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Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States

Executive Summary

Every state is at risk of significant cumulative premium increases in 2019-2021 due to continued federal uncertainty in the individual market. The uneasy conditions in many states have been exacerbated by recent decisions made at the national level, such as the removal of the federal penalty for being uninsured; the introduction of association health plans and short-term, limited-duration plans that could promote higher costs and the siphoning of healthy consumers; and the potential of continued underinvestment in marketing and outreach to consumers eligible for coverage in those states that rely on federal marketplace.

A new Covered California analysis finds that absent any federal policy action, premium increases for every state could range from 12 to 32 percent in 2019, with cumulative increases from 2019-2021 potentially ranging from 35 to 90 percent.

Health care is local, and conditions and market environments are unique to each state. There are, however, key indicators of a state being more likely to be on the high or low range of the forthcoming premium increases. The two factors reflected in this analysis are the 2016 risk mix of the state and the trend in marketplace enrollment from 2017 to 2018. The report also includes data on other factors that provide important context regarding each state's situation, including the percent of consumers with more than one insurer option and the premiums consumers pay for individual market coverage in those states. Based on this analysis, 17 states could be at a higher risk of experiencing cumulative premium increases of 90 percent or more, and 19 states could be at a higher risk of experiencing hikes of 50 percent.

Highlights:

- **All states' individual markets risk higher than normal premium increases — ranging from 35 to 90 percent over three years — due to continued uncertainty at the federal level, but state variation informs understanding of local risks.**
- **Premium increases in the individual markets will likely range from 12 to 32 percent in 2019, and cumulative increases from 2019-2021 will range from 35 percent to more than 90 percent.**
- **Increases are on average more than double the rate of medical inflation as a result of healthier consumers leaving the individual market.**
- **The report identifies 17 states that are more likely — because of their historic risk mix and enrollment — to have cumulative premium increases of 90 percent or more and 19 additional states are at a higher risk of experiencing hikes of 50 percent.**
- **Policy actions could both lower premiums and promote more plan competition by reducing uncertainty — with independent actuarial analysis finding that reinsurance or similar programs could cut premium increases in half, bringing them to single digits in many states.**

This report is a national economic analysis of potential premium increases, state-by-state impacts and estimates of positive effects of federal policies, informed by actuaries, economists and Milliman, which developed estimates on the potential impact of a national reinsurance program. The analysis was sponsored by Covered California as part of its efforts to understand future trends and inform the national policy discussion.

The report also identifies several policy actions at the federal or state level that could ease the uncertainty in the market, provide stability and mitigate the impacts of any rate changes. These policy actions include instituting an invisible high-risk pool or reinsurance program, directly funding cost-sharing reduction subsidies, providing additional subsidies to consumers to purchase insurance, increasing marketing and outreach investments, and introducing state-level policies. Just as the potential premium increases are subject to wide state-level variation, the potential impacts of different stabilization policies will vary by state. The analysis in this report shows that a federally funded, state-based invisible high-risk pool or reinsurance program would reduce premiums in 2019 between 10 and 20 percent. Other policies that could reduce premiums that are modeled in this report include the moratorium on the health insurance tax for 2019 (which is projected to reduce premiums in 2019 by 1 to 3 percent), and enhanced marketing and outreach (which is projected to reduce premiums between 6 and 8 percent over three years).

Introduction

Recent health care actions taken by Congress and the federal administration — elimination of the insurance mandate penalty, proposing greater flexibility to allow for association and short-term, limited-duration plans — are expected to draw consumers out of the individual market, sowing market instability and raising the specter of large premium increases in 2019 and beyond. At the same time, the Continuing Resolution passed on Jan. 22, 2018 (PL 115-120), included a one-year moratorium on the health insurance tax for 2019, which will lower revenue to the federal government from all lines of health insurance business, but will have the effect of reducing premiums in the individual (and other) markets between 1 and 3 percent.

The effects of these policies will vary by state. However, absent federal policies to stabilize the individual marketplace, a previous Covered California report[1] found the statewide average premium increases in 2019 could range from 12 to 32 percent — with some carriers in certain states having even higher rate increases, depending on state factors.

