Reports and Research

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January 17, 2019 Board Meeting

By Covered California

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January 8, 2019

Seema Verma
Administrator of the Center for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244

Re: Covered California comments on Patient Protection and Affordable Care Act; Exchange Program Integrity CMS-9922-P (RIN 0938-AT53)

Dear Administrator Verma:

Covered California submits these comments in response to the proposed Program Integrity regulations CMS-9922-P, specifically, on the unnecessary proposal to require separate billing for non-Hyde abortion services. We provide the following comments based on our experience and analysis of the necessary efforts to ensure ongoing sustainability for state-based marketplaces and effective services to the consumers we serve. Through our strong relationships with the 11 health insurance companies participating in Covered California, we have created a robust health insurance market that fosters a competitive environment while empowering consumers to choose plans that give them the best value.

Covered California believes these proposed regulations are unnecessary, would impose a substantial burden, and will not be beneficial for consumers or the individual market. Current rules and processes ensure that funds are segregated, and no federal funds are used for non-Hyde abortion services. Should Health and Human Services (HHS) not withdraw this proposed rule, Covered California requests that HHS delay the effective date to allow time for affected entities to mitigate consumer confusion and implement the required changes to information technology systems.

As proposed, HHS would withdraw its previous guidance, which permits Qualified Health Plan (QHP) issuers to satisfy the separate payment requirement in one of several ways, including by sending the enrollee a single monthly bill that separately itemizes the premium amount for non-Hyde abortion services. Currently, HHS also allows consumers to make the payment for non-Hyde abortion services and the payment for all other services in a single transaction. HHS is now proposing to require issuers to send—and consumers to pay—two entirely separate bills for the premium

attributable to certain (non-Hyde) abortion services and the premium for all other services. Additionally, HHS is proposing that any consumer who fails to pay the full premium in both bills will be terminated for non-payment (subject to state and federal grace periods).

Increased Consumer Confusion

If finalized, this regulation will be confusing for consumers and will likely lead to consumers dropping coverage due to inadvertently not paying the full premium. While HHS asserts that consumer confusion can be mitigated by sending bills only through email or other electronic communication, this does not address the underlying confusion that will occur due to two separate bills being sent to a consumer for their QHP. Not only does this practice conflict with widely accepted industry standards, there is no practical way to implement such a policy as a consumer cannot be forced into forgoing mail as their preferred method of communication. In California, we encourage our consumers to opt into email as their preferred communication but even after our encouragement, 70% of enrollees continue to receive communications via standard mail. HHS's proposal also does not consider the fact that some individuals do not have consistent access to the internet and would be unable to receive or make their monthly premium payment.

Increased Administrative Burden on the Exchange and QHP Issuers

These proposed regulations will impose millions of dollars of new costs and significant operational burdens on Exchanges and QHP issuers, diverting resources from other important work that Exchanges and carriers perform to provide affordable and reliable health coverage to their consumers. For example, Covered California will need to protect the market from known adverse impacts of this proposed regulation by redirecting vital funds from other programs to consumer outreach and marketing.

In addition, before QHP issuers could implement the segregated billing requirement, several complex and costly operational changes would have to be made, including significant modifications to enrollment and billing systems to generate two bills for every policy, for each month of enrollment, as well as additional postage, printing, credit card processing, and banking fees. QHP issuers will also need to devote time and money into system testing for billing accuracy, monthly quality assurance measures, and verification and reconciliation of the two separate bills.

As part of the increased awareness campaign and additional regulatory burdens put in place by these proposed regulations, Exchanges and QHP issuers would be required to generate and send notices regarding the need to make separate payments and additional notices for the many new consumers who inadvertently fail to pay the full premium amount and enter into a grace period for nonpayment.

Furthermore, Exchanges will experience an increased burden on its service centers and certified enrollers due to a significant increase in consumer questions regarding billing

errors, grace periods, notices, and requests for appeals and reinstatements. The proposal's immediate effective date is not feasible for exchanges and issuers, forcing them to be 'non-compliant' should the proposed rule be finalized.

These regulations will cause significant consumer confusion and impose serious administrative and operational burdens on Covered California. If these new, unnecessary and burdensome regulations are implemented, Exchanges could not possibly put them in place in the time proposed.

Sincerely,

Peter V. Lee
Executive Director

cc: Covered California Board of Directors

December 28, 2018

Alex Azar
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue SW.
Washington, DC 20201

Alexander Acosta
Secretary of Labor
U.S. Department of Labor
200 Constitution Ave, NW Ste. S-2524
Washington, DC 20210

Steven Mnuchin
Secretary of the Treasury
Department of Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Covered California comments on Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans; CMS-9918-P (RIN 0938-AT90)

Dear Secretary Azar, Secretary Acosta, and Secretary Mnuchin:

Covered California is submitting comments in response to the proposed Health Reimbursement Arrangements (HRAs) regulations CMS-9918-P. We provide the following comments based on our experience and analysis of what efforts are necessary to ensure a viable risk mix in the individual market generally and in particular to ensure the ongoing sustainability for state-based marketplaces and states that may operate in the federally-facilitated marketplace. In summary, because of consumer confusion these proposed regulations will cause, a lack of a federal data source to appropriately verify APTC eligibility for consumers offered HRAs, and the potential adverse impact on the risk mix of the market, we do not think that, as drafted, these regulations will benefit consumers in the Exchange marketplace. To the extent these regulations are finalized, we make specific recommendations related to the need to add safeguards and provide for sufficient time to assure viable implementation. Covered California's concerns and recommendations are further explained below.

Increased Consumer Confusion

The proposed regulations require employees, who are offered an HRA, to consider the HRA offer and decide if they should seek an affordability determination from an Exchange. In order to make that decision, employees will need to distinguish and understand four different types of HRA offerings – an HRA integrated with group or other coverage, an individual-market-integrated HRA, an excepted benefit HRA, and a qualified small employer health reimbursement arrangement (QSEHRA) – and accurately communicate which type of HRA their employer is offering when seeking an affordability determination from an Exchange. Only two of these HRA options, an individual-market HRA and QSEHRA, require employers to provide employees with information about eligibility for premium tax credits. This places the burden on employees to figure out what they're offered and understand complex eligibility requirements for premium tax credits that will lead to increased employee confusion surrounding their health insurance choices. For example, employees with an offer of an HRA will not only need to understand how an HRA impacts their eligibility for tax credits, but they will also need to understand the implications of "opting out" of an HRA.

Consumers who are confused by their options may inadvertently provide inaccurate information to Exchanges, placing the consumer at risk of improperly obtaining subsidies which they would ultimately have to pay back. Additionally, confused consumers may make disallowed coverage choices.

The consumer confusion and demands on Exchange service centers as well as agents and brokers will mean time and effort is distracted from the job of enrolling consumers in affordable coverage. Consumers will contact Exchange service centers and other enrollment channels for help, putting an inappropriate burden on service channels to explain the nuanced differences of HRAs, excepted benefits HRAs, QSEHRA's to consumers, and how each option interplays with premium tax credits. Extensive training for agents and brokers who are marketing individual ACA compliant products will be necessary.

Absence of Verification Could Lead to Inappropriate APTC Determinations

To confirm that employees receive the appropriate eligibility for APTC, Exchanges are required to verify certain eligibility requirements with electronic data sources. There is no electronic data source available for state-based Exchanges, such as Covered California, and the federally-facilitated marketplace, to verify the information on HRA offerings that an employee is reporting to the Exchange. Without verification, Exchanges are at risk of inappropriately determining eligibility for APTC. Inaccurate eligibility determinations will lead to HRA-related appeals and additional employee frustration regarding repayment of APTC and the potential for tax liability.

For the reasons stated above, Covered California asks that the effective date of this regulation be delayed until viable and federally-hosted electronic data source for APTC

eligibility verification exists and to allow time for IT systems to be changed and to address employee confusion.

To the extent that these rules become finalized, the Departments of Treasury, Labor, and Health and Human Services (Departments) should consider various modifications to the rules to mitigate the consumer and operational challenges outlined above as well as to adequately prevent adverse selection to the market. Covered California offers the following recommendations:

1. **Strengthen Safeguards to Prevent Market Segmentation and Health Condition Discrimination**
   In the proposed regulation, the Departments of Treasury, Labor, and Health and Human Services (the Departments) conclude that there is significant risk of market segmentation and health factor discrimination that justify regulations aimed at preventing employers from intentionally or unintentionally steering participants with adverse health conditions into the individual market. If employers were permitted to shift less healthy individuals or less healthy classes of employees (including creating certain classes of employees) into the individual market, individual market premiums will increase, thereby increasing subsidy costs for the federal government and premiums for unsubsidized enrollees, both on and off-Exchange. To address this concern, the proposed regulation requires individual-market-integrated HRAs to be offered to entire classes of workers (rather than to specific workers) and prohibits employers from offering workers a choice between individual market coverage and a traditional group health plan. The proposed regulation allows employers to delineate classes based on any combination of a broad set of worker characteristics.

   Covered California is concerned that the proposed list of classes is so broad it may facilitate precisely what the regulation states it seeks to protect; allowing employers to create classes that steer participants with adverse health factors into the individual market. In addition to the proposed "safeguards," the Departments should consider additional safeguards to ensure that there is not an incentive to discriminate based on a health condition. Examples of additional safeguards include:
   - A 30-day maximum waiting period for employees who have not satisfied a waiting period for coverage
   - Limitations on class sizes. For example, employers with less than 10 employees should not be allowed to create classes and no class of employees should be allowed to contain less than a certain number of employees. The Departments could consider a requirement that each class of employees must be a minimum of 10% of the total employer workforce

2. **Complicated System Modifications Require Additional Implementation Time**

   The proposed regulations require Exchanges to perform a new affordability calculation for consumers who are offered an individual-market-integrated HRA and other account-based group health plans through their employer. Specifically, the regulations require that consumers who are offered this type of HRA, but wish to apply for premium tax credits, seek an affordability determination from an Exchange. To make this determination, all state-based Exchanges and the federally-facilitated marketplace must develop new system logic to support this calculation, which is based on the lowest cost silver plan in a consumer's region, consumer's household income, HRA amount and duration, employment status, availability to dependents, and the affordability percentage for that year. Exchanges must also develop new questions to support the affordability calculation, adding to the already lengthy application for health care coverage, as well as dynamically hide these new questions from consumers that are potentially eligible for Medicaid programs. Due to the complexity of the required changes, Covered California cannot fully incorporate these new questions and calculations of eligibility into its system by the proposed January 1, 2020, implementation date.

For the reasons stated above, Covered California has significant concerns about the insufficient safeguards and complexity of changes required of Exchanges in the proposed regulations. Should the Departments finalize the proposed rules, Covered California requests to delay the effective date of this regulation until at least 2021 to allow time for IT systems to be changed and to address employee confusion surrounding eligibility.

Sincerely,

Peter V. Lee
Executive Director

cc: Covered California Board of Directors

California Health Care Foundation

UCLA CENTER FOR HEALTH POLICY RESEARCH

October 2018

Issue Brief

ACA Reduces Racial/Ethnic Disparities in Health Coverage

Differences in the uninsured rate between white, African American, and Asian/Pacific Islander Californians have been eliminated; however, the coverage rate for Latinos still lags behind.

Under the Patient Protection and Affordable Care Act (ACA), millions of Californians have gained health coverage. These gains have come either through the expansion of Medicaid (called Medi-Cal in California) to low-income adults earning up to 138% of the federal poverty guideline (FPG), or through Covered California, the state's ACA health insurance marketplace, where people earning up to 400% FPG can purchase subsidized insurance coverage. The major coverage expansions of the ACA were implemented starting in 2014, and by 2016 the uninsured rate among nonelderly Californians had fallen from 15.5% to a historic low of 8.5%.

This brief examines health care coverage rates and sources of coverage among nonelderly (under age 65) Californians based on the 2017 California Health Interview Survey (CHIS). The authors focus on nonelderly Californians because those over 65 are nearly universally covered by Medicare. For ease of presentation, the nonelderly uninsured rate is referred to in the text as the "uninsured rate."

In 2017 multiple unsuccessful attempts by the Trump administration and Congress to repeal the ACA and enact policies that would have reduced the number of Californians with coverage created uncertainty for consumers about coverage options and requirements. California also took steps to mitigate the effects of certain federal actions. Federal actions and the uncertain environment may not have had a heavy influence on Californians' decisions regarding coverage for 2017, due in large part to timing. For example, 2017 open enrollment for Covered California ended on January 31, 2017, before ACA repeal attempts began in earnest and before many of the federal actions were announced. Covered California's 2018 open enrollment began in November 2017, near the end of CHIS data collection for 2017. 2018 CHIS data may better capture the effects of 2017 federal actions and uncertainties.

This brief focuses on changes from 2013 to 2017 to compare pre- and post-ACA implementation. It also flags important changes from 2016 to 2017. Only changes that are statistically significant

(see definition below) are highlighted. (The term "changed significantly" is used throughout the brief to mean a statistically significant change.)

Undocumented Adults: What Counts as Insurance?

In this brief, in keeping with previous CHIS analyses, all Californians reporting Medi-Cal coverage are considered covered by Medi-Cal. This includes undocumented adults who are not eligible for full-scope Medi-Cal but may have used restricted-scope Medi-Cal. Restricted-scope Medi-Cal is not comprehensive coverage, covering only emergency and pregnancy-related services. When asked by survey researchers about health coverage, some undocumented immigrants who have used restricted-scope Medi-Cal may respond that they have Medi-Cal coverage. If undocumented immigrants reporting Medi-Cal were considered uninsured, the number of Californians who are uninsured would be higher, as would the number of uninsured among some demographic groups, such as Latinos.

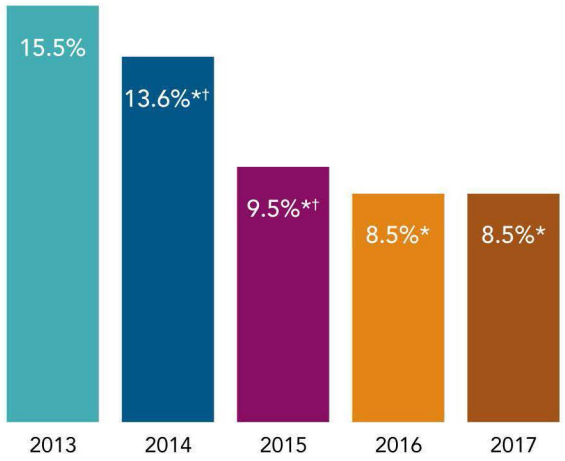
Statistical significance is a mathematical test that helps researchers assess whether differences are real or the result of random chance. In these survey findings, if a change is "statistically significant" the CHIS team is confident the change occurred due to a factor other than random chance.

Key Findings

Uninsured rate remained stable and nearly 50% lower than before ACA implementation.

In 2017 the uninsured rate among nonelderly Californians was 8.5%, just over half the 15.5% uninsured rate in 2013, before full implementation of ACA coverage provisions. Since 2016, with the ACA's main coverage provisions in place since 2014, California's nonelderly uninsured rate has been stable.

Figure 1. Uninsured Rate Among Californians Age 0–64, 2013–2017



*Significantly different from 2013 ($p < 0.05$).
†Significantly different from previous year ($p < 0.05$).
Source: California Health Interview Survey, 2017.

2016's historic narrowing of disparities in coverage between most racial/ethnic groups was maintained, although Latinos continued to experience a higher uninsured rate than others.

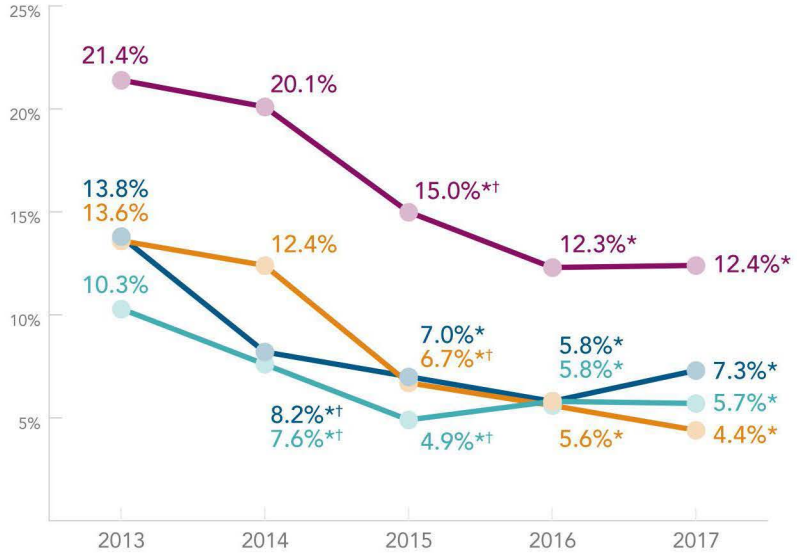
The ACA has significantly reduced the uninsured rate among all racial/ethnic groups in California and has produced historic declines in racial disparities in health coverage rates.

Between 2013 and 2017, the uninsured rate declined by more than 40% for each group, with slightly larger declines among African Americans and Asians/Pacific Islanders (see Figure 2, page 3). By 2016, there was no statistically significant difference between the uninsured rates for non-Latino whites (5.8%), African Americans (5.8%), and Asians/Pacific Islanders (5.6%) — the first time such equity in health coverage rates had been achieved between these racial/ethnic groups since CHIS began collecting data in 2001.

Although Latinos experienced a significant decline in their uninsured rate, dropping from 21.4% in 2013 to 12.4% in 2017, the coverage rate for Latinos continued to lag behind other racial/ethnic groups.

In 2017, there continued to be no statistically significant difference in the uninsured rate between non-Latino whites, African Americans, and Asian/Pacific Islanders. Between 2016 and 2017, uninsured rates remained statistically stable within each racial/ethnic group.

Figure 2. Uninsured Rate Among Californians Age 0–64, by Race/Ethnicity, 2013–2017



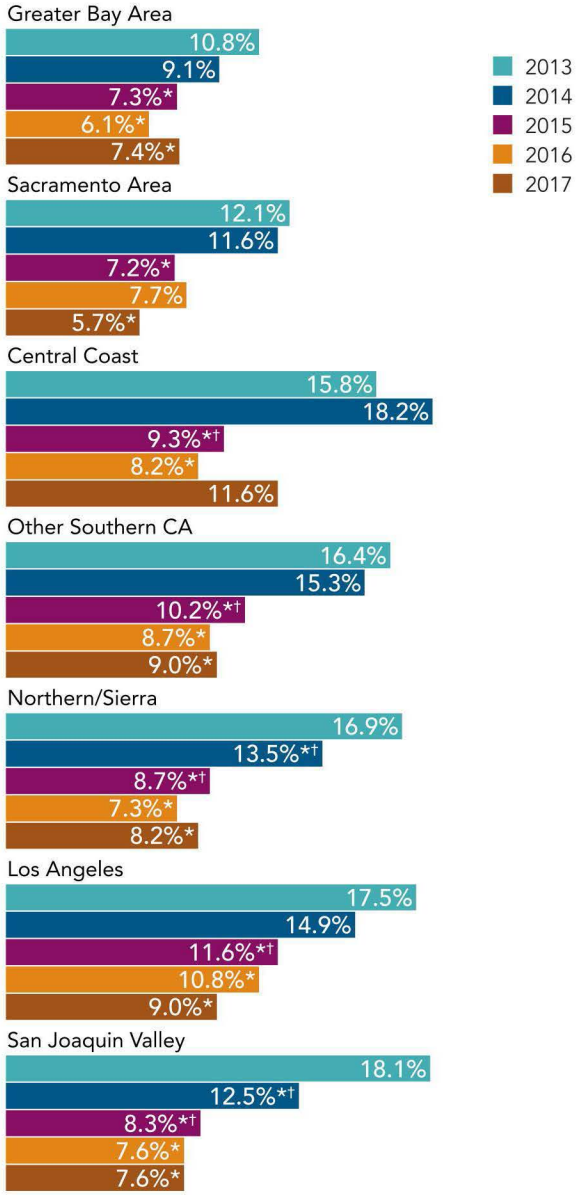
In 2017, there continued to be no statistically significant difference in the uninsured rate between non-Latino whites, African Americans, and Asian/Pacific Islanders.

Coverage gains maintained in most California regions, but variation across regions continued.

In 2017, every region of California had experienced a statistically significant decrease in its uninsured rate compared to 2013, with the exception of the Central Coast. (See Figure 3.) The San Joaquin Valley, which had the highest uninsured rate in 2013 (18.1%), experienced the largest decline, reaching a low of 7.6% in 2017. The Greater Bay Area had the lowest uninsured rate in 2013 (10.8%) and has experienced the smallest decline, reaching a low of 6.1% in 2016. By 2017, the Sacramento area had the lowest uninsured rate (5.7%) and the Central Coast had the highest (11.6%).

Most of the change in the uninsured rates within each region occurred between 2013 and 2015. Since then, rates have remained stable.

Figure 3. Uninsured Rate Among Californians Age 0–64, by Region, 2013–2017



FIGURES 2 AND 3:
*Significantly different from 2013 ($p < 0.05$).
†Significantly different from previous year ($p < 0.05$).

Notes: While the uninsured rate among African Americans crept up slightly to 7.3% in 2017, it is not a statistically significant change. See Appendix for a list of counties within each region.

Source: California Health Interview Survey, 2017.

Coverage gains maintained for low- and moderate-income Californians.

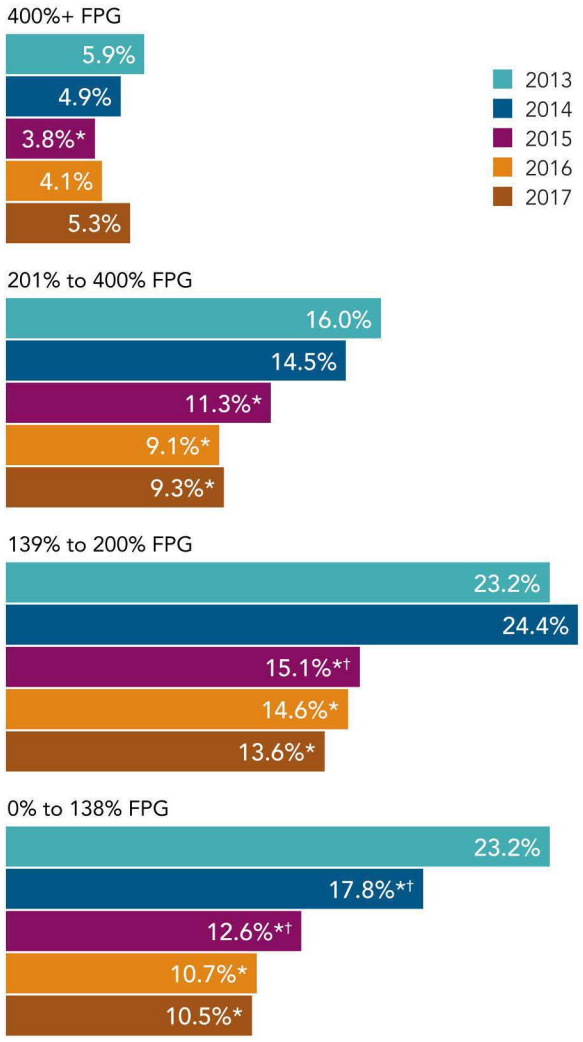
Under the ACA, low- and moderate-income families (earning up to 400% FPG) have seen the biggest decreases in their uninsured rates, reflecting the ACA's Medicaid expansion and subsidized private coverage for those earning up to and including 400% FPG. In fact, the biggest decline occurred among those earning 138% FPG or less, the income eligibility threshold for Medi-Cal, although large and significant declines also occurred among those earning 139% to 200% FPG and 201% to 400% FPG (see Figure 4).

Table 1. Federal Poverty Guidelines, 2017

	100%	138%	400%
Single Adult	$12,060	$16,643	$48,240
Family of Four	$24,600	$33,948	$98,400

The biggest decline in the uninsured rate has occurred among those earning 138% FPG or less, the income eligibility threshold for Medi-Cal.

Figure 4. Uninsured Rate Among Californians Age 0–64, by FPG, 2013–2017



*Significantly different from 2013 ($p < 0.05$).
†Significantly different from previous year ($p < 0.05$).

Note: See Table 1 for 2017 federal poverty guidelines (FPG) income values for single adults and families of four.

Source: California Health Interview Survey, 2017.

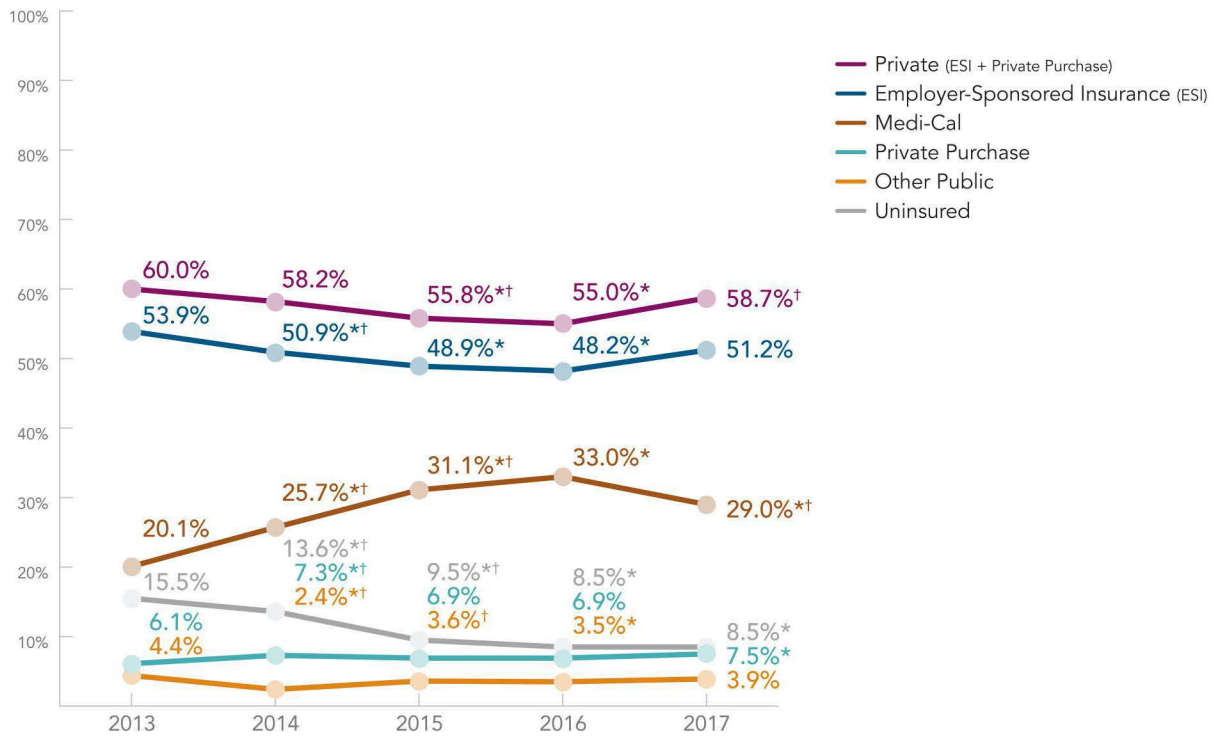
Medi-Cal enrollment decreased; private coverage rebounded.

Under the ACA, the percentage of Californians covered by Medi-Cal rose substantially, from 20.1% in 2013 to 33% in 2016 (see Figure 5, page 5). Although most Californians have continued to get their coverage through their jobs, the percentage with employer-sponsored insurance (ESI) declined between 2013 and 2016.

However, between 2016 and 2017, these trends started to shift. The percentage of Californians with coverage through Medi-Cal decreased significantly, from 33.0% to 29.0% (though it remained significantly higher than 2013). Meanwhile, the percentage of Californians with private insurance coverage (defined as including ESI and insurance purchased on the individual market, both on and off Covered California) rose significantly from 55.0% to 58.7%. This increase in private coverage offset decreases in Medi-Cal enrollment, resulting in a stable uninsured rate, and may reflect a growing economy and improvements in household income across the state.[1]

1. "Local Area Unemployment Statistics, 2008–2018," Bureau of Labor Statistics, data.bls.gov; "Real Median Household Income in California," Federal Reserve Bank of St. Louis, fred.stlouisfed.org.

Figure 5. Source of Health Insurance Coverage, Californians Age 0–64, 2013–2017



*Significantly different from 2013 ($p < 0.05$).
†Significantly different from previous year ($p < 0.05$).

Source: California Health Interview Survey, 2017.

Summing It All Up — and Looking Ahead

The story of health insurance coverage in 2017 is one of overall stability. The tremendous gains under the ACA largely persisted, including historic progress in narrowing racial/ethnic disparities in coverage. However, lagging progress among Latinos, persistent variation across regions, and many Californians still being uninsured point to the need for further work to ensure all Californians can get the coverage they need.

Continued monitoring of the uninsured rate will be particularly important going forward given the uncertainty created at the federal level around the ACA in 2017. In addition to the multiple ACA repeal attempts, many other federal policies in 2017, such as the elimination of cost-sharing reduction payments to insurers on the ACA health insurance marketplaces, were potentially destabilizing. The 2018 CHIS data may help show if the 2017 federal policy environment affected Californians' decisions around enrolling in, or purchasing, coverage.

Visit www.chcf.org for additional analyses focused on access metrics as well as future examinations of affordability drawing on CHIS and other data sources.

Methodology

In this fact sheet, health insurance coverage has been measured as coverage at a point in time (at time of survey response), rather than as coverage over the past year. Each respondent was coded into a single health insurance coverage type based on the following hierarchy: uninsured, Medicare, Medi-Cal, ESI, private direct purchase (which includes purchase on the individual market including on and off Covered California), and other public coverage. Those with Medicare were then reclassified into "other public coverage." For these reasons, the estimates included in this brief may not be comparable to estimates from other sources that report coverage over the past year or use a different health insurance hierarchy. See also "Undocumented Adults: What Counts as Insurance?" on page 2.

The measure of income included in this fact sheet is based on family income earned in the past month as a percentage of the FPG issued by the Department of Health and Human Services. The data also contain measures of income based on household income in the past calendar year as a percentage of the federal poverty thresholds issued by the Census Bureau. The family income as a percentage of the FPG measure was included because this measure is more consistent with the income and poverty line measures used to determine eligibility for federal programs, including Medicaid and health insurance exchange premium subsidies.

Data for this fact sheet were drawn from the newly released 2017 California Health Interview Survey (CHIS), in conjunction with data from the previously released 2011–16 CHIS annual data files. CHIS covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. CHIS is based on interviews conducted continuously throughout the year, with respondents in approximately 20,000 California households annually. For more information about CHIS, please visit CHIS online at www.chis.ucla.edu.

About the Author

Tara Becker, PhD, is a senior public administration analyst at the UCLA Center for Health Policy Research.

About the UCLA Center for Health Policy Research

The UCLA Center for Health Policy Research is one of the nation's leading health policy research centers.

The Center is the home of the California Health Interview Survey (CHIS) and is affiliated with the UCLA Fielding School of Public Health.

PB2018-10.

About the Foundation

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

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

For more information, visit www.chcf.org.

Appendix. California Counties within the CHIS Regions

CENTRAL COAST	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
GREATER BAY AREA	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
LOS ANGELES	Los Angeles
NORTHERN/SIERRA	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
SACRAMENTO AREA	El Dorado, Placer, Sacramento, Yolo
SAN JOAQUIN VALLEY	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare
OTHER SOUTHERN CALIFORNIA	Imperial, Orange, San Bernardino, San Diego, Riverside

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Thomas G. McGuire
Sonja Schillo
Richard C. van Kleef

Working Paper 25374
http://www.nber.org/papers/w25374

NATIONAL BUREAU OF ECONOMIC RESEARCH
1050 Massachusetts Avenue
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December 2018

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NBER working papers are circulated for discussion and comment purposes. They have not been peer-reviewed or been subject to the review by the NBER Board of Directors that accompanies official NBER publications.

Reinsurance, Repayments, and Risk Adjustment in Individual Health Insurance: Germany, The Netherlands and the U.S. Marketplaces

Thomas G. McGuire, Sonja Schillo, and Richard C. van Kleef

NBER Working Paper No. 25374
December 2018
JEL No. I10,I11

ABSTRACT

Reinsurance can complement risk adjustment of health plan payments to improve fit of payments to plan spending at the individual and group level. This paper proposes three improvements in health plan payment systems using reinsurance. First, we base reinsurance payments on spending not accounted for by the risk adjustment system, rather than just high spending. Second, we propose pairing reinsurance for individual-level losses with repayments for individual-level profits. Third, we optimize the weights on the risk adjustors taking account of the presence of reinsurance/repayment. We implement our methodology in data from Germany, The Netherlands and the U.S. Marketplaces, comparing our modified approach to plan payment with risk adjustment as currently practiced in the three settings. The combination of the three improvements yields very substantial improvements in the individual-level fit of payments to plan spending in all three countries.

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1. Introduction

Reinsurance -- extra payments a health plan receives once spending for an individual exceeds a pre-defined threshold[1] -- can complement risk adjustment of health plan payments to improve fit of payments to plan spending at the individual and group level. Reinsurance can reduce selection incentives not corrected by risk adjustment and mitigate a plan's business risk. Where used, however, reinsurance payments typically make up a small share of total plan payments.[2] The reason is two-fold. First, like other forms of risk sharing, reinsurance dilutes incentives for cost control. Second, reinsurance payments must be financed, either by reducing the funds available for risk adjustment or by external sources. Nonetheless, even when reinsurance is only a very small share of total payments, because it targets the highest-cost cases, a little reinsurance goes a long way to reducing the variation in health care costs not accounted for by risk adjustment (Swartz, 2006).

This paper proposes three improvements in health plan payment systems using reinsurance. First, we base reinsurance payments on spending *not accounted for by the risk adjustment system*, which we refer to as *residual spending*, rather than just *high spending*. Targeting reinsurance to residuals rather than spending is more effective at reducing variation in individual-level profits and losses.

Second, we *pair reinsurance with repayments*. It is well-known that risk adjustment payment models underpay for individuals with extremely high spending by amounts that can rise to millions of dollars or Euros. But there is another side to the mismatch of payments to spending. Sophisticated disease-based risk adjustment algorithms (as are in place in the three countries studied here) generate plan payments for individuals with (multiple) disease indicators that can run into the hundreds of thousands of dollars or Euros. And sometimes, recording of disease indicators in health claims notwithstanding, plans spend little to treat the individuals *predicted* to be expensive. For some individuals, plan spending is much less than plan revenue.[3] A repayment policy that limits plan gains along with a reinsurance policy that limits plan losses further improves fit of the payment

[1] This has also been referred to as 'excess loss compensation' (Van de Ven et al., 2000).

[2] An exception is reinsurance in the free-standing prescription drug plans in Medicare Part D where reinsurance payments make up more than half of total plan payments. The original design of the Part D reinsurance program was not intended to constitute such a large share of payments, and various reforms have been proposed to reduce the share of reinsurance payments. Medicare Payment Advisory Commission (March, 2014).

[3] Risk adjustor variables are imperfect signals of an individual's health status. For example, use of home care in the prior year (one of the risk adjustor variables used in the Netherlands) identifies people with very different risk types, e.g. young people recovering from an incidental hospital treatment and elderly people with progressive end-of-life health problems. A compensation based on the average predicted spending for these risk types likely generates substantial overpayments for the first group.

system. Furthermore, pairing repayments with reinsurance has the attractive feature that pay-ins from plans on highly profitable enrollees help finance the pay-outs to plans for the enrollees with very large losses.

Third, we *optimize the weights on the risk adjustors taking account of the presence of reinsurance/repayment*. Risk adjusted payments to plans are intended to cover spending which is the responsibility of the health plan. Risk adjusted payments need not cover spending that will be taken care of by reinsurance. We show that a simple iteration optimizes the regression weights predicting plan spending net of reinsurance/repayment and optimizes the upside and downside thresholds where reinsurance and repayment, respectively, should kick in. The benefits of this integrated approach to estimation can be illustrated with a simple example. Imagine a risk adjustment model that includes a morbidity indicator x which identifies a group of people with high spending on average but with considerable variation around the average. A payment weight for this indicator based on the average incremental spending in the group will underpay some people and overpay others. Our integrated estimation procedure accounts for the presence of reinsurance which directly improves fit for the group members with spending much above the group average. The consequent reduction in the estimated payment weight indirectly improves fit for those with lower than average costs. A similar argument could be made for the beneficial effects of the repayment component.

We implement our methodology in data from Germany, The Netherlands and the U.S. Marketplaces, comparing our modified approach to plan payment with risk adjustment as currently practiced in the three settings. The combination of 1) targeting reinsurance/repayment to residual spending rather than absolute spending, 2) supplementing reinsurance with repayments for highly overpaid enrollees, and 3) optimizing regression weights in the presence of reinsurance/repayment yields very substantial improvements in the individual-level fit of payments to plan spending in all three countries. Conducting empirical risk adjustment research in parallel in three countries is a novel contribution. Similar results in the three distinct individual health insurance markets supports the generality of our findings about the impacts of health plan payment alternatives considered.

Previous research in the three countries and elsewhere has investigated the properties of supplementing risk adjustment with reinsurance or other forms of risk sharing. Studies in the US, including a number focusing on the Marketplaces,[4] have found that conventional reinsurance,

[4] The following papers all use payment systems modelled on the Marketplaces. Geruso and McGuire (2016) use MarketScan data from 2008-09, and Zhu et al., (2013) and Layton, McGuire and Sinaiko (2016) use data from the Medical Expenditure Panel Survey (MEPS) with characteristics matching likely Marketplace

defined on spending rather than residuals, improves fit at the person level as well as at the level of groups defined by use of certain services. Consistent findings emerge in research in Israel (Brammli-Greenberg, Glazer and Waitzburg, 2018) the Netherlands (Van Barneveld et al., 1998, 2001), and Switzerland (Schmid and Beck, 2016). As far as we know, Schillo et al. (2016), in a paper on Germany, are the first to propose and check a reinsurance system based on residual spending – also highly effective at improving fit of the payment model.[5]

A limitation on gains at the individual level (as is done with a repayment feature) has been paired with a limitation on losses (the reinsurance function) in U.S. Medicare payment models for hospital and home health care. Medicare pays hospitals prospectively on the basis of Diagnosis-Related-Groups (DRGs), but if the cost of a stay exceeds a fixed loss threshold, Medicare covers 80% of the cost above the threshold. On the other side of the realized cost distribution, if a patient is transferred and their length of stay at the transferring hospital is lower than the DRG-specific geometric mean, Medicare pays a per diem rate – in effect, requiring a repayment from the DRG-based payment.[6] For long-term care (LTC) hospitals, 'short-stay outliers' receive less than full payment.[7] A short-stay outlier is a stay length that is less than or equal to $5/6^{th}$ of the LTC-DRG specific geometric mean length of stay. For these cases, Medicare pays roughly the LTC-DRG per

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participants. Using an updated version of the data used for calibration of the ACA risk adjustment models -- the same data are used in this paper -- Layton, Ellis, McGuire and Van Kleef (2017) show that reinsurance paired with prospective risk adjustment produces an individual-level fit of payments to costs much higher than concurrent risk adjustment with no reinsurance.

[5] In a related approach some research groups have studied including a variable representing "high cost" as a risk adjustor directly. Schillo et al. (2016) study including an indicator for high-cost groups, Layton and McGuire (2017) propose including costs above the reinsurance attachment point as a risk adjustor, and Van Kleef and Van Vliet (2012) include an indicator of persistent high cost in multiple previous years as an adjustor, an approach subsequently incorporated in the Dutch risk adjustment model.

[6] Centers for Medicare and Medicaid Services (CMS). "Medicare Claims Processing Manual. Chapter 3-Inpatient Hospital Billing. (2018) Section 20.1.2.4 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf. The Medicare Learning Network (MLN). Acute Care Hospital Inpatient Prospective Payment System. March 2018 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/acutepaymtsysfctsht.pdf

[7] Centers for Medicare and Medicaid Services (CMS). "Medicare Claims Processing Manual. Chapter 3-Inpatient Hospital Billing. (2018) Section 150.9.1.1 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf. Long-term care hospitals specialize in providing care to patients with complex needs (often transferring from an intensive care unit) who usually stay more than 25 days. https://www.medicare.gov/Pubs/pdf/11347-Long-Term-Care-Hospitals.pdf

diem amount.[8] Finally, in the home health setting also, reinsurance supplements payments for cases for which spending during the 60-day episode greatly exceeded the 60-day case-mix adjusted payment. On the other hand, beneficiaries whose episode consisted of four or fewer visits are paid a standardized amount per visit rather than the full 60-day adjusted episode payment.[9] In this light, our paper imports the idea of reinsurance/repayment from these other areas, with the added features that we designate thresholds based on spending *residuals*, and we optimize the risk adjusted payment amount for the presence of the up and down-side risk sharing.

Section 2 contains a brief overview of risk adjustment and risk sharing in health plan payment in the three countries as well as a description of the data used for the empirical application. In the case of The Netherlands and the Marketplaces, the data are those actually used to calibrate the national risk adjustment system. The data from Germany are from a large sickness fund operating nationwide. In all countries, we split the data into equal-sized "training" and "test" samples to avoid overfitting problems. All estimation, including reinsurance thresholds, is done on the training samples. All outcome measures are calculated on the test samples.

Section 3 presents the results in step-wise fashion in order to isolate the contribution of each modification we propose. All simulations are balanced-budget, meaning any risk sharing is financed by reducing funds available for the risk-adjusted payment. Our baseline is current practice: a risk adjustment model estimated on total spending without regard for any reinsurance or other risk sharing features. We then add conventional reinsurance – i.e. based on spending – equal to 2% of total spending in each country.[10] By choosing the same percentage devoted to reinsurance we can more readily compare results across the three health insurance markets. We next target reinsurance to *residual* spending. Next, we add a repayment feature defined on negative residual spending (where risk adjustment payments exceed spending) and set the repayments equal to 2% of total spending. Finally, in the context of residual-based reinsurance and repayments, we reestimate the risk adjustment weights and simultaneously optimize the weights and the up and down-side thresholds

[8] The Medicare Learning Network (MLN). Fiscal Year (FY) 2018 Inpatient Prospective Payment System(IPPS) and Long Term Care Hospital (LTCH) PPS Changes. October 2017 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf

[9] CMS.gov website, Home Health PPS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

[10] In this paper we choose the shares of spending allocated by reinsurance (and repayments) for purposes of illustration. In practice, the regulator might set these parameters in the light of the tradeoffs involved in improving selection-related incentives at the expense of reducing incentives for cost control. We make some comments on this tradeoff in the context of reinsurance and repayment policy later in the paper.

for reinsurance and repayment. After this exercise for a fixed share devoted to reinsurance, we show results for various combinations of reinsurance and repayment, all with optimized regression weights. Specifically, we study the four combinations of reinsurance at 1% and 2% and repayment at 0% and 1%. All this is done in parallel in the three countries to compare the impacts of identical policies in different health insurance markets.

We find that in spite of major differences in patterns of health care spending and risk adjustment practices in the three countries, residual-based reinsurance and repayment has powerful and remarkably similar impacts on individual-level fit across settings. In the optimized systems, 2% residual-based reinsurance paired with 2% residual-based repayments leads to improvements in individual-level payment fit varying from about 30 percentage points in the Netherlands and the Marketplaces to about 40 percentage points in Germany. Section 4 comments on the practical application of our findings and discusses some potential next steps in research. Methodologically, the primary takeaway from our paper is that full optimization of payment system parameters requires teamwork between risk-adjustment weights and reinsurance/repayments. Empirically, the primary takeaway is that modifying payment systems using 2% reinsurance/2% repayment based on residual spending and optimized risk adjustment weights approximately doubles the individual-level fit of conventional risk adjustment models.

2. Health Plan Payment in Germany, The Netherlands and the U.S. Marketplaces

Individual health insurance markets in Germany, The Netherlands and Marketplaces in the U.S. are organized around principles of regulated (or managed) competition, as first proposed by Enthoven (1980). Belgium, Colombia, Israel, Switzerland, and Medicare Advantage (the private option for Medicare beneficiaries in the U.S.) among other countries and sectors, share some similar features.[11] Regulated competition puts health plans in competition with the goal of generating incentives for cost containment and efficient plan design.[12] In policies that differ country-by-country, regulators promote competition by allowing health plans some, but limited, discretion about plan design (e.g. in terms of provider network and cost sharing options). At the same time,

[11] McGuire and Van Kleef, eds. (2018) contains descriptions of the individual health plan markets structured as regulated competition in 14 countries and sectors.

[12] By 'health plan competition' we mean competition among health insurers who offer one or multiple health plans. A 'health plan' refers to a health insurance product. All consumers who have the same 'health plan' have an identical contract with the same insurer concerning benefits coverage, cost-sharing, quality, services, etc. Since objectives and strategies of insurers can differ across health plans (primarily in the U.S. and The Netherlands), this paper will speak of health plans instead of insurers as decision makers.

the regulators manage competition in order to guarantee public objectives such as affordability and accessibility. In all three countries, enrollee premiums do not differ according to the health status of individuals while some form of risk adjustment of plan payment is done centrally to transfer funds to plans enrolling more costly individuals. Risk adjustment is designed to ensure plan viability, but more importantly, to counter plan incentives to attract the healthy and deter the sick from joining the plan.

2.1 Germany

The public health insurance system in Germany is the largest individual health insurance market in the world, both in terms of the number of lives covered and in the total plan payments (Wasem et al., 2018). In 1996, free choice of sickness funds was introduced for all members of the social health insurance system. Two years prior, in 1994, risk adjustment was established to provide equal opportunities for sickness funds with diverging risk profiles of their insured. In 2009, the formerly mostly demographic risk adjustment system became morbidity-based. Since then the payments to the sickness funds are calculated by an individual-level least squares regression weighted by the fraction of the year the individual is insured in the social health insurance system. Risk adjustors (see Table 1) are included in the form of dummy-variables. The model is prospective: expenditures from one year are explained by demographic characteristics from the same year but the morbidity characteristics are taken from the previous year.[13] From 2002 until 2009, risk adjustment was complemented by reinsurance from a high expenditure pool through which sickness funds were reimbursed 60% of spending above a certain individual threshold. With the introduction of the morbidity-based risk adjustment the high expenditure pool was abolished. Debate continues about reintroduction of elements of reinsurance.[14]

Data from Germany used in this paper are from one large national insurer.[15] Table 2 summarizes some features of the German data as well as for the other countries.

2.2 The Netherlands

Since 2006, The Netherlands have had a national health insurance system based on principles of regulated competition, with a risk adjustment system that has been improved over time. In the early years, the risk adjustment system was supplemented with reinsurance to mitigate

[13] The German regression is run on cost per day which is equivalent to an annualization.

[14] See for example Drösler et al. (2017).

[15] More description of the data source is contained in Schillo et al. (2016).

selection incentives remaining after risk adjustment and to mitigate plans' business risk due to financial uncertainties surrounding specific healthcare system reforms. As risk adjustment was improved and the health insurance market stabilized, reinsurance thresholds were increased; in 2014, reinsurance was abolished altogether. In 2018, the Dutch risk adjustment system consists of three different models, one for each of the following categories: somatic care, mental health care, and out-of-pocket payments due to the mandatory deductible of 385 Euros per adult per year (Van Kleef et al., 2018a). For simplicity, our analyses will be based on the model for somatic care only. This model accounts for about 85% of total spending and includes 193 risk classes, which are described in Table 1. Risk classes take the form of dummy variables indicating whether an individual is a member of a class or not. Currently, risk adjustor coefficients are derived by an individual-level weighted least squares regression of annualized expenditures in 2015 on demographic variables from year 2015 and the disease indicators listed in Table 1 from 2014 or before. Data on expenditures and characteristics cover the entire Dutch population with a health plan in 2015. Prior to estimation, some modifications are applied to make the available data representative for 2018 (e.g. including modifications for changes in the benefits package).[16]

Data from The Netherlands are those actually used for calibration of plan payment models, and have been used in a number of research papers.[17]

2.3 U.S. Marketplaces

The U.S. Marketplaces, created as part of the Affordable Care Act (2010) and popularly known as "Obamacare," began enrolling individuals and families in 2014 (Layton, Montz and Shepard, 2018). These markets, organized at the state level, are intended to provide affordable health insurance for those who do not receive insurance through their employers or through public programs providing coverage for the elderly (Medicare) or for low-income families (Medicaid). The law included a number of reforms which shifted the individual health insurance market toward a version of regulated competition, including income-related subsidies, (partial) community rating of premiums, mandated coverage of a basket of "essential health benefits," and guaranteed issue and renewal provisions prohibiting plans from rejecting applicants based on their health status. As of

[16] In the regression model expenditures are annualized and the observations weighted by the fraction of the year an individual was enrolled in 2015 (which can be smaller than 1.0 due to birth, death, migration and other factors). For example, a person with a half-year enrollment and 2,000 Euro expenditures is given a weight of 0.5 and annualized expenditures of 4,000 Euro (2,000/0.5).

[17] For some recent papers see Layton, McGuire and Van Kleef (2016), Van Kleef et al., (2017), Van Veen et al., (2017).

the first quarter of 2018, about 10.6 million Americans were enrolled in a Marketplace plan, 87% of whom receive premium subsidies, representing over 70% of the individual health insurance market. The extent of coverage in Marketplace plans ranges from approximately 60% on average for "bronze" plans to 90% for "platinum" plans. The Marketplace risk adjustment model assigns risk scores to enrollees based on their demographics and observed diagnoses during the concurrent plan year (i.e. calendar year). Risk scores are calculated using a model developed by the Department of Health and Human Services (HHS), the HHS Hierarchical Condition Categories (HHS-HCC) model. The HHS-HCC model predicts an enrollee's medical spending in the current year by mapping diagnoses coded on insurance claims into one of currently 127 HHS-selected HCCs, which were drawn selected from the larger set of HCCs available in the diagnostic classification system).[18] A "temporary" reinsurance component was part of the Marketplace payment system in the first three years, and due to a continuing concern about high-cost cases, a modest reinsurance function was restored through changes in the formula transferring funds among health plans (Jost, 2016; Layton and McGuire, 2017). As of August, 2018, seven states in the U.S. have received waivers from the federal government to reintroduce reinsurance in their Marketplaces.[19]

The U.S. data are an updated version of the MarketScan data used to calibrate plan payment models in the Marketplaces. The 8.2 million sample from the larger MarketScan files is drawn using the same exclusion/inclusion criteria used by HHS in estimating risk adjustment models, as has been done in previous research on Marketplace payment models.[20]

3. Residual-Based Reinsurance and Repayment, and Optimized Risk Adjustment Weights

This section defines parameters of the plan payment systems and summarizes the payment systems studied in the simulations.

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[18] Kautter et al. (2014) describe the choice of the original 100 HCCs. In 2016, there were 127 HCCs. In 2018 some modifications were added using drug use indicators and enrollment duration factors. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2018-Benefit-Year-Final-HHS-Risk-Adjustment-Model-Coefficients.pdf.

[19] https://www.commonwealthfund.org/blog/2018/affordable-care-act-under-trump-administration?omnicid=EALERT1465357&mid=mcguire@hcp.med.harvard.edu.

[20] See Layton et al. (2017), Layton and McGuire (2017). Following practice for estimating risk adjustment models in the Marketplaces, our sample is restricted to those individuals who had both prescription drug and mental health coverage and who had no negative or capitated claims. In addition, we further restricted our sample population to those continuously enrolled for twelve months who were in a non-HMO plan in the first and last month. The U.S. data are for full-year enrollees only, following current practice used for estimation of risk adjustment models for the Marketplaces.

3.1 Plan Payment Models

A risk adjustment payment consists of the summed product of the scores on a set of risk adjustor variables and the payment weights on these variables which we call the β weights. The risk adjustor variables differ by country as set out in Table 1. We treat the choice of risk adjustors as given. That is, for the plan payment models studied for Germany, for example, the risk adjustor variables are the same as those actually used and described in Table 1. Model 1 in the first row in Table 3 refers to this risk-adjustment-only payment model where the β weights are estimated in a least-squares procedure following the estimation practices used in each country.

Model 2 adds conventional reinsurance. A plan receives a reinsurance payment equal to spending less a preset threshold of spending, referred to as an attachment point.[21] Figure 1 depicts typical reinsurance defined on plan spending per person. Some individuals within an insurance pool will have spending at zero. For those with positive values of spending, the distribution is highly skewed to the right. In a typical large population, there will be individuals with spending in the millions of dollars or Euros. We set the threshold in our first set of models such that 2% of total plan payments consist of reinsurance and finance the reinsurance by a flat reduction of the risk adjustment payment from all individuals (equal to 2% of mean spending).

Model 3 begins incorporating the ideas in this paper. Keeping the same risk adjustment weights estimated in Model 1, reinsurance now applies to spending residuals after risk adjustment rather than total spending. A typical distribution of residuals, i.e., spending less risk adjustment payment, is depicted in Figure 2. Residuals could be positive or negative (and must average zero in the population used for estimating the risk adjustment payment weights). A positive residual indicates the plan is spending more than it is paid. A large right tail persists after risk adjustment because risk adjustment payments do not fully capture extreme spending. Reinsurance based on residuals reimburses a plan for residual spending above a positive residual threshold. Residual-based reinsurance in our first set of analyses redirects the 2% in reinsurance payments.

Model 4 also keeps the β weights from Model 1 but adds a repayment feature to the plan payment system, requiring a plan to repay residual spending below a negative threshold. For example, the negative threshold might be -$100k, in which case a plan would have to return any individual-level overpayment exceeding $100k. Figure 2 shows what a reinsurance/repayment

[21] Reinsurance can pay less than 100% of costs above a threshold. For simplicity, we assume a reinsurance share of 100%, though our methods would work for other shares.

system looks like, with upper and lower thresholds based on residuals defining the regions for reinsurance and repayment.

Finally, Model 5 optimizes the β weights to take account of the presence of reinsurance and repayments. Specifically, the β weights are reestimated on plan obligations net of reinsurance and repayment. New β weights, however, imply new thresholds for reinsurance and repayment. With these new β weights the distribution of residuals changes and we refigure the thresholds that would set aside 2% of funds for reinsurance and for repayment. With new thresholds, we reestimate β weights again and repeat the iterative procedure until β weights and reinsurance/repayment thresholds no longer change materially.[22]

3.2 Combinations of Residual-based Reinsurance and Repayment

A second set of analyses studies various combinations of residual-based reinsurance and repayment all with optimized β's. Specifically, we consider the following alternatives, with the first number indicating the percent of funds set aside for residual reinsurance and the second number the percent designated for residual repayment: (1,0), (1,1), (2,0).

3.3 Metrics of Plan Payment Performance

We report several metrics for plan payment system performance beginning with fit at the individual level. When plan payments are the predicted values from a risk adjustment regression, fit at the individual level is simply the R^2 from the risk adjustment model. Any net contribution of risk sharing to fit is captured by a generalization of the R^2 referred to as 'Payment System Fit' (PSF).[23] PSF is an R^2-type statistic (analogous to a pseudo-R^2) measuring the degree to which plan payments for individual i, R_i, track spending for that individual, Y_i. PSF recognizes that the payment a plan receives for an individual, R_i, can include other components in addition to the predicted spending from a risk adjustment model.

$$PSF = 1 - \frac{\sum(Y_i - R_i)^2}{\sum(Y_i - \bar{Y})^2} \qquad (1)$$

We also measure individual fit by Cumming's Prediction Measure (CPM), a linear version of (1).[24]

Payment system alternatives are also commonly evaluated on how funds are redistributed among different population groups, defined, for example by a specific illness. Policy evaluations in

[22] We found there is little gained from iterating after the second time.

[23] For other applications of payment system fit see Geruso and McGuire (2016) and Layton et al. (2017).

[24] Although R-squared is by far the most commonly reported statistic, CPM is also frequently used. For a discussion of the many measures used in risk adjustment research, see Van Veen et al. (2015).

each country define groups of interest based on illness, previous levels of spending, past health care use, and other information available in the country.[25] In order to define a group of potential interest in parallel across the three countries, we study over/undercompensation for those in the top decile of spending in the previous year. Persistence of spending means that the high spenders from last year are likely to be underpaid in the current year. Our group-level payment fit measure, the predictive ratio (PR), is, as a ratio, comparable across the three health insurance markets. Letting the index g designate those in the top decile last year

$$PR_g = \frac{\sum_g R_g}{\sum_g Y_g} \qquad (2)$$

PR_g will take a value like 80% if plan payments for this group underpay on average by 20%. PR_g closer to 100% indicates better plan payment performance for this group.

Finally, we track the redistributions accomplished by the payment system in relation to the baseline risk-adjustment payment model with no reinsurance/repayment. Funds redistributed between models 2-5 and model 1 are measured by the absolute value of changes in payment at the individual level between the two systems. For example:

$$\text{Funds redistributed for model 2} = \sum_i |(R_i^2 - R_i^1)| \qquad (3)$$

where R_i^2 is the payment for individual i in model 2 and R_i^1 is the payment in model 1. Funds redistributed measures the potential of a payment system to affect group-level allocations for as-yet unspecified groups. To make measure (3) comparable across the three settings, we present the funds redistributed as a percentage of total spending. We do not regard funds distributed as a measure of plan performance; it simply tells us how much money is moved around with the various payment models.

4. Results

In each country, data were randomly divided into equal-sized training and test samples. All estimation, including selection of reinsurance and repayment thresholds, is conducted on the training sample; all outcome measures are calculated on the test sample. For example, when we estimate risk adjustment models, the β weights are estimated on the training sample, but fit statistics are reported from the test sample. Similarly, when we choose an upper threshold in order for reinsurance to pay for the top 2% of spenders, the choice is made based on the distribution of

[25] For a review of some of these evaluations from Europe and the U.S., see Layton et al. (2017).

spending in the training sample. Results reported on the test sample will therefore not yield exactly 2% set aside for reinsurance.

4.1 Base Risk Adjustment Model and Residuals

We estimate risk adjustment models on total spending with the current specification used in each country. Table 4 reports summary statistics from the test samples for the risk adjustment models and information on the distribution of residuals (i.e. spending less risk adjustment predictions). The values of the R-squared are similar to those in other reports, 24.6% for Germany (Drösler et al., 2017), 31.6% for the Netherlands (Cattel et al., 2017), and 35.8% for the U.S. Marketplaces (Layton, Montz and Shepard, 2018). Better fit for the Marketplace model compared to that for Germany or The Netherlands is because Marketplaces use a concurrent risk adjustment model rather than the prospective models used in the other two countries.

Positive residuals result when spending is higher than predicted; negative residuals result when spending is lower than predicted. The mean absolute deviation ranges from over five thousand dollars in the Marketplaces to less than two thousand Euros in The Netherlands. Even after risk adjustment, the maximum residuals are in the millions of dollars or Euros, and the minimum residuals in the hundreds of thousands of dollars or Euros. Properties of the left side of the distribution of residuals depend heavily on the risk adjustment model. The minimum possible value for residual spending is the maximum value for predicted spending from the risk adjustment model (if that person spends nothing). In all three countries risk adjustment generates substantial overpayments for a meaningful share of the population. In Germany and The Netherlands one percent of the population is overpaid by about 10k Euros or more, and in the Marketplaces, overpayment exceeds $25k for one percent of the population. The median residual in each country is negative. In all three countries, residuals do not turn positive until about the 75th percentile of the distribution. This means that the large majority of the population is profitable for plans; losses are concentrated in the much smaller share of the population on the right side of the residual distribution.

4.2 Residual-Based Reinsurance and Repayment

Table 5 reports results for Models 1-5 listed in Table 3. In Models 2-3, reinsurance payments sum to 2% of total spending. In Models 4-5, reinsurance payments and repayments each sum to 2% of total spending. Risk adjustment alone leaves the top decile of spenders from the previous year undercompensated in each country, with the U.S. Marketplaces showing the lowest PR; the Dutch model is most successful by this metric. The Dutch model contains risk adjustors

based on prior high spending (see Table 1) which partially address underpayment for the last-year high-spending group.

The second set of rows for Model 2 shows the impact of conventional reinsurance. Setting aside 2% of funds for reinsurance corresponds to reinsurance thresholds of €140k in Germany, €122k in the Netherlands, and $350k in the U.S. Marketplaces. Notably, these thresholds touch a very small fraction of the population, less than .1 % in all markets – another indicator of the concentration of spending on the far-right tail of the spending distribution. Conventional reinsurance at 2% has a powerful effect on individual fit of payments to spending. Compared to the risk-adjustment-only model, PSF more than doubles for Germany, and moves to the range of around 60% in all three countries. PR for the top-decile of spenders in the prior year increases everywhere.[26] Conventional reinsurance moves about 4 % of the funds in comparison to risk-adjustment only in all three countries.

Model 3 targets the 2% set aside for reinsurance to residuals from the base risk adjustment model rather than spending. Thresholds defined in terms of residuals are lower than with conventional reinsurance since the risk adjustment amount is subtracted from spending to define residuals. Still, less than .1 % of the population is affected by residual-based reinsurance at 2%. Targeting the same reinsurance funds to residuals rather than spending buys an increase of about 3 percentage points in PSF in all countries. The 3 percentage point gain in individual fit compared to Model 2 is 'free' in incentive terms since the funds set aside for risk sharing are the same. Moreover, the 3 percentage point increase is substantial compared to potential improvements from adding risk-adjustor variables to already rich models.[27] Targeting residuals does not improve the PR for the top-decile of spenders in the prior year; in fact, it decreases slightly in all three markets. A potential explanation for this finding is that – in contrast to conventional reinsurance (Model 2) – residual-based reinsurance avoids 'double' payments for people with both high predicted spending and high

[26] Note that the PR for the top decile of spenders in t-1 is likely to be sensitive to how reinsurance is financed and whether or not risk adjustment weights are optimized for the presence of reinsurance. More specifically, the combination of a flat contribution and no optimization (as is true for model 2) is likely to result in double payments for people with both high predicted spending and high actual spending. Since these people are likely to be overrepresented in the group of high spenders in t-1, this group as a whole is likely to benefit from these overpayments.

[27] For example, Van Kleef et al. (2018b) find that inclusion of chronic conditions reported by general practitioners would improve the R-squared of the Dutch risk adjustment model by <.01. The latest published evaluation of the CMS-HCC risk adjustment system (Pope et al., 2011) reports an increase in R-squared of .014 between V12 and V21. V21 was, however, viewed as too gameable and some variables were dropped in the V22 put in place. The R-squared of V22 will thus be less than for V21.

actual spending (see also footnote 26). Assuming these people are overrepresented in the top decile of spending in the prior year, this group as a whole might receive less payment under residual-based reinsurance than under conventional reinsurance, thereby lowering the PR. This finding indicates that switching from spending-based reinsurance to residual-based reinsurance may not improve group-level fit for some groups of interest. Finally, funds redistributed increase only slightly in relation to conventional reinsurance.

Residual-based repayments at 2% are added to the payment models in the results for Model 4 in the next set of rows. The repayment threshold is much lower in absolute value than the reinsurance threshold because, as we have seen, the residual distribution is much less skewed on the left. While less than .1% of the population remain touched by reinsurance, the repayment threshold is crossed by less than 1% of the population in the three countries. Repayments augment payment system fit further in the .02 - .04 range. PR for the top-decile of spenders in the prior year decreases slightly. Some of those with high spending last year would generate high risk scores this year, and may fall in the highly overcompensated group if spending for whatever reason falls a lot this year. Taking funds from these people increases undercompensation from past high spenders. A repayment feature has little effect on the share of funds redistributed.[28]

The last set of results optimizes β weights in each country, derived from the iterative procedure described earlier. Thresholds from the previous set of rows (e.g., $209,826 for the reinsurance threshold for the Marketplaces) are used to truncate the left and right-hand side of the spending distribution for estimation of the β weights. Iteration is required since the thresholds from the "old" model are not exactly right for the "new" model. Reestimation of β weights has some interesting effects. The thresholds for reinsurance fall, which leads to slightly more people crossing the reinsurance threshold. Both in absolute and in relative terms, the effects of reestimation on the thresholds for repayment are bigger. Consequently, the share of population crossing the repayment threshold falls substantially, to, for example in the Marketplaces, only .28%. Reestimation of β weights must improve payment system fit, but the gains in fit at the individual level are small, in the third decimal place in all countries. PR for the previous high spenders is improved in relation to Model 4, but remains below the PR with Models 2 and 3. Optimization of β weights adds to the redistribution of funds in comparison to the base risk adjustment model. Whereas Model 4 only

[28] One possibility: (in modalities without optimization/changes of RA weights) 2% reinsurance will always result in about 4% redistribution (2% due to the reinsurance payments themselves and 2% due to the necessary reinsurance contributions). It doesn't really matter who makes the reinsurance contributions.

affects payments for people in the reinsurance and repayment ranges, Model 5 affects payments for other people too (due to changes in risk adjustment payment weights).

Results for PSF from Table 5 are summarized in Figure 3. The improvements in individual fit are very large, and remarkably similar in the three markets. Adding 2% conventional (i.e. spending-based) reinsurance to risk adjustment comes with a substantial gain in PSF. Changing from conventional to residual-based reinsurance gives non-trivial improvement. Adding 2% residual-based repayments also improves fit, though not as much as 2% (residual-based) reinsurance. The latter is because the residual distribution is more skewed on the right than on the left. Optimization of risk adjustment for the presence of 2% reinsurance/2% repayments does not substantially affect PSF. Note however that the importance of basing reinsurance on residuals and optimizing β weights is likely to increase as the share of funds devoted to reinsurance increases. The intuitive explanation is that with larger shares of reinsurance, overlap with risk adjustment payments is greater. Paying on residuals and optimizing the β's both contribute to avoiding overlap.

4.3 Reinsurance and Repayment with Alternative Thresholds

Table 6 presents the results for four new combinations of residual-based reinsurance and repayment. All payment models in Table 6 are similar to Model 5 from Table 5 except the share of funds devoted to reinsurance or repayment is the same or less. For each of the repayment/reinsurance modalities in the table β weights are optimized. Generally, the payment alternatives do little to increase the PR for last year's high spenders relative to conventional reinsurance. With residual-based reinsurance at 1%, with or without repayment, PSF is 50% or higher, increasing the individual-level fit of the Dutch model by 20 percentage points and the models in Germany and the US Marketplaces by 30 percentage points. When residual-based reinsurance is 2% of funds, with and without repayments, PSF is in the 60% range or higher, ultimately doubling the PSF in comparison to the current risk adjustment model in each market. For all the options shown, the number of people touched by reinsurance or repayment is very small, less than .05% (5 in 10,000) in all simulations.

Figure 4 summarizes the increments to PSF by residual-based reinsurance and repayment with optimized β weights. Patterns are very similar in all three countries.

Results in Table 6 and Figure 4 bear on the tradeoff of loss of cost containment incentives from risk sharing and fit of the payment system at the individual level. Incentives are diluted as

more funds are devoted to reinsurance or repayment.[29] The loss of cost control incentives depends on plan expectations about patterns of cost, but is approximated by the share of funds devoted to reinsurance and repayment.[30]

5. Discussion

Where reinsurance and risk adjustment are applied simultaneously, individual-level fit is maximized by basing reinsurance on the residuals that remain after risk-adjustment payments, and calibrating risk-adjustment weights on the spending net of the risk-sharing features of the payment system. Reinsurance can be flanked by repayments to further improve the fit in the tails of the residual distribution. Full optimization of payment system parameters to improve fit requires teamwork between risk-adjustment weights and reinsurance/repayments. Our paper shows that it is straightforward to mesh choice of risk adjustment weights with choice of risk sharing parameters. We do this for a series of models with the data actually used to build the payment systems in The Netherlands and the U.S. Marketplaces, and with a large insurer's data from Germany.

