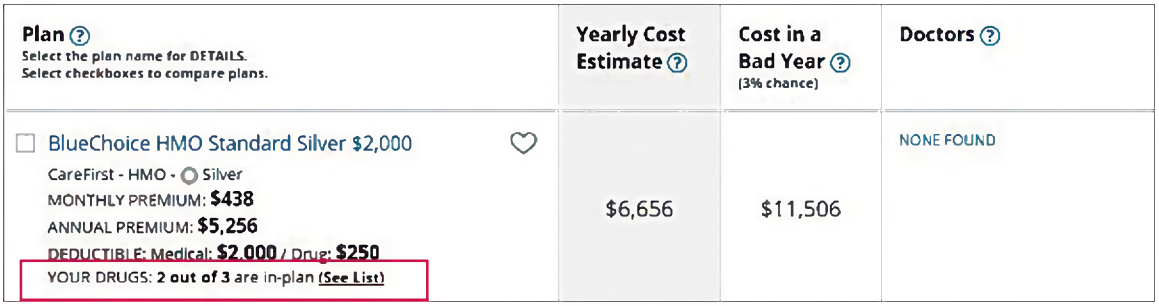
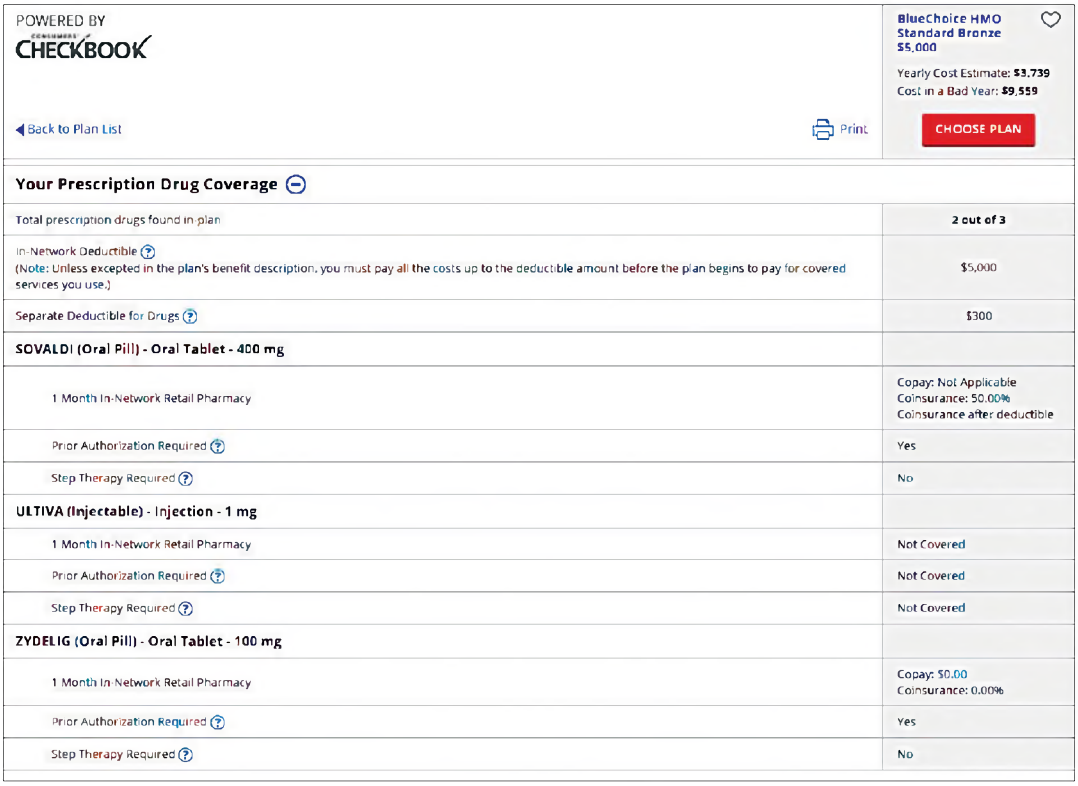


Figure 23: DC Health Link Prescription Drug Coverage Tool



POWERED BY CHECKBOOK

BlueChoice HMO Standard Bronze $5,000

Yearly Cost Estimate: $3,739
Cost in a Bad Year: $9,559

Back to Plan List | Print | CHOOSE PLAN

Your Prescription Drug Coverage	
Total prescription drugs found in plan	2 out of 3
In-Network Deductible (Note: Unless excepted in the plan's benefit description, you must pay all the costs up to the deductible amount before the plan begins to pay for covered services you use.)	$5,000
Separate Deductible for Drugs	$300
SOVALDI (Oral Pill) - Oral Tablet - 400 mg	
1 Month In-Network Retail Pharmacy	Copay: Not Applicable Coinsurance: 50.00% Coinsurance after deductible
Prior Authorization Required	Yes
Step Therapy Required	No
ULTIVA (Injectable) - Injection - 1 mg	
1 Month In-Network Retail Pharmacy	Not Covered
Prior Authorization Required	Not Covered
Step Therapy Required	Not Covered
ZYDELIG (Oral Pill) - Oral Tablet - 100 mg	
1 Month In-Network Retail Pharmacy	Copay: $0.00 Coinsurance: 0.00%
Prior Authorization Required	Yes
Step Therapy Required	No

Out-of-Pocket Cost Calculators

Marketplaces first introduced OOP cost calculators in the second open enrollment period. These tools translate information entered by a consumer into estimates of the OOP costs that can be expected during a plan year. To estimate OOP costs, these calculators ask consumers to input demographic and health information. The amount of information used to estimate costs varies by website, as shown in Table 11.

Cost-sharing information alone rarely delivers an accurate estimate of projected spending without application to a person's specific health care needs. Though most marketplaces have some type of OOP cost calculator, the data driving the calculations varies significantly, so some OOP cost calculators are more useful than others. However, these remain important tools, as research shows that consumers view cost exposure as the most important factor when selecting a plan.[20]

Some OOP cost calculators are separate from the plan shopping pages, though all marketplace websites integrate the results of the calculators into the shopping experience of their consumers. For instance, while Connecticut has a separate calculator that is accessible both through the plan shopping page and through a separate link on its marketplace homepage, consumers can elect to pull their calculator results into the plan shopping page.

Table 11: Inputs for Out-of-Pocket Cost Calculators

Marketplace	Age	Sex	Overall Health Status	List of Conditions	Number of Prescriptions Expected	Number of Physician Visits Expected	Number of Surgeries Expected
HealthCare.gov			✔	✔			
California					✔	✔	
Colorado			✔				
Connecticut	✔	✔	✔	✔			✔
District of Columbia			✔	✔			
Idaho					✔	✔	
Maryland							
Massachusetts	✔	✔					
Minnesota			✔	✔			
New York							
Rhode Island			✔	✔			
Vermont[21]			✔	✔			
Washington							

Marketplace OOP cost calculators also vary in the outputs delivered. The majority of marketplace websites display yearly cost estimates, but some provide more detailed cost breakdowns, such as projections of costs of care in particularly bad or good years. Table 12 details the variety of available outputs across marketplaces.

Table 12: Outputs Available from Out-of-Pocket Cost Calculators

Marketplace	Estimates of Costs in Bad/ Good Year	Yearly Cost Estimate (Including Premium)	Costs with Insurance vs. without Insurance	OOP Costs by Metal Level	Information Underlying Cost Calculator Data
HealthCare.gov		✔			✔
California					
Colorado		✔			
Connecticut		✔	✔	✔	✔
District of Columbia		✔			
Idaho					
Maryland					
Massachusetts					
Minnesota	✔	✔			
New York					
Rhode Island		✔			
Vermont	✔	✔			
Washington					

Of note, Connecticut's marketplace offers an assessment of what an individual's estimated annual OOP costs would be if that person had insurance as compared to what those costs would be if the individual was uninsured (see Figure 24). The Connecticut marketplace also offers a feature that displays estimated annual total costs of coverage ranges within each plan metal level (see Figure 25).

Figure 24: Connecticut's Out-of-Pocket Cost Calculator Output for Consumer with Insurance and without Insurance

WITH INSURANCE	WITHOUT INSURANCE
Total medical costs that would be shared by the health plan and you: **$122,680.00**	Total medical costs that you would be responsible for: **$272,625.00**

Note: The projected medical costs are annual.

Figure 25: Connecticut's Out-of-Pocket Cost Calculator Output for Costs by Metal Level

Metal Level	Total Cost Range
Bronze	$637.06 - $737.29
Silver	$681.22 - $847.26
Gold	$579.16 - $710.19
Catastrophic	$805.04 - $823.69

Recommendations to Make Key Plan Information Accessible

RECOMMENDATION 1: AT A MINIMUM, PLACE PRIMARY CARE PROVIDER, SPECIALIST AND ALL PRESCRIPTION DRUG TIERS' COST-SHARING INFORMATION ON INITIAL DISPLAY PAGES, IN ADDITION TO PREMIUM AND DEDUCTIBLE COSTS.

- Cost-sharing amounts for common services are crucial information for consumers to consider when choosing a health plan. Requiring consumers to click to details pages can increase confusion and may give the impression that these details are not important to consider in selecting a plan.
- When details are displayed on the initial page, marketplaces should clearly note where benefits are subject to a combined or separate drug deductible. Consumer confusion can result when that information appears only on the details pages.

RECOMMENDATION 2: EMBED BOTH THE SBC AND SOB INTO MARKETPLACE WEBSITES TO ENSURE THESE DOCUMENTS ARE EASILY ACCESSIBLE.

- Consumers need information on covered services and the associated cost sharing for each service. This information is essential to making informed decisions when selecting health coverage. Embedding the SBC and SOB, both important consumer materials, would ensure this information is accessible.

RECOMMENDATION 3: EMBED PROVIDER AND DRUG SEARCH TOOLS IN MARKETPLACE WEBSITES.

- Consumers may prefer receiving care from particular providers or need coverage of specific medications. All marketplace websites should have embedded provider and drug search tools, and existing tools should be enhanced, so consumers can more easily select plans that include their preferred providers and/or medications.

RECOMMENDATION 4: INCREASE THE ACCURACY OF OOP COST CALCULATORS AND MAKE THE RESULTS EASY TO UNDERSTAND.

- OOP cost calculators are important tools for consumers that give a personal context to the many coverage and cost-sharing details. However, OOP cost calculators vary widely in their precision.
- Marketplaces should improve the accuracy of these tools by offering additional inputs and using more personalized data in the calculation, such as specific medications a patient takes and the corresponding cost sharing, in order to deliver results that are as meaningful as possible to consumers.

Conclusion

The health care marketplaces continue to help consumers more easily compare and assess their health care coverage options. The FFM and SBMs have continued to evolve and change over four open enrollment periods, becoming stronger, more efficient and more easily navigable. From offering improved sorting and filtering options to better integrating provider and prescription drug tools, marketplace administrators continue to find new and innovative ways to connect consumers with the plans that best meet their health care and financial needs. We are confident that health insurance marketplace administrators can use the recommendations in this report to help even more consumers purchase the health insurance plans that are right for them in the future.

Endnotes

1 Michael E. Martinez, M.E., Zammitti, E.P., & Cohen, R.A. (2017, February). *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2016.* National Center for Health Statistics Publication. Retrieved 1 March 2017, from https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf

2 See Centers for Medicare & Medicaid Services. (2016, September 6). *CMS awards consumer assistance funding to support 2017 Health Insurance Marketplace enrollment* [Press release]. Retrieved 12 April 2017, from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-09-06.html

3 Colorado has two anonymous browsing portals. While we have elected to show one representation of exchange features for Colorado, the inclusion of a certain feature or tool may only exist on one of the two shopping platforms. It should be noted that interested customers are not able to enroll in coverage through http://planfinder.connectforhealthco.com/. The portal accessed at https://prd.connectforhealthco.com/individual does allow customers to continue to enroll in coverage.

4 Rhode Island has two anonymous browsing portals. While we have elected to show one representation of exchange features for Rhode Island, the inclusion of a certain feature or tool may only exist on one of the two shopping platforms. The portal accessed at https://healthyrhode.ri.gov/HIXWebI3/DisplayGetStarted.action has a more inclusive and comprehensive shopping tool. However, such portal is only accessible by clicking on "enroll in coverage," agreeing to be redirected, not creating an account but navigating to the home page, and then selecting "anonymous browsing." The other anonymous shopping portal is available at http://healthsourceri.com/calculator/ through the marketplace homepage.

5 45 C.F.R. 155.205(c)(2)(iii)(A).

6 45 C.F.R. 155.205(c)(2)(i)(A).

7 See Taylor, E.A., Carman, K.G., Lopez, A., Muchow, A.N., Roshan, P., & Eibner, C. (2016). *Consumer Decisionmaking in the Health Care Marketplace.* Rand Corporation Publication. Retrieved 1 March 2017, from http://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1567/RAND_RR1567.pdf

8 Ubel, P. A., Comerford, D. A., & Johnson, E. (2015). Healthcare.gov 3.0 – Behavioral Economics and Insurance Exchanges. *The New England Journal of Medicine, 372* (8), 695–98.

9 See note 4. The portal accessed at http://healthsourceri.com/calculator/ sorts by premium, and the portal accessed at https://healthyrhode.ri.gov/HIXWebI3/DisplayGetStarted.action sorts by metal level.

10 Giovannelli, J. & Curran, E. (2017, February). *Efforts to Support Consumer Enrollment Decisions Using Total Cost Estimators: Lessons from the Affordable Care Act's Marketplaces.* The Commonwealth Fund Publication. Retrieved 17 April 2017, from http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/feb/1929_giovannelli_total_cost_estimators_rb.pdf

11 Centers for Medicare & Medicaid Services. (2017, March 15). *Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016–January 31, 2017.* Retrieved 14 April 2017, from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

12 Percentages do not equal 100 percent because 5.17 percent enrolled in a gold plan and 0.5 percent enrolled in a platinum plan. See Access Health CT. (2016, March 17). *Board of Directors Meeting* [PowerPoint slides]. Retrieved 17 April 2017, from http://agency.accesshealthct.com/wp-content/uploads/2016/10/BOD-March-17-2016-Presentation.pdf

13 See Carpenter, E. (2015, August 19). *More than 2 Million Marketplace Enrollees Forgo Cost-Sharing Assistance* [Press release]. Retrieved 1 March 2017, from http://avalere.com/expertise/managed-care/insights/more-than-2-million-marketplace-enrollees-forgo-cost-sharing-assistance

14 Appleby, J. (2013, February 13). California Sets Standard Deductibles, Copays For Insurance Plans. *Kaiser Health News.* Retrieved 3 April 2017, from http://khn.org/news/california-sets-standard-deductibles-copays-for-insurance-plans/

15 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12204 (March 8, 2016) (to be codified at 45 C.F.R. pts. 144, 147, 153, 154, 155, 156, and 158). *Available at* https://www.federalregister.gov/documents/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017

16 Centers for Medicare & Medicaid Services. (2016, September 30). *UPDATE: Quality Rating Information Bulletin.* Retrieved 1 March 2017, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/UPDATE-Quality-Rating-Information-Bulletin.pdf

17 Centers for Medicare & Medicaid Services. (2016, September 30). *Updated CMS Bulletin on Network Breadth Information for Qualified Health Plans on HealthCare.gov.* Retrieved 1 March 2017, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/NA-Pilot-Final-Guidance-Clean-093016.pdf

18 DC Health Link. (2016, August 18). *DC Health Link Launches New Prescription Drug Tool* [Press release]. Retrieved 1 March 2017, from https://dchealthlink.com/node/2825

19 Ibid.

20 The Commonwealth Fund. (2015, September). *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not.* Retrieved 1 March 2017, from http://www.commonwealthfund.org/publications/issue-briefs/2015/sep/to-enroll-or-not-to-enroll

21 When recently reviewing this information, Vermont marketplace officials indicated that the age inputs in the initial page of the shopping experience are used by the OOP cost calculator and as such, the inclusion of this input should be accounted for in our analysis. However, in creating this chart, we only accounted for those inputs that were specific to the OOP cost calculators. Any element that was primarily gathered to inform the plan shopping experience is not indicated here because it is not specific to the OOP cost calculator.

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Interim Results of the 2017 Filing Season

March 31, 2017

Reference Number: 2017-40-028

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INTERIM RESULTS OF THE 2017 FILING SEASON

Highlights

Final Report issued on March 31, 2017

Highlights of Reference Number: 2017-40-028 to the Internal Revenue Service Commissioner for the Wage and Investment Division.

IMPACT ON TAXPAYERS

The filing season, defined as the period from January 1 through mid-April, is critical for the IRS because it is during this time that most individuals file their income tax returns and contact the IRS if they have questions about specific laws or filing procedures.

WHY TIGTA DID THE AUDIT

The objective of this review was to provide selected information related to the IRS's 2017 Filing Season. TIGTA plans to issue the final results of our analysis of the 2017 Filing Season in September 2017.

WHAT TIGTA FOUND

In preparation for the 2017 Filing Season, the IRS made significant changes to its processes and procedures to address legislative requirements, including the program and integrity provisions of the Protecting Americans From Tax Hikes Act of 2015. The IRS began accepting and processing individual tax returns on January 23, 2017, as scheduled.

As of March 3, 2017, the IRS received approximately 61 million tax returns – 57.4 million (94 percent) were electronically filed (e-filed) and 3.6 million (6 percent) were filed on paper. The IRS has issued 49.4 million refunds totaling more than $148.8 billion. In addition, as of March 2, 2017, the IRS processed 1.7 million tax returns that reported nearly $6.4 billion in Premium Tax Credits that were either received in advance or claimed at the time of filing. Approximately 1.8 million taxpayers reported shared responsibility payments for a decrease of 33.3 percent from the prior year. However, the amount of shared responsibility payments reported increased 20 percent over the prior year to $1.2 billion. It should be noted the amount of the shared responsibility payment increases each year.

The IRS continues to expand its efforts to detect tax refund fraud. As of March 4, 2017, the IRS reports that it identified 30,674 tax returns with $961 million claimed in fraudulent refunds and prevented the issuance of $918.6 million (95.6 percent) in fraudulent refunds. In addition, the IRS reports that expanded use of controls to identify fraudulent refund claims before they are accepted into the processing system has identified approximately 10,954 fraudulent e-filed tax returns as of February 28, 2017, and 2,317 paper-filed tax returns as of March 16, 2017. The IRS also identified and confirmed 14,068 fraudulent tax returns involving identity theft as of March 2, 2017, and identified 17,227 prisoner tax returns for screening as of March 4, 2017.

The IRS continues to offer more self-assistance options that taxpayers can access 24 hours a day, seven days a week, including its IRS2Go app; YouTube channels; interactive self-help tools on IRS.gov; and Twitter, Tumblr, and Facebook accounts. In addition, as of March 2, 2017, approximately 27.4 million total attempts and 19 million net attempts were made by taxpayers to contact the IRS by calling the various customer service toll-free telephone assistance lines. The IRS reports that approximately 10.4 million calls were answered with automation. IRS assistors have answered nearly 4.7 million calls and provided a 76.2 percent Level of Service with a 7.1 minute Average Speed of Answer.

Finally, during Fiscal Year 2017, the IRS plans to assist approximately 3.4 million taxpayers through face-to-face contact at the Taxpayer Assistance Centers, which is a 23.6 percent decrease from Fiscal Year 2016.

WHAT TIGTA RECOMMENDED

This report was prepared to provide interim information only. Therefore, no recommendations were made in the report.

TREASURY INSPECTOR GENERAL
FOR TAX ADMINISTRATION

DEPARTMENT OF THE TREASURY

WASHINGTON, D.C. 20220

March 31, 2017

MEMORANDUM FOR COMMISSIONER, WAGE AND INVESTMENT DIVISION

FROM: Michael E. McKenney
Deputy Inspector General for Audit

SUBJECT: Final Audit Report – Interim Results of the 2017 Filing Season (Audit # 201740004)

This report presents selected information related to the Internal Revenue Service's (IRS) 2017 Filing Season results. As part of our Fiscal Year 2017 Annual Audit Plan, we are conducting several ongoing audits that are related to specific issues in this report. This review addresses the major management challenge of Implementing the Affordable Care Act and Other Tax Law Changes. We will continue to provide IRS management with information on any areas of immediate concern throughout our audit process.

This report was prepared to provide information only. Therefore, we made no recommendations in the report. However, we provided IRS management officials with an advance copy of this report for review and comment prior to issuance.

Copies of this report are also being sent to the IRS managers affected by the report information. If you have any questions, please contact me or Russell P. Martin, Assistant Inspector General for Audit (Returns Processing and Account Services).

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Abbreviations

ACA	Affordable Care Act
ACTC	Additional Child Tax Credit
AOTC	American Opportunity Tax Credit
ATIN	Adoption Taxpayer Identification Number
APTC	Advance Premium Tax Credit
CTC	Child Tax Credit
e-file(d), e-filing	Electronically File(d); Electronic Filing
EIN	Employer Identification Number
EITC	Earned Income Tax Credit
HCTC	Health Coverage Tax Credit
IRS	Internal Revenue Service
ITIN	Individual Taxpayer Identification Number
PATH Act	Protecting Americans From Tax Hikes Act of 2015
PTC	Premium Tax Credit
RRP	Return Review Program
SRP	Shared Responsibility Payment
SSN	Social Security Number
TAC	Taxpayer Assistance Center
TIGTA	Treasury Inspector General for Tax Administration

Background

The annual tax return filing season is a critical time for the Internal Revenue Service (IRS) as this is when most individuals file their income tax returns and contact the IRS if they have questions about specific tax laws or filing procedures. During Calendar Year 2017, the IRS expects to receive approximately 152 million individual income tax returns (approximately 17 million paper filed and 134.3 million electronically filed (e-filed)). The IRS plans to process individual income tax returns at five Wage and Investment Division Submission Processing sites[1] during the 2017 Filing Season. In addition, the IRS expects to provide assistance to millions of taxpayers via the telephone, e-mail, website, social media, and face-to-face assistance.

One of the continuing challenges the IRS faces each year in processing tax returns is the implementation of new tax law changes as well as changes resulting from expired tax provisions. Before the filing season begins, the IRS must identify the tax law and administrative changes affecting the upcoming filing season. Once identified, the IRS must revise the various tax forms, instructions, and publications. It also must reprogram its computer systems to ensure that tax returns are accurately processed based on changes in the tax law. Errors in the IRS's tax return processing systems may delay tax refunds, affect the accuracy of taxpayer accounts, or result in incorrect taxpayer notices.

Tax law changes affecting the 2017 Filing Season

- ***The Patient Protection and Affordable Care Act (ACA)***[2] – Enacted March 23, 2010, provides incentives and tax breaks to individuals and small businesses to offset health care expenses. It also imposes Shared Responsibility Payments (SRP), administered through the tax code, for individuals and businesses that do not obtain health care coverage for themselves or their employees. For the 2017 Filing Season, the IRS will continue its efforts to verify claims for the Premium Tax Credit (PTC).[3] Taxpayers who

[1] See Appendix V for a glossary of terms. IRS Submission Processing sites in Fresno, California; Kansas City, Missouri; and Austin, Texas, will process paper-filed and e-filed tax returns. Sites in Andover, Massachusetts, and Philadelphia, Pennsylvania, will process only e-filed tax returns.

[2] Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[3] A refundable tax credit to assist individuals and families in purchasing health insurance coverage through an Affordable Insurance Exchange.

purchase insurance through an Exchange[4] are required to file a tax return and attach Form 8962, *Premium Tax Credit (PTC)*, to claim the PTC and reconcile any Advance PTC (APTC) payments[5] that were made to an insurer on their behalf.

The ACA also requires individuals to report on their compliance to maintain minimum essential health insurance coverage.[6] Individuals who do not maintain minimum essential coverage or qualify for an exemption from the requirement must make an SRP. On January 20, 2017, the President issued the *Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Appeal* directing Federal agencies to exercise authority and discretion available to them to reduce potential burden on taxpayers in complying with ACA requirements.

- ***The Trade Preferences Extension Act of 2015***[7] – Enacted June 29, 2015, prohibits individuals claiming the foreign earned income exclusion or housing deduction from receiving the refundable Additional Child Tax Credit (ACTC).[8] In addition, this Act retroactively extended the Health Coverage Tax Credit (HCTC) for Tax Year 2014 and continued the credit through Tax Year 2019.[9] The HCTC is a tax credit that pays a portion of qualified health insurance premiums for eligible individuals and their families.

  Beginning with Calendar Year 2016, eligible individuals can choose to receive the HCTC on a monthly basis. Individuals can have up to 72.5 percent of their qualified health insurance premiums paid in advance. The Treasury Inspector General for Tax Administration (TIGTA) is conducting a separate review to assess the effectiveness of the IRS's implementation of advance HCTC payments.[10] It should be noted that the HCTC is not part of the ACA. However, the legislation contains some important modifications that require coordination of this credit with the PTC under the ACA and other provisions of the ACA.

  Finally, this legislation requires that an individual claiming the American Opportunity Tax Credit (AOTC), Lifetime Learning Credit, or the Tuition and Fees Deduction must

[4] The Exchange is where taxpayers find information about health insurance options, purchase qualified health plans, and, if eligible, obtain help paying premiums and out-of-pocket costs.

[5] An APTC is paid in advance to a taxpayer's insurance company to help cover the cost of premiums.

[6] Minimum essential coverage is health insurance coverage that contains essential health benefits including emergency services, maternity and newborn care, preventive and wellness services, doctor visits, hospitalization, mental health services, and prescription drugs.

[7] Pub. L. No. 114-27.

[8] The ACTC (the refundable portion of the Child Tax Credit) is used to adjust the individual income tax structure to reflect a family's reduced ability to pay taxes as family size increases.

[9] The HCTC originally expired at the end of Calendar Year 2013.

[10] TIGTA, Audit Number 201640034, *Implementation of Advance Health Coverage Tax Credit Payments.*

statement, which is generally on Form 1098-T, *Tuition Statement*, provides the name, address, and Employer Identification Number (EIN) of the educational institution. An exception to the statement requirement is allowed if the taxpayer claiming the benefit has taken certain steps to obtain a statement from the institution. This provision is effective for tax years beginning after June 29, 2015.

- ***Consolidated Appropriations Act of 2016***[11] – Enacted on December 18, 2015, contains the Protecting Americans From Tax Hikes Act of 2015 (PATH Act), which extended numerous tax provisions that expired at the end of Tax Year 2014. Many of the provisions were permanently extended, while others were extended for either two or five years.

  The PATH Act also contains a number of provisions referred to as program integrity provisions intended to reduce fraudulent and improper Earned Income Tax Credit (EITC),[12] Child Tax Credit (CTC),[13] ACTC, and AOTC[14] payments. The majority of the program integrity provisions were effective January 1, 2016, and affect the processing of Tax Year 2016 returns. Figure 1 provides a description of the integrity provisions included in the PATH Act.

Figure 1: PATH Act Integrity Provisions

Provision	Description	Effective Date
Section 201: Modification of filing dates of returns and statements relating to employee wage information and nonemployee compensation to improve compliance	Modifies the due dates of Forms W-2, *Wage and Tax Statement,* and documents reporting nonemployee compensation such as Forms 1099-MISC, *Miscellaneous Income (Info Only),* to January 31. Also provides additional time for the IRS to review refund claims based on the EITC and the ACTC in order to reduce fraud and improper payments. No refund based on claims for the EITC or the ACTC shall be made to a taxpayer before February 15.	January 1, 2016 (2017 Filing Season)
Section 203: Requirements for the issuance of Individual	Modifies the period an ITIN will remain active. The provision requires the IRS to deactivate ITINs that are not used on a tax return at least once in the last three tax years. In addition,	December 18, 2015 (2016 Filing Season)

[11] Pub. L. No. 114-113 (H.R. 2029).

[12] The EITC is used to offset the impact of Social Security taxes on low-income families and to encourage them to seek employment.

[13] A tax credit for families with dependent children that is used to reduce the individual income tax burden for families, better recognize the financial responsibilities of raising dependent children, and promote family values.

[14] A partially refundable Federal tax credit used to help parents and college students offset the costs of college.

Taxpayer Identification Numbers (ITIN)	starting on January 1, 2017, requires the IRS to deactivate ITINs issued prior to January 1, 2013.	
Sections 204 - 206: Prevention of retroactive claims	Prevents retroactive claims of the EITC after issuance of a Social Security Number (SSN) and prevents retroactive claims of the CTC/ACTC and the AOTC after the issuance of an SSN, ITIN, or Adoption Taxpayer Identification Number (ATIN). Taxpayers cannot file an amended tax return or original tax return for prior years to claim credits if the SSN, ITIN, or ATIN were not issued prior to the return due date.	December 18, 2015 (2016 Filing Season)
Section 207: Procedures to reduce improper claims	Expands the paid-preparer due diligence requirements with respect to the EITC and the associated $510 penalty for failure to comply, to cover returns claiming the CTC/ACTC and the AOTC.	January 1, 2016 (2017 Filing Season)
Section 208: Restrictions on taxpayers who improperly claimed credits in prior year	Expands the rules under current law which require individuals to recertify eligibility for the EITC claim after disallowance and bars individuals from claiming the EITC for 10 years if the credit was claimed fraudulently and for two years if they recklessly or intentionally disregarded the rules, to apply to the CTC/ACTC and the AOTC. Adds math error authority, which permits the IRS to disallow improper credits without a formal audit if the taxpayer claims the credit in a period during which he or she is barred.	January 1, 2016 (2017 Filing Season)
Section 211: EIN required for the AOTC	Requires that the individual taxpayer provide the EIN of the educational institution to which qualified tuition and related expenses were paid with respect to that individual in order to claim the AOTC.	January 1, 2016 (2017 Filing Season)

Source: The PATH Act.

Due to the extensive nature of the PATH Act integrity provisions affecting the 2017 Filing Season, we are conducting a series of audits to evaluate the IRS's implementation of these provisions.[15]

[15] TIGTA, Audit Number 201640034, *Implementation of Advance Health Coverage Tax Credit Payments*; TIGTA, Audit Number 201640031, *Implementation of Refundable Credit Integrity Provisions*; TIGTA, Audit Number

The interim 2017 Filing Season results are being presented as of several dates between February 8, 2017, and March 16, 2017, depending on when the data were available. Later this year, we will issue our 2017 Filing Season report. This review was performed with information obtained from the Wage and Investment Division Headquarters located in Atlanta, Georgia; the Wage and Investment Division Submission Processing function offices in Cincinnati, Ohio; and the Information Technology organization Headquarters in Lanham, Maryland. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. Detailed information on our audit objective, scope, and methodology is presented in Appendix I. Major contributors to the report are listed in Appendix II.

201640023, *Deactivation of the Individual Tax Identification Numbers*; TIGTA, Audit Number 201740002, *Internal Revenue Service Assignment of Individual Tax Identification Numbers*.

Results of Review

Processing Tax Returns

In preparation for the 2017 Filing Season, the IRS made significant changes to its processes and procedures to address legislative requirements. The IRS began accepting and processing individual tax returns on January 23, 2017, as scheduled. As of March 3, 2017, the IRS received approximately 61 million tax returns. Figure 2 presents comparative filing season statistics as of March 3, 2017.

Figure 2: Comparative Filing Season Statistics (as of March 3, 2017)

Cumulative Filing Season Data	2016 Actual	2017 Actual	% Change
Individual Income Tax Returns			
Total Returns Received (000s)	66,723	61,063	-8.48%
Paper Returns Received (000s)	4,087	3,628	-11.23%
E-Filed Returns Received (000s)	62,636	57,435	-8.30%
Practitioner Prepared (000s)	32,600	29,293	-10.14%
Home Computer (000s)	30,036	28,142	-6.31%
Free File (000s) *(also in the Home Computer total)*	1,355	1,169	-13.73%
Fillable Forms (000s) *(also in the Home Computer total)*	125	106	-15.20%
Percentage of Returns E-Filed	93.9%	94.1%	0.20%
Refunds			
Total Number Issued (000s)	53,508	49,352	-7.77%
Total Dollars (in millions)	$160,171	$148,832	-7.08%
Average Dollars	$2,993	$3,016	0.77%
Total Number of Direct Deposits 000s)	48,309	44,822	-7.22%
Total Direct Deposit Dollars (in millions)	$150,565	$140,661	-6.58%

Source: Multiple 2017 Filing Season reports. Totals and percentages shown are rounded. The 2016 Filing Season figures are through March 4, 2016, and the 2017 Filing Season figures are through March 3, 2017.

According to the IRS, the decline in the number of tax returns received compared to this time last year is the result of fewer processing days. For example, the 2016 Filing Season opened on January 19, 2016, four days earlier than the opening of tax return processing for the 2017 Filing Season.

Use of the savings bond and split refund options

Through March 2, 2017, a total of 15,297 individuals requested to convert refunds totaling $5.7 million into savings bonds. Additionally, 190,843 taxpayers chose to split tax refunds totaling $928 million between two or three different checking or savings accounts. Figure 3 shows a comparison of taxpayers' use of the split refund and savings bond options for Processing Years 2016 and 2017 as of March 2, 2017.

Figure 3: Use of Savings Bonds and Split Refunds for Processing Years 2016 and 2017

Savings Bonds	2016 Actual	2017 Actual
Total Returns	13,936	15,297
Total Refund Dollars to Bonds	$5.3 million	$5.7 million
Split Refunds		
Total Returns	306,193	190,843
Total Refund Dollars Split	$1.5 billion	$928.4 million

Source: TIGTA analysis of the IRS Individual Return Transaction File as of March 3, 2016, and March 2, 2017. Totals are rounded.

Implementation of Affordable Care Act Provisions

As of March 2, 2017, the IRS processed 1.7 million tax returns that reported nearly $6.4 billion in the PTCs that were either received in advance or claimed at the time of filing. Figure 4 provides the results from our analysis of tax returns filed and processed as of March 2, 2017.

Figure 4: PTC Statistics (as of March 2, 2017)

Total Tax Returns With a PTC	1,668,270
Total PTC Amount (includes the APTC and the PTC)	$6.4 billion
Total APTC Amount	$6.1 billion
Total PTC Claimed at Filing in Excess of the APTC	$299.5 million

Tax Returns on Which the PTC Equals the APTC Received	
Tax Returns	62,667
Total PTC Amount	$307.8 million
Tax Returns With an Additional PTC Amount (taxpayer is entitled to more PTC than what was received in the APTC)	
Total Tax Returns	649,293
Total PTC Amount (includes the APTC and the PTC)	$2.7 billion
Total APTC Amount	$2.4 billion
Total PTC Claimed at Filing in Excess of the APTC	$299.5 million
Tax Returns With Excess APTC Payments (taxpayer receives more APTC than the PTC entitled and has to repay)	
Total Tax Returns	956,310
Total PTC Amount	$2.6 billion
Total APTC Amount	$3.4 billion
Total APTC Reported in Excess of the PTC	$829.1 million
Total APTC Above the Repayment Limit (not repaid)	$264.6 million
Total APTC Below the Repayment Limit (repaid)	$564.5 million

Source: TIGTA analysis of individual tax returns processed as of March 2, 2017.

Minimum essential coverage and SRP requirements

As of March 2, 2017, the IRS received approximately 44.1 million tax returns reporting that all members of the taxpayer's family maintained minimum essential coverage as required by the ACA. Additionally, nearly 5.3 million taxpayers filed a return with a Form 8965, *Health Coverage Exemptions*, attached indicating that at least one taxpayer on the tax return is exempt from the minimum essential coverage requirement. Also, approximately 1.8 million taxpayers self-reported SRPs totaling $1.2 billion for not maintaining required coverage. Figure 5 shows a comparison of taxpayers reporting maintaining minimum essential coverage and self-reported SRPs for Processing Years 2016 and 2017 as of March 2, 2017.

Figure 5: Minimum Essential Coverage and SRPs – Processing Years 2016 and 2017 (as of March 2, 2017)

	Processing Year 2016	Processing Year 2017	% Change
Returns Reporting All Family Members Have Minimum Essential Coverage	47 million	44.1 million	-6.2%
Returns Claiming an Exemption From Minimum Essential Coverage	6 million	5.3 million	-11.7%
Returns Reporting an SRP	2.7 million	1.8 million	-33.3%
Amount of the SRP	$1 billion	$1.2 billion	20.0%[16]

Source: TIGTA analysis of individual tax returns processed as of March 2, 2017, and the IRS's ACA Filing Season Statistics Report Filing Season 2017, Cycle #9.

Processes established to identify noncompliant filers and assess SRP requirements were changed in response to an Executive Order

Beginning with the 2017 Filing Season, the IRS developed processes to identify taxpayers at the time tax returns are processed who did not report on their compliance with the minimum essential coverage and SRP requirements, *i.e.*, did not report coverage, claim an exemption, or pay the SRP. The IRS refers to these returns as a "silent return". The IRS planned to reject e-filed silent returns back to the taxpayer notifying them of the requirement to report minimum essential coverage, submit Form 8965 to claim an exemption, or pay the SRP. Paper-filed tax returns would be identified for correspondence with the taxpayer. Taxpayers who did not respond would be assessed the SRP.

On January 20, 2017, the President issued an Executive Order directing Federal agencies to exercise authority and discretion available to them to reduce potential burden on taxpayers in complying with ACA requirements.[17] In response to the Executive Order, on February 3, 2017,

[16] The SRP dramatically increased from Tax Year 2015 to Tax Year 2016. The family maximum for Tax Year 2015 was $975 and increased to $2,085 for Tax Year 2016. However, the maximum SRP is capped at the cost of the national average premium for a bronze level health plan through the Marketplace. For the 2017 Filing Season, $13,380 is the maximum amount of the SRP for a family with five or more members which is up from the $12,240 maximum the previous year.

[17] The Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Appeal directed Federal agencies to exercise authority and discretion available to them to reduce potential burden on taxpayers.

the IRS changed its processes and procedures for identifying taxpayers at the time tax returns were filed who failed to report on their compliance with the minimum essential coverage requirements. As a result, the IRS will process all silent e-filed and paper-filed tax returns rather than verifying the taxpayer's compliance before refunds are paid. However, the IRS noted that it will continue to address noncompliance with the minimum essential coverage and SRP requirements as part of its post-processing compliance program as it has done for prior tax years.

Evaluation of Key Tax Provisions Affected by Tax Year 2016 Tax Law Changes

We are in the process of evaluating the IRS's actions to implement key provisions of the PATH Act. We plan to issue our final report later this calendar year. The following present our results to date:

- ***Processes to hold refunds that include the EITC and the ACTC until February 15, 2017*** – Our analysis of 10.3 million returns with an EITC or ACTC claim processed as of March 2, 2017, with refunds totaling $51.2 billion found the IRS held refunds as required. These refunds included the EITC totaling $28.4 billion and the ACTC totaling $10.3 billion. For those returns that were held, the IRS released returns on or after February 15, 2017, that were not identified for additional review.

  The PATH Act also moved the filing date for Forms W-2 and Forms 1099-MISC that report nonemployee compensation to January 31st. This enables the IRS to validate the income used to support EITC and ACTC claims before refunds are issued. The IRS has developed processes to verify income on all tax returns including those with an EITC or ACTC claim. IRS management stated us that all EITC and ACTC claims that have unsupported income will flow through the Return Review Program (RRP) Systemic Verification program.

  IRS management indicated that all returns identified as potentially fraudulent will be addressed as part of the IRS's fraud prevention programs. IRS management indicated that the remaining returns with an income discrepancy will be addressed as part of the IRS's overall Questionable Refund Program.[18] Specifically, management stated that these returns will be referred to the Examination or Automated Questionable Credit programs. However, management indicated that only those returns with a refund greater than an established dollar tolerance will be selected for review by the Examination or Automated Questionable Refund programs. Our review of IRS internal guidelines confirms that not all returns that have an income discrepancy are referred to or reviewed

[18] The Questionable Refund Program is a nationwide, multifunctional program designed to identify fraudulent returns, to stop the payment of fraudulent refunds, and to refer identified fraudulent refund schemes to Criminal Investigation field offices.

by the IRS Examination function. As a result, only those EITC and ACTC claims that contain an income discrepancy and have a refund above the established dollar tolerance will be subject to additional review before the refund is paid. We are conducting a separate review of the effectiveness of the IRS's use of available Forms W-2 and Forms 1099-MISC to verify income on tax returns claiming the EITC or the ACTC. We plan to issue our report later this calendar year.

- ***Processes to identify and prevent EITC, CTC, ACTC, and AOTC claims by individuals filing tax returns for years prior to when a Taxpayer Identification Number was issued*** – Our review of tax returns filed as of February 8, 2017, found that the IRS did not notify 350 taxpayers that one or more SSNs, ITINs, or ATINs used to claim one of these credits were issued subsequent to the tax year for which their claim was filed. We alerted the IRS of our concerns on February 22, 2017. IRS management indicated that its review of 241 of the 350 returns we identified confirmed that taxpayers are not always being notified when their SSN, ITIN, or ATIN was not timely issued. IRS management indicated that internal guidance has been revised to clarify that employees are to validate returns to the current National Account Profile showing the SSN, ITIN, and ATIN issuance dates. IRS management also indicated that they have requested computer programming changes to address errors identified in processing EITC, CTC, ACTC, and AOTC claims for years prior to when a Taxpayer Identification Number was issued.

  In addition, we notified the IRS on March 9, 2017, that we identified an additional 14 prior year tax returns that were incorrectly identified as having an SSN, ITIN, or ATIN that was not timely issued. As a result, these individuals were issued a notice incorrectly informing them that the SSN, ITIN, or ATIN could not be used to claim the EITC, CTC, ACTC, or AOTC. As of March 2, 2017, the IRS has received 270,163 prior tax year returns. As of the date of this report, we have not received the IRS's response to our concerns.

  We are conducting a separate review to evaluate the IRS's processing of retroactive EITC, CTC, ACTC, and AOTC claims and plan to issue our report later this calendar year.

- ***Processes to identify CTC, ACTC, and AOTC claims filed by individuals with an inactive ITIN*** – The IRS was granted authority to systemically disallow CTC, ACTC, and AOTC claims filed by individuals with an inactive ITIN including those that are deactivated or revoked by the IRS.[19] In response, the IRS developed processes to identify tax returns filed with an inactive ITIN. As of March 1, 2017, the IRS has rejected

[19] The IRS revokes an ITIN when it later determines the ITIN should not have been issued or is no longer valid given certain conditions, such as the taxpayer is deceased or has been assigned an SSN.

195 e-filed returns with an inactive ITIN and identified an additional 88,071 e-filed and paper-filed tax returns for review.[20]

We are conducting a separate audit on the accuracy of the IRS's deactivation of the ITINs and plan to issue our report later this calendar year.

- ***Processes to ensure that tax return preparers are submitting Form 8867, Paid Preparer's Due Diligence Checklist, for all returns with a CTC, ACTC, and AOTC claim*** – The IRS revised the Form 8867 to include the expanded due diligence requirements for the CTC, ACTC, and AOTC. Tax return preparers are required to submit this form with each tax return they file with one of these credit claims. In addition, the IRS developed processes to systemically identify e-filed tax returns filed by a preparer that do not contain a Form 8867. The IRS sends the preparer an alert reminding the preparer of the Form 8867 requirement and notifying them that the IRS can impose a $510 penalty for failure to submit the Form 8867. The IRS reports that as of March 1, 2017, it identified and sent 1,311 notifications to paid preparers informing them about the missing Form 8867 and the new requirement. Our analysis of the 10.7 million tax returns with a CTC, ACTC, or AOTC claim filed by paid preparers as of March 2, 2017, identified 11,119 (0.1 percent) that did not include the Form 8867 as required.
- ***Processes to ensure that an educational institution EIN is provided when claiming the AOTC*** – The IRS has established processes to identify e-filed AOTC claims when the taxpayer indicates a statement was received from the educational institution and an EIN is not provided. However, IRS management stated that current reporting regulations do not require institutions to provide a statement that would include the institution EIN to all students. **********2********** **********2**********. IRS management indicated that the IRS is in the process of revising the regulations for institutions to be consistent with the new requirements for claiming education benefits. As of March 2, 2017, the IRS has received nearly 3.9 million returns claiming the AOTC totaling $3.4 billion.[21] We are in the process of determining how many of the 3.9 million returns**********2**********.

In addition to the previously mentioned provisions, we are also assessing the accuracy of the IRS's processing of individual tax returns affected by key tax provisions included in other legislation. To date, our assessments have identified:

[20] The IRS discontinued use of its e-file reject processes on January 19, 2017. Subsequent to January 19, 2017, all e-filed returns with an inactive ITIN are being identified for additional review.

[21] Our analysis only includes the refundable portion of the AOTC.

- ***Requirement to have a statement from the educational institution to claim the AOTC, Lifetime Learning Credit, and the Tuition and Fees Deduction*** – The IRS has not developed processes to identify education benefit claims at the time tax returns are filed for which the taxpayer did not have the required statement. Similar to identifying claims with the EIN of the educational institution, IRS management cited the inconsistency between institution reporting regulations and the taxpayer's requirement to have a statement. **********2********** **********2**********.

  In addition, IRS management indicated that processes intended to identify other potential AOTC errors will also identify some claims for which the taxpayer does not have the required statement. IRS management also stated that while the PATH Act strengthened the AOTC requirements, it did not provide the IRS with additional authority such as expanded math error authority to address taxpayer noncompliance. Finally, management noted that the PATH Act did not change the filing date for Form 1098-T. Institutions generally have until March 31 to file Form 1098-T with the IRS.[22] As such, these forms would not be available to verify claims at the time tax returns are filed. As of March 2, 2017, the IRS had received nearly 5.4 million tax returns claiming the AOTC, Lifetime Learning Credit, or the Tuition and Fees Deduction.

- ***Residential Energy Efficient Property Credit*** – We continue to identify that the IRS is incorrectly limiting taxpayers' Residential Energy Efficient Property Credit to the $500 ($1,000 if married filing jointly) limit associated with the Nonbusiness Energy Property Credit. Taxpayers can claim a credit based upon the costs of certain property such as solar electric and geothermal heat pump items that is generally limited to their tax liability. We previously reported this condition in the 2015 and 2016 Filing Seasons. On February 10, 2017, we alerted IRS management once again that corrective actions taken in response to our prior recommendations do not ensure that Residential Energy Efficient Property Credit claims are not improperly limited. The IRS agreed with our assessment and expected to correct computer programming errors on March 19, 2017. As of March 2, 2017, the IRS had improperly reduced Residential Energy Efficient Property Credit claims on 123 tax returns by a total of approximately $241,000.

Accuracy of IRS tax forms, schedules, publications, and information on IRS.gov

Each year, the IRS must update its tax forms, schedules, and publications as well as information on IRS.gov to accurately reflect tax changes. These changes include: inflationary adjustments, income limit phase-ins or phase-outs, and legislative changes. Overall, our review of the forms, instructions, and publications related to the previously discussed key tax provisions found that

[22] Paper-filed Forms 1098-T are to be filed with the IRS no later than February 28.

most have been accurately updated. However, our review identified some instances in which information related to these provisions was not always accurate or updated. For example:

- On December 2, 2016, we informed the IRS that our review of the draft instructions for Form 8863, *Education Credits (American Opportunity and Lifetime Learning Credits)*, dated August 26, 2016, and for Form 8917, *Tuition and Fees Deduction*, dated July 28, 2016, were not updated to reflect the new education benefit requirements as well as the exceptions to those requirements. The IRS responded that it is only addressing the Form 1098-T requirement by adding a new item to the "What's New" section to the Form 8863 based on wording used in the proposed regulations.
- On February 9, 2017, we notified the IRS of concerns we identified related to seven IRS instructional YouTube videos that did not contain a detailed description of the changes for the current filing season. The videos we reviewed discussed the refund delay for taxpayers claiming the EITC and the ACTC; taxpayers claiming the AOTC; taxpayers with ITINs; and inflationary adjustments to items such as personal exemptions and the standard deduction. In response to our observations, the IRS deactivated one video that it already had planned to update and removed a reference to a prior year on one video script. In addition, IRS management explained that the YouTube videos are intended to provide a broad overview of a given topic and refer viewers to available resources for additional details. As such, the information provided in the remaining videos is adequate for the videos' intended purpose.

Detecting and Preventing Tax Refund Fraud

As of March 4, 2017, the IRS reported that it identified 30,674 tax returns with $961 million claimed in fraudulent refunds and prevented the issuance of $918.6 million (95.6 percent) of those refunds. Figure 6 shows the number of fraudulent tax returns identified by the IRS for Processing Years 2014 through 2016 as well as the refund amounts that were claimed and stopped.

Figure 6: Fraudulent Returns and Refunds Identified and Stopped in Processing Years 2014 Through 2016

Processing Year	Number of Fraudulent Refund Returns Identified	Number of Fraudulent Refund Returns Stopped	Amount of Fraudulent Refunds Identified	Amount of Fraudulent Refunds Stopped
2014	2,180,613	2,066,394	$15,724,424,102	$15,209,859,119
2015	1,811,354	1,646,155	$12,369,252,837	$11,639,842,002
2016	1,067,878	991,681	$7,970,283,186	$7,648,398,857

Source: IRS fraudulent tax return statistics for Processing Years 2014 through 2016.

The decrease in the number of fraudulent tax refunds the IRS detects and stops is attributable to the continued expansion of processes to prevent fraudulent tax returns from entering the tax processing system, *i.e.* rejecting e-filed tax returns and preventing paper-filed tax returns from posting. For example, as of March 13, 2017, the IRS locked approximately 33.2 million taxpayer accounts of deceased individuals. The locking of a tax account results in the rejection of an e-filed tax return and prevention of a paper-filed tax return from posting to the Master File if the SSN associated with a locked tax account is used to file a tax return. According to the IRS, as of February 28, 2017, it had rejected approximately 10,954 fraudulent e-filed tax returns, and as of March 16, 2017, it had stopped 2,317 paper-filed tax returns from posting to the Master File.

Detection of tax returns involving identity theft

For the 2017 Filing Season, the IRS is using 197 identity theft filters to identify potentially fraudulent tax returns and prevent the issuance of fraudulent tax refunds. These filters incorporate criteria based on characteristics of confirmed identity theft tax returns, including amounts claimed for income and withholding, filing requirements, prisoner status, taxpayer age, and filing history.

Tax returns identified by these filters are held during processing until the IRS can verify the taxpayer's identity. The IRS attempts to contact the individual who filed the tax return and, if the individual's identity cannot be confirmed, the IRS removes the tax return from processing. This prevents the issuance of many fraudulent tax refunds. As of March 2, 2017, the IRS reported that it had identified and confirmed 14,068 fraudulent tax returns and prevented the issuance of $91.9 million in fraudulent tax refunds as a result of the identity theft filters. Figure 7 shows the number of identity theft tax returns the IRS identified and confirmed as fraudulent as of March 2, 2017, for Processing Year 2017 and as of a comparable time frame for Processing Years 2015 and 2016.

Figure 7: Identity Theft Tax Returns Confirmed As Fraudulent in Processing Years 2015 Through 2017

Processing Year	Number of Identity Theft Returns
2015	16,523
2016	31,578
2017	14,068

Source: IRS fraudulent tax return statistics for Processing Year 2015 (as of February 28, 2015); Processing Year 2016 (as of February 29, 2016); and Processing Year 2017 (as of March 2, 2017).

In February 2017, we reported[23] that with the passage of legislation to accelerate the reporting date of Forms W-2, the IRS should be able to significantly reduce the number of undetected tax returns reporting false wages and withholding if it compares available Form W-2 information to the tax return at the time the tax return is processed. Similar to Processing Year 2016, the IRS initiated a voluntary program in which 18 payroll providers were requested to submit Forms W-2 directly to the IRS by January 31, 2017. The IRS uses the identity theft models to compare this accelerated Form W-2 information to the tax return at the time the tax return is processed for identity theft detection. The IRS stated that as of March 2, 2017, it selected 21,461 tax returns for identity theft treatment based upon the early submission of Forms W-2.

Finally, in response to concerns raised by TIGTA regarding multiple refunds going to the same address or bank account, the IRS continues to use its clustering filter tool to group tax returns based on characteristics that include the address, zip code, and bank routing numbers. For the tax returns identified, the IRS applies a set of business rules in an attempt to ensure that legitimate taxpayers are not included. Tax returns identified are held from processing until the IRS can verify the taxpayer's identity. As of March 2, 2017, the IRS reports that, using this tool, it identified 72,622 tax returns and prevented the issuance of approximately $334.6 million in fraudulent tax refunds.

[23] TIGTA, Ref. No. 2017-40-017, *Efforts Continue to Result in Improved Identification of Fraudulent Tax Returns Involving Identity Theft; However, Accuracy of Measures Needs Improvement* (Feb. 2017).

Converting direct deposits to a paper check

In an effort to further reduce fraudulent tax refunds, the IRS limits the number of direct deposit refunds that can be sent to one bank account to three refunds. The IRS will convert the fourth and subsequent direct deposit refund requests to a paper check and send it to the taxpayer's address of record.[24]

In January 2017, we reported that our analysis of direct deposit requests made as of May 5, 2016, found that IRS processes still do not always convert direct deposits to a paper check when required.[25] The IRS received approximately 86 million requests for direct deposits as of May 5, 2016. Our analysis of the 86 million deposit requests identified 24,644 unique bank accounts with a total of 66,727 direct deposit attempts totaling $119.1 million that should have converted to a paper check. Of the 66,727 deposit attempts we identified, 5,605 (8.4 percent) deposit attempts totaling approximately $9.2 million did not convert to a paper check as required.

We also reported that processes did not convert direct deposits to paper checks in August 2015[26] and again in December 2015.[27] In response to these reports, IRS management stated that computer programming errors resulted in the IRS not properly identifying all direct deposit accounts with multiple deposit requests. According to IRS management, the IRS corrected two of the three issues and planned to implement computer programming changes to correct the third issue in Calendar Year 2016.

IRS management stated that additional programming changes were implemented in July 2016 to address the remaining condition we identified during the 2015 Filing Season. We are evaluating whether the IRS implemented programming changes to address the errors we identified during the 2015 Filing Season as planned. We will provide the final results of our assessment in our 2017 Filing Season report that will be issued later this year.

Screening of prisoner tax returns

As of March 4, 2017, the IRS reported that it identified for screening 17,227 potentially fraudulent tax returns filed by prisoners.[28] Figure 8 shows the number of prisoner tax returns identified for screening in Processing Years 2015 through 2017.

[24] The most current address the IRS has on record for a taxpayer where communications can be sent.

[25] TIGTA, Ref. No. 2017-40-014, *Results of the 2016 Filing Season* (Jan. 2017).

[26] TIGTA, Ref. No. 2015-40-080, *Results of the 2015 Filing Season* (Aug. 2015).

[27] TIGTA, Ref. No. 2016-40-008, *Continued Refinement of the Return Review Program Identity Theft Detection Models Is Needed to Increase Detection* (Dec. 2015).

[28] Tax returns filed using a prisoner's name and SSN.

Figure 8: Prisoner Tax Returns Identified for Screening in Processing Years 2015 Through 2017 (as of March 4, 2017)

Processing Year	Number of Prisoner Tax Returns Identified for Screening
2015	26,797
2016	20,224
2017	17,227

Source: IRS fraudulent tax return statistics for Processing Years 2015 through 2017 as of March 4, 2017.

To combat refund fraud associated with tax returns filed using prisoner SSNs, the IRS compiles a list of prisoners (the Prisoner File) received from the Federal Bureau of Prisons and State Departments of Corrections. Various IRS offices and functions use the Prisoner File in an effort to prevent and detect fraud. The Prisoner File is the cornerstone of the IRS's efforts to prevent the issuance of fraudulent refunds to individuals filing false tax returns using a prisoner SSN.

In addition, to further its efforts to identify prisoner tax returns, the *Bipartisan Budget Act of 2013,*[29] enacted in December 2013, amended the *Improper Payments Elimination and Recovery and Improvement Act*[30] to give the Secretary of the Treasury the authority to obtain Prisoner Update Processing System data from the Social Security Administration and make it available for those programs in which prisoners are ineligible for benefits. Specifically, the Act authorizes the IRS to compare the Social Security Administration prisoner information with any other Personally Identifiable Information derived from a Federal system of records. IRS management noted that the IRS is using the Prisoner Update Processing System data as part of the 2017 Filing Season prisoner identification process.

The RRP replaces the Electronic Fraud Detection System to detect tax refund fraud

The IRS retired the Electronic Fraud Detection System fraud detection processes on October 23, 2016. Beginning with the 2017 Filing Season, the RRP is now the IRS's sole source for detecting potentially fraudulent prisoner tax returns. The IRS stated that the RRP provides new and improved capabilities in its fraud detection and prevention processes. The RRP has

[29] Pub. L. No. 113-67, § 204.

[30] Pub. L. No. 112-248, 126 Stat. 2390.

real-time filtering capabilities and is designed to improve the IRS's ability to detect, resolve, and prevent fraud. We are conducting a separate review of the IRS's efforts to address prisoner fraud.[31] We plan to issue our report later this calendar year. In addition, we are conducting a separate review of the IRS's use of the RRP to detect and prevent fraud during the 2017 Filing Season.[32]

Providing Customer Service

Similar to past filing seasons, taxpayers have multiple options to choose from when they need assistance from the IRS, including assistance through the toll-free telephone lines, face-to-face assistance at the Taxpayer Assistance Centers (TAC) or Volunteer Program sites, and self-assistance through IRS.gov and various other social media channels, *e.g.*, Twitter, Facebook, and YouTube. The IRS continues its trend to depend more on technology-based services and external partners by directing taxpayers to the most cost-effective IRS or partner channel available to provide the needed service. The IRS notes that this approach allows it to focus limited toll-free and walk-in resources on customer issues that can be best resolved with person-to-person interaction. By using this approach, the IRS believes that it is able to improve its service to taxpayers by addressing and resolving more complex matters such as assistance to identity theft victims and people with tax account issues. For example, in an effort to continue to redirect taxpayers to online services, the IRS has expanded online tools available to taxpayers on IRS.gov:

- ***Interactive Tax Assistant*** – this tool is a tax law resource that takes taxpayers through a series of questions and provides them with responses to basic tax law questions. The IRS reports that from January 1 through March 4, 2017, a total of 522,956 requests had been completed which is a 21 percent decrease from the 663,276 requests that were completed during the same time period last filing season.
- ***Where's My Refund?*** – this tool allows taxpayers to check the status of their refunds using the most up-to-date information available to the IRS. The IRS reports that as of March 4, 2017, there have been 184 million uses of the tool. This is an 11.4 percent decrease over the same time last filing season.
- ***Am I Eligible for a Coverage Exemption or Required to Make an Individual Shared Responsibility Payment*** – this tool helps taxpayers determine if they are eligible for an exemption from the minimum essential coverage requirement or if they must make an SRP. According to the IRS, 40,032 taxpayers have used this tool as of March 2, 2017. This is an increase of more than 8.3 percent over the 36,966 uses for the same period last filing season.

[31] TIGTA Audit Number 201640007, *Follow-Up Review of Prisoner Fraud.*

[32] TIGTA Audit Number: 201740029, *Assessment of the IRS's Filing Season 2017 Fraud Detection Activities.*

- ***Individual Shared Responsibility Provision Payment Estimator*** – this tool allows taxpayers to estimate the amount they may have to pay if they did not maintain minimum essential coverage during the year. From January 1 through March 2, 2017, 77,033 taxpayers have used this tool which is 399 percent increase for the same period last filing season.

Self-assistance through IRS.gov and social media channels

The IRS continues to offer self-assistance options that taxpayers can access 24 hours a day, seven days a week. The most notable self-assistance option is the IRS's public Internet site, IRS.gov. The IRS has been actively steering taxpayers to its website as the best source for answers to their tax questions. The IRS reports 196.5 million visits to IRS.gov this filing season as of March 4, 2017.

Taxpayers can also interact with the IRS using IRS2Go, which is a mobile application that lets taxpayers access information and a limited number of IRS online tools. As of February 25, 2017, the IRS reports that the IRS2Go mobile application had 3.36 million active users.

In addition, the IRS uses various forms of social media including YouTube, Twitter, Tumblr, and Facebook. As of March 4, 2017, there have been 852,884 new views of IRS YouTube videos and a total of 158,554 Twitter followers.

Toll-free telephone level of assistance continues to increase

As of March 2, 2017, approximately 27.4 million total attempts and 19 million net attempts[33] were made by taxpayers to contact the IRS by calling the various customer service toll-free telephone assistance lines seeking help to understand the tax law and meet their tax obligations.[34] As of March 4, 2017, the IRS reports that 10.4 million calls were answered with automation, and telephone assistors answered nearly 4.7 million calls and provided a 76.2 percent Level of Service[35] with a 7.1 minute Average Speed of Answer. The Level of Service for the 2016 Filing Season was 72 percent. The IRS forecasts a 75 percent Level of Service for the 2017 Filing Season. Figure 9 shows a comparison of IRS toll-free telephone statistics as of March 4, 2017, for Fiscal Years 2014 through 2017.

[33] Total call attempts represent calls received during open and after hours. Total net call attempts represent calls received during open hours.

[34] The IRS refers to the suite of 29 telephone lines to which taxpayers can make calls as "Customer Account Services Toll-Free."

[35] The primary measure of service to taxpayers. It is the relative success rate of taxpayers who call for live assistance on the IRS's toll-free telephone lines.

Figure 9: Toll-Free Filing Season Telephone Statistics for Fiscal Years 2014 Through 2017 (as of March 4, 2017)

Statistic	Fiscal Year			
	2014	2015	2016	2017
Assistor Calls Answered	6,038,861	4,213,245	7,299,589	4,687,582
Level of Service	74.7%	38.5%	72.8%	76.2%
Average Speed of Answer (Minutes)	11.7	24.6	9.6	7.1

Source: IRS management information reports as of March 4, 2017. TIGTA converted the Average Speed of Answer in the reports from seconds to minutes.

The IRS continues to decrease the number of taxpayers it assists at the TACs

Each year, many taxpayers seek assistance from one of the IRS's 376 TAC walk-in offices. Although the IRS reports 376 TACs for the 2017 Filing Season, 24 TACs are not open as they have not been staffed. The IRS estimates that the number of taxpayers it will assist at its TACs will continue to decrease this fiscal year. The IRS plans to assist approximately 3.4 million taxpayers at the TACs in Fiscal Year 2017, an approximately 23.6 percent decrease from Fiscal Year 2016. The IRS indicated that budget cuts and its strategy of appointment service at the TACs, along with continued promotion of alternative service options, will result in the reduction of the number of employees to assist taxpayers at the TACs. Figure 10 shows the number of contacts by product line at the TACs for Fiscal Years 2014 through 2017.

Figure 10: TAC Contacts for Fiscal Years 2014 Through 2017 (in millions)

Contacts/Product Lines	Fiscal Year			
	2014	2015	2016	2017 Projections
Tax Accounts Contacts	3.6	3.8	3.1	2.4
Forms Contacts	0.4	0.3	0.1	0.1
Other Contacts[36]	1.4	1.5	1.2	1.0
Tax Law Contacts	0.1	0.1	0.1	<0.04
Totals	**5.5**	**5.6**	**4.5**	**3.4**

Source: IRS management information reports. Numbers shown are rounded and totals may not calculate due to rounding.

The IRS is implementing initiatives in an effort to better assist those individuals seeking assistance from a TAC. For the 2017 Filing Season, the IRS has transitioned all TACs to appointment service. The IRS indicated that it initially began providing services at the TACs by appointment in an attempt to alleviate long lines that sometimes occur at many TACs and to help ensure that taxpayers' issues are timely resolved. The IRS will attempt to resolve the taxpayer's question or provide the taxpayer with information on alternative services when they call to schedule an appointment. The IRS reports that as of February 18, 2017,[37] IRS employees answered over 1 million calls resulting in approximately 490,000 that necessitated a TAC appointment.

The IRS also noted that it provided service to 1.6 million taxpayers, of which 526,000 taxpayers were assisted on the telephone and 1.1 million taxpayers were assisted at a walk in office. Taxpayers served at the walk-in offices include taxpayers who had an appointment and those with an issue that did not require an appointment. In addition, the IRS stated that taxpayers that travel to a TAC without an appointment are assisted if there is availability. According to the IRS, an additional 140,000 taxpayers with issues that should have required an appointment were assisted without an appointment.

[36] Other Contacts includes but is not limited to: accepting Form 2063, *U.S. Departing Alien Income Tax Statement;* date-stamping tax returns brought in by taxpayers; screening taxpayers for eligibility of service; scheduling appointments (only in Fiscal Year 2015); and helping taxpayers with general information such as addresses and directions to other IRS offices or other Federal Government agencies.

[37] For Fiscal Year 2017 – October 1, 2016, through February 18, 2017.

The IRS also offers Virtual Service Delivery, which integrates video and audio technology to allow taxpayers to see and hear an assistor located at a remote TAC, giving taxpayers "virtual face-to-face interactions" with assistors. According to the IRS, taxpayers can use this technology to obtain many of the TAC's services. The goals for Virtual Service Delivery are to enhance the use of IRS resources, optimize staffing, and balance workload. For the 2017 Filing Season, the IRS is offering Virtual Service Delivery at 28 partner site locations, which is a decrease compared to 35 locations where this service was offered the previous year.[38] The IRS reports that as of March 4, 2017,[39] a total of 1,166 taxpayers have used the service.

Finally, the IRS has an initiative to co-locate staff with the Social Security Administration to assist taxpayers. For the 2017 Filing Season, the IRS has placed employees in four Social Security Administration locations. TIGTA is planning a follow-up audit to assess the IRS's efforts to expand customer service options to taxpayers seeking face-to-face assistance.

The volume of tax returns prepared at Volunteer Program sites continues to increase

The Volunteer Program continues to play an important role in the IRS's efforts to improve taxpayer service and facilitate participation in the tax system. It provides no-cost Federal tax return preparation and e-filing to underserved taxpayer segments, including low-income, elderly and disabled, rural, Native American, and limited-English-proficient taxpayers. As of March 5, 2017, approximately 1.5 million tax returns have been prepared at the 10,015 Volunteer Program sites nationwide. The IRS reports that the accuracy rate for volunteer returns filed as of March 8, 2017, is more than 94.6 percent. Figure 11 shows the number of tax returns prepared by volunteers from Fiscal Years 2014 through 2016.

Figure 11: Volunteer Program Statistics for Fiscal Years 2014 Through 2016

	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016	Percentage Change (Fiscal Year 2015 to Fiscal Year 2016)
Tax Returns	3,646,562	3,756,707	3,813,411	1.5%
Volunteers	93,082	90,826	89,121	-1.9%
Sites	12,319	12,057	11,831	-1.9%

Source: IRS management information system containing Fiscal Years 2014 through 2016 information. Percentages are rounded.

[38] For the 2017 Filing Season, the IRS is no longer offering Virtual Service Delivery at IRS locations. Access to this service is only available through external partner locations.

[39] For Fiscal Year 2017 – October 1, 2016, through March 4, 2017.

Accounts Management function's over-aged inventory decreased from Calendar Year 2015 to Calendar Year 2016

As of March 4, 2017, the IRS reports 520,814 cases in its over-aged inventory. In comparison, for the 2016 Filing Season, the IRS reported 1.2 million cases in its over-aged inventory as of February 27, 2016. Accounts Management function inventory includes but is not limited to amended tax returns, responses to taxpayer notices, identity theft cases, and applications for ITINs and is generally considered over-aged when it has been in inventory for more than a designated number of calendar days. Staff responsible for working Accounts Management function inventory are divided between working cases in inventory and staffing the customer service telephone lines.

While over-aged inventory remains high during the filing season, the IRS significantly reduced total over-aged inventory from 1.3 million cases at the end of Processing Year 2015 to 702,437 cases at the end of Processing Year 2016. According to IRS management, the drop in over-aged inventory during Processing Year 2016 was the result of $290 million in additional funding received for Fiscal Year 2016 which allowed the IRS to significantly improve telephone service that year and also freed up more resources to help reduce the Accounts Management function inventory. Figure 12 provides a comparison of the Accounts Management function inventory for Processing Years 2013 through 2016.

Figure 12: Comparison of Accounts Management Function Inventory As of the End of Processing Years 2013 Through 2016

	2013	2014	2015	2016
Total Inventory	2,580,527	2,542,125	2,890,392	1,669,543
Over-Aged Volume	1,187,255	1,168,181	1,318,446	702,437
Percentage Over-Aged	46.0%	46.0%	45.6%	42.1%

Source: IRS Accounts Management Inventory Report – Inventory Age Reports.

Appendix I

Detailed Objective, Scope, and Methodology

The overall objective of this review was to provide selected information related to the IRS's 2017 Filing Season.[1] TIGTA plans to issue the final results of our analysis of the 2017 Filing Season in September 2017. To achieve this objective, we:

I. Monitored online news outlets and forums to identify any preparation, filing, or processing issues that taxpayers are experiencing.

II. Determined if the IRS's monitoring systems indicate that individual tax returns are being processed timely and accurately.

A. Identified volumes of paper-filed and e-filed tax returns received through March 3, 2017, from the IRS Weekly Filing Season reports that provide a year-to-date comparison of scheduled return receipts to actual return receipts. The reports also provide a comparison to Fiscal Year 2016 receipts for the same period.

III. Determined if the IRS correctly implemented selected new tax law provisions that affect the processing of individual taxpayer returns during the 2017 Filing Season.

A. Determined if refunds from the EITC and the ACTC were properly held until at least February 15, 2017, as required by the PATH Act.

B. Determined if tax return preparers are submitting the Form 8867, *Paid Preparer's Due Diligence Checklist*, with each tax return claiming the EITC, ACTC, and/or AOTC.

C. Determined if processes were established to identify and prevent EITC, CTC, ACTC, and AOTC claims by individuals filing tax returns for years prior to when a Taxpayer Identification Number was issued.

D. Determined if processes were established to identify CTC, ACTC, and AOTC claims filed by individuals with an inactive ITIN.

E. Determine if processes were established to ensure that an educational institution EIN is provided when claiming the AOTC.

F. Determine if processes were developed to identify education benefit claims at the time tax returns are filed for which the required statement from the educational

[1] See Appendix V for a glossary of terms.

institution is not provided as required in order to claim the AOTC, Lifetime Learning Credit, and the Tuition and Fees Deduction.

IV. Identified and reviewed specific tax law changes to ensure that they are accurately reflected in all applicable forms, instructions, and publications.

V. Reviewed information related to the IRS's implementation of ACA tax provisions. Specifically, we analyzed the number and dollars of the PTCs received either in advance or claimed at the time of filing. In addition, we reviewed IRS statistics on minimum essential coverage and the SRPs.

VI. Identified online self-help applications provided by the IRS and ensured that the information and results provided are accurate.

VII. Identified results of the IRS's identity theft and tax refund fraud programs. We quantified fraudulent tax returns and tax returns filed by prisoners.

VIII. Compiled statistical information that is of interest to external stakeholders.

A. Determined if individuals have decreased their use of the split-refund option for depositing their refunds.

B. Determined if individuals have increased their use of the savings bond option for the direct purchase of savings bonds from their refunds.

IX. Identified results for the TAC Program.

X. Identified results for the Toll-Free Telephone Assistance Program.

XI. Identified results for the Volunteer Income Tax Assistance Program.

XII. Identified results for the Accounts Management function correspondence inventory.

XIII. Identified results for IRS self-assistance through IRS.gov.

Data validation methodology

During this review, we obtained extracts from the IRS's Individual Master File[2] and Individual Return Transaction File[3] databases for Processing Years[4] 2017 that were available on the TIGTA's Data Center Warehouse.[5] Before relying on the data, we ensured that each file contained the specific data elements we requested. In addition, we selected random samples of

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

[3] An IRS database containing transcribed tax returns from initial input of the original individual tax returns during tax return processing.

[4] The calendar year in which the tax return or document is processed by the IRS.

[5] TIGTA repository of IRS data.

each extract and verified that the data in the extracts were the same as the data captured in the IRS's Integrated Data Retrieval System.[6] We also performed analysis to ensure the validity and reasonableness of our data such as ranges of dollar values, transaction dates, and tax periods. Based on the results of our testing, we believe that the data used in our review were reliable.

Internal controls methodology

Internal controls relate to management's plans, methods, and procedures used to meet their mission, goals, and objectives. Internal controls include the processes and procedures for planning, organizing, directing, and controlling program operations. They include the systems for measuring, reporting, and monitoring program performance. We determined that the following internal controls were relevant to our audit objective: the process for planning, organizing, directing, and controlling program operations for the 2017 Filing Season. We evaluated these controls by monitoring IRS weekly production meetings, reviewing IRS procedures, and interviewing IRS management.

[6] IRS computer system capable of retrieving or updating stored information. It works in conjunction with a taxpayer's account records.

Appendix II

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Appendix III

Report Distribution List

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Office of the Commissioner – Attn: Chief of Staff
Deputy Commissioner for Services and Enforcement
Deputy Commissioner, Wage and Investment Division
Director, Accounts Management, Wage and Investment Division
Director, Business Modernization Office, Wage and Investment Division
Director, Customer Account Services, Wage and Investment Division
Director, Customer Assistance, Relationships, and Education, Wage and Investment Division
Director, E-File Services, Wage and Investment Division
Director, Field Assistance, Wage and Investment Division
Director, Joint Operation Center, Wage and Investment Division
Director, Stakeholder Partnership, Education, and Communications, Wage and Investment Division
Director, Strategy and Finance, Wage and Investment Division
Director, Submission Processing, Wage and Investment Division
Chief, Program Evaluation and Improvement, Wage and Investment Division
Director, Office of Audit Coordination

Appendix IV

Interactive Self-Help Tools and YouTube Videos

Interactive Self-Help Tools Reviewed	IRS YouTube Videos Reviewed
Where's My Refund? Tool	Individual Taxpayer Identification Number
Do I Need to File a Tax Return?	Do I Have to File a Tax Return?
How Much Is My Standard Deduction?	Education Tax Credits
Am I Eligible to Claim an Education Credit?	When Will I Get My Refund?
EITC Assistant	April 18 Is When Your Taxes Are Due in 2017
Alternative Minimum Tax Assistant for Individuals	Claiming the EITC or the ACTC? Your Refund May Be Delayed
	How to Use the Where's My Refund? Tool

Source: *www.YouTube.com* and *www.IRS.gov*.

Appendix V

Glossary of Terms

Term	Definition
Additional Child Tax Credit	The refundable portion of the CTC that was designed to reduce the income tax burden for families with dependent children.
American Opportunity Tax Credit	A partially refundable Federal tax credit used to help parents and college students offset the costs of college.
Average Speed of Answer	The average number of seconds taxpayers waited in the assistor queue (on hold) before receiving services.
Child Tax Credit	A tax credit for families with dependent children that is used to reduce the individual income tax burden for families, better recognize the financial responsibilities of raising dependent children, and promote family values.
Earned Income Tax Credit	The EITC is used to offset the impact of Social Security taxes on low-income families and to encourage them to seek employment.
Filing Season	The period from January 1 through mid-April when most individual income tax returns are filed.
Fiscal Year	Any yearly accounting period, regardless of its relationship to a calendar year. The Federal Government's fiscal year begins on October 1 and ends on September 30.
Free File	A free Federal tax preparation and e-filing program for eligible taxpayers developed through a partnership between the IRS and the Free File Alliance, LLC. The Alliance is a group of private sector tax software companies.

Term	Definition
Individual Return Transaction File	A database the IRS maintains that contains information on the individual returns it receives.
Individual Taxpayer Identification Number	A number created by the IRS to provide Taxpayer Identification Numbers to individuals who do not have and are not eligible to obtain a Social Security Number.
Level of Service	The primary measure of service to taxpayers. It is the relative success rate of taxpayers who call for live assistance on the IRS toll-free telephone lines.
Marketplace	Marketplace is the place for people without health insurance to find information about health insurance options and to purchase health insurance. It is also known as the Health Insurance Marketplace or Health Insurance Exchange
Master File	The IRS database that stores various types of taxpayer account information. This database includes individual, business, and employee plans and exempt organizations data.
Minimum Essential Coverage	Health insurance coverage that contains essential health benefits including emergency services, maternity and newborn care, and preventive and wellness services. Minimum essential coverage also includes doctor visits, hospitalization, mental health services, and prescription drugs.
Premium Tax Credit	A refundable tax credit created by the ACA to assist eligible taxpayers with paying their health insurance premiums.
Processing Year	The calendar year in which the return or document is processed by the IRS.
Shared Responsibility Payment	Beginning with the 2015 Filing Season, if a taxpayer or anyone in the taxpayer's tax household does not have minimum essential coverage and does not qualify for a coverage exemption, the taxpayer will need to make an SRP when filing his or her Federal income tax return.
Submission Processing Site	The data processing arm of the IRS. The sites process paper and electronic submissions, correct errors, and forward data to the Computing Centers for analysis and posting to taxpayer accounts.
Tax Year	The 12-month period for which tax is calculated. For most individual taxpayers, the tax year is synonymous with the calendar year.

Term	Definition
Taxpayer Assistance Centers	Walk-in sites where taxpayers can receive assistance when they believe their tax issue cannot be handled online or by telephone or when they want face-to-face assistance.
Volunteer Program	Includes the Volunteer Income Tax Assistance Program, including the Volunteer Income Tax Assistance Grant Program and the Tax Counseling for the Elderly Program. The Volunteer Program provides free tax assistance to persons with low to moderate income (generally $54,000 and below), the elderly and disabled, rural persons, Native Americans, and persons with limited English proficiency.

TO THE POINT
Quick Takes on Health Care Policy and Practice

2017 Federal and State Marketplace Trends Show Value of Outreach

Thursday, May 4, 2017

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

In the first three years of open enrollment for the Affordable Care Act's (ACA) health insurance marketplaces, the federal and a number of state governments worked aggressively to promote the value of health insurance, educate consumers about available financial assistance, and enroll individuals in coverage. Nearly all marketplaces (~/link.aspx?_id=42083EC8DD294C6F86C902BB2DD0AAF7&_z=z)—including the federally run marketplace and most state-operated marketplaces—saw incremental enrollment gains each year, despite the law's lower level of funding for outreach activities following their launch, as well as an increasingly charged political environment.