Since then, a wide range of organizations has analyzed the potential sources and impacts of premium increases in the individual market for 2019 and beyond, including America's Health Insurance Plans, Avalere Health, the Harvard Medical School and The Urban Institute.[2]

This issue brief and the associated actuarial analysis of reinsurance considers these new reports, along with expert consultation, to update estimates of statewide average premium increases for the years 2019 through 2021, reviews policies that could mitigate those increases and analyzes data that helps assess which states are more or less likely to be hardest hit by the potentially large premium spikes.

Potential Impact of Uncertainty on Premiums in 2019-2021

This updated analysis indicates that statewide average premium increases could range from 12 to 32 percent in 2019, with additional increases of 10 to 21 percent expected in both 2020 and 2021 (see Table 1: Projections of Individual Market Premium Changes Nationally in 2019, 2020 and 2021). Cumulatively, these premium increases would average 50 percent over the three-year period, with a projected range of 36 percent to 94 percent. As will be described further, we use indicators of marketplace stability to provide state-level estimates of potential risk for cumulative premium increases based on the ranges for 2019 through 2021.

Table 1: Projections of Individual Market Premium Changes Nationally in 2019, 2020 and 2021[3]

Factors Affecting Premiums	2019	2020	2021
Medical Trend for Individual Market	**7%**	**7%**	**7%**
Elimination of Individual Mandate Penalty	**+7 to 15%**	**+2.5 to 10%**	**+ 2.5 to 10%**
Enrollment effect due to decreases in federally facilitated marketplace states due to less marketing/ shortened open-enrollment period	**-2% to +9%**	**0% to +2%**	**0% to +2%**
Association Health Plans and Short-Term Policies	**+0.3% to 1.3%**	**+0.5 to 2%**	**+0.5 to 2%**
Total Increase Effect	**Range of 12% to 32%**	**Range of 10% to 21%**	**Range of 10% to 21%**
Total Cumulative Effect			**Range of 36% to 94%**

While most consumers who receive financial assistance through their marketplace could be insulated from these dramatic hikes, unsubsidized consumers would have no such protections. A previous Covered California analysis found there are an estimated 6 million Americans in the individual market, with a median income of $75,000, who do not receive financial help. Increases of this level could drive many consumers, especially healthy consumers, out of the market, fueling a cycle of continuing premium increases in future years.

Federal and State Policies That Could Affect Premiums and Promote Stability

The individual market is dynamic, and state and federal policy makers may consider a myriad of policies to help mitigate the effects of the factors described above. These include strategies to balance insurance risk pools, support for markets where there is disproportionate negative risk mix, and direct support to consumers to help make coverage more affordable.

Some of these policies include:

- **Institute a Reinsurance Program:** A Milliman analysis estimated a reinsurance program with annual nominal funding of $15 billion would result in a range of premium reductions from 10 to 20 percent depending on program design, circumstances of the state and the efficiency of the health plan. Previous Covered California analysis had shown that, because reinsurance programs result in lower premiums and lower expenditures for premium subsidies, the net cost to the federal government would be only $5 billion after the offset for reduced Advanced Premium Tax Credit spending.[4]

- **Directly Fund Cost-Sharing Reduction (CSR) Subsidies:** While funding CSRs would not directly reduce premiums, it would help provide certainty to participating insurers and reduce federal spending for Advanced Premium Tax Credits due to the workaround that was implemented during 2018. For states that broadly loaded the cost of the CSR program onto all metal tiers or onto both on- and off-exchange products, unsubsidized consumers would experience a one-time benefit from the return to the prior premium strategy.

