Reports and Research

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Reducing Premiums and Maximizing the Stabilization of Individual Markets for 2019 and Beyond: State Invisible High-Risk Pools/Reinsurance

One of the best routes to lower premiums for consumers and give improved stability to insurance carriers is to provide adequate federal funding for invisible high risk pools or reinsurance (hereafter "reinsurance"). The following three critical elements would help ensure carrier participation and substantially lower premiums.

1. **Programs should be adequately funded for at least two years, with recognition of the leveraging effects of net federal spending due to a reduction of premiums.**

   Proposals to fund reinsurance with net federal funding of $5 billion would result in a gross reinsurance amount of between $12 and $15 billion depending on the claims experience for the given year. This net funding would reduce consumer premiums by on average 12 percent with an expected state-specific range of 9 to 16 percent depending on the circumstances of each state's enrollment and risk profile. Such premium relief is critically needed given the removal of the individual mandate. Legislation prescribing the nature and level of federal funding for reinsurance could address this by explicitly providing that the appropriated funding is the "net" amount (e.g., the "scorable" amount after reductions in federal spending from decreased spending for Advanced Premium Tax Credits due to reductions in premiums).

2. **Provisions should allow for state-based initiatives and state flexibility while providing a commonly administered reinsurance program for non-applying states.**

   Fostering and encouraging state-based solutions is vital. At the same time, where states do not have the ability to manage and implement a reinsurance program, the states' residents should still benefit from the premium reductions and market stability that results from reinsurance-type mechanisms. Assuring that all Americans benefit from this program could be done by including legislative protections for residents of states that do not opt to submit for funding under the 1332 waiver process. A reinsurance program for states that do not apply, similar to that used for the reinsurance program administered for states in 2014, could assure that the residents of those states would still benefit from lower premiums and more plan competition.

3. **A single risk pool should be maintained to avoid risk selection and a return to insurance markets with care that is unaffordable or unavailable to many consumers.**

   Implementation of reinsurance programs should be done within each state's single risk pool for the individual market to ensure that health plans balance their risk mix with healthy and sick individuals from all of their products. Otherwise, insurance carriers could return to focusing on risk selection as the way to succeed in the individual market, instead of succeeding by providing high-value health care. Prior to 2014, carriers segregated high-risk consumers into separate risk pools that experienced substantial annual rate increases. Because the single risk pool requires carriers to consider the cost of all their enrollees, sicker consumers are protected from facing a major premium increase.

ADDENDUM: Reinsurance or High-Risk Pools as Cost Effective Paths to Promote Market Stabilization

Reinsurance, state-based high risk pools or similar types of risk-spreading mechanisms have been recognized by both Republicans and Democrats as potentially critical tools to promote stability in the individual health insurance market. In 2014, a temporary federal reinsurance program with approximately $8 billion in nominal funding had the effect of lowering premiums approximately 10 to 12 percent below what they would have been otherwise. This funding helped offset the higher costs of the known worse health risk in the non-group market and also helped "prime the pump" by encouraging more people to sign up for coverage given the lower rates.

Bipartisan legislation introduced in the Senate (S. 1835 Collins-Nelson) would fund state-based invisible high-risk pools or reinsurance programs. Policies such as these would provide state flexibility and stability to the market directly benefiting the entire individual market, both on- and off-exchange (for enrollees who do and do not receive a subsidy). This would stabilize the insurance market and reduce premiums for millions of Americans who do not benefit directly from the Affordable Care Act's subsidies now. In addition, these mechanisms could partially offset the likely premium spikes that would result from the repeal of the mandate penalty — impacts that will be primarily felt by middle class Americans who do not qualify for tax credits that can help make insurance more affordable. Market-stabilization funds would increase the likelihood that plans would stay in the individual market.

This analysis describes the cost to the federal government, the impacts on premiums and the mechanics that would be involved if stability funding is provided to the carriers. The descriptions that follow model the potential premium and budget impacts of an annual $5 billion "net" federal funding for risk stabilization in 2019 and 2020. This would translate into a nominal (before the reduction APTC subsidies) risk-stabilization fund of between $12 billion and $15 billion per year. The total two-year $10 billion cost to the federal government is less than the nominal funding amount because it would reduce premiums and thus similarly reduce federal payments for Advanced Premium Tax Credits (APTC).

Reinsurance funded at the net (after APTC offsets) $5 billion level would reduce 2019 premiums by an average of 12 percent with an expected state-specific range of 9 to 16 percent depending on the circumstances of each state's enrollment and risk profile. What follows is a step-by-step review of the assumptions and logic behind the benefits and federal costs of using the risk-stabilization reinsurance mechanism:

Critical Steps to Assessing Federal Spending Risk Stabilization Using Reinsurance:

1. Consistent with the 2014 reinsurance program trended forward to 2019, $5 billion in net funding (the "scorable" amount of increased federal spending after taking into account premium reduction and associated decline in APTC subsidies) would lead to an average reduction in premiums on- and off-exchange of approximately 12 percent, depending on the circumstances of each state's enrollment and risk profile.
2. A premium reduction of 12 percent would reduce the second lowest-cost Silver plan, the benchmark for the APTC and its associated subsidy costs by an equivalent amount. The entire nominal reinsurance funding would not all go toward reducing the APTC amount because:
    a. Some of the plans that qualify for the second-lowest-cost Silver plan are more "efficient" than the average plan, so their reduction in premium from reinsurance is actually lower than the 12 percent average reduction for all plans.
    b. Some of the reinsurance goes to off-exchange plans and to individuals on-exchange who are unsubsidized, which has no direct effect on the APTC (although it benefits unsubsidized consumers).

ADDENDUM: Reinsurance or High-Risk Pools as Cost Effective Paths to Promote Market Stabilization

3. Taking into account the two reduction factors in 2(a) and 2(b) above, modeling shows that between 67 and 75 percent of the risk stabilization fund would contribute to a reduction in APTC funding (lowering the second-lowest-cost Silver plan).

Note that the reinsurance analysis above is independent of other premium factors, such as policies for funding cost-sharing reductions and enforcement of the individual mandate. The penalty has distinct positive effect of promoting enrollment and improving the risk mix of the individual market, leading to lower premiums. Given estimates that non-enforcement of the penalty could itself result in premium increases of 8 percent to over 13 percent depending on the carrier and state local circumstances, reinsurance funding at the level described above could greatly mitigate the premium impacts of that policy change. It is likely that state-based high-risk pool mechanisms would have a similar impact, but separate modeling for the magnitude of their effect may be needed.

This analysis was prepared by John Bertko, chief actuary for Covered California. For questions, please contact Vishaal Pegany at vishaal.pegany@covered.ca.gov.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Keith Hall, Director

November 29, 2017

Honorable Patty Murray
Ranking Member
Committee on Health,
Education, Labor and Pensions
United States Senate
Washington, DC 20510

Re: The Bipartisan Health Care Stabilization Act of 2017 and the Individual Mandate

Dear Senator:

In October 2017, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) published a cost estimate for the Bipartisan Health Care Stabilization Act of 2017 (BHCSA), and in November 2017 the agencies published an updated estimate for repealing the individual health insurance mandate.[1] This letter responds to your request for additional information about those estimates.

In your letter of November 21, 2017, you asked about the combined effects of simultaneously passing the BHCSA and legislation that would repeal the requirement that most U.S. citizens and noncitizens who lawfully reside in the country have health insurance meeting specified standards. Specifically, you asked if legislation that combined the provisions would change the agencies' previous estimates of the number of people with insurance coverage or premiums in the nongroup insurance market.

In the estimate for the BHCSA, the agencies wrote that, relative to the Summer 2017 baseline, the legislation would not substantially change the number of people with health insurance coverage, on net. Because CBO's baseline incorporates the assumption that cost-sharing reductions (CSRs) will be fully funded, premiums would not change under the BHCSA relative to that baseline. In the estimate of repealing the individual health insurance mandate, the agencies wrote that repealing the mandate would

1. Congressional Budget Office, *Bipartisan Health Care Stabilization Act of 2017* (October 2017), www.cbo.gov/publication/53232; and *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (November 2017), www.cbo.gov/publication/53300.

result in a decrease of the number of people with health insurance of 4 million in 2019 and 13 million in 2027. In addition, the agencies estimated that 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 Summer 2017 baseline projections.

If legislation were enacted that incorporated both the provisions of the Bipartisan Health Care Stabilization Act and a repeal of the individual mandate, the agencies expect that the interactions among the provisions would be small; the effects on premiums and the number of people with health insurance coverage would be similar to those referenced above.

I hope that you find this information helpful; if you wish to have further information we will be pleased to provide it. The primary staff contacts for this analysis are Kate Fritzsche and Sarah Masi.

Sincerely,

Keith Hall
Director

cc: Honorable Lamar Alexander
Chairman

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January 2018 | Issue Brief

Individual Insurance Market Performance in Late 2017

Cynthia Cox, 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 began to regain profitability.

In this brief, we look at recently-released third 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 nine months of 2017 offer further evidence that the individual market has been stabilizing and insurers are regaining profitability, even as political and policy uncertainty and the repeal of the individual mandate penalty as part of tax reform legislation cloud expectations for 2018 and beyond.

Third quarter financial data reflects insurer performance in 2017 through September, before the Administration ceased payments for cost-sharing subsidies effective October 12, 2017. The loss of these payments during the fourth quarter of 2017 will diminish insurer profits, but nonetheless, insurers are likely to see better financial results in 2017 than they did in earlier years of the ACA Marketplaces.

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 third quarter 2011 through third quarter 2017 in the individual insurance market.[1] Third quarter data is year-to-date from January 1 – September 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.

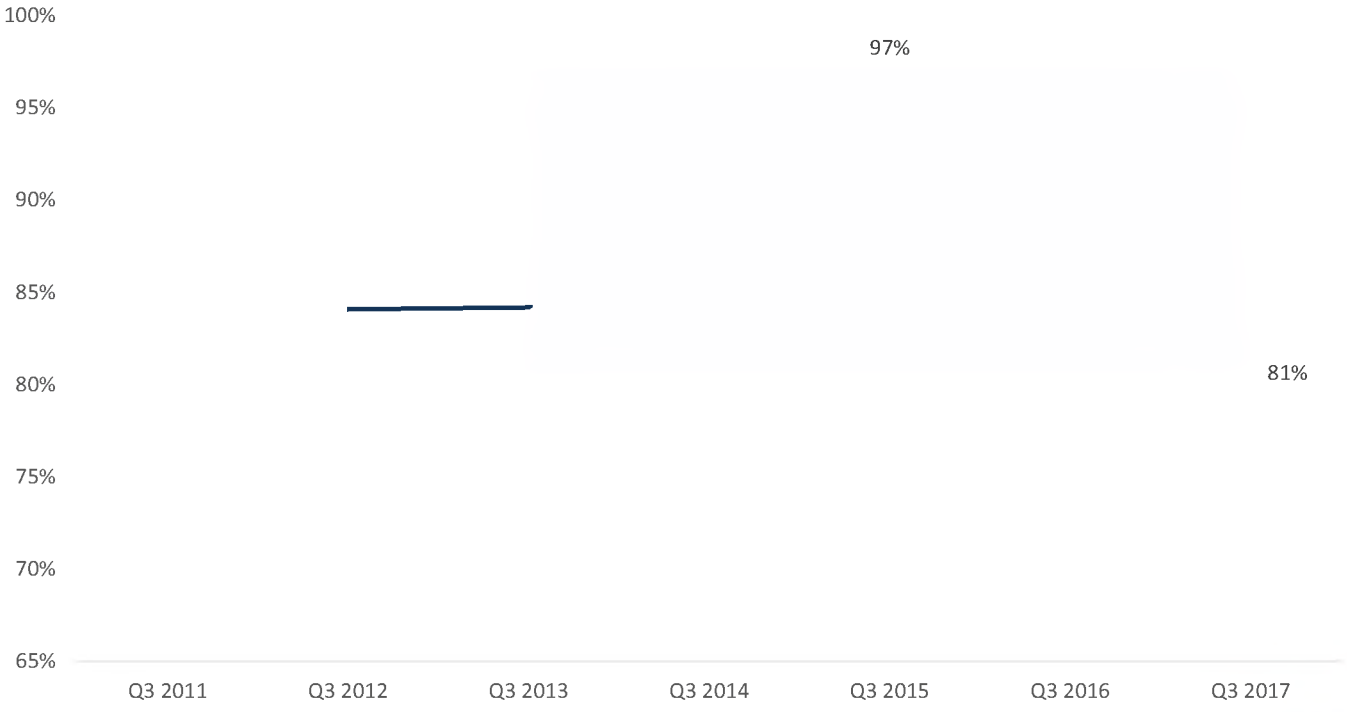
Medical Loss Ratios

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 Marketplaces, 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 81% through the third quarter. Third 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 likely to be impacted by the loss of cost-sharing subsidy payments during the last three months of the year, this is nevertheless a sign that individual market insurers on average were beginning to stabilize in 2017.