For the fourth open enrollment period (OEP) ending in early 2017, momentum behind enrollment efforts dwindled at the federal level following the presidential election. The new administration pushed to repeal (https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and) the ACA and made a last-minute $5 million cut (http://www.politico.com/story/2017/01/trump-white-house-obamacare-ads-234245) to outreach funding for the federally facilitated marketplace—a reduction that is under investigation (https://www.warren.senate.gov/files/documents/2017-3-23_HHS_IG_Letter_re_ACA_enrollment.pdf) by the U.S. Department of Health and Human Services' Office of Inspector General—leading to the first decline in enrollment. Meanwhile, some state-based marketplaces took a different approach, boosting enrollment efforts and finding short-term solutions to cost increases, that appears to have had an impact. Their success demonstrates the effectiveness of outreach in increasing enrollment in the marketplaces. Such enrollment is likely to increase the affordability of premiums by maintaining balance in risk pools.

Fourth Open Enrollment: Federal vs. State-Based Marketplaces

At the close of the fourth OEP, more than 9.2 million (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-02-03.html) consumers had selected coverage through the federal marketplace, reflecting a decline of 4 percentage points from 2016. Among the 17 states maintaining some or total control of marketplace functions, eight experienced a year-over-year reduction in plan selections, while nine saw a yearly increase. Though the majority of states saw a selection change of +/– 5 percentage points, four states—Colorado, Massachusetts, Minnesota, and Washington—experienced double-digit increases in selections.

Marketplace	OEP3 closing date	OEP3 closing enrollment	OEP4 closing date	OEP4 closing enrollment	Percent change
Federal	2/1/16	9,625,982	1/31/17	9,201,805	–4.6%
Arkansas*	2/1/16	73,932	2/1/17	70,374	–5.1%
California	2/7/16	1,572,074	2/6/17	1,556,676	–1.0%
Colorado	1/31/16	153,583	2/3/17	172,361	10.9%
Connecticut	1/31/16	116,019	1/31/17	111,542	–4.0%
District of Columbia	1/31/16	22,912	1/25/17	23,632	3.0%
Idaho	1/31/16	102,353	1/31/17	105,977	3.4%
Kentucky	1/31/16	93,666	1/31/17	81,155	–15.4%
Maryland	2/5/16	162,652	1/31/17	157,637	–3.2%
Massachusetts*	2/1/16	196,554	2/1/17	246,831	20.4%
Minnesota	1/31/16	85,390	2/9/17	117,654	27.4%
Nevada	2/1/16	88,145	1/31/17	89,061	1.0%
New Mexico	2/1/16	54,865	1/31/17	54,653	–0.4%
New York	1/31/16	271,964	1/31/17	242,880	–12.0%
Oregon	1/31/16	137,104	1/31/17	151,379	9.4%
Rhode Island	1/31/16	34,670	1/31/17	29,420	–17.8%
Vermont	1/31/16	29,440	2/4/17	31,736	7.2%
Washington	1/31/16	200,000	1/31/17	225,000	11.1%

Note: OEP3 = third open enrollment period; OEP4 = fourth open enrollment period.

* Arkansas' and Massachusetts' reporting reflects effective enrollments.

Data: Authors' analysis of state and federal enrollment reports.

Potential Factors Influencing Enrollment Changes in State-Based Marketplaces

Yearly enrollment gains are increasingly difficult to achieve and often require more targeted outreach—and these challenges were compounded by the ACA repeal threat. As a result, some state-based marketplaces took additional steps to promote enrollment toward the end of the sign-up period, which may have had a positive effect on final

selections.

- Oregon invested (http://www.courierpress.com/story/news/health/2017/01/27/oregon-health-officials-increase-obamacare-ads-despite-trumps-cuts/97162632/) an additional $100,000 in advertising in response to the administration's decision to cut outreach;
- Minnesota enacted a bill providing more than $300 million in premium relief to residents enrolling in marketplace coverage who miss the eligibility threshold for advanced premium tax credits;
- Washington extended the hours of its Customer Support Center, fielding more than 44,000 customer calls in the seven days leading up to the enrollment deadline; and
- Some states—including California, Colorado, and Minnesota—extended the enrollment period by a few days to allow consumers to complete started applications.

Among the state-based marketplaces that saw enrollment declines, several had successful enrollment in other markets or had made decisions that could have contributed to a decline. For example:

- Connecticut reported that insurers' decisions to cut or eliminate broker commissions for 2017 likely reduced enrollment, as 8,000 to 10,000 consumers with 2016 coverage that did not reenroll for 2017 had used brokers in the past. As a result, the exchange voted unanimously to require insurers to pay broker commissions in 2018.
- In October, when outreach is usually well under way, Kentucky was still in the process of transitioning (https://www.cms.gov/CCIIO/Resources/Letters/Downloads/Bevin_Final_Signed.pdf) from a fully state-based marketplace to a marketplace run on the federal platform. Relinquishing some controls to the federal system, in addition to criticism (http://www.npr.org/sections/health-shots/2016/01/12/462782543/kentucky-governor-tells-feds-he-will-dismantle-states-insurance-exchange) by a new governor who ran on dismantling the marketplace, could have affected enrollment, as consumer representatives warned (http://www.courier-journal.com/story/news/politics/2016/01/11/bevin-notifies-feds-hell-dismantle-kynect/78623024/).
- While New York's marketplace enrollment declined, it was largely a result of the continued implementation of a basic health program (https://info.nystateofhealth.ny.gov/sites/default/files/Essential Plan Fact Sheet 2017.pdf), which provides coverage for adults that fall between Medicaid and subsidy eligibility. Overall, enrollment into a non-Medicaid/Children's Health Insurance Program health plan rose by more than 250,000 (https://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-announces-enrollment-surges) compared to 2016.

Looking Forward

While it's difficult to identify the exact factors that led some states to experience high enrollment gains while others did not, early data suggest that state-based efforts to make larger investments in outreach and consumer assistance likely had an impact.

To help keep coverage options affordable, it's important to create a balanced risk pool by bolstering enrollment among healthy people. As illustrated, many state-based marketplaces demonstrated a commitment to this goal this year and saw results, while the federal marketplace scaled back efforts

(https://www.warren.senate.gov/files/documents/2017-3-23_HHS_IG_Letter_re_ACA_enrollment.pdf) late in the game and suffered the consequences. Maintaining stable marketplaces with affordable premiums will likely require continued outreach by federal and state authorities.

By Sandra L. Decker, Brandy J. Lipton, and Benjamin D. Sommers

Medicaid Expansion Coverage Effects Grew In 2015 With Continued Improvements In Coverage Quality

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ABSTRACT Previous research has demonstrated large gains in insurance coverage associated with the Affordable Care Act's (ACA's) Medicaid expansion in 2014. We used detailed federal survey data through 2015 to analyze more recent changes in coverage for low-income adults after the expansion. We found that the uninsurance rate fell in both expansion and nonexpansion states but that it fell significantly more in expansion states. By 2015 the post-ACA uninsurance rate for low-income adults had fallen by 7.5 percentage points more in expansion than in nonexpansion states, a difference that was similar (about 6.8 percentage points) in adjusted regression models. Private coverage increased in nonexpansion states, but significantly less than Medicaid coverage increased in expansion states. Rates of private coverage did not appear to decline in expansion states. Finally, Medicaid expansion was associated with significantly improved quality of health coverage, as reported by low-income adults.

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Under the Affordable Care Act (ACA), millions of low-income adults in states that expanded eligibility for Medicaid became newly eligible for the program, while others became eligible for income-based tax credits to purchase private insurance in 2014. As states consider whether to continue or initiate Medicaid expansion and Congress continues to weigh ACA repeal, replacement, or modification, it is especially important to evaluate information on its effects to date. Previous evidence suggests that in 2014, the first year of the implementation of the ACA's Medicaid expansion, coverage increases among low-income adults were greater in states that expanded Medicaid, compared to those that did not.[1] We used federal survey data to examine changes in coverage through 2015, the expansion's second year.

While some previous studies have assessed the impact of Medicaid expansion in 2015, they have typically done so using rapid-turnaround surveys with low response rates.[2–4] We used high-quality household interview data to assess changes in coverage through 2015 and to decompose the overall coverage changes into changes in both public and private coverage. We also examined coverage changes by respondents' sex, parental status, race/ethnicity, age range, and residence (urban versus rural area).

We found that uninsurance rates fell in 2014 in both expansion and nonexpansion states but that coverage gains were larger in expansion states. Coverage gains from expansion were even larger in 2015. By 2015 the uninsurance rate had fallen by about 7.5 percentage points more in expansion compared to nonexpansion states—a difference that was very similar to the difference (about 6.8 percentage points) in models that adjusted for factors described below and in the online Appendix.[5] Relative increases in Medicaid coverage in expansion states continued to grow in 2015. Private coverage increased in nonexpansion states, but significantly less

than Medicaid coverage did in expansion states. Rates of private coverage did not appear to decline in expansion states.

Study Data And Methods

DATA SOURCE, SAMPLE, AND OUTCOMES Our data for 2008–15 came from the National Health Interview Survey (NHIS), a nationally representative health survey of the US civilian noninstitutionalized population conducted by the National Center for Health Statistics. The NHIS is a repeated cross-sectional survey that uses a multistage area probability design to select a sample of households. It collects information on a wide variety of health topics, including insurance coverage. We analyzed data from a restricted-use version of the survey that included respondents' state of residence, which allowed us to determine whether each respondent lived in a state that expanded Medicaid in 2014 or 2015.

We analyzed health insurance coverage in four categories: no insurance, Medicaid or the Children's Health Insurance Program (CHIP), and private coverage (either group or nongroup). We also analyzed health insurance quality using answers to a question asked of one adult per household: "In regard to your health insurance or health care coverage, how does it compare to a year ago? Is it better, worse, or about the same?"

We limited our sample to respondents ages 19–64 whose family incomes were at or below 138 percent of the federal poverty level—the income level used to define the target population for the ACA Medicaid expansion. We also limited our sample to US citizens and noncitizens who had been in the United States for at least five years, to exclude recently arrived noncitizens (who are generally ineligible for Medicaid). Our sample consisted of 97,224 low-income adults who responded to the NHIS in the period 2008–15 and lived in states that expanded Medicaid in 2014 or in states that did not expand Medicaid in either 2014 or 2015. There was a subsample of 46,254 respondents for the question about changes in the quality of health insurance coverage.

STATISTICAL ANALYSIS Our study used a difference-in-differences approach: We examined changes in outcomes in the period 2014–15 compared to the period 2008–13 for Medicaid expansion states versus nonexpansion states.

Our main model focused on comparing states that expanded Medicaid in 2014 to states that did not expand Medicaid in either 2014 or 2015. (A list of states by expansion status is in the Appendix.)[5,6] For states that expanded Medicaid in 2014, we assessed the effects of the expansion in both the first year (2014) and the second year (2015). Our variables of interest were indicator variables for 2014 and 2015 and interactions between these two variables and an indicator variable for a state's having expanded Medicaid in 2014. (For additional details about our statistical model, see the Appendix.)[5] For the uninsurance rate outcome, we estimated an additional model that included states that expanded Medicaid in 2015. For this model with a sample size of 101,705 low-income adults (including those living in 2015 expansion states), we report effects only in 2015.

Following previous studies, we used linear probability models for ease of interpretation.[7] Sample weights available from the National Center for Health Statistics were used to produce nationally representative estimates. All models used robust standard errors clustered at the state level.[8]

Our study design rests on the assumption that trends in outcomes would not have differed between expansion and nonexpansion states absent the ACA. To test whether coverage trends were diverging based on expansion status before 2014, we used data for 2008–13 to estimate each outcome as a function of a linear quarterly time trend interacted with an indicator for Medicaid expansion status. Control variables (such as age and sex) that are listed in the Appendix were also included.[5] The significance of the coefficient for the interaction term served as a test of the difference in outcome trends between expansion and nonexpansion states before 2014.[9] The results indicated that trends in insurance status before 2014 were similar for states that subsequently expanded and those that did not expand, which suggests that divergent trends between these two groups of states beginning in 2014 were likely due to the implementation of the ACA Medicaid expansion.

Finally, since eligibility for public insurance among nonelderly nondisabled adults had previously been limited in most states to certain groups (for example, parents and pregnant women), we expected that Medicaid expansion might have had stronger effects on some subgroups (such as men and childless adults) whose members were less likely than others were to be eligible for Medicaid before the expansion. Accordingly, we conducted subgroup analyses for the uninsurance rate to assess whether the Medicaid expansions had larger effects on some subgroups than on others. Specifically, we estimated models with full interactions between the covariates and each subgroup variable. We present results for 2015 by sex, parental status (defined as being a parent to at least one child younger than age eighteen in the household), race/ethnicity (non-Hispanic white, non-Hispanic black,

Hispanic, and non-Hispanic Asian or other race), age range (ages 19–35 versus ages 36–64), and residence in a metropolitan area or in another area. All analyses were conducted using Stata, version 14.0.

LIMITATIONS Our analysis had important limitations. First, despite our quasi-experimental design, we cannot conclusively attribute causality to our findings because of the observational nature of the data. In particular, although we present estimates for changes in insurance status for both expansion and nonexpansion states, we are more confident in our estimates of the differences between these two groups of states than in our estimates for each group, since other events around the time that the ACA expansion was implemented could have influenced insurance coverage for both groups of states.

Second, the questions on insurance status and family income in the NHIS do not use the same timing. Insurance status is measured at the time of the survey. Questions about family income refer to self-reported income for the previous calendar year. To the extent that family income fluctuated from year to year, our sample of adults with incomes of no more than 138 percent of poverty may be imprecise.

Third, as is the case in most surveys, income measurement in the NHIS is subject to error and does not map directly to how income is used to determine Medicaid eligibility.[10] Taken together, these limitations mean that our sample likely included some adults who were not actually eligible for Medicaid in expansion states and excluded some adults who were eligible.

Study Results

CHANGES IN THE UNINSURANCE RATE Consistent with previous evidence,[1] Exhibit 1 shows that the percentage of low-income adults who were uninsured was higher in nonexpansion states than the percentage in expansion states even before 2014. Trends in this rate were fairly flat, which led to a steady difference in the uninsurance rate between the two groups of states. For instance, in 2013 the difference in the uninsurance rate was nearly 12 percentage points, with about 35 percent of low-income adults uninsured in states that subsequently expanded Medicaid compared to nearly 47 percent in nonexpansion states.

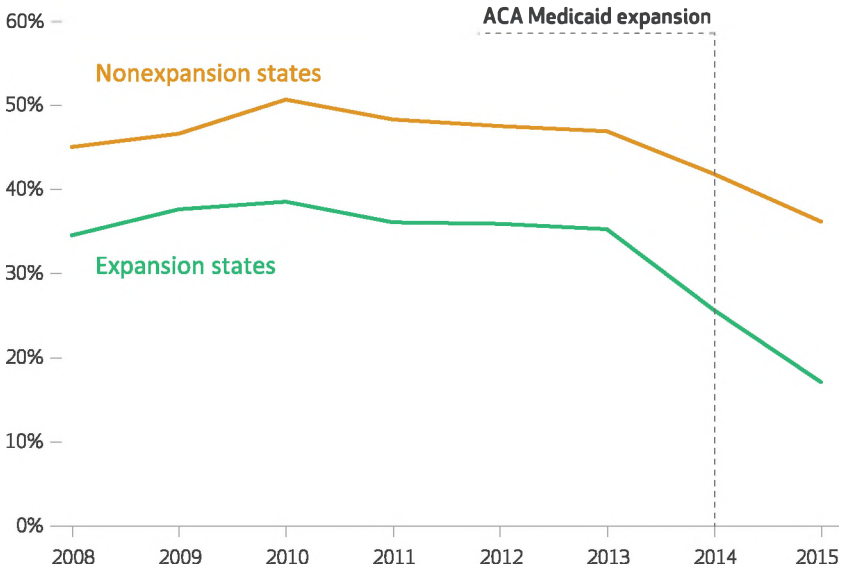
Beginning in 2014 the uninsurance rate declined in both groups of states, with the decline steeper in expansion states. The previous 12-percentage-point gap in the uninsurance rate for low-income adults widened to a gap of about 16 percentage points in 2014 and to one of about 19 percentage points in 2015. From 2013 to 2015 the uninsurance rate fell 18.2 percentage points in expansion states and 10.7 percentage points in nonexpansion states—a difference of 7.5 percentage points.

Consistent with the trends shown in Exhibit 1, the regression estimates from our difference-in-differences model demonstrate that the percentage of low-income adults who were uninsured decreased in both expansion and nonexpansion states in both 2014 and 2015, but decreased more rapidly in expansion states (Exhibit 2). In 2015 the regression-adjusted decline in the uninsurance rate was about 6.8 percentage points greater in expansion compared to nonexpansion states (compared to the unadjusted estimate of 7.5 percentage points). This was larger than the difference of 4.6 percentage points for 2014 alone. The difference between the two years was significant at the 10 percent level.[11]

CHANGES IN INSURANCE COVERAGE BY TYPE OF COVERAGE When we examined changes in coverage for low-income adults by source, we found that Medicaid or CHIP coverage increased 7.3 percentage points more in expansion compared to nonexpansion states in 2014 (Exhibit 2). This difference grew to 13.9 percentage points in 2015. As expected, Medicaid coverage increased only slightly in nonexpansion states in either year. The small increase was probably due to

EXHIBIT 1

Percentages of low-income nonelderly adults in Medicaid expansion and nonexpansion states who were uninsured, 2008–15



SOURCE Authors' analysis of data for 2008–15 from the National Health Interview Survey (NHIS). **NOTES** The sample consisted of 97,224 respondents to the NHIS ages 19–64 who had family incomes of up to 138 percent of the federal poverty level and who lived in an expansion state (defined as a state that expanded eligibility for Medicaid in 2014) or a nonexpansion state (defined as a state that did not expand eligibility in either 2014 or 2015). Five states and the District of Columbia expanded Medicaid under the Affordable Care Act (ACA) before 2014, and we considered them to be expansion states. Sample weights were used to produce nationally representative estimates.

EXHIBIT 2

Changes in 2014 and 2015 in insurance status for low-income adults in Medicaid expansion and nonexpansion states

	2014 (percentage-point change relative to 2008–13)			2015 (percentage-point change relative to 2008–13)		
	Expansion states	Nonexpansion states	Difference	Expansion states	Nonexpansion states	Difference
2014 EXPANSION STATES COMPARED TO NONEXPANSION STATES						
(1) Uninsured	−10.48***	−5.92***	−4.56**	−17.96*** [a]	−11.20*** [a]	−6.77*** [c]
SE	(1.67)	(1.28)	(1.82)	(1.75)	(1.78)	(2.00)
(2) Medicaid or CHIP	9.14***	1.88***	7.26***	15.81*** [a]	1.95*	13.86*** [c]
SE	(1.94)	(0.82)	(1.88)	(2.45)	(1.15)	(2.25)
(3) Private						
All private	2.09**	4.47***	−2.38**	2.92**	10.10*** [a]	−7.18*** [a]
SE	(0.95)	(0.75)	(1.08)	(1.34)	(1.36)	(1.58)
Individual market	1.95***	3.12***	−1.17*	2.79***	6.70*** [a]	−3.91** [b]
SE	(0.35)	(0.53)	(0.60)	(0.61)	(1.48)	(1.57)
Other private	0.14	1.35**	−1.21	0.13	3.40*** [c]	−3.26**
SE	(0.88)	(0.55)	(0.99)	(1.05)	(0.92)	(1.27)
(4) Coverage better than the year before	6.21***	1.42	4.79***	4.41***	2.30**	2.11*
SE	(1.28)	(1.15)	(1.32)	(1.25)	(1.06)	(1.12)
2014 AND 2015 EXPANSION STATES COMPARED TO NONEXPANSION STATES						
(5) Uninsured	—[d]	—[d]	—[d]	−17.35***	−11.40***	−5.96***
SE	—[d]	—[d]	—[d]	(1.65)	(1.80)	(2.03)

SOURCE Authors' analysis of data for 2008–15 from the National Health Interview Survey. **NOTES** The sample size for rows 1–3 is 97,224, as indicated in the text. The sample size for row 4 is 46,254, as also indicated in the text. The sample size for row 5 is 101,705, it includes the three states that expanded Medicaid in 2015. Estimates were obtained from linear probability regression models that included controls for respondents' age, sex, race/ethnicity, education, marital status, employment status, residence inside or outside of a metropolitan area, and citizenship status; a linear quarterly time trend; and state fixed effects. Models also included 2014 and 2015 dummy variables and the interaction between these variables and state Medicaid expansion status (expansion and nonexpansion states are defined in the Notes to Exhibit 1). Sample weights were used to produce nationally representative estimates, and standard errors were clustered at the state level. Asterisks are used to denote the significance of the estimate overall. Superscripts a, b, and c indicate that the 2015 estimate to the left of the superscript is significantly different from the analogous estimate for 2014 at the specified level. CHIP is Children's Health Insurance Program. [a]$p < 0.01$ [b]$p < 0.05$ [c]$p < 0.10$ [d]2014 estimates for models that include states that did not expand Medicaid until 2015 are not shown. **$p < 0.05$ ***$p < 0.01$

the welcome mat (or woodwork) effect—that is, an increase in participation in Medicaid among adults who were already eligible for the program (as a result of publicity about the ACA expansion, increased enrollment efforts, or other factors).[12]

Private insurance (primarily nongroup coverage) increased in both expansion and nonexpansion states in 2014 and 2015. The gains in expansion states could be due either to other factors changing in 2014 that affected both groups of states or to imprecise income measurements in the NHIS that incorrectly reported some individuals as having incomes below 138 percent of poverty when in fact they had higher incomes and thus were eligible for subsidized coverage in the health insurance Marketplaces rather than Medicaid.

We did not observe any significant decreases in private coverage in expansion states. This implies that increases in Medicaid coverage in expansion states came from low-income adults who would have otherwise been uninsured, not from people who dropped private coverage to sign up for Medicaid. In other words, we did not observe any direct crowd-out of private insurance as a result of the Medicaid expansion.

As expected, we found that the increase in private coverage was considerably larger in nonexpansion states, compared to expansion states, in both 2014 and 2015. The increase in private coverage in nonexpansion states is likely primarily attributable to adults with incomes of 100–138 percent of poverty—who would have been eligible for subsidized Marketplace coverage in nonexpansion states but not in expansion states (where they qualified for Medicaid instead). We found some evidence for this in sensitivity analyses by income.[13]

In terms of the quality of coverage, we found that, compared to low-income adults in nonexpansion states, those in expansion states were significantly more likely to report that their health insurance coverage was better than the year before in both 2014 and 2015. Specifically,

we estimated a difference-in-differences effect of about 5 percentage points in 2014, which declined to about 2 percentage points in 2015. The decline in this point estimate could be due to the fact that people who gained coverage in 2014 would presumably report that their coverage had improved in 2014 but not in 2015. However, the estimated improvement in quality of coverage was not significantly different for 2015, compared to 2014.

SUBGROUP ANALYSIS OF CHANGES IN THE UNINSURANCE RATE When we examined changes in the uninsurance rate by subgroup in 2015 (Exhibit 3), we found that the largest difference was between parents and childless adults. In 2015 Medicaid expansion was associated with an 11.3-percentage-point decline in the uninsurance rate for childless adults in expansion states, compared to those in nonexpansion states. Meanwhile, the difference-in-differences estimate for parents was a decline of 0.6 percentage point, which was not significant. Our results indicate that childless adults, who were less likely to be eligible for Medicaid before the ACA compared to parents, were particularly likely to gain insurance in expansion states under the ACA.

EXHIBIT 3

Uninsurance rates for low-income adults in Medicaid expansion and nonexpansion states in 2015 compared to 2008–13, among selected subgroups

	2008–13 mean (percent)		Regression estimates of chanes in uninsurance rate as of 2015 (percentage points)		
Subgroup	(1) Expansion state	(2) Nonexpansion state	(3) Expansion state	(4) Nonexpansion state	(5) Difference
Parent (ref)	34.98	51.99***	−13.36***	−13.06***	−0.60
SE	(2.82)	(3.46)	(1.85)	(2.00)	(2.00)
Childless adult	37.41	44.46**	−20.88*** [a]	−9.58*** [c]	−11.30*** [a]
SE	(3.05)	(1.85)	(2.18)	(2.11)	(2.67)
Male (ref)	43.00	52.71***	−20.76***	−11.50***	−9.26***
SE	(2.73)	(2.20)	(1.66)	(1.39)	(1.97)
Female	30.74	43.49***	−15.77 [a]	−11.09***	−4.68** [a]
SE	(2.65)	(2.56)	(2.07)	(2.41)	(2.23)
Resident of metro area (ref)	36.26	47.82***	−17.22***	−10.82***	−6.40***
SE	(3.18)	(2.50)	(1.92)	(2.03)	(2.31)
Resident of other area	36.90	46.92***	−22.03***	−11.14***	−10.89***
SE	(2.30)	(2.13)	(2.80)	(2.14)	(2.67)
Ages 19–35 (ref)	37.89	49.57***	−17.48***	−11.83***	−5.65**
SE	(2.73)	(2.83)	(2.27)	(1.77)	(2.24)
Ages 36–64	34.90	45.70***	−18.58***	−10.74***	−7.83***
SE	(2.85)	(2.08)	(1.77)	(2.46)	(2.50)
Non-Hispanic white (ref)	30.05	40.35***	−19.11***	−12.49***	−6.62***
SE	(1.69)	(1.51)	(2.18)	(2.42)	(2.41)
Non-Hispanic black	28.48	42.62***	−16.83***	−12.96***	−3.86*
SE	(2.09)	(1.07)	(2.29)	(1.57)	(2.14)
Hispanic	51.02	67.55***	−17.06***	−7.48*** [c]	−9.58***
SE	(2.74)	(2.59)	(1.76)	(1.87)	(2.29)
Non-Hispanic Asian or other race	32.80	48.48***	−14.07*** [c]	−5.42	−8.64
SE	(2.90)	(3.90)	(2.79)	(5.82)	(5.94)

SOURCE Authors' analysis of data for 2008–15 from the National Health Interview Survey. **NOTES** The samples of expansion and nonexpansion states are defined in the Notes to Exhibit 1. States that expanded Medicaid in 2015 were excluded from this analysis. *Parental status* was defined as being a parent to at least one child younger than age eighteen in the household. Estimates in columns 3–5 were obtained from linear probability regression models (explained in the Notes to Exhibit 2). Mean uninsurance rates for 2008–13 are provided in columns 1 and 2, for comparison to columns 3–5. To test for the significance of differences between subgroups, pooled models with interactions between all covariates and the subgroup variables were estimated. Sample weights were used to produce nationally representative estimates, and standard errors (the numbers in parentheses) were clustered at the state level. Asterisks are used to denote the significance of the estimate overall. Superscripts a and c indicate that the estimate to the left of the superscript is significantly different from the analogous estimate for the reference group at the specified level. [a] $p < 0.01$ [c] $p < 0.10$ *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

The difference-in-differences estimate for men was significantly larger than that for women: Medicaid expansion was associated with a 9.3-percentage-point drop in the uninsurance rate for men in expansion compared to nonexpansion states but with a 4.7-percentage-point drop for women. This result indicates that Medicaid expansion helped narrow a preexisting disparity in coverage (between men and women), but only in expansion states.

The uninsurance rate also appeared to decrease more after Medicaid expansion in rural areas compared to urban areas, although this difference was not significant. Similarly, expansion was associated with larger gains in coverage for adults ages 36–64 than for those ages 19–35 and for Hispanics than for whites, but these differences were not significant.

Discussion

Using high-quality, nationally representative government survey data, we found that the Medicaid expansion's effects on coverage among low-income adults continued to increase in 2015. The magnitude of the estimated improvement in the uninsurance rate after Medicaid expansion was similar in regression-adjusted models to the improvement in simple graphical analyses, which adds credibility to our results.

The results indicate that the benefits of Medicaid expansion identified in other research, such as improved access to care, quality of care, and self-reported health,[1,14,15] are likely to grow substantially over time as enrollment grows. Although previous work has reported changes in insurance status in 2015 typically using data from polling or from Internet or phone surveys,[2–4,16] our study uses a gold-standard federal government survey to analyze coverage changes for low-income adults; it is the first to analyze coverage effects for subgroups of adults.

The differential decline in the uninsurance rate in expansion states was mainly attributable to an increase in public coverage, as would be expected with expanded Medicaid eligibility. We found no decline in private coverage in expansion states, which suggests that new Medicaid eligibility did not lead people to drop private coverage to enroll in Medicaid. This is consistent with one analysis of the ACA's effects using census data[17] but differs from the results of another recent study.[18]

We did find a greater increase in private nongroup coverage in nonexpansion states, compared to expansion states. To the extent that this was due to the existence of Marketplace subsidies in nonexpansion states for people with family incomes of 100–138 percent of poverty, this differential change in private coverage would be fundamentally different than the traditional notion of crowd-out, in which public coverage expansion leads directly to a reduction in private insurance.[19] Distinguishing between those patterns of effects has important policy implications. However, since both types of coverage gains (Medicaid in expansion states and subsidized Marketplace coverage in nonexpansion states) stem directly from the ACA, they would likely both be reversed were the law to be repealed.

Our subgroup analyses indicated that Medicaid expansion produced its largest coverage gains among men and childless adults. This presumably reflects the fact that these groups were less likely than others to be eligible for Medicaid in most states before the ACA's Medicaid expansion. Whether improvements in access to care are also more concentrated in these groups is a worthwhile subject for future research.

Finally, part of the debate over state-level Medicaid expansion and federal consideration of ACA repeal focuses on the quality of Medicaid coverage, and our findings offer insights into this question. Our results show that not only did the Medicaid expansion increase coverage rates in 2014 and 2015, but it also improved the perceived quality of insurance coverage among low-income adults. This is valuable evidence, consistent with other analyses of Medicaid expansion,[1,18,19] that the ACA has produced important benefits for consumers.

Conclusion

Research on the effects of the Medicaid expansions as well as other provisions of the ACA will be critical to understanding the potential impacts of any future congressional consideration of ACA repeal, replacement, or modification, as well as state decisions to continue or initiate Medicaid expansions. Our findings offer new evidence that the ACA continues to produce large increases in coverage and improved quality of health insurance for millions of Americans. ■

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NOTES

1 Wherry LR, Miller S. Early coverage, access, utilization, and health effects associated with the Affordable Care Act Medicaid expansions: a quasi-experimental study. Ann Intern Med. 2016;164(12):795–803.

2 Sommers BD, Gunja MZ, Finegold K, Musco T. Changes in self-reported insurance coverage, access to care, and health under the Affordable Care Act. JAMA. 2015;314(4):366–74.

3 Collins SR, Rasmussen PW, Doty MM, Beutel S. The rise in health care coverage and affordability since health reform took effect [Internet]. New York (NY): Commonwealth Fund; 2015 Jan [cited 2017 Mar 24]. (Issue Brief). Available from: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf

4 Shartzer A, Long SK, Karpman M, Kenney GM, Zuckerman S. QuickTake: insurance coverage gains cross economic, social, and geographic boundaries [Internet]. Washington (DC): Urban Institute; 2015 Apr 27 [cited 2017 Mar 24]. Available from: http://hrms.urban.org/quicktakes/Insurance-Coverage-Gains-Cross-Economic-Social-and-Geographic-Boundaries.html

5 To access the Appendix, click on the Appendix link in the box to the right of the article online.

6 Five states (California, Connecticut, Minnesota, New Jersey, and Washington) and the District of Columbia expanded Medicaid under the ACA before 2014, and we considered them to be expansion states. Estimates of the effects of the ACA's Medicaid expansion on uninsurance rates in 2014 and 2015 are provided for these five states and the District of Columbia alone, and for the states that expanded Medicaid in 2014 alone, in Appendix Exhibit B (see Note 5).

7 Sommers BD, Buchmueller T, Decker SL, Carey C, Kronick R. The Affordable Care Act has led to significant gains in health insurance and access to care for young adults. Health Aff (Millwood). 2013;32(1):165–74.

8 Bertrand M, Duflo E, Mullainathan S. How much should we trust differences-in-differences estimates? Q J Econ. 2004;119(1):249–75.

9 For example, for the uninsurance rate outcome, the *p* value for the interaction between Medicaid expansion status and the linear quarterly trend was 0.62.

10 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Data sources for Modified Adjusted Gross Income (MAGI) conversions [Internet]. Washington (DC): ASPE; 2013 Feb 4 [cited 2017 Mar 24]. (Issue Brief). Available from: https://aspe.hhs.gov/basic-report/data-sources-modified-adjusted-gross-income-magi-conversions

11 As explained in Note 6, estimates of the 2014 and 2015 effects of the ACA's Medicaid expansion on the uninsurance rate are provided for only the early expansion states and for only the states that expanded in 2014 in Appendix Exhibit B (see Note 5). Estimates in the Appendix exhibit for early expansion states alone are similar to the estimates in Exhibit 2 for all expansion states. This is consistent with evidence from the item cited below in this note that the effects of early expansion were small. Estimates in the Appendix exhibit for 2014 expansion states, excluding early expansion states, are smaller than those in Exhibit 2 for all expansion states, although the differences are small. See Sommers BD, Arntson E, Kenney GM, Epstein AM. Lessons from early Medicaid expansions under health reform: interviews with Medicaid officials. Medicare Medicaid Res Rev. 2013;3(4):E1–19.

12 Sommers BD, Epstein AM. Why states are so miffed about Medicaid—economics, politics, and the "woodwork effect." N Engl J Med. 2011;365(2):100–2.

13 Although not subsidized, insurance coverage among people with income below poverty could have increased as a result of other ACA provisions, including the availability of private insurance through the Marketplace regardless of preexisting conditions. However, since premium subsidies were available only for families with incomes above poverty, most private insurance increases in nonexpansion states likely came from this group. Appendix Exhibit C shows private insurance rate outcomes for the sample with incomes below poverty (see Note 5). Point estimates for increases in private insurance in nonexpansion states for nonelderly adults with incomes below poverty were somewhat lower than estimates for the full sample of low-income adults.

14 Sommers BD, Blendon RJ, Orav EJ. Both the "private option" and traditional Medicaid expansions improved access to care for low-income adults. Health Aff (Millwood). 2016;35(1):96–105.

15 Cole MB, Galárraga O, Wilson IB, Wright B, Trivedi AN. At federally funded health centers, Medicaid expansion was associated with improved quality of care. Health Aff (Millwood). 2017;36(1):40–8.

16 Long SK, Karpman M, Kenney GM, Zuckerman S, Wissoker D, Shartzer A, et al. Taking stock: gains in health insurance coverage under the ACA as of March 2015 [Internet]. Washington (DC): Urban Institute; 2015 Apr 16 [cited 2017 Mar 24]. Available from: http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.html

17 Frean M, Gruber J, Sommers BD. Premium subsidies, the mandate, and Medicaid expansion: coverage effects of the Affordable Care Act [Internet]. Cambridge (MA): National Bureau of Economic Research; 2016 Apr [cited 2017 Mar 24]. (NBER Working Paper No. 22213). Available for download (fee required) from: http://www.nber.org/papers/w22213

18 Kaestner R, Garrett B, Gangopadhyaya A, Fleming C. Effects of ACA Medicaid expansions on health insurance coverage and labor supply [Internet]. Cambridge (MA): National Bureau of Economic Research; 2015 Dec [cited 2017 Mar 24]. (NBER Working Paper No. 21836). Available for download (fee required) from: http://www.nber.org/papers/w21836

19 Gruber J, Simon K. Crowd-out 10 years later: have recent public insurance expansions crowded out private health insurance? J Health Econ. 2008;27(2):201–17.

The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal

May 3, 2017

Authors

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Citation

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Abstract

Issue: By increasing health insurance coverage, the Affordable Care Act's Medicaid eligibility expansion was also expected to lessen the uncompensated care burden on hospitals. The expansion currently faces an uncertain future.
Goal: To compare the change in hospitals' uncompensated care burden in the 31 states (plus the District of Columbia) that chose to expand Medicaid to the changes in states that did not, and to estimate how these expenses would be affected by repeal or further expansion.
Methods: Analysis of uncompensated care data from Medicare Hospital Cost Reports from 2011 to 2015.
Findings and Conclusions: Uncompensated care burdens fell sharply in expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs. Estimated savings across all hospitals in Medicaid expansion states totaled $6.2 billion. The largest reductions in uncompensated care were found for hospitals in expansion states that care for the highest proportion of low-income and uninsured patients. Legislation that scales back or eliminates

Medicaid expansion is likely to expose these safety-net hospitals to large cost increases. Conversely, if the 19 states that chose not to expand Medicaid were to adopt expansion, their uncompensated care costs also would decrease by an estimated $6.2 billion.

Background

Prior to the Affordable Care Act (ACA), childless, nondisabled adults were ineligible for Medicaid in most states. The ACA allowed states to expand eligibility to nonelderly adults with incomes up to 138 percent of the federal poverty level (roughly $16,400 for an individual and $33,600 for a family of four in 2017). As of March 2017, 31 states and the District of Columbia had expanded Medicaid, while 19 states had not.[1(#/#1)]

One intended benefit of the Medicaid expansion was to reduce uncompensated care burdens that hospitals face. Uncompensated care is any treatment or service not paid for by an insurer or patient. We define uncompensated care costs as the sum of a hospital's losses on both charity care (when hospitals forgo or reduce the cost of care) and bad debt (when hospitals bill for services but cannot collect payment).

Our previous research, detailed in a 2016 *Health Affairs* article (http://content.healthaffairs.org/content/35/8/1471.abstract), found that hospitals in Medicaid-expansion states experienced a sizeable reduction in their uncompensated care costs between 2013 and 2014, from 4.1 percentage points to 3.1 percentage points of operating costs.[2(#/#2)] To see if this uncompensated care decrease has continued, we extended our analysis to 2015 and explored which hospitals saw the greatest decreases in uncompensated care costs.

This issue brief is intended to guide decisions around a possible ACA repeal and further state Medicaid expansions, as well as inform policies aimed at alleviating hospitals' uncompensated care burden. In 2015, U.S. hospitals provided a total of $35.7 billion in uncompensated care, according to the American Hospital Association.[3(#/#3)] However, this burden is unevenly distributed. Safety-net hospitals care for a larger-than-typical share of low-income and uninsured patients. In the past, Medicare and Medicaid disproportionate share hospital (DSH) payments provided significant financial relief to safety-net hospitals. But the ACA mandates a sizeable reduction in DSH payments.

Findings

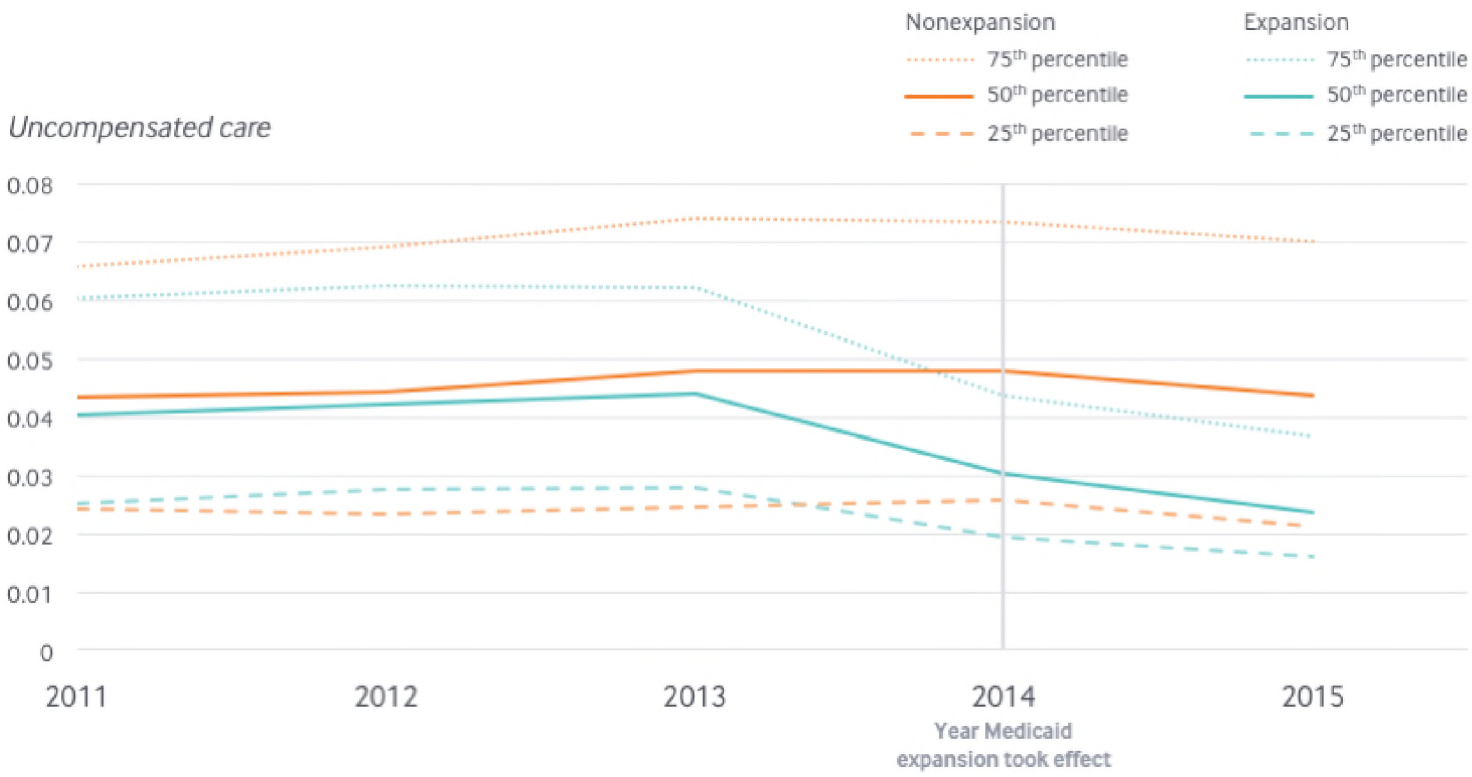
Uncompensated Care Declines in Expansion States Are Substantial Relative to Profit Margins

To identify trends in uncompensated care burdens for hospitals in expansion and nonexpansion states, we used data from Medicare Hospital Cost Reports to create a sample of 1,154 hospitals that report financial data for the calendar year. Focusing on hospitals within the 75th percentile, 50th percentile, and 25th percentile of the uncompensated care cost distribution, we found that between 2013 and 2014, these costs markedly declined in expansion states, and this downward trend continued into 2015 (Exhibit 1). The trajectories of uncompensated care costs were similar for hospitals across the three percentiles. In contrast, we found no similar break from historical trend in nonexpansion states.

Exhibit 1

Uncompensated Care by Medicaid Expansion Status, Year, and Percentile of Uncompensated Care

Percent adults ages 19-64



Note: Uncompensated care is presented as a share of operating costs.

Data: 2011-2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

Share

The decline in uncompensated care costs in expansion states is economically meaningful. For example, the share of uncompensated care costs between 2013 and 2015 fell from just over 6.2 percent to just under 3.7 percent of operating costs among hospitals with high burdens. Overall, this is a cumulative decrease of roughly 40 percent. The decreases among hospitals with medium and low uncompensated care burdens were smaller but also meaningful: 2 percentage points and 1.2 percentage points of operating costs, respectively.

These results suggest that all hospitals benefited from the expansion and that the hospitals that had the highest levels of uncompensated care prior to 2014 benefited the most. Pooling the hospitals in expansion states together, we found that uncompensated care costs decreased between 2013 and 2015 from 3.9 percentage points to 2.3 percentage points of operating costs, a decline of 1.6 percentage points of operating costs.

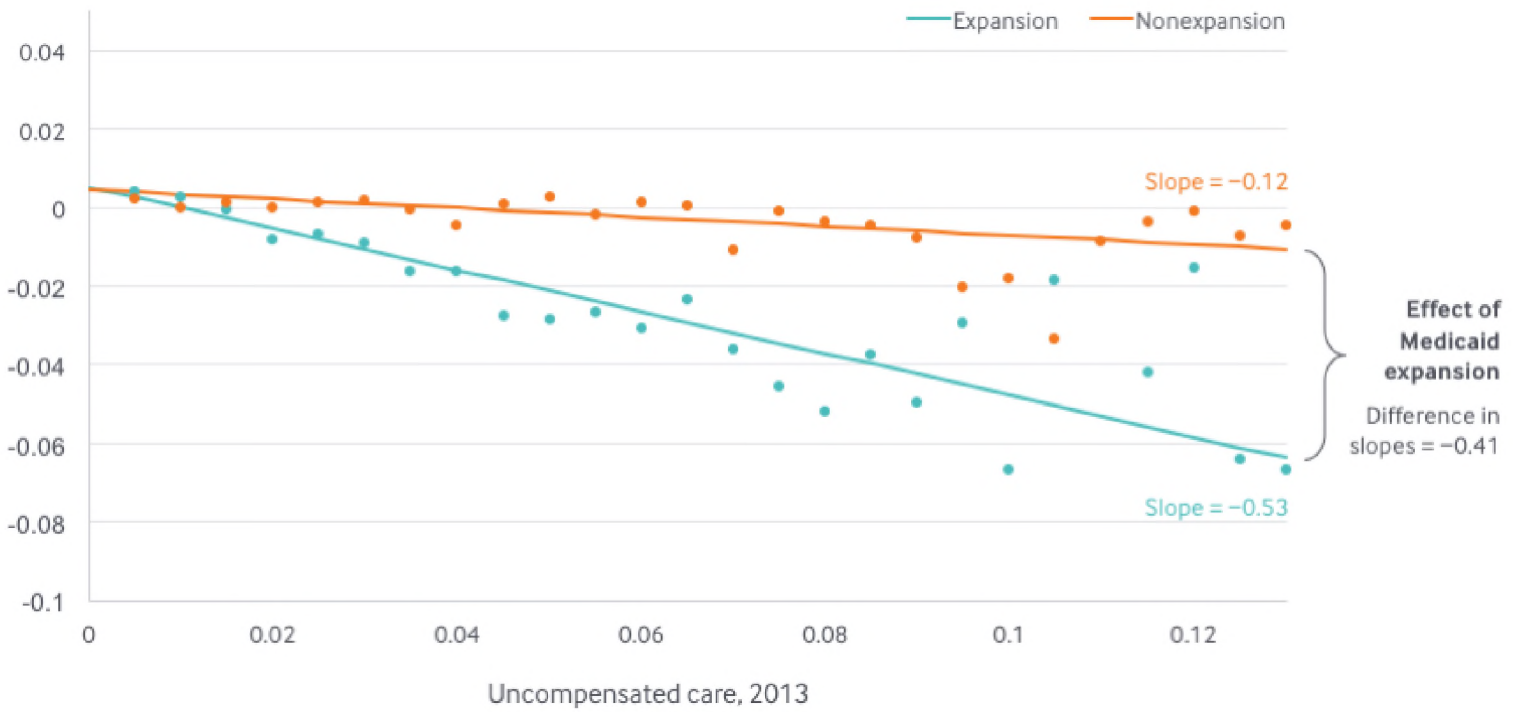
These reductions in uncompensated care costs are substantial relative to hospital profit margins. Roughly 40 percent of hospitals in our sample had operating margins less than 1.6 percentage points of operating costs in 2011.

For Every Dollar of Uncompensated Care Costs Hospitals in Expansion States Had in 2013, the ACA Erased 41 Cents by 2015

While hospitals in nonexpansion states did not experience dramatic declines in uncompensated care costs between 2013 and 2015, they did see small declines in these costs of 0.3–0.4 percentage points. To identify how much hospitals saved in uncompensated care costs from the Medicaid expansion versus other market changes, we conducted a trend analysis, computing the average change in uncompensated care costs from 2013 to 2015 (Exhibit 2).

Exhibit 2

Change in Uncompensated Care Costs, 2013-2015



Notes: Uncompensated care is presented as a share of operating costs. Hospitals are placed into bins based on their 2013 uncompensated care costs. For each bin, we then calculate the average change in uncompensated care costs from 2013 to 2015. Bins for expansion states are presented as teal dots, bins for nonexpansion states are presented as orange dots. The orange line is a regression line through the nonexpansion hospitals, and the teal line is a regression line through the expansion hospitals. For computing the least squares lines, uncompensated care values above or below the 2.5 percentile or 97.5 percentile are replaced with values at those respective percentiles. For creating the bins, we replace all hospitals above 13 percentage points of operating costs with 13 percentage points of operating costs.

Data: 2011-2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

Hospitals in Medicaid expansion states saw their uncompensated care costs decline by 0.53 percentage points between 2013 and 2015 for each additional percentage point of uncompensated care costs in 2013. In comparison, hospitals in nonexpansion states saw their uncompensated costs fall by only 0.12 percentage points for each

additional percentage point of uncompensated costs.

Overall, these estimates suggest that Medicaid expansion cut every dollar that a hospital spent on uncompensated care by 41 cents between 2013 and 2015.[4(#/#4)] Scaling these numbers to all hospitals in the 31 states (plus the District of Columbia) that expanded eligibility suggests that offering Medicaid to nonelderly adults reduced uncompensated care costs in these states by nearly $6.2 billion.[5(#/#5)]

If the 19 nonexpansion states were to expand Medicaid, uncompensated care in those states would fall from 6.1 percent of operating costs to an estimated 3.6 percent. This would reduce uncompensated care by $6.2 billion, the same amount as in the 31 states (plus D.C.) that expanded Medicaid. That is because prior to the ACA taking effect, hospitals in both groups of states had the same amount, dollarwise, of uncompensated care. Despite being much smaller in population than the expansion states, the nonexpansion states tend to have higher uncompensated care burdens.

Medicaid Expansion Reduced Uncompensated Care Burdens for Safety-Net Hospitals Not "Made Whole" by Medicaid DSH Payments

We also explored how the Medicaid expansion specifically impacted uncompensated care costs in safety-net hospitals compared to other hospitals. First we divided hospitals by their share of patients on Medicaid, which is one common measure of whether a hospital is a safety-net provider (Exhibit 3).

Exhibit 3

Uncompensated Care Costs by Medicaid Share, 2013-2015

	2013	2015	Change, 2013–2015
High 2013 hospital Medicaid share (>11%)			
Expansion states	0.049	0.029	−0.020
Nonexpansion states	0.061	0.057	−0.004
Difference	−0.012	−0.028	−0.016
Medium 2013 hospital Medicaid share (3.9%–11%)			
Expansion states	0.039	0.023	−0.016
Nonexpansion states	0.053	0.055	0.002
Difference	−0.014	-0.031	−0.017
Low 2013 hospital Medicaid share (<3.9%)			
Expansion states	0.030	0.019	−0.011
Nonexpansion states	0.033	0.032	−0.001
Difference	−0.003	−0.013	−0.010

Notes: Uncompensated care is presented as a share of operating costs. Uncompensated care values above or below the 2.5 percentile or the 97.5 percentile are replaced with values at those respective percentiles.

Data: 2011-2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

In expansion states, hospitals with the highest Medicaid shares in 2013 had slightly larger decreases in uncompensated care costs than hospitals with the lowest shares (0.020% vs. 0.011% of operating costs). While statistically significant, the relationship is weak.

This finding does not suggest that "safety net" hospitals are not benefiting from the Medicaid expansion. Instead, it indicates that looking only at Medicaid share is inadequate for identifying safety-net hospitals. To illustrate this point, we categorized hospitals by their total uncompensated and undercompensated care burden (Exhibit 4).[6 (#/#6)] This analysis considered shortfalls from all low-income patients, including the uninsured as well as those covered under Medicaid and the Children's Health Insurance Program. We also included safety-net compensation that is tied to serving these patients, such as Medicaid DSH payments, to determine whether these supplemental payments provide adequate financial assistance.

Exhibit 4

Uncompensated Care Costs by Total Uncompensated Care Burden, 2013-2015

	2013	2015	Change, 2013–2015
High 2013 burden (>7.9% of operating costs)			
Expansion states	0.071	0.038	−0.033
Nonexpansion states	0.093	0.086	−0.007
Difference	−0.022	-0.048	−0.026
Medium 2013 burden (4.7%–7.9% of operating costs)			
Expansion states	0.042	0.025	−0.017
Nonexpansion states	0.053	0.052	−0.001
Difference	−0.011	−0.027	−0.016
Low 2013 burden (<4.7% of operating costs)			
Expansion states	0.021	0.016	−0.006
Nonexpansion states	0.029	0.030	0.001
Difference	−0.008	−0.015	−0.007

Notes: Uncompensated care is presented as a share of operating costs. Uncompensated care values above or below the 2.5 percentile or the 97.5 percentile are replaced with values at those respective percentiles.

Data: 2011-2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

This analysis provides strong evidence that hospitals with higher overall uncompensated and undercompensated care burdens in 2013 benefited more from the Medicaid expansion than hospitals without large low-income populations. For example, among hospitals with the highest burdens, those in expansion states saw uncompensated care costs decrease by 2.6 percentage points more than hospitals in nonexpansion states. By contrast, among hospitals with the lowest safety-net burdens, those in expansion states saw uncompensated care costs decrease by only 0.7 points more than hospitals in nonexpansion states.

Hospitals that have benefited from the Medicaid expansion are hospitals that faced substantial shortfalls from serving low-income and uninsured populations. Existing federal funding mechanisms like DSH payments were not designed to mitigate shortfalls of this size. This analysis suggests that eliminating the Medicaid expansions and restoring Medicaid DSH as the primary mechanism for supplementary reimbursement to safety-net hospitals will reintroduce systematic disparities in hospital uncompensated care burdens. It also suggests that, if the Medicaid expansions are eliminated, policymakers will want to consider changing the way DSH payments are targeted so as to include a broader set of metrics.

Conclusion

Our analysis suggests that the Medicaid expansion has met the ACA goal of reducing uncompensated care burdens for hospitals. For each additional dollar spent on hospital services for Medicaid patients in expansion states, hospitals enjoyed an approximate 41-cent reduction in uncompensated care costs. When all hospitals in expansion states are considered, this translates into a $6.2 billion reduction in uncompensated care costs. If the 19 nonexpansion states were to expand Medicaid, uncompensated care costs in those states would, coincidentally, also fall by $6.2 billion.

There have been noticeable, but much smaller, decreases (0.3–0.4 percentage points) in uncompensated care costs in nonexpansion states. An important question beyond the scope of this brief is whether these decreases have been driven by other features or consequences of the ACA (for example, the individual mandate, the health insurance marketplaces, or outreach efforts to increase coverage) or whether other economic or hospital behavior factors are at play.

Further, our analysis suggests that reductions in uncompensated care costs were concentrated among hospitals that had large budget shortfalls from providing care to low-income and uninsured patients prior to the Medicaid expansions. This suggests that the expansions complemented other programs, such as Medicaid DSH payments, that offer help to safety-net hospitals.

The future of the Medicaid expansions remains uncertain. There is a chance that more of the 19 states that have not yet expanded Medicaid will do so in the future. It is also possible that these expansions will be scaled back or eliminated by future legislation. For example, the American Health Care Act, if it had become law, would have ended the ACA Medicaid expansion by 2020 and likely decreased the number of people gaining insurance through the marketplaces. Our results demonstrate the close relationship between the Medicaid program and hospital finances, suggesting there would be large decreases in uncompensated care costs from further expansion and large increases in those costs if the expansions are rolled back.

How This Study Was Conducted

This issue brief updates our 2016 *Health Affairs* article (http://content.healthaffairs.org/content/35/8/1471.abstract), in which we examined the evolution of uncompensated care costs from 2011 to 2014. We extend the analysis to include 2015 and see how these effects have evolved over time. For methodological details, we refer readers to our previous article.[7 (#/#7)]

In this update, we rely on data from the 2011–2015 Medicare Hospital Cost Reports. Our sample is restricted to 1,154 hospitals that report financial data on the calendar year. We created a sample of states that increased Medicaid eligibility for childless adults in 2014 and a sample of states that did not. Six states that made other substantive changes to their Medicaid programs between 2011 and 2015 were excluded.[8 (#/#8)] We dropped hospitals that were not present in all years or had missing or inconsistent data.

We measure a hospital's uncompensated care costs to be the sum of losses from charity care and bad debt, computed as a percentage of total operating costs. To make numbers that are comparable across hospitals of different sizes, we divided each hospital's uncompensated care costs by that hospital's 2011 operating costs. We examine how uncompensated care costs change after the 2014 Medicaid expansions for hospitals in expansion states compared to hospitals in nonexpansion states.[9 (#/#9)] We also examine whether safety-net hospitals (defined using a number of possible criteria) disproportionately benefited from the Medicaid expansion.

Notes

[1] Under the ACA, individuals who earn less than 100 percent of the federal poverty level are not eligible for subsidized coverage in the individual health insurance marketplaces.

[2] D. Dranove, C. Garthwaite, and C. Ody, "Uncompensated Care Decreased at Hospitals in Medicaid Expansion States but Not at Hospitals in Nonexpansion States (http://content.healthaffairs.org/content/35/8/1471.abstract)." *Health Affairs,* Aug. 2016 35(8):1471–79.

[3] American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet (http://www.aha.org/content/16/uncompensatedcarefactsheet.pdf)* (AHA, Dec. 2016).

[4] This is calculated as the differences in slopes between expansion and nonexpansion states: 0.53 – 0.12 = 0.41.

[5] The $6.2 billion figure is based on acute-care and critical-access hospitals filing a cost report and excludes Arizona, California, Massachusetts, and Minnesota. It extrapolates our estimates to all hospitals that had expanded Medicaid as of March of 2017. This includes five states that did not expand in 2014 but have since expanded: Pennsylvania, Indiana, Alaska, Michigan, and Louisiana.

[6] This is based on row 31 of schedule S-10 of the Medicare cost reports and is titled "Total unreimbursed and uncompensated care cost."

[7] See note 2.

[8] We continue the decision in our prior research to discard hospitals in Arizona, California, Massachusetts, and Minnesota. We also exclude Indiana and Pennsylvania because they expanded in 2015.

[9] In our *Health Affairs* article (http://content.healthaffairs.org/content/35/8/1471.abstract), we provide further confirmation that the changes in uncompensated care were, in fact, driven by the Medicaid expansion by illustrating that the decreases were largest for hospitals with populations in their catchment areas with incomes less than 138 percent of the federal poverty level—the new eligibility limit for childless adults.

How the Affordable Care Act Drove Down Personal Bankruptcy

Expanded health insurance helped cut the number of filings by half

By Allen St. John
May 02, 2017

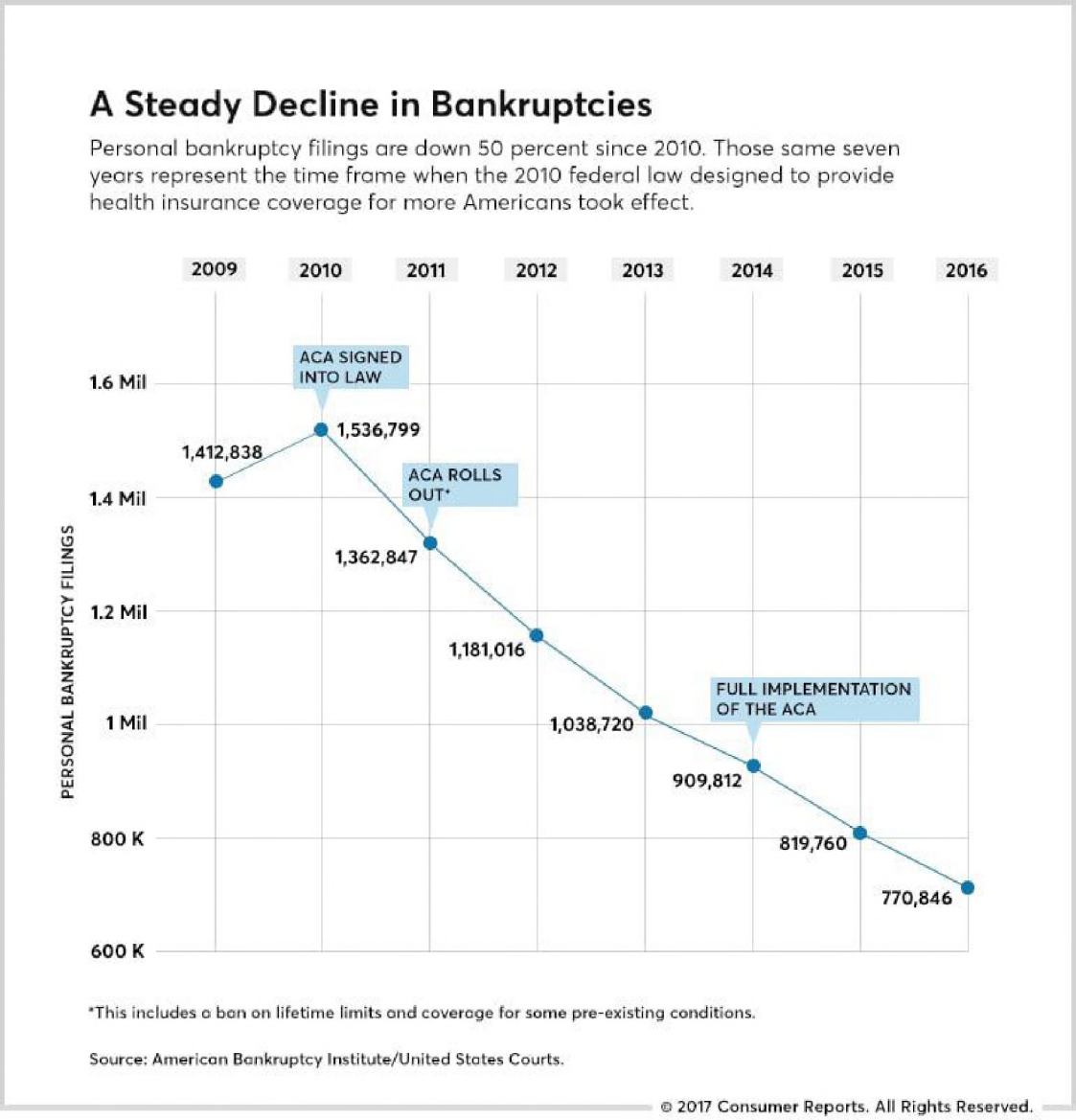
As legislators and the executive branch renew their efforts to repeal and replace the Affordable Care Act this week, they might want to keep in mind a little-known financial consequence of the ACA: Since its adoption, far fewer Americans have taken the extreme step of filing for personal bankruptcy.

Filings have dropped about 50 percent, from 1,536,799 in 2010 to 770,846 in 2016 (see chart, below). Those years also represent the time frame when the ACA took effect. Although courts never ask people to declare why they're filing, many bankruptcy and legal experts agree that medical bills had been a leading cause of personal bankruptcy before public healthcare coverage expanded under the ACA. Unlike other causes of debt, medical bills are often unexpected, involuntary, and large.

"If you're uninsured or underinsured, you can run up a huge debt in a short period of time," says Lois Lupica, a bankruptcy expert and Maine Law Foundation Professor of Law at the University of Maine School of Law.

So did the rise of the ACA—which helped some 20 million more Americans get health insurance—cause the decline in bankruptcies?

The many experts we interviewed also pointed to two other contributing factors: an improving economy and changes to bankruptcy laws in 2005 that made it more difficult and costly to file. However, they almost all agreed that expanded health coverage played a major role in the marked, recent decline.



Some of the most important financial protections of the ACA apply to all consumers, whether they get their coverage through ACA exchanges or the private insurance marketplace. These provisions include mandated coverage for pre-existing conditions and, on most covered benefits, an end to annual and lifetime coverage caps. Aspects of the law, including

provisions for young people to be covered by a family policy until age 26, went into effect in 2010 and 2011, before the full rollout of the ACA in 2014.

“It’s absolutely remarkable,” says Jim Molleur, a Maine-based bankruptcy attorney with 20 years of experience. “We’re not getting people with big medical bills, chronically sick people who would hit those lifetime caps or be denied because of pre-existing conditions. They seemed to disappear almost overnight once ACA kicked in.”

The first attempt to repeal and replace the ACA, in March, failed to gain enough Congressional support and never came to a vote.

Then in April, details of a new replacement plan were released. Although President Donald Trump has said that this new version, like the first bill that was pulled from consideration, will cover pre-existing conditions, the revised law gives states broad latitude to allow insurance companies to increase rates for consumers with an existing illness.

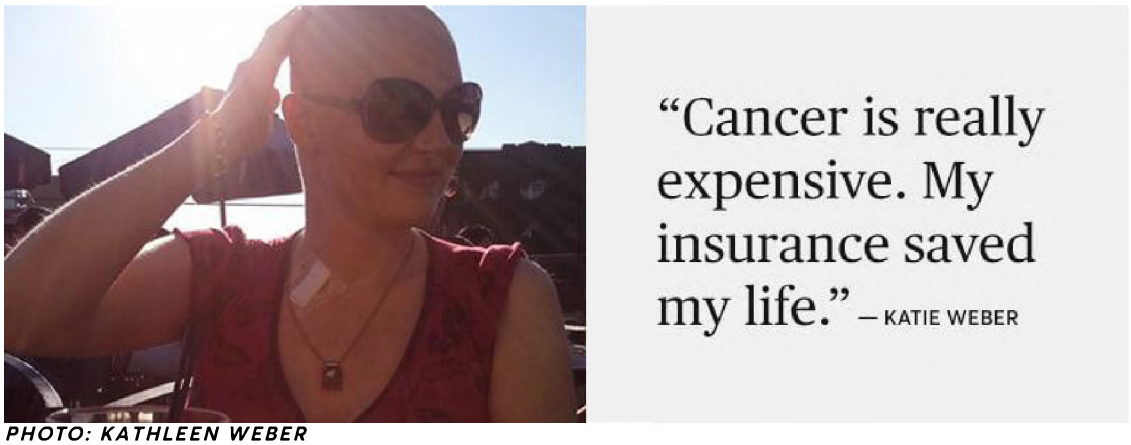


PHOTO: KATHLEEN WEBER

A Rare and Costly Diagnosis

Since the start of the year, more than 2,000 consumers have answered an online questionnaire from Consumer Reports' advocacy and mobilization team, sharing their experiences with the ACA. Katie Weber of Seattle was one of them.

In 2011, she had just landed her first job out of college, as a teacher with AmeriCorps, she explains in a phone interview. That's when the unusual numbness in her hand began, which she—and her doctor—at first mistook for a pinched nerve. Then came debilitating headaches and nausea and, ultimately, a diagnosis of medulloblastoma, a fast-growing cancerous brain tumor.

The treatment for her tumor was straightforward: surgery, radiation, then chemotherapy. Figuring out how to pay for it was much less clear. She worried that the insurance she had through AmeriCorps wouldn't cover enough of her bills.

Hear Katie Weber tell her story.

"It's a lot of money to do all that stuff, and to get all those MRIs."

"My dad said to me, 'Your health is the most important thing. If you have to declare bankruptcy at age 23, it's no big deal,'" Weber says.

Because of the ACA, she says, it never came to that. After her year with AmeriCorps, the new healthcare law enabled her to get coverage under her parents' insurance plan.

The ACA provisions required that the family's insurance company cover her even though she had already been diagnosed with cancer. That would not have been the case

before the ACA, which mandates the coverage of pre-existing conditions for all consumers.

Later, when she aged out of her parents' insurance, Weber was able to enroll in Apple Health, Washington state's version of Medicaid, a program that was expanded once the ACA was passed. That coverage, she says, has been crucial to her financial and medical well-being, especially once the cancer returned last fall.

Weber says she now spends more time discussing treatment options and less time worrying how she'll pay for MRIs and drugs. These are covered in full under her Apple Health policy.

"Cancer is really expensive," she says. "My insurance saved my life."

Numbers Plummet

If you want further testimony about how much personal bankruptcies have dropped over the past decade, talk to Susan Grossberg, a Springfield, Mass., attorney.

For more than 20 years she has helped consumers push the financial reset button when debt triggered by divorce, unemployment, or a costly illness or medical episode became too much to handle. "Medical debt can get really big really quickly," Grossberg says. "When you're in the emergency room they're not checking your credit score while they're caring for you."

With the advent of the ACA—and before that, expanded state healthcare in Massachusetts—she says fewer clients with large medical debts walked through her door.

Grossberg adds that her bankruptcy business has slowed so much that she has been forced to take on other kinds of legal work—landlord-tenant and housing discrimination cases—to cover her own bills.

The American Bankruptcy Institute suggested that veteran Chicago bankruptcy attorney and trustee David Leibowitz could also help parse the reasons for the decadelong decline.

First, he says, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 made it more difficult for consumers to file for bankruptcy. The law required credit counseling and income verification and forced many consumers to seek protection under Chapter 13, which restructures, but does not eliminate, most debt. The piles of paperwork also meant most filers needed a lawyer, which made bankruptcy more costly and therefore not an option for many poor consumers.

Read More of Our Healthcare Coverage

- **House Passes Legislation to Replace the Affordable Care Act**
- **What the GOP Vote to Replace the ACA Means for You**

- **Got a Pre-Existing Condition? Your Premium Could Rise Sharply Under New GOP Plan**
- **CR's Guide to Health Insurance**

Then there was the economy. After a slow and steady recovery following the housing crisis of 2008, Leibowitz explains that American consumers generally had fewer problems with their mortgages, better employment prospects, and greater access to credit, which made them less likely to file.

The final factor, according to Leibowitz, has been the ACA, which afforded health coverage to many more consumers and expanded protections for all.

Of course, not everyone sees such a direct connection between the decline in bankruptcies and the emergence of the ACA.

Thomas P. Miller, resident fellow at the American Enterprise Institute and co-author of "Why ObamaCare is Wrong for America" (HarperCollins, 2011), cautioned against "reaching broad conclusions" because the subject is so complex.

"Certainly there are fewer people declaring bankruptcy, and certainly fewer are declaring bankruptcy because of healthcare spending," he says. But his earlier research suggested that some studies exaggerated the degree to which high healthcare bills cause bankruptcies. "They tended to reflect other problems with credit card balances well beyond healthcare," he says. "It stems from multiple causes."

Figuring Out Why

Over the past decade, determining the cause-and-effect relationship between medical debt and bankruptcy has become a political football, particularly during the years the Obama administration was trying to pass the ACA through Congress.

The truth is that it's not that easy to determine how many bankruptcies are caused by medical debt. Examining the paperwork doesn't always offer insight because debtors often juggle their indebtedness, for example, using a credit card to pay an outstanding medical bill while leaving other debts unpaid.

But a 2014 study from Daniel Austin, a bankruptcy attorney and, at the time, a professor at the Northeastern University School of Law, offers some of the most in-depth research to date.

Austin and his team selected a nationwide group of 100 bankruptcy filers meant to represent a cross-section of the U.S. population, studied their paperwork, then followed up with a survey asking filers, basically, "Why?"

His team's research found that medical debt is the single largest factor in personal bankruptcy. First, Austin analyzed the paperwork of individual case files, which suggested that medical bills were a factor in 18 percent of filings. But when he directly asked the same filers, in a survey, the number was even higher, with 25 percent citing medical bills as a factor in their decision to file bankruptcy.

ILLUSTRATION: SÉBASTIEN THIBAULT

In addition to the nationwide group, Austin isolated a group of 100 bankruptcy filers from Massachusetts. Why Massachusetts? Because its citizens, starting in 2006, had been covered by a comprehensive state healthcare program similar to the ACA known as Romneycare, after the state's former governor, Mitt Romney.

The differences between the two groups were striking. Even though the Massachusetts filers owed substantially more in unsecured debt (that is, debt not backed by a home, a car, or another asset) than their counterparts in other states, they reported less than half as much medical debt, which is also unsecured.

"The average medical debt in Massachusetts in 2013 was relatively low at just $3,041 (6 percent of total unsecured debt) compared to $8,594 (20 percent of total unsecured debt) nationwide," Austin writes in his 2014 study, portions of which were published in the Maine Law Review.

“Only about 9 percent of Massachusetts debtors felt their bankruptcy filing was a result of medical bills,” Austin explains. “This compares to 25 percent for debtors from [other] jurisdictions.” Austin’s research found that comprehensive medical coverage in Massachusetts had all but eliminated medical bills as a cause for bankruptcy.

“Not only in absolute numbers—they had much smaller medical debt—but psychologically, medical debt did not loom nearly as large for people in Massachusetts as it did for other people in other states.” And in 2010, four years after Romneycare began, the state had a bankruptcy rate that was about 30 percent lower than that of other states.

In Search of Certainty, Consistency

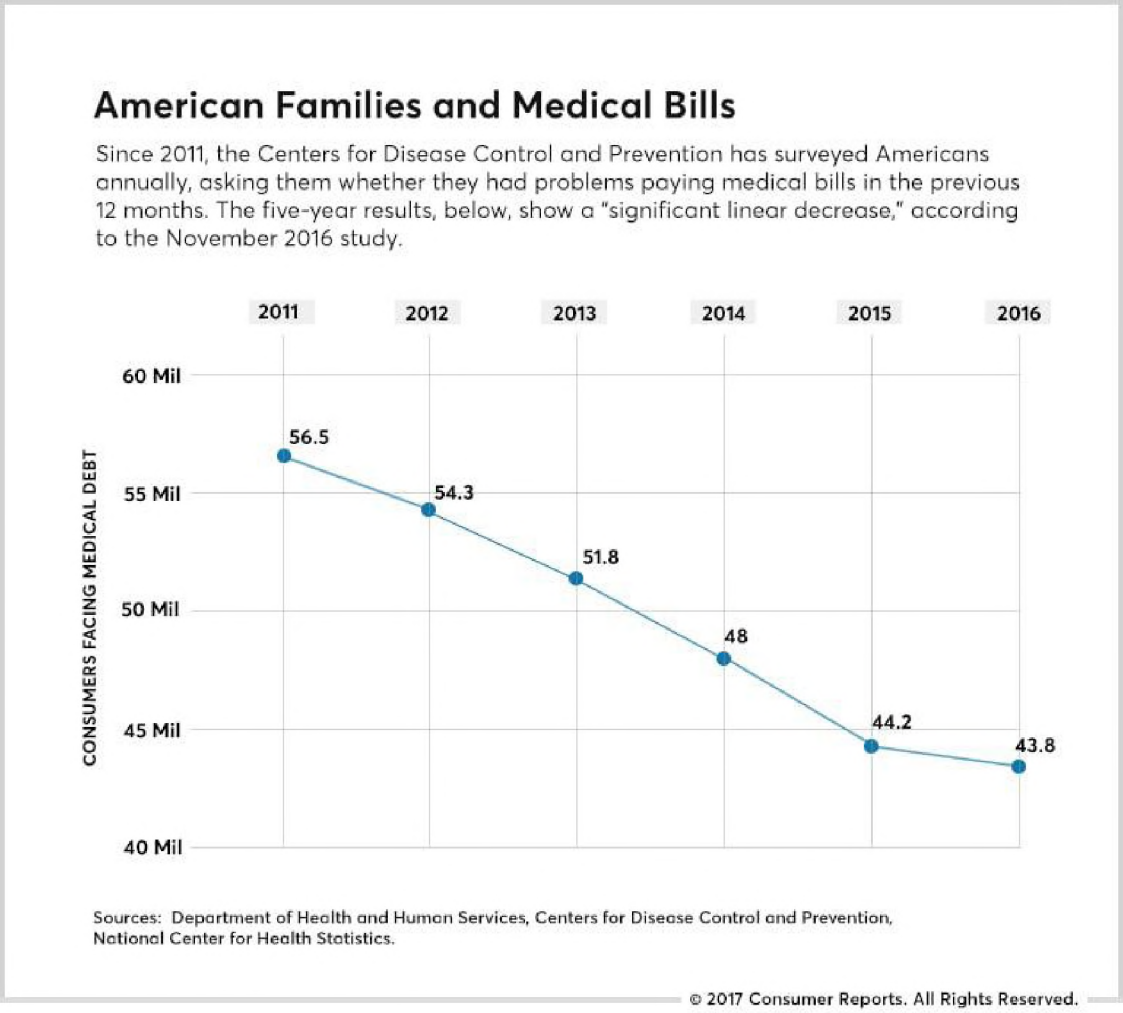
At its most basic level, health insurance allows consumers to pay for the medical care they need. Each year, the Centers for Disease Control and Prevention determines how well the system is working by surveying Americans and asking a simple but powerful question: Did you have problems paying medical bills in the last 12 months?

The percentage of those reporting problems has dropped from 21.3 percent of households when they first asked the question in 2011 to 16.2 percent in 2016. That’s almost 13 million fewer Americans no longer facing collection notices from a doctor or hospital.

“It’s been happening across the board, by race, by age, by insurance status, by gender,” says Robin Cohen, the study’s

lead author.

But insurance is also about peace of mind. And judging from the consumers who have shared their stories with Consumer Reports, that certainty is in short supply as the fate of the ACA is decided. People are wondering what comes next: Repeal? Replace? Improve? Retain and neglect? No one really knows the answer. Americans are concerned about how the future of healthcare will affect them and their families.



In CR's Consumer Voices survey in January 2017, 55 percent of consumers said they lacked confidence that they or their loved ones would be able to afford insurance to secure that care.

Don Shope of Ocean View, Del., said the availability of ACA coverage gave him the confidence to leave a corporate job and start his own consulting business. But now, with the ACA's future in limbo, he and his wife are watching the action in Washington and worrying that they might have to return to jobs with benefits.

"I'm not a liberal or a conservative, a Democrat or a Republican," Shope said in a phone interview. "Our biggest concern is that with repeal and replace we're going to be left high and dry."

He also believes in expanded health coverage for all. "If any American is sick, we should be willing to take care of them," Shope says. "It's the right thing to do. Economics and profit shouldn't be part of the healthcare equation."

Hanging On Every Dip and Turn

And then there's Kristin Couch, who has channeled the uncertainty into her own brand of activism.

"I was kind of anxious," Couch says about the day in March when Congress was set to vote on a less robust bill that would replace the ACA.

