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By Covered California

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Mr. Alex Azar
Secretary, Health and Human Services
United States Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Secretary Azar,

With this letter, we wish to inform you about how the four key initiatives you have outlined as a central focus of the Department's transformative agenda align with the activities of Covered California and our efforts to work with the public and private sectors to drive needed change in health care. Advancing a value-based health care system, cost and affordability of coverage, addressing opioid use and abuse, and seeking to lower the high-cost of prescription drugs are important areas of focus for the federal government, as well as for states and private sector groups across the nation. We hope to inform the policy dialogue as the Department develops strategies in these areas, and would like to take this opportunity to share information about some of the efforts Covered California is undertaking in collaboration with private sector and other public-sector groups.

As a state-based exchange, Covered California continuously works to identify and implement strategies that improve quality and care delivery, contain costs, promote value in care delivery, and ensure patients get the right care at the right time. What follow are examples of work we are doing in the four areas you have identified as critical areas of focus.

1) **Value-Based Reform**

Covered California has long recognized the benefits of advancing value-based initiatives in the health care delivery system. In partnership with carriers, providers, consumer advocates and other stakeholders, we have worked to incorporate value-based initiatives into our contracts with qualified health plans, including the following key payment reforms:

a. Promoting Patient Centered Medical Homes and Advanced Primary Care: Covered California aims to promote accessible, data-driven, team-based primary care through patient-centered medical homes. We believe that these efforts will be most effective with at least some population-based payment, such as a care management fee and adoption of payment based on performance. Our expectations of our eleven contracted health plans are that they increase the number of our enrollees getting care through team-based

care and that their payment strategy align with the Centers for Medicaid and Medicare Services' (CMS) Innovation Model for "Comprehensive Primary Care Plus" which aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.[1]

b. Accountable Care Organizations (ACOs): To promote integration and coordination of care, Covered California has adopted models that align with Accountable Care Organizations, characterized by a payment and care delivery model that seeks to tie provider compensation to quality metrics and reductions in the total cost of care for an assigned population of patients. ACOs provide incentives for participating providers (i.e. clinics, hospitals and physicians) to collectively share financial risk, working towards common goals to 1) reduce medical costs, 2) reduce waste and redundancy, 3) adhere to best care practices (i.e. evidence-based care guidelines, and 4) improve care quality. This priority aligns with CMS and includes accountability for all elements of the "triple aim," while ensuring a good choice of plans for consumers.

c. Maternity Care: Covered California encourages models that pay only for medically necessary care and remove financial incentives for excessive C-sections. Through Smart Care California, a multi-stakeholder initiative including purchasers, health plans and providers and led by Covered California in partnership with other state purchasers including CalPERS and the Department of Health and Human Services have agreed on a menu of payment options for maternity care emphasizing blended case rates.[2] Blended case rate reimburses physicians and hospitals, separately or together, the same flat rate regardless of whether by cesarean or vaginal delivery.

d. Quality Performance: Covered California has worked to ensure that its qualified health plans progressively align with the CMS Hospital Based Purchasing Program.[3] Covered California requires the health plans to promote and reward better quality care rather than pay simply for volume. To promote quality in hospitals, health plans are required to adopt a payment strategy that will increase the portion of payments made to hospitals based on performance, to at least six percent reimbursement using value based metrics that align with CMS measures for quality performance.

All of the eleven Covered California health plans are progressively adopting these reforms. As we look ahead to future years, we aim to continue advancing value-based initiatives and are happy to share information on the challenges and achievements we make along the way.

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[1] https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
[2] https://www.iha.org/our-work/insights/smart-care-california/focus-area-c-sections
[3] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-.html

2) Opioid Use and Abuse

In a statewide effort to address issues regarding opioids, Covered California, the California Department of Health Care Services, and the California Public Employee Retirement System are the state's three largest health care purchasers, purchasing or managing care for more than 40 percent - or 16 million - Californians. Together, we lead a public-private partnership which has proposed the following key strategies to address opioid abuse disorders and overdose:[4]

a. Prevention*:* Lower barriers to alternative pain treatments like physical therapy and coaching prescribers to limit quantity of drug in first prescriptions and/or applying rules to do so.

b. Management: Identify patients with chronic pain for case management and reduce dangerously high doses of opioids or combined treatment with sedatives (opioids + benzodiazepines).

c. Treatment: Remove prior authorization or step therapy requirements for Medication Assisted Treatment (MAT) and increase the number of buprenorphine prescribers.

d. Stop Overdose Deaths: Remove barriers to naloxone availability and promote co-prescribing naloxone with opioids.

Covered California is working to implement these strategies through our eleven health plans to ensure that those who need opioid abuse treatment will have the appropriate access to care. We are also monitoring how our contracted plans are doing. We know that over 6,000 of Covered California's enrolled consumer received treatment related to opioid abuse disorder or overdose. What we do not know and are working with plans and others to identify is how many should be getting such treatment. We look forward to working with partners in California and nationally to identify appropriate benchmarks and targets for our efforts.

3) High Cost Pharmaceuticals

Appropriate pharmaceutical use is often the best clinical treatment strategy, and can help successfully manage chronic and life-threatening conditions. As such, Covered California requires its qualified health plans to ensure that consumers have timely access to appropriate prescription medications. At the same time, Covered California is concerned with the trend in rising prescription drug costs, including those in specialty pharmacy, as well as compounding increases in costs of generic drugs, all of which reflect a growing driver of total cost of care. Covered California has implemented various strategies designed to help curb the impact of high-cost drugs, including:

a. High Value Prescribing: Qualified health plans are contractually required to annually report on their use of independent value-based assessment methodologies (such as the Institute of Clinical Economic Review Value Assessment Framework or the Drug Effectiveness Review Project) for

[4] https://www.iha.org/sites/default/files/files/page/smartcareca_payerprovider_strategies.pdf

prescription drug coverage and formulary design. Covered California tracks the health plans' activities and best practices with an eye toward future contract guidelines.

b. Patient Access: Covered California's patient centered benefit designs have a common formulary structure which includes monthly cap on the amount of cost-sharing for specialty and high costs drugs. For most plans, the cap is $250, except for Bronze plans where it is $500. This aspect of the benefit design spreads out required cost-sharing for enrollees, thereby helping to improve adherence to drug treatment regimens and preventing additional costs elsewhere in the health care system. It also served as a model that eventually was enacted in state law to apply to the entire individual market.

4) Ensuring Affordability in Healthcare

We know that affordability matters, and is a primary driver among consumers as to whether or not they may purchase coverage – especially those who are healthy and those middle-income Americans that do not receive federal premium assistance and bear the full weight of health care premiums. As such, we have leveraged our role as a state-based exchange in ongoing efforts to help bend the cost curve in various ways that make health coverage more affordable.

a. Carrier Initiatives: Building a competitive marketplace based on guaranteed issue, risk adjustment and standard benefit designs, identical across metal tiers for all products has helped keep underlying medical inflation in the low- to mid-single digits. We have helped foster carrier adoption of network contracting strategies that emphasize improved care through better integration and coordination as well as provider accountability for the triple aim. Several carriers actively monitor provider affordability and quality through data tools and use this information in network decisions.

b. Marketing and Outreach: As we have shared with you in previous correspondence, marketing and outreach are crucial investments to sell health insurance and promote enrollment in the individual market. California has demonstrated that by investing in marketing and outreach, premiums are lowered and the main beneficiaries are consumers who do not receive subsidies. California's experience shows that a stable individual insurance market does not just happen on its own — investments in marketing and outreach attract a healthier risk pool, lower premiums and encourage health insurance companies to participate in the market with more certainty and potential returns.

We would also like to add that we have been closely following potential federal policy changes with regard to short-term, limited duration insurance (STLDI) and association health plans. Covered California recently submitted comments to proposed federal rules related to STLDI, outlining concerns with regard to the potential negative impact that these plans could have on consumers and the individual market. While some may consider STLDI as a more affordable coverage option for some consumers, it would also come with significant drawbacks for many consumers – particularly those who would not be able to enroll in or renew the coverage due to pre-existing conditions and others who

likely have less coverage through STLDI and who would be left with uncovered medical bills when accessing needed care.

We continue to look toward ways to improve affordability within a framework that ensures consumers are able to enroll in quality coverage that meets their needs should they become ill, injured, or otherwise need care. In doing so, we will continue efforts to work with carriers, providers, and other stakeholders to lower costs in ways that will help moderate rates and add value to meaningful coverage for consumers.

As Covered California continues its planning for 2019 and beyond, we look forward to working with you on these and other areas to create lasting impacts in the market and health care system to the benefit of consumers. All of the strategic priorities you have outlined are timely and represent areas where reforms are needed. As always, we stand ready to be a resource, and hope that you will call upon us if there is information or insight we can provide that may help to inform the work of the Department with these undertakings.

Sincerely,

Peter V. Lee
Executive Director

cc: Administrator Seema Verma

Ideas to Make Health Care Affordable Again

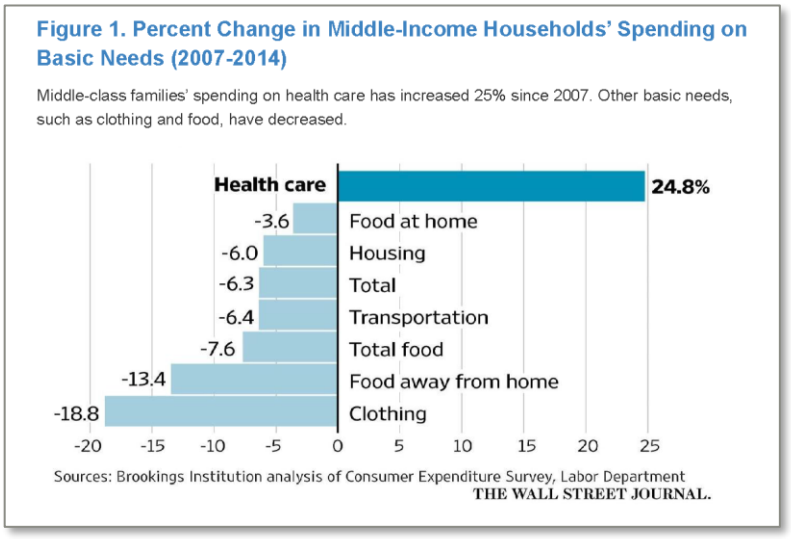
By Senator Bill Cassidy, M.D. (R-LA)

May 29, 2018

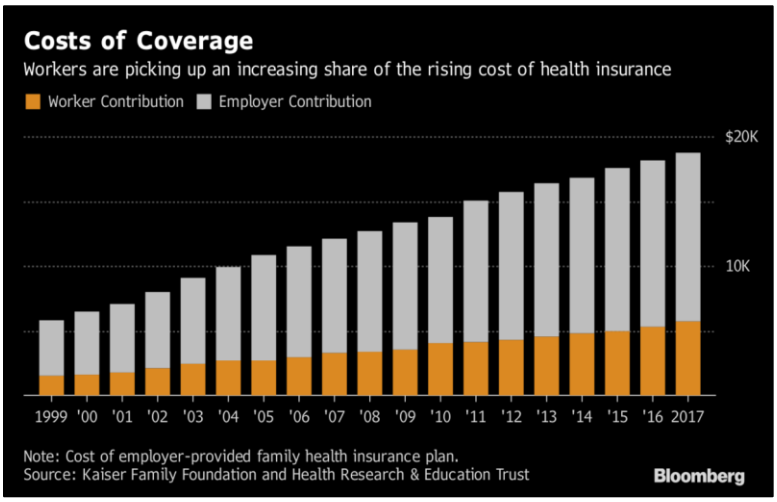
Executive Summary

More Americans are concerned about health care costs (85%) than are concerned about other common worries like retirement (73%), housing (66%), and child care (49%).[1] While Republicans, Democrats, and independents are divided over many health care issues, everyone agrees that the top health care priority should be lowering health care costs.[2] Americans know the status quo is unacceptable. They want solutions.

The United States spends almost twice as much on health care, as a percentage of its economy, as other developed countries — $3.3 trillion, or 17.9 percent of gross domestic product in 2016. This is the case even though Americans use about the same amount of health care as do citizens of other wealthy countries.[3] The high cost of health care more directly touches patients now than in the past, as over the last decade, patients have borne a greater share of rising costs in the form of higher premiums, higher deductibles, and higher out-of-pocket costs. From 2007 to 2014, middle-class families' spending on health care increased by nearly 25 percent, compared to decreases for other basic needs (see figure below).



Although the attention has been on premium increases in the individual market, average family premiums for employer-sponsored insurance have increased 20 percent since 2011, with deductibles increasing 49 percent over the same period.[4] Wages have not kept up.



The individual market is worse. The average on-exchange premiums increased 105 percent in the 39 states using Healthcare.gov in 2017, compared with the average individual market premiums in 2013.[5] This problem continues to be exacerbated by rising health care prices. In 2003, a group of influential economists published, "It's the Prices, Stupid," a paper that clearly illustrated the root problem of the U.S. health care system is high prices. Gerard Anderson of Johns Hopkins, one of the lead authors of that report, said the Affordable Care Act (ACA) "didn't reduce the actual, unit price" of health care and that "prices actually accelerated in growth post-ACA." Increased prices will continue to cause sky-rocketing premiums unless we get health care costs under control.

[1] https://consumers4qualitycare.org/research/
[2] https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-health-care-priorities-for-2017
[3] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1299
[4] https://www.kff.org/health-costs/press-release/average-annual-workplace-family-health-premiums-rise-modest-3-to-18142-in-2016-more-workers-enroll-in-high-deductible-plans-with-savings-option-over-past-two-years/
[5] https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf

Whether in the group or the individual market, more expensive health insurance premiums add to the financial pressure on families. In a recent survey, 20 percent of respondents said a premium increase of $25 per month would be unaffordable, and 50 percent of respondents said a $75 increase would make their plan unaffordable.[6]

As a doctor and a senator, I see that high health care costs make families sacrifice other basic needs, prevent companies from hiring and expanding, and strain state budgets. It is critical for leaders in Washington to work together and put the needs of the American people first.

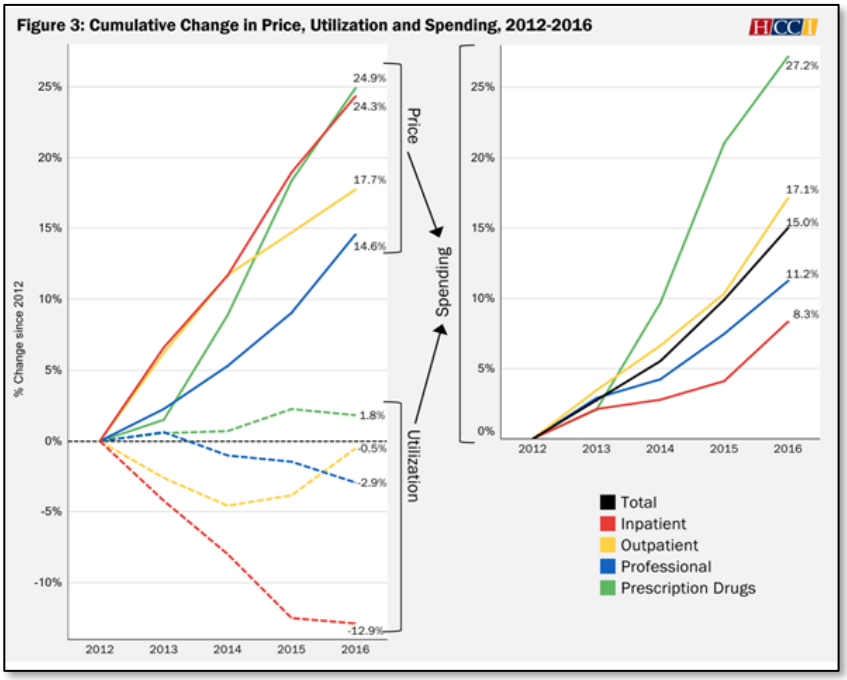
A start would be for members of Congress to take commonsense actions to lower health care costs by focusing on six policy areas:

I. Empowering patients to reduce their health care costs
II. Lowering health insurance premiums
III. Ending health care monopolies by increasing competition
IV. Decreasing drug costs for patients
V. Eliminating administrative burdens and costs
VI. Reducing costs through primary care, prevention, and chronic disease management

Focusing on these areas will provide relief to families, improve state and federal budgets, and give America a sustainable health care system that puts patients first.

I. Empowering Patients to Reduce Their Health Costs

Patients can and should have a larger say in how care is delivered and how much they are willing to pay. Currently, the health care system lacks tools found in a free market economy. When buying school supplies, getting an oil change, or shopping for groceries, the price and quality of the product or service is known before purchase. Not so in health care. As a result, the current system isn't open, accountable, or responsive to the needs of patients. Instead, it is expensive, bloated, and delivers mixed results. Prices for health care services have continuously risen, despite flat or decreasing demand (see figure below). A way to lower prices and return power to patients is by expanding the use and usefulness of health savings accounts (HSAs) and requiring price transparency.



First, Congress should make HSAs more useful and more used. These tax-preferred accounts allow patients to save money for future health expenditures. A Rand study found that individuals using HSAs generally spend less on health care and

[6] https://news.ehealthinsurance.com/_ir/68/20183/eHealth%20Survey%20-%20Costs%20and%20Consequences%20-%20April%202018.pdf

use fewer medical services. Rand also found that the majority of patients do not forgo needed primary and preventative care.[7] These accounts have worked so well that many employers looking to reduce health care expenses have moved their employees into these arrangements. But, as only individuals enrolled in high-deductible health plans (HDHPs) are eligible to have an HSA, Congress should allow Medicare and Medicaid beneficiaries to have the same options as individuals with private HDHP. Also, by expanding the type of plan that can be linked with an HSA to traditional policies with an actuarial value of 70 percent or less, more individuals will be able to save for future medical expenses. By expanding what an HSA can be used for, insurers can develop more innovative plan designs that fit the needs of patients, including the chronically ill.

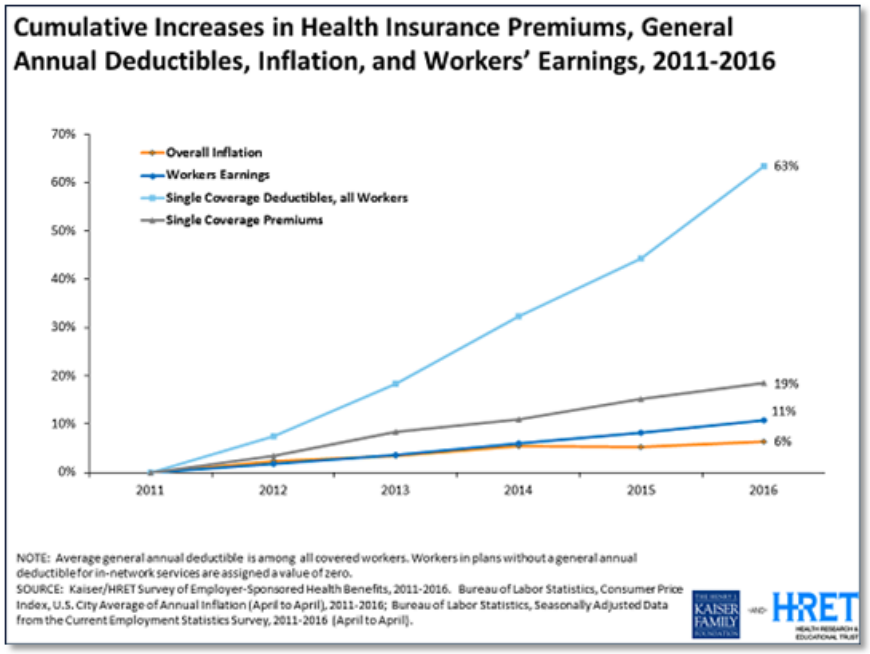
Second, Congress should require price transparency for elective medical services. The same Rand study found that a majority of people using HSAs lacked adequate information to make informed choices about medical care. A Kaiser study found that two-thirds of Americans say it is too difficult to find out what medical services cost.[8] Price transparency is about giving patients the price and quality information for elective services in advance so that they can make the decision that is best for their health and their pocketbook. Patients do make different choices and save money when they are able to compare prices and quality for health care services.[9] This must be accompanied by an education campaign to ensure consumers are aware that they can figure out the price and quality of their care ahead of time. Encouraging price transparency will lower costs, reduce pricing variation between providers, improve quality, and return power to the patient.

II. Lowering Health Insurance Premiums

Congress can provide immediate relief to those in the individual exchange by enacting the Bipartisan Stabilization Act, authored by U.S. Senators Lamar Alexander, Patty Murray, Susan Collins, and Bill Nelson. This bill was the product of an inclusive and deliberative process in which the Senate Committee on Health, Education, Labor, and Pensions held four hearings and four roundtables with leading experts. Specifically, the proposal would fund cost-sharing reduction subsidies, give states greater flexibility to innovate through the 1332 waiver process, ensure plans can be sold across state lines, provide federal funding for reinsurance or invisible high-risk pools, and make more affordable, copper plans available to patients in the individual market. All together, these actions could lower premiums by as much as 40 percent in the coming years compared to current projected levels.[10] It is unfortunate that Washington Democrats, including the bill's Democratic authors, recently voted against it. This raises the legitimate question of whether those on the other side are more interested in playing politics and blaming Republicans than lowering premiums in the individual exchange.

There are three more things Congress can do to make health insurance more affordable over the long-term. The first is to give states the option to combine the Medicaid expansion and the individual marketplace risk pools. States that did so would receive the money otherwise allocated to these patients and use it only for health insurance and risk-mitigation techniques such as reinsurance and high-risk pools. A state could find a state-specific innovation to provide affordable health insurance. For example, the Maine High Risk Pool worked well before the ACA closed it down. This is now a model for other reinsurance programs. Alaska has an individual market enrollment of 21,000 with two insurers that have a combined market share of 99 percent. Providing long-term stability to Alaska's individual market requires different solutions then the individual market in California, which has 2.45 million enrollees and 11 participating insurers. On the other hand, California has significant premium differences between Northern and Southern California, which the state could address. The distribution of funding should equalize the treatment of expansion and non-expansion states over a period of time but avoid harming expansion states with dramatic funding cuts. Flexibility to states would not jeopardize protections for individuals with pre-existing conditions.

[7] https://www.rand.org/pubs/research_briefs/RB9234/index1.html
[8] https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-health-care-priorities-for-2017
[9] https://www.publicagenda.org/pages/how-much-will-it-cost
[10] http://health.oliverwyman.com/transform-care/2018/03/a_proposal_to_lower.html



The second thing Congress can do to make health insurance more affordable over the long-term is create policies patients need as opposed to making them pay for that which they do not. Congress should codify the Trump Administration's regulations allowing the sale of short-term limited duration plans that are available for up to 364 days and have guaranteed renewability. States would still be allowed to regulate these plans as they see fit. This would allow more affordable insurance options to be available for individuals and families currently priced out of the individual market. These plans aren't the solution for everyone, but affordability correlates with purchasing insurance, so these plans will allow some uninsured individuals to enroll in a plan they can afford and provide them the protection they need in the event of an accident. Furthermore, there should be proper notification requirements to inform consumers about the differences between short-term plans and qualified health plans offered in the individual market. This notification process, along with current safeguards under the Public Health Services Act and the risk-mitigation dollars under the new streamlined grant to states, will ensure that individuals with pre-existing conditions are properly protected and have access to comprehensive and affordable health insurance.

Third, Congress should provide funding to states to encourage younger Americans to enroll in the individual market. Insurance experts agree that we can lower premiums in the individual market by improving the risk pool and increasing enrollment. Currently, young, healthy Americans are avoiding the individual market because it is too expensive. By incentivizing these presently uninsured individuals to enroll in the marketplace through additional premium assistance, we can increase coverage and reduce health care costs for all Americans in the individual market. States should also be given additional flexibility to experiment with other techniques and incentives to help individuals enroll in coverage.

III. Ending Health Care Monopolies by Increasing Competition

Our free market system allows companies to make a profit and pay their employees, but it should not allow monopolies to drive up costs and take advantage of patients. According to a 2015 JAMA study, annual health care expenditures increased by nearly a trillion dollars between 1996 and 2013, largely due to rising health care prices.[11] One way to lower prices is by increasing competition among providers and plans and ending the monopolies that are driving up prices. A new study found that:

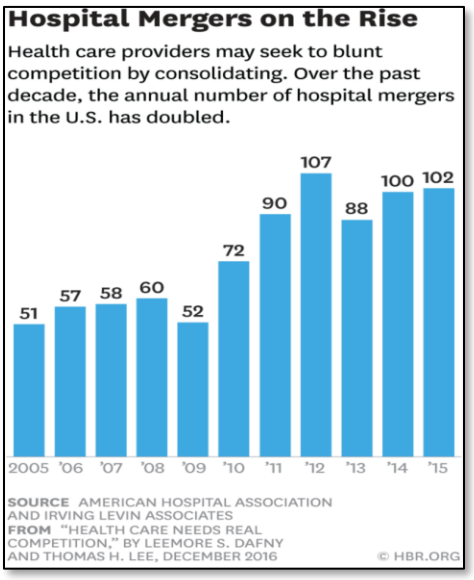
"prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals… In concentrated insurer markets the opposite occurs – hospitals have lower prices and bear more financial risk… Examining the 366 merger and acquisitions that occurred between 2007 and 2011, we find that prices increased by over 6 percent when the

[11] https://jamanetwork.com/journals/jama/article-abstract/2661579?redirect=true

merging hospitals were geographically close (e.g. 5 miles or less apart), but not when the hospitals were geographically distant."[12]

HHS should commission a comprehensive study of monopolies within the health care system. It should be broken down by geographic area and type of service. This will help governors, Congress, and regulators identify problem areas within the system and realign incentives to encourage greater competition and lower provider prices.

Monopolies by large health systems have been particularly devastating to patients in rural areas. Part of this is due to misaligned incentives in the Medicare program that favor urban providers. Under current law, hospitals are paid in part based on the cost of wages in their geographic area. The cost of wages should be considered when reimbursing providers, however, current policy does not have a floor or ceiling in place for this adjustment. As a result, urban hospitals continue to raise wages and get higher reimbursement rates from the federal government. Conversely, rural providers, which already have workforce challenges, get lower reimbursement because they can't raise wages at the same rate as urban providers. Congress should update the Medicare Wage Index to adopt a floor and a ceiling so that rural providers can be more competitive, and so that large, expensive, urban health systems can't keep artificially driving up prices. We can balance the fact that certain areas are required to pay more for wages with the fact that some urban hospitals are abusing an uncapped adjustment to further encourage consolidation and drive up costs to patients and taxpayers.



Current payment policies are exacerbating monopolies by incentivizing physicians to sell their practices to hospitals and discouraging lower cost settings of care from expanding or entering into the market. As we continue to move forward with delivery system reform that rightly encourages value over volume, it is important that Congress identify the hurdles to this evolution. The Medicare Payment Advisory Commission and the Medicaid and CHIP Payment Advisory Commission should conduct a comprehensive study to identify barriers to delivery system reform and make recommendations to Congress. This should include information on the impact payment differences for similar services provided by physicians, ambulatory surgery centers, and hospitals are adding unnecessary costs to the system and increasing the amount patients are paying.

Congress should also look at ways to promote lower-cost settings of care, freeing hospitals to specialize in the most complex diseases and conditions. These lower cost settings of care could include allowing greater use of ambulatory surgery centers, free-standing emergency rooms, rural emergency centers, and physician-owned hospitals. This should be done in a manner that ensures patients are receiving high-quality care and are not subjected to large, surprise medical bills. In addition, Congress should allow greater use of telemedicine and remove regulations that reduce competition.

Finally, the individual market has shown the consequences of insurance monopolies. Several states have experienced "bare counties" in which no insurance plan is available for that county on the individual market. This dynamic has led to insurers asking for a blank check to enter back into the market. Complicating matters is the fact that under current federal law, insurers that leave the individual market are barred from re-entering for five years. This rule had the admirable goal of trying to maintain stability in the market and keeping insurers from gaming the system by re-entering only when it is most profitable. Unfortunately, it leaves no discretion to states struggling with bare counties and unique market conditions. Congress should give states greater authority to respond to insurer monopolies and bare counties by giving authority to the states to decide when and how an insurer is banned from reentering the market. This will remove the rules currently hamstringing states' ability to negotiate and help them more proactively and creatively respond to insurer monopolies.

[12]http://www.healthcarepricingproject.org/sites/default/files/20180507_variationmanuscript_0.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top-stories

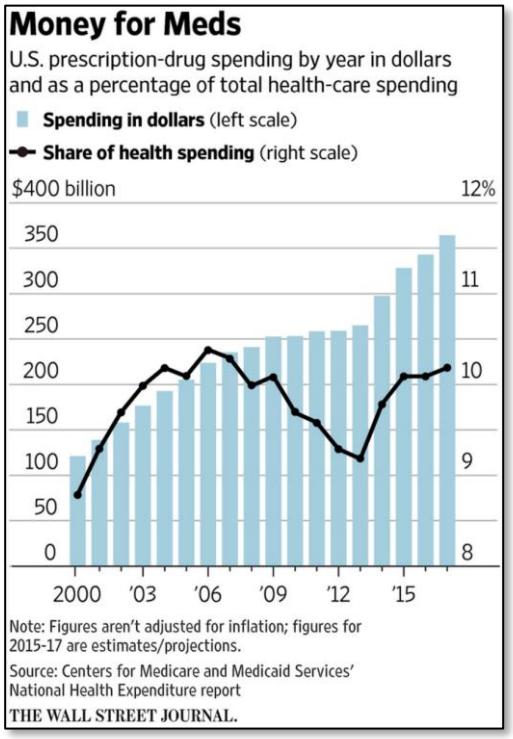
IV. Decreasing Drugs Costs for Patients

Americans across the political spectrum agree the costs of prescription medications are too high. There is a not a silver bullet for high drug costs, but any set of solutions must include the following:

1. Empowering patients through transparency
2. Realigning incentives towards innovation and better outcomes and away from 'me-too' drugs
3. Blunting tools of regulatory arbitrage and gaming the system
4. Bringing what the U.S pays for innovative drugs in line with other countries

Transparency means that a Pharmacy Benefit Manager cannot include gag clauses in which pharmacists cannot tell an insured patient that they could save money by paying cash instead of the insurance co-pay. It also requires giving the patient a "point of sale rebate," which is the same price that the insurance company pays for a drug instead of the full list price charged by the pharmaceutical company. Lack of transparency means pharmacies can charge a lot more. Consumer Reports had secret shoppers call for the cash price of a month's supply of five commonly used medicines at an online pharmacy, 25 different independent pharmacies and the major national chain pharmacies. For a month's supply of the same five drugs, the cost ranged from $69 to $1,351.[13]

Perhaps the best example of a "me-too" drug is Duexis, a combination of the generic, over-the-counter (OTC) drugs ibuprofen (Motrin) and famotidine (Pepcid). Duexis costs $2,600 per month.[14] Ibuprofen and famotidine OTC costs $20 per month. Unsuspecting and unknowing patients, directly or indirectly through higher insurance premiums, pay $2,600 a month for $20 worth of generic OTC medicine.



To realign incentives towards innovation and better outcomes and away from 'me-too' drugs, pharmaceutical companies should receive greater returns for truly innovative drugs that treat costly and deadly or disabling conditions than for "me-too" copycat drugs or drugs that treat a nuisance like toenail fungus. This could be accomplished by expediting reviews for innovative, high-priority drugs and providing longer protection for truly innovative cures. In turn, states and insurers need the ability to enter into value-based contracting to both afford expensive drugs and ensure there truly are better health outcomes.

Where possible, regulatory arbitrage should be addressed by market forces. To illustrate, Martin Shkreli-led Turing Pharmaceuticals purchased Daraprim, and was the only supplier of this generic drug. Turing used monopoly power to raise the price from $13.50 to $750 per pill.[15] Shkreli relied on regulatory hurdles to prevent competition.

To end this practice, when there is only one generic manufacturer, U.S. purchasers should be able to buy at will drugs off the international market, provided that the purchased medicine is manufactured at a facility certified by the FDA or certain, equivalent international agencies such as the European Medicines Agency (EMA) that is producing an approved drug distributed using guidelines and logistics as safe and secure as mandated by U.S. law. Unlike reimportation, this proposal ensures the safety of the drug supply chain and uses market forces to drive competition and lower costs.

Regulatory arbitrage can also be addressed by aggressively preventing companies from limiting generic competition through "pay to delay," or by buying competing product lines and shutting them down. Other issues include "evergreening," in which minor, insignificant changes to a product are used to keep a competing product from entering the market, and misusing the Risk Evaluation and Mitigation Strategy (REMS) process, in which manufacturers limit

[13] https://www.consumerreports.org/drug-prices/shop-around-for-better-drug-prices/)
[14] https://www.drugs.com/compare/duexis
[15] https://www.nytimes.com/2015/09/21/business/a-huge-overnight-increase-in-a-drugs-price-raises-protests.html

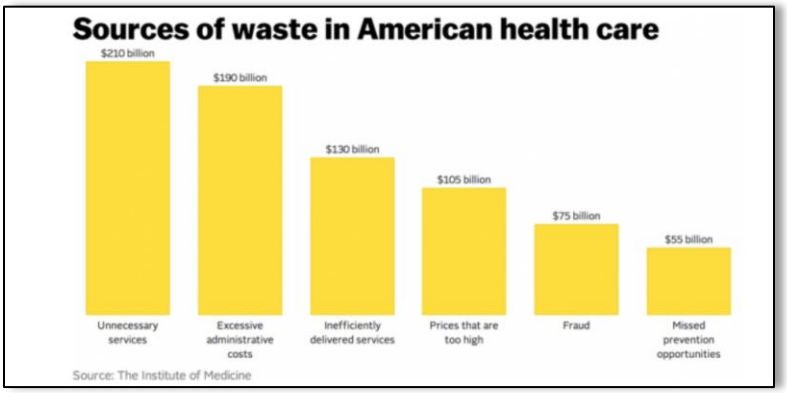
access to drug samples so that a potential generic competitor cannot test their version against the original manufacturer. An egregious example of gaming is when the Orphan Drug Act was used to increase the price of a drug costing $50 a vial to $40,000.[16][17]

For these and other reasons, Americans pay more for drugs than other countries. According to a study published in JAMA, Americans spend $1,443 per person on pharmaceuticals a year, compared to the average of $749 in other developed countries.[18] There are several ways to decrease what the U.S. pays for new drugs.

A third party can be contracted with to make sure a new drug is truly innovative (see above regarding Duexis). If there are multiple drugs in a class, a taxpayer-funded program such as Medicare should not pay more than the lowest-priced drug in that class, and the classes should not be defined so narrowly that similarly acting drugs are in different classes. To ensure that Americans pay comparable prices to other countries, what U.S. taxpayers pay for a new medicine should be pegged to a market-basket of what other larger, advanced economies pay. For drugs first introduced in the U.S. and/or quite novel products (e.g. gene therapy), alternative payment models should be developed and approved. These models could include paying for the therapy over many years, value-based purchasing where the manufacturer rebates the cost of the medicine if therapy fails, and licensing the unlimited use of a medicine for a set payment in defined populations.

These are some ideas to lower drug costs that will preserving incentives to find cures for disabling and deadly diseases.

V. Eliminating Administrative Burdens and Costs



A 2017 report by the Organization for Economic Cooperation and Development (OECD) shows that U.S. health care administration costs (the planning, regulating, and managing of health systems and services) account for more than eight percent of U.S. health care spending. This is by far the highest in the developed world, with other developed countries averaging only three percent spent on administration. Reducing burdensome regulations on providers and stakeholders would aid significantly in lowering unnecessary health care costs. Congress should start by repealing the employer mandate and its reporting requirements, which add significant costs to employers and discourage them from hiring more workers. More must also be done to provide regulatory relief to providers and health systems trying to advance delivery system reform. The U.S. Department of Health and Human Services (HHS) should conduct a comprehensive study of current regulations and pursue a goal of reducing costs associated with these regulations by at least 10 percent. This should include reforming the meaningful use program that is turning highly educated and compensated health professionals into data entry clerks. Additionally, more must be done to consolidate existing quality measures and reorient the system toward outcomes measures that are designed by and tailored to specific types of providers. Finally, Congress should address medical liability reform. Defensive medicine and frivolous lawsuits have contributed to unnecessary health care spending and ultimately led to costs spiraling out of control.[19]

VI. Reducing Costs through Primary Care, Prevention, and Chronic Disease Management

To lower health care costs over the long-term, we must realign the system to focus on prevention, primary care, and the social determinants of health that lead to bad outcomes and expensive chronic conditions. Enacting change on this front will take a long time, but Congress and the administration can take steps now to put the country on the right path.