Figure 1

Average Third Quarter Individual Market Medical Loss Ratios, 2011 - 2017



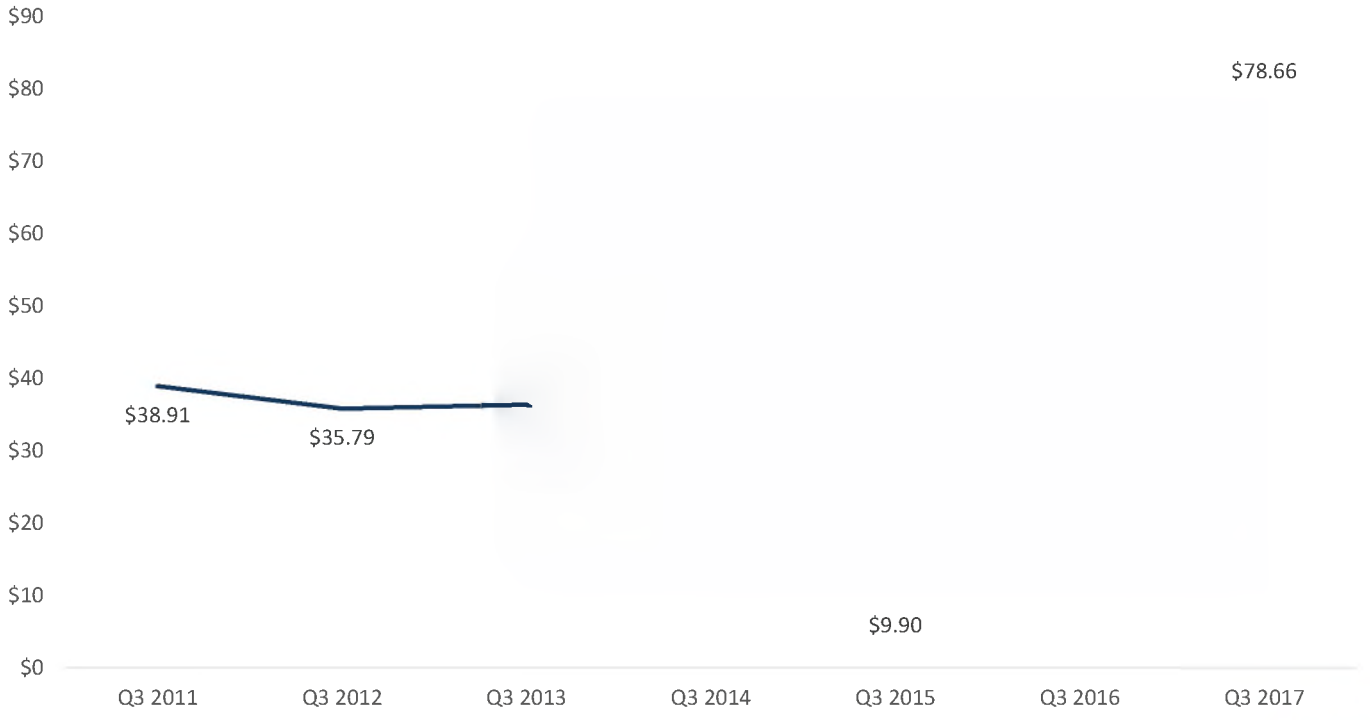
Note: Q3 data is year-to-date from January 1 – September 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM. Note: Figures above represent simple loss ratios and differ from the definition of MLR in the Affordable Care Act

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, third 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 Third Quarter Individual Market Gross Margins Per Member Per Month, 2011 - 2017



Note: Q3 data is year-to-date from January 1 – September 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

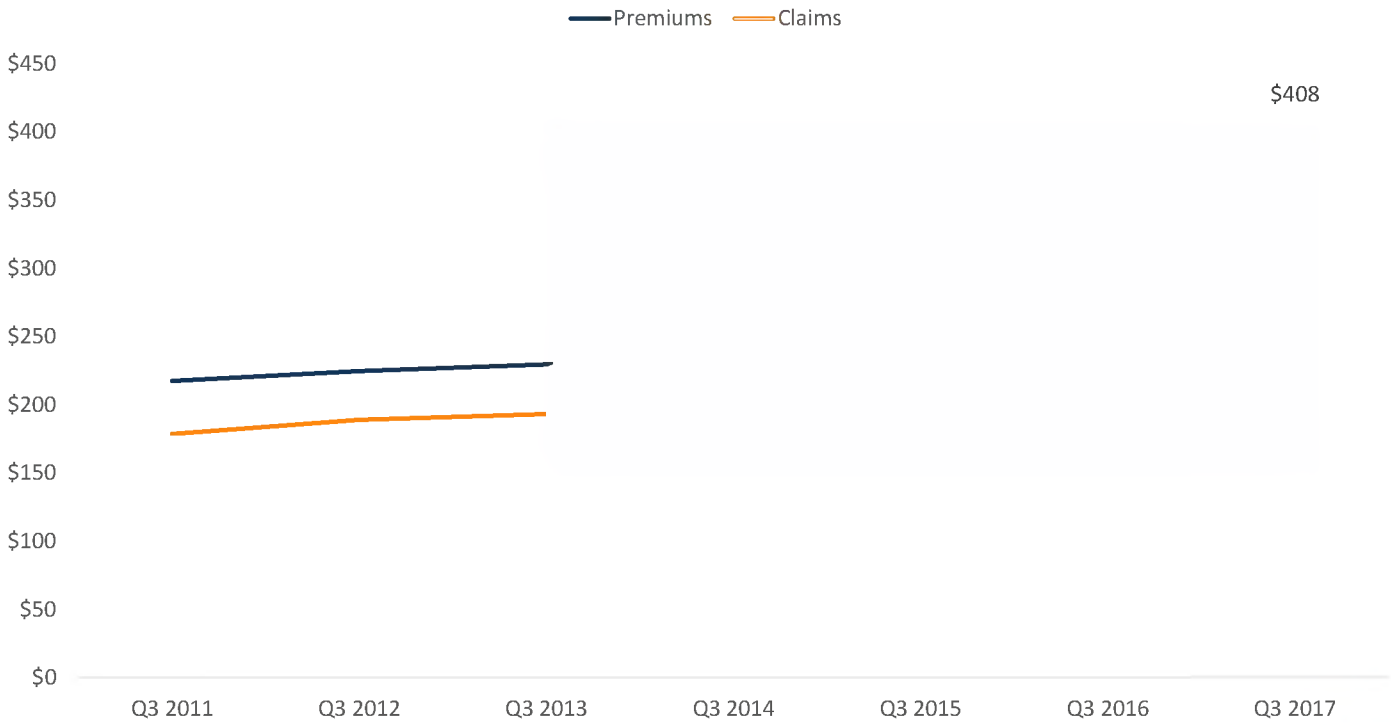
Looking at gross margins, we see a similar pattern as we did looking at loss ratios, where insurer financial performance improved dramatically through the third quarter of 2017 (increasing to $79 per enrollee, from a recent third quarter low of $10 in 2015). Again, third quarter data tend to indicate the general direction of the annual trend, and while annual 2017 margins are unlikely to end as high as they are in the third 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 17% from third quarter 2016 to third quarter 2017, while per person claims grew only 4%.

Figure 3

Average Third Quarter Individual Market Monthly Premiums and Claims Per Person, 2011 - 2017



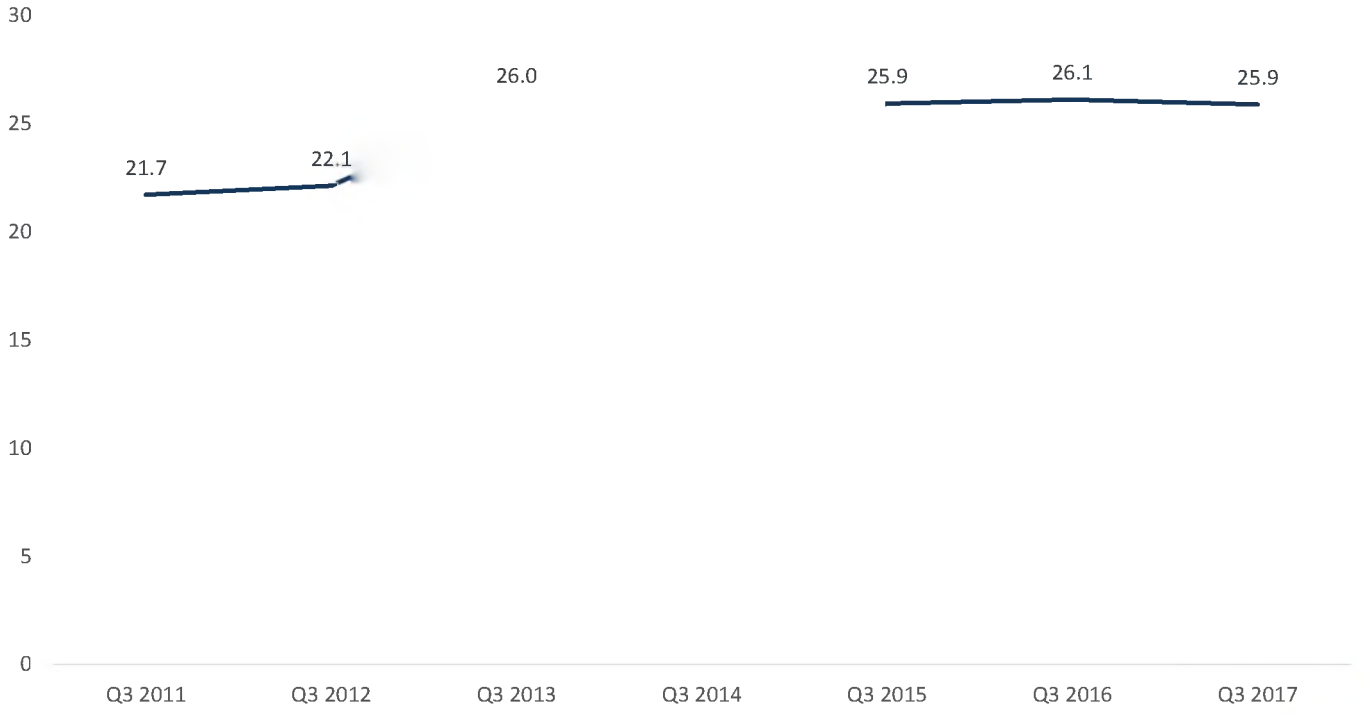
Note: Q3 data is year-to-date from January 1 – September 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

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 third quarter of 2017, it does not appear that the enrollees today are noticeably sicker than last year.

On average, the number of days individual market enrollees spent in a hospital through the third quarter of 2017 was similar to third quarter inpatient days in the previous two years. (The third 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 Third Quarter Individual Market Monthly Hospital Patient Days Per 1,000 Enrollees, 2011 - 2017



Note: Q3 data is year-to-date from January 1 – September 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

Third quarter results from 2017 suggest the individual market was stabilizing and insurers in this market were regaining profitability. Insurer financial results as of the third quarter 2017 – before the Administration's decision to stop making cost-sharing subsidy payments and before the repeal of the individual mandate penalty in the tax overhaul – showed no sign of a market collapse. Third 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 late 2017. Some insurers have exited the market in recent years, 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. The decision by the

Administration to cease cost-sharing subsidy payments led 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. Signups through the federal marketplace during the recently completed open enrollment period were higher than many expected, which could help to keep the market stable. However, continued policy uncertainty and the repeal of the individual mandate as part of tax reform legislation complicate the outlook for 2018 and beyond.

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 third quarter but did file third 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 third 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, third 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.

A Century of Advancing Health Care for All

What's at Stake: States' Progress on Health Coverage and Access to Care, 2013–2016

December 14, 2017

Authors

Susan L. Hayes, Sara R. Collins, David Radley, Douglas McCarthy

Citation

S. L. Hayes, S. R. Collins, D. C. Radley, and D. McCarthy, *What's at Stake: States' Progress on Health Coverage and Access to Care, 2013–2016,* The Commonwealth Fund, December 2017.

Abstract

- **Issue:** Given uncertainty about the future of the Affordable Care Act, it is useful to examine the progress in coverage and access made under the law.
- **Goal:** Compare state trends in access to affordable health care between 2013 and 2016.
- **Methods:** Analysis of recent data from the U.S. Census Bureau and the Behavioral Risk Factor Surveillance System.
- **Findings and Conclusions:** Between 2013 and 2016, the uninsured rate for adults ages 19 to 64 declined in all states and the District of Columbia, and fell by at least 5 percentage points in 47 states. Among children, uninsured rates declined by at least 2 percentage points in 33 states. There were reductions of at least 2 percentage points in the share of adults age 18 and older who reported skipping care because of costs in the past year in 36 states and D.C., with greater declines, on average, in Medicaid expansion states. The share of at-risk adults without a recent routine checkup, and of nonelderly individuals who spent a high portion of income on medical care, declined in at least of half of states and D.C. These findings offer evidence that the ACA has improved access to health care for millions of Americans. However, actions at the federal level —

including a shortened open enrollment period for marketplace coverage, a failure to extend CHIP funding, and a potential repeal of the individual mandate's penalties — could jeopardize the gains made to date.

Background

The year 2017 marked a turning point in the implementation of the Affordable Care Act. Republicans in Congress attempted to repeal and replace the Affordable Care Act numerous times, ultimately failing but promising to try again. In addition, the Trump administration significantly cut funding for outreach and enrollment activities during 2018's open enrollment period for the marketplaces, and disrupted markets by declining to pay insurers money owed to them for providing cost-reduced plans for lower-income enrollees. In December, Senate Republicans passed a tax bill that included a provision to repeal the ACA's individual mandate penalties, paid by most people who do not have health insurance. Given these developments, many Americans are confused about the ACA's status, which could reduce the number of people who enroll in health plans for the coming year, despite strong enrollment thus far.

It is useful to assess the changes in coverage and access that happened across states under the law before this tumultuous year. Between 2013, the year before the ACA's major coverage expansions took effect, and the end of 2016, the number of uninsured Americans under age 65 fell by an estimated 17.8 million.[1](#/#1) Uninsured rates declined in every state and the District of Columbia (Exhibit 1).

In this issue brief, we examine the extent to which health care access and affordability improved from 2013 to 2016 for residents in each of the 50 states and D.C. We use six indicators: uninsured rates for working-age adults and for children, three measures of adults' access to care, and the percentage of individuals under age 65 with high out-of-pocket medical costs relative to their income (Exhibit 2). These measures align with those reported in the Commonwealth Fund's ongoing series of *Health System Performance Scorecards (/publications/health-system-scorecards)*.

Findings

Adult Uninsured Rates Reach Record Lows

In 2016, in 47 states, the uninsured rate for adults ages 19 to 64 was at least 5 percentage points lower than it had been in 2013, before the ACA coverage expansions. In the remaining three states and the District of Columbia, the rate was lower, but by a lesser margin (Exhibit 3, Appendix Table 1 (/~/media/files/publications/issue-brief/2017/dec/hayes_2017_state_access_and_coverage_appendix_tables.pdf?la=en)).

Roughly a quarter of states experienced double-digit improvement in their adult uninsured rate, led by New Mexico, where it plummeted from 28 percent to 13 percent over the three-year period. Eleven of the 13 states that experienced at least a 10-percentage-point drop had expanded Medicaid by January 2016. The two exceptions were Florida, which has not expanded Medicaid but enrolled more people in the marketplace than any other state, and Louisiana, which expanded Medicaid in July 2016.

By the end of 2016, in 21 states and District of Columbia, fewer than one of 10 working-age adults lacked health coverage. Three years earlier, that was only true in Massachusetts and D.C. In 2013, at least one of five working-age adults was uninsured in 22 states but by 2016 this was only the case in Oklahoma and Texas.

For the majority of states, the rates fell the most during the first two years of the coverage expansions. In Montana and Louisiana, which implemented the Medicaid expansion the most recently, the rates dropped 4 and 3 percentage points, respectively, between 2015 and 2016.