The 31-year-old public relations executive, of Gainesville, Ga., has started to follow health-care politics in the intense, almost obsessive way some people follow sports. The morning after Election Day, she called the offices of her local congressional representatives, urging them to preserve the protections the ACA offers.

Couch began caring about healthcare as a high school senior when she was diagnosed with lupus and since then has become something of a reluctant expert on how to manage not only her treatment but also the insurance that pays for it.

With friends and neighbors she talks about the law in simple but personal terms. “I tell people, ‘I have a pre-existing condition, and this has helped me,’” she says of the ACA. Couch follows the healthcare debate in Washington so closely because she knows firsthand what happens when you don’t have adequate coverage.

Hear Kristin Couch tell her story.

"I tell people, 'I have a pre-existing condition, and this has helped me.' "

Couch remembers the time, before the ACA, when a new immunosuppressive drug that wasn’t covered by her policy became available. “It was expensive,” she explained in an interview, “but it worked, and I knew I needed it. Every month I’d just put it on a credit card. When your medication is thousands of dollars a month, that’s the start of being in debt.” She considered bankruptcy but ultimately worked her way out from under the pile of medical bills.

As a result of the ACA, her coverage shifted again when her employer no longer offered a traditional plan and she had to switch to one with a high $3,000 deductible. Initially she was stunned by her out-of-pocket costs, but she quickly realized that her total costs would be capped once she’d met that threshold.

Are you worried about healthcare costs? Join Consumer Reports' efforts to #ProtectOurHealthcare.

“It seemed scary and it seemed different,” she explains. “But it actually saved me money.” And now, she says, “I don’t have to worry about how much a new drug costs.”

So on the March day the House of Representatives was supposed to vote on repealing the ACA, she worried that the insurance she’d come to depend on was about to be yanked away. Only after emerging from a client meeting did she learn the vote had been canceled. “I started crying I was so happy,” Couch recalls. “It’s like a weight has lifted.”

But Couch’s relief was short-lived. Now she’s back to paying close attention to the rhetoric and vote-counting deals in Washington, awaiting another possible vote on the newly revised plan. “I'm still optimistic,” she said this week. “I think enough people will stand up and fight for the coverage.”

Financial Performance of Health Insurers: State-Run Versus Federal-Run Exchanges

May 1, 2017

Authors

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Synopsis

Researchers compared health insurers' profitability in 2013 and 2014, the years before and after the introduction of the Affordable Care Act's (ACA) insurance marketplaces. The median loss for insurers overall in both years was 4 percent. Insurers performed better in states that operated their own health insurance marketplaces than in states that used the federal marketplace, with the difference largely driven by medical loss ratios.

The Issue

"Millions of newly covered beneficiaries presented insurers a golden business opportunity, but the new restrictions on medical underwriting meant that insurers faced uncertain actuarial risk in pricing their products."

The ACA changed the dynamics of the individual health insurance market with rules intended to expand coverage and reforms to how individual insurance is priced and sold. In the years since the law went into effect, there have been concerns over insurers' profitability, as some companies have sustained losses or left the market entirely. A Commonwealth Fund–supported study published in *Medical Care Research and Review* examined insurers' key financial measures over two years (2013 and 2014) to assess profitability, identify factors driving financial performance, and compare performance in states that ran their own health insurance marketplace and those that used the federal marketplace.

Key Findings

- For established insurers with significant enrollment, profit/loss levels remained statistically the same, with median losses of about 4 percent in both 2013 and 2014.
- Insurers did better in states that operated their own marketplaces. In states with state-run marketplaces, 24 insurers went from a negative profit margin to a positive one in 2014, while 10 were positive in both 2013 and 2014. In total, 34 out of 76 insurers (45%) had positive profit margins in the state-run marketplaces in 2014.
- In the federal marketplace, only four insurers went from a negative to a positive margin in 2014; 15 insurers were positive in both 2013 and 2014. Nineteen of 68 insurers (28%) had positive profit margins in the federal marketplace.
- In states that used the federal marketplace, insurers' median medical loss ratio—the percentage of insurance premium dollars spent on medical expenses and quality improvement—increased by 10 percentage points, while their median administrative cost ratio dropped by five percentage points. In states with their own marketplaces, there was no significant change in insurers' medical loss ratio, but the administrative cost ratio dropped three percentage points.

The Big Picture

The authors conclude that the ACA's implementation in 2014 "did not substantially disrupt the individual market among existing insurers of credible size." However, they noted differences, largely driven by medical loss ratios, between states that operated their own marketplaces and those using the federal marketplace. Factors that likely contributed to higher profitability include:

- greater efforts by some states to publicize their exchange and generate more enrollment, which may have resulted in a more balanced risk pool;
- political cultures that were more supportive of the ACA in general;
- greater accuracy in actuarial projections; and
- a higher likelihood of expanding Medicaid, which takes higher-risk people out of the marketplace pool.

By focusing on the more manageable of these factors, like expanding outreach and enrollment efforts or improving actuarial projections, states might be able to improve the financial outlook for insurers participating in the marketplaces, the authors say.

About the Study

The authors used two data sets maintained by the Center for Consumer Information and Insurance Oversight, based on mandatory reporting by all regulated health insurers. The final sample included 144 insurers with a total of 7.8 million members. The authors looked at medical loss ratios, administrative costs, and operating profit.

The Bottom Line

The median insurer reported losses of 4 percent in the individual market in both 2013 and 2014, suggesting that the ACA did not substantially disrupt the individual market among established insurers.

Issue Brief
April 2017

Milbank Memorial Fund

Lessons from State-Based Exchanges for Future Health Reform Initiatives

by W. David Helms, PhD

Message from the President

The decision to establish state-based insurance exchanges in response to the Affordable Care Act (ACA) was a major policy and operational commitment by 16 states and the District of Columbia. Financial, technical, management, and governance resources had to be martialed and new functions developed and implemented under demanding circumstances. It will not be the last time state officials are called upon to respond to changes in the external environment because of significant changes in government policies and operations.

Learning from past experience is an important opportunity for future efforts. In 2016, a gathering of most of the original leaders of these exchanges provided a chance for them to reflect on the lessons learned and the implications for future health system reform efforts by state policymakers. The Milbank Memorial Fund was pleased to support the facilitation of the meeting and the publication of this issue brief, which attempts to capture these lessons. The brief uses the policy capacities framework developed in a recently published Milbank Memorial Fund report, State Policy Capacity and Leadership for Health Reform.

State officials will continue to wrestle with how to define and implement the roles of state government in assuring that the health system delivers on the goals of improved population health, efficient care, and a better patient experience of care. Regardless of the policy decisions made, state governments will need to develop and maintain the capacities to implement those policy decisions.

We hope the evidence and experience compiled here are useful for state leaders as they do this vital work. We appreciate the open, constructive comments of the participants in the session and the careful facilitation of the meeting and compilation of the issue brief by its author, W. David Helms.

Christopher F. Koller
President
Milbank Memorial Fund

Introduction

In April 2016, the original directors of state-based exchanges came together in Denver, Colorado, to reflect on their experiences in pursuing the implementation of this option under the Affordable Care Act (ACA). Nine original directors participated in the retreat; some of those not able to participate provided written responses to a follow-up survey about the lessons they had learned implementing their state exchange.

To inform future state health reform initiatives, this Milbank Memorial Fund issue brief summarizes their collective lessons, using the state health policies capacities framework developed by Forest and Helms,[1] and identifies what the directors believe to be the critical success factors for any major state-based health policy implementation activity.

Sixteen states and the District of Columbia sought certification from the Department of Health and Human Services as state-based exchanges. These states selected chief executive officers or executive directors for their exchanges between 2010 and 2012, before the launch date of October 1, 2013. All were experienced health care or health policy executives, and many had public sector backgrounds. States also selected executives from the private sector, including some with private health insurance experience.

The ACA provided three options for a state-based exchange's legal structure: public agency, quasi-governmental agency, or nonprofit organization. Of the original 17 entities that sought certification as state-based agencies, eight were operating as either a separate state agency or within a current state agency, seven as quasi-governmental agencies, and two as new nonprofit organizations, as shown in Table 1.

It should be noted that while these states continued to operate as state-based exchanges throughout the period, some replaced their information technology (IT) platforms with the federal platform—healthcare.gov. States adopting the quasi-governmental option for their

[1] Forest PG, Helms WD. Milbank Memorial Fund. State policy capacity and leadership for health reform. https://www.milbank.org/publications/state-policy-capacity-leadership-health-reform/. Published April 2017. Accessed April 14, 2017.

legal structure varied greatly in several key areas such as governance structure, authorizing environment (e.g., reporting as an executive branch agency to the governor or to an independent governing board), and adherence to state procurement and contracting rules. As befitting the range of legal authority among the state-based exchanges, some executives were appointed by the governor or were current state officials, while others were recruited and selected by governing boards.

Table 1. States Electing to Pursue the State-Based Exchange Option and the Director's Prior Experience

States and District of Columbia	Exchange Model Implemented	State Exchange Governance Model	Director's Prior Experience
California	State-based exchange	Independent state agency	Public and private nonprofit
Colorado	State-based exchange	Nonprofit organization	Private sector
Connecticut	State-based exchange	Quasi-governmental	Public sector
District of Columbia	State-based exchange	Quasi-governmental	Public and private nonprofit
Hawaii	State-based exchange; federal platform	Nonprofit organization	Public and private sector
Idaho	State-based exchange; federal platform	Quasi-governmental	Private sector
Kentucky	State-based exchange; federal platform	State agency	Public sector
Maryland	State-based exchange	Quasi-governmental	Private sector
Massachusetts	State-based exchange	State agency	Public sector
Minnesota	State-based exchange	Quasi-governmental	Public and private sector

Nevada	State-based exchange; federal platform	Independent state agency	Private sector
New Mexico	State-based exchange; federal platform	Quasi-governmental	Private sector
New York	State-based exchange	State agency	Public sector
Oregon	State-based exchange; federal platform	State agency	Public sector
Rhode Island	State-based exchange	State agency	Public sector
Vermont	State-based exchange	State agency	Public and private nonprofit
Washington	State-based exchange	Quasi-governmental	Public and private sector

Source: National Conference of State Legislatures, Health Insurance Exchanges or Marketplaces: State Profiles and Actions, as of October 31, 2016.

In reflecting on the experiences of implementation and launch, the directors expressed an overwhelming feeling of privilege and gratitude on being chosen to lead their state's historic efforts at building a state-based exchange. At the same time, many reported being challenged by the level of scrutiny, media attention, and political divisiveness that accompanied their every move. While there was the inevitable sense of competition among the states, this group emphasized the tremendous collaboration and sharing of information as everyone built and progressed at their own pace, all targeted toward the launch of their exchanges on October 1, 2013.

The 17 original exchange directors operated with varying degrees of state political support. Most states that implemented a state-based exchange had their governor and at least one branch of the legislature in support of this approach. Even states in which the governor and legislature supported the implementation of a state-based exchange encountered significant challenges and political opposition during development and implementation. The directors emphasized the importance of having national and state political backing, both to support the launch of the new exchange and to build the broad public support needed to enroll those eligible for coverage.

States with divided political control of the governor's office and legislature noted that the absence of unified support made implementing a state-based exchange more difficult. They operated in an environment where the staff was under constant scrutiny, and their actions were repeatedly questioned.

A director from a state with prior successful health reforms noted that "the lack of national support for ACA health reforms played out in our state, where we also lacked bipartisan support for these reforms." He went on to explain that the lack of political consensus nationally and at the state level made implementing the ACA reforms much more difficult than when states had implemented prior health reforms "where we had the level of bipartisan support needed to be successful."

Another state leader reported that "with the ACA, Republicans hated the reform, and Democrats didn't like it because it limited the state's ability to do the reform as we would have preferred. The uncertainties about whether the ACA would survive politically and what our state would do if that didn't happen meant that our assignment came with a federal mandate that wasn't fully supported."

One director emphasized that the "lack of harmonization between federal and state laws resulted in a misaligned vision and strategy for our health insurance marketplace."

Another stated that given the need to integrate federal and state laws and regulations, the federal government needs to be more willing "to grant flexibility and be more reality based."

While all involved were deeply grateful for the opportunity to serve as an exchange director, they acknowledged that this was a very intense, 24/7 responsibility. That only a relatively small number of the original directors remain in the role today reflects the demands of the position and the changing political support for this reform.

The next time states undertake major health system reform it will be important to remember that the executives recruited for these roles will need strong support from their state leaders. It is with this experience in mind that these directors offer the lessons they learned to inform future challenges states may face in implementing major national and state health reforms.

Lessons to Guide Future Health Reform

Regardless of the political context and the policy positions, certain capacities are needed to develop and implement major health reforms: clearly defined leadership, governance, roles, and mechanisms; staff capacity; and federal resources and assistance from other sources.[1] This section applies these principles to the development and implementation of state-based exchanges.

Leadership, Governance, Roles, and Mechanisms

Leadership: Exercising and Cultivating It

State directors said leadership was especially challenging because of what they described as working in a fishbowl-type environment, where they often faced a contentious political

environment. Their strategy for dealing with this was to strive for bipartisan support. One state executive sought to address this situation by having "bipartisan representation on the exchange board and making significant efforts to engage all stakeholders."

Regardless of the exchange structure—whether state government, quasi-governmental, or nonprofit corporation—state directors agreed that, as one director said, they "must have a great relationship with and support from the governor's office." It was also important to secure the governor's leadership to "prioritize operational practicality over political opportunity."

Another director said the need for "clear, early, consistent risk communications up the leadership chain of command is essential. If your message isn't being heard, you need to alter your process and the language for delivering it."

Support of elected officials is clearly needed to manage the scope of the project. One director said, "We conveyed early and often the need for support to manage stakeholders' expectations in order to meet the launch deadline." Countless times stakeholders heard from exchange staff, the exchange board, the governor's office, and, finally, legislators that things they'd like to have in the exchange would have to wait.

Another state director emphasized the importance of instilling legislators' support and a sense of ownership when using an independent entity such as an exchange with a separate governance structure.

Several state directors stressed the importance and value of their stakeholder engagement process. One director said, "Our upfront investment in reaching out to stakeholders certainly paid off for us when we encountered pressing implementation issues; they were willing to work with us on their resolution."

Another director noted that identifying "stakeholders early and empowering them with policy decisions was important to building buy-in, trust, and ownership." Yet another director said that its "stakeholder working group process that used consensus-based policy development was critical to our success."

Another director emphasized the need to balance the consumer advocates' objectives for the new exchanges with demands insurers were making before they would agree to participate. In the end, "we need to have enough insurers to be willing to offer plans on our exchange!"

Governance

Regardless of the exchange structure selected, managing governance was crucial. One state director reported that four entities were critical to the success of its exchange and expanded Medicaid: two executive agencies that reported to the governor; an insurance commissioner's office, which was a separate elective office; and the exchange with its own board. With the strong support of the exchange board, the state director explained that "we

were able to hold the line on requests from the other entities to revisit decisions that would prevent us from staying on schedule." When new challenges emerged, "I would set the direction, communicate that with the key partners, and manage the consequences."

A state director with an exchange with a quasi-governmental structure emphasized that ideally you "want a small board with 'independent' board members who are invested in the success of the exchange."

Another director cautioned that it is very important "to avoid having both politically appointed members with a conflict of interest and issuers [insurers] serve on this marketplace board."

One director also urged states "to avoid having large boards made up of representatives of different perspectives, such as hospitals and insurers." It is far better to have a "skills-based board with critical expertise in policy, marketing, and business."

Having strong advisory processes is critical to overall leadership and to governance. As one director emphasized, "Advisory processes and engagement are crucial. You cannot over-engage or be too transparent."

Roles

Whatever the structure, the directors were unified in their view that the exchange structure must have "clear accountability with a single point of authority." One director emphasized the importance of clarifying roles and responsibilities early on across the state policy, business, and IT leadership and then "stick to 'swim lanes' and understand who has decision-making responsibility and authority for which issues and questions."

State directors emphasized the need for a clear and effective partnership with the Medicaid program without "being swallowed or subsumed by it," as one director said. While the need for effective linkage between the exchange and Medicaid made good policy sense, this required the "melding of Medicaid and its government health plans to the commercial world with private health plans." This director noted that it was a challenge to prevent state officials and legislators from viewing the exchange "as a version of Medicaid or another public program rather than as self-sufficient businesses that need to sell products (even with subsidies)."

Speaking about the relationship with Medicaid, one director of an exchange with a separate quasi-governmental structure said, "We have very different cultures stemming from our being a small nimble organization with a modest budget as compared to Medicaid with its large bureaucracy and a multibillion-dollar budget. To get the exchange up and running with a good shopping experience and integrated eligibility, we had to defer some of the Medicaid functionality and that, in turn, caused problems in our relationship with Medicaid."

The director of an exchange that was part of state government noted that the "upside of having the marketplace and Medicaid being co-located in the same public agency is that we already had excellent working relationships, in contrast to other states where the marketplace and Medicaid have very separate reporting relationships."

Prioritizing financial sustainability from day one was very important for successful implementation. First, stand-alone state exchanges needed to be self-sustaining once federal grants were no longer available. Second, political opponents of the ACA often cited high cost of implementation as a key reason for their opposition to the law. Given that health care is often one of the largest costs in state budgets, "attention to the financial aspects of a major new policy will always need to be addressed."

Mechanisms: Data, Analysis, and Information Technology

One state director noted the importance of having access to sufficient data to demonstrate progress to legislators and other stakeholders. This became a critical component of this exchange's implementation to maintain the legislative backing that was required to stay in business.

With the extensive attention given to the problems many states encountered with the IT systems they were developing, state directors noted that this challenge was made even more difficult by the slow issuance of federal guidance. When states made decisions before federal guidelines were issued, several states reported that they had to retrofit their systems, which caused significant challenges.

Several state directors noted that IT development for their exchanges got caught up in an across-the-board standardization of IT that their states were undertaking. "This caused delays that our launch timeline could not afford," said one director.

States learned the importance of getting outside technical expertise to assist with their requests for proposal for development of their exchange IT system and to help review the responses.

After the launch, several states began making longer-term investments in systems development. These developments were needed for the premium aggregation function and to move from the "choice and eligibility IT system" to investing in claims analysis and utilization data. As one state director said, "If we hadn't done this, we would not have been doing our job of understanding what we were getting for our money."

Staff Capacity

Recruiting qualified and committed staff was a major challenge for all directors. One director said he had to quickly "recruit a team that could hit the ground running with the ability to execute under pressure." Regardless of the exchange structure, states needed to move quickly and flexibly to meet aggressive implementation timelines.

Several states acknowledged the important role that personnel departments played in expediting the normal recruitment procedures to secure staff and contractors. One state director noted that because it was easier to hire contractors, "over half of our personnel were contractors at one point."

State exchanges established as quasi-governmental entities had more flexibility to hire staff with expertise and qualifications needed to run an exchange. One director heading a quasi-governmental entity noted that the use of an external recruitment firm to locate staff for critical expertise areas was key to its success. This structure "allowed us to operate as a private organization and avoid having to go through state procurement and hiring."

Another state director whose exchange had a quasi-governmental structure acknowledged that while recruiting and hiring posed challenges, "the lure of being involved with something historic was intriguing to many." This director sought "risk-takers and those able to thrive within an environment of few rules, no blueprint, and even limited resources as we built an organization. I asked everyone I interviewed about being with a start-up organization, and those that found that enticing, challenging, and fun were who we hired."

In a state where the exchange was part of an existing state agency, the director said, "We were able to use existing state systems for personnel and contracting. This meant we didn't have to use our limited time before launch to develop those systems and could concentrate on building the new exchange mechanisms." This director noted that the state staff had expertise and experience with the Medicaid and children's health insurance programs and were familiar with approaches to expand coverage to the populations served by these programs. The state also provided strong expertise in regulation of the health insurance industry. "But we did need to add staff with expertise in small business, IT systems, and in marketing and outreach," the director said.

State directors reported that they needed staff with both public- and private-sector experience. "Public-sector expertise was needed to operate with other public agencies and for accountability. Private-sector expertise was needed in the areas of marketing, sales, plan management, and contracting—all areas where deep experience in the public sector is rare. This meant that we had to be ready to pay more than traditional civil service compensation for key areas of need," said one director.

The biggest recruiting challenge all exchanges faced was finding skilled IT professionals. As one director said, we had "an enormous IT build to start with." Given the inability to compete with private-sector IT salaries, many states used outside consultants and contractors to provide IT expertise. Consultants and contractors also contributed expertise in actuarial analysis, marketing, financial planning, and business modeling.

Several states said it helped to have a staff that had worked together on previous state reforms. One director said its key staff had "extensive experience in working together—many of us for over 10 years. Staff had worked across the key agencies including Medicaid and insurance, so we already had the trust of key agency officials."

Several directors emphasized that their "staff capacity had to evolve as the exchange moved from a start-up organization needed for launch to an operational organization." To make that transition, one director said, "We needed a 20% changeover in the staffing to meet basic business functions such as accounting for time and managing our fixed budget."

Another director said, "We didn't know what we didn't know and were overwhelmed, like other states, with the initial enrollment volume." This created tremendous first-year staffing and resource burdens for the exchange which were needed to operate the call center, to deploy navigators and in-person assisters, and to strengthen relationships with agents and brokers.

Federal Resources and Assistance from Other Sources

State directors agreed that they had sufficient funding to develop their state-based exchanges. But some noted that while they had enough federal funding, it took time to get state authority to use those grant funds.

Another director noted that while they obtained the resources by following the usual steps to get federal funds, "The real challenge was managing the many 'suggestions' on how to use our federal grants from what seemed like everyone related to health care and continuing to keep our focus and direction on getting the exchange launched on schedule."

The federal government, primarily through the Centers for Medicare and Medicaid Services and its Center for Consumer Information and Insurance Oversight, convened state directors frequently. Groups such as the Robert Wood Johnson Foundation, the National Academy for State Health Policy, and the National Governors Association also provided opportunities for state directors to share their challenges and obtain guidance.

Frequent national and regional conferences involved state directors as speakers and panelists. They used these opportunities to share their experiences and challenges and compare progress toward implementation.

State exchange directors report how much they valued the peer support network they established both to share updates and what they were learning about implementation issues. This network also provided an effective voice for representing the interests of state-based exchanges (as distinguished from the interests of those states participating under the partnership and federally facilitated exchange options) in deliberations with the Centers for Medicare and Medicaid Services and its Center for Consumer Information and Insurance Oversight. In early 2013, supported in part by a Robert Wood Johnson Foundation grant, the state directors organized the state health exchange leadership network staffed by the National Academy for State Health Policy.

Critical Success Factors

Reflecting on their experiences with implementing state-based exchanges under the ACA, state directors identified the following as most critical to the successful development of an exchange:

1. Leadership and governance
2. Management of scope
3. Experience and expertise of core staff

These lessons are not unique to state-based exchanges; they are relevant for any state health policy reform involving a significant operational and client-engaging component, notably Medicaid.

As states continue efforts to improve the quality, accessibility, and affordability of health care and prepare for potential changes in the ACA, these critical areas serve as important reminders, born of hard experience, of what will be required for success.

Leadership and Governance

Strong leadership and clear lines of governance and accountability were consistently mentioned as the critical success factors. Regardless of legal structure (e.g., state agency, quasi-governmental, or nonprofit), clear authority was essential to determining design requirements to meet implementation deadlines and the launch date of October 1, 2013.

Most states noted the critical role governors played throughout the start-up phase to secure the cooperation of key state agencies, legislative leaders, major stakeholders, and the public. State exchange directors emphasized that a strong relationship with the governor's office was essential, regardless of whether the exchange was part of state government or a quasi-governmental entity.

In many states, the governor set the overall direction and provided political support, but some states established coordinating committees comprised of relevant state agency directors to guide the exchange's development. Directors emphasized that having the authority to make key decisions in a timely manner was essential for a successful launch.

Even though many exchanges were established as separate from existing government agencies, the successful implementation of an exchange required "support from and collaboration with state officials and agencies including the governor, state Medicaid agency and Department of Insurance, policymakers, federal regulatory agencies, and the media."

Maintaining legislative support for the implementation of a state-based exchange required establishing strong relationships and open channels of communication with legislators who demanded immediate results and data as evidence as the new system became operational.

Management of Scope

"Managing governance and scope were our key success factors," one director said, adding that this was "what separated successful launches from challenged ones—along with picking the right vendor!"

Another director noted that given the short timeline from the appointment of the exchange board and hiring of the director, it was not possible to build all the desired components for the individual and small-group marketplaces. This director said they had to "right shift" some functions to the second and third years.

Another director noted that the success of the new independent structure grew out of the "discipline of knowing from day one that we would need to stand on our own as a business." It was also "critical that our initial board members were savvy and committed to the success of our exchange and willing to make tough calls," said the director.

Effective governance requires fostering strong public-private partnerships and community engagement. Several directors reported that their extensive working group processes, which involved both key stakeholders and community groups, were critical to developing broad-based support for their exchanges. Stakeholders assisted with marketing and outreach and provided expertise to address technical insurance issues. Several directors said the decision to invest in building these relationships was critical to success.

Community engagement is a key part of effective management. "You can't just sit back and wait for them to bring you issues," one director said. "You need to be engaging them early on because they will have good ideas and will be more supportive if you have involved them early on."

Relying on a public-private partnership model requires a clearly articulated and shared vision to enable its success. Partnership models must align accountability and responsibility to optimize success.

Experience and Expertise of Core Staff

A director from a state with extensive experience with health reform initiatives emphasized the need to start with a core staff that has capable technical skills and relevant experience. This staff must be willing to take on the challenge of implementing major reforms and must have energy and passion for the reform process.

"There was not one person on our leadership team that didn't want to expand health insurance coverage," the director said. "Everybody needs to understand that there will be risks in the reform and that there will be bumps in road. In order for an exchange to survive, the director must maintain positive relationships on behalf of the exchange with key public and private stakeholders in order for this new mechanism to thrive."

Most directors said a strong core staff was critical to their success. Several directors noted that resources are needed to supplement this staff with specialized expertise. It is important to recognize that there is expertise outside of government, which several states found in their state's health insurance industry.

The staff implementing an exchange needs to "understand insurance market dynamics and invest in solutions to address them, such as the need for a good risk mix," one director said. That director attributes early success to "our engagement with health plans on design and pricing and on their support for big marketing budgets."

Several directors noted that staff expertise must evolve throughout the implementation process. "The questions we had before launch are really different than the questions faced post launch," a director said. "Now we are facing the real issues consumers face as they begin getting their coverage—which is, after all, what this is all about!"

Several directors attributed their success with implementing their state-based exchanges to what they learned from their experience implementing state health reforms.

Conclusion

Reflections by the original leaders of state health insurance exchanges provide critical insights into what is required for effective reforms of the individual and small group markets. With the ACA, the federal and state governments were tasked with working together to blend their respective roles, resources, and capabilities. The experience of these state leaders illustrates the inherent difficulties of making significant changes in providing affordable health coverage to those obtaining health insurance in the individual and small group markets. Exchange directors' reflections and unflagging commitment to improving access to health care also provide an example of the capacities and leadership skills that state leaders will need to undertake in future health reforms.[1]

The Author

David Helms' career has focused on advancing health care improvements through planning, policy analysis, and research and on the development of new initiatives to expand coverage for the uninsured. He is currently a senior associate in the department of health policy and management at the Johns Hopkins Bloomberg School of Public Health, where he teaches a course on state health care policy. From 2000 to 2010, Dr. Helms was president of AcademyHealth, the national society for the fields of health services research and health policy analysis. From 2011 to 2014, Dr. Helms served as director of the LMI Center for Health Reform working on the implementation of federal and state health exchanges established under the Affordable Care Act. He received his PhD in economics and public administration from the Maxwell School of Citizenship and Public Affairs at Syracuse University.

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Milliman White Paper

The Federal Invisible High Risk Pool

Effect on premium rates, individual marketplace enrollment and use of federal funds

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I. EXECUTIVE SUMMARY

Concept

The Federal Invisible High Risk Pool (FIHRP) is a proposed risk sharing/transfer mechanism to cover certain high-cost claimants in the individual health insurance market that also facilitates coverage for those with pre-existing conditions. Introduced as an amendment to the American Health Care Act of 2017 (AHCA), the FIHRP creates a high risk pool that covers claims for persons whose insured plan benefits exceed $10,000 per year; those healthcare providers are paid at a lower rate than what commercial carriers typically negotiate. The FIHRP is funded by a combination of carrier premium contributions along with proceeds from the Patient and State Stability Fund (PSSF).

Analysis

This paper addresses the following:

- The effect of a FIHRP on premiums in the individual insurance marketplace
- The cost of the program including how much PSSF or other funds would be needed to supplement the 90% of the policy premium that is paid to the FIHRP
- Individual insurance enrollment, including those maintaining their coverage and uninsured persons becoming insured, compared to enrollment levels without the FIHRP
- The effect that the rate reduction attributed to the FIHRP has on the rates by age if the 3:1 age curve is replaced by a 5:1 age curve

As requested by The Foundation for Government Accountability (FGA), we evaluated the effect of the FIHRP under two scenarios. The first scenario assumes that the persons insured under the existing ACA marketplace can remain in their current plans, with their current rating mechanisms, rate subsidies, and that a new program is created that can be priced to the expected healthcare costs of the persons enrolling in that program, with no risk adjustment between this new program and the existing risk pool. This initial scenario was reviewed first assuming the original ACA risk pool would not benefit from a FIHRP, and second assuming that the original risk pool would benefit from a FIHRP.

Throughout our analysis, we assumed that all of the existing ACA rules continue to apply, including but not limited to guaranteed issue, pre-existing condition exclusions, and the individual mandate. If any of these provisions were to change in any way, the results in this report will be different.

Scenario 1 Policy Assumptions

We have modeled a hypothetical Federal Invisible High Risk Pool with the following characteristics:

- The individual market is bifurcated into two risk pools and the FIHRP only applies to those in the new risk pool. (Although the impact of applying to both risk pools is also modeled.) The new risk pool does not provide for subsidies such as APTCs or CSRs.
- Carriers in the individual marketplace, both on and off exchange, must cede to the FIHRP any individual that has one of eight mandatory ceding medical conditions: chronic obstructive pulmonary disease (COPD), uterine cancer, prostate cancer, metastatic cancer, rheumatoid arthritis, congestive heart failure (CHF), renal failure, or HIV/AIDS.
- It allows voluntary ceding into the FIHRP of other lives at the discretion of the carriers, subject to eligibility requirements. The FIHRP eligibility requirements restrict coverage to newly insured lives and to persons who change carriers, at the time they make that change in carriers.
- Whenever an individual is ceded into the FIHRP, all persons covered under that individual's contract, including any covered dependents, must be ceded.

- The FIHRP premium (the amount paid by the insurance carrier to the FIHRP) is set at 90% of the insurer's premium charged for the lives that are ceded to the FIHRP. Under the current ACA rules, we assume this means the premium paid by the covered person along with any premium tax credits provided.
- The FIHRP will have additional funds available to it, by making use of a state's proceeds from the PSSF.
- FIHRP benefits and payment rates to healthcare providers will be paid based on 100% of Medicare-allowed reimbursement, rather than a carrier's regular commercial reimbursement arrangements.
- FIHRP benefits attach at $10,000 of benefits paid by the insurer per individual per year, with 100% of benefits in excess of $10,000 covered by the FIHRP.

Outcomes

In a scenario under which a new and separate risk pool is created and operates alongside the current ACA risk pool, the introduction of the FIHRP would impact only to this new pool may:

- Reduce average premiums in the new risk pool in the individual marketplace by 12% to 31%
- Reduce the number of uninsured individuals by 1.1 to 2.2 million
- Require the Federal government to spend $3.3 billion to $16.7 billion in the first year (PSSF or similar program funds)

Our range of estimates is based on several key FIHRP program characteristics that are unknown at this time. As a result, we evaluated the FIHRP under various implementation scenarios. Two key assumptions are risk pooling and eligibility. In the 12% to 31% premium reduction scenario, we assume that individuals who are newly insured or who change carriers are included in a new separate risk pool. In this new separate risk pool scenario, we focus on the effect of the FIHRP in the new risk pool; we also evaluate the effect of the FIHRP on the grandfathered risk pool in the individual health insurance market if the FIHRP is or is not available in that risk pool.

Scenario 2 Policy Assumptions and Outcomes

The second scenario assumes the existing ACA requirements of a single risk pool continues to apply; all carriers are required to price all products to the individual marketplace average morbidity, with risk adjustment among carriers after the end of the year to adjust all carriers to that marketplace average. The FIHRP would be implemented into the existing risk pool.

We estimate that introduction of the FIHRP into that current marketplace may:

- Reduce average premiums in the individual marketplace by 2% to 11%
- Reduce the number of uninsured individuals by 740,000 to 1.6 million
- Increase federal government costs by $5.4 billion to $17.0 billion in the first year (PSSF or similar program funds)

Range of Factors Impact Outcomes

While we observe that the average premiums decreased with the FIHRP, the magnitude of the premium reduction varies considerably depending on a number of variables addressed in this report. There are four inter-related elements that affect the balance between reduced premiums and PSSF funding needed in our analysis:

- Healthcare provider reimbursement at 100% of Medicare allowable rates for the claims in excess of $10,000 that are incurred by high cost claimants who are ceded to FIHRP
- 90% of direct policy premiums for lives ceded to FIHRP are used to help fund FIHRP
- Eligibility of inclusion in risk transfer program
- Level of PSSF or similar proceeds from state of federal agencies

In addition, the rules for eligibility for inclusion in FIHRP and the extent of improved risk pool morbidity as younger and healthier members enroll due to reduced premiums also effect the magnitude of rate decreases as well as the change in number of persons insured in the individual marketplace.

We expect that the number of uninsured individuals will decrease with the FIHRP. Reduced premiums provide additional incentive to uninsured individuals to obtain coverage, which leads to enrollment growth in the individual health insurance market. We anticipate that greater premium reductions will lead to an increased number of individuals who purchase coverage.

Additional funding will be required from state or federal agencies to supplement the FIHRP premiums contributed by individual insurance carriers on behalf of program enrollees. The amount of additional funding depends on a number of variables, including eligibility rules and the basis for setting the FIHRP premiums.

II. INTRODUCTION

The American Health Care Act of 2017 (AHCA) was introduced as H.R.1628 in March 2017. A subsequent amendment included a provision for a high risk pool program.[1] The amendment, named the Federal Invisible High Risk Pool (FIHRP), establishes a risk transfer mechanism to fund high cost claimants in the individual marketplace. Using portions of a state's Patient & State Stability Fund (PSSF), FIHRP premiums at 90% of adjusted premiums charged by carriers, and with benefits under FIHRP being covered at 100% of Medicare allowed amounts, the FIHRP is intended to reduce premiums in the individual marketplace, both on and off exchange, which encourages increased enrollment and results in fewer uninsured lives.

The FIHRP is similar to a reinsurance program established in Maine in 2012, named the Maine Guaranteed Access Reinsurance Association (MGARA). MGARA is widely credited as the cause of reducing rates materially in the Maine individual marketplace.[2]

Milliman serves as the actuary for MGARA, so we were contacted to evaluate the FIHRP.

This report replaces the April 7, 2017 report with the same subject; the only change is the addition of the rate reduction percentages in Scenario 2 of Attachment A.

[1] The full amendment is available at http://amendments-rules.house.gov/amendments/Palmer322170833193319.pdf.
[2] Allumbaugh, J., Bragdon, T., & Archambault, J. (March 2, 2017). Invisible high-risk pools: How Congress can lower premiums and deal with pre-existing conditions. Health Affairs Blog. Retrieved April 5, 2017, from http://healthaffairs.org/blog/2017/03/02/invisible-high-risk-pools-how-congress-can-lower-premiums-and-deal-with-pre-existing-conditions/.

III. BACKGROUND

We have modeled a hypothetical Federal Invisible High Risk Pool with the following characteristics:

- Carriers in the individual marketplace, both on and off exchange, must cede to FIHRP any individual that has one of eight mandatory ceding medical conditions: chronic obstructive pulmonary disease (COPD), uterine cancer, prostate cancer, metastatic cancer, rheumatoid arthritis, congestive heart failure (CHF), renal failure, or HIV/AIDS.
- It allows voluntary ceding into FIHRP of other lives at the discretion of the carriers, subject to eligibility requirements. The FIHRP eligibility requirements restrict coverage to newly insured lives and to persons who change carriers, at the time they make that change in carriers.
- Whenever an individual is ceded into FIHRP, all persons covered under that individual's contract, including any covered dependents, must be ceded.
- The FIHRP premium (the amount paid by the insurance carrier to the FIHRP to reinsure the members) is set at 90% of the insurer's premium charged for the lives that are ceded to FIHRP. Under the current Patient Protection and Affordable Care Act (ACA) rules, we assume this means the premium paid by the covered person along with any premium tax credits provided.
- The FIHRP will have additional funds available to it, by making use of a state's proceeds from the PSSF. Although the specific details are still unclear, our analysis assumes that some alternative funding mechanism will be adopted at the federal and/or state levels. This additional funding is necessary to cover the portion of the FIHRP costs in excess of the premium revenue (i.e., the 90% collected from carriers).
- FIHRP benefits and payment rates to healthcare providers will be paid based on 100% of Medicare allowed reimbursement, rather than a carrier's regular commercial reimbursement arrangements.
- FIHRP benefits attach at $10,000 of benefits paid by the insurer per individual per year, with 100% of benefits in excess of $10,000 covered by the FIHRP.

All states must participate in the FIHRP, and all healthcare providers would have to accept 100% of Medicare allowed amounts as payment in full for the claims in excess of $10,000 with no balance billing to patients.

The introduction of the FIHRP requires that persons who are eligible to be ceded to the FIHRP complete a health questionnaire to be used by the carrier to determine if the person will be ceded. The definition of who is eligible to be ceded is one of the variables in our analysis. One possibility is that a carrier can cede anyone they insure, whether the person is newly insured with the carrier, changing plans, or staying with a current plan. The other possibility is that persons staying with the same plans with their current carriers are not eligible to be ceded to the FIHRP.

Ceding of risk to the FIHRP is mandatory within the eligible class of persons for anyone who has one of the eight prescribed medical conditions. Carriers may elect to cede others to the FIHRP based on the information contained in the medical questionnaire. If a person is ceded to the FIHRP, all persons covered under that person's insurance contract must also be ceded.

As noted above, one underlying premise of the FIHRP program is that carriers pay a premium to the FIHRP that is equal to 90% of the policyholder premium adjusted to reflect the value of the ceded claims being paid at 100% of Medicare (rather than at the usual, and presumably higher, negotiated commercial reimbursement rate).

We assume the carriers will reduce their current, pre-FIHRP rates, as follows:

- Remove the expected claim costs for claims in excess of $10,000 per life, based on the expected morbidity of the population that will be ceded, with claims paid based on commercial reimbursement
- Add the expected premium payable to the FIHRP that will cover the cost of the claims that have been removed
- Multiply the net of the items above by the percentage of the population that is expected to be ceded to the FIHRP.

In certain scenarios, we assumed that only individuals newly enrolled in a plan would be eligible to have their claims covered by the FIHRP. We took this to mean that eligible members are those who were previously uninsured and are newly insured, as well as members who previously had coverage but switched to a new insurance carrier.

We evaluated the effect of the FIHRP under two scenarios. The first assumes that the persons insured under the existing ACA marketplace are "grandfathered" into their current plans, rating mechanisms, and rate subsidies, and that a new program would be created that can be priced to the expected healthcare costs of the persons enrolling in that program, with no risk adjustment between this new program and the existing risk pool. This initial scenario was reviewed first assuming the original ACA risk pool would not benefit from the FIHRP, and second assuming that the original risk pool would benefit from the FIHRP.

The second scenario assumes that the existing ACA requirements of a single risk pool continue to apply; all carriers are required to price all products to the individual marketplace average morbidity, with risk adjustment among carriers after the end of the year to adjust all carriers to that marketplace average. The FIHRP would be implemented into the existing risk pool.

Based on our analysis, we conclude that the FIHRP will reduce the average premiums in the individual insurance market. This reduction is driven by two key factors. One is the definition of the premium the insurers will pay to the FIHRP. The Amendment to H.R.1628 states: "Each member insurer shall remit 90 percent of paid premiums for policies covering any individual ceded by the insurer to the FIHRP under this section. The FIHRP may consider adjustments to the premium rates charged coverage in FIHRP to reflect the use of effective cost containment and managed care arrangements by an insurer." We assume that "paid premiums for policies" is the total policy premium; that is, the sum of the amount paid by the insured plus any Premium Tax Credits. The "adjustments to the premium rates" is an important element in assessing the magnitude of premium reductions that may arise due to FIHRP. For purposes of this analysis, we have assumed that the provision allowing adjustments will be expanded to include an adjustment when FIHRP benefits are paid based on 100% of Medicare allowed amounts. The second factor is the total amount available from federal or state funds, such as the PSSF in the AHCA, that are available to support the FIHRP. The larger that amount, the greater the rate reduction.

To illustrate, if the FIHRP claims are paid based on regular commercial fees, and if the subsidy from federal and/or state funds is zero, the premium reduction would be 0%, assuming there is no charge for expenses to administer the FIHRP. The FIHRP claims are the claims over $10,000 that are built into the insurer's premium; their cost is being transferred from the insurer to the FIHRP. If the only source of funding for the claims is the FIHRP premiums, the premiums must cover all of the claims. Hence, for FIHRP in total, the premiums the FIHRP charges to carriers offsets the claims that the carriers cede to the FIHRP.

The existence of the Medicare reimbursement basis on FIHRP creates a favorable spread between the claims that the insurer has ceded and what the FIHRP will pay. That spread creates an additional element to be reflected in the sharing of the cost of FIHRP between the premiums paid to FIHRP and PSSF funds. For example, if the premiums paid by the carrier to FIHRP are not adjusted to reflect Medicare reimbursement, the PSSF share of the total cost will be reduced. Conversely, if the premiums paid by insurers to FIHRP can be reduced in anticipation of Medicare reimbursement, insured persons benefit by a lower premium, while PSSF funding would be higher.

SCOPE OF REVIEW

This paper addresses the following questions under each of the two scenarios described above:

1. How the enactment of FIHRP would affect the premiums in the individual insurance marketplace.
2. The cost of the program including how much PSSF or other funds would be needed to supplement the 90% of the policy premium that is paid to FIHRP.
3. Individual insurance enrollment, including those maintaining their coverage and uninsured persons becoming insured, compared with enrollment levels without the FIHRP.
4. The effect that the rate reduction attributed to the FIHRP has on the rates by age if the 3:1 age curve is replaced by a 5:1 age curve.

Milliman's nationwide databases[3] supplemented with the actual experience under Maine's MGARA program served as the source of the assumptions used in the analyses that developed the observations presented in this paper. We also relied on Milliman's Health Care Reform Financing Model, and Milliman's Managed Care Rating Model. The values presented herein are estimates based on analysis of the data, MGARA published actual experience, and consultant informed judgment. Actual results will differ from the values presented. Changes to any provisions of the FIHRP, as assumed here and as described in this report, will also affect the results; such effects could be material. Because of differences by state in the costs of healthcare, the distribution of insureds by income level, and the number of uninsureds, a given state's results will differ from the nationwide values.

In the first scenario we analyzed, we assumed that the existing ACA program at the beginning of 2017 remains in place for persons covered under that program. This includes retaining the 3:1 age curve, guaranteed issue, no pre-existing condition exclusions, and the individual mandate. In the newly established risk pool that is established alongside the existing one, rates are set based on the expected demographics and health characteristics of the persons expected to enroll, on a 5:1 age curve, and the presence of the FIHRP as described above. We expect that enrollment in this new risk pool will come largely from the currently uninsured population as well as persons insured in the individual marketplace today with little rate subsidy (i.e., the Advance Premium Tax Credit).

In the second scenario we analyzed, we assumed that no changes are made to provisions of the Affordable Care Act (ACA) other than the items enumerated above. We also assumed that the eight mandatory ceding conditions, the premium of 90% of the policy premium paid to FIHRP, and 100% of Medicare as the basis for the FIHRP claims are prescribed values; as such, we have used them as given without analysis. Results will differ if any of these parameters change.

This report does not address administrative and operational issues and costs related to the implementation and operation of the FIHRP, nor does the report address the effect that the FIHRP benefits may have on risk adjustments payable or receivable or on cost sharing reduction payments. Geographic variations and the level of carrier participation will also affect the results.

[3] The Milliman research database contains nationwide administrative medical claim data for 2014 and includes several million commercially insured members and 3 million members from the individual market with ACA-related indicators.

IV. MAJOR FINDINGS

This section of the report addresses many different possible structural and financial arrangements under which FIHRP may be introduced. We have assessed changes within the existing individual marketplace single risk pool, introduction of a new, healthier, individual risk pool residing alongside the existing risk pool, FIHRP coverage being available to everyone in the individual marketplace or only to certain segments of the population, rates for coverage under FIHRP being set at different levels, and other factors.

Attachment A is a one-page summary of the results that we computed based on each of the major combinations of these elements. Attachment A includes the estimated premium rate reductions, changes in the number of uninsured lives, lives migrating to the new risk pool, federal savings in APTC payments, and subsidies needed from PSSF or similar sources.

The remainder of this section of the report describes these scenarios in more detail, providing context for the results summarized in Attachment A.

SCENARIO 1 – FIHRP IN NEW RISK POOL

The starting point for the analysis is the current ACA single risk pool for the individual marketplace. That program provides guaranteed issue, coverage of pre-existing conditions, and it includes Advance Premium Tax Credits (APTCs) and cost-sharing reductions (CSRs), along with a 3:1 age curve. The marketplace that provides insurance in this risk pool has several carriers in each marketplace, each one offering its own plans of benefits. Open enrollment occurs annually, during which time eligible persons can change plans within a carrier, switch carriers, become uninsured or, for the currently uninsured, purchase insurance. Changes to the current ACA risk pool rules will have an effect on the results presented in this report.

A new risk pool will be introduced that would operate along with the current risk pool.

Ceding of risk to the FIHRP is mandatory within the eligible class of persons for anyone who has one of the eight prescribed medical conditions. Carriers may elect to cede others based on the information contained in the medical questionnaire. If a person is ceded to the FIHRP, all persons covered under that person's insurance contract must also be ceded.

We performed our analysis and developed estimates based on our interpretation of the draft language of the amendment along with discussions with the Foundation for Government Accountability leadership. Many details of how the new risk pool would be created and managed would have to be described in regulations, should the bill become a law. Below is a list of the assumptions we made as to how the mechanics of the FIHRP and new risk pool would work.

The new risk pool would run alongside the current ACA risk pool. We made the following assumptions regarding the current risk pool:

- The premium rate level for the current risk pool does not change after migration of lives to the new risk pool. In reality, if the healthier lives in the current risk pool move to the new risk pool, the rates for the existing risk pool will need to be increased. *The more people that migrate to the new risk pool, the bigger the difference in the rate levels will be between pools. As a result, the existing pool's rates may spiral out of control until the only lives remaining in that pool are persons with CSRs and APTCs such that they pay little for their coverage.*
- We assumed insurance carriers who are participating in the current individual market will continue to do so. Any significant changes in carrier participation will affect these results.
- We assume the two risk pools, each operating in the individual market under different rules, can co-exist without disruptions other than what we have evaluated. Any regulatory measures necessary to assure that were outside the scope of this analysis.

- We test two alternatives, one in which the FIHRP applies only to the new risk pool, and one in which the FIHRP applies to the existing risk pool as well as the new risk pool.
- The current risk pool covers all of the APTC and CSR enrollees; the new risk pool does not provide for those features. In effect, the new risk pool operates like an off-exchange program.
- The current risk pool is not expected to enroll new lives other than APTC and CSR enrollees.

The new risk pool has the following characteristics:

- We assumed the new risk pool would truly be treated as a separate pool of members. Carriers would be able to develop separate rates and offer different plans for this new pool. It would operate as a new single risk pool. We assumed the same rating rules would still apply separately to the pool, including a mandated premium age rating curve, essential health benefit (EHB) requirements, unisex rating, etc.
- We assumed the plans of benefits in the new risk pool would be similar to those in the existing risk pool, such that plan design differences would not be a factor in an individual's decision to move to the new pool. The analyses are based on an average marketplace benefit plan, similar to a typical silver plan.
- We assumed that the ACA subsidies would still apply in the existing ACA risk pool and would **not** apply in the new risk pool. Specifically, members enrolled in the new risk pool would not have access to Advance Premium Tax Credits, Cost-Sharing Reduction subsidies, etc.
- We assumed that in the first year of operation, members currently enrolled in the existing ACA markets would have the option to migrate to the new risk pool. We also assumed that persons who are currently uninsured would have the option to enroll in either the new or existing risk pool. However, in our analysis, we assumed that the uninsured would enroll in the new risk pool if they were to choose to purchase insurance.

Effect of the FIHRP on Individual Marketplace Premium Rates

Table 1
Effect of FIHRP on Marketplace Rates
Reduction in Rate Levels from Current without FIHRP to New with FIHRP

FIHRP Premium as % of Direct Premium	FIHRP Reimbursement Basis	Rate Reduction
90%	Medicare	16-31%
90%	Commercial	12-23%

Under this scenario, we made significant simplifying assumptions, namely that the rates for the existing ACA products will remain unchanged from their current levels. This assumption implies there is no reduction in rates due to the FIHRP, which would be the scenario under which the FIHRP applies only to the newly created block of business. In several portions of the report below, we also consider and discuss the impact of having the FIHRP apply to the existing risk pool as well as the new risk pool. It also implies that the rates for the existing risk pool do not increase because of the outward migration of members to the new risk pool. As indicated earlier, the rates for the existing risk pool would need to increase as the healthier lives migrate from the existing risk pool to the new risk pool.

We further estimate that the persons who will enroll in this new risk pool are younger and healthier than those in the existing risk pool. Because there is no risk adjustment between pools in this scenario, the rates for this new product can reflect the lower medical costs of the anticipated covered population.

This assumption that the persons moving to the new risk pool are healthier than those in the existing risk pool implies that the rates for the existing risk pool should increase. Should such an adjustment be made, we would have a situation under which, as the current risk pool rates increase due to migration, more of the remaining people will migrate out, requiring the current risk pool rates to increase further. This results in a "death spiral" for the existing risk pool. In order for these two pools to operate alongside each other, managing the effect of the migration is essential.

Based on these assumptions, we expect the premium rate level in this new risk pool, for a product with the same benefits as the existing risk pool, could be 10% to 20% lower than the rate in the existing risk pool because of a healthier risk pool, before demographic adjustments and before introduction of FIHRP.

After incorporating the FIHRP with FIHRP benefits paid at 100% of Medicare and assuming that the rates paid by carriers to the FIHRP are adjusted downward from 90% of the policy premium to reflect Medicare reimbursement, the rate reduction becomes 16% to 31%. If FIHRP benefits are paid based on regular commercially negotiated fees, the rate reduction becomes 12% to 23%. A reduction to the required rate level, then sloped to a 5:1 age curve, will further reduce the average rate per member in the new risk pool because of the shift in demographic mix of the covered population. For example, a uniform reduction in the rate table of 25% could result in a reduction in the weighted average rate per covered life of 30% to 35% or more, with the difference from 25% being attributed to the risk pool having more younger lives and fewer older lives than the risk pool before the demographic shift.

Among the major items that affect the rate reduction are the following:

- Enrollment in this pool comes from the uninsured population that is eligible to enroll in a QHP along with migration of persons that are insured in the current risk pool and move to the new pool because of the lower premium rate.
- Based on data from Milliman's 2014 databases, the average risk score of insured persons off exchange is around 15% lower than that of persons insured on and off exchange combined. This difference is a combination of health status, demographics, and plan richness differences. The off exchange population, along with the on exchange population with little or no premium tax credits, are the segment of the insured population most likely to migrate to the new risk pool, as they will benefit from the full reduction in rates.
- The persons who are eligible to purchase a QHP but remain uninsured are assumed to be healthier than average, based on the premise that those persons who have medical conditions that generate substantial medical expenses are more likely to have already enrolled than those who do not.
- The magnitude of a person's rate reduction influences their likelihood of participating in this new individual marketplace risk pool. For example, persons presently insured under an individual policy have a greater likelihood of moving to the new program if their rate decrease is 20% compared with a rate decrease of 5%. We assume a greater reduction from current rates is needed to attract persons who are presently uninsured. For persons with subsidized premiums, the comparison is between 100% of the new premium and the subsidized rate they pay today.
- The shift from a 3:1 age curve to 5:1 in the new risk pool accompanied by an average rate reduction will give a bigger than average rate reduction to younger persons and less of a reduction, possibly even a rate increase, for older persons. As a result, we anticipate that the demographic composition of the new risk pool will be younger than the current risk pool.

Effect on the Number of Lives Insured in the Individual Marketplace

In this section of the report, we estimate the number of lives that will be covered in the individual marketplace. The estimates vary considerably based on assumptions about the likelihood that persons who are presently uninsured will become insured because the premium rates in the marketplace have been reduced. We strongly encourage the reader to review the estimates in context with the assumptions underlying their development.

Table 2 below shows estimated enrollment under the scenario where only the new risk pool benefits from the FIHRP. We estimate that around 1.3 million to 2.2 million (13% to 20%) of the uninsured population that is eligible to purchase a QHP today will enroll in this new program. In addition, 4.2 million to 5.7 million persons who receive no premium subsidy or very little premium subsidy will also migrate from the existing program to the new program. Table 2 illustrates the change from the existing marketplace enrollment status to the projected enrollment in each of the current and new risk pools under this scenario.

Table 2

	Estimated 2017 Lives by Insured Status, Before FIHRP	2017 Lives Remaining in Existing Pool	2017 Lives in New Risk Pool
Insured On Exchange:			
No Subsidy	1,601,000	411,000	1,612,000
With Subsidy	9,073,000	9,073,000	0
Insured On Exchange Total	10,674,000	9,484,000	1,612,000
Insured Off Exchange	5,100,000	1,310,000	5,133,000
Total Insured	**15,774,000**	**10,794,000**	**6,745,000**
Uninsured but Eligible for QHP	**10,700,000**	**8,935,000**	
Total QHP Eligible Individual Market	26,474,000		

More of the current uninsured population is likely to purchase coverage in this new risk pool than under Scenario 2; the driver is a 24% lower premium rate. The scenario below assumes that both the existing pool, with newly insured lives eligible for FIHRP, and the new risk pool will benefit from the FIHRP. We estimate that around 1.2 million to 2.0 million (11% to 19%) of the uninsured population that is eligible to purchase a QHP today will enroll in this new program. In addition, 3.6 million to 5.0 million persons who receive no premium subsidy or very little premium subsidy will also migrate from the existing program to the new program because of lower premium rates. Table 3 illustrates the change from the existing marketplace enrollment status to that projected under this scenario.

Table 3

	Estimated 2017 Lives by Insured Status, Before FIHRP	2017 Lives Remaining in Existing Pool	2017 Lives in New Risk Pool
Insured On Exchange:			
No Subsidy	1,601,000	574,000	1,409,000
With Subsidy	9,073,000	9,073,000	0
Insured On Exchange Total	10,674,000	9,647,000	1,409,000
Insured Off Exchange	5,100,000	1,827,000	4,491,000
Total Insured	**15,774,000**	**11,474,000**	**5,900,000**
Uninsured but Eligible for QHP	**10,700,000**	**9,100,000**	
Total QHP Eligible Individual Market	26,474,000		

The first column of Table 3 is the same as Table 2 — our estimate of the 2017 distribution of persons enrolled in individual insurance plans and the portion of the uninsured population that is eligible to purchase a qualified health plan. The second column estimates the lives remaining in the existing risk pool after the new pool has been created and lives migrate to that pool. The third column estimates the lives that have migrated into the new risk pool by segment of the population, along with the reduced number of uninsured persons.

Table 4 below shows the reduction in the estimated number of uninsured based on the rate reductions illustrated above.

Table 4
Scenario 1
Effect of FIHRP on # of Uninsured Lives

New Risk Pool Rate as % Current Rate	Current Risk Pool Rate as % Current Rate	Difference in Rate Levels Between Risk Pools	Reduction in Uninsured	% Reduction in Uninsured Eligible for QHP
76%	100%	24%	1.3-2.2 million	13%-20%
76%	94.5%	20%	1.2-2.0 million	11%-19%

PSSF or Similar Proceeds from State or Federal Agencies Required to Fund the FIHRP

Under this scenario, the existing ACA individual risk pool remains in place. For the following illustration, we assume that FIHRP applies only to the new risk pool. As a result, the PSSF subsidies needed to support the existing risk pool become zero. The PSSF subsidies would only be used for the FIHRP in the new risk pool.

For persons covered under the new risk pool, we estimate the FIHRP premiums paid by the carriers for ceded lives will need to be supplemented by around $3.3 billion per year in PSSF or other funds provided by the federal government and/or states. This amount is based on rates being 24% lower than current marketplace rates and 17% of the lives covered by the pool being ceded, which is due either to the mandatory ceding conditions or voluntary ceding.

Table 5
Cost of FIHRP measured by funding needed to supplement Premiums paid to FIHRP

FIHRP Premium as % of Direct Premium	FIHRP Payment Basis	Include Closed Block?	Additional Annual Funding Needed
90%	Medicare	Yes	$3.3 billion

Effect That the Rate Reduction Will Have on the Change in Rate Slope From 3:1 to 5:1

The rates in this new risk pool are established using a 5:1 age curve. We have compared the rates under the existing risk pool before the FIHRP, with a 3:1 age curve, to the rates under the new risk pool, after the FIHRP, with a 5:1 age curve.

Table 6 below shows the combined effect of changing the age-curve from 3:1 to 5:1, along with an assumed 24% rate reduction arising from implementing the FIHRP and from the expected morbidity difference of the new risk pool. Note that the premiums shown in the first column using the 3:1 age curve represent premiums that would be payable today in the current risk pool. This is because the premiums shown below in this scenario assumes that the FIHRP only applies to the new risk pool. Members deciding whether or not to migrate into the new risk pool will base their decisions on the rate change shown in the table below.

Table 6
Changes in Average 2017 Premiums – 3:1 Before FIHRP v. 5:1 After FIHRP

Age Band	Before FIHRP 3:1 Age Curve	After FIHRP 5:1 Age Curve	$ Difference	% Difference
<20	$265	$151	-$114	-43.0%
20-29	$339	$199	-$139	-41.2%
30-39	$397	$265	-$132	-33.2%
40-49	$480	$360	-$120	-25.0%
50-59	$724	$638	-$86	-11.9%
60+	$950	$896	-$54	-5.7%

The potential rate change for members between the existing and new risk pools range from -43.0% for members under age 20 to -5.7% for members over age 60. Figure 1 below graphs the premiums by age under the 3:1 and 5:1 age curves before the FIHRP, and the 5:1 age-curve after the FIHRP for Scenario 1.

Figure 1

Scenario 1 - Premiums by Age in 3:1 Age Band Before FIHRP, 5:1 Age Band Before FIHRP, 5:1 Age Band After FIHRP

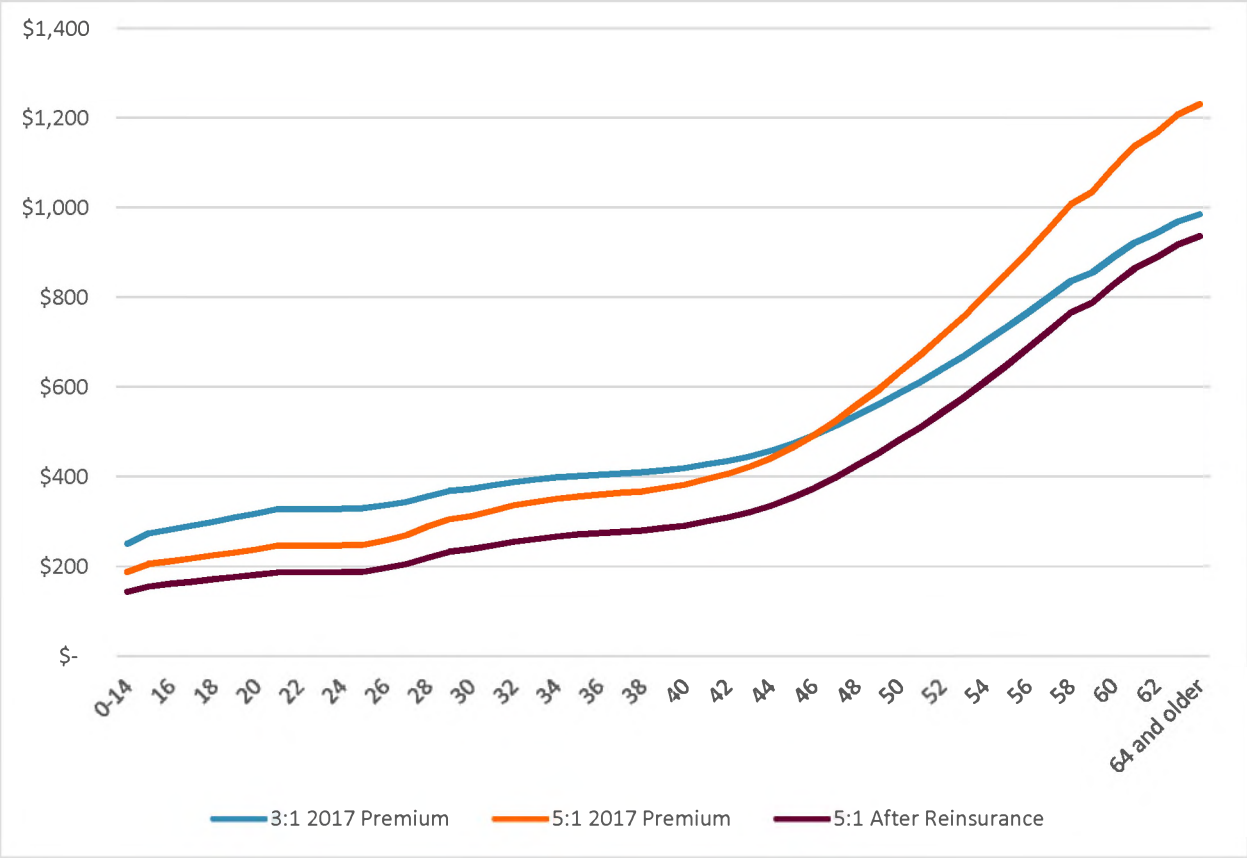


Table 7 provides a comparison similar to Table 6 with one change. It is assumed that the FIHRP applies in the current risk pool for newly insured lives of those that change carriers. Table 7 below shows the combined effect of changing the age-curve from 3:1 to 5:1, along with an assumed 15% rate reduction arising from the expected morbidity difference of the new risk pool and the claims covered by the FIHRP. Note that the premiums shown in the first column using the 3:1 age curve are 5% lower than the

premiums shown in Table 6. This is to reflect the impact of the FIHRP on the rates for the existing risk pool. The members deciding whether or not to migrate into the new risk pool will base their decisions on the rate change shown in the table below.

Table 7
Changes in Average 2017 Premiums – 3:1 After FIHRP vs. 5:1 After FIHRP

Age Band	Before FIHRP 3:1 Age Curve	After FIHRP 5:1 Age Curve	$ Difference	% Difference
<20	$250	$151	-$99	-39.7%
20-29	$320	$199	-$121	-37.8%
30-39	$375	$265	-$110	-29.3%
40-49	$453	$360	-$94	-20.7%
50-59	$684	$638	-$46	-6.7%
60+	$898	$896	-$2	-0.2%

SCENARIO 2 – FIHRP IN EXISTING RISK POOL

In this scenario, we assume there is no new risk pool. The current ACA risk pool is the only mechanism for purchasing individual health insurance. We also assume that the provisions of the current ACA single risk pool for the individual marketplace remain the same. This includes Advance Premium Tax Credits (APTCs) and cost-sharing reductions (CSRs), along with a 3:1 age curve. The marketplace that provides insurance in this risk pool has several carriers in each marketplace, each one offering its own plans of benefits. Open enrollment occurs annually, during which time eligible persons can change plans within a carrier, switch carriers, become uninsured or, for the currently uninsured, purchase insurance.

We have evaluated the effect of the FIHRP on the existing risk pool based on two different eligibility conditions. One assumes that only persons who are newly insured with a carrier, either by changing carriers or by entering the insurance market, are eligible to participate in the FIHRP. The other assumes that a carrier can cede to the FIHRP any of its members, including those that have been and remain insured with the carrier.

Effect of the FIHRP on Individual Marketplace Premium Rates

Table 8
Effect of FIHRP on Marketplace Rates in Current Risk Pool

FIHRP Premium as % of Direct Premium	FIHRP Reimbursement Basis	Include Closed Block?	Rate Reduction
90%	Commercial	No	1-2%
90%	Commercial	Yes	2-4%
90%	Medicare	No	4-7%
90%	Medicare	Yes	7-14%
45%	Medicare	No	6-10%

We estimate that the existence of the FIHRP with its premiums fully adjusted to reflect FIHRP claim payments at 100% of Medicare will reduce average premiums in the individual marketplace by about 4% to 7%. The range of possible rate reductions is largely influenced by the proportion of insured lives that are voluntarily ceded to FIHRP; the calculations used a range from 5% to 15% of the individual marketplace as becoming reinsured. That range is a blend of judgment and experience under MGARA in 2012 and 2013. In addition, 7% of the individual marketplace lives are ceded to the FIHRP because they have one of the automatic ceding medical conditions or because they are part of a contract covering someone with one of those conditions. The potential magnitude of rate decrease is dampened by the

requirement that existing insured lives who remain with their current insurers are not eligible for participation in the FIHRP. We estimate the segment of the marketplace that will be eligible for participation in the FIHRP represents about 57% of the total individually insured population[4]; that percentage will increase over time as more people change carriers.

We assume that 57% of the total individual market will be eligible for the FIHRP. We derived the 57% assumption as the ratio of individuals who switched plans to all individual who reenrolled plus the percent of new individuals from 2017 Open Enrollment.[5] There are two unknown dynamics that may affect this assumption. Each dynamic has a directionally opposite effect on this assumption. As a result, we relied on the 57% estimate derived from CMS data.

Individuals who change carriers are eligible for the FIHRP. The 57% percent assumption is based on the number of individuals who selected a different plan. A portion of the individuals who changed plans did not necessarily change carriers. Individuals who change plans but remain with a single carrier are not eligible for voluntary FIHRP enrollment. This dynamic would reduce the FIHRP eligibility assumption.

Carriers may elect to no longer offer products in the individual marketplace in 2018. When a carrier exits a market, the individuals who were previously insured are disrupted and are forced to either select a plan with a new carrier or become uninsured. The extent to which carriers exit the individual market in 2018 is uncertain at this time. This dynamic would increase the FIHRP eligibility assumption, and will affect other assumptions as well.

Because the single risk pool concept requires a consistent morbidity assumption for the entire individual marketplace, the reduction in claims arising from the portion of the population that is eligible to participate in the FIHRP must be spread across the entire individual population, diminishing the average rate decrease. If this restriction were not in place, such that persons remaining with their current insurers could be ceded to the FIHRP, we estimate that the premium reduction would be 7% to 14%; the range is influenced by the same 5% to 15% of persons being voluntarily ceded to the FIHRP described above.

The payment rate for claims ceded to the FIHRP can have a material effect on the rate reduction. Medicare provider reimbursement levels are lower than commercial. If FIHRP benefits were paid based on regular commercial insurance negotiated fees and not 100% of Medicare, or if the premium insurers pay to the FIHRP did not reflect the Medicare reimbursement rate, we estimate that the rate reduction would be only 1% to 2%, versus the 4% to 7% mentioned above.

The concept of the FIHRP premium rate being set at 90% of the policy premium is one answer to the balance between the reduction in the individual marketplace rates and the spread of the cost of FIHRP between the carriers and the PSSF or similar fund. For example, if the FIHRP premium were set at 45% of the policy premium and could reflect Medicare reimbursement, the rate reduction would be around 6% to 10% of premium if only newly enrolled or those switching carriers can be ceded and no additional lives are ceded to FIFRP, compared with the 4% to 7% illustrated above. The lower the FIHRP premium the insurer pays, the more the cost of the FIHRP needs to be borne by PSSF. The section below that deals with the cost of FIHRP addresses this subject in more depth using some examples.

To summarize the points above, for the FIHRP to be appropriately funded, the following equation needs to hold true:

$$(90\%\ Rei \quad ce\ P\ emi\ m) \geq Rei \quad ed\ Cl\ im\ - PSSF\ Co\ t\ ib\ tio\ + Co\ t\ to\ Admi\ i\ te\ FIHRP$$

In addition to the factors described above, the following are among the major items that affect the change in the marketplace rates:

[4] Derived from: Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight: Health Insurance Marketplace Public Use Files. OE2017_STATE_PUF_FINAL.xlsx, available at https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html plus actuarial judgment.
[5] Derived from CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid., plus actuarial judgment.

- Based on nationwide data from Milliman's 2014 databases, fewer than 5% of the persons insured in the individual marketplace have one of the eight conditions that require automatic ceding to the high risk pool.
- Claims for persons with one of the eight automatic ceding conditions are more than five times that of the average person in the individual marketplace, based on the same 2014 Milliman databases. People with these conditions represent around 30% of the total claims in the individual marketplace.
- When adding in family members on the policy that includes a person with one of the eight automatic ceding conditions, the average claim cost is about three times the claim cost for the average person in the individual marketplace. About 7% of the individual marketplace membership is represented by the persons with any of the eight conditions together with the other family members covered by an individual insurance policy.
- We estimate that 5% to 15% of lives in the individual marketplace will be ceded to FIHRP on a voluntary basis by carriers. This estimate is based on consultant judgment, with reference to the MGARA experience in 2012 and 2013 when Maine's reinsurance program was in operation.

Effect on the Number of Lives Insured in the Individual Marketplace

In this section of the report, we estimate the number of lives that will be covered in the individual marketplace. The estimates vary considerably based on assumptions about the likelihood that persons who are presently uninsured will become insured because the premium rates in the marketplace have been reduced. We strongly encourage the reader to review the estimates in context with the assumptions underlying their development.

We estimate that, as a result of the rate reduction resulting from FIHRP, the number of uninsured lives eligible for qualified health plans (QHPs) will drop by about 8% to 13% or 800 thousand to 1.4 million people nationwide; these figures are based on the FIHRP reducing rates by 4% to 7% as described earlier. Persons who are currently insured and pay 100% of the individual marketplace premium will remain insured; the reduction in premium rates will support their decisions to continue to purchase individual insurance. Similarly, persons receiving premium subsidies in the APTC program under the ACA will likely retain their coverage. Many of the people receiving APTCs already have their premiums capped at a percentage of household income; some will see a modest reduction in their costs as the lower premiums drop below the cap, while others will continue to have their premium contributions capped and will see no change in their premium costs.

Table 9 illustrates the distribution of the nationwide individual insurance marketplace by insured status. It shows the number of persons in each of the cohorts described above, along with the changes in their enrollment status arising from the rate reduction generated by the FIHRP.

Table 9

	Estimated 2017 Lives by Insured Status, Before FIHRP	2017 Lives After FIHRP, Newly Enrolled Lives Only	2017 Lives After FIHRP, Including Existing Block
Insured On Exchange:			
No Subsidy	1,601,000		
With Subsidy	9,073,000[6]		
Insured On Exchange Total	10,674,000[7]		
Insured Off Exchange	5,100,000[8]		
Total Insured	**15,774,000**	16,889,000	17,039,000
Uninsured but Eligible for QHP	**10,700,000[9]**	9,585,000	9,435,000
Total QHP Eligible Individual Market	26,474,000	26,474,000	26,474,000

The first column of Table 9 shows the number of persons covered by the individual insurance marketplace in 2017 or who are uninsured and would be eligible to be covered by a QHP in the individual marketplace. The second column illustrates the increase in the number of insured, offset by a corresponding decrease in the number of uninsured, if the individual insurance premium rates decreased by 5.5%, which corresponds to the midpoint of the range of rate decreases we estimated if eligibility for participation is limited to persons who become newly insured or who change carriers. We estimate that the number of uninsured would decrease by 1.1 million under this scenario. The last column shows that, if the eligibility for participation in the FIHRP were expanded to all persons presently insured in the individual marketplace or who become insured, the rate reduction becomes 10.5%, the midpoint of the range of rate decreases of 7% to 14% we estimated under this scenario. We estimate that the number of uninsured lives decreases by about 1.25 million persons. Table 10 compares the reduction in number of uninsured when FIHRP eligibility includes or excludes the persons who remain covered by their current insurer (i.e. the closed block).

Table 10
Effect of FIHRP on # of Uninsured Lives

FIHRP Premium as % of Direct Premium	FIHRP Payment Basis	Include Closed Block?	Reduction in Uninsured	% Reduction in Uninsured eligible for QHP
90%	Medicare	No	800k-1.4 mil	8-13%
90%	Medicare	Yes	900k-1.6 mill	9-15%

Though the rate reduction will primarily benefit those persons who are paying most or all of their individual premium, the federal government will see a reduction in its APTC expenses because the marketplace premium, which is the foundation for the APTC payments, has reduced. We estimate that this reduction in the federal government's annual payment for APTCs will be approximately $2.2 billion in 2017, using the 5.5% rate reduction described above. The actual amount will vary based on the actual premium reductions, the change in the number of lives in the individual marketplace, and the mix of persons whose premiums are and remain limited by their income cap and those whose premiums drop below the income cap.

[6] Derived from CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid., plus actuarial judgment, and CMS 2016 Effectuated Enrollment Snapshot, available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html.
[7] Derived from CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid., and marketplacestatefinal2016 (1).xlsx, plus actuarial judgment.
[8] Derived from ASPE Issue Brief (October 19, 2016). Health Insurance Marketplace Enrollment Projections for 2017 at http://www.aspe.hhs.gov/.
[9] ASPE Issue Brief (October 19, 2016), Ibid.

PSSF or Similar Proceeds from State or Federal Agencies Required to Fund the FIHRP

Table 11
Cost of FIHRP measured by additional funding needed to supplement Premiums paid to FIHRP

FIHRP Premium as % of Direct Premium	FIHRP Payment Basis	Include Closed Block?	Additional Annual Funding Needed
90%	Medicare	No	$5.4 billion
90%	Medicare	Yes	$9.9 billion

On a nationwide basis, we estimate that the FIHRP premiums, if adjusted for Medicare reimbursement, will need to be supplemented by at least $5.4 billion per year in PSSF or other funds provided by the federal government and/or states. This amount assumes a rate reduction of 5.5%, 10% of the individually insured lives are voluntarily ceded, and ceding is allowed only for a carrier's new enrollees and enrollees changing carriers. The sum of the premiums charged plus these additional funds are needed to cover all of the FIHRP claims for the lives that have been covered by the FIHRP. Note that we have not included any provision for expenses to operate the FIHRP; such expenses would add to the amount that needs to be covered by funds in excess of the FIHRP premium rate.

If FIHRP eligibility is expanded to include those persons who remain insured with their current carrier, if the rate reduction is 10.5%, and if that 10% of lives are voluntarily ceded, the supplemental dollar amount increases to $9.9 billion per year, exclusive of funds to administer the program.

Effect That the Rate Reduction Will Have on the Change in Rate Slope From 3:1 to 5:1

Under the ACA, individual market premium rates for persons age 64 and higher can be no more than three times the rate for a person age 21 covered by the same plan of benefits. A proposal to increase that rate slope from three times to five times has been under consideration. A reduction in the average rate level that is due to introduction of the FIHRP or a comparable program would reduce rates at all ages, moderating the impact of a change in age curve; in particular, it would dampen the increase in rates at older ages, and would create a larger decrease at younger ages.

The following tables illustrate relative rate levels under the current 3:1 age curve and an illustrative 5:1 age curve (Table 12), and the 5:1 age curve with rates reduced by 10.5% due to FIHRP (Table 13). The amount of the actual rate reduction between current rates on a 3:1 age curve and the reduced rates reduced due to FIHRP is presented in Table 14. A 10.5% rate reduction used in the illustration is with the same as the reduction described earlier if FIHRP eligibility is extended to the entire current risk pool. The results presented below will vary based on the rate decrease assumed.

Table 12 below shows the isolated effect on rates that results from changing the 3:1 age-curve to a 5:1 curve to 2017, with no premium reduction due to the FIHRP.

Table 12
Changes in Average 2017 Premiums – 3:1 Age Curve vs. 5:1 Age Curve

	2017 Average Premium			
Age Band	3:1 Age Curve	5:1 Age Curve	$ Difference	% Difference
<20	$265	$199	-$66	-25.0%
20-29	$339	$262	-$77	-22.7%
30-39	$397	$348	-$48	-12.2%
40-49	$480	$473	-$7	-1.4%
50-59	$724	$838	$115	15.9%
60+	$950	$1,178	$228	24.0%

The values in Table 12 include the monthly premium rate and the dollar and percent change in the premium by age-band due only to the change in age curve from 3:1 to 5:1. These values do not reflect how the premiums by age might change due to subsequent enrollment shifts in reaction to the change in age curve. Average premium changes range from -25% for enrollees under age 20, to 24% for members over age 60. The rates in Table 12 were calibrated so that the total dollars of premium revenue would remain unchanged for a nationwide average distribution of individual marketplace membership by age.

Table 13 below isolates the effect of implementing the FIHRP on premiums that are already under the 5:1 age-curve.

Table 13
Changes in Average 2017 Premiums – Before and After FIHRP

Age Band	Before FIHRP 5:1 Age Curve	After FIHRP 5:1 Age Curve	$ Difference	% Difference
<20	$199	$178	-$21	-10.5%
20-29	$262	$234	-$27	-10.5%
30-39	$348	$312	-$37	-10.5%
40-49	$473	$423	-$50	-10.5%
50-59	$838	$750	-$88	-10.5%
60+	$1,178	$1,054	-$124	-10.5%

Note that the percentage reduction in premium by age is constant and is equal to the rate reduction that is assumed to result from FIHRP. The effect on costs of the claims ceded under the FIHRP will be spread across the entire individual risk pool as a percent of premium under single-risk-pool rating requirements. The percent difference is consistent across all ages due to the requirement of a single marketplace rate for a given plan of benefits that can be adjusted only for age, geographic area and smoking status.