- **Provide Additional Subsidies to Consumers to Purchase Insurance:** Increasing the financial assistance that is available to consumers — by either raising the amount of Advanced Premium Tax Credit available to consumers or increasing the number of consumers who would be eligible to receive the credits — would help more Americans afford coverage and increase the overall health of the consumer pools.
- **Increase Marketing and Outreach:** Consumers have biases that influence their perception about having insurance coverage (e.g., the research on optimism bias shows that the young and healthy frequently underestimate their risk of illness or injury).[5] To overcome these biases, increasing spending on targeted marketing can help persuade consumers that health insurance coverage is important. By achieving enrollment among healthier individuals, the improved risk mix is likely to have a very positive return on investment, with the beneficiaries of that investment being federal taxpayers — who benefit from reduced per-person Advanced Premium Tax Credits — and unsubsidized individual market enrollees, who benefit from lower premium increases.
- **State-Based Penalties for Non-Coverage:** As displayed in Table 1: Projections of Individual Market Premium Changes Nationally in 2019, 2020 and 2021, the elimination of the federal mandate penalty is expected to increase premiums in a range of 7 to 15 perecent in 2019 and an additional 2.5 to 10 percent in 2020 and 2021. Institution of alternative policies, such as a state-based mandate, could mitigate some of these increases and the overall disruption the elimination of the penalty will cause for markets.[6]
- **State Regulations on Association Health Plans or Short-Term, Limited-Duration Plans:** States could adopt regulations that prohibit carriers from offering plans that do not provide comprehensive coverage or protect consumers with pre-existing conditions, or provide oversight of these offerings.
- **Auto-Enrollment:** State or federal policies could promote automatic enrollment of eligible individuals, such as for those who lose employer-based coverage, earn too much for Medicaid or "age out" of coverage eligibility from parents' plans.[7]

Federal and state action is needed to ensure the existence of healthy, stable markets (see Table 2: Recommended Policies to Reduce Premiums). The issues affecting markets are multi-faceted and vary across states, and policymakers should consider a mix of policy options that, in combination, can achieve the goal of ensuring that individuals have access to quality, affordable choice of coverage. In tandem with the policies outlined above, policymakers must also ensure that they are balancing consideration of other goals, including managing health care costs and ensuring that consumers continue to receive protections that are universally agreed upon, such as guaranteed issue and prohibition of lifetime limits.

Table 2: Potential Policies to Reduce Premiums

Proposed Policy Action	Estimated Reduction[8]
Create a multiyear reinsurance program with $15 billion in annual federal funding starting in 2019 (premiums would increase by about the value of reinsurance when the program halted)	10 to 20 percent
Fund CSR payments for 2017, 2019 and 2020	Unlikely to lower premiums for most consumers, see discussion on page 3
Moratorium on health insurance tax for 2019 (premiums would increase when "holiday" ends)	1 to 3 percent
Fund comprehensive marketing and outreach for 2019 to 2021 (premium reductions tied to success at enrolling healthier population)	6 to 8 percent

Projecting Potential Impacts on States: Applying Known Factors to Predict Potential Market Stability and Premium Increases

Insurance markets vary: Demographics, market penetration, policy objectives and costs differ across states. While no single indicator or even a compilation of many indicators can predict with precision the impact on premiums state by state, this report examines underlying risk mix and marketplace enrollment trends across the 50 states and the District of Columbia as indicators of market stability (Table 3: State-by-State Summary of Risk for Instability and Premium Increases). All states will see significant premium increases in the future if efforts are not made to address these factors. Data shows variance in the intensity of these factors across states, illustrating the need for urgent and multifaceted solutions to balance markets and offset premium increases.

While many factors influence premium costs, premiums are ultimately driven by the overall "health" of states' individual markets, meaning the likelihood that each state's market is stable, competitive and provides coverage at lower cost. Such factors include (1) the risk mix or overall health of those participating in the market and (2) recent enrollment trends. Each indicator has some limitations but, taken together, they provide a signal of the potential impact on premiums.

The degree to which each factor, and others not listed here, will influence premiums requires additional data and is beyond the scope of this snapshot. Still, to underscore the reality that all states are at risk of major — and in some cases, dramatic — rate increases, the summary score of marketplace risk reflecting the CMS risk scores from 2016 (as a measure of risk mix achieved from 2014 to 2016), and the recent open enrollment performance (as the latest indicator of risk trend) are used to group states into three categories: significant, high, and catastrophic marketplace risk (see Table 3: State Indicators of Individual Premium Increases and Market Instability and Figure 1: National Overview — State-by-State Interactive Mapping of Premium Increase and Instability Risk. The data interactive on http://hbex.coveredca.com/data-research/data-viz/individual-market-risks-by-state-2019/ allows users to view a composite or "summary" score for the two indicators.