Uninsured Rates Drop Substantially for Adults with Low Incomes, Especially in Expansion States

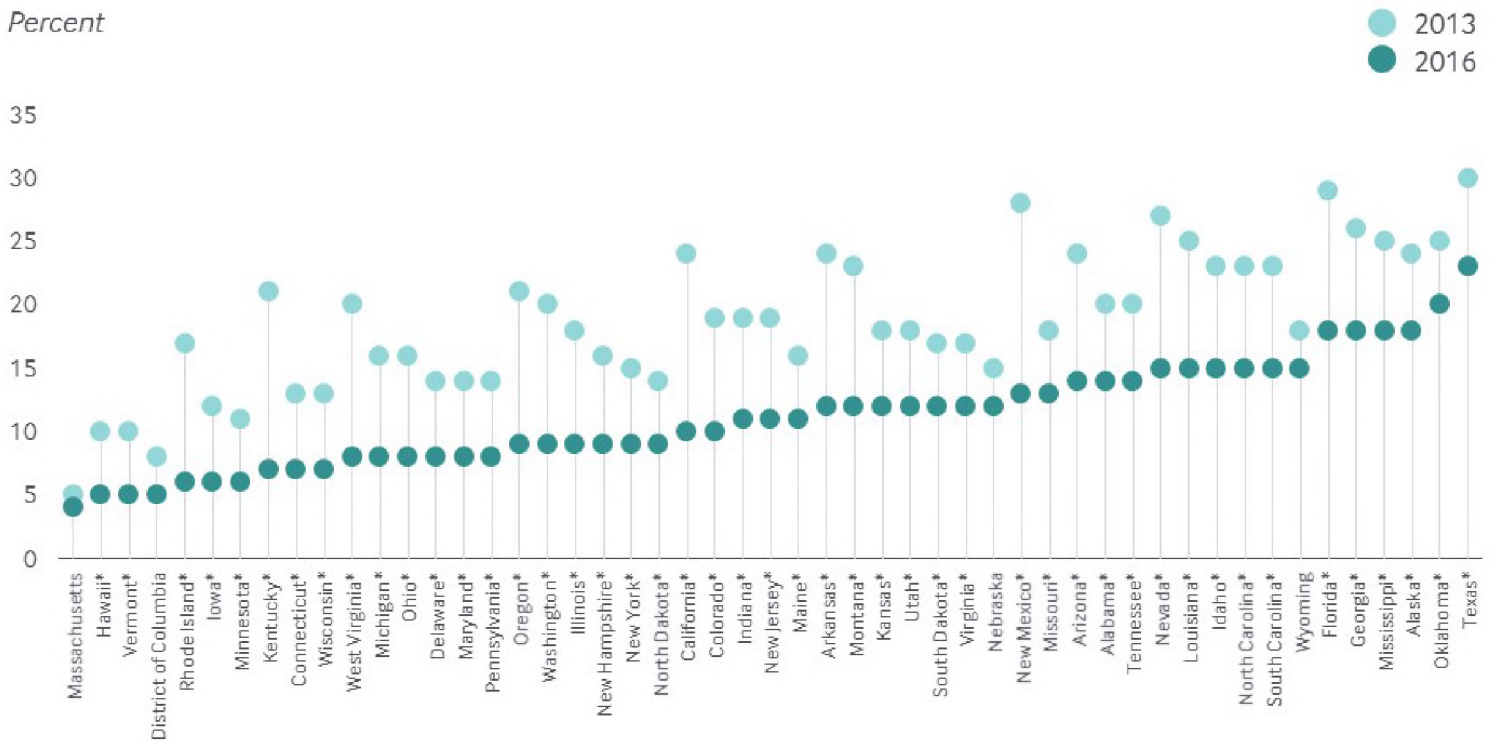
Historically, working-age adults with low incomes have had the greatest risk of being uninsured. The Affordable Care Act's income-related insurance reforms were targeted to help them. From 2013 to 2016, the national uninsured rate among adults 19 to 64 with incomes below 200 percent of the federal poverty level fell from 38 percent to 23 percent. This meant an estimated 9.9 million more low-income adults had health insurance in 2016 than in 2013.

As expected, the gains were greatest in states that chose to expand Medicaid. Nine expansion states slashed their uninsured rate among adults with low incomes by more than 20 percentage points (Exhibit 4, Appendix Table 2 (/~/media/files/publications/issue-brief/2017/dec/hayes_2017_state_access_and_coverage_appendix_tables.pdf?la=en)).

By 2016, the uninsured rate among low-income adults was 15 percent or less in a third of states and the District of Columbia. With the exception of Wisconsin, all have expanded Medicaid.[2 (#/#2)] In contrast, the rate was more than 30 percent in Alaska, Florida, Georgia, Mississippi, Oklahoma, and Texas. Of these, only Alaska has expanded Medicaid. In all six, a lack of awareness of the marketplaces and the availability of subsidized coverage likely contributed to the high rates.[3 (#/#3)]

Exhibit 3

The Uninsured Rate for Working-Age Adults Declined in Every State



Note: States are arranged in rank order based on their current data year (2016) value. For the purposes of this exhibit, we count the District of Columbia as a state.
* Denotes states with at least −0.5 standard deviation change (decrease of at least 5 percentage points) between 2013 and 2016.
Data source: U.S. Census Bureau, 2013 and 2016 1-Year American Community Surveys, Public Use Micro Sample (ACS PUMS).

The Commonwealth Fund

Source: S. L. Hayes, S. R. Collins, D. Radley, and D. McCarthy, *What's at Stake: States' Progress on Health Coverage and Access to Care, 2013–2016*, The Commonwealth Fund, December 2017.

More Children Get Covered

For years, uninsured rates among children under 19 have been much lower than those for working-age adults, thanks largely to the Children's Health Insurance Program (CHIP), enacted with bipartisan support in 1997, and to higher Medicaid income eligibility levels for children.

Even so, the nation made more progress toward ensuring all children have health insurance between 2013 and 2016. Nationally, the uninsured rate for children dropped from 8 percent to 5 percent; two-thirds of states saw their rates drop by at least 2 percentage points. The biggest reductions came in Nevada (8 percentage points) and Montana (6 percentage points) (Exhibit 5, Appendix Table 1 (/~/media/files/publications/issue-brief/2017/dec/hayes_2017_state_access_and_coverage_appendix_tables.pdf?la=en)).

Not all states were as successful. North Dakota children's uninsured rate was 2 percentage points higher in 2016 than in 2013, and Alaska's rate increased by 2 points between 2015 and 2016. Both states join Texas in having a children's uninsured rate of at least 10 percent.

Fewer Adults Face Cost Barriers to Care

The ACA aimed not only to cover more people, but to improve access to care by reducing financial barriers. Between 2013 and 2016, there was a reduction in the share of adults age 18 and older who reported a time in the last year when they had not gone to the doctor when needed because of cost. This rate fell from 16 percent to 13 percent nationally, and decreased by 2 percentage points or more in nearly three-quarters of states and the District of Columbia (Exhibit 6, Appendix Table 1 (/~/media/files/publications/issue-brief/2017/dec/hayes_2017_state_access_and_coverage_appendix_tables.pdf?la=en)).

The greatest reductions (5 to 7 percentage points) were in Arkansas, California, Kentucky, New Mexico, Oregon, Tennessee, and Washington. Except for Tennessee, these states all expanded Medicaid as soon as federal resources became available in January 2014 and were among the states with the largest improvement in adult uninsured rates.

Medicaid expansion made a clear difference in reducing cost barriers to care for low-income and minority adults (Exhibit 7, Appendix Table 2 (/~/media/files/publications/issue-brief/2017/dec/hayes_2017_state_access_and_coverage_appendix_tables.pdf?la=en)). For example, between 2013 and 2016, far fewer low-income adults went without care because of costs in states that expanded Medicaid than did low-income adults in states that did not.

As with uninsured rates, states' progress on this measure was concentrated in the first two years of the coverage expansions. Most states held the line last year, but in Louisiana, Maine, and Wyoming, the share of adults who went without care because of costs increased by 2 percentage points between 2015 and 2016.

Fewer People Spend a Large Share of Income on Health Care

People who are uninsured often pay the full cost of their medical bills.[4 (#/#4)] Increasingly, even those with insurance are at risk for high out-of-pocket medical costs because of high-deductible plans and other cost-sharing.[5 (#/#5)] We examined how many people under age 65 (including both those insured and uninsured) were living in households that spent a high share of their annual income on medical care during 2015–2016 compared to 2013–2014 (Exhibit 8, Appendix Table 1 (/~/media/files/publications/issue-brief/2017/dec/hayes_2017_state_access_and_coverage_appendix_tables.pdf?la=en)).[6 (#/#6)] (See box for description of high out-of-pocket spending.)

As uninsured rates declined across the country, so did the share of individuals under age 65 living in households where out-of-pocket spending on medical care was high relative to income. Income growth was also a likely factor in the decline. Between 2013–2014 and 2015–2016, the percentage of people with high out-of-pocket costs declined by 2 points or more in half of states and D.C.

Alaska, Idaho, Nevada, Oregon, and Tennessee saw the greatest improvement, with a 5-to-6-percentage-point reduction. The only two states where the rate of nonelderly residents with high out-of-pocket costs substantially worsened (i.e., increased by 2 to 3 percentage points) were Alabama and Virginia.

How does the *Scorecard* define high out-of-pocket spending on medical care?

We used two thresholds to identify individuals under age 65 with high out-of-pocket spending relative to income: those living in households that spent 10 percent or more of annual income on medical expenses (excluding premiums, if insured); and people who spent 5 percent or more, if the household's annual income was below 200 percent of the federal poverty level. The measure of high out-of-pocket spending reported in this brief includes both insured and uninsured people. This population-based measure is therefore much broader than the underinsurance measure reported in other Commonwealth Fund publications, which is limited to adults ages 19–64 who are insured all year and includes a component of deductible burden.[7](#/#7)

Access to Routine Care for At-Risk Adults Improved in More Than Half of States

We also examined the share of at-risk adults — that is, those who could be at greater risk for poor health outcomes if they do not receive care — who had not visited a doctor for a routine checkup in at least two years. (See box for description of at-risk adults.) Between 2013 and 2016, this rate improved nationally, dropping from 14 percent to 12 percent. More than half of states and D.C. experienced at least a 2-percentage-point improvement.

The greatest improvement (5 points) was seen in Arizona, Arkansas, California, Kentucky, Oklahoma, and Oregon (Appendix Table 1 (/~/media/files/publications/issue-

Who are "at-risk" adults?

The at-risk group includes everyone age 50 and older, since people in that age group need recommended preventive screenings and vaccinations, and many have chronic conditions. It also includes the subset of adults ages 18 to 49 who report chronic illnesses or being in poor or fair health.

brief/2017/dec/hayes_2017_state_access_and_coverage_appendix_tables.pdf?la=en)). With the exception of Oklahoma, these states have all expanded Medicaid. In Louisiana and in Tennessee, the rate on this access measure worsened by 2 to 3 percentage points over the three years.

Little Progress in Access to Dental Care

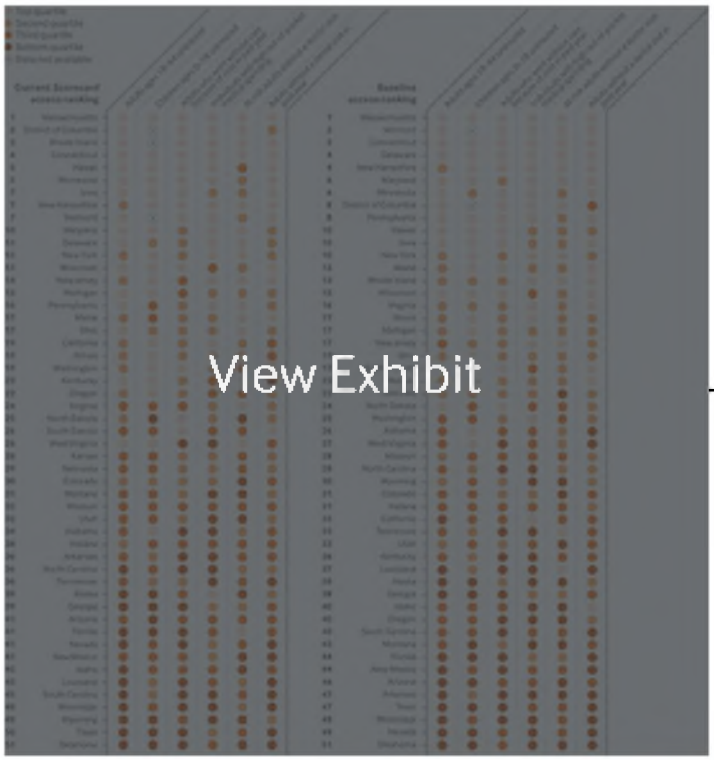
From 2012 to 2016, states showed little progress in improving access to dental care for adults. At the national level, the share of people age 18 and older who went without a dental visit in the past year remained essentially unchanged at 16 percent. The best and the worst state rates, 10 percent and 20 percent, respectively, also stayed the same (Appendix Table 1 (/~/media/files/publications/issue-brief/2017/dec/hayes_2017_state_access_and_coverage_appendix_tables.pdf?la=en)). In the U.S., dental care is typically covered under a separate policy than medical care; fewer adults have dental coverage than have health insurance.[8 (#/#8)] Moreover, the ACA did not address dental care for adults. Only six states along with D.C. improved their rates by 2 to 3 percentage points between 2012 and 2016.[9 (#/#9)] Nine other states saw their rates worsen by an equal margin over the same time period.

How States Stack Up

Looking at the states' overall rankings across all six indicators of health care access and affordability, the current top-ranked Massachusetts (1st), the District of Columbia (tied for 2nd), Connecticut (4th), and Hawaii and Minnesota (tied for 5th), were all ranked among the top 10 states in access in 2013, before the ACA's coverage expansions took effect (Exhibit 9). Rhode Island moved up to a tie for second place from 13th in 2013.

Exhibit 9

Summary of Health System Performance Across the Access Dimension



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States that had repeated success and those with the most dramatic upward shifts in rankings since the 2013 baseline period all had expanded Medicaid by January 1, 2016. Arkansas, California, Kentucky, Montana, Oregon, and Rhode Island all made double-digit jumps in ranking; Nevada moved up eight places; Washington State and D.C. each rose six places. Wyoming, a nonexpansion state, dropped 19 places, the most of any state, falling from 30th place in the baseline ranking to 49th. On average, states that expanded Medicaid by January 2016 moved up nearly three places between 2013 and the current rankings, while states that did not expand by then dropped about four spots.

Implications

After three years of the ACA's major coverage expansions, the number of uninsured working-age adults and children in the United States had fallen to a record low. This historic decline was accompanied by widespread reductions in cost-related access problems and improvements in access to routine care for at-risk adults, particularly in states that expanded Medicaid. If the 19 states that have not yet expanded Medicaid decided to expand, they could see similar positive effects for their residents.

There is no deadline for adopting the Medicaid expansion. In November, Maine residents voted to expand Medicaid under a citizen-initiated ballot referendum, indicating that popular support for expanding the program may exist in states where elected officials have rejected it. While implementation in Maine could face hurdles because of opposition from the state's governor, similar efforts are now under way in other nonexpansion states.