It will come as no surprise to researchers that conventional reinsurance can markedly improve the individual-level fit of a payment system. We add to this by showing that with a fixed share of funds going to reinsurance, teamwork – paying on residuals/optimizing risk-adjustment weights – gives fit another boost. The empirical results in terms of introduction of residual-based reinsurance, repayment, and optimized risk adjustment weights work in remarkable parallel in the three health insurance markets, with their different risk-adjustment models, health care systems, and

[29] Reinsurance based on residuals after risk adjustment is likely to improve incentives for cost control over conventional reinsurance with the same budget for reinsurance. The argument is parallel to that made by Van Kleef, Van de Ven and Van Vliet (2009) in the case of "shifted deductibles" where the authors moved the deductible range to be more likely to hit where the marginal decisions were being made about consumption. The deductible range was moved higher for those with higher predicted costs. In our case of "shifted reinsurance," moving the range where reinsurance kicks in higher for individuals likely to be higher costs makes it less likely a plan could anticipate being in the reinsurance range for any individual. Thus, reinsurance based on residuals maintains plans' incentives to control costs even for those with very high predicted costs. Our constraint on incentives is best interpreted as a simple operational way for a regulator to limit the degree incentives are diluted with reinsurance/repayment, not as a precise measure of "power" of a plan payment contract.

[30] With "static" expectations, the loss of incentive is just equal to the share of plan spending devoted to reinsurance and repayments. With perfect foresight, a plan knows that for persons destined to fall above the reinsurance or below the repayment threshold, the marginal spending is not plan responsibility, and the incentive effects are equal to the share of spending associated with the individuals over or below the thresholds.

simple magnitudes of spending. We come out of our analysis with a high degree of confidence that our findings generalize to other health care systems and payment models.

Teamwork adds to fit "for free" in the sense of creating no extra incentive cost associated with risk sharing. For any given share of funds devoted to risk sharing, joint optimization of payment and risk-adjustment parameters is worthwhile to improve fit. By analysis of a series of risk-sharing options, we quantify the tradeoff for a regulator, showing what can be had in terms of better fit at what cost in terms of the incentive effect of risk sharing. We regard the tradeoff to be very favorable. Massive gains in individual-level fit can be had touching only a very small portion of the individuals in the insurance pool.

Consideration of incentive effects of a payment system are important but complex. Even putting aside incentives related to risk selection, the cost control incentives of risk-adjusted payments are not always straightforward. The incentive effects of reinsurance and other risk-sharing features are evident, and can be measured in terms of the share of people or the share of funds affected. Risk-adjusted payments, depending on the adjustors used and their weights, also dilute cost-control incentives but the magnitude of the effects are less clear. Use of a concurrent risk adjustment model as in the US Marketplaces or use of past spending as a risk adjustor as in The Netherlands each also dilute incentives for cost control. More generally, any risk adjustor variable based on health care activity increases incentives for that activity to be undertaken.[31]

An alternative way to frame a policy discussion about incentives would be to ask, for example, what is the way to achieve a given fit with the least sacrifice in terms of incentives? A series of interesting questions emerges from this perspective. Suppose we were to ask, for The Netherlands, what would be needed in terms of residual-based reinsurance to achieve the same level of fit (in terms of the measure used in the Netherlands) as now but dropping past-spending groups from the risk adjustor variables? Or, for the Marketplaces, what level of residual-based reinsurance would be needed to achieve a target level of fit if only diagnoses from inpatient episodes counted toward morbidity indicators? Ideally, a regulator would have available comparative information about the incentive effects of risk adjustment as well as of any risk sharing. This is an open and important area for future research.

[31] This incentive is distinct from the incentive to "upcode" (or "right code") which refers to coding practices not incentives to do more. Use of risk adjustor variables based on activities reported in claims generally include both types of incentives.

We showed in our simulations that a little bit of residual-based reinsurance improves fit markedly keeping the current risk adjustment in place. A corollary is that a little bit of residual-based reinsurance could instead compensate for a simplification of the risk adjustment formula, going in the opposite direction to decades of research in all three countries seeking new risk adjustor variables to add to the formula. Simplification by dropping potentially problematic risk adjustors can improve incentives. Future work can study the simplifications that could be achieved by judicious use of targeted risk sharing.

The focus on residual spending calls attention to residuals on the other side of the spending distribution: individuals for whom risk adjustment payments greatly exceed what they spend. Our simulations explored this new territory in payment system design. Repayments, the mirror-image of reinsurance -- are an intriguing policy option. Repayments improve fit at the individual level. Repayments obviously also "give money back". If funds repaid, for example, were set equal to the funds devoted to reinsurance, the same level of funding could be devoted to risk adjustment before and after introduction of risk sharing. Very large left-hand side residuals also raise the simple question of whether it is necessary and appropriate to confer profits on the order of hundreds of thousands of dollars or Euros to a plan for a single individual. Should we limit profits such that, for example, a plan can make no more than $50k on any one person?

Before deciding what, if anything, should be done to modify payment systems in light of the high overpayments, research is needed to learn more about the people who fall on the far left of the distribution of residuals. To note just two relevant questions: What combination of flags and services is associated with such gross overpayments? Are people on the left persistently on the left?

In this paper our performance metrics were chosen so as to be comparable across the three countries. It is well-recognized, however, that health plan payment systems need to be evaluated on other criteria than simply fit at the individual level. Ideally, these criteria follow the specific objectives of the regulator in each country or sector. For example, when a regulator is concerned about selection incentives regarding groups with chronic illnesses evaluation, metrics should adequately capture these incentives. We believe consideration of other criteria, such as under payment for persons with chronic conditions and the practical feasibility of our ideas in a specific institutional setting, is best pursued on a country-by-country basis.

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Table 1
Health Plan Payment in Germany, the Netherlands and the U.S. Marketplaces

	Germany (2018)	Netherlands (2018)	Marketplaces (2018)
Number of individuals covered	72.2 m	17.1 m	10.6 m
Average plan spending per person per year	3,034 €	2,504 €	$5,772 (silver plan benchmark average premium 2018)
Geographic market	National	National	State with sub-state rating areas
Number of plans	110	About 60 (varying by premium and contracted care; each plan can come with deductible options and group arrangements)	1-15, mean 4.2 varies by rating area
Premiums	Single premium per health plan	Single premium per plan; rebates for voluntary deductibles and group arrangements	Limited age bands
Risk adjustment data	Morbidity data from 2017; spending data from 2018. Interim payments are made prior to final reconciliation	Spending from 2015 (made representative for 2018, e.g. in terms of benefits package and projected spending)	2016 MarketScan data on large employers/insurers
Risk adjustment demographics	Age, sex, reduced earning capacity, reimbursement status	Age, sex, regional factors, socio-economic status, source of income, household composition, yes/no institutionalized, level of education	Age, sex, geography
Risk adjustment disease indicators	201 hierarchical morbidity groups (HMG) based on: • prescribed drugs • in- and outpatient diagnoses	124 morbidity indicators based on: • prescribed drugs (PCGs) • hospital diagnoses (DCGs) • physiotherapy diagnoses • mental care diagnoses • durable medical equipment • multiple-year high or low spending • one-year spending on home care	Based on 127 HCCs (2016)

Table 1 continued

	Germany (2018)	Netherlands (2018)	Marketplaces (2018)
Timing of risk adjustment disease indicators	Prospective (i.e. disease indicators are based on information from the prior year)	Prospective (i.e. disease indicators are based on information from one or multiple prior years)	Concurrent (i.e., disease indicators are based on data from the same year as spending predictions)
Risk adjustment estimation procedure	Weighted least squares	Weighted least squares	Weighted least squares
Risk adjustment comments	Separate model for sick leave payments	Separate models for somatic care, mental health care and out-of-pocket spending below the mandatory deductible	Separate models for age groups and tiers of coverage
Risk sharing	Reinsurance 2002 - 2008	Reinsurance until 2014; risk corridors until 2016	Reinsurance 2014-2016; functional reinsurance restored in 2017 through transfer formula.
R-squared from the risk adjustment regression	26%	32% for somatic care 23% for mental healthcare 33% for OOP spending	35%

Note: Due to the volume of information presented here notes for each element are not provided. There are some additional features of the payment systems in each country not contained in the table, for example, Germany has special rules for those living abroad and for a small number of individuals paid by cost reimbursement. For detailed descriptions of each of these payment models with much of the information covered here, see Wasem et al. (2018), Van Kleef et al. (2018) and Layton, Montz and Shepard (2018).

Table 2
Data from Three Countries (Full Samples)

	Germany	The Netherlands (somatic care only)	U.S. Marketplaces
Source	Nationwide operating sickness fund	Insurers and government agencies	Large employers/insurers
Number of individuals	2.9 million	17.0 million	9.8 million
Year	2015	2015	2016
1st percentile spending	€ 0	€ 50	$0
10th percentile spending	€ 98	€ 92	$0
90th percentile spending	€ 7,062	€ 4,573	$14,085
99th percentile spending	€ 35,591	€ 33,003	$80,974
Maximum Spending	€ 2,267,508	€ 7,819,446	$8,541,629
Age range	Entire population	Entire population	21-64
Percent with disease indicator	49.1%	26.7%	21.4%

Note: U.S. data only covers people with full-year enrollment. Data from Germany and the Netherlands also covers people who were enrolled only part of the year. In the Dutch data spending is annualized here; in the German data it is not. The € 50 spending at the 1st percentile in The Netherlands is a mandatory fee everyone pays to register with a practitioner.

Table 3
Plan Payment Models Studied

Payment Model	Risk-Adjustment	Reinsurance	Repayment
Model 1: Risk adjustment only	β weights from least squares regression on total plan spending	None	None
Model 2: Risk adjustment plus conventional (i.e. spending-based) reinsurance	β weights from least squares regression on total plan spending	Full reinsurance after threshold of spending; financed by flat reduction in risk adjustment payment	None
Model 3: Risk adjustment plus residual-based reinsurance	β weights from least squares regression on total plan spending	Full reinsurance after threshold of spending less risk adjustment payment; financed by flat reduction in risk adjustment payment	None
Model 4: Risk adjustment plus residual-based reinsurance and repayment	β weights from least squares regression on total plan spending	Full reinsurance after threshold of spending less risk adjustment payment; financed by repayments (and – when total reinsurance is larger than total repayments – a flat reduction in risk adjustment payment)	Full repayment after threshold of risk adjusted payment less spending; contributes to financing reinsurance
Model 5: Risk adjustment plus residual-based reinsurance and repayment and with optimized β weights	β weights from least squares regression on plan obligations net of reinsurance and repayment	Full reinsurance after threshold of spending less risk adjustment payment; financed by repayments (and – when total reinsurance is larger than total repayments – a reduction in risk adjustment payment via the optimized β weights)	Full repayment after threshold of risk adjusted payment less spending; contributes to financing reinsurance

Table 4

Residuals from the Base Risk Adjustment Model

	Germany	The Netherlands (somatic care only)	U.S. Marketplaces
Fit of the risk adjustment model			
R-squared	23.7%	31.6%	35.8%
CPM	24.0%	31.8%	28.3%
Residuals		(Euros or Dollars)	
Mean absolute deviation	3,566	1,985	5,559
Min	-334,029	-382,283	-529,274
1st percentile	-10,905	-8,988	-26,511
10th percentile	-3,283	-2,240	-5,037
25th percentile	-1,651	-1,098	-2,832
Median	-827	-444	-1,530
75th percentile	-110	-59	55
90th percentile	2,870	1,375	5,472
99th percentile	32,097	20,380	49,035
Max	1,892,219	7,812,633	3,578,792

Note: Statistics are reported from the test sample based on estimates from the training sample. Data from Germany and the Netherlands are annualized here. The maximum residual for Germany is the largest value for an individual enrolled for the full year. U.S. data are full-year enrollees.

Table 5
Risk Adjustment, Reinsurance, and Repayment

	Germany	The Netherlands	Marketplaces
Model 1: Base Risk Adjustment			
Payment System Fit	24.0%	31.6%	35.8%
PR_g	76.7%	94.5%	69.0%
Funds redistributed	NA	NA	NA
Model 2: Conventional (i.e. spending-based) Reinsurance 2%			
Attachment points			
Upper Threshold	€139,810	€122,044	$350,301
Lower Threshold	NA	NA	NA
Population affected			
Above Upper Threshold	.04%	.04%	.06%
Below Lower Threshold	NA	NA	NA
Payment System Fit	56.4%	55.6%	60.5%
PR_g	80.3%	96.9%	73.1%
Funds redistributed	3.9%	4.0%	4.3%
Model 3: Residual-based Reinsurance 2%			
Attachment points			
Upper Threshold	€102,789	€90,975	$209,959
Lower Threshold	NA	NA	NA
Population affected			
Above Upper Threshold	.07%	.07%	.07%
Below Lower Threshold	NA	NA	NA
Payment System Fit	59.9%	58.8%	62.6%
PR_g	79.9%	96.4%	73.2%
Funds redistributed	4.0%	4.1%	4.4%
Model 4: Residual-based Reinsurance and Repayment (2%, 2%)			
Attachment points			
Upper Threshold	€102,724	€90,929	$209,826
Lower Threshold	-€11,044	-€12,009	-$48,832
Population affected			
Above Upper Threshold	.07%	.07%	.07%
Below Lower Threshold	.96%	.59%	.34%
Payment System Fit	62.6%	61.7%	66.6%
PR_g	76.8%	92.6%	71.0%
Funds redistributed	4.0%	4.1%	4.1%
Model 5: Residual-based Reinsurance and Repayment (2%, 2%) with Optimized β weights			
Attachment points			
Upper Threshold	€101,179	€88,908	$206,502
Lower Threshold	-€13,830	-€15,198	-$54,801
Population affected			
Above Upper Threshold	.07%	.07%	0.08%
Below Lower Threshold	.61%	.41%	0.28%
Payment System Fit	63.0%	62.0%	6.8%
PR_g	78.4%	95.1%	.71.5%
Funds redistributed	6.2%	6.2%	5.9%

Table 6

Residual-Based Reinsurance and Repayment with Optimized β's

	Germany	The Netherlands	Marketplaces
Base Risk Adjustment			
Payment System Fit	24.0%	31.6%	35.8%
PR_g	76.7%	94.5%	69.0%
Funds redistributed	NA	NA	NA
Reinsurance 1%; Repayment 0%			
Attachment points			
Upper Threshold	€169,932	€150,650	$370,588
Lower Threshold	NA	NA	NA
Population affected			
Above Upper Threshold	.03%	.02%	.03%
Below Lower Threshold	NA	NA	NA
Payment System Fit	53.3%	51.6%	55.8%
PR_g	77.3%	94.7%	70.3%
Funds redistributed	2.6%	2.2%	2.8%
Reinsurance 1%; Repayment 1%			
Attachment points			
Upper Threshold	€166,474	€146,457	$353,552
Lower Threshold	€-19,700	€-22,159	$-80,484
Population affected			
Above Upper Threshold	.03%	.02%	.03%
Below Lower Threshold	.25%	.15%	0.14%
Payment System Fit	55.4%	53.8%	58.4%
PR_g	77.6%	94.9%	70.6%
Funds redistributed	3.5%	3.3%	3.3%
Reinsurance 2%; Repayment 0%			
Attachment points			
Upper Threshold	€105,068	€92,827	$223,529
Lower Threshold	NA	NA	NA
Population affected			
Above Upper Threshold	.07%	.07%	.07%
Below Lower Threshold	NA	NA	NA
Payment System Fit	60.2%	59.0%	63.0%
PR_g	77.6%	94.9%	70.9%
Funds redistributed	4.7%	4.1%	4.8%
Reinsurance 2%; Repayment 1%			
Attachment points			
Upper Threshold	€102,253	€89,860	$212,733
Lower Threshold	€-18,156	€-20,552	$-71,782
Population affected			
Above Upper Threshold	.07%	.07%	.07%
Below Lower Threshold	.28%	.18%	.16%
Payment System Fit	62.1%	60.9%	65.3%
PR_g	78.0%	95.0%	71.2%
Funds redistributed	5.5%	5.1%	5.1%

Figure 1

Conventional Reinsurance Defined in Terms of Spending

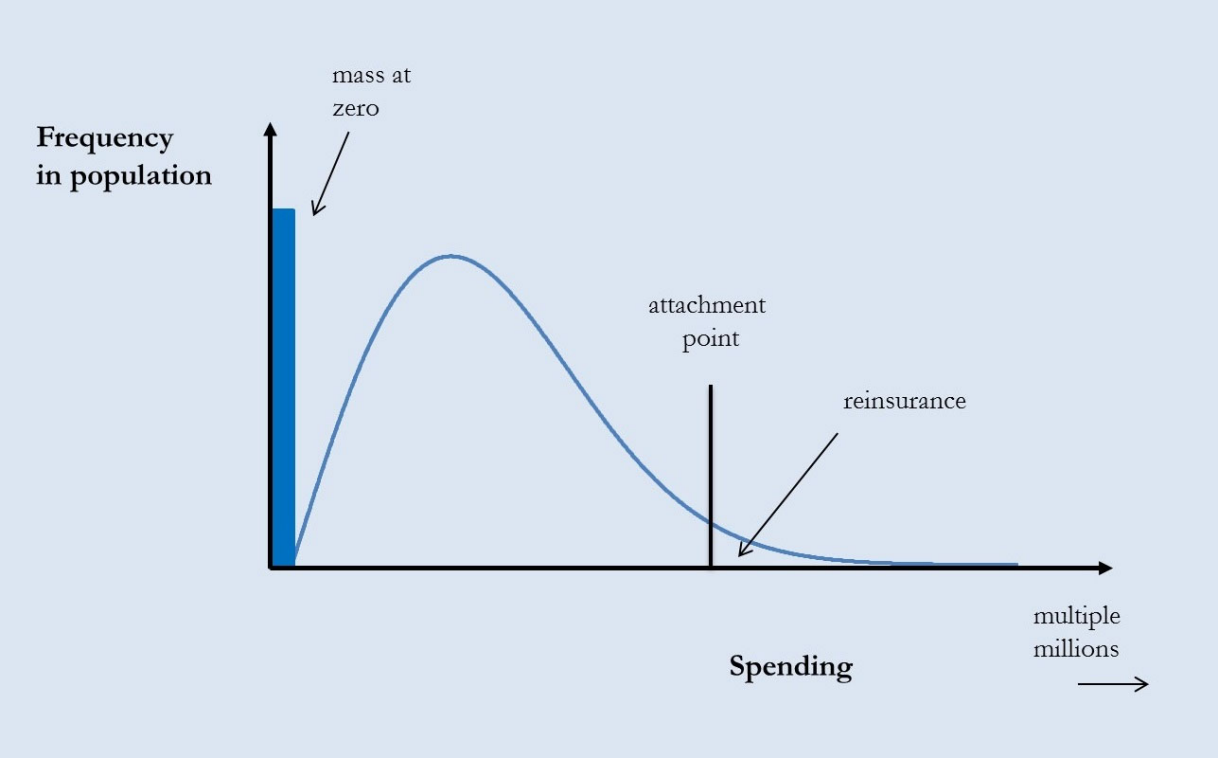


Figure 2

Reinsurance and Repayment Based on Residuals from Risk Adjustment

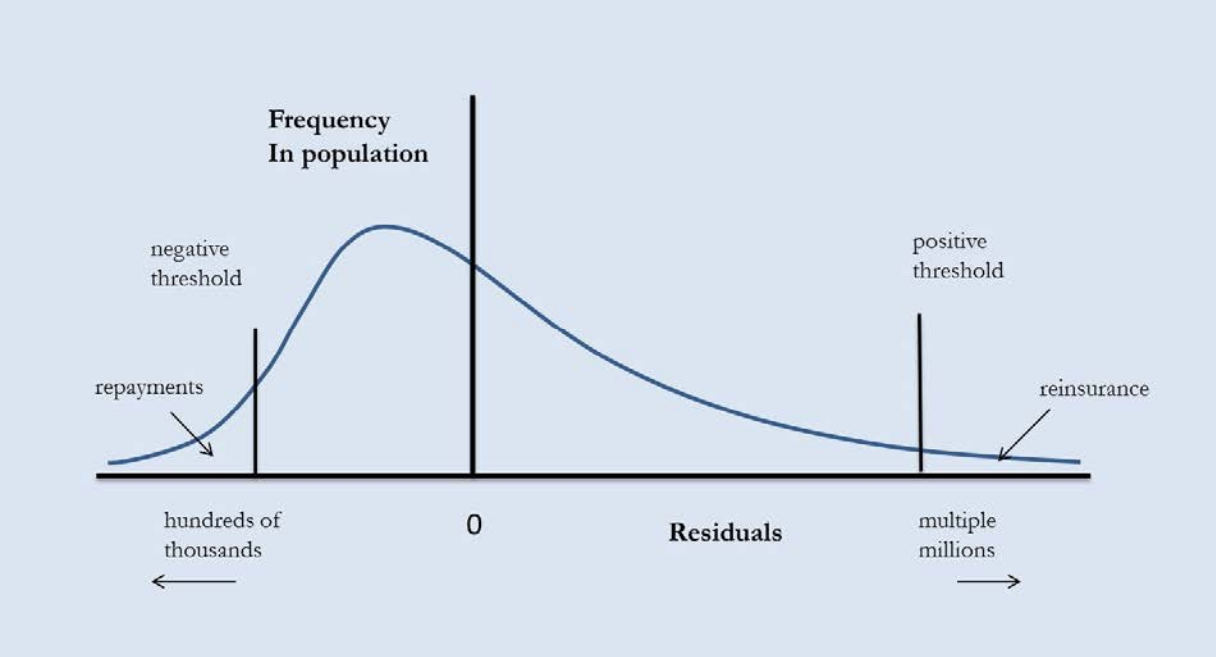


Figure 3

Payment System Fit of Five Models in Three Different Settings

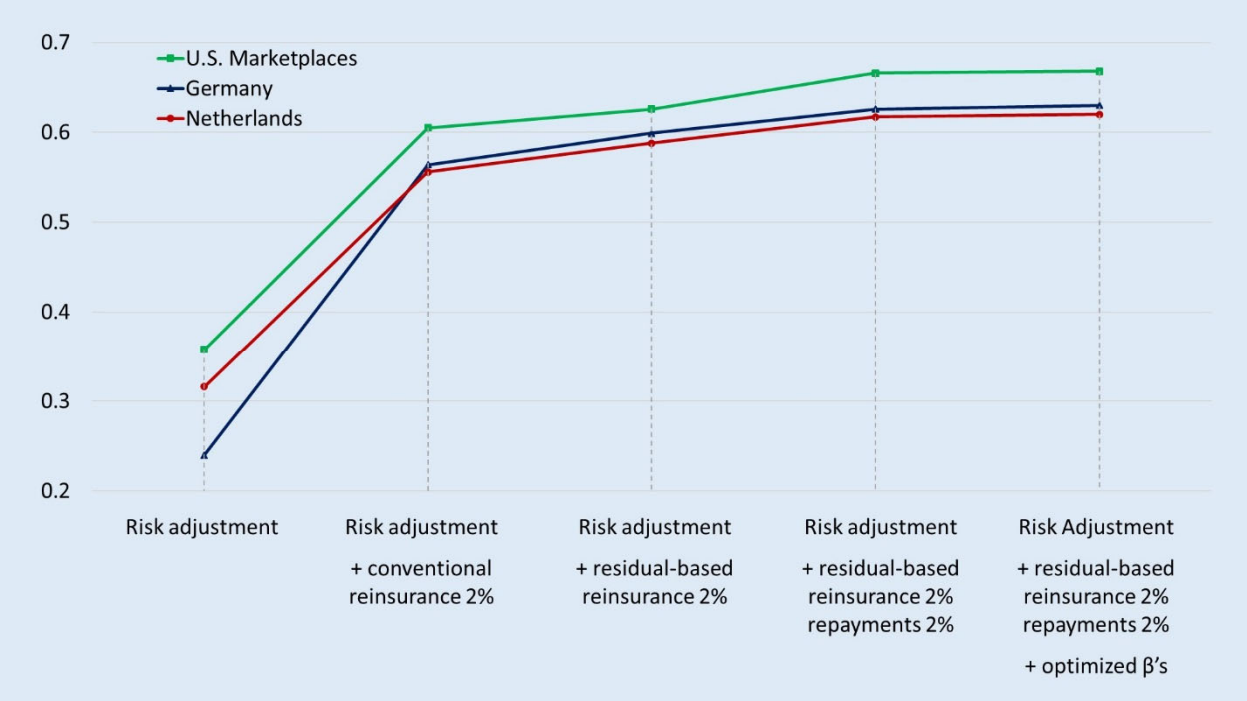
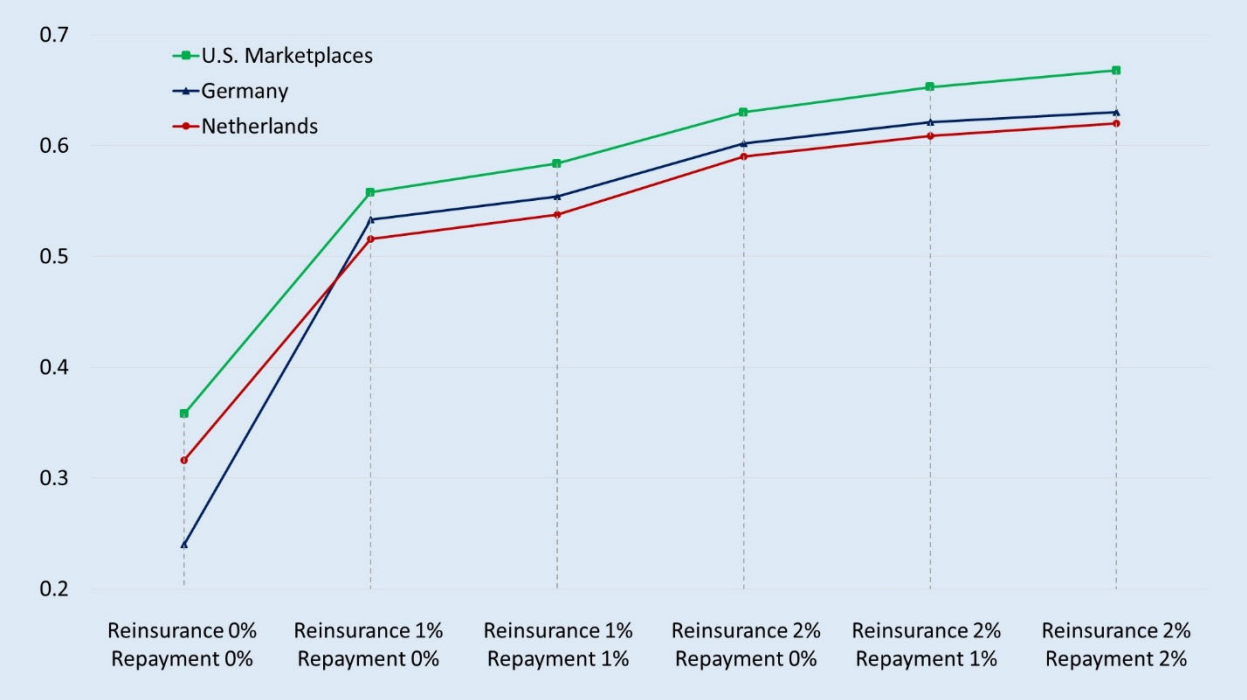


Figure 4

Payment System Fit of Six Combinations of Reinsurance/Repayment, all with Optimized Risk Adjustment Weights



Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act

Published: Dec 20, 2018

On December 14, 2018, a federal trial court judge ruled (https://affordablecareactlitigation.files.wordpress.com/2018/12/Texas-v.-US-partial-summary-judgment-decision.pdf) that the entire Affordable Care Act (ACA) is unconstitutional. While the trial court's ruling is likely not the last word on the ACA's constitutionality, this brief considers the complex and far-reaching impact were the entire law ultimately held to be invalid.

The case – brought by a number of Republican state attorneys general (AGs) and other plaintiffs – centers on the argument that the law's individual mandate is unconstitutional after Congress zeroed out the penalty associated with it in the tax bill in late 2017. The plaintiffs argue that the rest of the ACA is not severable from the mandate and should therefore be invalidated. The Trump administration agrees that the mandate should be judged unconstitutional, but argues that only the ACA's pre-existing condition protections are inseparable from the mandate and should be overturned, while the rest of the law should stand. A number of Democratic state AGs are defending the ACA as interveners in the case, arguing in part that Congress intended to keep the ACA in place when it set the individual mandate penalty to zero while leaving the rest of the law intact. The Trump administration has indicated (https://www.hhs.gov/about/news/2018/12/17/statement-from-the-department-of-health-and-human-services-on-texas-v-azar.html) that it intends to continue enforcing the ACA pending an expected appeal of the decision.

The number of non-elderly Americans who are uninsured decreased by 19.1 million (https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/) from 2010 to 2017 as the ACA went into effect. While the ACA's changes to the individual insurance market – including protections for people with pre-existing conditions, creation of insurance marketplaces, and premium subsidies for low and modest income people – have been the focus of much policy debate and media coverage, the law made other sweeping changes throughout the health care system that have an impact on nearly all

Americans. These include: the expansion of Medicaid eligibility for low-income adults; required coverage of preventive services with no cost sharing in private insurance, Medicare, and for those enrolled in the Medicaid expansion; phase-out of the "doughnut hole" gap in Medicare drug coverage; reductions in the growth of Medicare payments to health providers and insurers; new national initiatives to promote public health, the quality of care, and delivery system reforms; and a variety of tax increases to finance these changes. These provisions could all be overturned if the judge's decision is upheld.

> *If the Affordable Care Act were overturned, it would affect nearly all Americans in some way.* *(http://twitter.com/share?text=If+the+Affordable+Care+Act+were+overturned%2C+it+would+affect+nearly+all+Americans+in+some+way3A%2F%2Fwww.kff.org%2Ffc48c4c%2F)*

More than eight years after enactment, ACA changes to the nation's health system have become embedded and affect nearly everyone in some way. A court decision that invalidated the ACA, therefore, would also affect nearly everyone in at least some way. It would be a complex undertaking to try to disentangle it at this point. The following table summarizes the major provisions of the ACA, illustrating the breadth of its changes to the health care system and public attitudes towards those changes.

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
	Expanded Eligibility for Health Co
Medicaid Eligibility Expansion – Medicaid eligibility is expanded to include adults with income up to 138% FPL; however, the Supreme Court ruling in 2012 essentially made Medicaid expansion optional for states. – The federal government paid 100% of the cost of the expansion initially; this share phases down to 93% in 2019 and 90% in 2020 and beyond	– In FFY 2017, there were more than 17 million (https://www.kff.org/health-reform/state indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) Medicaid expansion enro in the 32 states and DC that had adopted the expansion. Of those enrollees, 12.7 million we newly eligible due to the ACA's Medicaid expansion
Subsidies for Non-Group Health Insurance – Eligible individuals who buy coverage through the Marketplace receive subsidies	– As of June 2018, 8.9 million (https://www.cms.gov/sites/drupal/files/2018-11/11-28-2018%20Effectuated%20Enrollment%20Table.pdf) marketplace enrollees received pre tax credits and 5.4 million (https://www.cms.gov/sites/drupal/files/2018-11/11-28-20120Effectuated%20Enrollment%20Table.pdf) received cost-sharing reductions – In 2018, there were about 0.8 million people enrolled in the Basic Health Plans in Minnesota (92,421 (https://www.mnsure.org/learn-more/aca/mnsure-working/index.jsp)) and New York (738,851 (https://www.health.ny.gov/press/releases/2018/2018-02-01_nysoh_announces_record_enrollment.htm))

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
based on income: premium tax credits for those with income 100-400% FPL; cost-sharing subsidies for those with income 100-250% FPL – States can also elect to run a subsidized Basic Health Plan for people with income between 133%-200% FPL	
Dependent Coverage to 26 – All non-grandfathered private group and non-group health plans must extend dependent coverage to adult children up to the age of 26	– About 2.3 million (https://aspe.hhs.gov/system/files/pdf/111826/ACA%20health%20insurance%20coverage%20brief%2009212015.pdf) young adults gained coverage a result of this provision
Health Insurance Marketplace – Establish new marketplaces where qualified health plans are offered to individuals.	– 10.3 million (https://www.cms.gov/sites/drupal/files/2018-11/11-28-2018%20Effectuated%20Enrollment%20Table.pdf) individuals had effectuated coverage throu the Marketplace as of the first half of 2018

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
– Marketplaces certify that qualified health plans meet all ACA requirements, provide subsidies to eligible individuals, operate a website to facilitate application and comparison of health plans, provide a no-wrong-door application process for individuals to determine their eligibility for financial assistance, and provide in-person consumer assistance through navigators	
	Federal Minimum Standards for Private He
Protections for Pre-existing Conditions – All non-grandfathered plans are prohibited from discriminating against	– 52 million people (27% of the nonelderly population) have a pre-existing condition that wo have been deniable in the pre-ACA individual market.

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
individuals based on their health status. – Insurers in the non-group, small group, and large group market must guarantee issue coverage – Large group, small group, and non-group health plans are prohibited from applying pre-existing condition exclusions – Insurers in the non-group and small group market may not vary premiums based on health status or gender or any other factor except: – Premiums can vary by age (up to 3:1), geography, and family size – Rescission of coverage is prohibited in the	

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
non-group, small group, and large group market	
Preventive Services – All non-grandfathered group and non-group plans must cover preventive health services without cost sharing. – Covered services include breast, colon, and cervical cancer screening, pregnancy-related services including breastfeeding equipment rental, contraception, well-child visits, adult and pediatric immunizations, and routine HIV screening. In addition, it was recently recommended that pre-exposure prophylaxis (PREP) to prevent HIV infection be included as well	– 84% (http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Surv 2018) of covered workers with employer-sponsored insurance (approximately 131 million people) were enrolled plans that must provide free preventive services as of 2017. – 13.1 million (https://www.kff.org/health-costs/event/web-briefing-for-journalists-k issues-ahead-of-marketplace-open-enrollment/) people were enrolled in individual market plans required to provide free preventive services, of 2017 – 17 million enrollees in Medicaid expansion states received coverag preventive services in 2017 – Prior to the ACA, 1 in 5 women (https://www.kff.org/womens-health-policy/fact sheet/preventive-services-for-women-covered-by-private-health-plans-under-the-affordable-care-act/) reported that they postponed or went without preventive care due to cost. – The share of women of reproductive age with large employer cover who had out-of-pocket spending on oral contraceptive pills fell from 22.7% in 2012 to 2.7% (https://www.healthsystemtracker.org/chart-collection/re trends-characteristics-workers-high-drug-spending-2016/#item-the-share-of-wome reproductive-age-who-had-out-of-pocket-spending-on-oral-contraceptive-pills-fell-sharply-after-the-aca) in 2016.

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
and if finalized, would be offered at no-cost	
Essential Health Benefits – All ACA compliant health plans in the individual and small group market must cover 10 categories of essential health benefits (EHB), including hospitalization, outpatient medical care, maternity care, mental health and substance abuse treatment, prescription drugs, habilitative and rehabilitative services, and pediatric dental and vision services	– In 2013, before the ACA EHB requirements took effect, 75% (https://www.kff.org/health reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted nongroup health plans did not cover maternity care, 45% did not cover substance use disor treatment, and 38% did not cover mental health services
Annual and Lifetime Limits – All group and non-group plans (including non-grandfathered) are prohibited from placing	– Prior to the ACA, in 2009, 59% (https://kaiserfamilyfoundation.files.wordpress.com/2013/04/7936.pdf) of covered workers' employer-sponsored health plans had a lifetime limit – 156 million (https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%2222asc%22%7D) people (57% of the U.S. non-elderly population) had employer coverage, as of 2017.

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
lifetime or annual limits on the dollar value of coverage for essential health benefits	
Cap on Out-of-Pocket Cost Sharing – All nongrandfathered private health plans must limit cost sharing for essential health benefits covered in network – The annual maximum for 2019 is $7,900 for an individual; $15,800 for family coverage	– Prior to the ACA, in 2009, 19% (https://www.kff.org/report-section/2018-employer-he benefits-survey-section-7-employee-cost-sharing/attachment/figure-7-43-2/) of cove workers had no limit on out-of-pocket expenses. Among those with out-of-pocket maximum all expenses counted toward the limit. For example, in 2009, among workers in PPOs with a of-pocket maximum, 85% were in plans that did not count prescription drug spending when determining if an enrollee had reached the out-of-pocket limit.
Minimum Medical Loss Ratios – Require all non-grandfathered private plans to pay a minimum share of premium dollars on clinical services and quality – Insurers must provide rebates to consumers for the amount of the	– In total, $4 billion (https://www.kff.org/health-reform/state-indicator/mlr-rebates-to activeTab=graph&currentTimeframe=0&startTimeframe=6&selectedDistributions= rebates&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D% 7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22% in medical loss ratio rebates have been issued across (https://fas.org/sgp/crs/misc/R42735.pdf) the individual, small group, and large group markets, from 2012 to 2018 (based on insurer financial results from the 2011-2017 plan yea

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With

Key Provision	People Affected/Dollars Involved
premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.	
Consumer Information and Transparency – All non-grandfathered health plans must provide a brief, standardized summary of coverage written in plain language – All non-grandfathered health plans must periodically report transparency data on their operations (e.g., number of claims submitted and denied)	
	Other Provisions Affecting Employers/G
Large employer mandate – Requires employers with at least 50 full time	

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
workers to provide health benefits or pay a tax penalty	
Waiting Periods – Employers that impose waiting periods on eligibility for health benefits (e.g., for new hires) must limit such periods to no more than 90 days	– Prior to the ACA, in 2009, 29% (https://www.kff.org/report-section/2018-employer-he benefits-survey-section-3-employee-coverage-eligibility-and-participation/attachment/figure-3-13/) of covered workers faced a waiting period of 3 m or more
	Consumer assistance
State Consumer Assistance Programs – Authorize federal grants for state Consumer Assistance Programs (CAPs) to advocate for people with private coverage. – Notice of claims denials by non-grandfathered private plans must include information about state CAPs that will help consumers file appeals	-CAPs were established in most states in 2010, though no appropriations for CAPs have sinc been enacted. Today 36 CAPs (https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assista programs.doc) are in operation – A report (https://www.cms.gov/CCIIO/Resources/Files/Downloads/csg-cap-summ white-paper.pdf) on the first year of CAP operations found the program helped 22,814 individuals successfully challenge their health plan decisions and obtained more than $18 million on behalf of consume

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
	Other Medicaid Provisions
Simplification of Enrollment Processes – States are required to simplify Medicaid and CHIP enrollment processes and coordinate enrollment with state health insurance exchanges.	– Prior to the ACA in 2013, 27 states had an asset test and 6 required face-to-face interviews parents; only 36 states had an online Medicaid application and 17 states allowed individuals apply by phone. By 2018 (https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-finding from-a-50-state-survey/), nearly every state had an online and telephone Medicaid applic and all states had eliminated asset tests and face-to-face interviews.
Long-term Care Services and Supports – Expands financial eligibility for 1915 (i) home and community-based services (HCBS, creating a new eligibility pathway to allow people not otherwise eligible to access full Medicaid benefits, allows states to target services to specific populations, and expands the services covered. – Creates a new Medicaid state plan option to	– 18 states (https://www.kff.org/medicaid/report/medicaid-home-and-community-b services-results-from-a-50-state-survey-of-enrollment-spending-and-program-polic elected the option to expand eligibility for 1915(i) HCBS services as of 2016. Almost 62,000 individuals received services and over $237 million was spent on these services. – As of 2016, 8 states (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending program-policies/) elected the option to cover attendant care services. O 353,000 individuals received services and $8.2 billion was spent on th services.

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
cover attendant care services and supports with 6% enhanced FMAP.	
Behavioral Health Parity – Mental health and substance use disorder services must be included in Medicaid Alternative Benefit Packages (ABPs) provided to Medicaid expansion adults and other adults, and the services must be covered at parity with other medical benefits.	– 17 million Medicaid expansion enrollees receive services through an ABP.
Medicaid Eligibility for Former Foster Care Youth up to Age 26 – Requires states to provide Medicaid to young adults ages 21 through 26 who were formerly in foster care.	
Medicaid Drug Rebate Percentage	– CBO (https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf) estimated federal savings of $38 billion ov years from the Medicaid prescription drug provisions in the ACA, including increases in the rebate percentage

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
– Increase Medicaid drug rebate percentage for most brand name drugs to 23.1% and increase Medicaid rebate for non-innovator multiple source drugs to 13%. Extend drug rebate program to Medicaid MCOs	
	Medicare Provisions
Part D Coverage Gap[1] Gradually close the Medicare Part D coverage gap ("doughnut hole"): – Phase down the beneficiary coinsurance rate for brand and generic drugs In the Medicare Part D coverage gap from 100% to 25% by 2020 – Require drug manufacturers to provide a 50% discount on the price of brand-	– 43 million people were enrolled in Medicare Part D in 2018 – In 2016, more than 5 million Part D (https://www.kff.org/medicare/issue-brief/closing-the-medicare-part-d-coverage-gap-trends-recent-changes-and-whats-ahead/) enrollees without low-income subsidies (LIS) had spending in t coverage gap and received manufacturer discounts averaging $1,090 brand-name drugs. Reinstating the coverage gap would increase cost incurred by by Part D enrollees who have relatively high drug spendi

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
name and biologic drugs in the coverage gap – Reduce the growth rate in the catastrophic coverage threshold amount between 2014 and 2019 to provide additional protection to enrollees with high drug costs	
Preventive services – Eliminate cost-sharing for Medicare covered preventive services. Authorize coverage of annual comprehensive risk assessment for Medicare beneficiaries.	– 60 million people have access to free preventive services; of these, Medicaid pays Medicar cost-sharing for 10 million full dual eligibles (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordinati Office/DataStatisticalResources/Data-and-Statistical-Resources.html).
Cost sharing in Medicare Advantage (MA) – Prohibit MA plans from imposing higher cost-sharing requirements	– 20 million people enrolled in Medicare Advantage plans in 2018

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
than traditional Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services deemed appropriate by the Secretary of HHS. This prohibition was extended to most Medicare-covered services.	
Restructure Medicare Advantage payments – Reduce federal payments to Medicare Advantage plans, to bring payments closer to the average costs of Medicare beneficiaries. – Provide quality-based bonus payments to Medicare Advantage plans – Require Medicare Advantage plans to maintain a medical loss ratio	– CBO estimated (https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf) repeal of the ACA Medicare Advantage pay changes would increase Medicare spending by about $350 billion over 10 years (2016-2025) – Higher Medicare spending would increase Medicare premiums and deductibles for beneficiaries and accelerate the insolvency of the Medicare Hospital Insurance Trust Fund.

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
of at least 85 percent; the administration extended this requirement to all Part D plans.	
Other provider payments – Reduce the rate at which Medicare payment levels to hospitals, skilled nursing facilities, hospice and home health providers, and other health care providers are updated annually. – Reduce Medicare Disproportionate Share Hospital (DSH) payments that help to compensate hospitals for providing care to low-income and uninsured patients. – Allow providers organized as Accountable Care Organizations (ACOs) that meet quality thresholds	– CBO estimated (https://www.cbo.gov/publication/50252) repeal of the ACA provider payment reductions would increase Medicare spending by another approximately $350 billi over 10 years (2016-2025). – Eliminating the Medicare Shared Savings Program ACOs could affec around 10.5 million Medicare beneficiaries (https://www.kff.org/faqs-medicare-accountable-care-organization-aco-models/) who were attributed to a MSSP ACO, as of 2018 – Higher Medicare spending would increase Medicare premiums and deductibles for beneficiaries and accelerate the insolvency of the Medicare Hospital Insurance Trust Fund.

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Es

Key Provision	People Affected/Dollars Involved
to share in cost savings they achieve for the Medicare Program.	
Medicare income-related premiums[2] Freeze threshold for income-related Medicare Part B premiums for 2011 through 2019. Establish new income-related premium for Part D, with the same thresholds as the Part B income-related premium.	– As originally enacted in the ACA, CBO estimated (https://www.cbo.gov/publication/213 $35.7 billion in savings from these provisions over 10 years

Additional Provisions

Beyond coverage-related provisions, the ACA made numerous other changes in federal law to safeguard individual civil rights, authorize new programs and agency activities, and finance new federal costs under the law. The Court ruling finding the ACA unconstitutiona could also result in an end to these provisions. They include:

Nondiscrimination

The ACA prohibits discrimination against individuals on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, under Section 1557, which builds on long-standing and familiar Federal civil rights laws. Regulations implementing Section 1557 issued by the Obama Administration further defined these protections to include gender identity and pregnancy status. However, a federal court issued a nationwide injunction prohibiting enforcement of the gender identity and pregnancy protections and new regulations are pending. Separate ACA regulations

governing marketplaces and qualified health plans, essential health benefits, and the individual and group market also provide nondiscrimination protections, including based on sexual orientation and gender identity, and are not directly affected by the 1557 ruling

Enforcement (https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html) by the Office o Civil Rights at the US Department of HHS is ongoing. In addition, individuals can file a civil lawsuit to challenge a nondiscrimination violation under Section 1557.

FDA Approval of Biosimilars

The ACA authorized the U.S. Food and Drug Administration (FDA) to approve generic version of biologics (biosimilars) and grant biologics manufacturers 12 years of exclusive use before generics can be developed. As of December 2018, the FDA has approved (https://www.fda.gov/drugs/developmentapprovalprocess/howdrugsaredevelopedandapproved/approvala 16 biosimilar products used in the treatment of cancer, rheumatoid arthritis, and other health conditions.

Innovation Center

The law also established an Innovation Center within the Center for Medicare and Medicaid Services (CMS) to test, evaluate and expand different payment structures and methods to save costs while maintaining or improving quality of care. Payment and delivery system models (https://innovation.cms.gov/) supported by the Innovation Center focu on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), for example, include care delivery for children (https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/) and pregnant women (https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/) affected by the opioid crisis, and models to reduce prescription drug costs.

Prevention and Public Health Fund

The ACA established the Prevention and Public Health Fund with a permanent annual appropriation to support activities related to prevention, wellness and public health activities. The law appropriated $7 billion annually through 2015 and $2 billion for each fiscal year thereafter, although Congress has since voted several times to redirect (https://www.apha.org/-/media/files/pdf/factsheets/pphf_fact_sheet.ashx?la=en&hash=8AD9EFD10E474FC3DDFD5C750BBEDC85A424F35F) a portion of funds from the Prevention and Public Health Fund for other purposes. Fund resources support (https://www.hhs.gov/open/prevention/index.html) federal, state, and local programs to fight obesity, curb tobacco use, prevent the onset of chronic conditions such as diabetes and heart disease, promote immunization, detect and respond to infectious diseases and other public health threats, and other initiatives.

Nonprofit Hospitals

The ACA set new requirements (https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r) for non-profit hospitals in order to retain their tax exempt status. These include a requirement to conduct a community needs assessment every 3 years and adopt a strategy to meet identified needs. Hospitals also must adopt and widely publicize financial assistance policies on the availability of free or discounted care and how to apply. In addition, hospitals must limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and must make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions.

Breastfeeding breaks & separate rooms

Employers with 50 or more employees must now provide adequate break time for breastfeeding women and a private space that is not a bathroom for nursing and pumping.

Menu labeling

Restaurants and retail food establishments with 20 or more locations and owners of 20 o more vending machines must include nutrition information, including calories, for their standard menu items.

Revenue Provisions

Many of the revenue provisions enacted under the ACA remain in effect but presumably would end if the law were found unconstitutional. For example, the ACA included a tax on pharmaceutical (https://www.irs.gov/affordable-care-act/annual-fee-on-branded-prescription-drug-manufacturers-and-importers) manufacturers and importers (generating annual fees of $2.8 billion in 2019 and thereafter) and a tax on health insurers (https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010) (generating annual fees of $14.3 billion in 2018, indexed annually by the rate of premium growth, but subject to a moratorium in 2019). The law also imposed a new medical device (https://www.irs.gov/newsroom/medical-device-excise-tax-frequently-asked-questions) excise tax of 2.3%, which Congress has voted several times to delay. Financing provisions also included a 10% tax on indoor tanning services (https://www.irs.gov/businesses/small-businesses-self-employed/indoor-tanning-services-tax-center), and limits on the deductibility of compensation of insurance company executives (https://www.irs.gov/instructions/i1120) (limited to $500,000 per individual per year). Under the ACA, the Medicare payroll tax (https://www.irs.gov/affordable-care-act/affordable-care-act-tax-provisions) was increased for high income earners (over $200,000 by individuals, $250,000 for married couples filing jointly), and a new 3.8% tax o net investment income (https://www.irs.gov/individuals/net-investment-income-tax) applied for higher income taxpayers. Finally, the ACA imposed the so-called Cadillac tax

(https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/congress-delays-cadillac-tax-until-2022.aspx) on high-value employer-sponsored health plans, which Congress has also voted to delay, most recently, until 2022.

Endnotes

1. Some of the coverage gap provisions were subsequently modified by the Bipartisan Budget Act of 2018. The BBA closes the Part D coverage gap in 2019 instead of 2020 by accelerating a reduction in beneficiary coinsurance from 30 percent to 25 percent in 2019; also increases the discount provided by manufacturers of brand-name drugs in the coverage gap from 50 percent to 70 percent, beginning in 2019. In 2019 and later years, Part D plans will cover the remaining 5 percent of costs in the coverage gap, which is a reduction in their share of costs (down from 25 percent).

   ← Return to text (https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/#endnote_link_121920-1)

2. Some of the Medicare income-related premium provisions have been modified by subsequent laws. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made changes to Medicare's income-related premiums by requiring beneficiaries with incomes above $133,500 ($267,000 for married couples) to pay a larger share of Part B and Part D program costs than under the original MMA and ACA provisions. Under MACRA, beginning in 2018, beneficiaries with incomes above $133,500 and up to $160,000 ($267,000-$320,000 for married couples) were required to pay 65 percent of Part B and Part D program costs, up from 50 percent prior to 2018, while beneficiaries with incomes above $160,000 and up to $214,000 ($320,000-$428,000 for married couples) were required to pay 80 percent of Part B and Part D program costs, up from 65 percent. The most recent change to Medicare's income-related premiums was incorporated in the Bipartisan Budget Act of 2018 (BBA). This change will affect beneficiaries with incomes above $500,000 ($750,000 for married couples) by requiring them to pay 85 percent of program costs beginning in 2019, up from 80 percent prior to 2019.

   ← Return to text (https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/#endnote_link_121920-02)

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A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs

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Timely Analysis of Immediate Health Policy Issues

DECEMBER 2018

In Brief

Since the implementation of the Affordable Care Act (ACA) coverage provisions in 2014, health insurance coverage has expanded significantly, but about 32 million people, or 12 percent of nonelderly US residents, are estimated to remain uninsured in 2020, and affordability issues persist for some. As a result, the debate continues over the most attractive next steps, ranging from incremental changes to the current system to widespread overhauls, including everything from ACA repeal with state block grant funding to full federalization of the health insurance system. This analysis focuses on improving the current system through incremental steps that would maintain the structure of the ACA but increase insurance coverage, enhance affordability, and contain costs. The reform package seeks to expand coverage in an efficient and policy-sustainable way.

We estimate the coverage and health care spending effects of four reform scenarios, each building upon the preceding scenario. The policy scenarios are as follows:

- **Scenario 1: Restore 2016 ACA policies.** Reinstate the ACA's individual mandate penalties and cost-sharing reductions and prohibit the expanded availability of short-term, limited-duration (STLD) plans.
- **Scenario 2: Expand Medicaid eligibility in all remaining states.** Add to scenario 1 full federal financing of the Medicaid expansion for all states and families with incomes up to 138 percent of the federal poverty level (FPL), adding autoenrollment of those receiving Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits.
- **Scenario 3: Improve marketplace financial assistance.** Add to scenario 2 enhancement of the ACA's premium tax credit and cost-sharing subsidy schedules, tie assistance to 80 percent actuarial value ("gold") coverage instead of 70 percent ("silver"), eliminate the tax credit "cliff," and introduce a permanent federal reinsurance program for the nongroup market.
- **Scenario 4: Reduce nongroup market premiums and out-of-pocket costs.** Cap provider payment rates paid by insurers in nongroup insurance markets at levels somewhat above Medicare levels.

Table 1 shows the number of uninsured people and people without minimum essential coverage (i.e., the uninsured plus those with STLD policies), federal government spending, and total national spending on acute care for the nonelderly population in 2020. By implementing all four of our policy scenarios, the number of uninsured would fall by 12.2 million people to 7.3 percent of the nonelderly population, and the number of people without minimum essential coverage would fall by 16.1 million. Excluding the people eligible but not enrolled for Medicaid/Children's Health Insurance Program (CHIP) (i.e., treating this group more like insured people because of their eligibility status), 8.1 million citizens and other legally present residents, or 3.1 percent of nonelderly legal US residents, would be effectively uninsured under these collective reforms in 2020. These reforms would increase federal spending on acute health care for the nonelderly by $119.2 billion in 2020, but total health care spending would increase by only $39.8 billion, or 1.8 percent, that year, because there would be significant savings to state governments ($7.2 billion), employers ($25.3 billion), households ($17.2 billion), and reduced demand for uncompensated care ($29.7 billion).

With the enhanced financial assistance, many households enrolling in marketplace-based coverage would be eligible for significantly lower premiums, deductibles, and out-of-pocket maximums. A family of four (two 35-year-old parents and two children) with income of 350 percent of FPL (about $88,500) could save almost $1,900 on premiums for coverage with a deductible $3,300 lower than that under current law. Thus, in addition to increased coverage, many families would find substantially more affordable coverage.

Table 1. Insurance Coverage and Health Care Spending on Acute Care for the Nonelderly Population under Current Law and Four Incremental Reform Scenarios, 2020

	Number of uninsured (millions)	Number without minimum essential coverage (millions)	Federal spending on acute care for the nonelderly ($ billions)	National spending on acute care for the nonelderly ($ billions)
Current law (ACA)	32.2	36.1	418.9	2,176.0
Scenario 1	30.0	30.0	407.5	2,170.7
Scenario 2	22.8	22.8	487.0	2,196.2
Scenario 3	21.1	21.1	549.9	2,234.9
Scenario 4	20.0	20.0	538.1	2,215.8

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Note: ACA = Affordable Care Act.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage.

Introduction

The ACA substantially improved affordability and access to medical care and reduced the number of uninsured Americans.[1] Between 2013 and 2016, the number of uninsured fell from 45.0 million to 26.5 million people (from 17.0 percent of the nonelderly population to 10.0 percent), according to the American Community Survey (ACS).[2] However, 26.5 million people remained uninsured. The Trump administration's policy changes (beginning in early 2017) have led to confusion among consumers and large increases in unsubsidized nongroup premiums. These policy changes will also likely lead to significant market instability beginning in 2019, when individual mandate penalties are eliminated and people begin to feel the effects of expanding the availability of STLD policies.[3] It is unclear how quickly premiums will fully reflect these changes, so we present estimates for 2020, rather than 2019.[4] The number of uninsured, high premiums, and cost-sharing requirements relative to some consumers' income, and some evidence that uninsurance may have already begun increasing since 2016 leads analysts and policymakers to consider further health reforms.[5]

Various incremental reforms may reverse recent changes and address the ACA's major shortcomings. In this analysis, we describe the cost and coverage implications of four policy scenarios, each building upon and shown in comparison with the previous scenario:

- **Scenario 1: Restore 2016 ACA policies.** Reinstate the ACA's individual mandate penalties and cost-sharing reductions and prohibit the expanded availability of STLD plans.
- **Scenario 2: Expand Medicaid eligibility in all remaining states.** Add to Scenario 1 full federal financing of the Medicaid expansion for all states and families with incomes up to 138 percent of FPL, adding autoenrollment of those receiving TANF or SNAP benefits.
- **Scenario 3: Improve marketplace financial assistance.** Add to Scenario 2 enhancement of the ACA's premium tax credit and cost-sharing subsidy schedules, tie assistance to 80 percent actuarial value ("gold") coverage instead of 70 percent ("silver"), eliminate the tax credit "cliff," and introduce a permanent federal reinsurance program for the nongroup market.
- **Scenario 4: Reduce nongroup market premiums and out-of-pocket costs.** Cap provider payment rates paid by insurers in nongroup insurance markets at levels somewhat above Medicare levels.

This analysis relies on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), which has been used extensively to estimate the cost and coverage implications of the ACA, reforms to the ACA, and repeal and replace proposals. We provide 2020 estimates of coverage and costs under current law and each of the four incremental reform steps previously delineated.

Methods

HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the ACS, which provides national and state representative samples. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program. HIPSM is designed to incorporate timely, real-world data when they are available. We regularly update the model to reflect published Medicaid and marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives. Here we describe approaches to simulating current law and the specific components of our four proposed policy scenarios. The appendix provides additional detail.

Simulation of Insurance Coverage and Health Care Spending under Current Law, 2020. We begin by estimating health insurance coverage and health care spending by governments, employers,

and households under current law. Our current-law ACA simulations are based on finalized effectuated enrollment in the marketplaces in each state under the 2018 open enrollment period. We capture the collective effect of policy changes implemented by the Trump administration by benchmarking the current-law simulation to 2018 marketplace enrollment, the most recent Medicaid enrollment data, and nongroup market premium changes between 2017 and 2018. We then age these benchmarks to our analysis year of 2020, accounting for estimated premium growth, changing demographics, and anticipated shifts in the income distribution.

Because the individual mandate penalties are still in place but will be set to $0 under current law in 2019, our 2020 current-law estimates must simulate elimination of these penalties, except in Massachusetts and New Jersey, which have passed legislation enacting their own penalties. In addition, effects of the Trump administration's recently finalized regulations allowing the expansion of sales of STLD policies will not be fully realized until at least 2019. States regulate these policies differently, so we must explicitly estimate the effect of eliminating the individual mandate penalties and expanded sales of STLD policies by state and incorporate these estimates into our simulation of current law in 2020. Then these policy changes will be reversed in our simulations of scenarios 1 through 4.[6]

Our 2020 current-law simulation also assumes that all states would instruct their insurers to add the costs associated with cost-sharing subsidies into their silver-level premiums, consistent with 2019 rules. Beginning with the Scenario 1 simulation, this "silver loading" approach would be reversed, and the federal government would directly reimburse insurers for the costs associated with these out-of-pocket subsidies for low-income people.

Estimating the Effect of the Individual Mandate. To simulate the effect of the individual mandate penalties, we compute eligibility for the most common mandate exemptions (income below the tax-filing threshold, lack of affordability of available premiums, undocumented status) and tax penalties for people without exemptions if they become uninsured. Our estimated number of families paying the tax penalty are similar to published Internal Revenue Service estimates, so the exemptions we cannot model (e.g., individual hardship circumstances and religious conscience objections) do not appear to substantially affect our results. We estimate the size of both the financial and nonfinancial effects of the mandate penalties based on total reported nongroup enrollment in the 2017 National Health Interview Survey and reported marketplace enrollment. This approach is described further in the appendix.

Estimating the Effect of Expanded Availability of Short-Term, Limited-Duration Policies. We assume that full-year STLD coverage would differ markedly from ACA-compliant nongroup coverage, because it has a lower actuarial value (approximately 50 percent); is not guaranteed issue; and permits health status, gender rating, and broad age rating variations. STLD plans do not cover all ACA essential health benefits, but we did not model benefit exclusions given the complexity involved. These differences ensure that those who prefer STLD to ACA-compliant plans, and those who can access the former if desired, will likely have lower health care needs. HIPSM captures the adverse selection behavior of healthier people leaving the ACA-compliant nongroup insurance market for STLD plans by iterating until coverage and premium changes stabilize. STLD plans do not meet the standards of minimum essential coverage; consequently, we categorize STLD purchasers as people without minimum essential coverage and group them with the uninsured. Beginning with the simulation of Scenario 1 (described previously), all states are treated as prohibiting the expansion of STLD plans beyond 2016 Obama administration levels.

Full Federal Funding of the ACA's Medicaid Expansion and Limited Autoenrollment. Under this reform, federal funding for the Medicaid expansion population would increase from its minimum of 90 percent (effective in 2020) to 100 percent. Although states would still administer the program, we assume that all states would take advantage of these federal dollars voluntarily or, alternatively, could be required to do so. Though some states could refuse to enroll the fully federally financed eligible people, we find this unlikely. We also identified people in our model who reported receiving either SNAP or public assistance income on the original ACS survey. If they were simulated to be eligible for Medicaid but would not otherwise enroll, we automatically enrolled them in Medicaid. However, our estimates understate the effect of auto-enrolling this population. Research shows that reporting on the ACS significantly understates SNAP receipt.[7] Consequently, more people would be auto-enrolled under this approach than we can estimate here.

In this analysis, we do not treat Medicaid expansions that have passed as ballot initiatives but which have yet to be financed and implemented as having expanded under current law. If these initiatives are implemented without further reforms, we will have somewhat over-estimated the government costs associated with Scenarios 2 to 4 here. Uncertainty with the actual political process surrounding these initiatives (Maine is a clear example) led us to treat only expansions legally in place (including Virginia) as part of current law.

Enhanced Financial Assistance for Enrollees in ACA Marketplaces. Elsewhere, we proposed enhanced premium tax credit and cost-sharing schedules to improve insurance affordability and reduce cost-sharing requirements for ACA-compliant nongroup insurance policies.[8] The changes to both schedules are used in this analysis and shown in Table 2. In addition to increasing financial assistance at all income levels, the approach

Table 2: Enhanced Premium Tax Credit and Cost-Sharing Reduction Schedule

	Premium Tax Credit Schedule Household Premium Caps as Percent of Income		Cost Sharing Reduction Schedule AV of Plan Provided to Eligible Enrollees (%)	
Income (% of FPL)	2019 ACA schedule: Pegged to silver (70% AV) premium, indexed	Proposed schedule: Pegged to gold (80% AV) premium, not indexed	2019 ACA schedule: Coverage provided in a silver plan	Proposed schedule: Coverage provided in a gold plan
100–138	2.08	0-1.0	94	94
138–150	3.11–4.15	1.0–2.0	94	94
150–200	4.15–6.54	2.0–4.0	87	90
200–250	6.54–8.36	4.0–6.0	73	85
250–300	8.39–9.86	6.0–7.0	70	85
300–400	9.86	7.0–8.5	70	80
≥ 400	NA	8.5	70	80

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; NA = not applicable.

The ACA premium tax credit schedule can be found at https://www.irs.gov/pub/irs-drop/rp-18-34.pdf. Under the ACA, premium tax credits are indexed to change as a function of the increase in health care costs relative to general inflation. Our proposal would eliminate the indexing, keeping the the percent of income caps fixed.

would extend premium tax credits above the current cap of 400 percent of FPL, providing a cap at 8.5 percent of income for all incomes above that level. As income increases, the extended premium tax credit falls to zero as the premium facing individuals and families falls below 8.5 percent of their income. In addition, the percent-of-income caps would no longer be indexed, and they would be tied to the second-lowest-cost gold (80 percent actuarial value plan) instead of silver (70 percent actuarial value) coverage. The approach would also make other components of the system consistent with this new schedule by setting the affordability threshold for exemption from the individual mandate penalties at 8.5 percent of family income (a modest increase from its 2019 level of 8.3 percent) and lowering the employer-sponsored insurance "firewall" to 8.5 percent of family income, a decrease from its current-law 2019 level of 9.86 percent. The latter means workers and their families would be eligible for marketplace financial assistance if the required contribution for worker-only coverage exceeds 8.5 percent of family income.

A Permanent Federal Reinsurance Program. To attract and maintain more insurers to compete in private nongroup insurance markets, we reintroduce a federal reinsurance program into these markets. We assume a gross federal cost of $10 billion. The effect of this type of reform is to reduce aggregate claims in the private nongroup markets by $10 billion, thereby lowering premium levels before computing premium tax credits. To put this $10 billion in perspective, Blewett et al. estimated that a national reinsurance program that reimbursed nongroup insurers for 90 percent of their claims between $40,000 and $250,000 per year would have a gross cost of $9.7 billion in 2019.[9] With lower premiums resulting from reinsurance, total federal spending on tax credits falls as well. Reinsurance programs under current law (seven states will have them in effect via Section 1332 waivers as of 2019)[10] are financed by federal savings on premium tax credits and state financing. However, under the reforms simulated here that bring in significantly more enrollees with enhanced premium tax credits, cost-sharing reductions, and an individual mandate, the federal savings on premium tax credits would more than pay for the $10 billion gross investment in the reinsurance program.

Estimating the Effect of Capping ACA-Compliant Nongroup Insurance Payment Rates at Competitive Market Levels. High provider payment rates in areas with limited provider competition and often limited insurer competition lead to higher premiums.[11] Increasing competition in these markets, particularly for providers, is extremely difficult because of the high cost of entry. Consequently, we have proposed elsewhere that provider payment rates applying to ACA-compliant nongroup insurers be capped somewhat above Medicare levels.[12] Therefore, monopoly or dominant provider systems could no longer require extremely high rates, leading to lower premiums. These payment rate caps would also lower the barriers to insurance market entry, allowing additional insurers to enter markets without having to effectively negotiate with providers for payment rates that approximate those negotiated by insurers already in those markets with large market shares. The Medicare Advantage program uses a similar approach by capping out-of-network payments at traditional Medicare payment rates. An alternative that achieves roughly the same savings, but could be somewhat more problematic politically, is a public option offered in the marketplaces.

Ideally, these payment rate caps would be set somewhat above Medicare levels. Without information on nongroup insurer provider payment rates, we proxy the ideal levels using those consistent with provider payments rates in the most competitive markets, which have five or more insurers. We estimated the premium effect of these highly competitive marketplaces in prior work and apply those findings here.[13] We found that benchmark premiums vary by number of insurers in the markets; markets with only one insurer are associated with an additional 35 percent in benchmark premiums, an additional 20 percent for markets with two insurers, an additional 10 percent for three insurers, and an additional 5 percent for four insurers. With provider payment caps in place, we assume these levels of savings relative to current premiums as a function of insurer competition.

These payment rate caps would reduce total premiums in the less competitive and more expensive marketplaces (before premium tax credits), reducing premium tax credits for the federal government and household premiums for enrollees ineligible for tax credits. The payment rate caps would also reduce out-of-pocket spending for nongroup enrollees using medical care before hitting their plans' out-of-pocket maximums. Here, we approximate the household savings on direct medical costs by applying the same percent savings as we apply to the benchmark premium to direct spending by households before reaching the out-of-pocket maximum.

Results

As described in the introduction, each successive reform scenario builds on the previous one by adding components in each scenario. The tables of findings are organized around each policy scenario and include the estimated distribution of health insurance coverage and health care spending. In each table, we compare the findings for the highlighted scenario with the previous scenario. Scenario 1 is compared with current law, and Scenario 4 is compared with both Scenario 3 and current law.

Current Law

Health Insurance Coverage. We estimate that, under current law, 36.1 million Americans, 13.1 percent of the nonelderly population, will not have minimum essential coverage (i.e., employer-based insurance, ACA-compliant nongroup coverage, Medicare, Medicaid, or other public insurance) in 2020 (Table 3, section A). Of that 36.1 million people, 32.2 million people will have no insurance, and 3.9 million people will have non–ACA compliant nongroup plans (i.e., STLD plans). These noncompliant plans will not cover all ACA essential health benefits, will not be guaranteed issue, and will be permitted to discriminate in benefits and premiums per enrollees' health status.

We estimate that over half of the nonelderly population (148.7 million people) will have employer-based insurance in 2020; 12.7 million people, or 4.6 percent, will have ACA-compliant nongroup insurance (most of those receiving tax credits through the marketplaces); 69.1 million people, or 25.1 percent, will have Medicaid or CHIP coverage; and the remaining 8.6 million people, or 3.1 percent, will have other public insurance coverage, such as Medicare or military coverage.