- **CMS Risk Score:** The risk score is a standardized measure used by the federal Centers for Medicare and Medicaid Services (CMS) to evaluate the overall health, or risk mix, of the consumer pool in the state's individual market, inclusive of both on-and off-marketplace enrollees. The risk score is calculated based on demographic and health status information of those enrolled in coverage. Based on the most recent available risk score data, states' risk ranges from ~1.3 (lower risk) to ~2.1 (higher risk).[9] Generally, health insurers must price their products based on the anticipated risk mix of their enrollees, with a sicker risk mix translating directly to higher premiums. This analysis assumes that states with higher risk scores are likely to see higher premiums rates overall.

  This analysis calculates the difference between the states' risk scores and the national average risk score to determine the relative risk mix in each state compared to the national average — negative values correspond to a healthier risk mix and positive values correspond to a less-healthy risk mix. Estimates are based on 2016 enrollees, and may not fully account for any major changes to states' market composition since then; however, CMS reports that risk scores have largely remained consistent across states between 2014 and 2016.[10]

- **Recent Enrollment Trend:** This analysis focuses on plan-selection trends seen on the health insurance marketplaces between the 2017 and 2018 coverage years. Many changes took place during the 2017 and 2018 coverage years that may have affected these trends, including consumer confusion over repeal of the insurance marketplaces and the individual mandate prompted by ongoing federal debates over repeal of the Affordable Care Act, large premium increases and shortened open-enrollment periods. This analysis considers enrollment growth or consistency as an indication of market stability, and it is probable that states with larger declines in enrollment have less-stable individual markets. However, data is not inclusive of off-insurance marketplace enrollment and so only provides a partial picture of overall enrollment trends.[11] Additional data is necessary to ascertain definitively the weight of these enrollment trends on overall market health.

These factors provide signals of likely premium trends and market stability in 2019. However, it is important to note that these indicators are not perfect predictors of premium rates and market stability due to changes in markets that have occurred since data was reported (e.g., implementation of new state or federal policies, shifts in market composition) which may impose additional influence over markets in 2019. Other factors that are not part of the summary score, but are displayed in the data interactive to provide additional context include:

- **Percent of Consumers With More Than One Insurer Option:** Availability of insurer choice varies across and within states, pending insurer decisions to sell coverage in defined regions within states. Since 2014, most states have seen declines in the number of insurers offering individual market products, particularly those offering coverage through the health insurance marketplaces. In 2018, states averaged 3.5 insurers participating on their health insurance marketplaces, compared with an average of five insurers per state in 2014.[12] Issuers have cited various reasons for exiting the markets, including a higher-than-anticipated risk score, underfunding of the federal risk-corridor program and uncertainty over implementation of policies affecting insurance markets (e.g., cost-sharing reduction payments, enforcement of the federal mandate).[13]