Actions at the federal level could, however, jeopardize the gains made under the ACA. Recent actions by the Trump administration, including a shortened open enrollment period for marketplace coverage and deep cuts in advertising and outreach, could reduce enrollment for 2018.[10 (#/#10)] In addition, Congress has yet to extend funding for the Children's Health Insurance Program, which expired at the end of September. In the absence of an extension, more than half of states are projected to run out of federal CHIP dollars by March 2018.[11 (#/#11)] The result could be a loss of coverage for millions of children.[12 (#/#12)]

Further, the tax bill passed by Senate Republicans included a repeal of the ACA's individual mandate penalties, which would mean a cancellation of the penalties owed by people who do not take up insurance. The Congressional Budget Office estimated that repealing the penalties would reduce the number of Americans with health insurance by 13 million by 2027 and significantly increase premiums for plans purchased in the individual market. This is because healthy individuals would be the most likely to forgo coverage, leaving sicker people (who are more expensive to insure) in the risk pool.[13 (#/#13)]

People who buy their own coverage on the individual market and who have incomes above 400 percent of the federal poverty level (about $48,200 for an individual and $98,400 for a family of four) — the threshold for ACA premium subsidies — would face the brunt of the premium increase.[14 (#/#14)] A recent Commonwealth Fund analysis estimates that a 40-year-old buying unsubsidized individual market coverage in one of the 39 states that uses the federally facilitated marketplace would face an average dollar increase in premiums ranging from $556 in North Dakota to $1,264 in Nebraska (Exhibit 10).[15 (#/#15)]

The findings in this issue brief offer further evidence that the Affordable Care Act has put access to health care in reach for millions of Americans, particularly for people in states that embraced the law. We will continue to monitor state trends in coverage and access to see what effect current and future policy changes will have.

Methods

The six health care access and affordability indicators reported here align with those reported in the Commonwealth Fund's ongoing series of *Health System Performance Scorecards (/publications/health-system-scorecards)*. For purposes of this analysis, we treat the District of Columbia as a state.

Indicators and Data Sources

1. *Percent of uninsured adults ages 19–64.*
   Data source: Authors' analysis of U.S. Census Bureau, 2013, 2014, 2015, and 2016 1-Year American Community Surveys, Public Use Microdata Sample (ACS PUMS).

2. *Percent of uninsured children ages 0–18.*
   Data source: Authors' analysis of U.S. Census Bureau, 2013, 2014, 2015, and 2016 1-Year American Community Surveys, Public Use Microdata Sample (ACS PUMS).

3. *Percent of adults age 18 and older who went without care because of cost during past year.*
   Data source: Authors' analysis of 2013, 2014, 2015, and 2016 Behavioral Risk Factor Surveillance System.

4. *Percent of individuals under age 65 with high out-of-pocket medical spending relative to their annual income.*
   This measure includes both insured and uninsured individuals. Two years of data are combined to ensure adequate sample size for state-level estimation.
   Data source: Ougni Chakraborty, Robert F. Wagner School of Public Service, New York University, analysis of 2014, 2015, 2016, and 2017 Current Population Survey, Annual Social and Economic Supplement.

5. *Percent of at-risk adults (all adults age 50 and older and adults ages 18–49 who are in fair or poor health or who were ever told they have diabetes or pre-diabetes, acute myocardial infarction, heart disease, stroke, or asthma) without a routine doctor visit in past two years.*
   Data source: Authors' analysis of 2013, 2014, 2015, and 2016 Behavioral Risk Factor Surveillance System.

6. *Percent of adults age 18 and older without a dental visit in the past year.*
   Data source: Authors' analysis of 2012, 2014, and 2016 Behavioral Risk Factor Surveillance System.

Measuring Change over Time

We considered an indicator's value to have changed if it was at least one-half (0.5) of a standard deviation larger than the difference in rates across all states over the two time periods being compared.

Scoring and Ranking

We averaged state rankings for the six indicators to determine a state's access and affordability dimension rank. More information on Scorecard methodology and indicator descriptions and source notes can be found in *Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance, 2017 Edition (/publications/fund-reports/2017/mar/2017-state-scorecard)*.

Notes

[1] Authors' analysis of ACS 2016 1-Year Estimates and 2013 1-Year Estimates.

[2] Wisconsin is unique compared to other nonexpansion states in that it has higher Medicaid eligibility thresholds; for example, Wisconsin provides Medicaid coverage to childless adults with incomes up to 100 percent of the federal poverty level.

[3] The Commonwealth Fund's most recent ACA tracking survey found 40 percent of uninsured adults were not aware of the health insurance marketplaces. 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).

[4] *Hidden Costs, Value Lost: Uninsurance in America (https://www.nap.edu/catalog/10719/hidden-costs-value-lost-uninsurance-in-america)* (National Academies Press, June 2003).

[5] 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 (/publications/issue-briefs/2017/oct/insurance-coverage-consumers-health-care-costs)* (The Commonwealth Fund, Oct. 2017).

[6] Two years of data were combined to ensure adequate sample size at the state level.

[7] The *Scorecard*'s measure of high out-of-pocket medical costs relative to income is a different measure than the Underinsurance measure in the Commonwealth Fund's Biennial Health Insurance Survey. (See 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 (/publications/issue-briefs/2017/oct/insurance-coverage-consumers-health-care-costs)* (The Commonwealth Fund, Oct. 2017.)) The *Scorecard* measure includes both uninsured and insured people ages 0–64 while the underinsurance measure is restricted to adults (ages 19–64) who have insurance. The *Scorecard* measure also captures only adults and children in households that incurred out-of-pocket costs. It does not capture, as the underinsurance measure does, those who did not seek care but who are at potential risk of high expenditures because their health insurance plan has a deductible that is large relative to their household income.

[8] National Association of Dental Plans, *Who Has Dental Benefits Today? (http://www.nadp.org/Dental_Benefits_Basics/Dental_BB_1.aspx)* (NADP, n.d.).

[9] In the Behavioral Risk Factor Surveillance System survey, the question on dental visits is asked every other year (in even years), so the data years for this indicator are 2012, 2014, and 2016.

[10] E. Curran and J. Giovannelli, "State-Based Marketplaces Push Ahead, Despite Federal Resistance (/publications/blog/2017/nov/state-based-marketplaces-push-ahead)," *To the Point,* The Commonwealth Fund, Nov. 2, 2017.

[11] Medicaid and CHIP Payment and Access Commission, *Federal CHIP Funding: When Will States Exhaust Allotments? (https://www.macpac.gov/publication/federal-chip-funding-when-will-states-exhaust-allotments/)* (MACPAC, July 2017).

[12] S. Rosenbaum, "What's Next for CHIP? (/publications/blog/2017/oct/whats-next-for-chip)" *To the Point,* The Commonwealth Fund, Oct. 18, 2017.

[13] Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate (https://www.cbo.gov/publication/53300)* (CBO, Nov. 2017).

[14] S. R. Collins, M. Z. Gunja, and H. K. Bhupal, "New Analysis Finds Senate Tax Bill Results in Premium Increases for Many Who Buy Their Own Coverage; Wealthiest to Benefit Most from Any Offsettng Tax Cuts (/publications/blog/2017/nov/senate-tax-bill-will-raise-premiums-for-many-who-buy-their-own-coverage)," *To the Point,* The Commonwealth Fund, Nov. 21, 2017.

[15] Ibid.

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TO THE POINT
Quick Takes on Health Care Policy and Practice

Young Adults Will Be Among the Last-Minute ACA Enrollees This Week: How Have the Coverage Expansions Affected Them?

Tuesday, December 12, 2017



By Munira Z. Gunja (/about-us/experts/gunja-munira-z), Sophie Beutel (/about-us/staff-contact-information/program-staff/program-support/beutel-sophie) and Sara R. Collins (/about-us/staff-contact-information/program-staff/senior-program-research-staff/collins-sara-r)

Open enrollment in the Affordable Care Act (ACA) marketplaces ends this Friday in the 39 states that use HealthCare.gov. Based on past open enrollment periods, the deadline may trigger a surge in marketplace visitors this week. Many of these last-minute enrollees will be young adults ages 19–34.

Ten states have extended their sign-up periods.

California	January 31
Colorado	January 12
Connecticut	December 22
D.C.	January 31
Maryland	December 22
Massachusetts	January 23
Minnesota	January 14
New York	January 31
Rhode Island	December 31

Young adults have made the largest gains in insurance coverage of any age group since the ACA went into effect, according to Commonwealth Fund and federal surveys. The Commonwealth Fund's Affordable Care Act Tracking Survey (http://www.commonwealthfund.org/interactives-and-data/surveys/affordable-care-act-tracking-surveys) and Biennial Health Insurance Survey (http://www.commonwealthfund.org/interactives-and-data/surveys/biennial-health-insurance-surveys) also found this new coverage is making it possible for young adults to afford and receive

health care. Yet the much shorter open enrollment period for the marketplaces this year — along with the tax bill's repeal of the individual mandate penalties — could erode coverage among young adults of all income levels.

Young Adults Have Made the Largest Gains in Insurance Coverage

Prior to the ACA, young adults were uninsured at higher rates (http://www.commonwealthfund.org/publications/fund-reports/2008/may/rite-of-passage--why-young-adults-become-uninsured-and-how-new-policies-can-help--2008-update) than the rest of the working-age adult population. In 2013, before the ACA marketplaces opened, more than one-quarter of 19-34-year-olds were uninsured. Young adults often lost coverage they had through a parent's plan or Medicaid on their 19th birthdays. College graduation was another coverage break point for many young adults.

Several provisions in the ACA — including subsidized private insurance in the marketplaces, expanded eligibility for Medicaid, and the option to stay on a parent's health plan until the age of 26 — were aimed at ensuring young adults wouldn't lose their health insurance when they hit certain life milestones. By 2017, the uninsured rate among young adults dropped to 16 percent.

Young black and Latino adults have made the greatest coverage gains — 15 and 17 percentage-point declines by 2016 respectively — since the law was signed in 2010.

Medicaid Expansion Particularly Helpful for Young Adults

Young adults have comprised a disproportionate share of enrollment in the Medicaid coverage expansion, which enables states to cover adults up to 133 percent of the poverty level, or about $16,000 a year. This is not surprising given that the largest share of uninsured young adults prior to the ACA were in lower- and moderate-income households. Young adults made up 34 percent of the adult population (/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage) but 41 percent of Medicaid enrollment in 2017.

A Majority of Young Adults Are Able to Access and Afford Care

The ACA Tracking Survey asked young adults if they used their new marketplace or Medicaid coverage to visit a doctor, hospital, or other health care provider, or to pay for prescription drugs. More than three-quarters (77%) reported using their coverage. Of those, 61 percent reported not being able to access or afford their care prior to obtaining it.

Young adults' expanded access to health insurance has helped them get the care they need. In 2012, our biennial health insurance survey found 29 million young adults, or 48 percent of those surveyed, reported they did not get needed care in the past 12 months because of cost. By 2016 this number had significantly declined to 21 million, or 33 percent— the lowest rate since the measure was added to the survey in 2003.

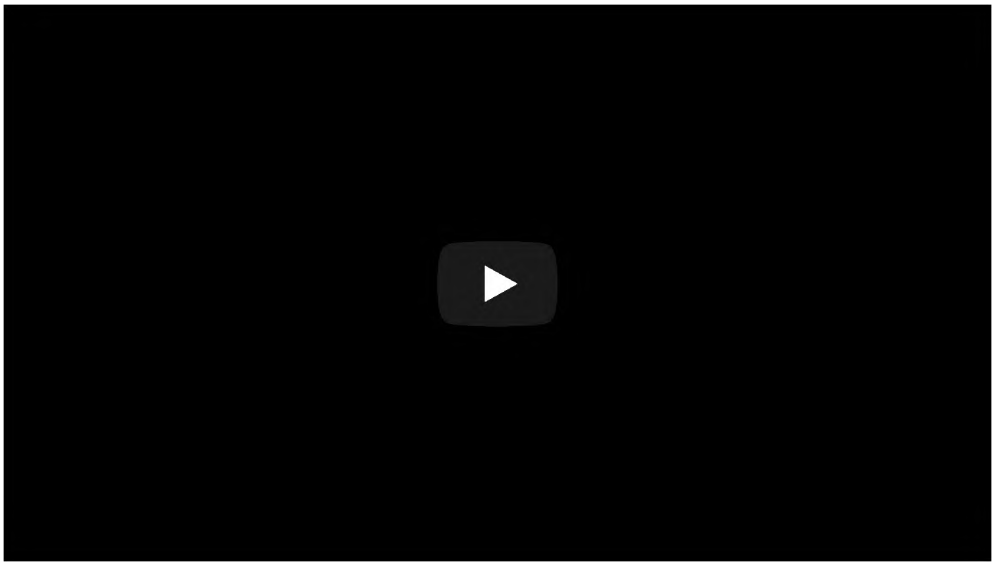
Since the passage of the ACA, the overwhelming majority of young adults have been satisfied with their marketplace or Medicaid coverage. In 2017, 94 percent of young adults reported being somewhat or very satisfied.

Policy Implications

The ACA's coverage expansions have enabled millions of young adults to access health insurance through their parent's plans, the marketplaces, and Medicaid. But 16 percent of young adults remain uninsured. Given the large role that Medicaid has played in coverage for this age group, expanding Medicaid in the 19 remaining states would lead to gains.

Along with Trump Administration actions affecting the marketplaces, such as the shorter open enrollment period for 2018, the repeal of the individual mandate penalties under congressional Republicans' tax bill could trigger coverage losses among young adults. These changes have the potential to reverse gains in access and reductions in

medical bill problems seen in this age group over the last four years. And the loss of a healthier group of enrollees will also mean higher costs and fewer plans (http://www.commonwealthfund.org/publications/blog/2017/nov/senate-tax-bill-will-raise-premiums-for-many-who-buy-their-own-coverage) for those across the age spectrum who continue to buy coverage in the marketplaces.



Press Release

Funding Reinsurance and Cost-Sharing Reductions Would Lower Individual Market Premiums and Increase Enrollment

Chris Sloan, Elizabeth Carpenter, Caroline F. Pearson | Dec 06, 2017

New analysis by Avalere examines the impact of two market stabilization proposals—funding the cost-sharing reductions (CSRs) and implementing a federal reinsurance program—on individual market premiums and enrollment.

As part of the debate over tax reform, Congress is discussing a proposal put forth by Senator Collins that would provide 2 years of reinsurance funding at $5B per year. Avalere estimates that level of reinsurance would reduce 2019 premiums by 4% and increase enrollment by 180,000 people (Table 1). According to Avalere, reinsurance helps protect insurers from high cost claims and, as a result, lowers premiums.