Health Care Spending. We estimate that, under current law, the federal government will spend $341.0 billion on Medicaid and CHIP acute care for the nonelderly and $77.3 billion on marketplace premium tax credits in 2020 (Table 3, section B). State governments will spend $198.5 billion on Medicaid and CHIP, and the six states (Alaska, Maine, Maryland, Minnesota, Oregon, and Wisconsin) that will have implemented their own reinsurance programs by 2019 under Section 1132 waivers are estimated to spend $721 million on those programs the same year, assuming no additional waivers are granted for 2020. The federal government will contribute an estimated $568 million in "pass through" funds to these state reinsurance programs, shifting funds from decreased premium tax credit costs associated with these programs back to the states to help fund the programs. Employers will spend $922.4 billion on their workers' premiums, and households will spend $563.0 billion in premiums and direct out-of-pocket payments at the point of service.

Scenario 1: Restore 2016 ACA policies. Restores the ACA's individual mandate and direct federal funding of cost-sharing reductions and reverses the recent expansion of short-term limited-duration policies.

Health Insurance Coverage. Scenario 1 essentially reverses the central policy changes made to the ACA since early 2017: the individual mandate would be reinstated, direct federal funding of cost-sharing reductions would be restored, and the regulatory change that allows the expansion of non–ACA compliant nongroup plans would be reversed (Table 3, section A). Compared with current law, these changes alone would decrease the number of people without minimum essential coverage by 6.1 million in 2020, from 13.1 percent to 10.9 percent, a 16.9 percent reduction. Approximately 30 million people would remain uninsured, however. The largest changes in coverage would be a 19.2 percent increase in the number of nonelderly people enrolling in nongroup insurance with tax credits (1.6 million more people) and a 64.7 percent increase in the number of people purchasing ACA-compliant nongroup insurance without tax credits (2.9 million more people).

Of the three components of this policy package, reinstating the individual mandate increases the number of people with minimum essential coverage the most. If the mandate were not included here, only 2.4 million people would gain minimum essential coverage (data not shown), instead of 6.1 million people.

Health Care Spending. Reversing these recent policy changes would decrease federal and national health spending. It would increase Medicaid/CHIP spending modestly ($3.3 billion federally, or 1 percent) compared with current law, largely because of increased enrollment (Table 3, section B). Federal spending on tax credits would decrease by $14.7

Table 3. Health Insurance Coverage and Health Care Spending for the Nonlderly in 2020 under Current Law and Reform Scenario 1 (thousands of people, millions of dollars)

Scenario 1: Restore 2016 ACA Policies: Individual Mandate, Direct Funding for Cost-Sharing Reductions, Elimination of Short-Term Limited-Duration Policy Extension

A. Health Insurance Coverage						
	Current Law (ACA)		Scenario 1		Difference from Current Law	
	Number	Percent	Number	Percent	Number	Percent
Insured	**239,069**	**86.9%**	**245,164**	**89.1%**	**6,095**	**2.5%**
Employer	148,684	54.0%	149,346	54.3%	663	0.4%
Nongroup (with tax credits)	8,286	3.0%	9,875	3.6%	1,589	19.2%
Nongroup (without tax credits)	4,412	1.6%	7,265	2.6%	2,853	64.7%
Medicaid/CHIP	69,056	25.1%	70,047	25.5%	990	1.4%
Other (including Medicare)	8,632	3.1%	8,632	3.1%	0	0.0%
Lacking minimum essential coverage	**36,064**	**13.1%**	**29,969**	**10.9%**	**-6,095**	**-16.9%**
Uninsured	32,206	11.7%	29,969	10.9%	-2,236	-6.9%
Alternative nongroup market	3,859	1.4%	0	0.0%	-3,859	-100.0%
Total	**275,134**	**100.0%**	**275,134**	**100.0%**	**0**	**0.0%**
B. Acute Care Health Spending						
	Current Law (ACA)		Scenario 1		Difference from Current Law	
	Dollars	Percent	Dollars	Percent	Dollars	Percent
Federal government	**$418,867**	**19.2%**	**$407,501**	**18.8%**	**$(11,365)**	**-2.7%**
Medicaid/CHIP	$341,012	15.7%	$344,303	15.9%	$3,291	1.0%
Marketplace PTCs and CSRs	$77,288	3.6%	$62,630	2.9%	$(14,657)	-19.0%
Reinsurance	$568	0.0%	$568	0.0%	$0	0.1%
State government	**$199,246**	**9.2%**	**$200,771**	**9.2%**	**$1,525**	**0.8%**
Medicaid/CHIP	$198,525	9.1%	$200,050	9.2%	$1,525	0.8%
Reinsurance	$721	0.0%	$721	0.0%	$0	0.0%
Employers	**$922,425**	**42.4%**	**$925,176**	**42.6%**	**$2,750**	**0.3%**
Households	**$563,023**	**25.9%**	**$571,751**	**26.3%**	**$8,728**	**1.6%**
< 138% FPL	$51,095	2.3%	$50,931	2.3%	$(164)	-0.3%
138%–250% FPL	$95,721	4.4%	$96,751	4.5%	$1,030	1.1%
251%–400% FPL	$139,450	6.4%	$140,268	6.5%	$818	0.6%
> 400% FPL	$276,757	12.7%	$283,802	13.1%	$7,045	2.5%
Uncompensated care	**$72,438**	**3.3%**	**$65,517**	**3.0%**	**$(6,921)**	**-9.6%**
Total	**$2,175,999**	**100.0%**	**$2,170,716**	**100.0%**	**$(5,283)**	**-0.2%**

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: PTC = premium tax credit. CSR = cost-sharing reductions. FPL = federal poverty level.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage (under "other").

billion, or 19.0 percent, as healthier people enroll in the private nongroup markets, reducing the average premium tax credit paid out. The savings in tax credits per person would more than offset the tax credits paid to additional enrollees, two-thirds of whom are ineligible for financial assistance. Employer spending would not change significantly, and household spending would increase by $8.7 billion, 80 percent of which is attributable to people with family income over 400 percent of FPL. The increased spending is clustered in these higher-income families because of higher enrollment in comprehensive health insurance coverage. STLD policies, which would be purchased almost exclusively by people less likely to use health care services and can be denied to people with health problems, tend to have low premiums for those able to purchase them. Households enrolling in comprehensive ACA-compliant coverage, instead of STLDs or going uninsured, would likely face higher premiums, particularly if they are ineligible for marketplace tax credits. Plus, because their out-of-pocket costs would likely be lower and covered benefits broader, some of these people would use more medical services. However, aggregate health spending increases by less than three percent for this income group. As insurance coverage increases, the demand for uncompensated care falls by 9.6 percent.

Scenario 2: Expand Medicaid Eligibility in All Remaining States. Adds to Scenario 1 full federal funding of the ACA's Medicaid expansion for all states and autoenrollment of Medicaid eligibles receiving TANF or SNAP.

Health Insurance Coverage. Scenario 2 addresses the issue that 18 states have thus far declined to expand Medicaid under the ACA, leaving many poor adult residents without access to any financial assistance for health insurance coverage. This step fully funds the cost of expansion in all states plus the District of Columbia, including states that have already voluntarily expanded. If all remaining states agree to enroll the new eligibles, or are required to do so by legislation, this step would reduce the uninsured by 7.1 million more people than Scenario 1, reducing the number uninsured to 22.8 million people, or 8.3 percent of the nonelderly population in 2020 (Table 4, section A). This change would increase the share of the nonelderly population enrolled in Medicaid or CHIP to 30.2 percent, or 83.1 million people. The most notable other change would be a 22.1 percent decrease in the number of people enrolled in nongroup coverage with tax credits, as people with incomes between 100 and 138 percent of FPL in states that had not previously expanded Medicaid eligibility move from subsidized marketplace coverage into Medicaid.

Health Care Spending. Compared with Scenario 1, the biggest changes in spending under Scenario 2 are increased federal government spending because of current-law Medicaid expansion costs shifting from states to the federal government and because of new federal spending on states that have not expanded Medicaid under current law (Table 4, section B). Federal spending increases further because administrative TANF and SNAP program data are used to identify and autoenroll some Medicaid eligibles. State spending on Medicaid/CHIP would be 4.5 percent lower (-$8.9 billion), and federal Medicaid/CHIP spending would be 27.7 percent higher ($95.5 billion). The significantly larger number of people insured in states that had not expanded Medicaid previously would also decrease demand for uncompensated care by 20.9 percent nationally ($13.7 billion). Newly eligible for Medicaid under the federal expansion, families with income at or below 138 percent of FPL would save $13.6 billion (26.8 percent nationally) on health care compared with Scenario 1.

Alternatively, offering states newly expanding Medicaid eligibility the same three years of full federal financing and subsequent phase-down to the 90 percent federal funding offered states in 2014 would be less costly for the federal government.[14] This approach would encourage states to contain program costs and would lower federal costs; however, the trade-off is likely lower participation by states and thus lower insurance coverage, at least in the foreseeable future.

Scenario 3: Improve Marketplace Financial Assistance. Adds to Scenario 2 enhanced premium tax credits and cost-sharing assistance plus federal reinsurance; standardizes affordability; and makes the employer-based insurance firewall threshold consistent with the highest percent-of-income cap in the tax credit schedule.

Health Insurance Coverage. This step improves coverage affordability and reduces the direct consumer cost of covered services by increasing the financial assistance provided to eligible marketplace enrollees at all income levels, including extending an 8.5 percent of income premium tax credit cap to all incomes of 400 percent of FPL or higher. As income increases, the extended premium tax credit falls to zero as the premium facing individuals and families falls below 8.5 percent of their income. We delineate the enhanced tax credit and cost-sharing assistance schedules in the methods section. This step also creates consistency between the exemption from the individual mandate penalty, the employer-sponsored insurance firewall, and the premium tax credits. We also add a permanent federal reinsurance program that would make nongroup market participation more attractive to insurers and would lower premiums for higher-income people paying the full premium (i.e., those for whom even the enhanced premium tax credits are not binding). In the nongroup insurance market, enrollees are likely to always be at somewhat higher health care risk than the larger population in the employer-sponsored insurance market. A permanent reinsurance program would spread this additional risk in a small percentage of the population more broadly across the population of taxpayers, further stabilizing this market.

These changes would increase the number of people purchasing nongroup insurance with a premium tax credit by 5.8 million people, or 75.6 percent, compared with Scenario 2 (Table 5, section A). The number of people buying

Table 4. Health Insurance Coverage and Health Care Spending for the Nonelderly in 2020 under Reform Scenarios 1 and 2 (thousands of people, millions of dollars)

Scenario 1: Restore 2016 ACA Policies: Individual Mandate, Direct Funding for Cost-Sharing Reductions, Elimination of Short-Term Limited-Duration Policy Extension
Scenario 2: Expand Medicaid Eligibility in All Remaining States: Scenario 1 Plus Full Federal Funding of Medicaid Expansion and Limited Autoenrollment

A. Health Insurance Coverage						
	Scenario 1		Scenario 2		Difference from Scenario 1	
	Number	Percent	Number	Percent	Number	Percent
Insured	**245,164**	**89.1%**	**252,285**	**91.7%**	**7,121**	**2.9%**
Employer	149,346	54.3%	145,804	53.0%	-3,542	-2.4%
Nongroup (with tax credits)	9,875	3.6%	7,693	2.8%	-2,182	-22.1%
Nongroup (without tax credits)	7,265	2.6%	7,028	2.6%	-237	-3.3%
Medicaid/CHIP	70,047	25.5%	83,129	30.2%	13,082	18.7%
Other (including Medicare)	8,632	3.1%	8,632	3.1%	0	0.0%
Lacking minimum essential coverage	**29,969**	**10.9%**	**22,849**	**8.3%**	**-7,121**	**-23.8%**
Uninsured	29,969	10.9%	22,849	8.3%	-7,121	-23.8%
Alternative nongroup market	0	0.0%	0	0.0%	0	n.a.
Total	**275,134**	**100.0%**	**275,134**	**100.0%**	**0**	**0.0%**
B. Acute Care Health Spending						
	Scenario 1		Scenario 2		Difference from Scenario 1	
	Dollars	Percent	Dollars	Percent	Dollars	Percent
Federal government	**$407,501**	**18.8%**	**$486,970**	**22.2%**	**$79,469**	**19.5%**
Medicaid/CHIP	$344,303	15.9%	$439,807	20.0%	$95,504	27.7%
Marketplace PTCs and CSRs	$62,630	2.9%	$46,595	2.1%	$(16,035)	-25.6%
Reinsurance	$568	0.0%	$568	0.0%	$0	0.0%
State government	**$200,771**	**9.2%**	**$191,852**	**8.7%**	**$(8,919)**	**-4.4%**
Medicaid/CHIP	$200,050	9.2%	$191,131	8.7%	$(8,919)	-4.5%
Reinsurance	$721	0.0%	$721	0.0%	$0	0.0%
Employers	**$925,176**	**42.6%**	**$909,953**	**41.4%**	**$(15,222)**	**-1.6%**
Households	**$571,751**	**26.3%**	**$555,587**	**25.3%**	**$(16,164)**	**-2.8%**
< 138% FPL	$50,931	2.3%	$37,295	1.7%	$(13,635)	-26.8%
138%–250% FPL	$96,751	4.5%	$95,311	4.3%	$(1,439)	-1.5%
251%–400% FPL	$140,268	6.5%	$139,493	6.4%	$(775)	-0.6%
> 400% FPL	$283,802	13.1%	$283,487	12.9%	$(315)	-0.1%
Uncompensated care	**$65,517**	**3.0%**	**$51,819**	**2.4%**	**$(13,698)**	**-20.9%**
Total	**$2,170,716**	**100.0%**	**$2,196,181**	**100.0%**	**$25,465**	**1.2%**

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: PTC = premium tax credit. CSR = cost-sharing reductions. FPL = federal poverty level.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage (under "other").

Table 5. Health Insurance Coverage and Health Care Spending for the Nonelderly in 2020 under Reform Scenarios 2 and 3 (thousands of people, millions of dollars)

Scenario 2: Expand Medicaid Eligibility in All Remaining States: Scenario 1 Plus Full Federal Funding of Medicaid Expansion and Limited Autoenrollment
Scenario 3: Improve Marketplace Financial Assistance: Scenario 2 Plus Enhanced Marketplace Subsidies; Federal Reinsurance Program; and Additional Changes to Create Consistency between the Premium Tax Credit Schedule, the Affordability Standard, and the Employer-Sponsored Insurance Firewall

A. Health Insurance Coverage						
	Scenario 2		Scenario 3		Difference from Scenario 2	
	Number	Percent	Number	Percent	Number	Percent
Insured	**252,285**	**91.7%**	**254,012**	**92.3%**	**1,727**	**0.7%**
Employer	145,804	53.0%	144,058	52.4%	-1,746	-1.2%
Nongroup (with tax credits)	7,693	2.8%	13,508	4.9%	5,815	75.6%
Nongroup (without tax credits)	7,028	2.6%	4,262	1.5%	-2,766	-39.4%
Medicaid/CHIP	83,129	30.2%	83,553	30.4%	424	0.5%
Other (including Medicare)	8,632	3.1%	8,632	3.1%	0	0.0%
Lacking minimum essential coverage	**22,849**	**8.3%**	**21,122**	**7.7%**	**-1,727**	**-7.6%**
Uninsured	22,849	8.3%	21,122	7.7%	-1,727	-7.6%
Alternative nongroup market	0	0.0%	0	0.0%	0	n.a.
Total	**275,134**	**100.0%**	**275,134**	**100.0%**	**0**	**0.0%**
B. Acute Care Health Spending						
	Scenario 2		Scenario 3		Difference from Scenario 2	
	Dollars	Percent	Dollars	Percent	Dollars	Percent
Federal government	**$486,970**	**22.2%**	**$549,916**	**24.6%**	**$62,946**	**12.9%**
Medicaid/CHIP	$439,807	20.0%	$441,777	19.8%	$1,970	0.4%
Marketplace PTCs and CSRs	$46,595	2.1%	$98,139	4.4%	$51,544	110.6%
Reinsurance	$568	0.0%	$10,000	0.4%	$9,432	1660.4%
State government	**$191,852**	**8.7%**	**$191,620**	**8.6%**	**$(232)**	**-0.1%**
Medicaid/CHIP	$191,131	8.7%	$191,620	8.6%	$489	0.3%
Reinsurance	$721	0.0%	$0	0.0%	$(721)	-100.0%
Employers	**$909,953**	**41.4%**	**$899,805**	**40.3%**	**$(10,149)**	**-1.1%**
Households	**$555,587**	**25.3%**	**$547,571**	**24.5%**	**$(8,016)**	**-1.4%**
< 138% FPL	$37,295	1.7%	$36,831	1.6%	$(464)	-1.2%
138%–250% FPL	$95,311	4.3%	$91,676	4.1%	$(3,636)	-3.8%
251%–400% FPL	$139,493	6.4%	$137,026	6.1%	$(2,467)	-1.8%
> 400% FPL	$283,487	12.9%	$282,037	12.6%	$(1,450)	-0.5%
Uncompensated care	**$51,819**	**2.4%**	**$45,998**	**2.1%**	**$(5,821)**	**-11.2%**
Total	**$2,196,181**	**100.0%**	**$2,234,909**	**100.0%**	**$38,728**	**1.8%**

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: PTC = premium tax credit. CSR = cost-sharing reductions. FPL = federal poverty level.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage (under "other").

nongroup insurance without a tax credit would decrease by 2.8 million people, or 39.4 percent compared with Scenario 2, and the number of uninsured would fall by an additional 1.7 million people, or 7.6 percent. Compared with Scenario 2, employer-sponsored insurance would decrease by 1.2 percent under this scenario, because modestly more people with employer-sponsored insurance offers would be eligible for marketplace financial assistance (because the employer-sponsored insurance firewall decreases to 8.5 percent from the current-law 2019 level of 9.86 percent).

Health Care Spending. Federal spending increases as the marketplace premium tax credit and cost-sharing assistance generosity increase in Scenario 3. In addition, state-specific reinsurance programs in Alaska, Maine, Maryland, Minnesota, Oregon, and Wisconsin would be replaced by a permanent, nationwide federally financed reinsurance program in the nongroup market. We assume this program would provide $10 billion in reinsurance funds. Given the increased number of people enrolled with premium tax credits in this scenario, the gross $10 billion cost of the reinsurance program is more than offset by lower aggregate federal spending on premium tax credits than would be the case absent the reinsurance (data not shown). Lower nongroup premiums from reinsurance translate into lower premium tax credits; the effect on premium tax credits is large here because of significantly higher enrollment under a scenario with enhanced subsidies.

In this scenario, federal government spending would be $62.9 billion, or 12.9 percent, higher than in Scenario 2 (Table 5, section B). With greater marketplace assistance, household spending for nongroup insurance enrollees in each of our four income groups would be lower. We estimate that household spending for people in families with incomes between 138 and 400 percent of FPL would be $6.1 billion lower, and spending by people in higher-income families would be $1.5 billion lower compared with Scenario 2. The change for the lowest-income group (incomes below 138 percent of FPL) is smallest because they are generally ineligible for marketplace financial assistance. The demand for uncompensated care would be even lower than in Scenario 2 (decreased by $5.8 billion or 11.2 percent) as uninsurance declines further.

Household Spending by Income and Age. The enhanced premium tax credits and cost-sharing assistance provided in this and the subsequent scenario have substantial implications for household premium affordability and direct out-of-pocket medical costs. Table 6 shows the household premium contributions required by different households under the ACA and Scenario 3. As noted before, the benchmark premium under the ACA is for a silver (70 percent actuarial value) plan, and the benchmark premium under Scenario 3 is for a gold (80 percent actuarial value) plan. Under the ACA, additional cost-sharing subsidies are provided for those with incomes up to 250 percent of FPL, and under Scenario 3, additional assistance is provided to this income group and then extended to people with incomes up to 300 percent of FPL.

We show the premium contributions and illustrative deductibles and out-of-pocket maximums for single adults at ages 25, 45, and 64 and at for four income levels, 138, 250, 350, and 450 percent of FPL under the ACA and Scenario 3. We also show illustrative deductibles and out-of-pocket maximums for a family of four (two adults both age 35 and two children) at the same income levels.[15]

Compared with the ACA, single adults with incomes just over the Medicaid expansion eligibility threshold (138 percent of FPL) would save $356 in premiums when purchasing the standard marketplace insurance package in 2020 under Scenario 3. The premium contributions are the same at all ages within the ACA and within Scenario 3 because enrollees' shares are capped at fixed income shares. The example low-income family would save $736 in premiums. Larger families would have larger premium contributions because the federal poverty level is higher for larger families than smaller families. The cost-sharing assistance would be comparable for these low-income households under both approaches.

As income increases to 250 percent, 350 percent, and 450 percent of poverty, and ACA premium contributions as a percent of income increase, enrollees will generate more household savings under the Scenario 3 premium tax credit schedule. The largest household premium savings from the Scenario 3 approach are seen for 64-year-old single adults and the family unit with income of 450 percent of FPL. Over 400 percent of FPL, no households are eligible for financial assistance under the ACA, but that assistance "cliff" is eliminated under Scenario 3. Sixty-four-year-olds face the highest premiums in the marketplace because of age rating and thus gain the most from this approach (almost $9,500), though significant premium savings would accrue to younger adults as well. Family premiums are essentially the sum of the premiums for the individuals in the unit (although the premium does not increase for families with more than two children), and the financial assistance extended to them under Scenario 3 results in savings of $9,000 in 2020 for the example family. The youngest adults at 450 percent of FPL gain less under Scenario 3 because the capped share of their income is close to the full unsubsidized premium, because age rating lowers their premiums.

The additional cost-sharing assistance and tying the premium tax credits to gold- rather than silver-level coverage also decreases out-of-pocket costs for these households. Cost-sharing subsidies for those at 250 percent of FPL are improved under Scenario 3 compared with the ACA; a typical deductible decreases by $1,650, and a typical out-of-pocket maximum falls by $3,800 for a single adult (and double that for a family). Though the Scenario 3 cost-sharing reductions would stop at 300 percent of FPL, cost-sharing savings would still accrue to higher-income enrollees because the premium tax credits are tied to gold instead of silver coverage. Thus, even without extra cost-

Table 6. Enrollee Portion of Annual Premium and Out-of-Pocket Structure, ACA versus Scenario 3, 2020

	138% of FPL			250% of FPL			350% of FPL			450% of FPL		
	ACA (94% AV)	Scenario 3 (94% AV)	Difference	ACA (73% AV)	Scenario 3 (85% AV)	Difference	ACA (70% AV)	Scenario 3 (80% AV)	Difference	ACA (70% AV)	Scenario 3 (80% AV)	Difference
Enrollee portion of premiums												
Single Age												
25	$524	$169	-$356	$2,554	$1,833	-$721	$4,217	$3,315	-$902	$4,722	$4,674	-$47
45	$524	$169	-$356	$2,554	$1,833	-$721	$4,217	$3,315	-$902	$6,791	$4,674	-$2,117
64	$524	$169	-$356	$2,554	$1,833	-$721	$4,217	$3,315	-$902	$14,108	$4,674	-$9,434
Family of four (two age 35, two children)	$1,085	$349	-$736	$5,281	$3,791	-$1,491	$8,721	$6,854	-$1,866	$18,689	$9,666	-$9,023
Out-of-pocket structure												
Single												
Deductible	$200	$200	$0	$2,650	$1,000	-$1,650	$3,150	$1,500	-$1,650	$3,150	$1,500	-$1,650
Out-of-pocket maximum	$700	$700	$0	$6,500	$2,700	-$3,800	$7,450	$7,200	-$250	$7,450	$7,200	-$250
Family												
Deductible	$400	$400	$0	$5,300	$2,000	-$3,300	$6,300	$3,000	-$3,300	$6,300	$3,000	-$3,300
Out-of-pocket maximum	$1,400	$1,400	$0	$13,000	$5,400	-$7,600	$14,900	$14,400	-$500	$14,900	$14,400	-$500

Notes: ACA = Affordable Care Act, current law. AV = actuarial value. FPL = federal poverty level. Plan data shown is the national median 2019 second-lowest-cost silver (and the associated cost-sharing reduction variations) and median second-lowest-cost gold plan among rating regions in states using the healthcare.gov platform, aged to 2020.

sharing subsidies, deductibles for people enrolling in the standard gold plan under Scenario 3 would be $1,650 lower than under the standard ACA plan, and the typical out-of-pocket maximum would be $250 lower.

Scenario 4: Reduce Nongroup Market Provider Payment Rates and Premiums. Adds to Scenario 3 provider payment rate caps for private nongroup insurers.

Health Insurance Coverage. This scenario adds in a new cost-containment feature: provider payment rate caps that would apply to private nongroup insurance plans for both in- and out-of-network coverage. These caps are intended to approximate rates somewhat higher than Medicare levels and reflect levels in the most competitive nongroup insurance markets (those with five or more insurers). We estimate that this policy would reduce nongroup market premiums in 430 out of 499 US rating regions. We estimate that this approach, added to the affordability enhancements included in previous scenarios, will not greatly affect coverage. The most noticeable coverage effects are an estimated 9.2 percent increase (392,000 more enrollees) in nongroup coverage purchased without tax credits and an estimated 6.7 percent increase (902,000 more enrollees) in nongroup coverage purchased with tax credits (Table 7, section A). The capped provider payment rates decrease nongroup insurance premiums for those ineligible for premium tax credits, and they decrease out-of-pocket costs for those covered by subsidized or unsubsidized nongroup coverage. Both changes would make nongroup insurance coverage more attractive to potential consumers, reducing the number of uninsured by an additional 1.1 million people, down to 7.3 percent of the nonelderly population.

Health Care Spending. The biggest effect of the provider payment rate caps introduced in Scenario 4 is to lower health care spending for services received by people enrolled in private nongroup insurance coverage. In nongroup market areas that are less competitive under current law, the provider payment rate caps would lower the costs of medical care the most. With lower health care costs, premiums and out-of-pocket payments for medical care decrease. This in turn decreases federal health care spending and household spending for those purchasing nongroup insurance coverage. We estimate that, with these caps, federal spending would decrease by $11.8 billion compared with Scenario 3, and household spending would decrease by $1.7 billion, almost

Table 7. Health Insurance Coverage and Health Care Spending for the Nonelderly in 2020 under Reform Scenarios 3 and 4 (thousands of people, millions of dollars)

Scenario 3: Improve Marketplace Financial Assistance: Scenario 2 Plus Enhanced Marketplace Subsidies; Federal Reinsurance Program; and Additional Changes to Create Consistency between the Premium Tax Credit Schedule, the Affordability Standard, and the Employer-Sponsored Insurance Firewall

Scenario 4: Reduce Nongroup Market Premiums and Out-of-Pocket Costs: Scenario 3 Plus Cap on Provider Payment Rates in Nongroup Market

A. Health Insurance Coverage

	Scenario 3		Scenario 4		Difference from Scenario 3		Difference between Scenario 4 and Current Law	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Insured	**254,012**	**92.3%**	**255,129**	**92.7%**	**1,117**	**0.4%**	**16,059**	**6.7%**
Employer	144,058	52.4%	143,528	52.2%	-530	-0.4%	-5,155	-3.5%
Nongroup (with tax credits)	13,508	4.9%	14,409	5.2%	902	6.7%	6,124	73.9%
Nongroup (without tax credits)	4,262	1.5%	4,654	1.7%	392	9.2%	242	5.5%
Medicaid/CHIP	83,553	30.4%	83,905	30.5%	353	0.4%	14,849	21.5%
Other (including Medicare)	8,632	3.1%	8,632	3.1%	0	0.0%	0	0.0%
Lacking minimum essential coverage	**21,122**	**7.7%**	**20,005**	**7.3%**	**-1,117**	**-5.3%**	**-16,059**	**-44.5%**
Uninsured	21,122	7.7%	20,005	7.3%	-1,117	-5.3%	-12,201	-37.9%
Alternative nongroup market	0	0.0%	0	0.0%	0	n.a.	-3,859	-100.0%
Total	**275,134**	**100.0%**	**275,134**	**100.0%**	**0**	**0.0%**	**0**	**0.0%**

B. Acute Care Health Spending

	Scenario 3		Scenario 4		Difference from Scenario 3		Difference between Scenario 4 and Current Law	
	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
Federal government	**$549,916**	**24.6%**	**$538,113**	**24.3%**	**$(11,803)**	**-2.1%**	**$119,246**	**28.5%**
Medicaid/CHIP	$441,777	19.8%	$443,388	20.0%	$1,611	0.4%	$102,376	30.0%
Marketplace PTCs and CSRs	$98,139	4.4%	$84,726	3.8%	$(13,414)	-13.7%	$7,438	9.6%
Reinsurance	$10,000	0.4%	$10,000	0.5%	$0	0.0%	$9,432	1661.7%
State government	**$191,620**	**8.6%**	**$192,041**	**8.7%**	**$421**	**0.2%**	**$(7,205)**	**-3.6%**
Medicaid/CHIP	$191,620	8.6%	$192,041	8.7%	$421	0.2%	$(6,484)	-3.3%
Reinsurance	$0	0.0%	$0	0.0%	$0	n.a.	$(721)	-100.0%
Employers	**$899,805**	**40.3%**	**$897,104**	**40.5%**	**$(2,701)**	**-0.3%**	**$(25,322)**	**-2.7%**
Households	**$547,571**	**24.5%**	**$545,847**	**24.6%**	**$(1,724)**	**-0.3%**	**$(17,176)**	**-3.1%**
< 138% FPL	$36,831	1.6%	$36,474	1.6%	$(357)	-1.0%	$(14,621)	-28.6%
138%–250% FPL	$91,676	4.1%	$91,279	4.1%	$(397)	-0.4%	$(4,442)	-4.6%
251%–400% FPL	$137,026	6.1%	$136,762	6.2%	$(264)	-0.2%	$(2,688)	-1.9%
> 400% FPL	$282,037	12.6%	$281,332	12.7%	$(705)	-0.2%	$4,575	1.7%
Uncompensated care	**$45,998**	**2.1%**	**$42,703**	**1.9%**	**$(3,295)**	**-7.2%**	**$(29,735)**	**-41.0%**
Total	**$2,234,909**	**100.0%**	**$2,215,808**	**100.0%**	**$(19,101)**	**-0.9%**	**$39,809**	**1.8%**

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: PTC = premium tax credit. CSR = cost-sharing reductions. FPL = federal poverty level.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage (under "other").

entirely because of lower spending in the nongroup insurance market (Table 7, section B).

All Policies Combined: Scenario 4 Compared with Current Law.

Health Insurance Coverage. We estimate that the collective steps included in Scenario 4 would decrease the number of people without minimum essential coverage by 16.1 million people in 2020 compared with the estimated 36.1 million people under current law, a decrease of 44.5 percent (Table 7, Section A). An additional 6.4 million people would have private nongroup insurance, a 50 percent increase (summing nongroup coverage with and without tax credits). Medicaid and CHIP coverage would be 21.5 percent higher than under current law, and employer-sponsored insurance would be 3.5 percent lower.

Of the estimated 20.0 million remaining uninsured under this scenario in 2020, 32.8 percent, or 6.6 million people, are undocumented immigrants and are thus ineligible for any financial assistance; 26.8 percent, or 5.4 million people, are eligible for Medicaid or CHIP at no or very low cost; and 19.7 percent, or 3.9 million people, are eligible for subsidized marketplace coverage (Figure 1). Broader outreach and enrollment assistance efforts could increase coverage among those who remain uninsured but are eligible for financial assistance. Providing program eligibility to undocumented immigrants could even further reduce uninsurance, but participation in public programs that may require sharing personal information has the potential to jeopardize their continued residence in the US. These 6.6 million undocumented uninsured people equal 50.9 percent of the estimated nonelderly undocumented population in the US (data not shown).

Those eligible for Medicaid or CHIP can enroll in coverage at any time during the year because these programs do not have limited open enrollment periods. Thus, those eligible for the programs can be enrolled at virtually no cost when they need medical care (although they may not seek medical care at the same rate as insured persons when not already enrolled). Thus, excluding those eligible for but not enrolled in Medicaid/CHIP (i.e., treating them more like insured people because of their eligibility status), our Scenario 4 estimates indicate that 8.1 million citizens and other legally present residents, or 3.1 percent of nonelderly legal US residents, would be effectively uninsured under these collective reforms in 2020 (data not shown).

Health Care Spending. Combining all four reform scenarios, we estimate that federal government health spending would be $119.2 billion, or 28.5 percent, higher than under current law; state government spending would be $7.2 billion, or 3.6 percent, lower; employer spending would be $25.3 billion, or 2.7 percent, lower; and household spending would be $17.2 billion, or 3.1 percent lower, with the lowest-income group's health spending 28.6 percent lower (Table 7, section B). Because of the substantial decrease in the number of uninsured people, the demand for uncompensated care would be $29.7 billion lower (41.0 percent) in 2020 than under current law. Accounting for all sources of payment, aggregate health spending for acute care for the nonelderly would increase by 1.8 percent.

The increased federal government cost over 10 years would be approximately $1.4 trillion (data not shown). This is compared with a 10-year estimated increase in federal costs of more than $30 trillion under the Sanders single-payer approach.[16]

Discussion

The ACA has significantly increased health insurance coverage, yet the nature of the law and decisions by 18 states not to expand Medicaid eligibility have still left many people uninsured. These issues have been exacerbated by policy changes since early 2017, such as the elimination of the individual mandate and expansion of STLD policies. Policymakers differ on the appropriate way to expand insurance coverage and the attractiveness of comprehensive system overhauls, such as single-payer-type proposals. Our analysis demonstrates the coverage and cost implications of various incremental approaches designed to expand coverage, improve affordability, and lower increases in government spending, while remaining consistent with the ACA framework. We provide estimates in steps, with each scenario building on the last, as one possible policy path. Obviously, there are an infinite number of policies and policy orderings that could be implemented, and thus the policy path presented here is illustrative.

Compared with current law, we find that the following policies combined would reduce the number of nonelderly uninsured people in the US by 37.9 percent and would reduce the number of nonelderly people in the US without minimum essential coverage by 44.5 percent:

- restoring the individual mandate and direct federal funding of cost-sharing reductions,
- reversing the expansion of STLD policies,
- fully federally funding the ACA's Medicaid expansion while instituting limited autoenrollment,
- enhancing marketplace financial assistance while creating more consistency in affordability thresholds and tax credit eligibility rules,
- creating a permanent nongroup market reinsurance program, and
- capping provider payment rates for nongroup insurers.

The number of nonelderly people without minimum essential coverage would fall from 36.1 million under current law to 20.0 million. Approximately 94 percent of legally present US residents would be insured. Household and employer spending would be 3 percent lower than under current law. For families with incomes at or below 400 percent of FPL, household health care costs would decrease by 7.6 percent (and would increase by 1.7 percent for those with incomes above 400 percent of FPL), with lower-income people receiving the most savings. Savings to the households benefiting from the expansion in Medicaid eligibility and greater marketplace financial assistance

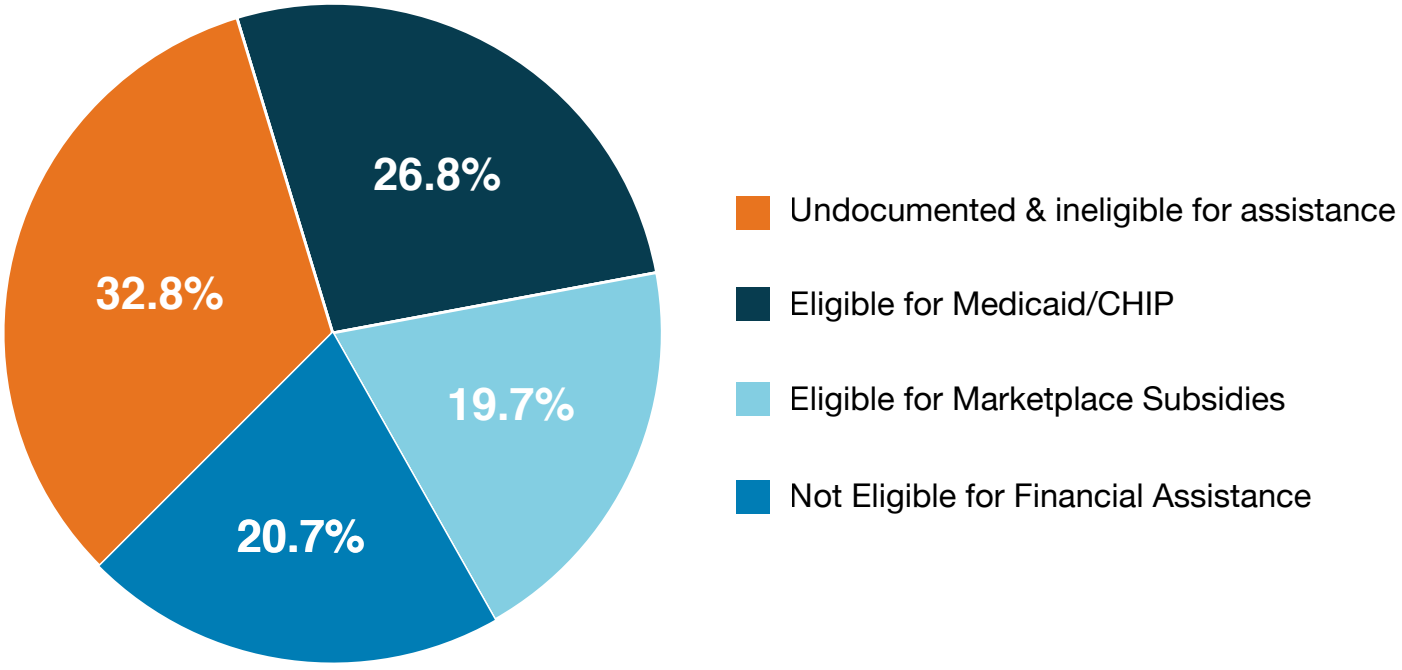
would be substantial. The demand for uncompensated care would fall by $29.7 billion, or 41.0 percent, compared with current law.

Achieving these gains would require increasing government spending (federal and state combined) by about 18 percent. The federal cost of these reforms would be $119.2 billion in 2020, an increase of 28.5 percent over current law acute health care spending for the nonelderly, but state government spending would decrease by $7.2 billion (3.6 percent).

As such, this approach provides an option for policymakers interested in increasing insurance coverage, improving affordability, and introducing a new cost-containment approach without overhauling the entire system. It offers significant improvements in coverage and affordability at a lower federal cost without dramatic changes to the entire health care system, making it a sustainable policy.

Because of the political challenges of reinstituting the ACA's individual mandate, we also estimated the implications of the full set of reforms in Scenario 4, except for the individual mandate. With all the other policy changes in place, 2.4 million additional people would be uninsured without the individual mandate for a total of 22.4 million people (8.1 percent of the nonelderly population; data not shown). The savings to the federal government in 2020 would be $5.7 billion, a reduction in government costs of just over 1 percent of our Scenario 4 estimate (data not shown). The effect on government spending would be small relative to the increase in the uninsured, because the healthiest people and those receiving the least financial assistance would be most likely to drop their coverage without a mandate.

Figure 1. Remaining Uninsured Under Scenario 4, in 2020



Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Appendix: Additional Information on Methods

Nongroup Insurance Coverage Outside Marketplaces. As of November 2018, no nationwide state-specific data are available on nongroup enrollment outside the marketplaces in 2018, so this was simulated in HIPSM based on premium increases between 2017 and 2018. This estimate was then updated using anticipated premium increases for 2019 and 2020.

Individual Mandate. Recent research using ACA data confirms the experience under the 2006 Massachusetts reforms, that the individual mandate's impacts on coverage are larger than penalties' dollar amount would suggest (Salzman 2017). To estimate the nonfinancial effect of the mandate and the size of the nongroup market outside the marketplaces, we use the total reported nongroup enrollment in the 2017 National Health Interview Survey (generally considered the most reliable national measure of enrollment in major health coverage) combined with reported marketplace enrollment. We simulate health insurance coverage based on financial factors (premiums, expected out-of-pocket costs, a measure of risk aversion, individual mandate penalties) and other factors known to affect individual and family coverage, and we compare the resulting coverage levels with benchmarks based on marketplace enrollment and the National Health Interview Survey. The difference between coverage levels based on financial factors and the benchmark is attributed to the nonfinancial effect of the individual mandate, and the model's simulated coverage is calibrated to hit those benchmarks in 2017. This enrollment from nonfinancial factors is aged to 2020, eliminated for the current-law scenario, and replaced under the Scenario 1, which reinstates the mandate penalties.

Expansion of Short-Term Limited Duration Policies. Our current law characterization of state regulations is based upon an analysis of state regulations by Georgetown University's Center on Health Insurance Reforms.[17] Per their detailed analysis, we categorize states into three groups based on any current legislation that would prohibit or limit the expansion of STLD plans beginning in late 2018 under Trump administration regulations. The recently finalized regulations would permit STLD policies to be issued for a maximum one-year plan period, as opposed to the previous three-month limit. Our three groups of states are: (1) those with regulations that would effectively prohibit the expansion of STLD policies; (2) those that would significantly reduce, but not prohibit, the expansion of STLD policies; and (3) those where the new regulations will effectively allow STLD policies to compete with ACA-compliant policies. These categories and our approach are consistent with our prior analysis of the effect of the regulations, but some states have increased their regulation of these plans since that analysis was released.[18] Our second and third categories are primarily based on duration limits of contract length and renewals. Many states have limits, but our categorization is based on people's ability to enroll in and extend or renew an STLD plan for up to 12 months. The states included in our first category, the most restrictive group, are California, Hawaii, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington. The states included in our second category are Michigan and Nevada. All other states and the District of Columbia fall into the third, least effectively regulated category.

NOTES

1 See Antonisse L, Garfield R, Rudowitz R, et al. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. Washington: Henry J. Kaiser Family Foundation; 2018. http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review. McMorrow S and Polsky D. Insurance Coverage and Access to Care under the Affordable Care Act. Philadelphia: University of Pennsylvania, Leonard Davis Institute; 2016. https://ldi.upenn.edu/brief/insurance-coverage-and-access-care-under-affordable-care-act.

2 Skopec L, Holahan J, Elmendorf C. Changes in Health Insurance Coverage 2013–2016: Medicaid Expansion States Lead the Way. Washington: Urban Institute; 2018. https://www.urban.org/research/publication/changes-health-insurance-coverage-2013-2016-medicaid-expansion-states-lead-way.

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4 Recent studies showing declines in some average premiums from 2018 to 2019 do not necessarily mean policy changes will not affect premiums. First, it is unlikely that the full impact will happen immediately, particularly because STLD regulations were only finalized this summer. Second, it is unclear how insurers factored these changes into their 2019 premiums, so we do not know what 2019 premiums would have been without the changes. Third, some evidence shows insurers may have reacted to the policy uncertainty in 2017 by setting overly high 2018 premiums. Fourth, several states were granted reinsurance waivers, which would reduce premiums from last year.

5 Changes in the number of uninsured between 2016 and 2017 varied across the major census surveys. The ACS showed a statistically significant increase, but the Current Population Survey and National Health Interview Survey showed small, statistically insignificant increases. See Berchick E, Hood E, Barnett J. Health Insurance Coverage in the United States: 2017. Suitland, MD: Census Bureau; 2018. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf. Cohen R, Martinez M, Zammitti E. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2018. Washington: National Center for Health Statistics; 2018. https://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201808.pdf.

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The Uninsured in Texas

Statewide and Local Area Views

Matthew Buettgens, Linda J. Blumberg, and Clare Pan

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The number of insured people in the US has increased significantly since implementation of the Affordable Care Act's (ACA's) coverage reforms in 2014. Since that time, the number of people insured nationally has increased by approximately 19 million (Skopec, Holahan, and Elmendorf 2018). However, the increase in coverage has occurred unevenly across the states, with states that have chosen to expand Medicaid eligibility under the law experiencing the largest increases in coverage. Nationally, we estimate that 11 percent of the nonelderly population (those below age 65) are uninsured in 2018. In comparison, we estimate that 19 percent of the Texas nonelderly population, 4.7 million people, remain uninsured; this is the highest uninsurance rate of any state in the country. Although the Texas uninsurance rate remains high, the state has seen a significant increase in coverage across a diverse group of residents since implementation of the ACA.[1]

This brief provides detailed characteristics of the Texas uninsured population as well as an analysis of how the characteristics of this population vary across localities. Such information can be valuable when developing policy approaches intended to expand insurance coverage. As a companion to this analysis, we have also prepared fact sheets exploring the characteristics of the uninsured in Texas counties and county groups (we place counties with small populations into groups for more reliable estimates). These fact sheets can be accessed here.

Methods

Survey data require time to collect and process, so the most recent year for which data are available lag behind the current year. Also, survey data often differ from administrative data on the number of people enrolled in programs such as Medicaid and the Children's Health Insurance Program (CHIP) and in Marketplace-based private coverage. To estimate the number and characteristics of uninsured

Texans in 2018 in a manner consistent with the latest enrollment data, we used the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

Estimating the Number of Uninsured Texans in 2018

HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the American Community Survey, which provides national and state representative samples of the US population. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures tool. HIPSM is designed to incorporate timely, real-world data when they are available. We regularly update the model to reflect published Medicaid and Marketplace enrollments and costs in each state. HIPSM is calibrated to reproduce the latest available Texas enrollment numbers for Medicaid, CHIP, and private Marketplace coverage with premium tax credits. As a check, we compared the 2018 HIPSM results with 2016 results from the American Community Survey and the National Health Interview Survey. The 2018 HIPSM Texas uninsurance rate was within 0.2 percentage points of both surveys. Further, the distribution of major characteristics of the uninsured, such as income, race and ethnicity, and age, were very similar in all three.

Estimates for Counties and Local Areas

The American Community Survey is designed to produce statistically valid estimates down to local areas called Public Use Microdata Areas (PUMAs). Each of these areas has roughly the same population. Texas contains 212 PUMAs. This is a cumbersome number of areas for presenting most results, and PUMAs do not necessarily correspond to easily identifiable jurisdictions. Consequently, we grouped PUMAs together in two different ways. First, we combined PUMAs into 41 counties or groups of less populous counties. Estimates for these counties and county groups are provided in fact sheets produced as part of this project. To the extent possible, our county groups correspond either with Texas Councils of Government or regional planning commissions. Each fact sheet shows the major characteristics of the uninsured in that area. The uninsurance rate and characteristics of the uninsured in individual counties or county groups can vary considerably from the statewide average. For example, 61 percent of the uninsured across the state are Hispanic and 24 percent are white, non-Hispanic. In Hidalgo county, however, 97 percent of the uninsured are Hispanic, and in North Texas (Wichita Falls), 62 percent of the uninsured are white, non-Hispanic.

Second, we used cluster analysis to define six clusters of PUMAs in which the characteristics of the uninsured were much closer to each other than to other localities. This allowed us to characterize local variation in the uninsured that county and county group estimates miss. For example, many large, urban counties contain many PUMAs—sometimes more than a dozen—that are notably different from each other. Local areas in each of these counties can be much more like other areas in Texas than their neighboring localities. All 212 Texas PUMAs fit into one of these six categories, which are most easily characterized by their composition of income and race and ethnicity: majority white and high income; majority white and low income; majority Hispanic and low income; large majority Hispanic and very low

income; plurality of a racial or ethnic group and medium income; plurality of a racial or ethnic group and low income. The cluster analysis identified these categories as those in which the characteristics of the uninsured were much closer to each other than to other localities. Here, a very low–income area is defined as one in which nearly 70 percent of the uninsured population has incomes below 138 percent of the federal poverty level (FPL); low-income areas are those in which roughly 60 percent of the uninsured population has incomes below 138 percent of FPL; medium income areas are defined as those in which just over 50 percent of the uninsured population has incomes below 138 percent of FPL; and the sole higher-income area has 46 percent of its uninsured population below 138 percent of FPL and nearly 30 percent above 300 percent of FPL. Areas with a plurality of racial or ethnic groups are those where no single racial or ethnic group constitutes at least 50 percent of the area's uninsured population. Areas with a large racial or ethnic majority are those where one racial or ethnic group constitutes over 80 percent of the area's uninsured population. Policy changes and outreach programs would likely have similar effects on the localities within each of these clusters.

Limitations

This analysis has several limitations. Our model is based on survey data, which necessarily involve some degree of error in reported characteristics such as income, citizenship, and receipt of benefits such as from the Supplemental Nutrition Assistance Program (SNAP). We have found that the characteristics of the uninsured are very similar across the American Community Survey and the National Health Interview Survey, increasing confidence in our estimates of the statewide distribution. However, reported receipt of SNAP is generally noticeably lower than the enrollment reported in administrative data in all surveys (Stevens, Fox, and Heggeness 2018). No estimates of characteristics of the uninsured at a local level are available other than from the American Community Survey, nor are publicly available administrative data on local enrollment in Medicaid, CHIP, or Marketplace coverage with tax credits, so there are no external benchmarks for our local estimates.

Results

Statewide Findings

In table 1, we show the characteristics of the statewide Texas nonelderly uninsured population.

SOCIOECONOMIC CHARACTERISTICS

Income. The uninsured are heavily concentrated at low incomes. About 60 percent of the uninsured have family modified adjusted gross income (MAGI) below 138 percent of FPL, and 88 percent have family MAGI below 300 percent of FPL. The uninsurance rate varies with income, ranging from 29 percent of those with incomes below 138 percent of FPL to only 4 percent of those with incomes above 400 percent of FPL.

TABLE 1

Characteristics of the Nonelderly Uninsured Population in Texas, 2018

	Thousands of people	Share of state total uninsured	Uninsurance rate
Socioeconomic characteristics			
Family modified adjusted gross income as a percentage of FPL			
<138%	2,822	60%	29%
138%–200%	617	13%	23%
200%–300%	685	15%	21%
300%–400%	302	6%	12%
>400%	268	6%	4%
Age			
0–18	640	14%	8%
19–34	1,992	42%	32%
35–54	1,624	35%	23%
55–64	440	9%	14%
Sex			
Male	2,437	52%	20%
Female	2,257	48%	18%
Race or ethnicity			
White, non-Hispanic	1,117	24%	12%
Black, non-Hispanic	454	10%	16%
Hispanic	2,842	61%	27%
Asians/Pacific Islanders	189	4%	16%
American Indian/Alaska Native	56	1%	18%
Other, non-Hispanic	37	1%	12%
Education (ages 19–64)			
Less than high school	1,214	30%	48%
High school	1,598	39%	29%
Some college	842	21%	20%
College graduate	400	10%	10%
Total	4,055	100%	25%
Health status			
Excellent	1,109	24%	17%
Very good	1,332	28%	19%
Good	1,540	33%	20%
Fair	543	12%	24%
Poor	170	4%	21%
Family type (ages 19–64)			
Single without dependents	1,734	43%	30%
Single with dependents	648	16%	33%
Couple without dependents	600	15%	15%
Couple with dependents	1,073	26%	22%
Total	4,055	100%	25%
Family receiving other benefits			
SNAP	1,297	28%	26%
Not receiving other benefits	3,398	72%	18%
Employment			
Family work status			
No worker in family	1,551	33%	31%
Only part-time worker in family	520	11%	31%
At least one full-time worker in family	2,623	56%	15%
Family firm size			
No worker in family	1,551	33%	31%
Only small-firm workers in family	1,190	25%	30%
At least one large-firm worker in family	1,953	42%	13%

	Thousands of people	Share of state total uninsured	Uninsurance rate
Major Industry (employed age 19–64)			
Agriculture	42	2%	40%
Mining	35	1%	12%
Manufacturing	186	7%	17%
Construction	409	15%	43%
Transportation	102	4%	19%
Wholesale and retail	399	15%	24%
Finance, ins, real estate	91	3%	12%
Professional	294	11%	23%
Education	91	3%	8%
Health and social service	256	10%	18%
Arts/entertainment/recreation	408	15%	42%
Other services	216	8%	35%
Other industries	126	5%	14%
Total employed	*2,656*	*100%*	*23%*
Citizenship			
Citizenship status			
US Citizen	3,095	66%	14%
Noncitizen	1,600	34%	54%
Family citizenship status			
All US citizens	2,704	58%	14%
At least one noncitizen in the family	1,990	42%	36%
English proficiency (age 19–64)			
Speaks very well or better	3,475	86%	22%
Does not speak very well or less proficient	580	14%	55%
Total	4,055	100%	25%
Language spoken at home			
English	1,854	39%	14%
Spanish	2,478	53%	34%
Other	363	8%	9%
Health insurance eligibility and coverage			
Program eligibility			
Eligible for Medicaid/CHIP	691	15%	12%
Eligible for Marketplace PTCs	809	17%	31%
Not currently eligible	3,194	68%	20%
Would gain Medicaid eligibility if Texas expands Medicaid	1,177	25%	38%
Would be ineligible even with Medicaid expansion	2,017	43%	20%
Mixed coverage scenarios			
All family members uninsured	3,076	66%	100%
At least one family member is enrolled in private coverage, nongroup or employer	152	3%	1%
At least one family member enrolled in public insurance	1,466	31%	17%
At least one child enrolled in Medicaid, and at least one adult is eligible for Marketplace PTCs, but not enrolled	111	2%	
At least one child enrolled in Medicaid, and at least one adult is eligible for Medicaid, but not enrolled	352	8%	
Total	**4,695**	**100%**	**19%**

Source: Urban Institute analysis, HIPSM 2018.

Notes: CHIP = the Children's Health Insurance Program; PTCs= premium tax credits; SNAP = the Supplemental Nutrition Assistance Program. Small firms are defined as employers with fewer than 50 employees. Data include people age less than 65 who are residents of Texas.

Age. Children make up only 14 percent of the uninsured and have an uninsurance rate far lower than adults; 8 percent of children are uninsured compared with 25 percent of all adults. This is mainly because of the availability of Medicaid and CHIP; children with incomes up to 206 percent of FPL are eligible for one of these public insurance programs in Texas.[2] By contrast, nondisabled adult parents are eligible for Medicaid only with incomes up to approximately 18 percent of FPL, and there is no income-related eligibility for nondisabled adult nonparents. Among adults, uninsurance rates decline with age, ranging from 32 percent of those age 19 to 34 uninsured to 14 percent of those age 55 to 64 uninsured.

Race and ethnicity. Sixty-one percent of the uninsured are Hispanic, 24 percent are non-Hispanic white, and 10 percent are non-Hispanic black. Hispanics have a notably higher uninsurance rate than any other race/ethnicity group: 27 percent are uninsured compared with 12 percent of non-Hispanic whites and 16 percent of non-Hispanic blacks.

Education. Nearly 70 percent of the uninsured adults in Texas have a high school education or less, with 39 percent having a high school diploma and 30 percent not having one. Uninsurance rates vary dramatically with educational attainment, ranging from 48 percent of those with less than a high school education down to 10 percent of college graduates.

Self-reported health status. Fifteen percent of the uninsured report being in fair or poor health. On average, people who report being in fair or poor health have notably higher levels of health care spending than those reporting better health.[3] The differences in health care spending between those reporting excellent, very good, or good health are much smaller on average.

Family structure. Forty-three percent of the adult uninsured are single without dependents, 16 percent are in single-parent families, 15 percent are in childless couples, and the remaining 26 percent are in two-parent families with dependents. Adults in single-parent families and singles without children have the highest uninsurance rates (33 percent and 30 percent, respectively). Twenty-two percent of adults in two-parent families are uninsured, and 15 percent of adults in couples without children are uninsured.

Receipt of other benefits. Twenty-eight percent of the uninsured report receiving SNAP benefits, and among all SNAP recipients, 26 percent are uninsured. This is a notably higher uninsurance rate than the 18 percent rate for those not receiving other benefits. As noted, survey data generally underreport receipt of SNAP, so we are likely underestimating the number of uninsured people receiving SNAP.

EMPLOYMENT-RELATED CHARACTERISTICS

Family work status. Two-thirds of the Texas uninsured are in working families. A majority (56 percent) are in families with at least one full-time worker. The uninsurance rates among families without workers and families with only part-time workers are identical (31 percent uninsured). By contrast, only 15 percent of people in families with at least one full-time worker are uninsured.

Firm size. Forty-two percent of uninsured Texans are in families with at least one adult who works in a large firm (defined as one with more than 50 employees), and 25 percent are members of families with only small-firm workers. The remaining 33 percent are in families with no worker. The uninsurance

rates for families without workers and families with only small-firm workers are nearly identical (31 percent and 30 percent uninsured, respectively). In contrast, only 13 percent of people in families where at least one adult works in a large firm are uninsured.

Industry. The three most common major industries that employ uninsured Texas adults are construction, wholesale and retail trades, and arts/entertainment/recreation services, each employing 15 percent of uninsured workers. Other common industries include professional services (11 percent), health and social services (10 percent), other services (8 percent), and manufacturing (7 percent). Considered another way, nearly half of uninsured workers are employed in a service industry, whether professional, education, health and social services, arts/entertainment/recreation, or other services.

CITIZENSHIP AND LANGUAGE

US citizenship. Two thirds of the uninsured are US citizens. However, US citizens are much less likely to be uninsured than people who are not US citizens (14 percent versus 54 percent uninsured, respectively). Likewise, fifty-eight percent of uninsured Texans are in families consisting entirely of citizens. Although most uninsured Texans are in families made up of only citizens, people in families with at least one noncitizen have a higher likelihood of being uninsured; 36 percent of people in families with at least one noncitizen are uninsured compared with 14 percent of people in all-citizen families. These large differences are attributable to US citizens tending to have higher incomes and more employment opportunities that come with offers of private health insurance (data not shown) combined with the fact that noncitizens are not eligible for subsidized public insurance programs.

Although citizenship is strongly correlated with insurance coverage, as is Hispanic ethnicity (as discussed), many of the uninsured Hispanic residents of the state are citizens. Consequently, citizenship only partly explains the differences in insurance coverage between Hispanic Texans and those of other races and ethnicities. Over 40 percent of uninsured Hispanic Texans are US citizens (1.2 million people; data not shown).

English proficiency and language spoken at home. Eighty-six percent of uninsured adults report speaking English very well or better. However, 53 percent of the uninsured report speaking Spanish as their primary language at home. Thus, most uninsured Hispanics are English proficient, but many prefer speaking Spanish at home. The uninsurance rate among those speaking Spanish at home is 34 percent, compared with 14 percent among those who primarily speak English at home.

HEALTH INSURANCE PROGRAM ELIGIBILITY AND COVERAGE OF FAMILY MEMBERS

Program eligibility. We estimate that 15 percent of the Texas uninsured are eligible for Medicaid or CHIP, and an additional 17 percent are eligible for premium tax credits for private Marketplace coverage. The remaining 68 percent of the uninsured (3.2 million people) are not currently eligible for any financial assistance for health insurance coverage. If Texas were to expand Medicaid eligibility, 1.2 million more uninsured people would become Medicaid eligible, making 57 percent of all uninsured Texans eligible for Medicaid, CHIP, or Marketplace premium tax credits.

Those currently eligible for Medicaid or CHIP have an uninsurance rate of 12 percent, which is low for Texas but still above the nationwide uninsurance rate of 11 percent. This low uninsurance rate among public coverage eligible Texans is because most of the eligible are children. Not only are the income eligibility thresholds higher for children, but their likelihood of enrolling in Medicaid or CHIP is high as well (Haley et al. 2018). Still, 691,000 people are uninsured and are eligible for free or low-cost coverage through Medicaid or CHIP, and additional investments in outreach and enrollment assistance could increase coverage significantly among this population.

Thirty-one percent of Texans eligible for Marketplace tax credits are uninsured. Nationwide, only 20 percent of those eligible for Marketplace tax credits are uninsured (data not shown). Therefore, this form of financial assistance for health coverage is underused in Texas relative to the rest of the country. Again, additional outreach and enrollment assistance could improve participation among this group.

Coverage of family members. Two-thirds of uninsured Texans are in families consisting entirely of uninsured people, 31 percent have at least one family member enrolled in Medicaid or CHIP, and 3 percent are in families with at least one member with private health coverage.

Local Variation

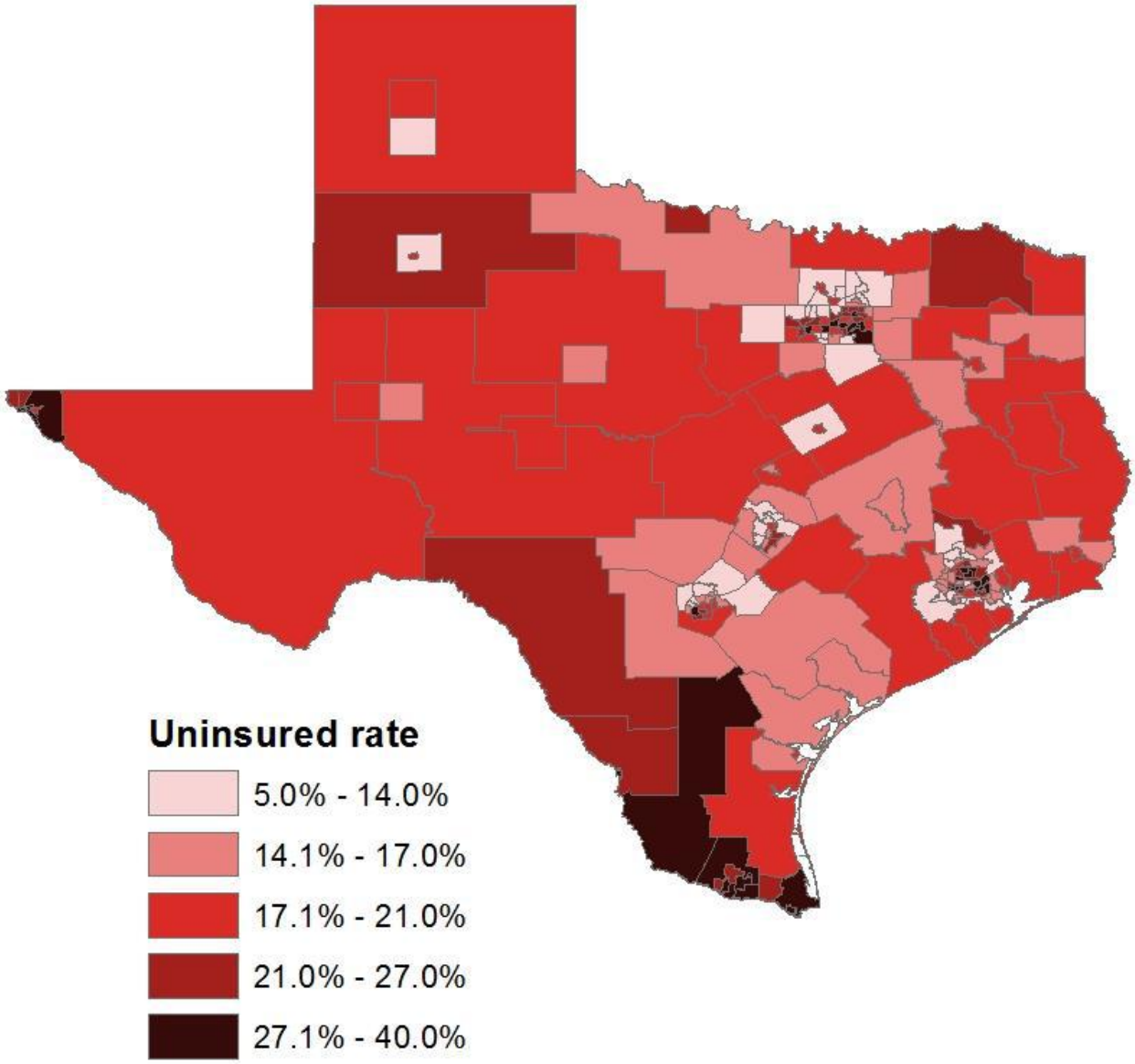
In figure 1, we map uninsurance rates for the 212 Texas PUMAs. The areas with the highest uninsurance rates (over 25 percent) are found in parts of major cities, El Paso, and the southern tip of Texas, ranging from Cameron and Hidalgo Counties up to McMullen and Live Oak Counties. Areas with the lowest uninsurance rates (less than 14 percent) are generally in suburban areas of major cities, along with areas around Waco and Amarillo. In Harris County (the Houston area), some PUMAs with uninsurance rates of 10 percent are adjacent to areas with uninsurance rates exceeding 30 percent.

In figure 2, we show local variation in the characteristics of the uninsured by assigning PUMAs to a small number of categories defined by cluster analysis. The uninsured populations in areas within each category are very similar to each other but noticeably different from those in the other categories. The cluster analysis defined the categories by local area income and racial and ethnic composition of the resident uninsured population. The race and ethnicity of the uninsured was the characteristic that most starkly distinguished localities.

Table 2 summarizes several basic characteristics of the locality groups defined by the cluster analysis. The two locality groups with the highest uninsurance rates are those in which the majority of the population's uninsured are Hispanic and have low or very low average income. These two locality groups account for more than 60 percent of the state's nonelderly uninsured population (2.8 million people) and 49 percent of the state's total nonelderly population. In these groups, roughly three-quarters of uninsured nonelderly adults have a high school education or less. The uninsured in the majority Hispanic, very low–income group are more likely to have family incomes below 138 percent of FPL, and the uninsured adults are somewhat more likely to have a high school education or less. The uninsured in this group are also the least likely to be in families of all US citizens.

FIGURE 1

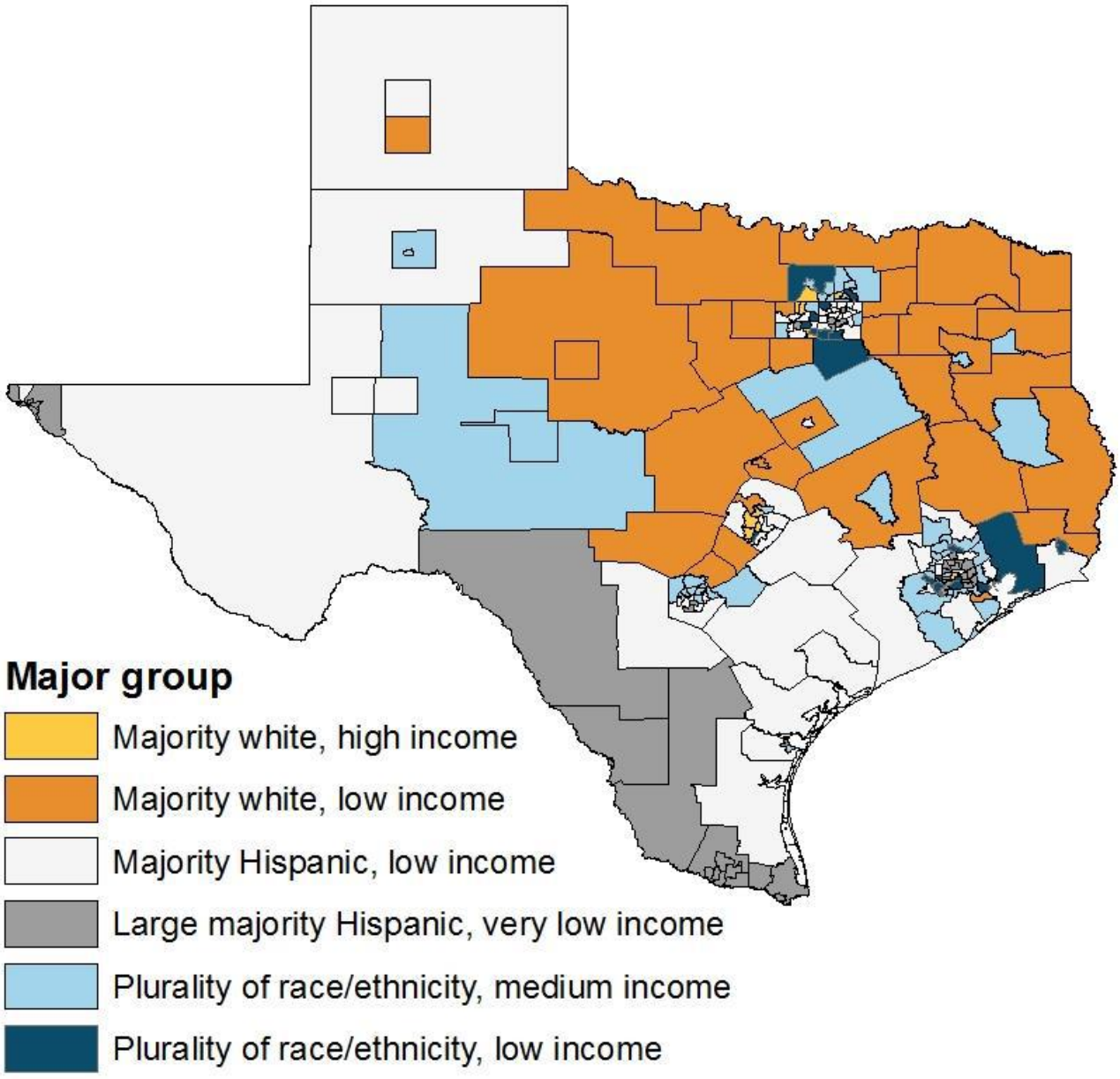
Local Area Uninsurance Rates of Nonelderly Texans, 2018



Source: Urban Institute, HIPSM 2018.