However, the absolute effect of premium decreases differ by age. The decreases range from $21 per member per month for members under age 20, to $124 per member per month for members 60 and over.

Table 14 below shows the combined effect of changing the age-curve from 3:1 to 5:1, along with an assumed 10.5% rate reduction arising from implementing the FIHRP.

Table 14
Changes in Average 2017 Premiums – 3:1 Before FIHRP vs. 5:1 After FIHRP

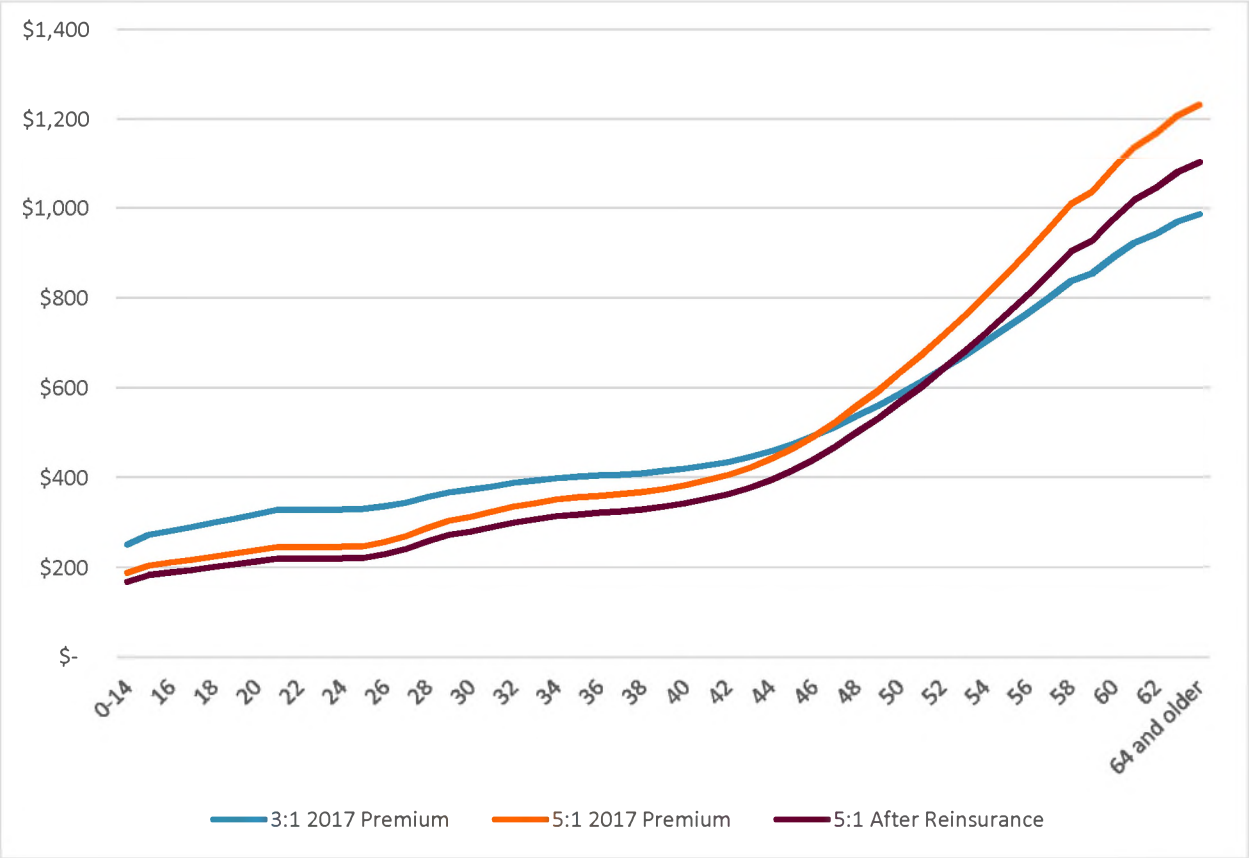
Age Band	Before FIHRP 3:1 Age Curve	After FIHRP 5:1 Age Curve	$ Difference	% Difference
<20	$265	$178	-$87	-32.9%
20-29	$339	$234	-$104	-30.8%
30-39	$397	$312	-$85	-21.4%
40-49	$480	$423	-$57	-11.8%
50-59	$724	$750	$27	3.7%
60+	$950	$1,054	$104	11.0%

After considering the effect on premiums due to both the change in age-curve and the reduction in premium from the FIHRP, the change in premiums ranges from a 32.9% decrease for members under age 20, to a 11.0% increase to members over age 60.

Figure 2 below graphs the premiums by age under the 3:1 and 5:1 age curves before the FIHRP, and the 5:1 age-curve after the FIHRP.

Figure 2

Premiums by Age in 3:1 Age Band Before FIHRP, 5:1 Age Band Before FIHRP, 5:1 Age Band After FIHRP



The change in age curve causes the premium slope to steepen; as a result, younger members see decreases in premiums while older members see increases. Premiums for members around age 46 will remain unchanged before FIHRP. The change that is due to the introduction of FIHRP will cause the premium to shift uniformly downward on a percentage of premium basis. The premiums after FIHRP with the 5:1 age-curve compared with the premiums before the FIHRP under the 3:1 curve remain roughly the same at age 52.

Different age distributions of the covered population and/or different rate decreases that are due to the FIHRP will produce different results from those illustrated above.

V. METHODOLOGY AND ASSUMPTIONS

DEVELOPMENT OF 2017 INDIVIDUAL MARKETPLACE ENROLLMENT BASELINE

We used publicly available data to develop assumptions regarding the size of the 2017 individual insurance market. To assess on-exchange plan selections for 2017, we utilized data from CMS's 2017 Health Insurance Marketplace Public Use files[10] and then applied an assumed effectuation percent of 87.4% which was derived from CMS estimates[11]. Off-exchange enrollment and uninsureds eligible for QHP purchase are based on Office of the Assistant Secretary for Planning and Evaluation (ASPE) 2017 marketplace projections[12] a report from the U.S. Department of Health and Human Services (HHS).

Using the data and assumptions just described, Table 2 above presents the 2017 individual marketplace baseline used in our analysis.

DEVELOPMENT OF ESTIMATED IMPACT OF THE FIHRP ON PREMIUMS

The CMS Public Use files indicate a 2017 on-exchange average per member per month (PMPM) premium of $473[13] which we assumed was appropriate for the entire individual market. Assuming an average loss ratio of 80%, this produces an average claim cost for the individual market of $378.40 PMPM.

We developed an illustrative benefit plan design that would produce an expected 2017 claim cost consistent with the average market claim cost described above when input into Milliman's Managed Care Rating Model (MCRM). The MCRM was calibrated for nationwide allowed charges based on average commercial provider reimbursement levels. We determined those reimbursement levels using Milliman's proprietary benchmarking discount model.

The FIHRP reimburses claims in excess of $10,000 for ceded lives at 100% of Medicare for medical services. Pharmacy claims are assumed to be reimbursed at commercial payment rates. In order to estimate the impact on the expected claim costs of the reduced reimbursement levels for claims that are ceded to FIHRP, we developed a claim probability distribution (CPD) for the illustrative benefit plan in the MCRM. Using this CPD, we estimated the cost of claims paid at commercial reimbursement levels for the first $10,000 in benefits. We then estimated the cost of claims above that attachment point for claims reimbursed at 100% of Medicare. We compared the total of these two amounts with the total cost of claims at commercial reimbursements to determine that if all lives in the individual marketplace had their medical claims in excess of $10,000 adjudicated based on 100% of Medicare fees, claim costs would drop by about 29% to 31%.

Because only newly insured enrollees or those enrollees who change carriers are eligible to be ceded to the FIHRP, the expected impact on marketplace claim costs is less than the 29% - 31% we developed based on 100% of the market being eligible.

We used the following assumptions to estimate the reduction to the average market premiums resulting from the introduction of the FIHRP:

[10] CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid.
[11] March 31, 2016 Effectuated Enrollment Snapshot https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html
[12] ASPE Issue Brief (October 19, 2016), ibid.
[13] CMS/CIIO, OE2017_STATE_PUF_FINAL.xlsx, ibid.

- 57% of the total individual market will be eligible for ceding to the FIHRP. As described earlier in this paper, this estimate was developed from CMS Health Insurance Marketplace Public Use Files.
- 7% of individuals will be ceded based on the presence of one of the eight auto-cede conditions. This estimate was developed from Milliman's 2014 consolidated database.
- 5% to 15% of individuals will be voluntarily ceded by carriers.

Based on these assumptions, we estimate that the total lives ceded to the FIHRP are 7% to 13% of the individual market (7% = 57% * [7% + 5%]; 13% = 57% * [7% + 15%]).

We also estimated that when adding in family members on the contract that includes a person with one of the eight automatic ceding conditions, the average claim cost is about three times the claim cost for the average person in the individual marketplace.

The reduction in average market claim cost was developed by first estimating the PMPM value of the ceded claims for the portion of the market that might be ceded to the FIHRP (7% to 13%), based on 300% morbidity for those lives. That amount was subtracted from the starting market claim cost for the total individual market to produce the adjusted claim cost for benefits ceded to FIHRP. We assumed that the expenses on a PMPM basis are unchanged. Finally, we solved for the premium payable to FIHRP for the portion of the market that might be ceded, under the various scenarios described earlier:

1. The FIHRP premium is 90% of the average premium, with no adjustment for Medicare reimbursement.
2. The FIHRP premium is 90% of the average premium, with a downward adjustment to account for ceded claims being reimbursed at Medicare levels.
3. The FIHRP premium is 45% of the average premium and is adjusted for the Medicare reimbursement of ceded claims.

The resulting premium reductions range from 1% to 14% and are dependent on the assumed portion of the market that will be ceded as well as the basis for determining the FIHRP premium.

DEVELOPMENT OF 5:1 AGE CURVE

We developed an age curve that can be used to build a 5:1 rating scheme where a person aged 64 or older would have premium levels five times the premium of a 21-year-old for the same plan. To create this 5:1 age rating curve we utilized a linear transformation of the existing federal 3:1 age curve in use illustrated by the following formula:

$$\text{5:1 Age Curve Factor} = \{\text{3:1 Age Curve Factor} * 2.0\} - 1.0$$

The exact age factors to be used have not been released along with the proposals being considered that would change the age rating to a 5:1 ratio. However, the methodology above is consistent with the equation developed by Saltzman and Eibner of the Commonwealth Fund Study.[14] This linear transformation causes a greater increase of the age factors of older ages because the differential between age factors is greatest at older ages.

Computing the corresponding premiums by age under the 5:1 age-curve requires computing the appropriate base premium and applying this rate to the age-factors. This base rate would result in premiums by age such that total aggregate revenues remain budget-neutral between the 3:1 and 5:1 age curve scenarios for a given population. We relied on the actual on-exchange 2016 individual market

[14] Saltzman, E. & Eibner, C. (September 2015). Technical Appendix: Rate Banding Analysis. The Commonwealth Fund. Retrieved April 6, 2017, from http://www.commonwealthfund.org/~/media/files/publications/blog/2015/eibner_rate_banding_tech_append_090215_clean_pf.pdf?la=en.

enrollment distribution by age from a report produced by ASPE. We assume that enrollment levels and distributions by age do not change under the 5:1 age curve when compared with the 3:1 scenario when illustrating the premiums by age. We also assume no further changes in population morbidity to illustrate the isolated impact of changing the age curve and implementing the FIHRP.

Potential member migration was estimated after the rate change by age was computed for the impact of moving to the 5:1 age curve and the introduction of the FIHRP. The existing individual market enrollment was segmented into separate cohorts by their household income in relation to the federal poverty level (FPL). This was done to model potential policyholder behavior separately because behavior is expected to be dependent on income level. No migration was assumed for those under 250% of the FPL.

Individuals in this income range qualify for advance Advance premium Premium tax Tax credits Credits (APTCs) as well as cost Cost-sharing Sharing reduction Reduction (CSR) subsidies. Introducing the FIHRP should lower premiums in the market. If members in this cohort are currently insured they will likely remain insured in the market where they have access to the same level of subsidization. If individuals in this cohort are uninsured despite the access to subsidies and CSR plans, they will likely remain uninsured. Therefore, it was assumed that no migration would take place for this cohort.

Individuals with incomes greater than 400% of the FPL do not qualify for any subsidization. They may be motivated to switch plans if the potential savings is great enough. To model the migration of this group, rate changes by age band were estimated. For each age band, a factor was used to estimate how many individuals would migrate to the new pool. The table below illustrates the assumed likelihood of migration by rate decrease. The likelihood of moving when the rate decrease is less than 5% is assumed to be 20%. It was assumed that all individuals would migrate at rate decreases over 40%.

Table 15
Migration Factors by Rate Decrease

Rate Decrease	Likelihood of Migration
0% -5%	20%
5% -10%	40%
10% -15%	55%
15% -20%	70%
20% -25%	80%
25% -30%	90%
30% -35%	95%
35% -40%	100%

Individuals with household income between 250% and 400% of the FPL qualify for lower levels of APTCs, and do not qualify for CSR subsidies. The impact of the tax credits that offset the premiums paid need to be considered when modeling behavior for this cohort. Tax credits by age band from the Milliman Health Care Reform Financial Model were used to estimate current net premiums under the existing risk pool. These net premiums were then compared with the projected premiums in the alternate risk pool to create a rate change. The same migration factors used in the table shown above were then used with these rate changes to estimate the number of members that would migrate.

Migration into the risk pool from the currently uninsured population was handled in a similar fashion. Members who are currently uninsured and have household incomes less than 400% of the FPL were assumed to remain uninsured. Uninsured individuals with income greater than 400% of the FPL were assumed to migrate into the alternate risk pool at 25% of the likelihood assumed for insured individuals in the same age-band. For example, if it was determined that the rate decrease for individuals in a particular age-band was -8%, we assumed 40% of the insured population and 10% of the uninsured population over 400% of FPL would migrate.

VI. CAVEATS, LIMITATIONS AND QUALIFICATIONS

This Milliman report has been prepared for the specific purpose of estimating the impact of the FIHRP on individual marketplace premium rates and enrollment. This information may not be appropriate, and should not be used, for any other purpose.

Any release of this report to a third party must be in its entirety; in particular, Attachment A should not be released other than in context with the rest of this report.

The information presented in this report is provided for the Foundation for Government Accountability. The Foundation may share this information with outside entities with Milliman's permission. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work product. Any third party recipient of this work product should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The material in this report represents the opinion of the authors and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views in this report related to the FIHRP, age rating rules, or any other policy.

Milliman does not provide legal advice, and recommends that Foundation for Government Accountability consult with its legal advisors regarding legal matters.

The authors are actuaries for Milliman, are members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

ATTACHMENT A — REVISED April 17, 2017

Scenario 1: New Risk Pool for Newly Insured Lives Alongside Existing ACA Risk Pool

Existing Risk Pool FIHRP Rate Components				New Risk Pool FIHRP Rate Components			Rate Reduction vs. Current Rates		Lives in Risk Pool		Uninsured		APTCs	PSSF
Existing	90%	Medicare	No	New	90%	Medicare	4-7%	16-31%	11.5mil	5.9 mil	1.2-2.0 mil	11-19%	$2.2 bil	$6.6 bil
Existing	90%	Medicare	Yes	New	90%	Medicare	7-14%	16-31%	12.0 mil	5.3 mil	1.1-1.8 mil	10-17%	$4.3 bil	$9.6 bil
Existing	No eligible for FIHRP			New	90%	Medicare	0%	16-31%	10.8 mil	6.7 mil	1.3-2.2 mil	13-20%	$0	$3.33 bil
Existing	90%	Commercial	No	New	90%	Commercial	1-2%	12-23%	11.8 mil	5.5 mil	1.1-1.9 mil	10-18%	$610 mil	$11.23 bil
Existing	90%	Commercial	Yes	New	90%	Commercial	2-4%	12-23%	12.0 mil	5.3 mil	1.1-1.8 mil	10-17%	$1.2 bil	$16.7 bil
Existing	No eligible for FIHRP			New	90%	Commercial	0%	12-23%	11.7 mil	5.6 mil	1.1-1.9 mil	10-18%	$0	$4.9 bil

Scenario 2: Current ACA Structure With Single Risk Pool

Existing Risk Pool FIHRP Rate Components					Rate Reduction vs. Current Rates	Uninsured		APTCs	PSSF
Pool	% of Direct	FIHRP Payment Basis	Include Closed Block?	Lives in Existing Risk Pool	Existing Pool	Reduction in Uninsured	% QHP-eligible	Annual Reduction in Federal Dollars	Annual PSSF Subsidy to Support FIHRP
Existing	90%	Commercial	No	16.8 mil	1-2%	740k-1.27 mil	7-12%	$600 million	$9.3 billion
Existing	90%	Commercial	Yes	16.8 mil	2-4%	740k-1.31 mil	7-12%	$1.2 billion	$17.0 billion
Existing	90%	Medicare	No	16.9 mil	4-7%	820k-1.41 mil	8-13%	$2.2 billion	$5.4 billion
Existing	90%	Medicare	Yes	17.0 mil	7-14%	930k-1.6 mill	9-15%	$4.3 billion	$9.9 billion
Existing	45%	Medicare	No	17.0 mil	6-10%	900k-1.52 mil	9-14%	$3.2 billion	$7.6 billion

The U.S. ACA Individual Market Showed Progress In 2016, But Still Needs Time To Mature

07-Apr-2017

The numbers are in. In line with S&P Global Ratings' forecast, 2016 was a marked improvement for most U.S. Blue Cross Blue Shield (Blues) insurers' operating performance in the Affordable Care Act (ACA) individual market. But target profitability is still a couple of years away.

Looking forward, we expect insurers, on average, to get close to break-even margins in this segment in 2017. But 2018 and beyond are still uncertain given potential legislative changes to the U.S. health insurance market and the pending legal battles over the cost-sharing reduction (CSR) subsidy. If the market continues unaffected, with a few fixes rather than an overhaul, we expect 2018, or Year 5 of the ACA individual market, to be one of gradual improvement with more insurers reporting positive (albeit low single-digit) margins. But if there are significant changes to the individual market, or if CSRs are made null and void, the market essentially has to restart with a new set of rules.

Overview

- The U.S. ACA individual market shows signs of improvement, as most insurers' 2016 results were better than 2015 results.
- But the market is still developing and will need a couple more years to reach target profitability.
- 2016 results and the market enrollment so far in 2017 show that the ACA individual market is not in a "death spiral."
- However, every time something new (and potentially disruptive) is thrown into the works, it impedes the individual market's path to stability.

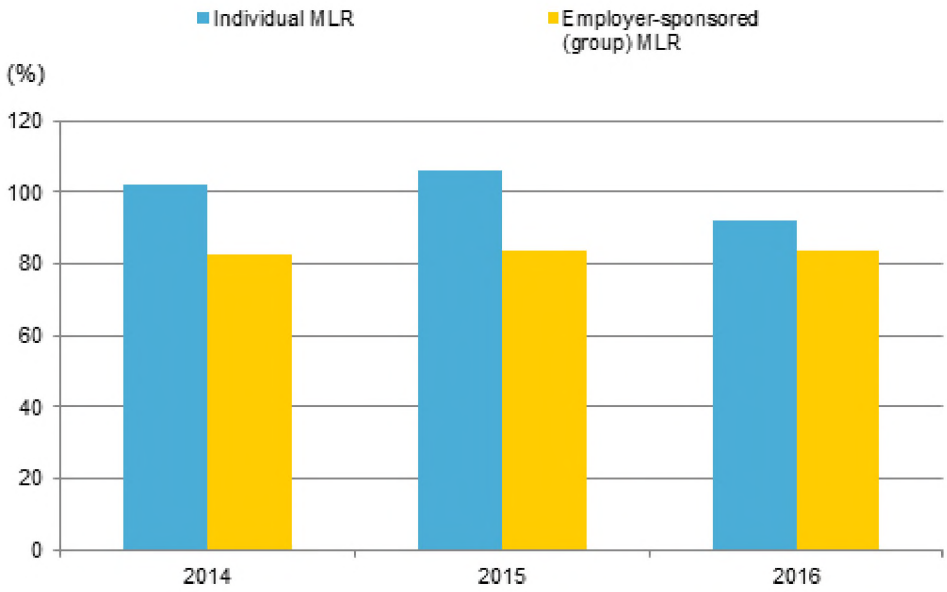
Other than operating performance, a key area of focus for the individual market is insurers' participation in the ACA marketplace (exchanges). Based on recent exit announcements, states like Tennessee and Iowa may have counties with no insurer on the exchange in 2018. This issue may worsen if the uncertainty around market rules and subsidies isn't clarified sooner rather than later. Insurers need to file their initial rates and products for 2018 in May and June of this year. Having them decide without adequate information may result in either higher-than-expected premium rate increases, or a few insurers hesitating to remain in the market.

Improvement In 2016, But Target Margins Are Still A Couple Of Years Away

As we have stated previously, we expect a five-year path to stability. 2016 was year 3. After starting on the wrong foot in 2014, and deteriorating further in 2015, we are seeing the first signs in 2016 that this market could be manageable for most health insurers. Other than a few exceptions like the Florida and New Jersey Blues, most Blue plans have struggled in this line of business. But the medical loss ratios (MLRs) for most Blues improved significantly in 2016. MLRs represent the percentage of premiums insurers pay out in claims. The weighted average MLR for the Blues included in our study was about 92% for full-year 2016, compared to 106% in 2015 and 102% in 2014.

Chart 1

Blues MLRs - Individual And Group Business Lines

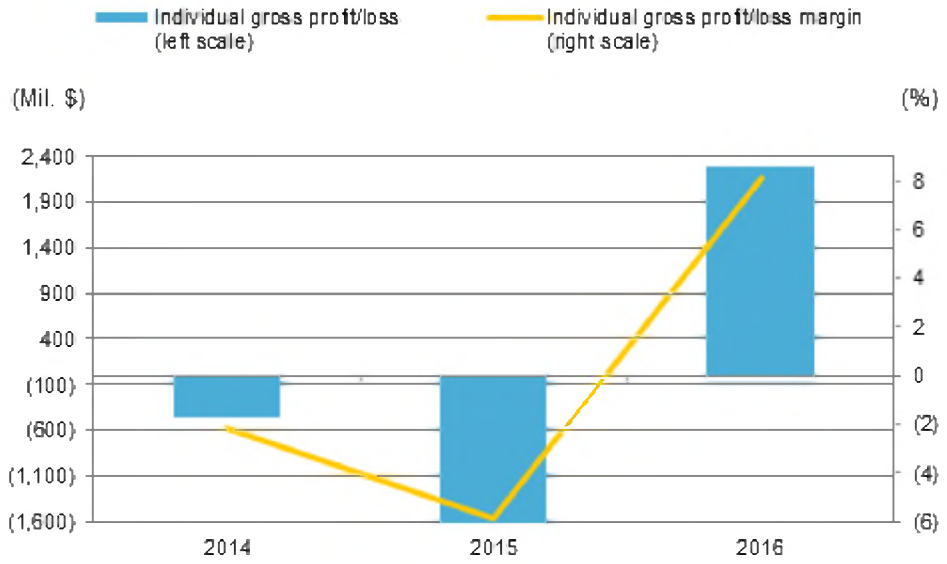


MLR calculated as incurred claims/premiums written. Source: NAIC annual statutory filings, S&P Global Ratings research.

On a gross profit/loss (before accounting for administrative cost) basis, an MLR below 100% indicates that the insurer had some money left over after paying medical claims. 2016 was the first year since the start of the exchanges that the Blues reported a gross profit (in aggregate) in the individual business line (see chart 2). But adding in administrative cost to get to underwriting profit/loss, most of the insurers (especially those with MLRs above 90%) would continue to report an underwriting loss. This means more time is needed for this market to mature before consistent underwriting profits are possible.

Chart 2

Gross Profit/Loss In The Individual Market

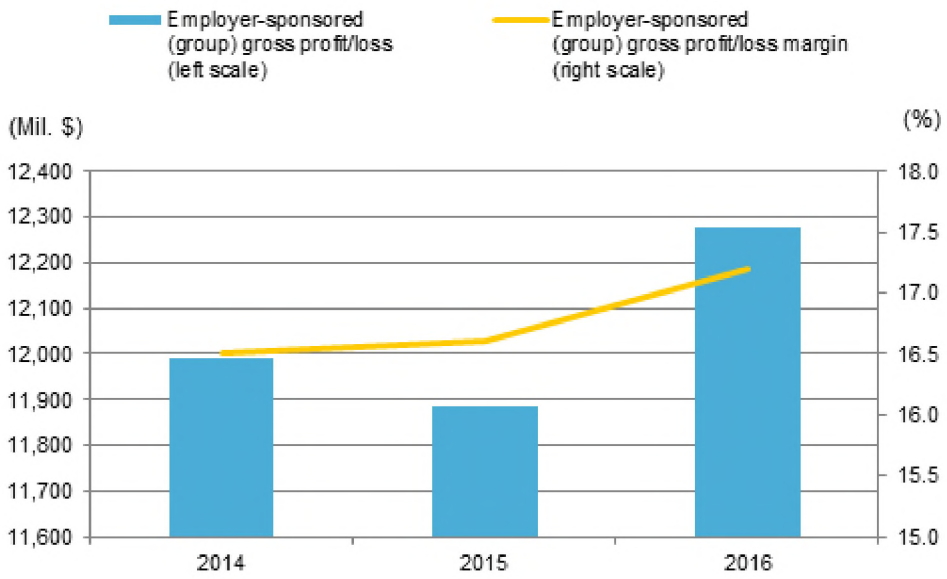


Gross profit/loss = premiums – claims; gross margins are before taking into account administrative costs. Source: NAIC annual statutory filings, S&P Global Ratings research.

Our analysis of 2016 results and the market enrollment so far in 2017 shows that the ACA individual market is not in a "death spiral." But it isn't on a stable footing either. As a point of comparison, we looked at the employer-sponsored (group) insurance market. The group line of business, which continues to be the dominant segment for the industry, remains fairly steady for most diversified insurers. Both the MLRs and gross margins (see charts 1 and 3) in the group business are better and more consistent than those in the individual market. The obvious difference is scale or size of the risk pool. But the other difference is maturity of the risk pool. Although the individual risk pool will not achieve the scale of the group market, it will mature with time.

Chart 3

Gross Profit/Loss In The Group Market



Gross profit/loss = premiums – claims; gross margins are before taking into account administrative costs. Source: NAIC annual statutory filings, S&P Global Ratings research.

Continued Improvement In 2017

Insurers have put in meaningful premium rate increases, along with product and network changes, for 2017. Besides correcting for morbidity risk, the pricing increases also attempt to cover for the end of the ACA reinsurance program. Unlike the risk corridor that failed to pay out as initially expected, the ACA reinsurance program proved fairly effective for insurers. Funded by reinsurance contributions by eligible insurers, the ACA reinsurance program paid out close to $16 billion for 2014 and 2015. The reinsurance program expires after 2016. We believe the continued pricing correction and network design changes, along with regulatory fine-tuning of ACA rules, will result in closer to break-even underwriting results, on average, for the individual market this year. But most will remain below their target profitability levels (low single-digit margins for the Blues) in 2017. It will take another year or two of continued improvements to get to that target.

The sharp rise in premium rates in 2017 didn't lead to a significant drop in enrollment, and perhaps a potential "death spiral." This is because of the stabilizing effect of ACA's income-based advanced premium tax credit (APTC). As per the Center for Medicare and Medicaid Services (CMS), the gross average monthly premiums (before APTC) for APTC-eligible enrollees increased more than 20% in 2017. But CMS noted that there was almost no year-over-year change in the net average premiums (post APTC). Over 80% of the enrollees on healthcare.gov received an APTC linked to the actual price or market premium; so as premiums went up, so did their subsidies. This effectively hedged them against the sharp premium increase. There was a decline of 5% in 2017 enrollment when compared to 2016 open enrollment, but it could have been far worse if not for the APTC and CSR subsidies.

Pricing And Participation Uncertainty In 2018

As insurers continue to adjust their products and pricing, we expect some premium rate increase in 2018 as well. If it remains business as usual, we expect 2018 premiums to increase at a far lower clip than in 2017. Premium increases are common in the insurance space. Even the group market undergoes premium increases each year. But the scale of increase is generally smaller than what happened in the individual market in 2017.

If it is business as usual, we expect low single-digit year-over-year growth in membership/enrollees for 2018. As for insurer participation, we expect most counties in the U.S. to continue to see at least one insurer on the exchange in 2018. However, based on recent company announcements, certain counties may be left without any insurer on the exchange in 2018. We observed some correlation between insurer participation and Medicaid expansion. For example, four out of the five states (Alabama, Alaska, Oklahoma, South Carolina, and Wyoming) that have one insurer on the exchange in 2017 also don't have an expanded Medicaid program. Insurers also consider other factors when deciding to participate on an exchange, including population size, morbidity levels, and their own tolerance for volatility in earnings.

Any significant overhaul or increased uncertainty may lead to a different result than we have forecasted for 2017 and 2018. If the legal battle over CSRs isn't concluded soon, or if insurers don't have clear assurances that they will be paid for CSRs in 2018, they will have to make a decision on pricing and participation without adequate information. Additionally, the spotlight will be on the U.S. Dept. of Health and Human Services to continue implementing ACA in its current form until a different health insurance reform bill becomes law. Clarification on the CSR subsidy, enrollment outreach, and enforcement of special enrollment periods and the individual mandate will top the agenda for the future stability of the individual marketplace. If insurers are uneasy regarding the future of the market, they may have to decide between adding an "uncertainty buffer" to their pricing or--worst case--exiting the exchanges altogether.

A Fragile Market Needs Time To Stabilize

We view the individual market as being in the early stage of development, and therefore somewhat fragile. There was an individual market before 2014, but the current ACA individual market is only four years old and needs time to stabilize. Additionally, right from the start multiple external factors have disrupted this market, such as technical issues with the healthcare.gov website in 2014, after-the-fact rule changes related to the grandmothered plans, altering the risk corridor to be budget-neutral, and the more recent CSR court case and potential for legislative overhaul. Every time something new (and potentially disruptive) is thrown into the works, it impedes the individual market's path to stability.

Blues Medical Loss Ratio For The Individual Market

(%)	2016	2015	2014	Total individual members (2016)	Participating States
Health Care Service Corp	96.2	118.3	112.7	1,158,117	IL, MT, NM, OK, TX
GuideWell Mutual Holding Co.	75.2	84.0	94.3	748,988	FL
Blue Cross and Blue Shield of North Carolina	83.0	102.7	91.6	373,673	NC
Carefirst Inc.	97.7	103.3	98.0	308,702	DC, MD
Arkansas Blue Cross & Blue Shield	92.7	93.9	92.4	270,574	AR
Independence Health	94.3	97.0	94.5	261,218	PA
Horizon Healthcare Services	85.1	76.5	83.5	196,161	NJ
BlueCross BlueShield of Tennessee Inc.	101.4	122.6	117.9	194,995	TN
Highmark Inc.	102.8	133.8	122.7	173,028	PA, NJ
Blue Cross & Blue Shield of Alabama Inc.	98.4	120.2	102.1	164,307	AL
Louisiana Health Service & Indemnity Co. (d/b/a Blue Cross and Blue Shield of Louisiana)	94.9	102.0	97.6	147,963	LA
Blue Cross and Blue Shield of South Carolina	88.5	91.2	85.0	131,784	SC
Blue Cross & Blue Shield of Arizona Inc.	90.1	105.5	105.0	129,065	AZ
Blue Cross Blue Shield of Michigan	79.8	83.1	81.8	118,452	MI
Blue Cross & Blue Shield OF Minnesota	113.2	134.7	122.4	102,434	MN
Premera Blue Cross	97.6	113.8	94.9	100,086	WA, OR
Cambia Health Solutions	89.3	94.5	104.7	99,909	OR, WA, UT, ID
Wellmark Group	97.5	101.9	94.5	95,587	IA
Blue Cross & Blue Shield Of Kansas City	98.7	104.7	109.1	94,222	MO

Blue Cross & Blue Shield of Kansas Inc.*	113.4	119.8	117.0	92,047	KS
Capital Blue Cross	107.1	104.6	94.9	85,900	PA
Blue Cross & Blue Shield of Massachusetts Group	107.6	104.9	95.8	81,802	MA
Blue Cross of Idaho Group	98.5	112.7	104.7	67,367	ID
Blue Cross & Blue Shield of Nebraska Inc.	107.5	114.7	109.6	56,921	NE
Mississippi Ins.	89.4	90.3	95.9	53,315	MS
Lifetime HlthCare	80.7	77.4	84.4	52,554	NY
Noridian Mutual Insurance Co. (d/b/a Blue Cross Blue Shield of North Dakota)	92.7	87.9	96.1	38,506	ND
Blue Cross & Blue Shield of Wyoming Inc.	102.1	90.2	83.2	32,377	WY
Blue Cross & Blue Shield of Vermont	95.4	95.4	104.5	28,751	VT
Blue Cross & Blue Shield of Rhode Island Inc.	90.2	88.7	90.0	27,340	RI
Hawaii Medical Service Assoc.	116.4	116.8	112.0	24,657	HI
HealthNow New York Inc.	99.1	79.4	75.2	10,499	NY

Blues with multiple entities have been grouped together based on available information. MLR calculated as amount incurred for provision of healthcare services / Health premium written. *One entity in the group has a life filing, for which we used earned instead of written premiums. Source: NAIC annual health statutory filings - Exhibit of premiums, enrollment & utilization, S&P Global Ratings research.

Additional Details

We focused on the Blues as a case study for our analysis. In most states, Blues have leading shares of their local individual markets and are participating on and off the exchanges. For Blues that have more than one legal entity, we combined the multiple entities where possible. We did not include the for-profit Blue plans that are part of the publicly traded Anthem Inc. group. Also, we did not include Blue Shield of California because statutory filing templates in California differ significantly from those in the remaining states.

Related Research

- Moving From "Repeal and Replace" To "What's Next" For U.S. Health Care, March 27, 2017
- The U.S. Health Insurance Market Is Poised To Move To A Defined-Contribution From A Defined-Benefit System Of Federal Financing, March 7, 2017
- U.S. Health Insurer 2017 Outlook: Stable Amid Heightened Industry Uncertainty, Jan. 3, 2017
- Deal Or No Deal: What Effect Could The DOJ Decision On U.S. Health Insurer Mega-Mergers Have On Credit Quality?, July 21, 2016
- Growth At A Cost: A Look At U.S. Insurers' Expansion And Profitability In The Individual Market, April 12, 2016

Only a rating committee may determine a rating action and this report does not constitute a rating action.

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Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies

Estimated Increases Range from 9% in North Dakota to 27% in Mississippi

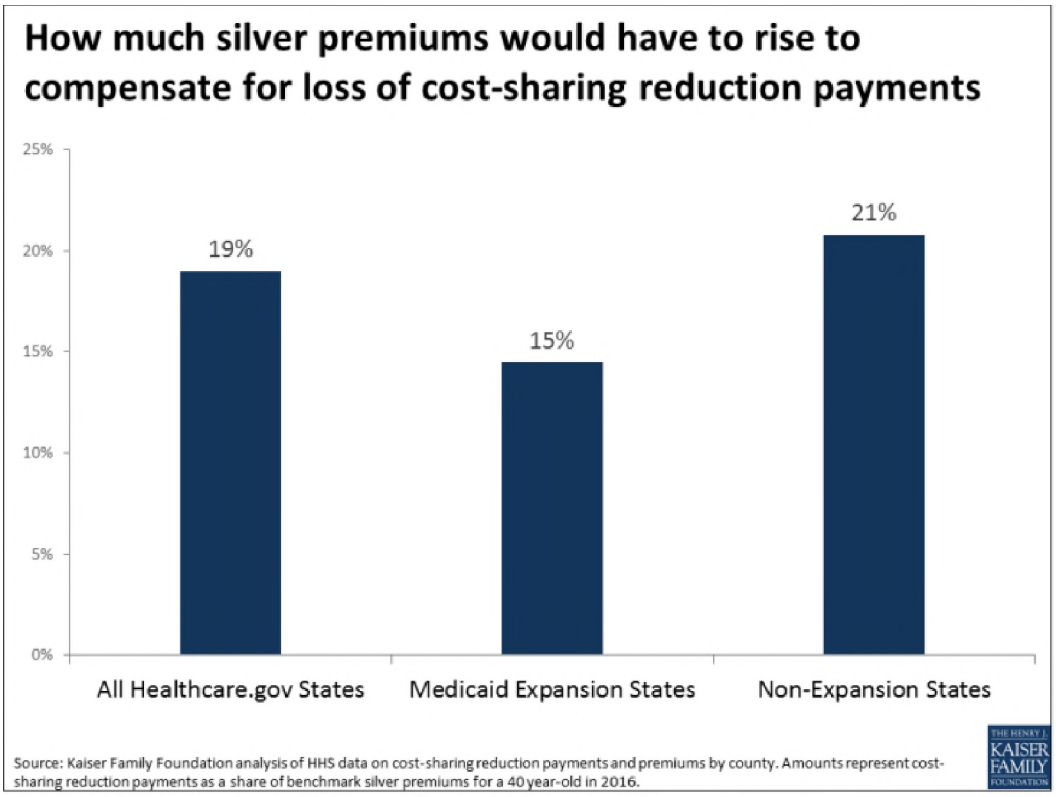
Apr 06, 2017

A new Kaiser Family Foundation analysis finds that the average premium for a benchmark silver plan in Affordable Care Act (ACA) marketplaces would need to increase by an estimated 19 percent for insurers to compensate for lost funding if they don't receive federal payment for ACA cost-sharing subsidies.

Established by the health law to reimburse insurers for the cost of reducing out-of-pocket costs for lower-income people buying marketplace plans (with incomes from 100% to 250% of the poverty level), the subsidies have been challenged in a lawsuit from the U.S. House. With a legal appeal pending, the federal government and Congress are in a position to choose whether to continue reimbursing insurers for their cost.

Among 12.2 million people who selected a 2017 ACA marketplace plan, about 58 percent, or 7.1 million, are receiving cost-sharing reductions. An earlier Foundation analysis of 2017 plans found the subsidies lower combined medical and prescription drug deductibles by as much as $3,354 and reduce annual out-of-pocket maximums by up to $5,587.

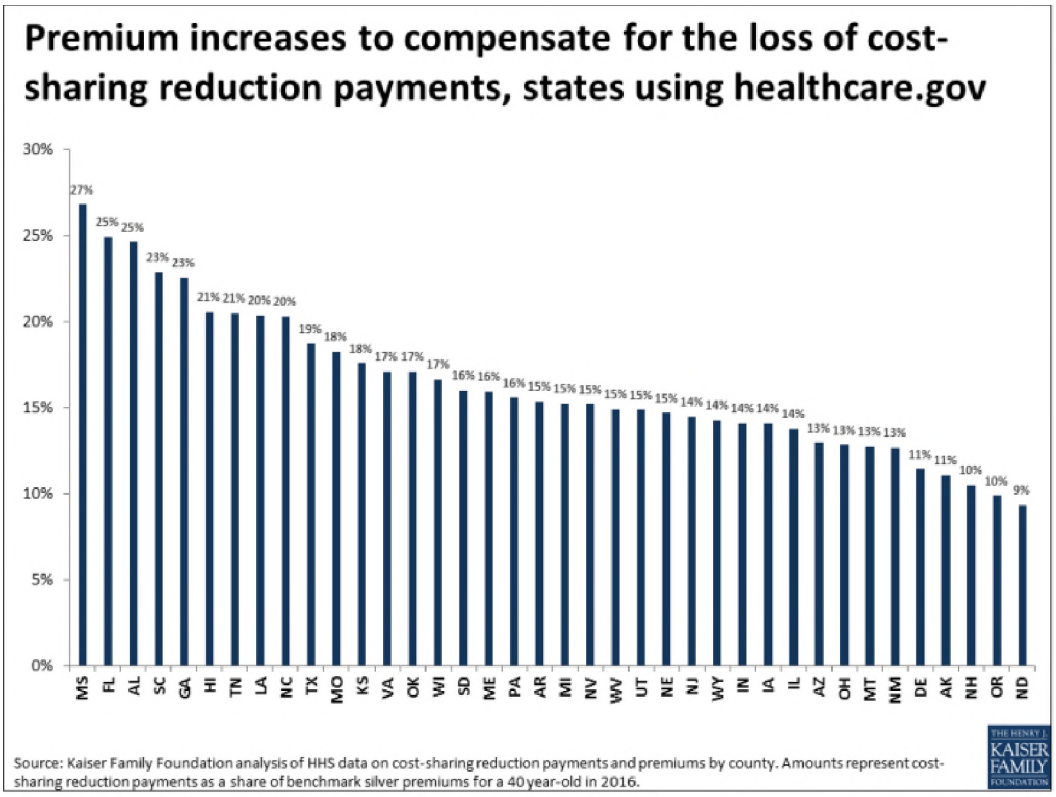
The Foundation's new analysis examines the amount insurers would need to increase premiums to make up for the lack of funding, if federal payments cease for the cost-sharing reduction program.



(https://kaiserfamilyfoundation.files.wordpress.com/2017/04/image-1-larger.png)

The analysis – based on cost-sharing subsidy payments and benchmark premiums in federa marketplace states in 2016, the most recent data available — finds that the estimated premium increase for silver plans would be higher (21%) in states that did not expand Medicaid under the ACA than in states that expanded Medicaid (15%). Cost-sharing subsidies are generally higher in states that have not expanded Medicaid because they hav a larger share of enrollees with incomes from 100% to 150% of the poverty level, who get the biggest cost-sharing reductions.

Estimated premium changes vary for the 38 states that used healthcare.gov in 2016, rangin from 9 percent in North Dakota to 27 percent in Mississippi.



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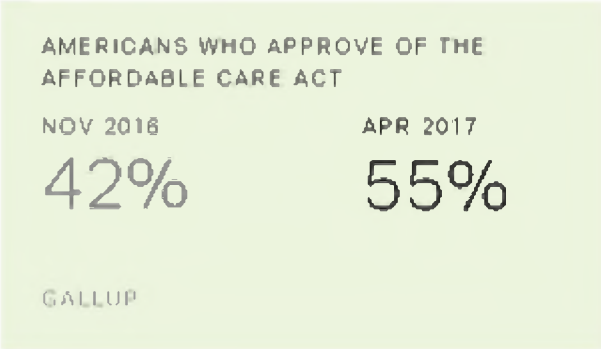
Foundation experts discussed the analysis today during a web briefing for journalists: *ACA Cost-Sharing Subsidies: How One Decision Could Disrupt Obamacare Marketplaces* (http://kff.org/health-reform/event/web-briefing-for-journalists-aca-cost-sharing-subsidies-how-one-decision-could-disrupt-obamacare-marketplaces/). Watch the archived recording here (http://kff.org/health-reform/event/web-briefing-for-journalists-aca-cost-sharing-subsidies-how-one-decision-could-disrupt-obamacare-marketplaces/).

GALLUP

APRIL 4, 2017

Affordable Care Act Gains Majority Approval for First Time

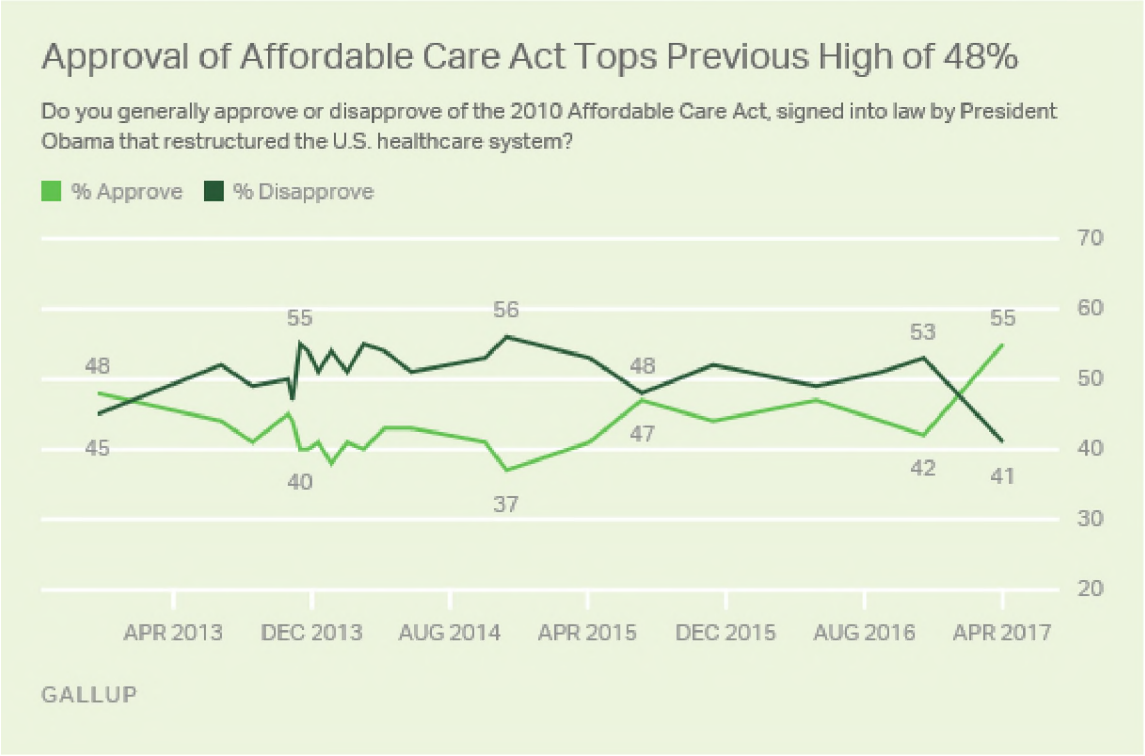


by Jim Norman

Story Highlights

- 55% approve, up from 42% right after 2016 election
- 40% want to keep law but make significant changes
- 30% want to repeal; 26% want to keep law as it is

WASHINGTON, D.C. -- Fifty-five percent of Americans now support the Affordable Care Act (ACA), a major turnaround from five months ago when 42% approved and 53% disapproved. This is the first time a majority of Americans have approved of the healthcare law, also known as Obamacare, since Gallup first asked about it in this format in November 2012.



Since the ACA's passage without a single Republican vote in its favor, the law has been a significant political issue in each of the past four national elections. Republicans' opposition to the ACA helped them win control of the House in 2010, control of the Senate in 2014 and the presidency last year. However, Republicans' plan to repeal and replace the healthcare law foundered last month, as House leaders' replacement bill ran into stiff opposition within the party.

Republicans, Democrats and independents are all more likely to approve of the ACA now than in November, a few days after Donald Trump's victory in the presidential election left Republicans in control of the legislative and executive branches. Independents have led the way in this shift toward approval, increasing by 17 percentage points compared with 10-point changes for both Republicans and Democrats. When including "leaners" (independents who lean toward either the Republican or Democratic Party) in the totals for both major party groups, Democratic approval has increased by 16 points, compared with eight points for Republicans.

Independents Lead Shift Toward Approval of Affordable Care Act

% Approve

	Nov 2016	Mar 2017	Change
	%	%	(pct. pts.)
U.S. adults	42	55	+13
Democrats	76	86	+10
Independents	40	57	+17

	Nov 2016	Mar 2017	Change
	%	%	(pct. pts.)
Republicans	7	17	+10
Democrats + leaners	71	87	+16
Republicans + leaners	11	19	+8

GALLUP

Although the ACA never garnered majority support in Gallup polling before this month, nearly half of Americans (48%) approved of it the first time the current version of the question was asked in November 2012. In response to a previous version of the question that asked whether Americans thought passing the healthcare law was a good thing or a bad thing, 49% said it was a good thing when the question was first asked in early 2010. However, support was a few percentage points lower each of the next two times it was asked.

Public Split, With Many Favoring Major Changes to ACA

Though a majority of Americans now approve of the ACA, only about one in four (26%) want to keep it largely as it is. Forty percent want to keep the law in place but make significant changes, while 30% want to repeal and replace it.

Democrats Split on Making Changes to ACA; Republicans Favor Repeal

Would you rather keep the ACA in place largely as it is, keep the ACA in place but make significant changes to it, or repeal the ACA and replace it with a new healthcare plan?

	Keep ACA in place as it is	Keep ACA in place with significant changes	Repeal and replace ACA
	%	%	%
U.S. adults	26	40	30
Democrats	44	47	5
Independents	23	44	28
Republicans	9	29	60

GALLUP

The differences in opinion between Democrats and Republicans on this issue affects their views on what action, if any, to take. Democrats are split on whether to keep the act largely as it is (44%) or keep it but make significant changes to it (47%). In contrast, a majority of Republicans (60%) want to

repeal and replace the law.

What Americans want Congress to do next regarding healthcare hinges on their views of the ACA:

- Twenty-six percent want to keep the law in place largely as it is.
- The 40% who want to keep the law but make significant changes are evenly split: 49% want Congress to continue to work on healthcare in the next few months, while 49% would like to see Congress turn its attention to other issues for the time being.
- Among the 30% who want the ACA repealed and replaced, most (64%) say Congress should continue to work on healthcare. Another 32% say Congress should turn to other issues.

Bottom Line

Trump vehemently attacked the Affordable Care Act during his presidential campaign -- and in the days immediately following his election, the public appeared to agree with him. However, in the five months since, as Republicans' efforts to replace the law with one of their own have failed to get off the ground, enough Americans have changed their minds about the ACA to create a majority favoring it for the first time.

If that majority holds, it would be a significant development. Politically, it creates a major obstacle to Trump and Congress' ongoing efforts to change or replace the law. In future elections, it could turn the GOP's opposition to the law from an asset into a liability. More importantly in the daily lives of Americans, it might mean that the most sweeping changes to the nation's healthcare system in decades will remain the law of the land for the foreseeable future.

These data are available in Gallup Analytics.

SURVEY METHODS

Results for this Gallup poll are based on telephone interviews conducted April 1-2, 2017, on the Gallup U.S. Daily survey with a random sample of 1,023 adults, aged 18 and older, living in all 50 U.S. states and the District of Columbia. For results based on the total sample of national adults, the margin of sampling error is ±4 percentage points at the 95% confidence level.

Each sample of national adults includes a minimum quota of 70% cellphone respondents and 30% landline respondents, with additional minimum quotas by time zone within region. Landline and cellular telephone numbers are selected using random-digit-dial methods.

View survey methodology, complete question responses and trends.

Learn more about how the Gallup U.S. Daily works.

RELEASE DATE: April 4, 2017
SOURCE: Gallup http://www.gallup.com/poll/207671/affordable-care-act-gains-majority-approval-first-time.aspx
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March 2017 | Issue Brief

Impact of Cost Sharing Reductions on Deductibles and Out-Of-Pocket Limits

Matthew Rae, Gary Claxton, Larry Levitt

The American Health Care Act (AHCA) proposes several changes to the financial support available to people enrolling in nongroup coverage. In addition to modifying the premium tax credits that people would get, the AHCA would eliminate the provision that reduces the cost sharing burden for lower- and moderate income enrollees who get their coverage through the federal or a state marketplace. The cost-sharing reductions are a key part of the financial support currently provided to these enrollees; over 6.4 million people were enrolled in a plan with reduced cost-sharing in 2016 (See State Health Facts). This note briefly describes the cost-sharing reductions in current law and illustrates their impact by looking at how these provisions affect average deductibles and out-of-pocket maximum limits in benchmark silver plans in 2017 in states using the federally facilitated marketplace.

How Cost Sharing Reductions Work

Under current law, people who are eligible for premium tax credits based on their income also may be eligible for a reduction in their cost sharing (i.e., deductibles, coinsurance, copayments, out-of-pocket limits) if they enroll in a plan in the silver tier. Insurers are required to reduce the cost sharing applicable to people with low and moderate incomes by increasing the actuarial value of the plan that people choose. A silver plan generally has an actuarial value of 70%, which means that the insurers expects to pay, on average, 70% of the covered costs of enrollees in the plan. Insurers must increase the actuarial value to 94% for enrollees with incomes below 150% of poverty, to 87% for enrollees with incomes between 150% and 200% of poverty, and to 73% for enrollees with incomes between 200% and 250% of poverty. They do this by creating variants (called cost sharing reduction, or CSR plans) of each silver plan they offer: each variant lowers the cost sharing to meet the higher actuarial value required. Insurers are periodically reimbursed for the additional claims expenses they incur from lowering the cost sharing in these plans.

The law provides insurers flexibility in determining how cost sharing is arranged in order to meet these actuarial value levels, although the out-of-pocket limits on cost sharing cannot exceed prescribed amounts. An out-of-pocket limit is the maximum an enrollee must pay toward cost sharing for services received in-network; after the limit is reached the insurer pays 100% of the cost for covered services. In 2017, the maximum out-of-pocket limit applicable for most plans is $7,150 for single coverage and twice that amount for family coverage. For CSR plans, the maximum out-of-pocket limits for single coverage are $2,350 for enrollees with incomes below 200% of poverty, and $5,700 for enrollees with incomes between 200% and 250% of poverty[1] (For More on Health Insurance subsidies). The limits for family CRS plans are twice the single limits. Table 1 illustrates how the cost sharing in a standard silver plan compares to cost sharing in its CSR variants.

Table 1: Example of Cost-Sharing Reductions on Plan Cost-Sharing				
	CSR - 94	CSR - 87	CSR - 73	Silver
Combined Medical and Drug Deductible (Individual)	$0	$500	$2,275	$2,400
Out-of-Pocket (Individual)	$1,250	$2,250	$5,700	$7,150
Primary Care Physician Visit	$0	$10	$20	$20
Specialist Physician Visit	$10	$30	$55	$55
Emergency Room Visit	$150	$205	$400	$400
Inpatient Facility	10%	20%	30%	30%
Inpatient Physician	10%	20%	30%	30%

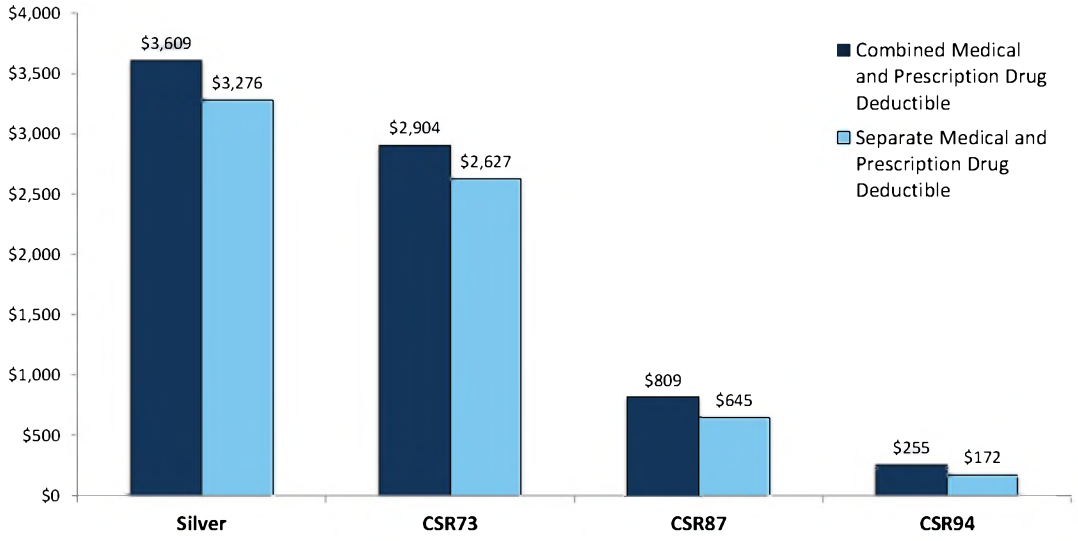
SOURCE: Plan charaestics for "Molina Marketplace Silver Plan" the Second Lowest Cost Plan in Franklin County, Ohio

Impact of Cost Sharing Reductions

To illustrate the impact of the provisions reducing cost sharing for low and moderate income enrollees, we look at the average reductions in deductibles and out-of-pocket limits in the silver plans offered in the federally facilitated marketplace (see Methods). We focus on the deductibles and out-of-pocket maximums because these are the most visible cost-sharing elements in policies.

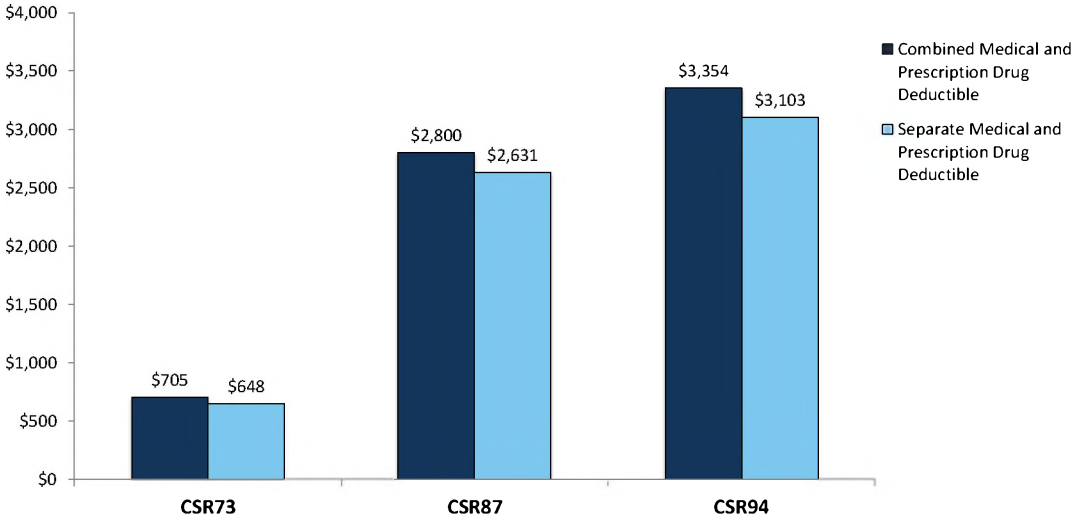
The cost sharing reductions significantly lower deductibles in these plans: for plans where there is a combined deductible for medical care and prescription drugs, the average deductible is reduced for those with incomes below 150% of poverty from $3,609 to $255, a savings of $3,354; for those with incomes between 150% and 200% of poverty the average deductible is reduced to $809 a savings of $2,800 and for enrollees with incomes between 200% and 250% of poverty, the average deductible is $2,904, a savings of $705 (Figure 1 and Figure 2). For plans with a separate deductible for medical care and prescription drugs, the comparable reductions in the deductible for medical care are $3,103, $2,631 and $648 (Figure 2).

Figure 1
Average Medical Deductible In Plans with Combined and Separate Medical and Prescription Drug Deductible



SOURCE: Kaiser Family Foundation analysis of Marketplace plans in the 39 states with Federally Facilitated or Partnership exchanges in 2017 (including Arkansas, New Mexico, Oregon, Kentucky and Nevada). Data are from Healthcare.gov Health plan information for individuals and families available here: https://www.healthcare.gov/health-plan-information-2017/

Figure 2
Average Savings in Plan Deductibles Between Silver Plans and Cost-Sharing Reduction Plans, 2017



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The impacts of the cost sharing reductions on the out-of-pocket limits in these plans is also large. The average combined medical and prescription drug out-of-pocket limit is reduced from $6,528 to $941 for a savings of $5,587 for enrollees with incomes below 150% of poverty. Likewise, the out-of-pocket maximum is reduced to $1,875 a savings of, $4,653 for enrollees with incomes between 150% and 200% of poverty, and reduced to$5,233 for enrollees with incomes between 200% and 250% of poverty, a savings of $1,294 (Figure 3 and Figure 4).

Figure 3
Average Out-Of-Pocket Limit In Plans with Combined Limit for Medical and Prescription Drug Cost Sharing

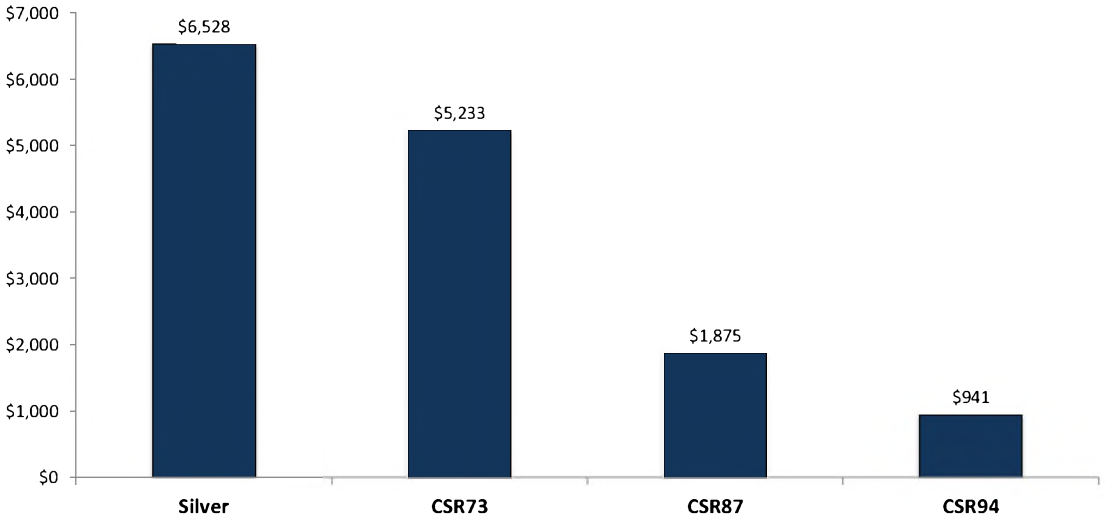

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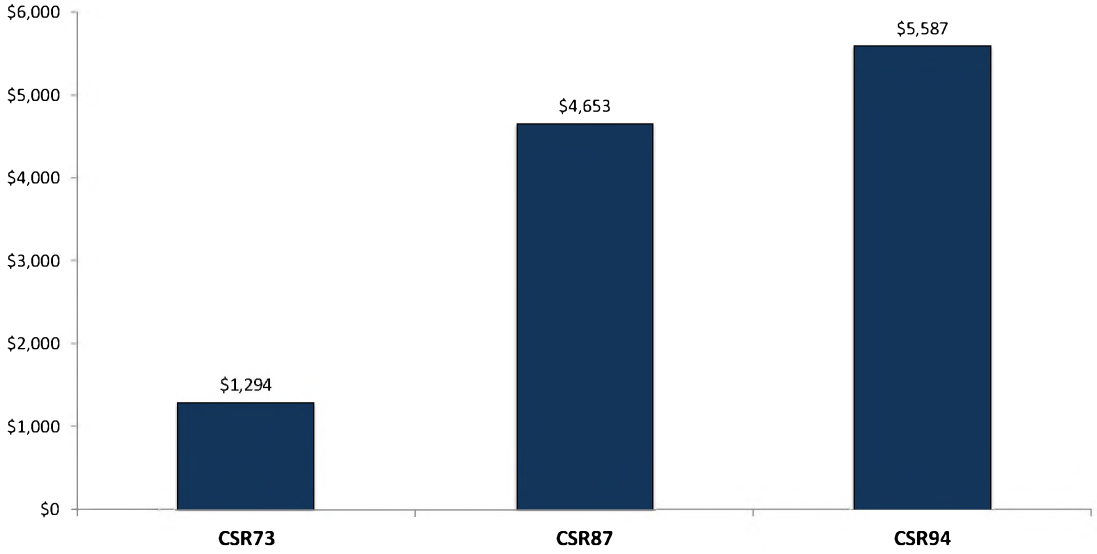
Figure 4
Average Difference in Out-of-Pocket Maximums Between Silver Plans and Cost-Sharing Reduction Plans, 2017



SOURCE: Kaiser Family Foundation analysis of Marketplace plans in the 39 states with Federally Facilitated or Partnership exchanges in 2017 (including Arkansas, New Mexico, Oregon, Kentucky and Nevada). Data are from Healthcare.gov Health plan information for individuals and families available here: https://www.healthcare.gov/health-plan-information-2017/

Discussion

The law provides considerable financial assistance for low and moderate income people who purchase non-group coverage. Premium tax credits, which are income adjusted, help make coverage more affordable, while reduced cost sharing helps to make the out-of-pocket costs at the point of service more affordable when they need care. Insurance policies can require significant cost sharing contributions from enrollees, which can strain the budgets of many families but often are out of reach for people with lower and modest incomes: in 2013, about one-third of nonelderly households with private insurance and with incomes above poverty did not have sufficient financial assets to meet deductibles of $2,500 for single person households or $5,000 for multi-person households, and the percentages are much higher for households with incomes between 100% and 250% of poverty (See Consumer Assets and Patient Cost-Sharing). While reductions in premium tax credits under the AHCA could put insurance out of reach for many low-income people, elimination of cost-sharing subsidies would make the insurance people do buy less valuable.

Methods

Data were obtained from the Data.HealthCare.gov 2017 QHP Landscape on March 17, 2017. Plans analyzed include those offered in 2017 in the 38 states using Healthcare.gov (which includes federally facilitated, supported, and partnership Marketplaces, including Oregon, New Mexico, Nevada and Hawaii).

The analysis focuses on plans in the Silver metal tier. Child-only plans were removed, and the remaining unique records (those with identical cost-sharing structures from the same issuer) were collapsed by state, thereby removing duplications where the same plans are offered in multiple counties within the state. For each Silver plan, we compared the deductible and out-of-pocket amounts with those in 73% actuarial value, 87% actuarial value, and 94% actuarial value cost-sharing variants. Averages are simple averages and not weighted by enrollment as plan-level enrollment data are not publicly available.

Endnotes

[1] 81 FR 12203. Table 10. https://www.federalregister.gov/documents/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017#h-131

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May 2017 | Issue Brief

Ten Ways That the House American Health Care Act Could Affect Women

Usha Ranji, Alina Salganicoff, Laurie Sobel, and Caroline Rosenzweig

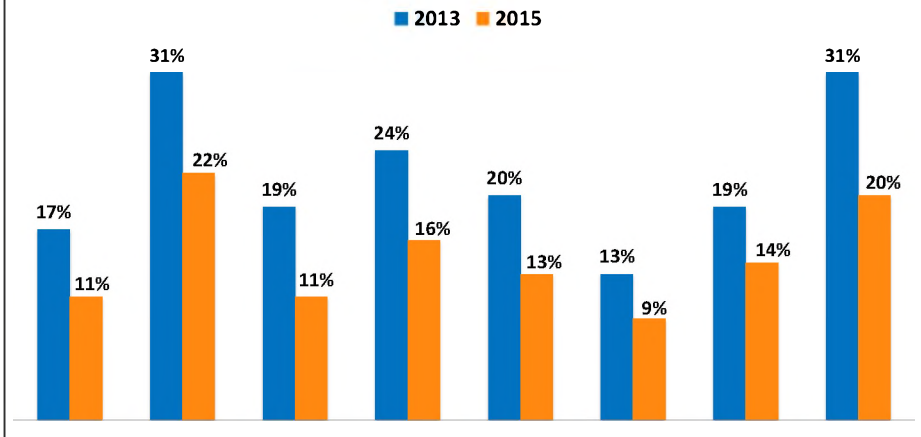
Women have much at stake as the nation debates the future of coverage in the United States. Because the Affordable Care Act (ACA) made fundamental changes to women's health coverage and benefits, changes to the law and the regulations that stem from it would have a direct impact on millions of women with private insurance and Medicaid. On May 4, 2017, the House of Representatives passed the American Health Care Act (AHCA), to repeal and replace elements of the ACA (**Appendix Table 1**). It would eliminate individual and employer insurance mandates, effectively end the ACA Medicaid expansion, cap federal funds for the Medicaid program, make major changes to the federal tax subsidies available to assist individuals who purchase private insurance, and ban federal Medicaid funds from going to Planned Parenthood. It would also allow states to waive the ACA's Essential Health Benefits requirements and permit health status as a factor in insurance rating for individuals who do not maintain continuous coverage with the goal of reducing insurance costs.[1] The Senate will now take up legislation to repeal and replace the ACA and may consider several elements that the House has approved in the AHCA. This brief reviews the implications of the AHCA for women's access to care and coverage.

ACA's Impact on Coverage and Access for Women

Since the ACA's passage, the uninsured rate has declined to record low levels. Between 2013 and 2015, the uninsured rate among women ages 19 to 64 fell from 17% to 11% **(Figure 1).** This drop was due in large part to the Medicaid expansion that was adopted by 31 states and DC, and the availability of federal tax credits to subsidize premium costs for many low and modest-income women and men. In addition to coverage improvements, fewer women face affordability barriers since the ACA was enacted. Women have consistently been more likely than men to report that they delay or

Figure 1

The Uninsured Rate Fell Among all Groups of Women between 2013 and 2015

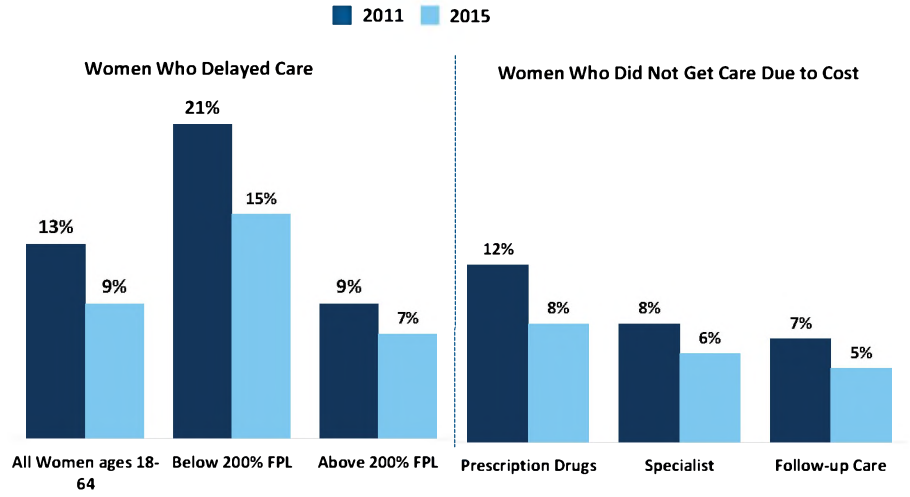


NOTE: Among women ages 19-64.
SOURCE: Kaiser Family Foundation analysis of the 2014 and 2016 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

go without needed care because of costs. The ACA addressed some of these financial barriers by providing subsidies for premiums and cost sharing, eliminating out of pocket costs for preventive services, lifting the lifetime limits on expenses insurance will cover, and requiring minimum levels of coverage for ten Essential Health Benefit categories. Since its passage, the share of women who report that they delayed or went without care due to costs has fallen (**Figure 2**). This drop has been particularly marked among low-income women, although costs continue to be a greater challenge for this group as well.

Figure 2

The Share of Women Who Delayed or Did Not Get Care Due to Cost Is Falling



NOTES: Among all women ages 18-64
SOURCE: Kaiser Family Foundation Analysis of the National Health Interview Survey 2011-2015.

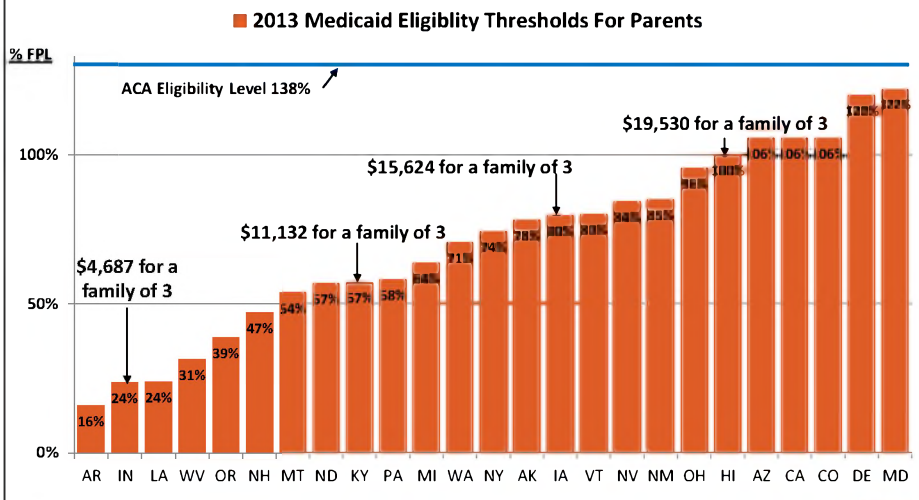
1. Medicaid Eligibility: Expansion and Work Requirements

Medicaid has been the foundation of coverage gains under the ACA. Eliminating federal funds for the ACA's Medicaid expansion could leave many of the nation's poorest women without a pathway to coverage.

Women comprise the majority of Medicaid beneficiaries—before the passage of the ACA and today. Prior to the ACA, compared to men, women were more likely to qualify for Medicaid because of their lower incomes and because they were more likely to meet one of the program's eligibility categories: pregnancy, parent of a dependent child, over 65, or disability. The ACA eliminates the program's "categorical" requirements, allowing states to extend Medicaid eligibility to all individuals based solely on income. In the 31 states and DC that have chosen to expand Medicaid, individuals with household incomes up to 138% of the Federal Poverty Level (FPL) qualify, and the federal government finances 95% of the costs.[2]

Figure 3

Prior to the ACA, Income Eligibility Levels for Parents Residing in Many States that Expanded Medicaid were Below Poverty



NOTE: Eligibility limits for parents in a family of three. CT, IL, ME, MA, MN, NJ, NY, RI, VT, WI & DC already offered coverage to parents at or above 133% FPL prior to the ACA.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

It is estimated that by 2015, 11 million adults had gained coverage as a result of the ACA's Medicaid expansion. This opened the door for continuous coverage to pregnant women who often became ineligible for coverage 60 days after the birth of their baby and had no other pathway to coverage as new mothers. The Medicaid expansion has also helped women who do not have children gain access to coverage, since before the expansion they were ineligible for coverage in most states. If passed, the AHCA bill would withdraw the enhanced federal funds for the Medicaid expansion except for beneficiaries enrolled as of December 31, 2019 who do not have a break in eligibility for more than 1 month. This loss of federal financing would leave states without the funds needed to continue supporting this expansion, potentially forcing some states to roll back eligibility for parents to the very low levels that were in place before the ACA **(Figure 3)**. For example, a single mother of two living in Louisiana or Indiana would not have qualified for Medicaid if her income exceeded $4,687. The Congressional Budget Office (CBO) estimates that, under the House AHCA bill, some states that have already expanded their Medicaid programs would not continue that coverage (some states might also begin to reduce coverage prior to 2020), and that no new states will adopt the expansion.

The AHCA bill would also amend the federal Medicaid statute to allow states to require some beneficiaries, including parents of children 6 and older and adults without disabilities, to show proof of employment. States would have flexibility to design the details of the work requirement within federal guidelines and would receive additional federal support to help cover the administrative costs of this change.

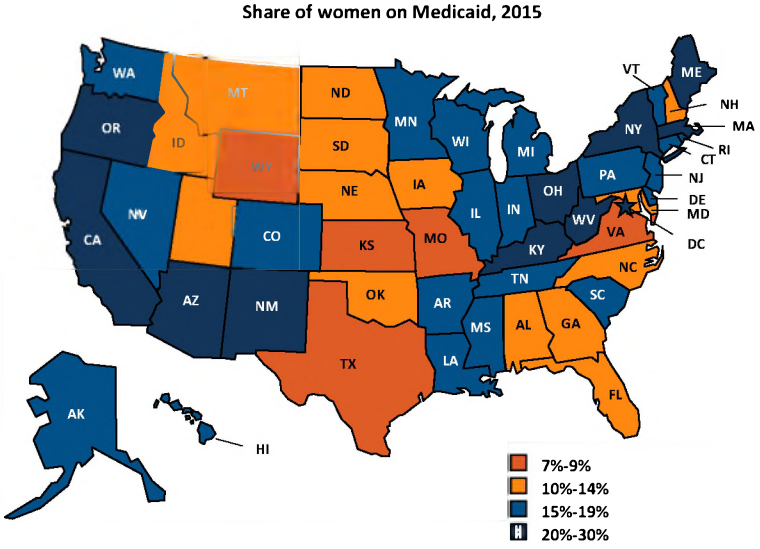
2. Capping Federal Medicaid Spending

Medicaid provides health coverage to nearly one in five women in the U.S. Capping the program would limit the federal dollars that states would receive for a program that pays for half of births, three-quarters of all public family planning, and provides supplemental coverage for nearly 1 in 5 senior women on Medicare.

Since its inception in 1965, Medicaid has evolved to become a leading source of coverage for low-income women of all ages **(Figure 4)**. The program provides health coverage to one in four women of reproductive age and one in four Latinas and African American women. Over the years, the program has also expanded to be the largest payor of maternity care and publicly-funded family planning in the U.S.

Figure 4

Medicaid is a Key Source of Coverage for Women in the U.S.



SOURCE: Kaiser Family Foundation, Health Insurance Coverage of Women 19-64, Medicaid 2015, State Health Facts, Kaiser Family Foundation Analysis of 2016 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

Medicaid is financed by a combination of federal and state dollars. For most beneficiaries, the federal government pays a percentage of costs, ranging between 50-75% depending on the state. Beginning in 2020, the AHCA would convert federal Medicaid funding from an open-ended matching system to an annual fixed amount of federal dollars. States could choose a "block grant" (for payment of services for children under 18 and poor parents of

dependent children) or a "per capita cap" approach for five enrollment groups (the elderly, individuals with disabilities, children, newly eligible adults, and all other adults). While a capped approach would reduce federal spending, it would also shift more responsibility to states to pay more of their own dollars if they want to sustain the program at current levels.