In addition to the reinsurance funding, Congress may vote on the legislation previously proposed by Senators Alexander and Murray, which would fund the CSRs. In combination, CSR funding and $5B in annual reinsurance could lower 2019 premiums by 18% and increase enrollment by 1.3M people. Avalere experts find that reinsurance funding would contribute to lower premium costs while in effect, but would have little effect on the market once funding expires. The current debate suggests reinsurance would only be funded for 2 years.

"Together, funding for reinsurance and paying the cost-sharing reductions would significantly reduce premiums," said Chris Sloan, senior manager at Avalere. "However, those effects only continue as long as the federal funding keeps flowing."

Avalere experts note; however, that these stabilizing effects could be overshadowed by the consequences of repealing the Affordable Care Act's individual mandate, which is included in the Senate's version of the tax reform bill. Consequences include increased premiums and reduced enrollment in the exchanges, according to estimates made by the Congressional Budget Office. Avalere's modeling makes estimates relative to current law and does not assume the individual mandate is repealed.

"While funding reinsurance and cost-sharing reductions would help mitigate the impact of mandate repeal, eliminating the requirement to purchase coverage would create additional uncertainty in the market," said Elizabeth Carpenter, senior vice

Authored By

Chris Sloan
Senior Manager

Elizabeth Carpenter
Senior Vice President

Caroline F. Pearson
Senior Vice President

Press Release

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president at Avalere. “As a result, it is important not to overlook the negative impact of repealing the individual mandate on long-term market stability.”

Table 1. Estimated Annual Impact of Reinsurance and CSR Funding on Individual Market Premiums and Enrollment, Relative to Current Law

Annual Reinsurance Amount	Premium Reduction		Change in Enrollment	
	2019	2020	2019	2020
Reinsurance Only				
$2.5B	-2%	-2%	90,000	121,000
$5B	-4%	-4%	180,000	244,000
$10B	-8%	-8%	361,000	491,000
$15B	-12%	-11%	543,000	741,000
Reinsurance and CSR Funding				
$2.5B	-16%	-16%	1,241,000	1,453,000
$5B	**-18%**	**-18%**	**1,342,000**	**1,592,000**
$10B	-21%	-21%	1,546,000	1,871,000
$15B	-24%	-24%	1,750,000	2,158,000

“Reinsurance is an effective policy solution, but it requires considerable federal funding to have a meaningful effect for consumers,” said Caroline Pearson, senior vice president at Avalere. “In order to substantially lower premiums, a reinsurance program would need more federal funding over a longer duration.”

METHODOLOGY

To conduct the analysis, Avalere used its proprietary individual market enrollment model to determine the project future impacts of federal funding of a reinsurance program and CSRs. The model relies on publicly available data provided by the Centers for Medicare & Medicaid Services, Assistant Secretary for Planning and Evaluation, and American Community Survey (ACS) demographics information. Additionally, Avalere uses its proprietary MORE^2 claims database to estimate the underlying risk of the population to project future premium increases and enrollee purchasing behavior in light of premium increases or decreases.

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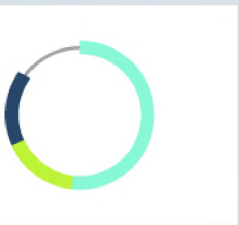

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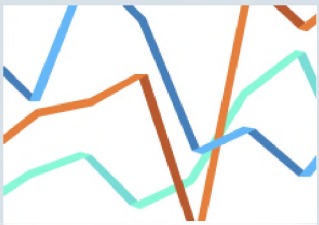

VA Formulary Coverage Much More Limited than Ohio Medicaid

Avalere Health
An Inovalon Company

1350 Connecticut Ave, NW
Suite 900
Washington, DC 20036

Phone 202.207.1300
Fax 202.467.4455
info@avalere.com

By Micah Hartman, Anne B. Martin, Nathan Espinosa, Aaron Catlin, and The National Health Expenditure Accounts Team

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National Health Care Spending In 2016: Spending And Enrollment Growth Slow After Initial Coverage Expansions

Micah Hartman (micah.hartman@cms.hhs.gov) is a statistician in the Office of the Actuary, Centers for Medicare and Medicaid Services (CMS), in Baltimore, Maryland.

Anne B. Martin is an economist in the CMS Office of the Actuary.

Nathan Espinosa is an economist in the CMS Office of the Actuary.

Aaron Catlin is a deputy director in the National Health Statistics Group, in the CMS Office of the Actuary.

The National Health Expenditure Accounts Team is recognized in the acknowledgments at the end of the article.

ABSTRACT Total nominal US health care spending increased 4.3 percent and reached $3.3 trillion in 2016. Per capita spending on health care increased by $354, reaching $10,348. The share of gross domestic product devoted to health care spending was 17.9 percent in 2016, up from 17.7 percent in 2015. Health spending growth decelerated in 2016 following faster growth in 2014 and 2015 associated with coverage expansions under the Affordable Care Act (ACA) and strong retail prescription drug spending growth. In 2016 the slowdown was broadly based, as spending for the largest categories by payer and by service decelerated. Enrollment trends drove the slowdown in Medicaid and private health insurance spending growth in 2016, while slower per enrollee spending growth influenced Medicare spending. Furthermore, spending for retail prescription drugs slowed, partly as a result of lower spending for drugs used to treat hepatitis C, while slower use and intensity of services drove the slowdown in hospital care and physician and clinical services.

Total health care expenditures in the United States reached $3.3 trillion in 2016, or 4.3 percent above the level of spending in 2015 (exhibit 1). The share of the economy devoted to health care reached 17.9 percent in 2016, up 0.2 percentage point from the 17.7 percent share in 2015. The increase in the share in 2016 occurred as health care spending grew 1.5 percentage points faster than the gross domestic product (GDP), which increased 2.8 percent. Per capita health care spending was $10,348 in 2016, or $354 higher than in 2015.

Over the past ten years the health sector has experienced major changes influenced largely by overall economic conditions, a low inflationary environment, and a more recent dramatic increase in health insurance coverage associated with the Affordable Care Act (ACA). During the period 2008–13, health care spending increased at historically low rates of growth, averaging 3.8 percent per year. Over this period, the Great Recession of 2007–09 and the subsequent mild recovery affected health insurance coverage and the use of health care. Additionally, medical price inflation was at historically low levels, in part because of lower economywide price growth and various legislative actions aimed at slowing health care spending growth. Following that period, 2014 and 2015 saw dramatic increases in health insurance enrollment, as major provisions of the ACA expanded insurance options under private health insurance Marketplaces and the Medicaid program—factors contributing to 8.7 million people gaining private health insurance and 10.2 million gaining Medicaid coverage in 2014 and 2015 (exhibit 2). In addition, growth in spending for retail prescription drugs was very strong in 2014 and 2015 (12.4 percent and 8.9 percent, respectively), mainly the result

EXHIBIT 1

National health expenditures (NHE), aggregate and per capita amounts, share of gross domestic product (GDP), and annual growth, by source of funds, calendar years 2010–16

Source of funds	2010[a]	2011	2012	2013	2014	2015	2016
EXPENDITURE AMOUNT							
NHE, billions	$2,598.8	$2,689.3	$2,797.3	$2,879.0	$3,026.2	$3,200.8	$3,337.2
Health consumption expenditures	2,456.1	2,539.9	2,644.0	2,725.9	2,876.4	3,047.1	3,179.8
Out of pocket	299.7	310.0	318.3	325.2	330.1	339.3	352.5
Health insurance	1,876.9	1,950.2	2,022.9	2,087.8	2,228.1	2,382.8	2,486.8
Private health insurance	864.3	898.6	928.2	946.4	999.9	1,068.8	1,123.4
Medicare	519.8	544.7	569.6	590.2	618.9	648.8	672.1
Medicaid	397.2	406.7	422.7	445.4	496.6	544.1	565.5
Federal	266.4	247.1	243.3	256.9	305.1	343.1	358.1
State and local	130.9	159.6	179.4	188.5	191.5	201.0	207.5
Other health insurance programs[b]	95.6	100.1	102.4	105.9	112.7	121.1	125.8
Other third-party payers and programs and public health activity	279.4	279.7	302.8	312.9	318.2	325.0	340.5
Investment	142.7	149.5	153.2	153.1	149.7	153.7	157.4
Population (millions)[c]	309.0	311.1	313.4	315.7	318.0	320.3	322.5
GDP, billions of dollars	$14,964.4	$15,517.9	$16,155.3	$16,691.5	$17,427.6	$18,120.7	$18,624.5
NHE per capita	$8,412	$8,644	$8,924	$9,121	$9,515	$9,994	$10,348
GDP per capita	$48,436	$49,879	$51,542	$52,880	$54,799	$56,580	$57,751
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	102.7	105.1	106.9	108.3	110.2	111.3	112.8
GDP price index	101.2	103.3	105.2	106.9	108.8	110.0	111.4
Real spending							
NHE, billions of chained dollars	$2,530	$2,558	$2,617	$2,659	$2,746	$2,877	$2,960
GDP, billions of chained dollars	$14,784	$15,021	$15,355	$15,612	$16,013	$16,472	$16,716
NHE as percent of GDP	17.4	17.3	17.3	17.2	17.4	17.7	17.9
ANNUAL GROWTH							
NHE	4.1%	3.5%	4.0%	2.9%	5.1%	5.8%	4.3%
Health consumption expenditures	4.2	3.4	4.1	3.1	5.5	5.9	4.4
Out of pocket	2.0	3.4	2.7	2.2	1.5	2.8	3.9
Health insurance	4.5	3.9	3.7	3.2	6.7	6.9	4.4
Private health insurance	3.8	4.0	3.3	2.0	5.7	6.9	5.1
Medicare	4.2	4.8	4.6	3.6	4.9	4.8	3.6
Medicaid	6.1	2.4	3.9	5.4	11.5	9.5	3.9
Federal	7.7	−7.2	−1.6	5.6	18.8	12.5	4.4
State and local	3.0	22.0	12.4	5.0	1.6	4.9	3.2
Other health insurance programs[b]	5.9	4.8	2.2	3.4	6.4	7.5	3.9
Other third-party payers and programs and public health activity	4.9	0.1	8.3	3.3	1.7	2.1	4.7
Investment	2.7	4.7	2.5	−0.1	−2.2	2.7	2.4
Population[c]	0.8	0.7	0.7	0.7	0.8	0.7	0.7
GDP, billions of dollars	3.8	3.7	4.1	3.3	4.4	4.0	2.8
NHE per capita	3.3	2.8	3.2	2.2	4.3	5.0	3.5
GDP per capita	2.9	3.0	3.3	2.6	3.6	3.3	2.1
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	2.7	2.4	1.7	1.3	1.8	0.9	1.4
GDP price index	1.2	2.1	1.8	1.6	1.8	1.1	1.3
Real spending							
NHE, billions of chained dollars	1.4	1.1	2.3	1.6	3.3	4.8	2.9
GDP, billions of chained dollars	2.5	1.6	2.2	1.7	2.6	2.9	1.5

SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and US Department of Commerce, Bureau of Economic Analysis, and the US Census Bureau. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Accounts methodology paper, 2016: definitions, sources, and methods [Internet]. Baltimore (MD): CMS; 2017 [cited 2017 Dec 6]. Available from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-16.pdf. Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2009–10. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [c]Estimates reflect the US Census Bureau's definition of *resident-based population*, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, members of the US Armed Forces overseas and US citizens whose usual place of residence is outside of the US. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts.

EXHIBIT 2

National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and annual growth, by source of funds, calendar years 2010–16

	2010[a]	2011	2012	2013	2014	2015	2016
PRIVATE HEALTH INSURANCE							
Expenditure (billions)	$864.3	$898.6	$928.2	$946.4	$999.9	$1,068.8	$1,123.4
Expenditure growth	3.8%	4.0%	3.3%	2.0%	5.7%	6.9%	5.1%
Per enrollee expenditure	$4,653	$4,858	$4,942	$5,044	$5,187	$5,445	$5,721
Per enrollee expenditure growth	6.0%	4.4%	1.7%	2.1%	2.8%	5.0%	5.1%
Enrollment (millions)	185.7	185.0	187.8	187.6	192.8	196.3	196.4
Enrollment growth	–2.1%	–0.4%	1.5%	–0.1%	2.7%	1.8%	0.0%
MEDICARE							
Expenditure (billions)	$519.8	$544.7	$569.6	$590.2	$618.9	$648.8	$672.1
Expenditure growth	4.2%	4.8%	4.6%	3.6%	4.9%	4.8%	3.6%
Per enrollee expenditure	$11,157	$11,408	$11,465	$11,509	$11,711	$11,951	$12,046
Per enrollee expenditure growth	1.7%	2.3%	0.5%	0.4%	1.7%	2.1%	0.8%
Enrollment (millions)	46.6	47.7	49.7	51.3	52.8	54.3	55.8
Enrollment growth	2.5%	2.5%	4.1%	3.2%	3.1%	2.7%	2.8%
MEDICAID							
Expenditure (billions)	$397.2	$406.7	$422.7	$445.4	$496.6	$544.1	$565.5
Expenditure growth	6.1%	2.4%	3.9%	5.4%	11.5%	9.5%	3.9%
Per enrollee expenditure	$7,361	$7,267	$7,268	$7,556	$7,533	$7,870	$7,941
Per enrollee expenditure growth	0.1%	–1.3%	0.0%	4.0%	–0.3%	4.5%	0.9%
Enrollment (millions)	54.0	56.0	58.2	58.9	65.9	69.1	71.2
Enrollment growth	6.0%	3.7%	3.9%	1.3%	11.9%	4.9%	3.0%
UNINSURED AND POPULATION							
Uninsured (millions)	48.1	45.6	44.8	44.2	35.5	29.5	28.6
Uninsured growth	4.7%	–5.1%	–1.9%	–1.3%	–19.5%	–17.1%	–2.8%
Population (millions)[b]	309.0	311.1	313.4	315.7	318.0	320.3	322.5
Population growth	0.8%	0.7%	0.7%	0.7%	0.8%	0.7%	0.7%
Insured share of total population	84.4%	85.3%	85.7%	86.0%	88.8%	90.8%	91.1%

SOURCES Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group; and US Department of Commerce, US Census Bureau. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see exhibit 1 notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2009–10. [b]Estimates are explained in exhibit 1 notes.

of an increase in spending for hepatitis C medication. As a result, health care spending increased 5.1 percent in 2014 and 5.8 percent in 2015 (exhibit 1).