FIGURE 2

Local Area Variation in the Characteristics of Uninsured Texans, 2018



Source: Urban Institute, HIPSM 2018.

TABLE 2

Characteristics of Texas Locality Groups

Categorized by race or ethnicity and income of their uninsured populations

	Large majority–Hispanic, very low–income group	Majority-Hispanic, low-income group	Majority-white, low-income group	Plurality of a race or ethnicity, low-income group	Plurality of a race or ethnicity, medium-income group	Majority-white, higher-income group
Total nonelderly population (thousands)	5,211	6,698	3,795	2,132	5,419	1,105
Number of uninsured (thousands)	1,449	1,386	621	338	790	110
Uninsured rate	28%	21%	16%	16%	15%	10%
Percent of all uninsured in the state	31%	30%	13%	7%	17%	2%
Share of uninsured in group with family income below 138% FPL	67%	59%	58%	58%	54%	46%
Share of uninsured adults in group with high school education or less	76%	72%	68%	61%	60%	38%
Share of uninsured in group in families with all members US Citizens	42%	55%	82%	62%	66%	80%

Source: Source: Urban Institute analysis, HIPSM 2018.

Notes: FPL = the federal poverty level. Locality groups were defined by using cluster analysis on the 212 Public Use Microdata Areas in Texas. The six resulting clusters (or groups) are those in which the characteristics of the uninsured are much closer to each other than to the characteristics of the uninsured in other localities.

The uninsurance rates are similar (15 to 16 percent) in the locality groups where the uninsured are mostly white and low income and in the two groups whose uninsured populations are characterized by a plurality of a race or ethnicity. These three groups account for 37 percent of the state's uninsured (1.8 million people) but 47 percent of the state's total nonelderly population. The education level of the uninsured adults in groups with a racial or ethnic plurality is somewhat higher than in the majority white, low-income group, with about 60 percent having a high school education or less in the plurality groups compared with 68 percent in the white, low-income group.

The locality group where the uninsured population is majority white and higher income has the lowest uninsurance rate of the six groups: 10 percent of the area's nonelderly population are uninsured. This group of localities accounts for about 5 percent of the state's nonelderly population and only 2 percent of the state's uninsured. The uninsured in this group are the most highly educated: only 38 percent have a high school education or less, they are the least likely to have income below 138 percent of FPL (46 percent), and they are largely in families composed entirely of US citizens (80 percent). Below, we provide more detail on the characteristics of the uninsured in each of these six locality groups.

Majority-white localities. Although 60 percent of uninsured Texans are Hispanic, 15 percent of them live in local areas where most of the uninsured are white, non-Hispanic. Most frequently, uninsured Texans living in majority-white localities are part of families where all family members are US citizens (about 80 percent) and proficient in English (94 percent). Workforce participation among the uninsured in these areas is moderately lower than in non–majority white localities.

Differences in income distribution and geography separate majority white localities into two distinct clusters. The *majority-white, higher-income* cluster (table 3) consists entirely of suburban areas of Dallas-Fort Worth, Austin, and Houston, and these areas combined include about 2 percent of the state's uninsured residents. This cluster differs from the statewide average characteristics of the uninsured in almost every respect. On average, the uninsured in this cluster have substantially higher incomes (46 percent with incomes below 138 percent of FPL and 28 percent with incomes above 300 percent of FPL), they are more highly educated (most of these uninsured people have at least some college), and they are overwhelmingly (80 percent) in families where all members are US citizens. The local areas in this cluster also have the lowest uninsurance rate (10 percent) across all our six clusters.

The second group of majority white localities fall into the *majority-white, low-income* cluster (table 4). About 13 percent of the Texas uninsured live in the areas in this cluster, which covers most of central and northeastern Texas, along with Potter county and a PUMA near Houston. Nearly 60 percent of the uninsured in this cluster have incomes below 138 percent of FPL; only 15 percent have incomes above 300 percent of FPL. Across all localities in this cluster, 16 percent of residents are uninsured.

Majority-Hispanic localities. About 61 percent of the uninsured live in areas where Hispanics make up the majority of the uninsured. The uninsured in these areas are less likely to be US citizens, they are somewhat less likely to have a high level of English proficiency (although English proficiency is still very common), and a majority speak Spanish as their primary language at home. Lower educational attainment is more common among uninsured people in these local areas, and it is more common for them to be in two-adult families with children. These areas have the highest uninsurance rates in Texas, in part because of the larger prevalence of noncitizens in their populations.

TABLE 3

Characteristics of the Nonelderly Uninsured in Texas Localities in the Majority-White, Higher-Income Group, 2018

	Thousands of people	Share of state total uninsured	Uninsurance rate
Socioeconomic characteristics			
Family modified adjusted gross income as a percentage of FPL			
<138%	51	46%	22%
138%–200%	11	10%	16%
200%–300%	18	16%	18%
300%–400%	13	12%	10%
>400%	17	16%	3%
Age			
0–18	14	13%	5%
19–34	46	42%	17%
35–54	37	33%	10%
55–64	13	12%	9%
Sex			
Male	57	51%	10%
Female	54	49%	10%
Race and ethnicity			
White, non-Hispanic	61	55%	9%
Black, non-Hispanic	7	7%	12%
Hispanic	24	22%	15%
Asians/Pacific Islanders	15	14%	12%
American Indian/Alaska Native	1	1%	8%
Other, non-Hispanic	1	1%	5%
Education (age 19–64)			
Less than high school	8	9%	43%
High school	28	29%	21%
Some college	26	27%	13%
College graduate	34	35%	8%
Total	96	100%	12%
Health status			
Excellent	30	27%	9%
Very good	34	30%	10%
Good	35	32%	11%
Fair	9	8%	13%
Poor	3	2%	13%
Family type (age 19–64)			
Single without dependents	52	54%	19%
Single with dependents	12	12%	22%
Couple without dependents	14	14%	7%
Couple with dependents	19	19%	7%
Total	96	100%	12%
Family receiving other benefits			
SNAP	14	12%	22%
Not receiving SNAP	97	88%	9%
Employment			
Family work status			
No worker in family	41	37%	24%
Only part-time worker in family	13	12%	23%
At least one full-time worker in family	56	51%	6%
Family firm size			
No worker in family	41	37%	24%
Only small-firm workers in family	27	25%	19%
At least one large-firm worker in family	42	38%	5%

	Thousands of people	Share of state total uninsured	Uninsurance rate
Major Industry (employed age 19–64)			
Agriculture	-	-	-
Mining	1	1%	7%
Manufacturing	4	6%	6%
Construction	5	7%	20%
Transportation	2	2%	6%
Wholesale and retail	10	16%	13%
Finance, ins, real estate	4	7%	7%
Professional	10	15%	9%
Education	3	5%	5%
Health and social service	7	11%	11%
Arts/entertainment/recreation	12	18%	24%
Other services	5	8%	19%
Other industries	2	4%	5%
Total employed	*65*	*100%*	*10%*
Citizenship			
Citizenship status			
US Citizen	92	83%	9%
Noncitizen	19	17%	23%
Family citizenship status			
All US citizens	88	80%	9%
At least one noncitizen in the family	22	20%	17%
English proficiency (age 19–64)			
Speaks very well or better	90	94%	12%
Does not speak very well or less proficient	6	6%	45%
Total	96	100%	12%
Language spoken at home			
English	72	65%	9%
Spanish	19	18%	20%
Chinese	3	3%	12%
Korean	2	1%	31%
Vietnamese	3	2%	25%
Other	12	11%	7%
Health insurance eligibility and coverage			
Program eligibility			
Eligible for Medicaid/CHIP	12	10%	9%
Eligible for Marketplace PTCs	28	25%	30%
Not currently eligible	71	65%	8%
Would gain Medicaid eligibility if Texas expands Medicaid	28	26%	29%
Would be ineligible even with Medicaid expansion	43	39%	5%
Mixed coverage scenarios			
All family members uninsured	84	76%	100%
At least one family member is enrolled in private coverage, nongroup or employer	7	6%	1%
At least one family member enrolled in public insurance	20	18%	14%
At least one child enrolled in Medicaid, and at least one adult is eligible for Marketplace PTCs, but not enrolled	3	3%	
At least one child enrolled in Medicaid, and at least one adult is eligible for Medicaid, but not enrolled	4	3%	
Total	110	100%	10%

Source: Urban Institute analysis, HIPSM 2018.

Notes: CHIP = the Children's Health Insurance Program; PTCs = premium tax credits; SNAP = the Supplemental Nutrition Assistance Program. Cells with sample size smaller than 100 are not shown. Small firms are defined as employers with fewer than 50 employees. Data include residents age 64 and younger.

TABLE 4

Characteristics of the Nonelderly Uninsured in Texas Localities in the Majority-White, Low-Income Group, 2018

	Thousands of people	Share of state total uninsured	Uninsurance rate
Socioeconomic characteristics			
Family modified adjusted gross income as a percentage of FPL			
<138%	359	58%	25%
138%–200%	77	12%	20%
200%–300%	91	15%	17%
300%–400%	49	8%	11%
>400%	46	7%	5%
Age			
0–18	83	13%	7%
19–34	261	42%	29%
35–54	210	34%	19%
55–64	67	11%	11%
Sex			
Male	328	53%	17%
Female	293	47%	15%
Race and ethnicity			
White, non-Hispanic	351	57%	14%
Black, non-Hispanic	59	10%	17%
Hispanic	184	30%	23%
Asians/Pacific Islanders	13	2%	19%
American Indian/Alaska Native	9	1%	15%
Other, non-Hispanic	6	1%	11%
Education (age 19–64)			
Less than high school	115	21%	40%
High school	250	46%	24%
Some college	125	23%	17%
College graduate	48	9%	9%
Total	538	100%	21%
Health status			
Excellent	143	23%	14%
Very good	174	28%	16%
Good	207	33%	18%
Fair	72	12%	19%
Poor	26	4%	19%
Family type (age 19–64)			
Single without dependents	239	44%	29%
Single with dependents	81	15%	29%
Couple without dependents	91	17%	12%
Couple with dependents	128	24%	16%
Total	538	100%	21%
Family receiving other benefits			
SNAP	160	26%	24%
Not receiving SNAP	461	74%	11%
Employment			
Family work status			
No worker in family	242	39%	28%
Only part-time worker in family	68	11%	28%
At least one full-time worker in family	311	50%	12%
Family firm size			
No worker in family	242	39%	28%
Only small-firm workers in family	136	22%	27%
At least one large-firm worker in family	243	39%	10%

	Thousands of people	Share of state total uninsured	Uninsurance rate
Major Industry (employed age 19–64)			
Agriculture	11	3%	35%
Mining	7	2%	14%
Manufacturing	25	7%	14%
Construction	46	13%	32%
Transportation	11	3%	14%
Wholesale and retail	49	14%	19%
Finance, ins, real estate	9	3%	10%
Professional	27	8%	19%
Education	11	3%	6%
Health and social service	34	10%	15%
Arts/entertainment/recreation	51	15%	35%
Other services	26	8%	29%
Other industries	39	11%	20%
Total employed	*347*	*100%*	*19%*
Citizenship			
Citizenship status			
US Citizen	531	86%	15%
Noncitizen	90	14%	51%
Family citizenship status			
All US citizens	511	82%	15%
At least one noncitizen in the family	110	18%	32%
English proficiency (age 19–64)			
Speaks very well or better	505	94%	20%
Does not speak very well or less proficient	33	6%	51%
Total	538	100%	21%
Language spoken at home			
English	441	71%	15%
Spanish	148	24%	31%
Other	32	5%	8%
Health insurance eligibility and coverage			
Program eligibility			
Eligible for Medicaid/CHIP	114	18%	13%
Eligible for Marketplace PTCs	134	22%	29%
Not currently eligible	373	60%	15%
Would gain Medicaid eligibility if Texas expands Medicaid	187	30%	36%
Would be ineligible even with Medicaid expansion	186	30%	10%
Mixed coverage scenarios			
All family members uninsured	412	66%	100%
At least one family member is enrolled in private coverage, nongroup or employer	25	4%	1%
At least one family member enrolled in public insurance	183	30%	14%
At least one child enrolled in Medicaid, and at least one adult is eligible for Marketplace PTCs, but not enrolled	15	2%	
At least one child enrolled in Medicaid, and at least one adult is eligible for Medicaid, but not enrolled	55	9%	
Total	621	100%	16%

Source: Urban Institute analysis, HIPSM 2018.

Notes: CHIP = the Children's Health Insurance Program; PTCs = premium tax credits; SNAP = the Supplemental Nutrition Assistance Program. Cells with sample size smaller than 100 are not shown. Small firms are defined as employers with fewer than 50 employees. Data include residents age 64 and younger.

Majority-Hispanic localities are also split into two distinct clusters based on income. The characteristics of the uninsured in the *large majority-Hispanic, very low–income* cluster differ the most from the statewide average characteristics of the uninsured (table 5). About 31 percent of the state's uninsured people live in areas that fit into this cluster, and 28 percent of the population in these localities is uninsured. The cluster covers most of the southern border areas, El Paso, and areas of major cities, particularly Houston and Dallas-Fort Worth. Just over two-thirds of the uninsured in this cluster have incomes below 138 percent of FPL. Hispanic residents make up 84 percent of the uninsured in this cluster, and 58 percent of the uninsured are in families that include at least one member who is not a US citizen. Seventy-six percent of uninsured adults in this cluster have a high school education or less, and 39 percent lack a high school diploma. Sixty-seven percent of this uninsured population are members of working families, and 55 percent are part of families with at least one full-time working adult. About 36 percent of the uninsured in this group report receiving SNAP benefits.

The second cluster of majority-Hispanic areas, the *majority-Hispanic, low-income* cluster, has an income distribution similar to the majority-white, low-income cluster, with nearly 60 percent of the uninsured having incomes below 138 percent of FPL (table 6). About 30 percent of uninsured Texans live in areas that fall into this cluster, which is found in the far western tip of the state and in the southeast, as well as in parts of the Dallas-Fort Worth area. Twenty-one percent of people living in this group of local areas are uninsured, and 28 percent of the areas' Hispanic residents are uninsured. Hispanics make up 65 percent of the uninsured in this cluster, and 45 percent of the cluster's uninsured are members of families that include at least one non–US citizen. Seventy-two percent of these areas' uninsured adults have a high school education or less. However, 70 percent are members of working families, and 59 percent have at least one family member who is a full-time worker. These employment rates are the highest among the uninsured in any of the six clusters. Twenty-seven percent of the uninsured in the cluster report receiving SNAP benefits.

Localities with a plurality of a race or ethnicity. The remaining 24 percent of the Texas uninsured live in areas where no single racial or ethnic group makes up a majority of the uninsured. These areas have a similar uninsurance rate (15 to 16 percent), and their uninsured populations have consistent rates of workforce participation (67 percent in working families, 56 percent with at least one full-time worker), citizenship (more than 60 percent are in families in which all members are US citizens), and English proficiency (near 90 percent). The educational attainment among their uninsured populations is similar as well, with a higher share of college degree holders (14 to 15 percent) than any other clusters except the majority-white, high-income group.

As similar as these areas are in many respects, they can still be separated into two clusters based on race or ethnicity, income, and geography. The most distinct is the *plurality of race or ethnicity, low-income* cluster (table 7), which includes 7 percent of the state's uninsured and is found in parts of the greater Houston and Dallas-Fort Worth areas, along with a PUMA in Austin. The income distribution in these areas is like that in the majority-white and majority-Hispanic low-income clusters. Its uninsured population is also the most racially and ethnically diverse. Non-Hispanic blacks and Asians/Pacific Islanders are much more common among the uninsured in this cluster than in any other (21 percent and 10 percent, respectively). In this cluster, 39 percent of the uninsured are Hispanic and 27 percent are white, non-Hispanic.

TABLE 5

Characteristics of the Nonelderly Uninsured in Texas Localities in the Large Majority–Hispanic, Very Low–Income Group, 2018

	Thousands of people	Share of state total uninsured	Uninsurance rate
Socioeconomic characteristics			
Family modified adjusted gross income as a percentage of FPL			
<138%	977	67%	34%
138%–200%	186	13%	29%
200%–300%	178	12%	26%
300%–400%	62	4%	16%
>400%	47	3%	8%
Age			
0–18	191	13%	10%
19–34	611	42%	46%
35–54	515	36%	36%
55–64	132	9%	22%
Sex			
Male	746	51%	29%
Female	703	49%	27%
Race and ethnicity			
White, non-Hispanic	70	5%	16%
Black, non-Hispanic	116	8%	20%
Hispanic	1,219	84%	31%
Asians/Pacific Islanders	31	2%	21%
American Indian/Alaska Native	9	1%	23%
Other, non-Hispanic	4	0%	15%
Education (age 19–64)			
Less than high school	493	39%	53%
High school	467	37%	39%
Some college	223	18%	30%
College graduate	75	6%	15%
Total	1,258	100%	37%
Health status			
Excellent	339	23%	25%
Very good	392	27%	27%
Good	481	33%	29%
Fair	179	12%	32%
Poor	58	4%	28%
Family type (age 19–64)			
Single without dependents	476	38%	40%
Single with dependents	218	17%	43%
Couple without dependents	191	15%	28%
Couple with dependents	373	30%	38%
Total	1,258	100%	37%
Family receiving other benefits			
SNAP	521	36%	29%
Not receiving SNAP	928	64%	20%
Employment			
Family work status			
No worker in family	480	33%	37%
Only part-time worker in family	166	11%	38%
At least one full-time worker in family	803	55%	23%
Family firm size			
No worker in family	480	33%	37%
Only small-firm workers in family	373	26%	38%
At least one large-firm worker in family	596	41%	20%

	Thousands of people	Share of state total uninsured	Uninsurance rate
Major Industry (employed age 19–64)			
Agriculture	10	1%	60%
Mining	8	1%	20%
Manufacturing	56	7%	31%
Construction	144	18%	58%
Transportation	35	4%	30%
Wholesale and retail	118	15%	37%
Finance, ins, real estate	24	3%	23%
Professional	89	11%	40%
Education	23	3%	12%
Health and social service	84	11%	29%
Arts/entertainment/recreation	102	13%	48%
Other services	67	9%	52%
Other industries	29	4%	19%
Total employed	*790*	*100%*	*35%*
Citizenship			
Citizenship status			
US Citizen	788	54%	19%
Noncitizen	661	46%	62%
Family citizenship status			
All US citizens	611	42%	20%
At least one noncitizen in the family	838	58%	40%
English proficiency (age 19–64)			
Speaks very well or better	1,020	81%	35%
Does not speak very well or less proficient	238	19%	57%
Total	1,258	100%	37%
Language spoken at home			
English	262	18%	18%
Spanish	1,114	77%	36%
Other	73	5%	10%
Health insurance eligibility and coverage			
Program eligibility			
Eligible for Medicaid/CHIP	212	15%	12%
Eligible for Marketplace PTCs	180	12%	33%
Not currently eligible	1,057	73%	36%
Would gain Medicaid eligibility if Texas expands Medicaid	355	24%	46%
Would be ineligible even with Medicaid expansion	702	48%	32%
Mixed coverage scenarios			
All family members uninsured	884	61%	100%
At least one family member is enrolled in private coverage, nongroup or employer	29	2%	2%
At least one family member enrolled in public insurance	536	37%	21%
At least one child enrolled in Medicaid, and at least one adult is eligible for Marketplace PTCs, but not enrolled	31	2%	
At least one child enrolled in Medicaid, and at least one adult is eligible for Medicaid, but not enrolled	123	9%	
Total	1,449	100%	28%

Source: Urban Institute analysis, HIPSM 2018.

Notes: CHIP = the Children's Health Insurance Program; PTCs = premium tax credits; SNAP = the Supplemental Nutrition Assistance Program. Cells with sample size smaller than 100 are not shown. Small firms are defined as employers with fewer than 50 employees. Data include residents age 64 and younger.

TABLE 6

Characteristics of the Nonelderly Uninsured in Texas Localities in the Majority-Hispanic, Low-Income Group, 2018

	Thousands of people	Share of state total uninsured	Uninsurance rate
Socioeconomic characteristics			
Family modified adjusted gross income as a percentage of FPL			
<138%	812	59%	29%
138%–200%	203	15%	25%
200%–300%	208	15%	22%
300%–400%	86	6%	13%
>400%	77	6%	5%
Age			
0–18	199	14%	9%
19–34	590	43%	34%
35–54	474	34%	25%
55–64	122	9%	14%
Sex			
Male	728	53%	22%
Female	658	47%	20%
Race and ethnicity			
White, non-Hispanic	282	20%	13%
Black, non-Hispanic	115	8%	16%
Hispanic	906	65%	28%
Asians/Pacific Islanders	52	4%	19%
American Indian/Alaska Native	19	1%	18%
Other, non-Hispanic	11	1%	14%
Education (age 19–64)			
Less than high school	385	32%	48%
High school	478	40%	29%
Some college	223	19%	20%
College graduate	100	8%	10%
Total	1,186	100%	26%
Health status			
Excellent	330	24%	18%
Very good	399	29%	20%
Good	450	33%	22%
Fair	160	12%	25%
Poor	46	3%	20%
Family type (age 19–64)			
Single without dependents	510	43%	31%
Single with dependents	192	16%	34%
Couple without dependents	167	14%	16%
Couple with dependents	317	27%	25%
Total	1,186	100%	26%
Family receiving other benefits			
SNAP	370	27%	25%
Not receiving SNAP	1,016	73%	10%
Employment			
Family work status			
No worker in family	415	30%	31%
Only part-time worker in family	147	11%	31%
At least one full-time worker in family	823	59%	17%
Family firm size			
No worker in family	415	30%	31%
Only small-firm workers in family	374	27%	32%
At least one large-firm worker in family	596	43%	14%

	Thousands of people	Share of state total uninsured	Uninsurance rate
Major Industry (employed age 19–64)			
Agriculture	14	2%	37%
Mining	13	2%	13%
Manufacturing	59	7%	18%
Construction	143	18%	47%
Transportation	31	4%	22%
Wholesale and retail	115	14%	25%
Finance, ins, real estate	26	3%	13%
Professional	90	11%	25%
Education	24	3%	9%
Health and social service	66	8%	18%
Arts/entertainment/recreation	128	16%	41%
Other services	63	8%	35%
Other industries	29	4%	13%
Total employed	*801*	*100%*	*24%*
Citizenship			
Citizenship status			
US Citizen	873	63%	15%
Noncitizen	513	37%	57%
Family citizenship status			
All US citizens	758	55%	15%
At least one noncitizen in the family	627	45%	38%
English proficiency (age 19–64)			
Speaks very well or better	997	84%	24%
Does not speak very well or less proficient	189	16%	56%
Total	1,186	100%	26%
Language spoken at home			
English	506	36%	14%
Spanish	772	56%	35%
Other	107	8%	12%
Health insurance eligibility and coverage			
Program eligibility			
Eligible for Medicaid/CHIP	198	14%	12%
Eligible for Marketplace PTCs	231	17%	31%
Not currently eligible	957	69%	22%
Would gain Medicaid eligibility if Texas expands Medicaid	326	24%	38%
Would be ineligible even with Medicaid expansion	631	46%	19%
Mixed coverage scenarios			
All family members uninsured	918	66%	100%
At least one family member is enrolled in private coverage, nongroup or employer	45	3%	1%
At least one family member enrolled in public insurance	423	31%	17%
At least one child enrolled in Medicaid, and at least one adult is eligible for Marketplace PTCs, but not enrolled	33	2%	
At least one child enrolled in Medicaid, and at least one adult is eligible for Medicaid, but not enrolled	95	7%	
Total	1,386	100%	21%

Source: Urban Institute analysis, HIPSM 2018.

Notes: CHIP = the Children's Health Insurance Program; PTCs = premium tax credits; SNAP = the Supplemental Nutrition Assistance Program. Cells with sample size smaller than 100 are not shown. Small firms are defined as employers with fewer than 50 employees. Data include residents age 64 and younger.

TABLE 7

Characteristics of the Nonelderly Uninsured in the Texas Localities in the Plurality of a Race or Ethnicity, Low-Income Group, 2018

	Thousands of people	Share of state total uninsured	Uninsurance rate
Socioeconomic characteristics			
Family modified adjusted gross income as a percentage of FPL			
<138%	196	58%	27%
138%–200%	44	13%	21%
200%–300%	51	15%	18%
300%–400%	25	7%	11%
>400%	23	7%	3%
Age			
0–18	42	13%	7%
19–34	141	42%	27%
35–54	122	36%	18%
55–64	33	10%	11%
Sex			
Male	173	51%	17%
Female	165	49%	15%
Race and ethnicity			
White, non-Hispanic	90	27%	11%
Black, non-Hispanic	72	21%	14%
Hispanic	132	39%	25%
Asians/Pacific Islanders	34	10%	15%
American Indian/Alaska Native	5	2%	22%
Other, non-Hispanic	4	1%	11%
Education (age 19–64)			
Less than high school	68	23%	46%
High school	114	38%	25%
Some college	72	24%	18%
College graduate	42	14%	9%
Total	296	100%	20%
Health status			
Excellent	79	23%	13%
Very good	103	30%	16%
Good	108	32%	17%
Fair	38	11%	21%
Poor	12	4%	20%
Family type (age 19–64)			
Single without dependents	136	46%	26%
Single with dependents	42	14%	27%
Couple without dependents	44	15%	12%
Couple with dependents	73	25%	16%
Total	296	100%	20%
Family receiving other benefits			
SNAP	78	23%	23%
Not receiving SNAP	260	77%	8%
Employment			
Family work status			
No worker in family	113	33%	30%
Only part-time worker in family	38	11%	29%
At least one full-time worker in family	188	56%	12%
Family firm size			
No worker in family	113	33%	30%
Only small-firm workers in family	89	26%	27%
At least one large-firm worker in family	137	40%	10%

	Thousands of people	Share of state total uninsured	Uninsurance rate
Major Industry (employed age 19–64)			
Agriculture	1	0%	26%
Mining	1	0%	4%
Manufacturing	12	6%	11%
Construction	24	13%	36%
Transportation	9	5%	16%
Wholesale and retail	34	18%	21%
Finance, ins, real estate	8	4%	9%
Professional	23	12%	17%
Education	9	5%	8%
Health and social service	17	9%	13%
Arts/entertainment/recreation	33	17%	35%
Other services	15	8%	28%
Other industries	5	3%	7%
Total employed	*192*	*100%*	*17%*
Citizenship			
Citizenship status			
US Citizen	234	69%	12%
Noncitizen	105	31%	43%
Family citizenship status			
All US citizens	210	62%	12%
At least one noncitizen in the family	128	38%	31%
English proficiency (age 19–64)			
Speaks very well or better	260	88%	18%
Does not speak very well or less proficient	36	12%	51%
Total	296	100%	20%
Language spoken at home			
English	169	50%	13%
Spanish	118	35%	31%
Chinese	4	1%	12%
Vietnamese	9	3%	22%
Other	40	12%	11%
Health insurance eligibility and coverage			
Program eligibility			
Eligible for Medicaid/CHIP	49	14%	11%
Eligible for Marketplace PTCs	66	19%	30%
Not currently eligible	224	66%	15%
Would gain Medicaid eligibility if Texas expands Medicaid	87	26%	35%
Would be ineligible even with Medicaid expansion	137	40%	11%
Mixed coverage scenarios			
All family members uninsured	228	67%	100%
At least one family member is enrolled in private coverage, nongroup or employer	13	4%	1%
At least one family member enrolled in public insurance	97	29%	16%
At least one child enrolled in Medicaid, and at least one adult is eligible for Marketplace PTCs, but not enrolled	7	2%	
At least one child enrolled in Medicaid, and at least one adult is eligible for Medicaid, but not enrolled	25	7%	
Total	338	100%	16%

Source: Urban Institute analysis, HIPSM 2018.

Notes: CHIP = the Children's Health Insurance Program; PTCs = premium tax credits; SNAP = the Supplemental Nutrition Assistance Program. Cells with sample size smaller than 100 are not shown. Small firms are defined as employers with fewer than 50 employees. Data include residents age 64 and younger.

TABLE 8

Characteristics of the Nonelderly Uninsured in Texas Localities in the Plurality of a Race or Ethnicity, Medium-Income Group, 2018

	Thousands of people	Share of state total uninsured	Uninsurance rate
Socioeconomic characteristics			
Family modified adjusted gross income as a percentage of FPL			
<138%	428	54%	25%
138%–200%	97	12%	19%
200%–300%	140	18%	19%
300%–400%	67	9%	11%
>400%	58	7%	3%
Age			
0–18	110	14%	6%
19–34	342	43%	25%
35–54	267	34%	16%
55–64	71	9%	10%
Sex			
Male	405	51%	15%
Female	385	49%	14%
Race and ethnicity			
White, non-Hispanic	263	33%	10%
Black, non-Hispanic	84	11%	14%
Hispanic	377	48%	22%
Asians/Pacific Islanders	43	5%	13%
American Indian/Alaska Native	12	2%	17%
Other, non-Hispanic	11	1%	11%
Education (age 19–64)			
Less than high school	145	21%	44%
High school	261	38%	23%
Some college	174	26%	16%
College graduate	101	15%	8%
Total	680	100%	18%
Health status			
Excellent	189	24%	12%
Very good	232	29%	14%
Good	258	33%	16%
Fair	85	11%	20%
Poor	26	3%	17%
Family type (age 19–64)			
Single without dependents	321	47%	25%
Single with dependents	103	15%	27%
Couple without dependents	92	14%	10%
Couple with dependents	164	24%	14%
Total	680	100%	18%
Family receiving other benefits			
SNAP	154	19%	21%
Not receiving SNAP	636	81%	10%
Employment			
Family work status			
No worker in family	259	33%	28%
Only part-time worker in family	88	11%	26%
At least one full-time worker in family	442	56%	11%
Family firm size			
No worker in family	259	33%	28%
Only small-firm workers in family	191	24%	24%
At least one large-firm worker in family	340	43%	9%

	Thousands of people	Share of state total uninsured	Uninsurance rate
Major Industry (employed age 19–64)			
Agriculture	6	1%	38%
Mining	6	1%	8%
Manufacturing	30	6%	11%
Construction	48	10%	28%
Transportation	15	3%	14%
Wholesale and retail	73	16%	18%
Finance, ins, real estate	19	4%	9%
Professional	55	12%	17%
Education	20	4%	7%
Health and social service	47	10%	14%
Arts/entertainment/recreation	83	18%	33%
Other services	38	8%	28%
Other industries	21	5%	10%
Total employed	*462*	*100%*	*17%*
Citizenship			
Citizenship status			
US Citizen	577	73%	12%
Noncitizen	213	27%	44%
Family citizenship status			
All US citizens	525	66%	11%
At least one noncitizen in the family	265	34%	31%
English proficiency (age 19–64)			
Speaks very well or better	602	89%	17%
Does not speak very well or less proficient	78	11%	53%
Total	680	100%	18%
Language spoken at home			
English	404	51%	11%
Spanish	307	39%	29%
Other	79	10%	10%
Health insurance eligibility and coverage			
Program eligibility			
Eligible for Medicaid/CHIP	107	14%	10%
Eligible for Marketplace PTCs	171	22%	30%
Not currently eligible	512	65%	13%
Would gain Medicaid eligibility if Texas expands Medicaid	194	25%	31%
Would be ineligible even with Medicaid expansion	318	40%	10%
Mixed coverage scenarios			
All family members uninsured	550	70%	100%
At least one family member is enrolled in private coverage, nongroup or employer	33	4%	1%
At least one family member enrolled in public insurance	207	26%	15%
At least one child enrolled in Medicaid, and at least one adult is eligible for Marketplace PTCs, but not enrolled	21	3%	
At least one child enrolled in Medicaid, and at least one adult is eligible for Medicaid, but not enrolled	50	6%	
Total	790	100%	15%

Source: Urban Institute analysis, HIPSM 2018.

Notes: CHIP = the Children's Health Insurance Program; PTCs = premium tax credits; SNAP = the Supplemental Nutrition Assistance Program. Cells with sample size smaller than 100 are not shown. Small firms are defined as employers with fewer than 50 employees. Data include residents age 64 and younger.

The remaining local areas with a plurality of a race or ethnicity form the *plurality of race or ethnicity, medium-income* cluster (table 8). This cluster is larger and more widely geographically distributed than the plurality of race or ethnicity, low-income cluster. The local areas in this cluster include 17 percent of the state's uninsured population and is found in the Houston-Galveston, Dallas-Fort Worth, and San Antonio areas, along with other areas in central and eastern Texas. About 54 percent of the uninsured in this cluster have incomes below 138 percent of FPL. More than 80 percent of the uninsured in this cluster are white, non-Hispanic or Hispanic (33 and 48 percent, respectively).

Discussion

At 19 percent of the population below age 65, Texas has the highest uninsurance rate in the country. However, the rate of uninsurance and the characteristics of the Texas uninsured population varies tremendously across the state. Thirty-one percent of the uninsured in Texas live in a group of local areas that have uninsurance rates near 30 percent, and 2 percent of the uninsured live in a group of areas with uninsurance rates around 10 percent. To design successful policy strategies for increasing coverage, the characteristics of the state's uninsured and the variation across geographic areas of the state must be considered. We highlight some of our central findings here along with their implications of policy initiatives.

Medicaid and CHIP. The uninsurance rate for children in Texas is less than one-third the rate for nonelderly adults (8 percent versus 25 percent). This difference is primarily because of the broader eligibility for public programs for the state's children. Texan children in families with incomes up to 206 percent of FPL are eligible for Medicaid or CHIP. However, the state has thus far decided not to expand Medicaid eligibility for adults up to 138 percent of FPL. Consequently, only 15 percent of the state's uninsured population are currently eligible for public insurance. If the state were to expand Medicaid eligibility to adults with incomes up to 138 percent of FPL, 1.2 million uninsured people currently ineligible for assistance would gain Medicaid eligibility. This assumes that, consistent with current Texas policy, legal immigrant noncitizens would not be eligible. Uninsured people in the majority-white, low-income cluster would gain the most from Medicaid expansion; 30 percent of the uninsured in these areas would gain Medicaid eligibility, making about 70 percent of all uninsured in those localities eligible for Medicaid, CHIP, or Marketplace premium tax credits.

Citizenship. Statewide, nearly 60 percent of the uninsured are in families consisting entirely of US citizens. However, 31 percent of the uninsured live in a group of local areas where a majority of the uninsured are in families with at least one noncitizen. The recent proposal to modify the federal public charge rule could exacerbate the uninsurance rate among both citizens and noncitizens in mixed-citizenship families because of fears that enrolling in insurance coverage that provides financial assistance could negatively affect at least some family members' ability to obtain citizenship. This report focuses on those currently uninsured, so we did not estimate the impact this might have on those already enrolled.

Employment. Two-thirds of the uninsured are members of working families and most (55 percent) are in families that include at least one adult who is a full-time worker. Families in which the adults work only part time have nearly the same uninsurance rate as families with no one in the work force. Part-time work is not generally a path to independent health coverage. Similarly, families whose workers are only employed in small firms have nearly the same high uninsurance rate as families with no one in the work force. Consequently, outreach strategies that involve employers and are focused on assisting workers and their family members to enroll in public programs and Marketplace coverage could reach a large number of uninsured Texans. This approach would be particularly useful when directed at small firms and those employing large numbers of part-time workers.

SNAP receipt. Twenty-eight percent of the Texas uninsured report receiving SNAP benefits. This is likely an underestimate because SNAP benefit receipt is underreported in household surveys. Nine states have Medicaid waivers allowing them to automatically determine the Medicaid eligibility of SNAP recipients and enroll them in Medicaid if they are deemed eligible. If Texas were to expand Medicaid, virtually all of the 1.3 million people currently uninsured and receiving SNAP benefits would be eligible for Medicaid and could be enrolled automatically through such a waiver. Still, several of the states with such waivers have not yet expanded Medicaid; most of these use their waivers to enroll more children in Medicaid and CHIP. This is a strategy Texas could put in place even without expanding Medicaid eligibility.

Educational attainment. Seventy percent of the state's uninsured population has a high school education or less. This has important implications for designing effective outreach and enrollment efforts, particularly under expanded eligibility for public insurance. Language in outreach and enrollment materials must be targeted to an audience with limited education, and in-person enrollment assistance will likely need to be widely available in the localities where most of the uninsured reside in order to be effective.

Marketplace with premium tax credits. Seventeen percent of the Texas uninsured are currently eligible for premium tax credits if they enroll in ACA Marketplace coverage. The uninsurance rate among those eligible for the tax credits is 31 percent in the state, compared with 20 percent nationwide. With additional investments in Marketplace outreach and enrollment assistance, the uninsurance rate within this eligible group can be reduced.

Racial and ethnic diversity across geographic areas. There are substantial geographic differences in the racial and ethnic composition of the Texas uninsured and in the language spoken at home. Statewide, 60 percent of the uninsured are Hispanic. However, 15 percent of the uninsured live in a group of local areas where most of the uninsured residents are non-Hispanic white. Another 31 percent live in a group of local areas where more than 80 percent of the uninsured are Hispanic, and nearly a quarter of the uninsured live in a group of local areas where no racial or ethnic group forms a majority of the uninsured.

Racial and ethnic diversity among the uninsured leads to corresponding differences in language spoken at home, although a large majority of the uninsured in all localities report speaking English very well or better. Cultural and language differences have significant implications for the design of effective outreach and enrollment assistance in coverage expansion efforts. The widespread availability of

materials in Spanish and a large number of Spanish-speaking in-person assisters and call center personnel are likely to be critical, even with high English proficiency among many of the uninsured. In addition, recruitment of members of the communities' racial or ethnic groups for outreach work is likely to be instrumental in increasing enrollment for those eligible for particular insurance programs.

Texas is a state with significant challenges in reducing the number of uninsured because of its size, racial and ethnic diversity, and large number of noncitizen residents. The characteristics of its local areas vary considerably economically as well. However, with the highest percentage of uninsured residents in the country, there remains considerable room for improvement. In the near term, substantial strides in increasing coverage and improving affordable access to care can be made by expanding eligibility for Medicaid and additional investments in outreach and enrollment assistance for public insurance programs and Marketplace-based insurance coverage. Without policy changes, however, the number and share of uninsured Texans will likely increase with time as rising health care costs continue to increase, making coverage less affordable for low- and middle-income residents, in turn putting more financial pressure on state government and health care providers.

Notes

[1] Three analyses estimated detailed changes in insurance coverage in Texas between 2013 and 2016 using an expanded representative of Texas residents in the Urban Institute's Health Reform Monitoring Survey (Marks, Ho, and Sim 2016a, 2016b, 2016c).

[2] "Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level," Kaiser Family Foundation, accessed December 4, 2018, https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/.

[3] Bradley Sawyer and Nolan Sroczynski, "How Do Health Expenditures Vary across the Population?" Kaiser Family Foundation, December 1, 2017.

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Matthew Buettgens is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

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The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families

December 7, 2018 | **Sara R. Collins** and **David C. Radley**

Recent national surveys show health care costs are a top concern in U.S. households.[1] While the Affordable Care Act's marketplaces receive a lot of media and political attention, the truth is that far more Americans get their coverage through employers. In 2017, more than half (56%) of people under age 65 — about 152 million people — had insurance through an employer, either their own or a family member's.[2] In contrast, only 9 percent had a plan purchased on the individual market, including the marketplaces.

In this brief, we use the latest data from the federal Medical Expenditure Panel Survey–Insurance Component (MEPS–IC) to examine trends in employer premiums at the state level to see how much workers and their families are paying for their employer coverage in terms of premium contributions and deductibles. We examine the size of these costs relative to income for those at the midrange of income distribution. The MEPS–IC is the most comprehensive national survey of U.S. employer health plans. It surveyed more than 40,000 business establishments in 2017, with an overall response rate of 65.8 percent.

Highlights

- After climbing modestly between 2011 and 2016, average premiums for employer health plans rose sharply in 2017. Annual single-person premiums climbed above $7,000 in eight states; family premiums were $20,000 or higher in seven states and D.C.
- Rising overall employer premiums increased the amount that workers and their families contribute. Average annual premium contributions for single-person plans ranged from $675 in Hawaii to $1,747 in Massachusetts; family plans ranged from $3,646 in Michigan to $6,533 in Delaware.
- Average employee premium contributions across single and family plans amounted to 6.9 percent of U.S. median income in 2017, up from 5.1 percent in 2008. In 11 states, premium contributions were 8 percent of median income or more, with a high of 10.2 percent in Louisiana.
- The average annual deductible for single-person policies rose to $1,808 in 2017, ranging from a low of $863 in Hawaii to a high of about $2,300 in Maine and New Hampshire. Average deductibles across single and family plans amounted to 4.8 percent of median income in 2017, up from 2.7 percent in 2008. In three states (Florida, Mississippi, and Tennessee), average deductibles comprised more than 6 percent of median income.
- Combined, average employee premium contributions and potential out-of-pocket spending to meet deductibles across single and family policies rose to $7,240 in 2017 and was $8,000 or more in eight states. Nationally, this potential spending amounted to 11.7 percent of median income in 2017, up from 7.8 percent a decade earlier. In Louisiana and Mississippi, these combined costs rose to 15 percent or more of median income.

Premiums for employer health plans rose sharply in 201

Average growth from previous year

Single-person plans Family plans

Download data

Data: Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2008–2017.

Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonw

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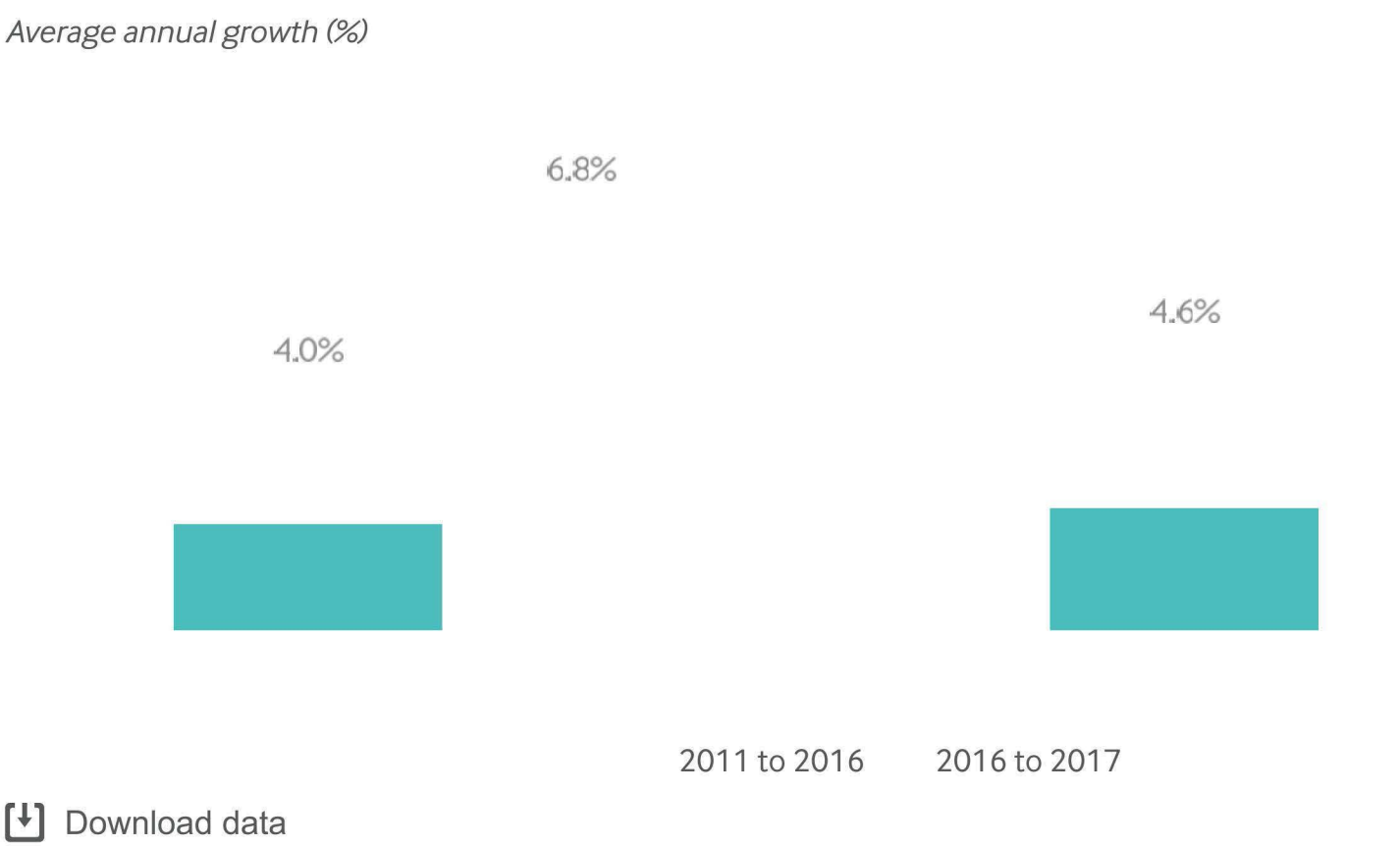
After modest annual growth for the five years between 2011 and 2016, premiums for employer health plans ticked up sharply in 2017, by 4.4 percent for single plans and 5.5 percent for family plans. Average single-person premiums increased in 45 states and D.C. and climbed above $7,000 in eight states (Alaska, Connecticut, Delaware, Massachusetts, New Jersey, New York, Rhode Island, Wyoming) (Table 1a). Family premiums increased in 44 states and D.C. and were $20,000 or higher in seven states (Alaska, Connecticut, Massachusetts, New Jersey, New York, West Virginia, Wyoming) and D.C. (Table 1b).

Employer premiums have risen, so have employee cont



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Data: Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2011, 2016, 2017.

Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonw

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People with job-based insurance pay about one-quarter of their overall premium cost, on average. This has changed little in recent years (Table 2). But in some states employees and their families pay a larger share. In 14 states, people with family plans paid for 30 percent or more of the cost of their insurance; in Delaware, Louisiana and Virginia, they paid 34 percent.

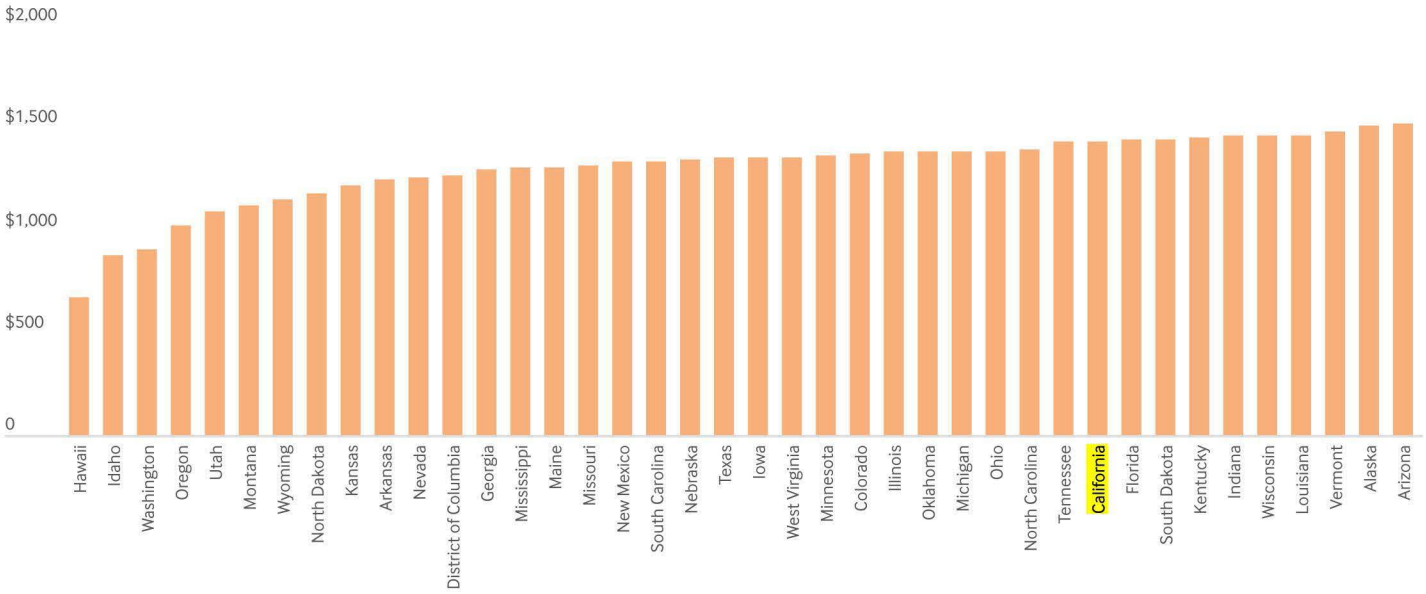
Even though the share of premiums paid by employees has remained stable, their payments are increasing. In 2017, because the rate of growth in employer premiums jumped overall, the amount employees paid climbed too. Between 2016 and 2017,

average employee premium contributions nationally rose by 6.8 percent to $1,415 for single-person plans and by 5.3 percent to $5,218 for family plans (Tables 3a and 3b).

Employee premium contributions vary widely by state.

Single coverage

U.S. average = $1,415



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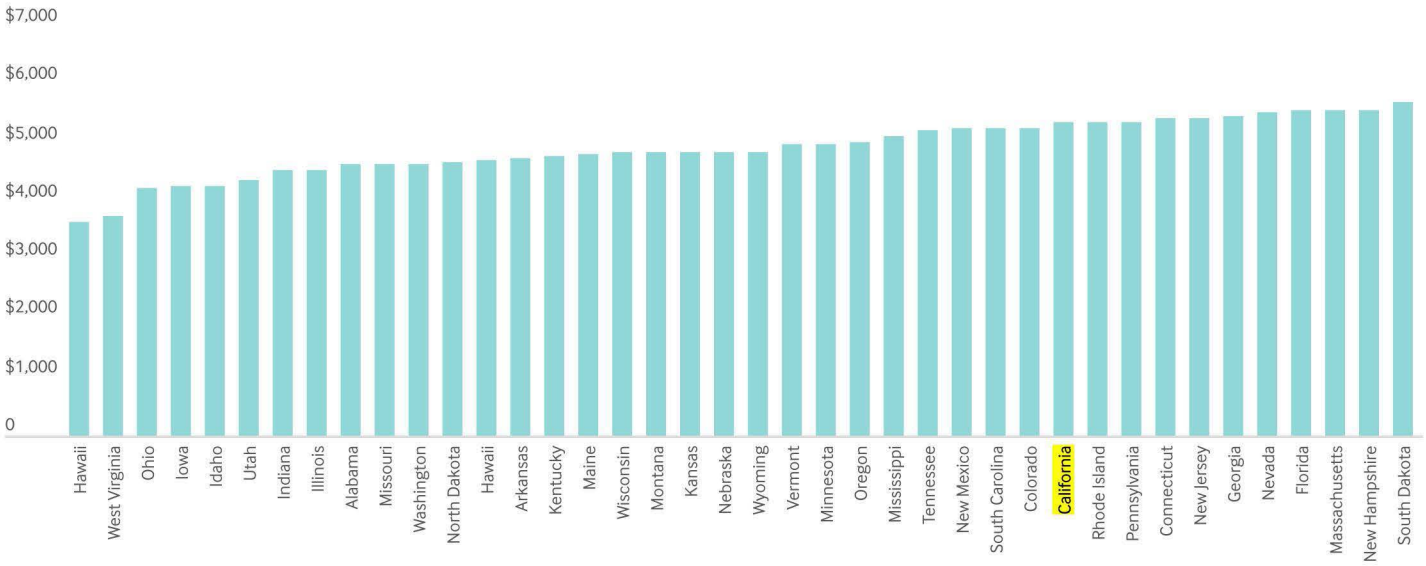
Family coverage

U.S. average = $5,218



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Data: Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2017.

Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonw

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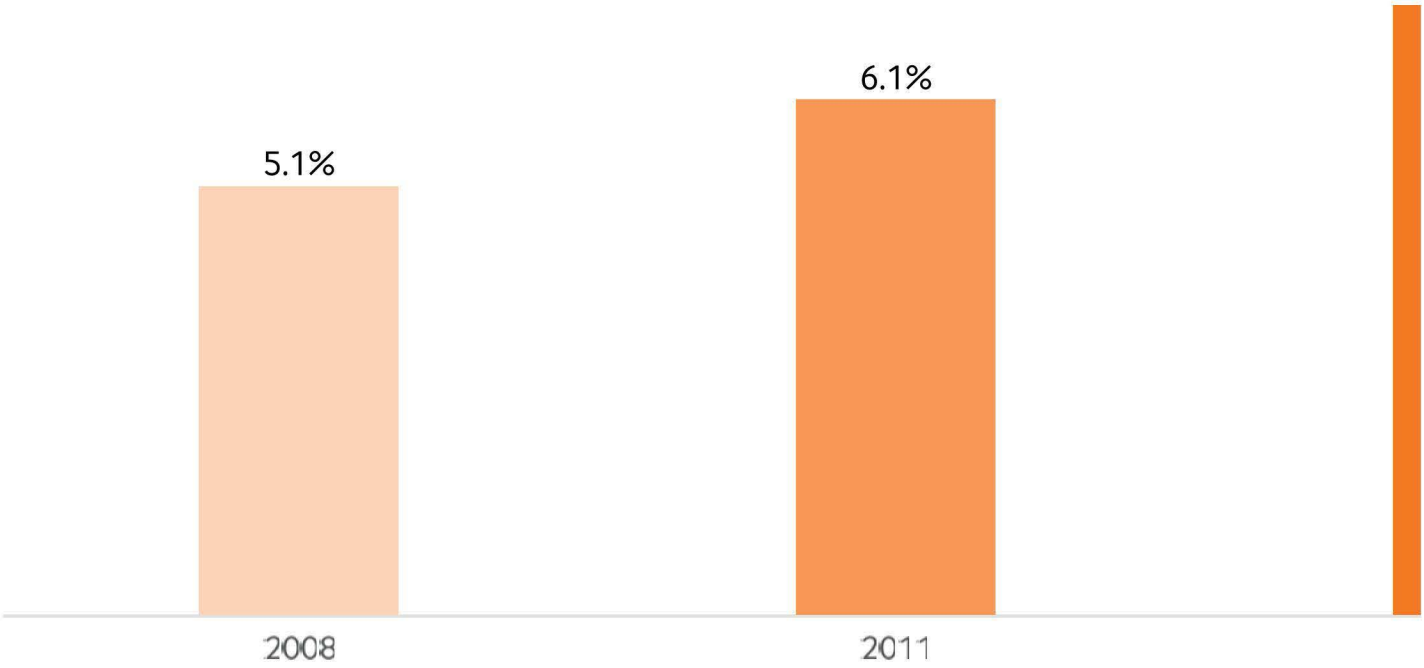
Contributions to single plans increased in 32 states and ranged from a low of $675 in Hawaii to a high of $1,747 in Massachusetts. Contributions to family plans rose in 36 states with the lowest in Michigan ($3,646) and the highest in Delaware ($6,533) (Tables 3a and 3b).

Worker payments for employer coverage are growing fa median income.

Employee premium contribution as share of median income



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Average employee premium contribution as percent of median state income in 2017

Click on a state to view more information

Note: Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), w in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimate the revised income questions. Household incomes have been adjusted for the likelihood that people in the same residence purchase h Data: Employee premium contribution: Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2008, 2011, 2017; Mediar Population Survey, 2008–09, 2011–12, 2017–18.

Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonw

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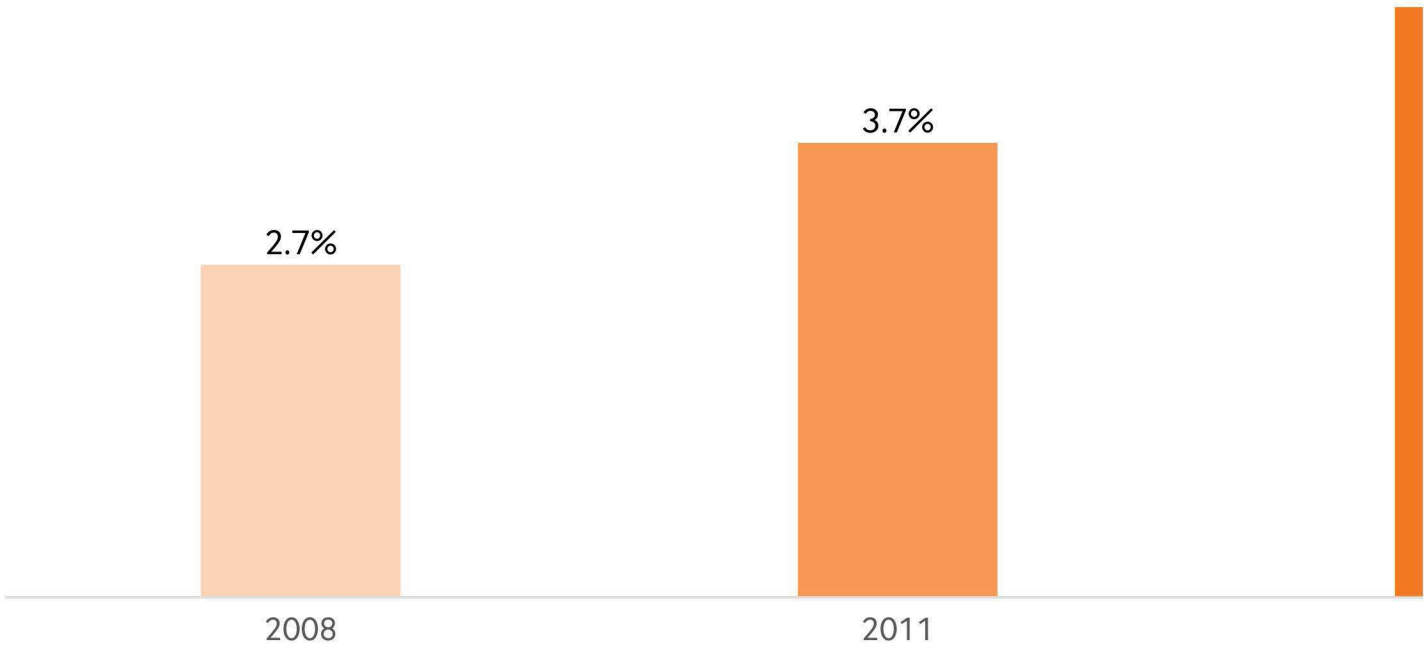
To see what these costs mean for people with incomes in the middle range of the U.S. income distribution (about $62,000 a year), we looked at the ratio of employee premium contributions to median income in the 50 states and D.C. The average employee premium cost across single and family plans amounted to 6.9 percent of median income in 2017, up from 5.1 percent in 2008 (Table 6). In 11 states (Arizona, Delaware, Florida, Georgia, Louisiana, Mississippi, Nevada, New Mexico, North Carolina, Oklahoma, Texas), premium contributions were 8 percent of median income or more, with a high of 10.2 percent in Louisiana.

Average deductibles are also outpacing growth in medi

Deductible as share of median income



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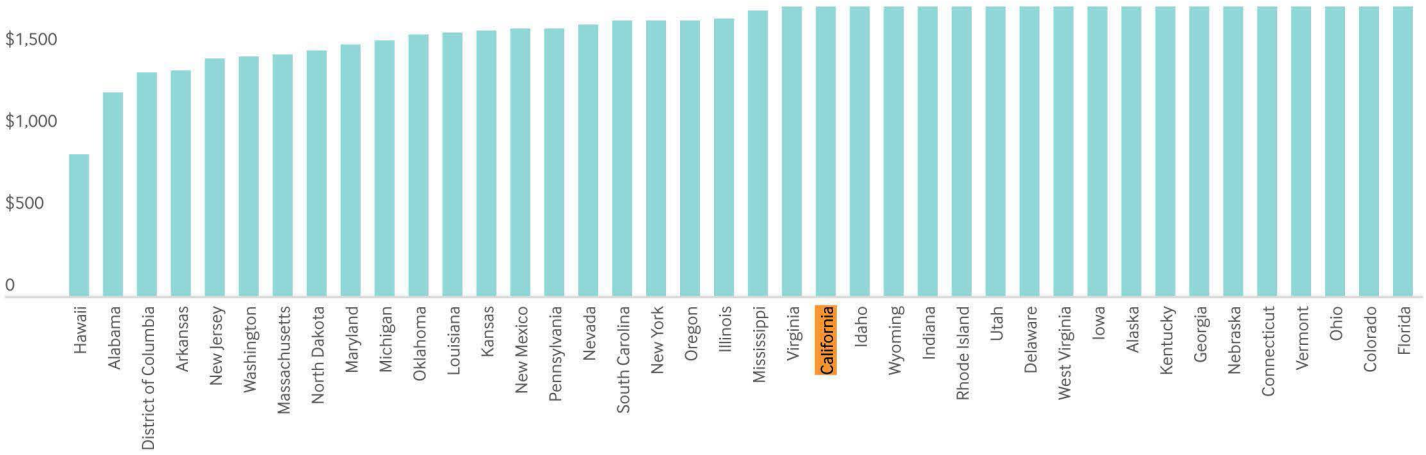
Average single-person deductibles for employer coverage, by state, 2017
U.S. average = $1,808

$2,500

$2,000



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Note: Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), w in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimate the revised income questions. Household incomes have been adjusted for the likelihood that people in the same residence purchase h Data: Deductible: Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2008, 2011, 2017; Median household income: C 09, 2011–12, 2017–18.

Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonw

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In many states, even though costs are rising, people are not getting insurance that protects them more because deductibles are also increasing. Deductibles are the amount of health care services people must pay for out-of-pocket before their insurance coverage kicks in. In 2017, the average deductible for single-person policies rose by 6.6 percent to $1,808 (Table 4). Average deductibles increased in 35 states and the District of Columbia, ranging from a low of $863 in Hawaii to a high of about $2,300 in Maine and New Hampshire.

Not everyone has enough medical expenses in a given year to meet deductibles. In fact, some services, like flu shots and other preventive care, are covered by plans before members meet their deductible. These are known as deductible exclusions. Among families that do spend enough to meet their deductibles, those at the midrange of the income distribution would spend 4.8 percent of their income on average before their coverage kicked in. In 2008, families at this income range spent 2.7 percent of income (Table 6).

Premium and deductible costs amounted to nearly 12 p median income in 2017.

Combined employee premium contribution and deductible as share of median income

Download data

Average employee premium contribution plus average deductible as percent of median state in

Click on a state to view more information

Note: Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), w in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimate the revised income questions. Household incomes have been adjusted for the likelihood that people in the same residence purchase h Data: Employee premium contribution and deductible: Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2008, 201 income: Current Population Survey, 2008–09, 2011–12, 2017–18.

Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonw

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Added together, the total cost of premiums and potential spending on deductibles averaged across single and family policies climbed to $7,240 in 2017 (Table 5). This combined cost ranged from a low of $4,664 in Hawaii to a high of more than $8,000 in eight states (Alaska, Arizona, Delaware, New Hampshire, North Carolina, South Dakota, Texas, Virginia).

For people with midrange incomes, total spending on premiums and potential out-of-pocket costs amounted to 11.7 percent of their income in 2017 (Table 6). This is up from 7.8 percent a decade earlier. In Louisiana and Mississippi, these combined costs rose to 15 percent or more of median income.

Conclusions and Policy Implications

Families' costs for employer health insurance are rising faster than median income. Moreover, even as costs climb, many families aren't receiving higher-quality insurance. The amount they have to spend out of pocket before their insurance coverage kicks in also continues to climb. While this study only considered families with middle incomes, lower-income families with employer coverage will use an even larger share of their income for health insurance costs.

People across the United States are not experiencing health care costs equally. There is variation across states in the size of employer premiums, the amount of employee contributions, deductibles, and median incomes.

In this study, families who could potentially spend the greatest amount of their incomes on insurance costs and deductibles are concentrated in the South. In Mississippi, for example, people on average spend 15 percent of their incomes on premiums and meeting deductibles. The overall premium for a family policy is below the national average, but families are asked to contribute 30 percent of the cost, which is higher than the national average. Further, Mississippi has one of the lowest median incomes in the country ($42,500) (Table 7). In contrast, people in New Hampshire pay more per year for their insurance and deductibles, but median income is among the highest in the country ($75,000).

Higher costs for insurance and health care have implications. People with low and moderate incomes may simply decide to go without insurance if it competes with other critical living expenses like housing, food, and education. In 2017, average per-person expenditures on food in the U.S. amounted to 13 percent of median income

and housing costs were 32 percent.[3] People with coverage but deductibles that are high relative to income are nearly as likely as those uninsured to skip needed health care, like filling prescriptions or going to the doctor when they are sick.[4]

The Affordable Care Act provides some protection to people with employer coverage. People with employer premium expenses that exceed 9.5 percent of their income are eligible for marketplace subsidies, which trigger a federal tax penalty for their employers. There's a catch: this provision only applies to single-person policies, leaving many middle-income families caught in the so-called "family coverage glitch." The data in this report show that the average employee contribution to a family plan exceeds 9.5 percent of state median income in 22 states and the District of Columbia (data not shown).

Policymakers have several options to reduce health insurance cost burdens for middle-income families and narrow the wide regional differences identified in this study. First, Congress could lower many families' premiums by repairing the family coverage glitch by pegging unaffordable coverage in employer plans to family policies instead of single policies.[5] Second, Congress could improve the cost protection of plans. Currently, under the ACA, people in employer plans may become eligible for marketplace tax credits if the actuarial value of their plan is less than 60 percent (i.e., covers less than 60 percent of their costs on average). Congress could increase this to 70 percent (the level of silver plans sold in the individual market) or higher. Third, Congress could require employers to increase the number of services that are covered before someone meets their deductible. Most employer plans currently exclude at least some services from their deductibles.[6] Congress could set a minimum set of exclusions for employer plans that might resemble the simple choice options that the Obama administration created for ACA marketplace plans.[7] Fourth, refundable tax credits could be made available to help insured Americans pay for qualifying out-of-pocket costs that exceed a certain percentage of their income.