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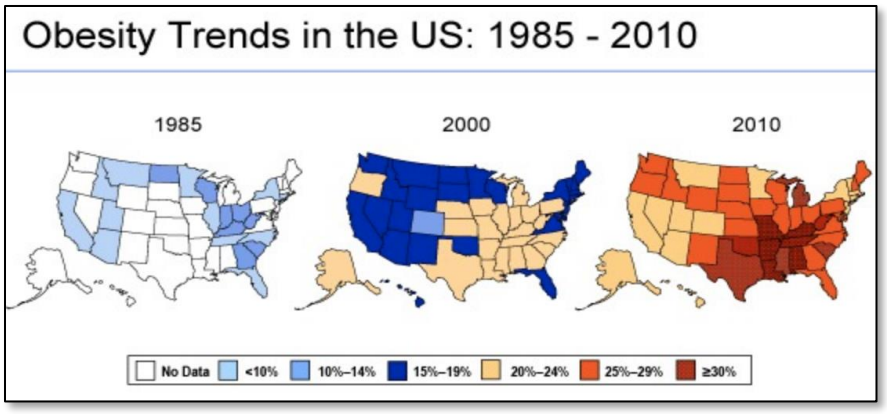
[16] https://www.nytimes.com/2012/12/30/business/questcor-finds-profit-for-acthar-drug-at-28000-a-vial.html
[17] https://www.cbsnews.com/news/the-problem-with-prescription-drug-prices/
[18] http://www.commonwealthfund.org/publications/in-the-literature/2018/mar/health-care-spending-united-states-other-high-income-countries
[19] http://money.cnn.com/2017/01/11/news/economy/healthcare-administrative-costs-us-obamacare/index.html



Patients do better when they have a relationship with a doctor or affiliated practitioner. Costs decrease when the providers and/or the patients have a financial incentive to control costs.[20] Physicians are best positioned to control cost and improve outcomes. Practice models that capitalize on this must be enabled. More must also be done to provide mental health and substance abuse treatment for patients on Medicaid. Congress should alter or remove the Medicaid Institutions for Mental Diseases (IMD) exclusion and give states greater flexibility to connect patients with the mental health and substance abuse services they need.

Obesity is a major public health crisis. According to the Centers for Disease Control and Prevention, more than 36 percent of U.S. adults have obesity.[21] The percentage of Americans with obesity is set to exceed 50 percent by 2030 unless we take immediate action to change the situation.[22] Obesity is the root cause of many chronic diseases plaguing seniors and driving up health care costs. According to Dr. Lee Kaplan, obesity medicine specialist at Massachusetts General Hospital, obesity is linked with more than 60 other chronic conditions.[23] In total, obesity accounts for more than 20 percent of annual health care costs.[24] Clearly, if we want to lower health care costs, we need to tackle the obesity epidemic. This will take an all-of-society approach. There isn't a single solution but addressing this must be a singular objective.

HHS should commission a comprehensive study on the social determinants of health and disparities that exist within the current system. The current disparities that exist between Americans of different races and socioeconomic status are frightening and a travesty. For example, according to a recent New York Times article regarding maternal and infant health disparities between races, "black infants in America are now more than twice as likely to die as white infants — 11.3 per 1,000 black babies, compared with 4.9 per 1,000 white babies, according to the most recent government data — a racial disparity that is actually wider than in 1850, 15 years before the end of slavery."[25] At the conclusion of this study, HHS should submit a list of recommendations to Congress on how to bend the cost curve and improve health outcomes by addressing these disparities.

Conclusion

Health care costs continue to weigh down American families. For too long, Washington has failed to take action that adequately addresses these concerns. Time and again, our elected officials have prioritized partisan finger-pointing rather than the needs of the American people. We can and must do better.

As a doctor, I want what's best for patients. It's time for Congress to challenge those who are protecting a broken system that imposes higher costs on families without delivering better value. The American people want action on policies that solve these problems and lower health care costs. I'm willing to work with the administration and anyone in Congress to enact legislation that addresses the six key policy issues laid out in this paper. No one has cornered the market on good ideas. With smart policy we can lower health care costs for American families.

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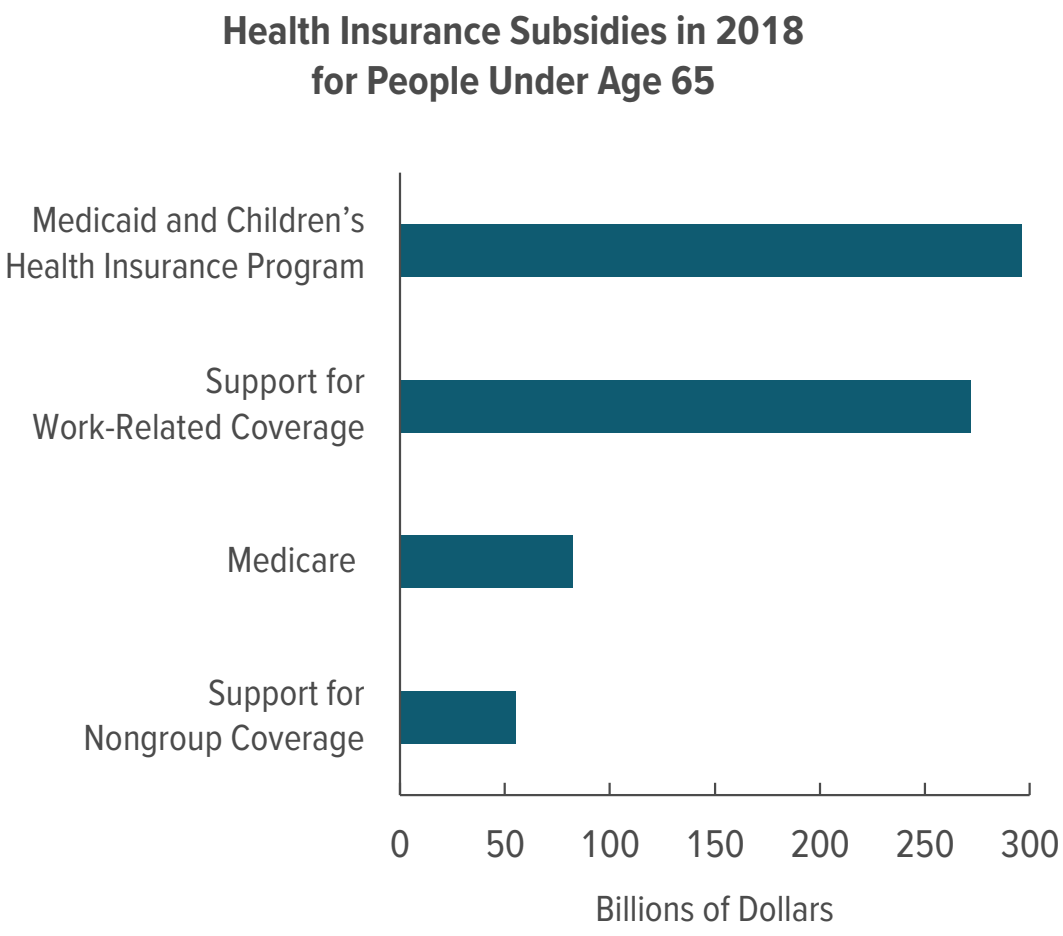
[20] http://www.commonwealthfund.org/publications/in-the-literature/2015/jun/effects-medical-home-intervention-on-quality
[21] https://www.cdc.gov/obesity/data/adult.html
[22] http://healthyamericans.org/assets/files/A.pdf
[23] Campaign to End Obesity: Dr. Lee Kaplan at Preventing and Treating Obesity in the Primary Care Setting 2013 Workshop - http://www.obesitycampaign.org/obesity_facts.asp
[24] http://campaigntoendobesity.org/documents/FinalLong-TermReturnsofObesityPreventionPolicies.pdf
[25] https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028



MAY 2018

At a Glance

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. This report updates CBO's baseline, providing estimates for the 2018–2028 period of the number of noninstitutionalized people under age 65 with health insurance and the federal costs associated with each kind of subsidy.

- In an average month in 2018, about 244 million of those people will have health insurance, and about 29 million will not. By 2028, about 243 million are projected to have health insurance and 35 million to lack it.

- Net federal subsidies for insured people in 2018 will total $685 billion. That amount is projected to reach $1.2 trillion in 2028. Medicaid and the Children's Health Insurance Program account for about 40 percent of that total, as do subsidies in the form of tax benefits for work-related insurance. Medicare accounts for about 10 percent, as do subsidies for coverage obtained through the marketplaces established by the Affordable Care Act or through the Basic Health Program.

- The market for nongroup health insurance (that is, insurance bought individually rather than through an employer) is expected to be stable in most areas of the country over the decade. Premiums for benchmark plans, which are the basis for determining subsidies in that market, are projected to increase by about 15 percent from 2018 to 2019 and by about 7 percent per year between 2019 and 2028.

- Since CBO's most recent report comparable to this one was published in September 2017, the projection of the number of people with subsidized coverage through the marketplaces in 2027 has fallen by 3 million, and the projection of the number of uninsured people in that year has risen by 5 million. Projected net federal subsidies for health insurance from 2018 to 2027 have fallen by 5 percent.

Contents

Notes

As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

Numbers in the tables and figures may not add up to totals because of rounding.

Unless the report indicates otherwise, all years referred to in describing estimates of spending and revenues are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Estimates of health insurance coverage reflect average monthly enrollment during a calendar year and include spouses and dependents covered under family policies. Those estimates are for the noninstitutionalized civilian population under age 65.

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028

Summary

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. In 2018, net subsidies for noninstitutionalized people under age 65 will total $685 billion, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate. That amount includes the cost of preferential tax treatment for work-related insurance coverage, the cost of Medicaid and Medicare coverage for people under age 65, and government payments for other kinds of health insurance coverage—such as plans purchased through the marketplaces established under the Affordable Care Act (ACA).

This report describes the basis for CBO's baseline projections of the federal costs for those subsidies under current law for the 2018–2028 period. Those projections of costs are built upon estimates of the number of people with health insurance of various kinds. During the coming year, CBO and JCT will use the projections presented here as the benchmark for assessing proposed legislation's effects on the subsidies.

How Many People Under Age 65 Are Projected to Have Health Insurance?

According to CBO and JCT's estimates, a monthly average of about 244 million noninstitutionalized civilians under age 65 will have health insurance in 2018. About two-thirds of the insured population under 65 will have coverage through an employer, and roughly a quarter will be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). A smaller number will have nongroup coverage, coverage provided by Medicare, or coverage obtained from various other sources. For example, about 4 percent, or 9 million people, are projected to obtain coverage through the marketplaces.

On average throughout the year, about 29 million people—11 percent of all noninstitutionalized civilians younger than 65—will be uninsured in 2018, CBO and JCT estimate (see Figure 1).[1] Between 2018 and 2019, in the agencies' projections, the number of uninsured people rises by 3 million, mainly because the penalty associated with the individual mandate will be eliminated and premiums in the nongroup market will be higher.[2] The elimination of the penalty was enacted as part of Public Law 115-97 (originally called the Tax Cuts and Jobs Act and referred to as the 2017 tax act in this report).

From 2019 through 2028, the number of people with insurance coverage is projected to rise, from 241 million to 243 million, under current law. The number of uninsured people is also projected to grow, from 32 million to 35 million, increasing the share of the under-65 population without insurance to 13 percent.

How Large Are the Projected Federal Subsidies, Taxes, and Penalties Associated With Health Insurance?

The estimated $685 billion in net federal subsidies in 2018 for health insurance coverage for people under age 65 (reflecting the combined effects of subsidies and taxes and penalties) would equal 3.4 percent of gross domestic product (GDP) (see Figure 2). That amount is projected to rise at an average annual rate of about 6 percent between 2018 and 2028, reaching $1.2 trillion, or 3.9 percent of GDP, in 2028. The estimates of subsidies are intended to be in the middle of the distribution of potential outcomes but are uncertain.

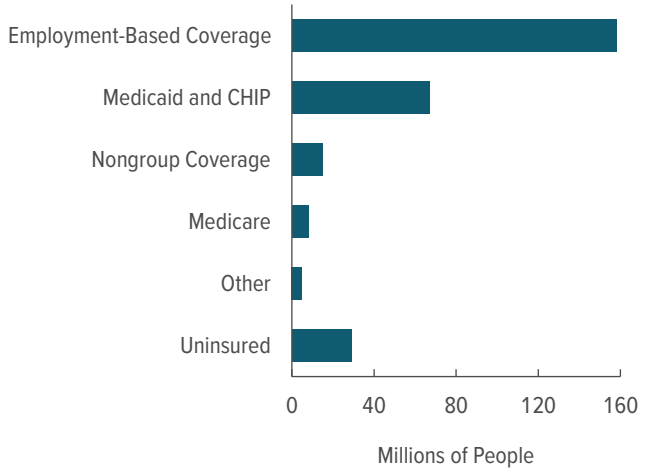
For the 2019–2028 period, projected net subsidies amount to $9.3 trillion. Two types of costs account for most of that total:

1. See Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

2. The individual mandate is a provision of law that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards and that imposes penalties on those without an exemption who do not comply.

Figure 1.

Health Insurance Coverage in 2018 for People Under Age 65



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

CHIP = Children's Health Insurance Program.

- Federal spending for people under age 65 with full Medicaid and CHIP benefits (excluding people who reside in a nursing home or another institution) is projected to amount to $4.0 trillion. That amount includes $842 billion for people made eligible for Medicaid by the ACA and $143 billion for CHIP enrollees.

- Federal subsidies for work-related coverage for people under age 65, which stem mainly from the exclusion of most premiums for such coverage from income and payroll taxes, are projected to amount to $3.7 trillion.

Other subsidy costs are smaller:

- Medicare benefits for noninstitutionalized beneficiaries under age 65 (net of their payments for premiums and other offsetting receipts) are projected to amount to $1.0 trillion. Such spending is primarily for people who are disabled.

- Subsidies for coverage obtained through the marketplaces or through the Basic Health Program are estimated to total about $0.8 trillion.

In the agencies' projections, the total cost of federal subsidies is offset to a small extent, $0.3 trillion, by taxes and penalties collected from health insurance providers, employers, and uninsured people.

How Stable Is the Nongroup Health Insurance Market Projected to Be?

The nongroup health insurance market is stable in most areas of the country over the next decade in CBO and JCT's projections—but that stability may be fragile in some places. In 2018, insurers are offering coverage in all areas, but about one-quarter of enrollees have access to only one insurer's plans. Stability would be threatened if more insurers exited markets with limited participation than entered them.

Although premiums have been increasing, most subsidized enrollees buying health insurance through the marketplaces are insulated from those increases. Out-of-pocket payments for premiums are based on a percentage of subsidized enrollees' income; the federal government pays the difference between that percentage and the premium for the benchmark plan used as the basis for determining subsidies. Those subsidies are anticipated to result in demand for insurance by enough people, including people with low health care expenditures, for the number of insurers in the marketplaces to be stable in most areas.

How Rapidly Are Premiums in the Nongroup Health Insurance Market Projected to Grow?

In 2018, the average premium for a benchmark plan—the gross amount not including any premium tax credits—is about 34 percent higher than it was in 2017. By CBO and JCT's estimates, in addition to rising health care costs per person, the increase was caused by three primary factors: First, insurers are no longer reimbursed for the costs of cost-sharing reductions (CSRs) through a direct payment; second, a larger percentage of the population lives in areas with only one insurer in the marketplace; and third, some insurers expected less enforcement of the individual mandate in 2018 (which would probably induce some healthier enrollees to leave the market).

CBO and JCT expect premiums for benchmark plans to increase by about 15 percent from 2018 to 2019, an increase that exceeds projected growth in overall spending for private health insurance. (That outcome includes the expected increase in nongroup premiums resulting from healthier people being less likely to obtain insurance after the elimination of the penalty related to the individual mandate.) The agencies expect premiums

for benchmark plans to increase by an average of about 7 percent per year between 2019 and 2028.

Many people who enroll in coverage through the marketplaces receive federal subsidies in the form of premium tax credits, and the premiums they pay net of those tax credits are often substantially lower than the gross premiums. The net premiums those people face are projected to decline or to grow more slowly than the premiums in the nongroup market for people with higher income who are ineligible for subsidies.

How Do These Projections Compare With Previous Ones?

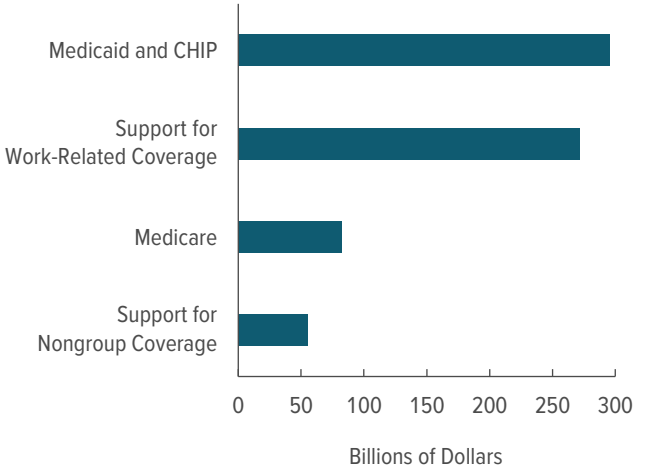
These projections update the preliminary projections of subsidies for insurance purchased through the marketplaces established under the ACA as well as revenues related to health insurance coverage for people under age 65 that were published in *The Budget and Economic Outlook* last month.[3] Compared with those preliminary estimates, federal spending for subsidizing health insurance marketplaces is now projected to be $4 billion lower in 2018 and $6 billion lower over the 2019–2028 period, and federal revenues associated with marketplace subsidies, work-related coverage, the excise tax on high-premium insurance plans, and penalties imposed on employers and uninsured people are projected to be $1 billion higher in 2018 and $24 billion higher over the 2019–2028 period, on net.

CBO's most recent report comparable to this one was published in September 2017.[4] For 2027 (the last year covered by that report and this one), CBO and JCT's projection of the number of people obtaining subsidized coverage through the marketplaces is now 3 million lower, and the projection of the number of uninsured people is now 5 million larger, than they were in that earlier report. The projection of net federal subsidies for health insurance from 2018 to 2027 is $481 billion (or 5 percent) lower. The largest contributors to that decrease are a $389 billion decline in projected subsidies for work-related coverage and a $202 billion decline in projected spending for Medicaid and CHIP.

Figure 2.

Health Insurance Subsidies in 2018 for People Under Age 65

Net federal subsidies for the year total $685 billion.



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

CHIP = Children's Health Insurance Program.

Projected Health Insurance Coverage

CBO broadly defines private health insurance coverage as a policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. Such coverage is often referred to as comprehensive major medical coverage.

CBO and JCT project that, on average during 2018, 89 percent of the noninstitutionalized civilian population under age 65 will have health insurance, mostly from employment-based plans and Medicaid. Other major sources of coverage include CHIP, nongroup policies, and Medicare. Over the 2019–2028 period, a slightly smaller percentage of that population is projected to be insured. CBO and JCT's projections of insurance coverage are inherently uncertain and represent the agencies' central estimates.

Employment-Based Coverage

The most common source of health insurance for the noninstitutionalized civilian population under age 65 is a current or former employer—either one's own or a family member's. CBO and JCT estimate that in 2018, a monthly average of about 158 million people (or about

3. See Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028* (April 2018), www.cbo.gov/publication/53651. The updated projections are incorporated in the adjustments to CBO's baseline budget projections that will be released later this week as part of the agency's analysis of the President's budget. See Congressional Budget Office, *An Analysis of the President's 2018 Budget* (forthcoming).

4. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

Table 1.

Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Total Population Under Age 65	273	273	274	275	275	276	276	276	277	277	278
Employment-Based Coverage	158	159	159	157	156	155	154	154	154	154	154
Medicaid and CHIP[a]											
Made eligible for Medicaid by the ACA	12	12	12	12	13	13	13	14	14	14	14
Otherwise eligible for Medicaid	49	48	48	49	49	49	50	50	50	50	50
CHIP	6	6	6	6	6	6	6	6	6	6	6
Subtotal	67	66	66	67	68	69	69	70	70	70	70
Nongroup Coverage and the Basic Health Program											
Nongroup coverage purchased through marketplaces[b]											
Subsidized	8	7	7	7	7	7	7	7	6	6	6
Unsubsidized	2	2	2	2	2	2	2	2	2	2	2
Subtotal	9	9	9	9	9	9	9	9	9	8	8
Nongroup coverage purchased outside marketplaces	5	4	4	4	4	4	4	4	4	4	4
Total, nongroup coverage	15	12	12	12	13	13	13	13	12	12	12
Coverage through the Basic Health Program[c]	1	1	1	1	1	1	1	1	1	1	1
Medicare[d]	8	8	8	8	8	8	8	8	9	9	9
Other Coverage[e]	5	5	5	5	5	5	5	5	6	6	6
Uninsured[f]	29	32	34	35	35	35	35	35	35	35	35
Memorandum:											
Number of Insured People	244	241	241	240	240	241	241	241	242	242	243
Insured as a Percentage of the Population											
Including all U.S. residents	89	88	88	87	87	87	87	87	87	87	87
Excluding unauthorized immigrants	91	90	90	89	89	89	89	89	89	90	90

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

Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in most years, 10 million people (or 4 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid.

Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation.

a. Includes noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

b. Under the ACA, many people can purchase subsidized health insurance coverage through marketplaces, which are operated by the federal government, state governments, or partnerships between the federal and state governments.

c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

e. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

f. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

58 percent of the population under age 65) will have employment-based coverage (see Table 1 on page 4). That number is projected to decline to 154 million, or about 55 percent of the population under age 65, in 2028.

Roughly half of the projected reduction in employment-based coverage over the next decade is attributable to the elimination of the penalty associated with the individual mandate, which CBO and JCT estimate will lead to 2 million fewer people enrolling in employment-based coverage in most years after 2018. In addition, the agencies estimate that health insurance premiums that are rising faster than wages will exert downward pressure on enrollment in employment-based coverage. However, an increase in employment over the next two years resulting from changes in the government's fiscal policy is estimated to mitigate the negative effect of the growth in premiums in the near term.

Medicaid and CHIP

The next-largest source of coverage among people under age 65 is Medicaid. In 2018, CBO estimates, a monthly average of 61 million noninstitutionalized people will receive full Medicaid benefits.[5] By 2028, that number is projected to grow to 64 million people (14 million made eligible through the ACA's expansion of Medicaid coverage at states' option, and 50 million eligible otherwise). CBO estimates that 6 million people, mostly children but also some pregnant women, will be enrolled in CHIP in 2018, on average. Together, Medicaid and CHIP are projected to provide insurance coverage for one-quarter of the population under age 65 in 2028.

CBO's estimates of Medicaid enrollment over the next decade reflect the agency's expectation that, if current federal laws remained in place, additional states would expand eligibility for the program and that more people would enroll in the program in states that have already done so. Most of the increase in enrollment during that period would stem from additional states expanding eligibility for the program, CBO estimates. Under the ACA, states are permitted to expand eligibility for Medicaid to adults under age 65 whose income is no more than 138 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL). The federal government pays a larger share of the costs for those people than it pays for those who are eligible otherwise. Currently, about 55 percent of people who meet the eligibility criteria established under the ACA live in states that expanded Medicaid. CBO anticipates that share would increase annually at a rate based on the historical pace of expansion since 2014. By 2028, about two-thirds of the people who meet the new eligibility criteria are projected to be in states that have expanded Medicaid coverage.

Nongroup Coverage and the Basic Health Program

Nongroup insurance covers a much smaller share of the population under age 65 than employment-based policies and Medicaid do. In 2018, a monthly average of about 15 million people under age 65 are expected to have such coverage, 9 million of whom will have purchased it through the marketplaces established under the ACA.[6] That number is a decline from 2017, when an estimated monthly average of 10 million people purchased nongroup coverage through the marketplaces. (Nongroup policies can be purchased either through the marketplaces—with or without government subsidies—or elsewhere.) An additional 1 million people are estimated to be participating in the Basic Health Program, which allows states to offer subsidized health coverage to certain low-income people outside the marketplaces.

Nongroup Coverage. Between 2018 and 2019, the number of people enrolled in health insurance through the nongroup market is projected to fall by 3 million, mainly because the penalty associated with the individual mandate will be eliminated and premiums faced by people who are ineligible for subsidies in the nongroup market will be higher. Enrollment in the nongroup market is then projected to remain between 12 million and 13 million in each year between 2019 and 2028. The

5. Some enrollees receive only partial benefits from Medicaid. They include Medicare enrollees who receive only assistance from Medicaid with out-of-pocket payments and premiums for Medicare, people who receive only family planning services, and unauthorized immigrants who receive only emergency services. Spending for enrollees who receive partial benefits is excluded from the estimates.

6. A total of 12 million people selected plans through the marketplaces by the close of the open-enrollment period established by the ACA. However, CBO and JCT estimate that the average monthly enrollment during the year will be lower than the total number of people who will have coverage at some point during the year because some people are covered for only part of the year: Those who experience a qualifying life event (such as a change in income or family size or the loss of employment-based insurance) are allowed to purchase coverage later in the year, and some people stop paying the premiums or leave their marketplace-based coverage as they become eligible for insurance through other sources.

agencies estimate that between 6 million and 7 million of those people will receive subsidies.

The stability in estimated enrollment over the 2019–2028 period is the net result of offsetting effects. On the one hand, CBO and JCT expect the following factors to put downward pressure on enrollment between 2019 and 2028:

- Some additional people will forgo health insurance in years after 2019 as the reaction to the elimination of the individual mandate penalty reaches its full effect, and
- More states are expected to expand eligibility for Medicaid, reducing the number of people projected to obtain coverage through the marketplaces, because people who are eligible for Medicaid are not permitted to receive subsidies for marketplace coverage.

On the other hand, the agencies expect the following effects to increase nongroup enrollment between 2019 and 2028:

- More people will purchase subsidized coverage because they will be eligible for larger tax credits that cover a greater share of premiums for certain plans offered through the marketplaces. Those higher tax credits are based on the higher premiums brought about by the fact that insurers are no longer reimbursed for the costs of CSRs through a direct payment (see Box 1).
- More uninsured people will purchase short-term, limited-duration insurance (STLDI) offered in the nongroup market outside the marketplaces, reflecting a probability that a proposed regulation expanding such coverage takes effect (see Box 2 on page 10).

Stability in the Marketplaces. Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people who live in areas with participating insurers and on the likelihood that premiums will not rise in an unsustainable spiral. In the marketplaces, where premiums cannot be based on individual enrollees' health status, the market for insurance would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable for insurers.

In CBO and JCT's projections, the marketplaces are stable in most areas in large part because most enrollees purchasing subsidized health insurance there are insulated from increases in premiums. The subsidies—combined with the rules requiring insurers to offer coverage for preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and the effects of other requirements—are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures, to attract at least one insurer almost everywhere.

Moreover, data about insurers' profitability in 2017 provide some indication that the market is stable in most areas of the country.[7] Insurers' profitability, as measured by the share of premiums that goes toward their administrative costs and profits rather than paying for claims, increased in 2017, moving close to pre-ACA levels. That evidence suggests that the premium increases in 2017 were sufficient to account for the underlying health risk of the nongroup population.

Nevertheless, about 26 percent of the population lives in counties with only one insurer in the marketplace in 2018, up from 19 percent in 2017.[8] Several factors may have led insurers to withdraw from those markets, including low enrollment (both in the marketplaces and outside them) in part because of increases in premiums paid by people without subsidies; uncertainty about the enforcement of the individual mandate; and uncertainty about the federal policies affecting the nongroup market, including how preliminary regulations that would allow a wider range of insurance products to be sold might affect the nongroup market if they are finalized. Additional withdrawals are possible in 2019—in response to lower anticipated enrollment stemming from repeal of the penalty related to the individual mandate. Still, with steady demand for insurance in the marketplaces, CBO and JCT expect the number of insurers in

7. See Cynthia Cox, Ashley Semanskee, and Larry Levitt, *Individual Insurance Market Performance in 2017* (Kaiser Family Foundation, May 2018), http://tinyurl.com/yd3z5tm9.

8. Calculations based on data from Ashley Semanskee and others, *Insurer Participation on ACA Marketplaces, 2014–2018* (Kaiser Family Foundation, November 10, 2017), https://tinyurl.com/y75j4mn7.

the marketplaces to stabilize thereafter in most areas of the country.

Substantial uncertainty continues to exist about federal policies affecting the nongroup market and about the effects of eliminating the penalty related to the individual mandate. That uncertainty may affect insurers' decisions to participate in the nongroup market in future years, and such withdrawals could threaten market stability in some areas of the country.

Gross Premiums for Benchmark Plans in the Marketplaces. Premiums for benchmark silver plans in the marketplaces—which are key drivers of subsidy amounts—increased by an average of 34 percent from 2017 to 2018. That increase occurred for three main reasons:

- *CSRs.* CBO and JCT estimate that gross premiums for silver plans offered through the marketplaces are, on average, 10 percent higher in 2018 than they would have been without the announcement in October 2017 that the Administration would no longer reimburse insurers for the cost of CSRs through a direct payment without an appropriation for that purpose. Because insurers are required to provide lower cost-sharing for enrollees in silver plans purchased through the marketplaces even in the absence of a federal payment, most insurers increased gross premiums for those plans to cover the costs of CSRs. CBO and JCT estimate that the effects of the lack of a direct payment for CSRs will continue to phase in over the next few years, putting upward pressure on premiums for silver plans offered through the marketplaces.

- *Limited Competition.* The increase in the percentage of the population that lives in a county with only one insurer in the marketplace between 2017 and 2018 probably contributed to the growth in national average benchmark premiums in 2018, because areas where only one insurer offers coverage through the marketplace tend to have higher benchmark premiums than areas where multiple insurers compete against one another to offer coverage.

- *Uncertainty.* CBO and JCT also estimate that some of the increase in benchmark premiums from 2017 to 2018 was related to insurers' uncertainty about whether the individual mandate would be enforced. Such a reduction in enforcement would probably cause some healthier enrollees to leave the market.

The agencies expect insurers to raise premiums for benchmark plans offered through the marketplaces in 2019 by an average of roughly 15 percent over the premiums charged in 2018. Part of that increase is projected to occur because plans are expected to have a less healthy mix of enrollees after the penalty related to the individual mandate is no longer levied beginning on January 1, 2019. In total, CBO and JCT expect, premiums for nongroup health insurance will be about 10 percent higher in 2019 than they would have been if the individual mandate penalty remained in place and was enforced. The lack of a direct payment for CSRs and the rising costs of health care per person are also anticipated to contribute to the overall increase.

After a few years, average premiums for benchmark plans will rise largely with growth in health care spending per person, CBO and JCT expect.[9] As a result, average benchmark premiums in the marketplaces are projected to increase by an average of close to 10 percent per year over the 2019–2023 period and then by an average of roughly 5 percent per year over the 2024–2028 period, after the effects of the elimination of the individual mandate penalty and of the lack of a direct payment for CSRs are expected to be fully phased in. Overall, between 2018 and 2028, the average benchmark premium is projected to grow by an average of about 7 percent per year. Those growth rates are about 2 percentage points lower in real terms (after the effects of inflation are removed).

Gross Premiums by Tier and Age. In addition to the key role that gross premiums for benchmark silver plans play in determining subsidies, gross premiums for all tiers of plans—including bronze and gold, for example—reflect the amounts paid by people without subsidies. Gross premiums, which differ by age, geographic area, and smoking status, affect the number of people with different types of health insurance coverage.

Although premiums for benchmark silver plans increased by an average of 34 percent from 2017 to 2018, the premiums for the lowest-cost bronze and gold plans increased by 17 percent and 18 percent, respectively. Insurers' increasing silver plan premiums to cover the cost of CSRs contributed to that difference. Most

9. For discussion of how CBO and JCT project premiums, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), pp. 9–11, www.cbo.gov/publication/51130.

Box 1.

Cost-Sharing Reductions in the Congressional Budget Office's Spring 2018 Baseline

Background

The Affordable Care Act (ACA), in section 1402, requires insurers who participate in the marketplaces established under that act to offer cost-sharing reductions (CSRs) to eligible people. CSRs reduce deductibles and other out-of-pocket expenses like copayments.

To qualify for CSRs, people must generally purchase a silver plan through a marketplace and have income between 100 percent and 250 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL).[1] The size of the subsidy varies with income. For example, in 2017, by the Congressional Budget Office's estimates, the average deductible for a single policyholder (for medical and drug expenses combined) with a silver plan varied according to income in the following way:

Income as a Percentage of the FPL	Approximate Deductible (Dollars)
Above 250 (Without CSRs)	3,600
Between 200 and 250	2,900
Between 150 and 200	800
Between 100 and 150	300

Before October 12, 2017, the federal government reimbursed insurers for the cost of CSRs through a direct payment. However, on that date, the Administration announced that, without an appropriation for that purpose, it would no longer make such payments to insurers. Because insurers are still required to offer CSRs and to bear their costs even without a direct payment from the government, most have covered those costs by explicitly increasing premiums for silver plans offered through the marketplaces for the 2018 plan year, and CBO expects all insurers to do so beginning in 2019.[2] (For the most part, insurers did not increase premiums for other plans to cover the cost of CSRs because the requirement for CSRs does not generally apply to those plans.)

Budgetary Treatment

CBO and the staff of the Joint Committee on Taxation (JCT) have long viewed the requirement that the federal government compensate insurers for CSRs as a form of entitlement authority. Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, which specifies rules for constructing CBO's baseline, requires that the agency assume full funding of entitlement authority.[3] On that basis, CBO included the CSR payments as direct spending (that is, spending that does not require appropriation action) in the agency's June 2017 baseline.

For the spring 2018 baseline, CBO and JCT project that the entitlement for subsidies for CSRs is being funded through higher premiums and larger premium tax credit subsidies instead of a direct payment. The projection reflects the way insurers are currently reimbursed for the cost of providing CSRs to eligible enrollees in light of the Administration's change in policy in October 2017.

1. In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the portion of covered medical expenses paid by the insurer differs. The average percentage of covered expenses paid by the insurer is called the actuarial value of the plan. Silver plans differ from other plans because they must provide CSRs to eligible enrollees. For people at most income levels, the actuarial value of a silver plan is 70 percent. People who qualify for CSRs are eligible for silver plans with higher actuarial values: 73 percent for people with income between 200 percent and 250 percent of the FPL; 87 percent for people with income between 150 percent and 200 percent of the FPL; and 94 percent for people with income between 100 percent and 150 percent of the FPL. The actuarial values of bronze and gold plans are 60 percent and 80 percent, respectively.

   Individuals with income generally between 100 percent and 400 percent of the FPL are also eligible for tax credits to help cover a portion of their premiums. The size of those premium tax credits varies with income and premiums.

2. In 2018, in a few states, insurers did not explicitly increase premiums for silver plans in the marketplaces to account for CSRs because state regulators did not allow them to do so. Some insurers nevertheless raised premiums substantially for reasons that were not fully specified; in constructing its baseline, CBO attributed part of such increases to CSRs. Other insurers in those states did not raise premiums by much or at all, but, on the basis of information provided by those insurers, CBO projected that those premiums were sufficient to cover the cost of CSRs. Together, those situations involved fewer than 3 percent of subsidized enrollees in 2018, CBO estimates. For more information, see Sabrina Corlette, Kevin Lucia, and Maanasa Kona, *States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments* (The Commonwealth Fund, October 2017), https://tinyurl.com/y728ro2y.

