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November 27, 2017

Acting Secretary Eric Hargan
Attention: CMS-9930-P
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW.
Washington, DC 20201

Re: Covered California comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019; CMS-9930-P (RIN 0938-AT12)

Dear Acting Secretary Hargan,

Covered California is submitting comments in response to the proposed regulations CMS-9930-P. In making these comments we want to underscore appreciation that the Department of Health and Human Services (HHS) continues to support innovation by States operating state-based marketplaces (SBMs) by allowing for flexibility in implementing many of the proposed regulations. We provide the following comments based on our experience and analysis of what efforts are necessary in order to ensure a viable risk mix and ongoing sustainability for states that may operate in the federally-facilitated marketplace.

USER FEE

The Department of Health and Human Services (HHS) is proposing to update the Federally Facilitated Exchange (FFE) user fee for 2019 (with a fee of 3.5 percent of premium) and for state-based exchanges on a Federal Platform (SBE-FP) (with a fee of 3 percent of premium). Although the FFE user fee does not apply to SBMs such as Covered California, we want all marketplaces across the nation to be successful and make these comments to contribute to building on the success we have already seen across the nation.

Covered California believes that when the FFE or state-based exchanges spend less proportionally on marketing and outreach, this jeopardizes their respective risk pools and negatively impacts the premium trend in future years. If HHS were spending a comparable percentage of premium for the FFE as is California (1.4 percent), we

estimate that its total expenditures for marketing, outreach and sales for 2018 would be over $480 million. This would be money well spent to ensure a good risk mix and keep premiums low for all those – both subsidized and unsubsidized – who enroll in states supported by the FFE.

The fundamental element required for the success of any marketplace is generating enrollment that reflects, and continually refreshes, the risk mix to ensure the lowest possible premiums for all consumers. Exchanges face constant churn with a substantial portion of consumers moving out of exchanges each year to other forms of coverage and new enrollees joining as they become newly eligible. A good risk mix and a viable business proposition for exchanges does not "just happen" – insurance must be sold. Selling insurance – which is different than providing a free benefit to a beneficiary, as is the case in most Medicaid programs – requires ongoing and significant investments in marketing and outreach to both promote retention of current enrollees and attract new enrollees that reflect a balanced risk pool.

In September, Covered California released a report – "Marketing Matters: Lessons from California to Promote Stability and Lower Costs in the National and State Individual Insurance Markets" – which shows marketing and outreach are proven ways to increase enrollment, lower premiums, save consumers money and stabilize the individual insurance market. The report finds that not only are marketing and outreach critical investments to promote enrollment, but they appear to have a large return on investment since bringing more healthy people into the risk pool further lowers premiums, saving money for everyone. Covered California's extensive marketing and outreach helped the state's individual market have one of the best take-up rates and lowest risk scores in the nation. As a result, premiums were between $850 million and $1.3 billion lower than they would have been if the state had the national average risk mix in 2015 and 2016. Covered California estimates that every marketing dollar it has spent has yielded more than a three-to-one return on investment (ROI). Efforts to promote the value of coverage and the options available to consumers boosted the enrollment of healthy consumers and likely lowered premiums by five to eight percent in 2015 and 2016.

STANDARDIZED OPTIONS – SIMPLE CHOICE PLANS

The Department of Health and Human Services is proposing to discontinue standardized plan options for the 2019 benefit year. In 2017, HHS began allowing insurers in the FFM to begin offering standardized plans that would be displayed in a manner that would make them easy for consumers to find. These standardized plans cover more basic services before consumers meet their deductibles, ensuring that consumers can obtain basic care without a financial barrier.

Covered California offers patient-centered benefit designs that were developed with input from consumer advocates, health plans, and policy experts. The benefits of patient-centered benefit designs are significant and allow consumers seeking coverage through the marketplace to easily compare health plans knowing the every health plan

has the same cost-sharing levels and benefits. Patient-centered benefit designs were designed to minimize financial barriers to access for consumers, reduce confusion and to have designs that actively reinforce efforts to promote higher value care delivery, such as better use of primary care. Covered California's patient-centered benefit designs allow consumers at every metal tier to visit their primary care physical without the cost being subject to a deductible.

Covered California urges HHS to reconsider ending standardized plan options for the 2019 benefit year and consider expanding the integration of simple choice plans in the federal marketplace. In fact, we urge HHS to only promote the use of simple choice plans on healthcare.gov as these plans have common deductibles and annual limits on out-of-pocket spending. More choice is not always better as consumers with expensive health care conditions could, for example, inadvertently select a plan that limits coverage for specialty drugs. In addition, all too often consumers face unnecessary deductibles not because of their making uninformed choices but because of confusion.

ESSENTIAL HEALTH BENEFITS

HHS proposes to provide greater flexibility to states when selecting their essential health benefits (EHB) benchmark plans for benefit years 2019 and beyond. Covered California appreciates the flexibility afforded to states to retain their current EHB benchmark plan without taking any action, as any changes to the current EHB structure would be a significant undertaking.

SHOP

HHS proposes to allow SHOPs to operate in a leaner fashion, which the FF-SHOP will take advantage of. This includes ceasing FF-SHOP online enrollment and premium aggregation. While we appreciate the apparent flexibility given to state-based exchanges, Covered California does seek additional clarity regarding the ability of state-based SHOPs to operate with added flexibility, including under the rules governing the status quo. While preamble language suggests such flexibility is possible, mandatory regulatory language in the proposed rules do not specifically carve out state-based SHOPs nor provide the option for state-based SHOPs to apply alternative protocols or to maintain the status quo.

Thank you for your consideration of our comments. If you have any questions or would like more information, please feel free to contact me.

Sincerely,

Peter V. Lee
Executive Director

cc: Covered California Board of Directors

November 21, 2017

John R. Graham
Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Concerns with Recent ASPE Reports Regarding Individual Marketplace Costs, Enrollment and Trends

Assistant Secretary Graham:

We would like to bring to your attention concerns with regard to the interpretation of data and research contained in recent reports released by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Specifically, we are concerned that recent reports regarding individual marketplace costs, enrollment and trends have not conveyed the appropriate context and analysis that would allow readers of ASPE's data and research to draw accurate conclusions and foster a better understanding of the complex issues being evaluated, and more importantly that their "Key Findings" could lead to readers being confused about the actual impacts reflected in the underlying data. Given ASPE's role as an advisor to the U.S. Health and Human Services secretary, and its role in informing a broad array of policy makers and the public, we share these concerns in hopes that they will be viewed as constructive and advance policy-making that is truly "evidence-based."

ASPE has a clear charge of advising the secretary of the U.S. Department of Health and Human Services on "*policy development in health, disability, human services, data, and science*" and *"provid[ing] advice and analysis on economic policy."* ASPE's work also informs the broader policy-making community. Given its important charge, ASPE's efforts must be anchored in solid analysis of complex information so that it is viewed as a trusted source of data and research to be used to drive policy decisions. Over the years, the rigorous methods and careful attention to detail that is the hallmark of most ASPE research is a standard that has earned it respect and appreciation nationally, and served as a model for other national and state-level agencies to follow.

To the extent ASPE produces and shares meaningful and useful information, it not only ensures the Health and Human Services Secretary can most ably advise the president on policy options, but also helps policy makers, academic researchers and the media professionals who educate the broader public about federal programs and frame complex issues of importance to millions of Americans. To that end, we offer observations about some of ASPE's recent work. Two ASPE reports on health coverage in the individual insurance market were recently released: Individual Market Premium Changes: 2013-2017 (which compares premium changes for plans purchased in 2013 and 2017) and Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange (which is an annual report that analyzes health plan choices and premiums for the upcoming benefit year). The reports appear to provide data and research in a

way that limits readers' ability to accurately interpret findings, and which could easily mislead readers to erroneous conclusions.

As is always the case with reports that look only at the "Federal Health Insurance Exchange," these reports exclude from their analysis the 12 state-based marketplaces — which represent the experience of 25 percent of Americans.[1] We understand that in some cases, ASPE may not have available the data required to report on State-Based Marketplace states, but their exclusion means ASPE reports do not provide a complete perspective on the experience Americans are having in the individual markets. While it is certainly the case that the federal government has a more direct role in managing the federal marketplace, ASPE and HHS are responsible for ensuring the effective implementation of the Patient Protection and Affordable Care Act in all 50 states. And, the extent to which state-based efforts to implement the Affordable Care Act are more or less effective is a vital piece of information that should inform the Secretary and policy makers at the national and state levels.

For example, while the Key Findings of the report on 2018 Health Plan Choice and Premiums highlights the fact that eight states in the Federal Exchange will only have one carrier in their state, the fact that none of the State-Based Marketplaces have only one carrier is not highlighted. Similarly, the reality that in twenty states, when the State-Based Marketplace (SBM) states are included, have more than four carriers in their state is not highlighted. Understanding state variation is vital to diagnosing the reasons for different performance across states and this cannot be done without examining the entire nation.

The extent to which state-based efforts to implement the Affordable Care Act are more or less effective is a vital piece of information that should inform the secretary and policy makers at the national and state levels. We would welcome ASPE initiatives to research impacts on all 50 states. In the interim, we believe it is essential to clearly denote in any "key findings" or summaries that the analysis may not reflect the experience in the SBM states.

Beyond the issue of the exclusion of State-Based Marketplaces, however, even with the limited data considered we found that:

- The "Key Findings" do not reflect the actual impact experienced by most consumers.
- Data is reported with incomplete context and analysis.

Observations in more detail on these reports can be found in the attached "Review of ASPE Reports on Individual Market Trends and Premiums." Two examples of "findings" recently used by Acting Secretary Hargan that were taken directly from the lead "Key Highlights/Summaries" from the ASPE reports highlight why the framing and presentation of the data are misleading. While the points are technically accurate, they are misleading because they narrowly interpret the data and fail to reflect the realities of the vast majority of consumers about whom, in theory, the data is supposed to represent. The result are "findings" that are misleading and create unfair representations of the consumer experience in the individual market.

1. **"Individual market premiums in 39 states on the federal exchange rose 105 percent" from 2013 (immediately prior to the Affordable Care Act).[2]**

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[1] Based on the CMS-issued effectuated enrollment report, the 39 states on healthcare.gov collectively have 7.7 million enrollees, or 75 percent, and the 12 state-based marketplaces have 2.6 million enrollees, or 25 percent. Available at: https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

[2] Remarks by Acting Secretary Hargan on Health Reform to the U.S. Chamber of Commerce, Oct. 17, 2017. Available at: https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/remarks-on-health-reform-to-the-us-chamber-of-commerce.html

This "key finding" does not accurately represent the premium experience of most consumers in the individual market during 2013 to 2017, as reflected in ASPE data.

- Based on the CMS-issued report on open enrollment for 2017 coverage, 10 million Americans — representing a majority (58 percent) of those in the individual market — were receiving Advance Premium Tax Credits (APTC).[3] For these individuals, their average monthly premium was $106 in 2017 — *a 54 percent decline from the 2013 average premium*.[4]

- For those who do not receive financial help, premiums may have indeed risen by the reported amount for the federal marketplace states, but in virtually all cases, the benefits purchased for these premiums are far more robust than what consumers received prior to implementation of the Affordable Care Act. While there is passing reference to the fact that these are not "apples-to-apples" comparisons, there is no attempt to measure or indicate that for many of these individuals who needed and received care, they were better off financially.

- The pre-Affordable Care Act premiums also reflect a very different market, one that denied applicants seeking coverage and often excluded consumers with pre-existing conditions. This situation yielded 2013 premiums for a very different cohort of enrollees.

2. **"Now, for the 2018 plan year, we have seen benchmark premiums increase 37 percent."[5]**

This "key finding" only reflects data for consumers who do not receive financial help. It fails to reflect the data for consumers who receive financial help and, for those without subsidies, does not accurately reflect their experience:

- *On average the eighty-four percent of enrollees in Healthcare.gov who receive tax credits saw their premiums drop by about 3 percent in 2018 from 2017* (see Table 6, page 10: from $142 per month to $138 per month for a 27-year-old). While the data relevant to this fact can be found embedded in the report, it is not included in the "Key Findings." Instead, readers must do their own calculation of premium and the impact of the Advance Premium Tax Credit to see what average consumers would see when they renewed their coverage or enrolled through healthcare.gov.

- The "Key Findings" section also reports that the portion of "enrollees with access to a plan for $200 or less" declined to 6 percent. However, this finding only reflects data pertaining to consumers who do not receive financial help. It fails to report that for the 84 percent of enrollees who get financial help, this is *not* the premium that they will pay. The body of the report itself identifies the fact that in 2018, 80 percent of enrollees will be able to purchase a plan for $75 or less (see

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[3] A recent Congressional Budget Office report identified 17 million people purchasing individual health coverage inside and outside of the marketplace. Available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf

[4] The $106 average premium after APTC for the 39 states on the federal marketplace is the best publicly available number reported by CMS in its final enrollment report. While this report does not focus on effectuated enrollment, the average net premium should be the same or fairly similar. See more at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html.

[5] "Remarks by Acting Secretary Hargan on Health Reform to the American Action Forum and the Council for Affordable Health Coverage." Nov. 1, 2017. Available at: https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/remarks-on-health-reform-to-the-american-action-forum-and-the-council-for-affordable-health-care.html.

Table 9, page 14), but this is not included as a "Key Finding" even though it is a clearer representation of consumers' experience.

- *For individuals who do not receive a subsidy, the reported 37 percent increase figure is misleading because it is largely inapplicable.* The reported premium is for the second-lowest-cost Silver plan on healthcare.gov. However, the vast majority of consumers who purchase individual coverage without financial help do so off-exchange.[6] For 2018, given the fact that across the nation most health plans loaded the cost of paying for the cost-sharing reduction (CSR) program in the form of a surcharge on their Silver subsidized premium and not on their off-exchange products, the vast majority of those who do not get a subsidy will pay much less than the reported premium increase.

- Finally, in the body of the report there is reference to the fact that "many states required issuers to load an additional premium increase onto silver plans to account for uncertainty associated with ongoing CSR litigation." However, there is no attempt to put in context the fact that in many states, the largest single contributing factor to the cited 37 percent increase is the added surcharge included in the premium price to offset the loss of federal funding for the cost-sharing reduction program. As an ASPE research product describing recent individual market premium increases, the full context, amount and implications of the CSR price impact should be reflected in the report. As policy discussions continue regarding the cost-sharing reduction program, it is critical that the premium impacts on consumers and on taxpayers of the loss of federal funding to the program be made clear.

At Covered California, we can relate to the challenge and responsibility ASPE faces in distilling and communicating to the public and policy-makers complex health policy issues. From a mass of data, a public agency must choose what it interprets, summarizes and includes in "Key Findings" – which many readers may rely on exclusively to draw conclusions, without taking a deeper look into the data and research. Presenting isolated data points without appropriate explanation does not serve and could mislead policy makers. Data in context and with accurate framing can become useful information for policy makers as they seek to find the best path forward to construct policies that balance the issues related to:

- Affordability of coverage, for those who do and do not receive financial assistance;
- The nature and implications of coverage for those who are getting the care they need; and
- The costs to individuals, taxpayers and other key stakeholders.

As part of our ongoing efforts to inform the national policy discussion, Covered California regularly shares data and research that describes our marketplace, the enrollee risk mix and premium impacts on both subsidized and unsubsidized Californians in the individual market. The news from California has been generally positive: we have robust and continued plan competition and choice for consumers; benefit designs that foster consumer-driven markets; premium trends that over the past four years have averaged in single digits; a good risk mix; and a huge reduction in the uninsured.

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[6] A recent Congressional Budget Office Report estimates 2 million unsubsidized consumers purchasing coverage through marketplaces and 5 million consumers purchasing coverage outside marketplaces for 2018. Available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf.

That said, we have also been consistent about reporting “bad news.” For example, when releasing the premium increases for 2018, we headlined the 12.5 percent overall rate increase, even though on average for those receiving subsidies their costs will go down. We seek to make information available both about the overall premium increase and the impact on those receiving subsidies in order to paint a full and clear picture of the marketplace, and will continue to do so to ensure that we remain a credible source of research, data, and policy analysis that policy makers and the public can trust.

As an organization that seeks to practice and inform evidence-based policy-making, we are consumers of the data and research that is developed by ASPE. We look forward to future reports, and will continue to offer comments and feedback as they arise, and we similarly invite your review and feedback of our own analyses. We hope you will find helpful the attached “Review of ASPE Reports on Individual Market Trends and Premiums” and we will be happy to make ourselves available for any questions you may have.

Please know that we send these comments with sincere interest in continuing to work with the administration, providing technical assistance based on our own latest research and findings, and learning together so that we can improve health coverage and health care outcomes for all.

Sincerely,

Peter V. Lee
Executive Director

cc: Eric D. Hargan, Acting Secretary, U.S. Department of Health and Human Services
Seema Verma, Administrator, the Centers for Medicare and Medicaid Services

Attachment: Review of ASPE Reports on Individual Market Trends and Premiums

Review of ASPE Reports on Individual Market Trends and Premiums

November 21, 2017

ASPE Data Point: Individual Market Premium Changes: 2013-2017, May 23, 2017 **Key Findings in ASPE Report (Verbatim)**	**Policy and Market Context Discussion**
Premiums for individual market coverage have increased significantly since the Affordable Care Act's key provisions have taken effect, but most estimates have focused on annual increases and have not captured the comprehensive increase in premiums since 2013, and thus do not accurately capture the ACA's true effect.	The assertion that the report is intended to "accurately capture the ACA's true effect" is challenged by the report's failing to discuss (a) the impact of financial assistance that immediately lowers the reported *gross* premiums for a majority of consumers; and (b) the changes in product quality (level of coverage, guaranteed issue) that accompanied the changes in prices. **Impact of financial assistance:** When ASPE released the Data Point report, CMS had already released the final enrollment report for Nov. 1, 2016, through Jan. 31, 2017. This report stated that 10.1 million Americans were receiving an Advance Premium Tax Credit (APTC), and their net premium was on average $106 (a 54 percent decline from the "average premium" in 2013).[7] (The only reference to APTC in the Data Point report is in a note to Appendix B, which states APTC was not taken into account in the analysis of average premiums.) **What was covered by the premium in 2013 was substantively different from what was covered in 2017:** This is not an "apples-to-apples" comparison. Prior to 2014, coverages varied very dramatically and many important categories of care were not covered. In some cases the addition of this coverage certainly increased premiums, but this also directly resulted in lower costs to consumers for the care they received. The 2013 data looks at the entire individual market, and the 2017 data excludes from its analysis the estimated 32 percent of enrollment that is off-exchange (which includes the grandfathered plans that are certainly lower cost and subject to pre-Affordable Care Act underwriting and health screening). (The potential that the exclusion of the off-exchange market may "potentially bias" the "premium increase slightly upward" is referenced in the "Limitations"

[7] The $106 average premium after APTC for the 39 states on the federal marketplace is the best publicly available number reported by CMS in its final enrollment report. While this report does not focus on effectuated enrollment, the average net premium should be the same or fairly similar. See more at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html.

	section of the report, but with no context of the potential importance of this difference.) The fact that the premiums in 2013 were the product of millions of Americans either being excluded from any coverage due to pre-existing conditions, or granted coverage at lower costs due to some conditions being excluded from coverage, is referenced obliquely as an area for "further work."
Comparing the average premiums found in 2013 MLR data and 2017 CMS MIDAS data shows average exchange premiums were 105% higher in the 39 states using Healthcare.gov in 2017 than average individual market premiums in 2013. Average monthly premiums increased from $232 in 2013 to $476 in 2017, and 62% of those states had 2017 exchange premiums at least double the 2013 average.	As noted above, in 2013, there was no guaranteed issue in the individual market. Medical underwriting allowed insurers to deny coverage based on pre-existing conditions or effectively price consumers out of the market based on health status, as well as rate based on gender.[8] Coverage sold in the individual market also lacked standards for minimum actuarial value and essential health benefits. This often resulted in bare-bones coverage and plans that did not cover benefits such as maternity care and prescription drugs, and some even excluded inpatient care, labs and imaging.[9] Under the Affordable Care Act, from 2014 through 2017, consumers had guaranteed issue in the individual market, access to coverage that covered essential health benefits, actuarial levels that defined the amount of financial coverage a plan must provide, and Advanced Premium Tax Credits that defrayed the cost of coverage.

[8] It is estimated that prior to the ACA, 52 million Americans faced difficulty enrolling in coverage in the individual market due to a declinable pre-existing condition. See more at: https://www.kff.org/other/state-indicator/estimated-number-of-non-elderly-adults-with-declinable-pre-existing-conditions-under-pre-aca-practices/

[9] U.S. Department of Health & Human Services. "Essential Health Benefits: Individual Market Coverage." 2011. https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage

ASPE Data Point: Individual Market Premium Changes: 2013-2017, May 23, 2017 **Additional Potential Key Findings**	**Policy and Market Context Discussion**
The availability of Advanced Premium Tax Credits directly lowered costs of coverage for a majority of those in the individual market (58 percent).	Based on the CMS-issued report on open enrollment 2017 — issued on March 15, 2017 (two months before this data point) — 10.1 million Americans received APTC. Taken with the other on-exchange enrollment and the estimate of 32 percent off-exchange enrollment, this means most Americans in the individual market received APTC. While the Key Finding references this fact, by never "doing the math" on the impact of this assistance or reflecting it in premium reported in the two "lead" findings, the relevance to most Americans in the individual market is hard to interpret.
For the majority of individuals who received a tax credit on the federal marketplace in 2017, their cost of coverage for 2017 was $106 per month; this means that for these individuals the cost of receiving a far richer and comprehensive set of benefits dropped $126 (a 59 percent reduction from 2013 average premium costs).	Understanding the actual impact on consumers is critical to evaluating the impact and the potential effect of increased enrollment from subsidized individuals on improving the health mix of the individual market overall.

ASPE Research Brief: Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange, Oct. 30, 2017 **Key Findings (Verbatim)**	**Policy and Market Context Discussion**
Benchmark Premiums: The average monthly premium for the second-lowest cost silver plan (SLCSP), also called the benchmark plan, for a 27-year-old increased by 37% from plan year 2017 (PY17) ($300) to PY18 ($411).	Premium increase is a potentially important indicator for policy makers, but it has very different impacts for consumers who are and are not receiving financial assistance. The "37 percent increase" figure is misleading for both populations. For those receiving subsidies, their costs are on average going down in 2018. For those not receiving subsidies, the vast majority do not purchase through Healthcare.gov and will likely experience a much lower premium increase than the 37% highlighted in the report. This report looks only at healthcare.gov products, pricing and hence consumer enrollment. Highlighting the "gross" premium increase on exchange is misleading for three reasons: 1. The vast majority of those who enroll through Healthcare.gov (84 percent in 2017; see Table 5, page 10) have premiums that are reduced by the Advance Premium Tax Credit. For these individuals, their effective premium *decreased* by about 3 percent (based on calculating changes in actual consumer expense after applying APTC for sample households. See Table 6, page 10). 2. Most Americans who do not receive a subsidy purchase their health insurance "off-exchange." Since about half of the growth in benchmark premiums for 2018 is attributed to the administration's discontinuance of reimbursements for Affordable Care Act cost-sharing reduction plans,[10] and in most states insurers have offset CSR funding by increasing premium rates for *only* "on-exchange Silver" (using the second-lowest-cost Silver, or "benchmark" plan, as the basis for annual premium increases) this finding misrepresents what unsubsidized consumers would ever experience.

[10] A Kaiser Family Foundation analysis found that Silver marketplace premiums would have to increase by 19 percent to offset the loss of CSR funds. The CSR surcharge placed by insurers on Silver plans ranges from 7.1 percent to 38 percent. See more at: https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/.

	3. By selecting the second-lowest-cost Silver plan as the basis of comparison (and not Bronze, Gold or other metal tiers that did not generally include the "CSR surcharge") the report tips the scales to show inaccurate and artificially inflated premium increases.
Premium Growth: For the first time, annual growth in the average monthly premium available to a 27- year-old for the SLCSP, at 37%, outpaced that of the lowest-cost plan (LCP), at 17%. For enrollees who are eligible to receive advance premium tax credits (APTCs), the larger increase for the benchmark plan premium may result in these enrollees paying a lower portion of their premiums compared to prior plan years; especially if they select plans from metal levels other than silver.	It is hard to understand why the change in the relationship between the "second-lowest-cost Silver plan" and the "lowest-cost Silver plan" is a "Key Finding." Without more context, it is not clear what "key takeaway" this finding is meant to provide to readers. By repeating the inaccurate and misleading finding regarding the "annual growth in the average monthly premium" to be 37 percent, and using the policy shorthand of SLCSP — instead of highlighting that the whole point of the "second-lowest-cost Silver plan" is relevant only to the determination of the subsidy level for those who receive it — the finding appears to simply reinforce confusing data in the prior finding.
Subsidies: The average APTC ($555) will increase by an estimated 45% from PY17 ($382) and by 114% from PY14 ($259). In PY14 through PY17, more than 80% of enrollees were in plans for which APTCs were paid, while approximately 60% were in plans to which cost-sharing reductions were paid.	The fact that the vast majority of Healthcare.gov enrollees receive a subsidy ("more than 80 percent." See Table 5, page 10, which states 84 percent for 2017, a share that has held steady during from 2014 to 2017) and a substantial increase in APTC (from $382 in 2017 to $555 in 2018) is indeed a critical "Key Finding." Given that the first finding focused solely on gross premiums, a finding on changes to tax credits would shed important light on the more fundamental issue -- affordability. Yet the ASPE findings leave it to the reader to "do the math," obscuring the bottom line fact that "on average" the cost of coverage for about 84 percent of HealthCare.gov enrollees went down for 2018.

Lowest-Cost Plan Available: The percentage of current enrollees with access to a plan for $200 or less decreased from 16% for PY17 to 6% to PY18. If enrollees were to stay within their current metal level, only 2% will have access to coverage with premiums of $200 or less for PY18.	For the 16 percent of Healthcare.gov enrollees who do *not* receive APTC, understanding what they need to pay in premium, how that is changing over time and how it relates to their ability to pay are all important and potentially instructive to policy makers. That said, a statistic about the percentage of enrollees who have access to a plan with a gross premium less than $200 (see Table 8, Page 13) is not itself meaningful and is potentially misleading to policy makers, given the fact that: 1. The vast majority of Healthcare.gov enrollees (84 percent) receive APTC to offset this cost (see Table 5, page 10) and for these individuals, coverage in 2018 is even *more* affordable in 2018 than 2017, with their average premium after APTC going down about 3 percent (see Table 6, page 10). 2. For the consumers who receive the federal tax credit, the premium is *not* their financial bottom line. Rather, the report identifies that more consumers have access to a "lowest-cost plan" that is less than $75 per month, from 71 percent of enrollees in 2017 to 80 percent of enrollees in 2018 (see Table 9, page 14), but chooses not to identify this fact in the "Key Findings." 3. Similarly, nearly 9 in 10 (86 percent) of consumers in 2018 can obtain coverage for less than $150 per month after the Advanced Premium Tax Credit (APTC) (see Table 9, Page 14). 4. For individuals *not* receiving a subsidy, as discussed earlier, the premium figures for 2018 are misleading since they reflect health insurance companies' loading the cost of the CSR program, which can, for most unsubsidized individuals, be avoided by purchasing a Silver plan off-exchange (or switching to a different metal tier on-exchange).

Issue Participation: Issuer participation in the Exchange continue to decline with 132 total state issuers in PY18, down from 167 in PY17. Eight states in PY18 will have only one issuer: Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina and Wyoming.

The following summary data builds on a shortcoming of the report itself with regard to issuer participation and plan choice, in that it describes only the federal marketplace states.[11] When the 12 state-based marketplaces are included, the overall picture is a better representation of the individual markets nationally.

	Federally Facilitated Marketplace (FFM) States	State-Based Marketplace (SBM) States	All States
1 Issuer	5	0	5
2 Issuers	7	4	11
3 Issuers	9	1	10
4 Issuers	7	1	8
5+ Issuers	11	6	17
1 Issuer	8	0	8
2 Issuers	12	5	17
3 Issuers	6	0	6
4 Issuers	5	2	7
5+ Issuers	8	5	13

Useful information that would help make data on issuers and the number of plan and product offerings more meaningful would include conveying the reality that "all care is local." Instead of the "Key Findings" reflect only totals and the circumstances of consumers with only one carrier, important information can be found in the fact of significant variation across states. While there are eight states in the federally facilitated marketplace with only one issuer, as of 2018 even just among Federal

[11] This table was created using two data sources: 1) The number of issuers for the 39 states on the federally facilitated marketplace is from Table 1A (page 19) of the ASPE report; and 2) the number of issuers for state-based marketplaces was obtained from a recent Kaiser Family Foundation analysis examining insurer participation, available at: https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/.

	Exchange states there were also eight states that had five or more issuers. When State-based Marketplaces are included in the analysis, we see that no State-based Marketplaces have only one carrier and across the nation twenty states have four or more carriers (among them California, which has eleven). For example, with this information, what we see is that a majority of states (26 states, or 51 percent) have three or more issuers in 2018. The importance of this data is not to describe the glass as "half full" versus "half empty," but to draw attention to policy makers to the wide variation, and flag for further research why even in the face of unprecedented uncertainty in the individual market there remain so many states with robust competition and the need to better understand the contributing factors to fostering more effective individual markets.

Issuer and Plan Options: 29% of current enrollees will have only one issuer to choose from, up from 20% in PY17. The average number of qualified health plans (QHPs) available to enrollees is 25 for PY18, down from 30 in PY17. Alaska, Arizona, Iowa, and Mississippi enrollees will have the fewest QHPs in PY18 (an average of 5 QHPs per county), while Florida will have the highest (an average of 55 QHPs per county).	As with the prior notes, context is critical to the data presented. Beyond providing averages and the change in enrollees with only one issuer, there are no summary findings that could be very relevant in areas such as: 1. Because of the wide variation in issuer and health plan availability, displaying averages only and focusing on the one-issuer states means the report does not help understand the variability across the nation. Additional key findings in this area could include: • Almost half (45 percent) of enrollees have three or more issuers from which to choose. (See Table 2, page 5.) • The "glass half full" portrayal of the single issuer option is that over 70 percent of enrollees have multiple choices of carriers — even in the face of carrier exits. 2. What number of issuers is "enough" to promote effective competition at the health-plan level? How many Americans are in markets that meet or exceed that level? • The key finding related to the number of health plans in a region does not assist consumers or policy makers in assessing what is either good or bad (beyond the clearly challenging data point of only one issuer, which translates to five health plans in the four states referenced, since each carrier offers standard metal tiers). • There is no evaluation or framing of what number of carriers or health plans is potentially good or bad. Behavioral-economics literature is clear that "more choice" is not always good for consumers.[12] But what does that mean for a single carrier offering more benefit-design variations or the nature of consumers' choices?

[12] Hanoch, Yaniv, Thomas Rice, Janet Cummings, and Stacey Wood, "How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit," *Health Services Research*, Vol. 44, No. 4, August 2009, pp. 1157–1168; Barnes, Andrew J., Yaniv Hanoch, and Thomas Rice, "Determinants of Coverage Decisions in Health Insurance Marketplaces: Consumers' Decision-Making Abilities and the Amount of Information in Their Choice Environment," *Health Services Research*, Vol. 50, No. 1, February 2015, pp. 58–80; Johnson, Eric J., Ran Hassin, Tom Baker, Allison T. Bajger, and Galen Treuer, "Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture," *PLOS ONE*, Vol. 8, No. 12, December 18, 2013, p. e81521; and Abaluck, Jason, and Jonathan Gruber. *Improving the Quality of Choices in Health Insurance Markets*. Working Paper No. 22917. National Bureau of Economic Research, Dec. 2016. Web. 28 Feb. 2017.

	3. What is the nature of the choice consumers have and the products available to them? • The "Key Findings" provide summary data of what is presented in the detailed tables describing numbers of issuers, health plans and health plans per issuer. None of those descriptions, however, helps one understand what sort of designs are available to consumers. For example, one major concern raised about benefit designs in general is the impact of high deductibles resulting in care being effectively out of reach for many consumers. Instead of reporting on just the number of health plans, the report could collect and total the number of health plans through which consumers do *not* need to meet a deductible prior to seeing clinicians in outpatient settings. (Note: In California, this would be all health plans at the Silver, Gold and Platinum tiers.)

ASPE Data Point: Individual Market Premium Changes: 2013-2017, May 23, 2017

Additional Potential Key Findings

Affordability: Advance Premium Tax Credits adjust to insulate consumers from rate changes and, on average, the cost of coverage for consumers receiving the APTC is going down about 3 percent in 2018 (see Table 6):

- A 27-year-old earning $25,000 in 2018 will on average get a monthly tax credit of $273, a 73 percent increase compared to the tax credit in 2017. As a result, this consumer's net premium is $138 per month for a $411 benchmark plan in 2018. This amount is $4 lower than the consumer's net premium of $142 per month in 2017 for a $300 benchmark plan, after receiving $158 in APTC.

- A family of four earning $60,000 in 2018 will on average get a monthly tax credit of $1,088, a 60 percent increase compared to the tax credit in 2017. As a result, this family's net premium is $397 per month for a $1,485 benchmark plan in 2018. This amount is $10 lower than the family's net premium of $407 in 2017 for a $1,088 benchmark plan, after receiving $678 in APTC.

The display of "Benchmark Premiums" and "APTC" in Table 6 (page 10) does not facilitate the interpretation of what happens to the vast majority (84 percent) of marketplace enrollees who receive APTC. These consumers are not only insulated, but their actual costs will on average go down in 2018 — but not only is this not a "Key Finding" for the report, but the data on this issue is presented in way that requires readers to do their own math to calculate the impact. When calculated the clear fact that for the 84 percent of market place enrollees who receive APTC will have <u>their</u> premium costs go down about 3 percent in 2018 – it is hard to comprehend that this is not a "Key Finding".

Variation on Cost and Affordability: In the body of the report and in the attached exhibits, the report provides extensive description of the "Second Lowest Cost Plan" and the "Lowest Cost Plan" (See Figure 1 and Tables 3, 4, 8, 9 and Tables 5A and following in the Appendix). The detail provided is then summarized in the very few "Key Findings" identified above, which provide very little context or help to readers to understand the wide variation in costs both across states and within states.

As the summary chart that follows begins to explore, the cost variation is substantial both between states and within states. For 2018, what is potentially "misleading" about the discussions of the Second Lowest Cost Silver Plan is, as discussed above, this is not what consumers getting subsidies pay and for those who do not get subsidies in most states they can by silver products without the CSR-surcharge.

Nonetheless, with appropriate context, gross premiums – at silver and bronze – can be important reference points for understanding both health care costs, risk mix of those coverage and market competitiveness. Understanding these factors requires looking at variation. For example, while the Average SLCSP for a 27-Year Old for all Healthcare.gov states is $411; it ranges from a low of $312 (Ohio – 24 percent lower than average) to a high of $710 (Wyoming – 73 percent higher than the average).

As interesting as these figures are, averages rarely tell the whole story or provide the best tools for policy makers. As detailed in the attached, while California's Average SLCSP for a 27-Year Old is $352 (14 percent less than the national average); in major metropolitan

areas it ranges from $277 (Los Angeles – 32 percent lower than the national average) to $414 (Oakland – 1 percent higher than the average) – and a spread between Los Angeles and Oakland of 49 percent.

Similarly, the variation within Pennsylvania is as or more interesting than is the fact that it's Average SLCSP for a 27-Year Old is $472 (15 percent higher than the national average).

- In Pittsburgh the rate is $293 (29 percent lower than the national average)
- In Philadelphia it is $521(27 percent higher than the national average)
- A spread between Pittsburgh and Philadelphia of 78 percent.

These examples seek to flag the sort of variation that policy makers need to understand and grapple with in terms of understanding the cost drivers and potential ways to address them.

HIGHLIGHTS OF REGIONAL VARIATION IN 2018 GROSS PREMIUMS FOR 27 YEAR OLD: SECOND LOWEST SILVER (SLS) AND LOWEST-COST PLAN (LCP)

Data for OH and PA from ASPE brief (https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf) and Covered California from internal estimates.

	Statewide	Lower Cost Region			Higher Cost Region			Range	
	Average Premium	Average Premium	Difference From Statewide		Average Premium	Difference From Statewide		Difference Between Lower and Higher Regions	
		$	$	%	$	$	%	$	%
California		Los Angeles			Oakland				
Second Lowest Silver	$ 352	$ 277	$ (75)	-21%	$ 414	$ 62	18%	$ 137	49%
Lowest-Cost Plan	$ 233	$ 206	$ (27)	-12%	$ 262	$ 29	12%	$ 56	27%
Florida		Miami			Jacksonville				
Second Lowest Silver	$ 382	$ 349	$ (33)	-9%	$ 376	$ (6)	-2%	$ 27	8%
Lowest-Cost Plan	$ 256	$ 243	$ (13)	-5%	$ 267	$ 11	4%	$ 24	10%
Pennsylvania		Pittsburgh			Philadelphia				
Second Lowest Silver	$ 472	$ 293	$ (179)	-38%	$ 521	$ 49	10%	$ 228	78%
Lowest-Cost Plan	$ 300	$ 199	$ (101)	-34%	$ 329	$ 29	10%	$ 130	65%

Choice: Consumers can save by switching plans, including the lowest-cost option in the same metal tier, or a Bronze or Gold plan due to a larger increase in the benchmark plan for 2018.

Quantifying potential savings associated with shopping would not only benefit consumer's pocketbook, but also the federal government, which would pay out less in APTC.

On page 18 of the report, it notes that prior reports included analysis of the impacts on consumers of shopping and switching plans, as well as income stratification and other analysis. The report states this information is "not included" for the 2018 federal marketplace.

One of the key values of marketplaces is the value of being able to shop and switch plans. In California, the potential rate increases have been substantially lower because consumers do shop and switch.

While Healthcare.gov provides consumers decision-support tools, consumers first need to get to the marketplace. For this reason, rate changes should be messaged within the context of encouraging consumers to shop for a better deal.

Reasons for Premium Increases: The report makes no attempt to describe the reasons behind 2018 rate increases, when the data is public and would help inform policy makers.

What follows are the reasons cited by different sources examining the individual market:

- Medical inflation (ranging from 5 to 9 percent).
- Expiration of the health insurance tax holiday (ranging from 2 to 4 percent).
- Morbidity corrections and change in health status (ranging from 1 to 4 percent).
- Cost-sharing reduction pricing: most often loaded on Silver exchange products only (ranging from 7 to 38 percent).
- Federal policy uncertainty, such as the continued enforcement of the tax penalty (ranging from 2 to 9 percent).

November 20, 2017

Seema Verma
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Request for Information on Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Administrator Verma,

Covered California is submitting comments in response to the request for information on the future of the Center for Medicare and Medicaid Innovation. Covered California is the state's health insurance Marketplace, where Californians can find affordable, high-quality health plans.

The mission of the Center for Medicare and Medicaid Innovation (CMMI) is one that involves identifying, developing, testing, and disseminating alternative models of paying for, organizing, and delivering care. Highlighting the importance of improving health care quality at a reduced cost, the Affordable Care Act (ACA) provided the Secretary of Health and Human Services (HHS) the authority to scale new payment approaches nationally that demonstrably reduced costs without adversely affecting quality or improved quality without a significant downside.

Covered California's Commitment to Delivery System Reform

Covered California believes that promoting a delivery system that drives high health care, lowers costs and reduces the highly variable quality of care in the United States is as important as focusing on expanding health coverage. Covered California's health plan contract terms build on the CMS requirement that Qualified Health Plans implement a Quality Improvement Strategy for 2017. From its founding, Covered California has engaged in a multi-stakeholder process with other California purchasers, health plans, providers and consumer advocates to develop a robust set of initiatives to promote better quality and lower cost health care. This work culminated in all eleven contracted health plans adopting a common strategy in partnership with Covered

California so that providers have a consistent set of priorities and target metrics to achieve.

Covered California's contracted health plans are committed to taking concrete steps related to all elements of the quality improvement and delivery system reform strategy including:

- Accountability for quality performance in developing their provider networks for Covered California enrollees;
- Alignment with the Center for Medicare and Medicaid Services' initiatives, and those of CMMI, through promotion and adoption of integrated and coordinated models of care within all products, including in PPOs and EPOs;
- Adoption of value-based standard benefit designs and payment reforms that align with and support integration and coordination of care;
- Tracking, trending and reducing disparities in health outcomes by ethnic/racial group and gender; and
- Improving transparency in enrollee cost share and quality of care in enrollee provider selection.

Across these initiatives, Covered California promotes not only alignment with Medicare's movement to promote value, but also with other purchasers, such as CalPERS, the Department of Health Care Services (which runs California's Medicaid program) and private employers. For more comprehensive details, Covered California welcomes CMS to examine the quality improvement and delivery system reform strategy referenced here as Attachment 7 of the Covered California 2017 Individual Market QHP Issuer Contract.

CMMI's Future Path: The Need for Continued Alignment with Other Purchasers

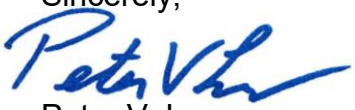
Looking ahead, CMMI should not leave behind the work under current demonstration projects. For example, CMMI has launched initiatives to strengthen primary care value both through supporting clinical transformation to advanced primary care models and the Comprehensive Primary Care Plus (CPC+) model, moving away from a fee-for-service model toward population-based payment with performance bonuses based on standard measurers of quality and utilization. Leveraging this work, as of 2017, Covered California required that all enrollees, whether covered by an HMO or PPO, be matched with a primary care physician and requires plans to adopt payment strategies aligned with CPC+. Covered California's intent is to build on the evidence that delivery systems that emphasize the role of the primary care physician as the preferred initial point of entry into the health care system demonstrate higher value. Similarly, Covered California expects health plans to align with the CMMI Accountable Care Organization models.

As CMS begins the next phase for the Innovation Center, it must build on the progress made on improving the health of populations while reducing the cost of care. It is important to consider that as CMMI continues to pursue current initiatives and launch

new ones, the best way for CMS to effectively move the needle on value-based care is through engagement and partnerships with states (both in their management of Medicaid and as major employers), Exchanges, employers and private insurers. Through our strategy to combine coverage expansion with quality improvement and delivery system reform, Covered California is targeting a tipping point for the adoption of innovative reforms affecting the entire population of California. We can only move to impact the delivery system by working with clinicians and the delivery system in concert with CMS and other purchasers.

Thank you for your consideration of our comments. If you have any questions or would like more information, please feel free to contact me.

Sincerely,



Peter V. Lee
Executive Director

cc: Covered California Board of Directors

AAFP

2017 PCPCC Fall Conference

States Build on Primary Care Models to Expand Access

October 17, 2017 12:02 pm Michael Laff (mailto:aafpnews@aafp.org) Washington, D.C. – As federal lawmakers consider the best way to extend health care to the uninsured, they might find lessons in states that make primary care the foundation for increasing access to care.

Experts discussed the strategies used by some successful state health care initiatives in presentations during the Patient-Centered Primary Care Collaborative Fall Conference (https://pcpccevents.com/wp-content/uploads/2017/10/PCPCC-2017-Fall-Conference-Final-10-6-172.pdf) held here Oct. 11-12.

Peter Lee, J.D., executive director of Covered California, discusses how the state insurance marketplace maintains a competitive environment while keeping many residents covered. Lee spoke during the 2017 Patient-Centered Primary Care Collaborative Fall Conference.

Peter Lee, J.D., executive director of Covered California, discussed how this state insurance exchange maintains a balance between affordable plans for consumers and a market that insurers want to be in.

In all its contracts with insurers, Covered California requires participating plans to address four priorities:

- promotion of primary care,
- health disparities,
- coordinated care and
- a move away from strict fee-for-service payment.

Putting primary care at the center of health care helps solve a problem that Lee pointed out: the fact that expanding coverage through public spending initially leads to increased ER visits, which critics point to as evidence that expansion does not control costs. But he said that's because the ER is the normal point of care for people who were recently uninsured.

STORY HIGHLIGHTS

- Experts at the Patient-Centered Primary Care Collaborative Fall Conference discussed strategies used by various successful state health care initiatives.
- Covered California assigns every individual who enrolls in plans through its marketplace to a primary care clinic and exempts primary care office visits from deductibles.
- Oregon's Patient-Centered Primary Care Home program earmarks 12 percent of spending to primary care.

"We have to change the culture by moving their normal point of care," Lee said.

As an important step toward this goal, in 2017, Covered California assigned every enrollee to a primary care clinic within 60 days.

"We told patients, 'If you don't know where to go, start here,'" Lee said.

Another strategy to emphasize primary care has been to exempt primary care office visits from deductibles for patients who obtain coverage through Covered California. Lee pointed out that low-income patients are unlikely to schedule primary care visits if they face a high deductible.