Health care cost growth is the primary driver of premium growth across all health insurance markets. This means that income-related cost protections like these will need to be paired with systemwide efforts to slow medical spending. These efforts could include: innovation in care organization and provider payment to achieve greater value and better health outcomes, addressing the increasing concentration of insurer and provider markets through antitrust policy,[8] and slowing the growth rate of

prescription drug costs.[9] Policymakers will need to recognize that the increasing economic strain of health care costs facing middle-income and poor Americans is driven by multiple interrelated factors and will require a comprehensive solution.

HOW WE CONDUCTED THIS STUDY

This issue brief analyzes state-by-state trends in private-sector health insurance premiums and deductibles for the under-65 population from 2008 to 2017.

The data on total insurance costs, employee premium contributions, and deductibles come from the federal government's annual survey of employers, conducted for the insurance component of the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS–IC). The MEPS–IC is administered to workplace establishments. Establishments represent a work location, not necessarily a firm, which can employ people in many locations. Workplace establishments are selected each year from the U.S. Census Bureau's Business Register — a confidential list of establishments in the United States. Once selected, establishments are contacted via mail and telephone to establish a point-of-contact at the establishment who is knowledgeable about the health insurance benefits offered to employees. Survey respondents (generally workplace administrators) are asked about each of the health plans, up to four plans, offered to employees that work at the establishment location. If the establishment offers more than four plans, details are collected about the four plans with the largest enrollment. In 2017, MEPS–IC surveyed 40,044 establishments and had a response rate of 65.8 percent. The number of surveyed establishments and response rates were similar to prior years.

Total premium and other insurances costs are compared with median household incomes for the under-65 population in each state. Income data come from the U.S. Census Bureau's Current Population Survey (CPS) of households, and are adjusted slightly to account for the likelihood that individuals residing in the same household are likely to purchase health insurance together (referred to as a health insurance unit). Note that the CPS revised its income questions in 2013, affecting the denominator in our ratio estimates: prior to 2014, this is derived from the traditional CPS income questions, while ratio estimates from 2014 are derived from the revised income questions. Two years of CPS date ending in the stated year are combined to generate reliable state-level income estimates (e.g., 2017 median income estimates are combined 2017 and 2018 CPS data).

The premiums presented represent the average total annual cost of private group health insurance premiums for employer-sponsored coverage, including both the employer and employee shares. We also examine trends in the share of premiums that employees pay and average deductibles. We compared average out-of-pocket costs for premiums and average deductibles to median income in states to illustrate the potential cost burden of each and the total if the worker/family incurred these average costs. The Agency for Healthcare Research and Quality reports MEPS–IC premium, employee contribution, and deductible data separately for single (employee only) and family plans; we include these data in Tables 1 through 4. However, average employee out-of-pocket costs (Tables 5 and 6) are combined estimates, weighted for the distribution of single-person and family households in the state. For example, the average total employee premium contribution reported in Table 5 is equal to (MEPS–IC single-plan contribution for state i * share of single person households in state i) + (MEPS–IC family plan contribution for state i * share of multiple person households in state i). The same approach is used to calculate average total deductibles. Average combined employee premium contribution and deductible — also referred to as total potential out-of-pocket spending — is the sum of the household distribution weighted premium contribution and deductible estimates.

The tables provide state-specific data. This analysis updates previous Commonwealth Fund analyses of state health insurance premium and deductible trends.

NOTES

1. Eric C. Schneider et al., *Health Care in America: The Experience of People with Serious Illness* (Commonwealth Fund, Oct. 2018).

2. Authors' analysis of U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates, accessed via **American Fact Finder**, Table #B27010.

3.. Bureau of Labor Statistics, "**Consumer Expenditures — 2017**," news release (U.S. Department of Labor, Sept. 11, 2018).

4. Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty, *How Well Does Insurance Coverage Protect Consumers from Health Care Costs?: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016* (Commonwealth Fund, Oct. 2017).

5. Christine Eibner, Sarah Nowak, and Jodi Liu, *Hillary Clinton's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit* (Commonwealth Fund, Sept. 2016).

6. Jon R. Gabel et al., *Consumer Cost-Sharing in Marketplace vs. Employer Health Insurance Plans, 2015* (Commonwealth Fund, Dec. 2015).

7. The Trump administration ended simple choice plans in 2018. See Sara R. Collins, "**The Trump Administration's New Marketplace Rules: Regulatory Simplification or More Complexity for Consumers?**" *To the Point* (blog), Commonwealth Fund, Apr. 13, 2018.

8. Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, "**Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices**," *Health Affairs* 37, no. 9 (Sept. 2018): 1409–16.

9. Henry Waxman et al., *Getting to the Root of High Prescription Drug Prices* (Commonwealth Fund, July 2017).

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Proposed Public Charge Rule Could Jeopardize Recent Coverage Gains among Citizen Children

Genevieve M. Kenney, Jennifer M. Haley, Robin Wang

December 2018

On October 10, 2018, the administration proposed a rule that would change regulations governing "public charge" determinations for applicants seeking lawful permanent residence (a "green card") or a temporary visa.[1] Though the new rule explicitly indicates that benefit use by citizen children would not be counted in parents' public charge determinations and that certain groups will not be affected, experience suggests such policy changes can have broad "chilling effects" that lead to immigrant families opting out of public benefits and avoiding interactions with government authorities. Among a range of such concerns, the rule is expected to discourage immigrant families from seeking out public health insurance coverage through Medicaid or the Children's Health Insurance Program (CHIP) for their children (Artiga, Garfield, and Damico 2018; Batalova, Fix, and Greenberg 2018; Fix and Passel 1999; Kaiser Family Foundation 2018; Zallman et al. 2018).[2]

Our analysis finds that in 2016, 6.8 million citizen children living with one or more noncitizen parents had Medicaid/CHIP coverage. Overall, one in five Medicaid/CHIP-enrolled children were citizens living with noncitizen parents, indicating that disenrollment from Medicaid/CHIP among even a small share of this group would have large effects nationally. Using data from the American Community Survey (ACS), this brief examines trends in uninsurance and Medicaid/CHIP participation among citizen children with and without noncitizen parents between 2008 and 2016.[3] Over that period, federal and state-level policies to increase health insurance coverage rates among the general population also

included outreach, eligibility, and enrollment efforts targeted at immigrant families. We find the following:

- **Between 2008 and 2016, the uninsurance rate fell by 10.0 percentage points among citizen children with any noncitizen parents and by 3.5 percentage points among those with only citizen parents**. Nationally, the uninsurance rate was more than halved for both groups, and the uninsurance gap between citizen children with and without noncitizen parents narrowed from 9.0 percentage points to 2.6 percentage points.
- **Between 2008 and 2016, Medicaid/CHIP participation increased by 15.5 percentage points to 93.3 percent for citizen children with noncitizen parents and by 10.5 percentage points to 94.0 percent for those with citizen parents.**[4] The gap in participation between these two groups nearly closed over this period. Further, participation rates rose in each region, and like trends in uninsurance, changes in Medicaid/CHIP participation reduced regional differences between children with and without noncitizen parents.
- **In 2016, an estimated 10.3 million citizen children lived with one or more noncitizen parents, constituting 13.2 percent of all US children.** Younger, Hispanic, and Asian/Pacific Islander children were more likely than other children to live with noncitizen parents; more than one in six infants and toddlers, more than a quarter of Asian/Pacific Islander children, and more than a third of Hispanic children were citizens living with noncitizen parents.
- **At least one in six children was a citizen with noncitizen parents in California (27.6 percent), Nevada (24.0 percent), Texas (21.3 percent), Arizona (17.3 percent), New Jersey (17.0 percent), and New York (16.6 percent).** In 2016, nearly half of all citizen children with noncitizen parents (48.7 percent) lived in just three of these states—2.6 million in California, 1.6 million in Texas, and 733,000 in New York.
- **Nationally, 6.8 million citizen children with noncitizen parents were enrolled in Medicaid/CHIP in 2016, a fifth of all Medicaid/CHIP-enrolled children.** The share of Medicaid/CHIP-covered children who were citizens with noncitizen parents was higher than 20 percent in nine states—California (40.2 percent), Nevada (35.5 percent), Texas (31.5 percent), New Jersey (27.2 percent), Arizona (26.9 percent), New York (23.8 percent), Colorado (23.2 percent), Illinois (22.6 percent), and Washington (21.8 percent).

The proposed public charge rule puts the recent coverage progress for citizen children at risk. If the regulation's chilling effects reduce Medicaid/CHIP coverage in immigrant families, the impact could be large, given that one in five Medicaid/CHIP-enrolled children is a citizen child with noncitizen parents. Further, infants and toddlers; Hispanic and Asian/Pacific Islander children; and children living in states such as Arizona, California, Colorado, Illinois, Nevada, New Jersey, New York, Texas, and Washington, where a higher share of children enrolled in Medicaid/CHIP are citizens with noncitizen parents than the national average, would be disproportionally affected. Moreover, the proposed rule will likely reduce Medicaid coverage among lawfully present noncitizen parents.[5] We find that 2.2 million Medicaid/CHIP-enrolled citizen children had a noncitizen parent with Medicaid coverage in 2016. The

anticipated declines in Medicaid/CHIP enrollment among citizen children and their parents under the proposed rule would likely increase uninsurance and reduce access to health care for both children and parents; increase financial strains and stresses on families; and adversely affect children's long-term educational attainment, future earnings, and health and well-being—not only limiting their own potential but their ability to contribute to society later in life (Blau and Mackie 2017; Cohodes et al. 2014; Goodman-Bacon 2016; Howell and Kenney 2012; Miller and Wherry 2016; Paradise and Garfield 2013; Shonkoff, Boyce, and McEwen 2009; Sommers, Gawande, and Baicker 2017; Wherry, Kenney, and Sommers 2016).

Introduction

On October 10, 2018, the administration published a proposed rule in the Federal Register that would change immigration regulations governing public charge for applicants seeking lawful permanent residence (a "green card") or a temporary visa.[6] Under the proposed rule, assessments of applicants' potential for becoming public charges would expand to include new programs, benefits, and factors including nonemergency Medicaid, the Supplemental Nutrition Assistance Program, housing assistance, income, work status, education, English proficiency, age, household size, and health status. The proposed rule suggests some groups applying for a green card, such as refugees and asylees, would be exempt, and that children's Medicaid or CHIP coverage would not affect their parents' public charge determination, but it is unclear how children's receipt of benefits might affect their future green card applications in adulthood. Experience indicates that immigration policy changes reach beyond just the immigrants whose statuses are directly implicated, leading to a broader chilling effect that reduces public benefit take-up by others in immigrant families, including citizen children (Fix and Passel 1999). Thus, children may still be adversely affected, because their parents lose public benefits or confusion and concern about a noncitizen parent or child's future prospects for legal permanent residence leads families to disenroll or not seek public benefits (Artiga, Garfield, and Damico 2018; Batalova, Fix, and Greenberg 2018; Kaiser Family Foundation 2018; Zallman et al. 2018).[7] Because parents' coverage affects the entire family, reduced take-up or disenrollment from public coverage for parents or their children would put children's coverage and access to care and the family's financial stability and well-being at risk.[8]

This brief assesses citizen children living with noncitizen parents and examines changes in health insurance coverage and participation in Medicaid/CHIP for citizen children with and without noncitizen parents between 2008 and 2016. We focus on citizen children living with noncitizen parents because they are the largest group of US children who would be affected by potential declines in coverage under the rule's implementation. However, the impacts of the proposed rule would likely extend beyond the families of noncitizens; immigrant families with naturalized citizens and even nonimmigrant families could be affected if the rule affects others in their extended family or community. Historically, children with noncitizen parents have had higher levels of uninsurance and lower participation in Medicaid/CHIP than those with citizen parents, which could be associated with barriers to enrollment and retention such as language challenges, confusion about enrollment processes, and misconceptions about eligibility

(Kenney et al. 2010, 2012; Kenney, Lynch, et al. 2011; Pereira et al. 2012). The period from 2008 to 2016 was one of rapid policy change, including CHIP reauthorization and enactment of the Affordable Care Act (ACA). Federal policies implemented over this time, such as the ACA's Medicaid expansion, the provision of subsidies for Marketplace coverage, enrollment and outreach efforts, and the imposition of an individual coverage mandate, were expected to increase coverage among all children, including citizen children with noncitizen parents (Kenney, Buettgens, et al. 2011). In addition, some policies were targeted to children in immigrant families.

Under CHIP reauthorization in 2009 and 2015, many of the outreach grants awarded to local organizations to boost Medicaid/CHIP enrollment and retention focused on immigrants, linguistic minorities, Hispanic communities, and children living with noncitizen parents (Hill et al. 2013).[9] States were also permitted to cover "lawfully present" children (and pregnant women) who meet the income eligibility criteria for Medicaid/CHIP and had been in the country fewer than five years, a policy that has been adopted by two-thirds of states; states can also receive enhanced federal match rates for translation services for children in Medicaid and CHIP, which could aid enrollment and retention (Brooks et al. 2018; Kaiser Commission on Medicaid and the Uninsured 2009).[10] Additional relevant changes under the ACA included new options for some immigrant parents to purchase subsidized Marketplace coverage or enroll in Medicaid coverage, regulations prohibiting the use of immigration status information provided on Medicaid/CHIP or Marketplace applications for immigrant enforcement purposes, availability of translated information for non-English speakers, and enrollment efforts targeting Hispanic communities (Schwartz and Brooks 2016).[11] Together these policy changes were expected to increase awareness of immigrant families' insurance coverage options and take-up of public health insurance programs available to immigrants' children. In addition to improving access to preventive care and other services for children and families' financial stability, evidence shows that increased public coverage contributes to better long-term educational, financial, health, and related outcomes for children (Cohodes et al. 2014; Goodman-Bacon 2016; Howell and Kenney 2012; Miller and Wherry 2016; Paradise and Garfield 2013; Shonkoff, Boyce, and McEwen 2009; Sommers, Gawande, and Baicker 2017; Wherry, Kenney, and Sommers 2016).

We use data from the 2008–16 ACS and the Urban Institute's Medicaid/CHIP Eligibility Simulation Model to assess changes in uninsurance and Medicaid/CHIP participation for citizen children with noncitizen parents, defined as those living in a family with one or more noncitizen parents present in the household, and citizen children with citizen parents, defined as living in a family with only citizen parents (either native-born or naturalized) present in the household.[12] We assess patterns nationally, regionally, and for selected states and subgroups. We also assess the number and characteristics of Medicaid/CHIP-covered citizen children with noncitizen parents, who are most likely to be affected by shifts in Medicaid/CHIP enrollment under the new regulations, both nationally and for selected states and subgroups.

Results

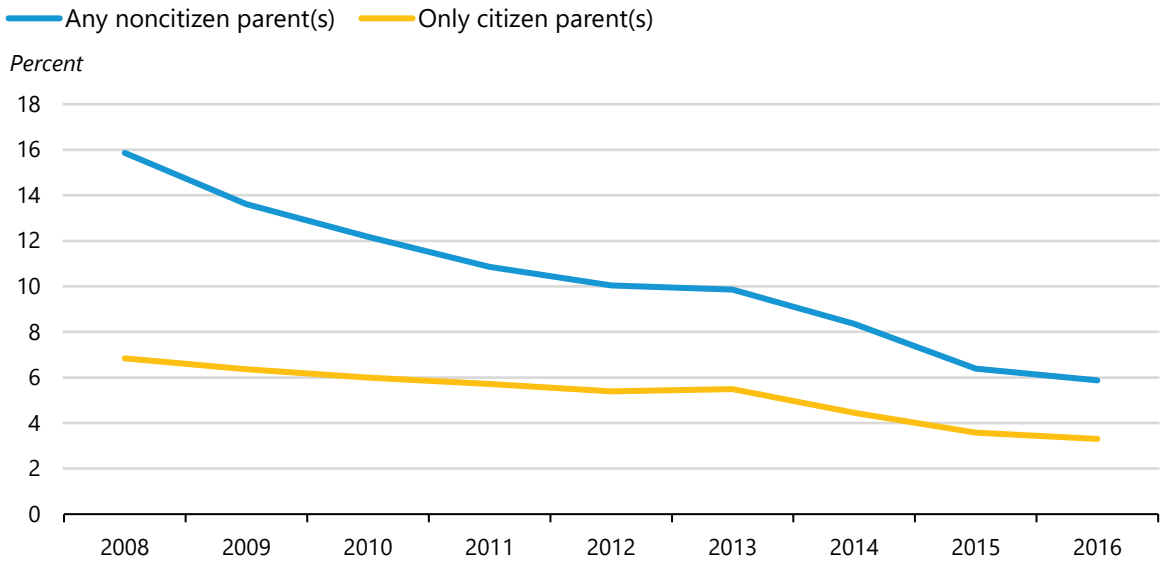
How Did Uninsurance among Citizen Children with Noncitizen Parents Change between 2008 and 2016?

Between 2008 and 2016, uninsurance fell by 10.0 percentage points among citizen children with any noncitizen parents and by 3.5 percentage points among those with only citizen parents (figure 1). The uninsurance rate was more than halved for both groups, and the uninsurance gap between citizen children with and without noncitizen parents narrowed from 9.0 percentage points to 2.6 percentage points. In 2016, however, citizen children with noncitizen parents were still nearly twice as likely as those with only citizen parents to be uninsured (5.9 percent compared with 3.3 percent).

FIGURE 1

Uninsurance among Citizen Children, 2008–16

By parents' citizenship status



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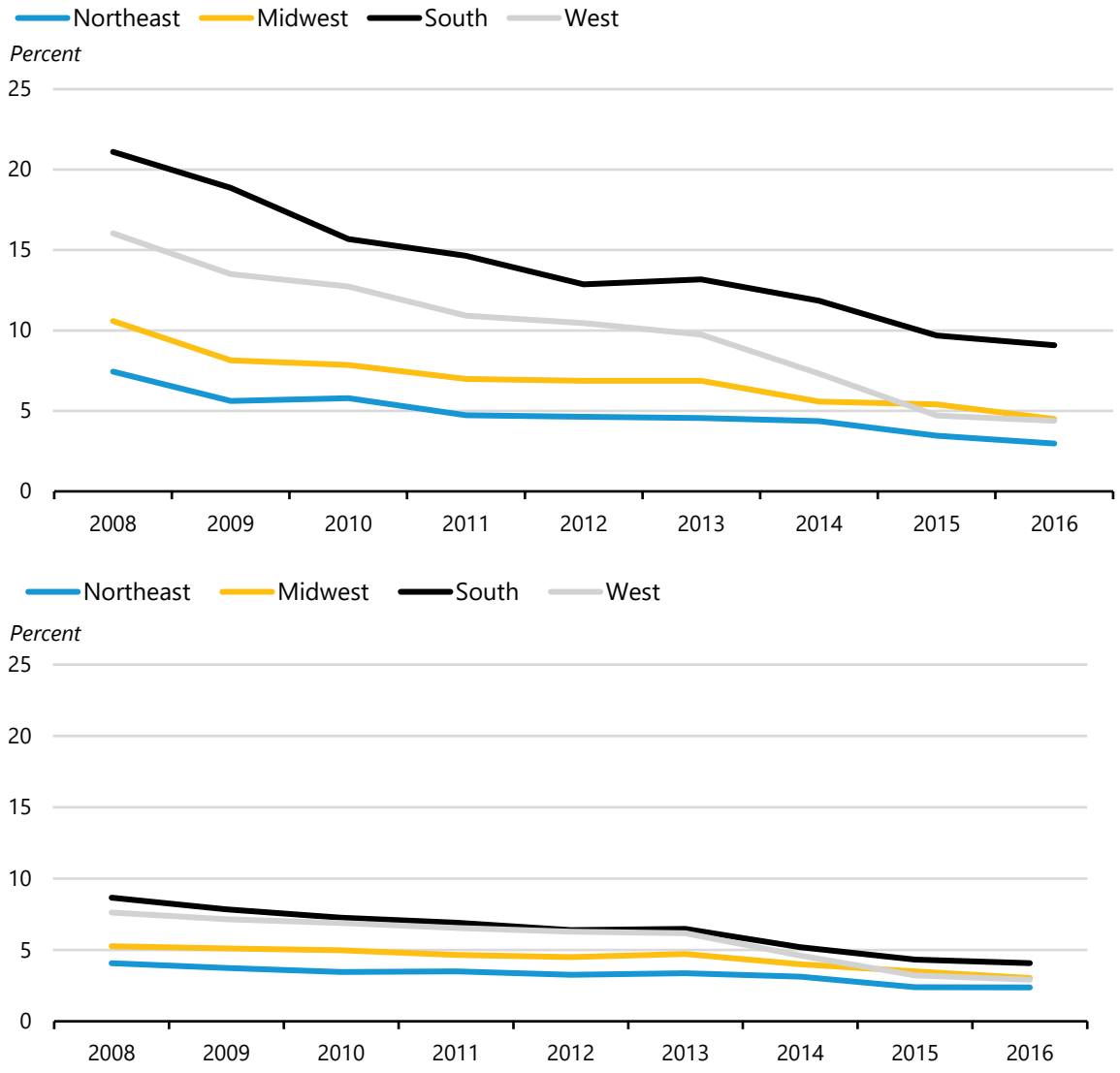
Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.
Notes: Children are ages 18 and younger. Excludes children not living in a household with a parent and noncitizen children.

Uninsurance fell between 2008 and 2016 in each region of the country among both groups of citizen children (figure 2). Consistent with national patterns, declines were over twice as large among citizen children with noncitizen parents than among citizen children with only citizen parents in each region. Declines reduced differences in uninsurance across regions, especially among children with noncitizen parents, yet regional differences remained; those with noncitizen parents in the South remained over twice as likely as other children to be uninsured in 2016.

FIGURE 2

Uninsurance among Citizen Children by Region, 2008–16

With any noncitizen parents (top) versus only citizen parents (bottom)



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Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.
Notes: Children are ages 18 and younger. Excludes children not living in a household with a parent and noncitizen children.

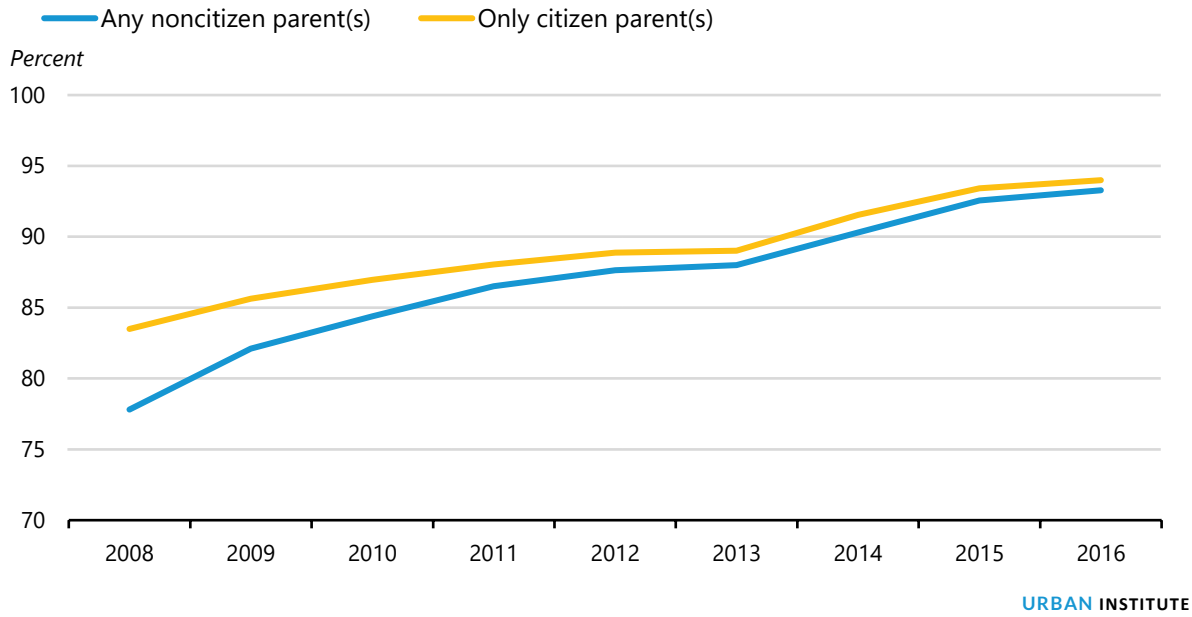
How Did Medicaid/CHIP Participation among Citizen Children with Noncitizen Parents Change between 2008 and 2016?

Over the period that uninsurance rates declined for these children, the Medicaid/CHIP participation rate among eligible citizen children with both noncitizen and citizen parents increased (figure 3). The participation increases among children with any noncitizen parents were larger than those with only citizen parents, substantially narrowing the gap in participation rates between the two groups from 5.7 percentage points in 2008 to 0.7 percentage points in 2016. In 2008, an estimated 77.8 percent of Medicaid/CHIP-eligible citizen children with noncitizen parents and 83.5 percent of those with citizen parents participated in Medicaid/CHIP. Between 2008 and 2016, participation rose by 15.5 percentage points to 93.3 percent for children with noncitizen parents and by 10.5 percentage points to 94.0 percent for those with only citizen parents.

FIGURE 3

Medicaid/CHIP Participation among Citizen Children, 2008–16

By parents' citizenship status



Source: Authors' tabulations of American Community Survey data from the Integrated Public Use Microdata Series.
Notes: Children are ages 18 and younger. Excludes children not living in a household with a parent and noncitizen children.

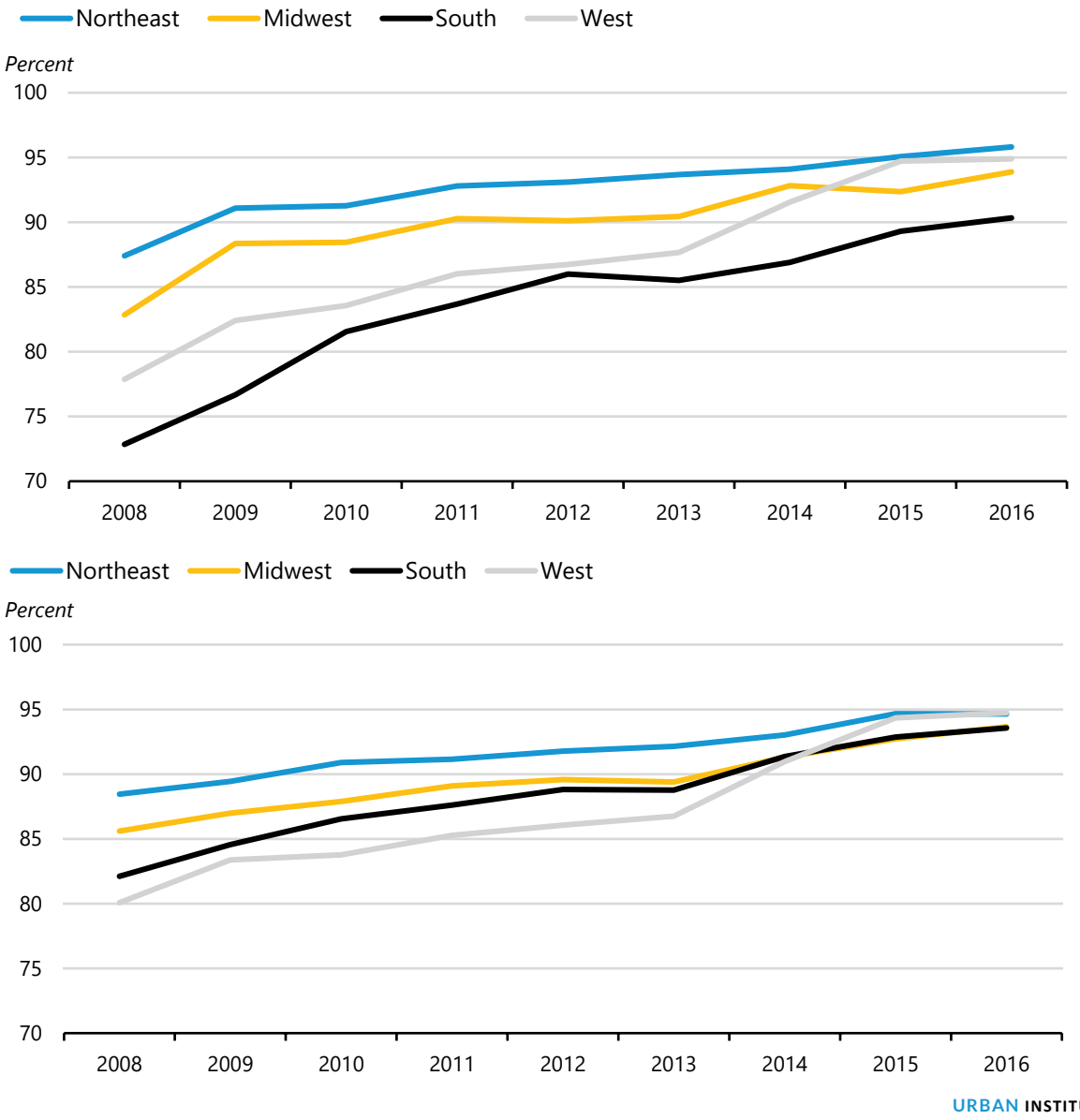
Between 2008 and 2016, Medicaid/CHIP participation rose by 8.4 percentage points to 17.5 percentage points across regions among children with noncitizen parents and by 6.2 percentage points to 14.7 percentage points among those with citizen parents, with larger increases among those with noncitizen parents in each region (figure 4). Thus, like trends in uninsurance, gaps in participation between citizen children with and without noncitizen parents narrowed within and across regions over this period. However, some regional differences in participation remained among citizen children with noncitizen parents; for instance, participation was nearly 95.0 percent in the West and Northeast,

compared with 90.3 percent in the South.

FIGURE 4

Participation in Medicaid/CHIP among Citizen Children by Region, 2008–16

With any noncitizen parents (top) versus only citizen parents (bottom)



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Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.
Notes: Children are ages 18 and younger. Excludes children not living in a household with a parent and noncitizen children.

How Many Citizen Children Lived with Noncitizen Parents in 2016?

Though children gained coverage between 2008 and 2016, the proposed public charge rule could reverse this trend, leading to reductions in Medicaid/CHIP coverage among children, particularly if they have noncitizen parents. In 2016, 10.3 million citizen children lived with one or more noncitizen parents, and 62.4 million citizen children lived with only citizen parents (table 1). One in every seven citizen children living with parents in 2016 (14.2 percent) had at least one noncitizen parent.[13] Another 3.1 million citizen children did not live in a household with parents, and an estimated 2.1 million children were not citizens.

TABLE 1

Family Structure and Citizenship Status among Children, 2016

	Number (thousands)	Percent of citizen children living with parents	Percent of all children
Citizen children with any noncitizen parents	**10,306**	**14.2**	**13.2**
Only noncitizen parents	6,201	8.5	8.0
Both noncitizen and citizen parents	4,105	5.6	5.3
Citizen children with only citizen parents	**62,426**	**85.8**	**80.1**
Citizen children not living in a household with parents	**3,109**	**NA**	**4.0**
Noncitizen children	**2,077**	**NA**	**2.7**

Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.

Note: NA = not applicable. Children are ages 18 and younger. Only parents present in the child's household are included.

What Are the Characteristics of Citizen Children with Noncitizen Parents?

Citizen children with any noncitizen parents tended to be younger than those with only citizen parents; though most children in both groups were over age 5, 37.0 percent of children with noncitizen parents were age 5 or younger, compared with 30.3 percent of children with only citizen parents (table 2). About one in six infants and toddlers was a citizen with noncitizen parents, compared with about one in ten adolescents. Over two-thirds of citizen children with noncitizen parents were Hispanic (68.6 percent), 10.9 percent were Asian/Pacific Islander, 10.7 percent were non-Hispanic white, and 5.6 percent were non-Hispanic black. Over a third of Hispanic children in the US (37.6 percent) and more than a quarter of Asian/Pacific Islander children in the US (29.4 percent) were citizens living with noncitizen parents.

TABLE 2

Characteristics of Children Living with Parents, 2016

By parents' citizenship status

	Any Noncitizen Parents			Only Citizen Parents		
	Number (thousands)	Percent in subgroup	Percent of all children	Number (thousands)	Percent in subgroup	Percent of all children
Age						
Birth to 2	1,944	18.9	16.7	9,331	14.9	80.0
3 to 5	1,864	18.1	15.5	9,622	15.4	80.2
6 to 12	4,043	39.2	13.9	23,527	37.7	81.1
13 to 18	2,455	23.8	9.7	19,947	32.0	79.1
Race/ethnicity						
White	1,106	10.7	2.8	36,808	59.0	92.4
Black	581	5.6	5.5	9,101	14.6	86.3
Hispanic	7,065	68.6	37.6	10,207	16.4	54.4
Asian/Pacific Islander	1,125	10.9	29.4	2,080	3.3	54.4
US total	**10,306**	**100.0**	**13.2**	**62,426**	**100.0**	**80.1**

Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.

Notes: Does not show children not living in a household with a parent or noncitizen children. Excludes from race/ethnicity panel children whose race was classified as American Indian/Alaska Native or other/multiple races because of small sample size.

Where Do Most Citizen Children with Noncitizen Parents Live?

Twenty states had 100,000 or more citizen children with noncitizen parents in 2016 (table 3). Together, these states were home to 87.4 percent of all citizen children with noncitizen parents. Ten states—Arizona, California, Florida, Georgia, Illinois, New Jersey, New York, North Carolina, Texas, and Washington—had at least 250,000 citizen children with noncitizen parents. In 2016, nearly half of citizen children with noncitizen parents (48.7 percent) lived in just three states—2.6 million lived in California, 1.6 million in Texas, and 733,000 in New York. At least one in six children was a citizen living with noncitizen parents in California (27.6 percent), Nevada (24.0 percent), Texas (21.3 percent), Arizona (17.3 percent), New Jersey (17.0 percent), and New York (16.6 percent).

TABLE 3

Citizen Children Living with Any Noncitizen Parents, 2016

	Number (thousands)	Percent[a]
California	2,645	27.6
Texas	1,639	21.3
New York	733	16.6
Florida	609	13.9
Illinois	437	14.2
New Jersey	355	17.0
Georgia	301	11.3
Arizona	299	17.3
North Carolina	255	10.4
Washington	253	14.7
Virginia	195	9.8
Colorado	182	13.7
Maryland	176	12.4
Nevada	171	24.0
Massachusetts	158	10.7
Pennsylvania	148	5.2
Michigan	122	5.3
Oregon	116	12.6
Tennessee	106	6.7
Indiana	106	6.3
Other 31 states	**1,299**	**6.0**
US total	**10,306**	**13.2**

Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.

Notes: Includes states with 100,000 or more citizen children with any noncitizen parents, sorted by total number of citizen children with noncitizen parents. Children are ages 18 and younger.

[a] Percent refers to citizen children living with any noncitizen parents as a share of the total child population in the state or nation.

How Many Citizen Children with Noncitizen Parents Were Enrolled in Medicaid or CHIP in 2016?

To the extent that the proposed changes to the public charge rule are implemented, fear over immigration-related repercussions could lead noncitizen parents to drop Medicaid or CHIP coverage for their children. Nationally, 6.8 million citizen children enrolled in Medicaid/CHIP lived with noncitizen parents in 2016, constituting one in five Medicaid/CHIP-enrolled children nationwide (table 4).[14] Previous research indicates that though nearly all citizen children with noncitizen parents have at least one full-time worker in the family, many of these workers are in low-wage jobs, which often have limited access to employer-sponsored coverage (Artiga, Garfield, and Damico 2018). Overall, we find 2.5 million Medicaid/CHIP-enrolled citizen children age 5 and under with noncitizen parents, of which nearly 1.3 million are age 2 or under. Another 2.7 million are ages 6 to 12, and 1.5 million are ages 13 to 18. Nearly half of all Medicaid/CHIP-enrolled children who were Hispanic (47.3 percent) and a third who were Asian/Pacific Islander (33.4 percent) were citizens living with noncitizen parents.

TABLE 4

Medicaid/CHIP-Enrolled Citizen Children Living with Any Noncitizen Parents, 2016

	Number (thousands)	Percent[a]
Age		
Birth to 2	1,273	22.3
3 to 5	1,230	21.9
6 to 12	2,722	21.0
13 to 18	1,537	16.3
Race/ethnicity		
White	473	3.8
Black	335	5.2
Hispanic	5,354	47.3
Asian/Pacific Islander	397	33.4
US total	**6,762**	**20.0**

Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.
Notes: Does not show children not living in a household with a parent or noncitizen children. Excludes from race/ethnicity panel children whose race was classified as American Indian/Alaska Native or other/multiple races because of small sample size.
[a] Percent refers to Medicaid/CHIP-enrolled citizen children living with any noncitizen parents as a share of the total Medicaid/CHIP-enrolled child population in the subgroup or nation.

What Are the Patterns of Medicaid/CHIP Coverage among Citizen Children with Noncitizen Parents across States?

Among the 20 states with at least 100,000 citizen children with noncitizen parents in 2016, the share of all Medicaid/CHIP-covered children who were citizens with noncitizen parents ranged from 6.4 percent to 40.2 percent (table 5). In nine of these states—California (40.2 percent), Nevada (35.5 percent), Texas (31.5 percent), New Jersey (27.2 percent), Arizona (26.9 percent), New York (23.8 percent), Colorado (23.2 percent), Illinois (22.6 percent), and Washington (21.9 percent)—more than one in five children covered by Medicaid/CHIP was a citizen child with noncitizen parents, higher than the national average of 20.0 percent. These children constituted more than one in four Medicaid/CHIP-covered children in Arizona, California, Nevada, New Jersey, and Texas. An estimated 1.9 million children in California and nearly 1.1 million in Texas—along with over 200,000 in Florida, Illinois, New Jersey, and New York and over 100,000 in Arizona, Colorado, Georgia, Maryland, Nevada, North Carolina, and Washington—were Medicaid/CHIP-covered citizen children with noncitizen parents.

The impacts of the proposed rule are likely to be even greater for Medicaid/CHIP-enrolled citizen children who have noncitizen parents enrolled in Medicaid, because parents may drop coverage and become uninsured. Nationwide, an estimated 2.2 million Medicaid/CHIP-enrolled citizen children had a noncitizen parent with Medicaid coverage in 2016 (figure 5).[15]

TABLE 5

Medicaid/CHIP-Enrolled Citizen Children with Noncitizen Parents, 2016

	Number (thousands)	Percent[a]
California	1,876	40.2
Texas	1,071	31.5
New York	498	23.8
Florida	399	19.1
Illinois	296	22.6
New Jersey	207	27.2
Arizona	199	26.9
Georgia	193	16.1
North Carolina	187	16.4
Washington	163	21.9
Colorado	121	23.2
Nevada	104	35.5
Maryland	101	19.8
Massachusetts	95	17.6
Pennsylvania	88	7.5
Virginia	82	13.7
Oregon	79	18.8
Tennessee	74	9.9
Indiana	69	10.5
Michigan	62	6.4
Other 31 states	**799**	**8.7**
US total	**6,762**	**20.0**

Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.

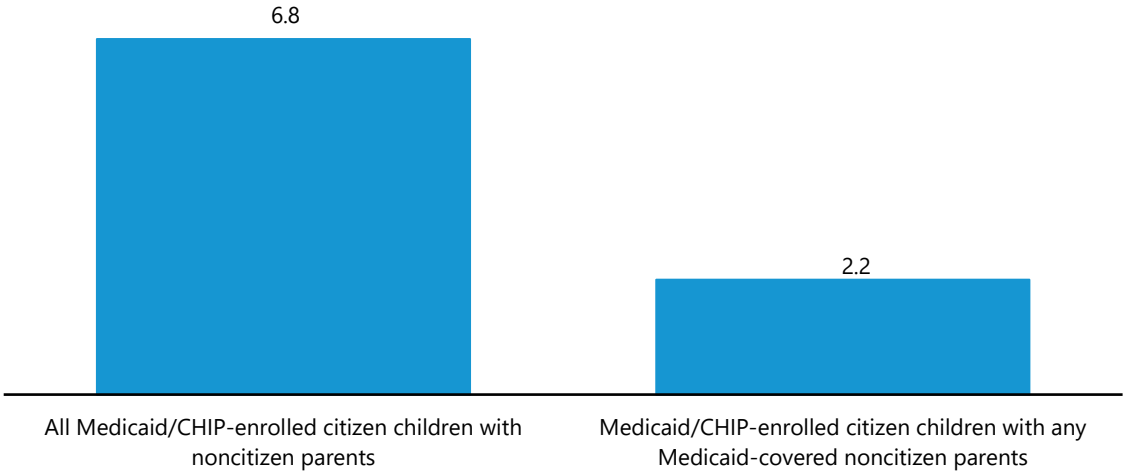
Notes: Includes states with 100,000 or more citizen children with any noncitizen parents, sorted by number of Medicaid/CHIP-enrolled citizen children with noncitizen parents. Children are ages 18 and younger.

[a] Percent refers to Medicaid/CHIP-enrolled citizen children living with any noncitizen parents as a share of the total Medicaid/CHIP-enrolled child population in the state or nation.

FIGURE 5

Medicaid/CHIP Coverage among Citizen Children and Their Noncitizen Parents, 2016

Millions of children



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Source: Authors' tabulations of American Community Survey data from Integrated Public Use Microdata Series.
Notes: Children are ages 18 and younger. Children having a Medicaid-enrolled noncitizen parent lived with at least one noncitizen parent reporting Medicaid coverage at the time of the survey.

Conclusion

Several recent federal policy changes have aimed to increase health insurance coverage rates among children that also included outreach, eligibility, and enrollment investments targeted at immigrant families. Between 2008 and 2016, Medicaid/CHIP participation rose and uninsurance fell among citizen children, with larger gains among those with noncitizen parents, substantially narrowing participation and uninsurance gaps between children with and without noncitizen parents. But under the administration's proposed public charge rule, concerns about consequences for parents' immigration status could cause families to drop coverage for which their children remain eligible, eroding these gains. Data from the ACS suggest the impact could be large: an estimated 6.8 million citizen children with noncitizen parents in 2016 had Medicaid/CHIP coverage. Nationally, one in five Medicaid/CHIP-enrolled children was a citizen child living with noncitizen parents, indicating that disenrollment from Medicaid/CHIP among even a small share of this group would have large effects nationally. Furthermore, the impact could be even greater among infants and toddlers and Hispanic and Asian/Pacific Islander children, because a larger share of them are citizens living with noncitizen parents, as well as children who live in states such as Arizona, California, Colorado, Illinois, Nevada, New Jersey, New York, Texas, and Washington, where the share of citizen children living with noncitizen parents was greater than the national average. Effects on families would be compounded if noncitizen

parents also disenroll from Medicaid, potentially affecting the estimated 2.2 million Medicaid/CHIP-enrolled citizen children with Medicaid-enrolled noncitizen parents nationwide.

Immigration policy shifts are already leading to worries about immigration-related consequences for public benefit use, which are reportedly reducing enrollment of children in public programs (Artiga and Ubri 2017; Bovell-Ammon et al. 2018).[16] In addition to effects on citizen children with noncitizen parents, the proposed regulation, if adopted, will also likely affect noncitizen children who are legally present, who were not the focus of this analysis but some of whom qualify for Medicaid/CHIP. These children may not enroll in or maintain Medicaid/CHIP coverage for fear that it would prohibit them from seeking legal permanent residence later. If fewer legally present noncitizen children enroll in Medicaid/CHIP because of these concerns, research indicates that their rates of uninsurance will rise and access to care will fall (Saloner, Koyawala, and Kenney 2014). Moreover, eligible uninsured children may be less likely to receive coverage for which they qualify. The rule's effects could also extend beyond families with noncitizens; for example, immigrant families with naturalized citizens and nonimmigrant families could also be affected if the rule affects their extended family or others in their community. The rule could also create operational and financial challenges for states' Medicaid programs, which would have adverse implications for states' budgets and economies.[17]

The anticipated declines in Medicaid/CHIP enrollment under the proposed public charge rule would likely lead to higher uninsurance among citizen children in immigrant families (Artiga, Garfield, and Damico 2018; Batalova, Fix, and Greenberg 2018; Fix and Passel 1999; Kaiser Family Foundation 2018; Zallman et al. 2018),[18] putting their recent coverage gains at risk. This would not only reverse longstanding Medicaid/CHIP policy goals but would likely reduce citizen children's access to health care and cause financial strains for their families, as well as harm their long-term development, educational and work prospects, and health and well-being (Blau and Mackie 2017; Cohodes et al. 2014; Goodman-Bacon 2016; Howell and Kenney 2012; Miller and Wherry 2016; Paradise and Garfield 2013; Shonkoff, Boyce, and McEwen 2009; Sommers, Gawande, and Baicker 2017; Wherry, Kenney, and Sommers 2016), limiting their potential and ability to contribute to society later in life.

Data and Methods

Data Source

This brief uses the 2008–16 ACS, an annual survey fielded by the US Census Bureau.[19] This analysis focuses on noninstitutionalized civilian children ages 18 and under who were US citizens at the time of the survey and lived in a family with at least one parent. We analyze citizen children with noncitizen parents, defined as living in a family with one or more noncitizen parents in the household, and citizen children with citizen parents, defined as living in a family with only citizen parents in the household.[20] An additional 3.1 million citizen children did not live in households with their parents, and 2.1 million children were not citizens; these groups are excluded from some tabulations in this brief.

Noncitizens include both lawfully present individuals, such as legal permanent residents, refugees, asylees, and those otherwise temporarily or permanently authorized to live in the United States, and undocumented noncitizens. Although the proposed public charge rule applies only to green card applications, with some exceptions for groups such as refugees and asylees, chilling effects will likely extend into the broader immigrant community (Kaiser Family Foundation 2018). Each year of the ACS includes a national public use sample of at least 75,000 citizen children with noncitizen parents. State-level analyses included the 20 states with an estimated population of 100,000 or more citizen children living with noncitizen parents in 2016, all of which had state-specific samples of at least 500 cases. The ACS is fielded continuously throughout the year, so the estimates reported here reflect averages for each year.

Medicaid/CHIP Eligibility and Participation

To assess Medicaid/CHIP eligibility, we use the individual and family information survey respondents provide and apply the Medicaid/CHIP eligibility rules (including income, immigration, and other rules) for each person's state of residence in the survey year (the District of Columbia is considered a state in this analysis). For 2008 through 2013, we use the Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model, which applies the pre-ACA Medicaid eligibility rules for 2013 by using information on eligibility guidelines, including the amount and extent of income disregards and asset tests, which varied widely across states (Lynch, Haley, and Kenney 2014). For 2014 through 2016, we use the Health Insurance Policy Simulation Model–ACS version, which builds on the Medicaid/CHIP Eligibility Simulation Model and applies ACA rules that took effect in 2014 and any changes during 2014, 2015, and 2016, including the shift to eligibility determination procedures based on modified adjusted gross income (Brooks et al. 2015, 2016; Buettgens 2011; Buettgens et al. 2013). Further detail on this methodology is available in Kenney and colleagues (2016).

Medicaid/CHIP participation rates are calculated as the ratio of Medicaid/CHIP-eligible enrolled people to the sum of Medicaid/CHIP-eligible enrolled people plus Medicaid/CHIP-eligible uninsured people, excluding those with both Medicaid and private coverage (including military coverage) and those with Medicaid/CHIP coverage who do not have a known eligibility pathway. Participation rates excluding people with private coverage are often used to indicate how successfully programs reach their primary target populations.

Analysis

We assess changes in uninsurance and Medicaid/CHIP participation among citizen children with and without noncitizen parents between 2008 and 2016 nationally and regionally, and, using 2016 data, we assess patterns nationally and for selected states and subgroups. We also assess the number and characteristics of citizen children with noncitizen parents who are covered by Medicaid/CHIP, nationally and for selected states and subgroups. Health insurance coverage is measured as status at the time of the survey; coverage categories analyzed here are being uninsured (including exclusively using Indian Health Service coverage, which by convention is treated as lack of coverage) or having

Medicaid/CHIP coverage (which is defined on the ACS as having "Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability").[21] We also estimated parental coverage status among citizen children with noncitizen parents; children were identified as having a Medicaid-enrolled noncitizen parent if at least one noncitizen parent reported Medicaid coverage at the time of the survey. To address potential misclassification of coverage in the ACS, we applied a set of coverage edits (Lynch et al. 2011).

We tested changes over time and differences across groups using two-tailed tests and note changes/differences with p-values less than 0.01. State-level analyses included the 20 states with an estimated 100,000 or more citizen children living with noncitizen parents in 2016.

Limitations

As with all studies of health insurance coverage and Medicaid eligibility and participation, we note that both coverage and eligibility status are likely measured with error. Modeling eligibility before and after implementation of the ACA's coverage provisions requires different approaches that could introduce bias into comparisons of model results between the two periods. This could then over- or understate differences between pre- and post-ACA periods (Kenney et al. 2016, 2017).[18] Though our estimates of the number and composition of citizen children with noncitizen parents are consistent with other analyses using other data sources or methodologies (Artiga, Garfield, and Damico 2018; Batalova, Fix, and Greenberg 2018),[22] there may be inherent error in self-reported citizenship status in survey data. Finally, although changes in uninsurance and Medicaid/CHIP participation we observe between 2008 and 2016 occurred under ACA implementation, CHIP reauthorization, and policy efforts to boost participation in Medicaid/CHIP, including among immigrant families, other economic and demographic changes also occurred, so the changes cannot be directly attributed to these policy shifts.

Notes

[1] Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114, 51296. (Oct. 10, 2018).

[2] Hamutal Bernstein and Archana Pyati, "Expanding the 'public charge' rule jeopardizes the well-being of immigrants and citizens," *Urban Wire* (blog), Urban Institute, October 3, 2018, https://www.urban.org/urban-wire/expanding-public-charge-rule-jeopardizes-well-being-immigrants-and-citizens; "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard," Manatt, October 11, 2018, https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population.

[3] See the data and methods section for more detail on the data source and methodology.

[4] Participation rates are defined as the ratio of Medicaid/CHIP-eligible enrolled people to the sum of Medicaid/CHIP-eligible enrolled people plus Medicaid/CHIP-eligible uninsured people, excluding those with both Medicaid and private coverage and those with Medicaid/CHIP coverage who do not have a known eligibility pathway. See data and methods section for more detail.

[5] Emily Johnston, Genevieve M. Kenney, and Jennifer M. Haley, "Penalizing immigrants for obtaining Medicaid coverage puts child and family well-being at risk," *Urban Wire* (blog), Urban Institute, forthcoming.

[6] Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114, 51296. (Oct. 10, 2018).

[7] Hamutal Bernstein and Archana Pyati, "Expanding the 'public charge' rule jeopardizes the well-being of immigrants and citizens," *Urban Wire* (blog), Urban Institute, October 3, 2018, https://www.urban.org/urban-wire/expanding-public-charge-rule-jeopardizes-well-being-immigrants-and-citizens; "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard," Manatt, October 11, 2018, https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population.

[8] Emily Johnston, Genevieve M. Kenney, and Jennifer M. Haley, "Penalizing immigrants for obtaining Medicaid coverage puts child and family well-being at risk," *Urban Wire* (blog), Urban Institute, forthcoming.

[9] "Outreach and enrollment grants," Centers for Medicare & Medicaid Services, accessed November 12, 2018, https://www.insurekidsnow.gov/campaign/funding/index.html.

[10] As used in the Children's Health Insurance Program Reauthorization Act of 2009, "lawfully present" people include lawful permanent residents; refugees; asylees; and other foreign-born people permitted to stay temporarily or indefinitely, who are not legal permanent residents and otherwise qualify for Medicaid/CHIP (Fortuny and Chaudry 2011). By 2012, 13 states had opted to receive enhanced federal match rates for translation services for children in Medicaid and CHIP.

[11] In addition to these federal policy changes, by 2018, seven states, including the District of Columbia, used state funds to cover all income-eligible children regardless of immigration status. See Rebecca J. Adams, "Undocumented kids get health care in six states, DC," USC Annenberg, Center for Health Journalism, January 22, 2018, https://www.centerforhealthjournalism.org/fellowships/projects/undocumented-kids-get-health-care-six-states-dc.

[12] Medicaid/CHIP participation is calculated as the ratio of enrolled children to the sum of enrolled and eligible uninsured children. Health insurance coverage estimates have been adjusted to account for likely misreporting on the ACS (Kenney et al. 2016; Lynch et al. 2011). See data and methods section for more detail.

[13] Less than 2 percent of children with citizen parents had additional noncitizen family members in the household, few of whom were siblings or other children.

[14] Another 843,000 noncitizen children were enrolled in Medicaid or CHIP; data not shown.

[15] Children with Medicaid-enrolled noncitizen parents were identified by having one or more noncitizen parents reporting Medicaid coverage at the time of the survey.

[16] Helena Bottemiller Evich, "Immigrants, fearing Trump crackdown, drop out of nutrition programs," *Politico*, September 3, 2018, https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292; Erica Greenberg and Archana Pyati, "Could 'public charge' reduce public preschool participation among immigrant families?," *Urban Wire* (blog), Urban Institute, November 5, 2018, https://www.urban.org/urban-wire/could-public-charge-reduce-public-preschool-participation-among-immigrant-families; Paige Winfield Cunningham, "The Health 202: Under Trump, immigrants back away from Medicaid, Obamacare subsidies," the *Washington Post*, April 11, 2018, https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/04/11/the-health-202-under-trump-immigrants-back-away-from-medicaid-obamacare-subsidies/5accda4e30fb0406a5a122fe/?noredirect=on&utm_term=.f8caf943d53f.

[17] Anita Cardwell and Maureen Hensley-Quinn, "State health officials concerned about the proposed public charge rule," State Health Policy Blog, National Academy for State Health Policy, November 20, 2018, https://nashp.org/state-health-officials-concerned-about-the-proposed-public-charge-rule/.

[18] Hamutal Bernstein and Archana Pyati, "Expanding the 'public charge' rule jeopardizes the well-being of immigrants and citizens," *Urban Wire* (blog), Urban Institute, October 3, 2018, https://www.urban.org/urban-wire/expanding-public-charge-rule-jeopardizes-well-being-immigrants-and-citizens; "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard," Manatt, October 11, 2018, https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population.

[19] Steven Ruggles, Katie Genadek, Ronald Goeken, Josiah Grover, and Matthew Sobek, "Integrated Public Use Microdata Series: Version 7.0," University of Minnesota, accessed November 12, 2018, https://doi.org/10.18128/D010.V7.0.

[20] The number and composition of citizen children with noncitizen parents we identify are similar to those identified in other analyses using different data sources or methodologies (Artiga, Garfield, and Damico 2018; Batalova,

Fix, and Greenberg 2018). Analyses of the impact of the proposed rule are sensitive to the definition of the population of children studied; for example, the Children's Partnership (2018) identified a somewhat smaller number of Medicaid/CHIP-enrolled citizen children with noncitizen parents in California, but our analysis studied a different age group, used different data years, and incorporated edited coverage indicators. Artiga and Damico (2018) used a much broader definition of the population potentially affected by the new rule, identifying 19.8 million children in Current Population Survey data who were either noncitizens or citizens with a citizen or noncitizen immigrant parent. The comparable estimate from the 2016 ACS would be similar, at 19.0 million.

[21] The proposed rule includes Medicaid, but not CHIP, as a public benefit to be considered in public charge determinations; however, the proposed rule requests comments about inclusion of CHIP in the regulation, indicating CHIP coverage may be included as a negative factor in the final rule. However, very few parents have CHIP coverage.

[22] "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard," Manatt, October 11, 2018, https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population.

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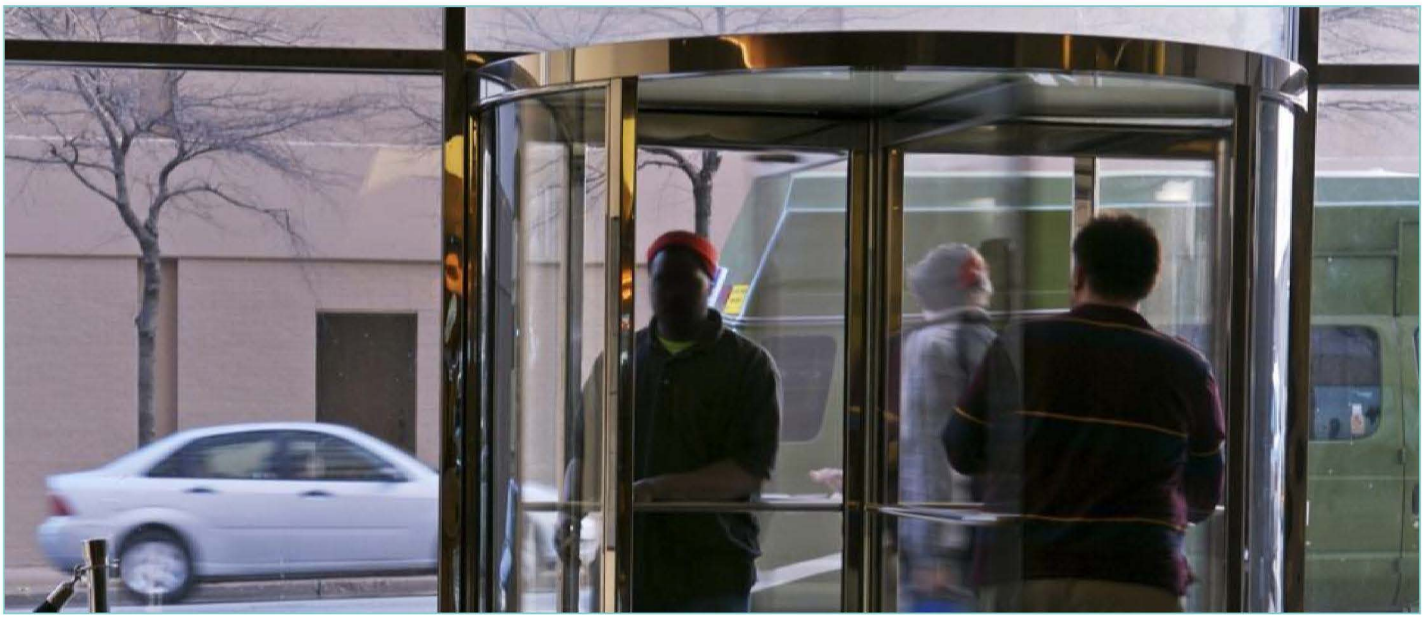
Who Entered and Exited the Individual Health Insurance Market Before and After the Affordable Care Act?

Evidence from the Medical Expenditure Panel Survey

November 29, 2018 | **Sherry A. Glied** and **Adlan Jackson**



ABSTRACT

- **Issue:** The Affordable Care Act (ACA) made it easier for older adults and those with medical conditions to enroll in individual-market coverage by eliminating risk rating and limiting age rating. While the ACA also encourages young and healthy people to enroll through subsidies and the individual mandate, it's not clear

whether these incentives have been sufficient to prevent the risk pool from becoming disproportionately old and sick.

- **Goal:** To assess whether patterns in individual-market participation changed following ACA implementation.
- **Methods:** Comparison of Medical Expenditure Panel Survey (MEPS) data for the periods 2003–09 and 2014–15.
- **Findings and Conclusion:** The analysis found few differences in individual-insurance market participation before and after the ACA. Adverse selection occurred during both: people switching into individual insurance coverage after being uninsured were higher utilizers prior to the switch than were those who remained uninsured. Those who disenrolled from individual plans tended to be lower utilizers of care before switching compared with those who kept their coverage. The main difference was that more people — especially young adults — switched from Medicaid to individual insurance, and vice versa, after the ACA. Adverse enrollment or disenrollment in the individual market did not increase following ACA implementation. The combination of easing rating rules and encouraging participation appears to have maintained market stability.

Background

Much attention in recent years has focused on the impact of the Affordable Care Act (ACA) on the stability of the individual health insurance market. The law's elimination of medical underwriting and health-rating restrictions, and its limits on age rating, have made the market more attractive to older, sicker people. In an effort to promote a balanced risk pool, the law also included an individual mandate to purchase coverage, intended to incentivize young and healthy adults to buy coverage, as well as subsidies to make coverage less costly for lower-income Americans.[1] (The mandate penalty was set to zero under the 2017 Tax Cuts and Jobs Act.)

Health insurers, while generally supportive of the ACA, have expressed concerns that those who entered the individual market following its implementation, and those who retained coverage throughout the year, were less healthy than those who chose not to enter or who exited the market.[2] Some insurers have argued that federal regulation has constrained their ability to serve the young and healthy population,[3] and advocated for deregulation to allow them to offer less comprehensive and cheaper plans that would appeal to those with fewer medical needs. Some also argue that

ACA's special enrollment periods should be modified to discourage the enrollment of people with greater health needs.[4] They have advocated for broader age bands, more limited special enrollment periods, and higher mandate penalties.

This issue brief explores whether the ACA's provisions, on balance, led to a deterioration in the risk pool in the individual market. Using the Medical Expenditure Panel Survey (MEPS), we examined the patterns of those who enrolled in individual coverage from other types of coverage and from being uninsured and their utilization of health care services before (2003–09) and after (2014–15) the implementation of the ACA's individual-insurance market provisions. We focus on adults under age 63.

Findings

We used the MEPS to track how many people changed insurance types — across Medicaid, Medicare, employer-sponsored insurance, individual insurance, and no coverage — over two-year periods (Exhibits 1 and 2).

Exhibit 1

Switching to and from Individual-Market Coverage Amc Adults, Pre- and Post-ACA

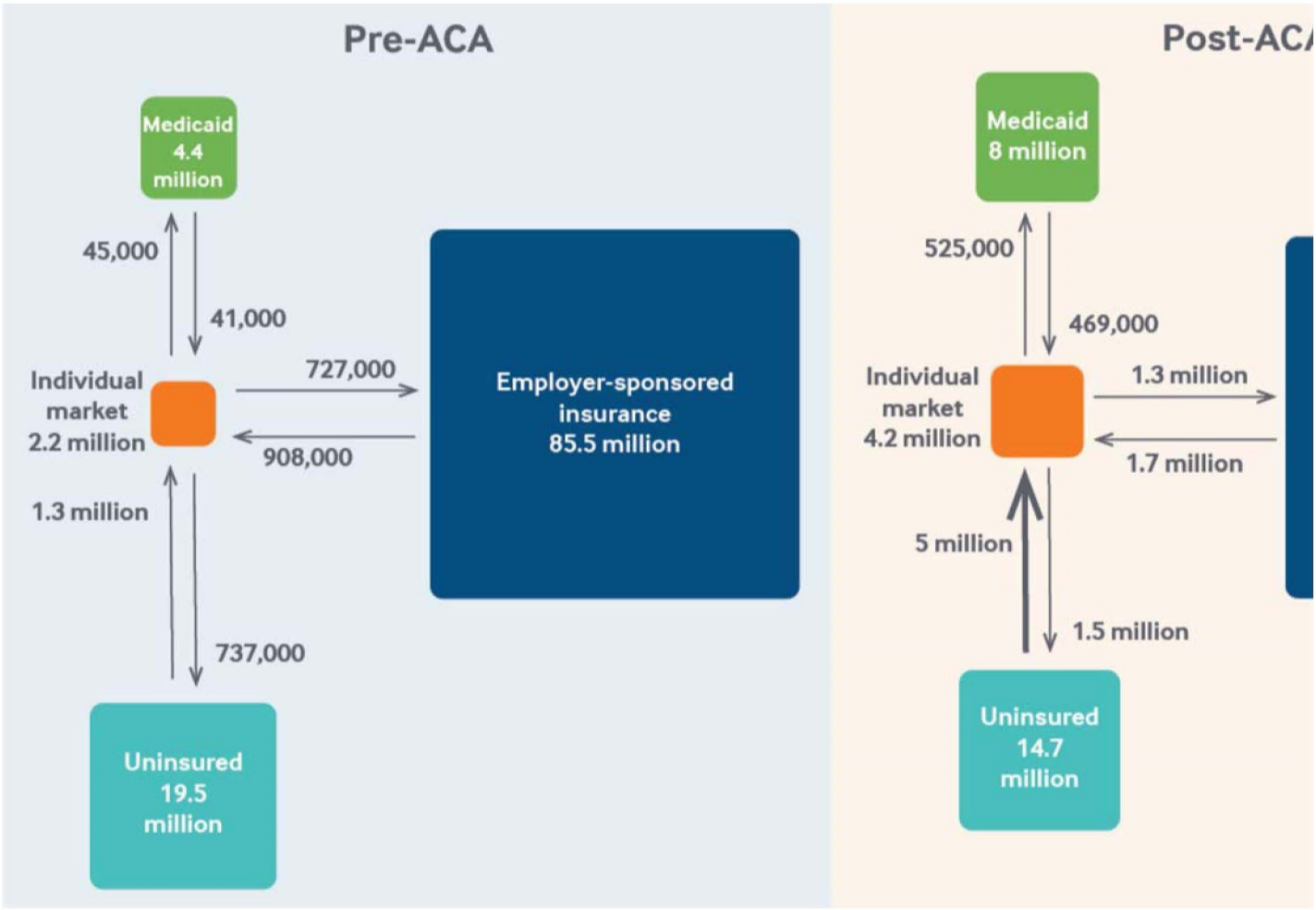
	Pre-ACA, 2003–09 (two-year averages)				Post-ACA, 2014-		
	People switching to individual-market coverage from . . .		People switching from individual-market coverage to . . .		People switching to individual-market coverage from . . .		Pe indiv
	Number	Percent	Number	Percent	Number	Percent	N
Medicaid	41,000	0.5%	45,000	1.2%	469,000	3.2%	5
Employer-sponsored	908,000	0.9%	727,000	18.7%	1,726,000	1.8%	1,:
No insurance	1,305,000	3.4%	737,000	18.9%	5,030,000	12.0%	1,4
Did not switch				**60.7%**			

Data: Authors' analysis of Medical Expenditure Panel Survey (MEPS) data for years 2003–09 and 2014–15.

Source: Sherry A. Glied and Adlan Jackson, *Who Entered and Exited the Individual Health Insurance Market Before and After the Affordal Medical Expenditure Panel Survey* (Commonwealth Fund, Nov. 2018).

Exhibit 2

Switching In and Out of the Individual Market in the Pre ACA Periods



Data: Authors' analysis of 2012 Medicare Current Beneficiary Survey (MCBS) data projected to 2016 population.

Source: Sherry A. Glied and Adlan Jackson, *Who Entered and Exited the Individual Health Insurance Market Before and After the Affordal Medical Expenditure Panel Survey* (Commonwealth Fund, Nov. 2018).

In the pre-ACA period, most people who joined the individual market had previously been uninsured. On average, about 1,305,000 people switched from being uninsured to holding individual-market coverage during each two-year MEPS panel. Such coverage, however, attracted only a small minority of those who had been uninsured — some 3.4 percent of the over 38 million uninsured adults. Nearly as many people,

about 908,000, switched from employer-sponsored to individual-market coverage in the average two-year period. However, because far more people began with employer coverage, this group constituted less than 1 percent of those who held employer coverage. In the average two-year period before the ACA, just 41,000 people (0.5% of those who began with Medicaid) switched from Medicaid to individual-market coverage.

In the post-ACA period, as expected, there was a substantial increase in the number of previously uninsured adults entering the individual market. About 5,030,000 people switched from being uninsured to holding individual coverage during the two-year period beginning January 2014, or 12 percent of those who began the period uninsured. The numbers switching from employer to individual coverage doubled in the post-ACA period, as people leaving employer coverage enrolled in individual-market coverage, rather than becoming uninsured (**Appendix Exhibit A1**).

Switching from Medicaid increased by a factor of 10. Nearly 469,000 people moved from Medicaid into individual-market coverage in the post-ACA period, amounting to 3.2 percent of those who initially held Medicaid coverage. This increase corresponded with a decrease in the proportion of people leaving Medicaid and becoming uninsured (**Appendix Exhibit A2**). Because of the availability of subsidized individual-market coverage and the mandate to have coverage, people who lost eligibility for Medicaid because their incomes rose bought individual-market coverage instead of becoming uninsured.