3. 2 U.S.C. §907(b)(1) (2012). Entitlement authority is the authority for federal agencies to incur obligations to make payments to entities that meet the eligibility criteria set in law.

Continued

Box 1. Continued

Cost-Sharing Reductions in the Congressional Budget Office's Spring 2018 Baseline

That approach complies with section 257 of the Deficit Control Act because the CSR entitlement is assumed to be fully funded. CBO adopted that revised baseline treatment of the financing of CSRs after consulting with the House and Senate Budget Committees. On the basis of an analysis of insurers' rate filings, CBO and JCT estimate that gross premiums for silver plans offered through the marketplaces are, on average, about 10 percent higher in 2018 than they would have been if CSRs were funded through a direct payment. The agencies project that the amount will grow to roughly 20 percent by 2021.

Effect on the Baseline

The size of premium tax credits is linked to the premiums for the second-lowest-cost silver plans offered through the marketplaces: Out-of-pocket payments for premiums for enrollees who are eligible for subsidies are based on a percentage of their income, and the government pays the difference through the premium tax credits. As a result, in CBO's projections, higher gross premiums for silver plans increase the amount of tax credits paid by the federal government, thereby covering insurers' costs for CSRs. Higher gross premiums for silver plans do not significantly affect the out-of-pocket payments that subsidized enrollees make for premiums for silver plans offered through the marketplaces because the structure of the premium tax credit largely insulates them from those increases.

For plans besides silver ones, insurers in most states have not increased gross premiums much, if at all, to cover the costs of CSRs. Because the premium tax credits are primarily based on the income of enrollees and not the nature of the plan they choose, enrollees could use those credits to cover a greater share of premiums for plans other than silver ones in those states. For example, more people are able to use their higher premium tax credits to obtain bronze plans, which cover a smaller share of benefits than silver plans, for free or for very low out-of-pocket payments for premiums. Also, some people with income between 200 percent and 400 percent of the FPL can purchase gold plans, which cover a greater share of benefits than do silver plans, with similar or lower premiums after tax credits. As a result of those changes, in most years, between 2 million and 3 million more people are estimated to purchase subsidized plans in the marketplaces than would have if the federal government had directly reimbursed insurers for the costs of CSRs.

Higher gross premiums for silver plans affect premiums for people who are not eligible for premium tax credits (most of whom have income above 400 percent of the FPL). However, many of those enrollees have options for purchasing other plans to avoid paying the premium increases resulting from the October 2017 policy change regarding the government's payments for CSRs. Just as insurers in most states have not appreciably increased premiums for plans other than silver ones to cover the costs of CSRs, insurers in many states have not increased the premiums of silver plans sold outside the marketplaces to cover the costs of CSRs either. Therefore, many people who are not eligible for subsidies are able to select a plan besides a silver one or a silver plan sold outside the marketplaces and avoid paying the premium increases stemming from the lack of a direct appropriation for CSRs.

Future Cost Estimates

In recent cost estimates for legislation that would appropriate funding for the payments to cover the costs of providing CSRs, CBO and JCT estimated that the appropriation would not affect direct spending or revenues because such payments were already incorporated in CBO's baseline projections.[4] After consulting with the budget committees about the baseline and about cost estimates relative to that baseline, CBO will continue that practice.

For legislation that would change the means of funding the CSR entitlement, CBO will estimate that enactment would not affect the federal deficit—because the obligations stemming from the entitlement can be fully satisfied through a direct payment or higher premiums and larger premium tax credit subsidies. However, if legislation was enacted that appropriated funds for direct payments for CSRs, the agency would update its baseline projections to incorporate those appropriations and to lower its projections of premium tax credits and other effects—because insurers would no longer increase gross premiums for silver plans offered through the marketplaces to cover the costs of providing CSRs.

4. See Congressional Budget Office, cost estimate for the Bipartisan Health Care Stabilization Act of 2018 (March 19, 2018), www.cbo.gov/publication/53666, and letter to the Honorable Lamar Alexander on the appropriation of cost-sharing reduction subsidies (March 19, 2018), www.cbo.gov/publication/53664.

Box 2.

Association Health Plans and Short-Term, Limited-Duration Insurance

The baseline presented in this report incorporates estimates from the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) of two recent regulations proposed by the Administration. The first regulation—published on January 5, 2018—would make it easier for business associations and other entities to offer health insurance through what are termed association health plans (AHPs) and multiple employer welfare associations, which are legal arrangements that allow business associations or unrelated employers to jointly offer health insurance and other fringe benefits to their members or employees. The second regulation—published on February 21, 2018—would expand the maximum policy length of short-term, limited-duration insurance (STLDI) plans from 3 months to 364 days. In accordance with CBO's standard practice for incorporating the effects of proposed rules, the baseline incorporates an assumption reflecting a 50 percent chance that the final issued rules will be the same as the proposed ones and a 50 percent chance that no new rules like the proposed ones will be issued.[1] The effects described here represent the agencies' estimates if the rules were implemented as proposed.

Estimated Effects of the Proposed Regulations

The agencies expect that the regulations would affect the small-group and nongroup insurance markets by allowing the sale of insurance products that do not comply with many current insurance regulations governing those markets. For example, insurers could offer plans that do not meet the minimum standards for benefits that insurers in the small-group and nongroup markets must provide, and insurers could also vary premiums on the basis of sex, occupation, and other personal characteristics. Both employers with healthier workforces and individuals who are relatively healthy and have income too high to qualify for premium tax credits for health insurance would find such plans appealing because the premiums would be lower than those for insurance products that comply with the current rules governing the small-group and nongroup markets.

By CBO and JCT's estimates, starting in 2023 (when the effects of both rules are estimated to be fully phased in), roughly 6 million additional people would enroll in either an AHP or STLDI plan as a result of the proposed rules, with about 4 million in AHPs and about 2 million in STLDI plans. (Of the 2 million additional enrollees in STLDI plans, fewer than 500,000 would purchase products not providing comprehensive financial protection against high-cost, low-probability medical events. CBO considers such people uninsured.)[2] The agencies estimate that the rules would decrease the number of uninsured people by roughly 1 million in 2023 and each year thereafter, with the majority of the previously uninsured enrolling in STLDI plans.

In 2023 and later years, about 90 percent of the 4 million people purchasing AHPs and 65 percent of the 2 million purchasing STLDI plans would have been insured in the absence of the proposed rules, CBO and JCT estimate. Because the people newly enrolled in AHPs or STLDI plans are projected to be healthier than those enrolled in small-group or nongroup plans that comply with the current regulations governing those markets, their departures would increase average premiums for those remaining in other small-group and nongroup plans. As a result, premiums are projected to be 2 percent to 3 percent higher in those markets in most years.

1. See Congressional Budget Office, letter to the Honorable John M. Spratt Jr. about how CBO reflects anticipated administrative actions in its baseline projections (May 2, 2007), www.cbo.gov/publication/18615. If final versions of the rules are promulgated, CBO and JCT will account for any changes from the regulations and will include estimates of the full effects of the final rules in subsequent cost estimates and in future baseline projections of health insurance coverage and federal subsidies for it.

2. In developing those estimates, CBO and JCT consulted with numerous policy and legal experts, industry associations, insurers, and state insurance regulators. On the basis of those conversations, the agencies expect that if the proposed STLDI regulation was finalized, a range of new STLDI insurance products would be sold. A small percentage of those plans would resemble current STLDI plans, which do not meet CBO's definition of health insurance coverage. In addition to those plans, insurers would, CBO expects, offer new types of short-term products resembling nongroup insurance products sold before the implementation of the Affordable Care Act. Those new products would probably limit benefits, be priced on the basis of individuals' health status, and impose lifetime and annual spending limits, and insurers could reject applicants on the basis of their health and any preexisting conditions. The majority of those plans would probably meet CBO's definition of private health insurance because they would still provide financial protection against high-cost, low-probability medical events.

Continued

Box 2. Continued

Association Health Plans and Short-Term, Limited-Duration Insurance

CBO and JCT estimate that the proposed rules would reduce the federal deficit by roughly $1 billion over the 2019–2028 period if implemented as proposed (and simultaneously, as assumed). On the basis of information obtained from stakeholders, CBO and JCT project that the rule on AHPs would primarily affect the small-group market and that the rule on STLDI plans would primarily affect the nongroup market. Over the 2019–2028 period, outlays for marketplace subsidies would increase on net by $2 billion, and revenues would increase by $3 billion. The net increase in marketplace subsidies reflects an increase in subsidies stemming from higher premiums, mostly offset by a reduction in the number of people receiving those subsidies.

Comparison With Other Estimates

CBO and JCT's assessment of the effects of the AHP and STLDI rules is in line with other published analyses, although comparing results is difficult because the policy scenarios evaluated are different. One outcome that is straightforward to compare is the effect of the rules on premiums for the small-group and nongroup plans that comply with the current regulations governing those markets. For that measure, CBO's estimate of a 2 percent to 3 percent increase in premiums accords with most other published estimates but is lower than the 6 percent increase estimated by the Chief Actuary for the Centers for Medicare & Medicaid Services (CMS).[3] Similarly, CBO's estimate of 4 million enrollees in AHPs is similar to other estimates.[4]

For the STLDI regulation, different analyses have reported very different measures, but most have reported the number of people leaving nongroup plans that comply with the current regulations governing that market. On that measure, CBO and JCT's estimate is significantly higher than the Administration's estimate contained in the proposed rule but lower than estimates in other published analyses.[5] Specifically, the Administration estimates in the proposed rule that fewer than 0.2 million people will leave the nongroup plans for STLDI plans, and other analyses show a range of 1.1 million to 2.2 million—compared with the agencies' estimate of almost 1 million departures in most years for both AHPs and STLDI plans (most of those for the latter).

3. For an analysis of how both rules would affect premiums for small-group and nongroup plans that comply with the regulations governing those markets, see Covered California, *Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States* (March 8, 2018), Table 1, https://tinyurl.com/yb5bpc2y. For an analysis of how AHPs would affect premiums for nongroup plans, see Sabrina Corlette, Josh Hammerquist, and Pete Nakahata, "New Rules to Expand Association Health Plans," *The Actuary Magazine* (web exclusive, May 2018), https://tinyurl.com/yavdxagj. For CMS's analysis of the STLDI rule, see Centers for Medicare & Medicaid Services, "Estimated Impact of STLD Proposed Rule (2018)" (April 6, 2018), https://go.usa.gov/xQPpj.

4. For an analysis of expected enrollment in AHPs, see Dan Mendelson, Chris Sloan, and Chad Brooker, "Association Health Plans Projected to Enroll 3.2 Million Individuals," *Avalere* (press release, February 28, 2018), Table 2, https://tinyurl.com/yb6plqdh.

5. For the estimate in the proposed rule, see Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 7437, 7441 (proposed February 21, 2018), https://go.usa.gov/xQPY5. See also Centers for Medicare & Medicaid Services, "Estimated Impact of STLD Proposed Rule (2018)" (April 6, 2018), https://go.usa.gov/xQPpj. For a summary of other assessments, see Christopher Pope, "Evaluating Assessments of Short-Term Insurance Deregulation," *Health Affairs Blog* (blog entry, May 9, 2018) Exhibit 1, https://tinyurl.com/y9xbps6k. One of the assessments cited assumes that the individual mandate remains in place, so comparing its estimates with those of other assessments is difficult. The more comparable assessments are Michael Cohen, Michelle Anderson, and Ross Winkelman, "Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market" (prepared by Wakely Consulting Group for the Association for Community Affiliated Plans, 2018), Table 1, https://tinyurl.com/y7ccesj7; and Linda J. Blumberg, Matthew Buettgens, and Robin Wang, *Updated: The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Urban Institute, March 14, 2018), https://tinyurl.com/yc37zx3o.

insurers did not increase premiums for plans in other tiers to cover the cost of CSRs because the requirement to offer CSRs does not generally apply to those plans.

After 2018, growth in gross premiums is projected to be slightly slower for bronze than for silver plans mainly because premiums for silver plans are expected to absorb more of the costs for CSRs during the next few years. Such growth for gold plans is projected to be slower than for silver or bronze plans mainly because the fast growth in premiums for silver plans in the marketplaces is expected to cause some people to choose gold plans instead of silver plans and the health of those people is anticipated to reduce the average costs borne by gold plans. The fast premium growth of silver plans is projected to make those plans increasingly unattractive over time to people not eligible for subsidies. By the end of the coming decade, gross premiums for gold plans are projected to be lower than gross premiums for silver plans, and the gold plans will provide more generous benefits for people not eligible for CSRs.

Increases in gross premiums for a particular tier are the same across age groups in percentage terms, but gross premium amounts themselves differ substantially by age. For people without subsidies, premiums are estimated to be slightly less than three times higher for a 64-year-old than a 21-year-old, on average, after accounting for regulations in different states. For example, CBO and JCT estimate average premiums for a 21-year-old, a 45-year-old, and a 64-year-old who buy the lowest-cost gold plans through the marketplaces to be about $8,800, $12,600, and $25,700, respectively, in 2028 (see Figure 3). Those estimates represent a national average of premiums excluding any premium tax credits, reflecting the geographic distribution of people who have coverage through the marketplaces.

Net Premiums for People Eligible for Subsidies. Because many people who enroll in coverage through the marketplaces receive federal subsidies in the form of premium tax credits, the net premiums that enrollees pay are often substantially lower than the gross premiums discussed above. In 2017, the average gross premium for subsidized enrollees in all states that use the federally facilitated marketplace platform healthcare.gov was about $5,850, but the average net premium paid after subsidies was about $1,250 (see Figure 4). In 2018, gross premiums in those states grew substantially, to an average of about $7,650 for subsidized enrollees. Although people not receiving subsidies paid the gross amount, net premiums for subsidized people fell to an average of about $1,050 because average tax credits increased substantially.[10] Average tax credits increased because the average premium for a benchmark silver plan rose. Those tax credits can be used to buy a plan in any tier. Because the tax credits grew so much more than premiums for bronze and gold plans, enrollees receiving subsidies often saw a significant reduction in their net premiums for those plans from 2017 to 2018.

The net premiums faced by people eligible for subsidies in the nongroup market, whose income is less than 400 percent of the FPL, vary substantially by income as well as by tier and by age. However, the general trends over time for such people can be illustrated by the premiums for people with income at 225 percent of the FPL (see Figure 5).

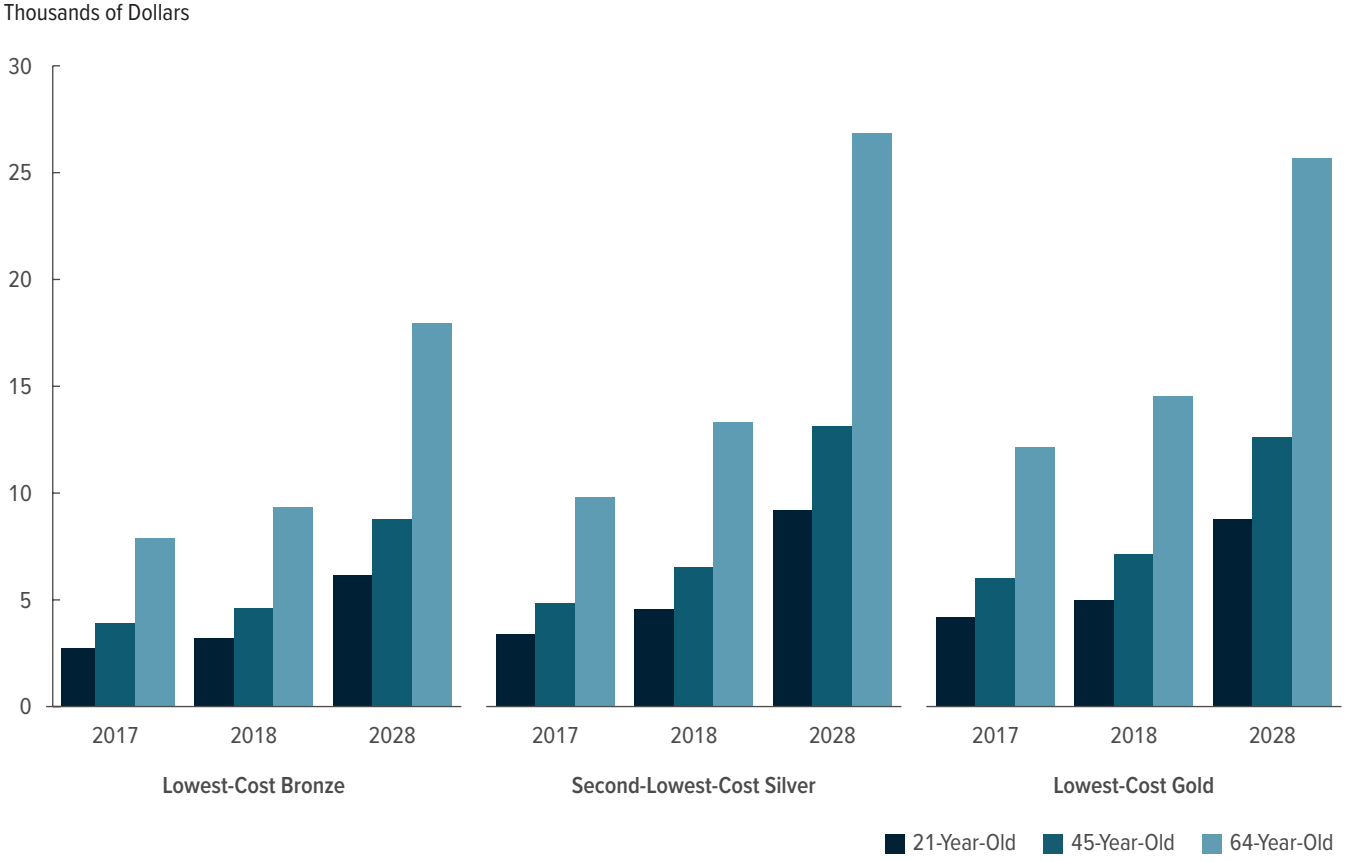
For silver plans, growth in net premiums for people with that amount of income—and for many other people eligible for subsidies—is estimated to be about 5 percent per year between 2018 and 2028 in nominal terms and 3 percent in real terms. That growth is limited by several factors that apply equally across age groups. For example, net premiums are limited to be no more than a certain percentage of people's income.

For bronze and gold plans, growth in net premiums in CBO's projections is heavily influenced by premium tax credit amounts, which are linked to the second-lowest-cost silver plan in the marketplaces. Because the gross premiums for those silver plans rose so much in 2018, the net premiums for bronze and gold plans for people eligible for tax credits in 2017 fell substantially in percentage terms between 2017 and 2018 for people with income at 225 percent of the FPL and for many other people eligible for subsidies (if the 2017 net premiums were greater than zero). Between 2018 and 2028, the projected nominal growth in those premiums varies significantly by age and tier as well as income. However, after the effects of inflation are removed, net premiums for bronze and gold plans for many people eligible for subsidies are generally projected to decline over that period.

10. CBO's calculations are based on data on plans selected during the open-enrollment period for each year. See Centers for Medicare & Medicaid Services, "2017 Marketplace Open Enrollment Period Public Use Files," https://go.usa.gov/xQ5ba, and "2018 Marketplace Open Enrollment Period Public Use Files," https://go.usa.gov/xQ5bC.

Figure 3.

Illustrative Examples, for Single Individuals, of Gross Premiums for Health Insurance Purchased Through the Marketplaces



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

Dollar amounts have been rounded to the nearest $50.

CBO and the staff of the Joint Committee on Taxation projected the average national gross premiums for a 21-year-old, a 45-year-old, and a 64-year-old in the nongroup health insurance market, taking into account the different age-rating methodology used in each state. The benchmark premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which a person resides. For bronze and gold plans, the premiums displayed in the figure are for the lowest-cost plan available in the marketplace in the area in which a person resides.

The actuarial value of a plan—the percentage of costs for covered services that the plan pays on average—differs by income. Bronze plans and gold plans have actuarial values of 60 percent and 80 percent, respectively. For people whose income is greater than 250 percent of the FPL, a silver plan has a standard 70 percent actuarial value.

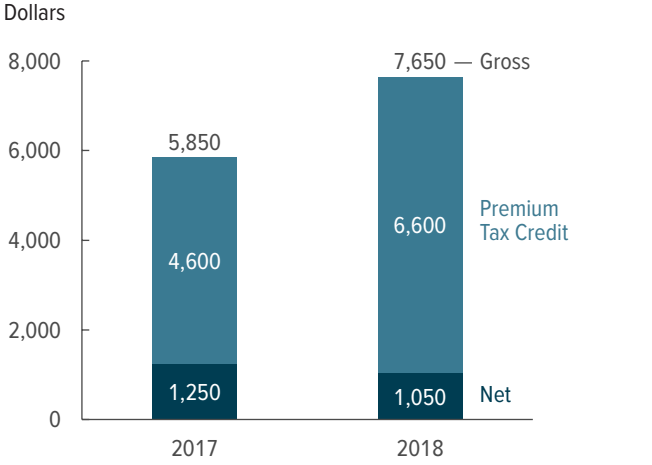
FPL = federal poverty level.

Basic Health Program. Under the ACA, states have the option to establish a Basic Health Program, which is primarily for people whose income is between 138 percent and 200 percent of the FPL. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would have been eligible through a marketplace. States can use those funds, in addition to funds from other sources, to offer health insurance that covers a broader set of benefits or requires smaller out-of-pocket payments than coverage in the marketplaces does.[11] So far, Minnesota and New York have created a Basic Health Program. In total, about 1 million people are projected to be enrolled in such a plan in each year from 2018 through 2028.

11. For more information about the Basic Health Program, see Centers for Medicare & Medicaid Services, "Basic Health Program" (accessed May 1, 2017), www.medicaid.gov/basic-health-program/index.html.

Figure 4.

Gross and Net Premiums for Subsidized Enrollees in States Using Healthcare.gov



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

Data are for enrollees receiving advanced payments of premium tax credits in states that use the federally facilitated marketplace platform healthcare.gov. The data are based on the plans selected during the open-enrollment period for each year.

Medicare and Other Coverage

Although Medicare is best known for providing coverage for people age 65 or older, it also covers some people who are under age 65. Many of those younger enrollees receive that coverage because they have qualified for benefits from the Social Security Disability Insurance program. (In general, people become eligible for Medicare two years after they qualify for disability insurance.) Between 8 million and 9 million people under age 65 are projected to be covered by Medicare in 2018 and in each year over the 2019–2028 period.

Other miscellaneous sources of coverage account for 5 million to 6 million people each year from 2018 to 2028. Those sources include student health plans, the Indian Health Service, and foreign sources.

Uninsured

An average of 29 million people under age 65 are projected to be uninsured in 2018. (In this report, CBO and JCT consider people uninsured if they are not covered by a plan or are not enrolled in a government program that provides financial protection from major medical risks.)

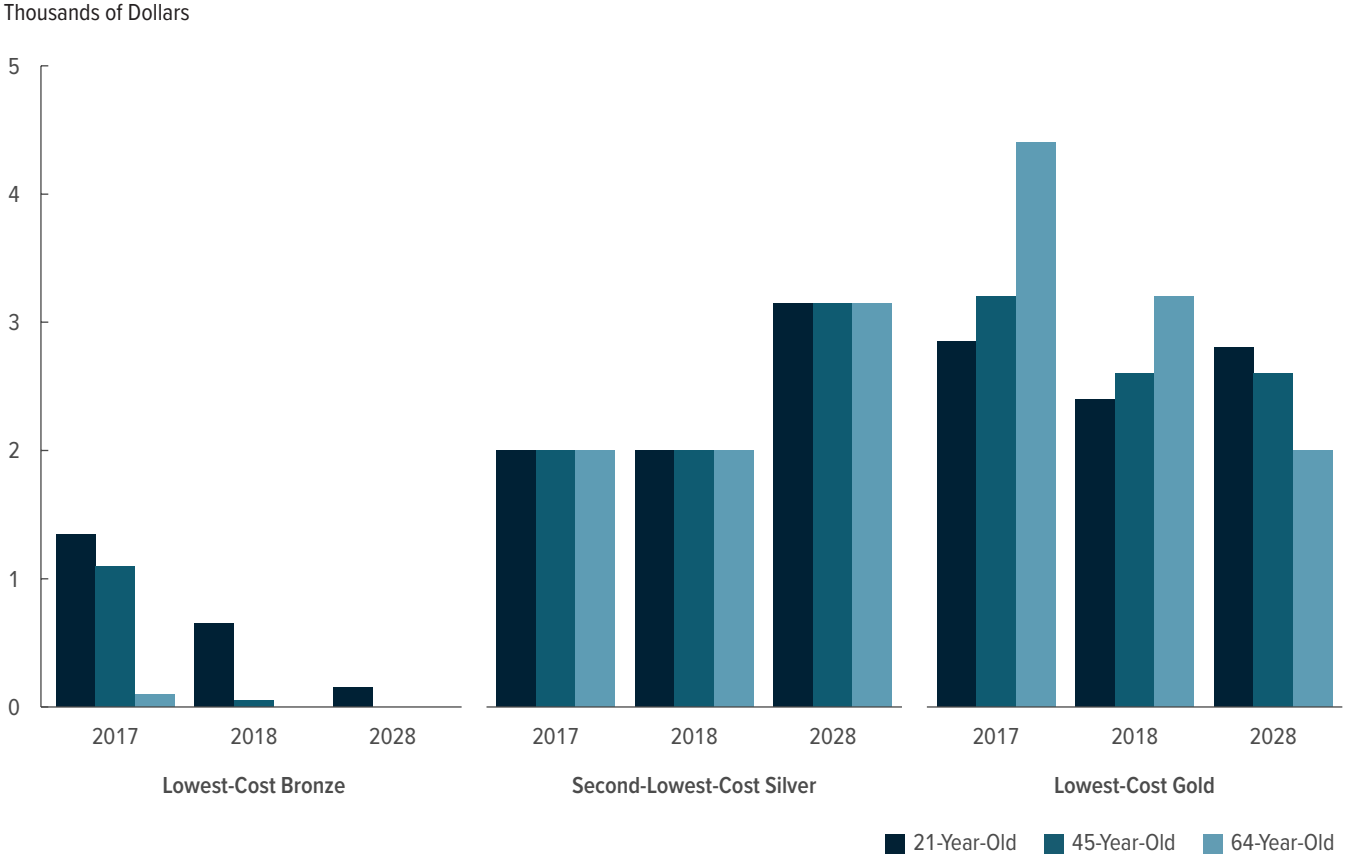
The number of uninsured people is projected to rise by 3 million in 2019, mainly because of the elimination of the penalty associated with the individual mandate and the higher premiums resulting from that change. That number rises by another 3 million over the following two years, on net, as more people adjust to the fact that they no longer face the mandate penalty. The effects of the penalty's elimination more than offset downward pressure on the number of uninsured people, which strengthens from 2019 to 2021. That pressure stems from higher premium tax credits caused by the lack of a direct appropriation for CSRs and from proposed regulations that would expand the use of association health plans (AHPs) and STLDI plans.

In most years over the next decade, and at the end of that period, about 13 percent of people under age 65 are projected to be uninsured, leaving about 35 million people uninsured in 2028.[12] In that year, according to CBO and JCT's estimates, about 20 percent of those uninsured people would be unauthorized immigrants and thus ineligible for subsidies through a marketplace or for most Medicaid benefits; about 10 percent would be ineligible for Medicaid because they live in a state that had not expanded coverage; about 20 percent would be eligible for Medicaid but would not enroll; and the remaining 50 percent would not purchase insurance to which they had access through an employer, through the marketplaces, or directly from insurers.

12. The sum of the estimates of the number of people enrolled in health insurance plans and the number of people who are uninsured exceeds CBO and JCT's estimate of the total population under age 65 by 10 million in most years, because some people will have multiple sources of coverage. A common example is people who report having both employment-based coverage and Medicaid. To arrive at the estimates given here, CBO and JCT did not assign a primary source of coverage to people who reported multiple sources; the resulting amounts align better with estimates of spending as well as with information about health insurance coverage from household surveys. (By contrast, when CBO and JCT have estimated changes in the sources of insurance coverage stemming from proposed legislation, the agencies have used only people's primary source of coverage to count them, an approach that has generally proved more useful for that purpose.)

Figure 5.

Illustrative Examples, for Single Individuals With Income at 225 Percent of the FPL, of Net Premiums for Health Insurance Purchased Through the Marketplaces



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

Dollar amounts have been rounded to the nearest $50.

CBO and the staff of the Joint Committee on Taxation projected the average national gross premiums for a 21-year-old, a 45-year-old, and a 64-year-old in the nongroup health insurance market, taking into account the different age-rating methodology used in each state. Net premiums equal gross premiums minus the projected premium tax credits for which a person is eligible. Premium tax credits are calculated as the difference between the benchmark premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage generally grows over time. For the purpose of determining the premium tax credits, eligibility is based on the most recently published FPL as of the first day of the annual open-enrollment period for coverage for that year. The benchmark premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which a person resides. For bronze and gold plans, the premiums displayed in the figure are for the lowest-cost plan available in the marketplace in the area in which a person resides.

The actuarial value of a plan—the percentage of costs for covered services that the plan pays on average—differs by income. Bronze plans and gold plans have actuarial values of 60 percent and 80 percent, respectively. For people whose income is greater than 250 percent of the FPL, a silver plan has a standard 70 percent actuarial value. The cost-sharing amounts (out-of-pocket payments required under insurance policies) are reduced for covered people whose income is generally between 100 percent and 250 percent of the FPL. Those cost-sharing reductions generally have the effect of increasing the actuarial value of a typical silver plan from 70 percent to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent.

Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. A modified adjusted gross income at 225 percent of the FPL equaled $27,150 in 2017 and $27,300 in 2018; the amount is projected to be $34,550 in 2028.

FPL = federal poverty level.

Projected Subsidies for Health Insurance Coverage

The federal government encourages people to obtain health insurance by making it less expensive than it would be otherwise. For people under age 65, the government subsidizes health insurance coverage in four main ways:

- Giving tax benefits for work-related coverage,
- Providing roughly three-fifths of all funding for Medicaid (while requiring states to provide the remainder),
- Offering tax credits to eligible people who purchase coverage through the health insurance marketplaces, and
- Providing coverage through the Medicare program to people under age 65 who receive benefits from the Social Security Disability Insurance program or who meet certain other criteria.

The costs of those subsidies are partly offset by related taxes and penalties that the federal government collects. They include excise taxes on providers of health insurance and penalty payments from large employers that do not offer health insurance that meets certain standards.

If current laws did not change, the net federal subsidy for health insurance coverage for people under age 65—that is, the cost of all the subsidies minus the taxes and penalties—would be about $685 billion in 2018 and would total $9.3 trillion over the 2019–2028 period, CBO and JCT estimate (see Table 2). Those sums reflect projections by the agencies about choices that people would make about obtaining health insurance and are subject to considerable uncertainty.

Work-Related Coverage

Health insurance that people receive from employers is the most common source of subsidized coverage for people under age 65. Employers' payments for workers' health insurance coverage are a form of compensation, but unlike cash compensation, those payments are excluded from income and payroll taxes. In most cases, the amounts paid by workers themselves for their share of the cost of employment-based coverage are also excluded from income and payroll taxes. Another work-related subsidy is the income tax deduction for health insurance premiums that can be used by self-employed people, including sole proprietors and workers in partnerships (who may purchase insurance individually or as part of a group). In addition, some small employers that provide health insurance to their employees are eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

JCT estimates that subsidies for work-related coverage for people under age 65 will total about $272 billion in 2018.[13] That amount is estimated to grow to $489 billion in 2028 and to total $3.7 trillion over the 2019–2028 period. The amount of the tax subsidy for work-related coverage is very large because the number of people with such coverage is large. (It is important to note that the estimated subsidies are not equal to the tax revenues that would be collected if those subsidies were eliminated, because in that event, many people would adjust their behavior to reduce the tax liability created by the change.)

Medicaid and CHIP

Outlays for all noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits are estimated to amount to $296 billion in 2018. Over the 2019–2028 period, estimated outlays total $4 trillion: $842 billion (or 21 percent of the total) for people made eligible for Medicaid by the ACA and $3.2 trillion (or 79 percent) for people eligible for Medicaid or CHIP otherwise. Medicaid spending for the noninstitutionalized population under age 65 accounts for roughly 80 percent of total projected Medicaid spending for medical services over the 2019–2028 period.

Nongroup Coverage and the Basic Health Program

In 2018, subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues (that is, premium tax credits, net spending and revenues related to risk adjustment and reinsurance, and grants to states), and payments for the Basic Health Program will total $55 billion, CBO and JCT estimate. Over the 2019–2028 period, such costs are projected to total $760 billion and to consist of the following main components:

13. That estimate excludes federal spending on medical benefits provided by the Department of Veterans Affairs and on the Defense Department's TRICARE program. For more information about those programs, see Congressional Budget Office, "Military and Veterans' Health Care," www.cbo.gov/topics/health-care/military-and-veterans-health-care.

- Outlays of $624 billion and a reduction in revenues of $79 billion for premium tax credits, totaling $703 billion (those tax credits cover a portion of eligible people's health insurance premiums and, because they are refundable, they can reduce individuals' tax liability below zero, resulting in outlays);

- Outlays of $57 billion for the Basic Health Program; and

- Outlays of $70 billion and revenues of roughly the same amount related to payments and collections for risk adjustment and reinsurance.

The third component of those subsidies is projected to have no net costs over time. The risk-adjustment and reinsurance programs were established under the ACA to stabilize premiums in the nongroup and small-group insurance markets by reducing the likelihood that particular insurers with a disproportionate share of less healthy enrollees would bear especially high costs.[14] The programs, which were implemented in 2014, make payments to insurers with less healthy enrollees; those payments are financed by collecting funds from insurers with healthier enrollees in the case of risk adjustment and by an assessment on a broad range of insurers in the case of reinsurance. The payments under the risk-adjustment and reinsurance programs are recorded in the budget as mandatory outlays, and the collections are recorded as revenues. In CBO's projections for the 2019–2028 period, risk-adjustment and reinsurance payments and collections total about $70 billion; almost all of that amount is for risk adjustment, as the last claims eligible for the reinsurance program are from plan year 2016. (Collections and payments ultimately offset each other exactly, but because of differences in the timing of collections and payments, slight discrepancies between the two will occur in any given period.)

Subsidies for insurance obtained through the marketplaces and outlays for the Basic Health Program depend on the number of people who purchase such coverage; the premiums for benchmark plans; and certain characteristics of enrollees, such as age, family size, and income. Combined, those subsidies and outlays for the Basic Health Program are projected to average $6,300 per subsidized enrollee in calendar year 2018 and to rise to about $12,440 in 2028.

14. The small-group insurance market is for health insurance generally purchased by or through employers with up to 50 employees; starting in 2016, states could expand the definition to include employers with up to 100 employees.

Medicare

Net outlays for Medicare coverage for noninstitutionalized people under age 65 are projected to be $82 billion in 2018 and to total $1 trillion over the 2019–2028 period. That amount is about one-eighth of total projected net spending for the Medicare program.

Taxes and Penalties

Taxes and penalties related to health insurance coverage are expected to reduce the total amount of federal subsidies for such coverage by $21 billion in 2018. Under current law, those taxes and penalties would total $313 billion over the 2019–2028 period, CBO and JCT estimate—mostly from a tax on health insurance providers and from penalties imposed on some employers for not offering to their employees health insurance that meets specified standards.

Excise Tax on High-Premium Insurance Plans. An excise tax on certain high-cost employment-based coverage is scheduled to be imposed beginning in 2022. The tax was originally supposed to take effect in 2018, but lawmakers have delayed its implementation until 2022.[15] In CBO and JCT's projections, collections of that tax total $47 billion over the 2019–2028 period.