"There is no continuity of care if you are thinking about a $3,000 deductible between you and the doctor," Lee said.

The design of the California marketplace attracts a high volume of healthy individuals, which allows insurers to lower costs and keep premiums down. It also keeps the state from facing the problem of insurers pulling out of the market and leaving scant competition. Eleven insurers participate in Covered California, the same number as when the program began.

On average, enrollees stay with Covered California plans for 26 months, and 40 percent leave each year. Eighty-five percent of those who leave Covered California sign on with another plan, compared to only about 50 percent of those who leave the federal exchanges. Lee explained that many young individuals decide they are healthy enough to leave their plans without an alternative after they have insurance for a year.

California is not the only state reporting success with increased access. In 2009, Oregon wanted to transform primary care by moving 75 percent of all residents into a patient-centered medical home (PCMH) model. The transition was completed in 2012; now there are 630 PCMH practices statewide, and 80 percent of residents obtain care in one of these practices.

Although the transformation is a success in terms of access, the state is still working to make it financially sustainable for practices to make changes such as integrating the services of behavioral health specialists and pharmacists, said Evan Saulino, M.D., Ph.D., a family physician who serves as clinical adviser for Oregon's Patient-Centered Primary Care Home program.

Oregon officials looked nationally for programs that illustrated sufficient investment. They modeled their system on a Rhode Island program that devotes 12 percent of health care spending to primary care. As a comparison, Medicaid also spends about 12 percent on primary care, but for commercial insurers, that average falls to just 6.5 percent.

"There were huge differences in investment without any explanation," Saulino said.

To back up the state's requirement, Oregon asked insurers to report their annual expenditures on primary care. The state's medical home model saved $240 million in health costs in its first three years, Saulino noted.

Such outcomes suggest the possibility of more widespread change.

"There are some things that both parties can agree upon across the political spectrum, and primary care transformation is one of them," Saulino said.

Related *AAFP News* Coverage

Patient-Centered Primary Care Collaborative Report

Broader Look Shows How PCMH Touches Practices, Patients (http://www.aafp.org/news/practice-professional-issues/20170725pcpccreport.html)
(7/25/2017)

2016 PCPCC Fall Conference

Panel Highlights Team Approaches to Patient-centered Primary Care (http://www.aafp.org/news/practice-professional-issues/20161114pcpccteams.html)
(11/14/2016)

3 comments

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Robert Charles Bowman, MD • October 18, 2017 8:35 PM

States are not likely to be building primary care. Cost cutting has dominated their policy for decades. They have also been told of the wonders of innovation and micromanagement – but not the consequences.

Changes in the financial design assure decline of access and primary care. Hard work is required to build primary care and access. The 1950s through the 1970s are evidence of the one time of hard work and building up of primary care and access. The 1990s through the present have been the opposite. Rosy statements about improvements and solutions during a

time of failure do not help.

Demonstrating success in access is not possible because of the current financial model. Those who discuss success before the financial model is addressed have demonstrated their lack of awareness in the key areas – primary care, care where most Americans most need care, and insurance plan deficits. Places with concentrations of the least supportive private and public plans have deficits of workforce and access – by design.

Revenue too low, costs of delivery increasing, and complexity increasing in multiple dimensions is the Triple Threat impairing primary care and access. Triple Threat has long been compromising generalist and general specialty practices which provide 90% of local access services where most Americans are found.

No state makes primary care the foundation for increasing access to care. These are words spoken by associations or consultants or politicians or staffers. Your best source about access to care are about 36% of family physicians that can deliver volumes about the lack of state, federal, local, employer, and insurance plan consideration of primary care as a foundation.

Primary care does not need promotions of magical solutions. Primary care needs funding. The funding must be specific to the team members that deliver the care and in ways that allow them first to do their basic jobs and then to work toward higher functions such as coordination, outreach, integration, and working with the community on the resources, jobs, and other efforts that actually do shape health, education, and economic outcomes.

Primary care funding could be a way to address disparities. Instead primary care is paid too little and is paid 15% less where most Americans most need care. This results in disparities in access, social determinants, and outcomes as dictated by the financial design for health care.

Coordinated care is a pied piper dream. It is a myth for most Americans that have half enough primary care and the worst private and public plans or the least ability to pay. When primary care in lowest concentration counties gets 70 billion instead of 40 billion and mental health funding to these counties is doubled, then there can be discussion of integration and coordination. Until then, there is little to integrate or coordinate.

Movements away from fee for service have yet to demonstrate anything but worsening of the financial design for primary care, especially where most needed. Fee for service has not been demonstrated to harm primary care or patients where most Americans most need care. But overutilization in higher to highest workforce concentration counties has been rampant at 2 to 4 times the national average for various specialized services. Those who assume overutilization clearly act to destroy access where workforce is insufficient – by financial design.

There cannot be transformation in primary care without a solid financial foundation. The numbers and claims made about Triple Aim, Pay for Performance, Primary Care Medical Home, Value Based, digitalization, and micromanagement do not add up. In fact they subtract

from care, caring, numbers of delivery team members, and access

In 2621 lowest physician concentration counties with 40% of the population and 70,000 primary care physicians (90,000 primary care physician equivalents), there are only 40 billion dollars for revenue for primary care. Lower collection rates subtract about 2 billion. Innovation, digitalization, regulation, and certification have subtracted 6 to 8 billion dollars – dollars that cannot be spend on team members, clinicians, physicians, care, and caring because they have been shipped to serve those coming up with created solutions – a choice made rather than hard work and investment in primary care team members.

When you steal from the poor to give to the rich, it is called worsening of disparities. In addition fewer patients can be seen due to EHR and other complications arising from the last decade of rapid change. After a decade of ridiculous claims made about all of the wonderful cost, quality, and outcomes improvements – some accountability is required.

Robert Charles Bowman, MD • October 18, 2017 8:37 PM

How can any claims of access success be made when those who deliver access are being compromised, and compromised to a greater degree where most Americans most lack access?

How can you claim success when the numbers and articles indicate little or no increase in revenue, and billions stolen from primary care practices (and their communities), and decreased productivity, and decreased morale, and increased turnover frequency and cost per lost employee?

Have you even seen the sad situations that people face with even average insurance when they try to get to primary care, or when they do get into primary care but cannot do so in a timely fashion, and cannot get to other care because of the logjam called primary care?

How can you claim access improvement when all MD DO NP and PA sources of primary care are falling to ever lower proportions active in primary care positions? The newest classes of family physicians are likely to dip below 50% remaining in primary care, if not already. Family medicine was the last to be compromised below 50%, but it has fallen fast – and by financial design. Family practice positions filled by MD DO NP and PA are by far the most important because they are the only positions distributed according to the population – but fewer and fewer of each indicates failure in access.

How can you claim access improvements with huge levels of insurance plan churn and constant revolving doors of practices, clinicians, and physicians?

How can you integrate primary care and mental health when half of Americans are found in places with half enough of each – where primary care ends up doing 60% of local mental health services instead of the usual 50% because mental health is even more impaired by Triple Threat than primary care?

For decades those delivering access where needed have indicated the need for more support, more colleagues, and more team members but the designs are shrinking women's health, public health, primary care, general surgery, general orthopedics, and mental health.

Michigan BCBS is an example of dollars invested in primary care, not more requirements disabling primary care to a greater degree. Investment matters. Consultants and certifications do not.

Oregon Primary Care Medical Home did not save the money indicated. Other claims made such as ER visits saved were contradicted by actual figures. The cost of establishing primary care medical home in 630 practices in Oregon was easily 250 million to 350 million dollars.

As CBO demonstrated with managed care and managed cost, the costs of the intervention negated the savings. Small practice costs are $80,000 to $120,000 per primary care physician which is why many small primary care practices, those where primary care is most needed, and those paid least by private and public payers have not implemented PCMH.

Donald Claude Brown, MD • October 19, 2017 9:15 AM

Thank you, Dr. Bowman. Even if the AAFP ignores them, there are many of us who appreciate your well-reasoned, evidence-based comments.

Yet another article heaping praise on those who are working to destroy our specialty.

Stockholm Syndrome, anyone?

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Cuts to the ACA's Outreach Budget Will Make It Harder for People to Enroll

October 11, 2017

Authors

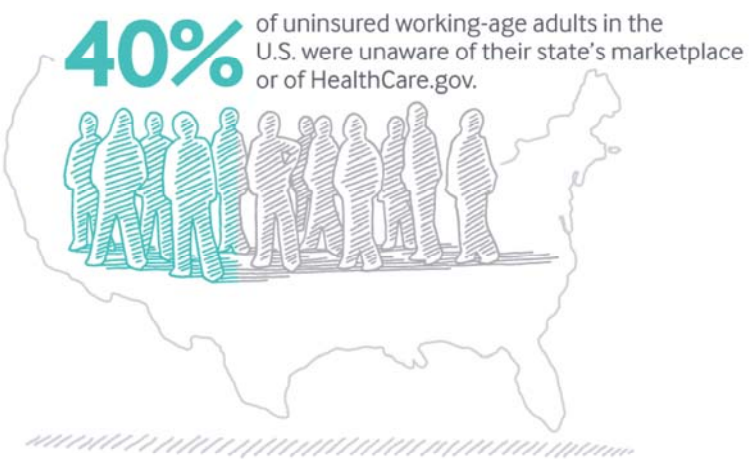
Shanoor Seervai

By Shanoor Seervai

At a recent concert in Clearwater, Florida, Jodi Ray was proud to recognize the lead singer — a previously uninsured man in his forties, whom she helped get health coverage. Ray, who directs a navigator program that helps individuals enroll in health insurance in Florida, guided him through the process of buying a plan through the Affordable Care Act's (ACA) health insurance marketplace.

"He told me that he couldn't even remember the last time he went to a doctor, ever," she said. "The next time I saw him, he was playing with his band. He was so excited, he came up to me and said, 'Guess what? I went and had a physical.'"

Navigators like Ray play a key role in getting information to those who don't know about their coverage options. A recent Commonwealth Fund ACA tracking survey



(http://www.commonwealthfund.org/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage) found that two of five (40%) of America's 27.5 million uninsured working-age adults (http://www.commonwealthfund.org/publications/blog/2017/sep/number-of-uninsured-americans-dropped-by-1-million-in-2016) were not aware of their state's marketplace or of HealthCare.gov (http://www.healthcare.gov/), the federal website for people seeking health insurance.

As 2017's open enrollment period (beginning on November 1) approaches, navigators like Ray are at risk of not being able to do their job — helping enroll some of America's most vulnerable populations, including low-income people in remote areas, racial and ethnic minorities, immigrants who don't speak English, and formerly incarcerated individuals.

The Trump administration announced in August that it will cut the federal ACA advertising budget from $100 million in 2017 to $10 million in 2018, and reduce support for the navigator program, from $62.5 million to $37 million. Grants ran out for navigators on September 1, and they were asked to submit new budgets (https://khn.org/news/latest-snag-in-aca-sign-ups-those-who-guide-consumers-are-hitting-roadblocks/) to the Centers for Medicare and Medicaid Services, but it's unclear if or when these funding requests will be approved. The uncertainty around funding is effectively pausing the navigator program — organizations are halting operations and laying off staff (https://www.vox.com/platform/amp/policy-and-politics/2017/9/8/16268572/trump-obamacare-navigators).

The decision to gut outreach efforts is likely to destabilize the individual marketplaces when they open on November 1 for 45 days (half of last year's 90-day enrollment period, and with closures nearly every Sunday). To counter the widespread uncertainty and misinformation about open enrollment under the Trump administration, a group of former health officials in the Obama administration on October 4 launched a project to provide guidance on coverage called Get America Covered (https://getamericacovered.org/). "Getting accurate information out is exceptionally important now, knowing that we have this shortened open enrollment period and a lot of people can be caught off guard," Ray said.

The Commonwealth Fund has found that better information about choices and costs has a positive impact on enrollment, particularly among people who are eligible for subsidies. Results from the tracking survey (http://www.commonwealthfund.org/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage) revealed two-thirds (66%) of adults who received personal assistance when they shopped for coverage enrolled, compared to fewer than half (48%) who had not received assistance.

State experiences offer some additional insight into the impact of education and assistance. Analysis of 2017 marketplace enrollment trends (http://www.commonwealthfund.org/publications/blog/2017/may/2017-federal-state-marketplace-trends-show-value-of-outreach) by Georgetown University researchers found that state-based efforts to bolster outreach and enrollment — such as bigger investments in advertising or extending the enrollment signup period — likely increased enrollment. Conversely, states such as Texas that restricted outreach saw lower enrollment. Harvard researchers (http://www.commonwealthfund.org/publications/q-and-a/2015/jun/how-state-policies-affected-aca-enrollment) who examined state policies in Arkansas, Kentucky, and Texas found navigator programs improved the enrollment success rate of applicants by about 8 percentage points (from 85% to 93%).

Despite this evidence, not only has the total funding for navigator grants been reduced, but if grantees receive funding at all, it will be based on their ability to meet their enrollment goals during the previous year (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Policies-Related-Navigator-Program-Enrollment-Education-8-31-2017pdf.pdf). For example, if a navigator meets 50 percent of its enrollment target in 2017, it will receive half its grant funding in 2018.

It isn't clear whether or not enrolling someone in Medicaid or the Children's Health Insurance Program counts towards these performance goals, even though navigators are expected to assist anyone in need of coverage regardless of program eligibility (https://ccf.georgetown.edu/2017/09/07/reduced-funding-for-navigators-and-public-education-could-harm-nations-success-in-covering-kids/). This makes the goal of meeting targets doubly harmful to the poor — if enrolling them in Medicaid doesn't count, navigators may be forced to focus on enrolling those with higher incomes, who will buy insurance on the marketplaces.

"The fear is that if the metric is how many people you enrolled, that'll lead to incentives to sign up as many of the easy to enroll as you can and not spend the time on the hard to reach," explains JoAnn Volk, a senior research fellow at the Georgetown University Center on Health Insurance Reforms. "You can't match up funding with enrollment levels, because there are many reasons people don't enroll in the marketplace — affordability, eligibility for Medicaid, complicated immigration status."

Those who are hard to reach are most at risk of lacking coverage: as the Commonwealth Fund's survey found

The fear is that if the metric is how many people you enrolled, that'll lead to incentives to sign up as many of the easy to enroll as you can and not spend the time on the hard to reach.

JoAnn Volk

Senior Research Fellow, Georgetown University Center on Health Insurance Reforms

(http://www.commonwealthfund.org/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage), those with low incomes, and racial and ethnic minorities, are most likely to lack coverage, in part because they may be unaware of the marketplaces.

New York, which has a well-developed navigator program, associates an increase in the insurance rate among racial and ethnic minorities with the benefits of increased awareness that the navigator program has been able to generate, according to Elisabeth Benjamin, vice president of Health Initiatives at the Community Service Society of New York, a nonprofit.

Vulnerable communities, who have a higher need for preventive care, "because the social determinants of health drive higher rates of diabetes, heart disease, and asthma, are also much harder to reach and require more effort," Benjamin said. But they are the ones who get left out when resources are depleted. "Not all enrollments are created equal."

A navigator guides an individual through the enrollment process during an enrollment event at the University of South Florida. Photo courtesy of Florida Covering Kids & Families.

New York State's navigator program, which is state-funded, has been successful in part because navigators have good coverage options to offer: the state has both expanded Medicaid eligibility and made available the ACA's Basic Health Plan. Nearly 700,000 New Yorkers have enrolled in this plan, which offers quality coverage without deductibles, for free or for $20 per month.

New York has also invested in other outreach efforts, in particular, advertising and media campaigns.

Other states have found that strategic marketing and outreach are vital investments to increase not just enrollment, but also continued coverage. "The marketing piece is key for making sure healthy people stay covered," said Peter Lee, executive director of Covered California, the state's health insurance marketplace.

California alone budgeted $111 million for marketing and outreach (which includes navigator programs) in 2018. This may seem like a lot, but marketing and outreach actually help California save money, because higher enrollment leads to lower premiums and a more stable marketplace. A recent Covered California report (http://hbex.coveredca.com/data-

Marketing pays for itself several times over. Our modeling shows that marketing is vital and critical, and cutting it leads to a far worse risk mix.

Peter Lee

Executive Director, Covered California

research/library/CoveredCA_Marketing_Matters_9-17.pdf) estimates that marketing and outreach expenses in 2015 and 2016 likely lowered premiums by 6 percent to 8 percent.

The logic is simple: if more healthy people buy insurance, insurance companies can charge lower premiums, which, in turn, incentivize more healthy people to buy insurance. "Marketing pays for itself several times over," Lee said. "Our modeling shows that marketing is vital and critical, and cutting it leads to a far worse risk mix."

California, like New York, no longer relies on the federal government to fund its marketing and outreach efforts. But in states that aren't able to invest on their own, federal money for outreach can go a long way for enrollment.

The marketplaces open in less than one month for 2018 enrollment, at a time of uncertainty and turbulence. At greatest risk are those who lack coverage, or who may allow their coverage to lapse, including people with low incomes and minorities. "Cutting funds for outreach at a time when there is shortened open enrollment creates more and more barriers to reaching the remaining uninsured, and those at risk of losing coverage," Volk said.

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Congressional Budget Office

NOVEMBER 2017

Repealing the Individual Health Insurance Mandate: An Updated Estimate

The Affordable Care Act (ACA) includes a provision, generally called the individual mandate, that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards and that imposes penalties on those without an exemption who do not comply. In response to interest from Members of Congress, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have updated their estimate of the effects of repealing that mandate. As part of repealing the mandate, the policy analyzed would eliminate the penalty that people who have no health insurance and who are not exempt from the mandate must pay under current law.

The analysis underlying this estimate incorporates revised projections—of enrollment in health insurance, premiums, and other factors—made as part of the usual process CBO follows to update its baseline projections. This report updates a budget option published in December 2016 and is not based on specific legislative language.[1]

The Results of CBO and JCT's Analysis

CBO and JCT estimate that repealing that mandate starting in 2019—and making no other changes to current law—would have the following effects:

- Federal budget deficits would be reduced by about $338 billion between 2018 and 2027 (see Table 1).
- The number of people with health insurance would decrease by 4 million in 2019 and 13 million in 2027 (see Table 2).
- Nongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade.
- Average premiums in the nongroup market would increase by about 10 percent in most years of the decade (with no changes in the ages of people purchasing insurance accounted for) relative to CBO's baseline projections.

Those effects would occur mainly because healthier people would be less likely to obtain insurance and because, especially in the nongroup market, the resulting increases in premiums would cause more people to not purchase insurance.

If the individual mandate penalty was eliminated but the mandate itself was not repealed, the results would be very similar to those presented in this report. In CBO and JCT's estimation, with no penalty at all, only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law. If eliminating the mandate was accompanied by changes to tax rates or premium tax credits or by other significant changes, then the policy analyzed here would interact with those changes and have different effects.

For this analysis, CBO and JCT have measured the budgetary effects relative to CBO's summer 2017 baseline, which underlies the Concurrent Resolution on the Budget for Fiscal Year 2018.[2] In that baseline, the ACA's other provisions, including premium tax credits and

1. See Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026* (December 2016), www.cbo.gov/publication/52142.

2. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801. For additional information about the baseline presented in that report, see *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

Table 1.

Estimate of the Net Budgetary Effects of Repealing the Individual Mandate

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Total, 2018–2027
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	-4	-9	-19	-23	-24	-25	-26	-27	-28	-185
Medicaid	0	-5	-9	-16	-20	-22	-24	-26	-28	-29	-179
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	0	*	*	*	*	*	*	*	1
Change in Penalty Payments by Uninsured People	0	*	5	5	5	5	5	6	6	6	43
Medicare[d]	0	1	2	4	5	5	5	6	7	7	44
Other Effects on Revenues and Outlays[e]	0	*	-2	-6	-8	-8	-9	-9	-10	-10	-62
Total Effect on the Deficit	**0**	**-8**	**-13**	**-33**	**-40**	**-44**	**-47**	**-49**	**-51**	**-54**	**-338**
Memorandum:											
Total Change in Direct Spending	0	-7	-14	-30	-36	-40	-42	-44	-46	-49	-307
Total Change in Revenues[f]	0	1	-2	3	4	4	5	5	6	6	31

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's summer 2017 baseline.

Changes in budget authority would equal the changes in outlays shown.

Except as noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.

* = between -$500 million and $500 million.

a. "Related spending and revenues" includes spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on both outlays and revenues.

c. Effects on the deficit include the associated effects that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

e. Consists mainly of the effects that changes in taxable compensation would have on revenues.

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 2.

Effects of Repealing the Individual Mandate on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Change in Coverage Under the Policy										
Medicaid[a]	0	-1	-2	-4	-4	-4	-4	-5	-5	-5
Nongroup coverage, including marketplaces	0	-3	-4	-5	-5	-5	-5	-5	-5	-5
Employment-based coverage	0	*	-1	-2	-2	-3	-3	-3	-2	-2
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	4	7	12	12	12	12	13	13	13

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's summer 2017 baseline. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under age 65, and they include spouses and dependents covered under family policies.

For these estimates, CBO and the staff of the Joint Committee on Taxation consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Numbers may not add up to totals because of rounding.

* = between -500,000 and zero.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

cost-sharing reduction (CSR) subsidies in the marketplaces that the legislation established, are assumed to remain in place.[3]

In the budget option presented last year, CBO and JCT examined the same policy starting a year earlier and relative to CBO's March 2016 baseline: They estimated that the policy would reduce federal budget deficits by $416 billion between 2018 and 2026 and increase the number of uninsured people by 16 million in 2026.

The differences between the budgetary effects shown here and those estimated in December 2016 stem from several sources. The current estimate relies on updated baseline projections related to the federal costs of subsidizing health insurance. This estimate also incorporates CBO and JCT's expectation that individuals' and employers' full reaction to the elimination of the individual mandate would phase in more slowly than the agencies previously projected. (The agencies have incorporated that expectation in all estimates for legislative proposals related to the mandate that they have prepared after the 2017 budget reconciliation process ended in September.) And this estimate includes an interaction with Medicare, whose "disproportionate share hospital" payments to facilities that serve a higher percentage of uninsured patients would be affected.[4]

In addition to updates to the baseline, which occur on a regular cycle, CBO and JCT sometimes make major

3. After consultation with the Budget Committees, CBO has not changed its baseline to reflect the Administration's announcement on October 12, 2017, that it would stop making payments for CSRs. The Balanced Budget and Emergency Deficit Control Act of 1985, which specifies construction of the baseline, requires that CBO assume full funding of entitlement authority. CBO has long viewed the cost-sharing subsidies as a form of entitlement authority—that is, legal authority for federal agencies to incur obligations and to make payments out of the Treasury for specified purposes. On that basis, in the agencies' initial cost estimate for the ACA and in all subsequent baseline projections, they have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action). For a related discussion, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), www.cbo.gov/publication/53009.

4. That interaction, which would add costs totaling $44 billion over the 2018–2027 period, was not included in the December 2016 estimate because, as is often the case with budget options, it followed a simplified method. However, during 2017, the interaction with Medicare has been included in estimates of the effects of major changes to policies affecting health insurance.

methodological changes to improve their estimates. Accordingly, the agencies have undertaken considerable work to revise their methods to estimate the effects of repealing the individual mandate. CBO's Panel of Health Advisers and experts at the American Enterprise Institute, the Office of the Actuary in the Centers for Medicare & Medicaid Services, the RAND Corporation, and the Urban Institute, along with other sources, have provided valuable information during that process.[5] However, the evidence available to inform CBO and JCT's work on that issue is limited. Because that work is not complete and significant changes to the individual mandate are being considered as part of the budget reconciliation process, the agencies are publishing this update now without incorporating major changes to their analytical methods.

However, the preliminary results of analysis using revised methods indicates that the estimated effects on the budget and health insurance coverage would probably be smaller than the numbers reported in this document. The agencies are continuing to work on those methods, and they expect to complete and publish an estimate including and explaining the revisions at some point after the current budget reconciliation process is complete or along with a future update to the baseline.

Uncertainty Surrounding the Estimates

CBO and JCT's estimates of this policy are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to it are all difficult to predict. The responses by individuals in the short term to a policy that would repeal the mandate are uncertain, for example.

The policy's nonfinancial effects—changes in people's tendency to comply with laws and attitudes about health insurance and their greater responsiveness to penalties than to subsidies—amplify its financial effects in CBO and JCT's analysis. The amplification from those nonfinancial effects is harder to project. In large part because of the difficulty in projecting that amplification, different organizations' estimates of the effects of repealing the mandate have varied. The effects could be smaller than those presented here: Some organizations have recently published such smaller estimates that appear to ascribe lesser effects to nonfinancial factors.[6] Alternatively, the nonfinancial effects of the mandate might grow over time—as the effects of many provisions of the tax code appear to have done after their implementation and as could occur if awareness and enforcement of the mandate changed. Under that circumstance, the effects of repealing the mandate could be larger over time.

CBO and JCT's baseline projections are also uncertain, and revisions to them would alter interactions and change the estimates of the effects of eliminating the mandate. For example, if there are no payments for CSRs, premiums in the marketplaces would probably be higher than projected in the baseline. (The Administration has halted those payments, but the baseline projections used in this estimate incorporated the assumption that they would continue.) Premiums that are higher than those in the baseline projections would tend to boost the budgetary savings under this policy by increasing the estimated per-person savings from people no longer enrolling in nongroup coverage. As another example, subsidized enrollment in the marketplaces might be lower than projected in the baseline, which would tend to decrease the budgetary savings under this policy.

Despite the uncertainty, some effects of this policy are clear: For instance, the federal deficit would be many billions of dollars lower than under current law, and the number of uninsured people would be millions higher.

5. For additional information, see Alexandra Minicozzi, Unit Chief, Health Insurance Modeling Unit, Congressional Budget Office, *Modeling the Effect of the Individual Mandate on Health Insurance Coverage* (presentation to CBO's Panel of Health Advisers, Washington, D.C., September 15, 2017), www.cbo.gov/publication/53105; and Congressional Budget Office, "Panel of Health Advisers" (accessed November 7, 2017), www.cbo.gov/about/processes/panel-health-advisers.

6. Those estimates were for the early years of policies that would have initially repealed the individual mandate and later made many other changes. See Office of the Chief Actuary, Centers for Medicare & Medicaid Services, *Estimated Financial Effect of the "American Health Care Act of 2017"* (June 2017), https://go.usa.gov/xnTzU; and Linda Blumberg, Matthew Buettgens, and John Holahan, *Implications of Partial Repeal of the ACA Through Reconciliation* (Urban Institute, December 2016), http://tinyurl.com/y6vkugs4.

This report updates CBO and JCT's estimate of the effects of a budget option that CBO published in December 2016. Susan Yeh Beyer, Kate Fritzsche, Jeffrey Kling, Sarah Masi, Kevin McNellis, Eamon Molloy, Allison Percy, Lisa Ramirez-Branum, and Robert Stewart prepared the report with guidance from Jessica Banthin, Chad Chirico, Holly Harvey, and Alexandra Minicozzi and with contributions from Ezra Porter and the staff of the Joint Committee on Taxation. Theresa Gullo, Mark Hadley, Robert Sunshine, and David Weaver reviewed the document; John Skeen edited it; and Casey Labrack prepared it for publication.

An electronic version is available on CBO's website (www.cbo.gov/publication/53300).

Keith Hall
Director

NATIONAL CENTER FOR HEALTH STATISTICS
National Health Interview Survey Early Release Program

Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2017

by Emily P. Zammitti, M.P.H., Robin A. Cohen, Ph.D., and Michael E. Martinez, M.P.H., M.H.S.A.
Division of Health Interview Statistics, National Center for Health Statistics

What's new?

- This report provides health insurance estimates from selected states using 2017 National Health Interview Survey data.

Highlights

- In the first 6 months of 2017, 28.8 million (9.0%) persons of all ages were uninsured at the time of interview—not significantly different from 2016, but 19.8 million fewer persons than in 2010.
- In the first 6 months of 2017, among adults aged 18–64, 12.5% were uninsured at the time of interview, 19.2% had public coverage, and 69.6% had private health insurance coverage.
- In the first 6 months of 2017, among children aged 0–17 years, 5.0% were uninsured, 42.6% had public coverage, and 54.0% had private health insurance coverage.
- Among adults aged 18–64, 69.6% (137.2 million) were covered by private health insurance plans at the time of interview in the first 6 months of 2017. This includes 4.5% (8.8 million) covered by private health insurance plans obtained through the Health Insurance Marketplace or state-based exchanges.
- The percentage of persons under age 65 with private health insurance enrolled in a high-deductible health plan (HDHP) increased, from 39.4% in 2016 to 42.9% in the first 6 months of 2017.

Introduction

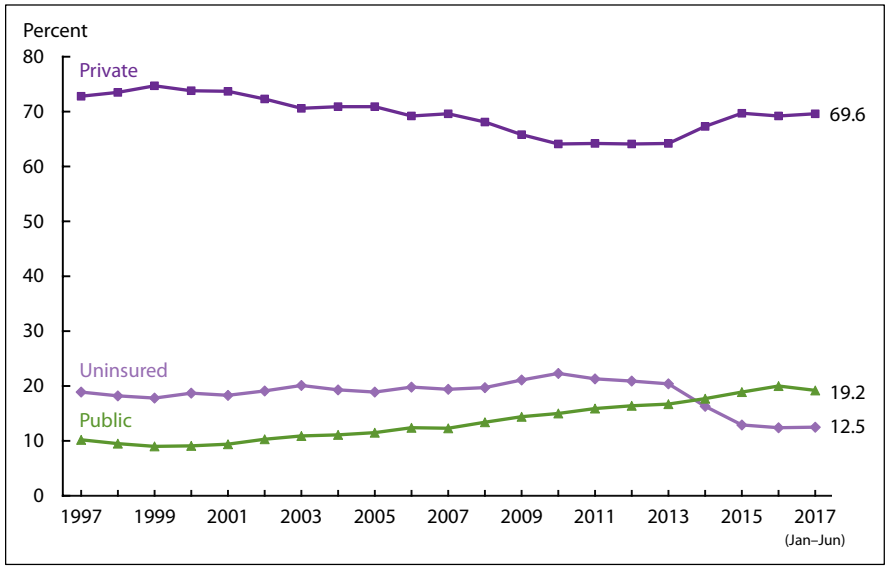
This report from the National Center for Health Statistics (NCHS) presents selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–June 2017 National Health Interview Survey (NHIS), along with comparable estimates from previous calendar years. Estimates for the first 6 months of 2017 are based on data for 39,480 persons.

Three estimates of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured at least part of the year prior to interview (which includes persons uninsured for more than 1 year), and (c) uninsured for more than 1 year at the time of interview. Estimates of public and private coverage, coverage through exchanges, and enrollment in high-deductible health plans (HDHPs) and consumer-directed health plans (CDHPs) are also presented. Detailed appendix tables at the end of this report show estimates by selected demographics. Definitions are provided in the Technical Notes at the end of this report.

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

Estimates for each calendar quarter, by selected demographics, are also available as a separate set of tables through the ER Program. For more information about NHIS and the ER Program, see Technical Notes and Additional Early Release Program Products at the end of this report.

Figure 1. Percentage of adults aged 18–64 who were uninsured or had private or public coverage at the time of interview: United States, 1997–June 2017



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 1997–2017, Family Core component.

Results

In the first 6 months of 2017, the percentage of persons of all ages who were uninsured at the time of interview was 9.0% (28.8 million). There was no significant change from the 2016 uninsured rate of 9.0% (28.6 million). A total of 19.8 million fewer persons lacked health insurance coverage in the first 6 months of 2017 compared with 2010 (48.6 million or 16.0%).

Long-term trends

In the first 6 months of 2017, among adults aged 18–64, 12.5% were uninsured at the time of interview, 19.2% had public coverage, and 69.6% had private health insurance coverage (Figure 1). After generally increasing, more recently, the percentage of adults aged 18–64 who were uninsured at the time of interview generally decreased, and corresponding increases have occurred in both public and private coverage among adults aged 18–64.

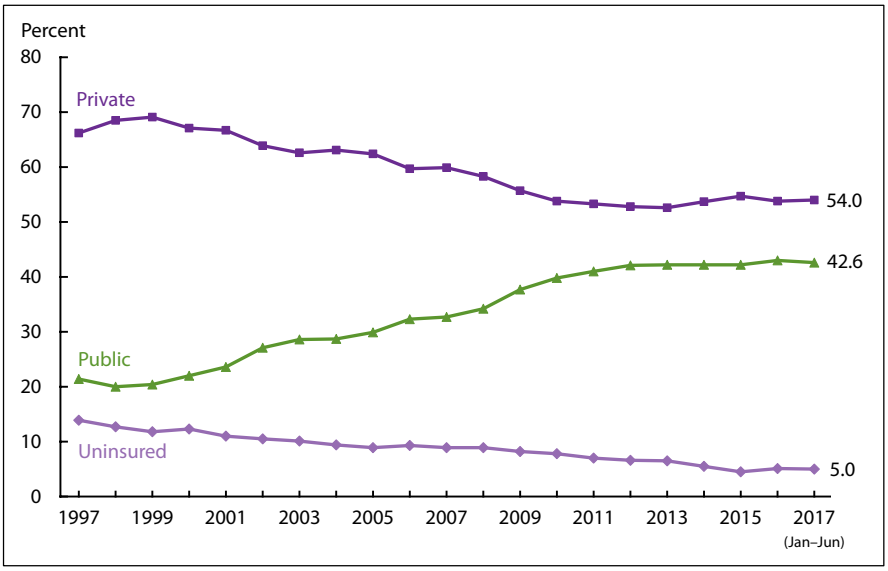
In the first 6 months of 2017, among children aged 0–17 years, 5.0% were uninsured, 42.6% had public coverage, and 54.0% had private health insurance coverage (Figure 2). The percentage of children who were uninsured generally decreased over time, however, the observed increase in the percentage of uninsured children from 4.5% in 2015 to 5.0% in the first 6 months of 2017 was not statistically significant. While the percentage of children with private health insurance coverage has decreased and public coverage increased over time, more recently, the percentage of children with public or private coverage has leveled off.

Short-term trends, by age

In the first 6 months of 2017, adults aged 25–34 were almost twice as likely as adults aged 45–64 to lack health insurance coverage (17.4% compared with 9.0%) (Figure 3). The percentage of adults aged 18–24 who were uninsured was 13.6%, while the percentage for those aged 35–44 was 13.9%.

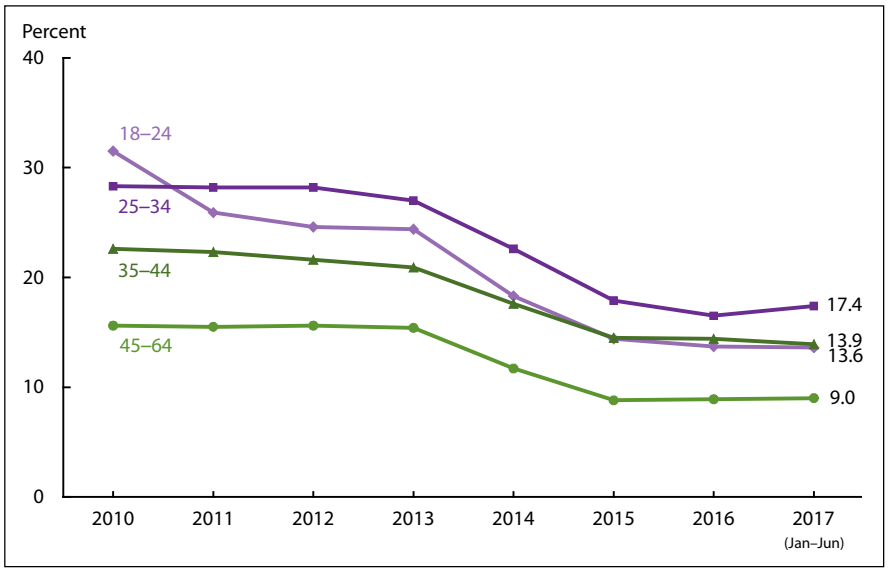
The percentage of those uninsured at the time of interview remained relatively stable from 2010 through 2013 for all age groups except adults aged 18–24 (Figure 3). Among adults aged 18–24, the percentage of those who were uninsured decreased, from 31.5% in 2010 to 25.9% in 2011, and then remained stable through 2013. For all age groups, the percentage of those who were uninsured decreased significantly from 2013 through the first 6 months of 2017. The magnitude of the decreases ranged from –6.4 percentage points for adults aged aged 45–64 to –10.8 percentage points for adults aged 18–24. For adults aged 18–24, 25–34, 35–44, and 45–64, the percentage of those uninsured at the time of interview did not change significantly from 2016 through the first 6 months of 2017.

Figure 2. Percentage of children aged 0–17 years who were uninsured or had private or public coverage at the time of interview: United States, 1997–June 2017



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 1997–2017, Family Core component.

Figure 3. Percentage of adults aged 18–64 who were uninsured at the time of interview, by age group: United States, 2010–June 2017



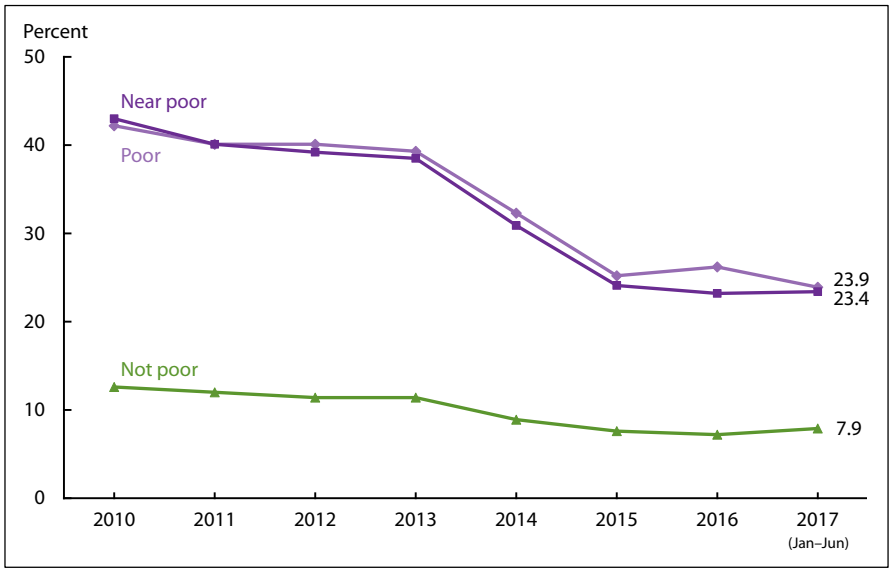
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Short-term trends, by poverty status

In the first 6 months of 2017, among adults aged 18–64, 23.9% of those who were poor, 23.4% of those who were near poor, and 7.9% of those who were not poor lacked health insurance coverage at the time of interview (Figure 4). A decrease was observed in the percentage of uninsured adults from 2010 through the first 6 months of 2017 among all three poverty status groups. However, the greatest decreases in the uninsured rate since 2013 were among adults who were poor or near poor. More recently, among adults who were poor, near poor, and not poor, there was no significant change in the percent uninsured from 2015 through the first 6 months of 2017.

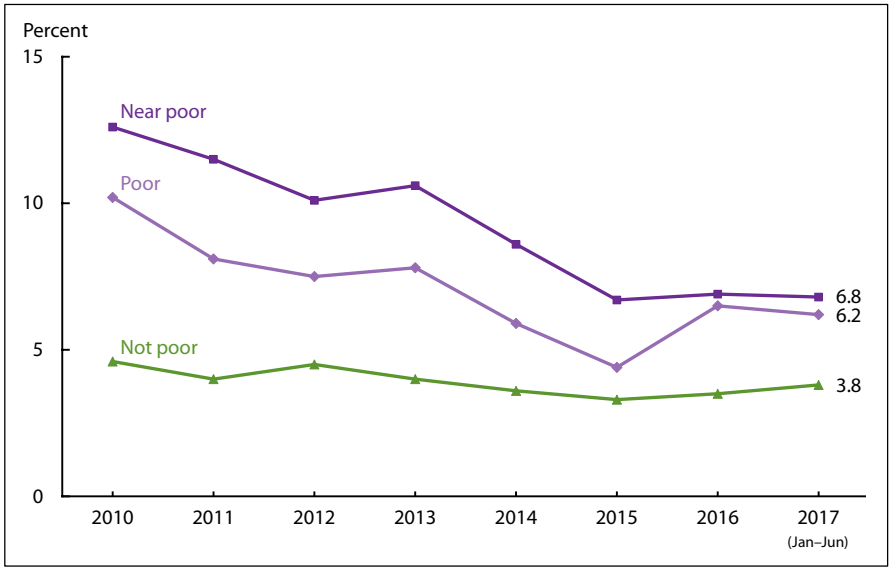
In the first 6 months of 2017, among children aged 0–17 years, 6.2% of those who were poor, 6.8% of those who were near poor, and 3.8% of those who were not poor lacked health insurance coverage at the time of interview (Figure 5). A general decrease in the percentage of uninsured children was observed among the poor, near poor, and not poor from 2010 through 2015. More recently, among children who were near poor and not poor, there was no significant change in the percentage who were uninsured from 2015 through the first 6 months of 2017. Among poor children, the percentage who were uninsured did appear to increase from 4.4% in 2015 to 6.5% in 2016 and then decline to 6.2% in the first 6 months of 2017. However, neither the change from 2015 through the first 6 months of 2017 nor the change from 2016 through the first 6 months of 2017 was significant.

Figure 4. Percentage of adults aged 18–64 who were uninsured at the time of interview, by poverty status: United States, 2010–June 2017



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Figure 5. Percentage of children aged 0–17 years who were uninsured at the time of interview, by poverty status: United States, 2010–June 2017

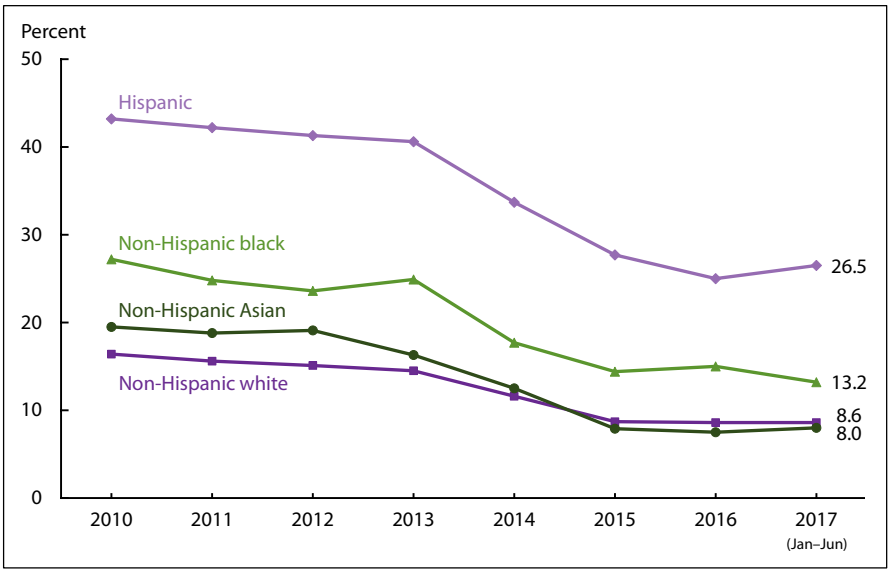


NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Short-term trends, by race and ethnicity

In the first 6 months of 2017, 26.5% of Hispanic, 13.2% of non-Hispanic black, 8.6% of non-Hispanic white, and 8.0% of non-Hispanic Asian adults aged 18–64 lacked health insurance coverage at the time of interview (Figure 6). Significant decreases in the percentage of uninsured adults were observed from 2013 through the first 6 months of 2017 for Hispanic, non-Hispanic black, non-Hispanic white, and non-Hispanic Asian adults. Hispanic adults had the greatest percentage point decrease in the uninsured rate from 2013 (40.6%) through the first 6 months of 2017 (26.5%). For all groups shown in Figure 6, the percent uninsured at the time of interview did not change significantly from 2016 through the first 6 months of 2017.