There was much less change in terms of people leaving the individual market. In the pre-ACA period, a roughly similar number (and percentage) of people left the individual market for employer insurance or became uninsured: 727,000 (18.7%) and 737,000 (18.9%), respectively. A much smaller group left individual coverage for Medicaid: 45,000 people, or 1.2 percent of the individual market.

In the post-ACA period, the pattern among those who switched from individual to employer coverage (1,308,000 people; 17.1%) or who became uninsured (1,463,000 people; 19.1%) was similar to that seen in the earlier period (though the baseline number of people in the individual market was much higher). By contrast, there was a large increase in the share of people with individual coverage who left that market and enrolled in Medicaid during the post-ACA period: 525,000 people, or 6.8 percent of those who had been covered through the individual market.

SWITCHING BY AGE GROUP

We also examined these patterns by age group (Exhibit 3). In the pre-ACA period, those entering the individual market who had previously been uninsured were disproportionately older adults. Among those initially uninsured ages 50 to 63, 4.2 percent switched to individual insurance over a two-year period. By contrast, just 3.4 percent of those between ages 35 and 49 and 2.7 percent between ages 25 and 34 switched from no coverage to individual coverage over a two-year period. Across age groups, the share of people switching to individual from employer insurance was consistently very low. In addition, very few people switched from Medicaid to individual coverage in the pre-ACA period.

Exhibit 3

Switching to Individual-Market Coverage from Medicaid Sponsored, or No Coverage, by Age Group

Data: Authors' analysis of Medical Expenditure Panel Survey (MEPS) data for years 2003–09 and 2014–15.

Source: Sherry A. Glied and Adlan Jackson, *Who Entered and Exited the Individual Health Insurance Market Before and After the Affordal Medical Expenditure Panel Survey* (Commonwealth Fund, Nov. 2018).

Add to ChartCart

In the post-ACA period, uninsured people in all age groups were more likely to switch into individual-market coverage, but the relative gains were greatest among younger people. About 11.4 percent of those initially uninsured between the ages of 25 and 34 switched to individual coverage, as did about 11.5 percent and 13.6 percent of the initially insured ages 35 to 49 and 50 to 64, respectively. There was little overall

change in the number of people switching from employer to individual coverage after the ACA, but the composition of this population shifted markedly toward older adults. This may reflect switching from COBRA policies (which allow people to retain their employer coverage for 18 months after leaving a job) to marketplace coverage among older adults eligible for subsidies. By contrast, the large increase in switching from Medicaid to individual-market coverage was concentrated among young adults. About 4 percent of young adults initially covered by Medicaid switched to individual-market coverage, as did 2.8 percent of middle-aged adults and 2.7 percent of older adults.

The stability of the individual market also depends on patterns of disenrollment, because the market can become unstable if a disproportionate number of young and healthy people leave (Exhibit 4). Many people switch out of individual-market coverage each year, most often into employer coverage. This behavior is particularly common among young adults. About one-third (32.8%) of people ages 25 to 34 who initially held individual coverage switched to employer coverage over each two-year panel, as they entered the labor market or got jobs with benefits. This pattern was somewhat less prevalent among older people: 20.2 percent of those ages 35 to 49 and 17.1 percent of those ages 50 to 63 with individual coverage switched to employer coverage. After the ACA, rates of switching from individual to employer coverage remained relatively stable among young adults. The absolute number of middle-aged and older adults switching from individual to employer coverage rose, as the total number with individual coverage increased. But among people who began with individual insurance, the share of those who switched to employer coverage declined.

Exhibit 4

Switching from Individual-Market Coverage to Medicaid Sponsored, or No Coverage, by Age Group

Download data

Data: Authors' analysis of Medical Expenditure Panel Survey (MEPS) data for years 2003–09 and 2014–15.

Source: Sherry A. Glied and Adlan Jackson, *Who Entered and Exited the Individual Health Insurance Market Before and After the Affordal Medical Expenditure Panel Survey* (Commonwealth Fund, Nov. 2018).

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After the ACA, there was a substantial increase in the number of people who left individual-market coverage for Medicaid, because of the expansion of eligibility for that program. About 18 percent of those ages 25 to 34 who had been initially enrolled in individual coverage switched to Medicaid in 2014–15, as did 4.7 percent of those ages 35 to 49 and 2.9 percent of those ages 50 to 63.

Overall, the main change in terms of age related to Medicaid. Pre-ACA, very few people of any age switched from individual coverage to Medicaid or from Medicaid into individual coverage. Post-ACA, a substantial number of people ages 25 to 34 switched from individual coverage to Medicaid and a slightly smaller number of people in this age group switched from Medicaid to individual coverage.

The main consequence of this was that the proportion of young people with individual coverage who maintained that coverage over time fell (**Appendix Exhibit A3**). Prior to the ACA, about 40 percent of those ages 25 to 34 who held individual coverage retained it through the end of the two-year period. In the post-ACA period, only 31 percent of those in this age group with individual coverage held it until the end of the period. There was almost no difference in the share of people ages 35 to 49 who held coverage continually in both periods (it increased from 56% to 59%). The share of those ages 50 to 63 who held individual coverage continually declined modestly, from 66 percent to 63 percent.

SWITCHING PATTERNS BY PRIOR HEALTH SERVICE UTILIZATION

To understand how switching patterns may have varied with health characteristics beyond age, we looked at the expenditures of people who switched coverage in the three months prior to a switch, comparing patterns before and after the ACA took effect.

To see whether those who were high users of health care services were more likely to join the individual market, we recorded total health expenditures incurred by people in the three months prior to a switch and compared them with the average three-month expenditures for people who did not switch (Exhibit 5). In the pre-ACA period, those who switched from employer to individual coverage had somewhat lower service use prior to their switch than those who did not switch ($395 vs. $710), while those entering the individual market after having been uninsured had higher average service use prior to the switch than did the typical continuously uninsured person ($295 vs. $190).

Exhibit 5

Average Health Expenditures in the Three Months Prior to Individual-Market Coverage from Employer-Sponsore or No Insurance, Compared to People Who Did Not Cha

	Switched TO individual market from . . .		Switched FROM indi
	Employer plan	**No insurance**	**Employer plan**
Pre-ACA, 2003–09	$395 ($710)	$295 ($190)	$335 ($670)
Post-ACA, 2014–15	$160 ($1,795)	$300 ($200)	$315 ($1,150)

Data: Authors' analysis of Medical Expenditure Panel Survey (MEPS) data for years 2003–09 and 2014–15.
Notes: Data in parentheses show average expenditures for those who did not switch coverage. Medicaid omitted because sample sizes

Source: Sherry A. Glied and Adlan Jackson, *Who Entered and Exited the Individual Health Insurance Market Before and After the Affordal Medical Expenditure Panel Survey* (Commonwealth Fund, Nov. 2018).

Health care costs grew rapidly between 2003–09 and 2014–15, so those who continuously held employer coverage had average spending about 2.5 times higher in the post-ACA period than in the pre-ACA period ($1,795 vs. $710) and those who continuously held individual coverage had average expenditures about 1.7 times higher in the later period ($1,150 vs. $670). Despite these increased expenditures among the continuously insured, the patterns of expenditures among switchers were very similar in the two periods. As in the pre-ACA period, those who switched from employer to individual coverage were somewhat lower utilizers than were those who did not switch, while those who switched from being uninsured to holding individual coverage had higher average service use before the switch than the typical uninsured person — suggesting that less healthy uninsured people were more likely to enroll in individual coverage. Likewise, those who switched out of individual coverage to either employer or no coverage had relatively lower spending than those who continuously held individual coverage in both periods — suggesting that healthier people and lower utilizers were more likely to disenroll from coverage.[5] The patterns of enrollment and disenrollment were nearly the same before and after the ACA.[6]

Discussion

Implementation of the ACA coverage expansions in 2014 led to a substantial increase in coverage in the individual market and in Medicaid. Overall, however, we see little evidence that implementation of these coverage expansions led to meaningful changes in patterns of enrollment in or disenrollment from individual-market coverage by age or health status.

After ACA implementation, many people switched from being uninsured to holding individual coverage, a substantial number switched from Medicaid to individual-market coverage, and a nearly equal number switched from individual coverage to Medicaid. Young adults were disproportionately likely to switch between Medicaid and individual coverage. This is consistent with the findings of Commonwealth Fund Affordable Care Act Tracking Surveys, which show increases in Medicaid coverage among young adults who, prior to the passage of the ACA, could not afford insurance.[7] Our results are also consistent with the finding of a 2017 analysis, which found that the ACA "increased transitions to Medicaid and nongroup coverage among the uninsured, while strengthening the existing employer-sponsored insurance system and improving retention of public coverage."[8] We did find some evidence that, after the ACA, older adults who might otherwise have participated in COBRA plans chose individual coverage instead.

We examined whether there was an increase in adverse enrollment or disenrollment in individual-market coverage by comparing expenditures among switchers in the pre- and post-ACA periods. In both periods, we found that people switching among types of coverage are lower utilizers than those who remain in the same type. In both periods, people who switched from being uninsured to purchasing individual coverage were slightly higher utilizers prior to the switch than those who remained uninsured and that, in both periods, those who switched from individual to no coverage were somewhat lower utilizers prior to the switch than those who remained covered by individual insurance. In other words, there has always been adverse selection and retention in the individual market relative to having no coverage, and that remained the case in the post-ACA period.

The ACA led to large numbers of people entering the individual market. Patterns of exit from the individual market remained relatively stable, except that more young people departed individual coverage for Medicaid. While health care service use

patterns among those entering and exiting didn't change, changes in the volume of entrances and departures may have led insurers to perceive that more adverse selection was occurring.

Policy Implications

The package of changes made by the Affordable Care Act provided greater incentives to purchase individual-market plans through subsidies, the individual mandate, and changes in risk-rating rules. This approach appears to have accomplished what was intended: expanding enrollment in the individual market without substantially increasing adverse selection.

Adverse enrollment and disenrollment have always been challenges in the individual market. Maintaining affordable access to coverage for people with preexisting health conditions requires offsetting measures to maintain market stability. As Congress and the Trump administration consider and implement policy reforms that weaken some of these measures (such as eliminating the penalty for not having health insurance or permitting the sale of plans that do not meet all ACA requirements), it will be important to consider their effects to avoid destabilizing the individual market.

HOW WE CONDUCTED THIS STUDY

We used data from the Medical Expenditure Panel Survey (MEPS) to conduct these analyses. Our sample included adults ages 25 to 63. We counted the number of switches in a panel or year by creating dummy variables that would count an individual if they had one type of health insurance in one month and a different type the following. The counts are recorded in Exhibit 1. The pre-ACA period, from 2003–09, represents three panels. Accordingly, counts are divided by three to give a single panel average.

We next analyze patterns of utilization and health care expenditures among those who changed their insurance coverage before and after implementation of the ACA.

We recorded the average spending in the three months prior to making a certain kind of coverage switch and compared them. To get data on individual's expenditures, we merged the event files, which contain expenditure data by month, with the full-year consolidated files by Dwelling Unit/Person ID. Using the same dummy variables for switches as above, we then recorded the sums of expenditures reported in the three months prior to a switch in insurance type. We then recorded the mean expenditure for each switch type. For those respondents that did not report switching, we recorded the average three-month expenditure over their two-year panel. These results are recorded in Exhibit 5. Expenditures were rounded to the nearest $5.

We appended the populations of the two periods together and ran linear regressions to ascertain the statistical significance of switching effects on utilization, and the effects of change in period.

To ascertain the statistical significance of the effects of different switching categories and the change in period on utilization, we ran linear regressions with dummy variables representing each switching category, and then ran regressions recording their interaction with a post-ACA variable.

Appendix Exhibit A1

Patterns of Exit from Employer-Sponsored Coverage in t Post-ACA Periods

Among those who began with employer-sponsored coverage:

	Pre-ACA (2003–2009)	Post-
Stayed employer-sponsored	85.0%	
Individual market	0.9%	
Medicaid	0.8%	
Uninsured	13.2%	
Medicare	0.1%	

Source: Sherry A. Glied and Adlan Jackson, *Who Entered and Exited the Individual Health Insurance Market Before and After the Affordal Medical Expenditure Panel Survey* (Commonwealth Fund, Nov. 2018).

Appendix Exhibit A2

Patterns of Exit from Medicaid in the Pre- and Post-ACA

Among those who began with Medicaid:

	Pre-ACA (2003–2009)	Post-A(
Stayed Medicaid	51.1%	
Individual market	0.5%	
Employer-sponsored	8.0%	
Uninsured	39.3%	
Medicare	1.1%	

Source: Sherry A. Glied and Adlan Jackson, *Who Entered and Exited the Individual Health Insurance Market Before and After the Affordal Medical Expenditure Panel Survey* (Commonwealth Fund, Nov. 2018).

Appendix Exhibit A3

Coverage Switching in the Pre- and Post-ACA Periods, b

Age		Pre-ACA (2003–2009)				Post-ACA (201		
		People switching to individual-market coverage from this source		People switching from individual-market coverage to this source		People switching to individual-market coverage from this source		
		Thousands of switchers over a two-year period	Percent of those who began with this source who switched to individual market	Thousands of switchers over a two-year period	Percent of those with individual-market coverage who switched to this source	Thousands of switchers over a two-year period	Percent of those who began with this source who switched to individual market	Tl s o
25–34	Medicaid	4	0.1%	9	1.3%	210	4.0%	
	Employer-sponsored	258	1.1%	231	32.8%	356	1.5%	
	Uninsured	389	2.7%	186	26.3%	1,749	11.4%	
	Did not switch				**39.7%**			
35–49	Medicaid	22	0.6%	22	1.6%	162	2.8%	
	Employer-sponsored	341	0.8%	282	20.2%	383	1.1%	
	Uninsured	524	3.4%	305	21.9%	1,769	11.5%	
	Did not switch				**56.2%**			
50–63	Medicaid	15	0.7%	14	0.8%	97	2.7%	
	Employer-sponsored	286	0.9%	262	17.1%	987	2.7%	
	Uninsured	386	4.2%	230	15.0%	1,512	13.6%	
	Did not switch				**65.8%**			

Source: Sherry A. Glied and Adlan Jackson, *Who Entered and Exited the Individual Health Insurance Market Before and After the Affordal Medical Expenditure Panel Survey* (Commonwealth Fund, Nov. 2018).

NOTES

1. Sara R. Collins et al., *How The Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016* (Commonwealth Fund, Feb. 2017).

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4. Matthew Eyles and Justine Handelman, *Appropriate Use of Special Enrollment Periods Is Key to Exchange Stability, Affordability for Consumers: Misused Special Enrollment Periods Impact All Consumers Through Higher Costs* (America's Health Insurance Plans and BlueCross BlueShield Association, Feb. 2016).

5. The only statistically significant change was the relative decline in preswitch spending among those who switched to individual-market coverage from employer-sponsored coverage in the post-ACA period.

6. We found similar results when we compared the average number of inpatient, outpatient, or emergency department events in the three months preceding a change in coverage in both time periods and when we recalibrated expenditures in each period based on the three-month expenditures of those continuously enrolled in individual-market coverage (to adjust for rising overall health care costs).

7. Sara R. Collins, Petra W. Rasmussen, and Michelle M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period* (Commonwealth Fund, July 2014).

8. John A. Graves and Sayeh S. Nikpay, "**The Changing Dynamics of U.S. Health Insurance and Implications for the Future of the Affordable Care Act**," *Health Affairs* 36, no. 2 (Feb. 2017): 297–305.

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Topics

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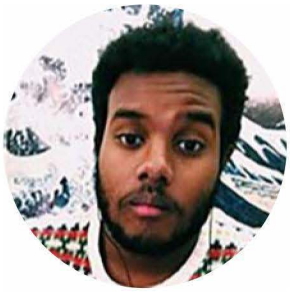

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Fact sheet

Effectuated Enrollment for the First Half of 2018

Nov 28, 2018 Affordable Care Act, Eligibility & enrollment

Share

Effectuated Enrollment for the First Half of 2018

This report provides average effectuated enrollment and premium data for the Federal and State-Based Exchanges for the first six months of the 2018 plan year. The Centers for Medicare & Medicaid Services (CMS) publishes effectuated enrollment data semiannually to provide a more accurate picture of enrollment trends for the Exchanges than indicated by the number of individuals who simply selected a plan during Open Enrollment. For coverage to be considered effectuated, individuals generally must pay their premium for the given month.

As of September 15, 2018, an average of 10.3 million individuals had effectuated their coverage through June 2018, meaning that they selected a plan and paid their premium, if applicable. The average effectuated enrollment for the first six months of 2018 was approximately 137,000, or 1 percent, higher compared to the same time period in 2017.[1]

Similar to past years, the number of individuals who effectuated coverage is lower than the number with plan selections at the end of Open Enrollment. The average number of consumers with effectuated coverage for the first half of 2018 was about 1.5 million lower than the number of consumers with plan selections at the end of the 2018

Open Enrollment Period.[2] However, this reflects lower attrition of consumers compared to the previous year. Effectuated enrollments for the first half of 2017 were about 2.1 million lower than the number of plan selections at the end of the 2017 Open Enrollment Period (as of September 15, 2017).

The data released today also show that the average monthly premium per enrollee for the first six months of 2018 was $595.89, an increase of 26 percent compared to the first six months of 2017, while the average monthly amount of advanced premium tax credits (APTC) per enrollee receiving APTC rose 39 percent to $519.18 when compared with the first six months of 2017 average APTC per enrollee with APTC. The average premium and average APTC amounts have been relatively stable since the start of the 2018 plan year, however, as indicated in the Early 2018 Effectuated Enrollment Snapshot. The proportion of total enrollees who received APTC in the first six months of the year was 87 percent, up from 84 percent in the first half of 2017.

Background Information

The primary source for the first half of 2018 average effectuated enrollment is payment and enrollment data. Effectuated enrollment is the average number of individuals who had an active policy from January through June of 2018, and who paid their premium (thus effectuating their coverage) as of September 15, 2018. This data includes effectuated enrollment for both State-Based Exchanges and States using the HealthCare.gov platform.

APTC enrollment is the average number of individuals who had an active policy from January through June 2018, who paid their premium, if applicable, and received an APTC. APTC is generally available if a consumer's household income is between 100 and 400 percent of the federal poverty level, and certain other criteria are met. A consumer was defined as having an APTC if the applied APTC amount was greater than $0; otherwise, a consumer was classified as not having APTC.

CSR enrollment is the average number of individuals who had an active policy from January through June 2018, who paid their premium, if applicable, and received cost-sharing reductions (CSR).[3] A consumer is generally eligible for CSR if the individual is eligible for APTC, has a household income between 100 percent and 250 percent of the federal poverty level, and enrolled in a health plan from the silver plan category. American Indians and Alaskan Natives are eligible for CSRs under different criteria.

To see a breakdown of the data by state, click here: https://www.cms.gov/sites/drupal/files/2018-11/11-28-2018%20Effectuated%20Enrollment%20Table.pdf

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[1] FIRST HALF OF 2017 AVERAGE EFFECTUATED ENROLLMENT REPORT, https://www.cms.gov/newsroom/fact-sheets/first-half-2017-average-effectuated-enrollment-report

[2] EXCHANGE 2018 OPEN ENROLLMENT PERIOD FINAL ENROLLMENT REPORT: Centers for Medicare & Medicaid Services, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html

[3] On October 12, 2017, the Acting Secretary of HHS directed that cost-sharing reduction payments to issuers be discontinued until a valid appropriation exists. Therefore, CSR enrollment is provided in this report for informational purposes only.

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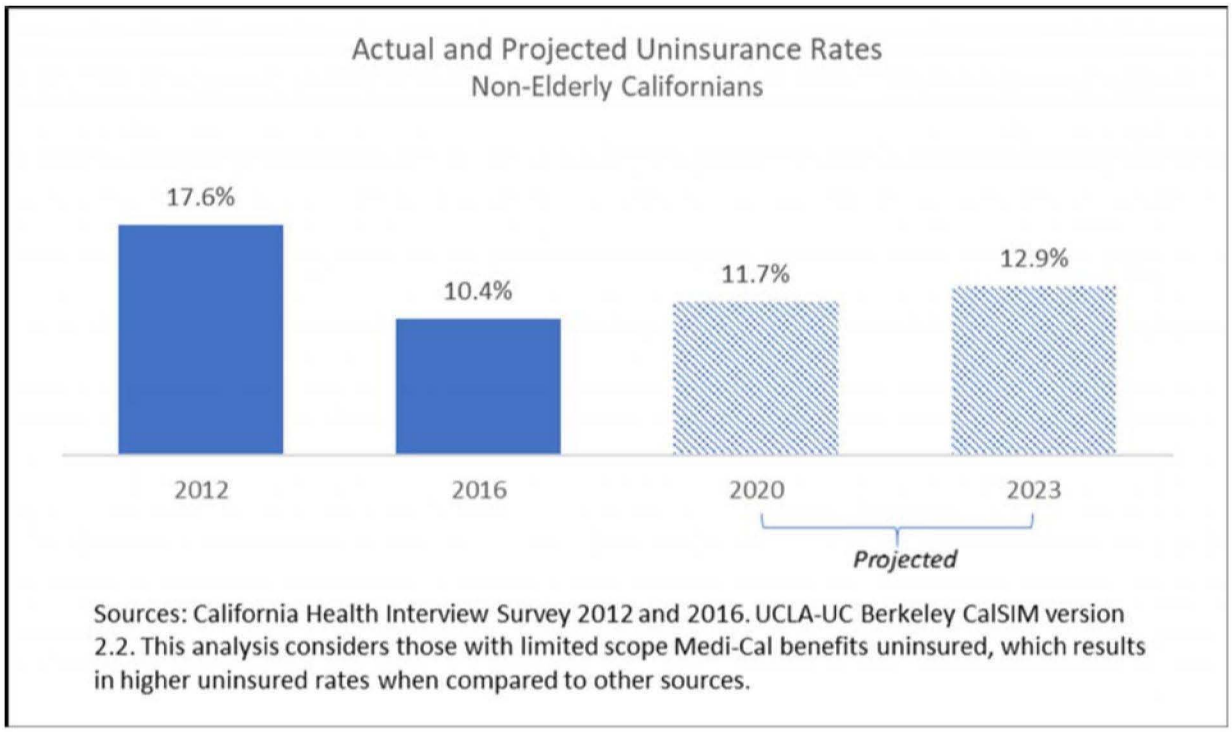
New Projections Estimate the Uninsured will Rise in California

November 28, 2018

By Trish Violett

In the years since implementation of the Affordable Care Act (ACA) California made steady progress in reducing the number of uninsured in the state. According to newly released projections from the California Simulation of Insurance Markets (CalSIM), a micro-simulation model developed by UC Berkeley and UCLA health policy researchers to estimate the impact of various elements of the ACA, this pattern is unlikely to continue without state policy intervention.

Newly released projections from the model estimate that the uninsured rate among non-elderly Californians will increase from 10.4 percent in 2016 to approximately 11.7 percent in 2020 and 12.9 percent in 2023, primarily attributed to the elimination of the federal individual mandate tax penalty beginning in 2019 and ongoing affordability concerns. The updated estimates are based on a definition of uninsured that includes undocumented adults who are only eligible for restricted scope Medi-Cal, which is limited to emergency and pregnancy-related services but does not provide comprehensive, ongoing coverage.



Characteristics of the Projected Uninsured

As of 2020, CalSIM projects an uninsured population of approximately 4 million individuals in California. Specifically, the uninsured are expected to be:

- *Undocumented adults*. More than one in three (1.5 million, or 37 percent) of the uninsured are expected to be undocumented, most between the ages of 30-49 (62 percent), and the majority with low incomes (65 percent with annual income under 138% of the Federal Poverty Level (FPL), or $16,754 for an individual).
- *Eligible for Medi-Cal but not enrolled*. Nearly 1 million individuals (900,000, or 22 percent of the uninsured) are expected to be eligible for Medi-Cal but not enrolled in the program. The unenrolled Medi-Cal-eligible population is expected to be primarily Latino (58 percent).
- *Eligible for subsidized coverage*. Around 530,000 (13 percent) of the uninsured will be eligible for but not enrolled in subsidized coverage through Covered California, and of those individuals, 70 percent will have incomes between 200-400 percent FPL ($24,120-$48,240 annual income for an individual), and 73 percent will be between the ages of 19-49.
- *Varied throughout the state*. Los Angeles County, which accounts for 26 percent of the state's population, will comprise 36 percent of the undocumented uninsured and 35 percent of the uninsured eligible for subsidized coverage through Covered California. The San Francisco Bay Area, which accounts for 19 percent of the state's population, will comprise 26 percent of the uninsured with incomes over 400 percent FPL (more than $48,240 annual income for an individual).

State Actions to Continue Reducing the Uninsured

In today's release of the new CalSIM estimates, the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research list several policies the state could pursue to continue increasing coverage, including expanding Medi-Cal eligibility to additional low-income adults, state-funded subsidies to improve affordability, and continued investment in outreach and enrollment assistance. For additional information on potential state policies to expand coverage and improve affordability, see the updated ITUP Issue Brief, *California Strategies: Covering California's Remaining Uninsured and Improving Affordability*.

California's Health Coverage Gains to Erode without Further State Action

November 27, 2018

Policy Brief

Authors: Miranda Dietz, Laurel Lucia, Dylan H. Roby, PhD, Ken Jacobs, Petra Rasmussen, MPH, Dave Graham-Squire, Xiao Chen, PhD , Gregory Watson, MS, Ian Perry, Gerald F. Kominski, PhD

In 2016, 10.4 percent of non-elderly Californians lacked insurance, compared to 16.6 percent in 2012, according to the California Health Interview Survey (CHIS). Without state action to protect and build upon these coverage gains, authors project that the uninsurance rate could grow to 11.7 percent in 2020, or approximately 4.0 million people, and to 12.9 percent in 2023, or 4.4 million people. These uninsured rates are based on a definition of insurance that excludes restricted-scope Medi-Cal for undocumented Californians.

The federal law zeroing out the ACA individual mandate penalty beginning in 2019 will result in lower individual market and Medi-Cal enrollment, but there is significant uncertainty about how much enrollment will decline in California. Using the California Simulation of Insurance Markets (CalSIM) microsimulation model and a range of assumptions about the extent to which the penalty influences enrollment decisions, the authors project that between 150,000 and 400,000 more Californians will be uninsured in 2020, growing to between 490,000 and 790,000 more uninsured in 2023, compared to if the ACA penalty had been maintained. The most substantial enrollment changes will occur in the individual market, where the authors project enrollment will decline by 10.1 percent in 2020 and 14.4 percent in 2023.

(https://www.shvs.org/)

NOV, 21, 2018

Proposed Marketplace Program Integrity Rule: Summary and Implications for States

Sabrina Corlette, Center on Health Insurance Reforms, Georgetown University

On November 9, 2018, the U.S. Department of Health & Human Services (HHS) published a **proposed set (https://www.gpo.gov/fdsys/pkg/FR-2018-11-09/pdf/2018-24504.pdf)** of new standards for the Affordable Care Act (ACA) marketplaces. The preamble describes these standards as part of HHS' efforts to improve marketplace "oversight and financial integrity." If finalized, they will be effective for the 2020 plan year. HHS is asking for comments on the proposal by January 8, 2019.

What is in the Program Integrity Proposed Rule?

HHS articulates the following priorities for its management of the marketplaces:

- Ensuring enrollees receive the correct amount of financial assistance for marketplace coverage, and that no premium tax credits (PTCs) or cost-sharing reduction (CSR) subsidies are used to pay for abortion services;
- Monitoring and effective oversight of the state-based marketplaces (SBMs) to ensure SBMs are meeting federal law requirements in a transparent manner; and
- Conducting oversight of participating health insurers by requiring maintenance of records and participation in investigations and compliance reviews.

In pursuit of these priorities, the proposed rule includes a few significant operational changes:

- **Biannual data checks.** Requiring SBMs to examine relevant data sources at least twice per year to determine whether enrollees have access to other sources of coverage, such as Medicare, Medicaid, CHIP, or if relevant, the Basic Health Program, that would render them ineligible for PTCs.
- **Authorized plan terminations for Medicare beneficiaries.** Adding a new field to the federally facilitated marketplace (FFM) application that would allow consumers to authorize the marketplace to receive information about the consumer's Medicare eligibility and enrollment. The consumer could further allow the marketplace to automatically terminate their marketplace plan if he or she is found to be dually enrolled. HHS encourages the SBMs to adopt similar changes if they have not already done so.
- **Separate bills for abortion coverage.** Requiring marketplace insurers to separately bill enrollees for the cost of abortion coverage. In other words, enrollees would receive two separate premium bills each month with instructions to remit two separate payments in two separate transactions. Insurers must bill a minimum of $1 per enrollee per month for the abortion coverage, even if the consumer's overall premium is less than $1/month due to premium tax credits.
- **Combating fraud and abuse.** Clarifying that the marketplaces may disclose applicants' personal information to other entities, such as state departments of insurance, in order to investigate and stop fraudulent enrollments by agents and brokers.

For greater detail on the provisions in the proposed rule, see Katie Keith's **summary (https://www.healthaffairs.org/do/10.1377/hblog20181108.108447/full/)** on Health Affairs.

Implications for States and Consumers

The proposed rule contains changes to marketplace operations that will need to be implemented by SBMs and new requirements for marketplace insurers that will require oversight from both SBMs and state departments of insurance (DOIs). These changes will also impact consumers. Below are a few considerations stakeholders may need to address if the proposed rule is finalized.

Biannual Data Checks

The proposed rule requires SBMs to conduct data matching checks at least twice per year to ensure that enrollees are not eligible for or enrolled in Medicare, Medicaid/CHIP or, if applicable, the Basic Health Program. For SBMs that do not currently do so, they will need to implement the necessary business, operational, and information technology changes to come into compliance by 2020. HHS estimates this will cost approximately $1.74 million per SBM.

However, HHS will deem any SBM that has a shared, integrated eligibility system with their state Medicaid program to be in compliance with this requirement. Similarly, if a SBM has an integrated eligibility system with its Basic Health Program, it will be deemed to be in

compliance. After finalizing this rule, HHS will be in touch with the SBMs to assess and confirm which ones will be exempt.

For SBMs that are not exempt and are not currently conducting data matching checks twice yearly, this new requirement will increase administrative costs and, depending on when the rule is finalized and technical specifications are provided, could be difficult to implement in time for the 2020 plan year. Further, although HHS is not proposing specific penalties for SBMs that fail to comply, the agency notes that it could impose a corrective action plan on a SBM that do not meet the new requirements.

HHS predicts that conducting these checks on a more frequent basis will reduce marketplace premiums because the risk profile of Medicare and Medicaid/CHIP beneficiaries tends to be sicker than typical marketplace enrollees. These checks can also help protect enrollees from receiving – and needing to repay – APTC for which they are not eligible.

Authorized Dis-Enrollment for Medicare Beneficiaries

HHS proposes to allow FFM enrollees to authorize the FFM to obtain Medicare eligibility and enrollment information about them. The consumer would further be able to request automatic termination of their marketplace plan if they are found to be enrolled in both programs. Medicare eligibility and enrollment for marketplace consumers has been a frequent source of confusion (https://www.medicarerights.org/newsroom/press-releases/030917-2), placing Medicare-eligible enrollees at risk for premiums for coverage they are not using or potential late enrollment penalties for Medicare Part B coverage. The authorization proposed in this rule could help mitigate problems for some beneficiaries by notifying them of impending Medicare enrollment and reducing incorrect tax credit receipt.

HHS encourages SBMs not already using the single streamlined application to provide this authorization opportunity on their own applications. However, they do not provide details on the operational, technology and data access changes that would need to take place to make this possible.

Separate Payments for Abortion Coverage

Marketplace insurers are responsible for implementing the new “two payments” policy. To ensure insurers’ compliance, HHS declares that if state regulators or marketplaces are not “substantially enforcing” these requirements, HHS will enforce them in the state’s place. Specifically, if state DOIs are not overseeing whether insurers are determining the actuarial value of abortion coverage, separately billing and collecting premiums of at least $1 per enrollee per month for the coverage, and segregating the premiums collected, then HHS will directly enforce the requirements. With respect to insurers operating in FFM states, HHS has put them on notice it will be requiring submission of documentation, including “detailed invoice and billing records” demonstrating compliance with the new requirements.

In addition, marketplace enrollees who fail to pay the abortion-related premium, even if it is only $1, could have their coverage discontinued for non-payment of premiums. SBMs will likely face increased consumer confusion, complaints, and potentially more plan dis-enrollments as a

result of this policy.

HHS estimates that 60 insurers across the SBM states currently offer approximately 1,000 plans that include abortion coverage. A likely result of this policy, if finalized, is that many of these insurers will no longer cover abortion services in order to avoid the administrative and compliance hassles. However, in a few SBM states coverage of abortion services is required; these states will need to consider the operational impacts of this requirement as well as the certainty of widespread consumer confusion.

Stay Tuned: More Marketplace Changes are Coming

The Program Integrity proposed rule is not the only set of marketplace policies expected from HHS this fall. The draft 2020 Notice of Benefit & Payment Parameters will be published soon; this annual rule is likely to include a wide range of additional policy and operational changes for the ACA marketplaces, insurance market reforms, and premium stabilization programs. When that happens, State Health & Value Strategies will be ready to provide states with analysis and support.

DOI: 10.1377/hlthaff.2018.05223

Back In (Regulatory) Action

October brought new guidance on state waivers, more litigation, and preparation for the next open enrollment period.

BY KATIE KEITH

After a quiet period, regulatory activity related to the Affordable Care Act (ACA) picked up again in October, as the Trump administration liberalized criteria for section 1332 state waivers and proposed expanding access to health reimbursement arrangements (HRAs). ACA-related litigation continues apace, and heading into open enrollment for 2019, premiums are stable and insurers' participation in the exchanges is up relative to last year.

New Guidance On Section 1332 Could Enable Broader State Changes

On October 22, 2018, the Department of Health and Human Services (HHS) and the Department of the Treasury released new guidance on section 1332, which allows for "state innovation waivers" under the ACA. These waivers enable states to pursue alternative coverage approaches that are consistent with ACA goals. The new guidance is a dramatic departure from the approach that the departments had previously taken, and it replaces Obama-era guidance from 2015.

Section 1332 allows states, with approval from HHS and Treasury, to waive only certain ACA requirements, such as the employer mandate and various rules for regulating qualified health plans. To waive these standards, states must demonstrate that their proposals provide coverage that is at least as comprehensive and affordable as coverage provided under the ACA (and that their plans do not increase the federal deficit). States must also enact laws to authorize the waiver application and follow certain procedures, such as allowing for public comment.

The new guidance significantly relaxes the departments' interpretation of these section 1332 "guardrails" relative to the 2015 guidance. Under the new guidance, states can seek a waiver to provide access to less comprehensive or less affordable coverage compared to the ACA, including through non-ACA-compliant, medically underwritten plans (such as short-term plans and association health plans), so long as residents who want to maintain ACA coverage can continue to do so.

HHS and Treasury will also focus only on the aggregate effects of a waiver, rather than the effect on a particular group. The 2015 guidance explicitly accounted for a waiver's effects on vulnerable residents (such as those who are elderly, have low incomes, or have serious health issues). By contrast, states can now propose options that may be detrimental for some residents if the proposal improves comprehensiveness and affordability for state residents as a whole. Finally, some states will be able to rely on existing legislation to authorize a section 1332 waiver instead of having to pass new legislation, which has been a barrier in some states.

The guidance notwithstanding, approval of a waiver that fails to meet the statutory section 1332 guardrails is likely to face legal challenges. It also remains to be seen how many states will take advantage of the new guidance and develop waivers not involving reinsurance programs, which have been the focus of all but one of the currently approved waivers. The guidance went into effect immediately, but the departments are accepting comments on the guidance for sixty days.

Health Reimbursement Arrangements Allowed In The Individual Market

On October 23, HHS, Treasury, and the Department of Labor issued a proposed rule to expand the use of HRAs. The proposed rule was developed in response to President Trump's executive order from October 2017 that directed the federal government to expand access to short-term, limited-duration insurance; association health plans; and HRAs. If finalized, the new rule on HRAs would complete the executive order's goals. As proposed, it would go into effect for plan and tax years beginning on or after January 1, 2020.

An HRA is a type of account-based group health plan that allows employers to fund medical care expenses for their employees on a pretax basis. Historically, HRAs (with some exceptions) had to be paired with an ACA-compliant group health plan and could not be used to pay premiums for coverage in the individual market. The proposed rule would reverse this precedent and make two major changes to the regulation of HRAs and other account-based group health plans.

First, the proposed rule would allow employers to provide an HRA that is integrated with individual health insurance coverage (HRA-IIHIC). The departments define *individual health insurance coverage* to include almost any coverage offered in the individual market (except short-term coverage). Employers could offer an HRA-IIHIC so long as they follow the six new integration rules outlined in the proposed rule. These integration rules are designed in part to help ensure that an HRA-IIHIC does not discriminate against employees based on health status; they would prevent an employer from steering employees or dependents away from a traditional group health plan and toward individual cov-

erage. The rule would also prohibit an employee who is offered or receives an "affordable" HRA-IIHIC from being eligible for premium tax credits and would authorize a special enrollment period in the individual market for those who gain access to an HRA-IIHIC.

Second, the proposed rule would allow employers to offer new "excepted benefits HRAs." Qualifying HRAs could be funded up to $1,800 and used to pay premiums for excepted benefits—benefits such as limited vision and dental coverage that are excepted from many ACA requirements—short-term plans, and premiums for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The expanded use of HRAs could spur employers that do not currently offer coverage to fund HRA-IIHICs, increasing access to coverage. Alternatively, the rule could lead to the loss of coverage if employers shift from group health plans to HRAs and employees do not accept the HRA or obtain other coverage. Still other consumers could find themselves newly ineligible for premium tax credits because of a new HRA-IIHIC option. The departments expect that by 2028 an estimated 10.7 million people would be in an HRA-IIHIC and 6.8 million people would no longer have traditional group coverage.

Whether these changes would be good for the individual market would depend on the risk profile of employees offered the new HRA-IIHIC option. The departments assume that employees with HRA-IIHICs would have slightly higher expected health care costs and, as a result, that premiums in the individual market would increase slightly.

The Latest In ACA Litigation

Litigation over the ACA shows no signs of slowing. October brought new district court rulings on cost-sharing reduction (CSR) payments and risk adjustment, new oral arguments, and countless legal filings.

Insurers continue to succeed in their claims against the federal government for unpaid CSR payments. In October Sanford Health Plan joined the Montana Health CO-OP in securing a judgment against the federal government for unpaid CSR payments. Both decisions were issued by Judge Elaine D. Kaplan of the Court of Federal Claims. Other insurers—including through a class action—have similarly sued, and the federal government could face significant obligations to repay unpaid CSRs for at least 2017.

On risk adjustment, Judge James O. Browning of the US District Court of New Mexico denied a request from the federal government to reconsider his prior ruling that part of HHS's risk-adjustment methodology was flawed. Judge Browning's decision had led HHS to temporarily suspend the risk-adjustment program earlier this year. Although HHS has taken steps to address this flaw for 2017 and 2018, it has not done so for 2014–2016; given his most recent ruling, it remains to be seen whether Judge Browning will be satisfied with HHS's justification for 2017 and 2018. HHS may appeal the decision or further justify its rationale for the part of the risk-adjustment formula in question.

Given recent oral arguments, more legal decisions are coming. In mid-October the Ninth Circuit Court of Appeals heard argument over whether to lift a nationwide injunction on recent rules on the contraceptive mandate. New rules issued late last year allowed any nongovernmental organization to avoid providing contraceptive coverage if it objected to doing so for religious or moral reasons.

These rules were successfully challenged by Democratic attorneys general in California and Pennsylvania; both courts granted a nationwide preliminary injunction to prevent the rules from going into effect. Both cases were appealed by the federal government, and the Ninth Circuit held oral arguments on October 19. In the meantime, two new HHS rules on the contraceptive mandate were recently reviewed by the White House and could be released any day.

On October 26 the federal government and a group of organizations representing safety-net insurers, psychiatrists, and patients appeared before Judge Richard Leon of the US District Court of the District of Columbia for a hearing on the recent regulation to expand access to short-term plans. The plaintiffs argue that the rule violates the ACA and is arbitrary and capricious; they have asked the court to enjoin the rule. At the hearing, Judge Leon appeared skeptical of some of the claims and indicated that a ruling likely will not come quickly.

Open Enrollment For 2019

The federal Marketplace—where open enrollment extends from November 1 to December 15—is largely stable for 2019. This is the first year that average monthly premiums for a benchmark plan will drop (by 2 percent relative to 2018), and insurers' participation is up (although it remains lower than it was for 2015 and 2016). Despite relatively stable premiums, an analysis from the Henry J. Kaiser Family Foundation suggests that premiums for 2019 silver plans would have been 16 percent lower but for decisions made by Congress and the Trump administration to, for instance, eliminate the individual mandate penalty and expand access to non-ACA-compliant plans.

Like last year, HHS will spend only $10 million on marketing and outreach and $10 million to support the navigator program—sizable reductions from prior years. Most HealthCare.gov operations will be unchanged for 2019, but HHS will make it easier for consumers to identify health savings account–eligible high-deductible health plans and plans that cover abortion services (beyond certain exceptions).

HHS also recovered from an attack on its direct enrollment pathway that potentially compromised the data of an estimated 75,000 people. The consumer-facing HealthCare.gov website and call center were not affected, and the direct enrollment pathway was quickly restored. ■

Katie Keith (katie.keith@georgetown.edu) is a principal at Keith Policy Solutions, LLC; an appointed consumer representative to the National Association of Insurance Commissioners; and an adjunct professor at the Georgetown University Law Center. [*Published online November 13, 2018.*] Readers can find more detail and updates on health reform on Health Affairs Blog (http://healthaffairs.org/blog/).

Harvard Business Review

COSTS

To Control Health Care Costs, U.S. Employers Should Form Purchasing Alliances

by David Blumenthal, Lovisa Gustafsson, and Shawn Bishop

NOVEMBER 02, 2018

TIM ROBBERTS/GETTY IMAGES

When it comes to health care costs, America's employers are at a crossroads. Competing for scarce labor in a tight market, they will have trouble continuing to shift medical bills onto employees as they have for several decades.

That means that to control costs going forward, employers may have to confront the true underlying causes of rising health care expenditures: high prices and health care inefficiencies. To address these challenges, they will have to band together in purchasing coalitions that give them the local market power to force health systems to reform.

Employers are the largest single provider and purchaser of health insurance in the United States, covering over 150 million workers and their dependents and purchasing 34% of all health care dispensed in the country. As a potential force for change, only the U.S. government can rival America's business community.

And in recent years, employers have enjoyed some success in controlling rising health care costs. Their premiums have been increasing 3% to 5% annually, rather modest by historic standards. As a percent of workers' compensation, employers' health care spending has held steady at between 8% and 9% since 2010. Much of this success seems attributable to the spread of high-deductible health plans (HDHPs), which have shifted more of the costs of care onto employees. The proportion of workers with HDHPs (deductibles of more than $1,300/$2,600 for an individual/family) increased from 6% to 22% between 2006 and 2018. High deductibles have the dual effect of reducing workers' use of services and employers' liability for the services employees use.

So what's the problem? There seems growing nervousness among employers that they've pushed high deductibles about as far as they can. Workers' increasing out-of-pocket costs are creating widespread discontent with the underlying costs of care — a problem largely driven by the high prices charged to private payers for health services and pharmaceuticals. Data from the Commonwealth Fund's biennial survey of the American public shows that the percent of U.S. workers who are underinsured — face out-of-pocket health care expenses greater than 10% of their income excluding premiums — increased from 10% in 2003 to 24% percent in 2016. Between 2011 and 2017, employees' premiums and deductibles grew faster than their median income. Beyond this, studies

clearly show that when workers face high upfront payments, they frequently skip services, some of which are critical to their long-term health and productivity, a pattern that must worry responsible employers.

Add to this picture the increasingly competitive labor market — which limits the tools companies can use to constrain health spending — and it becomes clear that employers may have to find new ways to tame the health care cost tiger in the future. They may have to address the underlying reasons for rising health care premiums, rather than just shifting more of those expenditures off their own books.

Those fundamental reasons are varied and complex but at least two stand out. The first is that health care providers charge employers very high prices — way higher than those paid by public insurers like Medicare and Medicaid. The second is that our health care system is highly inefficient and wasteful. It has enormous administrative costs. Care is fragmented and uncoordinated. We have too many high-priced specialists and not enough high-quality primary care to keep patients out of emergency rooms and hospitals when they could be cared for in less expensive (and dangerous) settings. In other words, employers need to get better deals on prices and remake our health care system while they're at it.

Employers are not new to this game. For decades, large sophisticated companies have undertaken pioneering experiments with reshaping the health care system. As far back as the early 1990s, Pitney Bowes focused on patient education and consumerism and prevention and care management to slow cost growth. Companies such as Boeing have experimented with direct purchasing of health care from providers, securing better prices, and eliminating the administrative costs of insurers. Other employers such as Walmart have cut deals to send their high-end elective procedures (e.g., open-heart surgery, hip and knee replacements) to centers of excellence that offered lower prices and higher quality. Employers have instituted wellness programs in the (now disappointed) hopes that health maintenance could lower costs of care. And companies have come together in regional coalitions such as the Pacific Business Group on Health and the Midwest Business Group on Health for the purpose of sharing lessons on how to become better health care purchasers.

The latest venture in employer health innovation is, of course, the alliance of Amazon, Berkshire Hathaway, and JPMorgan Chase. The as yet unnamed joint venture, led by the highly respected Dr. Atul Gawande, is promising to solve the health care conundrum for its parent companies and perhaps for the nation as a whole.

The fact is, however, that until employers switched to high-deductible plans, they enjoyed relatively little success in restraining health spending. This disappointing record reflects persistent challenges to their cost-control efforts.

The first challenge is lack of purchasing power. All health care is local, and efforts to negotiate better prices and reform health care delivery depend on an employer's ability to force price concessions and behavior change from local physicians and health care institutions. Collectively, employers may constitute an important share of health providers' market. But individually, with the exception of a few companies in a few markets, such as Boeing and Amazon in Seattle, no one employer has enough leverage to wrangle price concessions from area doctors and hospitals or induce them to reshape the way they do business. This is true even for large national companies because their aggregate workforce is spread across tens or hundreds of localities.

Efforts to form purchasing coalitions in local markets have had modest impact at best because employers have so little else in common and because antitrust laws limit their ability to collaborate. The growing consolidation among providers — 90% of metropolitan areas have highly concentrated hospital markets and 65% have highly concentrated specialist physician markets — also works to employers' disadvantage.

A second challenge facing employers is lack of sophistication as health care purchasers. Medicine is complicated, and while there are a handful of large employers such as Comcast or Walmart with the funds and motivation to hire sophisticated health benefits specialists, there are 7 million to 8 million mid-size and small employers who have their hands full just managing their core business in turbulent times. Even if they had the leverage to demand delivery system reforms from providers, most CEOs and CFOs largely lack the time and patience to grasp the complex, non-intuitive, and often experimental interventions involved: accountable care organizations, value-based purchasing, outcomes based pharmaceutical pricing and so on. Better to raise deductibles and move on.

A third challenge is that when employers try to reform health care, they can easily alienate employees. To get better health care deals, employers often have to channel their workers to a select group of providers who offer lower prices and/or better quality. This can sometimes mean bypassing prominent but highest-priced local facilities and specialists where workers are already getting their care or want to if they ever need it — for example, the Partners HealthCare system in Boston, Memorial Sloan Kettering in New York City, and MD Anderson Cancer Center in Houston. In tight labor markets, the last thing employers want to do is to get between workers and their doctors.

To achieve the kind of gains in controlling health care costs that employers want, they will have to get bigger and smarter in the future.

They will need to band together in local purchasing alliances, come to agreement on common features of health insurance products, and then, working with local insurers, wrangle price and delivery concessions from local providers. This will likely require newfound willingness on the part of employers to surrender the freedom to tailor each insurance product to their own specific preferences. It will also require that, working together, employers immerse themselves in the complex details of reforming health care delivery systems so that they push insurers to insist on greater provider accountability for cost and quality, better primary care and prevention, improved care coordination, reduction in administrative costs, and a variety of other nitty gritty health care reforms.

Employers will not be able to do this without help from government. They may need antitrust allowances to band together for joint purchasing of care. They will also need state and federal antitrust authorities to break up increasingly dominant local provider coalitions. They will certainly want to strongly encourage federal and state authorities to pursue value-based payment programs for federally insured populations in the hope that employed populations will benefit from these reforms as well. Some employers may even decide — despite innate opposition to government regulation — that the only way for them to stay in the business of providing insurance to employees will be to have government regulate health care prices in their states. This is the tactic that most industrialized countries use to keep health care affordable for their populations.

The alternative to these fairly radical changes in employer behavior is continuing the hollowing out of employer-sponsored insurance. Aside from the pain this will inflict on workers and their families, this trend could cause the American public generally to lose faith in our current system of employer-sponsored insurance, and open the way politically for alternatives, including government-provided coverage.

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Sal LoDico a month ago

Long ago and in a place far away, as the CHRO for a mid-sized company (4,000 employees), I worked with a major HR consulting firm's benefits team to initiate healthcare business alliances. One of the significant obstacles we faced the unwillingness and/or inability of employers to modify the design of their healthcare (medical, Rx, dental & vision care) plans to the degree necessary. It wasn't that the model was to be "one size fits all" (which it rarely does no matter the solution), nor that employers needed to be in alignment in terms of their employer-employee cost sharing philosophies.

Perhaps these many years later, the pain has reached the level where greater flexibility, advances in technology and a more open to innovation regulatory climate creates the right mix of factors for the business alliance concept to be effective.

In my opinion, the approach might be best to start with a business alliance using the "crawl, walk, run" approach, and thus not encompass all of the components of healthcare plans in the proof it can work phase.

In part, my opinion is based on the reality that there is still a substantial variance in the medical element of employer-sponsored healthcare. So perhaps an alliance would start off tackling one piece, such as Rx plans, for which the annual cost increases have become a major concern due to the double-edged sword of amazing advancements in disease prevention and treatment through the R & D initiatives, but with accompanying sometimes staggering costs to employers and employees.

Salvatore LoDico
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Why Are the Health Insurance Marketplaces Thriving in Some States but Struggling in Others?

November 15, 2018

| **Jon R. Gabel**, **Heidi Whitmore**, **Sam Stromberg**, and **Matthew Green**

ABSTRACT

- **Issue:** In 2017, health insurance marketplaces in some states were thriving, while those in other states were struggling. What explains these differences?
- **Goal:** Identify factors that explain differences in issuers' participation levels in state insurance marketplaces.

- **Methods:** Analysis of the Robert Wood Johnson Foundation's HIX Compare dataset, and the National Association of Insurance Commissioners' *2010 Supplemental Health Care Exhibit Report.*
- **Findings and Conclusions:** State policies and insurance regulations were key factors affecting the number of issuers participating in the marketplaces in 2017. Marketplaces run by states had more issuers than states that rely on the federally facilitated marketplace. States with fewer than four issuers tended to have policies in place that could have been destabilizing — for example, permitting the sale of plans not compliant with the Affordable Care Act's requirements regarding essential health benefits or guaranteed issue. Consumers in states that did not take steps to enforce these insurance market reforms still benefited from their protections, however; they were just enforced at the federal level. States with more issuers were also more likely to have expanded Medicaid. States with fewer issuers tended to be rural and have smaller populations, more concentrated hospital markets, and lower physician-to-population ratios.

Background

After multiple earlier efforts to repeal the Affordable Care Act (ACA) ended in failure, Congress enacted the Tax Cut and Jobs Act in December 2017, which repealed the penalties associated with the individual requirement to have health insurance.[1] The Congressional Budget Office estimates that the repeal of this requirement will increase the number of uninsured Americans between 2017 and 2028 from 29 million to 35 million.[2] Nonetheless, an altered ACA remains the law of the land.

Although ACA supporters and opponents hold vastly different views about health policy, they do share a common goal: increasing the number of issuers participating in the individual insurance market. Higher participation translates into more consumer choice and greater price-based competition among issuers.[3]

In 2017, marketplace competition, measured by the number of participating issuers, varied widely. Five states — Alabama, Alaska, Oklahoma, South Carolina, and Wyoming — each had only one issuer (the state's Blue Cross/Blue Shield plan). Five states — California, New York, Ohio, Virginia, and Wisconsin — had 11 or more issuers.

We examine contemporary and historical factors associated with the broad disparities in issuer participation in state marketplaces and the reasons that some are thriving while others are not. Our principal data come from the Robert Wood Johnson Foundation's HIX Compare, a national database on marketplace plans that contains information on issuer participation, premiums, and benefit design, among other characteristics, covering the period 2014 to 2017. Our second data source is the National Association of Insurance Commissioners' *2010 Supplemental Health Care Exhibit Report,* released in April 2011, which provides names of issuers offering coverage and their 2010 individual market enrollment in each state prior to implementation of the ACA marketplaces.

Findings

ISSUER PARTICIPATION BEFORE AND AFTER THE ACA

In the pre-ACA individual market of 2010, issuer participation varied widely. Exhibit 1 shows that in all states, one or more issuers had at least a 5 percent share of the individual market.[4] In most states, Blue Cross/Blue Shield plans had dominant market shares — more than 50 percent in 41 states and the District of Columbia. Ten states and the District of Columbia had four or more issuers that participated, with the others having two or three.

Exhibit 1

Number of Issuers with 5 Percent or Greater Market Sha Individual Market and Combined Market Share of All B Shield Plans in Individual Market, by State, 2010

Data: National Association of Insurance Commissioners, *2010 Supplemental Health Care Exhibit Report* (NAIC, 2011).

Source: Jon R. Gabel et al., *Why Are the Health Insurance Marketplaces Thriving in Some States but Struggling in Others?* (Commonweal

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In 2015, the ACA marketplaces' second year of operation, issuer participation had increased substantially from 2014. Only two states and the District of Columbia had a single issuer, while most of the rest had four or more (Exhibit 2). By 2017, the number of states with a single issuer had increased to five, still fewer than in the pre-ACA market.[5] The number of states with four or more issuers declined to 26, but in all, the number of those states remained substantially higher than in 2010.

Exhibit 2

Number of Issuers Participating on Individual Marketpl 2015 and 2017

Data: Robert Wood Johnson Foundation, HIX Compare, 2015–2017.

Source: Jon R. Gabel et al., *Why Are the Health Insurance Marketplaces Thriving in Some States but Struggling in Others?* (Commonweal

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STATE SOCIODEMOGRAPHIC EFFECTS ON ISSUER PARTICIPATION

Issuer participation in the marketplaces varied considerably by state sociodemographic characteristics. States with one issuer had populations that were substantially more rural: 38 percent in single-issuer states, compared to 31 percent in two- or three-issuer states and 23 percent in four-or-more-issuer states (Exhibit 3). States with four or more issuers were much more likely to have a large population — in fact, more than three times the average population of the five single-issuer states.

Exhibit 3

Number of Issuers Participating in States, by Sociodemo Health Care Market Characteristics, 2017

Data: Robert Wood Johnson Foundation, HIX Compare, 2017; National Association of Insurance Commissioners, Supplemental Health Ir Community Survey 5-Year Estimates, 2011–2015; 2010 United States Census; 2015–2016 Area Health Resource File; 2012 Dartmouth American Hospital Directory Hospital Statistics by State, 2017.

Note: The Herfindahl-Hirschman Index measures market concentration — the larger the index, the more concentrated the market.

Source: Jon R. Gabel et al., *Why Are the Health Insurance Marketplaces Thriving in Some States but Struggling in Others?* (Commonweal

Median family income was correlated with the number of issuers participating. For example, three of the five single-issuer states had median incomes in the lower third of the country, whereas only five of the 26 states with four or more issuers had median incomes in that lower bracket. At the rating-area level (see Appendix 1), greater population was significantly associated with higher issuer participation, while state-level rurality was not a significant factor.

INFLUENCE OF MARKET FORCES AND RATES OF UNINSURED ON INDIVIDUAL INSURANCE MARKETPLACE

Differences in issuer participation rates also were associated with market power and rates of the uninsured in each state. States with four or more participating issuers had more physicians per 1,000 people than states with one issuer (Exhibit 3). The higher rates of physicians in these states suggest that insurers had more power to build physician networks and negotiate with providers for prices more favorable to the insurers. Conversely, states with a smaller number of issuers were more likely states with greater hospital concentration (measured by gross patient revenue), suggesting that hospitals had more influence in negotiating prices with insurers and this may have deterred insurers from remaining in or entering the state. The Herfindahl-Hirschman Index, a measure of market concentration, was 1,152 in single-issuer states compared to 446 in states with four-plus issuers[6] (the higher the score, the more concentrated the market). In addition, single-issuer states had a higher share of

uninsured residents prior to ACA implementation compared to states with more issuers participating — a finding that may be related to the heavily rural, smaller populations and higher market concentration of single-issuer states.

The number of issuers participating in the individual market in 2010 was a weak predictor of issuer participation in 2017. Despite states' differences in issuer participation in 2017, all states had similar issuer numbers competing in 2010 (Exhibit 3). What appears instead to have been a more important factor was whether states' marketplaces were state-based or federally facilitated. (Exhibit 4). All five single-issuer states used the federally facilitated marketplace, whereas only 57 percent of states with four or more issuers used it. In general, state-based marketplaces used their wider authority to reduce consumer uncertainty and promote stability.[7,8]

Exhibit 4

Average Premiums and Medical Claims, 2012–2016

	One issuer (n=5)	2–3 issuers (n=2(
Total number of state regulations possibly affecting market stabilization	**4.8**	**3.0**
State's regulatory environment	**Share of states + D.C. (%)**	**Share of states + D (%)**
Presence of antinavigator law	40%	30%
Absence of market reforms	80%	30%
No Medicaid expansion	80%	40%
Marketplace was federally facilitated	100%	80%
Grandmothered plans allowed after January 1, 2014	100%	75%
State participation in NFIB lawsuit	80%	40%
Acquisition of CCIIO consumer outreach grants	0%	30%

Data: Robert Wood Johnson Foundation, HIX Compare, 2017; Henry J. Kaiser Family Foundation; and Center for Consumer Information a Insurance Oversight System. Data provided by the Center for Health Insurance Reform, Georgetown University.

Source: Jon R. Gabel et al., *Why Are the Health Insurance Marketplaces Thriving in Some States but Struggling in Others?* (Commonweal

EFFECT OF STATE HEALTH POLICY

Regulations and other ACA-related state policies were also associated with 2017 marketplace issuer participation (Exhibit 4).

We summed several state policies that could potentially destabilize the marketplaces. (See "How We Conducted This Study" for further detail.) States with one issuer in 2017 averaged 4.8 such policies, whereas states with four or more issuers averaged 3.0 policies.

Specifically, compared with single-issuer states, states with four or more issuers were:

- more likely to have expanded Medicaid
- less likely to permit grandmothered plans (73% vs. 100% of single-issuer states)[9]
- more likely to have adopted into state law 2014 ACA market reforms, such as guaranteed issue and essential health benefits.[10]

The absence of state-level market reform legislation consistent with the ACA could have raised concerns about potential gaps in the law's enforcement.[11] Moreover, single-issuer states in 2017 were less likely to have applied for and to have received a federal outreach grant from the Centers for Medicare and Medicaid Services (CMS).[12]

BEHIND THE NUMBERS

Our analysis found some common state characteristics associated with either thriving or struggling marketplaces. States using the federal marketplace tended to have fewer issuers, as did states that did not expand Medicaid and did not adopt into state law various 2014 insurance market reforms.[13] We also found that states' anti-ACA policies were associated with a reduction in the number of issuers participating.

Since the 2017 plan year, enrollment in states using the federal marketplace declined from 9.2 million to 8.7 million, while enrollment through state-based marketplaces remained stable.[14] Many of these latter states invested in enhanced marketing and publicized that their marketplaces were still fully functioning. Moreover, most extended the enrollment period beyond that set by the federal marketplace, and some engaged in other measures promoting enrollment, such as earlier, more targeted advertising and an increased advertising budget.[15]

CMS reports that 11.8 million people were enrolled in the marketplaces at the end of the 2018 plan year enrollment period, a decline of 3.7 percent from the prior year.[16,17] Recent federal policy initiatives have sought to scale back the ACA, such as by nearly eliminating the ACA advertising budget, reducing funding for navigator groups, and halving the duration of the sign-up period.[18] More recently, the U.S. Department of Health and Human Services announced it would cut navigator funding to just $10 million for the current enrollment period, down from $34 million from the previous year and down $63 million in 2017.[19] Other measures — ending cost-sharing reduction payments to issuers, an executive order allowing smaller employers as well as individuals access to non-ACA-compliant association health plans, and expanded access to short-term plans not required to comply with ACA individual health insurance regulations — also could have significant implications for costs and the stability of the marketplaces.[20,21]

While the repeal of the individual mandate included in the tax reform legislation passed in December 2017 will not go into effect until 2019, this measure has the potential to increase adverse selection, which would increase premiums for those purchasing health insurance. In the face of these measures, the relatively slight decline in enrollment appears to demonstrate the marketplaces' resiliency thus far. The fact that 83 percent of 2017 plan-year enrollees received premium subsidies, resulting in an average monthly premium of $89, likely contributed to the lack of a major enrollment decline.[22]

Conclusion

Many factors contribute to why some marketplaces have thrived while others have not. In 2017, factors affecting the number of issuers participating included state-run versus federally facilitated status, rural population, Medicaid expansion, and state responses to 2014 market reforms. The more recent legislative and regulatory changes, such as major reductions in federal advertising and navigator funding, also could have implications going forward, in particular for federal marketplace states.

Strengthening markets for consumers and issuers alike will require initiatives at the federal or state level. At this time, it is not clear whether Congress might make another effort to stabilize the markets by, for example, reestablishing a reinsurance

program. If legislative or regulatory changes do not occur at the federal level, states also could take steps to pass their own reinsurance programs to help stabilize individual markets, as was done in Minnesota, Alaska, and Oregon.[23,24]

HOW WE CONDUCTED THIS STUDY

Data

We used data from two primary sources: the Robert Wood Johnson Foundation's HIX Compare dataset and the National Association of Insurance Commissioners' *2010 Supplemental Health Care Exhibit Report* (SHCE), released in April 2011. The HIX Compare dataset provides information on the universe of marketplace plans from 2014 to 2017, while the SHCE dataset provides information on the individual insurance market in plan year 2010.

For marketplace years 2014–2017, using the Center for Consumer Information and Insurance Oversight's (CCIIO) Health Insurance Oversight System database, we counted all issuers that operated in a given state in a given year, identified by a five-digit code. For 2010, using SHCE data, we limited our universe of issuers to those with 3 percent or 5 percent or greater market share of the individual market that year. This prevented legacy issuers (those who did not enroll new members but whose long-term members were grandfathered in) and other very small issuers from affecting estimates. We calculated each issuer's market share based on total premiums earned. In addition, we calculated figures that helped describe each state's insurance market concentration in 2010, including the market shares of the top three issuers, the top Blues plan, and all Blues plans.

For context, we examined several historical, geographical, and market-level factors that could affect issuer participation—namely, state and county-level data on total population, population by race/ethnicity, and uninsured population from the American Community Survey five-year estimates, 2011–2015; We used the 2010 Census information to determine each state's rural population; the 2015–2016 Area Health Resource File to calculate each state's number of physicians per 1,000 residents; the Dartmouth Atlas to determine each state's number of inpatient hospital beds per 1,000 residents in 2012; Kaiser Family Foundation data on each state's hospital-adjusted expenses per inpatient;[25] and the American Hospital Directory to calculate state-level hospital market concentration of discharges, patient days, hospital beds, and gross patient revenue using a Herfindahl-Hirschman Index.

We also worked with researchers from the Center on Health Insurance Reforms at Georgetown University to incorporate measures of state regulatory policies that could impact market stabilization, including the decision to expand Medicaid (as of January 2017),[26] allowing non-ACA-compliant plans after 2014 (known as "grandmothered" plans),[27] whether states enacted legislation imposing restrictions on navigators or other ACA consumer assisters (as of June 2014),[28] the decision to adopt market reform policies called for in the ACA,[29] the acquisition of grants from CCIIO to aid in consumer outreach efforts regarding the marketplaces,[30] and a state's decision to participate in the landmark *National Federation of Independent Business v. Sebelius* Supreme Court case that challenged the Affordable Care Act.[31] All figures were weighted by state population.

Analysis

We calculated both descriptive and multivariate statistics using unweighted data, as we wanted to assess the relationship between states' policy and political decisions and issuer participation in states' marketplaces. The unit of analysis for descriptive statistics was the state because it is the locus of most policy decisions. For multivariate analysis, the unit was the rating area — a subunit of the state, such as counties or metropolitan statistical areas, that insurers use to adjust premium rates--to provide a sufficient number of observations (n=499 versus n=51). However, because many analytic variables did not differ across rating areas (and differed only across states), a flattening of the results may have occurred because of redundant data in the analysis.

Appendix 1 displays regression results without state-level fixed effects. The dependent variable was the expected number of issuers competing in a rating area, which was transformed to a natural log (Ln). Multicollinearity necessitated omitting some the policy and control variables. We used a Poisson distribution for statistical testing. The distribution for the dependent variable, number of issuers in a

rating area, was truncated at 0. Control variables included the rating area's population and the state's physicians per 1,000 population, hospital beds per 1,000 persons, hospital concentration, and share of its rural population.

Multivariate Findings

To isolate the effects of individual variables on issuer participation in rating areas, we conducted multivariate analysis. Two variables — allowance of grandmothered plans and antinavigator laws — had anomalous positive effects. This was likely related to the high degree of collinearity between a state's various policy decisions and alternate modeling specifications that produce coefficients that are different, but no more robust.

ACKNOWLEDGMENTS

We thank the Commonwealth Fund for the financial support that made this issue brief possible, and also Sara Collins for her insightful comments throughout the project. We also are grateful to Kevin Lucia of Georgetown University for his thoughtful review and guidance in examining Georgetown-collected data.

NOTES

1. Paige Winfield Cunningham, "**The Health 202: A Eulogy for the Individual Mandate**," *Washington Post,* Dec. 21, 2017.

2. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's Spring 2018 Projections* (CBO, n.d.).

3. Richard G. Frank and Thomas G. McGuire, "**Regulated Medicare Advantage and Marketplace Individual Health Insurance Markets Rely on Insurer Competition**," *Health Affairs* 36, no. 9 (Sept. 2017): 1578–84.

4. We used the 5 percent threshold to exclude legacy issuers who are not enrolling new members.

5. The states with one issuer were not the identical states in 2010 and 2017.

6. The Herfindahl-Hirschman Index measures market concentration. It is calculated as the sum of the square of the market share for each firm. We have converted percentages to integers. The larger the Herfindahl-Hirschman Index, the more concentrated is the market.

7. Justin Giovannelli and Emily Curran, *How Did State-Run Health Insurance Marketplaces Fare in 2017?* (Commonwealth Fund, March 2018).

8. Giovannelli and Curran, *How Did State-Run?* 2018.

9. Facing an uproar over higher premiums for individual and small-group plans in November 2013, the U.S. Department of Health and Human Services allowed plans that took effect from March 2010 and October 2013 to continue. These so-called grandmothered plans did not need to meet many of the requirements of the ACA.