With the main impacts of the ACA's enrollment expansions realized, health care spending increased 4.3 percent in 2016—a rate that was 1.2 percentage points slower than the average annual growth experienced in 2014 and 2015 but in line with the average annual growth rate of 4.2 percent during the period 2008–15. From a payer perspective, spending growth for all three major payers slowed in 2016. Growth in Medicaid (3.9 percent) and private health insurance (5.1 percent) was lower in 2016, in part because of decelerating enrollment growth. Medicare spending slowed (from 4.8 percent in 2015 to 3.6 percent in 2016) because of lower per enrollee growth rates for both the traditional fee-for-service program and Medicare Advantage. From a goods and services perspective, there was a dramatic deceleration in spending growth for retail prescription drugs (from 8.9 percent in 2015 to 1.3 percent in 2016) (exhibit 3), as a result of a decline in spending for drugs used to treat hepatitis C, fewer new drugs being introduced in 2016, and slower growth in prices for both brand-name and generic drugs. Additionally, spending growth for hospital care (4.7 percent) and physician and clinical services (5.4 percent) (exhibit 3) decelerated in 2016, in part because of slower growth in the use and intensity of services.

Factors Accounting For Growth

Aggregate national health care expenditures increased 4.3 percent, or 3.5 percent on a per capita basis, in 2016 (exhibit 1). Growth in per capita health spending can be further disaggregated into the price and nonprice factors that drive such growth. In 2016, medical price growth accounted for 1.4 percentage points of the 3.5 percent growth in per capita spending, while the

EXHIBIT 3

National health expenditures (NHE) amounts and annual growth, by spending category, calendar years 2010–16

Spending category	2010[a]	2011	2012	2013	2014	2015	2016
EXPENDITURE AMOUNT							
NHE, billions	$2,598.8	$2,689.3	$2,797.3	$2,879.0	$3,026.2	$3,200.8	$3,337.2
Health consumption expenditures	2,456.1	2,539.9	2,644.0	2,725.9	2,876.4	3,047.1	3,179.8
Personal health care	2,196.0	2,274.0	2,366.9	2,436.7	2,560.2	2,715.5	2,834.0
Hospital care	822.3	851.9	902.5	937.6	978.1	1,033.4	1,082.5
Professional services	688.3	716.6	743.2	759.4	792.5	837.7	881.2
Physician and clinical services	512.6	535.9	557.1	569.6	595.7	631.0	664.9
Other professional services	69.9	72.8	76.4	78.7	83.0	87.8	92.0
Dental services	105.9	108.0	109.7	111.1	113.8	118.9	124.4
Other health, residential, and personal care	129.1	131.7	139.1	144.2	151.6	164.8	173.5
Home health care	71.6	74.6	78.1	80.5	84.0	88.8	92.4
Nursing care facilities and continuing care retirement communities	140.5	145.4	147.4	149.0	152.4	158.1	162.7
Retail outlet sales of medical products	344.3	353.9	356.6	365.9	401.7	432.7	441.7
Prescription drugs	253.1	258.8	259.2	265.2	298.0	324.5	328.6
Durable medical equipment	39.9	42.3	43.7	45.1	46.7	48.6	51.0
Other nondurable medical products	51.2	52.8	53.7	55.7	57.0	59.6	62.2
Government administration	30.0	32.5	33.8	36.9	41.0	42.1	43.8
Net cost of health insurance	154.4	159.2	165.9	174.0	195.8	207.7	219.8
Government public health activities	75.6	74.3	77.4	78.3	79.4	81.7	82.2
Investment	142.7	149.5	153.2	153.1	149.7	153.7	157.4
Noncommercial research	49.2	49.7	48.4	46.6	45.9	46.5	47.7
Structures and equipment	93.5	99.8	104.8	106.5	103.8	107.2	109.7
ANNUAL GROWTH							
NHE	4.1%	3.5%	4.0%	2.9%	5.1%	5.8%	4.3%
Health consumption expenditures	4.2	3.4	4.1	3.1	5.5	5.9	4.4
Personal health care	3.9	3.5	4.1	2.9	5.1	6.1	4.4
Hospital care	5.5	3.6	6.0	3.9	4.3	5.7	4.7
Professional services	3.1	4.1	3.7	2.2	4.4	5.7	5.2
Physician and clinical services	3.0	4.5	4.0	2.2	4.6	5.9	5.4
Other professional services	4.3	4.2	5.0	3.0	5.4	5.9	4.7
Dental services	2.7	2.0	1.6	1.2	2.5	4.4	4.6
Other health, residential, and personal care	4.6	2.0	5.7	3.7	5.1	8.7	5.3
Home health care	5.7	4.2	4.7	3.1	4.3	5.8	4.0
Nursing care facilities and continuing care retirement communities	3.9	3.5	1.4	1.1	2.3	3.7	2.9
Retail outlet sales of medical products	1.0	2.8	0.8	2.6	9.8	7.7	2.1
Prescription drugs	0.1	2.2	0.2	2.3	12.4	8.9	1.3
Durable medical equipment	5.6	5.8	3.4	3.2	3.6	4.1	4.9
Other nondurable medical products	1.8	3.1	1.7	3.6	2.4	4.6	4.4
Government administration	1.6	8.1	4.0	9.2	11.2	2.8	4.0
Net cost of health insurance	11.8	3.1	4.2	4.9	12.5	6.1	5.8
Government public health activities	1.9	−1.7	4.2	1.1	1.5	2.9	0.6
Investment	2.7	4.7	2.5	−0.1	−2.2	2.7	2.4
Noncommercial research	8.5	0.9	−2.4	−3.7	−1.6	1.2	2.6
Structures and equipment	−0.1	6.7	5.0	1.6	−2.5	3.3	2.3

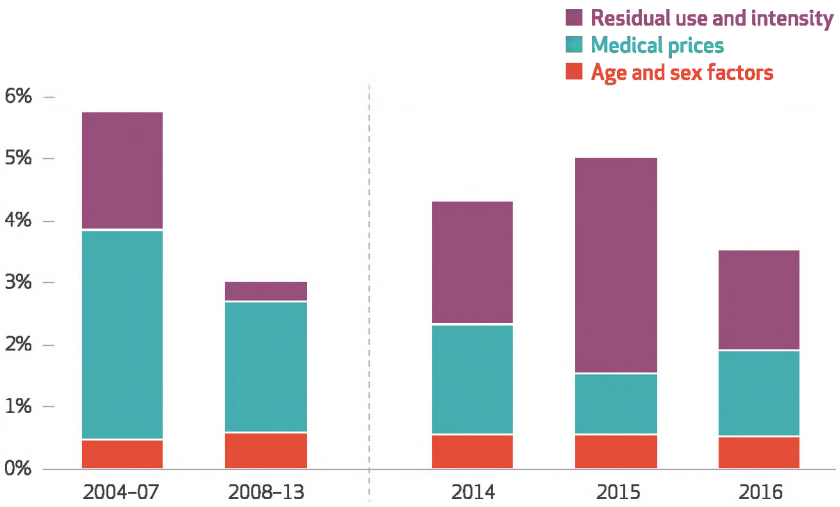
SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see exhibit 1 notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2009–10.

changing age and sex mix of the population accounted for 0.6 percentage point, and growth in the residual use and intensity of health care goods and services constituted the remaining 1.6 percentage points (exhibit 4).[1]

Medical price growth, which includes both economywide and medical-specific price inflation, was slightly faster in 2016 (1.4 percent) than in 2015 (1.0 percent). However, this rate was below the average annual growth of 2.1 percent in 2008–13 and well below the growth of 3.4 percent in 2004–07. The slight uptick in 2016 was due to slightly faster economywide price growth (1.3 percent compared to 1.1 percent in 2015) (exhibit 4) as measured by the GDP price index, while medical-specific price inflation was

EXHIBIT 4

Factors accounting for growth in per capita national health expenditures (NHE), selected calendar years 2004–16



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted National Health Expenditures (NHE) price deflator. "Residual use and intensity" is calculated by removing the effects of population, age and sex factors, and price growth from the nominal expenditure level.

essentially flat, increasing 0.1 percent in 2016 compared to almost no increase in 2014 and 2015. Prices grew more rapidly for all health care services and for durable medical equipment but slowed for retail prescription drugs and other nondurable medical products.

During the 2007–09 economic recession and in the years that followed, the use and intensity of health care goods and services experienced little to no growth, averaging just 0.3 percent during the period 2008–13. However, the significant expansion of health insurance coverage in 2014 and 2015 contributed to the increased use of health care goods and services, and use and intensity grew 2.0 percent in 2014 and 3.5 percent in 2015 (exhibit 4). In 2016, growth in use and intensity slowed to 1.6 percent, but this rate was still well above the average growth during 2008–13 and slightly lower than the pre-recession average annual growth of 1.9 percent during 2004–07.

Sponsors Of Health Care

In 2016 the federal government and households accounted for the largest shares of health care spending (28 percent each), followed by private businesses (20 percent), state and local governments (17 percent), and other private revenues (7 percent) (exhibit 5). Spending on health care by federal and state and local governments and households increased more slowly than in 2015, while spending by private businesses and other private revenue sources grew more rapidly.

After two consecutive years of rapid growth (10.9 percent in 2014 and 8.9 percent in 2015), federal government spending for health care slowed, increasing 3.9 percent in 2016. Despite the slower growth, this share of total health spending remained stable at 28 percent. The primary reason for the deceleration in federal spending growth in 2016 was federal Medicaid spending, which grew more slowly in 2016 (4.4 percent) as a result of less Medicaid enrollment growth. The much larger increases in federal Medicaid expenditures in 2014 and 2015 (18.8 percent and 12.5 percent, respectively) were attributable mainly to increased Medicaid funding, which fully financed newly eligible adults under the ACA (exhibit 1). In 2013, federal Medicaid payments represented 34 percent of total federal government expenditures on health; in 2014 the share increased to 37 percent, and in 2015 and 2016 the share remained stable at 38 percent.

State and local governments accounted for 17 percent of health expenditures in 2016, a share that has remained steady since 2014. Growth in this spending category decelerated from 4.8 percent in 2015 to 2.8 percent in 2016, driven by slower growth in spending for state and local government contributions to employer-sponsored private health insurance premiums (which constituted 33 percent of total state and local government health expenditures); growth in these spending contributions was 4.7 percent in 2016, following a rate of 7.7 percent in 2015. Also contributing to the slowdown was a deceleration in state Medicaid spending growth (which represented 37 percent of total state and local government spending on health), from 4.9 percent in 2015 to 3.2 percent in 2016 (exhibit 1), in part because of reduced supplemental payments to hospitals.

Health spending by private businesses accounted for 20 percent of total health spending from 2010 through 2016. Growth in this spending was 5.0 percent in 2016, following a rate of 4.4 percent in 2015 (exhibit 5). Contributions by private businesses to employer-sponsored private health insurance premiums represented the largest share of health spending by private businesses in 2016 (76 percent) and increased 4.9 percent in 2016.

Household spending for health care includes out-of-pocket spending, contributions to private health insurance premiums, and contributions to Medicare through payroll taxes and payment of premiums. Households accounted for 28 percent of total health care expenditures in 2016—a

EXHIBIT 5

National health expenditures (NHE) amounts, annual growth, and percent distribution, by type of sponsor, calendar years 2010–16

Type of sponsor	2010[a]	2011	2012	2013	2014	2015	2016
EXPENDITURE AMOUNT							
NHE, billions	$2,598.8	$2,689.3	$2,797.3	$2,879.0	$3,026.2	$3,200.8	$3,337.2
Businesses, household, and other private revenues	1,445.9	1,498.5	1,577.0	1,618.7	1,667.1	1,742.6	1,828.7
Private businesses	519.4	543.3	568.1	579.8	606.8	633.3	664.6
Household	751.5	776.2	809.0	832.1	854.9	897.5	938.8
Other private revenues	175.0	179.0	200.0	206.8	205.4	211.8	225.2
Governments	1,152.9	1,190.9	1,220.2	1,260.3	1,359.0	1,458.3	1,508.6
Federal government	731.0	730.0	731.4	752.7	834.7	908.9	944.1
State and local governments	421.9	460.8	488.8	507.6	524.3	549.3	564.5
ANNUAL GROWTH							
NHE	4.1%	3.5%	4.0%	2.9%	5.1%	5.8%	4.3%
Businesses, household, and other private revenues	2.5	3.6	5.2	2.6	3.0	4.5	4.9
Private businesses	1.0	4.6	4.6	2.1	4.7	4.4	5.0
Household	3.1	3.3	4.2	2.8	2.7	5.0	4.6
Other private revenues	4.8	2.3	11.7	3.4	-0.7	3.1	6.3
Governments	6.2	3.3	2.5	3.3	7.8	7.3	3.5
Federal government	7.5	–0.1	0.2	2.9	10.9	8.9	3.9
State and local governments	4.1	9.2	6.1	3.8	3.3	4.8	2.8
PERCENT DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, household, and other private revenues	56	56	56	56	55	54	55
Private businesses	20	20	20	20	20	20	20
Household	29	29	29	29	28	28	28
Other private revenues	7	7	7	7	7	7	7
Governments	44	44	44	44	45	46	45
Federal government	28	27	26	26	28	28	28
State and local governments	16	17	17	18	17	17	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see exhibit 1 notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2009–10.

share that has remained unchanged since 2014. In 2016, health spending by households grew 4.6 percent, after increasing 5.0 percent in 2015. The slower growth in 2016 resulted mainly from a deceleration in household contributions to employer-sponsored private health insurance premiums. Out-of-pocket spending is the largest category of household spending, at 38 percent in 2016, and it increased 3.9 percent in 2016, faster than the 2.8 percent increase in 2015 (exhibit 1)—partially because cost sharing for those with private insurance continued to increase. Growth in out-of-pocket spending in 2015 was relatively low, as the impacts of insurance coverage expansions and the subsequent effects on direct out-of-pocket spending were being realized.

Retail Prescription Drugs

Total retail prescription drug spending grew 1.3 percent in 2016 to $328.6 billion (exhibit 3). This low growth followed much stronger growth rates in 2014 and 2015 (12.4 percent and 8.9 percent, respectively), which were primarily the result of increased spending on new medicines and higher price growth for existing brand-name drugs. In particular, strong growth in spending for drugs used to treat hepatitis C contributed to high overall spending growth in 2014 and 2015. The 2016 rate of prescription drug spending growth is more in line with the lower average annual growth during the period 2010–13 of 1.2 percent—a rate that was driven by the shift to more consumption of generic drugs, which was partly influenced by the loss of patent protection of major brand-name drugs.[2] Despite these large fluctuations in growth rates over the past several years, retail prescription drugs' 10 percent share of national health expenditures in 2016 is similar to the share in 2009.