Figure 6. Percentage of adults aged 18–64 who were uninsured at the time of interview, by race and ethnicity: United States, 2010–June 2017

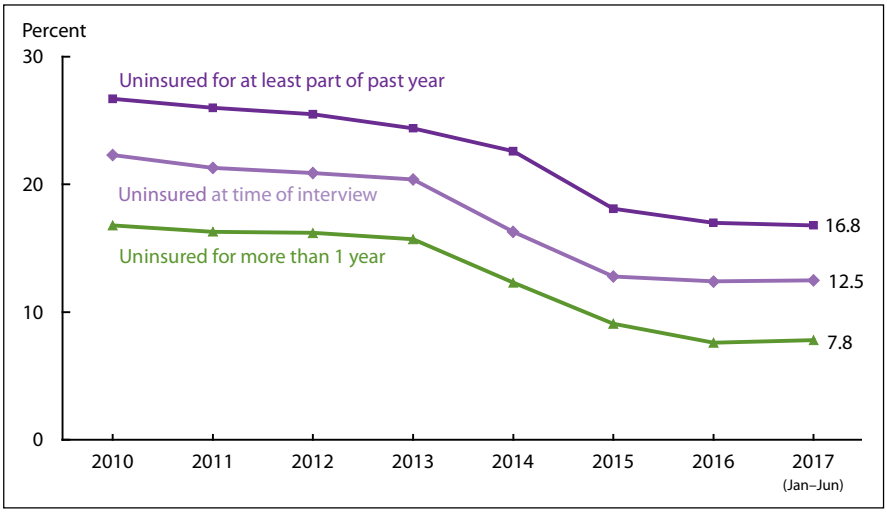


NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Periods of noncoverage

Among adults aged 18–64, the percentage of those who were uninsured at the time of interview decreased, from 22.3% (42.5 million) in 2010 to 12.5% (24.7 million) in the first 6 months of 2017 (Figure 7). The percentage of adults who were uninsured for at least part of the past year decreased, from 26.7% (51.0 million) in 2010 to 16.8% (33.1 million) in the first 6 months of 2017. The percentage of adults who were uninsured for more than 1 year decreased, from 16.8% (32.0 million) in 2010 to 7.8% (15.3 million) in the first 6 months of 2017. More recently, for all three measures of noncoverage, there were no significant changes from 2016 through the first 6 months of 2017.

Figure 7. Percentage of adults aged 18–64 without health insurance, by three measures of uninsurance: United States, 2010–June 2017



NOTES: Beginning in 2016, answer categories for those who were currently uninsured concerning the length of noncoverage were modified. Therefore, 2016 and 2017 estimates of "uninsured for at least part of the past year" and "uninsured for more than one year" may not be completely comparable with previous years. For more information on this change, see Technical Notes. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

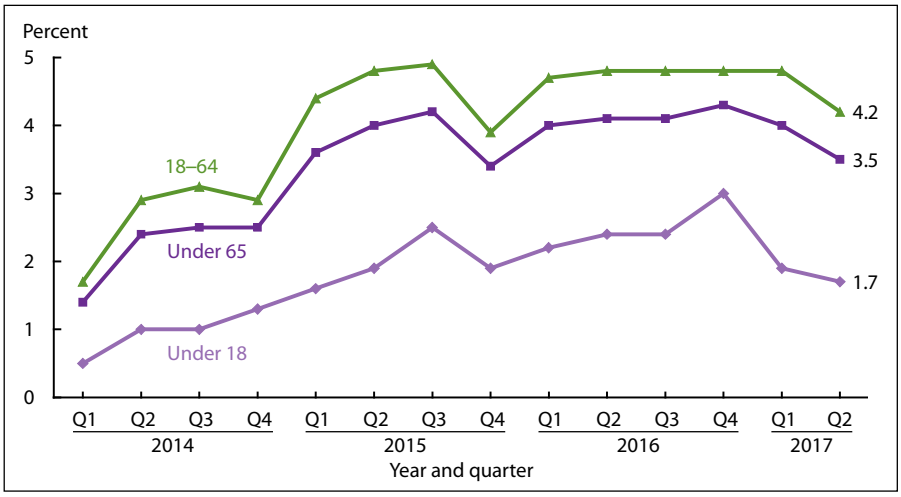
Private exchange coverage

Among persons under age 65, 65.4% (176.8 million) were covered by private health insurance plans at the time of interview in the first 6 months of 2017. This includes 3.7% (10.1 million) covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges. The observed decrease in the percentage of persons under age 65 who were enrolled in exchange plans from the second quarter of 2016 (4.1% or 11.1 million) to the second quarter of 2017 (3.5% or 9.5 million) was not significant (Figure 8).

Among adults aged 18–64, 69.6% (137.2 million) were covered by private health insurance plans at the time of interview in the first 6 months of 2017. This includes 4.5% (8.8 million) covered by private health insurance plans obtained through the Health Insurance Marketplace or state-based exchanges. The observed decrease in the percentage of persons aged 18–64 who were enrolled in exchange plans from the second quarter of 2016 (4.8% or 9.4 million) through the second quarter of 2017 (4.2% or 8.3 million) was not significant (Figure 8).

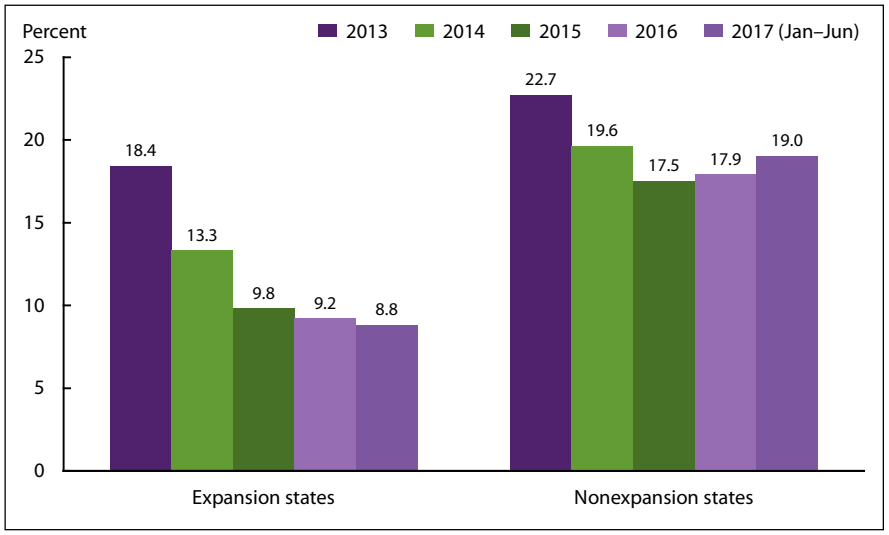
Among children aged 0–17 years, 54.0% (39.7 million) were covered by private health insurance at the time of interview in the first 6 months of 2017. This includes 1.8% (1.3 million) covered by plans obtained through the Health Insurance Marketplace or state-based exchanges. The percentage of children enrolled in exchange plans did not change significantly from 2.4% (1.8 million) in the second quarter of 2016 to 1.7% (1.2 million) in the second quarter of 2017. (Figure 8). Whereas the percentage of children who were enrolled in exchange plans decreased from the fourth quarter of 2016 (3.0% or 2.2 million) through the first quarter of 2017 (1.9% or 1.4 million), there was no significant change between the first quarter (1.9% or 1.4 million) and the second quarter (1.7% or 1.2 million) of 2017.

Figure 8. Percentage of persons under age 65 with private health insurance obtained through the Health Insurance Marketplace or state-based exchanges, by age group and quarter: United States, January 2014–June 2017



NOTES: Includes persons who had purchased a private health insurance plan through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act of 2010 (P.L. 111–148, P.L. 111–152). 2014 is the first year that all states had exchange-based coverage. All persons who have exchange-based coverage are considered to have private health insurance. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2014–2017, Family Core component.

Figure 9. Percentage of adults aged 18–64 who were uninsured at the time of interview, by year and state Medicaid expansion status: United States, 2013–June 2017



NOTES: For 2013 and 2014, there were 26 Medicaid expansion states. For 2015, there were 29 Medicaid expansion states. For 2016 and 2017, there were 32 Medicaid expansion states. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2013–2017, Family Core component.

Health insurance coverage, by state Medicaid expansion status

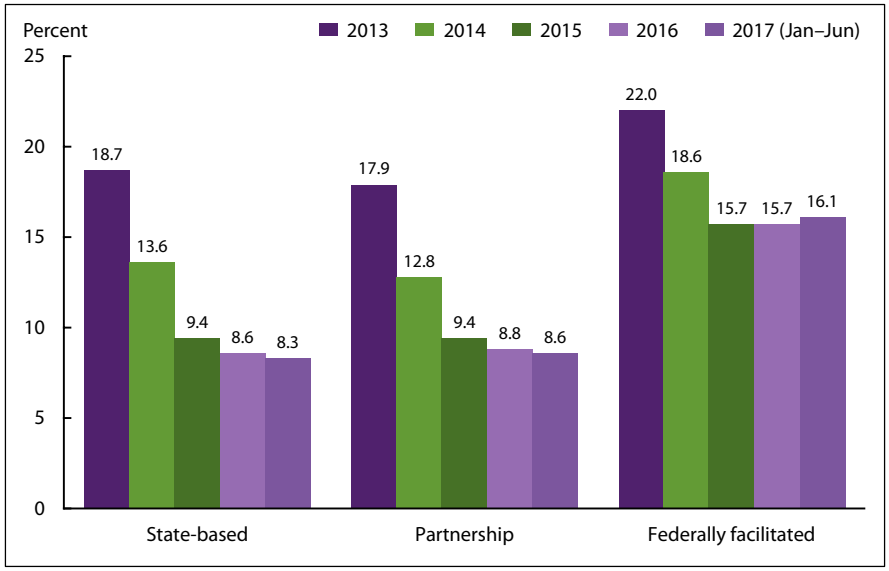
Under provisions of the Affordable Care Act (ACA) of 2010, states have the option to expand Medicaid coverage to those with low income. In the first 6 months of 2017, adults aged 18–64 residing in Medicaid expansion states were less likely to be uninsured than those residing in nonexpansion states (Figure 9). In Medicaid expansion states, the percentage of uninsured adults decreased, from 18.4% in 2013 to 8.8% in the first 6 months of 2017. In nonexpansion states, the percentage of uninsured adults decreased, from 22.7% in 2013 to 17.5% in 2015. This percentage increased from 17.5% in 2015 to 19.0% in the first 6 months of 2017.

Health insurance coverage, by state Health Insurance Marketplace type

Under provisions of ACA, each state has the option to set up and operate its own Health Insurance Marketplace, rely on a Federally Facilitated Marketplace operated solely by the federal government, or have a hybrid partnership Marketplace that is operated by the federal government but where the state runs certain functions and makes key decisions. In the first 6 months of 2017, adults aged 18–64 in states with a Federally Facilitated Marketplace were more likely to be uninsured than those in states with a state-based Marketplace or states with a partnership Marketplace (Figure 10).

Among adults aged 18–64, decreases were observed in the uninsured rates from 2013 through the first 6 months of 2017 in states with a state-based Marketplace, a partnership Marketplace, and a Federally Facilitated Marketplace. For all three Marketplace types, the percentage of adults aged 18–64 who were uninsured at the time of interview did not change significantly from 2016 through the first 6 months of 2017 (Figure 10).

Figure 10. Percentage of adults aged 18–64 who were uninsured at the time of interview, by year and state Health Insurance Marketplace type: United States, 2013–June 2017

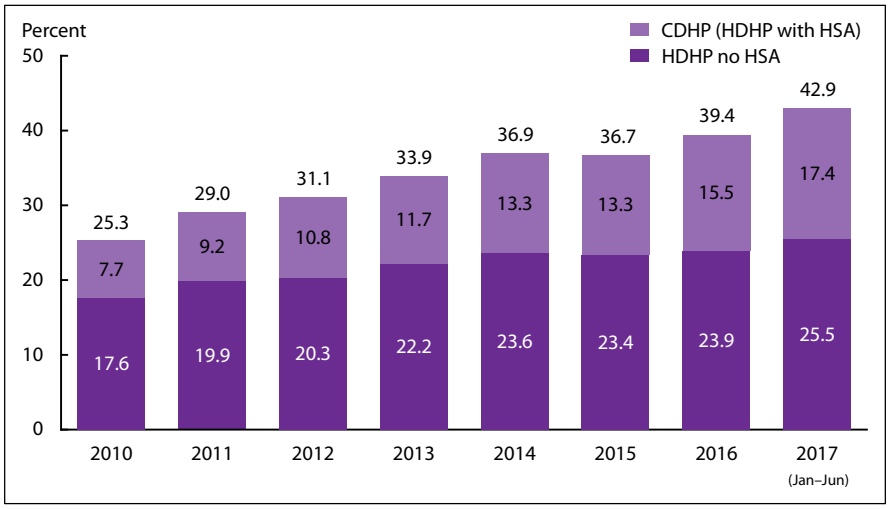


NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2013–2017, Family Core component.

Estimates of enrollment in HDHPs and CDHPs

In the first 6 months of 2017, 42.9% of persons under age 65 with private health insurance were enrolled in an HDHP, including 17.4% who were enrolled in a CDHP (an HDHP with a health savings account [HSA]) and 25.5% who were enrolled in an HDHP without an HSA (Figure 11) (see Technical Notes for definitions of HDHP, CDHP, and HSA). Among those with private health insurance, enrollment in HDHPs has generally increased since 2010. The percentage of persons enrolled in an HDHP increased 17.6 percentage points, from 25.3% in 2010 to 42.9% in the first 6 months of 2017. More recently, the percentage of those enrolled in an HDHP increased, from 39.4% in 2016 to 42.9% in the first 6 months of 2017. The percentage of persons enrolled in a CDHP more than doubled, from 7.7% in 2010 to 17.4% in the first 6 months of 2017. More recently, the percentage of those enrolled in a CDHP increased from 15.5% in 2016 to 17.4% in the first 6 months of 2017.

Figure 11. Percentage of persons under age 65 enrolled in a high-deductible health plan without a health savings account or in a consumer-directed health plan, among those with private health insurance coverage: United States, 2010–June 2017

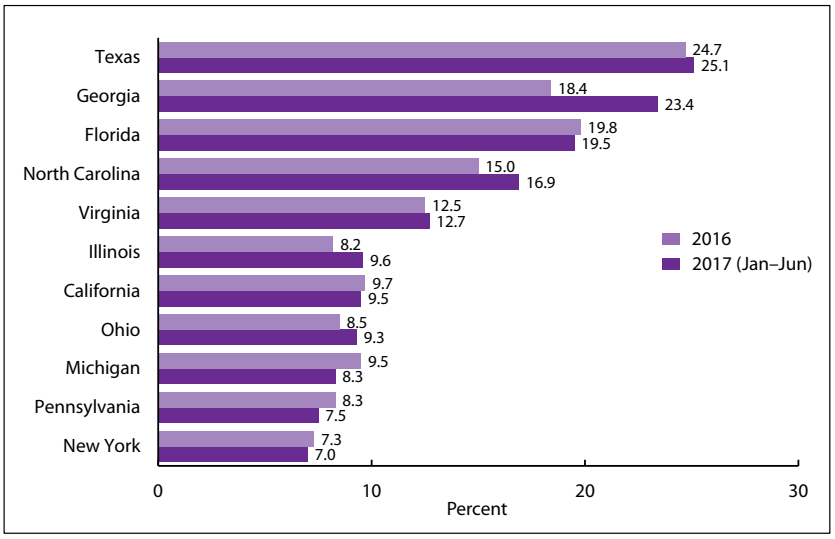


NOTES: CDHP is consumer-directed health plan, which is a high-deductible health plan (HDHP) with a health savings account (HSA). HDHP no HSA is a high-deductible health plan without an HSA. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Health insurance coverage in selected states

State-specific health insurance estimates for persons aged 18–64 are presented for 11 states (Figure 12). Between 2016 and the first 6 months of 2017, none of the observed differences in the percent uninsured among persons aged 18–64 were statistically significant for these 11 states.

Figure 12. Percentage of adults aged 18–64 who were uninsured at the time of interview by selected states and year: United States, 2016–June 2017



NOTES: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2016–2017, Family Core component.

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Technical Notes

The National Center for Health Statistics (NCHS) is releasing selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–June 2017 National Health Interview Survey (NHIS), along with comparable estimates from previous calendar years.

To reflect different policy-relevant perspectives, three measures of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured for at least part of the year prior to interview (which also includes persons uninsured for more than 1 year), and (c) uninsured for more than 1 year at the time of interview. The three time frames are defined as:

- *Uninsured at the time of interview* provides an estimate of persons who, at the given time, may have experienced barriers to obtaining needed health care.
- *Uninsured for at least part of the past year* provides an annual caseload of persons who may experience barriers to obtaining needed health care. This measure includes persons who have insurance at the time of interview but who had a period of noncoverage in the year prior to interview, as well as those who are currently uninsured and who may have been uninsured for a long period of time.
- *Uninsured for more than 1 year* provides an estimate of those with a persistent lack of coverage who may be at high risk of not obtaining preventive services or care for illness and injury.

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

Persons who were uninsured at the time of interview were asked the following question (HILAST): *Not including Single Service Plans, about how long has it been since [you/Alias] last had health care coverage?* In 2016, the answer categories for the HILAST question were modified to align NHIS responses to those of other national federal surveys. Therefore, 2016 and 2017 estimates of "uninsured for at least part of the past year" and "uninsured for more than 1 year" may not be completely comparable to previous years. Prior to 2016, the answer categories for the HILAST question were: 6 months or less; More than 6 months, but not more than 1 year ago; More than 1 year, but not more than 3 years ago; More than 3 years; and Never. Beginning in 2016, the answer categories for the HILAST question are: 6 months or less; More than 6 months, but less than 1 year; 1 year; More than 1 year, but less than 3 years; 3 years or more; and Never.

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

The 2017 health insurance estimates are being released prior to final data editing and final weighting to provide access to the most recent information from NHIS. Differences between estimates calculated using preliminary data files and final data files are typically less than 0.1 percentage point. However, preliminary estimates of persons without health insurance coverage are generally 0.1–0.3 percentage points lower than the final estimates due to the editing procedures used for the final data files.

Estimates for 2017 are stratified by age group, sex, race and ethnicity, poverty status, marital status, employment status, region, and educational attainment.

Data source

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

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

A new sample design was implemented with the 2016 NHIS. Sample areas were reselected to take into account changes in the distribution of the U.S. population since 2006, when the previous sample design was first implemented. Commercial address lists were used as the main source of addresses, rather than field listing; and the oversampling procedures for black, Hispanic, and Asian persons that were a feature of the previous sample design were not implemented in 2016. Some of the differences between estimates for 2016 and 2017 and estimates for earlier years may be attributable to the new sample design. Visit the NCHS website at https://www.cdc.gov/nchs/nhis.htm for more information on the design, content, and use of NHIS.

The data for this report are derived from the Family Core component of the 1997–2017 NHIS, which collects information on all family members in each household. Data analyses for the first 2 quarters of 2017 NHIS were based on 39,480 persons in the Family Core.

Data on health insurance status were edited using a system of logic checks. Information from follow-up questions, such as plan name(s), were used to reassign insurance status and type of coverage to avoid misclassification. The analyses excluded persons with unknown health insurance status (about 1% of respondents each year).

Data points for all figures can be found in the detailed appendix tables at the end of this report, appendix tables from previous reports, and quarterly tables available separately through the Early Release (ER) program.

Estimation procedures

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

Point estimates and estimates of their variances were calculated using SUDAAN software (RTI International, Research Triangle Park, N.C.) to account for the complex sample design of NHIS, taking into account stratum and primary sampling unit (PSU) identifiers. The Taylor series linearization method was chosen for variance estimation.

Trends in coverage were generally assessed using Joinpoint regression (2), which characterizes trends as joined linear segments. A Joinpoint is the year where two segments with different slopes meet. Joinpoint software uses statistical criteria to determine the fewest number of segments necessary to characterize a trend and the year(s) when segments begin and end. A limitation of using aggregated data and Joinpoint software alone for trend analysis of the National Health Interview Survey is that this approach does not account for year-to-year correlation or use the recommended degrees of freedom for statistical testing. Trends from 2010 through the first 6 months of 2017 were also evaluated using logistic regression analysis.

For January through June 2017, state-specific health insurance estimates are presented for 11 states for persons of all ages, persons under age 65, and adults aged 18–64. State-specific estimates are presented for 8 states for children aged 0–17 years. Estimates are not presented for all 50 states and the District of Columbia due to considerations of sample size and precision. States with fewer than 1,000 interviews for persons of all ages are excluded. In addition, estimates for children in states that did not have at least 300 children with completed interviews are not presented. The number of states included in each report may differ from year to year depending on how many states meet these criteria (for example, in the report released in November 2016, health insurance estimates were presented for 12 states for persons of all ages, persons under age 65, and adults aged 18–64).

Beginning with the 2017 NHIS, all estimates shown (with the exception of state estimates) meet the NCHS standards of reliability as specified in *National Center for Health Statistics Data Presentation Standards for Proportions* (3), unless otherwise noted. Current state estimates as well as other estimates based on the 2016 and earlier NHIS meet the former NCHS standard of having less than or equal to 30% relative standard error, unless otherwise noted. Differences between percentages or rates were evaluated using two-sided significance tests at the 0.05 level. All differences discussed are significant unless otherwise noted. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant.

Definitions of selected terms

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

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

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

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

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

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

In general, if a family member is reported to have coverage through the exchange, that report is considered accurate unless there is other information (e.g., plan name or information about premiums) that clearly contradicts that report. Similarly, if a family member is not reported to have coverage through the exchange, that report is considered accurate unless other information clearly contradicts that report. For a more complete discussion of

the procedures used in classifying exchange-based coverage, see https://www.cdc.gov/nchs/nhis/insurance.htm.

Based on these classification procedures, an average of 3.7% (standard error [SE] 0.17) of persons under age 65, 4.5% (SE 0.19) of adults aged 18–64, 1.8% (SE 0.19) of children under age 18 years, and 2.8% (SE 0.37) of adults aged 19–25 had exchange-based private health insurance coverage in the first 6 months of 2017. This equates to 10.1 million persons under age 65, 8.8 million adults aged 18–64, 1.3 million children, and 0.8 million adults aged 19–25. If these procedures had not been used and reports of coverage through the exchanges (or lack thereof) had been taken at face value, the estimates would have been higher. For example, an average of 4.5% (12.1 million) of persons under age 65 would have been reported to have obtained their coverage through exchanges in the first 2 quarters of 2017.

High-deductible health plan (HDHP)—For persons with private health insurance, a question was asked regarding the annual deductible of each private health insurance plan. HDHP was defined in 2015 through 2017 as a private health plan with an annual deductible of at least $1,300 for self-only coverage or $2,600 for family coverage. The deductible is adjusted annually for inflation. For 2013 and 2014, the annual deductible was $1,250 for self-only coverage and $2,500 for family coverage. For 2010 through 2012, the annual deductible was $1,200 for self-only coverage and $2,400 for family coverage.

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

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

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

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

Medicaid expansion status—Under provisions of ACA, states have the option to expand Medicaid eligibility to cover adults who have income up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of October 31, 2013, 26 states and the District of Columbia were moving forward with Medicaid expansion. As of January 1, 2016, 32 states and the District of Columbia were moving forward with Medicaid expansion.

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

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

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

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

Poverty status—Poverty categories are based on the ratio of the family's income in the previous calendar

year to the appropriate poverty threshold (given the family's size and number of children), as defined by the U.S. Census Bureau for that year (4–13). Persons categorized as "poor" have a ratio less than 1.0 (i.e., their family income is below the poverty threshold); "near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "not-poor" persons have incomes that are 200% of the poverty threshold or greater. The remaining group of respondents is coded as "unknown" with respect to poverty status. The percentage of respondents with unknown poverty status (19.1% in 1997, 28.9% in 2005, 12.2% in 2010, 11.5% in 2011, 11.4% in 2012, 10.2% in 2013, 8.8% in 2014, 8.8% in 2015, 7.8% in 2016 and 6.9% in the first 2 quarters of 2017) is disaggregated by age and insurance status in Tables IV, V, and VI.

For more information on unknown income and unknown poverty status, see the NHIS Survey Description documents for 1997–2016 (available from: https://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm).

NCHS imputes income for approximately 30% of NHIS records. The imputed income files are released a few months after the annual release of NHIS microdata and are not available for the ER updates. Therefore, ER health insurance estimates stratified by poverty status are based on reported income only and may differ from similar estimates produced later (e.g., in *Health, United States* [14]) that are based on both reported and imputed income.

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

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

Expanded regions—Based on a subdivision of the four regions into nine divisions. For this report, the nine Census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic division. This approach was used previously by Holahan et al. (15).

Additional Early Release Program Products

Two additional periodical reports are published through the NHIS ER Program. *Early Release of Selected Estimates Based on Data From the National Health Interview Survey* (16) is published quarterly and provides estimates of 15 selected measures of health, including insurance coverage. Other measures of health include estimates of having a usual place to go for medical care, obtaining needed medical care, influenza vaccination, pneumococcal vaccination, obesity, leisure-time physical activity, current smoking, alcohol consumption, HIV testing, general health status, personal care needs, serious psychological distress, diagnosed diabetes, and asthma episodes and current asthma.

Wireless Substitution: Early Release of Estimates From the National Health Interview Survey (17) is published semiannually and provides selected estimates of telephone coverage in the United States.

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

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

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

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

Suggested Citation

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Table I. Percentages (and standard errors) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than 1 year, by age group and selected years: United States, 1997–June 2017

Age group and year	Uninsured[1] at time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than 1 year[2]
All ages			
1997	15.4 (0.21)	19.5 (0.24)	10.4 (0.18)
2005	14.2 (0.21)	17.6 (0.23)	10.0 (0.18)
2010	16.0 (0.27)	19.8 (0.29)	11.7 (0.22)
2011	15.1 (0.25)	19.2 (0.29)	11.2 (0.21)
2012	14.7 (0.23)	18.6 (0.27)	11.1 (0.22)
2013	14.4 (0.26)	17.8 (0.27)	10.7 (0.23)
2014	11.5 (0.23)	16.5 (0.25)	8.4 (0.19)
2015	9.1 (0.19)	13.2 (0.23)	6.2 (0.15)
2016	9.0 (0.27)	12.5 (0.29)	5.2 (0.23)
2017 (Jan–Jun)	9.0 (0.32)	12.6 (0.35)	5.4 (0.23)
Under 65 years			
1997	17.4 (0.24)	21.9 (0.28)	11.8 (0.21)
2005	16.0 (0.24)	19.9 (0.26)	11.3 (0.21)
2010	18.2 (0.30)	22.5 (0.33)	13.3 (0.24)
2011	17.3 (0.29)	21.8 (0.33)	12.7 (0.25)
2012	16.9 (0.27)	21.3 (0.31)	12.7 (0.24)
2013	16.6 (0.30)	20.4 (0.32)	12.4 (0.27)
2014	13.3 (0.26)	19.0 (0.29)	9.7 (0.22)
2015	10.5 (0.22)	15.3 (0.27)	7.2 (0.17)
2016	10.4 (0.31)	14.5 (0.33)	6.1 (0.26)
2017 (Jan–Jun)	10.5 (0.36)	14.6 (0.39)	6.3 (0.26)
0–17 years			
1997	13.9 (0.36)	18.1 (0.41)	8.4 (0.29)
2005	8.9 (0.29)	12.6 (0.33)	5.3 (0.24)
2010	7.8 (0.32)	11.6 (0.37)	4.5 (0.23)
2011	7.0 (0.27)	10.9 (0.36)	3.7 (0.19)
2012	6.6 (0.27)	10.4 (0.35)	3.7 (0.19)
2013	6.5 (0.26)	10.0 (0.33)	3.6 (0.20)
2014	5.5 (0.27)	9.4 (0.40)	3.0 (0.19)
2015	4.5 (0.24)	7.7 (0.32)	2.3 (0.16)
2016	5.1 (0.31)	8.0 (0.31)	2.2 (0.22)
2017 (Jan–Jun)	5.0 (0.52)	8.7 (0.56)	2.3 (0.42)
18–64 years			
1997	18.9 (0.23)	23.6 (0.26)	13.3 (0.21)
2005	18.9 (0.26)	22.8 (0.28)	13.8 (0.23)
2010	22.3 (0.35)	26.7 (0.37)	16.8 (0.30)
2011	21.3 (0.34)	26.0 (0.37)	16.3 (0.31)
2012	20.9 (0.31)	25.5 (0.34)	16.2 (0.29)
2013	20.4 (0.37)	24.4 (0.38)	15.7 (0.34)
2014	16.3 (0.31)	22.6 (0.34)	12.3 (0.27)
2015	12.8 (0.27)	18.1 (0.33)	9.1 (0.22)
2016	12.4 (0.36)	17.0 (0.38)	7.6 (0.31)
2017 (Jan–Jun)	12.5 (0.37)	16.8 (0.39)	7.8 (0.27)

See footnotes at end of table.

Table I. Percentages (and standard errors) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than 1 year, by age group and selected years: United States, 1997–June 2017—Con.

Age group and year	Uninsured[1] at time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than 1 year[2]
19–25 years			
1997	31.4 (0.63)	39.2 (0.67)	20.8 (0.51)
2005	31.2 (0.65)	37.9 (0.68)	21.6 (0.54)
2010	33.9 (0.73)	41.7 (0.78)	24.1 (0.61)
2011	27.9 (0.71)	36.1 (0.77)	20.1 (0.61)
2012	26.4 (0.72)	33.0 (0.72)	19.6 (0.62)
2013	26.5 (0.71)	31.3 (0.79)	19.8 (0.61)
2014	20.0 (0.65)	26.9 (0.73)	14.2 (0.56)
2015	15.8 (0.58)	22.2 (0.68)	10.2 (0.43)
2016	14.7 (0.71)	20.1 (0.78)	7.7 (0.61)
2017 (Jan–Jun)	15.0 (0.79)	20.0 (0.87)	8.5 (0.63)

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

[2]In references to "part of the past year" and "more than 1 year," 1 year is defined as the 12 months prior to interview. Beginning in 2016, answer categories concerning the length of noncoverage were modified for those who were currently uninsured. Therefore, starting in 2016, estimates of "uninsured for at least part of the past year" and "uninsured for more than 1 year" may not be completely comparable to previous years. For more information on this change, see Technical Notes.

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

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2017, Family Core component.

Table II. Numbers (in millions) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than 1 year, by age group and selected years: United States, 1997–June 2017

Age group and year	Uninsured[1] at time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than 1 year[2]
All ages			
1997	41.0	51.9	27.7
2005	41.2	51.3	29.2
2010	48.6	60.3	35.7
2011	46.3	58.7	34.2
2012	45.5	57.5	34.1
2013	44.8	55.4	33.4
2014	36.0	51.6	26.3
2015	28.6	41.7	19.6
2016	28.6	39.9	16.7
2017 (Jan–Jun)	28.8	40.2	17.3
Under 65 years			
1997	40.7	51.4	27.6
2005	41.0	50.9	29.0
2010	48.2	59.6	35.4
2011	45.9	58.0	33.9
2012	45.2	56.8	33.9
2013	44.3	54.7	33.1
2014	35.7	50.8	26.1
2015	28.4	41.1	19.4
2016	28.2	39.3	16.5
2017 (Jan–Jun)	28.3	39.5	17.0
0–17 years			
1997	9.9	12.9	6.0
2005	6.5	9.3	3.9
2010	5.8	8.7	3.4
2011	5.2	8.1	2.7
2012	4.9	7.7	2.7
2013	4.8	7.3	2.6
2014	4.0	6.9	2.2
2015	3.3	5.7	1.7
2016	3.8	5.9	1.6
2017 (Jan–Jun)	3.6	6.4	1.7
18–64 years			
1997	30.8	38.5	21.7
2005	34.5	41.7	25.2
2010	42.5	51.0	32.0
2011	40.7	49.9	31.2
2012	40.3	49.2	31.2
2013	39.6	47.4	30.5
2014	31.7	44.0	23.9
2015	25.1	35.5	17.8
2016	24.5	33.4	14.9
2017 (Jan–Jun)	24.7	33.1	15.3

See footnotes at end of table.

Table II. Numbers (in millions) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than 1 year, by age group and selected years: United States, 1997–June 2017—Con.

Age group and year	Uninsured[1] at time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than 1 year[2]
19–25 years			
1997	7.7	9.7	5.1
2005	8.8	10.7	6.1
2010	10.0	12.3	7.1
2011	8.4	10.8	6.0
2012	7.9	9.9	5.9
2013	8.0	9.5	6.0
2014	6.0	8.1	4.3
2015	4.8	6.7	3.1
2016	4.4	6.0	2.3
2017 (Jan–Jun)	4.5	6.0	2.5

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

[2]In references to "part of the past year" and "more than 1 year," 1 year is defined as the 12 months prior to interview. Beginning in 2016, answer categories concerning the length of noncoverage were modified for those who were currently uninsured. Therefore, starting in 2016, estimates of "uninsured for at least part of the past year" and "uninsured for more than 1 year" may not be completely comparable to previous years. For more information on this change, see Technical Notes.

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

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2017, Family Core component.

Table III. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected years: United States, 1997–June 2017

Age group and year	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
All ages			
1997	15.4 (0.21)	23.3 (0.27)	70.7 (0.32)
2005	14.2 (0.21)	26.4 (0.30)	67.3 (0.37)
2010	16.0 (0.27)	31.4 (0.39)	60.2 (0.48)
2011	15.1 (0.25)	32.4 (0.37)	60.1 (048)
2012	14.7 (0.23)	33.4 (0.35)	59.6 (0.43)
2013	14.4 (0.26)	33.8 (0.36)	59.5 (0.49)
2014	11.5 (0.23)	34.6 (0.37)	61.8 (0.45)
2015	9.1 (0.19)	35.6 (0.42)	63.2 (0.46)
2016	9.0 (0.27)	36.8 (0.36)	62.5 (0.44)
2017 (Jan–Jun)	9.0 (0.32)	36.4 (0.54)	62.6 (0.50)
Under 65 years			
1997	17.4 (0.24)	13.6 (0.25)	70.8 (0.35)
2005	16.0 (0.24)	16.8 (0.29)	68.4 (0.39)
2010	18.2 (0.30)	22.0 (0.38)	61.2 (0.50)
2011	17.3 (0.29)	23.0 (0.37)	61.2 (0.51)
2012	16.9 (0.27)	23.5 (0.37)	61.0 (0.47)
2013	16.6 (0.30)	23.8 (0.35)	61.0 (0.52)
2014	13.3 (0.26)	24.5 (0.36)	63.6 (0.46)
2015	10.5 (0.22)	25.3 (0.43)	65.6 (0.50)
2016	10.4 (0.31)	26.3 (0.41)	65.0 (0.48)
2017 (Jan–Jun)	10.5 (0.36)	25.6 (0.49)	65.4 (0.50)
0–17 years			
1997	13.9 (0.36)	21.4 (0.48)	66.2 (0.57)
2005	8.9 (0.29)	29.9 (0.56)	62.4 (0.60)
2010	7.8 (0.32)	39.8 (0.73)	53.8 (0.75)
2011	7.0 (0.27)	41.0 (0.74)	53.3 (0.76)
2012	6.6 (0.27)	42.1 (0.72)	52.8 (0.73)
2013	6.5 (0.26)	42.2 (0.70)	52.6 (0.76)
2014	5.5 (0.27)	42.2 (0.65)	53.7 (0.68)
2015	4.5 (0.24)	42.2 (0.79)	54.7 (0.78)
2016	5.1 (0.31)	43.0 (0.65)	53.8 (0.71)
2017 (Jan–Jun)	5.0 (0.52)	42.6 (0.95)	54.0 (0.87)
18–64 years			
1997	18.9 (0.23)	10.2 (0.20)	72.8 (0.30)
2005	18.9 (0.26)	11.5 (0.22)	70.9 (0.36)
2010	22.3 (0.35)	15.0 (0.30)	64.1 (0.46)
2011	21.3 (0.34)	15.9 (0.29)	64.2 (0.45)
2012	20.9 (0.31)	16.4 (0.29)	64.1 (0.42)
2013	20.4 (0.37)	16.7 (0.30)	64.2 (0.47)
2014	16.3 (0.31)	17.7 (0.32)	67.3 (0.43)
2015	12.8 (0.27)	18.9 (0.36)	69.7 (0.43)
2016	12.4 (0.36)	20.0 (0.38)	69.2 (0.41)
2017 (Jan–Jun)	12.5 (0.37)	19.2 (0.44)	69.6 (0.46)

See footnotes at end of table.

Table III. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected years: United States, 1997–June 2017 — Con.

Age group and year	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
19–25 years			
1997	31.4 (0.63)	11.2 (0.46)	58.4 (0.71)
2005	31.2 (0.65)	12.9 (0.51)	56.5 (0.79)
2010	33.9 (0.73)	15.7 (0.55)	51.0 (0.84)
2011	27.9 (0.71)	16.8 (0.60)	56.2 (0.85)
2012	26.4 (0.72)	17.5 (0.59)	57.2 (0.85)
2013	26.5 (0.71)	16.1 (0.54)	58.1 (0.84)
2014	20.0 (0.65)	19.1 (0.64)	61.9 (0.88)
2015	15.8 (0.58)	19.5 (0.68)	65.7 (0.81)
2016	14.7 (0.71)	21.9 (0.79)	64.7 (0.88)
2017 (Jan–Jun)	15.0 (0.79)	20.0 (0.77)	65.8 (1.05)

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2017, Family Core component.

Table IV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–June 2017

Poverty status[1] and year	Uninsured[2] at time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	32.7 (0.80)	46.1 (1.01)	22.9 (0.93)
2005	28.4 (0.78)	50.6 (0.98)	22.1 (0.89)
2010	29.5 (0.83)	56.0 (0.98)	15.5 (0.70)
2011	28.2 (0.66)	56.2 (0.82)	16.6 (0.77)
2012	28.3 (0.65)	57.1 (0.83)	16.1 (0.83)
2013	27.3 (0.68)	59.0 (0.81)	14.7 (0.72)
2014	22.3 (0.66)	62.1 (0.80)	16.6 (0.69)
2015	17.2 (0.63)	65.6 (0.87)	18.5 (0.78)
2016	18.7 (0.94)	66.8 (1.01)	16.2 (0.71)
2017 (Jan–Jun)	17.3 (0.99)	64.4 (1.05)	19.4 (1.24)
Near poor (≥ 100% and < 200% FPL)			
1997	30.4 (0.70)	18.2 (0.56)	53.5 (0.80)
2005	28.6 (0.63)	30.0 (0.72)	43.2 (0.89)
2010	32.3 (0.69)	36.2 (0.63)	33.2 (0.77)
2011	30.4 (0.58)	37.7 (0.73)	33.5 (0.75)
2012	29.5 (0.56)	37.1 (0.66)	35.2 (0.75)
2013	29.3 (0.70)	39.1 (0.77)	33.4 (0.79)
2014	23.5 (0.60)	41.1 (0.74)	37.3 (0.81)
2015	18.2 (0.51)	45.1 (0.77)	39.1 (0.77)
2016	17.6 (0.63)	49.2 (0.89)	35.4 (0.85)
2017 (Jan–Jun)	17.6 (0.77)	49.3 (1.33)	35.3 (1.08)
Not poor (≥ 200% FPL)			
1997	8.9 (0.22)	5.3 (0.19)	87.6 (0.27)
2005	9.1 (0.22)	7.4 (0.22)	84.7 (0.30)
2010	10.7 (0.24)	9.7 (0.28)	81.0 (0.36)
2011	10.1 (0.25)	9.9 (0.26)	81.4 (0.36)
2012	9.8 (0.23)	10.3 (0.33)	81.3 (0.39)
2013	9.6 (0.24)	10.5 (0.29)	81.2 (0.39)
2014	7.6 (0.20)	9.9 (0.28)	83.7 (0.36)
2015	6.6 (0.19)	10.6 (0.31)	84.1 (0.38)
2016	6.4 (0.23)	11.2 (0.21)	83.9 (0.32)
2017 (Jan–Jun)	6.9 (0.35)	11.2 (0.32)	83.2 (0.39)
Unknown			
1997	21.6 (0.59)	13.2 (0.49)	66.7 (0.71)
2005	18.5 (0.48)	16.4 (0.48)	66.2 (0.68)
2010	22.7 (0.95)	21.0 (0.69)	57.3 (1.08)
2011	21.0 (0.64)	26.2 (0.95)	53.9 (1.09)
2012	20.4 (0.73)	28.8 (0.89)	52.1 (1.00)
2013	20.5 (0.76)	24.2 (0.94)	56.8 (1.24)
2014	15.0 (0.80)	22.2 (0.91)	64.1 (1.24)
2015	11.9 (0.80)	24.4 (1.16)	64.9 (1.20)
2016	13.2 (1.01)	27.0 (1.04)	61.6 (1.26)
2017 (Jan–Jun)	12.1 (1.33)	25.2 (1.91)	63.9 (2.17)

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

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2017, Family Core component.

Table V. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–June 2017

Poverty status[1] and year	Uninsured[2] at time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	40.2 (0.88)	34.3 (0.93)	26.8 (1.09)
2005	38.5 (0.95)	35.6 (0.98)	26.8 (1.03)
2010	42.2 (0.99)	38.8 (0.97)	19.6 (0.89)
2011	40.1 (0.92)	39.6 (0.93)	21.2 (1.02)
2012	40.1 (0.90)	40.8 (0.94)	20.2 (1.09)
2013	39.3 (1.00)	42.4 (0.95)	19.0 (0.97)
2014	32.3 (0.93)	46.6 (0.95)	21.9 (0.92)
2015	25.2 (0.90)	51.7 (1.08)	24.3 (1.04)
2016	26.2 (1.31)	53.7 (1.29)	21.6 (0.92)
2017 (Jan–Jun)	23.9 (1.42)	51.4 (1.42)	25.8 (1.60)
Near poor (≥ 100% and < 200% FPL)			
1997	34.9 (0.71)	14.6 (0.51)	52.6 (0.76)
2005	36.6 (0.73)	20.0 (0.61)	45.0 (0.85)
2010	43.0 (0.74)	23.7 (0.55)	34.7 (0.74)
2011	40.1 (0.72)	25.9 (0.69)	35.4 (0.75)
2012	39.2 (0.68)	25.2 (0.57)	37.2 (0.74)
2013	38.5 (0.84)	26.6 (0.78)	36.4 (0.78)
2014	30.9 (0.72)	29.6 (0.76)	41.2 (0.81)
2015	24.1 (0.62)	34.2 (0.80)	43.8 (0.79)
2016	23.2 (0.76)	38.5 (0.91)	40.3 (0.95)
2017 (Jan–Jun)	23.4 (0.94)	38.3 (1.31)	40.5 (1.06)
Not poor (≥ 200% FPL)			
1997	9.9 (0.22)	5.0 (0.18)	87.1 (0.26)
2005	10.7 (0.24)	6.2 (0.20)	84.4 (0.29)
2010	12.6 (0.27)	8.1 (0.27)	80.8 (0.36)
2011	12.0 (0.28)	8.3 (0.23)	81.1 (0.35)
2012	11.4 (0.26)	8.7 (0.29)	81.3 (0.38)
2013	11.4 (0.27)	8.9 (0.26)	81.2 (0.37)
2014	8.9 (0.23)	8.5 (0.26)	83.9 (0.35)
2015	7.6 (0.22)	9.1 (0.27)	84.7 (0.33)
2016	7.2 (0.25)	9.6 (0.22)	84.6 (0.29)
2017 (Jan–Jun)	7.9 (0.35)	9.4 (0.30)	84.1 (0.41)
Unknown			
1997	22.9 (0.58)	10.1 (0.41)	68.6 (0.65)
2005	21.2 (0.52)	11.3 (0.36)	68.7 (0.61)
2010	27.1 (1.10)	15.6 (0.63)	58.4 (1.11)
2011	25.6 (0.77)	17.6 (0.73)	58.1 (0.96)
2012	25.7 (0.88)	18.9 (0.76)	56.9 (0.92)
2013	24.3 (0.87)	17.6 (0.77)	59.5 (1.11)
2014	17.2 (0.88)	17.2 (0.81)	67.0 (1.20)
2015	13.8 (0.82)	19.6 (0.94)	67.7 (1.09)
2016	14.6 (0.90)	21.6 (0.91)	65.6 (1.03)
2017 (Jan–Jun)	14.5 (1.50)	19.8 (1.43)	66.5 (1.72)

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

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2017, Family Core component.