10. Katie Keith and Kevin Lucia, *Implementing the Affordable Care Act: The State of the States* (Commonwealth Fund, Jan. 2014). States identified as a "yes" failed to pass a new law or issue a regulation addressing any of the early market or 2014 ACA market reforms. In a number of these states, officials reported they were reviewing insurance policy forms, rates, and/or other materials for compliance with one or more reforms. In addition, some states may have decided not to address a particular reform because state law was already consistent with it or because the state had the authority to enforce federal law. The exhibit does not account for such existing laws or authority.

11. Katie Keith and Kevin Lucia, "**New Guidance: Federal Regulators Allow 'Collaborative Arrangements' for Enforcement**," *To the Point* (blog), Commonwealth Fund, Apr. 5, 2013.

12. Two notable anomalies occur with regard to these policies. First, states with more issuers in 2017 were highly likely to have joined in the National Federation of Independent Business (NFIB) lawsuit against the ACA, which could be seen as destabilizing. Here are two possible explanations for this incongruity. First, larger federal marketplace states (Florida, Georgia, Indiana, Michigan, Pennsylvania, Texas, Virginia, and Wisconsin), all with four or more participating issuers in 2017, joined in the lawsuit. Smaller federal marketplace states (e.g., Montana, Nebraska, Oklahoma, and West Virginia) did not. Second, states with four or more issuers in 2017 were more likely to have passed state legislation limiting activities of navigators as well. Many large states — Florida, Georgia, Illinois, Indiana, Ohio, Texas, Virginia, and Wisconsin — passed statutes that limited the role of navigators.

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25. Henry J. Kaiser Family Foundation, "**Hospital Adjusted Expenses per Inpatient Day**," State Health Facts (KFF, 2016).

26. Henry J. Kaiser Family Foundation, "**Status of State Action on the Medicaid Expansion Decision**," State Health Facts (KFF, as of Nov. 7, 2018).

27. Kevin Lucia, Sabrina Corlette, and Ashley Williams, "**The Extended 'Fix' for Canceled Health Insurance Policies: Latest State Action**," *To the Point* (blog), Commonwealth Fund, updated Nov. 21, 2014. Note that Colorado, New Mexico, and Oregon allowed the existence of noncompliant policies through 2015. At the time of publication, Arizona and Illinois allowed noncompliant policies through 2016, while leaving open the option to permit these policies to continue through 2017.

28. Justin Giovannelli, Kevin Lucia, and Sabrina Corlette, "**State Restrictions on Health Reform Assisters May Violate Federal Law**," *To the Point* (blog), Commonwealth Fund, June 23, 2014. These data are available for federally facilitated marketplaces only and do not include any actions that may have been taken by the states (including D.C.) that operate their own marketplace.

29. Keith and Lucia, *Implementing the Affordable Care Act,* 2014. States identified as a "yes" failed to pass a new law or issue a regulation addressing any of the early market or 2014 market reforms of the ACA. In a number of these states, officials reported that they were reviewing insurance policy forms, rates, and/or other materials for compliance with one or more reforms. In addition, some states may have decided not to address a particular reform because state law was already consistent with it or because the state has the authority to enforce federal law. The exhibit does not consider such existing laws or authority.

30. Center for Consumer Information and Insurance Oversight, *Consumer Assistance Program Grants: How States Are Using New Resource to Give Consumers Greater Control of Their Health Care* (CCIIO, n.d.).

31. Henry J. Kaiser Family Foundation, "**States' Positions in the Affordable Care Act Case at the Supreme Court**," State Health Facts (KFF, 2012).

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Strong Demand Expected for Marketplace Open Enrollment, Despite Administration Actions

By Tara Straw, Sarah Lueck, Shelby Gonzales, and Halley Cloud

On November 1, HealthCare.gov and most state-based marketplaces will begin the Affordable Care Act (ACA)'s sixth open enrollment period, with consumers signing up for 2019 coverage. This open enrollment launches at a time when two major federal policy changes undermining the marketplace take full effect. The first of these is the 2017 tax law's repeal of the penalty related to the ACA's individual mandate (the requirement that most people get health insurance or pay a fee). The second is new Trump Administration rules designed to promote short-term health plans and association health plans, which don't meet ACA benefit standards or include the ACA's protections for people with pre-existing health conditions. Both changes will likely raise premiums and reduce marketplace enrollment.

Nevertheless, the marketplaces have proven resilient in the face of Trump Administration actions that depress enrollment and will likely remain so in the coming year, for several reasons. Surveys show that the large majority of marketplace consumers are satisfied with their coverage, and they'll have even more insurer and plan choices in 2019. Most marketplace consumers are protected from rate increases by offsetting increases in their premium tax credits and, as in 2018, many will find good bargains among the more generous plans.

Administration Actions Will Depress Enrollment

After persistent efforts by congressional Republicans and the Trump Administration in 2017 to repeal the ACA, nearly 1 million fewer people signed up for marketplace plans in 2018 (11.8 million) than at the peak in 2016, the final year of the Obama Administration (12.7 million).[1] More recent Trump Administration actions threaten enrollment once again this year by causing premiums to rise, reducing assistance to consumers, and creating confusion among consumers.

[1] Centers for Medicare & Medicaid Services, "Health Insurance Exchanges 2018 Open Enrollment Period Final Report," April 3, 2018, https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2018-open-enrollment-period-final-report.

Administration Actions Push Up 2019 Premiums

Premiums in 2019 are higher than they otherwise would be, due to a series of Trump Administration actions. During the last two years, the Administration threatened to end cost-sharing reduction payments to insurers and then did so, proposed rule changes expanding substandard health plans that operate outside the ACA marketplaces and then finalized them, backed multiple attempts in Congress to repeal the ACA, and fostered a general atmosphere of uncertainty about whether and how it would enforce key provisions of the law.[2] Late in 2017, Congress passed legislation that eliminated the mandate penalty in 2019, as discussed below, though in some cases insurers raised their 2018 premiums in anticipation of that change or out of concern the Administration would weaken enforcement.[3]

Each of these actions exerted upward pressure on premiums in the individual market. Premiums in 2019 for silver "benchmark" plans are 16 percent higher on average as a result of the repeal of the mandate penalty, the loss of cost-sharing reduction payments, and the expansion of substandard plans, the Kaiser Family Foundation estimates.[4] So while average premiums for these plans will fall 2 percent in 2019 in the 39 states that utilize HealthCare.gov, as the Centers for Medicare & Medicaid Services (CMS) reported,[5] premiums should actually be falling more. Moreover, evidence indicates that flat or falling premiums reflect some insurers having set their 2018 premiums too high as they attempted to deal with sudden Administration policy shifts, especially the end of cost-sharing reduction payments in October 2017.[6]

It's good news that many consumers live in areas that will see little to no premium growth in 2019. However, while tax credits shield the large majority of marketplace consumers from premium increases, as discussed below, that is not the case for people with middle to high incomes. For people who must pay the full cost on their own, high premiums could discourage them from enrolling.

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[2] See "Sabotage Watch: Tracking Efforts to Undermine the ACA," Center on Budget and Policy Priorities, updated September 12, 2018, https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.

[3] Rabah Kamal *et al.,* "An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges," Kaiser Family Foundation, August 10, 2017, https://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/.

[4] Rabah Kamal *et al.*, "How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums," Kaiser Family Foundation, October 26, 2018, https://www.kff.org/health-costs/issue-brief/how-repeal-of-the-individual-mandate-and-expansion-of-loosely-regulated-plans-are-affecting-2019-premiums/.

[5] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "2019 Health Plan Choice and Premiums in HealthCare.gov States," October 26, 2018, https://aspe.hhs.gov/system/files/pdf/260041/2019LandscapeBrief.pdf.

[6] See Rachel Fehr, Cynthia Cox, and Larry Levitt, "Individual Insurance Market Performance in Mid-2018," Kaiser Family Foundation, October 5, 2018, https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-mid-2018/ and Matthew Fiedler, "How Would Individual Market Premiums Change in 2019 in a Stable Policy Environment?" USC-Brookings Schaeffer Initiative for Health Policy, August 2018, https://www.brookings.edu/wp-content/uploads/2018/08/Individual-Market-Premium-Outlook-20191.pdf.

Expansion of Substandard Health Plans Puts Consumers and Market Stability at Risk

In 2019, federal rule changes are expected to boost the number of people enrolled in short-term health plans and association health plans (AHPs). These types of health coverage do not meet ACA benefit standards or include the ACA's pre-existing condition protections, yet under the new federal rules, short-term plans and AHPs could become widespread alternatives to ACA plans in states that allow this to occur.

As of October 2, short-term plans can last up to one year and be extended, instead of being limited to three months as under prior rules. And AHPs, which are health plans that trade and professional groups offer to their members, can now be formed more easily and offered to self-employed individuals (and small businesses), even though they don't have to meet ACA standards that otherwise apply to coverage offered to individuals and small businesses. Neither AHPs nor short-term plans must meet the ACA's essential health benefits requirements, so they can leave out or sharply limit coverage for mental health care, prescription drugs, or substance use disorder treatment. AHPs can charge people higher rates based on characteristics such as gender, age, and occupation (though not health status). Short-term plans *can* deny coverage and charge higher rates based on health status; they also can impose dollar limits on the benefits they will pay out during the coverage period and broadly exclude coverage related to a person's pre-existing conditions.

Some consumers who would have enrolled in ACA marketplace plans could instead be lured to short-term plans or AHPs, particularly if they expect to be healthy or do not realize that the coverage is far less comprehensive than marketplace coverage. Companies offering short-term plans typically market them aggressively; in some cases they are explicitly targeting the ACA open enrollment period for a marketing push, even though there is no deadline to sign up for these plans.[7] This will likely increase consumers' confusion.

The looming expansion of substandard plans raises two major concerns. The first is that some consumers will enroll in a substandard plan and then get sick or injured, leaving them with high out-of-pocket costs or difficulty accessing coverage of needed services. The second is that the proliferation of such plans will cause the traditional insurance risk pool to deteriorate by siphoning off healthier enrollees, which would threaten the market's stability over time and leave individuals — specifically, those ineligible for premium tax credits — paying significantly higher premiums. The Urban Institute estimated that the federal expansion of short-term plans, combined with elimination of the individual mandate penalty, would increase premiums for ACA plans by 18.3 percent and leave 9 million fewer people with minimum essential coverage.[8]

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[7] Sarah Lueck, "Key Flaws of Short-Term Health Plans Pose Risks to Consumers," Center on Budget and Policy Priorities, September 20, 2018, https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers.

[8] 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 2018, https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.

Repeal of Individual Mandate Will Raise Premiums and Depress Enrollment

The coming open enrollment period will be the first since the 2017 tax law repealed the individual mandate penalty. In 2019 alone, eliminating the penalty will lower Medicaid enrollment by 1 million people and nongroup insurance enrollment (on and off the marketplace) by 3 million, while raising the number of uninsured by 4 million, the Congressional Budget Office (CBO) estimates.[9] In one survey of adults with insurance coverage, 5 percent overall said they would drop their coverage in 2019 due to repeal of the penalty, while 9 percent of people in the individual market said they wouldn't re-enroll.[10]

The individual mandate was intended to keep healthy people in the marketplace to maintain a stable risk pool. Without this nudge to enroll, premiums will rise. CBO estimated that premiums will be 10 percent higher in 2019 than they would be absent the change, as fewer healthy people will enroll in the regulated nongroup market and sicker people will remain.[11] *Nearly 8 in 10* insurers surveyed said they increased 2019 rates due to repeal of the penalty, by an average of 5 percent.[12] This follows double-digit premium hikes in 2018 driven by concerns about non-enforcement of the mandate and the other regulatory uncertainty fueled by the Trump Administration's year-long ACA repeal effort.[13]

Outreach Cuts Will Mean Less Assistance and Lower Enrollment

The Administration has sharply cut marketplace outreach and enrollment assistance, making it less likely that new consumers will learn about the coverage and financial assistance available to them. Outreach and marketing have shrunk to $10 million, a 90 percent cut since 2016, despite continued evidence that advertising yields enrollment gains.[14] (See Figure 1.) For purposes of comparison,

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[9] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 2018, https://www.cbo.gov/system/files?file=2018-06/53826-healthinsurancecoverage.pdf.

[10] Sara R. Collins *et al.,* "First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.-Mar. 2018," *To the Point*, Commonwealth Fund, May 1, 2018, https://www.commonwealthfund.org/blog/2018/first-look-health-insurance-coverage-2018-finds-aca-gains-beginning-reverse?redirect_source=/~/media/b404ef047f9e4858b22305756550caf0.ashx.

[11] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028."

[12] Beth Fritchen and Kurt Giesa, "Oliver Wyman Survey: The Affordable Care Act's Stabilization," Oliver Wyman, June 20, 2018, https://health.oliverwyman.com/2018/06/aca_survey.html.

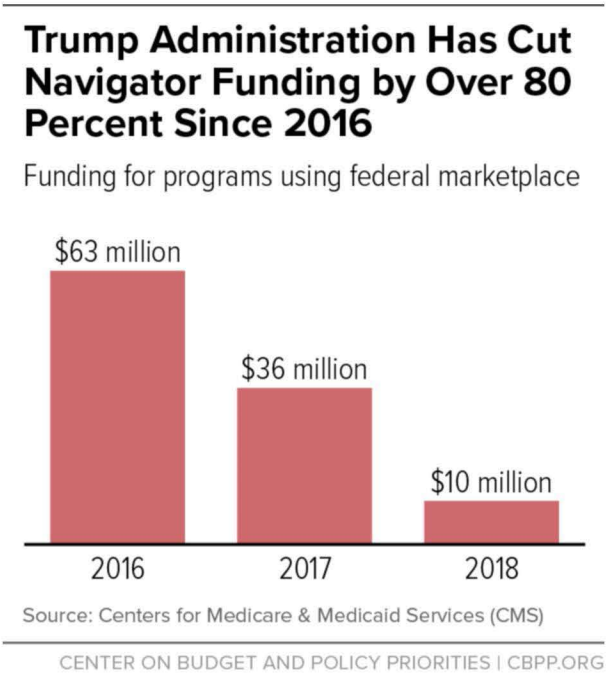
[13] For a general discussion, see Kurt Giesa, "Analysis: Market Uncertainty Driving ACA Rate Increases," Oliver Wyman, June 4, 2017, https://health.oliverwyman.com/2017/06/analysis_market_unc.html. An example of insurers' aggressive response to the loss of the mandate in their 2018 rates occurred in Pennsylvania, where UPMC received state approval for a rate increase of 41.15 percent, or more than five times the expected growth in medical costs (7.01 percent). See https://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/Documents/2018%20ACA/UPMC%20HO%20-%20IND%20-%202018%20Rate%20Decision%20Summary%20Final.pdf.

[14] Ariel Cohen, "CMS Not Increasing ACA Marketing and Outreach Budget for 2019," Inside Health Policy, September 21, 2018, https://insidehealthpolicy.com/daily-news/cms-not-increasing-aca-marketing-and-outreach-budget-2019. See, for example, Sarah E. Gollust *et al.,* "TV Advertising Volumes Were Associated with Insurance Marketplace Shopping and Enrollment in 2014," *Health Affairs*, June 2018, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1507.

California's state-based marketplace, which has made a concerted effort to invest in outreach and enrollment assistance, will spend $6.5 million on its statewide navigator program and $45 million on paid advertising.[15]

Similarly, CMS has cut funding for enrollment help by navigator programs by more than 80 percent since 2016, leaving only $10 million to spread across 34 states, despite an ongoing need for in-person assistance.[16] (Navigator programs raise awareness about the marketplace, help people apply for federal subsidies, provide impartial information about plan options, and help consumers with issues such as filing appeals and submitting eligibility documentation.) In Florida, five groups received nearly $6.6 million in navigator funding last year to enroll 1.7 million people, the most in any state; this year a single group will receive only $1.25 million to serve the entire state. In Texas, navigator coverage will fall far short of the previous, near statewide coverage, with no funded navigators in San Antonio, Dallas, Fort Worth, Austin, Corpus Christi, Waco, or the entire Texas Panhandle. Three states — Iowa, Montana, and New Hampshire — will have no navigator at all.

FIGURE 1



Compounding the harm of the funding cuts, the Administration abandoned the practice of awarding multiyear grants, which was meant to promote continuity and expertise among navigator organizations, instead announcing single-year funding only seven weeks before open enrollment.[17] This left little time for awardees to set their budgets and hire and train enrollment workers, or for qualified applicants denied grants to replace that funding with money from other sources.

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[15] Covered California, "Fiscal Year 2018-2019 Budget," June 15, 2018, https://hbex.coveredca.com/financial-reports/PDFs/CoveredCA_2018-19_Budget-6-15-18.pdf.

[16] Karen Pollitz, Jennifer Tolbert, and Maria Diaz, "Data Note: Further Reductions in Navigator Funding for Federal Marketplace States," Kaiser Family Foundation, September 24, 2018, https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/. See also Halley Cloud, "In Latest ACA Sabotage, Administration Nearly Eliminates Marketplace Enrollment Assistance Funds," Center on Budget and Policy Priorities, July 13, 2018, https://www.cbpp.org/blog/in-latest-aca-sabotage-administration-nearly-eliminates-marketplace-enrollment-assistance-funds.

[17] Centers for Medicare & Medicaid Services, "Grants Awarded for the Federally-Facilitated Exchange Navigator Program," September 12, 2018, https://www.cms.gov/newsroom/press-releases/grants-awarded-federally-facilitated-exchange-navigator-program.

Proposed "Public Charge" Changes Could Raise Immigrants' Fears

The Administration recently proposed a rule that could frighten families that include immigrants from obtaining marketplace coverage for which they are eligible. If finalized, the Department of Homeland Security rule would make it much harder for many immigrants lawfully in the country to remain here and for many seeking legal entry to come. The rule directs immigration officials to reject applications from individuals who seek lawful permanent resident status, or seek to enter the United States, if they have received — or are judged likely to receive in the future — any of an extensive array of benefits tied to need, including Medicaid. Although receipt of marketplace subsidies is not one of the benefits that would lead to rejection of an immigration application, the proposed requirements are complex and confusing. Many families that include immigrants may be afraid to apply for marketplace subsidies, given the Administration's harsh stance on immigration and the significant media attention that the proposed changes have received. (Consumers who apply for marketplace subsidies must also be screened for Medicaid eligibility; this link between the application processes for the two programs could cause further fear and confusion.)

The proposed public charge rule is far from becoming final, and it specifies that changes related to benefit use in the immigration process would not begin until 60 days after the rule is finalized. This should provide some reassurance to families seeking to enroll in health coverage. Still, many people will likely be deterred, fearing that enrolling in health coverage could prevent them from realizing their families' immigration-related goals.

Efforts to Undermine ACA Have Created Consumer Confusion

Some people who need health coverage likely doubt the ACA is still law. A Government Accountability Office (GAO) report documenting the factors that likely affected 2018 enrollment cited consumer confusion about whether the ACA had been repealed and whether coverage was still available.[18] After Congress's year-long effort to repeal the law in 2017, President Trump continued the repeal rhetoric this year, saying in the State of the Union that "[w]e repealed the core of disastrous Obamacare"[19] and stating as recently as May that "[e]ssentially, we are getting rid of Obamacare."[20]

Compounding consumer uneasiness, the Administration announced in June that it won't defend the ACA against a court challenge by 20 Republican-led states that seeks to invalidate the entire law.[21] In particular, the Justice Department asked the court to strike down two critical consumer

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[18] U.S. Government Accountability Office, "Health Insurance Exchanges: HHS Should Enhance its Management of Open Enrollment Performance," July 2018, https://www.gao.gov/assets/700/693362.pdf.

[19] Amy Goldstein, "Trump's claim that 'core of the disastrous Obamacare' is gone," *Washington Post*, January 30, 2018, https://www.washingtonpost.com/politics/2018/live-updates/trump-white-house/fact-checking-and-analysis-of-trumps-state-of-the-union-2018-address/trumps-claim-that-core-of-the-disastrous-obamacare-is-gone/?utm_term=.daaa4904aa52.

[20] See, for example, Michael Ollove, "Health Insurance Premiums Are Stabilizing, Despite GOP Attacks," Stateline, August 16, 2018, https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/16/health-insurance-premiums-are-stabilizing-despite-gop-attacks.

[21] Letter from the Office of the Attorney General, Department of Justice, to Speaker of the House of Representatives Paul Ryan, June 7, 2018, https://www.justice.gov/file/1069806/download.

protections: the provision that bars insurers from denying coverage to people with pre-existing conditions (guaranteed issue) and the prohibition on charging higher premiums to people because of their health status (community rating).

The insurance landscape for 2019 will also leave consumers confused. As noted, a flood of new plans with substandard benefits will be marketed alongside more comprehensive plans during marketplace open enrollment. At the same time, there will be fewer impartial, trained experts to explain the differences and little time to do it: once again, open enrollment for states using HealthCare.gov will be only 45 days long (ending on December 15), shorter than in many states with a state-based marketplace.[22]

The shorter open enrollment period will leave consumers with fewer opportunities to hear about HealthCare.gov and less time to visit, shop for plans, and get questions answered. It will also deny them the option of waiting out the holiday season and signing up for coverage in January. Low- and moderate-income families experience especially high financial stress in December, which may discourage them from enrolling in coverage at that time of year, a study by Harvard and Vanderbilt researchers found.[23]

Consumer Demand for Coverage Expected to Stay Strong

Despite the headwinds described above, marketplace coverage will remain attractive to consumers, for several reasons.

Most Marketplace Consumers Are Satisfied With Their Coverage

The starting point for open enrollment sign-ups is the roughly 10 million current marketplace consumers.[24] More than 80 percent of marketplace enrollees were satisfied with their coverage in 2017, similar to previous years, surveys show.[25] (See Figure 2.) Despite repeal of the individual

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[22] Six of the 12 states that operate their own enrollment platform (California, Colorado, District of Columbia, Massachusetts, Minnesota, and New York) extend their open enrollment period beyond the federal minimum. For a list of open enrollment deadlines in state-based marketplaces, see Louise Norris, "What's the Deadline to get Coverage during Obamacare's Open Enrollment Period?" healthinsurance.org, October 10, 2018, https://www.healthinsurance.org/faqs/what-are-the-deadlines-for-obamacares-open-enrollment-period/.

[23] Katherine Swartz and John Graves, "Shifting the Open Enrollment Period for ACA Marketplace Could Increase Enrollment and Improve Plan Choices," *Health Affairs*, July 2014, https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0007.

[24] Centers for Medicare & Medicaid Services, "Early 2018 Effectuated Enrollment Snapshot," July 2, 2018, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf.

[25] Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty, "Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March-June 2017," Commonwealth Fund, September 2017, https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand.

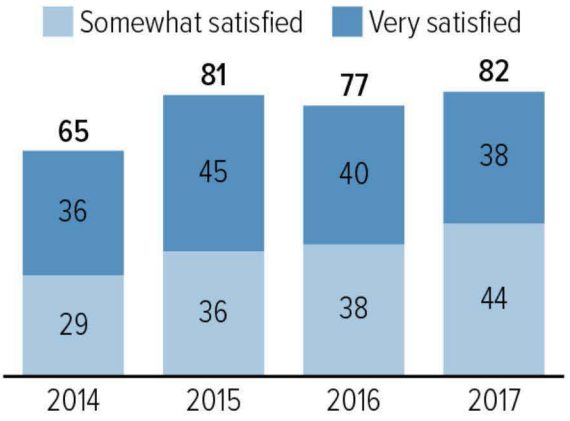
mandate penalty, 90 percent of individual market enrollees (on and off marketplace) plan to re-enroll for 2019.[26]

Re-enrollment isn't appropriate for all consumers; some obtain job-based coverage, experience income changes that make them eligible for Medicaid, or otherwise find a new source of coverage. Nonetheless, in previous years, high satisfaction rates among marketplace consumers have translated into high re-enrollment rates. Last year, for example, nearly 5.5 million consumers came back to HealthCare.gov or their state marketplace and actively selected a plan, in addition to the nearly 2.9 million who were re-enrolled automatically.[27] Returning consumers made up 73 percent of all 2018 enrollment.

FIGURE 2

Most Marketplace Consumers Are Satisfied with Their Coverage

Share of adult marketplace enrollees



Note: Consumers in the Affordable Care Act (ACA) marketplace

Source: Commonwealth Fund ACA Tracking Surveys

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Additionally, high satisfaction rates mean that as the ACA marketplaces mature, a growing number of people have prior, often positive marketplace experience. They may be more likely to return to the marketplace as "new" consumers if their circumstances change again.

Insurer Participation Will Increase

In recent years, some insurers reduced participation in ACA marketplaces or left them entirely due to financial losses and the unpredictable policy environment. But in 2019, some insurers are newly entering the marketplaces, others that left in 2016 and 2017 are returning, and existing insurers are expanding the areas they serve. According to CMS, 23 more insurers will offer plans in 2019 than did so during the last open enrollment period, and only five states are expected to have a single insurer offering marketplace coverage, down from eight states in 2018.[28] This will increase some consumers' array of plan choices (on average, consumers will have 26 plans to choose from, up from 25 in 2018), which could help them find a plan with features — such as a provider network and deductible level — that meet their needs. Greater competition among insurers also could help reduce premiums for people who don't qualify for subsidies.

[26] Ashley Kirzinger *et al.,* "Kaiser Health Tracking Poll – March 2018: Non-Group Enrollees," Kaiser Family Foundation, April 3, 2018, https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/.

[27] Centers for Medicare & Medicaid Services, "Health Insurance Exchanges 2018 Open Enrollment Period Final Report."

[28] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "2019 Health Plan Choice and Premiums in HealthCare.gov States."

In addition, if participating insurers ramp up their marketing activities and enrollment assistance, this could boost awareness about marketplace plan options, ACA subsidies, and the benefits of adequate coverage.

Most Marketplace Consumers Are Protected From Rate Increases

Under the ACA, marketplace consumers with incomes below 400 percent of the poverty level (about $100,000 for a family of four) can purchase silver benchmark coverage for no more than a specified fraction of their income, regardless of sticker price premiums. This fully shields them from premium increases. For example, a family of four with income of $50,000 is guaranteed the option to purchase benchmark coverage for no more than about 6.5 percent of their income, or about $270 per month. When sticker prices increase, the family's premium remains the same, with their premium tax credit adjusting to make up the difference. In 2018, while sticker price premiums for benchmark coverage increased by an average of 37 percent in HealthCare.gov states,[29] average net monthly premiums for the more than 85 percent of consumers qualifying for subsidies *fell* from $106 to $89.[30] (See Figure 3.)

The large majority of both current and potential marketplace enrollees are eligible for a premium tax credit. Eighty-seven percent of 2018 marketplace enrollees qualified for a credit.[31] Likewise, the Urban Institute estimates that one-quarter of the remaining uninsured (about 7.5 million of the 30 million uninsured) are potentially eligible for a credit because their incomes are below 400 percent of the poverty level.[32] The Department of Health and Human Services (HHS) and independent analysts estimate that a substantial majority of individual market consumers who purchase off-marketplace could qualify for a credit if they switched to marketplace coverage.[33]

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[29] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange," October 30, 2017, https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.

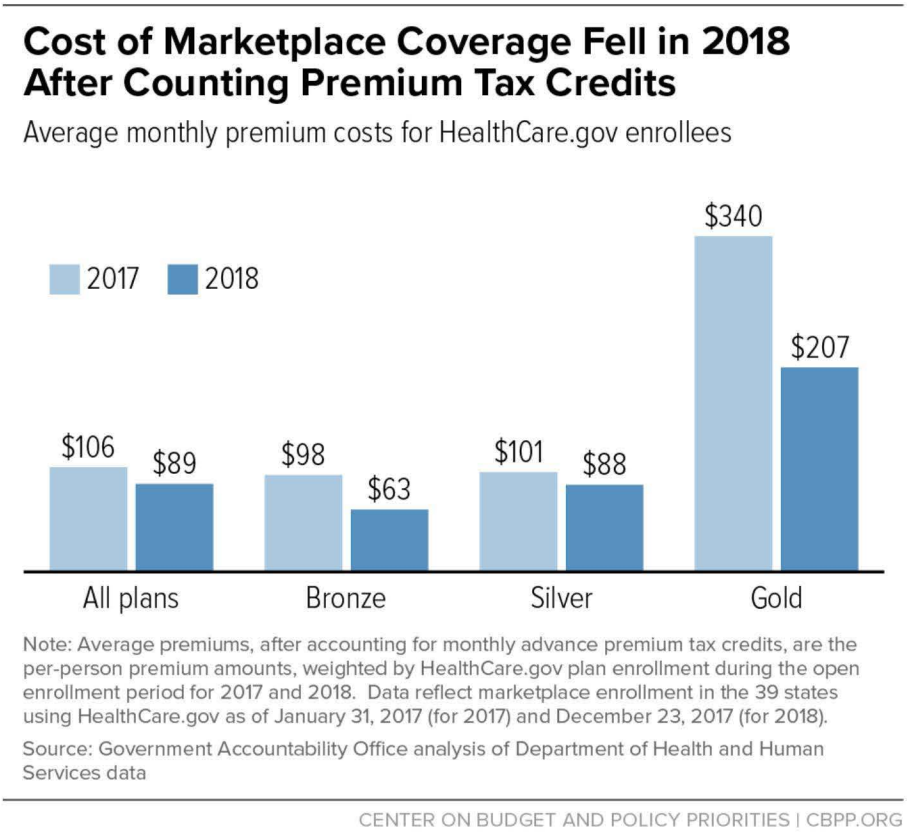
[30] Centers for Medicare & Medicaid Services, "Health Insurance Exchanges 2018 Open Enrollment Period Final Report"; Centers for Medicare & Medicaid Services, "Health Insurance Marketplaces 2017 Open Enrollment Period Final Open Enrollment Report," March 15, 2017, https://www.cms.gov/newsroom/fact-sheets/health-insurance-marketplaces-2017-open-enrollment-period-final-enrollment-report-november-1-2016.

[31] Centers for Medicare & Medicaid Services, "Early 2018 Effectuated Enrollment Snapshot."

[32] Linda J. Blumberg *et al.,* "Characteristics of the Remaining Uninsured: An Update," Urban Institute, July 2018, https://www.urban.org/research/publication/characteristics-remaining-uninsured-update/view/full_report.

[33] Department of Health and Human Services, Assistance Secretary for Planning and Evaluation, "About 2.5 Million People Who Currently Buy Off-Marketplace May Be Eligible for ACA Subsidies," October 4, 2016, https://aspe.hhs.gov/system/files/pdf/208306/OffMarketplaceSubsidyeligible.pdf. In addition, McKinsey analysts estimated that about 70 percent of consumers across the entire individual market have incomes below 400 percent of the poverty level. McKinsey Center for U.S. Health Reform, "Exchanges three years in: Market variations and factors affecting performance," May 2016, https://healthcare.mckinsey.com/exchanges-three-years-market-variations-and-factors-affecting-performance.

FIGURE 3



Many Consumers Can Afford More Generous Plans

Many consumers eligible for a premium tax credit will be able to find good bargains for 2019 coverage, similar to 2018. A large share of last year's premium increases resulted from the Trump Administration's decision to stop cost-sharing reduction payments, which reimburse insurers for the cost-sharing assistance the ACA requires them to provide to lower-income enrollees. This assistance is available only to consumers who enroll in marketplace silver plans, so insurers in most states raised premiums for silver plans but *not* for bronze, gold, or platinum plans to account for the loss of those payments. (This practice was referred to as "silver loading.")[34]

Consumers' premium tax credits rise to match increases in silver plan premiums, regardless of whether they purchase a silver plan or a different coverage tier. As a result, enrollees in 2018 coverage had a larger credit to apply to a marketplace plan; many found particularly good bargains among gold plans (which have higher premiums but significantly lower deductibles) and bronze plans (which have hefty deductibles but modest premiums), where the 2018 premium increases were much smaller than among silver plans. In 2018, the lowest-cost gold plan cost less than the lowest-

[34] David Anderson *et al.,* "Implications of CMS Mandating a Broad Load of CSR Costs," *Health Affairs* blog, May 15, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180511.621080/full/.

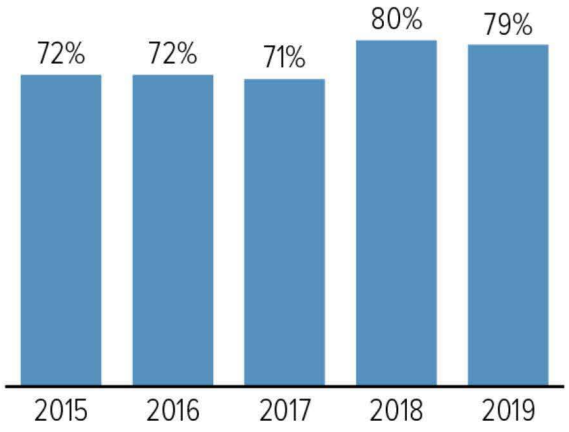
cost silver plan in nearly 500 counties nationwide, and more than half of people who were uninsured and eligible for marketplace coverage could have obtained a bronze plan for *zero* net premium.[35]

For consumers eligible for premium tax credits, silver loading will result in similarly good deals for bronze and gold plans in 2019, despite a 3 percent drop in the average monthly tax credit.[36] Overall, HHS estimates that 79 percent of HealthCare.gov consumers can find a 2019 plan with a premium of less than $75 per month after tax credits.[37] (See Figure 4.) Gold plans are also more affordable. For example, a 40-year-old consumer with income of $30,000 in Des Moines, Iowa, can choose a bronze plan with a $6,200 deductible at zero net premium, or for a premium of less than $7 per month, enroll in a gold plan with a $750 deductible.

FIGURE 4

79% of HealthCare.gov Consumers Can Enroll in a 2018 Plan for Less Than $75 Per Month

Share of consumers who can buy a plan for less than $75 per month, after accounting for tax credits



Source: Department of Health and Human Services

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In addition to creating bargains among gold and bronze plans, higher silver prices made more families eligible for premium tax credits (since eligibility is based on benchmark premiums as a specified share of household income). As a result, in 2018, enrollment among people with income between 301 and 400 percent of poverty was up 10 percent in states that use HealthCare.gov.[38] With premiums relatively unchanged in many areas, the same trend should continue for 2019.

Even consumers who are ineligible for premium tax credits might benefit. More than half of unsubsidized consumers enroll in bronze or gold plans,[39] and because premium increases will be smaller for those tiers than for silver plans, unsubsidized consumers may find better deals than they expect in those tiers. (Most will still face significantly higher premiums than they would have if not for the Administration's actions, however.) In some parts of the country, gold plans will cost

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[35] Ashley Semanskee, Gary Claxton, and Larry Levitt, "How Premiums are Changing in 2018," Kaiser Family Foundation, November 29, 2017, https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/.

[36] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "2019 Health Plan Choice and Premiums in HealthCare.gov States."

[37] *Ibid.*

[38] Andrew Sprung and David Anderson, "Mining the Silver Lode," *Health Affairs* blog, September 7, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180904.186647/full/.

[39] Ashley Semanskee, Gary Claxton, and Larry Levitt, "How Premiums are Changing in 2018," Kaiser Family Foundation, November 29, 2017, https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/.

consumers about the same as, or less than, silver plans, allowing unsubsidized consumers to reduce their premium *and* lower their deductible by switching from silver to gold. Likewise, bronze plans may offer a better deal than silver plans: while they still have higher deductibles, the premium discount they offer is substantial, as it was in 2018. The lowest-premium plan costs 29 percent less than the benchmark silver plan in 2019 on average across HealthCare.gov states — identical to last year.[40]

[40] Centers for Medicare & Medicaid Services, "Average Monthly Premiums for Second-Lowest Cost Silver Plan and Lowest Cost Plan for States Using the HealthCare.gov Platform, 2016-2019," data as of September 28, 2018, https://www.cms.gov/sites/drupal/files/2018-10/10-11-18%20Average%20Monthly%20Premiums%20for%20SLCSP%20and%20LCP%202016-2019.pdf.

October 2018 | Issue Brief

Why do Short-Term Health Insurance Plans Have Lower Premiums than Plans that Comply with the ACA?

Larry Levitt, Rachel Fehr, Gary Claxton, Cynthia Cox, Karen Pollitz

The Trump administration earlier this year issued a regulation that expands the availability of "short-term" health insurance plans that do not have to comply with any of the rules in the Affordable Care Act (ACA) for plans sold in the individual market. Specifically, the regulation allows short-term plans to be offered for up to 364 days and renewed at the discretion of the insurer for up to three years. Short-term plans are also expected to be more attractive now that ACA's individual mandate penalty has been repealed, since people previously enrolling in these plans were liable for the penalty.

Short-term plans pose tradeoffs for consumers. On the one hand, they typically have substantially lower premiums than ACA plans. On the other hand, they exclude people with pre-existing conditions – an estimated 27% of all non-elderly adults -- and offer more limited benefits than ACA plans.

In this analysis, we quantify the effects of the eligibility rules and more limited benefits generally found in short-term plans on the premiums in those plans. We estimate that by screening out people with pre-existing conditions and providing less comprehensive benefits, insurers may be able to offer short-term plans at premiums 54% lower than ACA-compliant plans.

Denial of Coverage to People with Pre-Existing Conditions

Short-term plans generally limit coverage of pre-existing conditions in two ways: by denying insurance altogether to people with pre-existing conditions, and by excluding coverage of pre-existing conditions for people who are offered a policy. By covering primarily people who are healthy at the time they apply, short-term plans have much lower claims costs than ACA-compliant plans and can charge substantially lower premiums.

We estimate conservatively that excluding coverage of pre-existing conditions results in 38% lower premiums relative to ACA-compliant plans.

Our estimate is derived by comparing average health care expenses paid by insurance for people with private health insurance overall – which includes a mix of both healthy and sick people in individual and employer-based plans – to average expenses for people who do not have a pre-existing condition that would have led to a denial of insurance before the ACA. The estimate is conservative because it assumes

that the ACA's risk pool includes a proportionate mix of healthy and sick enrollees, while it is likely that actual enrollment in ACA individual market plans are disproportionately sick. To the extent the current ACA risk pool is sicker than average, the potential reduction in premiums in short-term plans that exclude people with pre-existing conditions could be greater. If insurers start to offer guaranteed renewable short-term policies, the premium advantage would moderate as some enrollees develop health conditions over time. However, our review of products now on the market suggests that insurers are generally not yet offering a renewal option.

Limited Benefits

Short-term plans often exclude or severely limit benefits that ACA-compliant plans are required to cover, including prescription drugs, maternity care, mental health, and substance use treatment. Excluding people with pre-existing conditions eliminates a substantial amount of expenses in each of these benefit categories, but excluding the categories altogether further reduces spending and premiums.

Eliminating prescription drug coverage reduces premiums by an estimated 13%, after accounting for the reduction from excluding people with pre-existing conditions. This estimate is based on analysis of prescription drug expenses paid by private insurance for people without pre-existing conditions. Since the survey data on which this estimate is based do not account for rebates provided by drug manufacturers to insurance companies, it is likely slightly overstated.

Maternity expenses account for an estimated 3.4% of claims expenses in private insurance plans. However, because women who are pregnant at the time they apply for coverage would be excluded, the effect on premiums would be approximately one-quarter of that amount, or about 0.85%.

Mental health and substance abuse treatment account for 4.2% of claims expenses. It is difficult to estimate how much an insurance plan would pay for mental health and substance abuse, once people with pre-existing conditions (e.g., severe mental illness or a history of alcohol or substance abuse with recent treatment) are excluded. We assume half of the claims expenses for these services, or 2.1% total expenses, would be eliminated if plans did not cover mental health and substance abuse treatment.

In total, we estimate that the benefits often excluded or limited in short-term plans could reduce premiums by about 16%.

Other Factors Affecting Premiums

Short-term plans can be purchased with a variety of features, which will also affect the premiums they charge, including:

- **Deductibles, coinsurance, and copays.** Higher or lower levels of patient cost-sharing than in standard ACA-compliant plans (i.e., bronze, silver, and gold) will result in different premiums. Since short-term plans do not have to cap patient out-of-pocket costs like ACA-compliant plans,

they can be purchased with very high deductibles and lower premiums.

- **Dollar limits on coverage.** Short-term plans can and generally do impose annual limits on benefits, which results in lower premiums. In some cases, an enrollee can choose the level of the limit. Short-term plans also in some cases cap what they will pay for a day in the hospital or a physician visit, which lowers premiums but could result in balance billing for patients.

- **Age and gender rating.** The ACA prohibits premiums from varying by gender and limits the variation in premiums due to age to a ratio of three to one. Short-term plans are not subject to those restrictions.

- **Medical loss ratio.** Individual market insurers must have a medical loss ratio of at least 80% -- meaning 80% of premiums are spent on health care expenses – or pay rebates to consumers. Short-term plans can devote a larger share of premiums to overhead and profit, which may push premiums up.

Conclusion

Short-term health insurance plans present a tradeoff to consumers – lower premiums in exchange for more limited coverage and less protection than ACA-compliant plans. Overall, we estimate that short-term plans could provide coverage with fewer benefits at premiums 54% lower than ACA-compliant plans. However, the bulk of these premium savings result from exclusion of people with pre-existing conditions, for whom short-term plans are not an option.

The lower premiums will likely prove attractive to people who are healthy, especially those buying their own coverage now who have incomes too high to qualify for ACA premium subsidies. If such individuals opt for short-term plans and then become seriously ill or injured, however, they could face higher out-of-pocket costs.

To the extent short-term plans siphon off healthy enrollees attracted by lower premiums, ACA-compliant plans will be left with a sicker pool of enrollees, and individuals with pre-existing conditions not eligible for subsidies will face higher premiums.

Methods

Average total spending and prescription drug spending by private insurance come from the 2015 Medical Expenditure Panel Survey (MEPS). These spending averages are for people ages 18 to 64, with nine or more months of private insurance and zero months of Medicaid in 2015. For the purposes of this analysis, people with pre-existing conditions are those who have at least one declinable health condition, based on ICD9 codes, condition classification codes, and BMI data from MEPS.

October 2018

State individual mandates

Jason A. Levitis

USC-Brookings Schaeffer Initiative for Health Policy

This report is available online at: https://www.brookings.edu/research/state-individual-mandates-hows-and-whys

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EDITOR'S NOTE

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I. Introduction

On December 22, 2017, President Trump signed major tax legislation that eliminated the penalties associated with the Affordable Care Act's individual mandate, effectively repealing the requirement that most Americans maintain qualifying health coverage. Repealing the mandate, also referred to as the individual shared responsibility provision, is expected to lead to substantially higher individual-market health insurance premiums and rates of uninsurance. The tax law makes mandate repeal effective after 2018. With open enrollment for 2019 coverage set to begin November 1, states are considering whether and how to respond.

One policy response that has gained increased attention is a mandate at the state level. Massachusetts enacted a mandate as part of its 2006 health reform package, and it remains in effect today.[1] New Jersey and the District of Columbia (D.C.) recently enacted mandate legislation with rules closely resembling the federal rules, taking effect in 2019.[2] Vermont has enacted a mandate effective 2020, but without an enforcement mechanism; the legislation empanels a working group to develop recommendations.[3] Several other states have been considering mandate options.[4]

Enacting a state mandate is a straightforward way for states to avert the negative consequences of federal mandate repeal. It also offers states other advantages: it can help discourage the spread of insurance coverage that does not meet designated standards, facilitate state outreach to the uninsured, and serve as a source of revenue to finance other state policies aimed at improving insurance markets.

The key elements of mandate legislation are: (1) the coverage that qualifies; (2) the amount of penalties for not maintaining coverage; and (3) the exemptions available. States must also consider the administrative mechanisms they would use to collect mandate penalties and grant exemptions and reporting requirements to support compliance.

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[1] For a summary of the Massachusetts mandate, see "The Massachusetts Individual Mandate: Design, Administration, and Results," *Massachusetts Health Connector*, November 2017. See also Audrey Morse Gasteier, "With the Federal Individual Mandate Gone, States Might Step Up: Lessons From Massachusetts," *Health Affairs Blog*, January 16, 2018.

[2] For New Jersey legislation, see New Jersey State Legislature, "New Jersey Health Insurance Market Preservation Act". Bill No. A3380. For D.C. legislation, see District of Columbia Council, "Fiscal Year 2019 Budget Support Act of 2018," Act Number A22-0442.

[3] Vermont General Assembly, Vermont House Bill 696.

[4] See, for example, Dania Palanker, Rachel Schwab, and Justin Giovannelli, "State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers," *To the Point* (blog), Commonwealth Fund, June 14, 2018; Rachel Bluth, "A Health Plan 'Down Payment' Is One Way States Try Retooling Individual Mandate," *NPR*, March 8, 2018; and Stephanie Armour, "States Look at Establishing Their Own Health Insurance Mandates," *The Wall Street Journal*, February 4, 2018

Federal law and Massachusetts law offer somewhat different models for each of these elements. While each model has advantages, this paper recommends taking the federal model as the baseline to provide continuity for stakeholders and to simplify implementation. Such a mandate can be enacted using a common drafting method known as "conformity" with federal law, which defines state law by reference to federal law, with adaptations for state context. This approach simplifies drafting and permits states to adopt the federal government's regulations and sub-regulatory guidance[5] as a starting point to expedite implementation.

From this starting point, a state may adapt the law based on its needs and policy preferences. This paper discusses a range of changes states may elect, including some specific provisions of the Massachusetts law.[6]

II. Rationales for creating state individual shared responsibility provisions

Enacting a state mandate may help states achieve a range of policy objectives. Some of these objectives coincide with those of the federal mandate, and some are relevant to state mandates alone. This section of the paper discusses several of these objectives in turn.

A. Averting Premium Increases and Reductions in Coverage from Federal Mandate Repeal

The primary motivation for states to enact a mandate is to replace the federal mandate and its support for health insurance markets and coverage.

Pre-ACA markets were characterized by (1) insurer practices that disadvantaged consumers with preexisting health conditions or who developed serious health conditions,[7] (2) substantial populations who chose to go without coverage or could not afford it, and (3) substantial volumes of unpaid medical

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[5] The term "guidance," as used in this paper, refers to both regulations and other rulemaking documents issued by administrative agencies. For example, in addition to regulations, the IRS promulgates notices, revenue rulings, and revenue procedures.

[6] Model state legislative language reflecting this approach and presenting the various policy options is available at http://shvs.org/resource/model-legislation-for-state-individual-mandate/.

[7] These practices included, for example, exclusions for pre-existing conditions, charging higher premiums to those with a history of high health expenses, and using technicalities to retroactively cancel coverage for those who incurred unexpectedly large health care expenses once enrolled.

bills incurred by the uninsured that were ultimately borne by providers, governments, or other actors in the health care system.[8]

The ACA included several measures to address these problems. It prohibited insurer practices harmful to individuals with high medicals costs, like denying them coverage, charging them higher premiums, and cancelling their coverage without good cause. Because these protections alone tend to increase premiums, the ACA included several measures to make coverage more affordable and keep healthy people in the insurance pool. Specifically, it created subsidies to help low- and moderate-income consumers purchase individual-market health insurance. It created well-defined enrollment opportunities to make it harder to enroll only when sick. And it imposed an individual mandate to deter free-riding. Taken together, these measures created a market that made adequate health coverage broadly available and affordable.

Repealing the federal mandate weakens this structure. Mandate repeal is expected to reduce enrollment, especially among the healthy. Insurers respond to this "adverse selection" by increasing premiums, which will further reduce enrollment.

Consistent with this logic, the Congressional Budget Office (CBO) estimates that federal mandate repeal will increase premiums in the individual market by about 10 percent and increase the number of uninsured individuals by millions beginning in 2019, rising to around 9 million more uninsured once the effects are fully felt.[9] Urban Institute researchers reach similar conclusions, projecting that nationwide enactment of state mandates modeled on the federal one would reduce premiums by an average of 11.8 percent and lead to 7.5 million fewer uninsured.[10] (The Urban paper also provides state-by-state breakdowns of these estimates.) An estimate of the impact on California's market alone, based on a survey about responses to mandate repeal, suggests it will increase premiums 5 to 9 percent.[11]

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[8] Teresa Coughlin et al., "An Estimated $84.9 Billion In Uncompensated Care Was Provided In 2013; ACA Payment Cuts Could Challenge Providers," *Health Affairs*, May 2014. See also Teresa Coughlin et al., "Uncompensated Care for the Uninsured in 2013: A Detailed Examination," *Kaiser Family Foundation*, May 30, 2014.

[9] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 2018. The 9 million figure is derived from that report's statement that CBO's current estimate of "the reduction in health insurance coverage [due to mandate repeal] is about one-third smaller" than estimated in its November 2017 report. The earlier report showed a reduction of 13 million in 2025, 2026, and 2027 (the end of its estimating window). See Congressional Budget Office, "Repealing the Individual Health Insurance Mandate: An Updated Estimate," November 2017. Two-thirds of 13 million is about 8.7 million. The new report also found a reduction in health insurance coverage of 4 million in 2019.

[10] Linda Blumberg et al, "How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?" *Urban Institute*, July 20, 2018.

[11] Hsu et al., "Eliminating the Individual Mandate Penalty in California: Harmful But Non-Fatal Changes in Enrollment and Premiums," *Health Affairs Blog*, March 1, 2018. See also Matthew Fiedler, "How Did the ACA's Individual Mandate Affect Insurance Coverage?" *The Brookings Institution*, May 2018.

These predictions have been borne out by 2019 rate announcements, with many issuers pointing to mandate repeal as a key driver of higher premiums, even as other factors helped drive premiums down.[12]

A state mandate can avert or reverse these effects by standing in for the federal mandate. For example, New Jersey's insurance department estimates that its individual mandate reduced issuers' 2019 premium requests by about 7 percent relative to what they would have been without the mandate.[13]

B. Limiting the Spread of Association Health Plans, Short-Term Plans, and Other Substandard Coverage

States imposing a mandate choose which coverage qualifies and which does not. Imposing a fee on individuals without designated coverage discourages the sale and purchase of coverage that does not qualify. This influence may be especially valuable in limiting the reach of substandard coverage – coverage that fails to comply with one or more of the ACA's consumer protections or other insurance regulations. Substandard coverage can put consumers at risk and segment the market for health coverage, increasing premiums for ACA-compliant coverage.[14]

Two types of substandard coverage are currently of particular concern: association health plans (AHPs)[15] and short-term limited-duration coverage (short-term plans).[16] On October 12, 2017, President Trump released an Executive Order[17] instructing the Departments of Health and Human Services, Labor, and the Treasury (collectively, "the Departments") to consider loosening the rules governing the sale of these products. The Labor Department responded with regulations – finalized on June 19, 2018 – expanding the circumstances under which small employers and self-employed

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[12] See, for example, Sabrina Corlette, "The Effects of Federal Policy: What Early Premium Rate Filings Can Tell Us About the Future of the Affordable Care Act," *CHIRblog*, May 21, 2018. See also Fiedler, Matthew, "How Would Individual Market Premiums Change in 2019 in a Stable Policy Environment?" The Brookings Institution, Aug. 1, 2018.

[13] See New Jersey Department of Banking and Insurance, "NJ Department of Banking and Insurance Releases Proposed 2019 Rate Changes Submitted by Health Insurers," July 27, 2018.

[14] For a detailed discussion of substandard coverage and how states regulate it, see Kevin Lucia et al., "State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market," *The Commonwealth Fund*, March 29, 2018.

[15] For additional information on AHPs, see K. Lucia and S. Corlette, "President Trump's Executive Order: Can Association Health Plans Accomplish What Congress Could Not?" *To the Point (Blog)*, The Commonwealth Fund, Oct. 10, 2017.

[16] For additional information on short-term plans, see D. Palanker, K. Lucia, and E. Curran, "New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market," *To the Point (Blog)*, The Commonwealth Fund, Oct. 11, 2017.

[17] Trump, Donald, "Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States," *whitehouse*.gov, October 12, 2017.

individuals may purchase coverage through an AHP.[18] On August 1, 2018, the Departments finalized regulations extending the maximum duration of short-term plans from three months to 364 days and permitting renewals or extensions for up to three years.[19]

Both AHPs and short-term plans are exempt from key consumer protections applicable to the individual and small-group markets. AHPs are exempt from the ACA's essential health benefits requirement and some of its restrictions on setting premiums based on factors like age and gender. They are also generally exempt from state insurance regulations relating to disclosure and solvency; likely as a result, they have a history of fraud and insolvency.[20] Short-term plans are generally exempt from all the ACA consumer protections, including the prohibitions on underwriting, denying coverage, lifetime and annual limits, and rescissions when an enrollee gets sick.

These weaker standards generally allow short-term plans and AHPs to be sold more cheaply than conventional health insurance, for several reasons: (1) the plan terms can be less generous; (2) less generous terms discourage individuals with costly health care needs from enrolling; and (3) these plans may take additional steps to keep out high-cost individuals, including simply refusing to offer them coverage in the case of short-term plans. This leads to a departure of healthier enrollees from ACA-compliant markets, which raises premiums for ACA-compliant coverage. Independent modeling bears out this concern, generally finding an individual-market premium impact in the mid-single digits, though point estimates vary.[21] The resulting segmentation may benefit consumers with modest

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[18] Department of Labor Final Rule, "Definition of "Employer" under Section 3(5) of ERISA — Association Health Plans," Citation Pending, released for public inspection on June 19, 2018.

[19] Departments of the Treasury, Labor, and HHS, "Short-Term, Limited-Duration Insurance," 83 FR 38212, August 3, 2018 (released for public inspection August 1, 2018). The Executive Order also instructs federal agencies to consider loosening the rules governing health reimbursement arrangements (HRAs), but such guidance has yet to be issued.

[20] Kevin Lucia and Sabrina Corlette, "Association Health Plans: Maintaining State Authority is Critical to Avoid Fraud, Insolvency, and Market Instability," *The Commonwealth Fund*, January 24, 2018.

[21] For example, the CMS Office of the Actuary (which operates independently from CMS's political leadership) estimated that finalizing the short-term rules would increase premiums in the ACA-compliant individual market by about 6 percent by 2022: CMS Office of the Actuary, "Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule," April 6, 2018. A report by Avalere estimated that the AHP proposed rule would increase ACA-compliant premiums by 3.5 percent in the individual market and by 0.5 percent in the small group market: Avalere, "Association Health Plans: Projecting the Impact of the Proposed Rule," February 28, 2018. The Urban Institute estimates that the combination of the short-term proposed rule and individual mandate repeal would cause premium increases of 18.2 percent in states that do not restrict short-term plans, compared to 8.3 percent in states that effectively prohibit substandard short-term plans and 12.8 percent in states that substantially restrict them: Linda Blumberg et al, "The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," *Urban Institute*, February 2018. CBO estimates that together the short-term and AHP rules, if finalized, would increase ACA-compliant premiums between and 2 and 3 percent, but CBO does not break down the impact between the individual and small group markets: Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 2018. All of these increases are on top of the increases that would normally occur due to inflation, normal changes in utilization, etc.

health care needs. But it is generally harmful to those with pre-existing conditions, who may have to pay more for coverage or see their needs fall into benefit gaps.[22] Individuals with no history of illness may also be harmed if they enroll in such coverage and then unexpectedly have substantial health care needs and find the coverage capped, needed services excluded, or their plan insolvent. In addition, consumers may be unaware of the ways in which these plans are less comprehensive than ACA-compliant plans.

A state mandate can limit the reach of non-ACA-compliant coverage by effectively increasing its price by the amount of the penalty. This makes ACA-compliant plans comparatively more attractive, which helps keep their premiums from rising due to additional adverse selection. The New Jersey and D.C mandates both are not satisfied by AHPs that fail to meet specified standards. And both of these plus the federal and Massachusetts mandates are not satisfied by substandard short-term coverage.

A state mandate may be used in similar fashion to limit the reach of other substandard coverage. This may include:

- Health care sharing ministries, which are generally not treated as insurance by states and therefore not subject to either state or federal health insurance regulation;[23]
- Grandfathered plans, which are exempt from several key ACA market reforms.[24] The Massachusetts' mandate generally excludes these plans;[25]
- Substandard employer-sponsored coverage, for example employer coverage that lacks prescription drug coverage.[26] The Massachusetts' mandate generally excludes this coverage.

Using a mandate in this way may be particularly important to curb the growth of substandard AHPs, because states may lack other effective options for limiting them. States have historically had substantial authority to regulate AHPs, and the final AHP regulations appear to preserve that authority. But two risks remain. First, the proposed AHP regulations sought comment on the federal

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[22] The American Academy of Actuaries summarizes these concerns in its comment letter on the AHP proposed rule, warning that the rule would allow AHPs to "offer lower premiums to healthier and/or younger enrollees, deteriorating ACA markets and raising ACA premiums as healthier groups leave ACA plans for AHP plans." See American Academy of Actuaries, "Re: Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans," March 5 2018.

[23] See JoAnn Volk et al., "Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?" Commonwealth Fund, August 8, 2018.

[24] "Grandfathered Insurance Plans," *Health insurance rights & protections, healthcare.gov*

[25] Linda Blumberg and Lisa Clemens-Cope, "Reconciling the Massachusetts and Federal Individual Mandates for Health Insurance: A Comparison of Policy Options," *Urban Institute*, December 2012.

[26] The federal mandate generally recognizes all conventional employer-sponsored coverage. The ACA consumer protections require coverage in the small group market to provide the essential health benefits (EHBs), but plans in the large group and self-insured markets are exempt.

government preempting state regulation using authority granted by ERISA. The final rule did not adopt this approach, but it suggested the Administration would consider doing so if states "go too far in regulating [certain] AHPs in ways that interfere with the important policy goals advanced by this final rule." Second, even absent additional federal action, an AHP wishing to escape state regulation may assert that state rules are preempted under ERISA because they are inconsistent with the AHP final regulations.[27] States and others would likely go to court to challenge preemption under either of these scenarios, but the outcome is difficult to predict. In such a scenario, a state mandate may have a better chance of surviving a preemption challenge than would direct state regulation of AHPs, since a mandate applies to individuals rather than the ERISA-regulated entities themselves, and it is a creature of the state tax code, an area where ERISA jurisprudence has historically shown greater deference.

Using a state mandate in this way would most likely not eliminate the non-qualifying substandard coverage. Short-term plans have never satisfied the federal mandate, yet they continued to be sold and even increased their market share until regulations curtailed them in 2016.[28] But it would make these types of coverage less attractive and thereby reduce the risk they pose to consumers and insurance markets.

C. Facilitating Targeted Outreach to the Uninsured

Another benefit of a state mandate is that information about who remains uninsured can be leveraged to notify the uninsured of coverage options. This may include:

- **Direct Outreach to the Uninsured**. If a resident reports being uninsured (either paying a penalty or claiming an exemption), the state can send them a reminder during the next open enrollment season. The notice can describe available coverage options, including contact information for the state Marketplace. The ACA provides for the IRS to do this,[29] but the IRS has taken more limited action due to limited funding.[30] Such notices may be customized using

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[27] Katie Keith, "Final Rule Rapidly Eases Restrictions on Non-ACA-Compliant Association Health Plans," *Health Affairs Blog*, June 21, 2018.

[28] Kevin Lucia et al., "State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market," *The Commonwealth Fund*, March 29, 2018. Until 2016, short-term plans were allowed to last up to 364 days, much as under the proposed regulations. See final regulations at 81 FR 75316.

[29] See ACA section 1502(c).

[30] Instead of sending targeted notices to uninsured individuals, the IRS generally has relied on less direct approaches, like including general notifications in IRS publications and encouraging returns preparers to notify their clients. See, e.g., IRS, "Affordable Care Act - Notification of nonenrollment - §1502(c): Return Preparer Best Practices," [undated]. See also Treasury Inspector General for Tax Administration, "Affordable Care Act: Implementation of the Notification Requirement for Individual Filers Not Enrolled in Health Insurance," July 31, 2017.

information on the tax return. For example, the notice could inform the individual that they may be eligible for a substantial Marketplace subsidy based on the income and family size reported on the return.

- **Targeted Outreach to Areas and Groups with High Rates of Uninsurance**. The state can analyze the mandate data to identify geographic areas, age groups, etc., with high rates of uninsurance and then target those concentrations with media or on-the-ground outreach.

Massachusetts employs both of these approaches using information from its mandate, and officials there credit this outreach as an important reason for the success of its health reform and its low rate of uninsurance.[31] Several states have asked the IRS for the data needed to do this outreach themselves, but to the author's knowledge, the IRS has refused, likely due to data privacy rules.[32] Enacting a mandate of their own allows states to collect and employ this information themselves.

D. Maintaining Federal Health Care Spending in the State

Repealing the federal mandate is expected to substantially reduce federal spending on health care, primarily by reducing enrollment in federally subsidized coverage. These reductions in coverage and spending will be spread across the states. Enacting a state mandate can maintain coverage at higher levels in the state, thereby maintaining the federal dollars flowing into the state.

CBO's November 2017 analysis of federal mandate repeal included detailed estimates of the ways eliminating the mandate would reduce federal health spending. That analysis found that repeal of the mandate would reduce net federal spending on health care subsidies by about $380 billion over the 2018-2027 budget window. This primarily reflects a $185 billion reduction in spending on individual market subsidies[33] and a $179 billion reduction in federal spending on Medicaid and CHIP due to reduced coverage through those programs, as well as other smaller effects on other forms of coverage and programs.

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[31] For example, see "Massachusetts's Experience with a State Individual Mandate," *Massachusetts Health Connector*, January 23, 2018: slide 17.

[32] Section 6103 of the Internal Revenue Code generally permits the IRS to share tax return information only when specifically authorized. Sections 6103(d) authorizes the sharing of specified data with states to assist with state tax administration, but individual mandate data does not appear to be among the data that may be shared.

[33] Individual market coverage is heavily subsidized by the federal government. CBO has estimated that more than half of individual market enrollees receive the premium tax credit or other federal subsidies, with subsidies averaging $6,140 per subsidized enrollee in 2019; See Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027," September 2017, showing about 10 million of the 17 million individual market enrollees receiving subsidies in 2019.

CBO has subsequently reported that it has reduced its estimates of the coverage impact of the federal mandate by around one-third.[34] The new report does not provide updated estimates of the budgetary effects of mandate repeal, but if the change to the spending estimates were proportional, then CBO's updated estimate of the impact on net federal health care spending would be about $250 billion.

A state can avert this reduction in federal spending in the state by imposing a state mandate. A state mandate modeled on the federal mandate would generally maintain enrollment at what it would have been with the federal mandate in place, and thereby maintain federal health subsidy spending as well. A state mandate with different rules might affect enrollment and therefore federal spending differently.

E. Collecting State Revenue that Can be Used to Make Coverage More Affordable

Collecting revenue is not the main goal of a mandate, but the revenue it produces for a state may be put to good purpose. While the revenue may be used for anything, states considering mandates may direct it towards programs to make coverage more affordable, thereby helping state residents comply with the mandate. The Massachusetts, New Jersey, and D.C. mandates all take this approach, and other states that have considered mandates have generally contemplated this approach as well.

A state's penalty revenue from a mandate modeled on the federal one can be estimated from available data on the federal mandate. The most recent figures from the Treasury Department before the federal mandate was repealed projected that it would have raised about $5.7 billion total in tax year 2020.[35] IRS figures regarding mandate penalty collections by state in tax year 2016 – the most recent year available – can be used to allocate this amount among the states.[36] The results are shown in Table 1.[37]

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[34] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 2018. The report indicates that CBO now believes that the coverage impact of mandate repeal is about "one-third smaller" than it estimated in the November 2017 report.

[35] This figure comes from the current-law revenue estimates prepared by the Treasury Department and released May 23, 2017 to accompany the President's Fiscal Year (FY) 2018 Budget. By the time the FY 2019 Budget was released in early 2018, the federal mandate had been repealed, so updated figures were not included. The estimate shows receipts of $5.681 billion in FY 2021, which generally corresponds to collections for tax year 2020. This is generally consistent with the $5 billion estimate included with CBO's analysis of federal mandate repeal, found at Congressional Budget Office, "Repealing the Individual Health Insurance Mandate: An Updated Estimate," November 2017.

[36] Internal Revenue Service (IRS), "SOI Tax Stats – Historic Table 2." *State Data Tax Year 2016,* August 31, 2018.

[37] As explained in Section III.A, IRS data about federal mandate penalty collections overstate the likely amount that would be collected from low-income residents under a state mandate due to erroneous payments that occurred. It is unclear to what extent the Treasury projections for 2019 collections assumed that these erroneous payments would continue. By 2016 Treasury officials were aware of the erroneous payments and considering options to reduce them going forward, but it is unclear to what extent they would have reflected those potential improvements in their revenue projections. Accordingly, it is

A state may also need to take other considerations into account in determining the funding a mandate makes available. For example, to the extent a state mandate prevents a drop-off in Medicaid and CHIP enrollment, it will prevent a reduction in state spending in those programs. Conversely, by preventing an increase in the number of state residents without insurance, a mandate is likely to avert an increase in uncompensated care, which many states have programs to subsidize.[38] These considerations are discussed in greater detail in Appendix I.

States that realize net budgetary savings from a mandate can use those savings to make insurance coverage more affordable, thereby making it easier for state residents to comply with the mandate. Options include providing additional premium or cost-sharing subsidies, funding a state-based reinsurance program, or performing additional outreach. Depending on how these options are designed, state mandate revenue may be sufficient to pay for most or all of the cost. These options are explored in greater detail in Section IV.D.6.

possible that the estimates in Table 1 overstate the revenue that would be collected by a significant amount, perhaps as much as 25 percent.

[38] Matthew Buettgens, Linda J. Blumberg, and John Holahan, "The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation," *Urban Institute*, January 2017.

Table 1. Estimated Revenue from a State Mandate Modelled on the Federal Mandate, Tax Year 2020

State	Estimated Revenue ($ millions)	State	Estimated Revenue ($ millions)
Alabama	52.8	Montana	24.2
Alaska	20.8	Nebraska	34.8
Arizona	131.3	Nevada	62.2
Arkansas	48.5	New Hampshire	27.2
California	697.9	New Jersey	174.8
Colorado	112.7	New Mexico	30.9
Connecticut	48.7	New York	315.6
Delaware	12.7	North Carolina	174.2
District of Columbia	5.9	North Dakota	14.0
Florida	442.3	Ohio	145.9
Georgia	181.9	Oklahoma	66.5
Hawaii	11.7	Oregon	70.1
Idaho	37.7	Pennsylvania	170.4
Illinois	190.6	Rhode Island	16.7
Indiana	120.1	South Carolina	79.7
Iowa	39.2	South Dakota	12.9
Kansas	44.3	Tennessee	98.4
Kentucky	59.9	Texas	814.7
Louisiana	79.2	Utah	58.4
Maine	29.6	Vermont	11.5
Maryland	79.8	Virginia	135.9
Massachusetts	81.6	Washington	123.5
Michigan	149.4	West Virginia	27.2
Minnesota	70.8	Wisconsin	82.4
Mississippi	46.4	Wyoming	14.9
Missouri	92.4		
		U.S. Total	5,681.0

Source: Author's calculations based on Treasury Department forecasts in Public Budget Database from FY 2018 Budget, and IRS Statistics of Income (SOI) figures for tax year 2016.

Notes: (1) These estimates do not include other potential effects of an individual mandate on state budgets.

(2) State figures sum to 5,675.1, slightly less than U.S. total, because SOI data attribute some returns to "Other Areas," which generally includes filers residing abroad or in U.S Territories.

III. Additional considerations for states

This section addresses some additional factors that states considering a mandate may wish to take into account, with a focus on concerns that have been raised about enacting a mandate.