The excise tax is expected to cause some employers and workers to shift to health plans with lower premiums in order to entirely avoid paying the tax or to reduce their tax liability. Those shifts will generally increase income tax revenues, CBO and JCT estimate, because affected workers will receive less of their income in nontaxable health benefits and more in taxable wages. Including those increases in income tax revenues, JCT estimates receipts stemming from the imposition of the excise tax to total $168 billion over the coming decade.[16]

15. See section 101 of Div. P of the Consolidated Appropriations Act, 2016, P.L. 114-113, 129 Stat. 2242, 3037, and section 4002 of an act making further continuing appropriations for the fiscal year ending September 30, 2018, and for other purposes, P.L. 115-120, 132 Stat. 28, 29.

16. That amount is shown as a memorandum item in Table 2. If workers' wages were instead held constant, their total compensation would be reduced by the amount of the change in premiums. Their employers would have smaller deductions for compensation costs and hence more taxable income—and the resulting total revenues would be similar.

Table 2.

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	Total, 2019–2028
Work-Related Coverage												
Tax exclusion for employment-based coverage[a,b]	266	276	293	310	326	343	361	380	426	458	480	3,653
Income tax deduction for self-employment health insurance[c]	5	5	5	5	6	6	7	7	7	8	8	64
Small-employer tax credits[b]	1	1	1	1	1	1	1	1	1	1	1	8
Subtotal	272	282	299	316	332	350	368	387	434	466	489	3,725
Medicaid and CHIP[d]												
Made eligible for Medicaid by the ACA	59	62	63	68	74	80	87	93	99	105	111	842
Otherwise eligible for Medicaid	221	233	245	260	276	293	311	329	348	368	388	3,049
CHIP	16	16	14	13	13	13	14	14	15	15	16	143
Subtotal	296	310	323	340	363	386	411	436	462	488	514	4,034
Nongroup Coverage and the Basic Health Program												
Premium tax credit outlays	43	47	51	57	64	66	67	68	67	68	70	624
Premium tax credit revenue reductions	6	6	6	6	7	7	8	8	10	11	11	79
Subtotal, premium tax credits	49	53	57	63	71	73	74	75	76	78	81	703
Cost-sharing outlays	0	0	0	0	0	0	0	0	0	0	0	0
Outlays for the Basic Health Program	4	4	4	5	5	6	6	6	7	7	8	57
Collections for risk adjustment and reinsurance	-5	-5	-6	-6	-7	-7	-7	-8	-8	-8	-9	-71
Payments for risk adjustment and reinsurance	7	5	6	6	6	7	7	8	8	8	9	70
Marketplace grants to states	*	0	0	0	0	0	0	0	0	0	0	0
Subtotal	55	57	61	68	76	79	80	82	83	85	89	760
Medicare[e]	82	84	88	93	97	102	106	111	116	122	129	1,049
Taxes and Penalties Related to Coverage												
Gross collections of excise tax on high-premium insurance plans[f]	0	0	0	0	-1	-5	-5	-6	-8	-11	-12	-47
Penalty payments by uninsured people	-4	-3	0	0	0	0	0	0	0	0	0	-3
Net receipts from tax on health insurance providers[g]	-13	0	-14	-15	-16	-17	-18	-19	-20	-21	-22	-161
Gross collections of employer penalties[f]	-4	-8	-10	-11	-8	-9	-10	-10	-11	-12	-12	-101
Subtotal	-21	-11	-24	-26	-26	-31	-33	-35	-38	-43	-45	-313
Net Subsidies	**685**	**723**	**747**	**791**	**843**	**886**	**933**	**981**	**1,057**	**1,118**	**1,176**	**9,255**

Continued

Tax on Health Insurance Providers. Health insurers are subject to an excise tax (though legislation eliminated it for calendar year 2019). The law specifies the total amount of tax to be assessed, and that total is divided among insurers according to their share of total applicable premiums charged in the previous year. Some health insurers, such as firms operating self-insured plans and certain state government entities and tax-exempt providers, are fully or partly exempt from the tax.[17] Net revenues from the tax will be $13 billion in 2018 and under current law would increase to about $22 billion by 2028, for a total of $161 billion over the decade, CBO and JCT estimate.

17. A self-insured firm essentially acts as its own insurer and bears much of the financial risk of providing coverage to its workers.

Table 2. Continued

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	Total, 2019–2028
Memorandum:												
Average Subsidy per Subsidized Marketplace or Basic Health Program Enrollee (Dollars)	6,300	7,210	8,010	9,330	9,970	10,200	10,740	11,050	11,440	11,940	12,440	n.a.
Collections of Excise Tax on High-Premium Insurance Plans, Including the Associated Effects on Revenues of Changes in Taxable Compensation	0	0	0	0	-8	-16	-20	-24	-28	-34	-39	-168

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

Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

This table excludes outlays made by the federal government in its capacity as an employer.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; n.a. = not applicable; * = between zero and $500 million.

a. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. JCT made this projection; it differs from JCT's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are excluded here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

b. Includes increases in outlays and reductions in revenues.

c. JCT made this projection; it does not include effects stemming from the deduction for people over age 65.

d. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. Also, the federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; the government therefore tracks those groups separately.

e. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

f. The excise tax is scheduled to go into effect in 2022. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance. If those effects were included, net revenues stemming from the excise tax would total $168 billion over the 2019–2028 period, and revenues from penalty payments by employers would total $79 billion over that 10-year period.

g. Net receipts include effects of the excise tax on individual and corporate tax receipts. The tax is suspended in 2019.

Penalties on Employers. Some large employers that do not offer health insurance coverage that meets certain standards under the ACA will owe a penalty if they have any full-time employees who receive a subsidy through a health insurance marketplace.[18] The requirement generally applies to employers with at least 50 full-time-equivalent employees. In CBO and JCT's projections, payments of those penalties total $101 billion over the 2019–2028 period. However, the increased costs for employers that pay the penalties are projected to reduce other revenues by $22 billion, because employers would generally be expected to shift the costs of the penalties to workers by lowering taxable wages. Once that shift is taken into account, the net reduction in the deficit is $79 billion.

Uncertainty Surrounding the Estimates

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other parties will behave in the future are all difficult to predict, so the estimates in this report are uncertain. CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes.

18. To meet the standards, the cost to employees for self-only coverage must not exceed a specified share of their income (which is 9.56 percent in 2018 and is scheduled to grow over time), and the plan must pay at least 60 percent of the cost of covered benefits.

The actual distribution of health insurance coverage in future years could differ from the projections presented in this report for a variety of reasons. If national economic trends diverge from CBO's economic forecast, for example, that would alter the number of people offered insurance by their employers, as well as the number of people eligible for Medicaid or coverage through the marketplaces. Additionally, changes in laws or regulations would affect health insurance markets. For example, if proposed regulations take effect, AHPs and STLDI plans may have smaller or larger effects on enrollment and premiums in the small-group and nongroup insurance markets than projected in this report. Depending on how state insurance commissioners regulate those plans, those markets may expand, shrink, or, in some areas of the country, become unstable. Furthermore, such economic and regulatory factors may interact with one another in a variety of ways to bring about outcomes that differ from the projections presented here.

Many other factors will also affect federal subsidies for health care. One important factor is the extent to which the emergence and adoption of health care technology will raise or lower costs. New and less expensive medical procedures or treatments could prove effective in helping patients, which could lower costs. But other beneficial procedures and treatments might be more expensive. Other factors that could affect health care costs are changes in the structure of payment systems and innovations in the delivery of health care. Those changes could encourage providers to supply more cost-effective treatments and reduce costs per enrollee. Other changes could reach previously underserved populations and raise costs per enrollee.

Changes in the Estimates of Insurance Coverage and Subsidies Since September 2017

In CBO and JCT's current projections for the 2018–2027 period (the span covered by both last year's projections and the current ones), about 3 million more people are uninsured, on average, than the agencies estimated in September 2017. The agencies have decreased their estimate of the net federal subsidies associated with health insurance coverage for people under age 65 from $9.2 trillion to $8.8 trillion for that period (see Table 3).

Changes in the Estimates of Insurance Coverage

In most years of the 2018–2027 period, CBO and JCT have changed their projections in the following ways:

- The number of uninsured people is higher;
- Enrollment in subsidized and unsubsidized nongroup coverage is lower;
- Enrollment in Medicaid is lower; and
- Enrollment in employment-based coverage is higher.

Uninsured. In CBO and JCT's current projections, an average of 3 million more people are uninsured between 2018 and 2027 than the agencies estimated last September. However, the change in the number of uninsured people varies significantly over that 10-year period: In 2018, 1 million fewer people are projected to be uninsured, and in 2027, 5 million more people are projected to be uninsured.

Effects of Eliminating the Individual Mandate Penalty. The primary reason for the increase in the projected number of uninsured people in most years is the elimination of the penalty related to the individual mandate beginning in 2019. Without a penalty for not having insurance, fewer people are projected to enroll in health insurance because some people would have enrolled to avoid paying the penalty and because some people are expected to forgo insurance in response to the resulting higher premiums in the nongroup market.

The projections explained in this report incorporate revised methods for estimating the effects of eliminating the penalty. Using those updated methods, CBO and JCT estimate the reduction in health insurance coverage is about one-third smaller than the agencies previously estimated.[19]

The update was prompted by a reassessment of the decline in the number of uninsured people since 2012 and the reasons for it. CBO and JCT have long attributed only part of the decline to financial factors that reduced the cost of obtaining coverage or increased the cost of being uninsured: the expansion of publicly financed coverage by Medicaid, the availability of subsidies for insurance obtained through the marketplaces, and the financial effect of the individual mandate penalty. The agencies have attributed the remainder to nonfinancial factors that lowered barriers to obtaining

19. For information on the agencies' prior estimate, see Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (November 2017), www.cbo.gov/publication/53300.

coverage, including simplified procedures for participating in Medicaid, the existence of the marketplaces, outreach and advertising, and market rules having the effect of broadening coverage.[20] Other nonfinancial factors are related to the individual mandate, including people's tendency to comply with laws, widespread and growing expectations that most people should have coverage, and people's greater responsiveness to penalties than to subsidies.[21]

In CBO and JCT's current projections, compared with earlier ones:

- The total effect of all nonfinancial factors is smaller;
- The nonfinancial factors associated with the mandate explain a smaller share of the total effect of all nonfinancial factors; and
- The mandate has been in place for an additional year (five years in total), and people's expectations about whether one should have coverage are more established and, in CBO's current judgment, less sensitive to repealing the legal mandate.

Each of those revisions reduced the agencies' estimates of the effects of eliminating the mandate penalty, which include eliminating the effects of the financial penalty and almost all of the nonfinancial effects of the individual mandate.

Those revisions were based in part on CBO's analysis of data from the National Health Interview Survey (NHIS) to discern changes over time in the number of uninsured people. Whereas CBO and JCT previously relied more heavily on estimates from the Medical Expenditure Panel Survey—Household Component, the agencies now use the NHIS as their primary benchmark for information on the number of uninsured people because it is the earliest available source each year and provides more reliable estimates derived from a larger sample.[22] The revisions also took into account information from analysts at other organizations.[23]

Effects of Other Factors. Partially offsetting those changes to methods are some changes that would, all else being equal, tend to lower the estimated number of uninsured people:

- CBO and JCT have updated their projections of premiums in the nongroup market to account for how insurers and state insurance commissioners reacted to the lack of a direct appropriation for CSRs. As a result of that change in funding, about 2 million more people are estimated to purchase coverage through the nongroup market in most years than would have if the federal government had continued to directly reimburse insurers for the cost of CSRs; some of those people would otherwise have been uninsured.
- CBO and JCT have incorporated the effects of two proposed regulations that would expand AHPs and STLDI plans. In particular, following the usual procedures for incorporating the effects of proposed rules, the agencies have incorporated a 50 percent chance that the final issued rules will be the same as the proposed ones and a 50 percent chance that no new rules like the proposed ones will be issued. Accordingly, the number of uninsured people in the baseline is projected to be between 500,000 and 1 million lower in most years than it would otherwise have been.

20. Those market rules include prohibiting insurers from denying coverage or varying premiums because of an enrollee's health status, or limiting coverage because of preexisting medical conditions; they allow insurers to vary premiums only on the basis of age, tobacco use, and geographic location. In addition, the market rules require that nongroup plans cover certain categories of benefits defined as essential.

21. For additional information, see Alexandra Minicozzi, Unit Chief, Health Insurance Modeling Unit, Congressional Budget Office, *Modeling the Effect of the Individual Mandate on Health Insurance Coverage* (presentation to CBO's Panel of Health Advisers, Washington, D.C., September 15, 2017), www.cbo.gov/publication/53105.

22. For a discussion of the data that CBO and JCT use, see Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

23. See Ashley Kirzinger and others, *Kaiser Health Tracking Poll—March 2018: Non-Group Enrollees* (April 3, 2018), https://tinyurl.com/y9osz5pm; John Hsu and others, "Eliminating the Individual Mandate Penalty in California: Harmful but Non-Fatal Changes in Enrollment and Premiums," *Health Affairs Blog* (blog entry, March 1, 2018), https://tinyurl.com/ybmbbob9; S&P Global Ratings, "U.S. Tax Reform: Repeal of the Health Insurance Mandate Will Save Less Than Expected, and Will Not Support the Current Insurance Market" (November 16, 2017); Paul Spitalnic, *Estimated Financial Effect of the "American Health Care Act of 2017"* (Centers for Medicare & Medicaid Services, Office of the Actuary, June 13, 2017), https://go.usa.gov/xQDfG; and Linda J. Blumberg, Matthew Buettgens, and John Holahan, *Implications of Partial Repeal of the ACA Through Reconciliation* (Urban Institute, December 2016), https://tinyurl.com/y6vkugs4.

Table 3.

Comparison of Current and Previous Projections of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65

	2018			2018–2027		
	September 2017 Projection	Spring 2018 Projection[a]	Difference	September 2017 Projection	Spring 2018 Projection[a]	Difference
	Insurance Coverage During the Year[b] (Millions of people)			Average Insurance Coverage Over the Period[b] (Millions of people)		
Total Population	273	273	*	275	275	*
Employment-Based Coverage	157	158	1	153	156	3
Medicaid and CHIP[c]						
Made eligible for Medicaid by the ACA	13	12	*	15	13	-2
Otherwise eligible for Medicaid or CHIP	56	55	-1	55	55	*
Total	68	67	-1	70	68	-1
Nongroup Coverage and the Basic Health Program						
Subsidized nongroup	9	8	-2	10	7	-3
Unsubsidized nongroup	6	7	1	7	6	-2
Total	16	15	-1	18	13	-5
Coverage through the Basic Health Program[d]	1	1	*	1	1	*
Medicare[e]	8	8	*	9	8	*
Other Coverage[f]	5	5	*	5	5	*
Uninsured[g]	30	29	-1	31	34	3
	Effects on the Federal Deficit[h] (Billions of dollars)			Effects on the Cumulative Federal Deficit Over the Period[h] (Billions of dollars)		
Work-Related Coverage						
Tax exclusion for employment-based coverage[i,j]	297	266	-31	3,796	3,439	-357
Income tax deduction for self-employment health insurance[k]	7	5	-2	91	61	-30
Small-employer tax credits[j]	1	8	7	10	8	-2
Subtotal	306	279	-26	3,897	3,508	-389
Medicaid and CHIP[l]						
Made eligible for Medicaid by the ACA	76	59	-17	1,036	791	-245
Otherwise eligible for Medicaid or CHIP	238	237	-2	2,981	3,025	44
Subtotal	315	296	-19	4,017	3,815	-202
Nongroup Coverage and the Basic Health Program						
Premium tax credits	47	49	2	605	671	66
Cost-sharing outlays	9	0	-9	99	0	-99
Outlays for the Basic Health Program	5	4	-1	69	54	-15
Subtotal	62	55	-7	773	725	-48
Medicare[m]	81	82	2	1,011	1,003	-8
Taxes and Penalties Related to Coverage						
Gross collections of excise tax on high-premium insurance plans[n]	0	0	0	-29	-36	-7
Penalty payments by uninsured people	-4	-4	**	-51	-7	44
Net receipts from tax on health insurance providers[o]	-13	-13	0	-166	-152	13
Gross collections of employer penalties[n]	-12	-4	7	-207	-93	114
Subtotal	-28	-21	7	-453	-289	165
Net Subsidies[o]	**735**	**685**	**-50**	**9,245**	**8,764**	**-481**

Continued

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

Estimates of insurance coverage apply to calendar years, and estimates of the effect on the federal deficit apply to fiscal years.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; * = between -500,000 and 500,000; ** = between zero and $500 million.

a. Estimates are from CBO's adjusted April 2018 baseline. The adjustment reflects updates to the preliminary projections (contained in *The Budget and Economic Outlook: 2018 to 2028*, released on April 9, 2018) for subsidies for insurance purchased through the marketplaces established under the ACA as well as for revenues related to health care.

b. Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in most years, 10 million people (or 4 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid. Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

c. Includes noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

d. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

e. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

f. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

g. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

h. Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

i. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. JCT made this projection; it differs from JCT's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are excluded here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

j. Includes increases in outlays and reductions in revenues.

k. JCT made this projection; it does not include effects stemming from the deduction for people over age 65.

l. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. Also, the federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; the government therefore tracks those groups separately.

m. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

n. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance.

o. Net receipts include the effects of the excise tax on individual and corporate tax receipts. The tax is suspended in 2019.

- CBO and JCT have updated their estimates to include the recently enacted extension of funding for CHIP from 2018 to 2027. Because some people who will gain coverage through CHIP would otherwise have gone uninsured, its extension reduces projections of the number of uninsured people by fewer than 500,000 in each year.

Nongroup Coverage and the Basic Health Program. Average monthly enrollment in the nongroup market is now projected to be 1 million lower in 2018 and 5 million lower, on average, between 2018 and 2027 than estimated in September 2017. On average, over the 10-year period, subsidized enrollment is lower by 3 million people, and unsubsidized enrollment is lower by 2 million. Projections of enrollment in the Basic Health Program are not noticeably different.

The 2017 tax act's elimination of the individual mandate penalty accounts for most of the reduction in the projections of nongroup enrollment: Fewer people are expected to enroll in coverage through the nongroup market as a consequence. In addition, the extension of CHIP funding from 2018 through 2027 reduced estimates of enrollment in the nongroup market because some people

who will gain coverage through CHIP would otherwise have obtained nongroup coverage.

Those reductions in nongroup coverage are somewhat offset by the lack of direct federal funding for CSR payments. As discussed above, CBO and JCT estimate that funding CSRs through higher gross premiums and therefore higher premium tax credits will result in about 2 million more people purchasing coverage through the nongroup market in most years than would have if the federal government had continued to directly reimburse insurers for the cost of CSRs. In addition, CBO and JCT estimate that the proposed regulations that would expand STLDI plans would increase the number of people enrolled in nongroup coverage by fewer than 500,000 people. (That estimate reflects a 50 percent probability that the regulations will be finalized as proposed.)

Medicaid and CHIP. Relative to the September 2017 estimates, current estimates of enrollment in Medicaid and CHIP are 1 million lower for most years over the 2018–2027 period. The elimination of the individual mandate penalty was the largest factor reducing projected enrollment. In CBO's estimation, the penalty for not having insurance encouraged more people to enroll in Medicaid than would otherwise have been the case. For example, some people applied for coverage in the marketplaces as a result of the penalty and turned out to be eligible for Medicaid, and some Medicaid-eligible adults and children would have had to pay a penalty if they did not obtain insurance. As a result, when the penalty is eliminated, beginning in 2019, fewer people will enroll in Medicaid, CBO expects.

Partially offsetting that effect is additional estimated enrollment in CHIP stemming from the extension of funding for that program from 2018 through 2027.

Employment-Based Coverage. CBO and JCT increased last year's projections of enrollment in employment-based insurance coverage by 1 million people in 2018 and by an average of 3 million people between 2018 and 2027. Those net increases are the result of three main factors. First, the upward revision reflects an updated assessment of administrative data and data from household and employer surveys, which has led CBO and JCT to increase their estimate of the total number of people with employment-based coverage before 2018. Second, in its latest economic forecast, CBO projects that more people will be employed in most years over the coming decade than previously estimated, which boosts projected enrollment in employment-based coverage. Finally, partly on the basis of actual premiums for 2018, the agencies increased their projections of gross premiums for plans offered through the nongroup market, thereby increasing projected enrollment in employment-based coverage. (Because alternative sources of coverage would be more expensive, more employers are expected to offer insurance to their employees.)

Partially offsetting those factors increasing employment-based coverage is the elimination of the individual mandate penalty beginning in 2019. That factor has led CBO and JCT to lower their estimates of the number of people with employment-based coverage by 2 million in most years after 2018, relative to the September 2017 projections.

Changes in the Estimates of Subsidies, Penalties, and Taxes

In CBO and JCT's current projections, the net cost to the federal government of subsidizing health insurance coverage is $50 billion lower in 2018 and $481 billion (or about 5 percent) lower over the 2018–2027 period than it was in the agencies' September 2017 projections. Reduced estimates of the net cost of the tax exclusion for employment-based coverage and of Medicaid spending explain most of that decrease.

Tax Exclusion for Employment-Based Coverage. Estimates of the net cost of the tax exclusion for employment-based coverage are now $31 billion lower in 2018 and $357 billion lower over the 2018–2027 period. The cost of the exclusion depends on the number of people with employment-based coverage, the marginal tax rates of people enrolled in that coverage, and premiums for employment-based coverage. Although total enrollment in employment-based coverage is now projected to be higher than the September estimate, two other changes more than offset that effect: As a result of changes enacted in the 2017 tax act, marginal tax rates are estimated to be lower through 2025, and on the basis of new information available from the Internal Revenue Service about premiums in 2015, average premiums for employment-based coverage are, on net, estimated to be lower.

Medicaid and CHIP. CBO has reduced its projections of outlays for Medicaid and CHIP by $19 billion in 2018 and by $202 billion over the 2018–2027 period. Lower spending for Medicaid accounts for $280 billion of that net reduction, mostly because the elimination

of the individual mandate penalty is expected to lower enrollment in the program. In addition, the extension of funding for CHIP from 2018 through 2027 is estimated to generate savings for Medicaid because CBO had expected that, in the absence of extended funding for CHIP, states would switch some children who had been enrolled in CHIP to Medicaid.

CBO also has made technical revisions that have reduced its projections of Medicaid spending over the next decade. That reduction stems largely from lower-than-anticipated per capita costs in 2017 for people made eligible for Medicaid under the ACA and lower projections of cost growth for those enrollees.

As a result of the extension of funding for CHIP, CBO's current projection of outlays for the program over the 2018–2027 period is $78 billion higher than the September 2017 estimate.

Subsidies for Nongroup Coverage and the Basic Health Program. CBO and JCT's estimates of the net cost of subsidies for coverage through the marketplaces, along with estimates of related spending and revenues, are now $7 billion lower for 2018 and $48 billion lower for the 2018–2027 period. That net reduction results from the agencies' lower projections of subsidized enrollment through the marketplaces, partly offset by an increase in the estimated per-person cost of that coverage. The elimination of the individual mandate penalty accounts for most of the reduction in nongroup enrollment.

The estimated per-person cost of subsidized nongroup coverage is higher in the current projections for two main reasons. The lack of direct funding for CSRs increased average gross premiums for benchmark plans, which results in higher average subsidies. In addition, the elimination of the individual mandate penalty is expected to result in a less healthy mix of enrollees, thereby increasing projected average gross premiums and, therefore, subsidies.

Penalties and Taxes Related to Coverage. CBO and JCT have lowered their estimates of collections of penalty payments by individuals who do not purchase health insurance coverage meeting the ACA's standards by less than $500,000 in 2018 and by $44 billion over the 2018–2027 period. That reduction stems almost entirely from the 2017 tax act and its elimination of the penalty associated with the individual mandate beginning in 2019. As a result, CBO and JCT expect that no such penalties will be collected from people who are uninsured in 2019 or later years.

In addition, CBO and JCT have reduced their estimate of collections of penalty payments from employers that do not offer coverage meeting the ACA's standards by $7 billion in 2018 and by $114 billion over the 2018–2027 period as a result of new data from the Treasury Department showing less reported penalty liability than previously projected.

Comparisons of CBO and JCT's Projections With Actual Coverage and Subsidies

In order to improve CBO and JCT's baseline projections, the agencies compare their projections of health insurance coverage and federal subsidies for people under age 65 with actual enrollment and costs reported by the Administration, state governments, and surveys whenever possible. This report compares projections for 2017 published in March 2016 and September 2017 with actual amounts for 2017 (see Table 4).

Nongroup Coverage and the Basic Health Program

CBO and JCT's March 2016 projection of subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues, and payments for the Basic Health Program accounted for the largest estimating error for 2017. The agency estimated that those subsidies would total $55 billion in 2017—about $11 billion, or about 25 percent, more than the actual amount reported by the Administration for 2017.

CBO and JCT overestimated costs to the federal government because they overestimated the number of people who would enroll through the marketplaces, and receive subsidies, in 2017. In March 2016, CBO and JCT estimated that 12 million people would enroll in subsidized coverage through the marketplaces—about 4 million, or 50 percent, more than the actual number. At the time, CBO and JCT expected enrollment to grow from 2016 to 2017 as more people gained experience with the marketplaces and more employers responded to the availability of subsidies by declining to offer insurance to their employees. However, enrollment through the marketplaces changed little in 2017. As a result, in their September 2017 projections, CBO and JCT significantly reduced their estimates of enrollment through the marketplaces in 2017 and later years.

The effect on subsidies of overestimating enrollment in the March 2016 projection was partially offset by

Table 4.

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65 in CBO's March 2016 and September 2017 Projections Compared With Actual Coverage and Subsidies in 2017

	March 2016 Baseline	September 2017 Projection	Actual	Difference, March 2016–Actual	Difference, September 2017–Actual
	Selected Categories of Health Insurance Coverage for People Under Age 65 (Millions of people, calendar year 2017)				
Nongroup Coverage Purchased Through the Health Insurance Marketplaces[a]					
Subsidized	12	8	8	4	*
Unsubsidized	3	2	2	1	*
Total	15	10	10	5	*
Basic Health Program[b]	1	1	1	*	*
Uninsured[c]	26	28	28	-2	*
	Selected Categories of Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65 (Billions of dollars, fiscal year 2017)				
Medicaid and CHIP[d]					
Medicaid[e]	279	280	276	3	5
CHIP	13	16	16	-3	-1
Total	292	296	292	-1	4
Nongroup Coverage and the Basic Health Program					
Premium tax credits[f]	43	34	35	8	-1
Cost-sharing outlays[f]	9	7	6	3	1
Outlays for the Basic Health Program[f]	4	5	4	-1	**
Collections for risk adjustment and reinsurance[g]	-11	-9	-10	-1	1
Payments for risk adjustment and reinsurance[g]	10	9	9	2	**
Total	55	45	45	11	1

Continued

underestimating the average costs per subsidized enrollee.[24] In March 2016, CBO and JCT's estimate of average costs per subsidized marketplace or Basic Health Program enrollee was too low—by about 10 percent. Using information from the beginning of 2017, CBO and JCT increased their estimates of average costs in that year and later years in their September 2017 projection. All told, the agencies' September 2017 projection of subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues, and Basic Health Program payments for 2017 turned out to be $1 billion higher than the actual amount for that fiscal year.[25]

Other Subsidies and Revenues

For all other categories of subsidies, taxes, and penalties related to coverage for people under age 65 for which actual information for 2017 is available, CBO and JCT's March 2016 and September 2017 projections for 2017 differed by less than 5 percent from the actual amounts. For example, CBO estimated in March 2016 that outlays for noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits would be $292 billion and in September 2017, $296 billion. Actual spending in 2017 was $292 billion.

24. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2016* (March 2016), www.cbo.gov/publication/51385.

25. For calendar year 2017, the overestimate of total spending that could be calculated by multiplying CBO's September 2017 projection of enrollment by its projection of average costs is substantially larger than the overestimate for total spending in fiscal year 2017 mostly because the Administration stopped the payment of CSRs in October 2017 and those payments had been projected to continue in CBO's baseline.

Table 4. Continued

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65 in CBO's March 2016 and September 2017 Projections Compared With Actual Coverage and Subsidies in 2017

	March 2016 Baseline	September 2017 Projection	Actual	Difference, March 2016–Actual	Difference, September 2017–Actual
	Selected Categories of Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65 (Billions of dollars, fiscal year 2017)				
Medicare[d,h]	81	80	82	-1	-2
Penalty Payments by Uninsured People[i]	-3	-3	-3	**	**
Memorandum:					
Average Subsidy per Subsidized Marketplace or Basic Health Program Enrollee (Dollars, calendar year 2017)[j]	4,550	5,550	5,010	-460	540

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation; and additional sources listed below.

Comparisons are shown only for categories of health insurance and net federal subsidies associated with people under age 65 for which actual values are publicly available for at least part of 2017.

CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; * = between -500,000 and 500,000; ** = between -$500 million and $500 million.

a. Actual value based on data published by the Centers for Medicare & Medicaid Services. See Centers for Medicare & Medicaid Services, "2017 Effectuated Enrollment Snapshot" (accessed April 25, 2018), https://go.usa.gov/xR7j7 (PDF, 489 KB) and "First Half of 2017 Average Effectuated Enrollment Report" (accessed April 25, 2018), https://go.usa.gov/xQmaM.

b. Actual value based on information published by the state governments of Minnesota and New York, which are the only states that have used the program. See Randall Chun, MinnesotaCare (Minnesota House of Representatives, House Research Department, updated December 2017) www.house.leg.state.mn.us/hrd/pubs/mncare.pdf (104 KB); and New York State Department of Health, "2017 Open Enrollment Report," https://go.usa.gov/xQm9U.

c. Actual value reflects the number of uninsured people reported by the National Health Interview Survey adjusted downward to exclude people with Indian Health Service coverage, which CBO and JCT consider to be health insurance coverage. See Robin A. Cohen, Emily P. Zammitti, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017* (National Center for Health Statistics, May 2018), https://go.usa.gov/xQmKM (PDF, 530 KB).

d. See Department of the Treasury, "Final Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 2017 Through September 30, 2017, and Other Periods" (October 2017), https://go.usa.gov/xQmsd.

e. Actual value reported by the Department of the Treasury adjusted to reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

f. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of the Treasury" (February 2018), p. 956, https://go.usa.gov/xR7Dc.

g. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of Health and Human Services" (February 2018), pp. 449–450, https://go.usa.gov/xR7Dc.

h. Actual value reported by the Department of the Treasury adjusted to reflect benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

i. Actual value based on preliminary data from the Internal Revenue Service. See Internal Revenue Service, "SOI Tax Stats—Individual Income Tax Returns," Preliminary Data, Statistical Tables, Table 1—Individual Income Tax Returns: Selected Income and Tax Items (accessed April 19, 2018), https://go.usa.gov/xQm9k.

j. Estimates of actual costs per person are the ratios of costs to subsidized enrollment through the health insurance marketplaces or the Basic Health Program in a calendar year.

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About This Document

Each year, the Congressional Budget Office issues a series of publications describing its projections of the federal budget. This report provides background information that helps explain some of the projections in the most recent of those publications and also provides updated estimates. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations.

Kate Fritzsche and Kevin McNellis prepared the report with contributions from Sarah Masi. Susan Yeh Beyer, Alice Burns, Philippa Haven, Ben Hopkins, Sean Lyons, Eamon Molloy, Romain Parsad, Allison Percy, Ezra Porter, Lisa Ramirez-Branum, Robert Stewart, Chris Zogby, and the staff of the Joint Committee on Taxation contributed to the analysis. Jessica Banthin, Chad Chirico, Theresa Gullo, Leo Lex, Alexandra Minicozzi, and David Weaver provided guidance and helpful comments.

Mark Hadley, Jeffrey Kling, and Robert Sunshine reviewed the report; John Skeen edited it; and Casey Labrack prepared it for publication. The report is available on the agency's website (www.cbo.gov/publication/53826).

Keith Hall
Director
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How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65

In the United States, most people under age 65 are covered by private health insurance that they or their family members obtain through their employers (referred to as employment-based, or group, coverage). A smaller number of people buy private health insurance individually (through what is known as the nongroup market). Nongroup policies are available through the health insurance marketplaces established under the Affordable Care Act (ACA) or outside of them, through brokers or directly from insurers. Two of the major sources of public insurance coverage for people under 65 are Medicaid and the Children's Health Insurance Program (CHIP).

The federal government subsidizes private and public insurance coverage through various tax preferences and federal programs. Because those subsidies affect the federal budget in many ways, defining what constitutes coverage and estimating health insurance coverage for people under 65 are important steps in the process of preparing the Congressional Budget Office's baseline budget projections. The most recent year for which actual coverage data are available serves as the starting point for CBO's projections of health insurance coverage. This report provides details about that starting point. Specifically, the report:

- Describes how CBO defines health insurance coverage (private and public) for people under 65 who are not institutionalized and who are not members of the active-duty military;
- Explains how the agency estimates the number of insured and uninsured people in that population for the most recent year for which data on actual coverage exist; and
- Describes where CBO obtains the data to estimate coverage, the limitations of those sources, and how the agency adjusts its estimates because of those limitations.

(For a discussion of related work by CBO and other researchers, see the Appendix.)

How Does CBO Define Private Insurance Coverage?

Health insurance policies vary widely, ranging from those that offer substantial coverage for a variety of health care services to those that are limited in scope or offer a small amount of coverage. Therefore, in preparing any estimate of the number of people covered by health insurance, it is useful and important to identify where to draw the line when distinguishing between policies that provide comprehensive coverage and those that do not.

An important function of insurance is to provide financial protection against high-cost, low-probability events (such as car accidents, fires, or floods). Consistent with that notion, in the context of health care costs, CBO broadly defines private health insurance coverage as a policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. This type of coverage is often referred to as comprehensive major medical coverage. The agency grounds its coverage estimates on that widely accepted definition, which encompasses most private health insurance plans offered in the group and nongroup markets. The definition may include some short-term, limited-duration policies that provide comprehensive major medical coverage for a specified period and plans with very high deductibles. The desirability or adequacy of such coverage will vary on the basis of

people's preferences and income but that does not change CBO's definition of coverage. The definition excludes the following: policies with limited insurance benefits (known as mini-med plans); some types of short-term, limited-duration policies and long-term policies that do not provide comprehensive major medical coverage; "dread disease" policies that cover only specific diseases; supplemental plans that pay for medical expenses that another policy does not cover; fixed-dollar indemnity plans that pay a certain amount per day for illness or hospitalization; and single-service plans, such as dental-only or vision-only policies.

When specific requirements are established in law, CBO takes into account those definitions to further determine what policies count as private insurance coverage. To define coverage under the ACA, CBO relies on provisions in that law that established detailed requirements governing the benefits of private insurance coverage in the large-group market, which is generally defined as employers with more than 50 employees.

CBO also takes into account separate provisions of the ACA that define the requirements governing plans offered in the small-group market (generally defined as employers with up to 50 employees) and the nongroup market. Since 2014, new plans sold in those markets must cover 10 categories of health care benefits that the ACA defines as essential. Other provisions require that those plans' actuarial value (a summary measure of the depth of coverage) fall into specified categories (an actuarial value of 60 percent, 70 percent, 80 percent, or 90 percent). In limited circumstances, plans with an actuarial value of less than 60 percent—known as catastrophic plans—can be sold to certain individuals. (A plan with an actuarial value of 60 percent means that, for an average population, the plan will pay for 60 percent of covered health care expenses; enrollees are responsible for 40 percent of their health care expenses through some combination of deductibles, copayments, and coinsurance.) Some plans that existed before 2014 and are still being offered are exempt from those requirements or from certain ACA regulations. CBO counts those noncompliant plans and catastrophic plans as private insurance coverage because they typically provide comprehensive major medical coverage and are permitted under the ACA in limited circumstances.

If the provisions of the ACA that govern the definition of private insurance coverage were amended or if changes in regulations allowed more noncompliant plans to be sold, CBO would take those new laws and regulations into account when defining coverage. But the agency would continue to exclude plans that did not provide the minimum benefits afforded by comprehensive major medical coverage. In the absence of any definition, CBO would revert to the widely accepted definition of private insurance coverage—comprehensive major medical coverage with a minimum level of benefits, as described above. That definition of private insurance coverage is in keeping with what the agency has used to estimate coverage in the past.