While fixed federal financing would affect all individuals insured by Medicaid, one area that is particularly important for women is the program's coverage of family planning services. Currently, the federal government requires coverage of family planning services and supplies and pays for 90% of the cost of these services, a higher match than for all other services.[3] This higher federal payment rate provides states with an incentive to cover the full range of contraceptive methods. Under a per capita cap structure, states will still be required to cover family planning services, but there will no longer be an enhanced federal matching rate for family planning services provided to most beneficiaries. As a result, there may be less up-front financial incentive for states to cover the more expensive methods of contraception like IUDs, even though they are highly effective at preventing unintended pregnancies. Should states select a block grant option, family planning services would no longer be a mandatory benefit for non-disabled women on Medicaid.

If a state chooses a per capita cap structure, the AHCA would not change the financing structure for stand-alone family planning expansions that are currently in place in over half the states. These limited scope programs have allowed states to extend Medicaid coverage for family planning services to low-income women and men who do not have other family planning coverage. Since the AHCA's per capita cap does not apply to these programs, states could continue to receive a 90% federal matching rate for them. These programs may become increasingly important to women because the CBO predicts that under this bill the number of uninsured would rise by 24 million over the next 10 years, and these Medicaid family planning programs are often an important source of reproductive care for uninsured women.

Both capped financing approaches would limit states' ability to respond to rising costs, new and costly treatments, or public health emergencies such as the opioid epidemic or Zika. States may decide to make programmatic cuts such as cutting provider payments, particularly when facing fiscal pressures. For example, on average, Medicaid pays ob-gyns 76% of the Medicare rate[4] and a smaller share of the commercial rate. If states were to make further cuts to provider payments or to plans, the pool of participating providers could shrink in response to reduced rates, which could make it harder for many women enrollees to find a participating ob-gyn or cause delays in scheduling appointments.

3. Medicaid and Planned Parenthood

Planned Parenthood provides reproductive health services for many low-income women across the nation. Cutting off federal Medicaid payments to the organization could limit the availability of the most effective contraceptives, as well as STI and cancer screenings for many women on Medicaid.

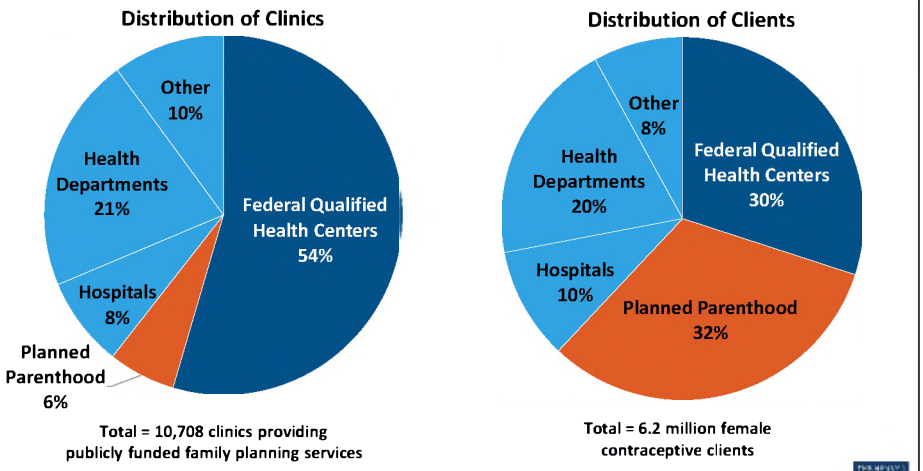
Many low-income women obtain reproductive care at safety-net clinics that receive public funds to pay for the care they provide. The network includes a range of clinics that provide a broad range of primary care services, such as community health centers (CHCs) and health departments as well as specialized clinics that focus on providing family planning services. The largest organization of specialized family planning clinics is Planned Parenthood, which receives federal support through reimbursement for care delivered to women and men on

Medicaid, as well as grant funds from the federal Title X family planning program. Despite comprising only 6% of the safety-net clinics that provided subsidized family planning services in 2015, Planned Parenthood clinics served 32% of women (nearly 2 million women) seeking contraceptive care at these centers (**Figure 5**).

Figure 5

Banning Planned Parenthood as a Medical Provider Could Limit Access to Family Planning Services for Many Low-Income Women

Health centers make up a greater share of providers, but Planned Parenthood clinics serve a disproportionate share of clients



SOURCE: Frost JJ, Frohwirth LF, Blades N, Zolna MR, Douglas-Hall A, & Bearak J. Publicly Funded Contraceptive Services At U.S. Clinics, 2015. Guttmacher Institute. April 2017.

Should it become law, the AHCA would prohibit federal Medicaid payments to Planned Parenthood for one year, even though federal law already prohibits federal dollars from being used to pay for abortions other than those to terminate pregnancies that are a result of rape, incest or a threat to the pregnant woman's life. The AHCA bill would provide additional funds to CHCs, presumably to compensate for loss of a major provider of care to women, but there are no specifics in the bill that would require the health centers to use these funds to provide services to women. There is also concern that CHCs do not currently have the capacity to fill the gap in care that would arise if Planned Parenthood were no longer a participating Medicaid provider.[5] Not all CHCs provide the same range of services as Planned Parenthood, and care at CHCs could be more costly than that provided by specialized family planning providers like Planned Parenthood.[6] The CBO's March 13, 2017 analysis of the AHCA stated that cutting off Medicaid payments to Planned Parenthood for one year would result in loss of access to services in some low-income communities because it is the only public provider in some regions. The report also stated that the policy would result in thousands of additional unintended pregnancies that would be financed by Medicaid.[7]

4. Abortion Coverage

Private and public coverage of abortion is currently limited in many states through the federal Hyde Amendment and state laws. The AHCA would go further than the ACA to restrict the availability of abortion coverage through private insurance policies.

Since 1976, the federal Hyde Amendment has limited the use of federal funds for abortion only to cases when the pregnancy is a result of rape or incest or is a threat to the woman's life. Since its first passage over 40 years ago, the amendment has dramatically limited coverage of abortion under Medicaid, as well as other federal programs.[8]

In private insurance, the ACA explicitly bars abortion from being included as part of the Essential Health Benefit package defined by states and allows states to ban all plans in their Marketplaces from covering abortion. States can also ban abortion coverage in all state regulated private plans.[9] As of March 2017, 25 states have laws limiting or banning coverage of abortion in ACA Marketplaces, and of these, 10 states ban abortion coverage in both the Marketplaces and in the private insurance market.

To ensure no federal dollars are used to subsidize abortion coverage, the AHCA bill would no longer make this a state option, rather it would ban abortion coverage in all Marketplace plans as well as prohibit the use of federal tax credits to purchase any plans that cover abortion that are available outside the Marketplace. The bill would limit employer coverage of abortion by disqualifying small employers from receiving tax credits if their plans cover abortion beyond Hyde limitations. It also prohibits the use of tax credits for all individuals seeking a COBRA policy that includes abortion coverage after leaving a job, regardless of employer size. This could discourage employers from including abortion coverage in their employees' health plans.

This provision would be in direct conflict with existing state policies in California and New York that require plans to cover abortion. Furthermore, for off market and COBRA plans, no plans in these states would be able to enroll individuals who receive tax credits. Therefore, if enacted, the AHCA's abortion coverage ban would likely face legal challenges.

5. Tax Credits, Premium and Cost-Sharing Subsidies

The AHCA would set the level of tax credit assistance using primarily age, and would repeal the ACA's cost-sharing protections for low-income individuals. Because women have a lower income than men at all ages, this approach could place women at a disadvantage compared to men.

Women comprise more than half (54%) of ACA marketplace enrollees in the 34 states that use the federally facilitated marketplace, healthcare.gov. Approximately eight in ten (81%) Marketplace beneficiaries receive a premium tax credit, which offsets premium costs and makes them more affordable. In 2015, more than one-third (37%) of women who purchased insurance on their own were low-income ($23,540 for a single person) compared to 31% of men. [10] The current subsidy structure under the ACA provides higher levels of subsidies to those who are low-income, older, and who live in areas with more expensive coverage.

The AHCA, in contrast, would take a very different approach and reduce the amount that the federal government would contribute to subsidies with the goal of reducing federal spending. The AHCA would provide a flat tax credit based on age only up until an income of $75,000 for a single individual, and phases out at higher incomes. This would result in a large decrease in tax subsidies to older Marketplace enrollees compared to what is available to them today.

The AHCA would set aside additional federal funds to assist older enrollees as well as services for pregnant women and newborns and individuals with mental health and substance use disorders, but how those funds would be allocated is still to be determined. Nonetheless, under the AHCA's tax credit methodology, people with lower incomes would receive significantly less than they do under current law. A higher share of women is poor or low-income than men, because women are more likely than men to head single parent households, work part-year or part-time, are paid less than men for similar work, and take breaks from the workforce to stay home and care for children and aging parents. As a result, this approach could disproportionately disadvantage women. In addition, the AHCA proposes to repeal the cost-sharing subsides available today under the ACA that provide additional protection from the high costs of deductibles, cost-sharing, and co-insurance to individuals with incomes below 250% of the federal poverty level.

6. Insurance Reforms

The ACA banned many of the long-standing discriminatory practices in the individual insurance market that translated into higher cost burdens for women. While the AHCA maintains the gender-rating ban and the dependent coverage expansion, it could allow states to permit insurers to charge higher premiums to individuals with health problems if they have a lapse in coverage.

Dependent Coverage

A popular element of the ACA is the provision that requires private health insurers that offer dependent coverage to children to allow young adults up to age 26 to remain on their parents' insurance plans. This provision was the first in the ACA to take effect, and it increased the availability of insurance to an age group that historically had a high uninsured rate (**Table 1**). In 2015, 39% of women ages 19 to 25 reported that they were covered as a dependent.[11]

Table 1: The ACA Made Many Insurance Reforms Affecting Women

Before the ACA	ACA Provision	AHCA Provision
Many employer plans did not offer coverage for adult dependent children. • 30% of women ages 19-26 were uninsured in 2009, the highest among all age groups of women.	Requires plans to extend dependent coverage up to age 26	AHCA does not change
Many individual plans used gender rating to charge higher premiums to women for same coverage as men • A 2012 study found 1/3 of plans charged 25 and 40 year old women at least 30% more than men	Bans gender rating	AHCA does not change
Insurers could charge more or exclude those with pre-existing conditions including: • Pregnancy • Prior C-section • Depression	Bans pre-existing condition exclusions	Retains pre-existing condition ban, but would charge those with coverage gaps 30% higher premiums for 1 year upon resuming coverage or state could request a waiver to permit insurers to charge higher rates to those with pre-existing medical conditions for 1 year.

Gender Rating

Prior to the ACA, non-group insurers in many states charged women who purchase individual insurance more than men for the same coverage, a practice called gender rating.[12] Yet, plans sold on the individual market often did not cover many important services for women, such as maternity care, mental health services, and prescription drugs.[13] An estimated 6.5 million women purchased coverage on the individual insurance market in 2011, and many of these women paid higher rates than men. Prior to the ACA, most of the women in this market were of reproductive age, working, and had incomes below 250% FPL.[14] The ACA bans gender rating and the AHCA would not change this.

Pre-Existing Conditions

One of the most popular provisions of the ACA has been the ban on pre-existing condition exclusions. In the years before the ACA was passed, insurance companies often denied or would not renew coverage to

individuals with a "preexisting condition," which included several conditions common among women such as pregnancy, breast cancer, or a prior C-section. The AHCA would not re-instate this practice, but individuals who do not maintain continuous coverage would be charged a penalty when they try to obtain health insurance after having a coverage gap. The penalty could be in the form of higher premium rates (30%) for one year. Alternatively, states could obtain a waiver to allow insurers to again engage in medical underwriting for one year, charging people with health problems higher rates. This would have the effect of raising premiums for people with pre-existing conditions such as pregnancy, prior C-section, or clinical depression.

7. Essential Health Benefits

The ACA instituted new rules that require all plans in the individual market as well as Medicaid expansion programs to cover ten categories of benefits. Of particular importance to women has been the inclusion of maternity care, preventive services, and mental health.

The ACA requires all Marketplace plans and Medicaid expansion programs to cover ten categories of "essential health benefits" (EHB). Each state chooses a benchmark benefit plan, which sets the floor for services that plans in that state must cover within each EHB category.[15]

Prior to the ACA, there were few federal requirements on what private plans in the individual market had to cover. The ACA established a floor for benefits that individual market plans must cover with the goal of reducing variation and adverse selection by standardizing "meaningful coverage." This is particularly important for women, as they are the exclusive users of maternity care and more frequent users of services in some other EHB categories, such as prescription drugs and mental health. Mental health services in particular were routinely excluded in individual plans prior to the ACA. Depression, anxiety, and eating disorders are all more common among women than men.

ACA Required Essential Health Benefits

- **Ambulatory patient services**
- **Emergency services**
- **Hospitalization**
- **Maternity and newborn care**
- **Mental health and substance abuse disorder services including behavioral health treatments**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices**
- **Laboratory services**
- **Preventive and wellness services**
- **Chronic disease management**
- **Pediatric dental and vision care**

The AHCA would allow states to apply for a waiver to define their own EHBs beginning in 2020. Waivers would be automatically approved unless the HHS Secretary issues a denial within 60 days of submission. This means states could choose to exclude mental health or maternity care (see pregnancy-related care section below) from their EHB requirements. While the idea of choice sounds appealing to some, it is antithetical to how insurance operates — by spreading the costs and risks across the pool of insured individuals. Plans that include a broader range of benefits would be considerably more expensive than they are today. In addition to state-level waivers, the AHCA bill would rescind the EHB requirement for Medicaid expansion programs, meaning that beneficiaries in this group would not be entitled to coverage for all ten categories. Existing Medicaid rules require states to cover some of the categories, such as hospitalization and maternity and newborn care, but others such as substance abuse treatment and prescription drugs are optional and offered at state discretion.

8. Preventive Services

Currently, all private plans, Medicaid expansion programs, and Medicare must cover recommended preventive services without cost sharing. Important services for women include: breast and cervical cancer screening, osteoporosis screening, pregnancy related services, well woman visits, and contraception.

In addition to EHBs, the ACA included a related requirement that all private plans cover federally-recommended preventive services without charging cost-sharing. In contrast to EHBs, which apply to individually purchased plans and Medicaid expansion only, the preventive services requirement applies to all forms of private insurance, including employer-sponsored and individual market plans. Prior to the ACA, the only federal–level requirements that applied to group plans were for coverage of a minimum length of stay after a delivery, availability of reconstructive surgery following a mastectomy, and parity for mental health services. The preventive services coverage requirement also applies to the Medicaid expansion and Medicare programs. This means that most adults with some form of private or public insurance now have coverage without cost-sharing for all of the services recommended by the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by the federal Advisory Committee on Immunization Practices (ACIP), and services for women recommended by the Health Resources and Services Administration.[16]

Among the slate of services covered, many are exclusively for women or address conditions that have a disproportionate impact on women (**Figure 6**). These services address some of the most common conditions for women, including breast cancer, cardiovascular disease, and obesity. For older women, the preventive services policy means that Medicare now covers the full cost of mammograms and bone density screenings, which were previously subject to 20% co-insurance before passage of the ACA.

Figure 6

ACA Requires All Private Plans, Medicare, and Medicaid Expansion to Cover Recommended Preventive Services Free of Cost Sharing

Cancer	Chronic Conditions	Vaccines	Healthy Behaviors	Pregnancy	Repro & Sexual Health
Breast Cancer Mammography Genetic screening & counseling Preventive medication	**Cardiovascular Health** Hypertension screening Lipid disorders screenings Aspirin	**Td booster, Tdap**	**Alcohol Misuse** Screening & counseling	**Breastfeeding** Counseling, consultations, equipment rental	**STI & HIV Counseling & Screening** Gonorrhea Syphilis Chlamydia HIV
Cervical Cancer Pap testing High-risk HPV DNA testing	**Type 2 Diabetes** Screening	**MMR**	**Diet** Counseling for adults w/high cholesterol, CVD risk factors, diet-related chronic disease	**Folic acid supplements**	**Contraception** All FDA approved methods as prescribed Sterilization procedures Patient education & counseling
Colorectal Cancer Fecal occult blood testing, colonoscopy, or sigmoidoscopy	**Depression** Screening	**Meningococcal Hepatitis A, B**	**Tobacco** Counseling & cessation interventions	**Tobacco & Cessation** Interventions	
	Osteoporosis Screening	**Pneumococcal**	**Interpersonal & Domestic Violence** Screening & counseling	**Alcohol Misuse** Screening/counseling	
	Obesity Screening Counseling & behavioral interventions	**Zoster**	**Well-Woman Visits**	**Other Screenings** Anemia, Hepatitis B, Chlamydia, Gonorrhea, Syphilis, Bacteriurea, Rh incompatibility, Gestational Diabetes	
		Influenza			
		Varicella			
		HPV			

NOTE: Orange indicates service exclusive to women.
SOURCE: U.S. DHHS, "Recommended Preventive Services." Available at http://www.healthcare.gov/center/regulations/prevention/recommendations.html

The AHCA would maintain preventive services requirements for private plans, but would repeal the requirements for the Medicaid expansion population. Preventive services for adults are covered at state option for other Medicaid beneficiaries. States could opt to roll back coverage of preventive services for this group.

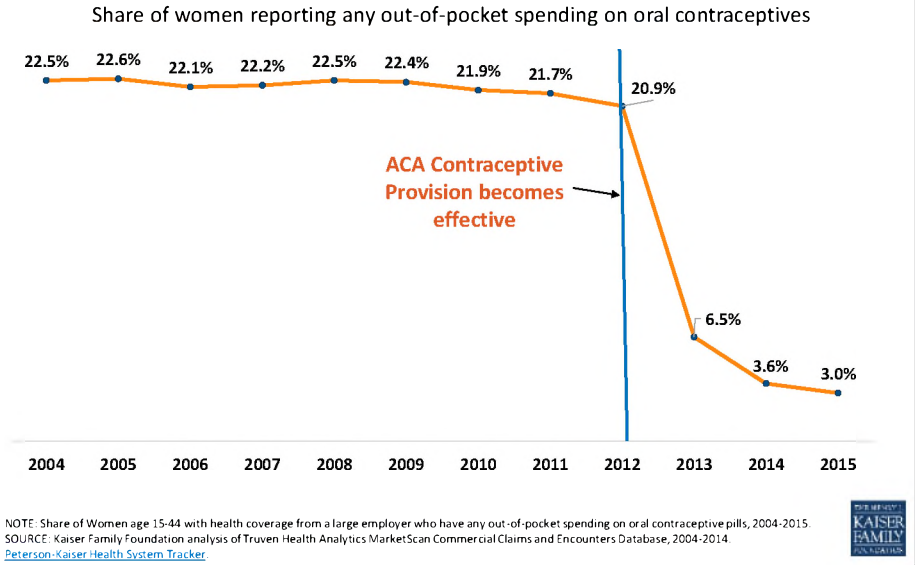
9. Contraceptive Coverage

Today, the majority of women with private insurance have no cost contraceptive coverage. This preventive benefit has reduced women's out-of-pocket spending on birth control and made the most effective, but often costly, contraceptive methods affordable for most insured women. This provision could be eliminated or modified through regulatory changes without the need for Congressional action.

Current law requires that most private plans include coverage of all FDA-approved contraceptive methods for women at no additional cost. Research has found that the requirement has had a large impact in a short amount of time. For example, in the first two years that the policy was in effect, the share of women with any out of pocket spending on oral contraceptives fell sharply to just 3.0% of women with employer-sponsored insurance (**Figure 7**).[17] Similar effects have been documented for other contraceptives, including IUDs.[18]

Figure 7

The Contraceptive Coverage Policy Has Had a Large Effect on Out-Of-Pocket Spending in a Short Amount of Time



NOTE: Share of Women age 15-44 with health coverage from a large employer who have any out-of-pocket spending on oral contraceptive pills, 2004-2015.
SOURCE: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2004-2014.
Peterson-Kaiser Health System Tracker.

The AHCA bill does not specifically address the contraceptive coverage requirement. However, President Trump and Secretary Price have expressed support for advancing "religious freedom,"[19] and this provision has been at the heart of two cases that have reached the Supreme Court where employers have claimed that the requirement violates their religious beliefs. The contraceptive coverage requirement was implemented through a series of agency regulations that included contraception in the package of women's preventive services, defined the religious exemption and accommodation available to houses of worship and faith-based nonprofits respectively, and clarified that plans must cover 18 contraceptive methods. Since these requirements are in regulations, the Trump Administration can issue new regulations and guidance to permit employers and insurers to cover fewer methods, or to exempt more employers with religious objections without the need for congressional action.[20] President Trump's Executive Order Promoting Free Speech and Religious Liberty specifically calls on the Secretaries of Labor, Treasury, and Health and Human Services to amend regulations to protect conscience-based objections to the ACA's preventive-care mandate.[21] The goal of this is to exempt any employer with a religious or moral objection from the contraceptive coverage requirement, even though current regulations already relieve employers from paying for such coverage while assuring that women have coverage for contraceptives.

If the federal requirement is eliminated or scaled back, the scope of contraceptive coverage would again be shaped by employers, insurance plans, and state policy. More than half (28) of states have laws requiring plans in their states to cover contraceptives, but these are more limited than the ACA. Only five of the 28 states require coverage of the full range of contraceptives without cost sharing, but these state-level mandates do not apply to self-funded plans, which cover most insured workers.[22]

10. Pregnancy-Related Care

Today, pregnant and postpartum women have a greater range of protections and benefits than they did prior to the ACA. These range from mandatory maternity and newborn coverage, to no-cost prenatal screening, and breastfeeding supports. The AHCA would allow states to define the Essential Health Benefits requirements with a waiver, potentially excluding coverage for maternity care.

Before the ACA, pregnant women seeking insurance in the individual market were routinely turned away as having a pre-existing condition. Furthermore, many individual plans did not cover maternity services because it was not required in this market. Some individual plans offered separate maternity coverage as a rider which could be costly, ranging from roughly $15 to $1600 a month.[23] Some plans also imposed a waiting period before the rider took effect. These discriminatory practices were limited to the individual market because coverage for maternity services has been required for decades both under Medicaid and in most employer-sponsored plans due to the Pregnancy Discrimination Act. The ACA changed this by including maternity and newborn care as part of the EHB package that must be included in individual private plans as well as under Medicaid expansion. While some states had required individual plans in their states to cover maternity services to varying degrees prior to the ACA, most did not.[24] In addition, the ACA made other improvements through coverage of preventive services such as no-cost prenatal screenings and breastfeeding supports.

ACA Reforms Improving the Availability of Maternity Care

- **Maternity and newborn care are essential health benefits**
- **Pregnancy no longer a pre-existing condition**
- **Prenatal visits, recommended screening tests, folic acid supplements covered without cost sharing in all new private plans, and Medicaid expansion**
- **Medicaid expansion provides pathway to coverage for mothers who previously may have lost coverage postpartum**
- **Breastfeeding supports for nursing mothers**
    - **Breast pumps and lactation consultation covered without cost sharing**
    - **Breaks and private area to express milk required in workplace**

The AHCA would weaken some of the protections for pregnant women that are currently in place. By halting funds for Medicaid expansion, some new mothers would lose coverage once the 60-day postpartum period ends and become uninsured. Furthermore, it would permit states to waive the current federal EHB standards, potentially allowing states to remove or scale back maternity services as a required benefit. The bill would also allot funds to the Patient and State Stability Fund for pregnancy and newborn care, but there are no details on how it will be used.

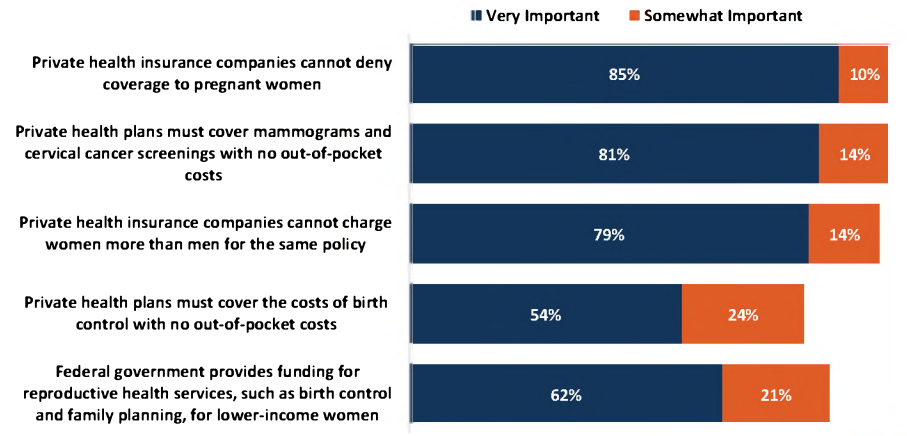
Some have touted the benefits of excluding maternity coverage for those who will not need it such as men and older women as a way of giving policyholders more flexibility to choose their own coverage and purchase less expensive plans. However, this also means that the risk pool for plans that include maternity services would primarily be comprised of women who anticipate using maternity care, and would likely greatly increase costs for women who sought such coverage. Furthermore, given that nearly half of pregnancies are unintended some women would buy coverage that does not include maternity care thinking they won't need it, only to find out their coverage falls short when they are pregnant.

Conclusion

Today, women's health coverage levels are at an all-time high. In addition to the coverage gains in the Marketplaces and Medicaid, many of the long-standing discriminatory practices in the individual insurance market that translated into higher cost burdens for women have been banned. Minimum standards for benefits that individual plans must cover through the EHB and the preventive services requirements for all private plans have assured that most insured women have coverage for a broad range of recommended services that they need such as maternity care, mental health services, and preventive services such as mammograms, pap smears, and contraceptives. Recent polling shows that the American public values these protections, including those for poorer women **(Figure 8)**. In addition, while the AHCA would prohibit federal Medicaid funds to Planned Parenthood for one year, 75% of Americans say they favor continued federal funding for Planned Parenthood.[25]

Figure 8

Majority Support for ACA's Women's Health Provisions and Federally Funded Family Planning for Low-Income Women



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted March 6-12, 2017).

If enacted, the AHCA would alter subsidies for private insurance, eliminate the Medicaid expansion, ban Medicaid funding to Planned Parenthood, place a cap on Medicaid spending, and turn EHB standards over to the states. This legislation would have considerable impact on women, particularly low-income women who rely on subsidies and those who are on Medicaid. The Senate will now take up their own debate about the future of the ACA. In addition to legislation, many of the ACA's other provisions could be amended through federal-level administrative actions. Given the gains that women have made in access to meaningful and affordable coverage, they have much at stake in the current debate over the future of our nation's private and public insurance programs.

Appendix 1: Comparison of Women's Health Provisions in the ACA and House AHCA	
Affordable Care Act (ACA)	**House American Health Care Act (AHCA)**
Medicaid Policy	
Allow states to expand Medicaid eligibility to all adults up to 138% FPL.	Repeal enhanced federal match for Medicaid expansion except for those enrolled as of December 31, 2019 who do not have a break in eligibility of more than 1 month; Convert federal Medicaid funding to a per capita allotment or block grant and limit growth beginning in 2020 using 2016 as a base year.
Planned Parenthood	
Planned Parenthood may receive federal reimbursements under Medicaid's "any willing provider" provision.	Prohibit federal Medicaid funding for Planned Parenthood clinics for one year.
Abortion	
Prohibit abortion coverage from being required. Federal premium and cost-sharing subsidies cannot pay for abortion beyond Hyde limitations. Allows qualified health plans to cover abortion, but plan must segregate federal subsidy funds from private premium payments or state funds. Prohibit plans from discriminating against a provider because of unwillingness to provide, pay for, cover, or refer for abortions.	Prohibit all qualified health plans from covering abortion beyond Hyde limitations. Prohibit federal premium tax credits from being applied to premiums of non-Marketplace and employer COBRA plans that cover abortion services beyond Hyde limitations. Ban small employers from receiving tax credits if their plans include abortion coverage beyond Hyde limitations.
Subsidies	
Premium tax credits based on age, income and location to eligible individuals with incomes between 100-400% FPL on a sliding scale. Provide cost-sharing subsidies to eligible individuals with household income between 100%-250% FPL.	Replace ACA income-based tax credits with flat tax credit adjusted for age only. Repeals cost-sharing subsides as of January 1, 2020.
Preexisting conditions	
Prohibit pre-existing conditions exclusions, which historically have included pregnancy, prior C-section, and mental illnesses, and rate surcharges based on health status.	Retain ban on pre-existing conditions exclusions. Those with coverage gaps could be charged 30% more for premiums for the first year of resuming coverage or state could request a waiver to permit insurers to medically underwrite for one year, charging sicker individuals higher rates for that year.
Gender Rating	
Ban discriminatory premium pricing based on gender in all group and individual insurance plans.	Ban on gender rating is not changed.
Essential Health Benefits (EHB)	
Require all private insurance plans to cover 10 EHB categories, including maternity care and mental health services.	EHB standards are repealed for the Medicaid expansion population. States could apply for a waiver to re-define EHBs for the individual and small group health insurance markets.
Preventive Care	
Require almost all private plans to cover preventive care without cost-sharing, including contraception and breast cancer screenings.	Requirement for individual and group plans to cover preventive benefits, without cost sharing is not changed.

Endnotes

[1] Amendment to H.R. 1628 Offered by Mr. MacArthur. April 25, 2017.

[2] Legislation extends Medicaid coverage to all individuals with incomes up to 133% of the poverty level (FPL) and includes a provision to disregard first 5% of income, effectively extending Medicaid to all individuals with incomes up to 138% FPL.

[3] Kaiser Family Foundation. (2012). Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP).

[4] Zuckerman S, Skopec L, McCormack K. (2013). Reversing the Medicaid Fee Bump: How Much Could Medicare Physician Fees for Primary Care Fall in 2015? Urban Institute.

[5] Rosenbaum S. (2017). Can Community Health Centers Fill the Health Care Void Left by Defunding Planned Parenthood? *Health Affairs* Blog.

[6] Ibid

[7] Congressional Budget Office (CBO). "American Health Care Act." March 13, 2017.

[8] Salganicoff A, Rosenzweig C, Sobel L. (2016). The Hyde Amendment and Coverage for Abortion Services. Kaiser Family Foundation.

[9] Salganicoff A, Beamesderfer A, Kurani N, Sobel L. (2014). Coverage for Abortion Services and the ACA. Kaiser Family Foundation.

[10] Centers for Medicare and Medicaid Services (CMS). Health Insurance Marketplaces 2017 Open Enrollment Period: January Enrollment Report. January 10, 2017.

[11] Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

[12] National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act.

[13] Committee on Energy and Commerce, U.S. House of Representatives. "Memorandum on Maternity Coverage in the Individual Health Insurance Market" at page 37. October 12, 2010.

[14] Kaiser Family Foundation and Urban Institute analysis of 2012 Current Population Survey, Bureau of the Census, 2012.

[15] The Center for Consumer Information & Insurance Oversight. Centers for Medicare and Medicaid Services (CMS). Information on Essential Health Benefits (EHB) Benchmark Plans.

[16] Institute of Medicine (IOM). (2011). Clinical Preventive Services for Women: Closing the Gaps. Washington, DC: The National Academies Press.

[17] Peterson-Kaiser Health System Tracker. (2016). Examining high prescription drug spending for people with employer sponsored health insurance.

[18] Becker NV & Polsky D. (2015). Women Saw Large Decrease In Out-Of-Pocket Spending for Contraceptives after ACA Mandate Removed Cost Sharing. *Health Affairs,* 34(7), 1204-11.

[19] Letter to Gail Buckley, President Catholic Leadership Conference. October 5, 2016.

[20] Sobel L, Salganicoff S, Rosenzweig C. (2017). The Future of Contraceptive Coverage. Kaiser Family Foundation.

[21] Presidential Executive Order Promoting Free Speech and Religious Liberty. May 4, 2017.

[22] Sobel L, Salganicoff S, Rosenzweig C. (2017). The Future of Contraceptive Coverage. Kaiser Family Foundation.

[23] National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act.

[24] Ibid.

[25] Kaiser Family Foundation. Kaiser Health Tracking Poll: ACA, Replacement Plans, Women's Health. March, 15 2017.

Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act: Interactive Maps

Apr 27, 2017

Related Analysis: How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits (http://kff.org/health-reform/issu act-repeal-and-replace-plans-might-shift-health-insurance-tax-credits/)

These maps compare county-level estimates of premiums and tax credits under the Affordable Care Act (ACA) in 2020 with what they'd re Health Care Act (AHCA) as unveiled March 6 by Republican leaders in Congress.

The maps were updated on March 21, 2017 to show estimates of how much a person buying their own insurance would have to pay unde House replacement bill. The maps include premium tax credit estimates by county for current ACA marketplace enrollees at age 27, 40, o income of $20,000, $30,000, $40,000, $50,000, $75,000, or $100,000.

Note: As of May 4, 2017, the AHCA would allow states to waive certain consumer protections, including essential health benefits, commun If a state takes up such a waiver, the premium amounts for that state in this interactive would no longer be applicable. For example, enro their health status, with healthy people paying less and sicker people or those with pre-existing conditions paying more. The map also do assistance under the ACA that lowers deductibles and copayments for low-income marketplace enrollees. For example, in 2016, people m of poverty enrolled in a silver plan on healthcare.gov received cost-sharing assistance worth $1,440; those with incomes between 150 – 2 $1,068 on average; and those with incomes between 200 – 250% of poverty received $144 on average.

Generally, people who are older, lower-income, or live in high-premium areas (like Alaska and Arizona) receive less financial assistance u Additionally, older people would have higher starting premiums under the AHCA and would therefore pay higher premiums. Because yo incomes and living in lower cost areas would receive more financial assistance and would have lower starting premiums on average, the premiums on average.

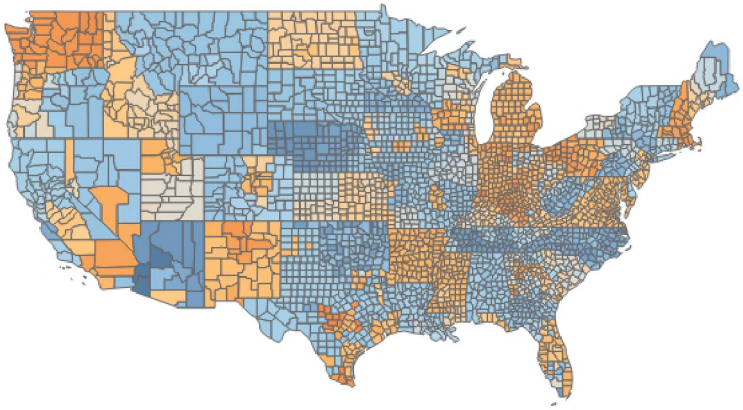
Most current Healthcare.gov enrollees have lower incomes:

- About 66% of have incomes at or below 250% of poverty (approximately $31,250 for a single individual in 2020), with the bulk (44% of incomes at or below 150% of poverty (approximately $18,750 in 2020).
- About 36% of enrollees are under age 35, 37% are age 35 to 54, and 27% are 55 or older.

Both the ACA and the American Health Care Act include tax credits in their approach. However, the law and the proposal calculate credit ACA takes family income, local cost of insurance, and age into account, while the replacement proposal bases tax credits only on age, with individuals with incomes above $75,000.

For more on the subject, go to How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits (http://kff.org/hea affordable-care-act-repeal-and-replace-plans-might-shift-health-insurance-tax-credits/).

Premiums Paid Under the Affordable Care Act vs American Health Care Act, in 2020



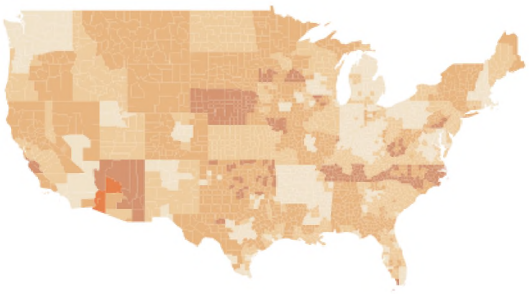
335,518 views

Our method of estimating premiums before tax credits under the AHCA is based on Congressional Budget Office (CBO) projections (https://www.cbo.gov/publication/52486), which suggest that the premium for a 40-year-old under the AHCA would be similar to the premium fo ACA, before accounting for tax credits and for the same level of coverage. We therefore assume that the premium before tax credits for th silver plan under the ACA is equal to the premium for a similar plan (with 70% actuarial value) under the AHCA for a 40-year-old. To arri 27-year-old premium under the AHCA, we use a 5:1 age curve, since the AHCA would change age rating from 3:1 to 5:1. We assume that st own age curves with ratios smaller than 3:1 (i.e. New York, Vermont, Massachusetts, and the District of Columbia) would maintain their st under the AHCA.

A second interactive map below displays the same information as in the first map, but with a focus on the share of one's income that wou plan premium under both the ACA and the AHCA. Like the map above, it does not include cost-sharing assistance available for lower-inco nor does it account for changes that may be made to increase the amount of financial assistance available to older enrollees in the AHCA.

Premium Payment as a Share of Income

American Health Care Act



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March 2017 | Issue Brief

How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits

Cynthia Cox, Gary Claxton, Larry Levitt

An important part of the repeal and replacement discussions around the Affordable Care Act (ACA) will involve the type and amount of subsidies that people get to help them afford health insurance. This is particularly important for lower and moderate income individuals who do not have access to coverage at work and must purchase coverage directly.

The ACA provides three types of financial assistance to help people afford health coverage: Medicaid expansion for those with incomes below 138% of poverty (the Supreme Court later ruled this to be at state option); refundable premium tax credits for people with incomes from 100% to 400% of the poverty level who purchase coverage through federal or state marketplaces; cost-sharing subsidies for people with incomes from 100% to 250% of poverty to provide lower deductibles and copays when purchasing silver plans in a marketplace.

This analysis focuses on alternative ways to provide premium assistance for people purchasing individual market coverage, explaining how they work, providing examples of how they're calculated, and presenting estimates of how assistance overall would change for current ACA marketplace enrollees. Issues relating to changing Medicaid or methods of subsidizing cost-sharing will be addressed in other analyses.

Premium Tax Credits Under the ACA and Current Replacement Proposals

The ACA and leading replacement proposals rely on refundable tax credits to help individual market enrollees pay for premiums, although the credit amounts are set quite differently. The House Leadership proposal released on March 6, the American Health Care Act, proposes refundable tax credits which vary with age (with a phase-out for high-income enrollees) and grow annually with inflation. The tax credits under the ACA vary with family income and the cost of insurance where people live, as well as age, and grow annually if premiums increase.

These various tax credit approaches can have quite different implications for different groups of individual market purchasers. For example, the tax credits under the ACA are higher for people with lower incomes than for people with higher incomes, and no credit is provided for individuals with incomes over 400% of poverty. The current replacement proposal, in contrast, is flat for incomes up to $75,000 for an individual and $150,000 for a married couple, and so would provide relatively more assistance to people with upper-middle incomes. Similarly, the ACA tax credits are relatively higher in areas with higher premiums (like many rural areas), while the replacement proposal credits do not vary by location. If premiums grow more rapidly than

inflation over time (which they generally have), the replacement proposal tax credits will grow more slowly than those provided under the ACA.

What is a Tax Credit, and How is it Different from a Deduction?

A **tax credit** is an amount by which a taxpayer can reduce the amount they owe in federal income tax; for example, if a person had a federal tax bill of $2,500 and a tax credit of $1,000, their tax liability would be reduced to $1,500. A **refundable** tax credit means that if the amount of the tax credit is greater than the amount of taxes owed, the taxpayer receives a refund of the difference; for example, if a person had a federal tax bill of $1000 and a tax credit of $1,500, they would receive a refund of $500. Making the credit refundable is important if a goal is to assist lower-income families, many of whom may not owe federal income tax. An **advanceable** tax credit is made available at the time a premium payment is owed (which similarly benefits lower-income families so that they can receive the financial assistance upfront). The ACA and a number of replacement proposals allow for advance payment of credits.

A tax credit is different from a **tax deduction**. A deduction reduces the amount of income that is taxed, while a credit reduces the amount of tax itself. For example, if a person has taxable income of $30,000, a $500 deduction reduces the amount of taxable income to $29,500. If the person's marginal tax rate is 15%, the deduction reduces the person's taxes by 15% of $500, or $75. Because people with lower incomes have lower marginal tax rates than people with higher incomes – and, typically don't itemize their deductions – tax credits are generally more beneficial to lower income people than deductions.

The next section describes the differing tax credit approaches in more detail and draws out some of the implications for different types of purchasers.

How the Different Tax Credits Are Calculated

The ACA provides tax credits for individuals with family incomes from 100% to 400% of poverty ($11,880 to $47,520 for a single individual in 2017) if they are not eligible for employer-provided or public coverage and if they purchase individual market coverage in the federal or a state marketplace. The tax credit amounts are calculated based on the family income of eligible individuals and the cost of coverage in the area where the live. More specifically, the ACA tax credit for an eligible individual is the difference between a specified percentage of his or her income (Table 1) and the premium of the second-lowest-cost silver plan (referred to as the benchmark premium) available in the area in which they live. There is no tax credit available if the benchmark premium is less than the specified percentage of premium (which can occur for younger purchasers with relatively higher incomes) or if family income falls outside of the 100% to 400% of poverty range. For families, the premiums for family members are added together (including up to 3 children) and compared to specified income percentages. ACA tax credits are made available in advance, based on income information provided to the marketplace, and reconciled based on actual income when a person files income taxes the following.

Take, for example, a person age 40 with income of $30,000, which is 253% of poverty. At this income, the person's specified percentage of income is 8.28% in 2017, which means that the person receives a tax credit if he or she has to pay more than 8.28% of income (or $2,485 annually) for the second-lowest-cost silver premium where he or she lives. If we assume a premium of $4,328 (the national average benchmark premium for a person age 40 in 2017), the person's tax credit would be the difference between the benchmark premium and the specified percentage of income, or $4,328 - $2,485 = $1,843 (or $154 per month).

Table 1: Affordable Care Act Tax Credit Premium Cap, by Income in 2017

Income % Poverty	Premium Cap (maximum % of income one must pay for second-lowest silver plan available to in their area)
Under 100%	No Cap
100% – 133%	2.04%
133% – 150%	3.06% – 4.08%
150% – 200%	4.08% – 6.43%
200% – 250%	6.43% – 8.21%
250% – 300%	8.21% – 9.69%
300% – 400%	9.69%
Over 400%	No Cap

Source: Kaiser Family Foundation

The American Health Care Act takes a simpler approach and specifies the actual dollar amounts for a new refundable tax credit that could be used to purchase individual market coverage. The amounts vary only with age up until an income of $75,000 for a single individual, at which point they begin to phase out. Tax credits range from $2,000 for people under age 30, to $2,500 for people ages 30 to 39, $3,000 for people age 40 to 49, $3,500 for people age 50 to 59, and $4,000 for people age 60 and over starting in 2020. Eligibility for the tax credit phases out starting at income above $75,000 for single individuals (the credit is reduced, but not below zero, by 10 cents for every dollar of income above this threshold, reaching zero at an income of $95,000 for single individuals up to age 29 or $115,000 for individuals age 60 and older). For joint filers, credits begin to phase out at an income of $150,000 (the tax credit is reduced to zero at an income of $190,000 for couples up to age 29; it is reduced to zero at income $230,000 for couples age 60 or older; and it is reduced to zero at income of $290,000 for couples claiming the maximum family credit amount). People who sign up for public programs such as Medicare, Medicaid, public employee health benefit programs, would not be eligible for a tax credit. The proposal further limits eligibility for tax credits to people who do not have an offer available for employer-provided health benefits.

Table 2 shows how projected ACA tax credits in 2020 compare to what would be provided under the American Health Care Act for people at various incomes, ages, and geographic areas. To show the ACA amounts in 2020, we inflated all 2017 premiums based on projections for direct purchase spending per enrollee from the National Health Expenditure Accounts. This method applies the same premium growth across all ages and geographic locations. Note that the table does not include cost-sharing assistance under the ACA that lowers deductibles and copayments for low-income marketplace enrollees. For example, in 2016, people making between 100 – 150% of poverty enrolled in a silver plan on healthcare.gov received cost-sharing assistance worth $1,440; those with incomes between 150 – 200% of poverty received $1,068 on average; and those with incomes between 200 – 250% of poverty received $144 on average.

Table 2: Projected Annual Premium Tax Credit available in the Individual Market under the Affordable Care Act and the American Health Care Act, 2020

Income (2020 FPL)	Age	Affordable Care Act			American Health Care Act		
		Reno, NV	US Average	Mobile, AL	Reno, NV	US Average	Mobile, AL
$20,000 *(160% FPL)*	27	$2,899	$3,225	$4,522	$2,000	$2,000	$2,000
	40	$3,745	**$4,143**	$5,725	$3,000	**$3,000**	$3,000
	60	$9,030	$9,874	$13,235	$4,000	$4,000	$4,000
$40,000 *(320% FPL)*	27	$0	$103	$1,400	$2,000	$2,000	$2,000
	40	$623	**$1,021**	$2,603	$3,000	**$3,000**	$3,000
	60	$5,908	$6,752	$10,113	$4,000	$4,000	$4,000
$75,000 *(600% FPL)*	27	$0	$0	$0	$2,000	$2,000	$2,000
	40	$0	**$0**	$0	$3,000	**$3,000**	$3,000
	60	$0	$0	$0	$4,000	$4,000	$4,000
$100,000 *(800% FPL)*	27	$0	$0	$0	$0	$0	$0
	40	$0	**$0**	$0	$500	**$500**	$500
	60	$0	$0	$0	$1,500	$1,500	$1,500

Source: Kaiser Family Foundation analysis.
Notes: In the 2017 ACA exchange markets, premiums in Reno, NV and Mobile, AL are approximately representative of the 25th and 75th percentile, respectively. 2017 ACA premiums were increased according to National Health Expenditure projections for direct purchase. Under the ACA, people with incomes below 250% of the poverty level receive additional financial assistance for cost-sharing (not shown above).

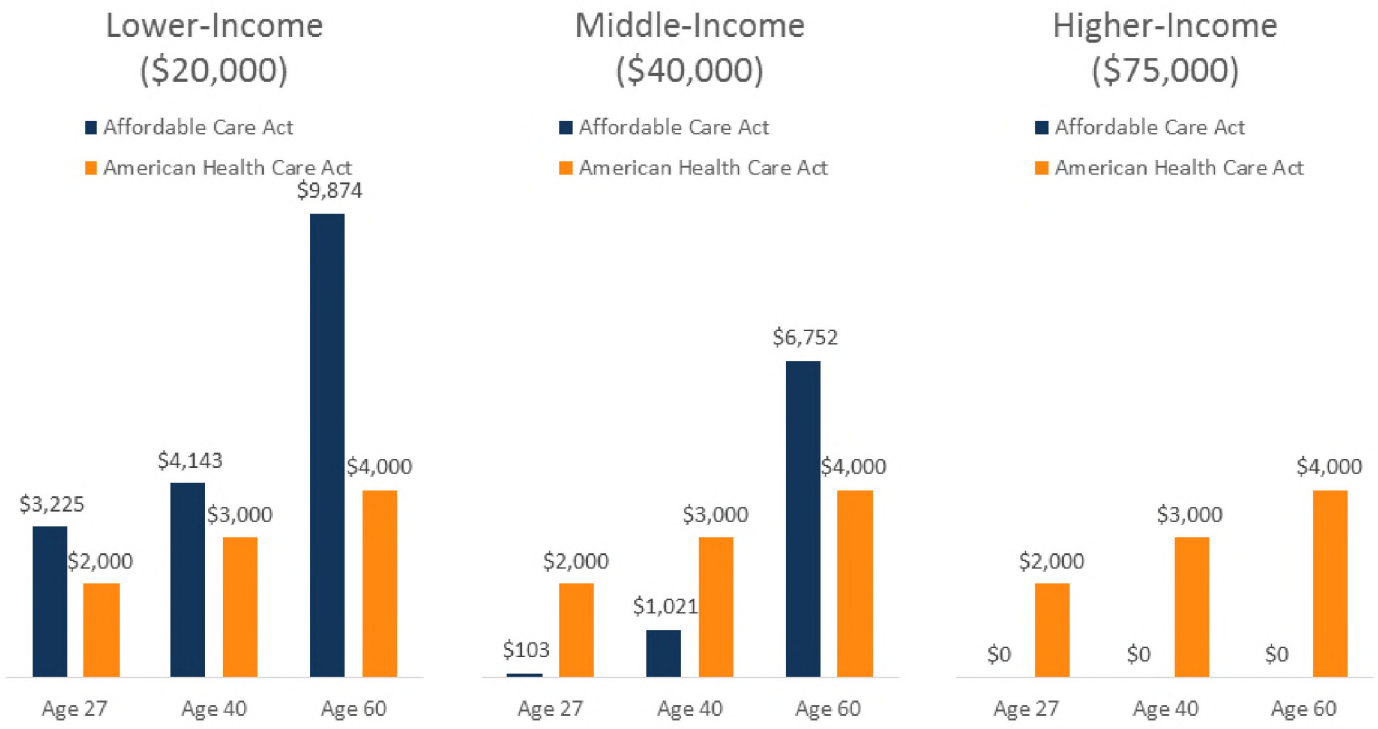
Under the ACA in 2020, we project that a typical 40-year-old making $20,000 per year would be eligible for $4,143 in premium tax credits (not including the additional cost-sharing subsidies to lower his or her deductibles and copayments), while under the American Health Care Act, this person would be eligible $3,000. For context, we project that the average ACA premium for a 40-year-old in 2020 would be $5,101 annually (meaning the tax credit in the ACA would cover 81% of the total premium) for a benchmark silver plan with comprehensive benefits and reduced cost-sharing. A $3,000 tax credit for this same individual under the American Health Care Act would represent 59% of the average 40-year-old benchmark silver premium under the ACA.

Generally, the ACA has higher tax credit amounts than the replacement plan for lower-income people – especially for those who are older and live in higher-cost areas – and lower credits for those with higher incomes. Unlike the ACA, the replacement plan provides tax credits to people over 400% percent of the poverty level (phasing out around 900% of poverty for a single person), as well as to people current buying individual market coverage outside of the marketplaces (not included in this analysis).

While replacement plan tax credits vary by age – by a factor of 2 to 1 for older adults relative to younger ones – the variation is substantially less than under the ACA. The big differences in ACA tax credits at different ages is due to the fact that premiums for older adults can be three times the level of premiums for younger adults under the ACA, but all people at a given income level are expected to pay the same percentage of their income towards a benchmark plan. The tax credit fills in the difference, and this amount is much higher for older adults. These differences by age would be even further magnified under the American Health Care Act (which permits premiums to vary by a factor of 5 to 1 due to age). Before the ACA, premiums for older adults were typically four or five times the premiums charged to younger adults.

Figure 1

How House Republicans' health reform plan might shift average health insurance tax credits, based on income and age, in 2020



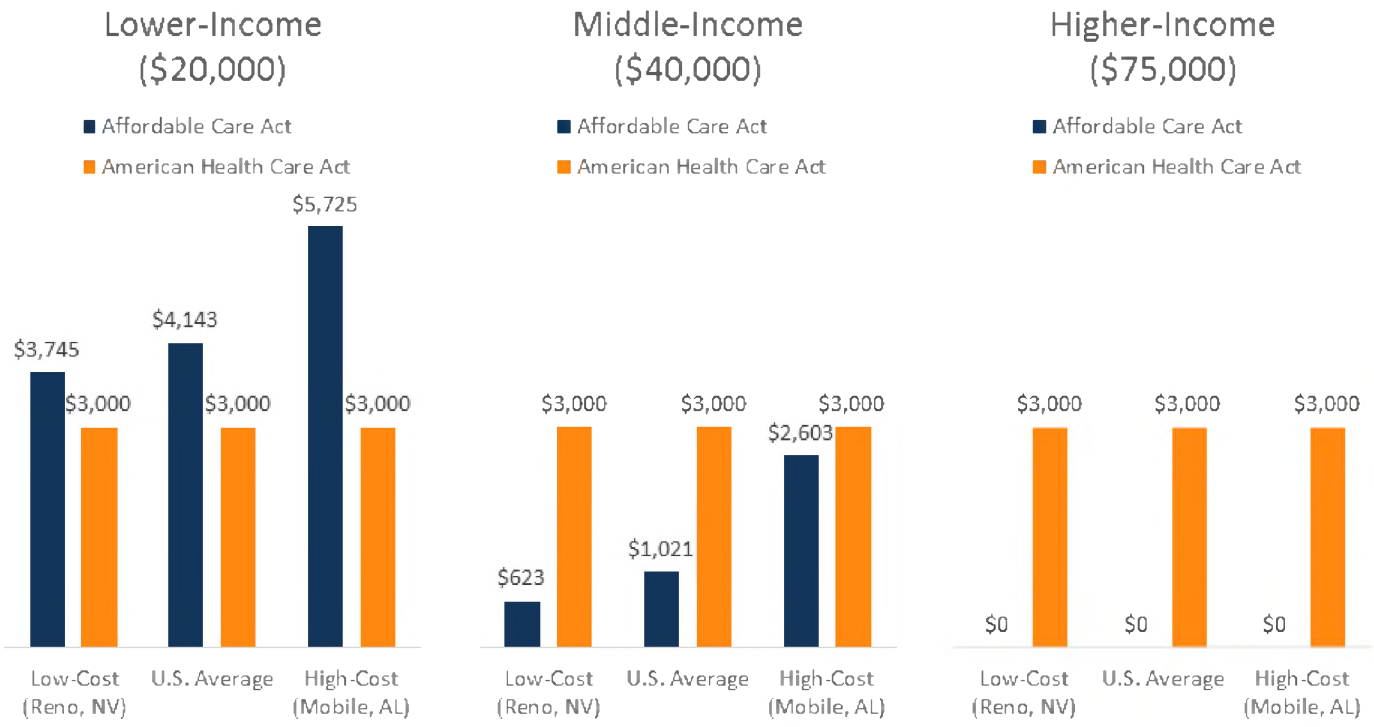
Source: Kaiser Family Foundation analysis. Note: Data for Affordable Care Act represent the average tax credit available across all counties in the United States, at a given age.

The tax credits in the ACA vary significantly with premium costs in an area (see Table 2 and Figure 2). At a given income level and age, people receive bigger tax credits in a higher premium area like Mobile, Alabama and smaller tax credits in a lower premium area like Reno, Nevada. Under the ACA in 2017, premiums in Mobile, Alabama and Reno, Nevada approximately represent the 75th and 25th percentile, respectively.

The disparities between the ACA tax credits and those in the American Health Care Act will therefore vary noticeably across the country. For more on geographic differences between the ACA and the replacement plan, see Tax Credits under the Affordable Care Act vs. the American Health Care Act: An Interactive Map.

Figure 2

How House Republicans' health reform plan might shift health insurance tax credits for a 40-year-old, by income & geography, 2020

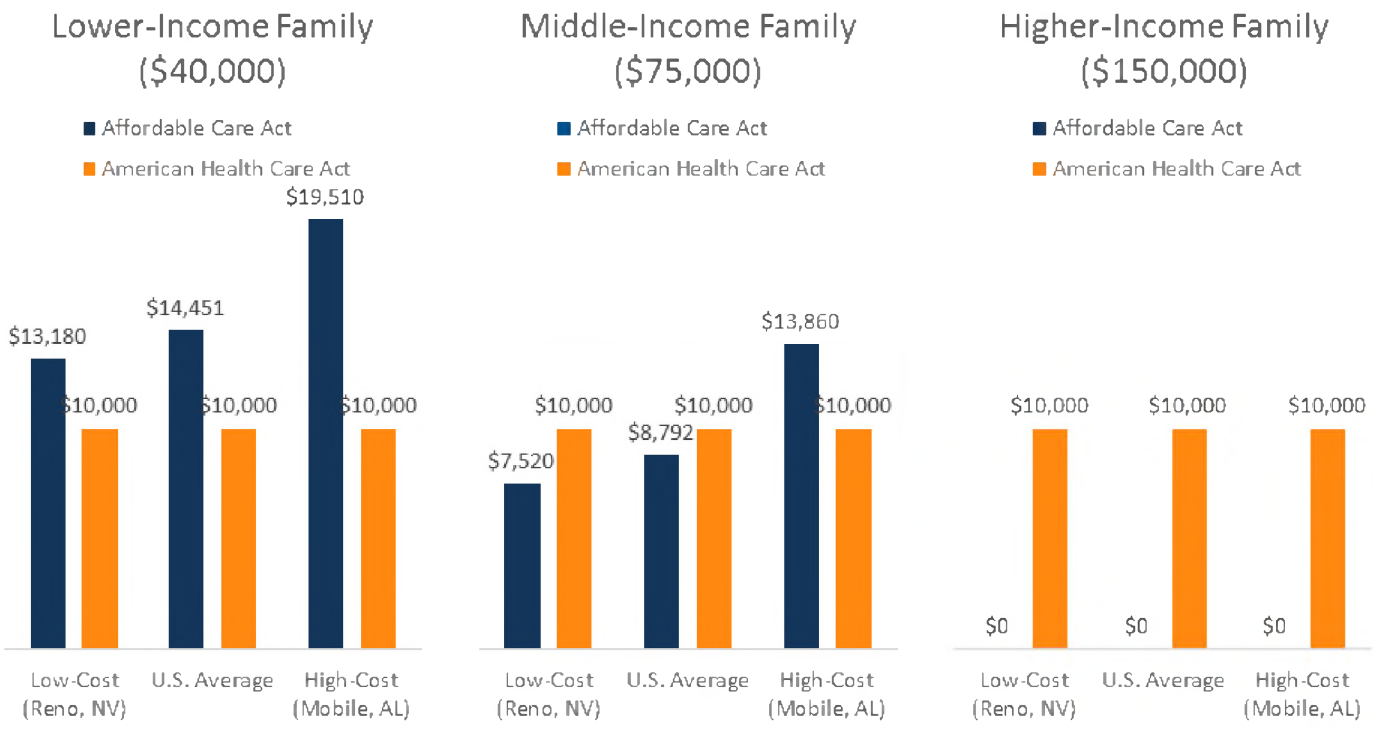


Source: Kaiser Family Foundation analysis. Notes: Data represent the tax credit available for a 40 year old adult. In the 2017 ACA exchange markets, premiums in Reno, NV and Mobile, AL are approximately representative of the 25th and 75th percentile, respectively. 2017 ACA premiums were increased according to National Health Expenditure projections for direct purchase.

The same general pattern can be seen for families as individuals, with lower-income families – and particularly lower-income families in higher-cost areas – receiving larger tax credits under the ACA, while middle-income families in lower-cost areas would receive larger tax credits under the American Health Care Act (Figure 3).

Figure 3

How House Republicans' health reform plan might shift health insurance tax credits for a family of four, by income & geography, 2020

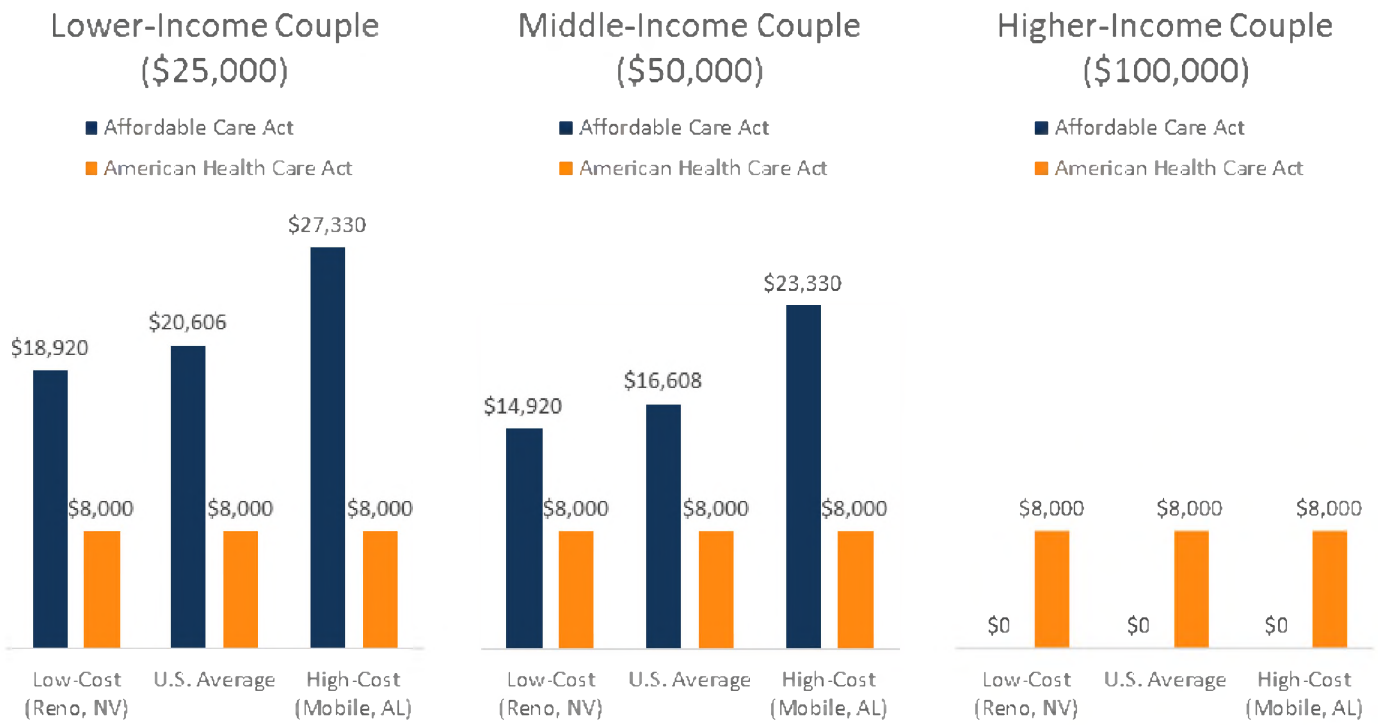


Source: Kaiser Family Foundation analysis. Notes: Data represent the tax credit available for a family of four with two 40-year-old adults and two kids. In the 2017 ACA exchange markets, premiums in Reno, NV and Mobile, AL are approximately representative of the 25th and 75th percentile, respectively. 2017 ACA premiums were increased according to National Health Expenditure projections for direct purchase.

Figure 4 below shows how tax credits under the ACA differ from those in the American Health Care Act for a couple in their 60's with no children. In this scenario, because premiums for older adults are higher and the ACA ties tax credits to the cost of premiums, a 60-year-old couple would receive larger tax credits under the ACA than the American Health Care Act at lower and middle incomes, but would receive a larger tax credit under the American Health Care Act at higher incomes.

Figure 4

How House Republicans' health reform plan might shift health insurance tax credits for a 60-year-old couple, by income & geography, 2020



Source: Kaiser Family Foundation analysis. Notes: Data represent the tax credit available for two 60-year-old adults. In the 2017 ACA exchange markets, premiums in Reno, NV and Mobile, AL are approximately representative of the 25th and 75th percentile, respectively. 2017 ACA premiums were increased according to National Health Expenditure projections for direct purchase.

Estimates of Tax Credits Under the ACA and the American Health Care Act Over Time

We estimated the average tax credits that current ACA marketplace enrollees are receiving under the ACA and what they would qualify for if the American Health Care Act were in place.

Table 3: Average Annual Premium Tax Credit for Current Marketplace Enrollees under the Affordable Care Act (ACA) and the American Health Care Act 3-year, 5-year, and 10-year projections

Year	Affordable Care Act	American Health Care Act	Change from ACA
2020 (3 years)	$4,615	$2,957	-36%
2022 (5 years)	$5,342	$3,160	-41%
2027 (10 years)	$6,648	$3,729	-44%

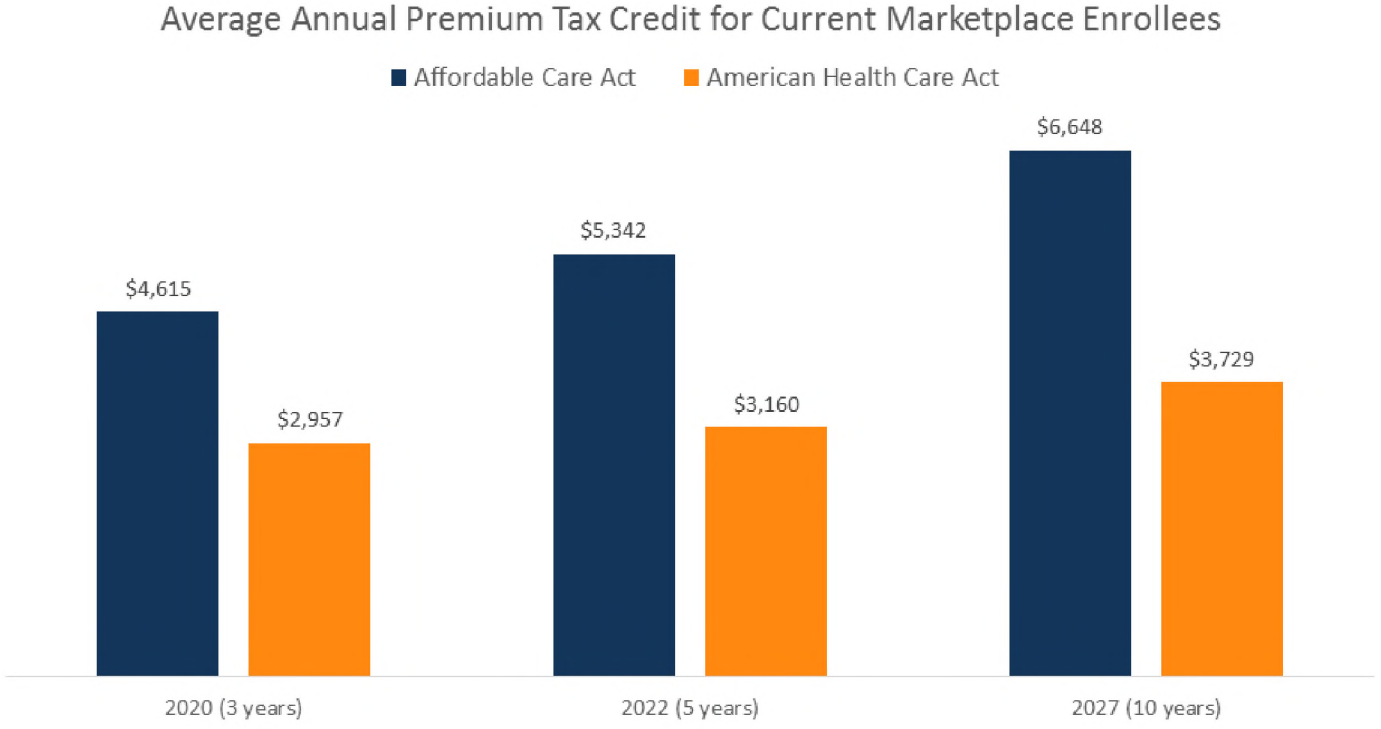
Source: Kaiser Family Foundation analysis of data from Healthcare.gov, state-based exchanges, and Congressional Budget Office. Note: Amounts above represent the average tax credit received based on the age distribution of current Marketplace enrollees.

The average estimated tax credit received by ACA marketplace enrollees in 2017 is $3,617 on an annual basis, and that this amount will rise to $4,615 by 2020 based on projected growth rates from the Congressional Budget Office. This includes the 81% who receive premium subsidies as well as the 19% who do not.

We estimate – based on the age distribution of marketplace enrollees – that current enrollees would receive an average tax credit under the American Health Care Act of $2,957 in 2020, or 36% less than under the ACA (see Table 3 and Figure 3). While many people would receive lower tax credits under the Affordable Health Care Act, some would receive more assistance, notably the 19% of current marketplace enrollees who do not qualify for ACA subsidies.

Figure 5

Over time, the average tax credit received under Republican replacement plans would grow slower than under the ACA



Source: Kaiser Family Foundation analysis of data from Healthcare.gov, state-based exchanges, and Congressional Budget Office.
Note: Amounts above represent the average tax credit received based on the age distribution of current Marketplace enrollees.

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While ACA tax credits grow as premiums increase over time, the tax credits in the American Health Care Act are indexed to inflation plus 1 percentage point. Based on CBO's projections of ACA tax credit increases and inflation, the disparity between the average credits under the ACA and the two replacement plans would widen over time. The average tax credit current marketplace enrollees would receive under the American Health Care Act would be 41% lower than under the ACA in 2022 and 44% lower in 2027.

Discussion

Like the ACA itself, the American Health Care Act includes refundable tax credits to help make premiums more affordable for people buying their own insurance. This might seem like an area where a replacement plan could preserve a key element of the ACA. However, the tax credits are, in fact, structured quite differently, with important implications for affordability and which groups may be winners or losers if the ACA is repealed and replaced.

For current marketplace enrollees, the American Health Care Act would provide substantially lower tax credits overall than the ACA on average. People who are lower income, older, or live in high premium areas would be particularly disadvantaged under the American Health Care Act. People with incomes over 400% of the poverty level – including those buying individual market insurance outside of the marketplaces – do not get any financial assistance under the ACA but many would receive tax credits under the replacement proposal.

The underlying details of health reform proposals, such as the size and structure of health insurance tax credits, matter crucially in determining who benefits and who is disadvantaged.

Methods

We compare estimated tax credit amounts for the year 2020 because that is the first year credits are available under the American Health Care Act. To inflate ACA tax credits, we started by inflating unsubsidized premiums across all ages and geographies according to the National Health Expenditure (NHE) projections for growth in direct purchase insurance spending per enrollee, then inflated poverty guidelines using CPI projections from the Congressional Budget Office (CBO), and required premium contributions using the ratio of growth in employer-sponsored insurance spending per enrollee and GDP per capita (from NHE).

To compare the average tax credit received by current marketplace enrollees (in Table 3 and Figure 3) under the ACA, we estimated the average 2017 tax credit across all states (in state-based exchanges, we based this on premium growth in those states, adjusted for differences in how fast tax credits grow relative to premiums) then adjusted for the share of Marketplace enrollees receiving a tax credit and inflated it based on CBO projections for average tax credits. For the American Health Care Act, average tax credits were weighted based on the age distribution of current marketplace enrollees and then indexed based on CPI + 1%. Although tax credits phase out for high-income enrollees in the AHCA, we assume that very few current marketplace enrollees have incomes high enough for the tax credit to phase out, and thus do not take this into account in calculating the average tax credit under the AHCA for current marketplace enrollees.

The U.S. Health Insurance Market Is Poised To Move To A Defined-Contribution From A Defined-Benefit System Of Federal Financing

07-Mar-2017

"Fragile" or "Handle with care" should be the label on a shipping crate carrying the U.S. health insurance market. The fragility of any national health insurance framework comes from the complex interconnectedness of multiple stakeholders and financing elements. Perhaps most entwined into the fabric of U.S. health insurance is the financing support that the federal government provides to all major forms of comprehensive health insurance. Currently, over $1 trillion of federal support comes to this market, with most of it akin to a defined-benefit type of financing system. From subsidies in the individual market (under-65), to federal funding of Medicaid, to tax deductions in employer-sponsored health insurance, current federal support keeps the health insurance market (dysfunctional as it may be) intact.

Overview

- The American Health Care Act (ACA replacement proposal), if signed into law, will fundamentally change federal financing of healthcare, especially for the Medicaid and individual insurance segments.
- We expect a decline in enrollment in the individual (2 million–4 million) and Medicaid (4 million–6 million) segments, resulting in a decline in premiums.
- Profitability will likely improve, as the replacement plan can result in an improved risk pool in the individual market.
- Our ratings on U.S. health insurers remain unaffected by this bill.

S&P Global Ratings believes that it is highly likely that "repeal and replace" will alter substantially how U.S. healthcare is financed, consumed, and regulated. On March 6, 2017, the first house bill--The American Health Care Act--was released as a possible replacement for the Affordable Care Act (ACA). This proposed replacement bill still has to traverse the legislative process, and there could be changes along the way. We analyzed the key aspects of this replacement bill to understand its potential impact on the insured rates, insurers' premiums, and insurers' profitability. We expect changes in federal financing to the individual and Medicaid segments to reduce insured rates, and somewhat dampen organic growth potential for insurers. As for profitability, we expect margin improvements for insurers in the individual market and continued low-single-digit margins in the Medicaid segment. The employer/group and Medicare Advantage segments should be mostly unaffected by the replacement bill (see table 1).

Table 1

Net Impact Of ACA Replacement Plan On Number Of Insured, Insurers' Top And Bottom Lines

Insured rate	Negative: Individual and Medicaid segments will see drop in enrollment
Insurers' premiums/revenues	Negative: Somewhat tempered potential for future organic growth
Insurers' profitability	Neutral to positive: Individual market margins should improve, while other segments should hold steady

Quantifying The Federal Support For Comprehensive Health Insurance

As per the Congressional Budget Office (CBO), the federal government's annual mandatory outlays for the major health care programs were $1.1 trillion, which was the largest piece (44%) of its total mandatory outlays in 2016. Not included in that number is the potential tax deductions for the employer-sponsored segment. The CBO

estimated that the employer-based group segment, which represents about 65% of the total insured population, received $266 million of tax exclusions for 2016.

Table 2

Federal Support Entwined In U.S. Health Insurance Framework

Insurance segments	Federal funding of health insurance (bil. $)
Tax exclusion for employer-based coverage*	266
Small-group tax credits*	1
Medicare¶	692
Medicaid¶	368
Individual (subsidies and related spending)¶	43
Children's Health Insurance Program¶	14
Total	1,384

*2016 estimated. Source: "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's March 2016 Baseline," CBO, March 2016. ¶2016 actual mandatory outlays. Source: "The Budget and Outlook: 2017 To 2027," CBO, January 2017.

Individual (Under-65) Insurance Segment: Highest Impact From Potential Replacement Plan

Insurers' current positions in the individual market

In aggregate, the individual insured segment accounts for less than 10% of total premium revenues for U.S. insurers. Even though it is the smallest business segment for most insurers, it has seen rapid growth in membership and premiums since 2014. Several aspects of the ACA, including guaranteed issues, public exchanges, and coverage under a parent's plan until age 26 helped increase insured numbers in this segment. But perhaps the key driver of the increase was the federal funding support currently provided to more than half of the individuals insured in this segment.

Although insurers saw top-line growth since 2014, profitability has been a struggle for the industry. Other than a handful of insurers, most reported underwriting losses in this segment. In aggregate, we estimate the industry had underwriting losses of over $3 billion in 2014 and $4.5 billion in 2015 for this segment. We expect 2016 and 2017 to be better than 2015, in aggregate, but still below insurers' target profitability levels (see "**The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer**," published Dec. 22, 2016, on RatingsDirect).

Current federal funding for the individual market

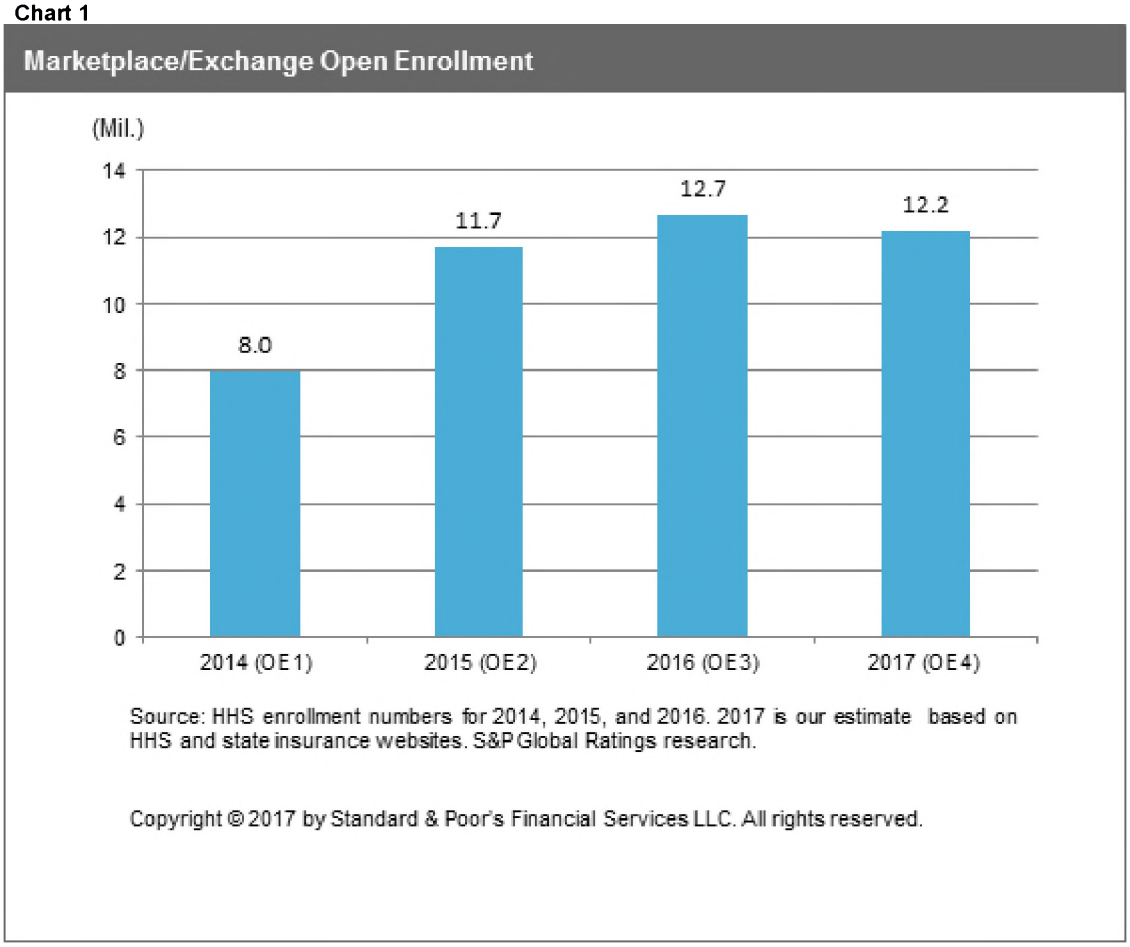
The federal outlay for the individual market was about $42 billion in 2016, most of which is related to the income-based subsidies provided to the insured in this segment. ACA introduced two forms of income-based subsidies to the individual market:

- Advanced premium tax credit (APTC): Individuals (not eligible for Medicaid) between 100%-400% of the federal poverty line (FPL) receive a tax credit that reduces the premium they need to pay for the health plan. This tax credit is linked to the second-cheapest silver plan available on the exchanges. The amount of tax credit also changes with the price of the insurance plans (or cost of the benefit) in the marketplace.
- Cost-sharing reduction (CSR): Individuals (not eligible for Medicaid) between 100%-250% of FPL receive a CSR that decreases out-of-pocket costs (e.g., deductible, coinsurance, etc.).