A. Impact on Low-Income Individuals

Some observers have raised concerns about the distributional impact of the federal mandate, pointing to IRS data suggesting that the penalty is paid disproportionally by low-income individuals.[39]

The impact of a mandate – or any policy – on low-income individuals is important to consider. But there are reasons to believe that a state mandate based on the federal mandate strikes an appropriate balance – or could with straightforward adjustments. First, it is important to note that the tax return data in question overstate the impact a state mandate would have on low-income individuals, especially if a state makes straightforward adjustments. Second, the mandate should be considered in light of the ACA's treatment of low- and moderate-income individuals more broadly, including the broad range of mandate exemptions and generous subsidies available to them. Third, applying the mandate relatively broadly is important for achieving the policy goals of a mandate and the ACA generally.

- **Historical Federal Data Reflect Erroneous Payments that States Can Avoid**. IRS tax return data, released by the IRS Statistics of Income (SOI) division, show substantial numbers of low-income taxpayers making mandate payments. For example, for tax year 2016 (the most recent data available), almost 400,000 mandate penalty payers had incomes under $15,000, and 1.9 million had incomes between $15,000 and $30,000.[40] Together, these groups accounted for about 35 percent of the dollar value of penalties reported.[41]
  While concerning on their face, these figures overstate the likely impact of a state mandate on low-income individuals. The reason is that they count erroneous payments that resulted from two temporary implementation weaknesses. The IRS has now taken steps to improve its

[39] See, for example, Rachel Greszler, "Why Eliminating Obamacare's Individual Mandate Should Be Part of Tax Reform," *Heritage Foundation*, November 27, 2017; The Office of Senator Steve Daines, "Fact Sheet: Repealing Obamacare's Individual Mandate," [undated]; and Dan Mangan, "Senate's GOP tax reform bill seeks repeal of Obamacare individual mandate," *CNBC*, November 14, 2017.

[40] Author calculations based on IRS Statistics of Income, "Individual Income Tax Returns Publication 1304," Table 2.7—Affordable Care Act Items, by Size of Adjusted Gross Income.

[41] Ibid.

processes, and states could adopt these improvements and others to avert high rates of erroneous payments.[42]

The first issue was that the IRS's return processing systems accepted and processed returns reporting mandate payments from taxpayers who were evidently eligible for an exemption. The National Taxpayer Advocate (NTA) reported that for tax year 2014, over 400,000 tax returns – mostly with low-incomes – showed mandate payments despite including other information sufficient to establish an exemption, such as income under the tax filing threshold.[43] The NTA recommended that IRS modify its systems to limit these overpayments. The IRS took several actions after the fact to address these overpayments, but systems changes were apparently not made in time for tax years 2015 and 2016, so return data from those years reflect the higher error rates.[44]

The second implementation issue was a lack of clear information about the affordability exemption. The operation of this exemption makes it available to virtually all individuals who are eligible for Medicaid – even though these individuals are generally eligible for free coverage.[45] In states that chose to expand Medicaid eligibility under the ACA, the income cut-off for Medicaid is generally 138 percent of the federal poverty line, or FPL.[46] Thus, individuals with incomes in this range are generally exempt from the mandate. This covers a large group outside those eligible for the filing-threshold exemption: for a family of four in 2016, the filing threshold was $20,700,[47] while 138 percent of FPL was $33,463.[48] IRS forms and instructions

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[42] The author worked closely with the IRS on ACA implementation and shares responsibility for implementation decisions. More generally, Congress charged the IRS with implementing the ACA's several dozen tax provisions but then repeatedly cut IRS funding. Despite these challenges, the IRS generally implemented the ACA's many tax provisions accurately and on time.

[43] Taxpayer Advocate Service, "2015 Annual Report to Congress — Volume One," pg. 170. See also Taxpayer Advocate Service, "Fiscal Year 2016 Objectives Report to Congress — Volume One," pg. 41, indicating that most were eligible for the filing threshold exemption.

[44] Taxpayer Advocate Service, "Fiscal Year 2017 Objectives Report to Congress — Volume One," pg. 140.

[45] The affordability exemption applies to individuals whose cost to purchase coverage exceeds a percent of income (8 percent in 2014, then indexed). But Medicaid coverage, which is generally free, is ignored for this purpose. Medicaid-eligible individuals are not eligible for the premium tax credit, and the unsubsidized premium for a bronze plan is generally well above the affordability threshold for a low-income individual. As a result, unless they are eligible for highly subsidized employer coverage, they generally treated as having no affordable coverage options.

[46] Due to the Supreme Court decision in *NFIB*, states can choose whether to expand Medicaid eligibility up to 138 percent of FPL or to leave it at a lower level. In states that opted not to expand Medicaid eligibility, there is an exemption, created through guidance, for those who would be Medicaid-eligible had the state opted to expand Medicaid. *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

[47] IRS, "Tax Guide for Individuals 2016."

[48] Author calculation based on HHS, "Computations for the 2016 Annual Update of the HHS Poverty Guidelines for the 48 Contiguous States and the District of Columbia," April 25, 2016.

for tax years 2014 through 2016 did not clearly explain this rule.[49] There are no public estimates of the resulting erroneous payments, but Treasury Department officials who examined the issue thought it was likely a substantial number of taxpayers.[50]

The IRS took a variety of measures to address these issues after the fact, including clarifying the instructions, sending taxpayers letters encouraging them to file amended returns, and sending refunds unprompted to taxpayers whose payments were clearly erroneous.[51] But these measures are not reflected in the available SOI data, which are based on returns as initially filed.[52] As a result, the historical IRS figures include at least hundreds of thousands – and perhaps over one million – payments by low-income individuals that should never have been paid (and that in some cases were refunded).

Fortunately, states can take straightforward actions to prevent similar erroneous payments. Measures include checking for apparent overpayment during return processing, ensuring that forms and instructions accurately capture and emphasize the exemptions available, and using administrative authority to create a simpler exemption rule for those who are Medicaid-eligible. These measures are discussed in detail in Section IV.D.4.[53]

- **The ACA's Broader Policy Context for Low- and Moderate-Income Individuals**. The ACA implemented an integrated network of policies aimed at ensuring that coverage was affordable for low- and moderate-income individuals and that individuals were only required to obtain coverage when those measures were successful. It provides generous subsidies to help them afford coverage, including generally-costless Medicaid coverage for those with incomes up to 138 percent of FPL and Marketplace subsidies up to 400 percent of FPL.[54] It

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[49] See IRS Form 8965 and its instructions, for tax years 2014, 2015, and 2016. All of these versions include two errors. First, the "Marketplace Coverage Affordability Worksheet," which taxpayers use to determine whether Marketplace coverage counts as affordable, erroneously suggests that Medicaid-eligible individuals can get the premium tax credit (PTC), which is the lynchpin of exemption eligibility for this group. Second, the form and instructions include no indication that an individual who is Medicaid-eligible should consider the affordability exemption at all. The instructions for tax year 2017 addressed this issue, clarifying the affordability exemption calculation and flagging this as a "common mistake."

[50] Author conversations with fellow Treasury Department officials, 2016.

[51] Taxpayer Advocate Service, "2016 Annual Report to Congress — Volume One," pg. 268.

[52] Specifically, the SOI tables in question include a footnote stating "This table is based on tax returns as initially processed by IRS and does not reflect amended returns or errors that were corrected after initial processing."

[53] In addition to these measures states can take, a separate change in federal law in the recent tax bill will help to limit erroneous payments by low-income individuals under a state mandate. The tax bill increased the filing thresholds, effective in 2018. For example, the threshold for a family of four will increase from $20,700 in 2017 to $24,000 in 2018. As a result, individuals in this range can claim the filing threshold exemption, which is simpler to understand than the affordability exemption.

[54] Marketplace subsidies include premium support (through the premium tax credit) for those with incomes up to 400 percent of FPL and cost-sharing support (through cost-sharing reductions) up to 250 percent of FPL. For example, in 2019 a family of 3 with income of $40,000 is eligible for coverage with an 87 percent actuarial value (meaning the enrollees' cost-sharing on average amounts to 13 percent of the health care costs they incur) by paying a monthly premium of about $200.

provides a broad range of mandate exemptions for those with the lowest incomes, those who cannot afford coverage, those in certain protected classes, and those facing other challenges in maintaining coverage.[55] These subsidies and exemptions are coordinated to ensure there is an exemption for individuals who fall into gaps in the subsidy structure.[56]

Taken together, this structure ensures that the lowest-income individuals are offered free coverage and are exempt from the penalty, while moderate-income individuals are offered relatively generous subsidies and owe a penalty only if they choose to turn down affordable coverage without good cause. Given this structure, many of the remaining uninsured have highly affordable coverage options: a Kaiser Family Foundation analysis found that over half of uninsured individuals who are eligible for Marketplace coverage could purchase coverage for less than the federal mandate penalty.[57]

- **Applying the Mandate Broadly Is Important for Achieving its Goals.** While (1) the historical IRS data reflect erroneous payments by low- and moderate-income individuals, and (2) the ACA's broader structure aids and protects these individuals, some of them – especially those with moderate incomes – actually owed a penalty. That is by design. Low- and moderate-income individuals account for a large and disproportionate share of the uninsured.[58] This exposes them to catastrophic health and financial risks, weakens the risk pool, and generates uncompensated care costs that must ultimately be borne by providers, governments, or others in the health care system. The ACA's wider structure helps to mitigate the concerns about a mandate's costs for these individuals. But broadly exempting them would substantially weaken the mandate's ability to address these problems, and this must be weighed against the financial savings for the individuals involved.

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[55] In addition to the filing threshold and affordability exemptions, the federal mandate also includes exemptions for those ineligible for Medicaid because they reside in a non-expansion state, undocumented immigrants and non-resident aliens, many Native Americans, those with a religious objection to social insurance, those facing a variety of specific "hardship" situations such as the loss of a job or the death of a family member, and those facing miscellaneous hardship situations that make it difficult to maintain coverage. For a complete list of available exemptions, see irs.gov, "2017 Instructions for Form 8965." For details about hardship exemptions, see healthcare.gov, "Hardship exemptions, forms & how to apply."

[56] For example, there are exemptions for (1) for individuals ineligible for Medicaid because their state has not expanded Medicaid eligibility, (2) individuals who are incarcerated or undocumented (and thus ineligible for subsidies), and (3) individuals affected by the so-called "family glitch," which denies the premium tax credit (PTC) to certain families who are eligible for employer-sponsored that may cost substantially more than the PTC's affordability threshold.

[57] Matthew Rae et al., "How Many of the Uninsured can Purchase a Marketplace Plan for Less Than Their Shared Responsibility Penalty?," *Kaiser Family Foundation*, November 2017.

[58] For example, about 50 percent of the uninsured have incomes under 200 percent of FPL, and 80 percent have incomes under 400 percent of FPL. See Figure 4 in "Key Facts about the Uninsured Population."

B. Implementation Costs for States and Stakeholders

As with any statutory requirement, implementing a state mandate creates operational costs and challenges for the state and compliance costs for taxpayers. These costs and challenges may be minimized through policy choices, making implementation manageable for most states.

To minimize implementation costs, both the federal mandate and Massachusetts' mandate are implemented through the existing individual income tax systems. This approach allows the state to rely on an established administrative apparatus for public communications, return processing, and payment collection. A single line can be added to the state income tax return, where taxpayers check a box indicating that they had coverage or report a payment. The payment is included with the income tax payment or reduces the refund. A simple one-page form is used to claim certain exemptions.[59] (States without income taxes cannot rely on this approach. Appendix III discusses options for these states.[60])

Beyond incorporating a state mandate into the state income tax system, this paper describes an approach that further limits implementation costs by closely tracking the federal mandate. As explained further in Section IV.A, this allows states to adapt federal guidance, forms, instructions, and educational materials rather than starting from scratch. And it creates a relatively seamless transition for taxpayers.

Adopting this approach makes implementing a mandate relatively straightforward for states, and nearly effortless for taxpayers. But the state would need to adapt forms and other materials, modify its form processing systems, develop procedures to grant exemptions, and administer the rules on an ongoing basis. The precise cost will depend on a state's current administrative apparatus and implementation decisions.

C. Philosophical Concerns

Ideological considerations are generally beyond the scope of this paper, but it may be helpful to review them at a high level given their prominence in debates about coverage mandates.

The federal mandate has long been one of the most controversial provisions of the ACA. A major source of this controversy is philosophical opposition to the government requiring the purchase of health insurance, or indeed any product. Opponents have argued that a mandate conflicts with the bedrock

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[59] See IRS, "Form 8965." A state exemption form could likely be even simpler: Form 8965 includes three separate sections for claiming exemptions whereas a state could likely combine those three sections into one to create an even simpler form.

[60] Forty-one states and D.C. currently levy broad-based income taxes. Urban Institute, "Individual Income Taxes".

American value of self-determination.[61] To the extent that these values are reflected in the Constitution, they provide the basis for the legal challenge in the *NFIB v. Sebelius*,[62] the landmark litigation challenging the mandate. In that case, the Supreme Court upheld the mandate penalty as an exercise of the Constitutional taxing power but rejected Congressional authority to require the purchase of insurance through its regulatory powers.

There are several responses to these concerns. One is to note that remaining uninsured is not a purely personal decision: it has consequences for others like higher premiums and more uncompensated care.[63] In this respect, a health coverage mandate is not unlike decades-old state requirements to purchase auto insurance.[64] Another response is to focus on the Supreme Court holding that the mandate is supportable as a tax, and to note that the mandate is economically equivalent to other tax provisions that incentivize the purchase of certain goods. Others note that Massachusetts' mandate has been in place for 10 years without any apparent impairment to liberty.

These arguments are unlikely to sway hardcore partisans on either side. But there is reason to believe that such divisions may not be dispositive, at least at the state level. The Massachusetts mandate has not been the subject of major repeal efforts, and health reform there is generally non-controversial (and was enacted on a bipartisan basis and signed by a Republican governor).[65] In Vermont, the mandate bill passed this year with broad bipartisan support and was signed by the Republican governor.[66] And the D.C. legislation was passed unanimously and responds to the unanimous recommendation of an advisory group representing a broad range of interests, including the D.C. Chamber of Commerce.[67] In short, philosophical opposition to the mandate is far from universal. A state should consider the values and priorities of its own residents as it decides how to proceed.

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[61] For example, see Hans Von Spakovsky, "Individual Mandate Goes Against Basic Freedom and Liberty," *U.S. News*, March 25, 2012; and Robert Moffit, "Obamacare and the Individual Mandate: Violating Personal Liberty and Federalism," *Heritage Foundation*, January 18, 2011.

[62] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).

[63] See Linda Blumberg et al, "How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?" *Urban Institute*, July 20, 2018.

[64] Jennifer Wriggins, "Is the Health Insurance Individual Mandate 'Unprecedented?': The Case of Auto Insurance Mandates," April 6, 2012.

[65] For example, a 2010 survey found that 66 percent of non-elderly adults in Massachusetts support its health reform law: Blue Cross Blue Shield of Massachusetts Foundation, "Health Reform in Massachusetts – Expanding Access to Health Insurance Coverage – Assessing the Results," March 2014: slide 29.

[66] Vermont General Assembly, "H.696 bill status."

[67] See "Recommendations of the Reconvened ACA Advisory Working Group to the District of Columbia Health Benefit Exchange Authority," April 6, 2018, pg. 19-20.

IV. Designing a state individual shared responsibility provision

A mandate generally consists of a requirement that non-exempt individuals maintain qualifying health coverage or pay a penalty. The key design elements are:

- The definition of qualifying coverage;
- The amount of the penalty;
- The exemptions available; and
- The administrative apparatus, such as procedures for granting exemptions and a requirement for third-party reporting of coverage to verify compliance.

There are numerous options for each of these elements. The federal mandate and the Massachusetts mandate offer similar but slightly different approaches to each.

This paper recommends taking the federal mandate as a baseline for a state mandate. Doing so maximizes continuity for stakeholders given the short timeline for standing up a state IRSP. It also simplifies legislative drafting and the timely promulgation of guidance. And it readily accommodates specific policy changes, including adopting specific aspects of the Massachusetts mandate.

The rest of Section IV walks through this general approach and specific design considerations. Section IV.A explores reasons for taking the federal mandate as a starting point. Section IV.B describes the statutory components of mandate legislation following this approach. Section IV.C describes technical changes that are necessary to adapt the federal mandate for use at the state level. And Section IV.D explores policy options to change the federal framework without unduly complicating implementation.

Recommended Approach to Creating a State Mandate

- Use federal law as baseline
- Enact state mandate through conformity with federal mandate as of a fixed date (pre-repeal)
- Incorporate federal regulations and other legal guidance as starting point
- Make technical adjustments for state context
- Make policy adjustments as desired to reflect state preferences

A. Why State Mandates Should Generally Be Based on the Federal Mandate

For a state developing mandate legislation, the natural starting points are the two models enacted to date: the federal mandate and the Massachusetts mandate. These versions are quite similar in broad strokes. Both have definitions of qualifying coverage that include most conventional public and private health coverage. Both impose penalties that increase based on ability to pay and are capped based on

the cost of coverage. Both provide exemptions for short coverage gaps and individuals with low incomes, unaffordable coverage, and other hardships. Both require providers of health coverage to report coverage to the revenue authority, with a copy of the statement to the covered individual. And both are administered through the existing income tax system but rely on the health insurance Marketplace to grant certain exemptions on a prospective basis. (These similarities are not surprising, given that the Massachusetts health reform law was the primary model for the ACA.)

But there are differences at the margins. The Massachusetts mandate imposes substantive requirements on employer coverage to qualify, while the federal mandate categorically recognizes most employer coverage and relies on insurance regulations for substantive standards. The threshold for the affordability exemption under the federal mandate is 8 percent (indexed) of income,[68] while in Massachusetts the threshold percentage varies based on income. The penalty amounts follow somewhat different schedules, with the Massachusetts penalty generally smaller at very low and very high incomes and larger in the middle. The reporting requirements apply to somewhat different entities and require somewhat different information. The two use somewhat different administrative processes and different terminology – for example, qualifying coverage is called "minimum essential coverage" by the ACA and "minimum creditable coverage" by Massachusetts. Some marginal rules differ as well: Massachusetts counts an individual as covered for a month if they had coverage for at least 15 days; under the ACA it is one day.[69]

This paper recommends adopting the federal mandate as a baseline for a state mandate and incorporating Massachusetts rules only as specifically needed. The New Jersey and D.C. mandates both reflect this approach. This recommendation is not based on any judgement as to the merits of two existing mandates. Both have generally functioned well, and some features of Massachusetts' policy have important advantages, as discussed below. Rather, the preference is based on several practical considerations related to the federal mandate having already been in effect nationwide:

1. **Eases and Expedites Stakeholder Adjustment.** Adopting a state mandate similar to the federal mandate provides continuity for stakeholders, who have spent several years learning about and adjusting to the ACA rules and have little or no familiarity with Massachusetts' rules or others. These stakeholders include:

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[68] The 8 percent figure is indexed to reflect the observed growth in the share of income consumed by health insurance premiums. Specifically, it is indexed to reflect "the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period." 26 U.S. Code § 5000A(e)(1)(D). For 2019, the figure will be 8.3 percent.

[69] As explained in greater detail below, the Massachusetts mandate also contains a coordination provision that reduces the amount of the Massachusetts penalty by the amount of any federal penalty, thereby preventing individuals from being penalized twice.

- Insurers, who have spent substantial resources developing systems to track and report coverage and who would need substantial lead time to modify these systems and plan offerings and materials;
- Employers, who must choose coverage to offer to their employees and are familiar with the current ACA-compliant offerings;
- Tax preparers, who must explain the mandate rules and build software reflecting them; and
- Taxpayers, who must ultimately comply with the rules.

Adjusting to a new set of rules would impose substantial additional cost on all these stakeholders. And it would take time. With enforcement of the federal mandate ending at the end of this year, there are reasons to make a state mandate effective as quickly as possible.[70]

2. **Simplifies Legislative Drafting.** Using the federal mandate as a baseline allows states to enact a mandate through "conformity" with federal law, a common state legislative drafting technique in which state law is defined by reference to federal law.[71] Many state Tax Codes rely on conformity to simplify legislative drafting, state implementation, and taxpayer compliance. For example, 27 states define adjusted gross income (AGI) for state tax purposes by reference to federal AGI.[72] Many states do the same thing with tax credits, for example providing an earned income tax credit (EITC) that is defined as a certain percentage of the federal EITC.[73]

Enacting a state mandate by conforming to the federal mandate greatly simplifies and shortens the required legislative language.[74] It also emphasizes the continuity between the state mandate and the federal one.

Conformity is generally described as either "rolling," meaning that the state Code incorporates the current federal rules on an ongoing basis, or "static," meaning that the state adopts the federal rules

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[70] A good example is Massachusetts requiring 15 days of coverage in a month to satisfy the mandate versus one day under the federal mandate. This difference has relatively little given policy valence given that most coverage is monthly and the existence of the exemption for short coverage gaps. But adopting the Massachusetts rule would impose substantial cost on insurers, who have implemented tracking and reporting systems based on the one-day rule and would need to open new contracts with vendors to change to the 15-day rule.

[71] Mike Porter et al., "State conformity to federal provisions: exploring the variances," *Deloitte*, reprinted from *State Tax Notes*, July 10, 2017.

[72] Nicole Kaeding & Kyle Pomerleau, "Federal Tax Reform: The Impact on States," *Tax Foundation*, March 2017. For an example of state law taking this approach, see Ohio Revised Code section 5747.01, "Income tax definitions."

[73] IRS, "States and Local Governments with Earned Income Tax Credit." For an example of state law taking this approach, see Maine Revised Statutes section 5219-S, "Earned Income Credit."

[74] While it is easiest to incorporate the federal mandate by cross-reference (conformity), the other necessary statutory elements are simpler to restate in full, since they are shorter and reflect more changes from the Federal laws.

as of a certain date.[75] To avoid incorporating the repeal of the federal mandate, a state mandate should conform to the federal mandate as of a date before the enactment of the tax bill. For example, the New Jersey and D.C. legislation both adopt December 15, 2017 as the date of conformity, as this date falls between the publication of the most recent normal-course agency guidance on the federal mandate[76] and the passage of the tax bill.

3. **Facilitates the Adoption of Regulations and other Guidance.** Adapting the federal mandate allows states to rely on federal regulations and other guidance rather than starting from scratch. This is important given the extensive and detailed guidance implementing section 5000A and the brief time states may have to implement a mandate. [77] Stakeholders need guidance with adequate lead time to adjust to any new rules. The IRS and HHS spent several years promulgating individual mandate guidance. It covers a wide range of topics and provides some non-obvious substantive interpretations.[78] Developing guidance from scratch risks providing rules that are suboptimal, late, or both.
4. **Emphasizes Status Quo and Avoids Winners and Losers.** A state mandate based on the federal one may be easier to defend, as it merely restores the status quo and makes the ACA whole again. By contrast, imposing new rules is more likely to invite debate over design issues. Similarly, adopting federal rules minimizes creating winners and losers, which are likely if, for example, the penalty formula changes or certain coverage no longer satisfies the mandate.

Adopting the federal mandate as a baseline does not preclude making specific policy changes to incorporate Massachusetts rules – or other changes – on a case-by-case basis. For example, as discussed above, there may be good reason to exclude certain substandard plans from satisfying a state mandate, even if they satisfy the federal mandate. There are long-standing and straightforward methods for incorporating such modifications into state law enacted using conformity.[79]

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[75] Nicole Kaeding & Kyle Pomerleau, "Federal Tax Reform: The Impact on States," Tax Foundation, March 2017.

[76] IRS Notice 2017-74, "Section 5000A Guidance for Individuals with No Available Marketplace Bronze-Level Plan," December 6, 2017.

[77] For a list of regulations and guidance issued under the federal individual mandate, see IRS, "Affordable Care Act Tax Provisions for Individuals," under the heading "Individual Shared Responsibility Provision."

[78] For example, the guidance covers what constitutes minimum essential coverage; the details of the penalty calculation, including for partial-year coverage; the definition of "affordable" for purposes of the affordability exemption, including how it is determined for dependents of employees offered employer-sponsored coverage; the conditions that qualify for a hardship exemption; eligibility and administrative rules for other exemptions; rules for indexing the various parameters; rules for calculating the national average bronze plan that caps the penalty; and substantive and procedural rules for designating additional minimum essential coverage.

[79] The common approach is to cross-reference the relevant federal provisions(s) and then add a list of specific changes. For example, see the treatment "adjusted gross income" in Ohio Revised Code section 5747.01, "Income tax definitions."

For all these reasons, most states will be best served by taking federal law as the starting point for a state mandate. A state that takes a different path should be prepared for a longer and more difficult implementation process for the state and stakeholders, and the possibility of stronger stakeholder resistance.

B. Components of State Mandate Legislation

Taking the approach called for in this paper generally requires state legislation with four components, each based on different sections of the ACA. The elements may break down differently based on a state's drafting conventions.

1. **Individual Shared Responsibility Requirement and Penalty**. This is the core of mandate legislation, imposing a requirement for individuals to maintain coverage and a penalty equal to the federal penalty as defined in section 5000A of the Internal Revenue Code. Incorporating the federal penalty pulls in the federal rules for qualifying coverage, exemptions, and penalty amounts.
2. **Program to Provide Certain Exemptions**. This section sets up a state program to grant the few exemptions that are not claimed on the tax return, generally because they need to be available outside the tax filing season. The language can draw from portions of sections 1311 and 1411 of the ACA, which provide for the program under which CMS, through the federally facilitated Marketplace, currently grants certain exemptions.
3. **Coverage Reporting**. This section requires insurance companies and other providers of qualifying health coverage to provide information reporting on the fact of coverage to the state revenue agency and to enrollees. Such reporting is currently required (to the IRS and enrollees) under section 6055 of the Internal Revenue Code. Section 6055 remains in effect and is used for purposes other than the mandate, so its reporting is likely to continue. A state can craft its reporting requirement to minimize any burden on reporting entities by (a) permitting them to submit the same information to the state revenue agency as they currently submit to the IRS under section 6055, and (b) allowing them to send nothing additional to enrollees who already receive forms under section 6055. This section should include some important modifications for state context, as explained in Appendix II below.
4. **Outreach to the Uninsured**. This section provides for outreach about coverage options to individuals who pay the penalty or claim an exemption. As explained above in Section II.C, enacting a mandate provides the state with valuable information for doing targeted outreach

to the uninsured. This outreach provision is based on a similar requirement in ACA section 1502(c).[80]

Adapting the federal statutory provisions for state context requires some technical changes, as explained in Section IV.C. Policy changes may also be incorporated, as discussed in Section IV.D.

C. Technical Adjustments to Adapt the Legislation for State Context

While the federal rules for the mandate and related provisions will generally work for states, some technical adjustments should be made to reflect state-specific factors and differences between federal and state authority. These adjustments are generally included in New Jersey's and D.C.'s mandate legislation.

Examples of these technical adjustments include:

- The federal mandate provides an exemption for individuals with gross incomes below the income tax filing threshold. This serves the dual goals of ensuring that individuals with very low incomes are not penalized and avoiding a new tax filing requirement for individuals not otherwise required to file. A state can ensure that its mandate supports these same goals by creating a similar exemption tied to the state income tax filing requirement.
- The federal mandate penalty is capped at the national average bronze premium, as calculated annually by the IRS.[81] With the federal mandate penalty repealed, the IRS will likely stop performing that calculation, and states may not have the necessary nationwide premium data. State mandate penalty legislation can address this issue by capping the penalty at the state average bronze premium. Tailoring the cap to specific conditions in the state in this way also seems consistent with the purpose of the cap.
- Both the ACA and Massachusetts require health insurers and other providers of qualifying coverage to report on the fact of coverage to the revenue agency, with a copy to covered individuals. But a state cannot require Medicare and other federal programs to do reporting. Also, state requirements related to employer benefits like health coverage may be subject to legal challenge based on ERISA preemption, especially if the requirements refer to ERISA concepts. To address this, a state reporting requirement should be carefully drafted, including following Massachusetts in exempting federal programs and assigning reporting responsibility for employer-sponsored insurance to the employer rather than the ERISA plan.

A complete list of suggested technical adjustments is included in Appendix II.

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[80] Model state legislative language reflecting this approach is available at http://shvs.org/resource/model-legislation-for-state-individual-mandate/.

[81] See, for example, IRS, Rev. Proc. 2018-43, August 17, 2018.

D. Policy Changes for States to Consider

While there are advantages, discussed above, to modeling a state mandate closely on the federal rules, there may be good reason to make discrete policy changes. This section discusses some changes that states may want to consider, including several based on Massachusetts rules. The changes discussed here can generally be made without significantly complicating state implementation or stakeholder compliance. The New Jersey and D.C. mandates each incorporate several of these options.

1. Discouraging Substandard Coverage

As discussed in Section II.B, substandard health coverage poses risks both to the individuals it covers and to insurance markets broadly. Enacting a state mandate that does not recognize this coverage can limit its impact by effectively increasing its price relative to ACA-compliant coverage. The mandates in Massachusetts, New Jersey, and D.C. all go further than the federal mandate in this regard.

Not recognizing substandard coverage requires delineating substandard coverage from coverage that does satisfy the mandate. There are three common approaches to drawing these lines:

- **Categorical Exclusions**. Mandate legislation may explicitly exclude certain whole categories of coverage from satisfying the mandate. The federal mandate takes this approach with short-term plans[82] and with another type of limited coverage called excepted benefits,[83] and the New Jersey and D.C. mandates adopt these rules by cross-referencing federal definitions. This approach may be attractive when a state concludes that a category of coverage is seldom if ever adequate.[84]
- **Substantive Standards**. Mandate legislation may impose substantive requirements that certain coverage must meet to satisfy the mandate. The Massachusetts mandate has long done this with employer plans and grandfathered plans. It requires most private coverage to provide consumer protections, including substantially providing a broad set of benefits similar to the ACA's essential health benefits.[85] The New Jersey mandate adopted a similar approach towards AHPs by incorporating the state's current substantive requirements for AHPs into its

[82] In particular, section 5000A's list of qualifying coverage includes "plans in the individual market," which under section 2791(b)(5) of the Public Health Service Act excludes "short-term limited duration insurance."

[83] See 26 U.S. Code § 5000A(f)(3).

[84] Each of the mandate laws discussed here come with an administrative safety valve for categorical exclusions, allowing the executive branch to designate additional coverage as satisfying the mandate on a case-by-case basis. This provision has been rarely if ever used for short-term plans and excepted benefits.

[85] Massachusetts Health Connector, "MCC Certification Application for Plan Years Beginning on or after 1/1/2017."

requirements for AHPs to satisfy the mandate.[86] This approach may be attractive when a state concludes that a category of coverage may be inadequate when it fails to meet certain additional standards. Besides AHPs, this may be an attractive option for employer plans, grandfathered plans, and health care sharing ministries.[87]

- **Excluding New Plans**. A state may recognize coverage of certain types only if it was offered in the state or complied with rules in effect as of a certain date. The D.C. mandate takes this approach with AHPs, counting them as qualifying coverage only if they previously offered coverage in D.C. or comply with the federal rules in place before the new AHP regulations were finalized.[88] This approach may be attractive when a state concludes that a category of coverage has historically been relatively harmless but could pose risks if it were to gain market share, especially under new, looser rules.

2. Rationalizing Interaction with Federal Mandate Penalty

When the ACA passed, Massachusetts had to contend with the possibility of taxpayers being subject to two mandate penalties. To avoid double penalties, the state adopted rules providing that the state penalty would be reduced by the amount of any federal penalty paid.[89] This approach (as opposed to repealing its mandate) allowed Massachusetts' state-specific rules to continue to have effect. For example, individuals with employer coverage that satisfies the federal mandate but not the additional requirements of the Massachusetts mandate have continued to owe the Massachusetts penalty, effectively discouraging such coverage.

With the federal mandate penalty repealed, the Massachusetts offset rule will soon have no effect. Nonetheless, an offset provision may be worth including. It is not inconceivable that a federal mandate will be reinstated if experience shows insurance markets faring better in states with mandates. And the provision seems harmless: it has no effect without the federal penalty in place, and a generally desirable effect with the federal penalty in place. Both the New Jersey and D.C. mandates include such a rule.

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[86] New Jersey State Legislature, "New Jersey Health Insurance Market Preservation Act". Bill No. A3380 section 4a. This approach was a designed as a safeguard in case federal AHP regulations are held to preempt states' substantive regulation of AHPs. In that case, New Jersey's substantive AHP requirements might no longer apply, but an AHP violating them would not satisfy the mandate.

[87] Under the federal mandate, health care sharing ministries do not satisfy the mandate, but individuals with these products are exempt from the mandate, which generally has the same effect. Working within this framework, state mandate legislation could attach any substantive standards to eligibility for this exemption. For example, legislation could provide that an individual in a health care sharing ministry is exempt from the mandate only if the ministry accepts all applicants, covers any pre-existing conditions, and charges the same price regardless of an applicant's health status.

[88] Muriel Bowser, "Fiscal Year 2019 Budget Support Act of 2018," Chapter 50: Health Insurance Individual Responsibility Requirement, March 22, 2018.

[89] Mass.gov, "Learn about the Assessment of Penalties," accessed, under the heading "Massachusetts Interaction with Federal Health Care Shared Responsibility Payment."

Another option would be to provide that the state mandate is zeroed out if the federal mandate comes back. This would have the advantage of simplicity, but it would negate any state-specific features a state included in its mandate, such as limiting the impact of substandard coverage.

Finally, omitting any rule defining the relationship with a federal penalty is not a huge risk, as a state could change its law to avoid double payment once the federal mandate was restored.

3. Rationalizing the Operation of the Affordability Exemption

The ACA and Massachusetts mandates both provide an exemption for individuals who lack an affordable option to purchase coverage. Both define "affordable" by comparing the individual's required contribution – generally the individual's cost of coverage – to a fraction of the individual's income. But the federal mandate defines "required contribution" in a way that leads it to grant exemptions in certain instances where an exemption is likely not appropriate, so states may wish to conform this specific rule to Massachusetts' approach.

Conceptually, the required contribution is the lowest price for which an individual could purchase qualifying coverage. That is how Massachusetts defines it. The ACA generally follows that approach for individuals not eligible for employer-sponsored coverage: the required contribution is the amount the individual would have to pay towards the lowest-cost bronze plan on the Marketplace, net of any available premium tax credit (PTC). But for individuals eligible for employer-sponsored coverage, the ACA defines the required contribution as the lowest amount they would have to pay for employer-sponsored coverage – even if Marketplace coverage would be cheaper.

This creates some undesirable outcomes. Consider an individual eligible for unaffordable employer coverage as well as highly subsidized Marketplace coverage. Under the federal rule, her required contribution is based on the unaffordable employer offer. As a result, the individual qualifies for the affordability exemption even though she is in fact eligible for highly affordable Marketplace coverage. This is problematic in its own right, but it also creates some potentially troubling inequities. Consider a similar individual but without the unaffordable employer offer. His required contribution is based on the highly subsidized Marketplace coverage, so no exemption is available. In other words, the two individuals can purchase Marketplace coverage for the same (highly affordable) amount, yet one is exempt from the mandate because she also has a second, unaffordable option.

This issue can be readily addressed by tweaking the definition of required contribution to follow Massachusetts' rule: the required contribution is the lesser of the amounts the individual would need to pay for Marketplace coverage or employer coverage. This addresses the horizontal inequity described above, fits more intuitively with the term "required contribution," and avoids needlessly exempting individuals with highly affordable coverage options.

4. Avoiding Erroneous Payments by Low-Income Individuals

Section III.A above considered the impact of a state mandate on low-income individuals, noting that (1) widely-discussed IRS data overstate the likely impact a state mandate would have on low-income individuals, so long as the state takes straightforward measures to avoid erroneous payments; (2) the ACA provides a coordinated array of mandate exemptions and generous subsidies for low-income individuals; and (3) applying the mandate broadly is important for achieving its policy goals. This section discusses the straightforward measures for avoiding erroneous payments by low-income individuals. State legislation based on the federal mandate likely provides administrative authority for a state to adopt any or all of these options, without any additional specific authority. But a state could also write these measures into its mandate legislation to provide greater assurance, as D.C. has done.[90]

- **Implement Return Processing Filters to Catch Erroneous Payments**. Most tax returns are filed electronically,[91] permitting the IRS and state revenue agencies to check for errors that are apparent on the face of the return. These errors include computational mistakes, transcription errors, and leaving required fields blank. As the National Taxpayer Advocate noted, many of the erroneous payments of the federal mandate penalty came from low-income individuals, most with income below the filing threshold. A state could greatly reduce these errors by incorporating real-time checks into its return processing system.
- **Provide Instructions and Other Materials that Accurately Reflect, and Emphasize, the Affordability Exemption**. As explained above, the operation of the affordability exemption makes it available to most Medicaid-eligible individuals, but this operation is complex and unintuitive. IRS forms and instructions for tax years 2014 through 2016 did not clearly explain this rule. The instructions for tax year 2017 took steps to address this issue, clarifying the affordability exemption calculation and adding reminders that Medicaid-eligible individuals should see if they qualify.[92] States should incorporate these improvements and could further clarify this language and add additional reminders and online resources.

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[90] It should be noted that a state might reasonably prefer not to exempt Medicaid-eligible individuals from the mandate. Applying the mandate to them would likely increase Medicaid take-up, while also increasing the share of mandate penalties paid by poor taxpayers. Even for a state with this policy preference, the current approach is flawed, as it imposes the mandate penalty selectively on those poor taxpayers who misunderstand the rules

[91] For example, in 2018, 92 percent of returns have been efiled: efile.com, "U.S. Taxpayers efiled More Than 126 Million Returns in 2018," as of May 2018. While data on state efiling is less readily available, the virtually every state with an income tax permits it, so the rate is probably comparable; see TaxAct, "E-filing States-Stand Alone vs. Piggyback," 2015.

[92] In particular, the tax year 2017 instructions (1) changed the "Marketplace Coverage Affordability Worksheet," which taxpayers use to determine whether Marketplace coverage counts as affordable, to reflect that Medicaid-eligible individuals cannot get the PTC; and (2) added a "Tip" flagging this rule; and (3) flagging this issue in a section listing "common mistakes." See IRS, "Form 8965 instructions – tax year 2017."

- **Create a Clearer Exemption for Medicaid-Eligible Individuals**. Clarifying and emphasizing the affordability exemption rules can increase the likelihood that Medicaid-eligible people will claim it. But the rule is inherently complex and unintuitive, so some level of error is likely to continue.[93] A state could provide stronger assurances that such individuals would not pay a penalty by providing a simpler exemption for Medicaid-eligible individuals. For example, a state could provide an expanded low-income exemption for anyone with income under 138 percent of FPL. The D.C. legislation follows an approach like this, tying an exemption to D.C.'s income threshold for Medicaid eligibility. A state basing its mandate on federal rules could also create this exemption administratively using the authority to designate new categories of hardship exemptions.

A state could also consider changes that exempt larger numbers of relatively low-income individuals. For example, a state could adopt an affordability exemption similar to the one in Massachusetts, which ties the threshold to a percent of income.[94] For the reasons discussed above, this would materially weaken the mandate, rather than just avoiding overpayments, and thus reduce its impact on coverage and premiums. It would also be a relatively more complicated change to make, as it would replace the uniform 8 percent (indexed) exemption threshold with a sliding scale. States considering such changes must weigh these concerns against their goals in broadening the exemption.

5. Increasing the Penalty

After early-year enrollment figures in the individual market came in lower than forecast, some observers suggested that the penalty was too small to create a sufficient enrollment incentive.[95] In keeping with this concern, some state mandate proposals have called for more aggressive penalties.[96]

There is little evidence for the claim that the federal mandate is too small to be effective. The federal mandate penalty phased in over time and was felt by taxpayers only after the fact, so observations from the first few years likely understate its impact.[97] The best evidence from recent research is that the

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[93] As explained above, intuitively the "required contribution" for an individual who can enroll in Medicaid at no cost is zero. But in fact it is generally the full (unsubsidized) premium for a Marketplace bronze plan.

[94] mass.gov, "2017 Massachusetts Schedule HC Health Care," Table 3: Affordability, January 16, 2018.

[95] For example, see Rachel Roubein, "Should ObamaCare's individual mandate penalties, subsidies increase?" *The Hill*, October 18, 2016. See also Avik Roy, "Obamacare's Dark Secret: The Individual Mandate is Too Weak," *Forbes*, July 11, 2012.

[96] See Fiona M. Scott Morton, "The Connecticut Individual Healthcare Responsibility Fee," *Yale Institute for Social and Policy Studies*. February 5, 2018, calling for a fee that is generally 9.66 percent of income.

[97] Specifically, the federal mandate penalty reached its full value (generally $695 per uninsured adult plus half that per uninsured child, or 2.5 percent of household income over the filing threshold, whichever is greater) only in 2016. Given that most 2016 tax returns were filed in early 2017, the open enrollment period in late 2017 was the first one when people were likely to be aware of the full size of the penalty. Results from the 2017 open enrollment period suggest surprisingly strong

federal mandate had a substantial impact on coverage.[98] And the federal mandate is generally approximately the same size as the Massachusetts mandate,[99] which evidence suggests has been quite effective.[100]

The fact that the current penalty is large enough to motivate changes in behavior does not, of course, establish that it is optimally sized. A larger penalty would probably increase coverage more, so states wishing to surpass the coverage levels achieved under the ACA could evaluate options for doing so. These benefits must be weighed against the disadvantages, including higher costs to individuals, reduced continuity with the federal mandate, and potentially greater political resistance. In the near term, it seems likely that these disadvantages will deter most states interested in implementing their own individual mandates from imposing penalties higher than those in place under the federal mandate. In the longer term, the appropriate size of a mandate penalty is a question that would benefit from additional research.

6. Using Mandate Penalty Revenue to Make Coverage More Affordable

States that realize net budgetary savings from a mandate and wish to use those savings to make insurance coverage more affordable have several options. These options would generally increase enrollment in the individual insurance market, especially among healthier consumers, thereby reducing premiums. Several of these options could be funded in great part or entirely by the revenue from a mandate.

- **Reinsurance**. Mandate revenue can cover most or all of the cost of a state reinsurance program. Seven states have applied for and received federal approval to establish these programs as part of section 1332 State Innovation Waivers, which provide federal funding to

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performance given the various factors depressing take-up. See, e.g., Katie Keith, "Marketplace Enrollment Remained Stable, Increased in State-Based Marketplaces, NASHP Reports," *Health Affairs Blog*, February 8, 2018. While it is impossible to tease out the effect of various factors in play, experience with the fully-phased-in mandate penalty could be a reason for the strong results.

[98] Matthew Fiedler, "How Did the ACA's Individual Mandate Affect Insurance Coverage?" *The Brookings Institution*, May 2018. As Fiedler explains, evaluating the mandate's impact is complicated because the mandate took effect in 2014, at the same time as the Medicaid expansion, Marketplaces and related subsidies, and several insurance market regulations. In an effort to isolate the mandate's effect, Fiedler focuses on the impact on individuals with incomes over 400 percent of the poverty line, who were less affected by these contemporaneous changes.

[99] Linda J. Blumberg and Lisa Clemans-Cope, "Reconciling the Massachusetts and Federal Individual Mandates for Health Insurance: A Comparison of Policy Options," *Urban Institute*, December 2012.

[100] Amitabh Chandra et al., "The Importance of the Individual Mandate — Evidence from Massachusetts," *New England Journal of Medicine*, January 27, 2011.

help pay for reinsurance programs.[101] New Jersey enacted its waiver authorization as part of a legislative package that also included its individual mandate, with mandate revenue dedicated to pay the state's share of the reinsurance program.[102] The actuarial firm Oliver Wyman has calculated that New Jersey's share of the cost of the reinsurance program in 2020 will be $105 million.[103] This is substantially less than the state's $175 million in potential revenue from a mandate in 2020, as shown in Table 1. Wyman also estimates that the federal government would pitch in $218 million in 2020 – a substantial advantage of this approach.

- **Affordability Wrap**. States with state-based marketplaces could use mandate revenue to support programs that "wrap around" federal affordability subsidies, thereby making premiums or cost-sharing more affordable for low- and moderate-income individuals. Massachusetts and Vermont have long-standing wraps for individuals eligible for federal Marketplace subsidies, with Massachusetts' program funded in part by its mandate.[104] Minnesota had such a program in 2017 for Marketplace enrollees ineligible for federal subsidies.[105]

  State mandate revenue may be sufficient to cover much or all of the cost of such a wrap, depending on its specific design. For example, for state fiscal year 2018, Vermont's premium assistance wrap cost was forecast to cost $6.6 million, and its cost-sharing wrap cost was forecast to cost $2.6 million[106] – together this comes to less than the $11.3 million a state individual mandate in Vermont could raise in 2020, per Table 1. More broadly, RAND researchers writing for the Commonwealth Fund analyzed two representative options for expanding the PTC that are analogous to state wraps – increasing the PTC for those currently

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[101] See Heather Howard, "More States Looking to Section 1332 Waivers," State Health and Value Strategies, updated August 16, 2018. For more information on 1332 reinsurance waivers, see Joel Ario and Jessica Nysenbaum, Manatt Health, "State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States," *State Health and Value Strategies*, March 2018.

[102] Katie Jennings, "New Jersey will become second state to enact individual health insurance mandate," *Politico*, Updated May 31, 2018. The waiver application has since been approved. See Seema Verma, Letter to Marlene Caride, August 16, 2018. In addition, the recommendations issued by the Executive Board of the D.C. Health Benefits Exchange (DCHBX) called for using mandate revenue to support a reinsurance program without a 1332 waiver, though the legislation did not ultimately include such a program.

[103] State of New Jersey, "New Jersey 1332 Waiver Application," July 2, 2018.

[104] Massachusetts Health Connector, "ConnectorCare Health Plans;" and Lawrence Miller and Steven Costantino, "Cost Sharing Program," Presentation to Vermont Health Reform Oversight Committee, September 15, 2015. The DCHBX recommendations also called for a wrap of this sort, though it was not included in the legislation.

[105] See mn.gov, "Health Insurance Subsidy Program." Minnesota's program was allowed to expire after 2017, when its reinsurance program took effect.

[106] See Vermont Department of Health Access, Medicaid Program Enrollment and Expenditures Report for Q3 SFY 2018, June 1, 2018.

receiving it and expanding it to those above 400 percent of FPL. RAND found the two options would cost $5.9 billion and $4.9 billion respectively in 2020[107] – each comparable to the Treasury Department's forecast of $5.7 billion in nationwide mandate revenue for that year. By contrast, Massachusetts' generous ConnectorCare program costs over $300 million per year[108] – far more than the $82 million that would be expected from a mandate there modelled on the federal one. And Minnesota's 2017 program cost $137 million, far more than the $71 million a state mandate might raise there.[109]

- **Outreach**. States could spend the funds on outreach and education programs to help more people get covered. Deep cuts in federal outreach funding have created a potential need for states to do more.[110] Research by Covered California suggests that this can be effective in driving enrollment and lowering premiums.[111] The D.C. mandate generally takes this approach, though mandate revenue may also be used for other purposes supporting the availability or affordability of health coverage.[112] Revenue from a state mandate is likely more than enough to pay for a generous outreach campaign. For example, nationwide federal spending on Marketplace outreach and navigators in 2016 (before recent deep cuts) totaled about $163 million – a fraction of the $5.6 billion of potential revenue from state mandates.[113] Even a highly aggressive outreach program like California's would easily be covered – it cost $111 million for 2018, compared to potential mandate revenue there of around $600 million.[114]
- **Individual Down Payments or Accounts**. Several states have explored options to use a taxpayer's payment for going uninsured towards the future health care expenses of that specific taxpayer, thereby reframing the "penalty" as a "down payment." There are at least two versions of this concept.

  The first version is allowing individuals' payments to be used towards their future premiums. This approach is found in legislation that was introduced in Maryland, based on a proposal

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[107] Christine Eibner and Jodi Liu, "Options to Expand Health Insurance Enrollment in the Individual Market," Commonwealth Fund, October 19, 2017.

[108] Author communications with Massachusetts Health Connector Staff, September 4, 2018.

[109] Minnesota Office of the Legislative Auditor, "Premium Subsidy Program," May 7, 2018

[110] Tim Jost, "CMS Cuts ACA Advertising By 90 Percent Amid Other Cuts To Enrollment Outreach," *Health Affairs Blog*, August 31, 2017.

[111] Peter Lee et al., "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," *Covered California*, September 2017.

[112] See section 47-5008(c) in Muriel Bowser, "Fiscal Year 2019 Budget Support Act of 2018," Chapter 50: Health Insurance Individual Responsibility Requirement, March 22, 2018.

[113] Timothy Jost, "CMS Cuts ACA Advertising by 90 Percent Amid Other Cuts to Enrollment Outreach, " Health Affairs Blog, August 31, 2017.

[114] Ibid.

developed by Families USA.[115] This approach could incentivize coverage by reducing the price of coverage for consumers who have been required to make a payment in the past, and by appealing to individual's aversion to "losing" the payments they have made. On the other hand, this approach effectively decreases the cost to consumers of going uninsured in the first place. Taking these opposing dynamics together, the net coverage impact (relatively to a plain mandate) is unclear.

The second version is directing penalty payment towards individual accounts to pay for health care services. This approach is found in legislation released in Connecticut based on a proposal from faculty at the Yale School of Management.[116] This approach would likely do less to increase enrollment in traditional health coverage than a conventional individual mandate, as it would weaken the initial incentive to enroll (by reducing the loss from staying uninsured) without later reducing the cost of coverage.

Implementing either of these approaches presents tricky design questions and would add to the operational build for the state. The Maryland approach would require changes to enrollment procedures and therefore is probably feasible only for states with State-Based Marketplaces not using the federal enrollment platform.[117] That said, recasting the mandate penalty as a benefit to consumers may be attractive politically.

Conclusion

The repeal of the federal mandate, combined with a series of adverse federal administrative actions, threatens to weaken the ACA in important ways – increasing premiums and cutting into coverage gains.

States and their residents will be adversely affected by many of these actions, but they are not powerless. They have tools at their disposal to take control of their insurance markets and protect their residents. A state mandate is an important tool on that list. It is a straightforward way to protect the health insurance market by merely restoring rules in effect under the ACA, while also offering other benefits like limiting the impact of substandard plans, facilitating coverage outreach, and raising revenue that can be used to support affordability. States would do well to consider it.

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[115] Stan Dorn, "The 'Protect Maryland Health Care Act' Will Use Health Insurance Down Payments to Prevent Insurance Costs from Skyrocketing," *Families USA*, January 30, 2018.

[116] Fiona M. Scott Morton, "The Connecticut Individual Healthcare Responsibility Fee," *Yale Institution for Social and Policy Studies*, February 5, 2018.

[117] For lists of states with state-based marketplaces and state-based marketplaces using the federal platform, see CMS.gov, the Center for Consumer Information & Insurance Oversight, "State-based Exchanges," updated September 15, 2017.

APPENDIX I: Additional Budgetary Consideration for Enacting a Mandate

A discussed above, a state mandate raises revenues through penalty collections. But creating a state mandate could also affect the state budget through other channels. This section considers CBO's estimates of the federal budgetary impacts of mandate repeal and how those may translate to states.

As discussed above, CBO's November 2017 analysis of mandate repeal provided detailed estimates of the impact on coverage and the federal budget. CBO's May 2018 baseline indicated that it had revised its methodology and now believes that its November 2017 coverage impact estimates were too large by about one-third. But the May 2018 report did not provide a detailed breakdown of its revised coverage impact estimates, and it did not provide any indication of how its revised coverage estimates would translate to revised budgetary estimates. Accordingly, the discussion below refers to the November 2017 figures in order to illustrate the broad magnitude of various federal budgetary effects, which is helpful in understanding the likely patterns of effects on state budgets. The impacts based on CBO's updated estimates of the mandate's effects would likely be somewhat smaller.

CBO's November 2017 report projected that repealing the ACA's mandate would create substantial net federal budget savings because the forgone penalty revenue is more than offset by lower spending on federal health care subsidies. In other words, the federal mandate increased deficits. For states, the fiscal calculus appears far more favorable. The reason is that, while a state mandate would collect about the same amount of revenue from the state's residents as the federal mandate, the resulting increase in the state's net health care spending is likely to be far lower than the impact on federal spending.

It is important to note that the impact of each of these factors will vary from state to state, depending on the state's tax system, uncompensated care programs, Medicaid and CHIP matching rates, other health care subsidies, insurance market conditions in the state, and other factors. In addition, the extent to which these factors would be taken into account for budgeting purposes depends on state budgeting rules and conventions.

For all these reasons, the figures below should be approached with caution. States considering a mandate should rely on state-specific analysis that reflects its specific rules and conditions.

- **Individual Market Subsidies**. CBO projected that the largest federal budget impact from mandate repeal, $185 billion over the budget window, would come from lower subsidies for individual market coverage (largely the premium tax credit). State analogs to these subsidies are extremely rare.[118] Thus there is generally no analogous cost to the state.

[118] As noted above, Massachusetts and Vermont provide individual market subsidies that wrap around the federal subsidies.

- **Medicaid**. CBO projected that eliminating the mandate would reduce net federal spending on Medicaid by $179 billion over the budget window. On average, states pay for about 37 percent of the cost of Medicaid coverage.[119] But there is reason to believe that figure may be even lower for Medicaid enrollment induced by a mandate. The reason is that, as discussed in detail above, higher-income Medicaid-eligible individuals are more likely than those with lower incomes (below the income tax filing threshold) to be subject to the mandate, or to believe that they are. Medicaid-eligible individuals with higher incomes are generally eligible under the ACA Medicaid expansion and for these individuals the federal government generally pays a large share of the cost: 93 percent in 2019 and 90 percent in 2020 and thereafter.[120] As a result, to whatever extent a state mandate increases Medicaid coverage, it is likely to come at disproportionately small cost to the state.
- **Tax Exclusion for Employer-Sponsored Coverage**. CBO did not break out this figure, but included it as the main portion of a $62 billion figure labeled "Other Effects on Revenues and Outlays." The value of the tax exclusion is generally proportional to the marginal tax rate on wages. The average state marginal tax rate on wages was about one-fifth of the average federal rate, according to the most recently available data.[121] Accordingly, the impact on state revenues is likely to be much smaller than the federal impact, with the specific impact heavily dependent on the state's income tax system.
- **Uncompensated care costs**. CBO estimated that repealing the mandate would increase Medicare spending by $43 billion over the budget window, largely due to "Disproportionate Share Hospital" payments. Many states have programs that similarly reimburse for uncompensated care and therefore can expect savings in uncompensated care programs from a mandate. Before the tax bill passed, the Urban Institute estimated that states were on track to spend $14.1 billion on uncompensated care in 2019 – or about $488 per uninsured person.[122] Adding millions of people to the ranks of the uninsured would greatly increase the need for this state aid and could lead to automatic increases in state spending, depending on how a state's uncompensated care programs are structured.[123]

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[119] Kaiser Family Foundation, "Federal and State Share of Medicaid Spending, FY 2016."

[120] Robin Rudowitz, "Understanding How States Access the ACA Enhanced Medicaid Match Rates," *Kaiser Family Foundation*, September 19, 2014.

[121] The most recently available data come from NBER calculations based on state and federal tax law in effect in 2016, run off samples drawn from 2008. See National Bureau of Economics Research, "Marginal Tax Rates by Income Type," 2018.

[122] Matthew Buettgens, Linda J. Blumberg, and John Holahan, "The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation," *Urban Institute*, January 2017.

[123] The Urban Institute's July 2018 analysis estimated how much a mandate would reduce uncompensated care in each state in 2019, totaling $11.4 billion. However, these figures represent the total cost of uncompensated care, not the cost to the state budget. Linda Blumberg et al, "How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?" *Urban Institute*, July 20, 2018.

APPENDIX II: Technical Adjustments to Federal Mandate Rules for State Context

This appendix lists changes to federal mandate provision that a state should consider including in state mandate legislation to adapt the rules to a state's legal framework and context. The first section describes general adjustments. The second describes adjustments specifically applicable to the coverage reporting requirement. The New Jersey and D.C. mandate laws generally include all of these adjustments.

General Adjustments for State Context:

- **Cap the penalty based on state-average premiums rather than national-average premiums**. Section 5000A caps the mandate penalty at the national average bronze plan premium. IRS has published guidance with this amount for tax years 2014 through 2018; for 2017 it is $283 per month per individual.[124] With the federal mandate penalty zeroed out for 2019, the IRS is likely to stop producing this figure, so states will need to calculate a cap themselves. Doing so based on premiums in the state ensures both that the state has the requisite information and that the cap is well-tailored to conditions in the state.
- **Exempt residents of other states**. The Massachusetts mandate does not apply for months when a taxpayer is not a Massachusetts resident.[125] This is similar to the ACA exemption for residents of U.S. territories and other countries.
- **Exempt individuals with incomes below the state income tax filing threshold**. The federal mandate provides an exemption for individuals who are not required to file a federal income tax return because their gross incomes are below the income tax filing threshold.[126] This serves the dual goals of exempting individuals with very low incomes[127] and avoiding the imposition of a tax filing requirement on individuals not otherwise required to file. To achieve these same goals, state mandate legislation can include a similar exemption tied to the state income tax filing requirement.[128]

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[124] IRS, Rev. Proc. 2018-43, August 17, 2018.

[125] mass.gov, "Health care reform for individuals."

[126] IRS, "Individual Shared Responsibility Provision – Exemptions: Claiming or Reporting," last modified February 16, 2018.

[127] Massachusetts Technical Information Release, "TIR 17-1: Individual Mandate Penalties for Tax Year 2017," February 3, 2017.

[128] The federal mandate provides two similar exemptions based on the filing threshold: a statutory exemption for those with household income below the filing threshold, and an exemption created by regulations for those with gross income below the filing threshold. The latter was created because the income tax filing requirement is tied to gross income. The state exemption should generally be designed to track the state filing rule.

- **Adopt federal guidance as starting point**. As explained above in Section IV.A, states can take federal guidance implementing the mandate as a starting point to avoid the need for a lengthy and resource-intensive guidance exercise. Adopting federal guidance as a starting point can be readily accomplished by incorporating federal regulations and other guidance into the state Code of Regulations or a similar record, much as the state Code can incorporate federal law. Federal guidance under sections 5000A and 6055 should generally be included, although adapted to any differences in state law. To ensure that states still control their own destiny, the state legislation should specify that any changes to this guidance made by state officials supersede the federal rules. As with section 5000A itself, federal guidance would apply as in effect on December 15, 2017.[129]
- **Adapt legislation to state conventions**. The federal mandate includes numerous references to federal agencies, officials, Code sections, etc. Such references and terminology need to be adapted to reflect state institutions and conventions.

Adjustments to Federal Reporting Requirement to Reflect State Legal Authority

Both the ACA and Massachusetts require health insurers and other providers of qualifying coverage to report on the fact of coverage to help verify compliance with the mandate. The reporting goes to the revenue agency with a copy to covered individuals. The two requirements differ somewhat in what is reported and who is required to report. This paper recommends a hybrid of the two versions, with Massachusetts' rules for who must report in recognition of state legal authority and the federal rules on what is reported to ease the transition.

- **Who must report**. The ACA reporting requirement, in section 6055 of the Internal Revenue Code, requires reporting from all providers of minimum essential coverage. This includes health insurers; sponsors of self-insured group health plans; federal and state agencies that administer health programs like Medicare, Medicaid, Veterans Affairs (VA) coverage, and Tricare; and any entity that provides coverage designated minimum essential coverage by HHS.

  The Massachusetts reporting requirement, by contrast, applies to only certain types of coverage and places the reporting responsibility on different entities.[130] These changes are apparently in recognition of limits on states' legal authority, and thus should be considered by other states as well.

  First, the Massachusetts requirement does not apply to Medicare, VA coverage, Tricare, or other purely federal programs. This is likely because states cannot generally impose

[129] Depending on administrative law in the state, conforming with section 5000A "as in effect on" December 15, 2017, may be sufficient to incorporate federal guidance without separately discussing the incorporation of guidance.

[130] malegislature.gov, "General Law - Part I, Title IX, Chapter 62C, Section 8B."

requirements on federal agencies. For individuals with these types of coverage, other information like the individual's age or employer can be used to help verify coverage.

Second, Massachusetts places the primary reporting responsibility on any "employer or other sponsor of an employment-sponsored health plan." Only if coverage is not under a "Massachusetts-based employment-sponsored health plan" is Medicaid or the health insurer required to report. Massachusetts law also specifies that reporting entities may "contract with service providers" to provide the reporting (and, indeed, many employers rely on insurers to submit the reporting).[131] These provisions appear designed to help the reporting requirement survive legal challenge under ERISA, which preempts certain state regulation of group health plans. While an analysis of ERISA preemption law is beyond the scope of this paper, two things that may help state laws survive ERISA challenge are (1) avoiding references to ERISA group health plans or other ERISA concepts, and (2) minimizing the burden from the state law. Structuring the reporting responsibility like the Massachusetts rules achieves both of these ends.

- **What must be reported**. Both the federal and Massachusetts reporting requirements are relatively simple. For each enrollment group (generally, a family), they require a list of covered individuals and the months of the year covered, along with identifying information about the coverage provider. The federal requirement also requires that insurers providing coverage under a group health plan identify the employer. The biggest difference between the two requirements is that the federal structure uses taxpayer identification numbers (generally, social security numbers) to identify covered individuals, while Massachusetts uses dates of birth and subscriber numbers.[132] (Section 6055 also requires the reporting of some additional information, such as the amount of advanced tax credit payments made through the Marketplace, but federal regulations eliminated those requirements as unnecessary.[133])

  To maximize continuity and minimize the burden on reporting entities, states can follow the federal approach, while simplifying it further and providing an additional safe harbor. The simplification relates to fully insured employer-sponsored coverage: while section 6055 requires information about both the insurance company and the employer, state legislation can follow Massachusetts in permitting that one or the other be provided. The safe harbor would permit the reporting responsibilities to be satisfied by providing the same information that is currently reported under the federal requirement. Taken together these features will maximize continuity for reporting entities and minimize compliance costs, further supporting state authority in light of ERISA.

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[131] Massachusetts Department of Revenue, "Health Care: Frequently Asked Questions for Employers," General Question #2.

[132] See IRS Form 1095-B and Massachusetts Form MA 1099-HC.

[133] Federal Register, "Information Reporting of Minimum Essential Coverage," 79 FR 13220, March 10 2014.

- **Who the reporting goes to**. Both the federal reporting requirement and Massachusetts' require that the reporting goes to the revenue agency (IRS or Massachusetts Department of Revenue), with a copy to the enrollee. As result, many Massachusetts residents currently receive two statements documenting that they had coverage. This seems like an unnecessary duplication of effort, especially in the context of a state mandate closely matching the federal one. Accordingly, to minimize the burden on report entities, state legislation can provide that a coverage provider need not send a statement under the state law to enrollees who already get them under federal law.
- **Findings of fact**. To further support the case for ERISA compliance, a state may also include findings of fact in its legislation. Such findings may note, for example, that the reporting requirement is designed to minimize burden and is necessary for the successful enforcement of the mandate, which protects several compelling state interests, including a stable insurance market, a prospering economy, and the health and welfare of state residents. They may also emphasize that the mandate and reporting requirement are both tax provisions, given that there are some indications of greater deference under ERISA to state tax rules.

APPENDIX III. Considerations for States without Income Taxes

As discussed in the body of this paper, implementing a state mandate is generally straightforward because it can be operationalized through a state income tax system, as both the Massachusetts and federal mandates were operationalized through existing income tax systems. This approach allows the state to use its existing infrastructure of forms and instructions, payment mechanisms, return processing systems, and enforcement procedures; and it allows individuals to complete their filing responsibilities as part of an existing interaction with the state.

Without this infrastructure, implementing a state mandate is a heavier lift for both the state and its residents.

Yet states without income taxes do have options, especially if they are motivated to think outside the box. The following three seem the most promising:

1. Requiring Residents to Submit an Individual Mandate Form

A state without an income tax could require residents to submit a paper or electronic form capturing the mandate content that is currently included on federal income tax forms. Residents owing a mandate penalty would include a payment.

Implementing a state mandate with this structure comes with a significant cost to both the state and its residents. The state would face the one-time cost of developing an administrative apparatus to administer the mandate and the ongoing cost of doing so. State residents would need to take a whole new action each year. The burden on individuals could be mitigated by allowing residents to submit their information through a simple online form, or by incorporating the form into tax preparation software. But alternatives would be needed for individuals without ready access to or comfort with computers, which would mean substantial numbers of paper letters going back and forth, which is costly.

2. Piggybacking on an Existing State Procedures

Even states without income taxes have other ways that they interact regularly with residents. One or more of these existing programs might provide a platform for a mandate without developing an entirely new infrastructure or requiring residents to have additional annual interactions with the state. For example, states may have state-based property taxes or may impose excise taxes on utilities or cell phones. While not as straightforward as an income tax, a state willing to think creatively could develop ways to incorporate a mandate into these programs. These approaches might not reach a state's entire population, but they might reach enough people to achieve the benefits of a mandate.

3. Using Administrative Data to Make Initial Determinations

To avoid imposing a new responsibility on state residents to submit a form, a state could instead put the onus on the state to determine who might owe a mandate payment and initiate contact. The process would begin with the state collecting a list of those with health coverage and comparing it to a list of state residents. The state would then reach out to individuals who appeared to be state residents without coverage, and asking them to respond. The mailing could include a simple form the individual could return to claim an exemption, indicating that they actually had coverage, or make a payment. The state could also delay collecting payments for a year or two, until it developed a more reliable list of who in the state has long-term coverage (like Tricare or disability-based Medicare).

A key challenge to this approach is addressing gaps in the coverage list. As explained above in Section IV.C, states do not have authority to require reporting of federal programs like Medicare and Veteran Administration coverage. This creates a risk of false positives – states sending letters to individuals who actually have full-year coverage. States have several tools to address this concern. First, a state would probably refrain from sending letters to anyone over 65, given that they likely have Medicare. Second, the state may have a record of who is a veteran through state veterans' programs. Third, a state's database would likely improve over time. For example, if the state sent a notice the first year and the recipient responds that they have VA coverage or disability-based Medicare coverage, the state could then refrain from sending them letters in future years. The same approach could be used with individuals who qualify for exemptions that generally are ongoing, such as the ones for members of Indians tribes and for individuals with religious conscience objections. Over time, a state would have a better sense of whom to correspond with. Following this approach, a state might choose to initially refrain from collecting any penalty or to rely exclusively on self-assessment until there is greater comfort that the system is working.

Another challenge to this approach is acquiring reliable data for the two lists. For the list of those with coverage, states can rely on an information-reporting requirement like the one described in this paper. For the list of state residents, states have several options.

- **Existing reporting about employees and self-employed individuals**. Employers must generally provide states with employee payroll information for purposes of payroll taxes and unemployment insurance;[134] states may also require self-employed individuals to register as businesses or to pay a specific tax. Combining these lists could produce a fairly comprehensive list of everyone working in the state. Given that most retirees receive Medicare and most other non-workers are exempt from the mandate, this list may be good enough to work with.

[134] Social Security Administration, "State Directory of New Hires," Section 453A of the Social Security Act.

- **IRS data sharing**. States can receive federal tax return information from the IRS to assist with state tax administration through information sharing agreements.[135] States without income taxes may not have such agreements, but they are entitled to them as long as the meet IRS data security standards. With such an agreement, a state could receive a list of state residents who filed a federal income tax.
- **List from other sources**. States may have fairly comprehensive lists of state residents from other contexts. For example, a substantial majority of American adults have a driver's license.[136] The rate likely varies considerably among states and is likely even higher excluding the elderly (who almost universally have Medicare) and poor (who are exempt from a mandate anyway).

[135] IRS, "IRS Information Sharing Programs." This sharing is authorized by section 6103(d) of the Internal Revenue Code.

[136] Michael Sivak and Brandon Shoettle, "Recent Decreases in the Proportion of Persons with a Driver's License Across All Age Groups," *University of Michigan Transportation Research Institute*, January 2016.

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