Table VI. Percentages (and standard errors) of children aged 0–17 years who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–June 2017

Poverty status[1] and year	Uninsured[2] at time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	22.4 (0.99)	62.1 (1.31)	17.5 (1.09)
2005	13.0 (0.92)	73.3 (1.32)	15.0 (1.10)
2010	10.2 (0.96)	82.0 (1.22)	9.2 (0.70)
2011	8.1 (0.62)	84.4 (0.87)	8.9 (0.72)
2012	7.5 (0.58)	85.9 (0.80)	8.8 (0.78)
2013	7.8 (0.62)	86.1 (0.88)	7.7 (0.69)
2014	5.9 (0.52)	87.3 (0.72)	8.0 (0.62)
2015	4.4 (0.47)	87.9 (0.86)	9.1 (0.81)
2016	6.5 (0.70)	88.0 (0.97)	7.4 (0.71)
2017 (Jan–Jun)	6.2 (0.90)	85.9 (1.43)	8.8 (1.32)
Near poor (≥ 100% and < 200% FPL)			
1997	22.8 (0.96)	24.3 (0.93)	55.0 (1.15)
2005	14.7 (0.79)	47.3 (1.21)	40.0 (1.31)
2010	12.6 (0.73)	59.2 (1.16)	30.5 (1.18)
2011	11.5 (0.69)	60.8 (1.17)	29.9 (1.07)
2012	10.1 (0.70)	61.0 (1.30)	31.1 (1.18)
2013	10.6 (0.72)	64.4 (1.16)	27.3 (1.17)
2014	8.6 (0.65)	64.3 (1.23)	29.4 (1.19)
2015	6.7 (0.59)	66.4 (1.17)	29.8 (1.14)
2016	6.9 (0.62)	69.9 (1.11)	26.0 (1.01)
2017 (Jan–Jun)	6.8 (1.24)	70.2 (2.31)	25.5 (1.66)
Not poor (≥ 200% FPL)			
1997	6.1 (0.33)	6.3 (0.32)	88.9 (0.43)
2005	4.6 (0.30)	10.7 (0.47)	85.6 (0.52)
2010	4.6 (0.29)	14.9 (0.57)	81.4 (0.61)
2011	4.0 (0.27)	15.0 (0.55)	82.1 (0.58)
2012	4.5 (0.31)	15.2 (0.62)	81.3 (0.64)
2013	4.0 (0.28)	15.6 (0.62)	81.2 (0.65)
2014	3.6 (0.28)	14.4 (0.56)	83.1 (0.58)
2015	3.3 (0.26)	15.5 (0.69)	82.1 (0.74)
2016	3.5 (0.27)	16.5 (0.52)	81.5 (0.58)
2017 (Jan–Jun)	3.8 (0.50)	17.3 (0.78)	80.3 (0.78)
Unknown			
1997	18.3 (0.90)	21.4 (0.97)	61.7 (1.18)
2005	11.0 (0.66)	30.8 (1.05)	59.3 (1.16)
2010	8.8 (0.89)	38.1 (1.71)	53.7 (1.74)
2011	10.4 (0.76)	45.9 (1.70)	44.5 (1.66)
2012	8.2 (0.77)	51.8 (1.50)	41.2 (1.49)
2013	9.2 (1.00)	43.7 (2.16)	48.6 (2.20)
2014	8.0 (1.41)	37.9 (2.01)	54.8 (2.05)
2015	6.3 (1.36)	37.9 (2.33)	56.6 (2.24)
2016	8.9 (2.13)	43.6 (2.36)	49.3 (2.86)
2017 (Jan–Jun)	5.2 (1.47)	40.5 (3.89)	56.5 (4.13)

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

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2017, Family Core component.

Table VII. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and sex: United States, January–June 2017

Age group and sex	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Age group (years)			
All ages	9.0 (0.32)	36.4 (0.54)	62.6 (0.50)
Under age 65	10.5 (0.36)	25.6 (0.49)	65.4 (0.50)
0–17	5.0 (0.52)	42.6 (0.95)	54.0 (0.87)
18–64	12.5 (0.37)	19.2 (0.44)	69.6 (0.46)
18–24	13.6 (0.78)	21.6 (0.86)	65.6 (1.02)
25–34	17.4 (0.69)	19.2 (0.80)	64.1 (0.84)
35–44	13.9 (0.55)	16.1 (0.66)	71.0 (0.82)
45–64	9.0 (0.41)	19.9 (0.59)	73.2 (0.65)
65 and over	0.9 (0.13)	95.2 (0.35)	47.6 (1.26)
19–25	15.0 (0.79)	20.0 (0.77)	65.8 (1.05)
Sex			
Male			
All ages	10.0 (0.37)	34.3 (0.49)	63.2 (0.49)
Under age 65	11.6 (0.42)	24.3 (0.47)	65.6 (0.51)
0–17	5.1 (0.63)	42.5 (0.96)	54.0 (0.86)
18–64	14.1 (0.46)	17.2 (0.47)	70.2 (0.52)
18–24	14.9 (0.92)	18.2 (1.05)	67.7 (1.24)
25–34	20.0 (0.95)	15.3 (0.87)	65.6 (1.08)
35–44	15.9 (0.85)	13.3 (0.89)	71.9 (1.11)
45–64	9.8 (0.58)	19.8 (0.72)	72.8 (0.81)
65 and over	0.7 (0.18)	94.7 (0.52)	48.2 (1.30)
19–25	16.5 (1.02)	16.4 (0.92)	67.8 (1.28)
Female			
All ages	8.0 (0.32)	38.4 (0.69)	62.1 (0.61)
Under age 65	9.4 (0.35)	26.9 (0.62)	65.1 (0.60)
0–17	4.8 (0.48)	42.7 (1.16)	54.1 (1.07)
18–64	11.1 (0.39)	21.2 (0.57)	69.1 (0.55)
18–24	12.3 (1.10)	25.1 (1.21)	63.5 (1.36)
25–34	14.9 (0.75)	23.1 (1.19)	62.7 (1.08)
35–44	12.0 (0.72)	18.9 (0.93)	70.2 (1.00)
45–64	8.3 (0.40)	20.0 (0.63)	73.7 (0.70)
65 and over	1.1 (0.15)	95.5 (0.37)	47.1 (1.40)
19–25	13.4 (1.11)	23.7 (1.24)	63.7 (1.48)

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 2017, Family Core component.

Table VIII. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race and ethnicity and year: United States, 2010–June 2017

Race and ethnicity and year	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Hispanic or Latino			
2010	31.9 (0.72)	32.0 (0.78)	36.6 (0.81)
2011	31.1 (0.68)	33.6 (0.74)	36.1 (0.82)
2012	30.4 (0.71)	34.0 (0.71)	36.4 (0.74)
2013	30.3 (0.66)	33.4 (0.62)	37.0 (0.76)
2014	25.2 (0.59)	34.6 (0.78)	41.2 (0.89)
2015	20.8 (0.56)	36.2 (0.84)	43.8 (0.81)
2016	19.3 (0.93)	37.1 (1.02)	44.9 (1.02)
2017 (Jan–Jun)	19.6 (0.87)	36.8 (1.55)	44.4 (1.48)
Non-Hispanic white, single race			
2010	13.7 (0.30)	16.4 (0.42)	71.4 (0.57)
2011	13.0 (0.32)	17.1 (0.39)	71.4 (0.55)
2012	12.7 (0.28)	17.3 (0.39)	71.5 (0.51)
2013	12.1 (0.29)	17.9 (0.38)	71.6 (0.53)
2014	9.8 (0.25)	18.1 (0.41)	73.6 (0.50)
2015	7.4 (0.21)	18.9 (0.48)	75.4 (0.54)
2016	7.5 (0.24)	19.8 (0.40)	74.5 (0.42)
2017 (Jan–Jun)	7.5 (0.36)	18.7 (0.46)	75.5 (0.62)
Non-Hispanic black, single race			
2010	20.8 (0.63)	36.3 (0.79)	44.6 (0.84)
2011	19.0 (0.51)	36.9 (0.83)	45.6 (0.85)
2012	17.9 (0.50)	38.2 (0.77)	45.4 (0.79)
2013	18.9 (0.51)	37.5 (0.92)	44.9 (1.01)
2014	13.5 (0.49)	40.3 (0.76)	47.7 (0.86)
2015	11.2 (0.48)	39.2 (1.01)	51.3 (1.02)
2016	11.7 (0.55)	40.0 (1.18)	50.1 (1.04)
2017 (Jan–Jun)	10.4 (0.72)	40.4 (1.17)	50.8 (1.32)
Non-Hispanic Asian, single race			
2010	16.8 (0.76)	14.9 (0.98)	69.1 (1.17)
2011	16.0 (0.89)	17.6 (1.14)	67.0 (1.40)
2012	16.4 (0.93)	16.6 (0.85)	67.5 (1.24)
2013	13.8 (0.81)	17.5 (1.00)	69.4 (1.27)
2014	10.6 (0.61)	16.7 (0.86)	73.4 (1.01)
2015	6.7 (0.51)	18.0 (1.34)	75.9 (1.44)
2016	6.3 (0.60)	18.9 (1.26)	75.3 (1.18)
2017 (Jan–Jun)	7.1 (1.22)	18.9 (1.68)	74.2 (1.54)
Non-Hispanic, other races and multiple races			
2010	22.4 (4.83)	30.3 (2.14)	48.7 (3.83)
2011	19.1 (1.78)	32.5 (1.60)	50.6 (1.89)
2012	16.4 (1.33)	35.8 (1.77)	50.8 (2.16)
2013	16.0 (1.17)	35.9 (1.75)	50.1 (1.97)
2014	12.8 (1.30)	36.2 (1.69)	52.7 (2.01)
2015	11.1 (1.00)	37.0 (1.86)	53.7 (1.99)
2016	12.6 (0.97)	37.3 (1.87)	52.7 (2.04)
2017 (Jan–Jun)	14.3 (1.76)	36.6 (3.05)	51.5 (2.91)

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Table IX. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race and ethnicity and year: United States, 2010–June 2017

Race and ethnicity and year	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Hispanic or Latino			
2010	43.2 (0.91)	16.3 (0.64)	41.1 (0.85)
2011	42.2 (0.89)	18.1 (0.63)	40.3 (0.82)
2012	41.3 (0.89)	19.0 (0.64)	40.4 (0.73)
2013	40.6 (0.88)	18.0 (0.62)	42.1 (0.70)
2014	33.7 (0.76)	20.6 (0.73)	46.4 (0.86)
2015	27.7 (0.72)	23.0 (0.84)	50.0 (0.85)
2016	25.0 (1.20)	24.9 (1.15)	51.4 (1.08)
2017 (Jan–Jun)	26.5 (1.07)	23.9 (1.28)	50.5 (1.20)
Non-Hispanic white, single race			
2010	16.4 (0.35)	12.8 (0.34)	72.2 (0.52)
2011	15.6 (0.35)	13.4 (0.31)	72.5 (0.48)
2012	15.1 (0.31)	13.7 (0.33)	72.7 (0.46)
2013	14.5 (0.34)	14.4 (0.32)	72.7 (0.49)
2014	11.6 (0.29)	14.6 (0.36)	75.3 (0.47)
2015	8.7 (0.25)	15.7 (0.42)	77.3 (0.47)
2016	8.6 (0.25)	16.6 (0.34)	76.6 (0.38)
2017 (Jan–Jun)	8.6 (0.35)	15.4 (0.41)	77.7 (0.54)
Non-Hispanic black, single race			
2010	27.2 (0.75)	25.3 (0.70)	49.3 (0.81)
2011	24.8 (0.65)	26.2 (0.75)	50.5 (0.79)
2012	23.6 (0.61)	27.0 (0.68)	50.8 (0.75)
2013	24.9 (0.62)	26.6 (0.80)	50.0 (0.91)
2014	17.7 (0.60)	30.5 (0.73)	53.4 (0.84)
2015	14.4 (0.57)	29.7 (0.84)	57.8 (0.90)
2016	15.0 (0.62)	29.9 (1.06)	56.7 (0.95)
2017 (Jan–Jun)	13.2 (0.87)	31.4 (1.10)	56.9 (1.09)
Non-Hispanic Asian, single race			
2010	19.5 (0.92)	11.2 (0.72)	70.2 (1.05)
2011	18.8 (0.96)	13.6 (0.87)	68.0 (1.27)
2012	19.1 (0.92)	13.2 (0.83)	68.2 (1.15)
2013	16.3 (0.88)	14.1 (0.91)	70.4 (1.28)
2014	12.5 (0.65)	13.7 (0.84)	74.5 (1.01)
2015	7.9 (0.58)	15.5 (1.16)	77.2 (1.27)
2016	7.5 (0.67)	16.2 (1.19)	76.8 (1.07)
2017 (Jan–Jun)	8.0 (1.37)	15.3 (1.54)	76.8 (1.28)
Non-Hispanic, other races and multiple races			
2010	32.8 (5.76)	20.6 (1.94)	48.5 (4.77)
2011	27.1 (2.01)	23.6 (1.53)	52.1 (2.17)
2012	24.9 (1.78)	26.1 (1.62)	52.0 (2.24)
2013	23.8 (1.66)	26.8 (1.84)	51.6 (2.26)
2014	19.5 (1.65)	25.2 (1.51)	56.9 (2.06)
2015	16.1 (1.42)	29.0 (1.76)	56.9 (1.88)
2016	17.6 (1.29)	28.9 (1.64)	55.5 (2.13)
2017 (Jan–Jun)	19.0 (1.78)	28.3 (3.44)	53.9 (3.23)

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Table X. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by selected demographic characteristics: United States, January–June 2017

Selected characteristic	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Race and ethnicity			
Hispanic or Latino	26.5 (1.07)	23.9 (1.28)	50.5 (1.20)
Non-Hispanic:			
White, single race	8.6 (0.35)	15.4 (0.41)	77.7 (0.54)
Black, single race	13.2 (0.87)	31.4 (1.10)	56.9 (1.09)
Asian, single race	8.0 (1.37)	15.3 (1.54)	76.8 (1.28)
Other races and multiple races	19.0 (1.78)	28.3 (3.44)	53.9 (3.23)
Region			
Northeast	7.9 (0.90)	19.9 (0.74)	73.6 (0.83)
Midwest	9.9 (0.66)	17.0 (0.70)	74.8 (0.90)
South	18.0 (0.55)	17.5 (0.72)	65.9 (0.62)
West	10.4 (0.85)	23.5 (1.27)	67.5 (1.33)
Education			
Less than high school	30.2 (1.22)	36.6 (1.55)	34.2 (1.10)
High school diploma or GED[4]	16.4 (0.60)	26.2 (0.80)	59.1 (0.95)
More than high school	7.7 (0.35)	13.4 (0.38)	80.3 (0.43)
Employment status			
Employed	11.5 (0.33)	11.6 (0.37)	77.7 (0.45)
Unemployed	28.7 (2.12)	35.6 (1.87)	37.0 (2.10)
Not in workforce	12.8 (0.61)	43.0 (0.79)	47.8 (0.87)
Poverty status[5]			
< 100% FPL	23.9 (1.42)	51.4 (1.42)	25.8 (1.60)
≥ 100% and ≤ 138% FPL	25.1 (1.81)	45.8 (2.13)	31.3 (1.57)
> 138% and ≤ 250% FPL	20.9 (0.90)	28.1 (1.24)	52.8 (1.09)
> 250% and ≤ 400% FPL	12.2 (0.64)	13.2 (0.66)	76.5 (0.95)
> 400% FPL	3.8 (0.27)	5.3 (0.38)	92.0 (0.43)
Unknown	12.9 (1.45)	17.4 (1.08)	70.4 (1.53)
Marital status			
Married	9.6 (0.37)	13.2 (0.49)	78.6 (0.56)
Widowed	10.5 (1.82)	39.3 (2.96)	54.1 (3.00)
Divorced or separated	15.1 (0.87)	30.5 (1.23)	56.2 (1.28)
Living with partner	19.2 (1.16)	22.7 (1.50)	59.2 (1.63)
Never married	15.5 (0.64)	24.7 (0.81)	61.0 (0.83)

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

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

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

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

[5]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. The percentage of respondents with "unknown" poverty status for this five-level categorization is 8.2%. This value is greater than the corresponding value for the three-level poverty categorization of poor, near poor, and not poor because of greater uncertainty when assigning individuals to more detailed poverty groups. For more information on poverty status, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

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

SOURCE: NCHS, National Health Interview Survey, 2017, Family Core component.

Table XI. Percentages (and standard errors) of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, in a high-deductible health plan without a health savings account, and in a consumer-directed health plan, and who were in a family with a flexible spending account for medical expenses, by year: United States, 2010–June 2017

Year	Enrolled in high-deductible health plan (HDHP)[1]	Enrolled in HDHP without health savings account (HSA)[2]	Enrolled in consumer-directed health plan (CDHP)[3]	In family with flexible spending account (FSA) for medical expenses
2010	25.3 (0.54)	17.6 (0.46)	7.7 (0.33)	20.4 (0.50)
2011	29.0 (0.54)	19.9 (0.41)	9.2 (0.35)	21.4 (0.53)
2012	31.1 (0.57)	20.3 (0.42)	10.8 (0.34)	21.6 (0.45)
2013	33.9 (0.68)	22.2 (0.48)	11.7 (0.43)	21.6 (0.48)
2014	36.9 (0.77)	23.6 (0.52)	13.3 (0.47)	21.2 (0.49)
2015	36.7 (0.68)	23.4 (0.50)	13.3 (0.42)	21.7 (0.51)
2016	39.4 (0.65)	23.9 (0.49)	15.5 (0.51)	22.1 (0.40)
2017 (Jan–Jun)	42.9 (0.71)	25.5 (0.78)	17.4 (0.49)	23.7 (0.59)

[1]HDHP was defined in 2017 as a health plan with an annual deductible of at least $1,300 for self-only coverage and $2,600 for family coverage. The deductible is adjusted annually for inflation. Deductibles for previous years are included in the Technical Notes.

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

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

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

SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Table XII. Percentages (and standard errors) of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, by year and source of coverage: United States, 2010–June 2017

Year	Employment based[1]	Directly purchased[2]
2010	23.3 (0.54)	48.0 (1.48)
2011	26.9 (0.53)	52.4 (1.49)
2012	29.2 (0.60)	54.7 (1.61)
2013	32.0 (0.67)	56.4 (1.50)
2014	36.2 (0.73)	54.1 (1.43)
2015	36.6 (0.72)	50.9 (1.50)
2016	39.6 (0.69)	51.9 (1.38)
2017 (Jan–Jun)	43.5 (0.74)	53.5 (2.26)

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

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

NOTES: For persons under age 65, approximately 8% of private health plans were directly purchased from 2010 through 2013. In 2014 through the second quarter of 2017, approximately 10% of private plans were directly purchased. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Table XIII. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Medicaid expansion status, and year: United States, 2010–June 2017

Age group, state Medicaid expansion status, and year	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Under 65 years			
Medicaid expansion states[4]			
2010	16.4 (0.42)	21.8 (0.54)	63.1 (0.70)
2011	15.3 (0.35)	23.1 (0.56)	62.9 (0.72)
2012	15.0 (0.34)	23.1 (0.50)	63.3 (0.63)
2013	14.9 (0.40)	24.1 (0.48)	62.3 (0.68)
2014	10.9 (0.29)	25.6 (0.49)	64.9 (0.59)
2015	8.2 (0.23)	26.7 (0.57)	66.4 (0.64)
2016	7.8 (0.24)	27.7 (0.53)	66.3 (0.60)
2017 (Jan–Jun)	7.4 (0.38)	26.9 (0.59)	67.2 (0.69)
Non-Medicaid expansion states[5]			
2010	20.3 (0.48)	22.1 (0.51)	59.0 (0.76)
2011	19.6 (0.50)	22.7 (0.50)	59.1 (0.78)
2012	19.2 (0.45)	24.0 (0.55)	58.3 (0.75)
2013	18.4 (0.48)	23.4 (0.51)	59.6 (0.80)
2014	16.0 (0.44)	23.2 (0.52)	62.1 (0.76)
2015	14.0 (0.41)	23.2 (0.58)	64.4 (0.78)
2016	14.7 (0.56)	23.9 (0.58)	62.8 (0.84)
2017 (Jan–Jun)	15.6 (0.51)	23.4 (0.84)	62.3 (0.69)
0–17 years			
Medicaid expansion states[4]			
2010	6.7 (0.46)	38.2 (1.05)	56.5 (1.06)
2011	5.9 (0.33)	40.2 (1.11)	55.4 (1.09)
2012	5.3 (0.32)	40.4 (1.00)	55.9 (1.07)
2013	5.6 (0.33)	41.3 (0.86)	54.5 (0.95)
2014	4.3 (0.33)	41.0 (0.84)	56.2 (0.88)
2015	3.8 (0.28)	41.1 (0.99)	56.7 (1.00)
2016	4.1 (0.33)	42.0 (0.92)	56.1 (0.97)
2017 (Jan–Jun)	3.7 (0.58)	41.6 (1.27)	56.6 (1.25)
Non-Medicaid expansion states[5]			
2010	9.0 (0.47)	41.7 (0.99)	50.7 (1.08)
2011	8.3 (0.46)	42.0 (1.02)	50.9 (1.11)
2012	8.0 (0.46)	43.9 (1.11)	49.4 (1.07)
2013	7.5 (0.40)	43.1 (1.12)	50.5 (1.23)
2014	6.7 (0.43)	43.5 (1.06)	51.0 (1.11)
2015	5.5 (0.42)	43.7 (1.27)	52.0 (1.26)
2016	6.7 (0.52)	44.4 (1.02)	50.3 (1.20)
2017 (Jan–Jun)	7.0 (0.95)	44.2 (1.60)	50.0 (1.18)
18–64 years			
Medicaid expansion states[4]			
2010	20.1 (0.47)	15.5 (0.40)	65.6 (0.62)
2011	18.9 (0.41)	16.6 (0.41)	65.8 (0.61)
2012	18.5 (0.39)	16.7 (0.38)	66.0 (0.53)
2013	18.4 (0.49)	17.7 (0.44)	65.2 (0.65)
2014	13.3 (0.34)	19.9 (0.46)	68.1 (0.56)
2015	9.8 (0.28)	21.5 (0.49)	70.0 (0.56)
2016	9.2 (0.25)	22.5 (0.41)	70.0 (0.49)
2017 (Jan–Jun)	8.8 (0.42)	21.6 (0.52)	71.1 (0.61)
Non-Medicaid expansion states[5]			
2010	24.8 (0.58)	14.4 (0.45)	62.2 (0.70)
2011	24.1 (0.60)	15.1 (0.42)	62.3 (0.71)
2012	23.7 (0.54)	16.1 (0.44)	61.8 (0.69)
2013	22.7 (0.59)	15.6 (0.41)	63.2 (0.69)
2014	19.6 (0.54)	15.3 (0.41)	66.5 (0.69)
2015	17.5 (0.52)	14.9 (0.44)	69.4 (0.67)
2016	17.9 (0.69)	15.7 (0.50)	67.8 (0.78)
2017 (Jan–Jun)	19.0 (0.43)	15.1 (0.62)	67.2 (0.65)

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

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

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

[4]For 2010 through 2014, states moving forward with Medicaid expansion included: AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV (as of October 31, 2013). Beginning with 2015, three additional states were included as expansion states: IN, NH, and PA. Beginning with 2016, three additional states were included as expansion states: AK, LA, and MT.

[5]For 2010 through 2014, states not moving forward with Medicaid expansion included: AL, AK, FL, GA, ID, IN, KS, LA, ME, MS, MO, MT, NE, NH, NC, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013). Beginning with 2015, three states have been removed from this grouping: IN, NH, and PA. Beginning with 2016, three additional states have been removed from this grouping: AK, LA, and MT.

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

SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Table XIV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Health Insurance Marketplace type, and year: United States, 2010–June 2017

Age group, state Health Insurance Marketplace type, and year	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Under 65 years			
State-based Marketplace states[4]			
2010	16.3 (0.46)	21.6 (0.66)	63.2 (0.80)
2011	15.9 (0.46)	23.6 (0.70)	61.8 (0.88)
2012	15.2 (0.43)	24.2 (0.66)	61.8 (0.83)
2013	15.2 (0.48)	25.0 (0.56)	61.0 (0.83)
2014	11.1 (0.38)	26.4 (0.63)	63.7 (0.78)
2015	7.7 (0.30)	28.1 (0.80)	65.4 (0.92)
2016	7.3 (0.27)	28.4 (0.70)	65.9 (0.72)
2017 (Jan–Jun)	6.9 (0.45)	27.8 (0.87)	66.7 (1.02)
Partnership Marketplace states[5]			
2010	14.7 (0.87)	22.5 (1.15)	64.8 (1.73)
2011	14.3 (0.71)	22.7 (1.28)	64.5 (1.72)
2012	14.1 (0.70)	20.8 (1.12)	66.7 (1.53)
2013	14.2 (0.83)	21.8 (1.07)	65.6 (1.42)
2014	10.2 (0.57)	24.4 (1.06)	67.2 (1.28)
2015	8.0 (0.59)	26.1 (1.20)	67.7 (1.42)
2016	7.0 (0.48)	26.3 (1.27)	68.8 (1.66)
2017 (Jan–Jun)	6.7 (0.68)	26.4 (1.38)	69.7 (1.56)
Federally Facilitated Marketplace states[6]			
2010	20.1 (0.48)	22.1 (0.50)	59.1 (0.70)
2011	18.8 (0.45)	22.6 (0.47)	60.0 (0.71)
2012	18.6 (0.41)	23.6 (0.50)	59.3 (0.67)
2013	17.9 (0.44)	23.3 (0.49)	60.2 (0.74)
2014	15.3 (0.40)	23.3 (0.50)	62.8 (0.69)
2015	12.8 (0.33)	23.4 (0.54)	65.3 (0.66)
2016	13.1 (0.45)	24.8 (0.51)	63.6 (0.69)
2017 (Jan–Jun)	13.5 (0.44)	24.1 (0.67)	63.7 (0.63)
0–17 years			
State-based Marketplace states[4]			
2010	6.7 (0.50)	38.0 (1.32)	56.4 (1.31)
2011	6.4 (0.47)	40.9 (1.43)	54.2 (1.39)
2012	5.4 (0.43)	42.2 (1.37)	53.9 (1.46)
2013	5.7 (0.37)	42.8 (1.05)	52.6 (1.18)
2014	4.2 (0.40)	42.0 (1.11)	54.9 (1.13)
2015	3.1 (0.34)	42.4 (1.32)	55.8 (1.41)
2016	3.6 (0.38)	42.7 (1.19)	55.8 (1.26)
2017 (Jan–Jun)	2.9 (0.46)	42.0 (1.94)	56.2 (1.91)
Partnership Marketplace states[5]			
2010	4.1 (0.78)	40.7 (2.21)	57.9 (2.31)
2011	4.2 (0.53)	39.6 (2.44)	58.0 (2.39)
2012	3.6 (0.69)	38.5 (2.20)	59.9 (2.26)
2013	4.2 (0.53)	38.4 (1.95)	59.2 (2.08)
2014	3.2 (0.51)	40.8 (1.88)	58.4 (1.99)
2015	4.3 (0.73)	40.3 (2.53)	57.5 (2.34)
2016	2.0 (0.40)	40.4 (2.54)	60.5 (2.49)
2017 (Jan–Jun)	1.6 (0.54)	43.8 (3.01)	59.2 (2.79)
Federally Facilitated Marketplace states[6]			
2010	9.2 (0.48)	40.7 (0.91)	51.3 (0.97)
2011	8.0 (0.40)	41.4 (0.93)	51.8 (1.01)
2012	7.9 (0.41)	42.7 (1.00)	50.8 (0.98)
2013	7.5 (0.39)	42.6 (1.02)	51.3 (1.11)
2014	6.6 (0.41)	42.6 (0.94)	52.0 (1.00)
2015	5.3 (0.35)	42.4 (1.06)	53.6 (1.04)
2016	6.6 (0.45)	43.6 (0.87)	51.5 (0.97)
2017 (Jan–Jun)	6.8 (0.82)	42.8 (1.25)	51.8 (1.11)

See footnotes at end of table.

Table XIV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age, state Health Insurance Marketplace type, and year: United States, 2010–June 2017—Con.

Age group, state Health Insurance Marketplace type, and year	Uninsured[1] at time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
18–64 years			
State-based Marketplace states[4]			
2010	19.9 (0.52)	15.3 (0.48)	65.9 (0.68)
2011	19.5 (0.53)	17.1 (0.52)	64.7 (0.75)
2012	18.8 (0.50)	17.7 (0.49)	64.7 (0.69)
2013	18.7 (0.60)	18.4 (0.52)	64.1 (0.80)
2014	13.6 (0.45)	20.6 (0.57)	67.0 (0.75)
2015	9.4 (0.37)	22.9 (0.69)	68.9 (0.81)
2016	8.6 (0.30)	23.4 (0.58)	69.5 (0.58)
2017 (Jan–Jun)	8.3 (0.52)	22.7 (0.78)	70.4 (0.89)
Partnership Marketplace states[5]			
2010	18.9 (1.12)	15.3 (0.90)	67.6 (1.59)
2011	18.4 (0.92)	15.9 (0.87)	67.1 (1.52)
2012	18.1 (0.85)	13.9 (0.79)	69.3 (1.36)
2013	17.9 (0.98)	15.7 (0.91)	68.0 (1.29)
2014	12.8 (0.68)	18.2 (0.98)	70.5 (1.22)
2015	9.4 (0.74)	20.8 (0.95)	71.5 (1.26)
2016	8.8 (0.59)	21.3 (0.88)	71.8 (1.41)
2017 (Jan–Jun)	8.6 (0.84)	20.0 (1.22)	73.5 (1.28)
Federally Facilitated Marketplace states[6]			
2010	24.5 (0.56)	14.7 (0.43)	62.2 (0.66)
2011	23.0 (0.54)	15.1 (0.39)	63.3 (0.64)
2012	22.8 (0.48)	16.1 (0.41)	62.7 (0.61)
2013	22.0 (0.54)	15.9 (0.41)	63.6 (0.64)
2014	18.6 (0.49)	15.8 (0.41)	66.9 (0.63)
2015	15.7 (0.42)	16.0 (0.43)	69.9 (0.57)
2016	15.7 (0.54)	17.4 (0.46)	68.5 (0.63)
2017 (Jan–Jun)	16.1 (0.38)	16.8 (0.52)	68.4 (0.55)

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

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

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

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

Table XV. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and expanded region: United States, January–June 2017

Age group and expanded region[1]	Uninsured[2] at time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
All ages			
All regions	9.0 (0.32)	36.4 (0.54)	62.6 (0.50)
New England	3.8 (0.48)	37.2 (3.05)	68.5 (2.37)
Middle Atlantic	5.8 (0.72)	35.3 (0.82)	67.4 (0.82)
East North Central	6.9 (0.70)	35.8 (1.14)	68.4 (1.39)
West North Central	8.4 (1.02)	30.5 (0.85)	72.8 (1.66)
South Atlantic	12.5 (0.61)	36.7 (2.05)	57.4 (1.11)
East South Central	9.2 (0.66)	41.3 (0.80)	56.4 (1.29)
West South Central	16.6 (1.05)	33.4 (0.94)	55.5 (1.06)
Mountain	8.9 (1.85)	35.4 (3.59)	62.1 (2.89)
Pacific	6.9 (0.60)	40.7 (1.21)	59.1 (1.59)
Under 65 years			
All regions	10.5 (0.36)	25.6 (0.49)	65.4 (0.50)
New England	4.6 (0.48)	23.8 (2.50)	73.2 (2.42)
Middle Atlantic	6.7 (0.81)	24.4 (0.64)	70.1 (0.97)
East North Central	8.1 (0.80)	24.4 (1.02)	69.8 (1.44)
West North Central	9.9 (1.15)	17.6 (0.83)	73.9 (1.53)
South Atlantic	14.8 (0.61)	24.9 (1.69)	61.5 (1.15)
East South Central	10.7 (0.78)	32.6 (1.04)	58.4 (1.18)
West South Central	18.8 (1.31)	24.3 (1.40)	58.1 (0.97)
Mountain	10.3 (1.99)	25.9 (2.64)	65.4 (2.57)
Pacific	8.0 (0.66)	30.9 (1.50)	62.3 (1.79)
0–17 years			
All regions	5.0 (0.52)	42.6 (0.95)	54.0 (0.87)
New England	*	33.9 (6.63)	65.2 (5.90)
Middle Atlantic	2.4 (0.72)	38.8 (1.66)	60.2 (1.59)
East North Central	*	38.7 (2.11)	59.7 (2.79)
West North Central	5.7 (1.58)	31.1 (1.93)	64.6 (1.76)
South Atlantic	6.5 (1.39)	46.8 (3.12)	47.5 (2.01)
East South Central	4.8 (1.44)	52.0 (2.51)	44.0 (3.25)
West South Central	7.4 (2.04)	48.2 (2.16)	46.0 (1.43)
Mountain	*	37.9 (2.81)	58.3 (2.62)
Pacific	3.9 (0.68)	47.8 (3.39)	49.4 (3.29)
18–64 years			
All regions	12.5 (0.37)	19.2 (0.44)	69.6 (0.46)
New England	5.6 (0.66)	20.4 (1.35)	75.8 (1.73)
Middle Atlantic	8.1 (1.00)	19.6 (0.79)	73.4 (0.93)
East North Central	9.2 (0.77)	19.1 (0.94)	73.6 (1.09)
West North Central	11.6 (1.24)	12.1 (0.88)	77.6 (1.60)
South Atlantic	18.0 (0.42)	16.7 (1.22)	66.9 (1.00)
East South Central	13.0 (0.83)	24.9 (0.88)	64.1 (0.87)
West South Central	23.2 (1.10)	14.9 (1.23)	62.9 (1.11)
Mountain	12.3 (1.95)	20.6 (2.82)	68.5 (2.69)
Pacific	9.5 (0.77)	24.7 (1.24)	67.0 (1.50)

*Estimate is not shown, as it does not meet standards of reliability or precision.

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

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

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

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

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

SOURCE: NCHS, National Health Interview Survey, 2017, Family Core component.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January 2016–June 2017

Age group and selected states[1]	Uninsured[2] at the time of interview		Public health plan coverage[3]		Private health insurance coverage[4]	
	[5]2016	2017 (Jan–Jun)	[5]2016	2017 (Jan–Jun)	[5]2016	2017 (Jan–Jun)
All ages						
All states[6]	8.9 (0.28)	9.0 (0.32)	36.5 (0.39)	36.4 (0.54)	62.8 (0.49)	62.6 (0.50)
California	7.2 (0.26)	6.8 (0.61)	39.9 (1.45)	41.5 (1.97)	58.5 (1.53)	57.2 (2.12)
Florida	13.5 (0.61)	13.5 (2.42)	39.1 (1.32)	39.0 (2.16)	54.0 (2.00)	52.4 (2.35)
Georgia	12.8 (1.20)	16.3 (1.79)	31.9 (1.90)	33.4 (2.50)	60.3 (2.57)	55.5 (3.42)
Illinois	5.4 (0.84)	6.3 (0.72)	34.4 (2.50)	32.8 (1.67)	71.5 (2.16)	70.6 (2.04)
Michigan	6.8 (0.69)	5.7 (1.11)	39.3 (2.79)	41.4 (2.21)	65.8 (2.78)	65.9 (2.12)
New York	5.5 (0.50)	4.7 (0.71)	37.5 (0.50)	38.2 (1.12)	65.0 (1.02)	64.6 (1.17)
North Carolina	10.6 (1.16)	11.0 (1.03)	33.0 (2.94)	36.1 (5.30)	63.3 (3.42)	59.3 (4.63)
Ohio	6.1 (0.72)	7.6 (1.53)	40.3 (1.61)	37.0 (2.41)	63.6 (1.61)	66.2 (3.46)
Pennsylvania	6.9 (1.02)	5.7 (1.26)	36.2 (1.45)	34.0 (1.88)	67.2 (2.04)	70.5 (2.02)
Texas	18.6 (1.69)	18.5 (1.25)	29.7 (0.63)	28.5 (1.10)	56.6 (2.30)	57.5 (1.62)
Virginia	8.6 (1.08)	10.1 (2.20)	34.1 (2.08)	31.5 (3.25)	66.0 (2.70)	66.5 (2.55)
Under 65 years						
All states[6]	10.3 (0.32)	10.5 (0.36)	25.8 (0.43)	25.6 (0.49)	65.5 (0.51)	65.4 (0.50)
California	8.3 (0.37)	7.8 (0.70)	30.8 (1.58)	32.1 (2.34)	62.0 (1.60)	60.8 (2.49)
Florida	16.4 (0.78)	16.3 (2.73)	25.8 (1.89)	25.8 (2.49)	58.7 (2.11)	58.7 (2.39)
Georgia	14.7 (1.33)	18.6 (1.95)	21.4 (1.88)	24.1 (2.74)	64.7 (2.94)	59.1 (3.95)
Illinois	6.4 (0.97)	7.3 (0.93)	22.7 (1.73)	21.3 (1.89)	72.7 (2.45)	73.0 (2.60)
Michigan	8.0 (0.81)	6.8 (1.29)	28.1 (2.78)	31.4 (1.88)	66.3 (3.15)	66.1 (2.16)
New York	6.5 (0.63)	5.5 (0.82)	26.2 (0.46)	27.9 (0.90)	69.1 (1.03)	67.7 (1.15)
North Carolina	12.0 (1.41)	12.8 (1.33)	23.0 (2.70)	25.7 (4.99)	66.5 (3.66)	62.5 (5.53)
Ohio	7.1 (0.83)	8.8 (1.66)	28.4 (1.81)	25.9 (2.97)	66.4 (1.74)	67.4 (4.08)
Pennsylvania	8.2 (1.17)	6.8 (1.44)	24.1 (1.57)	21.1 (1.87)	69.7 (2.31)	73.6 (2.63)
Texas	20.7 (1.86)	20.5 (1.51)	21.1 (0.92)	20.2 (1.22)	59.0 (2.45)	59.9 (1.46)
Virginia	9.9 (1.27)	11.9 (2.63)	23.9 (2.14)	20.3 (2.51)	67.4 (2.95)	69.5 (2.84)
0–17 years						
All states[6]	5.2 (0.30)	5.0 (0.52)	42.4 (0.67)	42.6 (0.95)	54.2 (0.75)	54.0 (0.87)
California	4.5 (0.56)	3.2 (0.69)	47.2 (2.33)	49.5 (4.46)	49.6 (2.43)	47.8 (4.18)
Florida	7.4 (0.93)	*	48.8 (2.08)	51.0 (5.89)	44.3 (2.09)	42.5 (3.92)
Georgia	5.8 (1.57)	*6.6 (2.12)	44.8 (3.17)	45.4 (6.53)	50.2 (4.03)	49.2 (5.47)
New York	*3.9 (1.32)	*1.1 (0.40)	36.9 (1.26)	41.3 (3.12)	61.3 (2.07)	58.1 (3.21)
North Carolina	3.7 (0.89)	3.4 (0.79)	43.8 (5.12)	50.3 (5.19)	53.5 (4.94)	46.3 (4.66)
Ohio	3.5 (0.97)	*	40.4 (4.08)	37.7 (6.18)	58.8 (4.67)	57.5 (7.78)
Pennsylvania	7.7 (1.81)	*4.9 (2.01)	36.7 (2.47)	33.7 (4.14)	57.8 (2.83)	62.8 (3.10)
Texas	11.4 (1.49)	9.0 (2.50)	43.3 (1.20)	42.1 (1.79)	46.2 (2.52)	49.4 (2.16)

See footnotes at end of table.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January 2016–June 2017 —Con.

Age group and selected states[1]	Uninsured[2] at the time of interview		Public health plan coverage[3]		Private health insurance coverage[4]	
	[5]2016	2017 (Jan–Jun)	[5]2016	2017 (Jan–Jun)	[5]2016	2017 (Jan–Jun)
18–64 years						
All states[6]	12.3 (0.36)	12.5 (0.37)	19.6 (0.39)	19.2 (0.44)	69.7 (0.45)	69.6 (0.46)
California	9.7 (0.36)	9.5 (0.85)	24.7 (1.28)	25.6 (1.88)	66.6 (1.26)	65.6 (2.12)
Florida	19.8 (1.24)	19.5 (2.20)	17.3 (1.30)	16.6 (1.28)	64.0 (1.93)	64.7 (2.74)
Georgia	18.4 (1.52)	23.4 (3.24)	11.6 (1.87)	15.4 (1.86)	70.8 (2.90)	63.1 (3.75)
Illinois	8.2 (1.30)	9.6 (1.28)	18.1 (1.32)	15.9 (1.82)	75.5 (2.20)	75.6 (2.36)
Michigan	9.5 (0.97)	8.3 (1.62)	24.8 (2.38)	25.0 (1.48)	67.8 (2.83)	69.8 (2.16)
New York	7.3 (0.68)	7.0 (1.10)	22.8 (0.42)	23.4 (1.28)	71.5 (0.93)	70.8 (1.20)
North Carolina	15.0 (1.87)	16.9 (2.09)	15.4 (2.14)	15.1 (4.35)	71.2 (3.43)	69.5 (5.60)
Ohio	8.5 (0.96)	9.3 (1.03)	23.7 (1.38)	21.6 (1.84)	69.3 (1.19)	71.0 (2.60)
Pennsylvania	8.3 (1.18)	7.5 (1.63)	18.9 (1.39)	16.4 (1.19)	74.7 (2.28)	77.6 (2.67)
Texas	24.7 (2.10)	25.1 (1.20)	11.6 (0.86)	11.4 (1.35)	64.5 (2.52)	64.2 (1.48)
Virginia	12.5 (1.52)	12.7 (2.60)	17.9 (1.78)	15.2 (2.06)	71.1 (2.66)	74.1 (3.17)

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error (RSE) greater than 30% and less than or equal to 50% and should be used with caution. Data not shown have an RSE greater than 50% or could not be shown due to considerations of sample size.

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

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

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

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

[5]2016 state estimates may not match those previously published using Early Release data, as they were updated with a revised weight intended to improve the accuracy of state estimates.

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

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

SOURCE: NCHS, National Health Interview Survey, 2016–2017, Family Core component.

Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

DECEMBER 2017

State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Short-Term Health Plans

Supported by the Robert Wood Johnson Foundation

In Brief:

- States have a critical role regulating short-term health plans
- This brief highlights 3 areas for state action
  - » Ban or limit short-term plans
  - » Reduce market segmentation risk
  - » Increase consumer disclosures & regulatory oversight

Contact Sabrina Corlette at sabrina.corlette@georgetown.edu or (202) 687-3003 for additional information.

OVERVIEW

In October 2017, President Trump issued an Executive Order to expand access to certain health insurance products—short-term limited-duration plans, association health plans, and health reimbursement arrangements. Although not yet fully implemented, the Executive Order has raised concerns about its impact on the Affordable Care Act's (ACA) consumer protections and on insurance markets.

As the primary regulators of private health insurance, states play a key role. This brief identifies a range of policy options that state policymakers can consider regarding the regulation of short-term coverage.[1] These policy options include 1) banning or limiting the sale of short-term coverage; 2) allowing the sale of short-term coverage but reducing the risk of market segmentation; and 3) increasing consumer disclosures and regulatory oversight.

WHAT IS SHORT-TERM COVERAGE?

Short-term coverage, or "short-term limited-duration insurance," is health insurance that, by definition, covers someone for less than 12 months and is not renewable. Short-term coverage was designed to fill temporary gaps in coverage. A consumer might, for instance, enroll in a short-term policy when between jobs or while in a waiting period for employer-sponsored coverage. Although designed to be temporary, in the first year of the ACA's market reforms, some insurers sold short-term policies that lasted for 364 days, just one day shy of 12 months, which allowed them to escape regulation under federal law as health insurance.

When categorized as short-term coverage, these plans do not have to comply with the ACA's consumer protections, such as the ban on preexisting condition exclusions and rescissions, the coverage of

1. We will address state policy options on the regulation of association health plans and health reimbursement arrangements in separate briefs.

essential health benefits, and maximum limits on consumer out-of-pocket spending (Exhibit 1). Because short-term coverage is not considered health insurance under the ACA, consumers who enroll in only short-term coverage may have to pay the ACA's individual mandate penalty in addition to premiums and any medical costs that are not covered by their policy.

Exhibit 1. Consumer Protections in ACA Plans Compared to Short-Term Coverage

Consumer Protection	ACA Plans	Short-Term Coverage
Includes coverage for preexisting conditions?	Yes	No – short-term plans can decline to offer coverage at all or exclude coverage for preexisting conditions
Prohibits higher rates based on health status?	Yes	No – short-term plans can charge a higher rate based on an individual's health status
Covers essential health benefits?	Yes	No – coverage varies by plan and there are generally no minimum or standard benefit requirements for short-term plans
Prohibits dollar caps on health care services?	Yes	No – short-term plans can include a dollar cap on services and stop paying medical bills after that cap is reached
Caps out-of-pocket expenses for consumers?	Yes	No – short-term plans may not have a maximum limit on consumer out-of-pocket costs
Allows consumers to use federal premium assistance based on their income?	Yes	No – premium tax credits cannot be used to purchase short-term plans
Satisfies the individual mandate?	Yes	No – consumers enrolled in a short-term plan may have to pay a penalty for failing to have minimum essential coverage

Short-term coverage generally is only available to consumers who can pass medical underwriting and provides minimal financial protection for those who become sick or injured. In a recent analysis, short-term policies regularly excluded coverage for preexisting conditions, did not cover entire categories of key benefits (such as mental health and substance use services, maternity care, or prescription drugs), and included out-of-pocket maximums ranging from $7,000 to $20,000 for only three months of coverage.