How Does CBO Define Public Insurance Coverage?

CBO defines as publicly insured people who receive full Medicaid or CHIP benefits. The agency's definition of publicly insured does not include people who receive partial Medicaid benefits—such as women who receive only family planning services or unauthorized immigrants who receive only emergency services. CBO also defines as publicly insured disabled adults under age 65 who are covered by Medicare. Additionally, CBO considers TRICARE policyholders and their dependents to be publicly insured (although active-duty military personnel are not included in the population for which CBO estimates insurance coverage). Moreover, CBO defines as publicly insured people who use the Indian Health Service (IHS) or the Veterans Health Administration (VHA). Lastly, CBO defines other miscellaneous sources of coverage, including student health plans and coverage from foreign sources, as health insurance.

What Data Sources Does CBO Use to Estimate Coverage?

To estimate the number of people with and without health insurance coverage, CBO combines data from household and employer surveys with administrative data about the operation of government programs (when available). CBO currently uses survey data as the basis for estimating employment-based private insurance coverage. The agency also uses survey data to estimate the number of people without coverage because no administrative data on the uninsured are available. By contrast, CBO relies on administrative data from the Centers

for Medicare & Medicaid Services (CMS) to estimate the number of people with private insurance coverage in the health insurance marketplaces. Similarly, CBO relies primarily on data from administrative records to count people with public insurance coverage through Medicaid, CHIP, and Medicare.

Certain administrative records, such as those that record program participation, are generally more accurate than reports from household surveys because they are based on complete tabulations instead of a sample and program funding is based on them. In addition, survey respondents typically misreport their sources of coverage to some degree. Survey data, however, are used to determine the demographic and income characteristics of Medicaid and CHIP enrollees because that information is lacking in administrative data. Survey data can thus fill in the gaps by providing estimates for types of coverage that are not included in administrative data or by showing how coverage varies on the basis of demographic variables, such as income and age.

To estimate the number of people with private insurance coverage or without coverage, CBO uses data from several household surveys: the National Health Interview Survey (NHIS); the Medical Expenditure Panel Survey (MEPS)—Household Component; and the Current Population Survey (CPS). The agency also uses data from one employer survey, the MEPS—Insurance Component. All of those surveys are used to estimate how public insurance coverage varies on the basis of demographic variables. In addition, CBO uses the Census Bureau's Survey of Income and Program Participation (SIPP) as the base data in its Health Insurance Simulation Model (HISIM). (In the next generation of its microsimulation model, now under development, CBO will use the CPS as its base data.)

CBO uses the SIPP as the base data in HISIM because it includes detailed information about individuals and families, such as demographic characteristics, income, health status, employment status, insurance coverage, and employers' offers of insurance. That detailed information allows CBO to make coverage projections for current and future years, and it supports the simulation of behavioral responses of individuals and families to changes in policy and the resulting changes in coverage.

The SIPP data alone, however, do not accurately indicate the extent of current insurance coverage. That is because survey respondents can misreport their sources of coverage and more recent data on insurance coverage are available from other sources. As a result, CBO adjusts the SIPP data to match coverage estimates developed from a combination of administrative data and other household and employer surveys (as discussed below). CBO takes that step so that its estimates of historical coverage reflect the most recent year for which data on actual coverage distributions exist; the estimates serve as the starting point for the development of future projections.

What Are the Challenges in Using Survey Data to Estimate Coverage?

The main challenge in using household survey data to estimate the number of people with and without health insurance coverage involves measurement. Important aspects include the following:

- Errors in the reporting of coverage status,
- Different reference periods (or reporting windows) across surveys, and
- A lack of information on the depth and extent of private insurance coverage.

Errors in the Reporting of Coverage Status

The potential for error on the part of respondents in reporting their insurance coverage is always present in household surveys, but it can depend, in part, on the way the survey questions are structured. For example, some surveys ask whether anyone in the household had coverage, whereas others ask whether each person in the household (by name) had coverage.

Data in the household surveys used by CBO and listed above substantially undercount the number of people with coverage through Medicaid and CHIP because of misreporting. Methodological research suggests that the reason for the undercount is that some respondents confuse those public insurance programs with other types of coverage, such as private insurance. Also, some people appear not to report having public insurance coverage because of the stigma associated with receiving public assistance. To correct for those measurement problems, CBO uses administrative data to count enrollees in Medicaid and CHIP.

Different Reference Periods

The reference period also varies across the surveys listed above. Some surveys ask respondents about their coverage at a particular *point in time*, such as on the date of the interview or during the previous few months. Other surveys ask respondents about their coverage at *any time* during the previous calendar year. The length of the reference period and the time that has elapsed since that reference period (the recall period) can affect the accuracy of respondents' answers. The more time that has passed since the reference period, the more difficult it is for respondents to correctly recall their coverage status.

Furthermore, the different reference periods might affect estimates of the number of people with and without coverage. For example, the number of people who are uninsured at any time during the year is generally higher than the number of people uninsured at a specific point during the year, which, in turn, is higher than the number of people uninsured for the entire year.

A related issue is that different reference periods might affect estimates of the number of people with specific types of coverage. In surveys that ask about coverage at any time during the year or over a certain period, respondents have the potential to report more than one type of coverage (such as employment-based coverage or Medicaid). That approach can generate higher estimates for specific types of coverage because many people may have different sources of coverage or temporary lapses in coverage throughout the year, such as between jobs.

Lack of Information on Private Insurance Coverage

Another challenge with household survey data is that they provide very little information on the depth and extent of private insurance coverage—in terms of the scope of benefits, the level and structure of cost sharing, and the actuarial value of plans. Although that information is lacking for households, some total statistics on the depth and extent of private insurance coverage in the employment-based market are available. The Agency for Healthcare Research and Quality has begun to publish such data from the MEPS—Insurance Component (a survey of private and state and local government employers). For policies in the health insurance marketplaces, detailed information about the scope of benefits, the amount and structure of cost sharing, and the actuarial value of plans is publicly available.

In addition to those measurement challenges, there is often a delay between when survey data are collected and when they are made available. The delay can be even longer if respondents are asked to report on their insurance coverage for a time before the date of collection, such as the previous year.

What Are the Challenges in Using Administrative Data to Estimate Coverage?

Using administrative data to estimate the number of people with health insurance coverage presents three main challenges. The first is the delay between the measurement period and the availability of the data. The second is that most sources of administrative data lack detailed information about a person's demographic characteristics, such as income and employment status. The third is that administrative data from multiple sources have the potential to misreport or overstate coverage. For example, the data might double-count people who have more than one insurance policy within a state or who sign up for coverage in more than one state during a given year.

How Does CBO Estimate the Number of People With Private Insurance Coverage?

CBO uses data from the MEPS—Insurance Component as a benchmark to estimate the number of employment-based private insurance policyholders. CBO then adjusts that benchmark to incorporate federal employees' health care coverage (because data from the MEPS—Insurance Component do not include federal agencies). CBO uses the MEPS—Insurance Component because it is based on employer responses rather than household responses. CBO supplements those data with an estimate of the average number of dependents covered by each employment-based policy from the MEPS—Household Component. In future years, CBO may incorporate administrative data from 1095 tax forms that count the number of people with employment-based coverage.

Estimating private insurance coverage for the nongroup market has become much easier following enactment of the ACA. Since the establishment of the health insurance marketplaces, CMS has collected administrative data that CBO uses as a benchmark of total enrollment in the marketplaces. To estimate enrollment in the nongroup market outside of the marketplaces, CBO primarily uses administrative data from insurance filings with CMS and similar data compiled by the National Association of Insurance Commissioners.

How Does CBO Estimate the Number of People With Public Insurance Coverage?

CBO uses data from two sources to estimate public insurance coverage provided through Medicaid and CHIP. To count enrollees in those programs, CBO uses administrative data submitted by the states to CMS. Those data provide the most accurate counts of public insurance coverage because people often misreport that coverage in household surveys. To determine the demographic and income characteristics of those Medicaid and CHIP enrollees, CBO uses household survey data from the SIPP.

CBO then adjusts the administrative data to better match its definition of public insurance coverage. For example, CBO excludes people who receive only partial Medicaid benefits. But even though those enrollees are not considered covered by Medicaid—as defined by CBO for purposes of determining public insurance coverage—they are included in CBO's counts of total Medicaid enrollment and spending.

Furthermore, CBO counts only people who are actually enrolled in Medicaid and CHIP when estimating coverage in those programs. Some people argue that individuals who are eligible for, but not enrolled in, public programs should be counted as insured because those people could enroll at any time. CBO does not count as covered people who are eligible for, but not enrolled in, Medicaid and CHIP because they do not generate federal spending for those programs.

CBO uses administrative data from CMS and the Social Security Administration to estimate the number of people under age 65 who have Medicare coverage. Those data include counts of Medicare enrollees by age group and eligibility category, which allows the agency to estimate the number of enrollees who are under the age of 65.

To estimate the number of people with coverage through TRICARE, IHS, VHA, and other miscellaneous sources, CBO also uses data from the SIPP. However, to assess the accuracy of those estimates, the agency compares them with the NHIS and MEPS—Household Component.

How Does CBO Estimate the Number of People Without Health Insurance Coverage?

The only reliable information about the number of people without health insurance coverage comes from federal surveys, and there is no single, definitive survey for measuring that population. For a variety of reasons, CBO uses data from the NHIS as its primary benchmark for estimates of the number of people who are uninsured. Those data are available more quickly than data from other surveys; and, because they are generated from a larger sample, they provide more reliable estimates of the uninsured. (Previously, CBO placed greater weight on the MEPS—Household Component.) Also, because the NHIS samples households continuously throughout the year and includes a question about insurance status on the day each household is surveyed, it produces the most accurate measure of the average number of people uninsured over the course of the year. The data more closely correspond to the concept of average enrollment that underlies CBO's projections.

Although CBO uses the NHIS as its primary benchmark for the uninsured, the agency also compares that benchmark to estimates from the MEPS—Household Component and the CPS, taking into account the strengths and weaknesses of those surveys, to continually evaluate the accuracy of the NHIS and better understand trends over time in the number of uninsured.

Appendix: Related Research

From the Congressional Budget Office

For CBO's most recent projections of health insurance coverage for people under age 65, see Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

For a discussion of the ways in which CBO would estimate health insurance coverage under alternative proposals, see Susan Yeh Beyer and Jared Maeda, "Challenges in Estimating the Number of People With Nongroup Health Insurance Coverage Under Proposals for Refundable Tax Credits," *CBO Blog* (December 20, 2016), www.cbo.gov/publication/52351.

For more information about the methods that CBO uses to make its projections of health insurance coverage, see Congressional Budget Office, "The Health Insurance Simulation Model Used in Preparing CBO's 2018 Baseline" (February 2018), www.cbo.gov/publication/53592; and *How CBO and JCT Analyze Major Proposals That Would Affect Health Insurance Coverage* (February 2018), www.cbo.gov/publication/53571.

For a discussion of various aspects of the private health insurance market, including the minimum value standard used to govern benefits in the large-group market, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), www.cbo.gov/publication/51130.

This report is an update to a previous blog post on this topic. See Jared Maeda and Susan Yeh Beyer, "How Does CBO Define and Estimate Health Insurance Coverage for People Under Age 65?" *CBO Blog* (December 20, 2016), www.cbo.gov/publication/52352. For related earlier discussion, see Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003), www.cbo.gov/publication/14426.

From Other Sources

The following studies discuss issues in estimating public and private insurance coverage using survey and administrative data.

Jean M. Abraham, Pinar Karaca-Mandic, and Michael Boudreaux, "Sizing Up the Individual Market for Health Insurance: A Comparison of Survey and Administrative Data Sources," *Medical Care Research and Review*, vol. 70, no. 4 (August 2013), pp. 418–433, https://tinyurl.com/y7kea80g.

Frederic Blavin and others, "An Early Look at Changes in Employer-Sponsored Insurance Under the Affordable Care Act," *Health Affairs,* vol. 34, no. 1 (January 2015), pp. 170–177, https://tinyurl.com/yd57mbho.

Michael H. Boudreaux and others, "Measurement Error in Public Health Insurance Reporting in the American Community Survey: Evidence From Record Linkage," *Health Services Research*, vol. 50, no. 6 (December 2015), pp. 1973–1995, https://tinyurl.com/ycntdo5p.

Kathleen T. Call, "Validating Self-Reported Health Insurance Coverage: Preliminary Results on CPS and ACS (Cross-Post)," *Blog & News* (State Health Access Data Assistance Center, May 2016), http://tinyurl.com/jsbbvbo.

Kathleen T. Call and others, "Medicaid Undercount and Bias to Estimates of Uninsurance: New Estimates and Existing Evidence," *Health Services Research*, vol. 43, no. 3 (June 2008), pp. 901–914, https://tinyurl.com/y9gqh43o.

Joel C. Cantor and others, "The Adequacy of Household Survey Data for Evaluating the Nongroup Health Insurance Market," *Health Services Research*, vol. 42, no. 4 (August 2007), pp. 1739–1757, https://tinyurl.com/yb6mg6oe.

Gary Claxton and others, "Health Benefits in 2014: Stability in Premiums and Coverage for Employer-Sponsored Plans," *Health Affairs,* vol. 33, no. 10 (October 2014), pp. 1851–1860, https://tinyurl.com/yawot5eh.

Gary Claxton and others, *Measuring Changes in Insurance Coverage Under the Affordable Care Act*, Data Note (Henry J. Kaiser Family Foundation, April 2014), http://tinyurl.com/z39wo6b.

Gary Claxton and others, *How Many People Have Nongroup Health Insurance?* Issue Brief (Henry J. Kaiser Family Foundation, December 2013), http://tinyurl.com/jf7penx (PDF, 403 KB).

Michael Davern and others, "An Examination of the Medicaid Undercount in the Current Population Survey: Preliminary Results From Record Linking," *Health Services Research*, vol. 44, no. 3 (June 2009), pp. 965–987, https://tinyurl.com/yc6bgywl.

Michael Davern and others, "Validating Health Insurance Coverage Survey Estimates: A Comparison of Self-Reported Coverage and Administrative Data Records," *Public Opinion Quarterly*, vol. 72, no. 2 (Summer 2008), pp. 241–259, www.jstor.org/stable/25167624.

Katherine Hempstead, *Preliminary Look at Some Carrier Data on Enrollment in the Non-Group Market* (Robert Wood Johnson Foundation, June 2014), https://tinyurl.com/y9qkkon9 (PDF, 417 KB).

Pinar Karaca-Mandic and Jean M. Abraham, *Using Data From the National Association of Insurance Commissioners for Health Reform Evaluation*, State Health Reform Assistance Network Issue Brief (Robert Wood Johnson Foundation, July 2013), http://tinyurl.com/hukzr12 (PDF, 275 KB).

Pinar Karaca-Mandic and others, "Going Into the Affordable Care Act: Measuring the Size, Structure, and Performance of the Individual and Small Group Markets for Health Insurance," in Ana Aizcorbe and others, eds., *Measuring and Modeling Health Care Costs* (University of Chicago Press, 2018), pp. 419–456, http://papers.nber.org/books/aizc13-1.

Jacob A. Klerman and others, "Understanding the Current Population Survey's Insurance Estimates and the Medicaid 'Undercount,'" *Health Affairs*, vol. 28, no. 6 (November/December 2009), pp. w991–w1001, https://tinyurl.com/y944zmoz.

Jacob Klerman, Michael R. Plotzke, and Mike Davern, "CHIP Reporting in the CPS," *Medicare & Medicaid Research Review*, vol. 2, no. 3 (Centers for Medicare & Medicaid Services, 2012), pp. E1–E14, https://go.usa.gov/xQKsM.

Annie Mach and Brett O'Hara, *Do People Really Have Multiple Health Insurance Plans? Estimates of Nongroup Health Insurance in the American Community Survey*, Social, Economic, and Housing Statistics Division Working Paper 2011-28 (Census Bureau, September 2011), http://go.usa.gov/x9cfw (PDF, 770 KB).

Joanne Pascale, Michel Boudreaux, and Ryan King, "Understanding the New Current Population Survey Health Insurance Questions," *Health Services Research*, vol. 51, no. 1 (February 2016), pp. 240–261, https://tinyurl.com/yc3u4xpp.

Joanne Pascale, Marc Roemer, and Dean Michael Resnick, "Medicaid Underreporting in the CPS: Results From a Record Check Study," *Public Opinion Quarterly*, vol. 73, no. 3 (Fall 2009), pp. 497–520, www.jstor.org/stable/40467615.

Michael R. Plotzke, Jacob Alex Klerman, and Michael Davern, "How Similar Are Different Sources of CHIP Enrollment Data?" *Journal of Economic and Social Measurement*, vol. 36, no. 3 (2011), pp. 213–225, https://tinyurl.com/ya4aakmn.

University of Minnesota State Health Access Center and others, *Research Project to Understand the Medicaid Undercount: Phase II Research Results—Examining Discrepancies Between the National Medicaid Statistical Information System (MSIS) and the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC)* (March 2008), http://go.usa.gov/x8RAY (PDF, 4.3 MB).

Marina Vornovitsky, "Measuring Health Insurance Coverage With the Current Population Survey and the American Community Survey" (Census Bureau, August 2015), http://go.usa.gov/x8RAm (PDF, 738 KB).

This report was prepared to enhance the transparency of the work of the Congressional Budget Office. In keeping with CBO's mandate to provide objective, impartial analysis, the document makes no recommendations.

Jared Maeda prepared the document with contributions from Susan Yeh Beyer and the staff of the Joint Committee on Taxation and with guidance from Jessica Banthin. Chad Chirico, Kate Fritzsche, Theresa Gullo, Leo Lex, Sarah Masi, Alexandra Minicozzi, Eamon Molloy, Allison Percy, Lisa Ramirez-Branum, Robert Stewart, and David Weaver provided comments.

Jeffrey Kling reviewed the document, Loretta Lettner edited it, and Jorge Salazar prepared it for publication. An electronic version is available on CBO's website (www.cbo.gov/publication/53822).

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Stakeholders Respond to the Proposed Short-Term, Limited Duration Insurance Rule. Part I: Consumer Advocates

Posted on **May 29, 2018** by **Rachel Schwab**

Earlier this year, the Trump administration proposed rules to relax federal restrictions on short-term, limited duration insurance (short-term plans). The proposal responds to President Trump's executive order directing the administration to expand the availability of short-term plans as an alternative to comprehensive insurance that complies with the Affordable Care Act (ACA).

Short-term plans were originally intended to fill temporary gaps in coverage. Because short-term products are not considered individual health insurance under federal law, they are not required to comply with the ACA's market reforms and consumer protections, such as the requirement to cover preexisting conditions, or the prohibition on charging higher premiums based on health status and other risk factors. Under the Obama administration, short-term products were limited to three months, including any renewals. The Trump administration's proposed rules would eliminate this restriction, allowing short-term plans to last up to 12 months, and allow renewals with insurer consent. For a more detailed description of the proposed rule, you can read our issue brief here.

After a 60-day comment period, the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury received over 9,000 comments from individuals, organizations, and government officials. CHIR reviewed a sample of comments from various stakeholder groups, including major medical insurers, consumer groups, carriers and brokers selling short-term plans, and state officials. For the first blog in our series, we summarize comments from seven consumer and patient advocacy organizations:

American Cancer Society-Cancer Action Network (ACS-CAN)

Community Catalyst

Young Invincibles

National Partnership for Women and Families (NPWF)

Families USA

AARP

Center on Budget and Policy Priorities (CBPP)

Consumer and patient advocates were united in their opposition to expanding the availability of short-term plans, and urged the agencies to rescind the rule or delay implementation to protect vulnerable populations and consumers at large from inadequate coverage, discriminatory practices, and higher premiums and reduced plan choices through the ACA's marketplaces. We summarize their comments on the potential impact of the rule below.

Discriminatory practices would harm consumer and patient populations

Consumer advocates were particularly troubled by the potential for widespread discrimination if short-term plans become a cheaper alternative to comprehensive health insurance. Short-term plans are not subject to the anti-discrimination provisions of the ACA. People with pre-existing health conditions and even people who fall into "high risk" categories, such as women and older adults, can be charged higher premiums or denied coverage altogether when applying for short-term plans.

The ACA made large strides in creating fair access to health insurance for women, sick people, and other vulnerable populations, and consumer and patient advocacy groups expressed that the resurgence of discriminatory health underwriting would be detrimental to this progress. NPWF noted that short-term carriers frequently charge women higher premiums, while gender rating is prohibited in the ACA-compliant market. AARP pointed out that the ACA's limit on insurers' ability to charge older people more than three times the premium of younger enrollees does not apply to short-term plans. They further noted that nearly half of Americans age 40-64 have preexisting conditions, for which they could be charged more or denied coverage outright.

Questioning the quality of coverage

Almost every consumer group in our sample voiced concern over the quality of coverage provided by short-term plans. Before the ACA, health plans routinely excluded coverage of essential health services. The ACA established a requirement for non-grandfathered plans sold to individuals and small businesses to cover ten Essential Health Benefit (EHB) categories, protecting access to comprehensive insurance and affordable care. Short-term plans, however, do not need to comply with this requirement.

Several organizations noted that expanding short-term products will lead to an influx of plans that are allowed to exclude coverage for services like maternity care, prescription drugs, mental health care, and preventive services. Consumer advocates disputed the proposed rule's claim that consumers may be prone to switch from ACA-compliant plans to cheaper, less comprehensive coverage because they do not believe the comprehensive benefits are "worth their cost." ACS-CAN cited a recent Kaiser Family Foundation poll that revealed 84% of respondents would prefer to enroll in their individual market plan rather than switching to a short-term plan. And CBPP pointed out that the aggressive marketing tactics of companies selling short-term plans may lead consumers to purchase coverage that has far fewer benefits and protections than they are led to believe.

Financial risks for consumers

While the sticker price of a short-term plan is typically lower than an ACA-compliant plan, many comments focused on the financial risks they pose. Because the cost of health care is too high for most people to pay for services entirely out of pocket, health insurance acts as a protection against financial hardship. The ACA standardized this protection in the individual market by setting an annual maximum on out-of-pocket expenditures, preventing insurers from imposing benefit caps, and creating standards for the proportion of premiums that insurers have to pay towards medical claims. Short-term plans do not have to comply with these requirements, and due to their numerous coverage exclusions, consumers can be left holding the bag for huge medical bills. For example, Community Catalyst pointed out that many short-term plans impose lifetime and annual limits on benefits, a practice prohibited by the ACA. This could lead to "woefully inadequate" coverage and pose substantial financial risks for consumers.

CBPP noted that short-term plans have a history of consumer complaints and legal disputes due to the fact that insurers deny claims for preexisting medical problems, citing one case in which a consumer was left with $400,000 in medical bills after undergoing treatment for breast cancer, a condition she was unaware of when she purchased the policy. Young Invincibles, an organization that advocates for young adults, argued that the lower up-front costs of short-term plans are likely to attract consumers with low health insurance literacy, who will flock to the cheaper plans despite their lack of financial protections. In addition to these risks, ACS-CAN cautioned that short-term plans are exempt from medical loss ratio (MLR) requirements, allowing insurers to spend fewer premium dollars on medical claims. They argue that expanding these products would lead to higher profit margins for insurers at the price of higher out-of-pocket costs for consumers.

Threats to the ACA-compliant market

In addition to consequences for consumers who enroll in short-term plans, comments highlighted the risks for the individual market if the rule is finalized as written, allowing short-term plans to proliferate. Several groups argued that increasing the availability of short-term plans will lead to an "uneven playing field," causing healthier individuals who can pass medical underwriting to leave the ACA-compliant market, while sicker individuals or those who want more comprehensive coverage will have to stay put, leading to adverse selection. ACS-CAN pointed out that, as the proposed rule states, "individual market issuers could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market," leading to dwindling plan selections and rising premiums for consumers. CBPP noted that changing the federal definition of short-term plans will likely lead to higher rates in 2019 by adding even more uncertainty that insurers must account for when setting individual market premiums for next year.

Definition of "short-term" inconsistent with current federal law

While large portions of consumer advocates' comments focused on the problems with short-term plans themselves, many of the organizations also questioned the legality of the proposed rule's definition of "short-term." Families USA and Young Invincibles noted that allowing short-term plans to last almost a full year is contrary to statutory language that was meant to restrict such coverage to limited time periods, rather than creating a loophole to permit plans to last just under 12 months (364 days). The organizations also argued that the ACA's reforms, which set certain standards for coverage, cannot serve their proper function if this expansion of short-term plans springs a leak in the risk pool, leading to a mass exodus of healthy consumers towards non-

ACA-compliant plans. CBPP pointed out that prior to the ACA, short-term plans served an important function for someone between jobs; however, with the advent of the ACA, individuals who lose employer-based coverage can sign up for a plan through a special enrollment period without having to undergo discriminatory medical underwriting. They contend that this makes the 364-day limit inappropriate under the current federal laws and regulations.

A Note on our Methodology

This blog is intended to provide a summary of some of the comments submitted by a specific stakeholder group: consumer and patient advocacy organizations. Comments were selected to provide a range of perspectives, including organizations that focus on specific patient and consumer populations. This is not intended to be a comprehensive report of all comments from consumer groups on every proposal in the short-term, limited duration insurance proposed rule. Future posts in this blog series will summarize comments from major medical insurers, carriers and brokers selling short-term plans, state-based marketplaces and state insurance regulators. For more stakeholder comments, visit http://regulations.gov.

Related Posts:

1. **Proposed Federal Changes to Short-Term Health Coverage Leave Regulation to States**
2. **Short-Term, Limited-Duration Insurance and Risks to California's Insurance Market**
3. **States Leaning In: Washington**
4. **April Research Round Up: What We're Reading**

This entry was posted in **CHIR**, **Implementing the Affordable Care Act** and tagged **consumer advocates**, **health insurance regulation**, **short-term coverage**, **short-term insurance**, **short-term limited duration insurance**, **short-term policy** by **Rachel Schwab**. Bookmark the **permalink [http://chirblog.org/stakeholders-respond-proposed-short-term-limited-duration-insurance-rule-part-consumer-advocates/]** .

One thought on "STAKEHOLDERS RESPOND TO THE PROPOSED SHORT-TERM, LIMITED DURATION INSURANCE RULE. PART I: CONSUMER ADVOCATES"

John Carlos

on **May 29, 2018 at 6:43 pm** said:

This issue discussion highlights that some insurers are gaming the definition of short term insurance. Some state insurance regulators require prior approval of insurance policy forms prior to usage or selling such insurance plans to consumers. State insurance regulators need to be vigilant in the approval of short term health insurance policy forms.

A Century of Advancing Health Care for All

TO THE POINT
Quick Takes on Health Care Policy and Practice

States Take the Lead on Reinsurance to Stabilize the ACA Marketplaces

Tuesday, May 22, 2018




By David Blumenthal, M.D. (/about-us/staff-contact-information/executive-managers/staff-contact-folder/blumenthal-david), Sara R. Collins (/about-us/staff-contact-information/program-staff/senior-program-research-staff/collins-sara-r), Shanoor Seervai (/about-us/staff-contact-information/program-staff/research-support/shanoor-seervai) and Herman K. Bhupal (/about-us/staff-contact-information/program-staff/program-support/bhupal-herman)

Recent actions by Congress and the Trump administration are likely to disrupt Affordable Care Act (ACA) marketplaces in 2019, leading to higher premiums for individuals and families. These actions include Congress' termination of financial penalties for failing to obtain health insurance and the administration's resistance to paying cost-sharing reductions for low-income purchasers of marketplace coverage, its encouragement of the sale of short-term policies and association health plans, and its defunding of advertising and outreach in federally facilitated marketplaces. Recent estimates (http://www.commonwealthfund.org/publications/blog/2018/apr/health-coverage-erosion) suggest that there have already been small but significant declines in coverage.

A total collapse of ACA marketplaces is unlikely because of continuing federal subsidies for the purchase of insurance by individuals with incomes below 400 percent of the federal poverty level. But those not eligible for subsidies may face higher premiums in some states, and some may be forced to forgo coverage. Those who remain in the market may be sicker than average, leading to a higher-risk pool and fueling premium increases.

A key way to mitigate the adverse effects of these recent policies is by offering reinsurance, a policy that is garnering bipartisan support at the federal and state levels.

What Is Reinsurance?

Reinsurance was a critical feature of ACA marketplaces in their first three years. The marketplaces were new, and insurers faced considerable uncertainty about the health status of enrollees. The law thus offered insurers some protection against unexpectedly high claims through a reinsurance program. Reinsurance protects insurers by limiting their exposure to very high, unpredictable medical expenses incurred by their members by covering some of those expenses when they exceed a certain threshold. For example, the ACA stipulated that insurers with claims costs that exceeded a threshold amount for a particular individual — $45,000 in 2014 — qualified for reinsurance payments for 100 percent of the excess up to $250,000. The program was financed by fees on both individual and employer plans, including self-insured employers, and was thus deficit neutral. It is estimated that reinsurance reduced average premiums in the marketplaces by as much as 14 percent.

The ACA legislation phased down the reinsurance program over 2014–2016 since it was assumed that as insurers gained more familiarity with enrollees, they could price their products with greater certainty. After the program ended in 2016, premiums rose in 2017 more sharply than they had in prior years, an increase that was partly attributed to the loss of reinsurance.

Industry stakeholders and health policy experts have suggested that reinsurance could stabilize the individual market (http://www.commonwealthfund.org/publications/blog/2017/jul/fixing-health-insurance-problems-bipartisan-approach). Researchers Chrissy Eibner and Jody Liu of RAND estimated (http://www.commonwealthfund.org/publications/fund-reports/2017/oct/expand-insurance-enrollment-individual-market) that reinstating the reinsurance program could reduce premiums in the marketplaces by 3.9 percent to 19.3 percent in 2020, depending on the generosity of the program. Because lower premiums also reduce what the federal government spends on tax credits, the researchers projected federal deficit savings of $2.9 billion to $13.1 billion. However, the researchers also assume that some of those fees ultimately would be passed on to people enrolled in private plans.

Federal reinsurance programs have appeared in a number of recent Congressional bills. Last year, ACA repeal-and-replace bills included reinsurance programs for the individual market that would be financed directly by the federal government. Senators Susan Collins (R–Maine) and Bill Nelson (D–Fla.) introduced a bill with a similarly structured reinsurance program at the end of 2017. And a recently introduced bill from Senators Jeff Merkley (D–Ore.) and Chris Murphy (D–Conn.) proposing that a Medicare plan be offered through the marketplaces and by employers also includes a reinsurance program.

Some of these proposals would fund reinsurance through upfront federal expenditures, rather than charging fees to insurers. Deficit reductions could be lower under this scenario, but may still be possible because the federal expenditures on reinsurance would be offset by savings on lower tax credit expenditures as

premiums fall. However, the RAND researchers find that the cost to taxpayers would be about the same under both approaches, since insurers would likely pass on fees to their customers in the form of higher premiums.

States Take the Lead

In the absence of consensus in Congress on how to strengthen the marketplaces, several states have secured, or are seeking, approval from the federal government to establish state-based reinsurance programs through the ACA's innovation waiver program (http://www.commonwealthfund.org/interactives-and-data/infographics/2017/oct/status-of-innovation-waivers-map). Under the waiver program, states can make changes to their marketplaces as long as they cover at least the same number of people and maintain the same levels of affordability. Reinsurance has been the most common innovation pursued by states.

Alaska, Minnesota, and Oregon have received federal approval to establish reinsurance programs. There are notable differences in their approaches:

- In Alaska (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf), medical claims for individuals with at least one of 33 high-cost conditions are covered by the Alaska Reinsurance Program. The program was responsible for preventing the state's last remaining insurer (https://www.healthaffairs.org/do/10.1377/hblog20170712.061031/full/) from leaving the individual market in 2017.

- In Minnesota (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Minnesota-Section-1332-Waiver.pdf), the reinsurance program covers 80 percent of claims for individuals up to $250,000 once a $50,000 threshold is passed. For the 2018 plan year, insurers submitted two sets of premiums, one assuming reinsurance and one without it. The rates accounting for reinsurance were approximately 20 percent lower (https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20171204.352539&format=full).

- Oregon's waiver application (http://healthcare.oregon.gov/DocResources/1332-application.pdf) sought approval for a program that would reimburse 50 percent of claims between a yet-to-be-established threshold up to $1 million. The U.S. Department of Health and Human Services approved (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html) the proposal in October 2017.

Six more states have passed legislation or submitted applications to establish reinsurance programs.

- On May 9, Maine (http://www.maine.gov/pfr/insurance/mgara/section_1332_innovation_waiver_application.pdf) became the latest state to submit a waiver application to the federal government seeking funding for a state-based reinsurance program. Earlier this year on April 18, Wisconsin also submitted a waiver

application (https://oci.wi.gov/Documents/AboutOCI/WI%201332%20DRAFT%20Waiver%20Application%203%2013%2018.pdf) for a reinsurance program.

- New Hampshire (https://www.nh.gov/insurance/legal/documents/nh1332waiverapplication.pdf) and Louisiana (http://www.ldi.la.gov/docs/default-source/documents/health/state-innovation-waiver-comprehensive-description.pdf?sfvrsn=6) are developing similar applications, and New Jersey (https://legiscan.com/NJ/bill/S1878/2018) and Maryland (https://www.marylandhbe.com/policy-legislation/public-comment/1332-waiver/) passed legislation in April to establish state-operated reinsurance programs.

Experience with reinsurance programs clearly demonstrates their efficacy in reducing health insurance premiums in the private individual market. Implemented at the federal level, such programs also reduce federal spending and deficits. Though enterprising states are moving forward with these initiatives, a more comprehensive national effort to help private insurers manage unpredictable risks in individual health insurance markets has enduring appeal.

May 2018 | Issue Brief

Individual Insurance Market Performance in 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 for 2017, and again last year during the debate over repeal of the health law.

In this brief, we look at recently-released annual financial data from 2017 to examine whether recent premium increases were sufficient to bring insurer performance back to pre-2014 levels, when new ACA insurance market rules took effect. These new data from 2017 offer further evidence that insurers in the individual market are regaining profitability, even as political and policy uncertainty, repeal of the individual mandate penalty as part of tax reform legislation, and proposed regulations to expand loosely-regulated short-term insurance plans cloud expectations for the future.

Annual financial data reflects insurer performance in 2017 through December of last year. The Administration ceased payments for cost-sharing subsidies effective October 12, 2017. The loss of these payments during the fourth quarter of 2017 diminished insurer profits, but nonetheless, insurers saw better financial results in 2017 than they did in earlier years of the ACA. Markets in parts of the country remain fragile, with little competition and an insufficient number of healthy enrollees to balance those who are sick. However, absent any policy changes, it is likely that insurers would generally have required only modest premium increases in 2018 and in 2019 as well. Insurers are now beginning to file proposed rates for 2019.