These subsidies perform almost as a stabilizer for the market. They create a floor below which the insured rate will likely not drop because the subsidies are linked to the actual price in the market. A prime example of the subsidies performing as planned was the 2017 open enrollment (OE4). Average premiums increased by 25% in 2017. Such an increase would have resulted in a fairly significant decline in enrollment if not for the subsidies. Close to 80% of the exchange enrollees received an income-based subsidy linked to the actual price or market premium; so as premiums went up, so did their subsidies. This effectively hedged them against the sharp premium increase. We estimate OE4

ended with 12.2 million enrollees, which was about 5% lower than the 2016 open enrollment (OE3). This decline was in line with our previously forecasted range for 2017 of a potential 4% year-over-year enrollment growth on the upper end, and an 8% decline on the lower end (see "**Slowing Down: ACA Insurance Marketplace Growth May Halt In 2017**," published Oct. 13, 2016, on RatingsDirect).

Chart 1



What may be the impact of a replacement funding plan?

- Net decline of 2 million to 4 million insured in this segment
- Increased affordability for the eligible younger population, and reduced affordability for the older population
- Improved profitability for insurers in this business segment as the risk pool will have a greater proportion of younger enrollees
- Larger differences between states both in terms of insured rates and benefits covered by insurance plans

Given the interconnected nature of the health insurance market, we evaluated the replacement financing proposal, along with other proposed changes (see table 3) such as potential reduced actuarial values, continuous coverage mandate, and wider rating age bands. Other aspects such as guaranteed issue and ability to add children to their parents" plan until 26 years of age will remain in the replacement plan.

Table 3

Key Potential Changes Between ACA And Proposed Replacement Plan

Key factors considered in analysis	Currently under the ACA	Proposed replacement plan*	Proposed effective date of replacement*
Federal financial support	Income-based federal APTC and CSR; uses the actual price of the second-cheapest silver plan in an individual's area as benchmark for amount of subsidy.	Fixed amount of age-based refundable tax credits (e.g., $2,000 for a 21-year-old increasing to $4,000 for a 64-year-old) that will not differ by area of residence. Limits tax credit based on modified adjusted gross income level.	Jan. 1, 2020

Permissible age variation in insurance premiums (rate bands)	3:1	5:1	Jan. 1, 2018
Plan benefit design/Levels of coverage	Metallic plans, such as Bronze (60% AV), Silver (70%), Gold (80%), Platinum (90%)	No national minimum; states will decide the requirements for their respective state	Jan. 1, 2020
Individual mandate	Individual has to pay a tax penalty if not enrolled in a qualified health plans (with some exceptions)	Insurance premiums can be 30% higher if "continous coverage" is not maintained	ACA mandate is repealed effective December 2015; Continous coverage requirement starts 2019

*Based on American Health Care Act (draft as of March 6, 2017).

Insurers are no longer allowed to underwrite or price based on medical conditions of the insured, but they are allowed to use a rating band, where they can charge differently depending on the age of the individual. This is based on the premise that younger individuals, in general, use medical services less than the older population. Under the current ACA rules, an insurer is allowed to charge 3x as much for a 64-year-old as for a 21-year-old. The replacement plan widens this rate band. The wider rate bands (5:1) will reduce premiums for the eligible younger population, while likely increasing premiums for the older population.

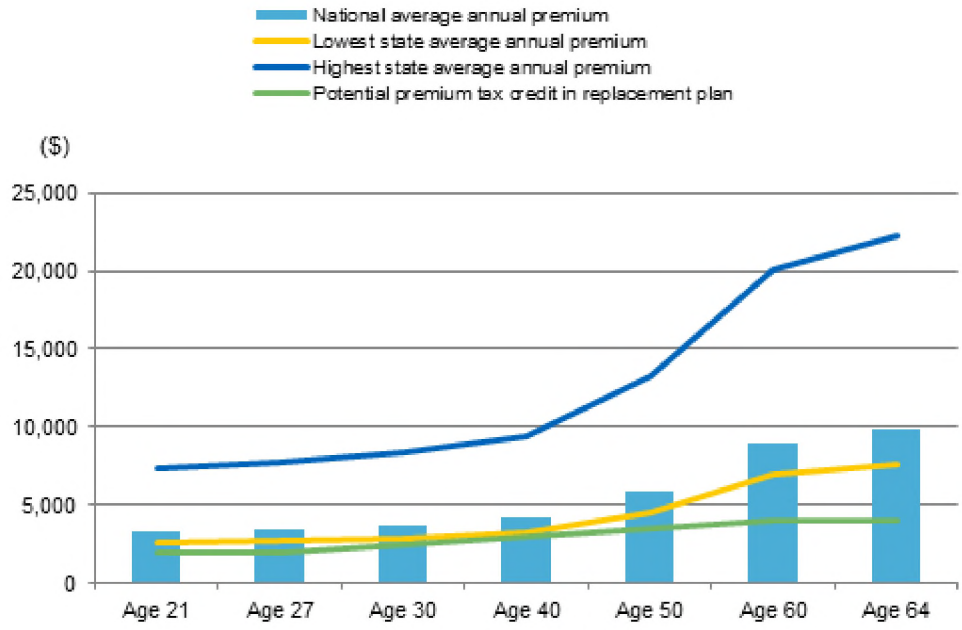
For example, we assumed that average premiums for a 21-year-old would decline by 20% (given the wider age bands and some reduction in actuarial value of plans) as a result of the replacement plan. Using the average national premium price from the 2016 marketplace, a 20% decrease would mean annual premiums of $2,625 compared to average annual premiums of $3,281 for the 21-year-old. However, the wider rate band would mean premiums for a 64-year-old could increase almost 30%, resulting in annual premiums of $13,125 (5x higher than the 21-year-old) compared to $9,844 (currently, 3x higher than the 21-year-old). The proposed tax-credits of $2,000 in the replacement plan, although not covering the entire premium cost for a 21-year-old, would reduce it by almost 75%. The proposed $4,000 tax credit for a 64-year-old falls well short of the potential premium cost, reducing premiums by only 30%.

Therefore, we expect the replacement plan to result in an increase in the younger (21-35 years) insured, and a higher decline in the older age (45-64 years) insured. We estimate the net impact would be a 2 million–4 million reduction in enrollees in 2019.

Another impact of the replacement scenario is the possible amplified variance among states. First, depending on how much flexibility states use to create minimum actuarial values, in some instances it may feel like a walk down memory lane. "Mini-med" or limited-benefit plans that were prevalent before the ACA in the individual market segment may make a comeback in some states, whereas other states may choose to maintain close to ACA-level essential benefits. Second, because the proposed replacement tax credits aren't linked to the underlying costs, individuals in states with higher premiums will see a less-effective benefit than states with lower premium rates (see chart 2). Health insurance premium rates can differ significantly among states. For example, the average premium for a silver plan in Alaska was almost three times as expensive as one in Hawaii. The current ACA system of APTC links the financial support to the underlying cost (price of the second-cheapest silver plan), and can be effective regardless of the insurance costs of each state. Thus, the potential shift to age-based prefixed tax credit will hurt states with higher-than-average premium rates, resulting in greater differences in insured rates among states.

Chart 2

Average Annual Premiums Compared To Proposed Tax Credit



Average is a simple average of premiums of all 2016 ACA silver plans sold on the federal-exchanges. Age 64 premium is estimated (actual data was unavailable) to be 3x the premium price of the 21-year-old. Source: HHS, American Health Care Act (draft March 6, 2017), S&P Global Ratings research.

The proposed replacement plan, similar to ACA, includes a disincentive for not buying insurance. The proposed plan changes the penalty of not having health insurance from a tax penalty to a "continous coverage" premium penalty. As per the "continous coverage" rule, an insurer can charge 30% higher premiums if an individual has lapsed coverage for more than 63 days. Continuous coverage may be a more effective disincentive in stopping individuals from jumping in and out of coverage based on need. But it will not solve the affordability issues and may prove to be a disincentive even for a lower-morbidity individual to sign up after missing coverage. However, the bigger impact may be felt more immediately if this proposal is signed into law soon. The ACA mandate penalty is repealed effective 2015, and the continuous coverage mandate isn't in place until 2019. So although the ACA mandate penalty wasn't very strong, it is still better to have some disincentive than none. This gap may lead to higher-than-expected lapses in 2017, which could be somewhat concerning for insurers already struggling with profitability issues in this segment.

As for health insurers' credit profiles, premiums will decline as enrollment declines, but profit margins will likely improve. This is because, starting in 2019, there will likely be a higher proportion of the younger population in the insured ranks, which is different from the current individual risk pool.

We didn't include high-risk pools in our analysis. The proposed bill appropriates $15 billion in 2018 and 2019, followed by $10 billion annually, to be distributed across states. States can use this "patient and state stability fund" for a few different things, including setting up a high-risk pool. High-risk pools are expensive endeavors. They have limited track records for success and may end up being cost-prohibitive to maintain in the longer term. We don't expect $15 billion across 50 states and DC to be sufficient for states to run high-risk pools. Instead, a reinsurance program, which was the most effective of the three ACA premium stabilization programs (referred to as 3Rs) may work better. A possible reinsurance program is mentioned as the "default federal safeguard" in the proposed rule.

Medicaid Insurance Segment: High Impact For Medicaid Expansion From Potential Replacement Plan

Insurers' current positions in the Medicaid market

In aggregate, Medicaid accounts for about 20% of insurers' total premiums, and like the individual segment it has had strong growth in the past couple of years. More states have moved to a managed Medicaid framework, in which they contract with private insurers to manage their Medicaid programs. Thirty-two states (including DC) expanded Medicaid eligibility for their residents post-ACA. In general, Medicaid has been a profitable (albeit, at lower margins) segment for insurers.

Current federal funding for the Medicaid market

Medicaid is funded jointly by the federal and state/local governments. The federal outlay for Medicaid was about $368 billion in 2016, which is approximately 60% of the total spending on this program. This federal share of Medicaid expenditure is greater for the beneficiaries who are newly eligible as a result of ACA's Medicaid expansion. Federal funds match 100% of the expenditure for the expansion in 2016, reducing to 90% for 2020 and beyond. (Under ACA, states could expand Medicaid eligibility to 138% of the federal poverty line. So far, 32 states, including DC, have undertaken this expansion.)

The method of Medicaid funding is linked to the actual costs of the state markets. States pay providers or managed care plans for Medicaid costs and then report those payments to the Centers for Medicare and Medicaid Services. The federal government pays the states a percentage of the costs of those reported medical services. This percentage, known as Federal Medical Assistance Percentage (FMAP), is calculated annually for each state. The actual FMAP differs by state, ranging from about 50%-70% in 2016.

What may be the impact of a replacement funding plan?

- Insured population in this segment will likely decline by 4 million–6 million after 2020-2024, as a portion of the "expansion" falls off the rolls
- Increased opportunity for private insurers as more states move to managed Medicaid model for running the program
- Insurers should continue to generate low single-digit profits in this segment, but can be squeezed in the longer term if states reduce reimbursement rates to offset their greater burden of the cost

The overall funding for Medicaid is shifted to a per-capita funding under the proposed replacement plan. This is different from the current form of funding that is close to a defined benefit financing of the program.

The proposal also changes the financing of the expansion population. It allows new enrollees to join the expansion ranks until Dec. 31, 2019. But, after 2019 it doesn't provide federal funding for any new eligible enrollees that aren't already on the roles or for any current enrollee that has more than a month's break in eligibility. This effectively puts Medicaid expansion in "run-off" after 2019. The Medicaid program enrollees generally have a lot of churn due to change in income levels. Starting 2020, even a low level of churn among the "run-off" expansion enrollees will result in a gradual decline in enrollment.

We expect expansion states (and DC) to be most affected in terms of potential reduction in Medicaid enrollees. As ACA's generous federal matching for the continued expansion is changed after 2019, states--depending on how stressed their budgets are--may be unable to continue funding new expansion enrollees. However, we don't expect all of the 32 states to go into "run-off." Assuming some states--especially those that had higher eligibility levels even before ACA--maintain their increased expansion expenditure (perhaps with some changes to benefit design) while others aren't able to, we estimate a drop of about 4 million–6 million Medicaid enrollees from 2020 to 2024.

Table 4

Enrollment Of Medicaid Expansion States (And DC)

States expanding Medicaid	Total Medicaid and CHIP enrollment, December 2016 (preliminary)	Average monthly Medicaid and CHIP enrollment, July-September 2013	Net change, July-September 2013 to December 2016	% change, July-September 2013 to December 2016
California	11,901,083	7,755,381	4,145,702	53.5
New York	6,390,438	5,678,417	712,021	12.5
Washington	1,810,889	1,117,576	693,313	62.0

Ohio	2,971,319	2,341,481	629,838	26.9
Kentucky	1,230,475	606,805	623,670	102.8
Colorado	1,375,041	783,420	591,621	75.5
Arizona	1,739,041	1,201,770	537,271	44.7
Pennsylvania	2,918,260	2,386,046	532,214	22.3
New Jersey	1,761,395	1,283,851	477,544	37.2
Illinois	3,099,444	2,626,943	472,501	18.0
Maryland	1,265,867	856,297	409,570	47.8
Louisiana	1,415,385	1,019,787	395,598	38.8
Arkansas	948,181	556,851	391,330	70.3
Michigan	2,297,344	1,912,009	385,335	20.2
Indiana	1,498,978	1,120,674	378,304	33.8
Massachusetts	1,661,951	1,296,359	365,592	28.2
Oregon	966,178	626,356	339,822	54.3
New Mexico	775,020	457,678	317,342	69.3
Nevada	623,574	332,560	291,014	87.5
West Virginia	567,064	354,544	212,520	59.9
Minnesota	1,026,547	873,040	153,507	17.6
Iowa	622,071	493,515	128,556	26.1
Rhode Island	294,264	190,833	103,431	54.2
Montana	243,320	148,974	94,346	63.3
New Hampshire	187,129	127,082	60,047	47.3
Hawaii	345,724	288,357	57,367	19.9
Alaska	173,321	122,334	50,987	41.7
District of Columbia	264,849	235,786	29,063	12.3
Delaware	241,664	223,324	18,340	8.2
North Dakota	84,587	69,980	14,607	20.9
Vermont	167,130	161,081	6,049	3.8
Connecticut	761,310	N.A.	N.A.	N.A.
Subtotal for all states expanding Medicaid	51,628,843	37,249,111	13,618,422	36.6

Source: CMS, Medicaid.gov. N.A.-Not available.

As their share of the expenditure increases, states will likely increase their use of private insurers to manage the program. As Medicaid managed care increases, insurers will likely see increased revenues from this program. But if the expansion states reverse their gains, it will take away some of the recent gains seen by the insurers. We expect insurers to remain profitable in this business segment, but margins may be squeezed in states where budgets force a reduction in managed Medicaid reimbursements.

Employer-Sponsored Or Group Insurance Segment: Mostly Unaffected By Proposed Replacement Plan

Insurers' current positions in the group market

In aggregate, the group segment accounts for about 60% of total premium revenues for U.S. insurers. This is by far the largest segment for the industry, and has also proven to be the most stable in terms of earnings. Insurers participate in two forms in this segment:

- Self-insured plans: The employer/group retains the insurance risk and pays a fee to the insurer to administer the program for its employees.

- Fully-insured plans: Insurer retains the insurance risk and gets paid a premium to take the insurance risk for the group's employees.

Current federal funding for the group market

Contrary to the individual and Medicaid markets, the employer/group market doesn't receive direct federal dollars in funding. But premiums paid toward group insurance are tax deductible. The Congressional Budget Office estimates that there was $266 billion of tax exclusion related to this segment in 2016.

The ACA introduced a tax (often referred to as the "Cadillac tax") to reduce this exclusion. The "Cadillac tax" has a 40% tax on high-cost employer health plans. The tax threshold (or amount above which the tax would become effective) was set at $10,200 for single coverage and $27,500 for family coverage. In December 2015, Congress delayed the implementation of the Cadillac tax until 2020.

What may be the impact of a replacement funding plan?

- No impact in the near term as "Cadillac tax" is further delayed to 2025
- If implemented in 2025, no significant change in insured rate in this segment

The Cadillac tax, which is the same in the replacement proposal, shows an interest in taxing premiums on employer plans. If implemented in 2025, we expect minimal change in the insured rate for this segment due to the tax. It is very likely that "buy-downs" (purchase of reduced-benefit plans) will increase in an attempt to limit the tax impact. This will accelerate the trend of increased cost sharing with the consumer. But we don't expect a meaningful amount of employees to drop coverage because of this tax.

As for insurers' revenues, the biggest impact will be on the "fully-insured" segments. Insurers' premiums will likely decline in this segment as the groups increase "buy-downs." We expect a minimal impact on the "self-insured" segment because insurers only receive an administration fee. But we remain cautious regarding any unintended impact on this segment, given this is the largest and most mature segment for the industry. Any unexpected, meaningful reduction in premiums can have a negative effect on margins, not due to medical claims cost issues, but because of the increased administration cost strain from a lower top line.

Medicare Advantage (MA) Insurance Segment: Limited To No Impact From Potential Replacement Plan

In aggregate, the MA segment accounts for about 12% of total premium revenues for U.S. insurers. The proposed replacement plan doesn't affect MA. We believe MA may be the "safest" program in terms of being protected from potential changes. This program is highly popular with seniors and generally has bipartisan support in Congress. We expect year-to-year MA reimbursement rates to be an ongoing issue (nothing new), but one that should be manageable for the industry. A potential shift of the MA program to a premium support program could also provide potential upside as it could open up the market to further managed-care penetration depending on the details of the program.

No Rush Delivery On This Package

The key to successful execution of a replacement plan is not just a plan that takes into account the interconnectedness of the marketplace, but one that also provides adequate time to adapt to the proposed changes. Sudden changes or lack of clarity in rule adds to uncertainty in this already complex framework. A two-to-three-year pathway (as provided for several of the key factors in the replacement plan) to implementation would provide insurers adequate time to modify products and strategies to the new rules.

However, this replacement bill isn't a done deal. The legislative process may take time, and tweaks to the bill are also likely. At this time, it is clear that the most affected segments will be the individual and Medicaid markets. Overall, we expect a decline in insured rates and insurance industry revenues due to loss of enrollees in those two segments. As for future growth, insurers will have to turn to MA, which remains the only clear path for organic growth.

Additionally, we cannot overemphasize the benefit from diversification in a rapidly changing industry. As is the case with any major industry reform, diversified companies will see a less-adverse impact than those concentrated in a single business segment. In this instance, the diversified health insures with less (as a percentage of their total revenues and earnings) exposure to the individual and Medicaid lines will see minimal adverse impact to their credit quality from a replacement plan. However, such a plan may affect insurers more who are concentrated in the individual market, which has the likelihood of becoming a smaller piece of the health insurance pie.

Data Behind Our Individual Market Forecast

For the individual market (under-65, non-Medicaid), we are forecasting a 2 million–4 million drop in enrollment from implementation of the replacement bill. We looked at various data points for our forecast. Three cohorts that weighed heavily on our forecast were:

- As per census data, about 10 million are uninsured in the 18-35 year age group. Based on our analysis we estimate a portion (about 35%-40%) of them will enroll under the proposed replacement plan. (100% enrollment of this population is unlikely. Even today, all subsidy qualified individuals haven't enrolled, which is why outreach remains important to this age group).
- Based on data from the U.S. Department of Health and Human Services, about half of the exchange population is between 45 and 64 years of age (we estimate that to be about 5 million). We assumed the majority of these enrollees will drop coverage in the proposed plan, since most currently get an income-based subsidy.
- A portion of current off-exchange nonsubsidy enrollees, most of whom we assumed to be in the 40-64 age-band, will drop coverage because of the impact of the wider rate band.

Only a rating committee may determine a rating action and this report does not constitute a rating action.

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Data Note: Americans' Challenges with Health Care Costs

Mar 02, 2017 | Bianca DiJulio (http://kff.org/person/bianca-dijulio/), Ashley Kirzinger (http://kff.org/person/ashley-kirzinger/), Bryan Wu (http://kff.org/person/bryan-wu/), and Mollyann Brodie (http://kff.org/person/mollyann-brodie/) (https://twitter.com/Mollybrodie)

As lawmakers debate the future of the country's health care system and outline plans to repeal and replace the Affordable Care Act, much of the current debate surrounds how to change or eliminate the health insurance marketplaces developed under the ACA where individuals eligible for financial assistance could compare plans and purchase insurance. While this is an important source of coverage for some, the vast majority of Americans with insurance have coverage from other sources, such as an employer, Medicaid or Medicare, and the public's top priority for lawmakers is reducing what Americans pay for health care. Two recent Kaiser Health Tracking Polls take stock of the public's current experience with and worries about health care costs, including their ability to afford premiums and deductibles. For the most part, the majority of the public does not have difficulty paying for care, but significant minorities do, and even more worry about their ability to afford care in the future. Some of the key findings include:

- Four in ten (43 percent) adults with health insurance say they have difficulty affording their deductible, and roughly a third say they have trouble affording their premiums and other cost sharing; all shares have increased since 2015.
- Three in ten (29 percent) Americans report problems paying medical bills, and these problems come with real consequences for some. For example, among those reporting problems paying medical bills, seven in ten (73 percent) report cutting back spending on food, clothing, or basic household items.
- Challenges affording care also result in some Americans saying they have delayed or skipped care due to costs in the past year, including 27 percent who say they have put off or postponed getting health care they needed, 23 percent who say they have skipped a recommended medical test or treatment, and 21 percent who say they have not filled a prescription for a medicine.
- Even for those who may not have had difficulty affording care or paying medical bills, there is still a widespread worry about being able to afford needed health care services, with half of the public expressing worry about this.
- Health care-related worries and problems paying for care are particularly prevalent among the uninsured, individuals with lower incomes, and those in poorer health; but women and members of racial minority groups are also more likely than their peers to report these issues.

HEALTH CARE COSTS ARE PUBLIC'S TOP PRIORITY FOR LAWMAKERS

While Democrats, independents, and Republicans are divided (http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-future-directions-for-the-aca-and-medicaid/) on what they want lawmakers to do when it comes to the Affordable Care Act, known commonly as Obamacare, according to a Kaiser Health Tracking Poll conducted in December (http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-health-care-priorities-for-2017/). Americans are less polarized on their worries about the cost of health care for individuals. A majority of Americans, regardless of party identification, think lowering the amount individuals pay for health care should be a "top priority" for President Trump and Congress and rank it at the top of the list of health care priorities. In addition, more than half of Americans say the same about lowering the cost of prescription drugs, including two-thirds (67 percent) of Democrats, and about six in ten independents (61 percent) and Republicans (55 percent).

Figure 1

Majority of Americans, Regardless of Party, Say Limiting Amount Individuals Pay for Health Care Should Be Top Priority

Percent who said each should be a top priority for Donald Trump and the next Congress to do when it comes to health care:

RANK	TOTAL	DEMOCRATS	INDEPENDENTS	REPUBLICANS
1	Lowering the amount individuals pay for health care (67%)	Lowering the amount individuals pay for health care (70%)	Lowering the amount individuals pay for health care (65%)	Lowering the amount individuals pay for health care (64%)
2	Lowering the cost of prescription drugs (61%)	Lowering the cost of prescription drugs (67%)	Lowering the cost of prescription drugs (61%)	Repealing the 2010 health care law (63%)
3	Dealing with the prescription painkiller addiction epidemic (45%)	Dealing with the prescription painkiller addiction epidemic (51%)	Dealing with the prescription painkiller addiction epidemic (46%)	Lowering the cost of prescription drugs (55%)
4	Repealing the 2010 health care law (37%)	Decreasing how much the federal government spends on health care over time (35%)	Decreasing the role of the federal government in health care (34%)	Decreasing the role of the federal government in health care (50%)
5	Decreasing the role of the federal government in health care (35%)	Decreasing the role of the federal government in health care (26%)	Repealing the 2010 health care law (32%)	Decreasing how much the federal government spends on health care over time (43%)
6	Decreasing how much the federal government spends on health care over time (35%)	Repealing the 2010 health care law (21%)	Decreasing how much the federal government spends on health care over time (35%)	Dealing with the prescription painkiller addiction epidemic (39%)

NOTE: Only top six responses listed.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)

Figure 1: Majority of Americans, Regardless of Party, Say Limiting Amount Individuals Pay for Health Care Should Be Top Priority

DIFFICULTY PAYING FOR HEALTH CARE

As large shares of the public say that lowering people's health care and prescription drug costs should be a top priority for lawmakers, sizeable shares of those with health insurance say that affording their premiums, deductibles, and other cost sharing expenses (copays for doctor visits and prescription drugs) is difficult for them. Specifically, about six in ten adult with health insurance say it is easy for them to afford to pay their premiums and cost

sharing expenses, while about a third report difficulty covering those expenses. When it comes to affording their deductibles, four in ten say it is difficult (43 percent) compared to half who say it is easy.

The shares saying they have a difficult time affording these types of medical costs has increased since 2015; from 27 percent to 37 percent for premiums, 34 percent to 43 percent for deductibles, and from 24 percent to 31 percent for copays for doctor visits and prescription drugs. These trends correspond with the ongoing trend of rising premiums, deductibles, and other types of cost sharing in the employer-sponsored insurance market.[1]

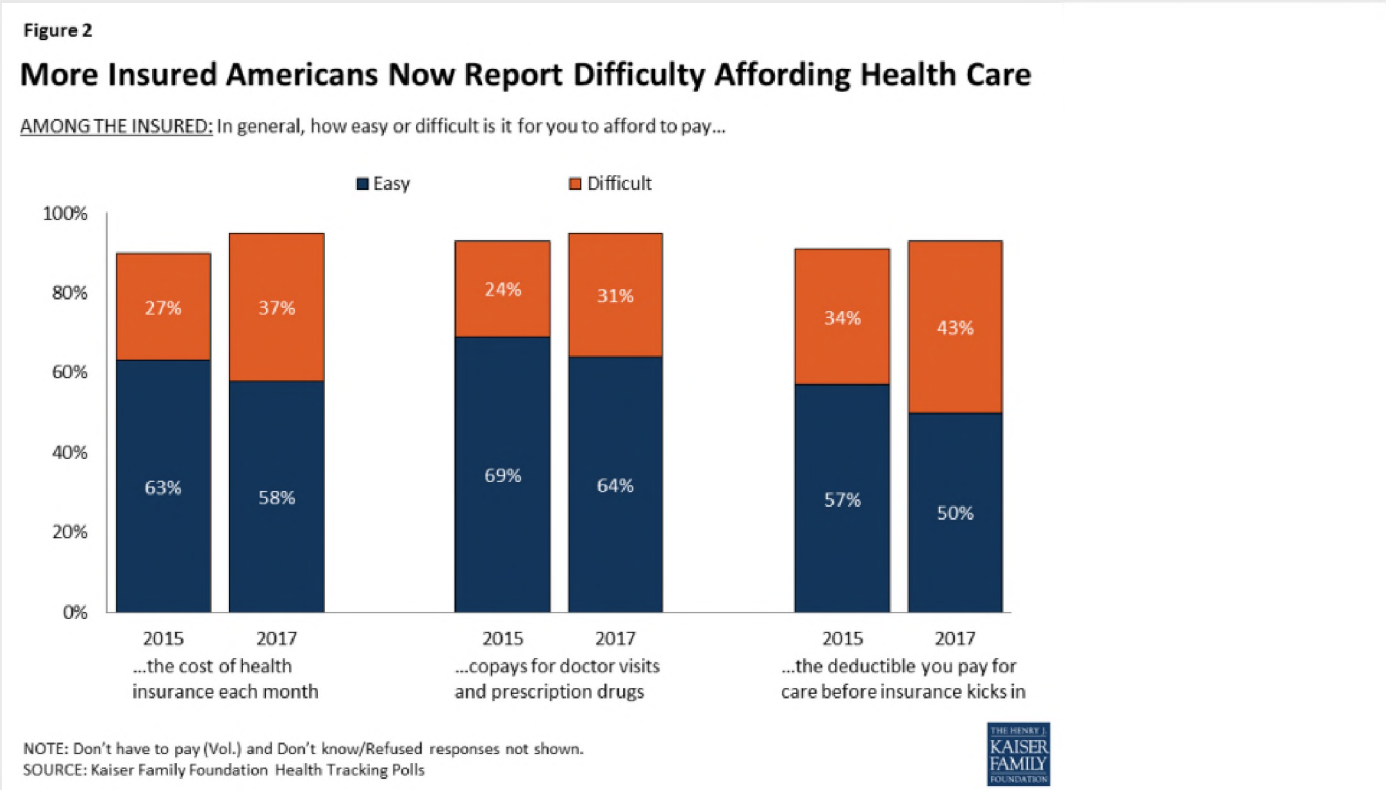


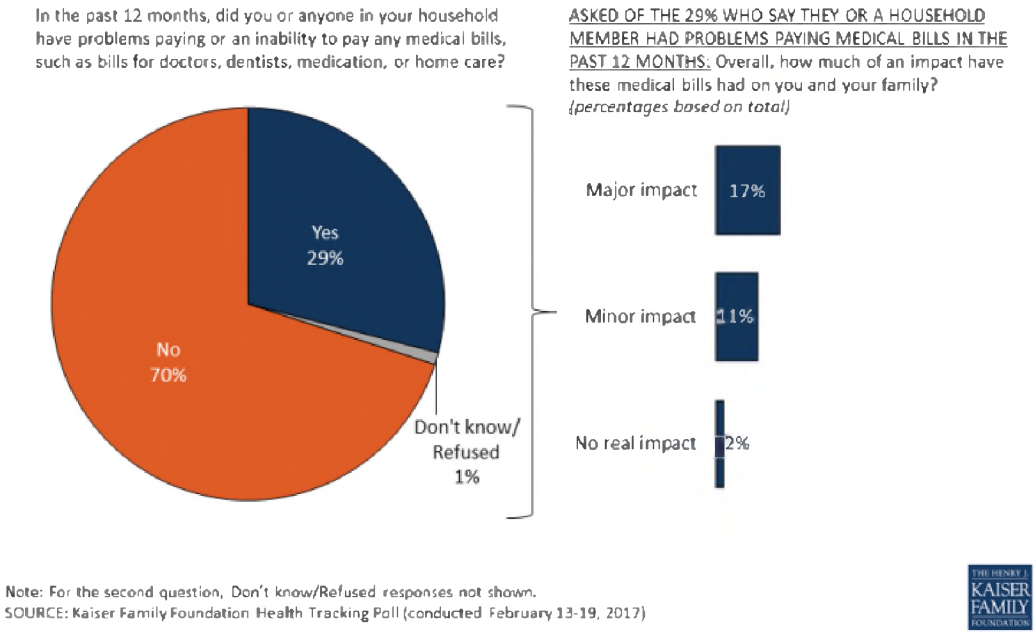
Figure 2: More Insured Americans Now Report Difficulty Affording Health Care

PROBLEMS PAYING MEDICAL BILLS, AND THEIR CONSEQUENCES

About three in ten U.S. adults (29 percent) say they or a household member have had problems paying medical bills in the past year, and most who have had trouble say the bills had a major impact on their family (58 percent of those who had medical bill problems, or 17 percent of all Americans). The share reporting their household has had problems paying medical bills has remained steady between about 25 and 30 percent for the past decade.

Figure 3

Most of Those Who Struggled to Pay Medical Bills Report Major Impacts on Their Family



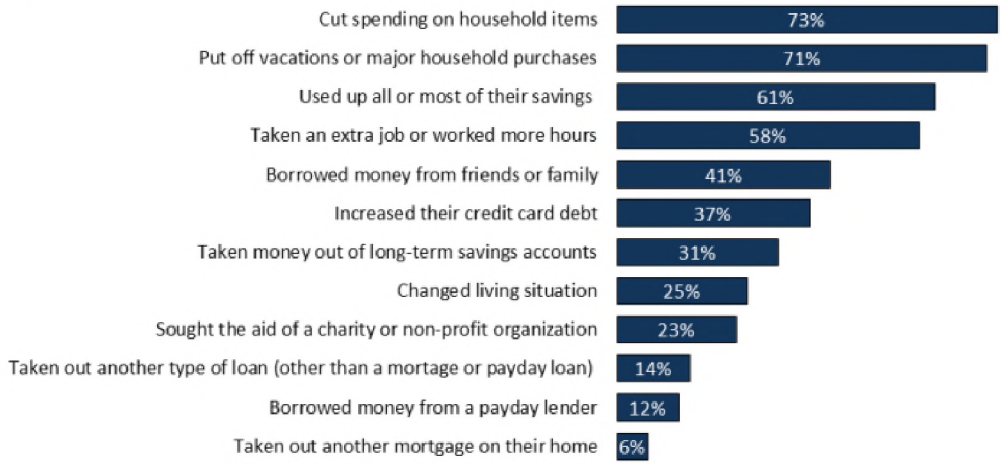
Note: For the second question, Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 13-19, 2017)

Those who report problems paying medical bills in the past year report a number of different responses to those challenges. For example, among those reporting problems paying medical bills, seven in ten report cutting back spending on food, clothing, or basic household items (73 percent) or putting off vacations or major household purchases (71 percent), and about six in ten say they have used up all or most of their savings (61 percent) or taken an extra job or worked more hours (58 percent) in order to pay the bills. Sizeable shares of those with problems paying medical bills also report increasing credit card debt (37 percent) or taking money out of retirement or other long-term savings accounts (31 percent), and a quarter say they have even changed their living situation in order to be able to pay the bills.

Figure 4

Those with Problems Paying Medical Bills Report Engaging in a Variety of Actions to Pay off Bills

AMONG THE 29% WHO SAY THEY OR A HOUSEHOLD MEMBER HAD PROBLEMS PAYING MEDICAL BILLS IN THE PAST 12 MONTHS: Percent who say they or someone else in their household did each of the following in the past 12 months in order to pay medical bills



NOTE: Question wording abbreviated. See topline for full question wording.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 13-19, 2017)

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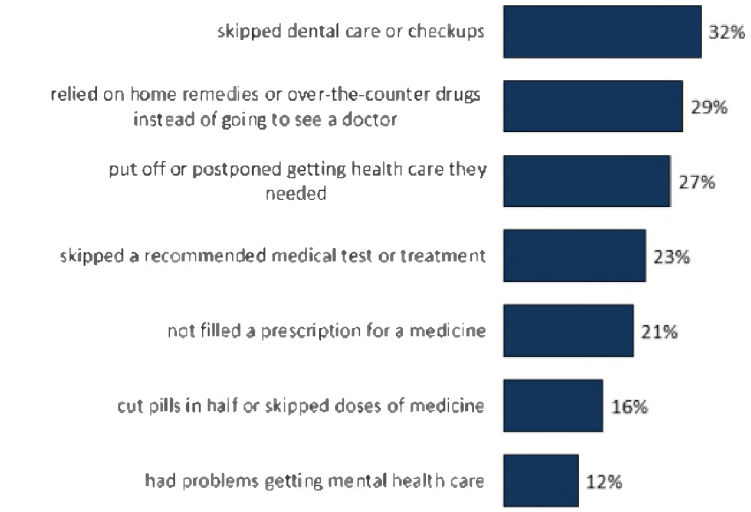
LARGE SHARES REPORT PUTTING OFF CARE DUE TO COST

Concerns about the cost of care also result in some Americans saying they or a family member put off or skipped some sort of health care in the past year because of the cost. Most common among these are skipping dental care (32 percent), relying on home remedie or over-the-counter drugs instead of going to see a doctor (29 percent), and putting off or postponing getting health care they needed (27 percent). About one in five also report they have skipped a recommended medical test or treatment (23 percent) or not filled a prescription for a medicine (21 percent) due to costs. Fewer, about one in eight, say they have cut pills in half or skipped doses (16 percent) or had problems getting mental health care (12 percent) due to costs.

Figure 5

Some Americans Report Putting Off or Postponing Care Due to Costs

Percent who say, in the past 12 months, they or a family member living in their household has done each of the following due to cost:



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)

THE HENRY J. KAISER FAMILY FOUNDATION

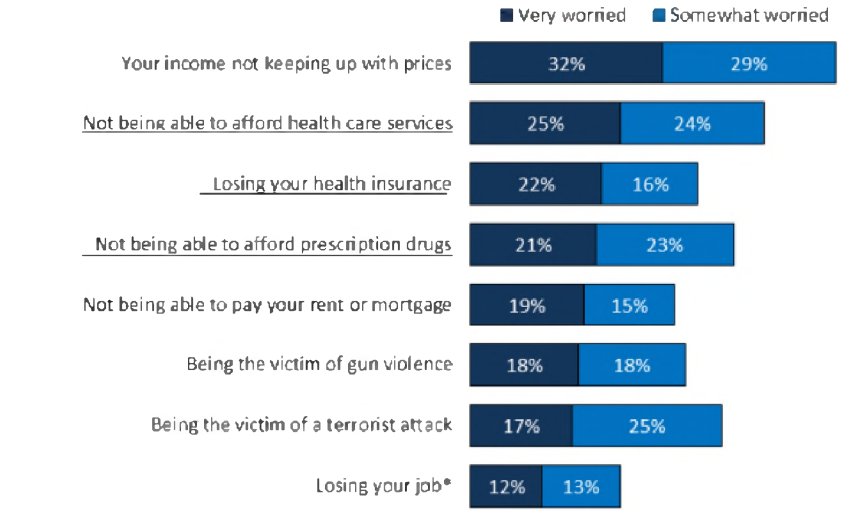
MANY AMERICANS WORRY ABOUT THE COST OF THEIR HEALTH CARE

Kaiser polls have also asked Americans how worried they are about a number of health-related concerns and economic issues, and find that worries about health care fall just below concerns about their income not keeping up with prices. About one-third of Americans say they are “very worried” about their income not keeping up with prices, followed closely by about one-fourth who are “very worried” about not being able to afford health care services they think they need (25 percent), losing their health insurance (22 percent), or not being able to afford prescription drugs (21 percent). Overall, half are at least somewhat worried that they won’t be able to afford needed health care services.

Figure 6

Cost Concerns, Including Health Care Costs, Top List of Worries

Percent who say they are worried about each of the following:



NOTE: "Losing your health insurance" was asked among those who were insured and "Losing your job" was asked among those who were employed. Question wording abbreviated. See topline for full question wording.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)

TROUBLE PAYING AN UNEXPECTED $500 MEDICAL BILL

Unexpected medical bills can catch people off guard without a way to pay for the expense and nearly half (45 percent) of Americans say they would have difficulty paying a surprise medical bill of $500. About one in five (19 percent) say they would not be able to pay the bil at all and another 7 percent say they would have to borrow money from a bank, payday lender, or friends or family to pay the bill, while 20 percent say they would put it on a credi card and pay it off over time. Half of Americans (47 percent) say they could pay the $500 bi in full right away. Among the uninsured and those with lower incomes, about a third of each group say they would not be able to pay a $500 bill at all (31 percent and 35 percent, respectively). In addition, four in ten of those who report being in fair or poor health say they wouldn't be able to pay an unexpected bill of $500.

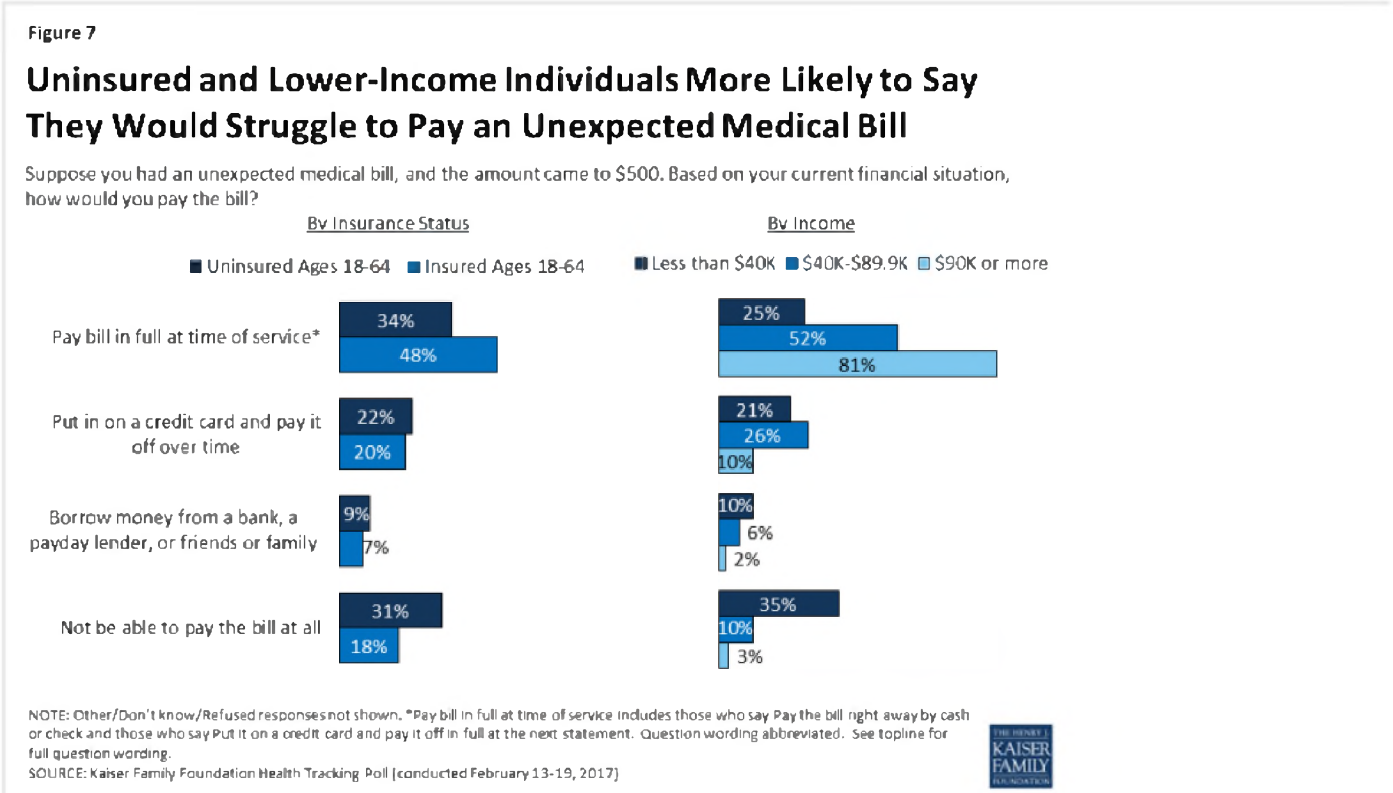


Figure 7: Uninsured and Lower-Income Individuals More Likely to Say They Would Struggle to Pay an Unexpected Medical Bill

PROBLEMS AND WORRIES OVER TIME

Despite an improved national economic situation and implementation of the ACA, there has been little movement in the share of the public that reports problems paying medical bills, putting off care due to cost, or worries about affording care, potentially reflecting continually rising premiums and deductibles.

Table 1: Public's Struggles with Health Care Over Time

Percent who say they...	March 2010	March 2011	May 2012	September/ December 2013	November 2015/ January 2016	December 2016/ February 2017
...had problems paying medical bills	30%	23%	26%	28%*	23%[†]	29%[a]
...put off care due to cost	57	52	58	57[±]	50[‡]	51[b]
...are very or somewhat worried about affording needed care (NET)	58%	52	48	60[±]	56[‡]	50[b]
...are "very worried" about affording needed care	29	20	25	33[±]	28[‡]	25[b]

*December [±]September [†]November 2015 [‡]January 2016 [a]February 2017 [b]December 2016
NOTE: For problems paying health care, the question wording for 2010 through 2013 was, "In the past 12 months, did you or another family member in your household have any problems paying medical bills, or not?" In 2015 and 2017, question wording was, "In the past 12 months, did you or anyone in your household have problems paying or an inability to pay any medical bills, such as bills for doctors, dentists, medication, or home care?"
Putting off care due to cost includes those who say yes to doing at least one of the following due to costs: skipping dental care o checkups, relying on home remedies or over-the-counter drugs instead of going to see a doctor, putting off or postponing getting health care they needed, skipping a recommended medical test or treatment, not filling a prescription for a medicine, cutting pills in half or skipping doses, or having problems getting mental health care.
SOURCE: Kaiser Family Foundation Health Tracking Polls (2010-2017)

LARGE VARIATION IN REPORTS OF PROBLEMS AND WORRIES ACROSS DEMOGRAPHIC GROUPS

Not surprisingly, people who are lower-income, uninsured, or who are in poorer health are more likely to report that they have difficulty affording health care and that the issue concerns them. For example, problems paying medical bills are more commonly reported by those in fair or poor health (52 percent), the uninsured (41 percent), and those with lower incomes (42 percent). And, about half of those in fair or poor health say they are "very" worried about being able to afford health care services they need.

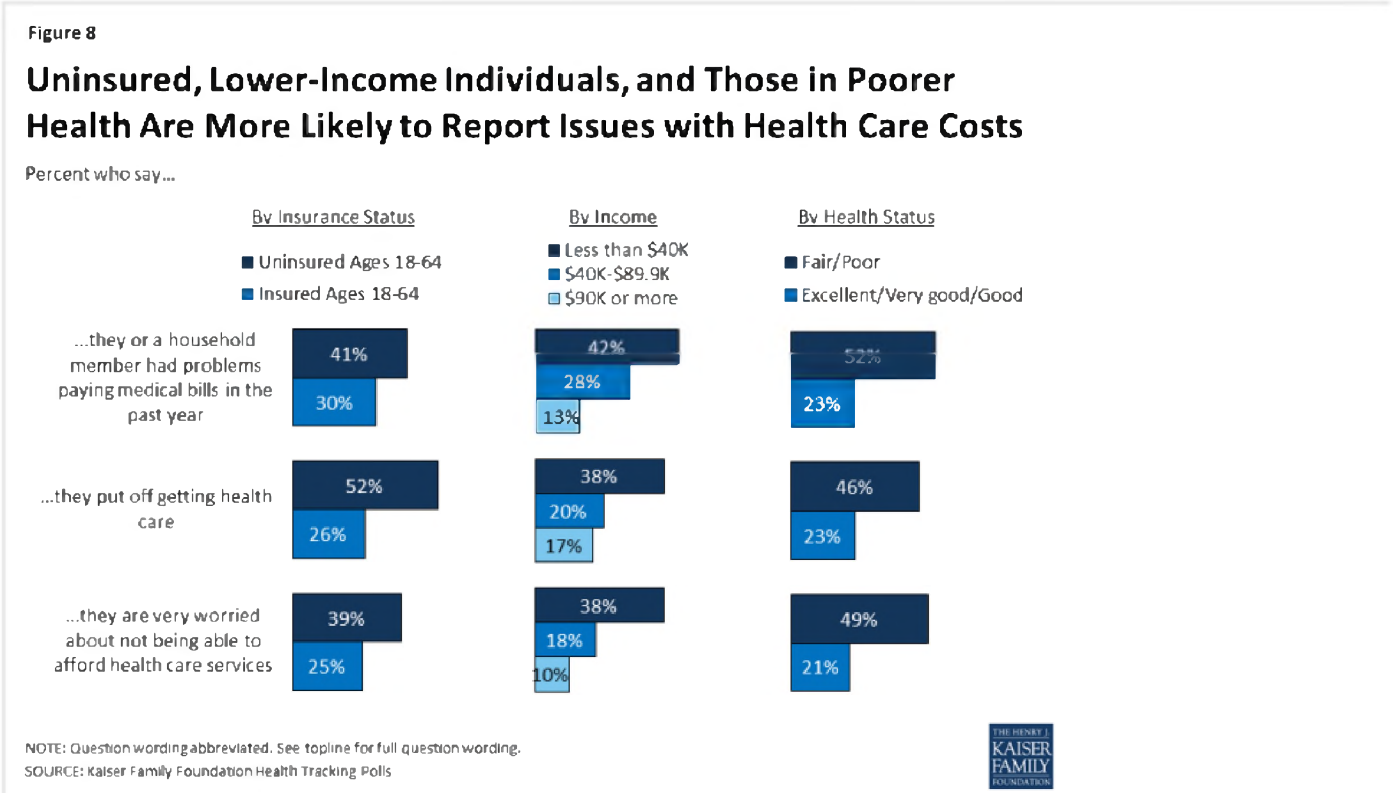


Figure 8: Uninsured, Lower-Income Individuals, and Those in Poorer Health Are More Likely to Report Issues with Health Care Costs

While having health insurance ultimately helps protect against high health care costs, those with health insurance who are lower income or in poor or fair health are more likely to say that they have difficulty affording expenses like premiums, deductibles, and other cost sharing. Among those with health insurance, about six in ten people with an annual household income of $40,000 or less say it is difficult for them to afford their deductibles (5 percent) and about half say it is difficult to afford their premiums (53 percent) and other cost sharing (46 percent), shares that are much higher than their upper-income counterparts.

In some cases, there are also differences in problems paying and worrying about health care costs across other demographic groups such as gender, racial and ethnic groups, and for those with ongoing health conditions or pre-existing health conditions. See Table 2 and Table 3 for full results across different demographic groups.

Table 2: Health Care Worries Vary by Health Status

	Total	Health Insurance and Age			Health Status		Health condition in household*	
		Insured, Ages 18-64	Uninsured, Ages 18-64	65 or older	Excellent/ Very good/Good	Fair/Poor	Yes	No
AMONG THE INSURED: Percent who say they have difficulty affording to pay…								
…the cost of health insurance each month	37%	38%	–	33%	30%	62%	43%	30%
…the deductible they pay for care before insurance kicks in	43	46	–	34	38	64	49	37
…co-pays for doctor visits and prescription drugs	31	33	–	24	24	59	38	22
Percent who say they or a household member had problems paying medical bills in the past year:								
	29%	30%	41%	20%	23%	52%	39%	19%
Percent who say that in the past year they or a family member…								
…skipped dental care or checkups	32%	30%	58%	22%	27%	56%	38%	25%
…relied on home remedies or over the counter drugs instead of going to see a doctor	29	28	53	18	26	44	34	24
…put off or postponed getting health care they needed	27	26	52	15	23	46	32	21
…skipped a recommended medical test or treatment	23	22	40	14	20	38	29	15
…not filled a prescription for a medicine	21	19	35	19	16	44	26	14
…cut pills in half or skipped doses of medicine	16	14	26	14	12	35	22	8
…had problems getting mental health care	12	10	31	7	9	26	17	6
Percent who say they are "very worried" about…								
…not being able to afford health care services they think they need	25%	25%	39%	17%	21%	49%	30%	19%
…not being able to afford the prescription drugs they need	21	20	32	18	17	43	27	15
…losing their health insurance	22	22	–	22	17	46	25	18

*For questions about difficulty affording health care expenses and problems paying medical bills, "health condition" refers to those with someone requiring ongoing medical treatment in their immediate family, as asked in February 2017. For questions about delaying or skipping care and health care worries, "health condition" refers to those with someone who has a pre-existing condition in their household, as asked in December 2016.
SOURCE: Kaiser Family Foundation Health Tracking Polls (conducted December 13-19, 2016 and February 13-19, 2017)

Table 3: Health Care Worries Vary by Socioeconomic Status

		Gender		Income			Race/Ethnicity		
	Total	Male	Female	Less than $40K	$40K-$89.9K	$90K or more	Non-Hispanic Whites	Non-Hispanic Blacks	Hispanic
AMONG THE INSURED: Percent who say they have difficulty affording to pay…									
…the cost of health insurance each month	37%	35%	38%	53%	29%	20	34%	44%	52%
…the deductible they pay for care before insurance kicks in	43	40	46	59	39	26	41	52	51
…co-pays for doctor visits and prescription drugs	31	29	32	46	28	11	26	39	49
Percent who say they or a household member had problems paying medical bills in the past year:									
	29	28	30	42	28	13	26	43	32
Percent who say that in the past year they or a family member…									
…skipped dental care or checkups	32	25	38	47	25	18	29	32	42
…relied on home remedies or over the counter drugs instead of going to see a doctor	29	25	33	38	28	18	27	28	38
…put off or postponed getting health care they needed	27	22	31	38	20	17	25	26	37
…skipped a recommended medical test or treatment	23	18	27	31	20	13	21	28	23
…not filled a prescription for a medicine	21	15	26	30	15	10	20	24	19
…cut pills in half or skipped doses of medicine	16	11	20	25	11	9	15	20	15
…had problems getting mental health care	12	8	16	20	8	3	10	15	18
Percent who say they are "very worried" about…									
…not being able to afford health care services they think they need	25%	22%	29%	38%	18%	10%	19%	38%	42%
…not being able to afford the prescription drugs they need	21	18	24	31	16	10	17	26	37
…losing their health insurance	22	19	25	35	15	8	16	35	39
SOURCE: Kaiser Family Foundation Health Tracking Polls (conducted December 13-19 2016 and February 13-19, 2017)									

Endnotes

1. Kaiser Family Foundation/Health Research & Educational Trust Survey of Employer-Sponsored Health Benefits, September 2016. http://kff.org/report-section/ehbs-2016-summary-of-findings/ (http://kff.org/report-section/ehbs-2016-summary-of-findings/)

← Return to text (http://kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/#endnote_link_210300-1)

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Early Effects of the Affordable Care Act on Health Care Access, Risky Health Behaviors, and Self-Assessed Health

Charles Courtemanche, James Marton, Benjamin Ukert, Aaron Yelowitz, and Daniela Zapata

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ABSTRACT

The goal of the Affordable Care Act (ACA) was to achieve nearly universal health insurance coverage through a combination of mandates, subsidies, marketplaces, and Medicaid expansions, most of which took effect in 2014. We use data from the Behavioral Risk Factor Surveillance System to examine the impacts of the ACA on health care access, risky health behaviors, and self-assessed health after two years. We estimate difference-in-difference-in-differences models that exploit variation in treatment intensity from state participation in the Medicaid expansion and pre-ACA uninsured rates. Results suggest that the ACA led to sizeable improvements in access to health care in both Medicaid expansion and non-expansion states, with the gains being larger in expansion states along some dimensions. No statistically significant effects on risky behaviors or self-assessed health emerge for the full sample. However, we find some evidence that the ACA improved self-assessed health among older non-elderly adults, particularly in expansion states.

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I. INTRODUCTION

The goal of the Patient Protection and Affordable Care Act (ACA) was to achieve nearly universal health insurance coverage in the United States through a combination of policies largely implemented in 2014 (Obama, 2016). Several recent studies, including Frean et al. (2016) and Courtemanche et al. (2017), have shown that the ACA led to gains in insurance coverage. The objective of this paper is to evaluate whether or not such coverage increases translated to changes in access to care, risky health behaviors, and, ultimately, short-run health outcomes.

A number of 2014 ACA provisions involved overhauling non-group insurance markets in an effort to ensure that one's health history did not provide a barrier to obtaining coverage. Specific regulations included guaranteed issue, which forbids insurers from denying coverage on the basis of applicant health status, and modified community rating, which imposes uniform premiums regardless of observable characteristics aside from age and smoking status. In addition, the federal government established a Health Insurance Marketplace to facilitate insurance purchases for individuals and small businesses. Each state was given the option of establishing their own insurance marketplace and fifteen did so in 2014 (KFF, 2014).

These reforms alone would likely lead to an adverse selection death spiral, with the influx of high cost beneficiaries causing relatively low-cost beneficiaries to drop their coverage, thus driving up premiums for those remaining in the insurance pool (Courtemanche and Zapata, 2014). This concern motivated another component of the ACA: the individual mandate. Beginning in 2014, individuals deemed to be able to afford coverage but electing to remain uncovered were penalized. The largest penalty that could be imposed was the maximum of either the total annual premium for the national average price of a Bronze exchange plan or $285

($975) in 2014 (2015).[1] In addition, an employer mandate, which required employers with 100 of more full-time equivalent employees to offer "affordable" coverage to at least 95 percent of their full-time employees and their dependents (children up to age 26) or face a penalty, took effect in 2015 (Tolbert, 2015).

The remaining challenge associated with promoting universal coverage, affordability, was addressed by the ACA in 2014 in two ways. First, sliding scale subsidies in the form of premium tax credits (PTC) became available to consumers in every state with incomes between 100 and 400 percent of the Federal Poverty Line (FPL) who did not qualify for other affordable coverage. Second, in states that opted to expand Medicaid via the ACA, anyone with income below 138 percent FPL became eligible for Medicaid coverage. Previously, Medicaid eligibility was typically restricted to those with low income among specific groups, such as children, single parents, pregnant women, the disabled, and the elderly. According to the Kaiser Family Foundation, 27 states participated in the Medicaid expansion in 2014, with three more implementing it in 2015 and another two in 2016.[2]

Theoretically, the expansion of insurance coverage brought about by the ACA should increase access to care because of the reduction in out-of-pocket prices, but this is not automatically the case. On the demand side, newly insured individuals may not have sufficient knowledge of the health care system to easily secure a regular primary care doctor. Somers and Mahadevan (2010) report that only 12 percent of adults have proficient health literacy. On the supply side, concerns have been raised about whether or not there are sufficient numbers of primary care physicians to treat all of these newly insured patients (Schwartz, 2012; Glied and

[1] The maximum increased to $2,085 in 2016. For more information, see: https://www.healthcare.gov/fees/fee-for-not-being-covered/

[2] See the following website for further information: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Ma, 2015). While the federal government increased Medicaid primary care reimbursement rates to Medicare levels in 2013 and 2014, only a few fully maintained this "fee bump" in 2015.[3]

Insurance coverage could influence risky health behaviors – such as smoking, drinking, and overeating – in either direction (Cawley and Ruhm, 2012). On one hand, improved access to care could translate to improvements in health behaviors via information, accountability, or treatments such as smoking cessation drugs or weight loss programs. On the other hand, insurance can theoretically worsen health outcomes through *ex ante* moral hazard, as the reduction in financial risks associated with unhealthy behaviors incentivizes such behaviors. Moreover, income effects from gaining free or subsidized coverage could influence behaviors by enabling consumers to spend money they had budgeted for direct purchase of health care on alcohol, cigarettes, and junk food or, conversely, on healthy food and gym memberships (Simon et al., 2017).

The net effect of insurance on health depends on the changes in both access to care and health behaviors and therefore is also theoretically ambiguous. The extent to which insurance-induced increases in health care utilization translate to better health depend on one's initial location along the health production function. Evidence suggests that "flat of the curve" care – perhaps due to uncertainty over treatment effectiveness, the principal-agent nature of the patient-doctor relationship, fee-for-service reimbursement, lack of coordination across health care providers, or malpractice liability – is common in the U.S. (Garber and Skinner, 2008). Moreover, the same issues with health literacy that could hamper efforts by the newly insured to

[3] For more on state plans with respect to Medicaid primary care reimbursement see: http://kff.org/medicaid/perspective/the-aca-primary-care-increase-state-plans-for-sfy-2015/?elq_cid=1679210 and https://www.advisory.com/daily-briefing/2015/04/23/states-to-continue-medicaid-pay-bump.

find a primary care doctor could also limit their ability to understand and comply with treatment recommendations.[4]

The purpose of this paper is to estimate the impact of the ACA's 2014 provisions on a variety of outcomes related to health care access, risky health behaviors, and self-assessed health. In addition to estimating the overall effect of the ACA on these outcomes, we also examine differential impacts resulting from state heterogeneity with respect to the choice to expand Medicaid via the ACA.

We separately identify the effects of the private and Medicaid expansion portions of the ACA by using an identification strategy developed in Courtemanche et al. (2017) to estimate the impact of the ACA on insurance coverage by exploiting differences across local areas in pre-treatment uninsured rates. To be more specific, we estimate a difference-in-difference-in-differences (DDD) model with the differences coming from time, state Medicaid expansion status, and local area pre-treatment uninsured rate. If our objective was merely to isolate the effect of the Medicaid expansion, this could potentially be achieved with a simpler difference-in-differences model comparing changes in states that expanded Medicaid to changes in non-expansion states. However, identifying the impact of the other components of the ACA (e.g. mandates, subsidies, marketplaces) is more difficult due to their national nature. We therefore exploit an additional layer of plausibly exogenous variation arising from the fact that universal coverage initiatives provide the most intense treatments in areas with high uninsured rates.[5]

Our data come from the 2011-2015 waves of the Behavioral Risk Factor Surveillance System (BRFSS), with the sample restricted to non-elderly adults. The BRFSS is well suited for

[4] Previous literature has shown a relationship between health literacy and health outcomes including health status, chronic illnesses, and hospitalizations (Cho et al., 2008; Berkman et al., 2011).

[5] Finkelstein (2007) uses a similar strategy to identify the impacts of another national program – Medicare – on health care spending. Miller (2012a) also uses this approach to estimate the impact of the Massachusetts reform on emergency room utilization without control states.

our study for three reasons. First, it includes a wide range of questions on health care access and self-assessed health. Second, with over 300,000 observations per year it is large enough to precisely estimate the effects of state-level interventions. Third, it was among the first large-scale health datasets to release data from 2015, allowing us to examine two calendar years of data after the full implementation of the ACA.

Our results suggest that the ACA substantially improved access to health care among non-elderly adults. Gains in insurance coverage were 8.3 percentage points in Medicaid expansion states compared to 5.3 percentage points in non-expansion states, while reductions in cost being a barrier to care were 5.1 percentage points in expansion states and 2.6 percentage points in non-expansion states. The ACA also increased the probabilities of having a primary care doctor and a checkup by 3.0 and 2.4 percentage points, respectively, in non-Medicaid-expansion states, with the effects not being statistically different in expansion states. Gains in access were generally largest among individuals with lower incomes and education levels.

However, the effects of the ACA on risky health behaviors and self-assessed health were less pronounced – at least after two years. For the full sample, we observe no statistically significant impacts on any of the risky behavior or health outcomes in either Medicaid expansion or non-expansion states. We do, however, find some evidence that the ACA improved self-assessed health among older non-elderly adults, particularly in expansion states.

II. LITERATURE REVIEW

In this section we review the literature on the impacts of expansions of insurance coverage. We divide the literature into studies focusing on coverage expansions prior to 2014 and those that examine the components of the ACA implemented in 2014.

Effects of Pre-2014 Insurance Interventions

There is an extensive literature spanning several decades examining the impact of the receipt of both public and private health insurance on a variety of outcomes, including access to care, utilization, spending, risky health behaviors, and health outcomes. Additional outcomes considered in this literature include labor market participation, job lock, and other public program participation. Cutler and Zeckhauser (2000) provides a thorough review of the health insurance literature, while Buchmueller et al. (2015) reviews the literature on Medicaid and Gruber (2000) reviews the literature on health insurance and the labor market. Here we provide a brief summary of the evidence on the effects of insurance-related interventions on outcomes related to access, risky behaviors, and health.

Causally interpretable evidence on the impacts of health insurance coverage dates back to the RAND Health Insurance Experiment of the 1970s-1980s, which randomly assigned individuals to insurance plans with different coinsurance rates and deductibles. Those assigned to a plan with no cost-sharing incurred about 20 percent higher medical expenses than others (Manning et al., 1987). However, on average this additional utilization did not translate to statistically significant effects on self-assessed health, smoking, or weight (Brook et al., 1983).

A substantial portion of the literature focuses on expansions of the Medicaid program. Evidence suggests that expansions for children and pregnant women in the 1980s and 1990s reduced low birthweight (Currie and Gruber, 1996a), infant mortality (Currie and Gruber, 1996b), and avoidable hospitalizations among children (Dafny and Gruber, 2005). However, other studies suggest that these expansions increased smoking among pregnant women (Dave et al., 2015) and had inconsistent effects on their health care utilization (Epstein and Newhouse, 1998). Research has also found that Medicaid expansions for childless adults in the early 2000s

increased self-reported access to care and health while reducing mortality, particularly related to HIV (Sommers et al., 2012; Sommers, forthcoming). Studies of the randomized 2008 Oregon Medicaid lottery found that Medicaid increased health care access and utilization along a broad range of dimensions and led to large, immediate gains in self-assessed health (Finkelstein et al., 2012; Taubman et al., 2014). However, no evidence was found of changes in smoking, obesity, or clinical indicators of physical health (Baicker et al., 2013; Finkelstein et al., 2012). Tello-Trillo (2016) shows that a large Medicaid disenrollment in Tennessee reduced access to care and self-assessed health.

Another branch of the literature studies the impacts of Medicare, the universal coverage program for U.S. seniors. Evidence shows that health care utilization increases sharply at the age of eligibility (Lichtenberg, 2002; Card et al., 2008), while mortality among patients admitted to the ER falls sharply (Card et al., 2009). However, other studies suggest that Medicare does not impact mortality more generally (Finkelstein and McKnight, 2008) and slightly worsens smoking and drinking habits (Dave and Kaestner, 2009).

Several studies have focused on the 2006 Massachusetts health care reform, a universal coverage initiative that featured a combination of insurance market reforms, mandates, and subsidies similar to the ACA. Kolstad and Kowalski (2012), Miller (2012a), Miller (2012b), and Van der Wees et al. (2013) all present evidence consistent with the reform improving access to primary care. Van der Wees et al. (2013) and Courtmanche and Zapata (2014) find that the reform also improved adults' self-assessed health, though an earlier study by Yelowitz and Cannon (2010) did not observe a statistically significant result. Courtemanche and Zapata (2014) also estimate that the reform reduced body mass index (BMI). Sommers et al. (2014) present evidence that the reform reduced mortality rates, though Kaestner (2015) disputes this finding.

Finally, another series of papers investigates the effects of the first major insurance expansion to occur under the ACA: a mandate for insurers to cover dependents up to 26 years old that took effect in 2010. Evidence suggests that this dependent coverage expansion increased access to care (Sommers et al., 2013; Barbaresco et al., 2015) and general health care utilization (Chua and Sommers, 2014; Akosa Antwi et al., 2015) but not utilization of preventive services (Barbaresco et al., 2015). Chua and Sommers (2014), Barbaresco et al. (2015) and Burns and Wolfe (2016) present evidence that the dependent coverage provision improved self-assessed health along some dimensions. Finally, Barbaresco et al. (2015) document a reduction in BMI.

To summarize, the evidence from these pre-2014 interventions suggests that health insurance can impact access to care, risky behaviors, and health outcomes but that the effects often vary substantially across contexts. For instance, the effects of insurance on self-assessed health appear to have been large and immediate in the cases of the Oregon Medicaid expansion and Massachusetts reform but more modest after the ACA dependent coverage expansion and virtually nonexistent in the RAND experiment. As another example, only the Massachusetts reform and dependent coverage provision appear to have led to weight loss. This underscores the necessity of obtaining credible evidence on the effects of the 2014 components of the ACA rather than simply relying on results from other settings.

In particular, even evidence from the prior interventions that have the most in common with the ACA – Medicaid and the Massachusetts reform – may not be reliable indicators. In contrast to the narrower population targeted by Medicaid expansions, the ACA expanded coverage to a much broader range of low and middle income families and childless adults, with only part of the expansion occurring via Medicaid. Marketplace plans differ from traditional Medicaid in terms of cost-sharing and provider networks. The effects of the Massachusetts

reform and ACA could differ because of the relatively low pre-reform uninsured rate in Massachusetts, differences in the socio-demographic characteristics of those gaining coverage, the relative public enthusiasm surrounding the Massachusetts law compared to the ACA, and the fact that the entire expansion among adults was done though subsidized private coverage in Massachusetts as opposed to the mix of public and private used by the ACA (Gruber, 2008).

Effects of the 2014 Components of the ACA

Much of the early evidence on the effects of the 2014 components of the ACA focuses on changes in coverage. At the national level, simple pre-post comparisons find increases in coverage of between 2.8 and 6.9 percentage points, depending on the time frame, dataset, and population group (Long et al., 2014; Smith and Medalia, 2015; Courtemanche et al., 2016; Obama, 2016; Barnett and Vornovitsky, 2016; McMorrow et al., 2016).[6] Other recent work uses more sophisticated econometric techniques to isolate the impact of different components of the ACA on coverage. Kaestner et al. (2015) and Wherry and Miller (2016) focus on the Medicaid expansions, while Frean et al. (2016) focus on the Medicaid expansions, subsidized premiums for Marketplace coverage, and the individual mandate. Using the identification strategy that we employ in this paper, Courtemanche et al. (2017) aim to estimate the impact of the ACA more generally, finding that it increased coverage by an average of 5.9 percentage points in Medicaid expansion states compared to 2.8 percentage points in non-expansion states in 2014.

A growing number of studies examine health-related outcomes besides insurance. Shartzer et al. (2015), Polsky et al. (2015), Kirby and Vistnes (2016), Sommers et al. (2015), and Sommers and Blendon et al. (2016) show that the timing of the ACA coincided with increased access to care, while Sommers et al. (2015) also document an improvement in self-assessed

[6] Although we focus our discussion on national studies, single-state investigations generally reach similar conclusions (Sommers et al., 2014, Sommers and Chua et al., 2016, Golberstein et al., 2015; Benitez et al., 2016).

health. However, it is unclear whether estimates based only on time-series variation are able to disentangle causal effects of the ACA from other national shocks. Three papers use difference-in-differences (DD) approaches to examine the impacts of the 2014 ACA Medicaid expansion on access, health behaviors, or self-assessed health after two years.[7] Using data from the Gallup-Healthways Well-Being Index, Sommers et al. (2015) find evidence that the Medicaid expansion improved access along some dimensions but did not significantly affect self-assessed health. Abramowitz (2016) finds that the Medicaid expansion was associated with a *reduction* in self-reported overall health using data from the Current Population Survey Annual Social and Economic Supplement. Simon et al. (2017) use data from the BRFSS and find that the Medicaid expansion increased some aspects of access and preventive care use among low-income childless adults. However, they find no evidence of effects on risky health behaviors or most of their self-assessed health measures.

Relative to these previous studies, our main contribution is to present causally interpretable evidence on the effects of the full ACA – as opposed to just its Medicaid portion – on access to health care, risky health behaviors, and self-assessed health. This is critical information in light of ongoing policy debates about the future of the ACA. While we adopt the DDD strategy of Courtemanche el al. (2017), our work is distinct because we examine outcomes beyond just insurance coverage, use a second year of post-treatment data, and use a different dataset (BRFSS instead of the American Community Survey).

A secondary contribution of our work is to offer an alternative identification strategy for the impact of the Medicaid expansion that relies on weaker assumptions than the DD approach used previously. Specifically, we do not need to assume that any differential changes in the

[7] Additionally, Sommers et al. (2012) find that early Medicaid expansions under the ACA in New York, Maine, and Arizona were associated with increases in access to care and self-assessed health.

outcomes between the expansion and non-expansion states in 2014 are attributable to Medicaid. Instead, our approach allows for other factors (e.g. underlying trends or enthusiasm for the other parts of the ACA) to contribute to this differential as long as they are not correlated with pre-treatment uninsured rates.

III. DATA

Our primary data source is the BRFSS, an annual telephone survey conducted by state health departments and the U.S. Centers for Disease Control and Prevention that collects data on preventive services, risky behaviors, and self-assessed health for all 50 states and the District of Columbia. A random digit dialing method is used to select a representative sample of respondents from the non-institutionalized adult population. The BRFSS is appealing for our study because its large number of observations, over 300,000 per year, allows us to precisely estimate the effects of the treatment expansions. This is important since only a fraction of the population is affected by the change in legislation, limiting plausible effect sizes.

Our main sample consists of 19-64 year olds from the 2011-2015 waves. We exclude individuals older than 64 since the ACA was not intended to affect the health care coverage of seniors. We begin the sample in 2011 because that was the first year in which the BRFSS included cell phones in their sampling. Since individuals who exclusively use cell phones are disproportionately young, this results in a discrete change in the sample means of many of our key variables (including insurance coverage) between 2010 and 2011. An additional benefit of excluding years prior to 2011 is that this limits the sample to years after the implementation of the ACA's dependent coverage expansion, preventing confounding from differences in state dependent coverage mandates prior to the ACA.

We utilize fourteen different health-related dependent variables.[8] The first four relate to health care access: dummy variables reflecting whether the respondent has any health insurance, had any medical care needed but not obtained because of cost in the previous year, has a primary care physician, and had a well-patient doctor check-up visit (e.g. physical) in the previous year. The next three outcomes related to risky health behaviors: dummies for whether one smokes, alcoholic drinks consumed per month, and a continuous variable measuring the respondents' body weight in the form of BMI.[9] Another set of outcomes relates to self-assessed health status: a dummy for whether overall health is good or better, a dummy for whether overall health is very good or better, a dummy for whether overall health is excellent, and days of the last 30 not in good mental health, not in good physical health, and with health-related functional limitations. Self-assessed health variables, though subjective, have been shown to be correlated with objective measures of health (e.g. Idler and Benyamini, 1997; DeSalvo et al., 2006; Phillips et al., 2010). While one might initially be skeptical that insurance expansions could meaningfully affect health in their first two years, prior evidence from the randomized Oregon Medicaid experiment (Finketstein et al., 2012) and the Massachusetts universal coverage initiative (Courtemanche and Zapata, 2014; Van der Wees et al., 2013) have shown that immediate gains in self-assessed health can indeed occur.

Our last outcome variable is a summary index of health that incorporates the three health behaviors, the overall self-assessed health index, and the three self-assessments that pertain to

[8] Note that we do not utilize the screening (e.g. colonoscopy, mammogram, pap test) variables available in the BRFSS because, in almost all states, they are only available in 2012 and 2014. This means that 2014 would be the only post-treatment year, which would be especially problematic since the questions use reflection periods of a year or greater (e.g. pap test in past year). In other words, it is not clear that 2014 would be a true "post-treatment" year for these outcomes, since part of the reflection period for respondents surveyed in that year would occur prior to the ACA taking effect.

[9] Results are robust to using an indicator for obesity (BMI $\geq$ 30) rather than continuous BMI. Self-reports of weight and height are well-known to suffer from measurement error, but studies implementing a correction method involving validation data from the NHANES have repeatedly shown that adjusting for this error does not affect the signs and significance of coefficient estimates (e.g. Cawley, 2004; Courtemanche et al., 2015).

physical/mental health and functional limitations. We follow Chetty et al. (2011) and Yelowitz (forthcoming) by first transforming each variable so that a higher value represents a more desirable outcome. We then standardize each of the seven variables by subtracting the mean and dividing by its standard deviation. Finally, we sum all seven variables and divide by the standard deviation of the sum to arrive at the final index with a standard deviation of one.

We include a wide range of control variables. The controls from the BRFSS are dummy variables for age groups (5-year increments from 25-29 to 60-64, with 19-24 as the reference group), gender, race/ethnicity (non-Hispanic black, Hispanic, and non-Hispanic white with other as the reference group), marital status, education (high school degree, some college, and college graduate with less than a high school degree as the reference group), household income category ($10,000-$15,000, $15,000-$20,000, $20,000-$25,000, $25,000-$35,000, $35,000-$50,000, $50,000-$75,000, and >$75,000, with <$10,000 as the reference group), number of children in the household (zero to four with five or more as the reference group), whether the respondent reports her primary occupation as student, and whether the respondent is unemployed. We also control for the Bureau of Labor Statistics' seasonally adjusted monthly state unemployment rate as well as dummy variables for whether states set up their own insurance exchanges and whether these exchanges experienced glitches (KFF, 2014; Kowalski, 2014).

A critical variable for our identification strategy is the uninsured rate in the respondent's "local area" in the pre-treatment year of 2013. The BRFSS does not contain county level identifiers continuously throughout our period of analysis, making it impossible for us to compute county level uninsured rates during the pre-treatment periods. Instead, we use information collected on type of location within a state. The BRFSS reports whether the respondents reside in the center city of an MSA, outside the center city of an MSA but inside the

county containing the center city, inside a suburban county of the MSA, or not in an MSA. However, no location information was collected from cell-phone respondents. We use this location variable to construct four sub-groups within each state: within a central city, suburbs, non-MSA, and location unavailable (i.e. cell phone sample). Based on these within-state classifications we calculate the pre-treatment average uninsured rates by location (considering "cell phone" to be a location for the sake of convenience) within a state. In order to ensure that each area contains a sufficient number of respondents to reliably compute pre-treatment uninsured rates, we combine the seven areas with fewer than 200 respondents in 2013 with other areas.[10] After doing this, there are 194 areas with 2013 uninsured rates computed from between 219 and 5,804 respondents, with the average being 1,475 and the median being 1,205.

Our Medicaid expansion variable comes from the Kaiser Family Foundation, a non-profit organization that collects a vast array of health policy information. This information includes whether a state implemented the Medicaid expansion as well as whether this expansion was done through private insurance via a Section 1115 waiver. Expanding under the Section 115 waiver, as done by Arkansas, Iowa, and Michigan, introduced cost sharing and premiums for enrollees and could therefore have had different effects than expanding via traditional Medicaid. We attempted to test for such differences but statistical power was insufficient to draw meaningful conclusions; we therefore simply classify the Section 1115 waiver states as being Medicaid expanders. Thus a total of 27 states (including the District of Columbia) participated in the 2014 Medicaid expansion and 30 states (including the District of Columbia) expanded by the end of 2015.

In our main specifications, we simply classify the 30 states that expanded Medicaid by 2015 as the treatment group for the Medicaid expansion and the other 21 as the control group.

[10] Specifically, we combine the central city and suburban parts of Wyoming into one area, and the same for Vermont, South Dakota, and Montana. We also combine the suburban and rural parts of Massachusetts, Arizona, and California.

The majority of the expansion states implemented their expansion in January 2014, with some exceptions. Michigan's expansion took effect in April 2014 and New Hampshire's in August 2014. In 2015, Indiana and Alaska expanded Medicaid in February and September, respectively. States are classified as part of the treatment group beginning the month of their expansion.