Because of these limitations, premiums for short-term coverage are much lower than premiums for ACA-compliant coverage and enrollment tends to skew younger and healthier. As a result, the availability of short-term coverage likely reduces the enrollment of younger, healthier people in ACA-compliant plans and contributes to adverse selection against the marketplaces.

> "The more available short-term plans are and the more attractive they become to healthy individuals, the greater the risk for market segmentation and adverse selection, and therefore higher premiums, in the ACA-compliant individual market."
>
> – *American Academy of Actuaries (Nov. 2017)*

HOW PRESIDENT TRUMP'S EXECUTIVE ORDER MIGHT BE IMPLEMENTED

In 2016, federal regulators cited concerns that short-term coverage was "being sold as a type of primary coverage" and "adversely impacting the risk pool" in the individual market. They adopted

a regulation that made it less attractive to sell short-term plans to potential marketplace enrollees. In particular, the rule prohibited insurers from offering short-term policies that lasted longer than three months and required each policy to include a prominent notice that it is not minimum essential coverage and thus does not satisfy the individual mandate. The rule also prohibited insurers from renewing short-term policies after the end of the three-month coverage period.

Under President Trump's Executive Order, federal regulators are widely expected to reverse the Obama-era regulation. The Executive Order directed the Secretaries of the Treasury, Labor, and Health and Human Services to expand the availability of short-term coverage and "consider allowing such insurance to cover longer periods and be renewed by the consumer." If the Trump administration reverses the rule, insurers could resume offering and renewing medically underwritten short-term coverage exempt from ACA rules that lasts up to 364 days (or a different maximum duration selected by federal regulators).

This would likely increase enrollment in short-term coverage. Proponents of short-term coverage argue that these plans promote consumer choice and lower-cost options compared to ACA-compliant plans. This may be especially true for consumers who do not qualify for marketplace subsidies in the face of rising premiums in ACA plans. Critics, however, note that short-term plans are not available to people with preexisting conditions, are low-cost because they cover few benefits, and expose consumers to serious financial risk in the face of unexpected health issues. They further argue that the proliferation of short-term plans siphons healthy risk away from ACA-compliant plans. At the same time, short-term plan enrollees who develop a health problem can shift to an ACA-compliant plan during the annual open enrollment period. This leaves a smaller and sicker risk pool for the traditional insurance market, resulting in fewer plan options and higher prices for major medical coverage.

STATE POLICY OPTIONS TO ADDRESS CONCERNS ABOUT SHORT-TERM COVERAGE

States have broad authority to regulate short-term coverage. Given changes anticipated under President Trump's Executive Order, we have identified a number of state policy options regarding the regulation of short-term coverage. State approaches will vary based on the state's legal authority and regulatory capacity; some states may need new legislation to fully regulate short-term coverage while others can leverage existing law to do so. The policy options below are not mutually exclusive and could be adopted as part of a comprehensive market stabilization strategy.

I. BAN OR LIMIT SHORT-TERM COVERAGE

State legislatures and insurance regulators could:

- **Require short-term coverage to comply with rules for the individual market.** States could apply individual market insurance rules, including those prescribed under the ACA, to short-term coverage. New Jersey and New York currently do not allow the sale of short-term coverage that does not comply with existing law in the individual market. This policy change would limit choices for consumers seeking short-term coverage, but would incentivize enrollment in ACA-compliant plans and improve the stability of the individual market.
- **Require short-term coverage to comply with some ACA market reforms.** States could apply some of the ACA's consumer protections to short-term coverage, such as coverage of essential

benefits; guaranteed issue, rescission, and pre-existing condition protections; and a cap on annual out-of-pocket costs. State regulators could also consider whether state or federal nondiscrimination protections apply to an insurer's line of business for short-term policies. These changes could help protect consumers, create a more level playing field between short-term coverage and ACA-compliant coverage, and reduce the risk of market segmentation.

- **Limit the duration of short-term coverage.** States could mimic the 2016 federal rule by limiting the length of short-term policies to three months and prohibiting renewals. States could also select a different maximum duration. For example, California and Minnesota limit the length of the policy to up to 185 days and restrict renewals. These changes could help ensure that short-term policies are being used to fill temporary coverage gaps that they were designed for instead of as a year-long substitute for major medical coverage.
- **Require nonrenewable short-term coverage to discontinue at the end of the calendar year.** States could require all short-term policies to discontinue on December 31st of each year without the option to renew and provide notice to consumers about the open enrollment period. Under this policy, consumers who miss the annual open enrollment period and do not qualify for a special enrollment period could enroll in a short-term policy only until they can enroll in ACA coverage. By ending short-term plans on December 31st, state policymakers could better incentivize enrollment in ACA-compliant plans.

II. REDUCE THE RISK OF MARKET SEGMENTATION

State legislatures and insurance regulators could:

- **Assess insurers that offer short-term coverage and reinvest these funds in a reinsurance program for the individual market.** States could require insurers to price short-term plans in a way that more closely resembles their true costs through a "free rider" assessment. This assessment could apply to insurers that offer short-term coverage and be reinvested in the individual market for reinsurance. The assessment would likely result in higher premiums, which could cause lower enrollment in short-term plans, higher enrollment in ACA plans, and a healthier overall risk pool. This change would help prevent free-riding on the ACA-compliant market by requiring short-term plans to contribute towards the health of the individual market.
- **Require short-term policies to meet a minimum medical loss ratio.** States could require short-term coverage to meet the same medical loss ratio that applies in the individual market. Current federal rules require individual market insurers to spend at least 80 percent of premiums on health care services. The average loss ratio for short-term coverage in 2016 was 67 percent, suggesting this line of business is more profitable than the individual market where loss ratios have been much higher since 2014. Imposing a higher medical loss ratio for short-term coverage would help level the playing field and increase the value of these policies for consumers.
- **Require completion of an ACA marketplace eligibility determination before allowing enrollment in short-term coverage.** States could prohibit insurers from selling a short-term policy to a consumer unless that consumer shows that they've already received a marketplace eligibility determination. This might mean that a consumer attests that they received a marketplace eligibility determination and do not qualify for subsidies or a special enrollment period through the marketplace. This requirement could help ensure that consumers better understand their coverage options and the availability of subsidies for ACA-compliant coverage.

III. INCREASE CONSUMER DISCLOSURES AND REGULATORY OVERSIGHT

State legislatures and insurance regulators could:

- **Require additional disclosures and educate consumers about short-term coverage.** States could require insurers to disclose that short-term policies are not minimum essential coverage and the other limitations of these policies through notice requirements on applications, policies, websites, and in marketing materials. States could also educate consumers about the risks associated with short-term plans. Several state insurance departments—such as Alaska, Indiana, Maryland, and Wyoming—have used their websites and alerts to inform consumers about the limitations and often deceptive marketing associated with some short-term plans.
- **Increase pre- and post-marketing oversight of short-term coverage and collect additional data.** States could subject short-term coverage to regulatory review—such as form and rate review—to improve pre-marketing oversight. States could also track enrollment in short-term policies and investigate whether higher broker commissions for short-term coverage are disadvantaging the ACA-compliant market. Doing so could help ensure that these policies meet applicable state requirements and provide information to regulators on what is being marketed in their state.

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About Georgetown University - Center on Health Insurance Reforms

The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace. For more information, visit www.chir.georgetown.edu/.

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BROOKINGS

Up Front

Repealing the individual mandate would do substantial harm

Matthew FiedlerTuesday, November 21, 2017

Editor's Note:

This analysis is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between the Center for Health Policy at Brookings and the University of Southern California Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

The tax legislation reported by the Senate Finance Committee last week included repeal of the individual mandate, which was created by the Affordable Care Act (ACA) and requires individuals to obtain health insurance coverage or pay a penalty. The Congressional Budget Office (CBO) has estimated that this proposal would cause large reductions in insurance coverage, reaching 13 million people in the long run.

Supporters of repealing the individual mandate have argued that the resulting reductions in insurance coverage are not a cause for concern because they would be voluntary. Rigorous versions of this argument acknowledge that individuals who drop coverage would lose protection against high medical costs, find it harder to access care, and likely experience worse health outcomes, but assert that the very fact that these individuals would choose to drop insurance coverage shows that they will be better off on net. On that basis, advocates of repealing the mandate claim that its repeal would do no harm. However, this argument suffers from two serious flaws.

The first flaw in this argument is that it assumes individuals bear the full cost of their decisions about whether to obtain insurance coverage; in fact, one person's decision to go without health insurance coverage shifts costs onto *other people*. Notably, CBO has estimated that the departure of healthy enrollees from the individual market spurred by repeal of the individual mandate will increase individual market premiums by 10 percent, causing some in that market to *involuntarily* lose coverage and causing those who remain to bear higher costs. In addition, many of those who become uninsured will end up needing health care but not be able to pay for it, imposing costs on other participants in the health care system. Because individuals who choose to become uninsured do not bear the full cost of that decision, they may choose to do so even in circumstances where the benefits of coverage—accounting for its effects on both the covered individual and the rest of society—exceed its costs.

The second flaw in this argument is that it assumes individual decisions about whether to purchase health insurance coverage reflect a fully informed, fully rational weighing of the cost and benefits. In fact, there is strong reason to believe that many individuals, particularly the healthier individuals most affected by the mandate, are likely to undervalue insurance coverage. This likely reflects a variety of well-documented psychological biases, including a tendency to place too much weight on upfront costs of obtaining coverage (including the "hassle costs" of enrolling) relative to the benefits insurance coverage would provide if the individual got sick and needed care at some point in the future. It is therefore likely that many people who would drop insurance coverage due to repeal of the individual mandate would end up worse off, even solely considering the costs and benefits to the individuals themselves.

The considerations described above mean that, in the absence of subsidies, an individual mandate, or some combination of the two, many people will decline to obtain insurance coverage despite that coverage being well worth society's cost of providing it. Furthermore, unless the current subsidies and individual mandate

penalty provide *too strong* an incentive to obtain coverage that results in *too many* people being insured—a view that appears inconsistent with the available evidence—then reductions in insurance coverage due to repealing the individual mandate would do substantial harm.

The remainder of this analysis takes a closer look at the two flaws in the argument that reductions in insurance coverage caused by repeal of the individual mandate would do no harm. The analysis then discusses why these considerations create a strong case for maintaining an individual mandate.

Individual decisions to drop insurance coverage impose substantial costs on other people

As noted above, supporters of repealing the individual mandate have often argued that the resulting reductions in insurance coverage would do no harm because they are the outcome of voluntary choices. One major flaw in this argument is that one person's decision to drop insurance coverage imposes costs on other people through a pair of mechanisms: increases in individual market premiums and increases in uncompensated care. I discuss each of these mechanisms in greater detail below.

Increases in individual market premium reduce coverage and increase others' costs

Repealing the individual mandate would reduce the cost of being uninsured and, equivalently, increase the effective cost of purchasing insurance coverage. That increase in the effective cost of insurance coverage would, in turn, cause many people to drop coverage. Because individuals with the most significant health care needs are likely to place the highest value on maintaining insurance coverage, the people dropping insurance coverage would likely be relatively

healthy, on average. In the individual market, those enrollees' departure would raise average claims costs, requiring insurers to charge higher premiums to the people remaining in the individual market.[1]

CBO estimates that, because of this dynamic, repealing the individual mandate would increase individual market premiums by around 10 percent. Those higher premiums would push some enrollees who are not eligible for subsidies out of the individual market. Higher premiums would impose large costs on unsubsidized enrollees who remained in the ACA-compliant individual market—around 6 million people—while increasing federal costs for subsidized enrollees who remain insured.[2]

CBO's estimates are at least qualitatively consistent with empirical evidence on the effects of the individual mandate. Perhaps the best evidence on this point comes from Massachusetts health reform. Research examining the unsubsidized portion of Massachusetts' individual market estimated that Massachusetts' individual mandate increased enrollment in the unsubsidized portion of its individual market by 38 percent, reducing average claims costs by 8 percent and premiums by 21 percent. Similarly, research focused on the subsidized portion of Massachusetts' market found that the mandate appears to have been an important motivator of enrollment, particularly among healthier enrollees.

Direct evidence on the effects of the ACA's mandate is relatively scant because it is challenging to disentangle the effect of the mandate from the effect of other policy changes implemented by the ACA. However, it is notable that the uninsured rate among people with incomes above 400 percent of the federal poverty level fell by almost one-third from 2013 to 2015. This trend is consistent with the view that the ACA's individual mandate has increased insurance coverage since these individuals are not eligible for the ACA's subsidies, and implementation of the ACA's bar on varying premiums or denying coverage based on health status, taken on its own, would have been expected to actually *reduce*

insurance coverage in this group. Because this estimate applies to only a relatively small slice of the population, it cannot easily be used to determine the total effect of the individual mandate on insurance coverage, but it does suggest that the mandate has had meaningful effects.

Repealing the individual mandate could also cause broader disruptions in the individual market for some period of time. Insurers would find it challenging to predict exactly what the individual market risk pool would look like after repeal of the mandate. Some insurers might elect to limit their individual market exposure until that uncertainty is resolved, particularly since the Trump Administration has signaled an intent to pursue other significant policy changes affecting the individual market. That uncertainty could cause some insurers to withdraw from the market, potentially leaving some enrollees without any coverage options. Alternatively, insurers could elect to raise premiums by even more than they expect to be necessary (e.g., by more than the CBO 10 percent estimate cited above) to ensure that they are protected in all scenarios, with significant costs to both individuals and the federal government. It is uncertain how widespread these types of broader disruptions would be in practice, but they are possible.

It is important to note that one person's decision about whether to purchase individual market coverage affects the premiums faced by others because of a conscious policy choice: the decision to bar insurers from varying premiums or denying coverage based on health status. Without those regulations, individual coverage decisions would have little or no effect on the premiums charged to others. But policymakers and the public have, appropriately in my view, concluded that these regulations perform a valuable social function by ensuring that health care cost burdens are shared equitably between the healthy and the sick. Having made that decision, other aspects of public policy must take account of the fact that one person's decision to go uninsured has consequences for the market as a whole.

Some newly uninsured individuals would need care, but be unable to pay for it

Dropping insurance coverage also allows individuals to shift a portion of the cost of the care they receive onto others in the form of uncompensated care. Even in the group of comparatively healthy individuals who elect to drop their coverage, some will get sick and need health care. Some of these individuals might be able to pay for that care out of pocket, but others—particularly those who get seriously ill—would likely be unable to pay for it. In some cases, that would cause these individuals to forgo needed care, but in other cases they would receive care without paying for it, either due to the legal requirement that hospitals provide care in emergency situations or through various other formal and informal mechanisms. (Although individuals would often still be able to access care without paying for it, they would frequently still be billed for that care, with potential downstream consequences for their ability to access credit.)

Uninsured individuals receive large quantities of uncompensated care in practice. Estimates based on the Medical Expenditure Panel Survey indicate that a non-elderly individual uninsured for the entire year received $1,700 in uncompensated care, on average, during 2013. Consistent with that fact, increases in the number of uninsured individuals increase the amount of uncompensated care. In the context of the Oregon Health Insurance Experiment, a randomized controlled trial of the effects of expanded Medicaid coverage, having Medicaid coverage was estimated to reduce the amount of uncompensated care an individual receives by almost $2,200 per year, on average. Quasi-experimental research has similarly found that increases in the number of uninsured individuals in a hospital's local area increase the amount of uncompensated care a hospital delivers and that the expansion in insurance coverage achieved by the ACA substantially reduced hospitals' uncompensated care burdens.

Precisely who bears the cost of uncompensated care, particularly in the long run, is not entirely clear. A portion of uncompensated care costs are borne by federal, state, and local government programs and, therefore, are ultimately borne by taxpayers. In 2013, around three-fifths of uncompensated care was financed by federal, state, and local government programs explicitly or implicitly aimed at this purpose. Increases in uncompensated care burdens are likely to lead to increases in spending on these programs. In some cases, those increases will happen automatically. For example, CBO finds that repealing the individual mandate will increase federal spending on the Medicare Disproportionate Share Hospital (DSH) program, which is intended to defray uncompensated care costs, by $44 billion over the next ten years because the formula for determining DSH payments depends on the uninsured rate. In other cases, changes may occur more indirectly, perhaps because higher uncompensated care burdens create political pressure to expand these programs (or make it harder to cut them).

Recent research focused on the hospital sector, which accounts around three-fifths of all uncompensated care, suggests that providers also bear a significant portion of uncompensated care costs in the form of lower operating margins. However, this *does not* imply that uncompensated care costs are ultimately borne by hospitals' owners. Indeed, this research finds that reductions in operating margins in response to increases in uncompensated care occur almost exclusively among non-profit hospitals, plausibly because for-profit hospitals are adept at locating in geographic areas where the demand for uncompensated care is relatively low. (Greater distortions where providers choose to locate and what services they choose to offer may be an important cost of increased uncompensated care.)

The impact of uncompensated care therefore depends to a significant degree on how non-profit hospitals cope with reduced operating margins. Evidence on this point is relatively limited. However, in instances where increases in uncompensated care burdens cause providers to incur outright losses, they are

likely to ultimately force facilities to close, which could reduce access to care or increase prices charged to those enrolled in private insurance by reducing competition. In instances where increases in uncompensated care burdens merely trim positive operating margins, lower margins presumably force hospitals to reduce capital investments or to reduce cross-subsidies to other activities such as medical education or research.

Individual decisions to drop insurance coverage may harm the individuals themselves

The argument that reductions in insurance coverage due to repeal of the individual mandate do no harm because they are voluntary has a second important flaw; specifically, this argument assumes that individual decisions about whether to obtain health insurance coverage reflect a fully informed, fully rational weighing of the costs and benefits. There is strong reason to doubt that assumption.

Economists commonly note that many people decline to take-up health even in settings where that coverage is free or nearly so. For example, analysts at the Kaiser Family Foundation (KFF) have estimated that, in 2016, there were 6.8 million people who were eligible for Medicaid or the Children's Health Insurance Program, but not enrolled in those programs, despite the fact that these programs had negligible premiums. Similarly, for this year's Marketplace open enrollment period, analysts at KFF estimated that among uninsured individuals eligible to purchase Marketplace coverage, around two-fifths could obtain a bronze plan for a premium of zero, but few expect all of these individuals to enroll.

This type of behavior is very challenging to explain as the outcome of a fully informed, fully rational decision-making process. The fact that individuals who do not purchase insurance coverage can shift significant costs to others, as discussed above, can help explain why some individuals value insurance at less

than the cost of providing it. But these factors cannot explain why enrollees would decline to obtain coverage that is literally free to them. In principle, "hassle costs" of enrolling in coverage could explain decisions to forgo coverage in these instances, but those hassle costs would need to be implausibly large to explain a decision to forgo an offer of free insurance coverage.

Precisely why individuals decline to take up insurance coverage even in settings where it seems clearly in their interest to do so is not fully understood. This review article catalogues a wide variety of psychological biases that may play a role, but three seem particularly important in this context:

- *Present bias:* Economists have documented that individuals generally exhibit "present bias," meaning that they place a large weight on current costs and benefits relative to similar costs and benefits in the future. In the context of insurance coverage, this type of bias is likely to cause individuals, particularly those who are currently healthy, to place too much weight on the upfront premium and hassle costs required to enroll in health insurance relative to the benefit of having insurance coverage if they get sick at some point in the future. This may cause individuals to decline to obtain insurance coverage even when it is in their economic interest, including in instances where the premium required to enroll is literally zero.

  Overweighting of small up front hassle costs appears to lead suboptimal decisions in many economic settings, but the retirement saving literature provides a particularly striking example. Simply being required to return a form to enroll in an employer's retirement plan has been documented to sharply reduce take-up of that plan, even in circumstances where employees forgo hundreds or thousands of dollars per year in employer matching contributions by declining to participate.

- *Overoptimistic perceptions of risk:* One core function of health insurance is to provide protection against relatively rare, but very costly, illnesses. Indeed, a

large fraction of the total value of a health insurance contract is delivered in those states of the world. In 2014, around 5 percent of the population accounted for around half of total health care spending.[3] But because these events are comparatively rare, many individuals, particularly healthier individuals, may have difficulty forming accurate perceptions of the risks they face. Research on Medicare Part D has found that individuals tend to place too much weight on premiums relative to expected out-of-pocket costs when choosing plans, providing some evidence that individuals do indeed underestimate risk (although research focused on insurance products other than health insurance has concluded that individuals may sometimes overestimate risk). Like present bias, misperceptions of risk can cause hassle or premium costs to receive too much weight relative to the actual benefits of coverage.

- *Inaccurate beliefs about affordability:* Enrollees could also have inaccurate information about the availability of coverage. Survey evidence has suggested that, as of early 2016, almost 40 percent of uninsured adults were unaware of the existence of the ACA's Health Insurance Marketplaces. Additionally, approximately two-thirds of those who were aware of the Marketplaces had not investigated their coverage options, with most saying that they had not done so because they did not believe that they could afford coverage. Individuals' beliefs about whether coverage is affordable may be accurate in some instances, but it is likely that they are not accurate in many other cases. Inaccurate beliefs may cause many individuals to fail to investigate their coverage options, including some who are eligible for free or very-low-cost coverage.

Reductions in insurance coverage from repealing the individual mandate would do substantial harm

The factors identified above provide strong economic rationale for implementing some combination of subsidies and penalties to strengthen the financial incentive to obtain health insurance coverage. These policy tools can compensate for the fact that individual decisions to go without coverage do not account for the ways in which those decisions increase costs for others. Similarly, in many (though not all) instances, financial incentives can help counteract psychological biases that cause individuals to go without insurance coverage even when it is against their own economic interest.

This discussion does not, of course, speak directly to *how large* subsidies and penalties should be. At least in theory, it is possible to overcompensate for the factors catalogued in the preceding section by creating *too large* an incentive to obtain coverage and thereby causing *too many* people to become insured. This occurs if the cost of the additional health care individuals receive when they become insured plus the administrative costs of providing that coverage exceeds the health benefits of the additional health care and the improved protection against financial risk.

Estimating the optimal size of subsidies and penalties is beyond the scope of this analysis. However, it is notable that virtually no one in the current policy debate is arguing that the United States insures *too many* individuals. Furthermore, there is reason to doubt that this is an empirically relevant concern. For example, the research on Massachusetts health reform by Hackmann, Kolstad, and Kowalski that was discussed earlier used their estimates to calculate the "optimal" mandate penalty to apply to unsubsidized enrollees. They conclude that just offsetting adverse selection justifies a mandate penalty similar in size to the one included in the ACA; also accounting for either uncompensated care or imperfections in consumer decision making could justify a considerably larger penalty.

It therefore seems difficult to justify repealing the individual mandate on the grounds that current policies provide an excessive overall incentive to obtain insurance coverage. Of course, policymakers might believe that it would be preferable to swap the mandate for larger subsidies, perhaps because they believe that it is inappropriate to penalize individuals for not obtaining coverage. In principle, sufficiently large increases in subsidies could offset the reduction in insurance coverage that repealing the individual mandate would cause. But such an approach would require large increases in federal spending since it would keep insurance enrollment at its current level by providing larger subsidies to each enrolled individual. In any case, the Senate Finance Committee bill does not take this approach. Rather than increasing spending on insurance coverage programs to mitigate coverage losses, the bill uses the reduction in spending on coverage programs caused by repealing the mandate (which results from lower enrollment in those programs) to finance tax cuts.

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[1]A related, though much more muted, version of this dynamic would unfold in employer-sponsored coverage. In particular, CBO estimates that 2 million people would no longer purchase employer coverage if the individual mandate were repealed. The resulting premium increases would be small in percentage terms because these changes would be spread over a larger pool of enrollees, but the total shift would still be significant in dollar terms.

[2]The Kaiser Family Foundation estimates unsubsidized ACA-compliant enrollment at 6.7 million. In another recent analysis, I estimate that there were approximately 6.4 million unsubsidized enrollees in the ACA-compliant market on average during 2016 and that premium increases would have been expected to reduce this number by around 12 percent, implying that there will be 5.6 million unsubsidized enrollees in ACA-compliant plans on average during 2017.

[3]Patterns are similar if one focuses solely on people with private insurance. Among non-elderly adults with private insurance, the top 5 percent of spenders accounted for 49 percent of spending. Among children, the corresponding share was 59 percent.

U.S. Health Reform—Monitoring and Impact

How Have Providers Responded to the Increased Demand for Health Care Under the Affordable Care Act?

November 2017

By Jane B. Wishner and Rachel A. Burton

Robert Wood Johnson Foundation

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URBAN INSTITUTE

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

SUMMARY

Roughly 20 million previously uninsured people have gained health insurance since the enactment of the Affordable Care Act (ACA).[1] To understand how health care providers met the increased demand for services, researchers from the Urban Institute conducted interviews with health care stakeholders in five communities that saw some of the largest percent increases in the number of insured people after the ACA's coverage expansions took effect: Detroit, Michigan; Lexington, Kentucky; Sacramento, California; Spokane, Washington; and Morgantown and nearby northeastern counties in West Virginia (which we refer to collectively as West Virginia). All five communities were in states that expanded Medicaid.

These interviews showed that as the demand for health care services increased, providers responded by expanding their staff, including hiring more advanced practice clinicians (such as nurse practitioners) and care coordinators; opening new or expanding existing health care sites; and/or extending their office hours. The number of urgent care and retail clinics also grew. Telemedicine has not expanded substantially, but respondents said that other payment and delivery reforms increased efficiency and helped providers meet the increased demand.

Despite these changes, gaps in provider capacity persist. Respondents reported that health professional shortages that predated the ACA—including significant shortages of primary care professionals in some communities—were exacerbated by increased demand from newly insured patients. Respondents in all five communities reported that the most significant unmet health care needs were behavioral health services (especially treatment for opioid use disorder), adult dental services, and specialty services (which varied by community).

To increase capacity, providers relied on revenue—particularly Medicaid revenue—from newly insured patients, and many federally qualified health centers (FQHCs) received assistance through ACA-funded grants. But respondents expressed doubts about their ability to maintain infrastructure enhancements and adequate capacity to meet patients' needs if Medicaid funding is scaled back, as was proposed in several congressional efforts to repeal and replace the ACA in 2017 (and is likely to be proposed again). Respondents also identified persistent health care professional workforce shortages as a major ongoing challenge.

BACKGROUND

The ACA expanded Medicaid coverage to nonelderly adults with incomes up to 138 percent of the federal poverty level and provided income-based premium tax credits and cost-sharing reductions to individuals purchasing private health insurance in the new ACA marketplaces. In 2012, the Supreme Court issued a ruling that effectively made the Medicaid expansion optional for states.[2] As of September 2017, 31 states and the District of Columbia had adopted the Medicaid expansion.[3] Roughly 20 million previously uninsured people have gained health insurance coverage since the ACA was passed.[1,4]

To help health care providers handle the anticipated influx of newly insured patients, the ACA included several initiatives designed to increase provider capacity.[5] The ACA included $11 billion to expand the capacity of community health centers, which primarily serve low-income patients and charge fees on a sliding scale based on patients' ability to pay.[6] These ACA funds were available to support ongoing operations; set up new care delivery sites; renovate existing sites; and expand the provision of preventive, behavioral health, and oral health services.[7] The ACA also included initiatives to train and attract new primary care providers to underserved areas of the country (e.g., through scholarships and loan repayment programs)[8] and provided temporary increases to Medicaid and Medicare payment rates for primary care services.[9,10]

Nevertheless, before the major coverage expansions took effect, there was concern that the existing supply of health care providers could not meet the increased demand.[11] Long wait times and difficulties finding new providers were reported anecdotally, especially in states that experienced large gains in the number of people with insurance.[12–15] Patients newly enrolled in Medicaid may have had a hard time finding providers who accepted their coverage because in most states Medicaid offers lower payment rates than Medicare or private insurance;[16] even before the ACA, a sizeable share of providers were unwilling to accept Medicaid.[17,18]

There is evidence that more people have access to health care and have obtained health care services since the ACA's major coverage expansions began in 2014. For example, a 2017 study analyzed four years of annual survey data (2013 to 2016) from three states—Arkansas and Kentucky, which expanded Medicaid, and Texas, which did not expand Medicaid and served as a control state—to assess the impact of Medicaid expansion on health care use and self-reported health among nonelderly low-income adults. Researchers found that Medicaid expansion was associated with "significant improvements in access to primary care and medications, affordability of care, preventive visits, screening tests, and self-reported health."[19] Another study analyzed national survey data and found that the first two years of the ACA's open enrollment periods (2014 and 2015) were associated with "significantly improved trends" in self-reported access to primary care and medications, affordability, and health among nonelderly adults.[20] The Urban Institute, analyzing data from the Health Reform Monitoring Survey (HRMS),[21] also found statistically significant trends toward increased access to care since the ACA: Between mid-2013 and March 2016, the share of parents receiving routine checkups increased by 3.0 percentage points, and the share of children receiving routine checkups increased by 1.9 percentage points; the share of parents reporting unmet need decreased by 5.7 percentage points; the share of parents reporting problems paying family medical bills decreased by 5.6 percentage points; and the share of parents reporting that they were confident their child could get health care if needed increased by 2.8 percentage points.[22] An analysis of HRMS data through the first quarter of 2017 showed significant declines in the shares of low- and moderate-income adults with problems accessing care since 2013.[23]

METHODOLOGY

To better understand how providers are handling the increased demand for health care services under the ACA, we conducted interviews in five communities with leaders of different types of health care organizations in 2017. We selected communities that experienced some of the largest drops in uninsurance between 2013 and 2016, included both urban and rural areas, and varied in their geographic region and health care provider landscape.[24] The study communities saw 69 to 72 percent reductions in their number of uninsured and 12 to 20 percent increases in their number of insured people (see Table 1). Each community had a median income lower than that of its state and was in a state that expanded Medicaid in 2014, although we did not select for these criteria.

We interviewed leaders of community health centers, health care systems (which operated both acute care hospitals and ambulatory care practices), provider associations, and an urgent care association, as well as some state Medicaid officials. Our main research questions were as follows:

- To what degree are health care providers experiencing an influx of newly insured patients in these communities?
- How well have providers met any new demand for care, and are there areas of unmet need?
- What changes, if any, have providers made to their delivery of care to accommodate these new patients? For example, are they hiring new or different kinds of staff, opening new practice sites, or increasing their use of telemedicine?
- What public or private programs, market developments, or contextual factors have made it easier (or harder) for providers to handle the influx of new patients seeking care?

Table 1: Study Areas

Geographic area[a]	Number of uninsured people		Percent decrease in number of uninsured people	Number of insured people		Percent increase in number of insured people
	2013	2016		2013	2016	
Outlying suburbs of Lexington, Ky. *(12 counties surrounding Fayette County)*	48,185	14,794	-69%	309,896	347,697	+12%
Northeastern and central Detroit, Mich. *(southwestern corner of Macomb County and northern part of Wayne County)*	43,705	13,724	-69%	229,147	262,532	+15%
Northern half of city of Spokane, Wash. *(middle of Spokane County)*	18,528	5,684	-69%	110,054	124,507	+13%
Northwestern part of city of Sacramento, Calif. *(northwestern corner of Sacramento County)*	20,374	5,634	-72%	90,736	108,767	+20%
Northeastern corner of West Virginia *(7 counties)*	45,938	14,198	-69%	255,247	289,183	+13%

[a] These are public use microdata areas (PUMAs), geographically contiguous areas containing at least 100,000 people that are defined for the dissemination of U.S. Census Bureau data. Calculations are based on the following PUMAs: Lexington area (PUMAs 2000, 2200, 2300); Detroit (PUMAs 3006, 3209); Spokane (PUMA 10501); Sacramento (PUMA 6705); and West Virginia area (PUMAs 300, 400). See endnote 24 for further details on these calculations. Other parts of these cities and areas also saw large reductions in the number of uninsured, although not as large as those in the selected PUMAs.

Because most of our interviews took place when Congress was actively considering repeal and replacement of the ACA, we also asked respondents how providers in their communities would be affected by retrenchment or elimination of the ACA's coverage expansions.

Interviews were transcribed and analyzed to identify findings, including observations common across multiple communities and observations that were less common.

OBSERVATIONS FROM THE FIVE STUDY COMMUNITIES

Changes in Demand for Services

Demand for health care services increased substantially.

Unsurprisingly, respondents reported that demand for services increased after the ACA's coverage expansions. This was true for all types of primary and specialty care and for community health centers and large health systems. Several primary care providers reported that people who only used the health care system for acute care before the ACA now came in more frequently and received preventive services and treatment for chronic conditions. Several respondents reported an increase in the number of patients with more complex health care needs and comorbidities. For example, respondents in multiple communities reported that demand for diabetes services increased significantly as more people were screened for and diagnosed with the disease. Some also noted that the coverage expansions brought a new challenge: the need to educate patients on how to appropriately use the health care system, including not using the emergency room to obtain primary care services.

For safety-net providers, the change in payer mix was more significant than the overall increase in the number of patients served.

Representatives of several safety-net providers reported that although the total number of patients increased, the bigger change for their organizations was the shift in payer mix to fewer uninsured patients and many more Medicaid-covered

patients; these respondents did not report a significant increase in privately insured patients. One FQHC respondent reported that the Medicaid expansion "flipped the payer mix upside down." This new source of revenue helped provider organizations increase their capacity to meet the increased demand.

Changes in Care Delivery

Health care systems and community health centers hired new staff, including advanced practice clinicians.

Hospital systems and community health centers in all five study communities responded to the increased demand for services by hiring more staff, including physicians, advanced practice clinicians (such as nurse practitioners and physician assistants), care coordinators, and administrative and health information technology staff. Hospital system respondents also reported hiring more specialists. Some health centers added or increased behavioral health services after the ACA expansions. Respondents reported that increased revenue from newly insured patients helped cover the cost of additional staff.

Many respondents reported hiring proportionately more advanced practice clinicians than physicians in primary care settings after the ACA expansions. In some cases, this was a response to physician shortages and challenges recruiting and retaining physicians. Most nurse practitioners work in the primary care environment, but some respondents reported hiring advanced practice clinicians to provide behavioral health services or to provide follow-up care for specialty services. Some practice sites, especially FQHCs, had already increased their reliance on advanced practice clinicians before the ACA, as part of a move toward patient-centered medical homes and a team-based approach to patient care. Advanced practice clinicians were also used in smaller sites, including school-based health centers and satellite sites in rural communities.

Respondents emphasized that increased hiring included administrative and health information technology staff to help manage the increased demand for services, shift to new billing models, and growing reliance on electronic health records. Some respondents reported that community health centers hired more staff who could serve as care coordinators, including registered nurses, social workers, medical assistants, and community health workers. In Sacramento, some health care providers employ health navigators to help patients use their new coverage, understand how to navigate the health care system, and avoid inappropriate use of emergency departments.

Providers opened new care delivery sites, expanded existing sites, and extended their operating hours.

Respondents reported more primary care sites in their communities after the ACA expansions, but more often they described expansions and upgrades to existing facilities to accommodate increased demand. The ACA provided substantial funding for FQHCs to support these capital investments. Some health system respondents reported an expansion in specialty care clinics, but this was not universal.

Health system and community health center respondents reported extending their hours to make care available outside the normal workday, including evening and weekend hours. Some FQHC respondents said that this trend started before the ACA and was tied to their adoption of the patient-centered medical home model. A state Medicaid official also reported that under Michigan's Primary Care Transformation demonstration project, which predated the state's Medicaid expansion, the patient-centered medical home model already required expanded hours, and that Michigan's 2016 Medicaid managed care contracts promote use of alternative hours to improve access for enrollees. In contrast, a Washington hospital respondent reported that offering extended hours was a direct response to the coverage expansions, particularly the Medicaid expansion, both because of increased demand for care and because many of the newly eligible Medicaid enrollees worked in jobs that did not offer flexibility during the workday to see a health care provider.

The number of urgent care centers and retail clinics increased.

Respondents reported an increase in the number of urgent care centers and, except in West Virginia, an increase in the number of retail clinics in pharmacies and/or retail outlets in their communities. Large health systems were most likely to open or expand urgent care sites after the ACA expansions. One health system respondent said that opening additional urgent care centers helped to "decompress" the emergency department. A respondent from another community explained, "As demand for hospitalization has gone down, hospitals are trying to expand their nets to capture more admissions. It's really an explosion of urgent care centers." The reported growth in urgent care sites is consistent with survey data published by the Urgent Care Association of America, which found that 96 percent of urgent care centers saw more patients in 2015 than in 2014, and that the total number of urgent care centers in the United States increased to 7,357 in 2016, a 10 percent increase over 2015.[25]

Respondents from FQHCs reported that they met some urgent care needs by offering extended hours and same-day appointments. They emphasized that freestanding urgent care clinics are not compatible with their practice model, which provides comprehensive primary care to patients, including tracking care and checking the status of preventive care screenings; this responsibility is tied to the federal funding they receive from the Health Resources and Services Administration. In contrast, many patients of urgent care clinics seek episodic care or treatment only for the condition that brought them to the clinic, rather than an ongoing primary care relationship with the provider.

Persistent Gaps in Provider Capacity

Health professional workforce shortages that predated the ACA's coverage expansions were exacerbated by the increased demand for care.

Many communities across the country have health care professional workforce shortages, including shortages of primary care physicians and shortages of providers in rural communities.[26] Although different communities had different kinds of shortages, respondents in all the study communities observed that increased demand for services intensified pre-ACA provider shortages. Respondents in Lexington, Spokane, and Sacramento said that the coverage expansions placed particular stress on primary care providers, which were reportedly in short supply before the ACA. West Virginia respondents said that they still struggle to recruit and retain providers of all types in rural communities. Of the five study communities, Detroit seemed to have been most successful in meeting the increased demand for primary care, perhaps because it was the largest city we studied and had several medical schools in the area; but pre-existing specialty shortages continued there even after the ACA expansions.

Several FQHC respondents reported significant challenges in recruiting and retaining primary care physicians, who could receive better pay, benefits, and administrative support in larger health systems. Respondents noted that many medical school students graduate with significant debt and seek better-paying jobs, including higher-paying specialties.

Respondents talked about two countervailing forces affecting newly insured patients' access to specialists. Some reported that it was easier to make referrals because their patients were no longer uninsured, but others reported longer wait times to see specialists now that more people were trying to access them. In all five communities, pre-existing shortages of psychiatrists and other physicians providing treatment for mental health (MH) and substance use disorder (SUD) were exacerbated by increased demand from newly insured people.

Increased demand has placed significant strains on primary care providers.

Respondents reported that primary care providers in their communities generally have been able to take in newly insured patients, but the increased demand has placed significant stress on many providers. Several respondents said that the increased availability of insurance coverage meant that many consumers accessed nonacute primary care and preventive services for the first time, which initially placed strains on primary care providers; many newly covered patients needed treatment for complex chronic conditions that had not been treated previously. Many FQHCs are moving toward a patient-centered medical home model—a trend that began before the ACA—and FQHC respondents reported that the model's team approach to care helped improve efficiency and alleviate the increased demand on physicians. But some respondents expressed concerns about physician burnout in the primary care setting, especially associated with the need to see more patients during each work day.

Behavioral health was the single most significant unmet need reported in all five communities.

The most consistent unmet need reported in all five communities was behavioral health. Respondents from all the study communities reported significant increased demand for MH/SUD treatment, particularly treatment of opioid use disorder. This increased demand for opioid use disorder treatment was attributed to an increase in the number of people who had coverage for MH/SUD treatment, as well as to an increase in the number of people with opioid use disorder. The increased demand for behavioral health services resulted in part from the ACA's requirement that newly insured Medicaid and marketplace plan enrollees have coverage including MH/SUD benefits. In Lexington and Morgantown, respondents said that the opioid epidemic created a huge need that existing providers could not meet. One West Virginia respondent said this problem was statewide, explaining, "The single largest health issue in [coal country] is behavioral health, over and even above diabetes and heart disease."

Access to certain specialty services remains limited.

The five study communities had shortages of different specialty services. Pre-existing health care professional shortages and the ACA's coverage requirements contributed to these areas of unmet need. Many patients who gained access to preventive services and primary care for the first time were diagnosed with diseases, including hepatitis C and diabetes, that they may have had for a while; this reportedly caused significant delays in seeing specialists such as endocrinologists and gastroenterologists.[19,27] Some respondents said that demand for

gastroenterologists also increased because many people were receiving referrals to specialists for colon cancer screenings, one of the covered preventive services under the ACA.

Respondents in Detroit, Lexington, and Spokane reported significant increased demand—and unmet needs—for adult dental services. These communities are in states that included adult dental benefits in their Medicaid benefits packages.[28]

Other Changes in Provider Practices

Use of telemedicine is increasing slowly but has not significantly enhanced provider capacity.

Respondents reported that telemedicine use increased modestly in their states and communities since 2013, but the move toward telemedicine has been gradual and may not be a direct response to ACA coverage expansions. Several respondents expressed interest in using telemedicine more, and many emphasized that in their states, telemedicine was used most often to provide care in rural communities. Respondents in Detroit, Lexington, and Morgantown said that their communities have many specialists, so they may not need telemedicine as much as rural areas do.

Respondents discussed two different types of telemedicine: (1) connecting a provider with a patient through a video connection; and (2) connecting a primary care provider in a remote location with a specialist located elsewhere. Sometimes care can be provided through a combination of both, for example, in a dermatology consultation with a specialist. Respondents said that academic medical centers and other large health systems provide and use telemedicine most frequently, and FQHCs use it minimally if at all. In West Virginia and Spokane, local academic medical centers were participating in Project ECHO,[29] an initiative that connects rural physicians to specialists to help treat complex patients.

Respondents said that telemedicine was used most commonly for telepsychiatry, to enable patients located in remote areas to interact directly with a psychiatrist. In Washington state, nonphysician behavioral health providers (e.g., counselors) use telepsychiatry to consult with psychiatrists. But one West Virginia respondent reported that the ACA's coverage expansions seemed to have reduced the use of telepsychiatry because "it's hard to get psychiatrists to do telemedicine clinics when there is a line [of patients] out the door of the physical office they're sitting in." According to respondents, dermatology was the next most common specialty accessed through telemedicine; it allows a primary care provider in a remote location to share images of a patient's skin with a specialist to assess whether the patient needs treatment or testing.

Web portals were used increasingly for direct communication between patients and their providers, but most respondents did not view such communications as a substitute for face-to-face appointments; instead, they said that a patient web portal promotes better, more efficient communication and allows patients to make online appointments.

Several respondents said that they had expected telemedicine to be more important in providing care after the ACA, but barriers to telemedicine remain, including reimbursement issues. FQHC respondents said that the low reimbursement rate for providing the video connection was a barrier to using telemedicine in their practices. In addition, if an FQHC has a psychiatrist on staff at its main clinic who sees a patient "virtually" in a satellite clinic, the FQHC cannot collect a telemedicine fee, but it could collect the telemedicine fee if the psychiatrist were not on staff. A respondent whose health system uses telemedicine and is trying to expand its use noted that private insurers do not consistently cover telemedicine services.

Health systems are buying up primary and specialty care practices, but this is not directly related to the ACA's coverage expansions.

Respondents reported that solo and small group practices in their communities are being bought up by larger health systems. The trend seemed particularly significant in Morgantown, West Virginia, where hospital systems have been acquiring primary and specialty care practices and smaller hospitals in the surrounding area. Respondents consistently said that such consolidation was part of a national trend, and none attributed the acquisitions to the ACA coverage expansions. Providers in independent practices were either close to retirement or seeking affiliation with a larger system to address changes in electronic health records, gain a stronger bargaining position for negotiations with insurers, and reduce the administrative burden of practicing medicine in a rapidly changing environment.

Impact of Government Policies on Provider Capacity

The ACA's coverage expansions generated more demand and more revenue for many providers, which increased their capacity to serve more patients. FQHCs also benefited from significant additional funding under the ACA. Respondents described other federal and state policies that may have had an impact on provider capacity.

The ACA's temporary fee bump for primary care providers in Medicaid may have helped meet increased demand, but Medicaid reimbursement rates are low and some providers remain unwilling to accept Medicaid patients.

The ACA required state Medicaid programs (both fee-for-service and managed care) to offer a temporary fee bump for primary care physicians, bringing their payment rates up to Medicare levels in 2013 and 2014. The federal government paid for the increase in those two years. States that wanted to continue the fee bump after 2014 were required to use state funds and conventional Medicaid matching rates. FQHCs are reimbursed by Medicaid under a prospective payment system, so the fee bump did not directly affect them. Respondents believed that the fee bump increased the number of providers willing to take Medicaid patients, but reported that many providers still do not. Respondents in multiple communities said that reimbursement rates in public insurance programs still cannot attract enough providers to participate. As of July 2016, Medicaid programs in California, Kentucky, Washington, and West Virginia had not continued any part of the Medicaid fee bump, and Michigan had partially continued the fee bump.[16]

Respondents from two states noted specific state Medicaid policies that promote provider participation. In Michigan, the state Medicaid program reimburses medical school faculty at higher rates than other providers. In California, a recent change in state Medicaid policies allows FQHCs to bill Medicaid for marriage and family therapists (before, they could only bill for psychiatrists, psychologists, and licensed clinical social workers); this helped meet the increased demand for behavioral health services.