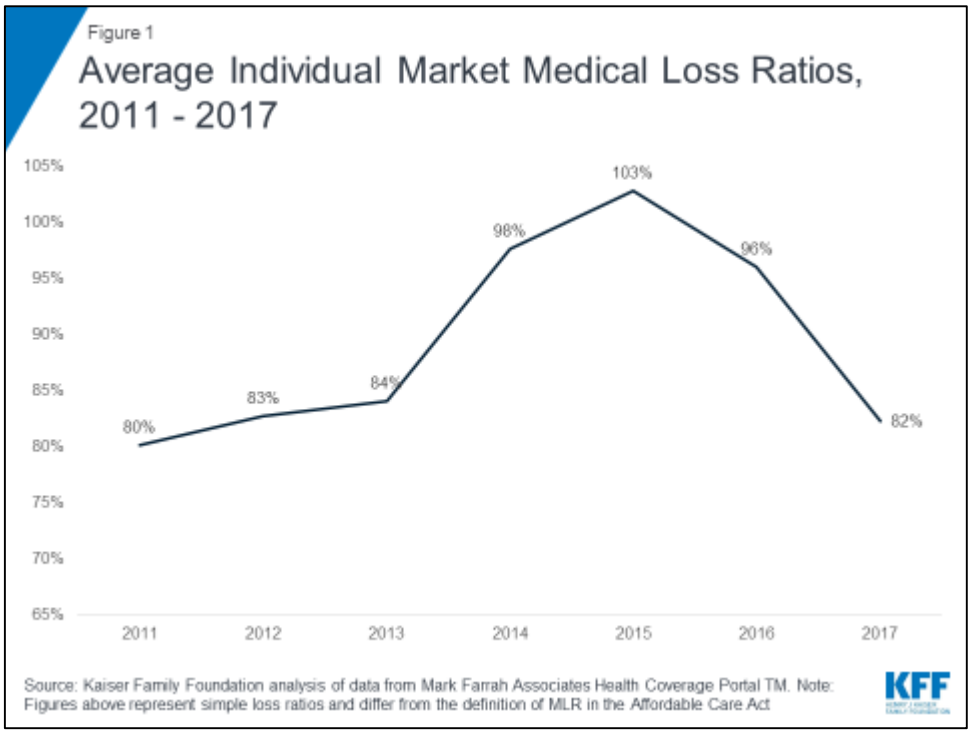
We use financial data reported by insurance companies to the National Association of Insurance Commissioners and compiled by Mark Farrah Associates to look at the average premiums, claims, medical loss ratios, gross margins, and enrollee utilization from 2011 through 2017 in the individual insurance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

Medical Loss Ratios

As we found in our previous analysis, insurer financial performance as measured by loss ratios (the share of health premiums paid out as claims) worsened in the earliest years of the Affordable Care Act, but began to improve more recently. This is to be expected, as the market had just undergone significant

regulatory changes in 2014 and insurers had very little information to work with in setting their premiums, even going into the second year of the exchange markets.

Loss ratios began to decline in 2016, suggesting improved financial performance. In 2017, following relatively large premium increases, individual market insurers saw significant improvement in loss ratios, averaging 82%. Though 2017 annual loss ratios are 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, better matching premium revenues to claims costs.



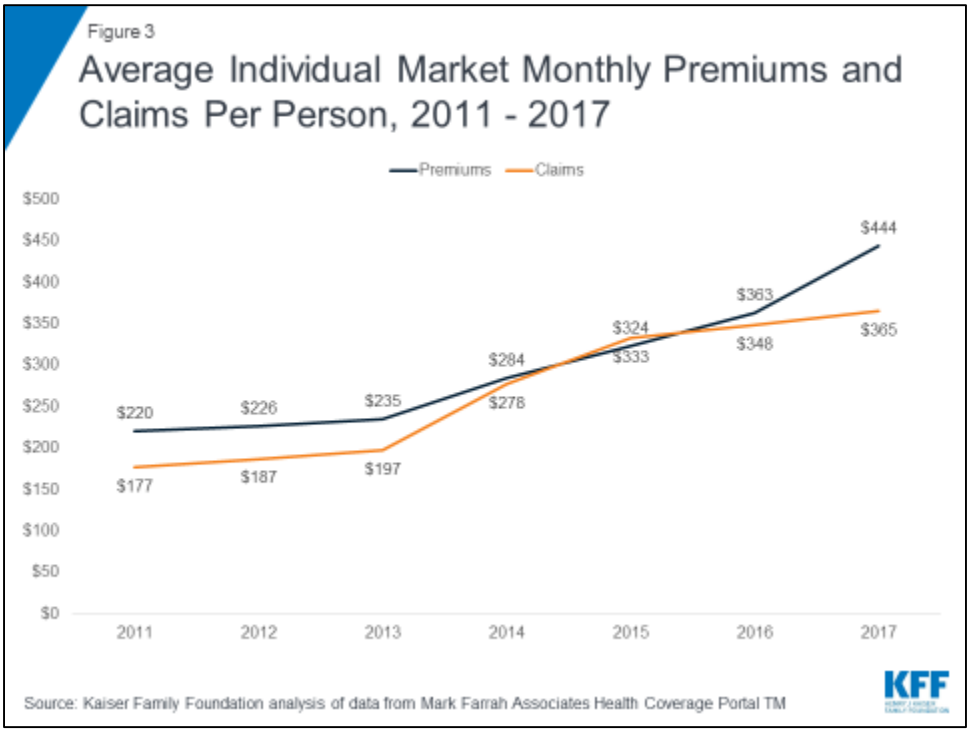
Margins

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.

Looking at gross margins, we see a similar pattern as we did looking at loss ratios, where insurer financial performance improved dramatically through 2017 (increasing to $79 per enrollee, from a recent annual low of -$9 in 2015). These data suggest that insurers in this market are on track to reach pre-ACA individual market performance levels, and that insurers are generally now earning a profit in the individual market.

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 22% from 2016 to 2017, while per person claims grew only 5%.



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 2017, it does not appear that the enrollees in the market last year were noticeably sicker than in the early years of ACA implementation.

On average, the number of days individual market enrollees spent in a hospital in 2017 was similar to inpatient days in the previous two years.

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

Annual results from 2017 suggest the individual market was stabilizing and insurers in this market were regaining profitability. Insurer financial results through 2017 – after the Administration's decision to stop making cost-sharing subsidy payments and before the repeal of the individual mandate penalty in the tax overhaul goes into effect – showed no sign of a market collapse. Annual 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 -- which is to be expected once people with pre-existing conditions were guaranteed access to insurance -- data on hospitalizations in this market suggest that the risk pool was stable on average and was not getting progressively sicker. 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 was stabilizing, there remain some areas of the country that are more fragile. In addition, policy changes have 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 in 2018, 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 declined somewhat, but were higher than many expected, which could help to keep the market stable. However, repeal of the individual mandate as part of tax reform legislation will take effect in 2019, combined with the likely expansion of loosely-regulated short-term insurance plans that could siphon off healthy enrollees from the ACA-regulated individual market. These changes will increase uncertainty for insurers and likely push premiums higher.

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 annual statement but did file current year 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 unadjusted 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 unadjusted health premiums earned and dividing by the total number of member months (average monthly enrollment) in the individual insurance market. Using earned premiums adjusted for taxes and fees to calculate loss ratios and gross margins increases the MLR by 5 percentage points and decreases the gross margin per member by $23 in 2017. On average across all years, using earned premiums adjusted for taxes and fees increases the MLR by 3 percentage points and decreases the gross margin per member by $10.

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.

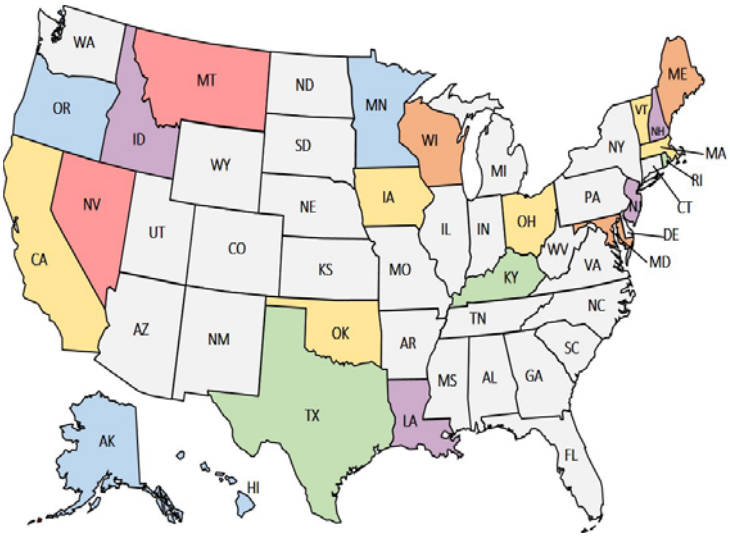
JUN, 04, 2018

More States Looking to Section 1332 Waivers

Heather Howard

As federal health reform legislation has stalled, health policy attention turns to the states, which have many tools to reform their health care systems. While 1115 waivers rightly get a lot of attention, because of their ability to reshape state Medicaid programs, the Affordable Care Act's Section 1332 waivers continue to be a promising avenue for states.

We have mapped out current state activity and included links to all the approvals, proposals, and even the authorizing legislation. You'll see that several states have approved waivers, but many more are actively considering them. The list is geographically and politically diverse – the one constant being that states are interested in seizing opportunities to improve health care for their residents.



(https://www.shvs.org/wp-content/uploads/2018/06/Status-of-State-Progress-Map-6.05.18.jpg)

Waiver Approved		
Alaska	Approved Waiver (https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/Alaska%201332%20State%20Innovation%20Waiver%20June%2015%202017.pdf?ver=2017-06-26-091456-033)	Application (https://www.commerce.alaska.gov/web/Po 201332%20State%20Innovation%20Waiver ver=2017-06-26-091456-033)
Hawaii	Approved Waiver (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Hawaii-1332-Letter-final-and-signed.pdf)	Application (https://governor.hawaii.gov/wp content/uploads/2014/12/REVISED-Hawaii- 10-2016.pdf)

Minnesota	Approved Waiver (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-MN.pdf) ***State Response*** (http://mn.gov/gov-stat/pdf/2017_10_03_GMD_1322_Waiver_Letter_to_Sec_Wright_Verma.pdf)	Application (https://www.cms.gov/CCIIO/Pr Innovation-Waivers/Downloads/Minnesota-
Oregon	Approved Waiver (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-OR.pdf)	Application (http://healthcare.oregon.gov/D application.pdf)

Application Submitted

Maine	Application (http://www.maine.gov/pfr/insurance/mgara/section_1332_innovation_waiver_application.pdf)	Legislation (https://legislature.maine.
Maryland	Application (https://www.marylandhbe.com/wp-content/uploads/2018/06/Final_Maryland 1332 State Innovation Waiver to Establish a State Reinsurance Program - May 31 2018.pdf)	Legislation (http://mgaleg Legislation (http://mgaleg
Wisconsin	Deemed Complete (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/WI-1332-Completeness.pdf)	Application (https://oci.wi 20WI%20Application.pdf) ***Attachment*** (https://oci.wi 201%20Wisconsin_1332% 20Report_04_17_2018.pdf

Waiver Application Submitted, No Longer Pending

California	***Withdrawn*** (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Application-Withdrawal-Request-01-18.pdf)	Application (https://www.cms.gov/CCIIO/Progra Initiatives/State-Innovation-Waivers/Downloads/Covered-California-Section-Waiver-Application-12-16-16.pdf)
Iowa	Deemed Complete (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-IA-Completeness-Letter.pdf), ***Withdrawn (https://governor.iowa.gov/sites/default/files/documents/Stopgap%20Measure%20letter.pdf)***	Application (https://iid.iowa.gov/documents/stat iowa-1332-waiver-submission), ***Supplement (https://www.cms.gov/CCIIO/Program Initiatives/State-Innovation-Waivers/Downloads/ Stopgap.pdf)***
Massachusetts	Deemed Incomplete (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Preliminary-Determination-Incompleteness-MA.pdf)	Application (https://www.mahealthconnector.or content/uploads/Massachusetts-Request-for-13 Innovation-Waiver-to-Stabilize-Premiums-09081
Ohio	Deemed Incomplete (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Ohio-Notice-Preliminary-Determination-Incomplete.pdf)	Application (http://insurance.ohio.gov/Consumer/Documen 201332%20State%20Innovation%20Waiver% 20Application.pdf)
Oklahoma	Deemed Complete (https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/OK-1332-Completeness.pdf) ***Withdrawn*** (https://www.ok.gov/health2/documents/Oklahoma%201332%20Waiver%20Withdrawal%209.29.17.pdf)	Application (https://www.ok.gov/health2/documents/1332% 20State%20Innovation%20Waiver%20Final.pdf)
Vermont	Incomplete	Application (http://dvha.vermont.gov/global-commitment-to-health/vermont-1332-waiver-fo innovation-application.pdf)

Public Draft of Application

Idaho	Draft Application (https://doi.idaho.gov/DisplayPDF?id=Draft1332Application&cat=publicinformation)

Louisiana	Draft Application (http://www.ldi.la.gov/consumers/insurance-type/healthinsurance/1332-waiver-proposal)	***Legislation Unsuccessful (http://www.legis.la.gov/legis/Bs=18RS&b=HB472&sbi=y)***
New Hampshire	Draft Application (https://www.nh.gov/insurance/legal/documents/nh1332waiverapplication.pdf)	Legislation (http://gencourt.state.nh.us/bsy=2017&id=714&txtFormat=h
New Jersey	Draft Application (http://www.state.nj.us/dobi/division_insurance/section1332/180531draftapplication.pdf)	Legislation (http://www.njleg.state.nj.us/2

Authorizing Legislation Enacted

Kentucky	Legislation (http://www.lrc.ky.gov/record/17rs/HB242.htm)
Rhode Island	Legislation (https://legiscan.com/RI/text/H5900/2015)
Texas	Legislation (ftp://ftp.legis.state.tx.us/bills/85R/billtext/html/senate_bills/SB01400_SB01499/SB01406S.htm)

Authorizing Legislation Passed, Vetoed

Montana	Legislation (http://leg.mt.gov/bills/2017/billhtml/HB0652.htm)
Nevada	Legislation (https://www.leg.state.nv.us/Session/79th2017/Reports/history.cfm?DocumentType=1&BillNo=374)

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Implications Of CMS Mandating A Broad Load Of CSR Costs

David Anderson, Louise Norris, Andrew Sprung, Charles Gaba

MAY 15, 2018 **DOI:** 10.1377/hblog20180511.621080

In October 2017, the Trump administration eliminated federal funding to reimburse insurers for cost-sharing reduction (CSR) subsidies, which they are obligated to provide to qualifying enrollees in the Affordable

Care Act (ACA) Marketplace. President Donald Trump had threatened to eliminate CSR funding throughout 2017, so insurers and insurance regulators in many states had anticipated the move by adding the cost of CSRs to premiums for 2018.

In the days following the elimination of CSR funding, 48 of 51 states (all but North Dakota, Vermont, plus the District of Columbia) allowed insurers to add CSR costs to 2018 premiums in some manner. To compensate insurers for the cost of CSRs, five states used a "broad load" uniform surcharge that applied to all individual policies on and off the exchanges. All other states used some variant of a "silver load," in which the cost of CSRs was added only to silver-plan premiums. A spreadsheet with each state's approach is available here. All of this was done in a hodge-podge fashion in 2017, with insurers and state regulators unsure what would happen at the federal level, and the official termination of CSR funding coming less than three weeks before the start of open enrollment.

Silver loading became the dominant strategy because the benefits to consumers were manifest. The Congressional Budget Office (CBO) has estimated that premiums are an average of 10 percent higher for on-exchange silver plans in 2018 than they would have been if CSR funding hadn't been terminated. Since ACA subsidies are tied to the premium of the benchmark silver plan, premium subsidies are also larger than they would have been if CSR funding had continued. Higher silver premiums due to concentrated silver loading led to higher federal costs, while generating dramatic discounts for non-silver plans. In many states, the steep increases in premium subsidies resulted in increased availability of zero-premium bronze plans (or nominal $1–3 per month premiums), as well as gold plans that were cheaper than or close in price to benchmark silver plans.

In 2019, many believed states' choices would be more uniform. The CBO expected almost all insurers and states to silver load because this approach benefits the greatest number of subsidized consumers. The experience of Colorado is instructive in this regard. Throughout the summer of 2017, the Colorado Division of Insurance was unsure if federal regulators would reject a silver-load strategy, so it elected broad loading as a less risky option. The state runs its own exchange and opted to extend open enrollment by nearly a month. Nonetheless, enrollment ended up slightly lower in 2018, with very little change in metal-level plan selections from 2017 to 2018. And while buyers with income in the range of 200 percent of the federal poverty level were able to access free or nearly free bronze plans in many states, a lowest-cost plan available to a person earning $24,000 in Denver is about $56 per month in 2018. Colorado regulators are planning to use the on-exchange silver-load strategy for 2019, assuming the federal government continues to allow it.

There is no mention of CSR loading strategies in the 2019 Notice of Benefit and Payment Parameters. Seema Verma, administrator of the Centers for Medicare and Medicaid Services (CMS), has repeatedly said that the issue is under consideration and has refused to comment on whether the federal government will impose a broad load requirement to reduce the amount that the federal government spends on premium subsidies.

Effect Of Broad Loading On Enrollees In ACA-Compliant Plans

If broad loading is required, there will be significant changes in the lived experience of the ACA for subsidized buyers in most states. In this case, all ACA-compliant plans offered on and off exchange would

include some CSR load. Between six and seven million nonsubsidized enrollees will be paying for actuarial value they do not receive. Premium hikes to pay for CSRs will be loaded on top of premium hikes stemming from repeal of the individual mandate penalty, estimated at 10 percent per year by the CBO. Some nonsubsidized silver buyers would be better off, while all other nonsubsidized buyers and some subsidized buyers would be worse off.

Many subsidized enrollees would lose the opportunity to access discounts in bronze and gold plans obtained in 2018. The 2018 Marketplace Public Use Files provide a basis for estimating how many subsidized current enrollees would likely pay more for less actuarial value, all other factors being equal, under broad loading. Since more detailed data are available for the 74.4 percent of enrollees who are in states that used the federal exchange, HealthCare.gov, we will focus the analysis there.

Since the ACA Marketplace launched in the fall of 2013, take-up has been disappointing in the upper-income range of subsidy eligibility. Many scholars have concluded that premium subsidies are inadequate for those who don't qualify for strong CSRs. Ironically, Trump's CSR cutoff provided a backdoor-subsidy boost to many in this category.

With some exceptions, bronze- and gold-plan discounts have most clearly benefited the one-third of subsidized enrollees who have household incomes above 200 percent of the poverty level. Almost all enrollees below that income threshold are eligible for strong CSR benefits. CSR benefits increase the actuarial value, which is the percentage the insurers pay of the group's expected costs, of a silver plan, from a baseline of 70 percent (with no CSR) to 94 percent for those with incomes up to 150 percent of poverty level and to 87 percent for those with incomes in the 150–200 percent poverty-level range. In

HealthCare.gov states, 90 percent of enrollees in the 100–150 percent poverty-level range chose silver plans in 2018, as did 78 percent of those in the 150–200 percent poverty-level range. In most cases, the value of the CSR benefit up to 200 percent of poverty level outstrips that of any discount in bronze or gold plans caused by silver loading.

The people who would be most affected by the end of silver loading are those who are subsidized, have incomes above 200 percent of poverty level, and did not buy silver plans. In 2018, there were 1.4 million HealthCare.gov enrollees in this category, making up 16 percent of all HealthCare.gov enrollees and 19 percent of subsidized enrollees. This population includes enrollees in the 200–250 percent poverty-level income range, who are eligible for "weak" CSRs that raise the actuarial value of a silver plan just three percentage points, to 73 percent. For many in this category, the value of discounts in bronze and gold outstripped this boost. Silver-plan selection in this income band accordingly dropped from 68 percent in 2017 to 53 percent in 2018 in HealthCare.gov states.

A small number of these bronze and gold enrollees are in states that did not allow silver loading for 2018. If the practice is not banned, however, all states will probably allow, encourage, or mandate it. We, therefore, include these enrollees in the "potentially harmed" total. In fact, the total would be somewhat higher if all states had silver loaded.

The state-based Marketplaces provide enrollment reports of varying types, but breakouts of metal-level selection by income are not uniformly available. California, Maryland, and Rhode Island had strong effects from silver loading; for example, steep bronze discounts as well as a near-quadrupling of gold-plan enrollment in California and Maryland and a doubling in Rhode Island.

Assuming the proportion of enrollees benefiting from silver loading is roughly the same in the state-based Marketplaces as on HealthCare.gov, there may be approximately 1.8 million nationally (16 percent of 11,750,000 enrolled and 19 percent of 9.8 million subsidized) who are disadvantaged if silver loading stops.

If, as discussed below, broad loading is confined to on-exchange plans, many nonsubsidized enrollees, who make up about 40 percent of the ACA-compliant individual market, will likely move off exchange (and be held harmless by CSR price-in). Thus, about 12 percent of the total market would likely be harmed by on-exchange broad loading. If all off-exchange ACA-compliant plans must bear part of the cost of CSRs, the "harmed" percentage rises to approximately half of all individual market enrollees.

Costs Of CSR Manipulation

While the CBO cautiously estimated that on-exchange silver-plan premiums are 10 percent higher in 2018 than they would have been otherwise, other estimates of the impact on overall premium increases due specifically to CSR reimbursement payments being cut off were higher, around 14 percent.

Nationally, nonsubsidized premiums for ACA-compliant individual market policies increased around 28 percent on average this year. Eleven points were due to "normal" medical trend increases, health insurance tax reimposition, and morbidity recalibrations. The other 17 points were due to administrative actions. Approximately 14 points could be directly attributed to the termination of CSR funding. The remainder was due to the reduction of Open Enrollment marketing, cuts in funding for outreach/navigator programs, and concerns that the

public would believe that the ACA's individual mandate had been weakened.

The federal government bears the risk of higher premiums for subsidized buyers. This protected the 9.8 million subsidized enrollees. However, many may have been indirectly harmed by some insurers having chosen to drop out of the individual Marketplace due to policy uncertainty.

Individuals who earn more than 400 percent of poverty level bear the entire risk of higher premiums. Approximately, 6.5 million nonsubsidized ACA policy enrollees (around 2.0 million on exchange and 4.5 million off exchange) would have faced the entire 28 rate hike unless states allowed for off-exchange plans to not load CSR costs.

The impact ranges tremendously. Some states saw nominal impact, especially states that didn't load CSR costs or states that had very little CSR cost to load because of extensive Medicaid eligibility or basic health programs that cannibalized the CSR population. At the other extreme, states such as Pennsylvania and Mississippi saw the CSR impact raise their rates by as much as $1,200 per enrollee.

Broad Loading Implications

As we described in an open letter last October before CSRs were terminated, the broad load option used by several states increased the relative price spreads of on-exchange plans: "Subsidized silver buyers will be no worse off as long as they buy the benchmark (second cheapest) silver plan or the cheapest silver plan, but they will likely be worse off if they buy a silver plan that is priced above the benchmark. Subsidized gold and platinum buyers will usually see higher premiums

—as will all nonsubsidized buyers across all metal levels. This strategy shrinks the market and makes the risk pool sicker."

In 2018, five states chose to broad load CSRs into all qualified health plan (QHP) premiums. These states lost, on average, more enrollment than states that engaged in any form of silver load strategies. For subsidy-eligible enrollees in broad load states, plans priced below the benchmark were generally cheaper than they would have been without a federal cutoff, while plans priced above the benchmark were generally more expensive. Those differences were slight compared to those that developed in silver load states.

In the four broad load states that used Healthcare.gov, no counties had a gold plan less expensive than the benchmark silver plan. Silver loading states on Healthcare.gov, in contrast, included more than 500 counties with at least one gold plan less expensive than benchmark silver. Counties that had large discounts on gold and bronze plans relative to the benchmark saw significant shifts away from silver. Those discounts likely boosted enrollment.

If CMS mandates broad loading, there will be significant distributional consequences. Most likely, a uniform, percentage surcharge will lead to very few if any counties having a single gold plan that is less expensive than the benchmark plan. In 2017, five counties using Healthcare.gov had at least one gold plan less expensive than the benchmark. Bronze plans will be modestly discounted relative to the benchmark, but the steep discounts generated by silver loading will disappear.

Detailed, actuarial simulations will be needed, but we anticipate significantly lower enrollment if states are required to spread the cost of CSRs to all plans instead of loading the costs only onto silver plans.

Off-Exchange Options

States may be able to insulate nonsubsidized off-exchange buyers from the incremental premium increases that would occur if CSR costs are broadly loaded onto all on-exchange plans. Some states, such as California, had insurers offer slightly different off-exchange-only silver plans that did not incorporate any CSR load. This off-exchange "switch" strategy could be expanded for all metal levels.

The recent Notice for Benefits and Payment Parameters (NBPP) could bolster the case for states that want to enable plans with no CSR load to be offered off exchange. The NBPP removed "meaningful difference" regulations, as Katie Keith explains: "The final rule eliminates the requirement that QHPs offered through the [federally facilitated exchanges] or [state-based exchanges on the federal platform] be 'meaningfully different' from other QHPs offered by the same insurer within a service area and metal level tier."

Previously, minor differences in plan design were needed to generate a new plan. Now, true clones can be offered as on-exchange and as off-exchange-only plans. If CMS does mandate broad loading, states may be able to argue that off-exchange plans should only be priced for the actual actuarial value and benefits that they will pay. States could allow and encourage all insurers that wish to compete for nonsubsidized, off-exchange plans to offer QHPs that have no CSR costs built into the premium. This broadening of the "switch" strategy will hold nonsubsidized buyers harmless from the change in CSR loading strategies.

Conclusion

If CMS were to require that states broadly loaded the cost of CSRs onto all plans, three results will occur. First, numerous subsidized buyers will shift out of bronze and gold plans and back to silver plans as the pricing advantage that silver loading created in 2018 will disappear. Secondly, the subsidized market will shrink as there will be fewer discounted bronze and gold plans, including substantially fewer free or near-free bronze plans. Marginal buyers will leave the market and remain uncovered. Finally, states will explore whether they can encourage or require widespread "switching" behavior so that off-exchange plans will not be priced with any CSR loading.

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TO THE POINT
Quick Takes on Health Care Policy and Practice

Americans' Confidence in Their Ability to Pay for Health Care Is Falling

Findings from the Affordable Care Act Tracking Survey, February–March 2018

Thursday, May 10, 2018

By Sara R. Collins (/about-us/staff-contact-information/program-staff/senior-program-research-staff/collins-sara-r), Munira Z. Gunja (/about-us/experts/gunja-munira-z), Michelle M. Doty (/about-us/staff-contact-information/program-staff/senior-program-research-staff/doty-michelle-m) and Herman K. Bhupal (/about-us/staff-contact-information/program-staff/program-support/bhupal-herman)

President Trump is expected to soon address the nation about the rising cost of prescription drugs. But Americans are worried about more than drug prices. New findings from the Commonwealth Fund Affordable Care Act Tracking Survey show that consumers' confidence in their ability to afford all their needed health care continues to decline.

Last week, we reported that the survey indicated a small but significant increase (http://www.commonwealthfund.org/publications/blog/2018/apr/health-coverage-erosion) in the uninsured rate among working-age adults since 2016. In this post, we look at people's views of the affordability of their health care. The Affordable Care Act Tracking Survey is a nationally representative telephone survey conducted by SSRS that tracks coverage rates among 19-to-64-year-olds, and has focused in particular on the experiences of adults who have gained coverage through the marketplaces and Medicaid. The latest wave of the survey was conducted between February and March 2018.[1](#/#1)

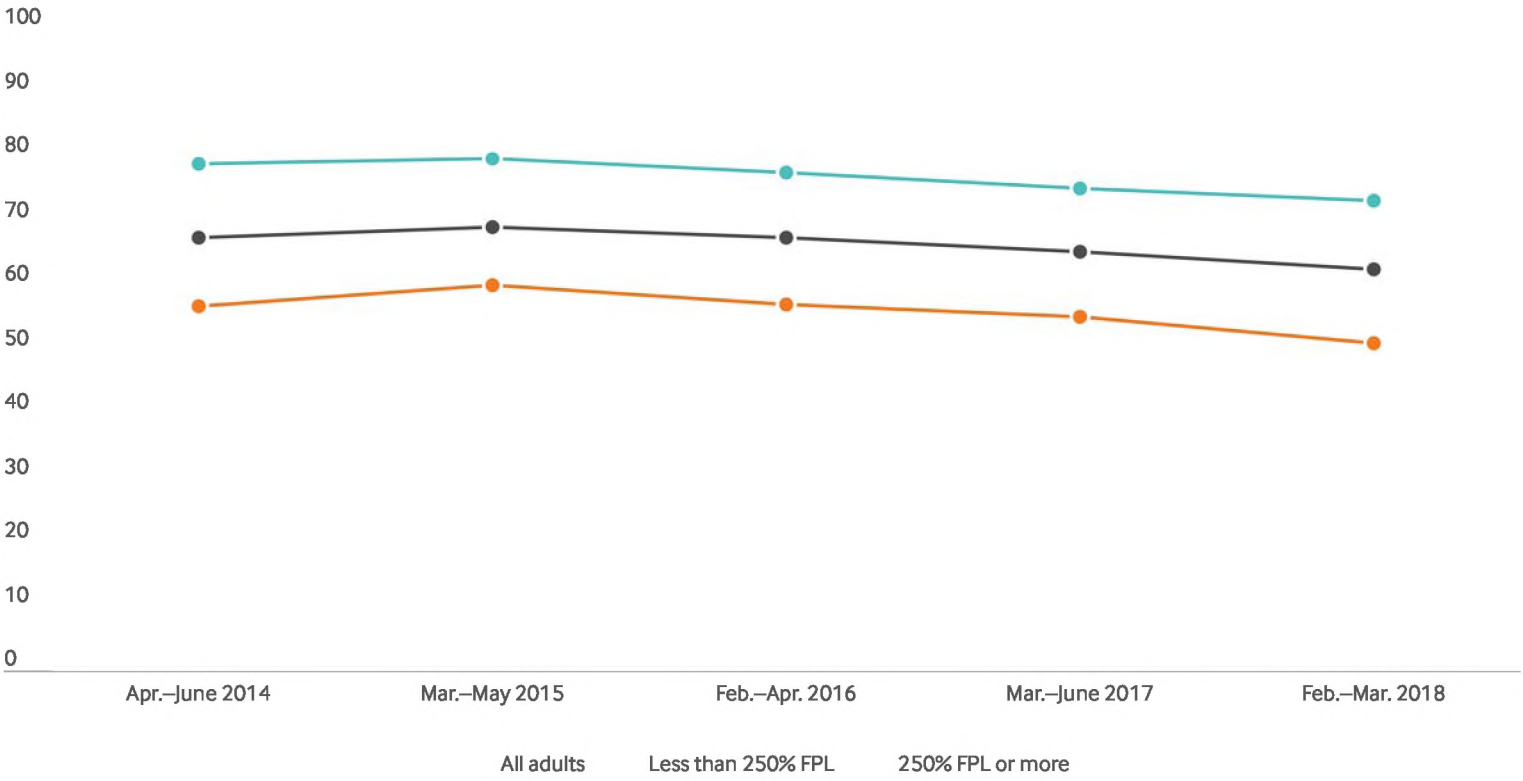
Findings

Confidence in Ability to Afford Health Care Continues to Decline

In each wave of the survey, we've asked respondents whether they have confidence in their ability to afford health care if they were to become seriously ill. In 2018, 62.4 percent of adults said they were very or somewhat confident they could afford their health care, down from a high of nearly 70 percent in 2015 (Table 1 (#/#Table 1)). Only about half of people with incomes less than 250 percent of poverty ($30,150 for an individual) were confident they could afford care if they were to become very sick, down from 60 percent in 2015 and about 20 percentage points lower than the rate for adults with higher incomes. There were also significant declines in confidence among young adults, those ages 50 to 64, women, and people with health problems. Declines were significant among both Democrats and Republicans.

The share of adults who feel confident they can afford the health care they need is falling

Percent of adults ages 19–64 who were very or somewhat confident they would be able to afford the care they need if they became seriously ill



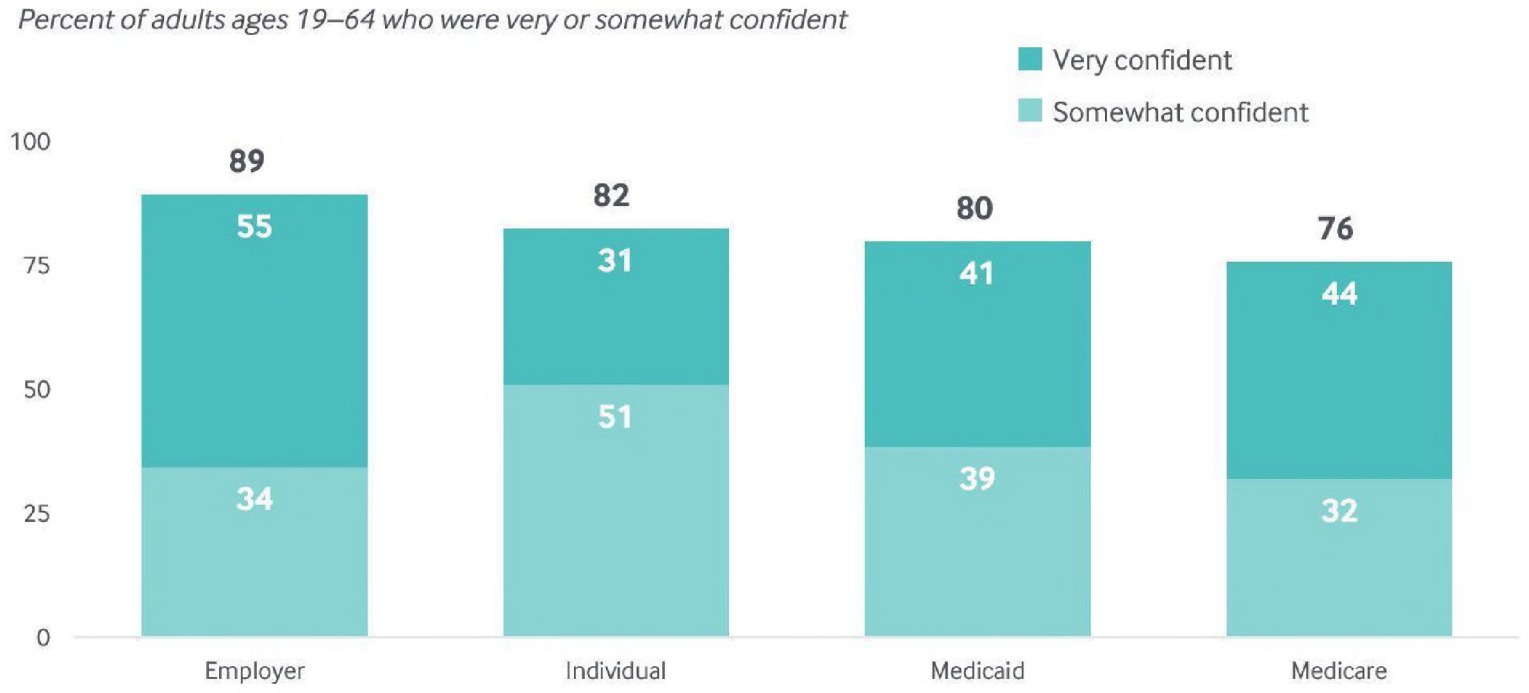
Data: Commonwealth Fund Affordable Care Act Tracking Surveys, Apr.–June 2014, Mar.–May 2015, Feb.–Apr. 2016, Mar.–June 2017, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point* (blog), Commonwealth Fund, May 10, 2018.

People in Employer Plans Have the Greatest Confidence in Their Insurance

We asked people with health insurance how confident they were that their current insurance will help them afford the health care they need this year. Majorities of adults were somewhat or very confident in their coverage; those with employer coverage were the most confident. More than half (55%) of adults insured through an employer were very confident their coverage would help them afford their care compared to 31 percent of adults with individual market coverage and 41 percent of people with Medicaid (Table 2 (#/#Table 2)). The least confident were adults enrolled in Medicare. Working-age adults enrolled in Medicare were the sickest among insured adults and the second-poorest after those covered by Medicaid (data not shown).[2 (#/#2)]

Adults with employer coverage are more confident their insurance will help them afford health care than those with other coverage



Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point* (blog), Commonwealth Fund, May 10, 2018.