Table 1 provides pre-treatment means and standard deviations of the dependent variables, while Online Appendix Table A1 does the same for the controls. We also report the summary statistics stratified into four groups based on whether the respondent's state expanded Medicaid and whether her local area's pre-treatment uninsured rate was above or below the median for individuals in the sample. According to Table 1, 79 percent of the sample had insurance at baseline. For both the high- and low-uninsured rate subgroups, individuals in Medicaid expansion states were slightly more likely to have insurance prior to 2014 than those in non-expansion states. Residents of Medicaid expansion states and states with pre-ACA uninsured rates below the median (column 3) had, on average, better health care access and self-assessed health than their counterparts even before the ACA was implemented. They were also more educated, more likely to be employed, and had higher incomes.

Our econometric design will account for these baseline differences, but will rely on the assumption of common counterfactual trends in the outcomes on the bases of Medicaid expansion status and pre-treatment uninsured rates. Figures 1 and 2 show that the pre-ACA trends are generally similar along these dimensions for most outcomes. Later, we will test the common trends assumption more formally through an event study analysis.

IV. ECONOMETRIC MODELS

For each outcome, our econometric objectives are to estimate the effects of both the fully implemented ACA (including the Medicaid expansion) and the ACA without the Medicaid

expansion. A major challenge in doing so is to disentangle the impacts of the nationwide components of the ACA (e.g. exchanges, mandates, subsidies) from underlying year-to-year fluctuations that would have occurred even in the law's absence. We adopt the DDD strategy Courtemanche et al. (2017) used to identify the impact of the ACA on health insurance coverage, which exploits variation across space in the intensity of treatment arising from differential pre-treatment uninsured rates. Adding this layer of geographic variation allows us to include time period fixed effects while still identifying the effects of the national (private) portion of the law.

Assuming that the extent of a geographic area's treatment is proportional to its baseline uninsured rate, the DDD model is

(1)

where

- is the outcome for individual *i* in area type (central city, rest of MSA, non-MSA, cell phone) *a* in state *s* in time period (month/year) *t*,
- is an indicator for whether period *t* is in the post-treatment period of January 2014 or later,
- is a vector of control variables,
- is an indicator for whether state *s* participated in the ACA's Medicaid expansion,
- is the pre-treatment (2013) uninsured rate in area type *a* within state *s*,
- represents time fixed effects for each month/year*area type combination (e.g. central city in January 2011); these not only control for time as flexibly as possible but also allow time trends to evolve differentially across individuals living in central city, suburban, and rural areas as well as those with only cell phones, and

- represents fixed effects for each geographic area (e.g. central city in Alabama).

Note that is not included in the model since it is captured by the time fixed effects, while the terms are not separately included since they are captured by the area fixed effects.

In (1), the effect of the ACA without the Medicaid expansion is given by

* , which means it is assumed to be 0 in a (hypothetical) area with a 0 percent uninsured rate at baseline and to increase linearly as the pre-ACA uninsured rate rises. (We have also experimented with non-linear functional forms for the uninsured rate and found that they do not reveal any meaningful new information.) The identifying assumption is that, in the absence of the treatment, any changes in the outcomes that would have occurred in 2014-2015 would not have varied differentially by area uninsured rates, conditional on the controls. We do *not* need to assume that there would have been no changes at all in the outcomes without the ACA (conditional on the controls), as would be the case in a pre-post comparison that did not utilize the variation in pre-treatment uninsured rates.

The effect of the Medicaid expansion is given by . As with the other components of the ACA, the impact of the Medicaid expansion is now assumed to vary linearly with the state's baseline uninsured rate. (Again, we found that considering non-linear functional forms did not reveal new information.) Since the Medicaid expansion should not causally affect insurance coverage in an area with a 0 percent baseline uninsured rate, we consider to reflect unobserved confounders rather than capturing part of the expansion's causal effect. This interpretation follows Miller (2012a) and Courtemanche et al. (2017). The identifying assumption for the impact of the Medicaid expansion is therefore that, without the ACA, differential changes in the outcomes in 2014-2015 between Medicaid expansion and non-

expansion states would not have been correlated with 2013 uninsured rates. This is a weaker assumption than would be required by a DD model, in which case one would have to assume that, conditional on the controls, there would have been *no* differential changes across expansion and non-expansion states.

Robustness Checks

We also conduct a number of robustness checks. The first several vary the set of control variables to address the possible concern that some of them could be endogenous to the ACA. Recall that the baseline model includes demographic (age, gender, and race/ethnicity), family (education, marital status, and number of children), economic (income, employment and student status, and unemployment rate), and health insurance exchange (interactions of *year* = 2014 with whether the state set up its own exchange and whether the exchange had glitches) controls. The first four robustness checks include only subsets of these variables: demographic controls only, demographic and family controls, demographic and economic controls, and demographic and exchange controls.

Next, recall that we do not know geographic area type (central city, suburbs, or rural) for individuals interviewed on a cell phone, necessitating our combining of all such individuals into a separate group within each state. The next robustness check aims to ensure that this decision does not meaningfully influence the results by dropping those interviewed on cell phones, ensuring the availability of the area type variable for everyone in the sample.

The following set of robustness checks addresses the potential concern that interacting and with the same uninsured rate variable may be problematic since the Medicaid and private portions of the ACA applied to different income ranges (under 138 percent of the FPL for Medicaid, above 138 percent in Medicaid expansion states and above

100 percent in non-expansion states for the exchanges/subsidies). The first such check interacts with the pre-ACA uninsured rate for respondents above 100 percent of the FPL and with the rate for those below 138 percent. Additional specifications use a 100 percent cutoff for both groups and a 138 percent cutoff for both groups.

Next, we consider alternative approaches to computing pre-treatment uninsured rates that utilize a larger number of individuals per area than our baseline strategy. This addresses possible concerns about using groups narrower than state to construct this key variable. First, we pool all three pre-treatment years when computing baseline uninsured rates rather than just using 2013 in order to increase the number of individuals in each area. Second, we drop the sub-state classifications and simply compute pre-treatment uninsured rates at the state level (using just 2013).

In another robustness check, we drop 19-25 year olds. Since this age group was treated by the 2010 ACA dependent coverage provision, their treatment status is somewhat ambiguous. With that said, Courtemanche et al. (2017) found that this age group still experienced large coverage gains in response to the 2014 ACA provisions, so we do not expect dropping 19-25 year olds to meaningfully impact our results.

The remaining robustness checks deal with the potentially ambiguous Medicaid expansion treatment status of some states. Many states partially expanded Medicaid under the ACA prior to 2014. Courtemanche et al. (2017) did not find meaningful differences in coverage gains between early expanders and states that did not expand at all until 2014, and Frean et al. (2016) find that many of the people who became eligible for Medicaid under the early expansions actually did not take up coverage until 2014. We therefore do not expect that including early expansion states as part of the treatment group will meaningfully impact the

results, but we consider alternative classifications to verify. One such approach restricts the sample to only the nine treatment states and twenty control states that did not have some form of Medicaid expansion prior to January 2014, as classified by Kaestner et al. (2015). Another uses the same nine treatment states but the full control group. Next, we only exclude the five states that Kaestner et al. (2015) describe as having comprehensive early Medicaid expansions prior to 2014. Our final robustness check drops the states that expanded Medicaid in 2014 or 2015 but whose expansion was not effective as of January 1, 2014.

V. RESULTS

Tables 2 and 3 report the results from the baseline DDD regression for each outcome. The top panel presents the coefficient estimates and standard errors for the variables of interest, while the bottom panel gives the implied effects of the ACA at the average pre-treatment uninsured rate. Indicators of statistical significance at the 0.1 percent, 1 percent, and 5 percent level are also shown.

We begin our discussion with the outcomes related to access – insurance coverage, having a primary care doctor, cost being a barrier to care in the past 12 months, and checkup in the past 12 months – which are in the first four columns of Table 2. Because the cost barrier and checkup variables reflect information from the past 12 months, treatment status in 2014 is ambiguous for these outcomes. For instance, for someone interviewed in March 2014, only three of the twelve months that determine one's answer to these questions are actually in the post-treatment period. We therefore drop 2014 in the regressions for these outcomes, explaining their smaller sample size.

The results suggest that the private portion of the ACA increased access to care along all observable dimensions. Specifically, at the average pre-treatment uninsured rate it increased the

probabilities of having insurance coverage, a primary care doctor, and a well-patient checkup by 5.3, 3.0, and 2.4 percentage points, respectively, while reducing the probability of cost being a barrier to care by 2.6 percentage points. The ACA therefore led to sizeable improvements in access even in states that did not expand Medicaid.

The Medicaid expansion led to additional gains in access along some dimensions. At the average pre-treatment uninsured rate, it increased insurance coverage by a statistically significant 3.1 percentage points and reduced the probability of reporting cost being a barrier to care by 2.5 percentage points. We do not find significant effects on having a primary care doctor or a well-patient checkup, though the magnitude for checkup is an economically meaningful 1.2 percentage points – around two-fifths as large as the effect on insurance.[11] Broadly speaking, our finding that the Medicaid expansion increased access along some but not all dimensions is consistent with the results from the DD studies by Sommers et al. (2015) and Simon et al. (2017).[12]

Combining the effects of the private and Medicaid components shows that the fully implemented ACA led to large gains in all access measures. Insurance coverage increased by 8.3

[11] Both the access variables for which we did not find statistically significant effects of the Medicaid expansion relate to primary care. One possible explanation is that newly enrolled Medicaid recipients may still have trouble accessing primary care, perhaps due to the temporary nature of the ACA Medicaid fee bump (MACPAC, 2015) leading to a smaller than expected change in physician Medicaid participation and / or some degree of access crowd-out due to the concurrent expansion of private (i.e. Marketplace) coverage. However, since the magnitude of the estimated effect on checkups is meaningfully large despite its statistical insignificance, we are reluctant to strongly push this explanation.

[12] The only noteworthy differences for specific access outcomes are that we find evidence of an effect on cost being a barrier to care but not having a primary care doctor, whereas the reverse is true for Sommers et al. (2015) and Simon et al. (2017). In our view, the difference in results for cost being a barrier to care is not a major discrepancy, as Sommers et al. (2015) and Simon et al. (2017) find the same signs and magnitudes that are only slightly smaller than ours – their estimates just do not quite reach statistical significance. The discrepancy in results for primary care doctor is more substantial, as our point estimate is essentially zero. In unreported regressions (available upon request), we replicated Simon et al.'s DD model and restriction of the sample to those with incomes below 100 percent FPL. We found that the estimated increase in probability of having a primary care doctor shrinks roughly in half (from about 4 to 2 percentage points) and becomes slightly statistically insignificant if we add the control for the state setting up its own exchange. This suggests some upward bias in the DD estimate due to unobserved differences in state attitudes toward the ACA, which we control for with our DDD approach.

percentage points, probability of having a primary care doctor rose by 3.1 percentage points, probability of cost being a barrier to care fell by 5.1 percentage points, and probability of having a checkup rose by 3.6 percentage points. Based on the pre-treatment sample means reported in Table 2, these results imply that the full ACA reduced the uninsured rate by 44 percent while also reducing the number of people without a primary care doctor by 12 percent, those with foregone care because of cost by 28 percent, and those not having an annual checkup by 10 percent.

The remaining three columns of Table 2 report the results for the three health behavior variables: BMI, probability of being a smoker, and drinks per month. We observe no statistically significant effects of the private portion, Medicaid expansion, or overall ACA on any of these outcomes. Moreover, the magnitudes are relatively small compared to those for the access outcomes: the estimated effects of the full ACA at the mean pre-treatment uninsured rate on BMI, smoking, and drinking are just 0.1 percent, 5.3 percent, and 1.8 percent of the corresponding sample means. Finally, the signs are mixed, with the full ACA reducing BMI and drinking, but increasing smoking. For these reasons, we suspect that these null results are more likely to represent "true zeros" than simply a lack of statistical power. Our findings for the Medicaid expansion are consistent with the null effects on risky behaviors found by Simon et al. (2017) using DD methods and a sample of only low-income adults.

Table 3 displays the results for the self-assessed health outcomes. We find no statistically significant effects of either the private or Medicaid components of the ACA on any of the outcomes. The implied effects of the full ACA represent just -0.4 percent, -0.4 percent, 2.5 percent, 1.4 percent, -3.7 percent, and 4.2 percent of the pre-treatment means of good or better health, very good or better health, excellent health, days not in good physical health, days not in

good mental health, and days with health-related limitations, respectively. These relatively small magnitudes, combined with the inconsistent pattern of signs, again increases our confidence that these null results reflect "true zeros." Our small and insignificant estimates contrast the large, early improvements in these same self-assessed health outcomes seen after the Massachusetts health care reform (Courtemanche and Zapata, 2014; Van der Wees et al., 2013) and randomized Oregon Medicaid experiment (Finkelstein et al., 2012). However, our null results for the Medicaid expansion are consistent with the lack of clear improvements in self-assessed health found by the DD studies in the ACA Medicaid expansion literature (Sommers et al., 2015; Abramowitz, 2016; Simon et al., 2017).

The reported results in Tables 2 and 3 only compute impacts of the ACA at the mean pre-treatment uninsured rate of 20.2 percent. Because area pre-treatment uninsured rates varied widely, ranging from 3 to 36 percent with a standard deviation of 8 percent, this approach disguises a great deal of heterogeneity. Figure 3 therefore shows how the predicted changes in our access outcomes vary across this range of uninsured rates in both expansion and non-expansion states. The effects on the health behavior and self-assessed health outcomes are never significant at any uninsured rate, so we do not present similar graphs for them.

The predicted effect of the full ACA on the probability of having insurance coverage reached as high as 14.7 percentage points in the area with the highest pre-treatment uninsured rate. Without the Medicaid expansion, this impact only reached 9.3 percentage points. The predicted impact of the full ACA on the probability of having a primary care doctor extends to 5.6 percentage points at the highest uninsured rate, with essentially no difference between Medicaid expansion and non-expansion states. For the cost barrier and well-patient checkup

outcomes, the maximum predicted effects of the ACA are 9 percentage points and 6.4 percentage points, respectively, in Medicaid expansion states and 4.5 and 4.3 in non-expansion states.

Lastly, the results for the robustness checks are available in Appendix Tables A2-A15 (one table for each outcome). In almost all cases, the findings from the baseline regressions persist across the various robustness checks.

VI. INSTRUMENTAL VARIABLES

A natural question with interpretation of the reduced-form results from the preceding section is whether we can assume the extensive margin of insurance coverage is the only mechanism through which the ACA affected the other outcomes. If this is true, then it would be reasonable to estimate an instrumental variables (IV) specification in which

and are instruments and insurance coverage is the endogenous variable.[13] This assumption is difficult to test and may not hold if, for instance, areas with higher baseline uninsured rates also had higher rates of underinsurance (e.g. bare-bones privately purchased policies), in which case the intensive margin of coverage quality is another mechanism through which our treatment variables could affect the other outcomes. Moreover, general equilibrium effects are possible; for instance, in areas with large numbers of newly insured residents, continuously covered individuals may face increased difficulty accessing providers, while those working in the health care industry may experience positive income shocks. For these reasons, we prefer to emphasize our reduced form approach as it allows for all of these mechanisms. Nonetheless, IV results can be informative about how large the effects of coverage on the outcomes would need to be for the extensive margin of coverage to be the only relevant mechanism.

[13] We are not able to estimate an IV model with both private and Medicaid coverage as endogenous variables because the BRFSS does not contain information on source of coverage.

Results from the IV model – with the full set of controls and fixed effects included – are presented in Table 4. We only report the results for the health care access outcomes since those were the only ones where significant effects emerged in the reduced form regressions.[14] In each column, we present the second-stage coefficient estimate for the health insurance variable along with its standard error, the first stage F-statistic from the test of joint significance of the two instruments, and the p-value for the overidentification test. In this case, the overidentification test essentially tests the null hypothesis that the estimated local average treatment effects of insurance would be statistically indistinguishable if either or were used as the sole instrument. A rejection of the null could therefore mean either that the effect of gaining coverage via the Medicaid expansion is different from the effect of gaining coverage through the private component of the ACA (in which case the IV specification captures a weighted average of these two effects), or that the Medicaid and private expansions activate other mechanisms besides simply the extensive margin of coverage (in which case the IV specification would be inappropriate).

The results show that the estimated effects of insurance on the other access outcomes are large and highly significant. Specifically, insurance coverage increases the probability of having a primary care doctor by 45 percentage points and the probability of having a well-patient doctor visit by 36 percentage points, while decreasing the probability of having foregone care by 47 percentage points. To provide a reference point, IV estimates from the Oregon Medicaid experiment show that Medicaid coverage increased similar access outcomes by between 20 and 34 percentage points (Finkelstein et al., 2012). Therefore, even if our IV estimates are slightly

[14] Not surprisingly, IV estimates for the health behavior and self-assessed health outcomes are highly insignificant. These results are available upon request.

overstated because of the presence of other possible mechanisms, the results still suggest a strong effect on access from the mix of private and public coverage induced by the ACA.

We find that our instruments generally perform well in the diagnostic tests. They generate first stage F-statistics that are more than an order of magnitude above the weak instrument threshold of 10. The overidentification test only rejects the null hypothesis for primary care doctor. This is not surprising given the very different reduced-form effects of the private and Medicaid components of the ACA on the probability of having a primary care doctor presented previously.

VII. EVENT STUDY MODEL

As discussed previously, a causal interpretation of our estimates depends on two key assumptions. First, conditional on the controls, changes in our outcomes in 2014-2015 would not have been correlated with pretreatment uninsured rates in the absence of the ACA. Second, differential changes in 2014-2015 between Medicaid expansion and non-expansion states would not have been correlated with pre-treatment uninsured rates. In this section, we indirectly assess the plausibility of these assumptions by estimating an event study model that includes the interactions of the treatment variables with the full set of year fixed effects, with 2013 being the base year. The model is

(3)

where $Y2011_t$, $Y2012_t$, $Y2014_t$, and $Y2015_t$ are indicators for whether year t is 2011, 2012, 2014, and 2015, respectively. The tests for differential pre-treatment trends (i.e., falsification tests) are

provided by evaluating whether the coefficients on the "treatment" variables in the pre-treatment years (θ_1, θ_2, θ_9, θ_{10}) are equal to 0.[15]

Table 5 presents the event study results for the seven outcomes related to health care access and health behaviors and Table 6 presents similar results for the seven outcomes related to self-assessed health using the full set of controls. In each table, the top panel presents the coefficient estimates of interest. Between the two tables there are a total of 56 falsification tests (four parameters of interest in each of fourteen regressions) and only three significant results at the 5 percent level. Three out of 56 is 5.3 percent, which is essentially the same as would be expected by chance. These results therefore provide some reassurance about the validity of our model to estimate causal effects for the "true" ACA.

Another advantage of the event study specification is that it allows us to distinguish between the effects of the ACA in 2014 and 2015. The most notable result is that the coverage gains from the ACA appear to have increased in the second year relative to the first year, with the increase coming entirely from the private portion. Specifically, in 2014 the fully implemented ACA increased the probability of a non-elderly adult being insured by 6.6 percentage points, with 3.9 percentage points coming from the private portion and the remaining 2.7 percentage points from Medicaid. These magnitudes are similar to those estimated by Courtemanche et al. (2017) using American Community Survey (ACS) data. In contrast, in 2015 the coverage gain from the full ACA jumped to 10.3 percentage points, with 6.3 percentage points coming from the private component and 4 percentage points from Medicaid.[16]

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[15] Recall that the coefficient on the variable in our main regression was assumed to capture unobserved confounders rather than part of the causal effect of the Medicaid expansion. We therefore do not consider θ_1 and θ_2 to provide additional falsification tests.

[16] Our finding of additional coverage gains in 2015 is consistent with the Cohen et al. (2016) descriptive examination of changes over time in coverage using the National Health Interview Survey (NHIS). They report in their table 17 that among non-elderly adults, the increase in those reporting coverage of any type was 4.1 percentage points between 2013 and 2014 and 3.5 percentage points between 2014 and 2015. For public (private) coverage,

Accordingly, the gains in primary care access and reductions in cost barriers also increased in 2015 relative to 2014, though these increases appear to have come entirely from the Medicaid expansion. The event study design also causes a few sporadic results to emerge for the health behavior and self-assessed health outcomes. In particular, the fully implemented ACA increased the probability of reporting excellent self-assessed health in 2015 (but not 2014) and reduced days in poor mental health in 2014 (but not 2015). These results, however, could simply be a byproduct of the large number of hypotheses tested by the event study models.

VIII. SUBSAMPLE ANALYSES

One possible explanation for the large number of null results, particularly for the Medicaid expansion, might be that the full sample includes various groups of people with different probabilities of being treated by the ACA. In this section, we examine whether more effects show up if we "zoom in" on the subpopulations most likely to experience larger gains in coverage (those with low-to-middle incomes and those with relatively low education levels) and / or larger gains in health and related outcomes (older, but not yet elderly adults) as a result of the ACA. We do this by running subsample regressions for those below versus above the median household income, those without a college degree versus college graduates, and those below versus above the median age. Unfortunately, perhaps due to the demanding nature of the DDD specification and the need for each subsample to have sufficient numbers of individuals in each area to reliably compute pre-treatment uninsured rates, splitting the sample into three or more groups results in estimates that are too imprecise to be useful. This is also why we do not stratify by race/ethnicity: the sample sizes for minority groups such as blacks and Hispanics are not sufficient to obtain meaningfully precise results.

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their table 18 (19) suggests the increase was 1 (3.1) percentage points between 2013 and 2014 and 1.2 (2.4) percentage points between 2014 and 2015.

Tables 7-12 report the results. Tables 7 and 8 stratify the sample by income. It is reassuring that the sizable gains in access were concentrated in the below-median-income subsample. The increase in insurance coverage from the full ACA was 11.9 percentage points for the lower income group – with the majority of this increase coming from the Medicaid expansion – compared with 2.0 percentage points for the higher income group. The gains in the other access outcomes appear to have been entirely concentrated among the lower income subsample. For this group, the effects on having a primary care doctor and an annual checkup were driven mostly by the private portion of the ACA while the reduction in cost barriers is driven mostly by the Medicaid expansion.

The results on risky health behaviors and self-assessed health generally show the same null effects we saw in Table 3, with a few exceptions. For instance, among the lower income subsample, the private portion of the ACA increased drinks per month while the Medicaid expansion decreased drinking by a similar amount. Additionally, the Medicaid expansion increased smoking among the higher income subsample – a result that seems likely to be spurious since this group would not have qualified for Medicaid. A couple improvements in the self-assessed health outcomes emerge for the lower income subsample: an increase in the probability of reporting excellent health in non-Medicaid-expansion states and a reduction in days not in good mental health in expansion states. However, we are reluctant to emphasize these results since they do not seem to fit a broader pattern, and we would expect a couple significant "effects" to emerge simply by chance given the large number of null hypotheses we are testing in these tables.

The patterns in Tables 9 and 10 – for those with less education versus more education – largely mimic the findings from our income stratification analysis. For those with less than a

college degree (which includes young individuals who may still be enrolled in school), the private portion of the ACA increased access to having a primary care doctor and an annual checkup; both the Medicaid and private portions increased insurance coverage and reduced cost barriers. Again, very few of the remaining outcomes on risky health behaviors or self-assessed health appear to have been affected. For those with a college degree, there are some muted effects on having a primary care doctor and cost barriers, but we largely see insignificant results.

Tables 11 and 12 divide the sample by age, where the median individual in our sample was approximately 43 years old. For both young and old, there were sizable gains in coverage: 8.5 percentage points from the full ACA for younger individuals and 7.2 percentage points for older ones. The full ACA also significantly increased the other access outcomes by roughly similar amounts among the two groups. However, there appears to be substantial heterogeneity in the extent to which these gains in access translated to improvements in health. There were no significant impacts of the private or public expansions in insurance on any risky health behavior or self-assessed health outcomes for the younger adults. In contrast, for the older half of our sample, the full ACA led to significant reductions in reports of days not in good physical health, not in good mental health, and with health-related limitations as well as an improvement in the composite health index. These gains appear to come mostly from the Medicaid rather than the private expansion. The evidence is less clear for the five-point self-reported measure of overall health: the private portion of the ACA increased the probabilities or reporting very good or excellent health, but the estimated effects of Medicaid expansion largely offset these gains so that the effects of the full ACA were insignificant. Nonetheless, the overall pattern of results appears to suggest an improvement in self-assessed health among the older half of our non-elderly adult sample along at least some dimensions.

IX. DISCUSSION

In this paper, we used data from the Behavioral Risk Factor Surveillance System to examine the effects of the 2014 ACA provisions on health care access, risky health behaviors, and self-assessed health. Using a DDD strategy that exploits variation in time, pre-treatment uninsured rates, and state Medicaid expansion status, we separately estimated the effects in both Medicaid expansion and non-expansion states. The results suggest that the ACA improved access to care along all observable dimensions – including health insurance coverage, having a primary care doctor and a well-patient checkup in the past year, and cost barriers – in both expansion and non-expansion states. The gain in coverage and reduction in cost barriers were significantly greater in expansion states. The magnitudes of the estimates imply effects of insurance on health care access that are at least as large as those observed in the Oregon Medicaid experiment. We did not observe any statistically or economically significant effects on the outcomes related to health behaviors or self-assessed health for the full sample of non-elderly adults. However, we did find evidence that the ACA improved self-assessed health among the older half of the sample in expansion states.

Our lack of significant results for risky health behaviors suggest that the *ex ante* moral hazard, improved access to health behavior-promoting medical care, and income effects brought about by insurance coverage either offset each other or are all relatively small. The extent of *ex ante* moral hazard may be modest because the consumption value of good health may be a sufficient deterrent even if an individual is insulated from the financial consequences of illness. Improved access to medical care may be of only limited value with regard to health behaviors since they are generally not as easy to treat as acute conditions. Income effects may also be relatively small given the mixed results in the literature as to the causal impact of income on

health behaviors and the potential for individuals to value in-kind spending on health insurance at less than its cost.[17,18]

Our inability to find clear evidence that the ACA improved self-assessed health contrasts the large, immediate gains in similar outcomes observed after the Oregon Medicaid experiment (Finkelstein et al., 2014) and Massachusetts reform (Van der Wees et al., 2013; Courtemanche and Zapata, 2014). The Oregon experiment was a unique context in that it was purely among low-income individuals who had demonstrated some interest in their health by actively registering for the lottery. The effects of the Massachusetts reform could plausibly differ from those of the ACA for several reasons, including differences in population demographics, the fact that the Massachusetts reform's insurance expansions for adults were done completely through private coverage as opposed to a mix of public and private coverage, and the greater prevalence of high deductibles in the ACA's private plans (Wharam et al., 2013). Another possible explanation is the relative lack of popularity of the ACA compared to these other interventions.[19] It has been hypothesized that the large, immediate gains in self-assessed health after insurance expansions may be attributable at least in part to a "warm glow" from gaining coverage (e.g. winning the lottery in Oregon, receiving insurance through a popular program in Massachusetts) rather than from actually utilizing additional medical care (Finkelstein et al., 2012;

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[17] See Cawley and Ruhm (2012) for an overview of the literature on the effect of income on risky health behaviors. Subsequent to their literature review, additional papers using natural experiments have continued to find mixed results (e.g. Au and Johnston, 2015; Averett and Wang, 2013; Kenkel et al., 2014; Apouey and Clark, 2015; Adams et al., 2012; Cowan and White, 2015).

[18] Around 84 percent of individuals with a Marketplace plan in 2015 qualified for an advance premium tax credit; conditional on qualifying, the advance PTC was $272 per month. See https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html. Gallen (2015) finds that each $1.00 of Medicaid spending is valued at $0.26-$0.35 to participants.

[19] Blendon et al. (2008) report that in June 2008, two years after the implementation of the Massachusetts health care reform, 69 percent of residents supported the law. In contrast, a tracking poll conducted by the Kaiser Family Foundation stated that in December 2016 only 43 percent of adults viewed the ACA favorably. For further information, on this poll see: http://kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=twoYear.

Courtemanche and Zapata, 2014). Perhaps the amount of "warm glow" is smaller if the intervention bringing about the coverage is controversial, such as with the ACA.

Several caveats of our work provide directions for future research. For instance, investigation of clinical health outcomes is necessary to provide a fuller picture of the ACA's health effects. Additionally, future studies should continue to track the indicators used in our paper over a longer time period, as the effects of insurance on health could take many years to fully materialize. Next, our identification strategy implicitly assumes that effects of the ACA are concentrated among those who lacked coverage prior to the law's implementation. Future research should investigate whether impacts could also occur among, for instance, those who switched from catastrophic to more comprehensive coverage as a result of the ACA's minimum standards for insurance plans, or who experienced significant income shocks as a result of the subsidies or changes in premiums.[20] Finally, note that understanding the ACA's effects on health care access and health outcomes provides only part of the story with regard to evaluating the welfare effects of the law. For instance, protection against financial risk is a critical component of the gains from insurance, so the consumption smoothing benefits of the ACA could confer a sizable benefit even in the absence of discernable short-run health effects. Hu et al. (2016) found evidence that the ACA's Medicaid expansion improved financial outcomes from credit report data. On the other hand, Pauly (2017) questions whether or not the poor should be allowed to purchase high-deductible marketplace plans. The ACA also contains a number of other components unrelated to insurance coverage, such as provider payment reforms and tax

[20] For instance, 7.7 percent of non-elderly adults directly purchased individual coverage prior to the 2014 reforms (author's calculations using the ACS). For these individuals, the ACA's premium tax credit could directly substitute for household income devoted to health insurance. While many of these people likely experienced positive income shocks, some may have been spending less on insurance prior to the ACA, perhaps because they were purchasing non-comprehensive policies (Clemans-Cope and Anderson, 2014). Thus, it is possible that the share of their budget spent on health insurance could have increased even in the presence of the subsidies.

increases, that each represent a part of the overall picture. Thus both the size and scope of the ACA have generated the need for a great deal of future research in order to better understand the multi-faceted nature of its impacts.

REFERENCES

Abramowitz, J. (2016). The Effect of ACA State Medicaid Expansions on Medical Out-of-Pocket Expenditures and Perceived Health. Working Paper.

Akosa Antwi, Y., A. Moriya, and K. Simon (2015). Access to Health Insurance and the Use of Inpatient Medical Care: Evidence from the Affordable Care Act Young Adult Mandate. *Journal of Health Economics*, 39: 171-187.

Adams, S., M.L. Blackburn, and C.D. Cotti (2012). Minimum Wages and Alcohol-related Traffic Fatalities among Teens. *Review of Economics and Statistics*, 94(3): 828-840.

Au, N. and D.W. Johnston (2015). Too Much of a Good Thing? Exploring the Impact of Wealth on Weight. *Health Economics, 24(*11): 1403-1421.

Apouey, B. and A. Clark (2015). Winning Big but Feeling No Better? The Effect of Lottery Prizes on Physical and Mental Health. *Health Economics*, 24(5): 516-538.

Averett, S. and Y. Wang (2013). The Effects of Earned Income Tax Credit Payment Expansion on Maternal Smoking. *Health Economics,* 22 (11): 1344-1359.

Baicker, K., S. Taubman, H. Allen, M. Bernstein, J. Gruber, J.P. Newhouse, and the Oregon Health Study Group (2013). The Oregon Experiment--Effects of Medicaid on Clinical Outcomes. *New England Journal of Medicine*, 368 (18): 1713-1722.

Barbaresco, S., C. Courtemanche, and Y. Qi (2015). Impacts of the Affordable Care Act Dependent Coverage Provision on Health-related Outcomes of Young Adults. *Journal of Health Economics*, 40: 54-68.

Barnett, J.C. and M.S. Vornovitsky (2016). Current Population Reports, P60-257(RV), Health Insurance Coverage in the United States: 2015. U.S. Government Printing Office, Washington, DC.

Benitez, J.A., L. Creel, and J. Jennings (2016). Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care. *Health Affairs*, 35 (3), 528-34.

Berkman, N., S.L. Sheridan, K.E. Donahue, D.J. Halpern, and K. Crotty (2011). Low Health Literacy and Health Outcomes: An Updated Systematic Review. *Annals of Internal Medicine,* 155 (2): 97 -107.

Blendon, R.J., T. Buhr, T. Sussman, and J.M. Benson (2008). Massachusetts Health Reform: A Public Perspective from Debate through Implementation. *Health Affairs*, 27 (6): w556-w565.

Brook, R.H., J.E. Ware, Jr, W.H. Rogers, E.B. Keeler, A.R. Davies, C.A. Donald, G.A. Goldberg, K.N. Lohr, P.C. Masthay, and J.P. Newhouse (1983). Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial. *New England Journal of Medicine*, 309 (23): 1426-1434.

Burns M.E. and B.L. Wolfe (2016). The Effects of the Affordable Care Act Adult Dependent Coverage Expansion on Mental Health. *Journal of Mental Health Policy*, 19 (1): 3-20.

Buchmueller, T., J.C. Ham, and L.D. Shore-Sheppard (2016). "The Medicaid Program," in: R.A. Moffit (ed.), Economics of Means-Tested Transfer Programs in the United States, Volume 1, chapter 1: 21-136. Cambridge, MA: National Bureau of Economic Research.

Card, D., C. Dobkin, and N. Maestas (2008). The Impact of Nearly Universal Insurance Coverage on Health Care Utilization: Evidence from Medicare. *American Economic Review*, 98 (5): 2242-2258.

Card, D., C. Dobkin, and N. Maestas (2009). Does Medicare Saves Lives? *Quarterly Journal of Economics*, 124 (2): 597-636.

Cawley, J. (2004). The Impact of Obesity on Wages. *Journal of Human Resources*, 39 (2): 451-474.

Cawley, J. and C. Ruhm (2012). "The Economics of Risky Health Behaviors," in: T.G. McGuire, M.V. Pauly, and P.P. Barros (eds.), Handbook of Health Economics, Volume 2, chapter 3: 95-99. New York, NY: Elsevier.

Chetty, R., J.N. Friedman, N. Hilger, E. Saez, D. Whitmore Schanzenbach, and D. Yagan. (2011). How Does Your Kindergarten Classroom Affect Your Earnings? Evidence from Project Star. *Quarterly Journal of Economics* 126: 1593-1660.

Cho, Y.I., S.Y.D. Lee, A.M. Arozullah, and K.S. Crittenden. (2008). Effects of Health Literacy on Health Status and Health Service Utilization amongst the Elderly. *Social Science and Medicine*, 66(8): 1809-1816.

Chua, K. and B.D. Sommers (2014). Changes in Health and Medical Spending among Young Adults under Health Reform. *Journal of the American Medical Association,* 311 (23): 2437-2439.

Clemans-Cope, L. and N. Anderson (2014). How many Non-Group Policies were Cancelled? Estimates from December 2013. Health Affairs Blog. Available from: http://healthaffairs.org/blog/2014/03/03/how-many-nongroup-policies-were-canceled-estimates-from-december-2013/.

Cohen, R.A., M.E. Martinez, and E.P. Zammitti (2016). Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2015. National Center for Health Statistics. Available from: http://www.cdc.gov/nchs/nhis/ releases.htm.

Courtemanche, C. and D. Zapata (2014). Does Universal Coverage Improve Health? The Massachusetts Experience. *Journal of Policy Analysis and Management,* 33 (1): 36–69.

Courtemanche, C., J. Marton, and A. Yelowitz (2016). Who Gained Insurance Coverage in 2014, the First Year of Full ACA Implementation? *Health Economics* 25: 778-784.

Courtemanche, C., J. Marton, B. Ukert, A. Yelowitz, and D. Zapata (2017). Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States. *Journal of Policy Analysis and Management,* 36 (1): 178-210.

Courtemanche, C., J. Pinkston, and J. Stewart (2015). Adjusting Body Mass for Measurement Error with Invalid Validation Data. *Economics and Human Biology,* 19: 275-293

Cowan, B.W. and D.R. White (2015). The Effects of Merit-Based Financial Aid on Drinking in College. *Journal of Health Economics*, 44: 137-149.

Currie, J. and J. Gruber (1996a). Health Insurance Eligibility, Utilization of Medical Care, and Child Health. *Quarterly Journal of Economics*, 111: 431–466.

Currie, J. and J. Gruber (1996b). Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women. *Journal of Political Economy*, 104: 1263–1296.

Cutler, D.M. and R.J. Zeckhauser (2000). "The Anatomy of Health Insurance," in: A.J. Culyer and J.P. Newhouse (eds.), Handbook of Health Economics, Volume 1, chapter 11: 563-643. New York, NY: Elsevier.

Dafny, L. and J. Gruber (2005). Public Insurance and Child Hospitalizations: Access and Efficiency Effects. *Journal of Public Economics*, 89: 109–129.

Dave, D. and R. Kaestner (2009). Health Insurance and Ex Ante Moral Hazard: Evidence from Medicare. *International Journal of Health Care Finance and Economics*, 9 (4): 367-390.

Dave, D.M., R. Kaestner, and G.L. Wehby (2014). Does Medicaid Coverage for Pregnant Women Affect Prenatal Health Behaviors? NBER Working Paper 21049. Cambridge, MA: National Bureau of Economic Research.

DeSalvo, K.B., N. Bloser, K. Reynolds, J. He, and P. Muntner (2006). Mortality Prediction with a Single General Self-Rated Health Question. *Journal of General Internal Medicine,* 21 (3): 267-275.

Epstein, A.M. and J.P. Newhouse (1998). Impact of Medicaid Expansion on Early Prenatal Care and Health Outcomes. *Health Care Financing Review*, 19: 85-99.

Finkelstein, A. (2007). The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare. *Quarterly Journal of Economics*, 122 (1): 1-37.

Finkelstein, A. and R. McKnight (2008). What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending. *Journal of Public Economics*, 92: 1644-1668.

Finkelstein, A., S. Taubman, B. Wright, M. Bernstein, J. Gruber, J.P. Newhouse, and K. Baicker, and the Oregon Health Study Group (2012). The Oregon health insurance experiment: Evidence from the first year. *Quarterly Journal of Economics*, 127: 1057–1106.

Frean, M., J. Gruber, and B.D. Sommers (2016). Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act. NBER Working Paper 22213. Cambridge, MA: National Bureau of Economic Research.

Galen, T.S. (2015). Using Participant Behavior to Measure the Value of Social Programs: The Case of Medicaid. University of Chicago Working Paper. Available from: http://web.ics.purdue.edu/~tgallen/Papers/TGallen_Using_Participant_Behavior_2015.pdf

Garber, A. and J. Skinner (2008). Is American Health Care Uniquely Inefficient? *Journal of Economic Perspectives*, 22: 27-50.

Glied, S. and S. Ma (2015). How will the Affordable Care Act Affect the use of Health Care Services? Commonwealth Fund Issue Brief 1804. Available from: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/feb/1804_glied_how_will_aca_affect_use_hlt_care_svcs_ib_v2.pdf

Golberstein, E., G. Gonzales, and B.D. Sommers (2015). California's Early ACA Expansion Increased Coverage and Reduced Out-of-Pocket Spending for the State's Low-Income Population. *Health Affairs*, 34: 1688-1694.

Gruber, J. (2000). "Health Insurance and the Labor Market," in: A.J. Culyer and J.P. Newhouse (eds.), Handbook of Health Economics, Volume 1, chapter 12: 645-706. New York, NY: Elsevier.

Gruber, J. (2008). Incremental Universalism for the United States: The States Move First? *Journal of Economic Perspectives*, 22: 51–68.

Hu, L., R. Kaestner, B. Mazumder, S. Miller, and A. Wong (2016). The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being. NBER Working Paper No. 22170. Cambridge, MA: National Bureau of Economic Research.

Idler, E.L. and Y. Benyamini (1997). Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies. *Journal of Health and Social Behavior*, 38 (1): 21-37.

Kaestner, R. (2015). Did Massachusetts Health Care Reform Lower Mortality? Not According to Randomization Inference. *Statistics and Public Policy*, 3(1): 1-6.

Kaestner, R., B. Garrett, A. Gangopadhyaya, and C. Fleming (2015). Effects of the ACA Medicaid Expansion on Health Insurance Coverage and Labor Supply. NBER Working Paper No. 21836. Cambridge, MA: National Bureau of Economic Research.

Kaiser Family Foundation. State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, 2014. Available from: http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/

Kenkel, D., M. Schmeiser, and C. Urban (2014). Is Smoking Inferior? Evidence from Variation in the Earned Income Tax Credit. *Journal of Human Resources*, 49 (4): 1094-1120.

Kirby, J.B. and J.P. Vistnes (2016). Access to Care Improved for People who Gained Medicaid or Marketplace Coverage in 2014. *Health Affairs*, 35(10): 1830-1834.

Kolstad, J. and A. Kowalski (2012). The Impact of Health Care Reform on Hospital and Preventive Care: Evidence from Massachusetts. *Journal of Public Economics*, 96(11): 909-929.

Kowalski, A. (2014). The Early Impact of the Affordable Care Act State-by-State. NBER Working Paper 20597. Cambridge, MA: National Bureau of Economic Research.

Lichtenberg, F. (2002). "The Effects of Medicare on Health Care Utilization and Outcomes," in A.M. Garber (ed.), Frontiers in Health Policy Research, Volume 5. Cambridge, MA: MIT Press.

Long, S.K., M. Karpman, A. Shartzer, D. Wissoker, G.M. Kenney, S. Zucherman, N. Anderson, and K. Hempstead (2014) Taking Stock: Health Insurance Coverage under the ACA as of September 2014. Washington, DC: Urban Institute. Available from: http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.html.

Manning, W., J.P. Newhouse, N. Duan, E.B. Keeler, A. Leibowitz, and M.S. Marquis (1987). Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment. *American Economic Review*, 77(3): 251-77.

Medicaid and CHIP Payment and Access Commission (MACPAC) (2015). An Update on the Medicaid Primary Care Payment Increase. Available from: https://www.macpac.gov/publication/an-update-on-the-medicaid-primary-care-payment-increase-3/

McMorrow, S., G.M. Kenney, S.K. Long, and J.A. Gates (2016). Marketplaces Helped Drive Coverage Gains in 2015; Affordability Problems Remained. *Health Affairs*, 35 (10): 1810-1815.

Miller, S. (2012a). The effect of insurance on emergency room visits: An analysis of the 2006 Massachusetts health reform. *Journal of Public Economics*, 96: 893–908.

Miller, S. (2012b). The Impact of the Massachusetts Health Care Reform on Health Care use among Children. *American Economic Review*, 102: 502–507.

Obama, B. (2016). United States Health Reform: Progress to Date and Next Steps. *Journal of the American Medical Association*, 316 (5): 525-532.

Pauly, M. (2017). Should Lower-Income People be Allowed to Buy Insurance with High Cost Sharing? *American Journal of Health Economics*, 3 (1): 1-9.

Phillips, A.C., G. Der, and D. Carroll (2010). Self-Reported Health, Self-Reported Fitness, and All-Cause Mortality: Prospective Cohort Study. *British Journal of Health Psychology*, 15(2): 337-346.

Polsky, D., M. Richards, S. Basseyn, D. Wissoker, G.M. Kenney, S. Zuckerman, and K.V. Rhodes (2015). Appointment Availability after Increases in Medicaid Payments for Primary Care. *New England Journal of Medicine*, 372(6): 537-545.

Schwartz, M. (2012). Health Care Reform and the Primary Care Workforce Bottleneck. *Journal of General Internal Medicine*, 27 (4): 469-472.

Shartzer, A., S.K. Long, and N. Anderson (2015). Access to Care and Affordability have Improved following Affordable Care Act Implementation; Problems Remain. *Health Affairs*, 10.

Simon, K., A. Soni, and J. Cawley (2017). The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions. *Journal of Policy Analysis and Management*, 36: 390-417.

Smith, J.C., and C. Medalia (2015) U.S. Census Bureau, Current Population Reports, P60-253, Health Insurance Coverage in the United States: 2014. U.S. Government Printing Office, Washington, DC. Available from: https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf.

Somers, Stephen A. and Roopa Mahadevan (2010). Health Literacy Implications of the Affordable Care Act. Center for Health Care Strategies, Inc. Available from: http://www.chcs.org/media/Health_Literacy_Implications_of_the_Affordable_Care_Act.pdf.

Sommers, B.D. (forthcoming). State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis. *American Journal of Health Economics*.

Sommers B.D., K. Baicker, and A.M. Epstein (2012). Mortality and Access to Care Among Adults after State Medicaid Expansions. *New England Journal of Medicine*, 367: 1025-34.

Sommers, B., Buchmueller, T., Decker, S., Carey, C. and Kronick, R. (2013). The Affordable Care Act Has Led to Significant Gains in Health Insurance and Access to Care for Young Adults. *Health Affairs*, 32: 165-174.

Sommers, B.D., R.J. Blendon, and E.J. Orav (2016). Both the 'Private Option' and Traditional Medicaid Expansions Improved Access to Care for Low-Income Adults. *Health Affairs*, 35: 96-105.

Sommers, B.D., K.P. Chua, G.M. Kenney, S.K. Long, and S. McMorrow (2016). California's Early Coverage Expansion under the Affordable Care Act: a County-level Analysis. *Health Services Research*, 51 (3): 825-845.

Sommers, B.D., M.Z. Gunja, K. Finegold, and T. Musco (2015). Changes in Self-Reported Insurance Coverage, Access to Care, and Health under the Affordable Care Act." *Journal of the American Medical Association*, 314 (4): 366-374.

Sommers, B.D., G.M. Kenney, and A.M. Epstein (2014) New Evidence on the Affordable Care Act: Coverage Impacts of Early Medicaid Expansions. *Health Affairs*, 33: 78-87.

Taubman, S.L., H.L. Allen, B.J. Wright, K. Baicker, and A.N. Finkelstein (2014). Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment. *Science*, 343 (6168): 263-268.

Tello-Trillo, D.S. (2016). Effects of Losing Public Health Insurance on Health Care Access, Utilization, and Health Outcomes. Working paper, University of Virginia. Available from: https://dsebastiantello.files.wordpress.com/2014/12/tenncare-05212016-21.pdf.

Tolbert, J. (2015). The Coverage Provisions in the Affordable Care Act: An Update. Kaiser Family Foundation Issue Brief. Available from: http://kff.org/health-reform/issue-brief/the-coverage-provisions-in-the-affordable-care-act-an-update/.

Van der Wees, P.J., A.M. Zaslavsky, and J.Z. Ayanian (2013). Improvements in Health Status after Massachusetts Health Care Reform. *Milbank Quarterly*, 91: 663-689.

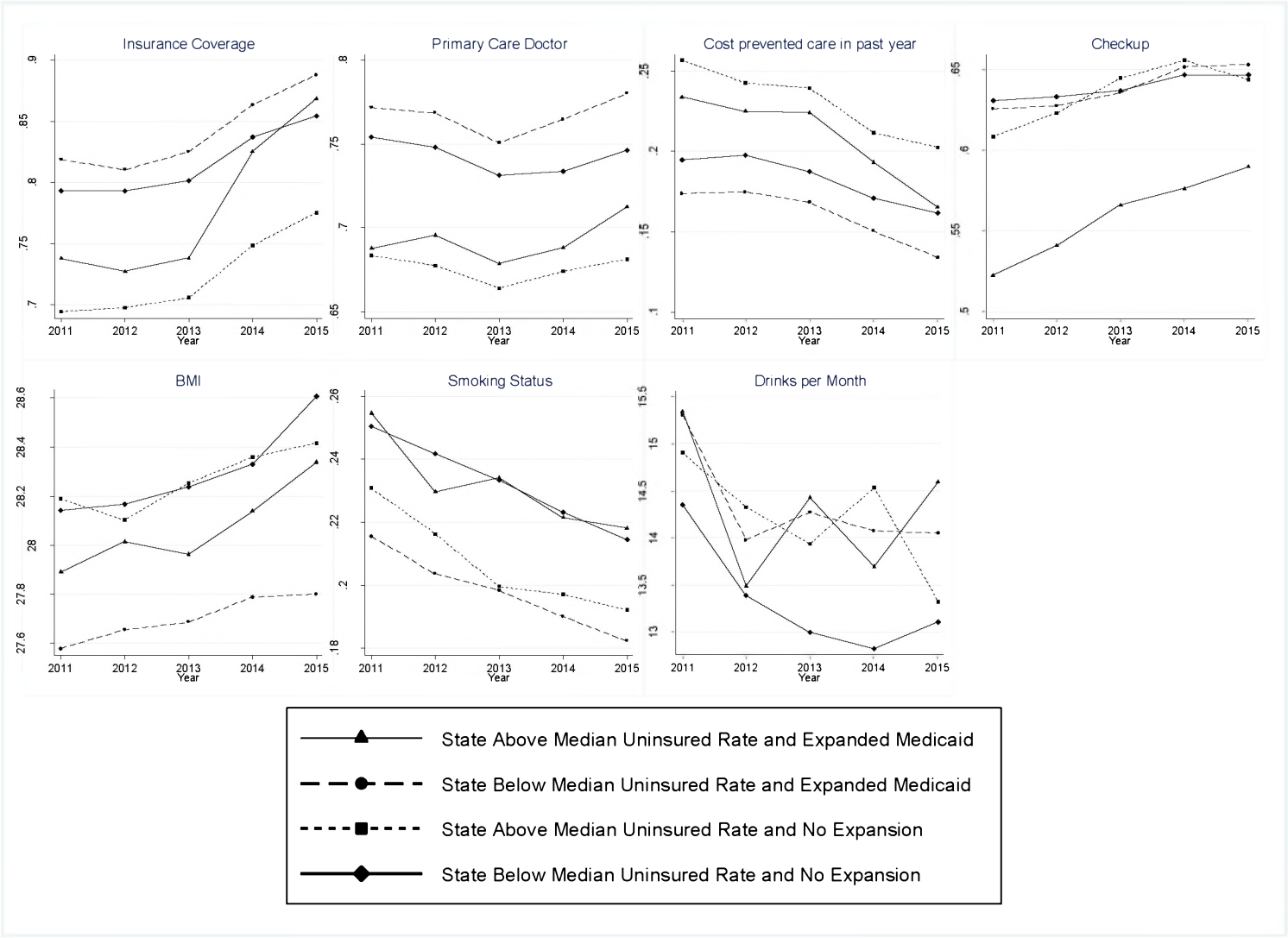
Wharam, J.F., D. Ross-Degnan, and M.B. Rosenthal (2013). The ACA and High-Deductible Insurance — Strategies for Sharpening a Blunt Instrument. *New England Journal of Medicine*, 369: 1481-1484.

Wherry, L. R. and S. Miller (2016). Early Coverage, Access, Utilization, and Health Effects Associated With the Affordable Care Act Medicaid Expansions: A Quasi-experimental Study. *Annals of Internal Medicine*, 164 (12): 795-803.

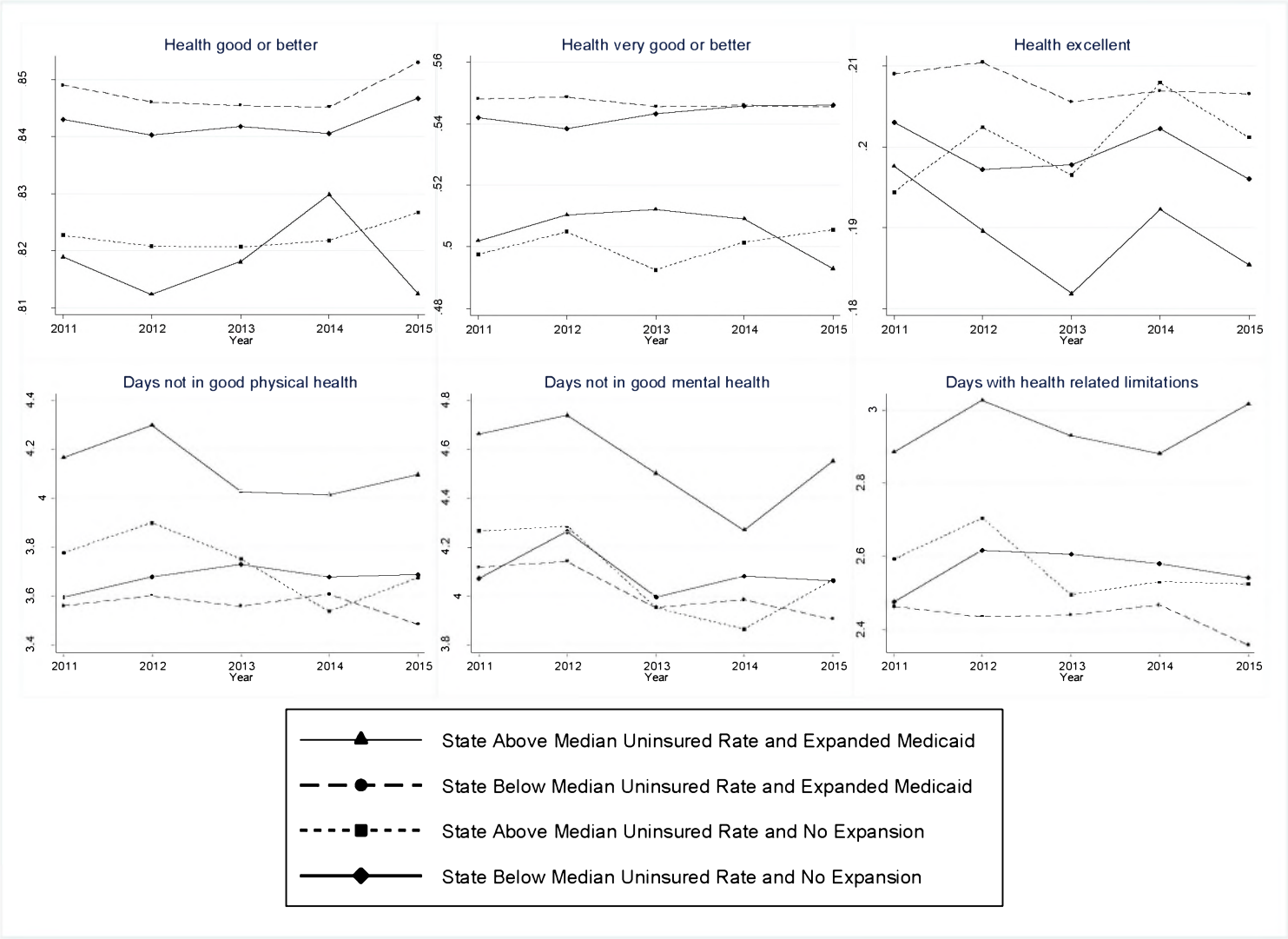
Yelowitz, Aaron. (forthcoming). Local Housing Costs and Basic Household Needs. *Empirical Economics*.

Yelowitz, A. and M. Cannon (2010). The Massachusetts Health Plan Much Pain, Little Gain. *Policy Analysis*, 657: 1–16.

Figures 1 – Changes in Health Care Access and Health Behaviors Over Time By State Medicaid Expansion Status and Pre-Treatment Uninsured Rate



Figures 2 – Changes in Self-Assessed Health Variables Over Time By State Medicaid Expansion Status and Pre-Treatment Uninsured Rate



Figures 3 – ACA Effects on Access and Risky Health Behaviors at Pre-Treatment Uninsured Rates

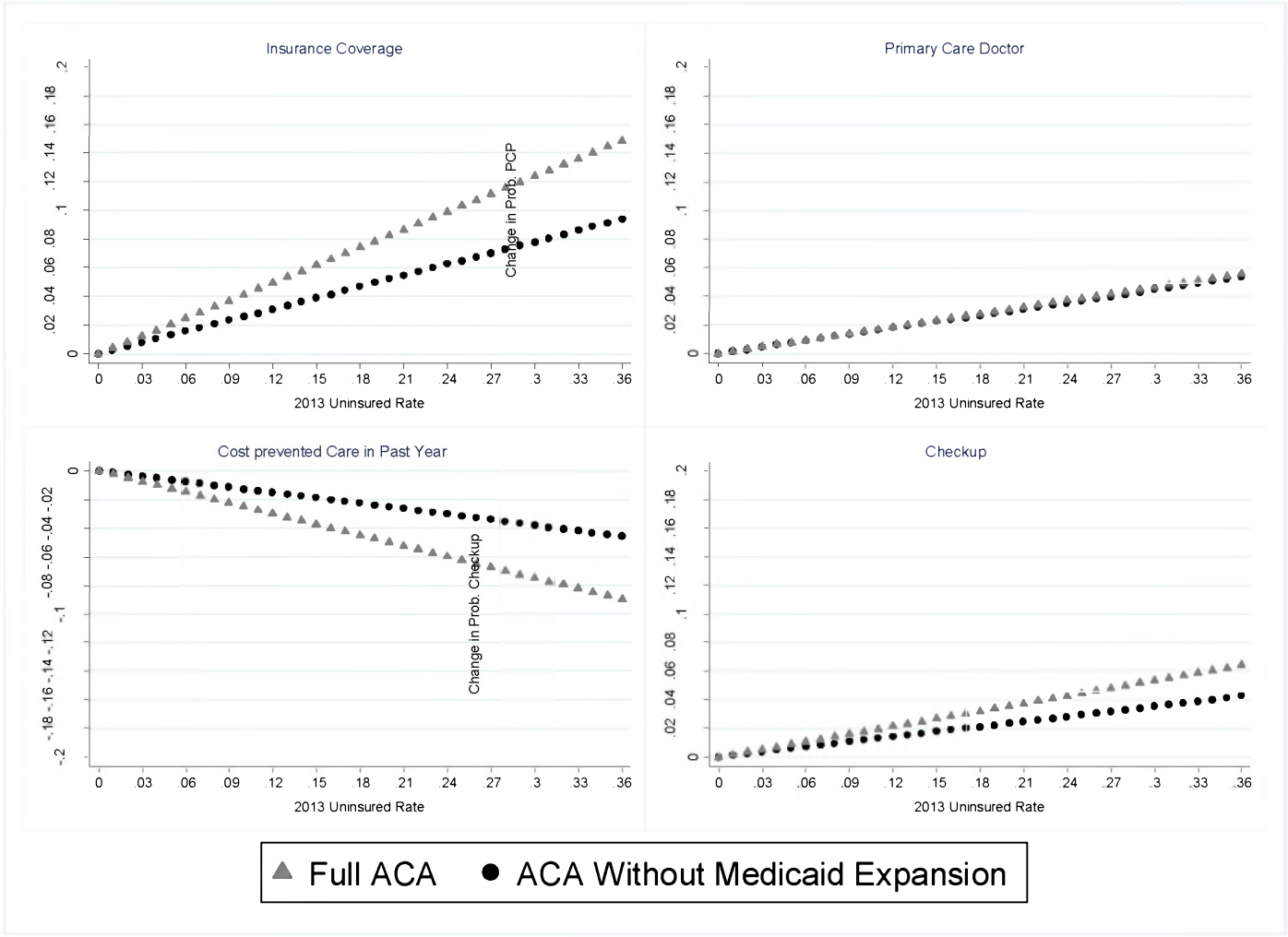


Table 1 – Means and Standard Deviations of Dependent Variables By State Medicaid Expansion Status and Pre-Treatment Uninsured Rate

	Full Sample	Medicaid Expansion; ≥ Median Baseline Uninsured	Medicaid Expansion; < Median Baseline Uninsured	Non-Expansion; ≥ Median Baseline Uninsured	Non-Expansion; < Median Baseline Uninsured
Any Insurance Coverage	0.788	0.791	0.868	0.710	0.805
	(0.409)	(0.407)	(0.339)	(0.454)	(0.396)
Primary Care Doctor	0.741	0.745	0.826	0.682	0.754
	(0.439)	(0.436)	(0.378)	(0.465)	(0.431)
Cost Barrier to Care in Past Year	0.192	0.202	0.144	0.241	0.187
	(0.394)	(0.401)	(0.351)	(0.427)	(0.389)
Well-Patient Doctor Visit in Past Year	0.627	0.586	0.673	0.632	0.629
	(0.484)	(0.492)	(0.469)	(0.482)	(0.483)
Overall Health Good or Better	0.840	0.810	0.851	0.824	0.864
	(0.367)	(0.392)	(0.356)	(0.381)	(0.363)
Overall Health Very Good or Better	0.535	0.511	0.565	0.505	0.544
	(0.499)	(0.499)	(0.496)	(0.499)	(0.498)
Overall Health Excellent	0.204	0.192	0.211	0.199	0.198
	(0.403)	(0.393)	(0.408)	(0.399)	(0.398)
Days Not in Good Physical Health in Past Month	3.660	4.489	3.940	4.149	4.099
	(7.964)	(8.639)	(8.073)	(8.362)	(8.326)
Days Not in Good Mental Health in Past Month	4.118	4.486	3.758	3.755	3.678
	(8.210)	(8.960)	(8.127)	(8.154)	(8.095)
Days with Health-Related Limitations in Past Month	2.518	3.066	2.553	2.572	2.570
	(6.797)	(7.505)	(6.877)	(6.463)	(6.975)
BMI	27.875	28.002	27.848	28.202	28.187
	(6.282)	(6.331)	(6.208)	(6.462)	(6.435)
Smoking Status	0.216	0.212	0.195	0.218	0.244
	(0.412)	(0.408)	(0.396)	(0.420)	(0.429)
Drinks per Month	14.285	13.080	13.782	14.103	13.740
	(35.824)	(32.600)	(32.187)	(37.640)	(35.173)

Note: Standard deviations in parentheses.

Table 2 – Effects of ACA on Health Care Access and Health Behaviors

	Insurance Coverage	Primary Care Doctor	Cost Barrier	Checkup	BMI	Smoker	Alcoholic Drinks per Month
Coefficient Estimates of Interest							
Medicaid Expansion * Post	-0.013	0.005	0.019	0.005	0.003	-0.022*	0.087
	(0.008)	(0.011)	(0.010)	(0.016)	(0.113)	(0.009)	(0.538)
Post * Pre-Treatment Uninsured	0.259***	0.148**	-0.127***	0.119*	-0.087	-0.0006	3.290
	(0.030)	(0.049)	(0.031)	(0.051)	(0.405)	(0.046)	(2.119)
Medicaid Expansion * Post * Pre-Treatment Uninsured	0.152**	0.007	-0.123**	0.060	-0.040	0.054	-0.607
	(0.045)	(0.065)	(0.042)	(0.067)	(0.528)	(0.045)	(2.397)
Implied Effects of ACA at Mean Pre-Treatment Uninsured Rate							
ACA without Medicaid Expansion	0.053***	0.030**	-0.026***	0.024*	-0.018	-0.0001	0.667
	(0.006)	(0.010)	(0.006)	(0.010)	(0.082)	(0.009)	(0.429)
Medicaid Expansion	0.031***	0.001	-0.025**	0.012	-0.008	0.010	-0.123
	(0.009)	(0.013)	(0.009)	(0.014)	(0.107)	(0.009)	(0.486)
Full ACA (with Medicaid Expansion)	0.083***	0.031**	-0.051***	0.036***	-0.026	0.011	0.544
	(0.010)	(0.011)	(0.010)	(0.009)	(0.094)	(0.007)	(0.571)
Pre-Treatment Mean and Standard Deviation of Outcome	0.811	0.742	0.183	0.635	27.951	0.208	14.285
	(0.391)	(0.437)	(0.386)	(0.481)	(6.375)	(0.406)	(35.824)
Sample Size	1,322,370	1,321,567	1,071,238	1,072,537	1,264,243	1,300,819	1,225,053

Notes: Standard errors, heteroscedasticity-robust and clustered by state, are in parentheses. *** indicates statistically significant at 0.1% level; ** 1% level; * 5% level. BRFSS sampling weights are used. All regressions include state*location type and year*location type fixed effects as well as the controls.

Table 3 – Effects of ACA on Self-Assessed Health

	Good or Better Health	Very Good or Better Health	Excellent Health	Days Not in Good Physical Health	Days Not in Good Mental Health	Days with Health-Related Limitations	Health Index
Coefficient Estimates of Interest							
Medicaid Expansion * Post	-0.005	0.009	0.004	-0.171	0.006	-0.334*	0.031
	(0.006)	(0.008)	(0.008)	(0.111)	(0.210)	(0.165)	(0.021)
Post * Pre-Treatment Uninsured	-0.043	0.028	0.038	-0.584	-0.396	-0.595	-0.003
	(0.023)	(0.0327)	(0.025)	(0.555)	(0.763)	(0.695)	(0.096)
Medicaid Expansion * Post * Pre-Treatment Uninsured	0.028	-0.036	0.014	0.336	-0.337	1.114	-0.070
	(0.030)	(0.041)	(0.033)	(0.537)	(0.878)	(0.811)	(0.104)
Implied Effects of ACA at Mean Pre-Treatment Uninsured Rate							
ACA without Medicaid Expansion	-0.009	0.006	0.008	-0.118	-0.080	-0.121	-0.006
	(0.005)	(0.006)	(0.005)	(0.112)	(0.155)	(0.141)	(0.020)
Medicaid Expansion	0.006	-0.007	-0.003	0.068	-0.068	0.226	-0.014
	(0.006)	(0.008)	(0.007)	(0.108)	(0.178)	(0.164)	(0.021)
Full ACA (with Medicaid Expansion)	-0.003	-0.002	0.005	-0.050	-0.149	0.105	-0.015
	(0.006)	(0.010)	(0.006)	(0.126)	(0.126)	(0.154)	(0.016)
Pre-Treatment Mean and Standard Deviation	0.841	0.537	0.204	3.634	4.071	2.500	-0.036
	(0.366)	(0.499)	(0.403)	(7.948)	(8.169)	(6.777)	(0.987)
Sample Size	1,321,799	1,321,799	1,321,799	1,309,624	1,310,641	1,316,271	1,324,849

See notes for Table 2.

Table 4 – Instrumental Variables Estimates of the Effect of Health Insurance on Health Care Access Outcomes

	Primary Care Doctor	Cost Barrier	Checkup
Any Insurance	0.446***	-0.469***	0.357***
	(0.080)	(0.075)	(0.092)
Sample Size	1,319,215	1,069,336	1,070,619
First-Stage F Statistic	618.16	704.79	703.35
Overidentification Test P-Value	0.001	0.144	0.721

See notes for Table 2.

Table 5 – Event Study Regressions for Health Care Access and Health Behaviors

	Insurance Coverage	Primary Care Doctor	Cost Barrier	Checkup	BMI	Smoker	Drinks per Month
Coefficient Estimates of Interest (2013 is base year)							
2011 * Pre-Treatment Uninsured	0.018	-0.057	0.094	-0.296***	0.602	0.035	-5.326
	(0.069)	(0.059)	(0.060)	(0.087)	(0.723)	(0.043)	(3.366)
2012 * Pre-Treatment Uninsured	-0.052	-0.022	-0.011	-0.173*	-0.950	0.022	0.926
	(0.067)	(0.081)	(0.056)	(0.066)	(0.622)	(0.046)	(4.642)
2014 * Pre-Treatment Uninsured	0.193***	0.115**	-0.129**	-0.0143	-0.435	0.010	8.360*
	(0.046)	(0.045)	(0.054)	(0.050)	(0.723)	(0.050)	(3.968)
2015 * Pre-Treatment Uninsured	0.310***	0.140	-0.106**	-0.021	-0.623	0.041	-3.211
	(0.066)	(0.117)	(0.052)	(0.088)	(0.614)	(0.041)	(3.336)
Medicaid Expansion * 2011 * Pre-Treatment Uninsured	0.027	0.054	-0.047	0.096	-0.167	-0.046	0.462
	(0.075)	(0.074)	(0.045)	(0.081)	(0.834)	(0.048)	(5.479)
Medicaid Expansion * 2012 * Pre-Treatment Uninsured	-0.001	0.113	-0.006	0.039	1.552	-0.094	-10.885
	(0.106)	(0.103)	(0.047)	(0.053)	(0.809)	(0.052)	(5.856)
Medicaid Expansion * 2014 * Pre-Treatment Uninsured	0.134*	0.011	-0.005	0.046	-0.391	0.019	-8.835*
	(0.062)	(0.074)	(0.050)	(0.060)	(0.916)	(0.050)	(4.117)
Medicaid Expansion * 2015 * Pre-Treatment Uninsured	0.197*	0.083	-0.142**	0.100	1.171	-0.024	-0.428
	(0.082)	(0.115)	(0.048)	(0.077)	(0.793)	(0.042)	(3.684)
Implied Effects of ACA at Mean Pre-Treatment Uninsured Rate							
ACA without Medicaid Expansion in 2014	0.039***	0.023**	-0.026*	-0.003	-0.088	0.002	1.695*
	(0.009)	(0.009)	(0.001)	(0.010)	(0.146)	(0.010)	(0.805)
ACA without Medicaid Expansion in 2015	0.063***	0.028	-0.022*	-0.004	-0.126	0.008	-0.651
	(0.013)	(0.024)	(0.010)	(0.018)	(0.124)	(0.008)	(0.677)
Full ACA (with Medicaid Expansion) in 2014	0.066***	0.026	-0.027***	0.006	-0.009	0.006	-0.096
	(0.012)	(0.015)	(0.008)	(0.013)	(0.128)	(0.011)	(0.752)
Full ACA (with Medicaid Expansion) in 2015	0.103***	0.045**	-0.050***	0.016	0.111	0.004	-0.564
	(0.013)	(0.014)	(0.012)	(0.010)	(0.182)	(0.007)	(0.845)

See notes from Table 2.

Table 6 – Event Study Regressions for Self-Assessed Health

	Good or Better Health	Very Good or Better Health	Excell-ent Health	Days Not in Good Physical Health	Days Not in Good Mental Health	Days with Health-Related Limitations	Health Index
Coefficient Estimates of Interest (2013 is base year)							
2011 * Pre-Treatment Uninsured	0.047	-0.062	-0.056	0.922	1.492	1.056	-0.105
	(0.048)	(0.047)	(0.055)	(1.606)	(1.191)	(0.687)	(0.166)
2012 * Pre-Treatment Uninsured	0.025	0.134	0.059	1.477	1.120	1.375*	-0.009
	(0.062)	(0.076)	(0.044)	(1.664)	(0.769)	(0.650)	(0.157)
2014 * Pre-Treatment Uninsured	-0.039	0.080*	0.061	-.515	-0.213	-0.292	0.039
	(0.038)	(0.033)	(0.042)	(1.142)	(0.836)	(0.625)	(0.091)
2015 * Pre-Treatment Uninsured	-0.007	0.088	0.044	0.358	1.300	0.370	-0.098
	(0.031)	(0.072)	(0.041)	(0.907)	(0.649)	(0.761)	(0.074)
Medicaid Expansion * 2011 * Pre-Treatment Uninsured	-0.048	0.007	0.124	-1.221	-0.686	-1.093	0.167
	(0.057)	(0.070)	(0.69)	(1.457)	(1.309)	(0.735)	(0.155)
Medicaid Expansion * 2012 * Pre-Treatment Uninsured	-0.062	-0.087	0.002	0.447	-0.794	-0.361	0.009
	(0.068)	(0.089)	(0.061)	(1.383)	(0.846)	(0.552)	(0.016)
Medicaid Expansion * 2014 * Pre-Treatment Uninsured	0.028	-0.081	0.045	0.715	-1.344	0.599	-0.046
	(0.043)	(0.059)	(0.051)	(1.236)	(0.774)	(0.997)	(0.125)
Medicaid Expansion * 2015 * Pre-Treatment Uninsured	-0.025	-0.066	0.049	-0.072	-0.855	0.873	0.003
	(0.052)	(0.092)	(0.054)	(1.062)	(1.019)	(0.847)	(0.094)
Implied Effects of ACA at Mean Pre-Treatment Uninsured Rate							
ACA without Medicaid Expansion in 2014	-0.008	0.016*	0.013	-0.105	-0.043	-0.059	0.008
	(0.008)	(0.007)	(0.009)	(0.232)	(0.170)	(0.127)	(0.019)
ACA without Medicaid Expansion in 2015	-0.001	0.018	0.009	0.073	0.263	0.075	-0.019
	(0.006)	(0.015)	(0.008)	(0.184)	(0.132)	(0.154)	(0.015)
Full ACA (with Medicaid Expansion) in 2014	-0.002	-0.0002	0.003	0.040	-0.316*	0.063	-0.002
	(0.009)	(0.011)	(0.008)	(0.176)	(0.134)	(0.199)	(0.020)
Full ACA (with Medicaid Expansion) in 2015	-0.006	0.004	0.019*	0.058	0.090	0.252	-0.019
	(0.009)	(0.014)	(0.009)	(0.175)	(0.150)	(0.168)	(0.019)

See notes from Table 2.

Table 7 – Income Below Median Subsample
(Pre-Treatment Uninsured Rate = 0.316)

	Insurance Coverage	Primary Care Doctor	Cost Barrier	Checkup	BMI	Smoker	Drinks per Month
ACA w/o Medicaid	0.052**	0.041**	-0.016	0.046*	-0.006	-0.005	1.728*
	(0.017)	(0.013)	(0.009)	(0.018)	(0.153)	(0.012)	(0.693)
Medicaid Expansion	0.067**	-0.002	-0.044*	-0.010	-0.091	0.019	-1.399*
	(0.026)	(0.021)	(0.017)	(0.023)	(0.209)	(0.014)	(0.643)
Full ACA (w/ Medicaid)	0.119***	0.038*	-0.060**	0.035	-0.098	0.013	0.330
	(0.019)	(0.017)	(0.019)	(0.018)	(0.165)	(0.010)	(0.816)
Pre-Treatment Mean and Standard Deviation	0.674	0.664	0.289	0.581	28.344	0.276	12.508
	(0.469)	(0.472)	(0.453)	(0.493)	(6.766)	(0.447)	(37.676)
Sample Size	672,937	672,627	548,521	549,596	638,395	660,975	640,349

	Good or Better Health	Very Good or Better Health	Excellent Health	Days Not in Good Physical Health	Days Not in Good Mental Health	Days with Health-Related Limitations	Health Index
ACA w/o Medicaid	-0.004	0.012	0.012**	-0.316	-0.300	-0.388	0.026
	(0.008)	(0.011)	(0.004)	(0.159)	(0.243)	(0.247)	(0.026)
Medicaid Expansion	0.005	-0.002	0.004	0.187	-0.233	0.504	-0.014
	(0.012)	(0.015)	(0.012)	(0.245)	(0.300)	(0.360)	(0.037)
Full ACA (w/ Medicaid)	0.001	0.009	0.016	-0.129	-0.533*	0.116	0.012
	(0.012)	(0.016)	(0.012)	(0.232)	(0.233)	(0.282)	(0.029)
Pre-Treatment Mean and Standard Deviation	0.768	0.426	0.155	4.798	5.276	3.482	-0.249
	(0.422)	(0.495)	(0.362)	(9.052)	(9.262)	(7.969)	(1.077)
Sample Size	672,765	672,765	672,765	663,572	664,825	668,102	674,849

See notes from Table 2.

Table 8 – Income Above Median Subsample
(Pre-Treatment Uninsured Rate = 0.062)

	Insurance Coverage	Primary Care Doctor	Cost Barrier	Checkup	BMI	Smoker	Drinks per Month
ACA w/o Medicaid	0.026***	0.010	-0.003	-0.006	-0.019	0.005	-0.335
	(0.006)	(0.007)	(0.005)	(0.012)	(0.061)	(0.005)	(0.340)
Medicaid Expansion	-0.007	-0.006	-0.004	0.010	0.084	0.015**	0.863
	(0.006)	(0.008)	(0.008)	(0.017)	(0.101)	(0.005)	(0.452)
Full ACA (w/ Medicaid)	0.020***	0.005	-0.007	0.004	0.065	0.020**	0.528
	(0.006)	(0.006)	(0.008)	(0.012)	(0.110)	(0.007)	(0.509)
Pre-Treatment Mean and Standard Deviation	0.933	0.837	0.070	0.684	27.289	0.141	16.474
	(0.249)	(0.369)	(0.255)	(0.465)	(5.580)	(0.348)	(33.297)
Sample Size	649,433	648,940	522,717	522,941	625,848	639,844	627,768

	Good or Better Health	Very Good or Better Health	Excellent Health	Days Not in Good Physical Health	Days Not in Good Mental Health	Days with Health-Related Limitations	Health Index
ACA w/o Medicaid	-0.006	0.002	0.006	-0.064	0.095	-0.017	-0.010
	(0.004)	(0.006)	(0.008)	(0.071)	(0.093)	(0.057)	(0.011)
Medicaid Expansion	0.003	-0.009	0.004	0.048	0.112	0.046	-0.022
	(0.005)	(0.008)	(0.009)	(0.111)	(0.137)	(0.084)	(0.013)
Full ACA (w/ Medicaid)	-0.003	-0.007	0.010	-0.017	0.207	0.029	-0.032*
	(0.004)	(0.008)	(0.009)	(0.111)	(0.115)	(0.085)	(0.013)
Pre-Treatment Mean and Standard Deviation	0.931	0.675	0.266	2.214	2.651	1.283	0.234
	(0.254)	(0.468)	(0.442)	(6.000)	(6.330)	(4.605)	(0.778)
Sample Size	649,034	649,034	649,034	646,052	643,712	648,169	650,000

See notes from Table 2.