State scope-of-practice laws can increase provider capacity by authorizing advanced practice clinicians to work independently of physicians.

Advanced practice clinicians, including physician assistants and nurse practitioners, are subject to licensing and scope-of-practice laws and regulations that vary by state. These rules set parameters on how much advanced practice clinicians could help meet the increased demand for care in the study communities.[30] Washington was the only state in our study that gives nurse practitioners authority to practice independently of a physician up to the full scope of their license.[31] Respondents in all study communities reported that nurse practitioners generally are allowed to practice with less direct supervision from physicians than physician assistants are; this creates incentives to hire more nurse practitioners than physician assistants. Washington state recently changed its scope-of-practice policies to authorize physicians to oversee five physician assistants (increased from three), which has made it easier to hire physician assistants to help meet increased demand. Washington also allows pharmacists to monitor chronic conditions and adjust medications and run anticoagulant and hypertension clinics. A Medicaid official in Washington explained, "[T]here's a recognition that we're not always having everyone work at the top of their license and that we need to fully take advantage of existing rules, regulations, and laws that allow broader scopes of practice for these other practitioners, particularly in team-based models."

Health care payment and delivery reforms helped increase provider capacity in some communities.

The ACA provided funding for payment and care delivery reforms, which coincided with increased demand for care among newly covered patients. These initiatives included efforts to increase efficiency, quality, and workforce capacity; many were funded by the ACA-created Center for Medicare and Medicaid Innovation. Respondents in Spokane and West Virginia said that the State Innovation Models (SIM) initiative helped meet increased demand. For example, the West Virginia SIM project includes a workforce development program. In addition to these large federally funded initiatives, a shift from fee-for-service payment to value-based purchasing reportedly helped increase efficiency. Several respondents said that the move to patient-centered medical home models improved efficiency and enabled health care organizations to coordinate care and use nonphysicians more effectively.

States and communities still struggle to rectify health professional workforce shortages.

Respondents emphasized the importance of loan repayment programs and other incentives to attract students to medical school and incentivize recent graduates to pursue primary care (as opposed to better-paying specialties) and seek residencies and jobs in community health centers, safety-net hospitals, and communities with underserved residents. State initiatives, such as scholarship programs and loan forgiveness programs, can supplement federal programs, but respondents said that funding for these efforts was insufficient to make a significant dent in the professional shortages.

Looking Forward: What Hinders Providers' Ability to Meet the Health Care Needs of Their Communities?

Respondents said that proposals to eliminate or cut back the Medicaid expansion and scale back the Medicaid program threaten care delivery.

We conducted most of our interviews during the first few months of 2017, a period of great uncertainty over congressional repeal and replacement of the ACA. The

legislation under debate at the time included a phaseout or elimination of the Medicaid expansion, significant changes in Medicaid financing that would reduce federal Medicaid funding in future years from funding levels under current law, and cuts in subsidies for consumers in the individual health insurance market.[32] Most respondents expressed concern and/or alarm over the potential impact of these proposals—particularly elimination of the ACA's Medicaid expansion. Respondents said these changes would have a negative impact on the clients they serve, leading people to forgo preventive and primary care and treatment for chronic conditions; overburdening local emergency departments, as some who lose insurance seek nonemergency care at hospitals; and reducing their organizations' capacity to provide care to people, as they begin to treat a higher percentage of uninsured patients. Some respondents raised concerns about FQHCs' ability to sustain the office expansions and new hires that had enabled them to serve more patients, if fewer people have insurance and health centers receive less revenue.

In West Virginia and Kentucky, respondents raised concerns about the potential loss of coverage for mental health and substance use disorder services, especially because it could reduce treatment for opioid addiction. A West Virginia FQHC respondent said of the statewide Medicaid program, "Of the expanded Medicaid population, there are 50,000 individuals in need of substance abuse treatment, and we do not have the resources to handle that on our own. If we lose the capacity to provide services to the population, it's just going to be a death spiral for those individuals." A Lexington respondent said that repeal of the Medicaid expansion would reduce behavioral health services; the respondent noted that after the coverage expansions, there was an "onslaught" of new patients with complex mental health and substance abuse issues that needed both behavioral health services and medical care.

Addressing persistent physician workforce shortages remains a challenge.

Respondents in all five communities identified behavioral health as the area with the most significant unmet need, even after the ACA's coverage expansions. Respondents also raised concerns about the health care workforce generally and the need for more policies to encourage people to become physicians, provide primary care, and serve rural and other underserved communities. Respondents mentioned several policies that they believed might encourage more professionals to work in rural and other underserved communities, including retaining cost-based payment systems for FQHCs in Medicaid, increasing residency program partnerships with community health centers, expanding loan repayment programs for physicians, and increasing incentives to draw medical students into primary care instead of higher-paying specialties.

Recent efforts to integrate behavioral health into primary care and to pursue payment and service delivery reforms help communities meet health care needs.

Several provider respondents discussed the importance of integrating behavioral health services into primary care and of reforming payment and care delivery to increase efficiency and improve outcomes. Several respondents reported that payment and delivery reforms—for example, adopting the patient-centered medical home model, which focuses on care coordination—make care delivery more efficient and thereby help meet patients' health care needs. One representative of an association of safety-net providers explained, "The real hard part, right now, is the ACA started a process of trying to build a value-based health care delivery system. And to do that, you have to build an infrastructure. Are we going to continue that? If not, are we going to go back to the old concept of 'treat 'em and street 'em'?"

CONCLUSION

Our interviews suggest that health care providers have adapted to the increased demand for services caused by the ACA. Providers responded by hiring more staff, relying more on advanced practice clinicians, and expanding facilities and hours. More urgent care centers and retail clinics opened. In contrast, telemedicine and increased reliance on electronic communications between patients and providers have not contributed significantly to meeting the increased demand. Despite increases in provider capacity, there are still areas of unmet need, particularly in behavioral health and other specialty services, and persistent professional workforce shortages that were exacerbated by the ACA's coverage expansions. Although health care delivery reforms, including greater care coordination, helped to increase efficiency among providers, many respondents reported that the increased demand for services placed significant stress on primary care providers. With the backdrop of congressional efforts to repeal and replace the ACA, most respondents also were bracing for coverage losses, which they expected to hurt patients' health as well as their organizations' finances and ability to serve their communities.

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Amid Heightened Market Uncertainty, Lower ACA Enrollment Is Forecasted F 2018

Oct 30, 2017

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This year has been quite an eventful one for the Affordable Care Act (ACA) individual health insurance market. Insurer exits, high than-expected premium rate hikes, a series of repeal-and-replace votes, the cancelation of future federal cost-sharing reduction (CSR) subsidies, an executive order on health care, and a recent discussion about a short-term bipartisan fix have all contributed the uncertainty that has been brewing lately.

As the ACA individual marketplace heads into its fifth open enrollment season (OE5), there remain several unanswered questions about the future of this market. Key among them, of course, is what the marketplace/exchange enrollment will be in 2018. S&P Global Ratings is forecasting that for OE5, ACA exchange enrollment will be 10.6 million–11.4 million. This is about 7%-13% lowe than the 12.2 million that signed up during the 2017 open enrollment season (OE4).

Download Table

Historical And Forecasted Individual Marketplace/Exchange Enrollment

(Mil.)	2014 (OE1)	2015 (OE2)	2016 (OE3)	2017 (OE4)	2018f (OE
End of open enrollment	8.0	11.7	12.7	12.2	10.6-1
Effectuated for the year	6.3	8.8	9.1	9.0*	8.3-

*Effectuated 2017 and forecast for 2018 are based on S&P Global Ratings' analysis. F--Forecast. Source: HHS and CMS reported enrollme numbers for 2014, 2015, and 2016.

We expect that most individuals who maintained ACA insurance for full-year 2017 will re-enroll in OE5, though fewer new enrollee will enter the marketplace. Individuals who bought insurance on an exchange during OE4 and paid their premiums for full-year 20 are highly likely to re-enroll for 2018. In addition, over 80% of this population likely receive an advanced premium tax credit (APTC which will offset the impact of the 2018 premium increases. As for new enrollees (individuals who haven't previously bought insurance on the exchanges), we are forecasting fewer people signing up in 2018 than during previous open enrollments. Our forecast took into account multiple factors, including the expectation of reduced active outreach at the federal level, a reduced bro presence in the individual market, shorter enrollment periods, and higher nonsubsidized premiums.

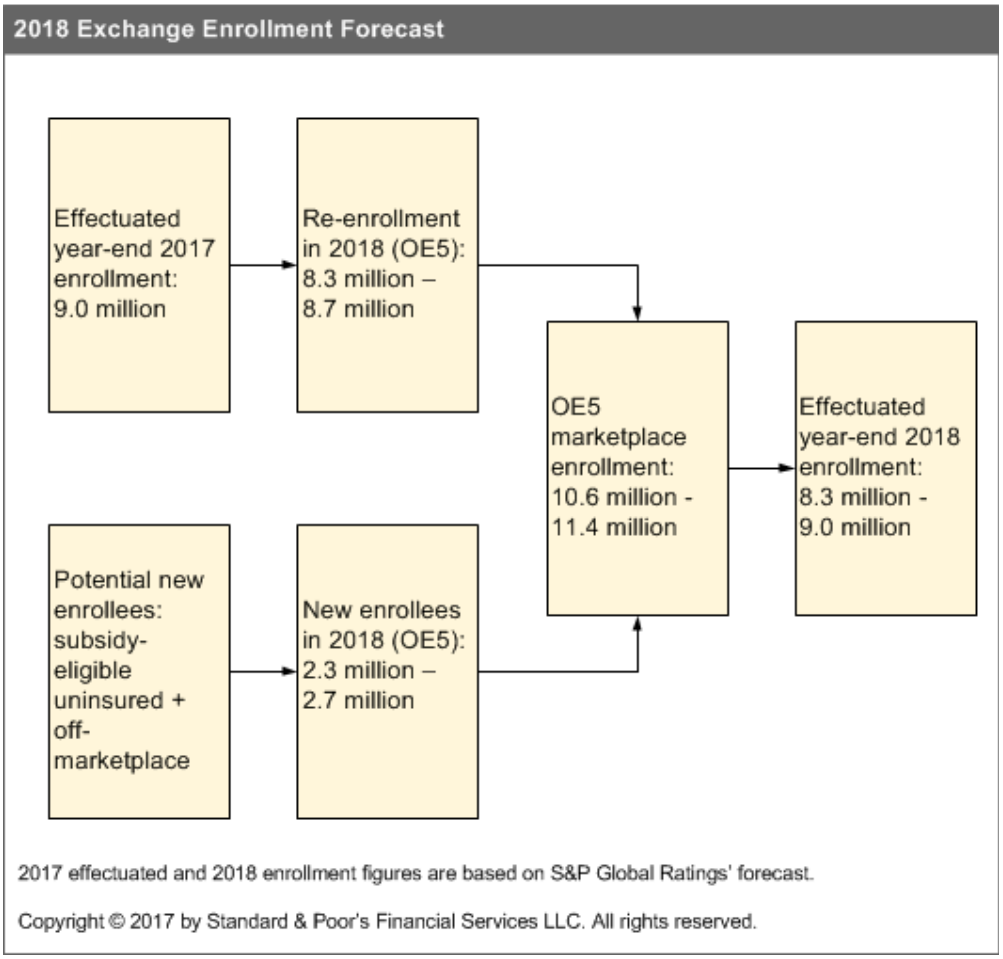
Although open enrollment is the most commonly cited figure, another important metric is full-year effectuated enrollment. This is tl average number of individuals who pay premiums and maintain coverage for the entire year, and it gives an indication of the sustainable size of this marketplace. Looking at the first three years of the exchange, about a quarter of the individuals who signe up initially dropped their coverage during the year. In our forecast for 2018, we are assuming a similar trend. We are forecasting effectuated enrollment to be 8.3 million–9.0 million at year-end 2018, which is flat with to 8% lower than our estimate for 2017 effectuated enrolment (9 million).

As for the exchange population beyond 2018, we expect a continuation of the trend of enrollment jumping at the beginning of the year and then gradually declining as the year proceeds. But the amount of decline throughout the year will decrease as the marke settles in at a sustainable size. To that end, we believe effectuated enrollment will stabilize at about the level of recent years. We don't expect it to grow meaningfully above 9 million without active outreach to the eligible individuals who remain uninsured. Insurance remains a product that is sold rather than bought, and this is especially the case when trying to gain wider acceptance health insurance among individuals who consider themselves young and invincible.

Subsidies, Outreach, And Premiums Drove Our Forecast

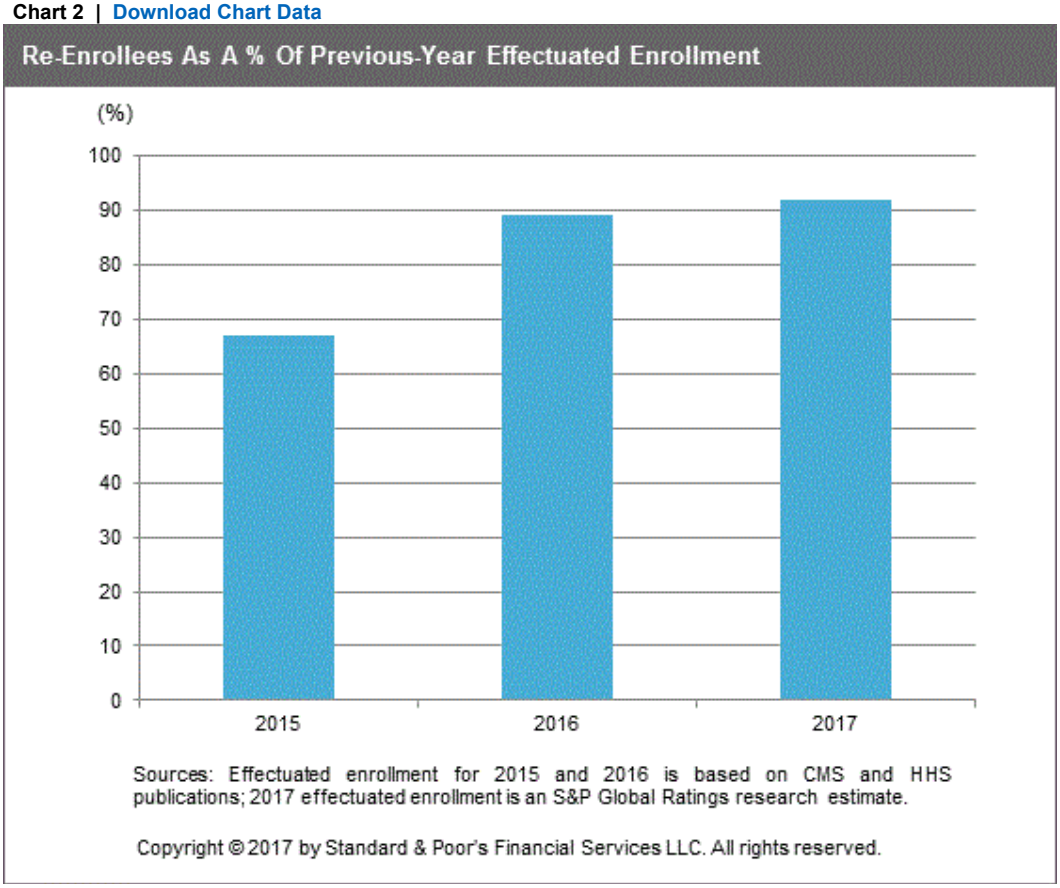
Chart 1 is a step-by-step explanation of how we arrived at our 2018 exchange enrollment forecast:

Chart 1



- Starting at the bottom: The starting point of our forecast is where the market will likely end in 2017. We are assuming 2017 full-year effectuated enrollr of about 9 million. This is about 25% lower than at the beginning of 2017 (OE4). This rate of decline is very similar to that of previous years.
- Adding a high re-enrollment rate: The majority of the effectuated 9 million will re-enroll during open enrollment, as has been the case in previous years fact, the ratio of re-enrollees to the previous year's effectuated enrollment has been growing (see Chart 2). In addition, we expect close to 85% of the effectuated 2017 enrollees to be hedged against the full impact of premium rate increases. This group receives an income-based tax credit or APTC tl is tied to the cost of the benchmark (the second-cheapest silver) plan on the marketplace. Thus, if everything else remains the same, their subsidies increase with the increased price of the benchmark plan.

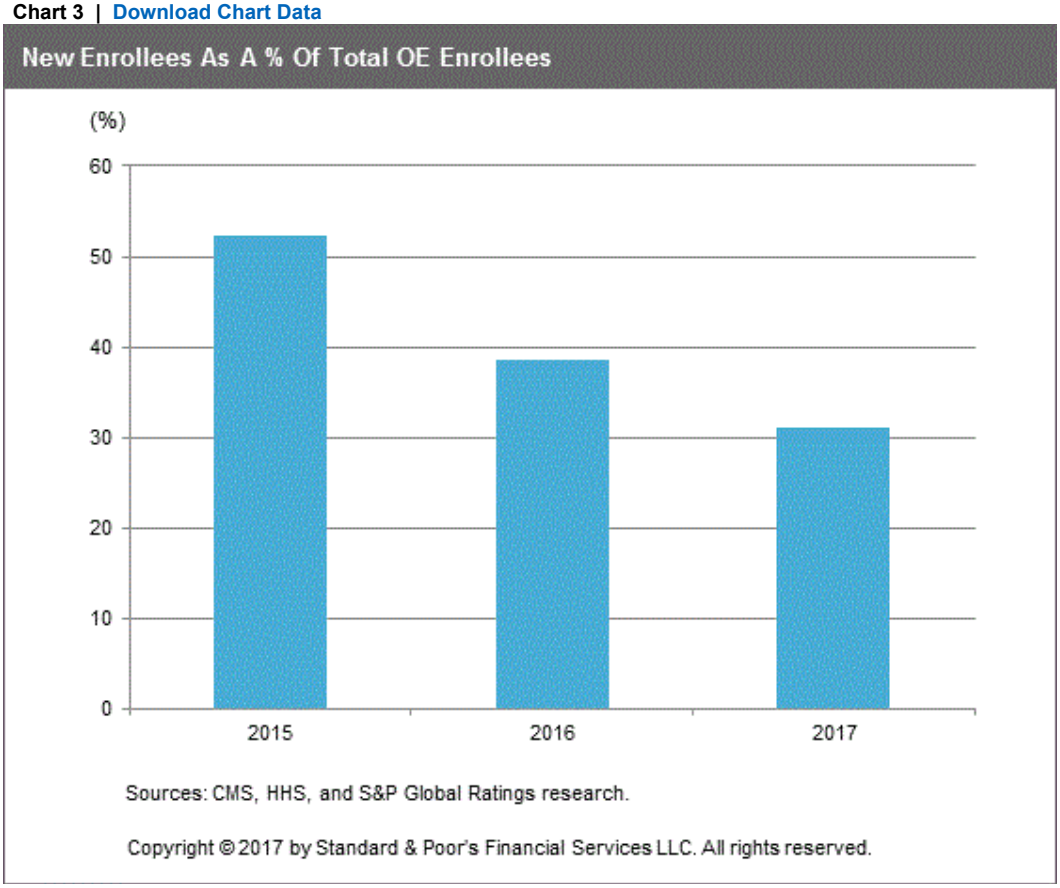
Chart 2 | **Download Chart Data**



- Acknowledging lapses among nonsubsidy marketplace enrollees: Of the estimated 9 million who maintained coverage for full-year 2017, some will not enroll in 2018. This is the population that doesn't receive any form of federal support. These individuals are the most price-sensitive because they are paying full premiums and will be most hurt by the premium rate increases expected in 2018.

- Adding a lower-than-historical level of new enrollees: As stated earlier, multiple factors led us to forecast fewer new enrollees for 2018. In addition, the percentage of new enrollees to total enrollees has been declining lately (see Chart 3).

Chart 3 | Download Chart Data



- Subtracting lapses during the year to get to effectuated enrollment: We expect a portion of the enrollees not to maintain coverage for the entire year. W are assuming that close to 80% of OE5 enrollees will have full-year effectuated coverage in 2017. This assumed lapse rate of 20% is lower than previ years, when it has averaged about 25%. We expect that as the individual market matures, the spike during open enrollment will be lower, and so lapse during the year will also be lower. This is a sign that the market is getting to a core level of enrollees.

Note that our forecast is lower than the current Congressional Budget Office estimate (as of September 2017) of 10 million marketplace enrollees for 2017 and 11 million for 2018.

Risks To The Forecast

Our forecast could be different from the actual 2018 enrollment if take-up rates among the eligible uninsured or off-marketplace population are much higher or lower than we assume in our analysis. We analyzed multiple data points, including previous take-u rates and income distribution of the eligible population. We also assumed a negative impact of reduced outreach and shorter enrollment periods. But actual experience can be different from our assumptions.

Actual enrollment could be lower than our forecast if re-enrollment rates among individuals receiving subsidies are lower than we have assumed. We took into account the income-based premium tax credit, which works somewhat like a shock absorber to the potential premium rate increases.

Actual enrollment could be higher in 2018 if there is a meaningful change in the U.S. unemployment rate. Our economists expect stable employment environment, meaning most working individuals will continue to have a job and will get health insurance throug their workplace.

Another factor that could lead to a difference between the actual enrollment and our forecast would be the price sensitivity of nonsubsidy marketplace enrollees. We have assumed that these individuals are highly price sensitive and that a portion will not re enroll in 2018 because of the increased premium rates. If the nonsubsidy marketplace population turns out to be less price-sensiti actual enrollment numbers might be higher than our forecast.

What Does This Mean For Market Premiums And Insurers?

The marketplace would benefit from growth in enrolment, especially if it helps improve the morbidity of the risk pool. But we don't expect that to happen in the near term. This means that for now, insurers will have to continue pricing for a higher-morbidity marketplace. On average, premiums, will not decline without a higher level of new enrollment or states using ACA waivers to crea reinsurance or other market-support mechanisms.

As we have said previously, we expect a five-year (starting in 2014) path to stability in the exchange business. Most insurers have gradually adjusted their product pricing and network design to bring them more in line with the morbidity and size of the individual market. Our previously stated expectation is that insurers, on average, will get close to break-even for this market segment in 201 and reach their target profitability in 2018. We are maintaining that forecast for now. But with the increased political risk around thi marketplace, making forecasts of a status quo is especially challenging. For example, most insurers didn't price for the recent announcement that CSR payments will be canceled for the remainder of 2017. This will have a negative impact on insurers' individual segment earnings for the last quarter. We could revise our forecast for the marketplace depending on actual impact of t CSR cancelation for the remainder of this year.

Related Research

- **Implementation Of The ACA Can Determine Future Stability Of The Individual U.S. Health Care Market**, July 28, 2017
- **The U.S. ACA Individual Market Showed Progress In 2016, But Still Needs Time To Mature**, April 7, 2017

Only a rating committee may determine a rating action and this report does not constitute a rating action.

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October 2017 | Issue Brief

How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums

Rabah Kamal, Ashley Semanskee, Michelle Long, Gary Claxton, and Larry Levitt

Insurers setting rates for health coverage options on the 2018 individual market have faced substantial uncertainty regarding whether or not the federal government would continue to make payments for cost-sharing reduction subsidies to insurers, as well as whether or not the administration would continue to enforce the Affordable Care Act's individual mandate. Following the September 27th deadline for insurers planning to offer coverage on the ACA's federal marketplace to finalize premiums and sign contracts, the federal government announced on October 12th that cost-sharing reduction (CSR) payments would end, effective immediately, unless Congress appropriated the funds. In some cases insurers also increased rates due to concerns that the individual mandate might not be enforced, although no formal change in enforcement has been announced.

Regardless of whether the federal government reimburses insurers for CSR subsidies, insurers are still legally required under the ACA to offer reduced cost-sharing via silver-level plans to low-income consumers with incomes up to 250% of the poverty level. Many insurers anticipated that the CSR payments might not continue and built the loss of payments into their premiums for 2018. In some cases, state insurance departments directed insurers what to assume regarding CSR payments, and in other cases regulators were silent. Some state insurance regulators approved two sets of rates, one to be used if CSR payments continued and another if they did not.

Following the October 12th cessation of CSR payments, many insurers that had assumed the payments would continue were able to adjust their 2018 rates upward, under the review of the federal Centers for Medicare and Medicaid Services (CMS), state insurance departments, and state-based marketplaces.

Insurers – often under the guidance or direction of state regulators – have taken one of four general approaches to the end of CSR payments:

1. Not adjust rates at all in response to the termination of CSR payments. Only two states (North Dakota and Vermont) are known to have prevented insurers from adjusting rates.
2. Increase premiums for all ACA-compliant individual market policies across-the-board, both inside and outside the marketplace.
3. Increase premiums for silver-level plans inside and outside the marketplace. Silver plans are relevant because cost-sharing reductions for low-income marketplace enrollees are only available in those plans.
4. Increase premiums only for silver-level plans inside the marketplace, under the logic that cost-sharing reductions are only available in marketplace silver plans.

Premiums for silver plans have particular significance in the ACA marketplace not only because they are the only plans that offer reduced cost-sharing, but also because the second-lowest cost silver plan in each area is the benchmark for tax credits provided to subsidize premiums for low and moderate income enrollees.

A crowd-sourced compilation of the strategies used in different states is available here.

This analysis seeks to quantify the impact of the termination of cost-sharing subsidy payments, based on publicly available data for 32 states and the District of Columbia. Table 1 below highlights those insurers that have explicitly factored into their final premiums the fact that cost-sharing subsidy payments will not be made *and* have specified the degree to which that assumption is influencing their premiums in public filings.

Insurers are not always consistent in how they report the premium effect of the end of CSR payments. In some cases insurers report the average impact across all ACA-compliant individual market plans, even though they have applied an increase only to silver plans, which is the approach most insurers seem to have taken. In other cases, insurers specifically cite how much of a surcharge they have applied to silver plans.

As shown in Table 1, among those insurers that specify the surcharge on silver plans for the discontinuation of CSR payments, the amount of the surcharge ranges from 7.1% to 38%.

For those insurers that report the impact on average across all plans – whether increases were actually applied to all plans or only to silver plans – the surcharge ranges from 0.1% to 27.2%. (Note that New York's insurers, at the low end of the range, are outliers. The basic health program in that state, known as the Essential Plan, covers people with incomes from 138% to 200% of the poverty level, meaning that few people in the marketplace are in the income range to receive cost-sharing reductions.)

These results are generally consistent with a KFF estimate released in April projecting that silver marketplace premiums would have to increase by 19% on average to compensate for the loss of CSR payments, with the amount varying substantially by state.

Table 1: Examples of 2018 Insurer Strategies and Rate Increases Attributed to Cost- Sharing Reduction Payments Ending, by State and Insurer

State	Insurer	Plans with CSR surcharges	Amount of CSR surcharge
Arkansas	Celtic Insurance Company	Silver - Both on and off-exchange	11.5% added to the overall rate increase
	QCA Health Plan	Silver - Both on and off-exchange	15.53% added to the overall rate increase
	QualChoice Life & Health Insurance Company	Silver - Both on and off-exchange	16% added to the overall rate increase
	USAble Mutual Insurance Company	Silver - Both on and off-exchange	6.4% added to the overall rate increase
California	L.A. Care Health Plan	Silver - Exchange only	21% added to silver exchange plans
	Blue Shield of California	Silver - Exchange only	8% or 16% added to silver exchange plans
	Health Net	Silver - Exchange only	12% or 13% added to silver exchange plans

	Molina Healthcare	Silver - Exchange only	12% or 20% added to silver exchange plans
	Kaiser Permanente	Silver - Exchange only	15% added to silver exchange plans
	Oscar Health Plan of California	Silver - Exchange only	10% added to silver exchange plans
	Sharp Health Plan	Silver - Exchange only	27% added to silver exchange plans
	Valley Health Plan	Silver - Exchange only	12% added to silver exchange plans
	Chinese Community Health Plan	Silver - Exchange only	16% added to silver exchange plans
	Western Health Advantage	Silver - Exchange only	17% or 18% added to silver exchange plans
	Anthem	Silver - Exchange only	11% added to silver exchange plans
Colorado	Bright Health Insurance Company	All metals levels	2.6% added to the overall rate increase
	Cigna Health and Life Insurance Company	All metals levels	8.5% added to the overall rate increase
	Colorado Choice Health Plans	All metals levels	6.1% added to the overall rate increase
	Denver Health Medical Plan	All metals levels	12% added to the overall rate increase
	HMO Colorado	All metals levels	1.6% added to the overall rate increase
	Kaiser Foundation Health Plan of Colorado	All metals levels	8.2% added to the overall rate increase
	Rocky Mountain HMO	All metals levels	14% added to the overall rate increase
Connecticut	Anthem Blue Cross and Blue Shield of Connecticut	Silver - Exchange only	16.7% added to silver exchange plans
	ConnectiCare Benefits	Silver - Exchange only	16.7% added to silver exchange plans
Georgia	Blue Cross Blue Shield Healthcare Plan of Georgia	Not specified	16.9% added to the overall rate increase
	Alliant Health Plans	Silver - Exchange only	22.3% added to the overall rate increase
	Kaiser Foundation Health Plan of Georgia	Silver - Exchange only	26.1% added to the overall rate increase
	Ambetter of Peach State	Not specified	27.2% added to the overall rate increase
Iowa	Medica Insurance Company	Silver - Unclear if all or exchange only	13.3% added to the overall rate increase
Indiana	Celtic Insurance Company	All metal levels	16.6% added to the overall rate increase
Kentucky	CareSource Kentucky	Silver - Both on and off-exchange	10.4% added to the overall rate increase
Maryland	CareFirst BlueChoice	Silver - Exchange only	20.14% added to silver exchange plans
	Group Hospitalization and Medical Services	Silver - Exchange only	15% added to silver exchange plans
	CareFirst of Maryland	Silver - Exchange only	15% added to silver exchange plans

	Kaiser Foundation Health Plan of the Mid-Atlantic States	Silver - Exchange only	16.86% added to silver exchange plans
Maine	Harvard Pilgrim Health Care	Silver - Both on and off-exchange	17.3% added to silver plans
	Maine Community Health Options	Silver - Exchange only	22% added to silver exchange plans
Michigan	Blue Care Network of Michigan	Silver - Both on and off-exchange	14.8% added to silver plans
	Blue Cross Blue Shield of Michigan	Silver - Both on and off-exchange	9.9% added to silver plans
	McLaren Health Plan Community	Silver - Exchange only	19% added to silver exchange plans
	Meridian Health Plan of Michigan	Silver - Both on and off-exchange	38% added to silver plans
	Molina Healthcare of Michigan	Silver - Both on and off-exchange	28.1% added to silver plans
	Physicians Health Plan	Silver - Exchange only	20% added to silver plans
	Priority Health	Silver - Both on and off-exchange	21.7% added to silver plans
Montana	Montana Health Cooperative	Silver - Both on and off-exchange	22% added to silver plans
	PacificSource Health Plans	Silver - Both on and off-exchange	12.1% added to silver plans
North Carolina	Blue Cross & Blue Shield of North Carolina	Not specified	14% added to the overall rate increase
New Mexico	CHRISTUS Health Plan	Silver - Both on and off-exchange	12.6% added to the overall rate increase
Nevada	Health Plan of Nevada	Silver - Exchange only	11% added to silver exchange plans
New York	Capital District Physicians Health Plan	Silver - Both on and off-exchange	0.3% added to the overall rate increase
	Health Insurance Plan of Greater New York	Silver - Both on and off-exchange	0.4% added to the overall rate increase
	Excellus Health Plan	Silver - Both on and off-exchange	0.2% added to the overall rate increase
	New York State Catholic Health Plan	Silver - Both on and off-exchange	0.6% added to the overall rate increase
	HealthNow New York	Silver - Both on and off-exchange	0.4% added to the overall rate increase
	Independent Health Benefits Corporation	Silver - Both on and off-exchange	0% added to the overall rate increase
	MetroPlus Health Plan	Silver - Both on and off-exchange	1.1% added to the overall rate increase
	MVP Health Plan	Silver - Both on and off-exchange	1.1% added to the overall rate increase
	Oscar Insurance Corporation	Silver - Both on and off-exchange	0.1% added to the overall rate increase
	UnitedHealthcare of New York	Silver - Both on and off-exchange	0.5% added to the overall rate increase
	Healthfirst PHSP	Silver - Both on and off-exchange	1.1% added to the overall rate increase
Ohio	CareSource	Silver - Unclear if all or exchange only	12.2% added to the overall rate increase
	Medical Health Insuring Corporation of Ohio	Silver - Exchange only	20% added to silver exchange plans

	Molina Healthcare of Ohio	Silver - Unclear if all or exchange only	21.4% added to silver plans
	Oscar Insurance Corporation of Ohio	Silver - Exchange only	14% added to silver exchange plans
	Paramount Insurance Company	Silver - Exchange only	23.5% added to silver exchange plans
	Summa Insurance Company	Silver - Exchange only	17.9% added to silver exchange plans
Oregon	BridgeSpan Health Company	Silver - Both on and off-exchange	7.1% added to silver plans
	Moda Health Plan	Silver - Both on and off-exchange	7.1% added to silver plans
	PacificSource Health Plans	Silver - Both on and off-exchange	7.1% added to silver plans
	Kaiser Foundation Health Plan of the Northwest	Silver - Both on and off-exchange	7.1% added to silver plans
	Providence Health Plan	Silver - Both on and off-exchange	7.1% added to silver plans
Pennsylvania	Capital Advantage Assurance Company	Silver - Exchange only	34.29% added to silver exchange plans
	First Priority Health	Silver - Exchange only	34.29% added to silver exchange plans
	Highmark	Silver - Exchange only	34.29% added to silver exchange plans
	Highmark Choice Company	Silver - Exchange only	34.29% added to silver exchange plans
	Highmark Health Insurance Company	Silver - Exchange only	34.29% added to silver exchange plans
	Geisinger Health Plan	Silver - Exchange only	34.29% added to silver exchange plans
	Keystone Health Plan East	Silver - Exchange only	34.29% added to silver exchange plans
	QCC Insurance Company	Silver - Exchange only	34.29% added to silver exchange plans
	UPMC Health Options	Silver - Exchange only	34.29% added to silver exchange plans
Rhode Island	Neighborhood Health Plan of Rhode Island	Silver - Exchange only	22.4% to 22.8% added to silver exchange plans
	Blue Cross & Blue Shield of Rhode Island	Silver - Exchange only	19.5% added to silver exchange plans
South Carolina	Blue Cross and Blue Shield of South Carolina	Silver - Exchange only	24% added to silver exchange plans
Tennessee	BlueCross BlueShield of Tennessee	Silver - Both on and off-exchange	14% added to the overall rate increase
	Cigna Health and Life Insurance Company	Silver - Both on and off-exchange	17.4% to 21.4% added to silver plans
	Oscar Insurance Company of Tennessee	Silver - Exchange only	17% added to silver exchange plans
Utah	University of Utah Health Insurance Plans	Silver – Exchange only	~30% added to silver exchange plans
	SelectHealth	Silver – Exchange only	~30% added to silver exchange plans
Virginia	HealthKeepers	Silver - Exchange only	12% added to silver exchange plans
	CareFirst BlueChoice	Silver - Exchange only	21% added to silver exchange plans

	Cigna Health and Life Insurance Company	Silver - Both on and off-exchange	18.8% - 20.5% added to silver plans
	Group Hospitalization and Medical Services	Silver - Exchange only	24% added to silver exchange plans
	Kaiser Foundation Health Plan of the Mid-Atlantic States	Silver - Exchange only	12.4% added to silver exchange plans
Washington	BridgeSpan	Silver - Exchange only	27% added to silver exchange plans
	Coordinated Care Corporation	Silver - Exchange only	10% added to silver exchange plans
	Kaiser Foundation Health Plan of Washington	Silver - Exchange only	23% added to silver exchange plans
	Kaiser Foundation Health Plan of the Northwest	Silver - Exchange only	18% added to silver exchange plans
	LifeWise Health Plan of Washington	Silver - Exchange only	14% added to silver exchange plans
	Molina Healthcare of Washington	Silver - Exchange only	12% added to silver exchange plans
	Premera Blue Cross	Silver - Exchange only	10% added to silver exchange plans

NOTES: "Not specified" indicates the insurer stated the amount of their overall average rate increase attributed to CSR payments ending but did not explicitly state how the increase was applied. Data for Colorado, Montana, and Pennsylvania were confirmed by state insurance departments.
SOURCE: Kaiser Family Foundation analysis of insurer rate filings to state regulators; state insurance regulators.

Discussion

Data on 2018 marketplace premiums indicate premiums will increase substantially for the vast majority of insurers due to the discontinuation of cost-sharing reduction payments. In many cases, the premium surcharges are only for silver-level plans.

How consumers themselves will be affected by these premium increases, if at all, will depend in some cases on the approach taken by insurers (sometimes at the direction of state regulators).

Eighty-four percent of marketplace enrollees receive premium subsidies through tax credits, and those tax credits will increase dollar for dollar along with benchmark silver premiums. These enrollees should not be affected financially by the premium surcharges. Lower-income consumers eligible for cost-sharing reductions will likely want to continue to enroll in silver plans to qualify for those reductions.

Marketplace enrollees with incomes 250-400% of the poverty level – who are eligible for premium subsidies but not cost-sharing subsidies – could in some instances be better off. They will receive bigger premium subsidies, and could use those to pay less than they would now for a bronze plan (with higher patient cost-sharing) or a gold plan (with lower patient cost-sharing).

How middle and upper income people ineligible for premium subsidies will be affected will depend largely on the approach taken by insurers and states. Where premiums are increasing across-the-board to offset the loss of cost-sharing subsidies payments, they will be unable to avoid higher premiums. Where only silver premiums are increasing, they can avoid paying a surcharge by enrolling in a bronze or gold plan. And, where only silver

premiums inside the marketplace are increasing, they can avoid paying more by enrolling in a bronze or gold marketplace plan or any type of plan outside the marketplace.

While consumers will generally be protected, the federal government could end up paying more in premium subsidies than it is saving in discontinuing the cost-sharing reduction payments.

Methods

Data were collected from health insurer rate filing submitted to state regulators. These submissions are publicly available for the states we analyzed. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that includes a base rate and other factors that build up to an individual rate. For some states where approved filings were unavailable, we gathered data from information released by state insurance departments. Premium data are current as of October 24, 2017; however, filings may still be updated before open enrollment for some states and insurers included in this analysis.

Options to Expand Health Insurance Enrollment in the Individual Market

October 19, 2017

Authors

Christine Eibner, Jodi Liu

Citation

C. Eibner and J. Liu, *Options to Expand Health Insurance Enrollment in the Individual Market* The Commonwealth Fund, October 2017.

Abstract

Issue: The individual insurance market functions better with larger numbers of people enrolled. Higher enrollment makes it is easier for insurers to set premiums that reflect their expected health care costs and allows them to spread administrative expenses over a larger base. Further, incentivizing healthy individuals to enroll may lead to lower average premiums.

Goals: To analyze six policy options for expanding enrollment: 1) enhancing tax credits for young adults; 2) increasing tax credit amounts; 3) extending credits to more people; 4) both increasing and extending credits; 5) adding standard reinsurance; and 6) adding generous reinsurance.

Methods: Analysis through RAND's COMPARE microsimulation model, which combines economic theory, nationally representative data, and experiential data to project consumer and business responses to policy changes.

Key Findings and Conclusions: Options to enhance, increase, or extend tax credits could increase total enrollment in the individual market by 1.0 million to 3.4 million and the insured population by 800,000 to 2.6 million. Adding reinsurance could increase enrollment by 1.2 million to 5.4 million and total coverage by 900,000 to 3.4 million. Costs for these options range from $2.5 billion to $18.8 billion, with those policies producing the biggest coverage gains generally requiring the biggest public investments.

Background

Approximately 22 million Americans receive health insurance through the individual insurance market, which includes federally subsidized health plans sold through the Affordable Care Act (ACA) marketplaces and other, unsubsidized plans subject to ACA regulations.[1 (#/#1)] Though much smaller than other parts of the health insurance market, the individual market serves a critical function by providing insurance for those with no access to job-based or public coverage.[2 (#/#2)] In part because of its small size, it has always faced challenges, including susceptibility to adverse selection and year-to-year variation in enrollment.[3 (#/#3)] It also has been disproportionately affected by the ACA, which changed regulations governing how individual-market insurers can price and sell their products. In recent years, many regions of the country have seen rising premiums and declining insurer participation.

Policymakers are seeking ways to shore up the individual insurance market and ensure coverage is affordable.[4 (#/#4)] Increasing the size of the individual-market risk pool is key: when more people enroll, it is easier for insurers to accurately set premiums and spread their administrative costs over a larger base. Further, people currently on the fence about enrolling tend to be those whose entry into the risk pool is most likely to lead to reduced premiums for everyone: individuals who are healthier than average and therefore use less health care.

In this report, we analyze several options to expand enrollment in the individual insurance market and thereby bring coverage to more Americans. We focus on options that have already been proposed by policymakers, and that would make the individual market more financially attractive to consumers (for example by reducing premiums or expanding access to tax credits). These options include:

- Providing young adults with enhanced advance premium tax credits (APTCs) — federal tax credits that reduce out-of-pocket premiums for eligible enrollees
- Increasing the generosity of APTCs for all currently eligible enrollees by reducing the required contribution for a benchmark plan
- Extending APTCs to those with incomes above 400 percent of the federal poverty level (FPL)
- Both increasing the generosity of APTCs and extending tax-credit eligibility to those with incomes above 400 percent of FPL
- Implementing some type of reinsurance program for insurers, which would pay some or all the costs of unusually high claims. Because reinsurance would be funded through fees on individual and employer insurance plans (as in the transitional reinsurance program available during the early years of the ACA), these policy options would not entail costs to the federal government.

We estimate how each of these policies would affect four outcomes: total insurance coverage in the United States, enrollment by source of coverage, individual-market premiums, and the federal deficit. We have previously analyzed several of these policy options.[5 (#/#5)] This analysis updates our prior work, standardizes reported outcomes so that they can be compared, and adds reinsurance, a policy we have not previously analyzed. We estimate all outcomes for calendar year 2020. Exhibit 1 describes each of the policies. We conducted the analysis using RAND's COMPARE microsimulation model, which uses economic theory and data to estimate the effect of health policy changes on insurance coverage and health care spending. For all analyses, we assumed that the federal government would

continue to pay cost-sharing reductions (CSRs) — the subsidies that reduce out-of-pocket copays, coinsurance, and deductibles for low-income marketplace enrollees. We also assumed that the individual mandate would continue to be enforced.[6 (#/#6)] When developing the baseline for estimating the effect of recent health reform legislation, the Congressional Budget Office also assumed enforcement of the individual mandate and payment of CSRs.[7 (#/#7)] The model and methods are described in more detail in Appendix A (/~/media/files/publications/fund-report/2017/oct/appendices_eibner_options_expand_hlt_ins_enrollment_appendices.pdf?la=en).

Findings

Changes in Insurance Coverage

Exhibit 2 shows the estimated change in insurance enrollment among nonelderly adults, overall and by source of coverage, under each of the policies considered. All the options would increase total insurance coverage and enrollment in the individual market, relative to current law. The change in total insurance relative to the ACA ranges from an increase of 800,000 individuals with enhanced APTCs for young adults to an increase of 3.4 million individuals under the generous reinsurance scenario. Increases in individual-market enrollment would exceed the increases in overall insurance coverage because some people would move from employer-sponsored insurance (ESI) to the individual market as a result of the policy changes. This shift would be most pronounced in the generous reinsurance scenario, leading to a 2.3 million reduction in ESI enrollment. As modeled, reinsurance in the individual market is funded through a fee on all health plans, including employer plans. The tax increases the cost of employer-sponsored insurance, causing some individuals to change their enrollment decisions.

Effects on Individual-Market Premiums

Incentivizing people to enroll in the individual market could lead healthier people to purchase insurance, causing premiums to fall. Reinsurance would further reduce premiums because it would partially offset the costs of the sickest individuals (see Appendix A (/~/media/files/publications/fund-report/2017/oct/appendices_eibner_options_expand_hlt_ins_enrollment_appendices.pdf?la=en) for discussion). Exhibit 3 reports the estimated change in individual-market premiums under each policy scenario, relative to current law. We report the change in silver premiums for a 40-year-old. Because of the ACA's age-rating provision, which allows insurers to charge older adults no more than three times as much as younger adults, the proportional change in premiums would be similar for all age categories. Premium estimates for a broader range of ages can be found in

Appendix B (/~/media/files/publications/fund-report/2017/oct/appendices_eibner_options_expand_hlt_ins_enrollment_appendices.pdf?la=en). These estimates focus on total insurance premiums, before accounting for tax credits.