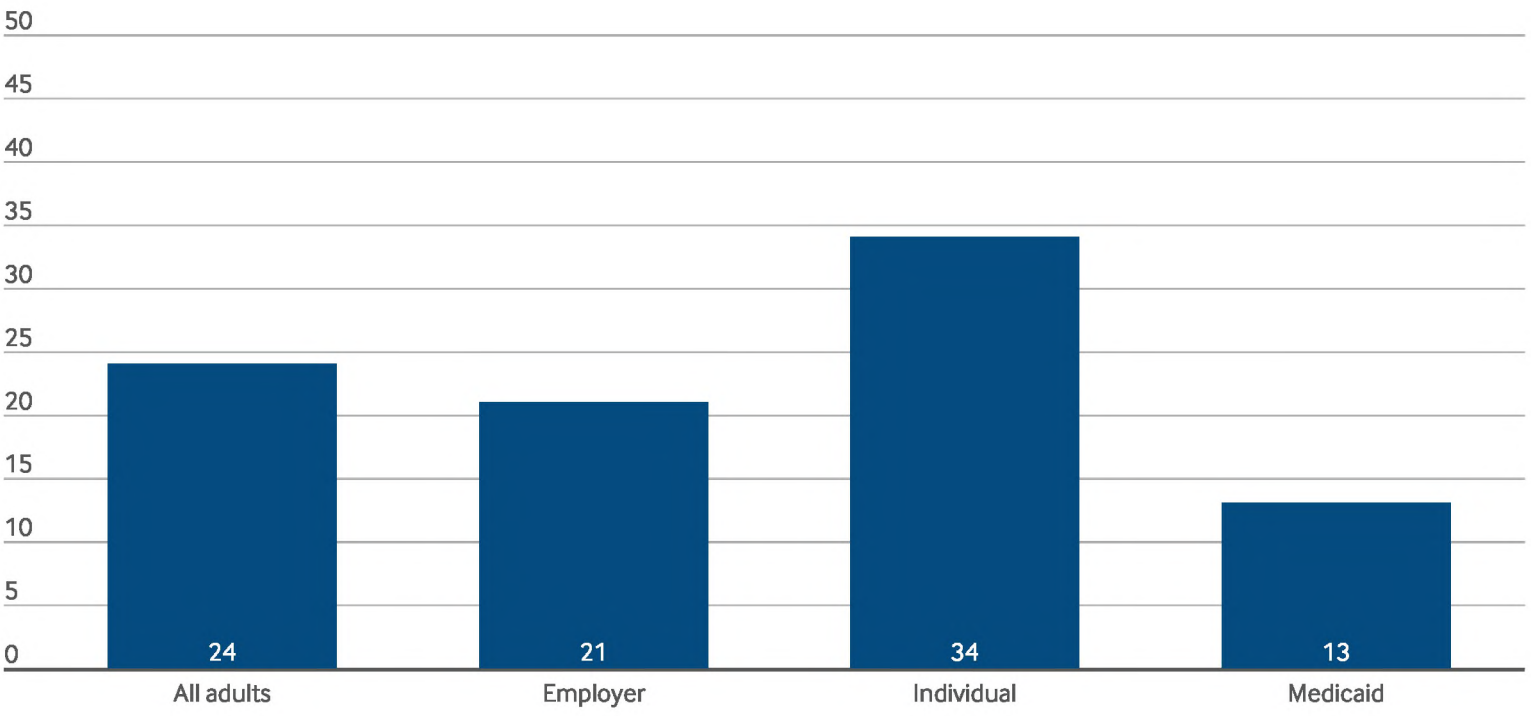
One-Quarter of Adults Said Health Care Became Harder to Afford

We asked people whether, over the past year, their health care, including prescription drugs, had become harder for them to afford, easier to afford, or if there had been no change. The majority (66%) said there had been no change, one-quarter (24%) said it had become harder to afford, and 8 percent said it had become easier (Table 3 (#/#Table 3)). People with individual market coverage were significantly more likely than those with employer coverage or Medicaid to say health care had become harder to afford. About one-third of adults with deductibles of $1,000 or more said health care had become harder to afford, twice the share of those who had no deductible. About one-third of those enrolled in Medicare and 41 percent who were uninsured also reported that their health care had become harder to afford.

One-third of adults with individual coverage report their health care has become harder to afford over the past 12 months

Thinking back over the past 12 months, would you say that (your/your family's) health care, including prescription drugs, has become harder for you to afford, easier to afford, or has there been no change?

Percent of adults ages 19–64 who said "harder to afford"



Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point* (blog), Commonwealth Fund, May 10, 2018.

Only About Half of Americans Would Have Money to Pay for an Unexpected Medical Bill

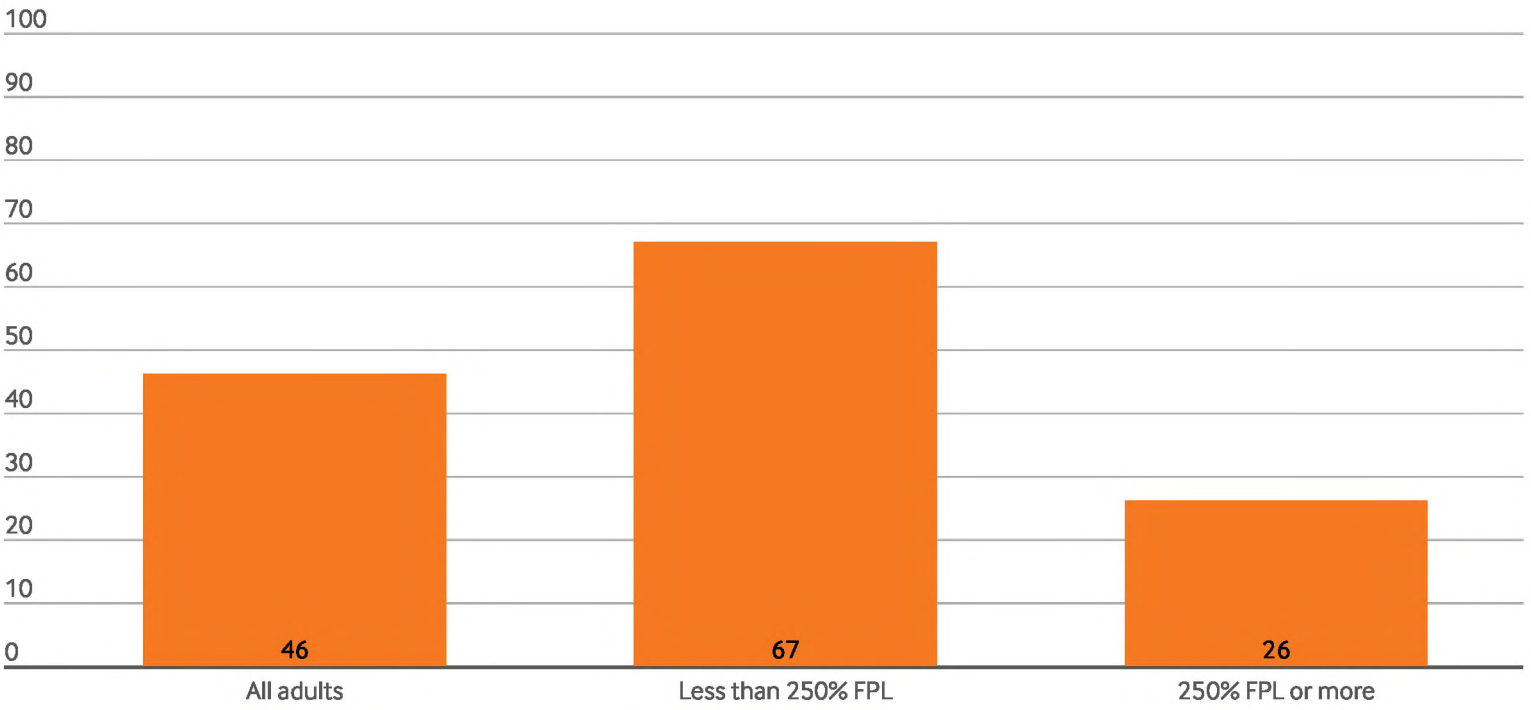
Accidents and other medical emergencies can leave both uninsured and insured people with unexpected medical bills, which usually require prompt payment. We asked people if they would have the money to pay a $1,000 medical bill within 30 days in the case of an unexpected medical event. Nearly half (46%) said they would not have the money to cover such a bill in that time frame (Table 4 (#/#Table 4)). Women, people of color, people who are uninsured, those covered by Medicaid or Medicare, and those with incomes under 250 percent of poverty were among the most likely to say they couldn't pay the bill.

Nearly half of working-age adults say they would not have the money to pay an unexpected $1,000 medical bill within 30 days

If you were to experience an unexpected medical event in 2018 that left you with a bill for $1,000, would you have the money to pay the bill within 30 days?

Percent of adults ages 19–64 who responded "no"
Switch between tabs at top to see different demographics

Income | Source of coverage | Gender | Race



Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point* (blog), Commonwealth Fund, May 10, 2018.

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Health Care Is Among People's Top Four Greatest Personal Financial Concerns

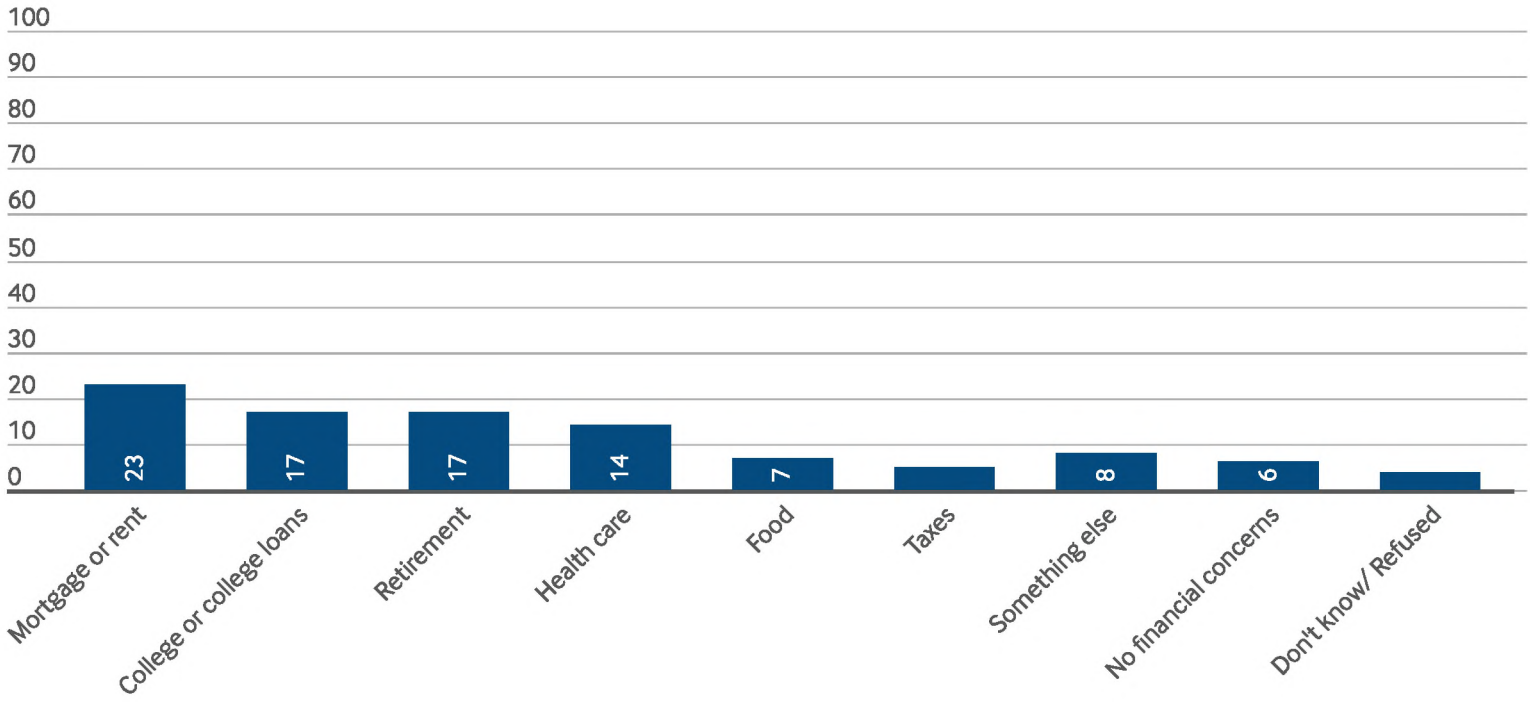
Fourteen percent of adults said that health care was their biggest personal financial concern, after mortgage or rent (23%), student loans (17%), and retirement (17%) (Table 5 (#/#Table 5)). Those most likely to cite health care as their greatest financial concern were people who could potentially face high out-of-pocket costs because they were

uninsured or had high-deductible health plans.

Fourteen percent of adults say health care is their greatest personal financial concern

What would you say is your *greatest* personal financial concern today — being able to pay for . . . ?

Percent of adults ages 19–64



Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point* (blog), Commonwealth Fund, May 10, 2018.

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Policy Implications

Uninsured adults are the least confident in their ability to pay medical bills. But the risk of high out-of-pocket health care costs doesn't end when someone enrolls in a health plan. The proliferation and growth of high-deductible health plans in both the individual and employer insurance markets is leaving people with unaffordable health care

costs. Many adults enrolled in Medicare for reasons of disability or serious illness also report unease about their health care costs. An estimated 41 million insured adults have such high out-of-pocket costs and deductibles relative to their incomes that they are effectively underinsured (http://www.commonwealthfund.org/publications/issue-briefs/2017/oct/insurance-coverage-consumers-health-care-costs). As this survey indicates, the nation's health care cost burden is felt disproportionately by people with low and moderate incomes, people of color, and women.

The ACA's reforms to the individual insurance market have doubled the number of people who now get insurance on that market to an estimated 17 million, with approximately half receiving subsidies through the ACA marketplaces. The ACA also has made it possible for people who were regularly denied coverage by insurers — older Americans and those with health problems — to get insurance. They are now entitled by law to an offer should they want to buy a plan.

But as this survey suggests, the ACA's reforms did not fully resolve the individual market's relatively higher costs for all those enrolled, compared to employer coverage or Medicaid. Moreover, recent actions by Congress and the Trump administration, including the repeal of the individual mandate penalty and loosened restrictions on plans that don't comply with the ACA, are expected to exacerbate those costs for many. In the survey, people with individual market coverage are more likely than those with employer coverage or Medicaid to say that their health care, including prescription drugs, has become harder to afford in the past year. They express less confidence than those with employer coverage that their insurance will help them afford their care this year. As explained in the first post (http://www.commonwealthfund.org/publications/blog/2018/apr/health-coverage-erosion), there are a number of policy options (http://www.commonwealthfund.org/publications/fund-reports/2017/oct/expand-insurance-enrollment-individual-market) that Congress can pursue that would improve individual market insurance's affordability and cost protection. In the absence of bipartisan Congressional agreement on legislation, several states are currently pursuing their own solutions (http://www.commonwealthfund.org/interactives-and-data/infographics/2017/oct/status-of-innovation-waivers-map). But if current trends continue, the federal government will likely confront growing pressure to provide a national solution to America's incipient health care affordability crisis.

Acknowledgments

The authors thank Robyn Rapoport, Rob Manley, and Erin Czyzewicz of SSRS and David Blumenthal, Don Moulds, Eric Schneider, Barry Scholl, Christine Haran, Deb Lorber, Paul Frame, Jen Wilson, Corinne Lewis, and Morgan Traina of the Commonwealth Fund.

Table 1

How confident are you that if you become seriously ill you will be able to afford the care you need?

Base: Adults ages 19–64 who were very or somewhat confident

	Apr.–June 2014	Mar.–May 2015	Feb.–Apr. 2016	Mar.–June 2017	Feb.–Mar. 2018
Percent	67.5%	69.0%	67.3%	65.3%	62.4%
Age					
19–34	68	69	63	67	63
35–49	67	66	67	65	61
50–64	67	72	72	65	63
Gender					
Men	70	70	68	66	66
Women	65	68	67	65	59
Race/Ethnicity					
Non-Hispanic White	70	71	69	69	64
Black	68	70	73	64	67
Hispanic	60	60	53	52	52
Poverty status					
Less than 250% poverty	57	60	57	55	51
250% poverty or more	79	80	78	75	73
Health status					
No health problem	73	74	72	71	70
Fair/Poor health status, or any chronic condition or disability^	62	65	62	60	56
Insurance status					
Uninsured	25	24	27	23	24
Employer	82	80	79	77	75
Medicare	63	69	73	60	59
Medicaid	61	67	59	64	53
Individual	67	67	62	64	60
Region					
Northeast	67	75	68	68	63
Midwest	71	71	70	70	71
South	65	66	67	62	60
West	69	67	64	65	59
Political affiliation					
Democrat	70	73	70	65	66
Republican	73	75	72	76	65
Independent	68	66	68	65	66
Voter registration status					
Registered	71	73	73	70	67
Not registered	57	58	59	57	55
Deductible amount					
No deductible	72	77	70	72	69

No deductible	72	77	70	72	69
$1,000 or more	72	66	70	70	65
$3,000 or more	68	53	62	67	61

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.
Data: Commonwealth Fund Affordable Care Act Tracking Surveys, Apr.–June 2014, Mar.–May 2015, Feb.–Apr. 2016, Mar.–June 2017, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point* (blog), Commonwealth Fund, May 10, 2018.

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Table 2

How confident are you that your health insurance will help you afford the health care you need this year?

Base: Insured adults ages 19-64

	Very confident	Somewhat confident	Very or somewhat confident	Not too confident	Not at all confident	Not too or not at all confident
Percent distribution	50%	36%	86%	8%	5%	12%
Age						
19–34	51	36	87	9	4	12
35–49	46	40	86	9	5	13
50–64	52	35	86	7	6	12
Gender						
Men	55	31	87	8	4	12
Women	45	41	86	8	5	13
Race/Ethnicity						
Non-Hispanic White	51	37	88	7	4	11
Black	48	35	84	10	6	16
Hispanic	49	36	85	8	5	13
Poverty status						
Less than 250% poverty	41	39	80	12	6	18
250% poverty or more	57	34	91	5	3	9
Health status						
No health problem	55	34	90	7	3	9
Fair/Poor health status, or any chronic condition or disability^	45	38	84	9	6	15
Insurance status						
Employer	55	34	89	6	4	10
Medicare	44	32	76	12	12	24

Medicaid	41	39	80	15	5	19
Individual	31	51	82	10	5	15
Region						
Northeast	50	39	89	8	3	10
Midwest	54	36	89	5	5	10
South	53	30	83	9	7	16
West	43	44	87	9	2	12
Political affiliation						
Democrat	49	39	88	7	4	11
Republican	52	34	87	8	4	11
Independent	51	37	89	6	6	11
Voter registration status						
Registered	52	36	88	7	5	11
Not registered	45	37	83	10	5	15
Deductible amount						
No deductible	53	33	86	8	5	13
$1,000 or more	42	42	83	10	7	16
$3,000 or more	36	42	77	13	9	22

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.
Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point (blog)*, Commonwealth Fund, May 10, 2018.

Table 3

Thinking back over the past 12 months, would you say that your health care, including prescription drugs, has become harder for you to afford, easier to afford, or has there been no change?

Base: Adults ages 19–64

	Harder to afford	Easier to afford	No change
Percent distribution	24%	8%	66%
Age			
19–34	18	10	68
35–49	30	6	64
50–64	26	7	66
Gender			
Men	22	7	68

Men	[illegible]	[illegible]	[illegible]
Women	27	8	64
Race/Ethnicity			
Non-Hispanic White	26	7	66
Black	19	9	70
Hispanic	25	10	60
Poverty status			
Less than 250% poverty	29	10	58
250% poverty or more	20	5	73
Health status			
No health problem	20	6	71
Fair/Poor health status, or any chronic condition or disability^	28	9	61
Insurance status			
Uninsured	41	5	48
Employer	21	6	72
Medicare	32	7	60
Medicaid	13	14	72
Individual	34	12	53
Region			
Northeast	18	11	68
Midwest	26	6	67
South	25	7	65
West	26	7	64
Political affiliation			
Democrat	21	7	70
Republican	25	7	66
Independent	26	7	65
Voter registration status			
Registered	24	6	68
Not registered	28	6	65
Deductible amount			
No deductible	15	12	72
$1,000 or more	32	5	62
$3,000 or more	34	4	62

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.
Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018." *To the Point* (blog), Commonwealth Fund, May 10, 2018.

Table 4

If you were to experience an unexpected medical event in 2018 that left you with a bill for $1,000, would you have the money to pay the bill within 30 days?

Base: Adults ages 19–64

	Yes	No
Percent distribution	52%	46%
Age		
19–34	56	42
35–49	49	50
50–64	52	47
Gender		
Men	61	37
Women	44	55
Race/Ethnicity		
Non-Hispanic White	59	40
Black	35	63
Hispanic	39	59
Poverty status		
Less than 250% poverty	31	67
250% poverty or more	72	26
Health status		
No health problem	64	34
Fair/Poor health status, or any chronic condition or disability^	42	57
Insurance status		
Uninsured	31	67
Employer	67	32
Medicare	20	78
Medicaid	20	78
Individual	59	39
Region		
Northeast	55	44
Midwest	55	43
South	50	49
West	53	46
Political affiliation		
Democrat	53	46
Republican	63	36
Independent	55	44

Voter registration status		
Registered	56	42
Not registered	35	63
Deductible amount		
No deductible	40	59
$1,000 or more	66	34
$3,000 or more	66	34

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.
Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018." *To the Point* (blog), Commonwealth Fund, May 10, 2018.

Table 5

What would you say is your greatest personal financial concern today?

Base: Adults ages 19–64

	Health care	Mortgage or rent	Food	Taxes	College or college loans	Retirement	Something else	No financial concerns
Percent distribution	14%	23%	7%	5%	17%	17%	8%	6%
Age								
19–34	7	27	7	3	30	7	8	6
35–49	17	23	6	5	16	18	7	5
50–64	18	19	8	7	6	26	8	6
Gender								
Men	13	24	6	6	15	17	8	8
Women	15	22	7	4	19	18	7	4
Race/Ethnicity								
Non-Hispanic White	15	21	5	5	16	22	8	4
Black	9	27	9	4	25	11	5	7
Hispanic	14	26	8	4	13	9	9	11
Poverty status								
Less than 250% poverty	14	27	12	3	19	7	7	5
250% poverty or more	14	19	2	7	16	26	8	7

Health status								
No health problem	13	23	4	5	20	18	7	8
Fair/Poor health status, or any chronic condition or disability^	15	23	9	5	15	16	8	4
Insurance status								
Uninsured	25	29	12	5	5	6	8	5
Employer	12	20	2	5	22	23	8	6
Medicare	14	26	20	1	3	14	11	8
Medicaid	9	29	14	1	20	5	9	6
Individual	17	25	8	9	10	18	6	6
Region								
Northeast	12	26	6	8	16	17	6	5
Midwest	16	15	7	5	19	17	11	7
South	14	24	7	4	15	17	8	8
West	14	26	6	3	20	17	7	4
Political affiliation								
Democrat	10	25	6	5	21	18	8	5
Republican	18	20	4	5	14	24	6	8
Independent	15	22	7	6	17	18	7	5
Voter registration status								
Registered	13	19	6	6	18	21	8	6
Not registered	14	31	12	3	12	9	8	7
Deductible amount								
No deductible	7	25	12	4	16	11	11	10
$1,000 or more	22	19	1	4	20	23	7	3
$3,000 or more	21	21	0	6	16	26	4	4

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.
Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "Americans' Confidence in Paying for Health Care Is Falling: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018." *To the Point* (blog), Commonwealth Fund, May 10, 2018.

How We Conducted This Survey

The Commonwealth Fund Affordable Care Act Tracking Survey, February–March 2018, was conducted by SSRS from February 6 to March 30, 2018. The survey consisted of telephone interviews in English or Spanish and was conducted among a random, nationally representative sample of 2,403 adults, ages 19 to 64, living in

the United States. Overall, 131 interviews were conducted on landline telephones and 2,272 interviews on cellular phones.

This survey is the seventh in a series of Commonwealth Fund surveys to track the implementation and impact of the Affordable Care Act. To see how the survey was conducted in prior waves, see our last publication (http://www.commonwealthfund.org/publications/issue-briefs/2018/mar/americans-views-health-insurance-turbulent-year).

As in all waves of the survey, the February–March 2018 sample was designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. Interviews in wave 7 were obtained through two sources: 1) stratified random-digit dial sample, using the same methodology as in Waves 1–6; and 2) households reached through the SSRS Omnibus where interviews were previously completed with respondents ages 19 to 64 who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. SSRS oversampled adults with incomes under 250 percent of poverty to further increase the likelihood of surveying respondents eligible for the coverage options as well as allow separate analyses of responses of low-income households.

The data are weighted to correct for oversampling uninsured and direct purchase respondents, the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. Similar to sample design in wave 6, the weights also corrected for oversampling respondents with a prepaid cell phone. The data are weighted to the U.S. 19 to 64 adult population by age by state, gender by state, race/ethnicity by state, education by state, household size, geographic division, and population density using the U.S. Census Bureau's 2016 American Community Survey. Data are weighted to household telephone use parameters using the CDC's 2016 National Health Interview Survey (NHIS).

The resulting weighted sample is representative of the approximately 190 million U.S. adults, ages 19 to 64. Data for income, and subsequently for federal poverty level, were imputed for cases with missing data, utilizing a standard general linear model procedure. The survey has an overall margin of sampling error of +/– 2.8 percentage points at the 95 percent confidence level. The overall response rate, including the pre-screened sample, was 7.5 percent.

Notes

[1] The survey firm SSRS interviewed a random, nationally representative sample of 2,403 19-to-64-year-old adults between February 6 and March 30, 2018, including 638 who have individual market, marketplace, or Medicaid coverage. The findings are compared to prior Affordable Care Act Tracking Surveys. The survey has an overall margin of error is +/– 2.8 percentage points at the 95 percent confidence level. See How We Conducted This Survey for more information on survey methods.

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

Marketplace Pulse: Bright Spots

Above-Average Performers in the Federally-Facilitated Marketplace

May 1, 2018

Author(s): Hempstead K

Katherine Hempstead, PhD, MA, senior adviser to the executive vice president, leads RWJF's work on health insurance coverage.

Most people are familiar with the general problems in the Affordable Care Act (ACA) marketplace, such as high premiums and lackluster carrier participation. And most are aware that the state-based marketplaces as a group have fared better (https://nashp.org/state-health-insurance-marketplace-enrollment-2017-and-2018/) than have the states that use the federally-facilitated market, i.e., the healthcare.gov (https://www.healthcare.gov/) platform.

Yet among the states that use the federally-facilitated marketplace, there is quite a bit of variation in market performance. Much has been written about especially unsuccessful places like Iowa, but there are also states on the federally-facilitated marketplace where market conditions are relatively good. Here we highlight one standout state from each region, based on a combination of enrollment, affordability, and carrier participation. (We exclude both state-based marketplaces and the five "partnership" states that use the federal platform to carry out their marketplace.)

Download graph (PDF) →

Recommended

Topics

Health Care Coverage and Access →

Bright Spot States by Region

	% Change in plan selections, 2017-2018	Cheapest Bronze 2018*	% Increase from 2017	Net change in number of carriers**
Northeast: ME, NH, NJ, PA	**-6.7%**	**$286**	**30.1%**	**-0.5**
New Jersey	-6.9%	$264	8.8%	1
South: AL, DE, FL, GA, LA, MS, NC, OK, SC, TN, TX, VA, WV	**-7.5%**	**$338**	**22.4%**	**-1**
Alabama	-4.6%	$287	4.9%	1
Midwest: IA, IL, IN, KS, MI, MO, ND, NE, OH, SD, WI	**-1.9%**	**$309**	**23.8%**	**-1**
Kansas	-0.6%	$283	9.4%	0
West: AK, AZ, HI, MT, UT, WY	**-4.5%**	**$335**	**11.6%**	**0**
Montana	-9.1%	$281	4.5%	0

Source: Data from the Centers for Medicare and Medicaid Services and Vericred, with the support of the Robert Wood Johnson Foundation. With appreciation to Joanna Selrup at Vericred

*Regional figure is the mean
**Regional figure is the median

The Northeast: Lowest cost region **(New Jersey)**

Many of the states in this region are state-based marketplaces, but of those on the federally-facilitated marketplace, New Jersey stands out. Their enrollment trend is average compared to the region. However, New Jersey is relatively well-priced, with a lowest-cost bronze plan of $264 compared to the regional average of $286. Most importantly, New Jersey saw a rare net increase in the number of carriers in 2018 with the re-entry of Oscar Health.

The Midwest: Smallest enrollment decline **(Kansas)**

Most of the states in this region are on the federally-facilitated marketplace, including a number of notoriously unsuccessful ACA marketplaces such as Iowa and Nebraska, where premiums increased dramatically. In Kansas, premiums increased by 9 percent, and the cheapest bronze plan was below the regional average ($283 versus $309). There were no counties with only one carrier in Kansas, either in 2017 or 2018, and no net change in carrier participation. In 2017, after Blue Cross Blue Shield of Kansas City exited two Kansas counties, Centene entered. Marketplace enrollment changed very little between 2017 and 2018.

The South: Worst carrier participation **(Alabama)**

Most states in this region are on the federally-facilitated marketplace, and carrier participation is particularly sparse, with the majority of counties having only one carrier. **Alabama had a below average decline in enrollment, and their cheapest bronze plan is more than $50 less than the regional average.** And while the majority of Alabama counties are served only by the state Blue plan, Bright Health entered several counties in the Birmingham area this year, making them one of only two states nationwide (the other is New Jersey) to have a net increase in the number of carriers in 2018.

The West: Most expensive region (**Montana)**

Montana is the standout state in terms of affordability and carrier participation. The lowest-cost bronze plan is well below the regional average, and Montana has maintained statewide participation from three carriers—their state Blue, a co-op, and a regional plan. Alaska gets honorable mention for their successful reinsurance program. Alaska's cheapest bronze plan declined by 25 percent between 2017 and 2018, and is now less expensive than those in Wyoming, Iowa, and Nebraska.

Factors Conducive to Good Performance

Better than average performance is attributable to some mix of state policy, demographics, carrier behavior and provider markets. As a group, New Jersey, Alabama, Kansas and Montana don't seem to have much in common. New Jersey alone has the kind of regulatory environment more often associated with state-based marketplaces (including a prior history of guaranteed issue and a ban on short-term plans). The New Jersey legislature recently moved to create (https://www.healthcaredive.com/news/new-jersey-moves-closer-to-its-own-individual-mandate/521383/) an individual mandate and a reinsurance program. Montana, Kansas, and Alabama, on the other hand, all permit short-term plans (http://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca) , and Kansas and Alabama have not even expanded Medicaid.

Yet there are some points of commonality. All four states seem to have relatively low enrollment in grandfathered and transition plans. (http://acasignups.net/18/04/11/giving-another-shot-how-many-are-still-enrolled-grandfatheredtransitional-plans-state) Carriers in Montana and New Jersey took early steps to eliminate them, while in Alabama and Kansas, enrollment seems to have withered fairly dramatically on its own as compared with other states. All four states used a variant of the "silver loading" approach to pricing this year. Finally, all have statewide or virtually statewide Blues plans with a dominant market share and a historical commitment to serve the individual market, and while this feature is by no means unique to these four states, its absence is notable in some of the states that struggle most.

Despite the political chaos around the individual market, current conditions are quite stable, and many participating carriers may be having their best year ever. In states with favorable market conditions, improved margins for Blues plans may create opportunities for new entrants. With rate filing underway, there is much speculation about participation decisions for 2019.

Our mission: to improve the health and health care of all Americans.

Factors Influencing 2019 Premiums in the Individual Market

ISSUE BRIEF

MAY 2018

KEY TAKEAWAYS

The individual market continues to face challenges and recent policy actions may exacerbate current market instability and place greater upward pressure on premiums in 2019.

Factors placing upward pressure on premiums include increases in medical trend and pharmacy costs, elimination of the individual mandate penalty, and the impact of new regulations that expand the availability of association plans and short-term plans. The one-year moratorium on the health insurance tax (HIT) can help mitigate or reduce premium increases for 2019.

AHIP will continue to work with state leaders, Congress and the Administration to ensure that every American has affordable choices for 2019 and beyond.

Background

The 2018 open enrollment period for the individual market has closed and planning is underway for the 2019 plan year. Health insurance providers are now making decisions about market participation, product offerings, and pricing for the 2019 plan year, with rate and product submissions beginning this month.

Factors Affecting Premiums in the 2019 Individual Exchange Marketplace	Estimated Premium Impact
Increases in medical trend—including medical price inflation and prescription drug cost increases	Increase 5.7%-6.5%
Elimination of individual mandate penalty	Increase 9%-10%
Expanded association health plans	Increase 2.7%-4.0%
Expanded short-term, limited duration plans	Increase 0.7%-1.7%
Incorporate moratorium on health insurer tax for 2019 into individual market rates	Reduce 3%

Based on data from the Centers for Medicare & Medicaid Services (CMS), **11.8 million consumers made a plan selection for coverage through federal and state-based exchanges**—a modest decrease in plan selections from 2017.[1] While plan selections in the federal exchange are down slightly from last year, enrollment in state-based marketplaces held steady in 2018, with 3.0 million people enrolled in state-based exchange-plan coverage.[2]

The key reason that 2018 open enrollment totals remained fairly constant is the availability of federal premium assistance. These advance premium tax credits, or APTCs, make coverage affordable for low- and moderate income individuals and families. This assistance is higher for individuals and families making less than 300 percent of the federal poverty level (FPL), but are available up to 400 percent FPL for those who lack access to affordable coverage through an employer.

For many well-documented reasons, the individual market continues to face stability challenges in its fifth year under the market reform rules of the Affordable Care Act (ACA). Moreover, recent policy actions and other proposals may exacerbate current market instability and place greater upward pressure on premiums for 2019. Amid this uncertain environment, this brief examines the key factors affecting individual market premiums in 2019 and policy solutions that could mitigate premium increases in 2019 and beyond.

Factors Influencing 2019 Premiums

Medical spending trends—including higher prescription drug prices—will push premiums higher.

Underlying health care costs continue to increase—driven in large part by medical price inflation and higher prescription drug prices. According to CMS national health expenditure projections, medical spending is expected to grow at an average rate of 5.7 percent per year[3] (2018-2019), while PwC projects 2018 medical cost trend at 6.5 percent.[4] Increases in medical trend are a **key driver** of health insurance premium increases— given that the vast majority of premium dollars goes to pay medical claims.[5]

Elimination of the individual mandate will increase premiums in 2019.

The Tax Cuts and Jobs Act of 2017 eliminated the individual mandate penalty (by reducing the penalty to $0) beginning for the 2019 plan year. According to the Congressional Budget Office (CBO) and independent actuaries, this would increase average premiums in the individual market by 9-10 percent.[6,7] Recent regulatory guidance by the Administration expanded the list of hardship exemptions to the mandate for 2018, which could inject further uncertainty in the market ahead of 2019.[8]

New federal regulations could further destabilize risk pools, which will place additional upward pressure on premiums.

The Administration's proposed rule to expand association health plans (AHPs) could pose new challenges to the individual and small-group markets. AHPs may offer lower rates to some via slimmer benefits and looser consumer protections— particularly for healthier, lower cost, lower risk groups and individuals. At the same time, they could also siphon off younger, healthier people and negatively impact the broader individual and small-group markets that must operate under the ACA's community rating and single risk pool rating requirements. A report by Avalere found that expanded association health plans—as contemplated under the Department of Labor's proposed rule—could increase premiums in the individual market by up to 4 percent, largely as a result of healthier enrollees shifting into AHPs.[9] Likewise, proposed regulations were recently released that seek to broaden the availability of short-term, limited duration insurance (STLDI) plans from the current three months to 364 days. STLDI policies, which are exempt from ACA requirements and consumer protections, would likely have a similarly negative impact on the individual market risk pool and lead to additional premium increases for 2019. An analysis by Wakely found that the proposed rule would likely increase premiums in the individual market by 1.7% in the near-term and up to 6.6% once these changes are fully implemented.[10]

Factors to Mitigate 2019 Premiums

Establishing a reinsurance or similar risk sharing program would lower premiums in 2019.