In 2016, fewer new medicines were approved—twenty-two compared to forty-five in 2015 and forty-one in 2014.[3] Spending for brand-name

drugs, which accounted for almost three-quarters of total retail prescription drug spending in 2016, grew more slowly partially because spending for drugs used to treat hepatitis C decreased, as fewer patients received treatment and net prices for these drugs declined.[4] Furthermore, aggregate spending growth for diabetes drugs decelerated in 2016 even as diabetes remained one of the fastest-growing therapeutic segments.[4]

Spending for generic drugs (excluding brand-name generics), which constituted 15.0 percent of total prescription drug expenditures, declined in 2016 primarily because of slower growth in prices.[4]

Utilization, measured as the number of prescriptions dispensed, increased 1.9 percent in 2016, accelerating from 1.4 percent growth in 2015.[5] This faster rate primarily resulted from acceleration in the number of prescriptions dispensed for drugs to treat high blood pressure and high cholesterol, as well as for mental health.[4] Although generic drugs accounted for a smaller share of total drug spending in 2016 than in 2015, they represented 84.1 percent of total dispensed prescriptions in 2016, up from 83.0 percent in 2015.[5]

Each of the major payers for retail prescription drug spending experienced slower growth in 2016. Private health insurance, the largest payer of prescription drugs (a 43 percent share in 2016), experienced a sharp slowdown from 10.4 percent growth in 2015 to just 0.8 percent in 2016. Medicare prescription drug spending, which accounted for a 29 percent share in 2016, decelerated from a rate of 9.3 percent in 2015 to 2.8 percent in 2016, driven by slower growth in spending for hepatitis C and diabetes drugs. Medicaid spending on prescription drugs, which constituted a share of 10 percent, slowed to a rate of 5.5 percent in 2016 following two years of double-digit growth primarily associated with expanded Medicaid enrollment. Out-of-pocket prescription drug spending, accounting for a 14 percent share in 2016, declined 1.0 percent because of the increased use of generics; more patients having zero out-of-pocket costs because of insurance arrangements; and contributions made by manufacturers, such as copayment coupons, to offset patients' out-of-pocket spending.[4]

Hospital Care

Spending for hospital care services represented 32 percent of total health care spending in 2016, a figure that was unchanged since 2013. Hospital expenditures reached $1.1 trillion and increased 4.7 percent in 2016, slower than the rate of 5.7 percent in 2015 (exhibit 3).

The slower growth in hospital care spending in 2016 reflected slower growth of 2.3 percent in the use and intensity of services, which was lower than the increase of 3.4 percent in 2015. This deceleration followed two years of accelerated growth in nonprice factors, as utilization increased in 2014 and 2015 largely because the share of the population with health insurance increased (from 86 percent in 2013 to 91 percent in 2015)—a result of implementation of the ACA and improved economic conditions.[6] However, enrollment growth slowed in 2016, as did the use of hospital services. Aggregate utilization measures for all hospitals in the US show that days and discharges both declined in 2016 (by 0.3 percent and 0.6 percent, respectively), following two years of positive growth.[7,8] Slower growth in the use and intensity of hospital services was partly offset by faster growth in hospital prices, which accelerated slightly from 0.9 percent in 2015 to 1.2 percent in 2016.[9]

For the major payers, hospital expenditures exhibited mixed trends, with slower growth in Medicaid and private health insurance spending, stable growth in Medicare spending, and faster growth in out-of-pocket spending. The slower growth in Medicaid and private health insurance spending was mainly the result of slower growth in enrollment following the initial impacts of the ACA expansion in 2014 and 2015. In addition, growth in Medicaid hospital spending slowed in part because of a decline in supplemental payments to hospitals.[10] Medicare hospital spending growth remained relatively flat for the fourth consecutive year, increasing within the range of 2.8 and 3.3 percent during 2013 to 2016. In 2016, traditional Medicare fee-for-service spending growth accelerated for hospital services but was offset by slower spending growth for Medicare Advantage. Finally, out-of-pocket hospital spending growth accelerated in 2016, following declines in 2014 and 2015. This more rapid growth was partly attributable to continued strong growth in enrollment in consumer-directed health plans, which tend to have higher copayments and deductibles than other forms of insurance.[11]

Physician And Clinical Services

Total spending for physician and clinical services grew 5.4 percent, reaching $664.9 billion, and accounted for 20 percent of total health care spending in 2016 (exhibit 3). Although growth was slightly slower in 2016 than in 2015 (5.9 percent), spending on physician and clinical services increased more rapidly in 2016 than expenditures for all other health care goods and services. Growth in spending for clinical services (8.2 percent in 2016), which represented just

over one-fifth of total spending in the physician and clinical services category, outpaced growth in spending for physician services (4.6 percent in 2016) for the twelfth consecutive year. Continued strong growth in spending for freestanding ambulatory surgical and emergency centers contributed to the faster growth in spending for clinical services.

In 2016, growth in the use and intensity of physician and clinical services was a driving factor in overall growth in spending for physician and clinical services, accounting for almost three-quarters of the 5.4 percent increase. The rate of increase in the use and intensity of those services, however, was slower in 2016 than in 2015, in part because health insurance enrollment (particularly for Medicaid and private health insurance) grew more slowly. Despite this slowdown, the use and intensity of physician and clinical services increased faster in 2016 than it did on average in 2007–13.

Both Medicare and Medicaid experienced slower growth in physician and clinical services spending in 2016, compared to 2015. Medicare spending on physician and clinical services, which constituted a 23 percent share in 2016, increased 3.8 percent after growing 4.7 percent in 2015. This deceleration was driven by the slowdown in physician spending under Medicare Advantage, which increased 6.9 percent in 2016 following growth of 12.2 percent in 2015. Medicaid spending on physician and clinical services experienced a larger slowdown, increasing only 4.1 percent in 2016 after growing 9.9 percent in 2015 and 21.8 percent in 2014, due in part to slower enrollment growth. Private health insurance spending on physician and clinical services, which represented a 43 percent share of all physician and clinical services spending, increased 5.8 percent in 2016, a slight uptick from 5.5 percent growth in 2015.

Medicaid

Total Medicaid spending, which comprises expenditures by federal and by state and local governments, reached $565.5 billion in 2016 and represented 17 percent of total national health spending (exhibit 1). Medicaid spending increased 3.9 percent in 2016—much slower growth than the rates in 2015 and 2014 (9.5 percent and 11.5 percent, respectively), both of which were due to the initial impacts of the ACA's expansion of Medicaid eligibility and enrollment during those two years.

Medicaid enrollment grew 3.0 percent in 2016 after increasing 4.9 percent in 2015 and 11.9 percent in 2014 (exhibit 2). The slower growth in 2016 followed a total increase in enrollment of 10.2 million people during 2014 and 2015 (averaging 8.3 percent per year), when most of the impact of the ACA Medicaid expansion occurred. Growth in Medicaid spending per enrollee slowed in 2016, increasing only 0.9 percent after growth of 4.5 percent in 2015. The slower growth in 2016 reflects states' increased efforts to control costs,[12,13] a decline in supplemental payments to hospitals, and a decrease in per enrollee costs for newly eligible adults.[14]

The slower growth in overall Medicaid spending was broadly based, with all Medicaid goods and services—except for nursing care facilities and continuing care retirement communities—experiencing decelerating growth in 2016. Hospital spending—the largest category at just over one-third of all Medicaid spending—increased 3.4 percent in 2016 following 8.6 percent growth in 2015. The slower Medicaid hospital spending growth was a result of slower growth in enrollment and decreases in supplemental payments. The second-largest category—other health, residential, and personal care—increased 5.7 percent in 2016, a slowdown from the 10.8 percent increase in 2015. The deceleration can be partly attributed to a slowdown in the growth of home and community-based waivers.[10]

Because the Medicaid expansion was fully federally funded, federal Medicaid spending continued to increase more rapidly (4.4 percent) than state and local spending (3.2 percent) in 2016 (exhibit 1). However, the difference was much smaller than it was in 2015, when federal Medicaid spending grew 12.5 percent, compared to 4.9 percent for state and local spending. During the period 2014–16, the level of federal Medicaid spending increased by $101 billion, while state and local spending grew by $19 billion.

Private Health Insurance

Private health insurance expenditures increased 5.1 percent in 2016 to reach $1.1 trillion (exhibit 2). This spending accounted for 34 percent of all health care spending in the US as private insurance continued to be the largest payer for health care goods and services, with just over 60 percent of the insured population covered by some form of private insurance in 2016.

The 5.1 percent growth in 2016 was slower than growth was in 2014 and 2015, when private health insurance spending increased 5.7 percent and 6.9 percent, respectively, as enrollment grew by 8.7 million over the two years (averaging 2.3 percent annually). The slowdown in private health insurance spending in 2016 was mainly driven by slower growth in enrollment, which increased less than 0.1 percent following 1.8 percent growth in 2015. The enrollment trend was

driven by decreased enrollment in directly purchased private insurance that was purchased outside of the Marketplace and by slower growth in enrollment in employer-sponsored insurance plans, all of which followed the initial impacts of the ACA coverage expansion in 2014 and 2015.

Per enrollee, private health insurance spending grew 5.1 percent in 2016—about the same rate as in 2015, 5.0 percent. The trend in per enrollee spending in 2016 reflected faster growth in the net cost of private health insurance and a slight slowdown in the growth of per enrollee benefit spending, from 5.9 percent in 2015 to 5.3 percent in 2016. The slightly slower growth in that spending was due in part to slower growth in spending for retail prescription drugs and the continued shift to high-deductible plans, which were partly offset by continued strong growth in the benefit trends for some of the newly covered expansion populations.[11,15]

The net cost of private health insurance, or the amount of private health insurance spending attributed to nonmedical benefit expenses (such as administrative costs, taxes, net gains or losses to reserves, and profits), grew faster in 2016, increasing 3.3 percent after almost zero growth in 2015. However, because the net cost of private health insurance grew more slowly than benefit spending (5.3 percent) in 2016, the net cost share of private health insurance expenditures was slightly lower (11.5 percent in 2016, compared to 11.7 percent in 2015).

Medicare

Total Medicare expenditures reached $672.1 billion in 2016 and constituted 20 percent of total health care spending (exhibit 2). Medicare spending grew 3.6 percent in 2016, slowing from a rate of 4.8 percent in 2015, while enrollment growth remained relatively stable, increasing 2.8 percent in 2016 compared to 2.7 percent in 2015. Medicare spending per enrollee increased at a slower rate in 2016 (0.8 percent) than in 2015 (2.1 percent). The deceleration was influenced by slower growth in spending for both the fee-for-service and the Medicare Advantage portions of Medicare, which accounted for 67 percent and 33 percent of total Medicare expenditures in 2016, respectively.

Fee-for-service Medicare spending growth slowed slightly from 2.2 percent in 2015 to 1.8 percent in 2016, while enrollment growth accelerated, increasing 1.6 percent in 2016 after 0.7 percent growth in 2015. Per enrollee spending growth also slowed for Medicare fee-for-service—increasing just 0.2 percent in 2016, following faster growth of 1.5 percent in 2015—and was primarily driven by slower growth in prescription drug spending and declines in spending for durable medical products and nursing home care.[16] The slower growth in fee-for service prescription drug expenditures was caused largely by reduced spending for drugs used to treat hepatitis C and diabetes, while the decline in expenditures for durable medical equipment was due to further implementation of the competitive bidding program, which established a new payment methodology and, in turn, lowered average prices.[17] For nursing home care, the decreased spending was a result of lower use of services and a smaller increase in the Medicare reimbursement rate.

Medicare Advantage spending, in contrast, had a larger impact on the overall deceleration in total Medicare spending, as growth slowed from 11.1 percent in 2015 to 7.4 percent in 2016. Because Medicare Advantage spending is based on capitated per member per month payments, trends in total spending are directly influenced by trends in enrollment.[18] The number of Medicare Advantage enrollees grew by 0.9 million to 17.9 million in 2016 (total Medicare enrollment increased 1.5 million to reach 55.8 million enrollees), or an increase of 5.2 percent, following growth of 7.6 percent in 2015. Accordingly, Medicare Advantage spending growth per enrollee slowed from 3.3 percent in 2015 to 2.0 percent in 2016. Over the past several years, Medicare Advantage payments were affected by changes associated with the ACA, including the phasing in of payment rates that are linked to fee-for-service costs, productivity adjustments that are tied to fee-for-service benchmark rates, the implementation of quality measures that are tied to bonuses and rebates, and the implementation of insurer fees. Additionally, Medicare Advantage payments were influenced by federal budget sequestration, which reduced Medicare benefit payments across the board by 2 percent per year, starting in 2013.

Spending for hospital care, physician and clinical services, and prescription drugs represented 76 percent of total Medicare expenditures in 2016. While growth in Medicare hospital care spending remained fairly stable in 2015 and 2016 (at 2.8 percent and 2.9 percent, respectively), spending growth slowed for Medicare physician and clinical services and for Medicare prescription drugs. The deceleration in physician and clinical services spending (from 4.7 percent growth in 2015 to 3.8 percent in 2016) was primarily due to slower growth in Medicare Advantage physician spending; in the fee-for-service program, physician and clinical services spending accelerated. For prescription drugs, the slowdown (from 9.3 percent in 2015 to 2.8 percent in 2016) was evident in both fee-for-service and

Medicare Advantage expenditures, and it was primarily due to slower growth in Part D spending—specifically, reduced utilization and higher manufacturer rebates for hepatitis C drugs and reduced spending on diabetes drugs resulting from slower price growth for insulin.

Out-Of-Pocket Spending

Total out-of-pocket spending (which includes all direct consumer payments such as copayments, deductibles, coinsurance, and spending for noncovered services) increased 3.9 percent in 2016 (exhibit 1)—the fastest rate of growth since 2007 and higher than the average annual growth of 2.0 percent in 2008–15. In 2016, out-of-pocket spending continued to account for 11 percent of all health care spending, unchanged since 2012.

In 2014 and 2015, out-of-pocket spending grew just 1.5 percent and 2.8 percent, respectively. Growth in both years was affected by changes in health insurance coverage, as the number of uninsured people (who pay out of pocket for a majority of their health care costs) was reduced from 44.2 million in 2013 to 29.5 million in 2015 (exhibit 2). Concurrently, however, increased utilization resulting from enrollment expansion and an ongoing shift toward enrollment in high-deductible health plans led to more out-of-pocket spending.[19] In 2016, 29 percent of covered workers were enrolled in these high-deductible plans, up from 24 percent in 2015 and 20 percent in 2014, making these plans a likely contributor to the faster growth in out-of-pocket spending in 2016.[11] At the same time, average private health insurance deductibles for single coverage plans increased 12 percent in 2016, compared to 8 percent in 2015 and 7 percent in 2014.[11]

Notably, hospital services experienced more rapid growth in out-of-pocket spending in 2016, with a 4.8 percent increase in such spending following declines of 5.1 percent and 2.8 percent in 2015 and 2014, respectively. This faster growth in 2016 was below the longer-term average annual growth rate of 6.8 percent in 2008–13. The decreases in out-of-pocket hospital spending in 2014 and 2015 were due in part to the expansion in health insurance coverage, while hospitals' uncompensated care costs declined.[20] In 2016, out-of-pocket spending grew the fastest for durable medical equipment (6.9 percent) and declined for retail prescription drugs (–1.0 percent).