Under all the proposed policies, the cost of individual-market premiums would fall. In the first four scenarios, premium changes relative to the ACA would be driven entirely by improvements in the risk pool. These improvements occur when healthy, low-cost people enroll, reducing average expenditure in the group. Adding enhanced tax credits for young adults would have the smallest effect on age-specific premiums among the policies considered. This is partly because the enhanced tax credit would lead to a relatively small change in enrollment. Additionally, because young adults are charged less than older enrollees, insurers have relatively little to gain if a healthy young adult enrolls. In contrast, because older adults can be charged up to three times as much as younger adults, attracting a healthy older person into the risk pool could have a bigger impact on premiums.

As expected, the declines in premiums would be particularly large in the reinsurance scenarios, because these options directly reduce the cost of insuring those with costly conditions. We estimate that the standard reinsurance scenario would decrease age-specific premiums by approximately 4 percent, while the generous reinsurance scenario would reduce age-specific premiums by 19 percent.

Effects on Federal Deficit

Exhibit 4 shows how the proposed policies would affect the federal deficit. The first four options — enhanced APTCs for young adults, extending APTCs to those with higher incomes, increasing APTCs for the currently eligible population, and both extending and increasing APTCs — would increase the federal deficit relative to current law. These deficit increases would be positively correlated with the size of the newly insured population. For example, enhanced tax credits for young adults, a policy that would increase the number of insured by 800,000 in 2020 (the most modest increase of all the policies), also would have a relatively small impact on the deficit, increasing government costs by a net $2.5 billion. Both extending APTCs and increasing their value, a policy that would increase insurance rolls by 2.6 million, would increase the deficit by $11.8 billion.

The two reinsurance scenarios stand out because they would reduce the federal deficit relative to the ACA, despite insuring more people. We assume that reinsurance would be funded by a tax on all individual and employer health plans (including self-funded plans), so the program is nearly costless from the federal government's perspective.[8 (#/#8)]

Yet, because reinsurance would reduce premiums on the individual market, it would lead to reductions on APTC spending. As a result, we estimate that the standard reinsurance program would reduce the federal deficit by roughly $2.9 billion in 2020, and the generous reinsurance program would reduce the federal deficit by roughly $13.1 billion in the same year.

Exhibit 4 presents results from the federal government's perspective, and hence may obscure the cost of the policies to taxpayers. We estimate that the per-enrollee health insurance fee needed to fund reinsurance would increase single ESI premiums by $35 per year in the standard scenario, and by $189 per year in the generous scenario. Below, we discuss the cost of the policies from the taxpayers' perspective.

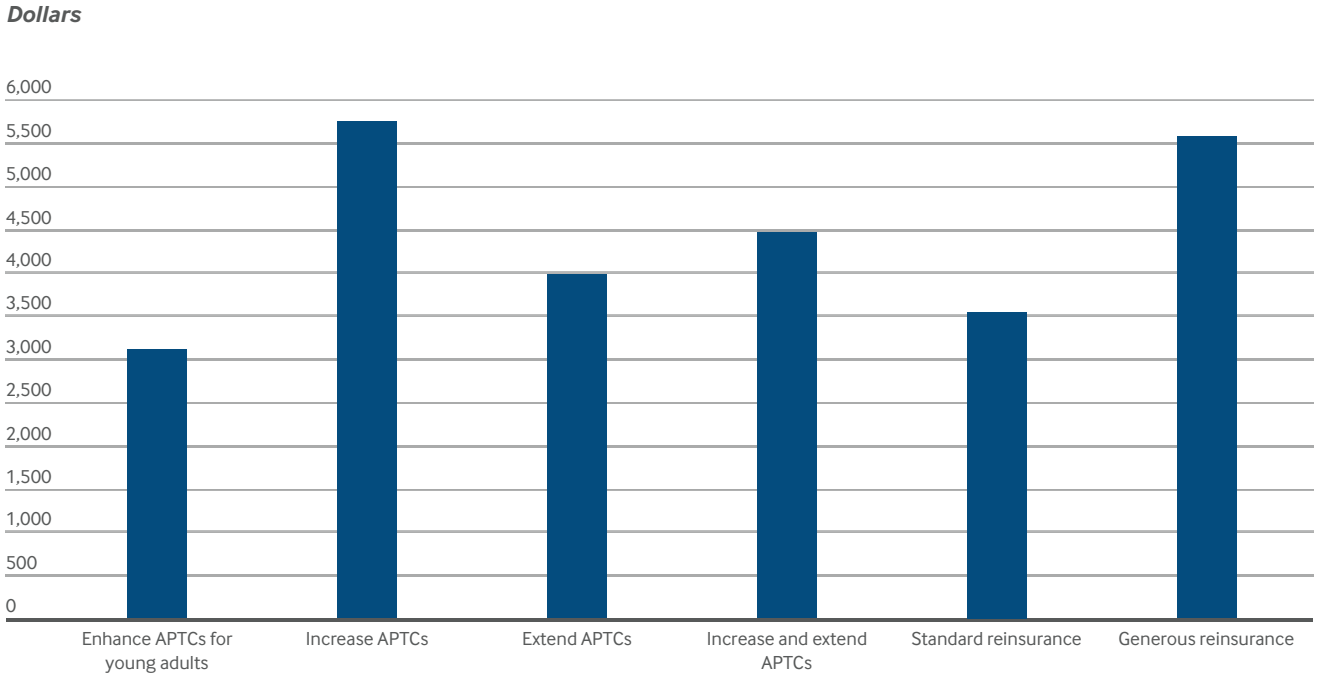
Change in Taxpayer Costs

The first four policy options would create an implicit cost to taxpayers because they would increase the federal deficit relative to the status quo. While the two reinsurance approaches would reduce the deficit, they would add a new fee on all health insurance plans, including employer-sponsored plans. Although the fee is levied on health plans rather than individuals, economic theory and past evidence suggest that these fees would be passed on to enrollees in the form of higher premiums.[9 (#/#9)] In Exhibit 5, we show the estimated ultimate increase in cost to taxpayers, defined as the deficit impact plus the cost of any new insurance fees, for each policy considered. From the taxpayers' perspective, generous reinsurance would be the costliest policy, followed by the policy that would extend APTCs to higher-income individuals and increase their value. These two policies also would yield the largest increase in the number of people with insurance.

By dividing the taxpayer costs estimated in Exhibit 5 by the number of newly insured enrollees, we calculate the taxpayer cost per newly insured individual (Exhibit 6). Based on this metric, enhancing APTCs for young adults would be the most efficient approach, yielding a cost per new enrollee of $3,112. While generous reinsurance would yield more new enrollees than any other option, it is a less efficient policy, with a taxpayer cost per new enrollee of $5,571.

Exhibit 6

Taxpayer Cost per New Enrollee, 2020, Modifications to Expand Coverage



Notes: APTCs = advance premium tax credits. Bars show the increase in cost to taxpayers relative to the ACA baseline divided by the number of newly insured individuals relative to the ACA baseline. The cost to taxpayers is the net deficit impact plus any new insurance fees.
Data: Analysis based on the RAND COMPARE microsimulation model.

Source: C. Eibner and J. Liu, *Options to Expand Health Insurance Enrollment in the Individual Market*, The Commonwealth Fund, October 2017.

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Alternative Reinsurance Scenarios

Because of the federal savings incurred from the reinsurance policies, it would be possible for the federal government to reduce the fees on health plans while achieving gains in insurance. Prior Republican health reform proposals, such as the American Health Care Act and the Better Care Reconciliation Act, included billions of dollars in federal funding for state stability funds that could be used for reinsurance. The finding that reinsurance could reduce APTC outlays creates an additional argument for federal investment in the program; officials from the Centers for Medicare and Medicaid Services used similar logic to justify federal investment in Alaska's state-run reinsurance program.[10](#/#10)

Alternatively, the federal government could use savings from fee-funded reinsurance programs to invest in other priorities. For example, policymakers could counterbalance the new tax on health plan enrollees with other policies aimed at reducing regulations on businesses, such as by reducing the number of firms subject to the ACA's employer mandate.

Exhibit 7 compares our baseline reinsurance scenarios with two alternative approaches: 1) the federal government investing up to $10 billion in the reinsurance program in 2020, and 2) levying the employer mandate to offer coverage only on firms with 500 or more workers (instead of firms with 50 or more workers, as the ACA now requires). The 500-worker threshold has been proposed by the bipartisan "Problem Solvers" caucus.[11 (#/#11)] The bottom line from these scenarios is that the reductions in the deficit could be used to reduce reinsurance fees or other taxes. However, the net impact on taxpayers would be somewhat similar, regardless of whether reinsurance is financed through fees on health plans or direct government spending. This is because we assume taxpayers benefit equally from deficit reductions and tax reductions. As a result, a policy that reduces the deficit but requires a new tax (or, in this case, a fee on health plans) is equivalent to a policy that has no deficit impact.

Exhibit 7

Impact of Alternative Reinsurance Scenarios, 2020

	Baseline reinsurance		Alternative 1: Federal investment in reinsurance of up to $10 billion		Alternative 2: Employer mandate threshold moved to 500 workers	
	Standard	Generous	Standard	Generous	Standard	Generous
Change in total insured relative to ACA (in millions)	0.9	3.4	1.1	3.5	1.0	3.2
Change in individual-market enrollment relative to ACA (in millions)	1.2	5.4	1.3	5.7	1.2	5.8
Reinsurance fee, per enrollee	$35	$189	$0	$134	$35	$189
Total cost of the reinsurance program (in billions)	$6.2	$34.1	$6.2	$34.1	$6.2	$34.1
Net deficit impact (in billions)	–$2.9	–$13.1	$1.9	–$4.5	$0.7	–$6.8
Additional cost to taxpayers (in billions)	$3.0	$18.8	$1.9	$18.1	$1.0	$19.3

Notes: Standard reinsurance covers 50 percent of claims between $90,000 and $250,000, and generous reinsurance covers 100 percent of claims between $45,000 and $250,000. In the baseline and employer-mandate scenarios, we assume reinsurance is funded entirely through a per-enrollee fee on all group, self-insured, and individual-market health plans. In Alternative 1, which includes federal investment in reinsurance, we assume the federal government contributes up to $10 billion to the reinsurance program in 2020, and that the remaining funds are raised through a per-enrollee fee on all group, individual, and self-insured health plan enrollees. The additional cost to taxpayers shown in the last line of the exhibit represents the net change in the deficit plus any new fees levied to fund the reinsurance program. In Alternative 2, we additionally assume that — from the taxpayers' perspective — the increase in the deficit stemming from relaxing the employer mandate would be offset by the reduction in employer penalty payments, which are ultimately born by taxpayers.
Data: Analysis based on the RAND COMPARE microsimulation model.

Source: C. Eibner and J. Liu, *Options to Expand Health Insurance Enrollment in the Individual Market*, The Commonwealth Fund, October 2017.

Conclusion

Policymakers have many options available to expand coverage in the individual market. In this report, we considered federal investments that would enhance, extend, or increase the tax credits available to enrollees, as well as reinsurance approaches that would lower premiums. On a cost-per-enrollee basis, we find that enhancing tax credits by $50 per month for young adults is the cheapest way to expand coverage. However, this approach would yield only about 800,000 newly covered individuals. By contrast, a generous reinsurance program would extend coverage to 3.4 million people.

The benefits of reinsurance come at a cost to taxpayers. As modeled, the reinsurance options would involve an annual fee on health plans of $35 to $189 for every enrollee, including those with employer insurance. Because reinsurance would lower federal spending on APTCs, adding a reinsurance program would reduce the federal deficit. After accounting for the deficit reduction, the reinsurance approaches modeled in this report would cost taxpayers between $3 billion and $18.8 billion in 2020. Relative to the other policy options, the standard reinsurance program is efficient — leading to a taxpayer cost (reinsurance fees plus deficit impact) of $3,537 per newly insured individual. The generous reinsurance would cost $5,571 per newly insured individual, higher than most other options.

All the policy options discussed in this analysis would lead to improvements in the risk pool by enticing lower-cost people to buy coverage. As a result, they could increase the long-term stability of the individual market. Additionally, all of the policies have design features that could be altered, potentially producing different results. For example, the effect of reinsurance depends on which enrollees are eligible for reinsurance payments and whether insurers must contribute coinsurance. Our standard reinsurance scenario, which covered 50 percent of enrollees' claims between $90,000 and $250,000, would insure less than one-third as many additional people as would our more generous reinsurance scenario. While we did not model alternative permutations of the other reforms examined in this report, these too have design features that could be altered to produce different results. For example, the size of the enhanced tax credit for young adults could be scaled up or down, and options to extend tax credits to those with modest incomes could include limits (e.g., 700 percent of FPL, or annual income of no more than $84,420 for an individual) or could require larger applicable percentage contributions for those with higher incomes.

Our analysis focused on a subset of options to expand enrollment that would make health insurance more attractive from the consumer's financial perspective. There are many other options that we did not consider. For example, reinsurance could be combined with changes to tax credits, or changes could be made to health plan design (e.g., to the cost-sharing requirements or scope of covered services). Another set of approaches might encourage enrollment by making consumers more aware of their health insurance options, helping people navigate marketplace websites, providing information about tax credits, and explaining key terms such as deductibles and coinsurance. We believe these additional approaches would complement the approaches we've analyzed here.

Notes

[1] Kaiser Family Foundation, *Health Insurance Coverage of the Total Population, 2016 (https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&selectedDistributions=non-group&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)* (Henry J. Kaiser Family Foundation, 2015).

[2] There are more than 150 million people with employer health insurance and more than 70 million people with Medicaid plans The Kaiser Family Foundation reports that 151 million nonelderly people had employer-sponsored insurance in 2015. See *Distribution of the Nonelderly with Employer Coverage by Age (https://www.kff.org/private-insurance/state-indicator/distribution-by-age-3/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)* (Henry J. Kaiser Family Foundation, n.d.). The Centers for Medicare and Medicaid Services reported 74.5 million Medicaid and CHIP enrollees as of May 2017. See Medicaid.gov, *July 2017 Medicaid and CHIP Enrollment Data Highlights (https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html)* (CMS, n.d.). Note that these figures include enrollees age 65 and older.

[3] M. B. Buntin, M. S. Marquis, and J. Yegian, "The Role of the Individual Health Insurance Market and Prospects for Change (http://content.healthaffairs.org/content/23/6/79.full)," *Health Affairs,* Nov./Dec. 2004 23(6):79–90.

[4] A. Goldstein, "Bipartisan Group of Governors Calls on Congress to Shore Up Elements of the Affordable Care Act (https://www.washingtonpost.com/national/health-science/bipartisan-group-of-governors-calls-on-congress-to-shore-up-elements-of-affordable-care-act/2017/08/31/7853b978-8e71-11e7-84c0-02cc069f2c37_story.html?utm_term=.f1e12b6a7b9b)," *Washington Post,* Aug. 31, 2017.

[5] E. Saltzman and C. Eibner, "Insuring Younger Adults Through the ACA's Marketplaces: Options to Expand Enrollment (/publications/blog/2016/dec/insuring-younger-adults)," *To the Point,* The Commonwealth Fund, Dec. 16, 2016; J. Liu and C. Eibner, *Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults (/publications/issue-briefs/2017/jul/marketplace-tax-credit-extension)* (The Commonwealth Fund, July 2017); and C. Eibner, S. Nowak, and J. Liu, *Hillary Clinton's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit (/publications/issue-briefs/2016/sep/clinton-presidential-health-care-proposal)* (The Commonwealth Fund, Sept. 2016).

[6] T. S. Jost, "The IRS Is Still Enforcing the Individual Mandate, Despite What Taxpayers May Believe (http://healthaffairs.org/blog/2017/08/21/the-irs-is-still-enforcing-the-individual-mandate-despite-what-many-taxpayers-believe/)," *Health Affairs Blog,* Aug. 21, 2017.

[7] See for example CBO's March 13 cost estimate for the American Health Care Act of 2017 (https://www.cbo.gov/publication/52486 (https://www.cbo.gov/publication/52486)) or their July 20 cost estimate for the Better Care Reconciliation Act of 2017 (https://www.cbo.gov/publication/52941 (https://www.cbo.gov/publication/52941)).

[8] Although, in net, reinsurance reduces spending on APTCs, the federal government pays some or all the reinsurance tax for individuals who receive tax credits.

[9] M. J. McCue and M. A. Hall, *What's Behind Health Insurance Rate Increases? An Examination of What Insurers Reported to the Federal Government in 2013–2014 (/publications/issue-briefs/2015/jan/why-are-health-insurance-rates-increasing)* (The Commonwealth Fund, Jan. 2015); and Congressional Budget Office, Private Health Insurance Premiums and Federal Policy (CBO, Feb. 2016).

[10] Centers for Medicare and Medicaid Services, *Alaska: State Waiver Innovation Under Section 1332 of the PPACA (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf)* (CMS, July 11, 2017).

[11] Office of Rep. Ryan Costello, "Rep. Ryan Costello and Problem Solvers Announce Bipartisan Healthcare Work (https://costello.house.gov/media-center/press-releases/rep-ryan-costello-and-problem-solvers-caucus-announce-bipartisan)," Press release, July 31, 2017.

Committee *for a* Responsible Federal Budget

How PAYGO Rules Could Affect Tax Reform

Oct 18, 2017 | Budget Process (/issue-area/budget-process)

Most of the discussion about rules that could prevent tax reform from increasing the deficit has focused on the Byrd Rule (http://www.wwew.crfb.org/papers/reconciliation-101). Congress could get around the rule, which prohibits increasing the deficit beyond the budget window, by having some of the tax cuts expire at the end of the budget window. A budgetary constraint that hasn't received as much attention are the pay-as-you-go (PAYGO) rules against legislation increasing the deficit within the budget window.

There are two basic rules that apply to legislation increasing the deficit over the ten-year budget window:

- **Senate PAYGO Rule** – The Senate PAYGO rule creates a 60-vote point of order against any legislation that would increase the deficit over five or ten years. Under normal consideration, this provision would likely be the death knell of any tax reform reconciliation bill that increased deficits.
- **Statutory PAYGO** – Statutory PAYGO provides for an across-the-board sequester of non-exempt mandatory spending programs if lawmakers enact net deficit-increasing legislation over the course of the year. Whenever lawmakers enact legislation affecting mandatory spending or revenues, the Office of Management and Budget (OMB) records the budgetary effect of the law. OMB then divides the ten-year effect and puts that amount on the PAYGO scorecard for each of the ten years. If Congress adjourns for the year with deficit increases still on the PAYGO scorecard, OMB issues an offsetting sequester of non-exempt mandatory programs.

The Consequences of Violating Statutory PAYGO

If Congress were to pass $1.5 trillion in unpaid-for tax cuts, statutory PAYGO would trigger a sequester unless waived (described in the circumvention section below). Such a sequester would have consequences.

Social Security and means-tested entitlements are exempt from the statutory PAYGO sequester. Medicare is subject to the sequester but limited to a reduction of 4 percent (on top of the 2 percent reduction already in effect because of the sequester under the Budget Control Act). Other mandatory programs subject to a full sequester include agriculture subsidies, student loans, the Social Services Block Grant, and mandatory spending in the Affordable Care Act other than exchange subsidies and Medicaid expansion.

If lawmakers enacted a $1.5 trillion tax cut this year (and all other legislation had no net effect), OMB would issue a sequester of $150 billion on mandatory spending for 2018. That same process would be repeated for each of the next nine years. Because the total base for the sequester is $114 billion in 2018, a deficit increase of $1.14 trillion or more would require the full 4 percent reduction in Medicare plus the ***elimination of all non-exempt programs***; in this case, a $1.5 trillion deficit increase would still leave a $36 billion increase in the 2018 deficit even if it were offset by statutory PAYGO spending cuts. It would require elimination of all these programs until 2027, at which point they would face 95 percent funding cuts.

Below is an illustrative table showing how the sequester might affect non-exempt mandatory programs in 2018 and 2027:

Program	2018 Sequester Cut (%)	2027 Sequester Cut (%)
Medicare	$28 billion (capped at 4%)	$56 billion (capped at 4%)
Agricultural Subsidies and Supports	$14 billion (100%)	$11 billion (96%)
Affordable Care Act's Risk Adjustment Program	$5 billion (100%)	$9 billion (96%)
Operations and Support for Customs and Border Patrol	$2 billion (100%)	$3 billion (96%)
Student Loan Administration	$2 billion (100%)	$2 billion (96%)
All Other Programs	$62 billion (100%*)	$69 billion (96%*)
Total	$114 billion (100%)	$150 billion (96%)

*Some programs have limits to the percentage by which they can be cut; for most programs, cuts can be up to 100%.
Source: calculations based on June 2017 CBO baseline.

Circumventing PAYGO

There are two ways Congress can get around the Senate PAYGO rule. The most straightforward way, which the Senate budget resolution (http://www.wwew.crfb.org/blogs/senate-budget-committee-releases-fy-2018-budget) would do, would be to include a provision in the budget resolution exempting specific legislation from the PAYGO rule. The budget resolution can pass with 51 votes, so including an exemption from Senate PAYGO rules would get around the 60-vote requirement. Senator Mark Warner (D-VA) has proposed an amendment to the budget to strike the exemption in the Senate budget resolution for reconciliation legislation, which if successful would require tax reform to adhere to PAYGO rules or else require 60 votes to override it.

The second way to get around the Senate rule would be to change how tax reform is scored. Congress would accomplish this by relying on dynamic scoring that would give tax reform credit for increased revenues from economic growth and a current policy baseline that assumes temporary tax breaks are extended. Using dynamic scoring would likely allow for a few hundred billion dollars (http://www.wwew.crfb.org/blogs/what-reasonable-amount-dynamic-revenue-tax-reform) of additional breathing room, while using the current policy baseline would mask another $460 billion of costs. Dynamic scoring would not be quite as gimmicky since it would still rely on the Joint Committee on Taxation's relatively reasonable assumptions for the dynamic score, but it would still make it easier for policymakers to satisfy PAYGO. Using a current policy baseline is

clearly a gimmick (http://www.crfb.org/blogs/current-policy-gimmick-would-add-half-trillion-debt) that would lower the bar for revenue neutrality.

However, neither of these strategies would get around statutory PAYGO, which requires a current law baseline and cannot be changed or waived in a budget resolution. In recent years, Congress has often circumvented statutory PAYGO by including a provision in the legislation that excludes the costs of it from the PAYGO scorecard. This tactic would not work in a budget reconciliation bill because it would violate the Byrd Rule (because waiver itself does not produce a change in outlays or revenues). If tax reform increased deficits and no other action was taken to offset that cost, the PAYGO scorecard would reflect the deficit increase and put into motion a sequester at the end of the year.

The other way Congress could get around statutory PAYGO is by passing legislation before the end of the year stopping a sequester. This legislation would "wipe the PAYGO scorecard clean" to remove the deficit increase so that no sequester is triggered. Doing this would require 60 votes in the Senate, but it is quite possible that the bill would clear that hurdle if Democrats supported the bill to prevent potentially draconian sequester cuts or if it were attached to must-pass legislation. That is what Congress did in the late 1990s and early 2000s when it passed legislation increasing the deficit, most notably the Bush tax cuts in 2001.

A History of Bipartisan Support for PAYGO

Despite Congress circumventing PAYGO over the past few years, both Senate PAYGO and statutory PAYGO have received bipartisan support since their inceptions. Senate PAYGO was enacted (https://fas.org/sgp/crs/misc/RL31943.pdf) by a Democratic Congress in the Fiscal Year (FY) 1994 budget resolution; it was then renewed by a Republican Congress in 1995, extending Senate PAYGO through 2002. A weakened version of Senate PAYGO existed until 2007, when a Democratic Congress revived it. In 2015, a Republican Congress permanently enacted Senate PAYGO by eliminating its expiration.

Statutory PAYGO has a similar bipartisan history. Originally passed as a result of the 1990 bipartisan budget agreement, statutory PAYGO then received support from the 1993 Clinton budget agreement and was extended under the 1997 balanced budget agreement. Though it was effectively eliminated in 2003, statutory PAYGO was revived by Congress in 2010 in its current form. The current version has no expiration date and affects all legislation today – though enforcement has been gamed, as mentioned above.

***

In short, the Senate PAYGO rule is unlikely to be a barrier to deficit-increasing tax reform as long as the exemption stays in the budget resolution. However, getting around statutory PAYGO will require legislation wiping the scorecard clean, which is not a certain prospect. Even if PAYGO rules ultimately don't prevent a deficit increase, they will at least require lawmakers to explicitly vote to overrule budgetary constraints, bringing more accountability to Members of Congress who vote to increase deficits. In addition, the existing PAYGO rules could be (http://www.wwew.crfb.org/papers/better-budget-process-initiative-strengthening-statutory-budget-enforcement) strengthened (http://www.wwew.crfb.org/papers/better-budget-process-initiative-strengthening-budget-resolution) to better guard against deficit-increasing legislation.

Note (10/24/2017): Since publication, we added the table showing what a sequester could call for.

Tags

PAYGO & CUTGO (/tags/paygo-cutgo) | Senate (/tags/senate)

How Well Does Insurance Coverage Protect Consumers from Health Care Costs?

Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016

October 18, 2017

Authors

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Citation

S. R. Collins, M. Z. Gunja, and M. M. Doty, *How Well Does Insurance Coverage Protect Consumers from Health Care Costs? — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016,* The Commonwealth Fund, October 2017.

Abstract

(http://www.commonwealthfund.org/interactives-and-data/surveys/biennial-health-insurance-surveys/2017/biennial-explorer)

- **Issue:** The United States has made historic progress on insurance coverage since the Affordable Care Act became law in 2010, with 20 million fewer people uninsured. However, we must also measure progress by assessing how well people who have insurance from all coverage sources are protected from high health care costs.
- **Goals:** To estimate the number and share of U.S. insured adults who are “underinsured” or have out-of-pocket costs and deductibles that are high relative to their incomes.
- **Method:** Analysis of the Commonwealth Fund Biennial Health Insurance Surveys, 2003–2016.
- **Findings:** As of late 2016, 28 percent of U.S. adults ages 19 to 64 who were insured all year were underinsured — or an estimated 41 million people. This is more than double the rate in 2003 when the measure was first introduced in the survey, and is up significantly from 23 percent, or 31 million people, in 2014. Rates

climbed across most coverage sources, and, among privately insured, were highest among people with individual market coverage, most of whom have plans through the marketplaces. Half (52%) of underinsured adults reported problems with medical bills or debt and more than two of five (45%) reported not getting needed care because of cost.

Background

The Affordable Care Act (ACA) has transformed the health insurance market, allowing Americans who lack job-based health benefits access to affordable health insurance options. The law's coverage expansions and protections have reduced the number of uninsured adults by more than 20 million.

Congress intended for the ACA to do more than expand access to insurance; it aimed for the new coverage to allow people to get needed health care at an affordable cost. Accordingly, for marketplace plans, the law includes requirements toward that end: an essential health benefit package, cost-sharing reductions for lower- income families, and out-of-pocket cost limits.[1 (#/#1)] For those covered by the law's Medicaid expansion, there is little or no cost-sharing in most states.[2 (#/#2)]

For people covered by employer-based insurance — which includes more than half of Americans under age 65, or more than 150 million people[3 (#/#3)] — plans were historically far more comprehensive and cost-protective than individual market coverage.[4 (#/#4)] However, over the past decade, premium cost pressures have led companies to share increasing amounts of health costs with workers, particularly in the form of higher deductibles.[5 (#/#5)] At the same time, income growth has been sluggish, leaving families increasingly pinched by health care costs.

In this issue brief, we focus on how well health insurance protects people from medical costs, using a measure of "underinsurance" from the Commonwealth Fund's Biennial Health Insurance Survey to examine trends from 2003 to 2016. Adults in the survey are defined as underinsured if they had health insurance

Who Is Underinsured?

In this analysis, we use a measure of underinsurance that takes into account an insured adult's reported out-of-pocket costs over the course of a year, not including premiums, and his or her health plan deductible. The measure was first used in the Commonwealth Fund's 2003 Biennial Health Insurance Survey. These actual expenditures and the potential risk of expenditures, as represented by the deductible, are then compared with household income. Specifically, a person who is insured all year is underinsured if:

- out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; or
- out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level ($23,760 for an individual and $48,600 for a family of four); or
- deductible is 5 percent or more of household income.

The out-of-pocket cost component of the measure is only triggered if a person uses his or her plan. The deductible component provides an indicator of the financial protection the plan offers and the risk of incurring costs before a person gets health care. The definition does not include people who are at risk of incurring high costs because of other design elements, such as exclusion of certain covered

continuously for the preceding 12 months but still had out-of-pocket costs or deductibles that were high relative to their incomes (see Box). The survey was conducted between July 12 and November 20, 2016. We examined underinsured rates across all coverage sources, including private (employer and individual market) and public (Medicaid and Medicare). It is the first time in this survey series that we are able to estimate underinsurance in the ACA's marketplace plans.

benefits and copayments. It therefore provides a conservative measure of underinsurance in the United States.

Survey Findings

Estimated 41 Million Adults Are Underinsured

As of July 2016 through November 2016, 28 percent of U.S. adults ages 19 to 64 who were insured all year, or an estimated 41 million people, were underinsured (Exhibit 1, Table 1 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)). This is more than double the rate in 2003 when the measure was first introduced in the survey, and is up significantly from 23 percent, or 31 million people, in 2014.[6](#/#6)

Underinsured rates by source of coverage. The underinsured population is predominantly composed of people in employer plans: 56 percent of underinsured adults had coverage through employers at the time of the survey (Table 2 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).[7](#/#7) This reflects the fact that the majority of insured adults have employer coverage. However, people with coverage through the individual market, including the ACA marketplaces, and Medicare beneficiaries who are disabled adults under age 65, are disproportionately represented among the underinsured.

The share of adults who were underinsured has climbed over time in each coverage group. Among adults with employer-based coverage at the time of the survey, 24 percent were underinsured, which is more than double the rate in 2003, and is up significantly from 2014 (Exhibit 2). People working in small firms historically have had somewhat higher underinsured rates than employees of larger firms. But in 2016, the share of adults in firms with 100 or more workers who were underinsured climbed significantly to 22 percent — the same rate as among workers in small companies.

People with individual market coverage, including those in marketplace plans, are significantly more likely to be underinsured than people in employer plans. In 2016, 44 percent of adults with individual market policies, including marketplaces plans, were underinsured.

One-quarter (26%) of adults with Medicaid coverage — the poorest adults in the survey — were underinsured in 2016. Medicaid requires little cost-sharing, but because people eligible for the program have very low incomes, minor out-of-pocket costs can comprise a large share of income.

Adults under age 65 with Medicare who were continuously insured are by far the sickest group of covered adults in the survey — 77 percent have a chronic condition or are in fair or poor health — and the second-poorest after Medicaid enrollees (data not shown).[8 (#/#8)] Many have very high health expenditures and low incomes. Almost half (47%) of adults in this group were underinsured in 2016.

Underinsured rates in the four largest states. The survey drew an additional sample of people in the nation's four most populous states.[9 (#/#9)] Adults in Florida and Texas were underinsured at higher rates than those in California and New York. Among adults who were insured all year, 32 percent of Floridians and 33 percent of Texans were underinsured compared with 21 percent of Californians and New Yorkers (Exhibit 3, Table 3 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

Differences in deductibles were a notable factor in the divide. Larger shares of adults in Florida and Texas had deductibles that were high relative to income compared to those in New York and California (Table 3 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)). According to federal data, deductibles in employer plans are both more prevalent and higher on average in Florida and Texas than in California and New York.[10 (#/#10)]

Higher Deductibles Are Increasingly a Factor in the Underinsured Rate

Between 2003 and 2016, deductibles were increasingly a factor in underinsurance: more people than ever before have plans with deductibles and more have deductibles that are high relative to income.

The share of privately insured adults who had health plans without deductibles has fallen by nearly half over the past 13 years, from 40 percent in 2003 to 22 percent in 2016 (Exhibit 4, Table 4 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)). At the same time, deductibles have grown in size. By 2016, more than one of 10 (13%) adults enrolled in a private plan had a deductible of $3,000 or more, up from just 1 percent in 2003.[11 (#/#11)]

Deductibles are outpacing growth in many families' incomes, and thus representing a greater share of income.[12 (#/#12)] In 2016, 12 percent of adults with insurance coverage all year, or 18 million people, had a deductible that comprised 5 percent or more of their income, up from 3 percent, or 4 million people, in 2003 (Exhibit 5, Table 1 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

High deductibles by coverage source. Deductibles that are high relative to income are more common in the individual market, but have grown increasingly prevalent in employer plans. Among those insured all year, about one-quarter of adults with individual market policies and marketplace plans had deductibles that equaled 5 percent or more of their income, up from 7 percent in 2003. Among people who had employer coverage, the share with a high deductible grew from 2 percent in 2003 to 13 percent in 2016 (Exhibit 5).

Large deductibles have been most common among small employers, but in 2016 the share of workers in large firms with high deductibles climbed significantly. Among adults with health benefits through their own employer who were working part-time or full-time in companies with 100 or more workers, the share with a high deductible relative to income climbed to 13 percent, the same rate as in small-employer plans.

When we examined the data more closely in the individual market, we found differences by income that likely reflect the effects of the Affordable Care Act's cost-sharing reductions. These reductions lower deductibles and other cost-sharing elements for lower-income enrollees in marketplace plans. In 2016, a smaller share of adults with incomes under 200 percent of poverty ($23,760 for an individual and $48,600 for a family of four) in the individual market had high deductibles relative to their income than did higher-income enrollees (data not shown). In contrast, in employer plans, lower-income enrollees have higher deductible burdens than do higher-income employees because the deductible amount does not vary with income. We have found a similar pattern in analyses of other survey data since the ACA's major coverage expansions in 2014.[13 (#/#13)]

Adults with Low Incomes or Health Problems Are at Greatest Risk of Underinsurance

People with low incomes in the United States are by far the most at risk of being underinsured. Among adults who had health insurance for the full year, 44 percent of those with incomes under 200 percent of the federal poverty level ($23,760 for an individual and $48,600 for a family of four) were underinsured in 2016, more than twice the rate of

adults with incomes over 200 percent of poverty (20%) (Exhibit 6). Low-income adults comprised 61 percent of the 41 million underinsured adults in 2016 (Table 2 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

People with health problems are also at greater risk of being underinsured because of their relatively higher health care costs. Among adults who were insured all year, more than one-third (34%) of those in fair or poor health or those with a chronic health problem were underinsured in 2016, compared to 23 percent of those in better health (Exhibit 6).

Underinsured Adults Have High Rates of Medical Bill Problems

Greater cost exposure is leaving Americans burdened with medical debt. Half (52%) of underinsured adults reported problems paying their medical bills or said they were paying off medical debt (Exhibit 7, Table 5 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)). This is about the same rate as adults who were uninsured for some time during the year and more than twice the rate reported by insured adults who were not underinsured (25%). The two states with the highest share of underinsured adults (Florida and Texas) also had the highest shares of insured adults who reported problems paying their medical bills (Table 3 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

Among adults with private coverage who had been insured all year, those with high deductibles were more likely to report problems with medical bills than those with low or no deductibles. Two of five (40%) adults with a deductible of $3,000 or more said they had difficulty paying their medical bills or had accumulated medical debt compared with 21 percent of those who did not have a deductible (Exhibit 8, Table 5 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

Among adults who were paying off medical bills over time, those who had high deductibles were carrying the largest debt loads. Nearly two of five (39%) privately insured adults with deductibles of $1,000 or higher were paying off accumulated medical bills of $4,000 or more (Table 5 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

Medical Bill and Debt Problems Have Long-Term Financial Consequences

Many adults who have struggled to pay their medical bills report lingering financial problems. People who are either underinsured or uninsured have the highest rates of such problems: both groups had higher debt loads and lower incomes than adequately insured adults (data not shown). Half (47%) of underinsured adults who had problems paying medical bills or had medical debt said they had used up all their savings to pay their bills; 40 percent said they had received a lower credit rating because of their bills (Exhibit 9, Table 5 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)). Over one-third (38%) of underinsured adults with medical bill problems said they had taken on credit card debt to pay bills. About 6 percent of underinsured adults reported they had to declare bankruptcy.

Underinsured Adults Report Not Getting Needed Care Because of Cost

Underinsured adults are more likely to skip needed health care because of cost than are adults with more cost-protective insurance. More than two of five (45%) underinsured adults reported not getting needed care because of cost in the past year, including not going to the doctor when sick, not filling a prescription, skipping a test or treatment recommended by a doctor, or not seeing a specialist (Exhibit 10, Table 6 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)). This is twice the rate of continuously insured adults who were not underinsured (22%). It is also close to the rate reported by adults who were uninsured (52%). The two states with the highest share of underinsured adults (Florida and Texas) also had the highest shares of insured adults who reported cost-related problems getting needed health care (Table 3 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

Privately insured adults who had health plans with high deductibles were more likely than those with no deductibles to report cost-related problems getting health care. More than two of five (47%) privately insured adults who were insured all year with a deductible of $3,000 or more reported not getting needed care because of cost compared with 22 percent of adults who did not have a deductible (Exhibit 11, Table 6 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

Many underinsured adults with health problems reported difficulty getting appropriate care. Among underinsured adults with at least one chronic health condition, nearly a quarter (24%) said they had not filled a prescription for their condition or had skipped a dose of their medication because of cost, compared with 10 percent of those with adequate coverage. (Exhibit 12, Table 6 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).[14 (#/#14)] Similarly, underinsured adults with chronic health conditions were more likely to say they had gone to the emergency room or stayed overnight in the hospital for their condition than were adequately insured adults with health problems.

Conclusion and Policy Implications

Since the passage of the Affordable Care Act in 2010, the nation has experienced gains in coverage, as well as improvements on key indicators of access and medical bill problems.[15 (#/#15)] These improvements reflect coverage gains — fewer people are exposed to the full cost of health care — as well as more comprehensive health plans with greater cost protection. This is especially true for low-income people covered by Medicaid and marketplace plans. But, as this analysis shows, the United States has not eliminated cost-related barriers to timely health care or protected people from medical debt. While these problems continue to be most apparent in the individual insurance market, they are increasing in the employer group market. Even public insurance programs like Medicare, which covers seniors and disabled people under age 65, leave many struggling to pay for health care.[16 (#/#16)]

The latest Republican-led effort to repeal and replace the Affordable Care Act would have significantly increased the cost of health care for many Americans. After that effort failed in September, the Trump administration took two major actions in October, which could also have the effect of increasing costs. The first was an executive order to federal agencies to write new regulations that would allow the sale of insurance products that skirt the ACA's consumer protections and cost-sharing standards.[17 (#/#17)] In the second action, the administration ended the federal payments for the ACA's cost-sharing reductions.[18 (#/#18)] At the other end of the political spectrum, Senator Bernie

Sanders has introduced legislation that would phase out the ACA and eliminate most cost-sharing in a Medicare-for-All framework. Seeking middle ground, Senators Lamar Alexander and Patty Murray held hearings on stabilizing the marketplaces in September, which included an appropriation for the cost-sharing reductions. To reduce the number of underinsured people in our health system, we also suggest the following policy options:

For people in individual market and marketplace plans

- ***Increase the cost coverage of health plans.*** The law's cost-sharing reductions (CSRs) increase the actuarial value (the percentage of medical costs covered on average by a health plan) of the marketplace's silver level plans from 70 percent to as high as 94 percent for people with incomes under 250 percent of poverty ($30,150 for an individual and $61,500 for a family of four). The Commonwealth Fund has found that these reductions have been effective in lowering deductibles for those eligible to levels in employer plans.[19 (#/#19)] To counteract the administration's executive order, Congress can immediately reinstate the cost-sharing reduction payments by making an appropriation. Since the Congressional Budget Office (CBO) has already assumed the cost of the CSRs in the federal budget baseline, the appropriation is a formality: it would not increase the federal deficit. To make health care more affordable for middle-class families, Congress could then consider extending the CSRs higher up the income distribution.

- ***Increase the number of services excluded from the deductible.*** Most plans sold in the individual market nationwide exclude certain services from the deductible, such as primary care visits and certain prescriptions.[20 (#/#20)] In 2016, the U.S. Department of Health and Human Services (HHS) provided a standardized plan option for insurers that excluded eight services from the deductible at the silver and gold level. These include primary and specialty care visits, urgent care visits, mental health and substance-use disorder outpatient visits, and all prescription drugs. HHS or Congress could make these exceptions mandatory for all plans. Covered California, the California marketplace, requires all health plans sold in the marketplace to exclude all physician visits and outpatient services from the deductible.

- ***Simplify the metal tiers and increase premium tax credits.*** As an alternative to extending cost-sharing reductions to people above 250 percent of poverty, Congress could lower the number of metal tiers in the individual market from four to two at higher actuarial values. For example, insurers could be required to sell just gold and platinum plans, which have actuarial values of 87 percent and 94 percent and much lower deductibles and copayments than silver and bronze plans. Tax credits would adjust to reflect the plans' higher premium costs. This avoids the circuitous route of covering insurers' costs through the cost-sharing reductions. Premium tax credits could be increased and extended to people earning more than 400 percent of poverty.[21 (#/#21)]

For people in employer plans

- ***Set a standard actuarial value for employer plans.*** Currently under the ACA, people in employer plans may become eligible for marketplace tax credits if the actuarial value of their plan is less than 60 percent. Congress could increase this level to 70 percent (the level of silver plans) or higher.

- ***Set standards for deductible exclusions in employer plans.*** Most employer plans exclude at least some services from their deductibles.[22 (#/#22)] Congress could set a minimum set of exclusions that could resemble the current standard plan option for the marketplaces.

Addressing the Key Driver of Insurance Costs: Health Care Cost Growth

Health care costs are the single largest factor in the growth of private insurance premiums in the United States. Insurers and employers have tried to manage premium growth by making consumers increasingly responsible through higher deductibles and other cost-sharing vehicles. Advocates of this approach argue that with more skin in the game, consumers will help to slow cost growth by choosing more-efficient providers and being more selective in the services they use. But years of experience with high-deductible health plans in the U.S. has yielded scant evidence that such a strategy is effective. Instead, as the survey findings indicate, many consumers have responded to higher deductibles by avoiding needed health care and skipping their medications.

Innovations under way in the delivery system, some of which stem from the ACA, have helped slow the rate of growth in health care costs in the past few years. But moving the nation closer to the performance of other countries on both cost and health outcomes will require considerably more work.[23 (#/#23)] While targeted consumer cost-sharing may help to reduce use of low-value health services, this approach is unlikely to be successful unless consumers are better informed on prices and the value of alternative approaches to their health care problems. Such information is largely unavailable. Evidence suggests that consumers cannot do the heavy lifting required to reduce the rate of growth in medical costs in the United States.

How This Study Was Conducted

The Commonwealth Fund Biennial Health Insurance Survey, 2016, was conducted by Princeton Survey Research Associates International from July 12 to November 20, 2016. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 6,005 adults age 19 and older living in the continental United States. A combination of landline and cellular phone random-digit dial (RDD) samples was used to reach people. In all, 2,402 interviews were conducted with respondents on landline telephones and 3,603 interviews were conducted on cellular phones, including 2,262 with respondents who live in households with no landline telephone access. Oversampling of the four largest states was conducted to reach a minimum of 1,000 interviews each in California, Florida, New York, and Texas.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. This report limits the analysis to respondents ages 19 to 64 (n=4,186), and much of the report focuses on adults who have been insured all year (n=3,268). Statistical results are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau's 2016 Annual Social and Economic Supplement.

The resulting weighted sample is representative of the approximately 187.4 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 14 percent response rate and the cellular phone component achieved a 10 percent response rate.

We also report estimates from the 2003, 2005, 2010, 2012, and 2014 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy that was used in 2016, except the 2003 and 2005 surveys did not include a cellular phone random-digit dial sample. In 2003, the survey was conducted from September 3, 2003, through January 4, 2004, among 3,293 adults ages 19 to 64; in 2005, the survey was conducted from August 18, 2005, to January 5, 2006, among 3,352 adults ages 19 to 64; in 2010, the survey was conducted from July 14 to November 30, 2010, among 3,033 adults ages 19 to 64; in 2012, the survey was conducted from April 26 to August 19, 2012, among 3,393 adults ages 19 to 64; and in 2014, the survey was conducted from July 22 to December 14, 2014, among 4,251 adults ages 19 to 64.