Table 9 – Non-College Graduate Subsample
(Pre-Treatment Uninsured Rate = 0.253)

	Insurance Coverage	Primary Care Doctor	Cost Barrier	Checkup	BMI	Smoker	Drinks per Month
ACA w/o Medicaid	0.059***	0.030*	-0.025*	0.031*	-0.021	-0.003	1.053
	(0.007)	(0.013)	(0.011)	(0.013)	(0.107)	(0.011)	(0.606)
Medicaid Expansion	0.040***	0.001	-0.036*	0.010	0.067	0.013	-0.559
	(0.013)	(0.017)	(0.015)	(0.016)	(0.152)	(0.012)	(0.762)
Full ACA (w/ Medicaid)	0.100***	0.032*	-0.062***	0.040***	0.046	0.010	0.494
	(0.014)	(0.013)	(0.015)	(0.011)	(0.120)	(0.010)	(0.803)
Pre-Treatment Mean and Standard Deviation	0.736	0.708	0.230	0.610	28.332	0.266	14.397
	(0.441)	(0.455)	(0.421)	(0.488)	(6.516)	(0.442)	(38.966)
Sample Size	805,370	804,971	654,250	655,238	767,571	791,481	767,463

	Good or Better Health	Very Good or Better Health	Excellent Health	Days Not in Good Physical Health	Days Not in Good Mental Health	Days with Health-Related Limitations	Health Index
ACA w/o Medicaid	-0.010	0.014	0.018***	-0.231	-0.060	-0.154	0.007
	(0.006)	(0.007)	(0.005)	(0.145)	(0.204)	(0.192)	(0.023)
Medicaid Expansion	0.010	-0.011	-0.008	0.127	-0.176	0.299	-0.017
	(0.009)	(0.012)	(0.007)	(0.156)	(0.261)	(0.260)	(0.028)
Full ACA (w/ Medicaid)	-0.000	0.003	0.010	-0.104	-0.236	0.146	-0.010
	(0.009)	(0.014)	(0.008)	(0.161)	(0.175)	(0.239)	(0.021)
Pre-Treatment Mean and Standard Deviation	0.802	0.393	0.168	4.254	4.682	2.967	-0.176
	(0.398)	(0.488)	(0.373)	(8.592)	(8.787)	(7.396)	(1.029)
Sample Size	805,178	805,178	805,178	795,368	796,668	800,482	807,390

See notes from Table 2.

Table 10 – College Graduate Subsample
(Pre-Treatment Uninsured Rate = 0.075)

	Insurance Coverage	Primary Care Doctor	Cost Barrier	Checkup	BMI	Smoker	Drinks per Month
ACA w/o Medicaid	0.021***	0.017**	-0.010*	0.007	-0.013	0.007	-0.157
	(0.003)	(0.006)	(0.005)	(0.008)	(0.100)	(0.005)	(0.438)
Medicaid Expansion	0.005	-0.007	-0.006	0.015	-0.181	0.002	0.870*
	(0.003)	(0.007)	(0.007)	(0.016)	(0.116)	(0.005)	(0.380)
Full ACA (w/ Medicaid)	0.027***	0.011	-0.016*	0.022	-0.194	0.008	0.713
	(0.004)	(0.006)	(0.007)	(0.014)	(0.144)	(0.004)	(0.409)
Pre-Treatment Mean and Standard Deviation	0.922	0.791	0.096	0.669	26.709	0.087	14.005
	(0.268)	(0.406)	(0.294)	(0.471)	(5.492)	(0.283)	(26.468)
Sample Size	517,000	516,596	416,988	417,299	496,672	509,338	500,654

	Good or Better Health	Very Good or Better Health	Excellent Health	Days Not in Good Physical Health	Days Not in Good Mental Health	Days with Health-Related Limitations	Health Index
ACA w/o Medicaid	0.003	-0.002	-0.013	0.067	-0.152	-0.099	-0.002
	(0.003)	(0.006)	(0.010)	(0.083)	(0.094)	(0.054)	(0.100)
Medicaid Expansion	-0.002	-0.008	0.013	0.013	0.196	0.201*	-0.013
	(0.004)	(0.008)	(0.011)	(0.139)	(0.142)	(0.093)	(0.016)
Full ACA (w/ Medicaid)	0.001	-0.010	-0.0003	0.080	0.044	0.102	-0.015
	(0.003)	(0.009)	(0.008)	(0.145)	(0.161)	(0.092)	(0.017)
Pre-Treatment Mean and Standard Deviation	0.938	0.709	0.296	2.118	2.660	1.912	0.325
	(0.242)	(0.454)	(0.457)	(5.736)	(6.233)	(5.776)	(0.754)
Sample Size	516,621	516,621	516,621	514,256	513,953	515,789	517,459

See notes from Table 2.

Table 11 – Age Below Median Subsample
(Pre-Treatment Uninsured Rate = 0.233)

	Insurance Coverage	Primary Care Doctor	Cost Barrier	Checkup	BMI	Smoker	Drinks per Month
ACA w/o Medicaid	0.056***	0.022*	-0.033**	0.021	-0.032	-0.001	0.882
	(0.006)	(0.010)	(0.011)	(0.011)	(0.098)	(0.012)	(0.591)
Medicaid Expansion	0.029*	0.005	-0.022	0.019	0.009	0.018	-0.326
	(0.012)	(0.014)	(0.015)	(0.015)	(0.149)	(0.013)	(0.656)
Full ACA (w/ Medicaid)	0.085***	0.027*	-0.055***	0.040***	-0.024	0.017	0.556
	(0.013)	(0.012)	(0.014)	(0.011)	(0.129)	(0.009)	(0.747)
Pre-Treatment Mean	0.757	0.675	0.208	0.577	27.449	0.225	15.194
and Standard Deviation	(0.429)	(0.468)	(0.406)	(0.494)	(6.273)	(0.417)	(37.965)
Sample Size	652,429	652,082	531,312	531,987	618,804	640,852	622,490

	Good or Better Health	Very Good or Better Health	Excellent Health	Days Not in Good Physical Health	Days Not in Good Mental Health	Days with Health-Related Limitations	Health Index
ACA w/o Medicaid	-0.003	0.003	0.004	-0.285	-0.075	-0.240	0.014
	(0.007)	(0.006)	(0.007)	(0.216)	(0.225)	(0.200)	(0.033)
Medicaid Expansion	-0.001	-0.010	-0.004	0.283	-0.113	0.333	-0.037
	(0.009)	(0.010)	(0.011)	(0.184)	(0.280)	(0.236)	(0.033)
Full ACA (w/ Medicaid)	-0.004	-0.007	0.001	-0.002	-0.188	0.093	-0.023
	(0.008)	(0.010)	(0.009)	(0.149)	(0.189)	(0.195)	(0.019)
Pre-Treatment Mean	0.874	0.571	0.226	2.943	4.130	2.061	0.012
and Standard Deviation	(0.332)	(0.495)	(0.418)	(6.921)	(8.042)	(5.958)	(0.929)
Sample Size	652,707	652,707	652,707	647,944	647,941	650,873	670,911

See notes from Table 2.

Table 12 – Age Above Median Subsample
(Pre-Treatment Uninsured Rate = 0.149)

	Insurance Coverage	Primary Care Doctor	Cost Barrier	Checkup	BMI	Smoker	Drinks per Month
ACA w/o Medicaid	0.037***	0.036*	-0.002	0.037*	-0.098	-0.004	0.396
	(0.010)	(0.015)	(0.008)	(0.015)	(0.122)	(0.006)	(0.602)
Medicaid Expansion	0.036**	0.002	-0.036**	0.004	0.120	-0.003	0.585
	(0.011)	(0.015)	(0.012)	(0.019)	(0.182)	(0.006)	(0.767)
Full ACA (w/ Medicaid)	0.072***	0.038**	-0.038***	0.042***	0.022	-0.007	0.981
	(0.008)	(0.012)	(0.010)	(0.012)	(0.135)	(0.006)	(0.724)
Pre-Treatment Mean and Standard Deviation	0.847	0.861	0.162	0.717	28.635	0.200	12.640
	(0.360)	(0.346)	(0.368)	(0.450)	(6.235)	(0.400)	(31.553)
Sample Size	669,941	669,485	539,926	540,550	645,439	659,967	645,627

	Good or Better Health	Very Good or Better Health	Excellent Health	Days Not in Good Physical Health	Days Not in Good Mental Health	Days with Health-Related Limitations	Health Index
ACA w/o Medicaid	-0.009	0.016*	0.012**	-0.045	-0.117	-0.098	0.004
	(0.005)	(0.006)	(0.004)	(0.157)	(0.127)	(0.101)	(0.011)
Medicaid Expansion	0.011	-0.019*	-0.008	-0.295	-0.234	-0.194	0.028*
	(0.008)	(0.007)	(0.007)	(0.179)	(0.137)	(0.118)	(0.013)
Full ACA (w/ Medicaid)	0.002	-0.003	0.004	-0.340*	-0.351*	-0.292*	0.032*
	(0.008)	(0.008)	(0.008)	(0.147)	(0.142)	(0.123)	(0.013)
Pre-Treatment Mean and Standard Deviation	0.779	0.472	0.163	4.956	4.077	3.333	-0.124
	(0.415)	(0.499)	(0.369)	(9.423)	(8.479)	(8.013)	(1.080)
Sample Size	669,092	669,092	669,092	661,680	662,700	665,398	653,938

See notes from Table 2.

Appendix Table A1 – Summary Statistics for Control Variables By State Medicaid Expansion Status and Pre-Treatment Uninsured Rate

	Full Sample	Medicaid Expansion; ≥ Median Baseline Uninsured	Medicaid Expansion; < Median Baseline Uninsured	Non-Expansion; ≥ Median Baseline Uninsured	Non-Expansion; < Median Baseline Uninsured
Age 25-29	0.105	0.107	0.104	0.107	0.105
	(0.306)	(0.308)	(0.303)	(0.300)	(0.307)
Age 30-34	0.118	0.121	0.117	0.120	0.118
	(0.323)	(0.325)	(0.320)	(0.317)	(0.322)
Age 35-39	0.107	0.106	0.102	0.103	0.099
	(0.302)	(0.306)	(0.299)	(0.296)	(0.302)
Age 40-44	0.119	0.114	0.118	0.124	0.116
	(0.323)	(0.320)	(0.320)	(0.318)	(0.320)
Age 45-49	0.108	0.103	0.108	0.108	0.106
	(0.309)	(0.304)	(0.305)	(0.306)	(0.303)
Age 50-54	0.130	0.127	0.131	0.129	0.131
	(0.336)	(0.332)	(0.333)	(0.337)	(0.329)
Age 55-59	0.104	0.105	0.106	0.098	0.104
	(0.304)	(0.306)	(0.302)	(0.308)	(0.297)
Age 60-64	0.096	0.103	0.096	0.095	0.098
	(0.294)	(0.299)	(0.293)	(0.295)	(0.292)
Female	0.497	0.491	0.497	0.499	0.498
	(0.499)	(0.499)	(0.499)	(0.499)	(0.499)
Black	0.122	0.066	0.096	0.188	0.134
	(0.327)	(0.235)	(0.332)	(0.312)	(0.341)
Hispanic	0.166	0.198	0.172	0.221	0.059
	(0.372)	(0.385)	(0.370)	(0.300)	(0.424)
White	0.633	0.651	0.636	0.542	0.750
	(0.482)	(0.463)	(0.482)	(451)	(0.497)
Married	0.524	0.521	0.518	0.20	0.553
	(0.499)	(0.499)	(0.499)	(0.499)	(0.499)
High school degree	0.267	0.278	0.259	0.274	0.289
	(0.443)	(0.451)	(0.446)	(0.447)	(0.443)
Some College	0.320	0.347	0.315	0.319	0.331
	(0.466)	(0.473)	(0.465)	(0.463)	(0.466)
College graduate	0.281	0.236	0.298	0.254	0.272
	(0.449)	(0.422)	(0.445)	(0.459)	(0.432)

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Appendix Table A1 – Continued

	Full Sample	Medicaid Expansion; ≥ Median Baseline Uninsured	Medicaid Expansion; < Median Baseline Uninsured	Non-Expansion; ≥ Median Baseline Uninsured	Non-Expansion; < Median Baseline Uninsured
No child	0.544	0.553	0.544	0.533	0.555
	(0.498)	(0.497)	(0.498)	(0.497)	(0.498)
One child	0.181	0.175	0.182	0.185	0.177
	(0.385)	(0.382)	(0.387)	(0.384)	(0.390)
Two children	0.166	0.166	0.168	0.167	0.160
	(0.372)	(0.366)	(0.371)	(0.370)	(0.372)
Three children	0.072	0.070	0.071	0.075	0.069
	(0.257)	(0.257)	(0.258)	(0.252)	(0.262)
Four children	0.025	0.025	0.024	0.028	0.026
	(0.156)	(0.158)	(0.155)	(0.148)	(0.160)
Unemployed	0.091	0.102	0.093	0.092	0.078
	(0.280)	(0.290)	(0.283)	(0.270)	(0.289)
Unemployment rate	8.053	8.716	8.421	7.880	6.829
	(1.628)	(1.362)	(1.745)	(1.525)	(1.499)
Student	0.051	0.051	0.055	0.048	0.045
	(0.221)	(0.213)	(0.239)	(0.240)	(0.241)
Income 10k to less than 15k	0.058	0.067	0.056	0.067	0.055
	(0.235)	(0.231)	(0.233)	(0.209)	(0.253)
Income 15k to less than 20k	0.080	0.095	0.072	0.098	0.081
	(0.271)	(0.261)	(0.273)	(0.255)	(0.285)
Income 20k to less than 25k	0.089	0.110	0.081	0.103	0.098
	(0.286)	(0.274)	(0.287)	(0.276)	(0.294)
Income 25k to less than 35k	0.103	0.120	0.097	0.112	0.109
	(0.304)	(0.294)	(0.304)	(0.294)	(0.310)
Income 35k to less than 50k	0.134	0.141	0.129	0.136	0.148
	(0.340)	(0.329)	(0.341)	(0.341)	(0.337)
Income 50k to less than 75k	0.154	0.151	0.156	0.139	0.165
	(0.360)	(0.351)	(0.359)	(0.369)	(0.346)
Income more than 75k	0.309	0.242	0.337	0.268	0.281
	(0.460)	(0.476)	(0.461)	(0.476)	(0.448)

Note: Standard deviations in parentheses.

Appendix Table A2 – Implied Effect of ACA on Probability of Any Insurance at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	0.048***	0.048***	0.052***	0.053***	0.062***	0.052***	0.053***	0.048***
	(0.007)	(0.008)	(0.006)	(0.006)	(0.006)	(0.006)	(0.006)	(0.006)
Medicaid Expansion	0.031**	0.031**	0.028**	0.031***	0.017	0.060***	0.058***	0.066***
	(0.010)	(0.011)	(0.011)	(0.009)	(0.015)	(0.010)	(0.009)	(0.010)
Full ACA (with Medicaid Expansion)	0.079***	0.080***	0.080***	0.083***	0.078***	0.112***	0.111***	0.114***
	(0.009)	(0.010)	(0.010)	(0.010)	(0.014)	(0.010)	(0.010)	(0.010)
Sample Size	1,333,480	1,328,980	1,322,370	1,322,370	852,953	1,322,370	1,322,370	1,322,370

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	0.056***	0.039***	0.056***	0.052***	0.048***	0.049***	0.052***
	(0.008)	(0.005)	(0.006)	(0.007)	(0.005)	(0.005)	(0.006)
Medicaid Expansion	0.034***	0.064***	0.029***	0.034*	0.027*	0.024*	0.033
	(0.009)	(0.013)	(0.008)	(0.015)	(0.010)	(0.009)	(0.009)
Full ACA (with Medicaid Expansion)	0.089***	0.103***	0.086***	0.085***	0.075***	0.073***	0.084***
	(0.009)	(0.011)	(0.008)	(0.015)	(0.011)	(0.010)	(0.010)
Sample Size	1,322,370	1,322,370	1,227,845	746,174	1,129,957	1,207,428	1,274,613

Notes: Standard errors, heteroscedasticity-robust and clustered by state, are in parentheses. *** indicates statistically significant at 0.1% level; ** 1% level; * 5% level. Sampling weights are used.

Appendix Table A3 – Implied Effect of ACA on Probability of having a Primary Care Doctor at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	0.028*	0.028*	0.028**	0.030**	0.012	0.036**	0.037**	0.033**
	(0.011)	(0.011)	(0.010)	(0.010)	(0.009)	(0.012)	(0.012)	(0.012)
Medicaid Expansion	0.003	0.003	-0.001	0.001	0.019	0.006	0.005	0.010
	(0.014)	(0.015)	(0.013)	(0.013)	(0.018)	(0.018)	(0.017)	(0.017)
Full ACA (with Medicaid Expansion)	0.031**	0.031**	0.027*	0.031**	0.031**	0.042**	0.042**	0.043**
	(0.011)	(0.011)	(0.010)	(0.011)	(0.015)	(0.015)	(0.015)	(0.016)
Sample Size	1,332,661	1,328,160	1,321,567	1,321,567	852,446	1,321,567	1,321,567	1,321,567

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	0.035***	0.032**	0.035**	0.032**	0.029*	0.030**	0.029**
	(0.010)	(0.010)	(0.011)	(0.012)	(0.010)	(0.010)	(0.010)
Medicaid Expansion	0.010	0.009	-0.006	0.001	0.008	-0.001	0.003
	(0.015)	(0.022)	(0.014)	(0.015)	(0.015)	(0.013)	(0.013)
Full ACA (with Medicaid Expansion)	0.044**	0.041**	0.029	0.033	0.037*	0.030*	0.031**
	(0.014)	(0.018)	(0.011)	(0.017)	(0.012)	(0.011)	(0.011)
Sample Size	1,321,567	1,321,567	1,226,827	745,735	1,129,281	1,206,714	1,273,853

See notes for Appendix Table A2.

Appendix Table A4– Implied Effect of ACA on Probability of having a Cost Barrier at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	-0.021*	-0.021*	-0.025***	-0.026***	-0.010	-0.031***	0.031***	-0.027***
	(0.009)	(0.008)	(0.006)	(0.006)	(0.011)	(0.008)	(0.008)	(0.007)
Medicaid Expansion	-0.027**	-0.028**	-0.024**	-0.025**	-0.050**	-0.031**	-0.029*	-0.035*
	(0.009)	(0.007)	(0.008)	(0.009)	(0.015)	(0.008)	(0.011)	(0.009)
Full ACA (with Medicaid Expansion)	-0.048***	-0.049***	-0.049***	-0.051***	-0.061***	-0.061***	-0.060***	-0.062***
	(0.010)	(0.010)	(0.010)	(0.011)	(0.011)	(0.012)	(0.012)	(0.012)
Sample Size	1,079,266	1,075,533	1,071,238	1,071,238	715,800	1,071,238	1,071,238	1,071,238

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	-0.030***	-0.018***	-0.023***	-0.020**	-0.024***	-0.025***	-0.026***
	(0.005)	(0.005)	(0.006)	(0.006)	(0.006)	(0.006)	(0.006)
Medicaid Expansion	-0.023	-0.045**	-0.033**	-0.045*	-0.019*	-0.022*	-0.024**
	(0.011)	(0.012)	(0.010)	(0.017)	(0.008)	(0.010)	(0.009)
Full ACA (with Medicaid Expansion)	-0.053***	-0.063***	-0.055***	-0.065**	-0.043***	-0.048***	-0.050***
	(0.011)	(0.011)	(0.010)	(0.020)	(0.010)	(0.012)	(0.011)
Sample Size	1,071,238	1,071,238	994,606	605,156	916,029	976,422	1,031,483

See notes for Appendix Table A2.

Appendix Table A5 – Implied Effect of ACA on Probability of Having a Checkup at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	0.021	0.021	0.024*	0.023*	0.047***	0.011	0.012	0.007
	(0.013)	(0.012)	(0.011)	(0.011)	(0.010)	(0.012)	(0.012)	(0.012)
Medicaid Expansion	0.012	0.013	0.013	0.012	-0.008	0.039*	0.035*	0.042**
	(0.014)	(0.014)	(0.013)	(0.013)	(0.017)	(0.015)	(0.015)	(0.014)
Full ACA (with Medicaid Expansion)	0.033***	0.034***	0.037***	0.035***	0.039*	0.050***	0.047***	0.049***
	(0.008)	(0.008)	(0.009)	(0.009)	(0.015)	(0.011)	(0.012)	(0.012)
Sample Size	1,080,580	1,076,836	1,072,537	1,072,537	716,568	1,072,537	1,072,537	1,072,537

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	0.021	0.014	0.023*	0.013**	0.021*	0.023*	0.024*
	(0.011)	(0.007)	(0.010)	(0.010)	(0.010)	(0.011)	(0.010)
Medicaid Expansion	0.016	0.040*	0.013	0.018	0.012	0.008	0.016
	(0.015)	(0.017)	(0.015)	(0.017)	(0.015)	(0.014)	(0.014)
Full ACA (with Medicaid Expansion)	0.037***	0.054***	0.037***	0.031	0.033**	0.032**	0.040***
	(0.010)	(0.010)	(0.011)	(0.016)	(0.011)	(0.010)	(0.009)
Sample Size	1,072,537	1,072,537	995,814	605,935	917,151	977,617	1,032,729

See notes for Appendix Table A2.

Appendix Table A6 – Implied Effect of ACA on BMI at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	-0.004	-0.023	-0.009	-0.018	0.105	-0.105	0.105	-0.112
	(0.086)	(0.087)	(0.082)	(0.082)	(0.091)	(0.101)	(0.091)	(0.104)
Medicaid Expansion	-0.072	-0.032	-0.006	-0.008	-0.132	0.059	-0.132	0.054
	(0.116)	(0.111)	(0.110)	(0.107)	(0.150)	(0.113)	(0.150)	(0.111)
Full ACA (with Medicaid Expansion)	-0.075	-0.055	-0.002	-0.026	-0.027	-0.046	-0.027	-0.057
	(0.108)	(0.105)	(0.099)	(0.094)	(0.112)	(0.108)	(0.112)	(0.113)
Sample Size	1,269,733	1,267,091	1,264,243	1,264,243	816,228	1,264,243	1,264,243	1,264,243

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	-0.046	-0.045	-0.101	-0.043	-0.059	-0.047	-0.052
	(0.085)	(0.101)	(0.099)	(0.099)	(0.078)	(0.079)	(0.078)
Medicaid Expansion	-0.029	0.164	0.025	-0.117	0.009	0.005	0.008
	(0.110)	(0.151)	(0.146)	(0.128)	(0.130)	(0.106)	(0.111)
Full ACA (with Medicaid Expansion)	-0.075	0.118	-0.076	-0.160	-0.050	-0.042	-0.044
	(0.103)	(0.097)	(0.119)	(0.154)	(0.121)	(0.098)	(0.094)
Sample Size	1,264,243	1,264,243	1,174,488	714,021	1,079,665	1,154,853	1,218,323

See notes for Appendix Table A2.

Appendix Table A7 – Implied Effect of ACA on Probability of being as Smoker at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	0.002	0.001	-0.002	-0.000	-0.009	0.002	0.002	0.003
	(0.010)	(0.010)	(0.009)	(0.009)	(0.006)	(0.012)	(0.012)	(0.012)
Medicaid Expansion	0.007	0.010	0.010	0.011	0.019*	0.011	0.010	0.010
	(0.011)	(0.010)	(0.009)	(0.009)	(0.009)	(0.012)	(0.012)	(0.011)
Full ACA (with Medicaid Expansion)	0.010	0.011	0.008	0.011	0.010	0.013	0.013	0.014
	(0.009)	(0.008)	(0.008)	(0.009)	(0.007)	(0.009)	(0.010)	(0.010)
Sample Size	1,307,003	1,304,045	1,300,819	1,300,819	841,849	1,300,819	1,300,819	1,300,819

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	0.000	0.000	-0.000	0.001	0.001	0.001	0.001
	(0.010)	(0.010)	(0.010)	(0.010)	(0.010)	(0.010)	(0.009)
Medicaid Expansion	0.013	0.019	0.006	0.017	0.011	0.006	0.011
	(0.010)	(0.013)	(0.009)	(0.010)	(0.009)	(0.009)	(0.009)
Full ACA (with Medicaid Expansion)	0.014	0.019*	0.006	0.018	0.011	0.008	0.013
	(0.008)	(0.008)	(0.006)	(0.009)	(0.009)	(0.008)	(0.007)
Sample Size	1,300,819	1,300,819	1,207,869	736,307	1,110,938	1,188,282	1,253,655

See notes for Appendix Table A2.

Appendix Table A8 – Implied Effect of ACA on Number of Drinks per Month at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	0.720	0.670	0.619	0.667	-0.464	0.521	0.542	0.425
	(0.456)	(0.445)	(0.423)	(0.430)	(0.779)	(0.508)	(0.509)	(0.509)
Medicaid Expansion	0.029	0.061	-0.167	-0.123	1.940	-0.983	-0.162	-0.013
	(0.509)	(0.504)	(0.481)	(0.486)	(1.063)	(0.476)	(0.528)	(0.479)
Full ACA (with Medicaid Expansion)	0.749	0.732	0.452	0.544	1.476	0.422	0.379	0.413
	(0.496)	(0.505)	(0.545)	(0.571)	(0.752)	(0.648)	(0.677)	(0.674)
Sample Size	1,273,660	1,270,939	1,268,117	1,268,117	821,086	1,268,117	1,268,117	1,268,117

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	0.520	0.115	0.485	0.743	0.795	0.707	0.774
	(0.473)	(0.468)	(0.728)	(0.479)	(0.478)	(0.429)	(0.444)
Medicaid Expansion	-0.278	0.612	-0.022	-0.731	-0.187	0.132	-0.245
	(0.546)	(0.643)	(0.787)	(1.021)	(0.587)	(0.529)	(0.489)
Full ACA (with Medicaid Expansion)	0.242	0.726	0.463	0.012	0.608	0.839	0.529
	(0.634)	(0.557)	(0.651)	(0.982)	(0.777)	(0.623)	(0.613)
Sample Size	1,268,117	1,268,117	1,178,584	718,539	1,082,450	1,158,646	1,221,714

See notes for Appendix Table A2.

Appendix Table A9 – Implied Effect of ACA on Probability of Having Good or Better Health at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	-0.012*	-0.010	-0.009	-0.009	-0.015	-0.009*	-0.009*	-0.007
	(0.005)	(0.005)	(0.005)	(0.005)	(0.008)	(0.004)	(0.004)	(0.004)
Medicaid Expansion	0.007	0.005	0.007	0.006	0.010	0.013	0.014	0.012
	(0.007)	(0.007)	(0.006)	(0.006)	(0.012)	(0.007)	(0.007)	(0.006)
Full ACA (with Medicaid Expansion)	-0.005	-0.005	-0.004	-0.003	-0.005	0.004	0.005	0.005
	(0.007)	(0.007)	(0.006)	(0.006)	(0.008)	(0.007)	(0.007)	(0.007)
Sample Size	1,332,950	1,328,431	1,321,799	1,321,799	852,112	1,321,799	1,321,799	1,321,799

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	-0.005	-0.004	-0.008	-0.010	-0.007	-0.009*	-0.008
	(0.004)	(0.004)	(0.004)	(0.005)	(0.005)	(0.004)	(0.005)
Medicaid Expansion	0.010	0.010	0.005	0.008	0.006	0.002	0.004
	(0.006)	(0.009)	(0.007)	(0.007)	(0.007)	(0.006)	(0.006)
Full ACA (with Medicaid Expansion)	0.004	0.006	-0.003	-0.002	-0.010	-0.007	-0.004
	(0.006)	(0.008)	(0.007)	(0.008)	(0.008)	(0.006)	(0.006)
Sample Size	1,321,799	1,321,799	1,226,723	745,721	1,129,381	1,206,947	1,274,025

See notes for Appendix Table A2.

Appendix Table A10 – Implied Effect of ACA on Probability of Having Very Good or Better Health at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	-0.003	-0.006	0.005	0.006	-0.001	0.007	0.006	0.008
	(0.007)	(0.006)	(0.005)	(0.005)	(0.009)	(0.006)	(0.006)	(0.006)
Medicaid Expansion	-0.005	-0.007	-0.008	-0.007	-0.001	-0.006	-0.002	-0.006
	(0.009)	(0.008)	(0.008)	(0.008)	(0.013)	(0.011)	(0.011)	(0.011)
Full ACA (with Medicaid Expansion)	-0.008	-0.008	-0.002	-0.002	-0.001	0.001	0.004	0.002
	(0.010)	(0.009)	(0.010)	(0.010)	(0.012)	(0.011)	(0.011)	(0.011)
Sample Size	1,332,950	1,328,431	1,321,799	1,321,799	852,112	1,321,799	1,321,799	1,321,799

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	0.008	0.008	0.010	0.003	0.006	0.006	0.005
	(0.005)	(0.005)	(0.007)	(0.006)	(0.006)	(0.006)	(0.006)
Medicaid Expansion	-0.003	-0.006	-0.009	-0.011	-0.005	-0.005	-0.009
	(0.009)	(0.010)	(0.009)	(0.012)	(0.010)	(0.009)	(0.008)
Full ACA (with Medicaid Expansion)	0.005	0.001	0.000	-0.008	0.001	0.002	-0.004
	(0.010)	(0.009)	(0.011	(0.015)	(0.012)	(0.011)	(0.010)
Sample Size	1,321,799	1,321,799	1,226,723	745,721	1,129,381	1,206,947	1,274,025

See notes for Appendix Table A2.

Appendix Table A11 – Implied Effect of ACA on Probability of Having Excellent Health at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	0.004	0.005	0.008	0.008	0.009	0.006	0.005	0.006
	(0.006)	(0.006)	(0.005)	(0.005)	(0.007)	(0.007)	(0.008)	(0.008)
Medicaid Expansion	-0.001	-0.004	-0.003	-0.003	-0.017	0.004	0.008	0.005
	(0.007)	(0.007)	(0.007)	(0.007)	(0.011)	(0.010)	(0.010)	(0.009)
Full ACA (with Medicaid Expansion)	0.002	0.002	0.004	0.005	-0.008	0.010	0.013	0.011
	(0.007)	(0.007)	(0.006)	(0.006)	(0.009)	(0.008)	(0.009)	(0.008)
Sample Size	1,332,950	1,328,431	1,321,799	1,321,799	852,112	1,321,799	1,321,799	1,321,799

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	0.009	0.013*	0.007	0.010	0.008	0.007	0.008
	(0.005)	(0.006)	(0.004)	(0.005)	(0.006)	(0.005)	(0.005)
Medicaid Expansion	-0.002	-0.006	0.001	0.007	-0.007	0.003	-0.004
	(0.007)	(0.011)	(0.006)	(0.008)	(0.007)	(0.007)	(0.007)
Full ACA (with Medicaid Expansion)	0.007	0.007	0.008	0.017	0.001	0.010	0.004
	(0.005)	(0.008)	(0.005)	(0.007)	(0.006)	(0.006)	(0.006)
Sample Size	1,321,799	1,321,799	1,226,723	745,721	1,129,381	1,206,947	1,274,025

See notes for Appendix Table A2.

Appendix Table A12 – Implied Effect of ACA on the Number of Days Not in Good Physical Health at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	-0.012	-0.052	-0.131	-0.118	-0.155	-0.173	-0.173	-0.216
	(0.135)	(0.127)	(0.113)	(0.113)	(0.110)	(0.135)	(0.135)	(0.126)
Medicaid Expansion	0.045	0.079	0.057	0.068	0.229	0.053	0.053	0.061
	(0.118)	(0.116)	(0.107)	(0.109)	(0.260)	(0.150)	(0.152)	(0.136)
Full ACA (with Medicaid Expansion)	0.033	0.027	-0.075	-0.050	0.074	-0.120	-0.120	-0.156
	(0.144)	(0.142)	(0.132)	(0.126)	(0.247)	(0.144)	(0.145)	(0.146)
Sample Size	1,320,243	1,316,045	1,309,624	1,309,624	844,163	1,309,624	1,309,624	1,309,624

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	-0.142	-0.241	-0.111	-0.074	-0.171	-0.118	-0.138
	(0.113)	(0.125)	(0.120)	(0.137)	(0.121)	(0.118)	(0.116)
Medicaid Expansion	0.045	0.114	0.164	0.030	0.127	0.036	0.009
	(0.116)	(0.177)	(0.130)	(0.224)	(0.121)	(0.097)	(0.114)
Full ACA (with Medicaid Expansion)	-0.097	-0.127	0.053	-0.044	-0.044	-0.082	-0.046
	(0.130)	(0.143)	(0.144)	(0.250)	(0.146)	(0.128)	(0.130)
Sample Size	1,309,624	1,309,624	1,215,345	738,477	1,118,979	1,195,925	1,262,176

See notes for Appendix Table A2.

Appendix Table A13 – Implied Effect of ACA on the Number of Days Not in Good Mental Health at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	-0.008	-0.026	-0.076	-0.008	0.030	-0.094	-0.102	-0.097
	(0.016)	(0.146)	(0.156)	(0.155)	(0.122)	(0.213)	(0.206)	(0.212)
Medicaid Expansion	-0.115	-0.085	-0.057	-0.068	-0.149	-0.250	-0.224	-0.256
	(0.164)	(0.162)	(0.176)	(0.178)	(0.282)	(0.226)	(0.217)	(0.212)
Full ACA (with Medicaid Expansion)	-0.123	-0.111	-0.133	-0.149	-0.120	-0.344*	-0.326	-0.353*
	(0.120)	(0.124)	(0.120)	(0.126)	(0.259)	(0.162)	(0.169)	(0.169)
Sample Size	1,321,277	1,317,107	1,310,641	1,310,641	844,984	1,310,641	1,310,641	1,310,641

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	-0.157	-0.284	-0.106	-0.072	-0.050	-0.078	-0.103
	(0.180)	(0.193)	(0.184)	(0.164)	(0.165)	(0.155)	(0.152)
Medicaid Expansion	-0.092	-0.066	0.050	-0.063	0.028	-0.043	-0.067
	(0.183)	(0.239)	(0.200)	(0.211)	(0.191)	(0.174)	(0.183)
Full ACA (with Medicaid Expansion)	-0.249	-0.350	-0.057	-0.136	-0.022	-0.121	-0.170
	(0.130)	(0.131)	(0.132)	(0.158)	(0.133)	(0.131)	(0.134)
Sample Size	1,310,641	1,310,641	1,216,192	739,295	1,119,831	1,196,872	1,263,185

See notes for Appendix Table A2.

Appendix Table A14 – Implied Effect of ACA on the Number of Days with Health-Related Limitations at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	-0.035	-0.052	-0.129	-0.121	0.073	-0.158	-0.159	-0.179
	(0.132)	(0.127)	(0.143)	(0.141)	(0.101)	(0.195)	(0.192)	(0.193)
Medicaid Expansion	0.176	0.198	0.206	0.226	-0.107	0.116	0.119	0.114
	(0.176)	(0.176)	(0.177)	(0.164)	(0.238)	(0.202)	(0.179)	(0.191)
Full ACA (with Medicaid Expansion)	0.141	0.146	0.076	0.105	-0.035	-0.042	-0.040	-0.065
	(0.182)	(0.189)	(0.179)	(0.154)	(0.213)	(0.200)	(0.192)	(0.206)
Sample Size	1,320,243	1,316,045	1,309,624	1,309,624	844,163	1,309,624	1,309,624	1,309,624

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Full Early Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	-0.165	-0.138	-0.059	0.027	-0.168	-0.069	-0.157
	(0.165)	(0.207)	(0.142)	(0.186)	(0.143)	(0.148)	(0.140)
Medicaid Expansion	0.229	-0.094	0.274	0.360	0.303	0.273	0.280
	(0.168)	(0.252)	(0.166)	(0.254)	(0.169)	(0.156)	(0.162)
Full ACA (with Medicaid Expansion)	0.064	-0.232	0.121	0.386	0.136	0.204	0.121
	(0.165)	(0.175)	(0.165)	(0.235)	(0.180)	(0.132)	(0.161)
Sample Size	1,309,624	1,309,624	1,215,345	738,477	1,118,979	1,201,881	1,262,176

See notes for Appendix Table A2.

Appendix Table A15 – Implied Effect of ACA the Health Index at Mean Pre-Treatment Uninsured Rate: Robustness Checks

	Demographic Controls Only	Demographic and Family Controls	Demographic and Economic Controls	Demographic and Exchange Controls	Drop Cell Phone Sample	<138% FPL Medicaid, >100% Private	<100% FPL Medicaid, >100% Private	<138% FPL Medicaid, >138% Private
ACA without Medicaid Expansion	-0.015 (0.022)	-0.010 (0.019)	0.001 (0.019)	-0.001 (0.019)	0.017 (0.025)	0.001 (0.026)	0.001 (0.026)	0.004 (0.025)
Medicaid Expansion	-0.004 (0.110)	-0.011 (0.20)	-0.013 (0.021)	-0.014 (0.021)	-0.013 (0.032)	0.007 (0.027)	0.005 (0.027)	0.005 (0.026)
Full ACA (with Medicaid Expansion)	-0.019 (0.020)	-0.021 (0.019)	-0.012 (0.017)	-0.015 (0.016)	0.004 (0.020)	0.007 (0.021)	0.006 (0.022)	0.009 (0.022)
Sample Size	1,320,243	1,316,045	1,309,624	1,309,624	844,163	1,309,624	1,309,624	1,309,624

	Uninsured Rate from 2011-2013	State Baseline 2013 Uninsured Rate	Drop 19-25 Year Olds	Drop All States with Early Expansion	Drop Treated States with Early Expansion	Drop States with Early Full Expansion	Drop Late 2014 and 2015 Expanders
ACA without Medicaid Expansion	0.008 (0.022)	0.017 (0.025)	0.004 (0.023)	-0.008 (0.023)	0.001 (0.021)	-0.005 (0.021)	-0.002 (0.020)
Medicaid Expansion	-0.007 (0.023)	0.014 (0.030)	-0.018 (0.024)	-0.027 (0.028)	-0.018 (0.023)	-0.013 (0.021)	-0.018 (0.021)
Full ACA (with Medicaid Expansion)	0.001 (0.018)	0.004 (0.020)	-0.013 (0.017)	0.035 (0.025)	-0.017 (0.019)	-0.018 (0.017)	-0.017 (0.017)
Sample Size	1,309,624	1,309,624	1,215,345	738,477	1,118,979	1,209,699	1,262,176

See notes for Appendix Table A2.

By Paul D. Jacobs, Michael L. Cohen, and Patricia Keenan

Risk Adjustment, Reinsurance Improved Financial Outcomes For Individual Market Insurers With The Highest Claims

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ABSTRACT The Affordable Care Act (ACA) reformed the individual health insurance market. Because insurers can no longer vary their offers of coverage based on applicants' health status, the ACA established a risk adjustment program to equalize health-related cost differences across plans. The ACA also established a temporary reinsurance program to subsidize high-cost claims. To assess the impact of these programs, we compared revenues to claims costs for insurers in the individual market during the first two years of ACA implementation (2014 and 2015), before and after the inclusion of risk adjustment and reinsurance payments. Before these payments were included, for the 30 percent of insurers with the highest claims costs, claims (not including administrative expenses) exceeded premium revenues by $90–$397 per enrollee per month. The effect was reversed after these payments were included, with revenues exceeding claims costs by $0–$49 per month. The risk adjustment and reinsurance programs were relatively well targeted in the first two years. While there is ongoing discussion regarding the future of the ACA, our findings can shed light on how risk-sharing programs can address risk selection among insurers—a pervasive issue in all health insurance markets.

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To expand access to insurance coverage, the Affordable Care Act (ACA) reformed the health insurance market for individual coverage. The law subsidizes the purchase of plans, prohibits insurers from denying an applicant coverage because of his or her health status, limits how premiums can vary by applicants' characteristics, and requires that insurers cover a minimum set of health benefits. The intended effect of these and other policies is an individual market (which includes the Marketplaces) where people who are sick can obtain the same coverage, for the same premiums, as people who are healthy.[1]

In an environment where insurers can no longer vary coverage or premiums based on health status, the ACA's risk adjustment program is designed to equalize health-related cost differences across plans. In the absence of risk adjustment, there would be stronger incentives for insurers to avoid covering sick individuals and to attract and retain healthy ones.

Risk adjustment is intended to make the costs of enrolling a healthy versus a sick person equivalent for health plans, and to lead to plan premiums that reflect the average health status of the entire population enrolled in a risk pool, instead of a particular plan's enrollees. Health plan premiums would then vary solely based upon such dimensions as level of coverage and network type, as well as cost or efficiency differences across issuers. Additionally, by reducing insurers' incentives to avoid covering high-cost peo-

ple, the risk adjustment program is designed to encourage insurers to focus on improving quality and reducing premiums through increased cost efficiency. Risk adjustment has long been used in other health insurance markets, including the Medicare prescription drug program, with the aim of leveling the playing field for competing insurers.

Under ACA risk adjustment, plans with healthier enrollees owe funds, while plans with sicker enrollees receive funds. To accomplish this, the risk adjustment program first calculates a risk score, which reflects the degree to which a plan's claims costs are expected to be above or below average because of the health status of its enrollees. The program then uses a formula to translate those health status differences into dollar transfer amounts that are "balanced"—meaning that payments to insurers with sicker-than-average enrollees are equal to (and entirely funded by) amounts owed from insurers with healthier-than-average enrollees.[2–4] Because transfers are balanced, the program does not, in the aggregate, compensate or penalize insurers if plans are systematically mispriced relative to costs.

Risk adjustment is a permanent program that began in 2014. The ACA also created two temporary programs, the reinsurance and risk corridors programs, to help stabilize premiums in the initial three years of the law's implementation. Reinsurance reduces insurers' risk in the individual market by reimbursing a portion of a plan's health spending for high-cost enrollees (those with annual claims totaling $45,000–$250,000 in 2014 and 2015), regardless of whether the plan has healthier or sicker enrollees, on average. In the risk corridors program, the government partially reimburses insurers with large losses and recoups money from insurers with high profits. The effects of the risk corridors program were beyond the scope of this article.

Since the initial results from the ACA risk adjustment program were released in June 2015, questions have been raised about how different types of insurers fared and the extent to which the program achieved its objective of accounting for health risk differences across plans. The American Academy of Actuaries found that in 2014 the risk adjustment program narrowed differences in insurers' financial performance.[5] Other organizations have questioned whether the risk adjustment formula is correctly compensating insurers.[6] Our analysis differs from previous work in using a better measure of health risk (insurers' paid claims costs associated with enrollees in ACA-compliant plans relative to the market average) and in analyzing only the precise set of insurers that were covered by the risk adjustment program operated by the Department of Health and Human Services (that is, all individual market insurers offering ACA-compliant plans).

This article examines results from the 2014 and 2015 risk adjustment and reinsurance programs for ACA-compliant individual market plans. We used data submitted by insurers to the Centers for Medicare and Medicaid Services (CMS) through the External Data Gathering Environment server reports. We examined how risk adjustment and reinsurance transfers varied across insurers, and we assessed how these program payments compared across insurers given their level of per enrollee claims costs. We found that for the 30 percent of insurers with the highest claims in 2014 and 2015, before risk adjustment, claims exceeded premium revenues by $90–$397 per enrollee per month. After revenues from risk adjustment and reinsurance were incorporated, this effect was reversed, with revenues exceeding claims by $0–$49 per enrollee per month. The transitional reinsurance program will reimburse insurers for high-cost enrollees covered before 2017. There is ongoing discussion regarding the future of the ACA, but our findings remain pertinent for understanding how risk-sharing programs can address risk selection among insurers, which is a pervasive issue in all health insurance markets.

Study Data And Methods

While both the individual and small-group markets are included in the risk adjustment program, we limited our analysis to the individual market. Because the potential for risk selection is greater when risks are not pooled across employer groups, the role of risk adjustment is particularly important in the individual market. Because of the very small number of people enrolled in catastrophic plans, we also excluded these, which are treated separately in the risk adjustment program.

We analyzed the data CMS received from insurers to calculate risk adjustment and reinsurance payments.[7] The data came from all states except Massachusetts, which operated its own risk adjustment program in 2014 and 2015. CMS received data at the plan level within each state. To assess insurers' financial performance, we conducted analyses at the insurer level within each state by calculating weighted averages using the number of enrollee-months across all plans offered by each insurer. Summary statistics presented in the text were weighted by the number of enrollee-months at the insurer level.

Our final data set included 468 insurer observations in 2014 and 533 in 2015. To assess the

Under ACA risk adjustment, plans with healthier enrollees owe funds, while plans with sicker enrollees receive funds.

overall impact in the initial two years, we combined both years in the analyses. As shown in online Appendix Exhibit 1,[8] results were quite similar when computed separately for each year.

We expressed risk adjustment transfers in dollars per enrollee per month. Positive values for transfers indicated that the insurer was a net recipient of funds across its plans; negative values indicated that the insurer owed payments to the risk adjustment program. By design, all risk adjustment transfers within a state market risk pool summed to zero. We also showed average revenues received through the reinsurance program—which, because reinsurance payments are funded primarily from outside the individual market, are always positive.

DIFFERENCES BETWEEN REVENUES AND CLAIMS COSTS We calculated revenues before risk adjustment and reinsurance, using reported premiums per enrollee per month. We also calculated the difference between revenues and claims costs, or the "revenue-claims difference." A negative revenue-claims difference indicated that before any reinsurance and risk adjustment transfers, the value of an insurer's paid health care claims exceeded its revenues.

To gauge how well the reinsurance and risk adjustment programs reimbursed insurers, we defined two additional measures: revenue-claims differences after reinsurance and revenue-claims differences after reinsurance and risk adjustment. The former incorporated any reinsurance amounts the insurer received as revenues. The latter additionally incorporated any risk adjustment receipts as positive revenues and any payments owed as negative revenues. We compared how each of these concepts varied by the health risk of an insurer's enrollees, as defined by per enrollee claims costs relative to the state average. We analyzed revenue-claims differences because these represent costs incurred by insurers that were not reimbursed through premium revenues.

Insurers with positive revenue-claims differences after risk adjustment and reinsurance transfers were incorporated were not necessarily profitable in the ACA individual market. This is because in addition to claims costs, insurers incur administrative and other expenses, and because of data limitations, these expenditures were not included in our analysis. An insurer's revenue-claims difference is related to its medical loss ratio, which is the ratio of paid claims costs (and other qualifying expenses) to premium revenues after risk adjustment and reinsurance payments are incorporated. Risk adjustment was intended to transfer funds to plans whose enrollees had greater overall health risk from plans whose enrollees had lesser health risk, and not to reimburse any set percentage of losses. Thus, unlike the medical loss ratio, we expressed revenue-claims differences in dollars rather than as a percentage of premiums.

HEALTH RISK As a proxy for the health risk of enrollees, we calculated the claims that the insurer paid, on average, per month of enrollment. Because claims may vary for reasons other than health risk, in Appendix Exhibit 2[8] we show the sensitivity of our results to using instead the percentage of an insurer's enrollees with at least one health condition. Results were quite similar for both measures.

CHARACTERISTICS OF INSURERS We assessed how revenue-claims differences varied by the size of the insurer and the percentage of its enrollees covered by relatively more generous plan benefit designs, as indicated by the plan's actuarial value or "metal" tier.[9] We also showed these differences by whether the parent insurance company offered Medicare Advantage plans, operated a Medicaid managed care organization (MCO), or sold plans exclusively outside of the Marketplaces.[10] We categorized insurers as offering Medicare Advantage plans or an MCO if they were either a solely owned Medicare Advantage or an MCO company or if they were a parent company that owned either a Medicare Advantage or an MCO subsidiary.

Revenue-claims differences before and after the risk adjustment and reinsurance payments were incorporated may vary by an insurer's type of parent company for a number of reasons, including how provider networks are structured or the cost of their enrollees. For example, compared to other insurers, MCOs likely had narrower networks, lower payment rates to providers, or networks with different types of physicians. And insurers exclusively selling outside of the Marketplaces, where premium tax credits were unavailable, may have had enrollees with

higher incomes than insurers with disproportionate enrollment in the Marketplaces.

Finally, we calculated revenue-claims differences by two types of state characteristics: whether the insurer's state had adopted the ACA's expansion of Medicaid eligibility and whether the state allowed individuals to remain in "transitional" plans. Transitional plans are those that had been in effect between March 2010 and October 1, 2013; were not subject to all ACA standards; and were not required to make or receive risk adjustment transfers.[11]

LIMITATIONS Our analysis had several limitations. First, the data in the External Data Gathering Environment server reports are aggregated to the plan level, which prevented us from analyzing individual determinants of health risk or assessing how the risk adjustment model could be improved. Second, in 2014 and 2015, the early years of ACA reform of the individual market, some insurers were still learning how to gather, aggregate, and submit data to CMS. If incomplete data were submitted, risk scores or reinsurance revenues might have been lower than they would have been if complete data were available. Third, we were not able to measure the breadth of provider networks or plan efficiency, both of which could affect claims costs.

Finally, our measure of revenues reflected insurer pricing in the first few years of the Marketplaces, and many insurers appeared to underprice their plans, leading to financial losses. Insurers may have underestimated the health risk of Marketplace enrollees, set premiums without knowing how their enrollees' health risk would compare to that in the overall Marketplace, deliberately underpriced plans to gain market share, or—in states that allowed enrollees to renew pre-ACA individual market policies—experienced more risk segmentation (that is, healthier people might have been more likely to stay enrolled in transitional plans, compared to sicker people). While our analysis did not directly address these issues, it is possible that premium setting changed in subsequent years, as insurers became better accustomed to the overall health risk in the Marketplaces and the risk adjustment program.

Study Results

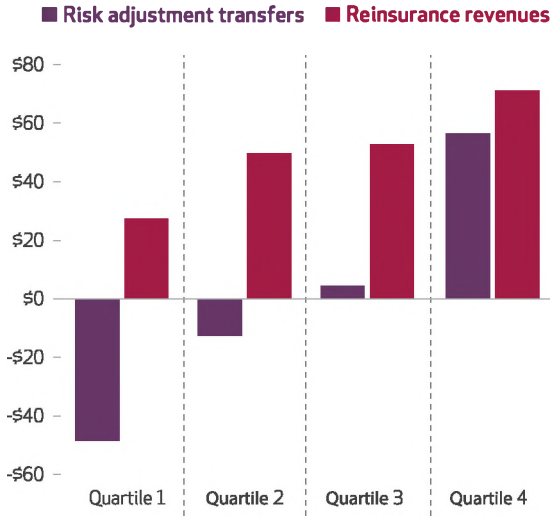
RISK ADJUSTMENT AND REINSURANCE PAYMENTS BY CLAIMS COSTS Receipts from risk adjustment and reinsurance varied greatly, depending on the insurer's paid claims costs per enrollee and the percentage of its enrollees with one or more health conditions (Appendix Exhibit 2).[8] For the risk adjustment program, on average, insurers in the lower two quartiles of paid claims per enrollee per month owed funds (and thus had negative risk adjustment transfers), while insurers in the higher two quartiles received funds (and thus had positive risk adjustment transfers) (Exhibit 1). Insurers in the lowest quartile owed the risk adjustment program $48 per enrollee per month, while insurers in the highest quartile received $56 per enrollee per month through risk adjustment. Transfers were much smaller in magnitude for insurers in the middle two quartiles. Consequently, most of the revenues transferred through the risk adjustment program went from insurers with relatively low paid claims to insurers with relatively high paid claims.

As noted above, reinsurance payments are always positive. On average, reinsurance revenues were higher when insurers had higher paid claims. Insurers in the highest quartile received more than two times what insurers in the lowest quartile received.

DIFFERENCES BETWEEN REVENUES AND CLAIMS COSTS BEFORE AND AFTER RISK ADJUSTMENT AND REINSURANCE For insurers in the lowest decile of claims costs in 2014 and 2015 (less than 47 percent of the average for their state), revenues exceeded claims by $171 per enrollee per month, on average (Exhibit 2). For insurers in

EXHIBIT 1

Per enrollee per month risk adjustment transfers and reinsurance revenues for insurers offering plans compliant with the Affordable Care Act, by quartile of paid claims, 2014–15



SOURCE Authors' analysis of data for 2014–15 from the External Data Gathering Environment server reports of the Centers for Medicare and Medicaid Services. **NOTES** A positive value for risk adjustment transfers indicates that insurers were due to receive risk adjustment funds. A negative value indicates that insurers owed risk adjustment payments. Quartiles of paid claims costs were calculated relative to the state average.

the highest decile of claims costs (more than 193 percent of the average), the reverse was true: Claims exceeded revenues by $397 per enrollee per month, on average. Accounting for reinsurance funds increased revenues across the deciles of insurers. As expected, insurers in the highest decile saw the largest change, with the revenue-claims difference narrowing from −$397 to −$222 per enrollee per month. For insurers in the lowest decile, reinsurance had a much smaller effect, as expected (changing only from to $171 to $181).

Incorporating the effects of risk adjustment transfers tended to move the revenue-claims difference closer to $0 for insurers across all deciles (Exhibit 2). For insurers in the lowest decile, the difference decreased from $181 to $67 per enrollee per month. For insurers in the highest decile, the difference increased considerably, from −$222 to $6 per enrollee per month. More broadly, before risk adjustment and reinsurance, we found that for the 30 percent of insurers with the highest claims in 2014 and 2015, claims exceeded premium revenues by $90–$397 per enrollee per month. After revenues from risk adjustment and reinsurance were incorporated, this effect was reversed, with revenues exceeding claims by $0–$49 per enrollee per month. While the increase in revenues after incorporating reinsurance and risk adjustment was most pronounced for the insurers in the highest decile, sizable increases were evident for the 60 percent of insurers who had negative revenue-claims differences before considering the effects of these programs.

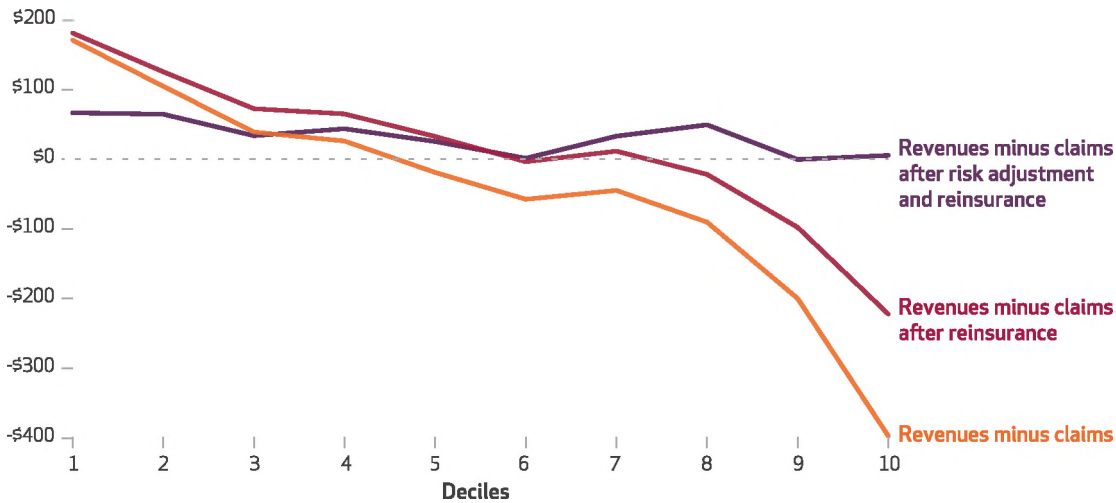
After both reinsurance and risk adjustment payments were incorporated, among insurers in the highest decile of claims costs, revenue-claims differences in the twenty-fifth to seventy-fifth percentiles increased substantially, approaching zero or becoming positive for some insurers (Exhibit 3). And of the insurers that began with positive revenue-claims differences, those in the twenty-fifth to seventy-fifth percentiles had differences that generally stayed positive after the effects of risk adjustment and reinsurance were included.

We also examined how revenue-claims differences varied by the characteristics of insurers, both before and after the effects of risk adjustment and reinsurance were considered. Before reinsurance and risk adjustment, there were substantial differences across types of issuers in revenues minus claims, but after transfers from reinsurance and risk adjustment were considered, performance was much more similar across issuers (Exhibit 4).

Specifically, we found that small insurers—

EXHIBIT 2

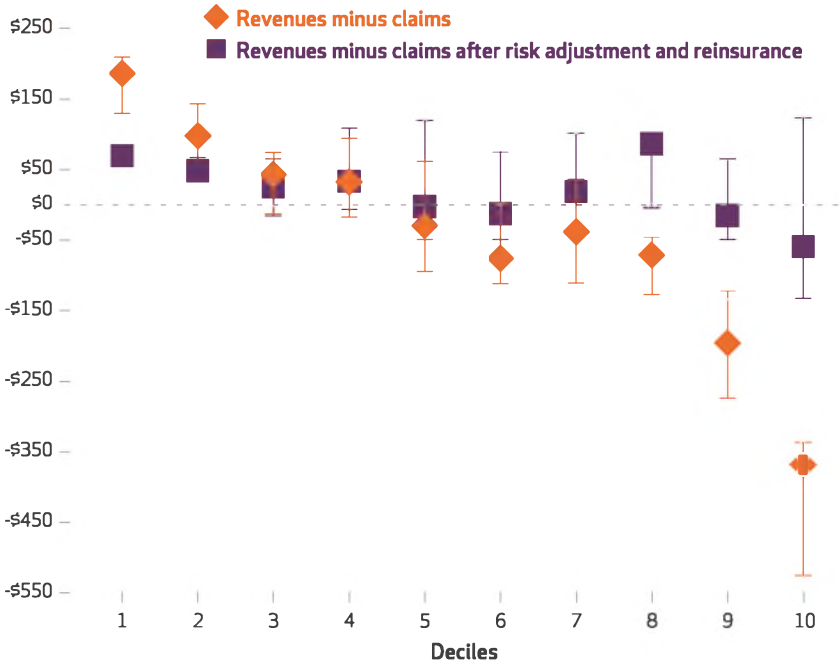
Per enrollee per month differences between revenues and claims costs for insurers offering plans compliant with the Affordable Care Act, by decile of paid claims, 2014–15



SOURCE Authors' analysis of data for 2014–15 from the External Data Gathering Environment server reports of the Centers for Medicare and Medicaid Services. **NOTES** "Revenues minus claims" refers to average premium revenues minus average claims. "Revenues minus claims after reinsurance" includes any reinsurance amounts the insurer received as revenues. "Revenues minus claims after risk adjustment and reinsurance" also includes any risk adjustment receipts or payments as positive or negative revenues, respectively. Deciles of claims relative to average claims in the insurer's state were unweighted to ensure that each decile contained an equal number of insurers (100 insurers were in each decile). The deciles are (from 1 to 10) <47 percent, 47–<67 percent, 67–<82 percent, 82–<91 percent, 91–<101 percent, 101–<109 percent, 109–<125 percent, 125–<148 percent, 148–<193 percent, and ≥193 percent.

EXHIBIT 3

Distribution of per enrollee per month differences between revenues and claims costs for insurers offering plans compliant with the Affordable Care Act, by decile of paid claims, 2014–15



SOURCE Authors' analysis of data for 2014–15 from the External Data Gathering Environment server reports of the Centers for Medicare and Medicaid Services. **NOTES** "Revenues minus claims" and "revenues minus claims after risk adjustment and reinsurance" are explained in the Exhibit 2 Notes. The bars represent the twenty-fifth to the seventy-fifth percentiles. Deciles of claims relative to average claims in the insurer's state were unweighted to ensure that each decile contained an equal number of insurers (100 insurers were in each decile). The deciles are explained in the Exhibit 2 Notes.

those with fewer than 5,000 full-year-equivalent enrollees—benefited the most from risk adjustment. While these insurers had a revenue-claims difference of –$81 per enrollee per month, on average, before risk adjustment and reinsurance payments were incorporated, that difference was $46 after these payments were incorporated. Before the effects of the two programs were considered, the revenue-claims differences varied from –$81 to –$17 per enrollee per month depending on the number of full-year-equivalent enrollees, but the differences varied only from $24 to $46 after risk adjustment and reinsurance revenues were included.

Before the reinsurance and risk adjustment payments were considered, insurers with less than 10 percent of their enrollees in gold and platinum plans had a positive revenue-claims difference ($11 per enrollee per month), which contrasted with the negative differences for insurers with higher shares of enrollees in gold and platinum plans. However, after the revenues from risk adjustment and reinsurance were incorporated, revenue-claims differences were positive for all of these groups and roughly similar, ranging from $23 to $33 per enrollee per month.

Before risk adjustment and reinsurance program revenues were incorporated, revenue-claims differences varied from –$85 to $4 per enrollee per month depending on the insurer's type of parent company. After those revenues were included, average revenue-claims differences were positive for all insurers, regardless of their type of parent company, and ranged only from $26 to $50. Furthermore, the rank ordering of revenue-claims differences did not change for the types of parent companies.

Before risk adjustment and reinsurance payments were incorporated, insurers operating in states that allowed transitional policies had large negative revenue-claims differences, in both states that had expanded eligibility for Medicaid (–$35) and those that had not (–$58). In contrast, in states that did not allow transitional policies, revenue-claims differences were larger, whether the states had expanded eligibility for Medicaid ($39) or not (–$5). Because risk adjustment transfers are balanced, these amounts changed only because of the effects of reinsurance.

Discussion

Risk adjustment and reinsurance are important mechanisms for fostering competition and reducing adverse selection when consumers choose from competing health plans. We studied the first two years of risk adjustment and reinsurance under the ACA and assessed how the differences between insurers' revenues and claims costs changed after risk adjustment and reinsurance payments across a range of insurer characteristics, including claims costs, insurer size, and type of parent company, were accounted for.

Risk adjustment and reinsurance payments varied with insurers' enrollee health mix, as measured by average claims costs and the percentages of enrollees with one or more health conditions (Exhibit 1 and Appendix Exhibit 2).[8] Insurers with below-average claims costs owed risk adjustment funds, while insurers with above-average claims costs received funds—with the highest payments coming from insurers with the lowest claims costs and the smallest percentages of enrollees with one or more health conditions. By contrast, reinsurance payments were positive for insurers across the claims distribution, reflecting the fact that, on average, all groups had some enrollees with high individual claims costs. Payments were greater for insurers with higher overall claims costs and a higher

EXHIBIT 4

Differences between per enrollee per month revenues and claims costs for insurers offering plans compliant with the Affordable Care Act, by insurer characteristics, 2014–15

Characteristic	Percent of enrollees	Difference before risk adjustment and reinsurance	Net gain from reinsurance	Net gain from risk adjustment	Difference after risk adjustment and reinsurance
All insurers	100	−$21	$50	$ 0	$30
SIZE (NUMBER OF FULL-YEAR-EQUIVALENT ENROLLEES)					
Small (fewer than 5,000)	3	−81	78	50	46
Medium (5,000 to fewer than 10,000)	3	−55	62	16	24
Large (10,000 or more)	93	−17	49	−2	29
PERCENTAGE OF ENROLLEES IN GOLD AND PLATINUM TIERS					
Less than 10%	31	11	42	−22	31
10–25%	39	−21	52	2	33
More than 25%	29	−55	57	21	23
TYPE OF PARENT COMPANY					
Medicaid MCO	59	4	47	−1	50
Participates in Medicare Advantage	82	−14	50	0	36
Has only off-Marketplace plans	5	−85	72	39	26
STATE ALLOWED TRANSITIONAL POLICIES AND EXPANDED MEDICAID					
Allowed policies and expanded	22	−35	50	0	15
Allowed policies and did not expand	43	−58	56	0	−3
Did not allow policies and expanded	31	39	45	0	84
Did not allow policies and did not expand	5	−5	38	0	33

SOURCE Authors' analysis of data for 2014–15 from the External Data Gathering Environment server reports of the Centers for Medicare and Medicaid Services. **NOTES** Amounts are rounded to the nearest whole dollar. "Revenues minus claims" and "revenues minus claims after risk adjustment and reinsurance" are explained in the Exhibit 2 Notes. "Full-year-equivalent enrollees" denotes member-months divided by twelve. Medicaid managed care organization (MCO) refers to an insurer that, either directly or through a subsidiary, offered managed care plans that covered Medicaid beneficiaries in the same state. Transitional plans are those that had been in effect between March 2010 and October 1, 2013, when the first Marketplace open enrollment period began, and were allowed to continue operating. They are not required to make or receive risk adjustment transfers and are not subject to all ACA standards.

share of enrollees with one or more health conditions.

To assess how program payments affected the relationship between insurers' revenues and claims costs, we compared the revenue-claims differences of insurers before and after accounting for revenues from the risk adjustment and reinsurance programs. For insurers in higher claims deciles, revenue-claims differences increased considerably after revenues from the two programs were incorporated. Moreover, the extent of those transfers appeared roughly proportional to the magnitude of the revenue-claims differences. The 30 percent of insurers with the highest per enrollee per month claims costs had revenue-claims differences that varied, on average, between −$397 and −$90 before risk adjustment and reinsurance payments were considered. Revenue-claims differences for these insurers varied between $0 and $49 after those revenues were included.

After the inclusion of risk adjustment and reinsurance payments, revenue-claims differences moved closer to zero for insurers that had either relatively low or relatively high claims costs. In particular, the differences narrowed after risk adjustment payments were incorporated (Exhibit 2). For the insurers with the lowest claims, revenues declined after these payments were incorporated, while for the insurers with the highest claims, revenues increased. This shift is consistent with a key intended impact of risk adjustment: to equalize health-related spending across both insurers that had enrollees with high health risks and those that had enrollees with low health risks.

Insurers with the highest claims costs saw the largest gains from the reinsurance program, which was a direct result of that program's goal to reimburse insurers for their high-cost enrollees. Because reinsurance transfers were funded primarily from outside the individual market, this program shifted revenue-claims differences positively across the distribution of insurers, when ranked by per enrollee claims costs. Of course, because insurers set premiums with an expectation of receiving revenues from the program, premiums were likely deliberately set lower than they would have been in the absence of a reinsurance program, reducing revenue-claims differences before incorporating reinsurance revenues. This may be one reason why, before reinsurance or risk adjustment payments were considered, the average revenue-claims differ-

ence across all insurers was negative (Exhibit 4). Additionally, these negative differences may reflect the effects of risk segmentation arising from transitional policies in some states.

We found strong evidence that while insurers with higher paid claims costs were systematically receiving funds from the risk adjustment program, the revenue-claims differences for insurers with lower paid claims costs largely remained positive even after risk adjustment payments were incorporated. In fact, for insurers with the most positive revenue-claims differences before payments from the risk adjustment and reinsurance programs were incorporated, the middle of the distribution of those differences largely remained positive after those payments were incorporated (Exhibit 3). Furthermore, our analysis of the distribution of insurers' financial outcomes in Exhibit 3 demonstrated that our main findings in Exhibit 2 were consistent across the distribution of issuers and not driven by the presence of a few insurers with anomalous outcomes that disproportionately influenced the averages.

We also considered how revenue-claims differences changed after risk adjustment and reinsurance payments were incorporated, depending on insurer characteristics. Across the range of insurer types we studied, we found that insurers whose claims initially exceeded revenues by the largest amounts experienced the largest net gains from risk adjustment and reinsurance. As a result, differences between revenues and claims narrowed across all of the types of insurers we studied after risk adjustment and reinsurance payments were incorporated.

In particular, insurers with different types of parent companies (Medicaid MCOs, those participating in Medicare Advantage, and insurers with only off-Marketplace plans) likely set up provider networks of varying breadths or attracted different types of enrollees. Nevertheless, these groups ended up with revenue-claims differences after risk adjustment and reinsurance payments that were much closer to one another than before the payments. Moreover, the rank ordering of those differences did not change after revenues from the two programs were incorporated. The absence of any change in rank ordering suggests that the risk adjustment program compensated insurers with the largest claims without indiscriminately burdening insurers with a leaner cost structure. Given the importance of the risk adjustment program in incentivizing insurers to be competitive and efficient while removing incentives to use risk selection, further research on this issue is warranted.

At a broad level, the incentives to focus on risk selection have been attenuated by the risk adjustment program.

Conclusion

There is currently a policy debate about the future of the ACA. Our analysis can inform this debate, particularly because any policy approach that relies on private health insurers' competing for enrollees will have to consider ways to address the effects of risk selection in insurance markets. Based on the experience within the structure of the Marketplaces, our results suggest that the risk adjustment and reinsurance programs were relatively well targeted in the first two years. Before risk adjustment and reinsurance transfers, insurers whose enrollees had high levels of health risk had substantially worse financial performance, compared to insurers whose enrollees had lower levels of risk. After the transfers, financial results were much more similar across insurers. Similarly, before the transfers, insurers with fewer enrollees had substantially worse results, compared to those with more enrollees. The transfers largely equalized the results, on average, between these groups of insurers. While insurers will still likely exercise the discretion they have to retain or attract particular types of enrollees, our findings suggest that, at a broad level, the incentives to focus on risk selection have been attenuated by the risk adjustment program.

In the near term, health care costs, state policies, and enrollment patterns across plans will also change in ways that will likely necessitate continued scrutiny to ensure that costs related to health risk are being sufficiently compensated. For example, CMS has finalized changes to the 2017 risk adjustment methodology, updating it to better reflect the costs of emerging treatments.[12] CMS has also finalized changes to the 2018 methodology, such as incorporating additional information about health risk from prescription drug use, partially compensating insurers for very high claims costs, and account-

ing for enrollees' duration of enrollment.[13] In addition, Alaska has enacted legislation to establish a state-funded program to help reimburse insurers for high-cost claims, and CMS has expressed interest in Alaska's approach.[14] Our results may be of interest to policy makers considering ways to structure risk adjustment and reinsurance programs to promote competition in health insurance markets. ■

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NOTES

1 Levitt L, Pollitz K, Claxton G, Damico A. How buying insurance will change under Obamacare [Internet]. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2013 Sep 24 [cited 2017 Feb 21]. Available from: http://kff.org/health-reform/perspective/how-buying-insurance-will-change-under-obamacare/

2 Kautter J, Pope GC, Keenan P. Affordable Care Act risk adjustment: overview, context, and challenges. Medicare Medicaid Res Rev. 2014; 4(3):E1–11.

3 Kautter J, Pope GC, Ingber M, Freeman S, Patterson L, Cohen M, et al. The HHS-HCC risk adjustment model for individual and small group markets under the Affordable Care Act. Medicare Medicaid Res Rev. 2014;4(3):E1–46.

4 Pope GC, Bachofer H, Pearlman A, Kautter J, Hunter E, Miller D, et al. Risk transfer formula for individual and small group markets under the Affordable Care Act. Medicare Medicaid Res Rev. 2014;4(3):E1–23.

5 American Academy of Actuaries. Insights on the ACA risk adjustment program [Internet]. Washington (DC): AAA; 2016 Apr [cited 2017 Feb 21]. Available from: http://actuary.org/files/imce/Insights_on_the_ACA_Risk_Adjustment_Program.pdf

6 Consumers for Health Options, Insurance Coverage in Exchanges in States. Technical issues with risk adjustment and risk corridor programs [Internet]. Boston (MA): CHOICES; 2015 Nov 4 [cited 2017 Feb 21]. Available from: http://nashco.org/wp-content/uploads/2015/11/CHOICES-White-Paper-on-Risk-Adjustment-Issues.pdf

7 Centers for Medicare and Medicaid Services. March 31, 2016, HHS-operated risk adjustment methodology meeting: discussion paper [Internet]. Baltimore (MD): CMS; 2016 Mar 24 [cited 2017 Feb 21]. Available from: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf

8 To access the Appendix, click on the Appendix link in the box to the right of the article online.

9 Actuarial value is defined as the percentage of total claims that the plan pays for a standardized population. On average, bronze plans pay about 60 percent of total claims costs, silver plans about 70 percent, gold plans about 80 percent, and platinum plans about 90 percent.

10 Insurers can belong to more than one of these categories. Although all new individual market health plans issued after 2014 must conform to ACA standards regarding benefits and how premiums may vary, insurers can nevertheless decide whether or not to offer their plans on the Marketplaces.

11 Cohen G. Letter to insurance commissioners [Internet]. Washington (DC): Centers for Medicare and Medicaid Services; 2013 Nov 14 [cited 2017 Feb 21]. Available from: https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF

12 Department of Health and Human Services. 45 CFR parts 144, 147, 153, et al.: Patient Protection and Affordable Care Act; HHS notice of benefit and payment parameters for 2017; final rule. Federal Register [serial on the Internet]. 2016 Mar 8 [cited 2017 Feb 21]. Available from: https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf

13 Department of Health and Human Services. Patient Protection and Affordable Care Act; HHS notice of benefit and payment parameters for 2018; amendments to special enrollment periods and the Consumer Operated and Oriented Plan Program. Federal Register [serial on the Internet]. 2016 Dec 22 [cited 2017 Feb 21]. Available from: https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018

14 Counihan K. Building on premium stabilization for the future. CMS Blog [blog on the Internet]. 2016 Aug 11 [cited 2017 Mar 2]. Available from: http://wayback.archive-it.org/2744/20170118125734/https://blog.cms.gov/2016/08/11/building-on-premium-stabilization-for-the-future/

Interactive Maps: Estimates of Enrollment in ACA Marketplaces and Medicaid Expansion

Feb 28, 2017

As the 115th U.S. Congress deliberates the future of the Affordable Care Act, an interactive map from the Kaiser Family Foundation provid number of people in each congressional district who enrolled in a 2016 ACA marketplace health plan and the political party of each distri January.

The analysis also includes maps charting the total number of people enrolled under the ACA Medicaid expansion in 2015 in states that im Medicaid expansion, along with the political parties of their governors and U.S. senators. As of January 2017, among states that adopted t have Republican governors, 14 have Democratic governors, and one has an Independent governor. In Washington, D.C., which also expar is a Democrat.

The map below shows estimates of ACA Marketplace enrollment as of March 2016 by congressional district, with red and blue districts re Republican or Democratic congressional representative. Districts with darker shading have a greater number of Marketplace enrollees. Marketplace enrollees nationally, 6.3 million live in Republican districts and 5.2 million live in Democratic districts. Marketplace enrollee range from 10,200 enrollees in West Virginia's District 3 to 96,300 enrollees in Florida's District 27, with a median of 24,300 enrollees per c enrollees per Democratic district range from 5,200 enrollees in Hawaii's District 1 to 94,100 enrollees in Florida's District 10, with a media district. The ten congressional districts with the highest number of Marketplace enrollees are all in Florida. There are 17 congressional di districts and 9 Democratic districts) with over 50,000 enrollees, located in the following states: Florida, North Carolina, Georgia, and Mont

Updated 2/28/2017: The map below now includes estimates of enrollees with advance premium tax credits and cost sharing reductions in districts in states using healthcare.gov (http://healthcare.gov).

Number of People Enrolled in ACA Marketplaces in 2016, by Congressional District

As of January 2017, 32 states including the District of Columbia implemented the ACA Medicaid expansion to adults. This expansion exten
many adults who were previously excluded from Medicaid. In 2015, about 14 million Medicaid enrollees were adults in the expansion gr
those who were made newly eligible by the ACA Medicaid expansion as well as a smaller group of enrollees who were eligible for Medica
eligibility pathways (see methods for more details). The expansion group accounts for 18% of all Medicaid enrollees. Since 2015, this num
enrollment has continued to increase and additional states have expanded, including Louisiana and Montana.

Number of People Enrolled in Medicaid Expansion in 2015, by State Governor's Party

Number of People Enrolled in Medicaid Expansion in 2015, by State Governor's Party as of January 2017
43,993 views

The map below shows the number of people enrolled in each state's Marketplace (as of March 2016) and through the Medicaid expansion
The map also shows the number of enrollees with advanced premium tax credits in each state, the estimated total annual premium tax cr
reform/state-indicator/average-monthly-advance-premium-tax-credit-aptc/?currentTimeframe=0) received by enrollees in state marketplaces, and the nu
cost sharing reductions in each state (as of March 2016). States are color-coded by the U.S. Senators' party affiliation with red states repre
Republican senators, blue states being those with two Democratic senators, and purple states having a mix of Republican and Democratic
2016, 4.0 million Marketplace enrollees live in red states, 4.4 million live in blue states, and 3.2 million live in purple states. In 2015, abou
expansion enrollees lived in red states, 10.4 million lived in blue states, and 2.3 million lived in purple states. (Washington, DC does not h
enrollees are not included in these totals).

Number of People Enrolled in ACA Marketplaces (2016) and Medicaid Expansion (2015), by Senators' Party

Number of People Enrolled in Affordable Care Act Marketplaces (2016) and Medicaid Expansion (2015),
by Governors' Party

47,198 views

METHODS

Marketplace enrollment by congressional district as of March 2016 is estimated using county-level plan selection data (from ASPE (https://a
selections-zip-code-and-county-health-insurance-marketplace-march-2016) for Healthcare.gov states, and from state reports for State-Based Marketpla
people who selected a Marketplace plan paid their premium and effectuated their coverage, adjustments were made to match each state's
totals. For Minnesota and New York, Basic Health Plan (BHP) enrollment is also included. Estimates of enrollees with advance premium ta
reductions are not available for state-based marketplaces because county-level advance premium tax credit and cost sharing reduction d
these states. A county/congressional district crosswalk was created using data from Missouri Census Data Center and state reports for the
been redistricted (VA, NC, and FL). For counties that cross congressional district boundaries, enrollment was proportionally assigned base
county population living in each congressional district. Enrollment is rounded to the nearest 100.

Medicaid enrollment is from both the Medicaid Budget and Expenditure System (MBES) and the California Department of Health Care Ser
for each month. In an effort to take into account that some beneficiaries are enrolled for only part of the year, maximum monthly enrollr
to estimate total annual enrollment. Enrollment is rounded to the nearest 100. States totals may not sum to national total due to rounding

Expansion Group Enrollment: Total number of adults who have enrolled in Medicaid as a result of the ACA expansion of the program. Th
newly eligible for Medicaid by the ACA Medicaid expansion and some enrollees in the expansion group who were eligible for Medicaid th
pathways. The not newly eligible enrollees group includes some childless adults in early expansion states as well as those who may be sul
adjustments. Some states already provided coverage at the traditional match rate to parents and adults without dependent children up to
statewide as of March 23, 2010, when the ACA was enacted. The law provides additional federal funding to these states through the "expa
for adults without dependent children under age 65; this "expansion state match rate" is higher than the traditional match rate. In additi
to make adjustments to account for individuals who would not have been eligible because of asset test requirements in place on Decembe
in effect for waiver populations receiving full benefits as of December 1, 2009, and other special circumstances. These adjustments may r
enrolled in the expansion category who do not qualify for the 100% federal match for newly eligible adults.

Louisiana and Montana expanded Medicaid after December 31, 2015 so no data is available (Montana on 1/1/16 and Louisiana on 7/1/16).
submitted data to CMS.

More information on the methods for estimating Medicaid expansion enrollment can be found here (http://kff.org/other/state-indicator/medicaid currentTimeframe=0).

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