Conclusion

Within the ten-year period 2007–16, the US experienced, among other events, the most severe economic recession since the Great Depression, followed by a mild economic recovery; medical price inflation that was at historic lows; and major changes to the health care system associated with the ACA. During these years, health care spending increased at the lowest rates in the history of the National Health Expenditure Accounts, but low economic growth led to an increase of 2.0 percentage points in the share of the economy devoted to health care, from 15.9 percent in 2007 to 17.9 percent in 2016. The resulting average increase of 0.2 percentage point per year is nearly equal to the historical annual average over the past half-century.

In 2016, as expected, health care spending growth slowed following the major expansion of health insurance coverage in 2014 and 2015, when the ACA expanded eligibility for the Medicaid program and provided access to private health insurance Marketplaces. The insured share of the population stabilized at 91 percent in 2016, the same as for 2015 but higher than the shares of 89 percent in 2014 and 86 percent in 2013. Not surprisingly, federal government spending grew more slowly in 2016, as the initial impacts of enrollment expansion were realized and Medicaid enrollment growth (particularly for the newly eligible) decelerated. At the same time, private health insurance spending growth slowed, as enrollment growth decelerated and the impact of new hepatitis C drugs lessened.

The slower growth in health care spending in 2016 was more in line with the average annual rate of growth during the period 2008–15 and was higher than growth for the overall economy. Because the unique factors that influenced the health sector over the past decade did not have as great an effect in 2016, this may be an initial indication that this year marks a return to the more typical relationship between annual rates of growth in health care spending and growth in nominal GDP. As a result, future health care expenditure trends are expected to be mostly influenced by changes in economic conditions and demographics, as has historically been the case.[21] ■

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NOTES

1 Growth in the use and intensity of health care goods and services includes changes in utilization as well as changes in the mix (or intensity) of the goods and services consumed. It is calculated as a residual and reflects growth in nominal health care spending less growth in the population, changes in the age and sex mix of the population, and medical price growth. As a residual, use and intensity cannot be estimated separately. The sum of the factors may not equal the total due to rounding.

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Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

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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 Fiedler Tuesday, 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.

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.

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.

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.

January 2, 2018

Market Segment Outlook: U.S. Health

Insurers overall have been able to adapt; therefore, A.M. Best does not expect any significant deterioration in general market conditions

A.M. Best is revising its outlook on the U.S. health insurance segment to stable from negative. The change to stable reflects a variety of factors that have led to improvement in earnings and risk-adjusted capitalization. The lower level of profitability in 2014 and 2015 was driven by the commercial individual segment; we note that, although the individual exchange business has reported losses, this segment still constitutes only a small portion of health insurers operations. Other product lines, particularly the employer group, remain profitable.

A repeal/replacement of the Patient Protection and Affordable Care Act (ACA) is still a possibility; however, A.M. Best believes that after several failed attempts to pass a bill in 2017, the House and Senate may choose to focus on other issues over the next fiscal year. Additionally, the majority of the changes to the ACA that were recommended in the proposed bills would take effect in the medium term (2020 and beyond), which would give insurers time to react and prepare. Furthermore, insurers have been able to handle the challenges facing the industry so far, and we do not expect any significant deterioration in market conditions over the next year.

Individual Markets Are Stabilizing

Health insurers have faced many challenges since 2014, driven by issues related to the ACA individual exchange business. However, this business constitutes a small portion of most health insurers' earnings and revenues. Although the segment has negatively impacted earnings, health plans have been profitable overall, driven by the combined operating results of the employer group, Medicaid, and Medicare Advantage lines of business.

Results of the ACA exchange business improved in 2016 and 2017, driven partially by consecutive years of high rate increases and a narrowing of provider networks. State regulators have been more accepting of higher rate increases to make sure that the business is priced correctly, and some have allowed factors for anti-selection to be included in the rates. The exchange membership still has a concentration of individuals who are higher risk and greater utilizers of services, but the exchange population has stabilized. Additionally, this year there were fewer new enrollees joining the exchange population, limiting the impact of pent-up demand for medical services. Furthermore, premium rate increases have been implemented and have taken into account the increased utilization and adverse selection for these high-utilization members.

Also noteworthy following the November 2016 presidential election was the concern associated with the fear of a repeal or replacement of healthcare reform—specifically of a potential increase in utilization, as individuals could have become anxious that they would lose their existing coverage and would rush to seek medical treatments and services. However, this spike did not occur, and medical cost trends were relatively flat in 2016 and 2017, also contributing to the stability we are observing.

Analytical Contacts:
Sally Rosen, Oldwick
+1 (908) 439-2200 Ext. 5280
Sally.Rosen@ambest.com

Doniella Pliss, Oldwick
+1 (908) 439-2200 Ext. 5104
Doniella.Pliss@ambest.com

Joseph Zazzera, Oldwick
+1 (908) 439-2200 ext. 5797
Joseph.Zazzera@ambest.com

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Best's Market Segment Outlooks

Our market segment outlooks examine the impact of current trends on companies operating in particular segments of the insurance industry over the next 12 months. Typical factors we would consider include current and forecast economic conditions; the regulatory environment and potential changes; emerging product developments; and competitive issues that could impact the success of these companies. Best's ratings take into account the manner in which companies manage these factors and trends.

A Best's Market Segment Outlook, like a Best's Credit Rating Outlook for a company, can be positive, negative, or stable.

- A positive market segment outlook indicates that A.M. Best expects market trends to have a positive influence on companies operating in the market over the next 12 months. However, a positive outlook for a particular market segment does ***not*** mean that outlook for ***all*** the companies operating in that market segment will be positive.
- A negative market segment outlook indicates that A.M. Best expects market trends to have a negative influence on companies operating in the market over the next 12 months. However, a negative outlook for a particular market segment does ***not*** mean that outlook for ***all*** the companies operating in that market segment will be negative.
- A stable market segment outlook indicates that A.M. Best expects market trends to have a neutral influence on companies operating in that market segment over the next 12 months.

We update our market segment outlooks annually, but may revisit them at any time during the year if regulatory, financial, or market conditions warrant.

Yet another important factor is that, since 2015, there has been a decrease in the number of carriers participating in the ACA exchange market and an increase in markets with only one or two carrier options for consumers, following the decision by several carriers to exit the ACA exchange market. This change to only a few carriers per market has resulted in insurers having a better understanding of the risk pools in the insured population and being able to plan for the entire pool. Furthermore, fewer carriers in the market can result in easier planning for the risk adjustment payments, as there can be more certainty of each plan's risk pool. When there is only one carrier in the market, there is no risk adjustment payment/receivable, as the insurer has all of the risk in the market and the risk pool is known.

More health insurers are reporting greater stability in their membership, with members staying with the same carrier from year to year. This stability provides insurance companies an opportunity to engage members in population health management and to aid in improving an individual's health and to prevent unnecessary hospitalization owing to untreated medical conditions. Furthermore, consistent membership can improve the predictability of claims experience.

Finally, the transitional reinsurance program ended in 2016, and there was some concern that health insurers' earnings could be negatively impacted by the lack of federal reimbursement. However, earnings for 2017 have actually improved, for the reasons mentioned above. With regard to the federal risk adjustment program, health plans are better able to report data and more accurately predict the receivable/payable for the program, although small, less sophisticated carriers still are under pressure, as any shift in risk adjustment payable amounts can negatively impact these companies because of their limited size.

Employer Group Remains Profitable

The employer group segment remains profitable, with carriers reporting stable to declining medical cost trends driven by prescription drugs, as no new high cost drugs were introduced in 2017. In addition, the growth of value-based provider arrangements has resulted in members becoming more educated about their options, including the cost of services. Lower utilization is driven in part by higher out-of-pocket costs resulting from high deductible health plans. However, membership in the employer sector remains flat, with any membership gains driven largely by accounts moving among health insurers. The economic and employment growth experienced in the U.S. has not translated into organic growth for employer group membership, as additions to staff have been concentrated in part-time and contractual workers, most of whom are not eligible for medical benefits.

Medicaid Growth Slows

The considerable premium growth from the Medicaid expansion in 2014 and 2015 has subsided, as no additional states have expanded Medicaid since. As such, much slower growth is expected in Medicaid managed care, with any additional increase in Medicaid members coming from states converting more programs to managed care and carriers winning specific contracts. Furthermore, per the ACA, states began to pay a portion of the costs for the Medicaid expansion population in 2017, with the percentage increasing each year until each state's portion reaches 10%, where its level of funding will remain. As a result, states may take a more stringent approach to Medicaid eligibility, including reviewing current members to ensure that they still qualify. Medicaid results are still profitable, but margins may decline slightly, as the rates that were set for the Medicaid expansion in 2014 and 2015 start to expire. Because the health risk of this population was unknown, rates may have been set higher initially to account for the uncertainty. With claims history/risk on the Medicaid expansion population now known, margins could compress slightly. However, the Medicaid line of business is expected to remain profitable.

Medicare Advantage Growth Continues, Margins Compress

Health insurers remain focused on Medicare Advantage, given the large number of individuals aging into Medicare every day, a trend that will persist as the baby boomers turn 65. As such, premium and membership growth are expected to continue. Margins for Medicare Advantage may decline slightly in 2018, as the health insurer fee returns, and given the price sensitivity of senior consumers, many health insurers tend to absorb the fee rather than pass it on in premiums. Margin compression will also be impacted by intensified competition, as more players are actively entering this segment. Nevertheless, Medicare Advantage remains profitable, albeit with lower margins, which is typical of a government-funded program.

Mergers & Acquisitions Accelerating—But With A Twist

With the U.S. Department of Justice blocking the mergers of Anthem Inc. and Cigna Corporation, and of Aetna Inc. and Humana Inc., the trend of large-scale mergers of health insurers appears to have ended, at least for the near to medium term. However, the new focus is on vertical integration: a merging of health care functions among providers, payers, care management, and finance. This new wave of vertical mergers may provide new lower cost care delivery opportunities over the medium term.

In December 2017, CVS Health Corporation announced that it had signed a definitive agreement to acquire Aetna Inc., which is in line with Aetna's strategy to build a local community presence to facilitate more efficient and appropriate care delivery. UnitedHealth Group Inc. continues to expand provider capabilities in its Optum operations, with acquisitions (announced in 2017) of Surgical Care Affiliates, The Advisory Board, and DaVita Medical Group. In December 2017,

Humana Inc. announced an agreement to acquire a 40% interest in Kindred Healthcare Inc.'s Kindred at Home Division. The minority interest in Kindred at Home will provide Humana an experienced home-health and hospice provider to help manage members with chronic conditions in their home.

Regulatory Issues Remain at the Forefront

The elimination of the cost sharing reduction (CSR) subsidy payment in fourth quarter 2017 will have a slightly negative impact on earnings. However, most carriers had already received a sizeable portion of the payment for the 2017 year. Additionally, the elimination of the CSR subsidy will not have an impact in 2018 for most carriers, as many state regulators allowed plans to adjust premium rates prior to the open enrollment, to avoid a potential negative financial impact in 2018.

The tax-bill's repeal of the individual mandate, which removes the penalty for not having insurance, takes effect in 2019. The penalty was low compared to the price of an ACA plan—for 2017, it was the greater of 2.5% of household income (maximum of the yearly premium for the national average priced Bronze plan sold on the exchange marketplace) or $695 per adult/$347.50 per child (maximum of $2,085). As the rates for the exchange product have risen over the past few years, many individuals have dropped coverage and opted to pay the penalty, which was still less expensive than paying for insurance. Additionally, given the high premium in the individual ACA exchange market, A.M. Best believes that most of those individuals who have coverage today (with no or only a partial premium subsidy) want or need comprehensive health insurance and will likely keep their coverage in force. We also note that the elimination of the individual mandate/penalty could be a positive for carriers that sell supplemental plans. These health plans would likely offer/design products to satisfy a lower price point than the ACA exchange product, resulting in both membership and premium gains.

In 2017, the House passed legislation to repeal and replace the ACA, but the Senate was unsuccessful. After months of discussion in Washington, the House and Senate have both moved on to other items on the agenda. A.M. Best believes that the repeal/replacement of the ACA may not be a high priority in 2018, given the contentious discussions that occurred in 2017, which could have an impact on the mid-term elections in 2018. However, the impact of the bills drafted in 2017 would not have been immediate, as most of the provisions would have taken effect in two or more years, which would give health insurers time to react.

Conclusion: No Significant Deterioration in Market Conditions Expected

The factors we discuss above have led to an overall improvement in earnings in 2016 and 2017. A.M. Best expects the individual ACA exchange business to continue to improve in 2018, as insurers take appropriate pricing actions. The other lines of business remain profitable and continue to offset any earnings pressure from the individual ACA exchange segment, which for most carriers represents a small portion of total earnings and revenues. Premium growth has slowed since 2014 and 2015 and is likely to be challenged—particularly in the employer group segment, with limited in-group enrollment gains, and in Medicaid, where states may start to revisit eligibility as the states' portion of the costs starts to grow. Slower premium growth, combined with an improvement in earnings, has allowed risk-adjusted capitalization to improve, a trend that we expect will continue.

Negative factors continue to impact the industry. However, A.M. Best believes that insurers overall have been able to adapt and thus does not anticipate any significant deterioration in general market conditions—hence, the revision in the outlook for the health insurance industry to stable.

At the same time, we note that smaller carriers, particularly those with a large portion of ACA exchange business, may continue to be negatively impacted by market conditions, as these companies may not have enough profitable employer group, Medicare Advantage, or Medicaid operations to offset losses from the individual business. Furthermore, given their small size and capital base, unexpected losses, a shift in regulations, or change in the amount of risk adjustment payments can have a negative impact on the carriers' balance sheet.

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WORLD HEADQUARTERS
1 Ambest Road, Oldwick, NJ 08858
Phone: +1 908 439 2200

WASHINGTON
830 National Press Building, 529 14th Street N.W., Washington, DC 20045
Phone: +1 202 347 3090

MEXICO CITY
Paseo de la Reforma 412, Piso 23, Mexico City, Mexico
Phone: +52 55 1102 2720

LONDON
12 Arthur Street, 6th Floor, London, UK EC4R 9AB
Phone: +44 20 7626 6264

DUBAI*
Office 102, Tower 2, Currency House, DIFC
P.O. Box 506617, Dubai, UAE
Phone: +971 4375 2780
*Regulated by the DFSA as a Representative Office

HONG KONG
Unit 4004 Central Plaza, 18 Harbour Road, Wanchai, Hong Kong
Phone: +852 2827 3400

SINGAPORE
6 Battery Road, #39-04, Singapore
Phone: +65 6303 5000

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