Notes

[1] With the exception of cost-sharing subsidies, these requirements also apply to health plans sold outside the marketplaces in the individual and small-group markets.

[2] S. Beutel, M. Gunja, and S. R. Collins, *How Much Financial Protection Do Marketplace Plans Provide in States Not Expanding Medicaid? (/publications/issue-briefs/2016/june/marketplace-states-not-expanding-medicaid)* (The Commonwealth Fund, June 2016).

[3] Congressional Budget Office, *Updated Budget Projections: 2015–2025 (https://www.cbo.gov/publication/49973)* (CBO, March 2015).

[4] The major insurance reforms in the Affordable Care Act are directed at the individual and small-group insurance markets where underwriting practices left many consumers and small businesses with poor health coverage or no coverage at all. But the law also extends some requirements to large-employer-based plans, including coverage of preventive services without cost-sharing, limits on out-of-pocket costs, and bans on lifetime and annual benefit limits. Low- and moderate-income workers in health plans with high cost-sharing are eligible for subsidized coverage through the marketplaces. Those with incomes under 138 percent of poverty are eligible for Medicaid in states that have expanded eligibility for their programs.

[5] S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel, *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch (/publications/issue-briefs/2016/oct/slowdown-in-employer-insurance-cost-growth)* (The Commonwealth Fund, Oct. 2016).

[6] All reported differences are statistically significant at the $p \leq 0.05$ level or better unless otherwise noted.

[7] This reflects the fact that most Americans have health insurance through an employer (see Table 2 (/~/media/files/publications/issue-brief/2017/oct/collins_underinsured_biennial_ib_tables.pdf?la=en)).

[8] People under age 65 may become eligible for Medicare if they are disabled and are receiving Social Security Disability Insurance or have been diagnosed with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS).

[9] M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *Insurance Coverage, Access to Care, and Medical Debt Since the ACA: A Look at California, Florida, New York, and Texas (/publications/issue-briefs/2017/mar/coverage-access-medical-debt-aca-california-florida-new-york-texas)* (The Commonwealth Fund, March 2017).

[10] S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel, *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch (/publications/issue-briefs/2016/oct/slowdown-in-employer-insurance-cost-growth)* (The Commonwealth Fund, Oct. 2016).

[11] Sample is limited to those who knew their deductible amount.

[12] S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel, *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch (/publications/issue-briefs/2016/oct/slowdown-in-employer-insurance-cost-growth)* (The Commonwealth Fund, Oct. 2016).

[13] S. R. Collins, M. Z. Gunja, and M. M. Doty, *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? — Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017* (/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage) (The Commonwealth Fund, Sept. 2017).

[14] Respondents had at least one of the following health conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

[15] S. R. Collins, M. Z. Gunja, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016 (/publications/issue-briefs/2017/feb/how-the-aca-has-improved-ability-to-buy-insurance)* (The Commonwealth Fund, Feb. 2017); and B. W. Ward, T. C. Clarke, and J. S. Schiller, *Early Release of Selected Estimates Based on Data from the January–June 2016 National Health Interview Survey (https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201611.pdf)* (National Center for Health Statistics, Nov. 2016).

[16] C. Schoen, K. Davis, and A. Willink, *Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status (/publications/issue-briefs/2017/may/medicare-out-of-pocket-cost-burdens)* (The Commonwealth Fund, May 2017).

[17] D. Palanker, K. Lucia, and E. Curran, "New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market (/publications/blog/2017/aug/short-term-health-plans)," *To the Point,* The Commonwealth Fund, Oct. 11, 2017; and T. Jost, "Trump Executive Order Expands Opportunities for Healthier People to Exit ACA (http://healthaffairs.org/blog/2017/10/12/trump-executive-order-expands-opportunities-for-healthier-people-to-exit-aca/)," *Health Affairs Blog,* Oct. 12, 2017.

[18] S. R. Collins, "A One-Two Punch to the Health Insurance Marketplaces and the People They Cover (/publications/blog/2017/oct/one-two-punch-to-health-insurance-marketplaces-and-people)," *To the Point,* The Commonwealth Fund, Oct. 13, 2017.

[19] S. R. Collins, M. Z. Gunja, and M. M. Doty, *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? — Findings from the*

Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017 (/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage) (The Commonwealth Fund, Sept. 2017).

[20] M. Z. Gunja, S. R. Collins, and S. Beutel, *How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services (/publications/issue-briefs/2016/mar/deductible-exclusions)* (The Commonwealth Fund, March 2016).

[21] J. Liu and C. Eibner, *Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults (/publications/issue-briefs/2017/jul/marketplace-tax-credit-extension)* (The Commonwealth Fund, July 2017).

[22] J. Gabel, H. Whitmore, M. Green et al., *Consumer Cost-Sharing in Marketplace vs. Employer Health Insurance Plans, 2015 (/publications/issue-briefs/2015/dec/cost-sharing-marketplace-employer-plans)* (The Commonwealth Fund, Dec. 2015).

[23] E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care (http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/)* (The Commonwealth Fund, July 2017).

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Individual Insurance Market Performance in Mid 2017

Ashley Semanskee and Larry Levitt

Concerns about the stability of the individual insurance market under the Affordable Care Act (ACA) have been raised in the past year following exits of several insurers from the exchange markets, and again with renewed intensity in recent months during the debate over repeal of the health law. Our earlier analysis of first quarter financial data from 2011-2017 found that insurer financial performance indeed worsened in 2014 and 2015 with the opening of the exchange markets, but showed signs of improving in 2016 and stabilizing in 2017 as insurers regain profitability.

In this brief, we look at recently-released second quarter financial data from 2017 to examine whether recent premium increases were sufficient to bring insurer performance back to pre-ACA levels. These new data from the first six months of 2017 offer further evidence that the individual market has been stabilizing and insurers are regaining profitability, even as political and policy uncertainty clouds expectations for 2018.

We use financial data reported by insurance companies to the National Association of Insurance Commissioners and compiled by Mark Farrah Associates to look at the average premiums, claims, medical loss ratios, gross margins, and enrollee utilization from second quarter 2011 through second quarter 2017 in the individual insurance market.[1] Second quarter data is year-to-date from January 1 – June 30. These figures include coverage purchased through the ACA's exchange marketplaces and ACA-compliant plans purchased directly from insurers outside the marketplaces (which are part of the same risk pool), as well as individual plans originally purchased before the ACA went into effect.

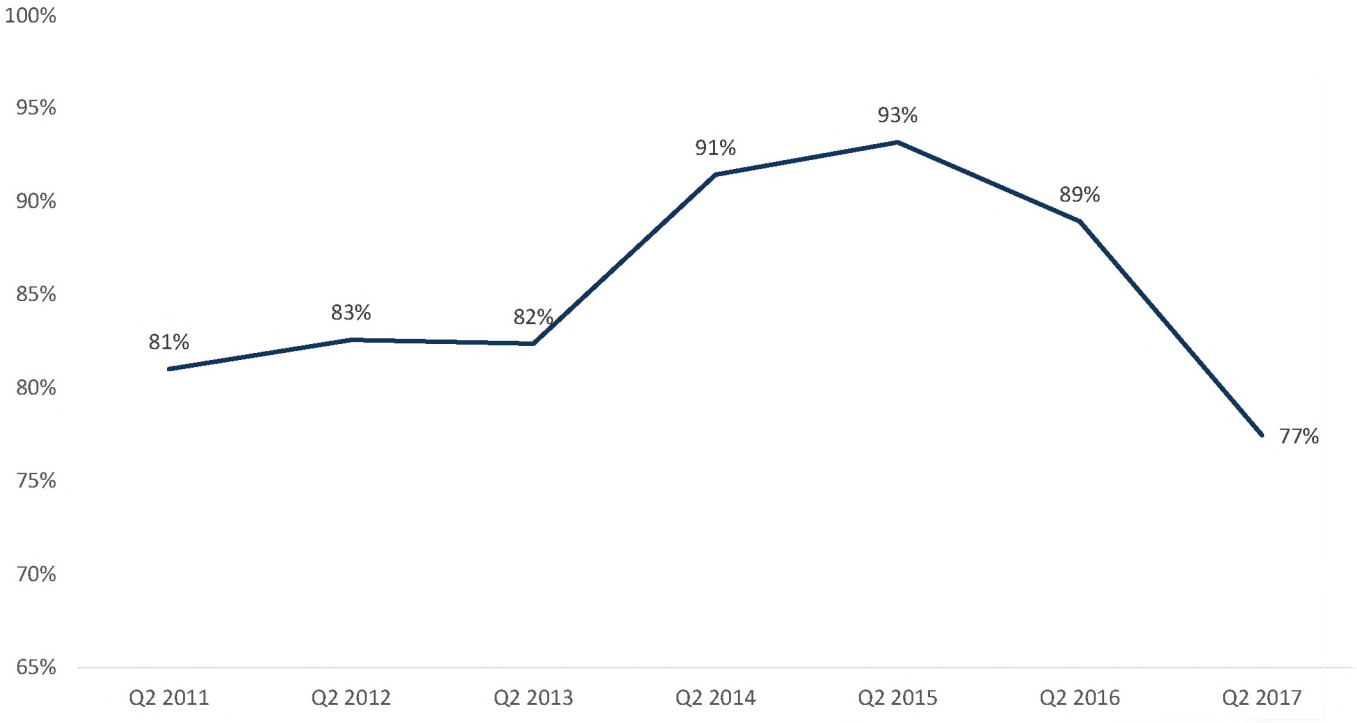
Medical Loss Ratios

As we found in our previous analysis, insurer financial performance as measured by loss ratios (the share of health premiums paid out as claims) worsened in the earliest years of the Affordable Care Act, but began to improve more recently. This is to be expected, as the market had just undergone significant regulatory changes in 2014 and insurers had very little information to work with in setting their premiums, even going into the second year of the exchange markets.

Loss ratios began to decline in 2016, suggesting improved financial performance. In 2017, following relatively large premium increases, individual market insurers saw significant improvement in loss ratios, averaging 77% through the second quarter. Second quarter loss ratios tend to follow the same pattern as annual loss ratios, but in recent years have been lower than annual loss ratios.[2] Though 2017 annual loss ratios are therefore likely to end up higher than 77%, this is nevertheless a sign that individual market insurers on average are on a path toward regaining profitability in 2017.

Figure 1

Average Second Quarter Individual Market Medical Loss Ratios, 2011 - 2017



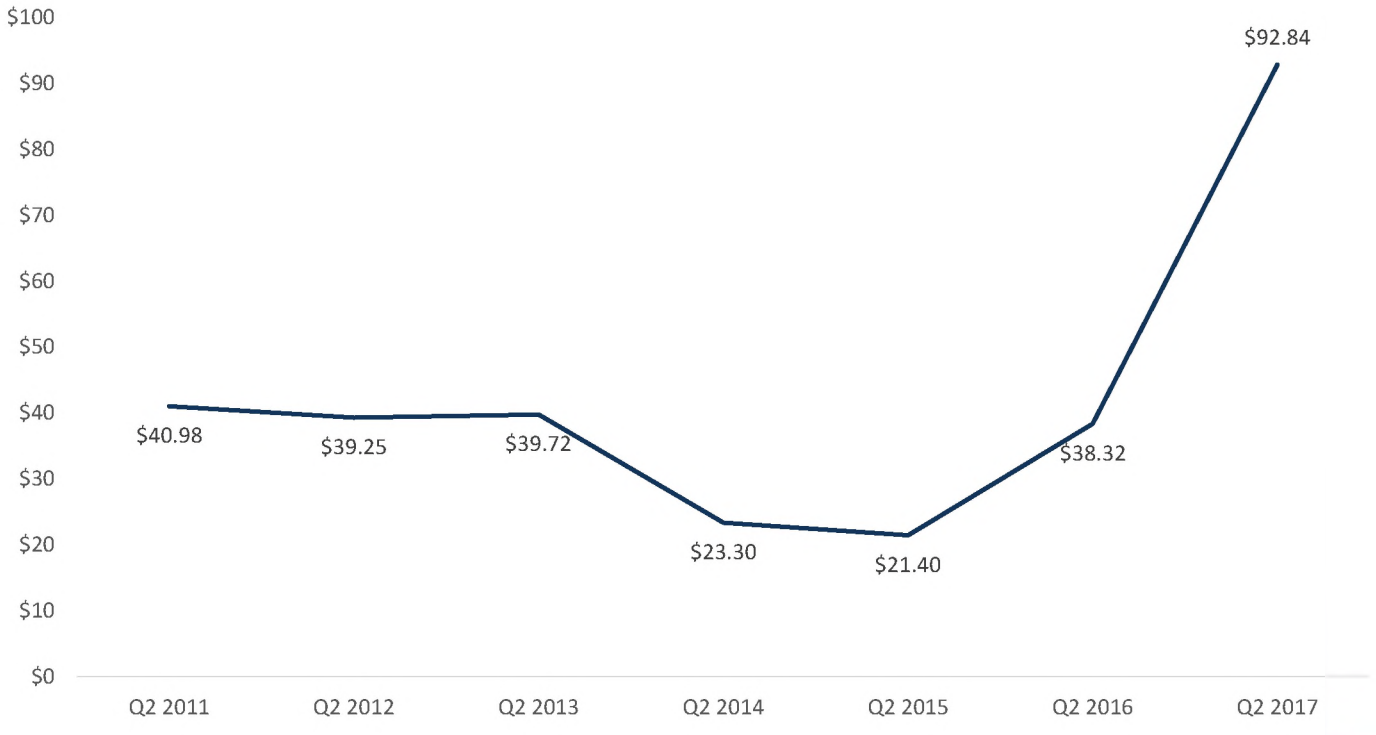
Note: Q2 data is year-to-date from January 1 – June 30. Figures above represent simple loss ratios and differ from the definition of MLR in the Affordable Care Act
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM.

Margins

Another way to look at individual market financial performance is to examine average gross margins per member per month, or the average amount by which premium income exceeds claims costs per enrollee in a given month. Gross margins are an indicator of performance, but positive margins do not necessarily translate into profitability since they do not account for administrative expenses. As with medical loss ratios, second quarter margins tend to follow a similar pattern to annual margins, but generally look more favorable as enrollees are still paying toward their deductibles in the early part of the year, lowering claims costs for insurers.

Figure 2

Average Second Quarter Individual Market Gross Margins Per Member Per Month, 2011 - 2017



Note: Q2 data is year-to-date from January 1 – June 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

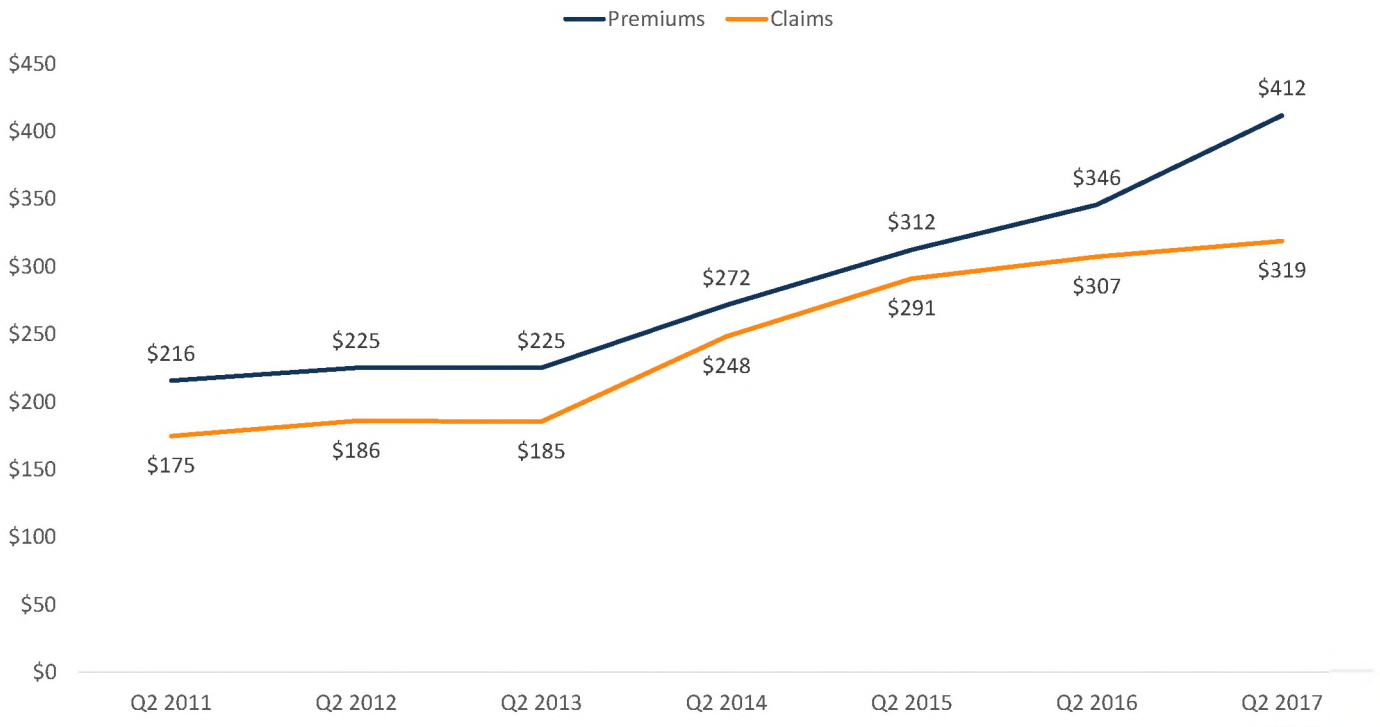
Looking at gross margins, we see a similar pattern as we did looking at loss ratios, where insurer financial performance improved dramatically through the second quarter of 2017 (increasing to $93 per enrollee, from a recent second quarter low of $21 in 2015). Again, second quarter data tend to indicate the general direction of the annual trend, and while annual 2017 margins are unlikely to end as high as they are in the second quarter, these data suggest that insurers in this market are on track to reach pre-ACA individual market performance levels.

Underlying Trends

Driving recent improvements in individual market insurer financial performance are the premium increases in 2017 and simultaneous slow growth in claims for medical expenses. On average, premiums per enrollee grew 19% from second quarter 2016 to second quarter 2017, while per person claims grew only 4%.

Figure 3

Average Second Quarter Individual Market Monthly Premiums and Claims Per Person, 2011 - 2017



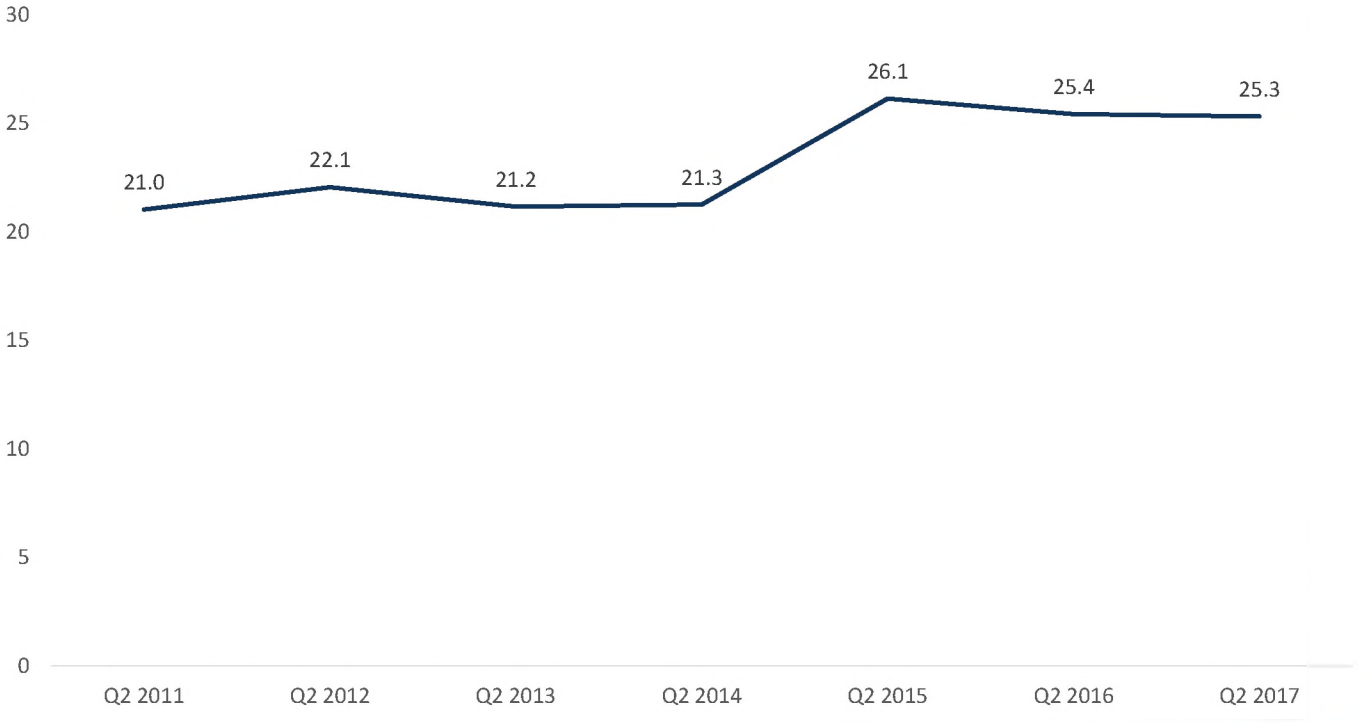
Note: Q2 data is year-to-date from January 1 – June 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

One concern about rising premiums in the individual market was whether healthy enrollees would drop out of the market in large numbers rather than pay higher rates. While the vast majority of exchange enrollees are subsidized and sheltered from paying premium increases, those enrolling off-exchange would have to pay the full increase. As average claims costs grew very slowly through the second quarter of 2017, it does not appear that the enrollees today are noticeably sicker than it was last year.

On average, the number of days individual market enrollees spent in a hospital through second quarter of 2017 was similar to second quarter inpatient days in the previous two years. (The second quarter of 2014 is not necessarily representative of the full year because open enrollment was longer that year and a number of exchange enrollees did not begin their coverage until mid-year 2014).

Figure 4

Average Second Quarter Individual Market Monthly Hospital Patient Days Per 1,000 Enrollees, 2011 - 2017



Note: Q2 data is year-to-date from January 1 – June 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

Taken together, these data on claims and utilization suggest that the individual market risk pool is relatively stable, though sicker on average than the pre-ACA market, which is to be expected since people with pre-existing conditions have guaranteed access to coverage under the ACA.

Discussion

Mid-year results from 2017 suggest the individual market is stabilizing and insurers in this market are regaining profitability. Insurer financial results show no sign of a market collapse. Second quarter premium and claims data from 2017 support the notion that 2017 premium increases were necessary as a one-time market correction to adjust for a sicker-than-expected risk pool. Although individual market enrollees appear on average to be sicker than the market pre-ACA, data on hospitalizations in this market suggest that the risk pool is stable on average and not getting progressively sicker as of early 2017. Some insurers have exited the market in recent years and further exits are planned for 2018, but others have been successful and expanded their footprints, as would be expected in a competitive marketplace.

While the market on average is stabilizing, there remain some areas of the country that are more fragile. In addition, policy uncertainty has the potential to destabilize the individual market generally. Mixed signals from the Administration and Congress as to whether cost sharing subsidy payments will continue or whether the

individual mandate will be enforced have led to some insurers to leave the market or request larger premium increases than they would otherwise. A few parts of the country were thought to be at risk of having no insurer on exchange, though new entrants or expanding insurers have since moved in to cover all areas previously at risk of being bare.

Methods

We analyzed insurer-reported financial data from Health Coverage Portal TM, a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners. The dataset analyzed in this report does not include NAIC plans licensed as life insurance or California HMOs regulated by California's Department of Managed Health Care; in total, the plans in this dataset represent at least 80% of the individual market. All figures in this data note are for the individual health insurance market as a whole, which includes major medical insurance plans sold both on and off exchange. We excluded some plans that filed negative enrollment, premiums, or claims and corrected for plans that did not file "member months" in the second quarter but did file second quarter membership.

To calculate the weighted average loss ratio across the individual market, we divided the market-wide sum of total incurred claims by the sum of all health premiums earned. Medical loss ratios in this analysis are simple loss ratios and do not adjust for quality improvement expenses, taxes, or risk program payments. Gross margins were calculated by subtracting the sum of total incurred claims from the sum of health premiums earned and dividing by the total number of member months (average monthly enrollment) in the individual insurance market.

Endnotes

[1] The loss ratios shown in this data note differ from the definition of MLR in the ACA, which makes some adjustments for quality improvement and taxes, and do not account for reinsurance, risk corridors, or risk adjustment payments. Reinsurance payments, in particular, helped offset some losses insurers would have otherwise experienced. However, the ACA's reinsurance program was temporary, ending in 2016, so loss ratio calculations excluding reinsurance payments are a good indicator of financial stability going forward.

[2] Although second quarter loss ratios and margins generally follow a similar pattern as annual data, starting in 2014 with the move to an annual open enrollment that corresponds to the calendar year, second quarter MLRs have been lower than annual loss ratios in the same year. This is because renewing existing customers, as well as new enrollees, are starting to pay toward their deductibles in January, whereas pre-ACA, renewals would occur throughout the calendar year.

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High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services

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ABSTRACT **Enrollment in high-deductible health plans (HDHPs) has greatly increased in recent years. Policy makers and other stakeholders need the best available evidence about how these plans may affect health care cost and utilization, but the literature has not been comprehensively synthesized. We performed a systematic review of methodologically rigorous studies that examined the impact of HDHPs on health care utilization and costs. The plans were associated with a significant reduction in preventive care in seven of twelve studies and a significant reduction in office visits in six of eleven studies—which in turn led to a reduction in both appropriate and inappropriate care. Furthermore, bivariate analyses of data extracted from the included studies suggested that the plans may be associated with a reduction in appropriate preventive care and medication adherence. Current evidence suggests that HDHPs are associated with lower health care costs as a result of a reduction in the use of health services, including appropriate services.**

High-deductible health plans (HDHPs) are insurance plans that have lower premiums but higher deductibles, compared to traditional health plans. HDHPs have higher cost-sharing requirements (that is, out-of-pocket spending by the patient), and it is hypothesized that this will provide patients with incentives to make higher-value health care decisions.[1,2] Enrollment in HDHPs has expanded since the enactment of the Affordable Care Act (ACA).[3] These plans are frequently combined with personal health accounts—combinations referred to as consumer-directed health plans. The personal health accounts can be either health savings accounts or health reimbursement arrangements. Health savings accounts are tax-free accounts used to pay for qualified medical expenses, and they must be paired with an HDHP. Health reimbursement arrangements are employer-funded accounts used to reimburse employees for their qualified medical expenses; these accounts need not be combined with an HDHP.[4] Value-based purchasing arrangements such as bundled payment and accountable care organizations encourage providers to be more cost conscious; HDHPs supplement such efforts by focusing on patients.

The landmark RAND Health Insurance Experiment randomly assigned families to health insurance plans with varying levels of cost sharing, ranging from none to 95 percent coinsurance.[5] For poorer families in plans that involved cost sharing, the amount of cost sharing was income-adjusted to one of three levels: 5 percent, 10 percent, or 15 percent of income. Out-of-pocket spending was capped at these percentages of income or at $1,000 annually, whichever was lower. The RAND study showed that cost sharing reduces health care costs by lowering utilization, but patients reduced their use of both appropriate and inappropriate services. The demand for health care was particularly reduced in low-income and vulnerable populations. Over the

years, these findings have been confirmed in multiple studies.[6] Nevertheless, the effect of HDHPs on enrollee health and health care utilization is controversial, and they are often considered "blunt instruments."[3,7] However, use of the plans is seen by many policy makers as a potent way to curb health care costs and is considered an important idea in health care reform.[4,8,9]

Randomized controlled trials help minimize selection bias and the effect of unmeasured confounders, compared with simple observational studies. Randomized controlled trials of the HDHPs' effects on the receipt of medical services have not been performed, and data on major health outcomes, such as mortality, are not available. However, the growing literature on the plans has evaluated a wide range of outcomes related to cost and use of health services. Policy makers and other stakeholders need the best available evidence to make decisions as the United States moves toward a system increasingly centered on HDHPs.[3]

The purpose of our research was to systematically review methodologically rigorous studies that examined the impact of HDHPs on relevant outcomes and to identify the characteristics of studies associated with reporting beneficial or detrimental impacts. Our results will be useful to policy makers, providers, and employers interested in the benefits and unintended consequences of the plans.

Study Data And Methods

Our systematic review was performed and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.[10]

STUDY INCLUSION CRITERIA We included quasi-experimental studies that compared an HDHP (either a stand-alone plan or part of a consumer-directed health plan) with a traditional health plan. Articles were included if they used designs that aimed to minimize selection bias (such as controlled before-and-after studies, difference-in-differences analyses, interrupted time series studies, and propensity score matching).[11,12] Studies that enrolled members of either individual or employer-sponsored health plans were eligible. We included only empirical, peer-reviewed, English-language articles. We excluded letters to the editor, policy briefs, executive summaries of governmental reports, commentaries, and Internet-based publications that had not been peer reviewed. The outcome of interest was health care use and spending for any health care setting, including preventive care, office visits, emergency department (ED) visits, hospitalizations, diagnostic testing, and prescription drug use.

IDENTIFICATION AND SELECTION OF STUDIES We searched MEDLINE and the Cochrane Central Register of Controlled Trials from inception to January 2017. Our detailed search strategy is available in online Appendix Exhibit A1.[13] Screening of titles and abstracts was done by one reviewer (Rajender Agarwal) in accordance with the inclusion criteria, and that was followed by full-text screening of relevant citations by two reviewers (Agarwal and Olena Mazurenko) working independently. Disagreements were resolved through consensus or referral to a third reviewer (Nir Menachemi). Reference lists of included studies were screened to identify any additional studies that met inclusion criteria.

DATA EXTRACTION We developed a template for evidence tables by using the population, intervention, comparator, and outcomes (PICO) framework. We extracted relevant information on study design, population, sample size, characteristics of HDHP and traditional plans, and the outcomes of interest. One reviewer (Agarwal) initially extracted this information from each included article and inserted it into evidence tables. In addition, we extracted data on all unique analyses reported in the articles. An analysis was considered to be unique if it examined discrete outcomes (such as rates of mammography screening or outpatient costs). An analysis was also categorized as unique if the study used one outcome but examined it in different populations, such as high-income versus low-income people.

We systematically classified all included analyses by using a standard coding sheet specifically developed for this study. All three reviewers approved the content of the coding sheet, which was then filled out by a second reviewer (Mazurenko) using the original articles as well as the evidence tables created by the first reviewer. A 20 percent random sample of articles was assessed by a third reviewer (Menachemi) to evaluate the interrater reliability of the collected variables.

STUDY FRAMEWORK Given the similarity between the design of HDHPs and previously examined cost-sharing arrangements, such as the RAND Health Insurance Experiment, we hypothesized that the plans would lead to a reduction in health care costs and use primarily because of the lower rates of use of inappropriate services (such as ED visits for low-intensity conditions). Also, given that the majority of HDHPs cover preventive services with no cost-sharing requirements, we predicted that enrollees in the plans would not reduce their use of preventive services.

We grouped studies by outcome under each

care setting and compared the findings of the studies in each group. We classified statistically significant study results as "beneficial effects" if they were shown to improve health outcomes or reduce costs, and we labeled unintended consequences from HDHPs' cost-sharing requirement "adverse effects."

DATA ANALYSIS We used descriptive analyses to examine the distribution of key variables that were reported in individual studies. We then used the chi-square statistic to investigate differences in the study characteristics of articles that found a beneficial effect and those that did not. All analyses were conducted in Stata, version 14. A p value of ≤ 0.05 was considered significant.

LIMITATIONS Several limitations of our study are worth mentioning. First, we acknowledge that no randomized controlled trials exist that examine the effects of HDHPs on outcomes. This is likely due to the methodological and logistical challenges inherent in such studies, and it limited the causal nature of the conclusions we drew. However, our inclusion criteria enabled us to focus on studies that used econometric techniques designed to minimize selection bias.

Second, many of the published studies came from a small number of research groups using a limited number of research populations. About a third of the studies we analyzed came from the same research group in Massachusetts, and these studies accounted for 20 percent of the reported beneficial findings.

Third, while there are tools to assess the risk of bias in observational and nonrandomized studies,[14,15] we did not believe that they would detect meaningful differences in the quality of rigorous quasi-experimental studies. Therefore, we did not undertake a formal quality assessment of our included studies.

Finally, we developed our framework to interpret the results of the included studies by assigning study findings to categories of "beneficial" or "adverse" effects. This approach was not intended to provide comprehensive definitions that would apply to all scenarios for all types of service use.

EXHIBIT 1

Selected characteristics of 28 quasi-experimental studies that compared a high-deductible health plan (HDHP) and a traditional health plan

Characteristic	Number of studies	Percent of studies
Externally funded	21	75.0
JOURNAL TYPE		
Health policy or health services	23	82.1
Clinical	5	17.9
STUDY LOCATION		
Single state	16	57.1
Other	11	42.9
STUDY SETTING		
Single employer	5	17.9
Multiple employers	22	78.6
HIGH-DEDUCTIBLE HEALTH PLAN TYPE		
With HSA, HRA, or both	14	50.0
Other	14	50.0
COMPARISON GROUP		
HMO, PPO or both	21	75.0
Other	7	25.0
NUMBER OF COMPARISON GROUPS		
One	15	53.6
More than one	13	46.4
STUDY POPULATION		
Adults only	19	67.9
Adults and children (<18 years old)	9	32.1
INTRODUCTION OF HIGH-DEDUCTIBLE HEALTH PLAN OPTION		
2001–04	17	60.7
2004–11	11	39.3
YEARS OF FOLLOW-UP		
One	16	57.1
More than one	12	42.9
DEDUCTIBLE AMOUNT		
Individual		
Less than $2,000	19	67.9
More than $2,000	2	7.1
Family		
Less than $4,000	17	60.7
More than $4,000	5	17.9
OUTCOMES ANALYZED[a]		
Utilization[b]	173	46.3
Costs	59	15.8
Prevention	69	18.4
Quality	20	5.3
Adherence	53	14.2
OUTCOME EFFECT[a]		
Beneficial	60	16.0
None	222	59.4
Adverse	92	24.6

SOURCE Authors' analysis of the studies (see Notes 16–43 in text). **NOTES** HSA is health savings account. HRA is health reimbursement arrangement. HMO is health maintenance organization. PPO is preferred provider organization. [a]There were 374 unique analyses (defined in the text) in the studies. [b]Cumulative utilization for office and emergency department visits and hospitalizations.

Study Results

Our literature searches identified 1,706 unique citations. Sixty-three of them were considered potentially relevant based on title and abstract screening, and the full texts for these studies were obtained (see Appendix Exhibit A2 for the PRISMA flow diagram).[13] Our detailed review of full-text studies ultimately yielded twenty-eight studies that met our inclusion criteria.[16–43] Three-fourths of the articles reported receiving external funding, and more than 80 percent were published in health policy or health services research journals as opposed to clinical journals (Exhibit 1). Nearly 60 percent of the studies used data from one state, of which

Massachusetts was the most common. Three-fourths of the studies used members of a managed care plan as a comparison group.

The twenty-eight studies collectively contained 374 unique analyses. For outcomes, nearly half of the studies focused on health services use, followed by health care costs, use of preventive services, and adherence to medication regimens (each examined by about 15 percent of the studies). Quality-of-care measures were the least common outcome, appearing in slightly more than 5 percent of the studies. Overall, one out of six analyses reported a beneficial effect of HDHPs on the outcomes they studied, while six out of ten reported no significant effect, and one out of four reported an adverse effect. Descriptive examples of beneficial and adverse effects are presented in Exhibit 2.

PREVENTIVE CARE The evidence base for this outcome consisted of twelve studies[16,17,21–23,25,34,35,37,39,41,42] (for information about the studies, see Appendix Exhibit A4).[13] Eight of these studies reported on HDHPs that had first-dollar coverage,[16,21,22,25,34,35,37,39] which allows enrollees in HDHPs to use preventive services with no cost sharing and potentially leads to higher use of these services. The plans were associated with a significant reduction in the use of preventive care in seven studies[16,17,21,25,37,41,42] (although four of these studies reported first-dollar coverage).[16,21,25,37] No significant difference was reported in the remaining five studies.[22,23,34,35,39]

OFFICE VISITS The evidence base for this outcome consisted of eleven studies[16,17,19,21,25,26,28,30,32,34,36] (Appendix Exhibit A5).[13] HDHPs were associated with a significant reduction in office visits, which led to a reduction in the use of both appropriate and inappropriate care, in six studies.[21,26,30,32,34,36] Four studies showed a significant reduction in nonemergency visits, expenditure, or both (beneficial effects).[16,17,25,28] The remaining study had inconsistent results.[19]

EMERGENCY DEPARTMENT VISITS The evidence base for this outcome consisted of nine studies[16,17,21,27,30,36,38,40,43] (Appendix Exhibit A6).[13] HDHPs were associated with a significant reduction in nonemergency visits (a beneficial effect) in three studies.[17,40,43] One study showed a significant increase in visits that was thought to result from fewer office visits and prescriptions.[21] Another study showed that males enrolled in the HDHP reduced visits at all severity levels.[27] A third study showed a significant reduction in high-severity visits among enrollees with low socioeconomic status.[38] The effects in the remaining three studies were unclear or not significant.[16,30,36]

HOSPITALIZATIONS The evidence base for this outcome consisted of ten studies[16,17,19,21,25,27,30,38,40,43] (Appendix Exhibit A7).[13] One study showed an initial significant reduction in hospitalizations among HDHP members followed by an increase, which suggests that the members initially deferred needed care.[40] A similar effect was seen in men but not in women in a second study.[27] Another study showed a significant reduction in hospitalizations among HDHP members with low socioeconomic status.[38] A significant reduction in expenditure (a beneficial effect) was seen in two studies.[16,25] No significant difference was seen in four studies.[17,19,21,43] The remaining study showed a significant reduction in hospitalizations, but it was unclear whether

EXHIBIT 2

Examples of the effects of high-deductible health plans on study outcomes

Outcome	Beneficial effect	Adverse effect
Preventive care	Increase in rate of screening (for example, colonoscopy, Pap smear, mammogram)	Decrease in rate of screening
Office visits	Decrease in unscheduled nonemergency visits	Decrease in primary care visits
ED visits	Decrease in low-severity visits	Decrease in high-severity visits
Hospitalizations	Decrease in low-acuity hospitalizations	Decrease in high-acuity hospitalizations
Diagnostic tests	Decrease in inappropriate diagnostic testing	Decrease in appropriate diagnostic testing
Prescription drug use	Increase in generic drug use	Decrease in medication adherence
Health care costs	Decrease in costs	Increase in costs
Quality	Increase in rate of HbA1C measurements among patients with diabetes	Decrease in rate of HbA1C measurements among patients with diabetes

SOURCE Authors' analysis. **NOTES** This framework was developed for the purpose of interpreting the results of the twenty-eight quasi-experimental studies (see Notes 16–43 in text) by assigning study findings to beneficial and adverse effect categories. It was not intended to provide comprehensive definitions that would apply to all scenarios for all types of service use. ED is emergency department. HbA1C is hemoglobin A1C.

these were necessary or avoidable.[30]

DIAGNOSTIC TESTING The evidence base for this outcome consisted of two studies[30,32] (Appendix Exhibit A8).[13] Both studies showed a reduction in laboratory and diagnostic tests among HDHP enrollees, although it was unclear whether these reductions were appropriate.

PRESCRIPTION DRUG USE The evidence base for this outcome consisted of thirteen studies[16–21,24,25,29–31,33,36] (Appendix Exhibit A9).[13] HDHPs were associated with a significant reduction in medication adherence in five studies.[18,20,21,24,30] A significant reduction in expenditure (a beneficial effect) was seen in three studies.[16,17,29] One study showed a significant increase in prescription drug use that was driven by an increased likelihood of using generic and essential medications (a beneficial effect), although the use of nonpreferred medications increased as well.[36] However, there was a significant reduction in drug spending among HDHP members with low incomes and chronic conditions in one study.[25] The effects in the remaining three studies were unclear or not significant.[19,31,33]

STUDY CHARACTERISTICS ASSOCIATED WITH REPORTING A BENEFICIAL RELATIONSHIP Bivariate relationships between study characteristics and the reporting of beneficial effects from HDHPs are presented in Appendix Exhibit A10.[13] We found that analyses focusing on outcomes related to prevention or medication adherence were significantly less likely to report a beneficial effect from the plans. Similarly, analyses that used a managed care cohort as a comparison group, used data from adult populations only, used data from a single employer, or were published in health policy and health services research journals (as opposed to clinical journals) were significantly less likely to report a beneficial effect from the plans. In contrast, analyses that examined health care costs, investigated plans with deductibles lower than $2,000 for an individual, and had the largest sample sizes for the HDHP group were significantly more likely to find a beneficial effect from the plans.

Discussion

To our knowledge, this is the first systematic review of the literature examining the relationship between high-deductible health plans and health care use. The results of our review show that the plans appear to reduce health care costs by decreasing the use of both appropriate (such as cancer screening) and inappropriate (such as low-severity ED visits) health services. Our findings are consistent with a large body of evidence on cost sharing, including the RAND Health Insurance Experiment.[5,6,44,45] Our review highlights the adverse effect of HDHPs on the use of preventive services. Enrollees in current HDHPs must meet a relatively large deductible, which encourages them to consider the opportunity costs of choosing between alternative health care options. Anna Dixon and colleagues conducted a survey and found that HDHP members change their health care behavior and forgo needed care to save money.[46] Thus, it is important to understand the relationship between beneficial and adverse health care use in the context of the plans. Most proposals to reform the US health care system stress the importance of providing preventive services with no out-of-pocket spending.[3,47] However, such health insurance reform efforts alone might not be sufficient, as research has shown that a majority of HDHP members are unaware of cost-sharing exemptions for preventive care.[48]

Several of the included studies demonstrated a reduction in medication adherence with HDHPs, and this finding was supported in our bivariate analysis. While some studies showed a reduction in health care use and adherence in low-income or chronically ill patients,[25,38] no definite conclusions can be drawn—given the relatively small number of studies that specifically focused on vulnerable populations.

An important finding of our systematic review is that studies using managed care cohorts as comparison groups were significantly less likely to find a beneficial effect from HDHPs. This finding may be driven by the fact that managed care plans have their own utilization control mechanisms that may achieve results similar to those of the mechanisms inherent in the HDHPs. For instance, both health maintenance organization and preferred provider organization plans typically impose higher out-of-pocket spending limits on enrollees who seek care from out-of-network providers. Currently, little is known about the impact of HDHPs offered concurrently with managed care plans.

Our review also found that studies using data from a single employer were significantly less likely to report a beneficial effect of HDHPs, compared with studies that included enrollees from multiple employers. This finding suggests several important points. First, the effects of the plans may be generalizable to larger populations. This is due to the fact that data from multiple employers are more likely to include a diverse set of enrollees (in terms of characteristics such as age, sex, and comorbidities). Second, studies of limited populations, including those derived from single employers, should be evaluated in their contexts. Third, characteristics of

the HDHP and comparator plans used in the single-employer analyses may be affecting this finding, which should be interpreted with caution.

An important contribution of our systematic review is the identification of areas for future research. Most of the included studies examined the effects of HDHPs on health care use and costs and did not consider important outcomes such as health status, morbidity, mortality, or patient experience. Although improving the US health care system will require achieving the simultaneous goals of cost reduction and quality improvement, overall population health should be the ultimate goal. Therefore, future studies should comprehensively examine the effects of HDHPs on the health and well-being of individuals and populations. Furthermore, about 25 percent of the studies did not include information about the deductible amount for the plan used in the analysis. Future studies should include detailed features of the plans in their design and assess how these features may be affecting various health outcomes of interest.

Our findings are also relevant to the changing political landscape, given recent congressional efforts to repeal and replace the ACA. Many health reform proposals, including the American Health Care Act of 2017, which was passed by the House of Representatives, aim to make HDHPs with health savings accounts more attractive for consumers by raising the annual contribution limits and reducing the Internal Revenue Service (IRS) penalty if funds are used for nonmedical purposes. With more consumers purchasing such plans, concerted efforts need to be made to educate the public on coverage and benefits. Legislative developments related to funding of the ACA's cost-sharing reduction payments to insurers will also have an impact on the insurance landscape.[49]

Conclusion

Current evidence on high-deductible health plans suggests that they are associated with lower health care costs resulting from a reduction in enrollees' use of health services. This includes appropriate care, such as recommended preventive services and medication adherence. Our summary of the literature is consistent with existing evidence that demonstrates a decrease in the use of necessary care with increased cost sharing. However, more research is needed to assess the effects of HDHPs on health outcomes in the longer term. ■

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