Several states are moving forward with establishing a new reinsurance program or other risk-pool funding through the section 1332 waiver process. Such programs would

reduce premiums by ceding some portion of high-dollar claims to the program, placing downward pressure on premiums across the entire individual market. An Avalere analysis estimated that establishing a premium stabilization program through reinsurance could lower premiums by between 4-12 percent depending on program design and available funding levels.[11,]

Suspending taxes and fees. Congress recently enacted legislation that established a moratorium on the health insurance tax (HIT) for 2019. We recommend further suspending the HIT in 2020 and beyond to place downward pressure on premiums, as it would otherwise be incorporated into premiums to cover the cost of the tax. This legislative action will reduce premiums by about 3 percent, or by about $230 annually per member in the individual market.[12]

Other Factors

Lack of federal funding for cost-sharing reduction (CSR) benefits will continue to challenge individual market stability in 2019. The October 2017 termination of CSR payments—which help nearly 6 million low-income Americans better afford medical services by lowering deductibles and co-payments—caused exchange plan premiums in 2018 to increase by 20 percent, on average.[13] Researchers at the Kaiser Family Foundation and Oliver Wyman similarly found that eliminating cost-sharing reduction payments increased premiums for the exchange silver benchmark plan by between 7-38 percent[14] and by 11-20 percent[15], respectively.

Changes in composition of the risk pool will affect premiums. Broad-based participation and coverage is critical to an affordable and stable insurance marketplace. Incentives to promote participation—particularly among younger, healthier individuals—are crucial to create a balanced risk pool and well-functioning market. As noted above, recent legislative action on the individual mandate and other proposed regulatory actions may further deteriorate the individual market risk pool by causing healthier, younger individuals to exit from the individual market. While the magnitude of the impact of the proposed rules is difficult to estimate until finalized, directionally, it is virtually certain that individual market premiums will be pushed higher.

Effectiveness of education and outreach. While the demand for health insurance coverage remained generally stable during the 2018 open enrollment period, sign-ups in healthcare.gov states are about 5 percent below last year's total. Studies have shown that cuts in advertising and outreach make it harder for people to enroll and could destabilize the individual marketplace.[16] By contrast, effective advertising and outreach can increase enrollment, expand coverage and lower premiums—as California's comprehensive outreach and marketing program was credited with lowering premiums by 6-8 percent.[17] An effective outreach and advertising effort—by both the federal

government and states—could help stabilize risk pools and lower premiums.

Conclusion

Health insurance providers are now making decisions about market participation and pricing for the 2019 plan year in a market that continues to face uncertainty and instability challenges.

While health insurance providers are committed to ensuring consumers have access to affordable coverage options, a number of factors will continue to place upward pressure on premiums for the 2019 plan year, including increases in medical trend, elimination of the individual mandate penalty and the impact of new federal regulations which could further destabilize risk pools and increase premiums. Moving forward, we will continue to work with state leaders, Congress, and the Administration to advocate for policies to ensure that every American has affordable choices for 2019 and beyond.

Endnotes

[1] CMS Health Insurance Exchanges 2018 Open Enrollment Final Report. April 3, 2018. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html
[2] CMS Health Insurance Exchanges 2018 Open Enrollment Final Report. April 3, 2018. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html
[3] CMS National Health Expenditure Projections 2016-2025. Forecast Summary. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf
[4] PwC Medical Cost Trend: Behind the Numbers 2018. https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html
[5] AHIP. Where Does Your Premium Dollar Go? May 22, 2018. https://www.ahip.org/wp-content/uploads/2017/03/HealthCareDollar_FINAL.pdf
[6] CBO—Repealing the Individual Health Insurance Mandate: An Updated Estimate. November 8, 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf
[7] Oliver Wyman Health—Analysis: Market Uncertainty Driving ACA Rate Increases. June 14, 2017. http://health.oliverwyman.com/transform-care/2017/06/analysis_market_unc.html
[8] CMS Guidance on Hardship Exemptions from the Individual Shared Responsibility Provision for Persons Experiencing Limited Issuer Options or Other Circumstances. April 9, 2018. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-Hardship-Exemption-Guidance.pdf
[9] Avalere Report - Association Health Plans: Projecting the Impact of the Proposed Rule. February 28, 2018. http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf?nc=1
[10] Wakely Report—Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market. http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf
[11] Avalere—Funding Reinsurance and Cost-Sharing Reductions Would Lower Individual Market Premiums and Increase Enrollment. December 6, 2017. http://avalere.com/expertise/managed-care/insights/funding-reinsurance-and-cost-sharing-reductions-would-lower-individual-mark
[12] Oliver Wyman—Estimated Impact of Suspending the Health Insurance Tax From 2017-2020. December 16, 2015. https://www.ahip.org/wp-content/uploads/2015/12/Oliver-Wyman-report-HIT-December-2015.pdf
[13] CBO—The Effect of Terminating Payments for Cost Sharing Reductions. August 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf

[14] Kaiser Family Foundation—How the Loss of Cost Sharing Subsidy Payments is Affecting 2018 Premiums. October 27, 2017. https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/

[15] Oliver Wyman Health—Analysis: Market Uncertainty Driving ACA Rate Increases. June 14, 2017. http://health.oliverwyman.com/transform-care/2017/06/analysis_market_unc.html

[16] Commonwealth Fund—Cuts to Outreach Will Make It Harder For People to Enroll. October 11, 2017. http://www.commonwealthfund.org/publications/features/%202017/slashing-aca-funding

[17] Covered CA. Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets. September 2017. http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf

New Rules to Expand Association Health Plans

How will they affect the individual market?

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MAY 2018 WEB EXCLUSIVE

The 2016 election ushered in a new federal approach to insurance regulation. While multiple Congressional efforts to repeal and replace the Affordable Care Act (ACA) did not succeed, the Trump administration has used its administrative authority to relax ACA rules and propose new rules that encourage the expansion of alternative coverage options. These alternatives would not have to comply with the full range of ACA protections, such as the essential health benefit package and adjusted community rating standards. Among these options are association health plans (AHPs).

The administration argues that AHPs will provide less expensive, albeit less comprehensive, coverage for small employers and individuals.[1] Critics argue that AHPs are likely to be attractive to a healthier and younger population, leaving an older and sicker population in the ACA-compliant individual and small-group markets. This in turn could result in higher premiums and fewer plan choices.[2] State-level regulation could mitigate adverse selection effects, but the proposed rule raises questions about the full scope of state authority.

This article provides an overview of the federal and state regulatory framework for AHPs and attempts to quantify the effects of an expansion of the AHP market on enrollment and morbidity in the ACA-compliant individual markets.

THE REGULATORY FRAMEWORK FOR AHPs

AHPs have long been a health plan option for small employers, the self-employed, and in some cases, individual purchasers. Prior to the enactment of the ACA, millions of individuals and small employers bought health insurance through associations.[3] Business and trade associations often offer coverage as part of their broader mission to serve the professional needs of their members. Some associations cater primarily to individuals, including the self-employed, while others cater to employer groups. Some associations cater to a population within a specific state, such as those operated by a state medical association or a local chamber of commerce. Others are domiciled in one state but market AHP coverage in multiple states. Prior to the ACA taking effect, some national associations were established by insurers with the sale of health insurance as the main, or in some cases only, purpose of membership.[4]

Pre-ACA Regulation of AHPs

The regulation of AHPs has been a combined federal and state endeavor. In general, states are the primary regulators of health insurance and health insurance issuers. Although state laws that relate to employee benefit plans are generally preempted under the federal Employee Retirement Income Security Act (ERISA), a 1983 law explicitly exempted AHPs from that preemption.[5] This means that states may apply and enforce state insurance laws with respect to these arrangements.

Specifically, states have authority to engage in financial regulation of AHP issuers to ensure that they are solvent. States further have authority to regulate the coverage to ensure compliance with state standards and the issuers' marketing and underwriting practices.

Prior to the ACA, many states exempted AHPs from rules and standards that applied to commercial insurers, such as filing requirements, underwriting restrictions, benefit mandates and solvency standards. Additionally, AHPs would sometimes set up headquarters in one state with limited regulatory oversight and then market policies to businesses and consumers in other states with more robust regulation of rating and plan benefits.[6]

The federal government, through the U.S. Department of Labor (DOL), is responsible for the enforcement of federal law with respect to employee benefit plans subject to ERISA. Thus, to the extent an AHP constitutes an employee welfare benefit plan, states and DOL have concurrent oversight responsibility. However, to date DOL has not considered an AHP offered by an association to member employers to be an employer benefit plan subject to ERISA (called a "bona fide" group or association) except under rare conditions, discussed in more detail below.

To the extent DOL deems an association a "bona fide" group that includes more than 50 employee members, it is considered a large employer health plan and small-group market rules, which in most states are more stringent than in the large-group market, do not apply. Until now, DOL has not considered associations with self-employed members to be eligible for bona fide group status.[7]

Post-ACA Regulation of AHPs

The ACA included reforms designed to curb past abuses and solvency concerns raised by AHPs. These included greater enforcement authority for DOL, criminal penalties for false statements to state or federal officials, federal registration and additional reporting requirements.[8]

More broadly, the ACA ushered in a suite of reforms and consumer protections that apply to commercial insurance, including insurance offered through AHPs, as shown in **Figure 1**.

Figure 1: Application of ACA Insurance Protections by Market Segment (Fully Insured)

ACA Market Reform	Individual Market	Small-group Market*	Large-group Market*
Guaranteed issue	Yes	Yes	Yes
Pre-existing condition exclusions prohibited	Yes	Yes	Yes
Out-of-pocket maximums	Yes	Yes	Yes
Annual and lifetime limits prohibited	Yes	Yes	Yes
Preventive services covered without cost-sharing	Yes	Yes	Yes
Essential health benefits	Yes	Yes	No
Rating rules	Yes	Yes	No
Single risk pool	Yes	Yes	No
Risk adjustment program	Yes	Yes	No

Medical loss ratio	80%	80%	85%

*Applies to fully insured products. The small-group market is defined in most states to be groups of up to 50 employees, with large group defined as groups with 51 or more employees.

The Obama administration in 2011 required that health insurance policies sold through an association to individuals must comply with the ACA's individual market reforms, while association coverage marketed to small employers must be regulated as small-group coverage.[9] This is sometimes referred to as the "look through" policy because the size of each individual employer determines whether the AHP is subject to individual, small-group, or large-group market rules under federal law.

Market studies suggest that in the wake of these rules, many AHPs dissolved.[10] However, AHPs in some states have asserted that they are bona fide employer groups under ERISA, and thus should be regulated as large-group coverage even when their membership includes small employers whose group plans are separately underwritten.[11] There is currently limited data available to determine how many of these types of AHPs exist and the size of their enrollment.

PROPOSED FEDERAL REGULATIONS: CHANGING THE FEDERAL-STATE FRAMEWORK FOR AHPs

In January 2018, DOL proposed regulations designed to expand the availability of AHPs for small businesses and self-employed individuals.[12] The rule, if finalized, would allow more groups to form AHPs so that they can offer coverage that is regulated under federal law as large-group coverage. Certain ACA requirements would apply to AHPs as large-group plans, including the prohibition of pre-existing condition exclusions, annual out-of-pocket maximums, the prohibition on annual and lifetime benefit limits, and coverage of preventive services without cost sharing. But AHPs would be exempt from other ACA requirements, such as the essential health benefit standard, limits on rating practices, the single risk pool, and the risk adjustment program (refer to Figure 1).

Gaining Large-group Status Under Federal Law

Prior to its 2018 rulemaking, when DOL assessed whether a group of employers can be considered a bona fide single employer group under ERISA, they considered three issues:

1. Whether the association is a bona fide organization with a purpose and function other than the provision of benefits;
2. Whether the employers share some commonality unrelated to the provision of benefits; and
3. Whether the employers that participate in the benefit program exercise control over the program.

If AHPs cannot meet the above tests, the federal "look through" policy adopted in 2011 means that AHP coverage sold to small employer and individual members must comply with the ACA rules that apply to the small-group and individual markets, respectively.

Under the proposed rule, AHPs could form an association solely to provide insurance benefits and gain the regulatory advantages of being treated as a large group. Additionally, DOL has proposed to expand what it means for employers to "share some commonality." To be considered a single-employer AHP, employer-members could be either:

1. In the same trade, industry, line of business or profession; or

2. Have their principal place of business in the same geographic region, either within a state or metropolitan area that includes more than one state, such as Washington D.C. or Kansas City.

If the former, the AHP could sell coverage nationwide, so long as its members are in the same trade, industry, line of business or profession.

Extending AHP Coverage to Individuals

Under current federal rules, employers who want to purchase small-group market coverage must have at least one employee who is not a spouse. The proposed rule would allow self-employed individuals to be treated as "employers" to join the association and at the same time treated as "employees" to be covered under the benefit plan. The proposed rule would require these "worker-owners" to earn a minimum income or work a minimum number of hours. However, the proposed income standard is vague and the rule would allow AHPs to rely solely on a written attestation from the individual that he or she meets these requirements. The proposed rule would further broaden AHPs' ability to cover individuals by allowing them to enroll former employees and family members, potentially including extended family.

Proposed Nondiscrimination Protections

Under current federal and many state rules, an AHP that achieves bona fide large-group status under ERISA is permitted to separately rate each employer-member of the AHP based on its claims experience or other rating factors. DOL is proposing new rules that would prohibit such health status discrimination among employer-members. Specifically, DOL has proposed that AHP membership, eligibility for benefits, benefit designs and premiums cannot be based on any health factor.[13] However, AHPs could adjust rates for members based on bona fide employment-based factors such as geographic location, date of hire, occupation and industry, and other factors such as age, marital status and gender.[14]

Furthermore, AHPs would not be required to cover the ACA's essential health benefits and could apply different plan designs to different groups within the AHP. For example, the rules appear to allow an AHP to offer a plan that covers maternity services to employers of a specific size (e.g., small employers) but not to self-employed members. The DOL requested public comment on the proposed nondiscrimination provision, and has signaled it could be removed or modified in the final rule.

Will State Regulation be Preempted?

DOL is also considering whether it should exempt certain AHPs from state insurance regulation. However, federal law requires that states' authority over AHPs' financial solvency be preserved, so states could continue to set solvency standards, require financial reports and conduct financial exams.

ANALYZING PROPOSED CHANGES TO AHP REGULATION

Proponents of the AHP rule argue that it will extend the advantages of being a large employer group, such as a greater array of plan options and administrative efficiencies, to small businesses and the self-employed. While DOL acknowledges that it is unable to quantitatively predict the impact of AHPs on the individual market, the agency asserts that "under the right conditions," the expanded availability of AHPs will result in lower premiums than those available in the ACA-compliant market. AHP proponents further contend AHP growth could come from younger healthy consumers who are currently uninsured.

AHP critics note that the lower premiums associated with AHPs derive from their ability to attract healthier enrollees and deter those with higher health care costs.[15] While the proposed rule includes a provision limiting AHPs from rating based on health status, individuals and groups could be charged less or more based on factors such as job classification, age, gender and industry. Additionally, AHPs could exclude benefits that appeal to employers and individuals with higher health risks, such as maternity care and prescription drugs. As a result, critics contend that AHPs could siphon a healthy population away from ACA-compliant plans, leaving a smaller and sicker risk pool for the traditional insurance market and fewer plan options and higher prices for the small businesses and individuals that remain.

ASSESSMENT OF THE ENROLLMENT AND MORBIDITY IMPACTS OF AHP PROPOSAL

This analysis focuses on quantifying the impact of the proposed rules on enrollment in ACA-compliant plans and the effect of that enrollment change on the morbidity of the individual market risk pool. Our projections assume that the emergence of a mature AHP market in response to the final rule will require at least one year to develop.

Due to uncertainty regarding how the final rules for AHPs will be written and how the market for AHPs will develop, this analysis includes a low estimate and a high estimate of the impact of the proposed changes. For example, the impact of the AHP regulations will depend upon policy and implementation factors such as:

- Whether the proposed rule's nondiscrimination provision is included in the final rule. If not, AHP insurers would be allowed to rate each group within the plan based on claims experience, meaning that health status related factors could be used to set rates and benefits for self-employed individuals (groups of one);
- The extent to which DOL tightens or loosens the criteria by which an AHP can gain bona fide single employer status;
- The extent to which DOL tightens or loosens the standards for being "self-employed" and tightens or loosens the process for verifying an individual's self-employed status;
- The extent to which the final rule preempts state authority to regulate AHPs; and
- How associations and insurers respond to the new rules, and the extent of AHP formation and marketing to self-employed individuals.

The "low" estimate in our analysis represents a scenario in which the final rule allows for the enrollment of the self-employed, establishes tightly defined nondiscrimination standards, and refrains from preempting state regulatory authority. It also assumes that DOL will require verification and documentation of an individual's self-employed status, and that relatively few AHPs are ultimately formed that market to self-employed individuals.

The "high" estimate represents a scenario in which the rule is finalized largely as proposed but does not include the proposed nondiscrimination provision, preempts some state regulatory authority, has limited or no verification processes of self-employed status, and receives a robust marketing response from AHPs.

Under the ACA, individuals had new incentives to buy ACA-compliant coverage because of the individual mandate penalty, premium and cost-sharing reduction (CSR) subsidies for individuals making less than 400 percent of the federal poverty level (FPL) who enroll through the ACA's insurance exchanges, and the requirement that insurers accept all applicants regardless of health status. The proposed rules for AHPs create incentives for more people to enroll in AHPs by offering lower-cost alternatives for self-employed individuals who are relatively young and healthy. Therefore, this analysis focuses on self-employed individuals enrolled in ACA-compliant plans who may have new incentives to shift to AHPs once the proposed rule is finalized.

Ten percent of all U.S. workers were self-employed in 2015.[16] However, the percentage of the individual market ACA enrollment that is self-employed is much higher because these individuals do not have access to employer-provided health insurance. Based on data from the Urban Institute,[17] and estimates of the size of the individual market ACA enrollment,[18] an estimated 24 percent of enrollees in ACA-compliant individual market policies are self-employed. The members who have incomes less than 250 percent of the FPL are not expected to move to an AHP, because the premium and cost-sharing subsidies for these members more than offset the higher morbidity that is expected in the individual ACA market. As income increases, the premium and cost-sharing subsidies are reduced, so moderate- to high-income individuals are projected to be more likely to move to AHPs as shown in **Figure 2**.

Figure 2: Self-employed Population in the Individual Market

Income	Percentage of Individual Enrollment Who are Self-employed*	Percentage of Self-employed Projected to Move to AHPs**	
		Low	High
<250% FPL	7%	0%	0%
250%–400% FPL	5%	7%	22%
Unsubsidized	12%	24%	78%
Total	24%	13%	43%

*Urban Institute, Health Insurance Policy Simulation Model 2018, simulation in 2016.
**The "low" and "high" projections reflect estimates about how many self-employed individuals will leave the ACA-compliant market for AHPs.

AHPs are expected to be attractive to younger and healthier individuals because under the proposed rule they are not required to offer the same comprehensive set of benefits required of ACA-compliant plans, and they are allowed to use enhanced rating factors based on age, gender, industry and other non-health-related factors. For example, an ACA-compliant plan in the individual market is limited to charging an older person no more than three times the premium charged to a younger person. This results in younger members subsidizing older members who, on average, spend much more than three times as much as younger members on health care services.[19] AHPs will likely be allowed to set premiums for policies that more accurately reflect the potential costs of older versus younger members, which should result in significant savings for younger individuals who move to AHPs.

To estimate the impact of the proposed AHP rule on health insurance enrollment among self-employed individuals in the ACA-compliant individual market, we used the Unified Rate Review Template (URRT) for

Single Risk Pool Plans data for plan year 2018 provided by the U.S. Centers for Medicare & Medicaid Services (CMS).[20] These files include 2016 experience for ACA-compliant individual market policies nationwide, both on- and off-exchange. This experience does not reflect carriers who left markets in 2017 and 2018, but still includes a significant amount of data regarding enrollment and morbidity by metal tier for on and off-exchange plans.

We modeled members leaving the ACA-compliant plans by metal tier (catastrophic, bronze, silver, gold and platinum) and estimated their relative morbidity compared to members remaining in ACA-compliant plans within those metal tiers.

Figure 3 shows the percentage of individuals expected to leave on-exchange plans for AHPs and their relative morbidity to individuals within a given metal tier. For example, the "low" scenario includes a projected 20 percent of members in catastrophic plans on-exchange moving to AHPs and these members would have a relative morbidity factor of 0.6, or be 40 percent healthier than the average member in a catastrophic plan on-exchange.[21] **Figure 4** illustrates that these same estimates were used for the catastrophic plans off-exchange, because members in these plans are not eligible for the ACA's premium or cost-sharing subsidies. Conversely, for silver-level plans, movement into AHPs is a relatively modest three percent under the "high" scenario, because the ACA's premium and cost-sharing subsidies insulate a majority of these enrollees from the full price of their plans.[22] However, the individuals who do shift to AHPs from silver-level exchange plans are likely to be significantly healthier, with a relative morbidity of just 0.3, or 70 percent healthier than average on-exchange silver plan enrollees.

Figure 3: On-exchange Projections

Metal Tier	2016 Morbidity*	Percentage Moving to AHPs		Relative Morbidity of Movers	
		Low	High	Low	High
Catastrophic	0.64	20%	60%	0.6	0.8
Bronze	0.70	5%	15%	0.4	0.5
Silver	0.95	1%	3%	0.3	0.3
Gold	1.33	0%	1%	–	0.3
Platinum	1.68	0%	1%	–	0.3
Total	0.97	2%	6%	0.3	0.4

*The 2016 morbidity was estimated based on the relative 2016 loss ratios in the experience from the 2018 URRT data.

Figure 4: Off-exchange Projections

Metal Tier	2016 Morbidity	Percentage Moving to AHPs		Relative Morbidity of Movers	
		Low	High	Low	High
Catastrophic	0.71	20%	60%	0.6	0.8
Bronze	0.81	10%	35%	0.5	0.6
Silver	1.05	5%	15%	0.4	0.5
Gold	1.23	0%	2%	–	0.3
Platinum	1.48	0%	2%	–	0.3

Total	1.06	5%	18%	0.3	0.5

Figure 4 shows the percentage of off-exchange individuals opting for AHPs instead of ACA-compliant plans off-exchange, and their morbidity relative to individuals within a given metal tier. Because individuals buying off-exchange are not eligible for the ACA's premium subsidies and thus pay the full premium, these individuals are more likely to migrate to lower-cost alternatives. For example, in the "high" scenario, we project that 35 percent of enrollees in ACA-compliant bronze plans will shift to AHPs, and that their relative morbidity will be 0.6, or 40 percent healthier than average off-exchange bronze plan enrollees.

In the "low" scenario, we project that, overall, three percent of the individual market (on and off-exchange) will leave and purchase an AHP. These members will be 62 percent healthier than the average health of the members remaining in the individual ACA market. As a result, the individual ACA market would see a 1.4 percent increase in average claims.

In the "high" scenario, we project that 10 percent of the individual market (on- and off-exchange) will leave and purchase AHPs. These members will be 54 percent healthier than the average health of the members remaining in the individual ACA market and the individual ACA market would see a 4.4 percent increase in average claims.

Limitations

These estimates are based on nationwide data and the impacts are expected to vary significantly by state due to variation in state regulation, the percentage of members receiving premium and CSR subsidies, and relative morbidity, as well as the percentage of members who are self-employed. Exchange enrollees receiving premium subsidies in each state range from 55 to 94 percent and enrollees eligible for a cost-sharing reduced plan range from 12 to 80 percent.[23]

Further, these estimates are based on actuarial judgement, derived from 2016 enrollment and morbidity data, and do not reflect intervening policy changes such as repeal of the ACA's individual mandate penalty, cuts to advertising and enrollment assistance for the ACA's exchanges, or the proposed relaxation of limits on short-term limited-duration insurance plans. The cumulative effect of these changes is likely to result in a further shift away from ACA-compliant individual market coverage and a higher relative morbidity of the ACA-compliant risk pool than is reflected here.

LOOKING FORWARD

Proposed federal rules would encourage the expansion of AHPs offering coverage to self-employed individuals that is exempt from ACA individual market rules, including underwriting limits, participation in a single risk pool, and the requirement to cover a minimum set of essential health benefits. Proponents of AHPs believe that they will provide individuals with lower-cost plan options, while critics note that they are likely to drive premiums up for individuals remaining in the ACA-compliant market.

There is considerable uncertainty about how the administration's proposed rule will be finalized, how many associations or issuers will form and market AHPs, and how other policy decisions, such as repeal of

the ACA's individual mandate penalty and the expansion of short-term limited duration insurance will affect the individual market.

Our analysis suggests that the positions of both AHP critics and proponents have merit. Younger, healthier individuals who are not eligible for the ACA's premium subsidies, who receive less generous subsidies due to higher income, or who are currently without coverage altogether, are likely to find less expensive plan options through AHPs. As many as 3 percent of enrollees in the individual market under our "low" scenario and 10 percent under our "high" scenario will gravitate to lower-cost AHPs. However, this will result in less enrollment and higher morbidity in the ACA-compliant individual market, leading to a 1.4 percent increase in claims costs under our "low" scenario and a 4.4 percent increase under our "high" scenario.[24] These changes will ultimately result in higher premiums for individuals remaining in the ACA-compliant market.

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REFERENCES:

1. The Federal Register. 2018. *Federal Register* 83 (4): 614. *https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2017-28103.pdf*

2. American Academy of Actuaries. 2017. "Issue Brief: Association Health Plans." February. *https://www.actuary.org/content/association-health-plans-0*

3. Kofman, M., K. Lucia, K., Bangit, E., and Pollitz, K. 2005. "Association Health Insurance: Is it Time to Regulate This Product?" *Journal of Insurance Regulation*, 24 (1): 31-45.

4. Ibid.

5. 29 U.S.C. §1144(b)(6)(A).

6. Supra note 3.

7. Federal law prevents associations that market coverage to self-employed individuals from being considered an ERISA-covered plan. ERISA requires that such plans be maintained by an employer or employee organization. Self-employed individuals without common law employees are not "employers" under federal law. 29 U.S.C. § 1002(1), (5). U.S. Department of Labor. 2013. "Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation." August. *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf*

8. 29 U.S.C. §§ 1021(g); 1131 et seq.

9. Cohen, Gary. 2011. "Insurance Standards Bulletin: Application of Individual and Group Market Requirements Under Title XXVII of the Public Health Service Act When Insurance Coverage Is Sold to, or Through, Associations." Centers for Medicare & Medicaid Services. September 1. *https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf* .

10. Corlette, Sabrina, Jack Hoadley, Kevin Lucia, and Dania Palanker. 2017. "Small Business Health Insurance and the ACA: Views From the Market 2017." The Urban Institute and Robert Wood Johnson Foundation. July.

https://www.urban.org/sites/default/files/publication/92291/2001459_small_business_health_insurance_and_the_aca_views_from_the_market_2017_0.pdf .

11. Lucia, Kevin, Sandy Ahn, and Sabrina Corlette. 2014. "Federal and State Policy Toward Association Health Plans in Oregon." The Urban Institute and Robert Wood Johnson Foundation. October. https://georgetown.app.box.com/s/bnae0s3lp15cmdrzipq6dyxsgefkaqq8.

12. Supra note 1.

13. The proposed rule defines "health factor" as health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability. Department of Labor. 29 CRF Part 2510: 36.

14. The preamble to the proposed rule further specifies that, subject to certain anti-abuse provisions for discrimination directed at individuals, a plan may treat beneficiaries as distinct groups based on the bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage, the relationship to the participant, marital status, age or student status and other factors if the factor is not a health factor.

15. Supra note 2.

16. Hipple, Steven F., and Laurel A. Hammond. 2016. "Self-employment in the United States." U.S. Bureau of Labor Statistics. March. https://www.bls.gov/spotlight/2016/self-employment-in-the-united-states/pdf/self-employment-in-the-united-states.pdf .

17. Urban Institute. 2018. "Urban Institute Health Insurance Policy Simulation Model." Simulation in 2016.

18. Centers for Medicare & Medicaid Services. 2017. "2017 Effectuated Enrollment Snapshot." June 12. https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf .

19. Health Care Cost Institute. 2015. "2014 Health Care Cost and Utilization Report." October. http://www.healthcostinstitute.org/files/2014%20HCCUR%2010.29.15.pdf .

20. The Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services. 2018. "Rate Review Data." Accessed April 2018. https://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html.

21. Even under the "high" scenario, in which we assume a relatively loose verification processes for determining self-employment, not all enrollees will qualify as self-employed for purposes of AHP enrollment.

22. In 2018, 83 percent of exchange enrollees are receiving APTCs; 53 percent are receiving CSR subsidies. Centers for Medicare & Medicaid Services. 2018. "Health Insurance Exchanges 2018 Open Enrollment Period Final Report."

23. These ranges exclude the District of Columbia, which, due to small number of CSR-eligible enrollees, is an outlier among the states. D.C. has 4 percent and 3 percent respectively. Kaiser Family Foundation. 2017. "Total Marketplace Enrollment and Financial Assistance." February. https://www.kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

24. The resulting impact on premiums would be slightly lower because some administrative expenses are not impacted by an increase in claims.

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OFFICE OF THE ACTUARY

Date: April 6, 2018

From: Paul Spitalnic, ASA, MAAA
Chief Actuary

Subject: Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule

On February 21, 2018, a proposed rule[1] was released by the Departments of Treasury, Labor, and Health and Human Services that would amend the definition of short-term, limited-duration (STLD) insurance policies. Specifically, the maximum life of such policies would be increased from 3 months to 1 year. However, there is nothing in the proposed rule that would prevent companies from underwriting and issuing new policies to individuals at the end of the 1-year coverage term. This memorandum provides the Office of the Actuary's estimates of the budgetary, enrollment, and premium effects of this proposed rule.

STLD plans are not considered individual market insurance policies, and therefore they are exempt from the statutory coverage requirements of the individual market. Moreover, they do not need to meet the essential health benefits requirements or the actuarial value requirements, they can be medically underwritten, and they are not eligible for Federal subsidies in the Health Insurance Marketplace. As a result, insurance companies would be able to offer these policies to individuals who are in good health at a substantially lower premium than available in the individual market. To model the impact of this policy change, we made the following assumptions:

- The impacts are estimated relative to the President's Fiscal Year 2019 Budget baseline, which is adjusted to reflect the repeal of the individual mandate.
- Due to the lower premium, 90 percent of healthy individuals with incomes over 400 percent of the Federal poverty level (and therefore unsubsidized) who have non-group coverage, and roughly one-third of healthy individuals with incomes between 300 and 400 percent of the Federal poverty level who have non-group coverage, would ultimately choose to purchase a STLD policy.
- The shift to these policies was modeled with a 4-year transition, and roughly two-thirds of the ultimate impact would occur in 2019.
- The STLD plans would have an average actuarial value of 50 percent and slightly lower non-benefit costs.
- In general, the assumptions and methods used here are the same as those in our previous health reform modeling.[2]

Based on our modeling, enrollment in the Marketplace is ultimately expected to decline by 0.8 million people by 2022 as shown in Exhibit 1. Of these 0.8 million, a large number are healthy, unsubsidized individuals moving to STLD policies, but a small number are unsubsidized

[1] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance
[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/AHCA2017.html

and unhealthy people who are dropping coverage as a result of the higher premiums. Similar shifting is expected to occur with off-Marketplace coverage, for which enrollment is projected to fall by about 0.9 million people by 2022. Take-up of the STLD policies is estimated to reach 1.9 million by 2022, and although a majority of these individuals are assumed to be enrollees who were previously covered in the individual market, some are expected to be new enrollees who are relatively healthy and join due to the lower premiums. Overall, the number of people covered by a STLD plan or in the individual market is expected to increase by roughly 0.2 million.

Exhibit 1—Estimated Impacts of the Short-Term Limited-Duration Policy Change on Enrollment in the Individual Insurance Market

Calendar Year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Current Law										
Marketplace	9.7	9.5	9.6	9.6	9.7	9.8	9.8	9.9	10.0	10.0
Other direct purchase[1]	5.3	5.0	4.9	4.8	4.6	4.5	4.3	4.2	4.2	4.1
Total	15.0	14.5	14.5	14.4	14.3	14.2	14.2	14.1	14.1	14.1
Proposed Rule										
Marketplace	9.1	8.9	8.9	8.8	8.9	9.0	9.0	9.1	9.1	9.2
Other direct purchase[1]	4.6	4.3	4.1	3.9	3.8	3.7	3.6	3.5	3.4	3.4
STLD	1.4	1.6	1.7	1.9	1.9	1.8	1.8	1.8	1.8	1.8
Total	15.2	14.7	14.7	14.7	14.6	14.5	14.4	14.3	14.3	14.3
Difference										
Marketplace	-0.6	-0.6	-0.7	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8
Other direct purchase[1]	-0.7	-0.8	-0.8	-0.9	-0.8	-0.8	-0.8	-0.8	-0.7	-0.7
STLD	1.4	1.6	1.7	1.9	1.9	1.8	1.8	1.8	1.8	1.8
Total	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2

[1]Off-Marketplace coverage includes enrollment in plans that we assume would meet the definition of insurance coverage. Most of these individuals are assumed to be enrolled in ACA-compliant plans.

Because the STLD plans are expected to enroll healthier individuals, those remaining in the Marketplace would be relatively less healthy, causing the average Marketplace gross premiums to rise. Based on our modeling, we estimate that gross premiums would ultimately increase by about 6 percent by 2022. Since premiums are based on income for individuals who are subsidized, there is no effect on net premiums for that group; however, the unsubsidized individuals would be subject to the 6-percent increase. A greater share of Marketplace enrollees would be subsidized because much of the unsubsidized population is expected to move to the STLD plans, and as a result the average net premium paid by Marketplace enrollees (both unsubsidized and subsidized) is ultimately expected to decline by 14 percent. Healthier individuals who opt for a STLD policy are estimated to pay a premium that is about half of the average Marketplace premium. These results are shown in Exhibit 2.

Exhibit 2—Estimated Impacts of the Short-Term Limited-Duration Policy Change on Marketplace Premiums

Calendar Year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Premium Rates										
Marketplace - Baseline	$602	$636	$666	$696	$727	$760	$794	$831	$868	$908
Marketplace - Proposed	$619	$661	$697	$739	$772	$807	$843	$882	$922	$964
STLD - Proposed	$342	$348	$350	$358	$374	$390	$408	$427	$446	$466
Premium Impact										
Marketplace										
Gross Premium	3%	4%	5%	6%	6%	6%	6%	6%	6%	6%
Net Premium	−11%	−12%	−13%	−14%	−14%	−14%	−14%	−14%	−14%	−14%
STLD										
Gross Premium[1]	−43%	−45%	−47%	−49%	−49%	−49%	−49%	−49%	−49%	−49%

[1]The change in gross premium for those choosing a short-term, limited-duration policy is measured relative to the average gross premium in the Marketplace.

Since gross premiums on the Marketplace are expected to rise and net premiums for the subsidized enrollees are expected to remain the same, the advanced premium tax credits will increase. We estimate that this outcome will increase Federal spending by roughly $38.7 billion over the next 10 years. Exhibit 3 summarizes the financial impacts during the 10-year period 2019-2028.

Exhibit 3—Estimated Federal Costs (+) or Savings (-) of the Short-Term Limited-Duration Policy Change

(In billions)

Fiscal Year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-28
Current Law											
Premium Tax Credits	$45.8	$44.6	$46.8	$49.5	$52.1	$54.9	$57.9	$61.0	$64.3	$67.8	$544.8
Proposed Rule											
Premium Tax Credits	$47.0	$46.7	$49.6	$53.2	$56.3	$59.3	$62.5	$65.9	$69.5	$73.3	$583.5
Federal Impact											
Premium Tax Credits	$1.2	$2.2	$2.8	$3.8	$4.2	$4.4	$4.7	$4.9	$5.2	$5.4	$38.7

Projections of individual market enrollment are premiums are inherently uncertain and this uncertainty is heightened as a result of the rapid changes in premium levels and policies such as the repeal of the individual mandate. In addition, there could be changes to state requirements for short-term plans that could significantly impact the results. We modelled the impacts as if these products would be available and marketed for all of 2019. Given the potential timing of the final rule, this may not be possible. Therefore the 2019 impacts could be far smaller than shown here.