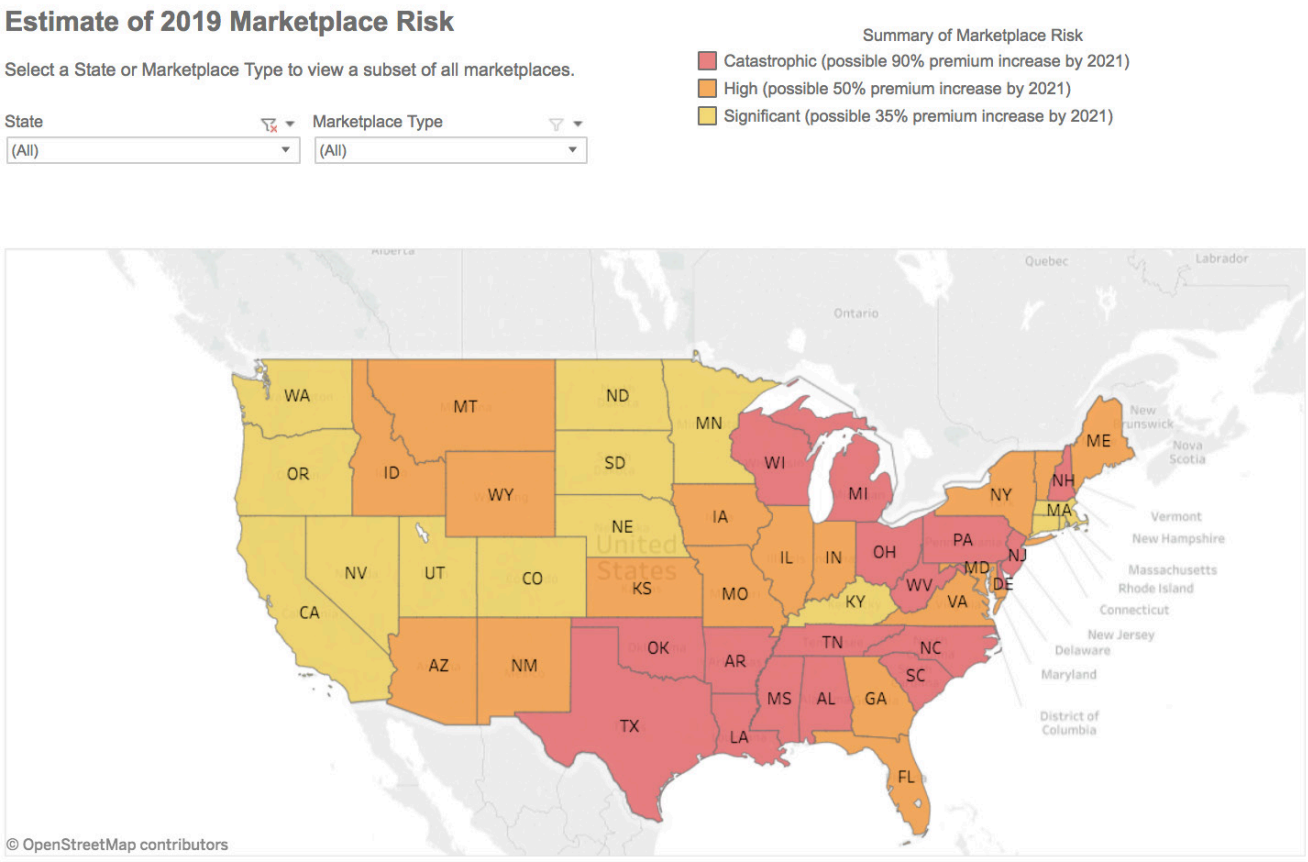
  Existence of insurer choice is important not only in providing consumer options, but because choice is directly correlated with lower premiums.[14] To understand current prevalence of market choice, this data interactive uses Kaiser Family Foundation data to calculate the proportion of marketplace enrollees with more than one insurance issuer available to them in 2018.[15] Since granular plan-selection data at the county

level will not be available until spring 2018, the Kaiser Family Foundation data relied on 2017 plan selections by county to weight overall share of consumers with more than one choice available. This approach provides a reliable estimate, but can be refined further when final open enrollment data for 2018 is available.[16]

- **Premiums and Tax Credits for 2017:** As policymakers consider the trends for 2019, it is useful to anchor the marketplace instability risk to the cost of coverage. Table 3 provides data on gross premiums (the cost for the unsubsidized), average tax credits, and net premiums (the premium paid by the consumer after tax credits, for those with subsidies only) from 2017.[17] Data from 2017 is used because premium rates are not distorted by the workaround by states for funding the cost-sharing reduction program through 2018 premiums, and also due to the unavailability of 2018 state-level data from CMS for calculating the average cost of coverage based on the plans consumers selected.

Consumers in much of the nation already face high premiums, particularly those who do not receive federal assistance in the form of the Advanced Premium Tax Credit or benefit from federal tax-supported employer-based coverage. These high premiums are a reflection of underlying health care costs and insurer pricing to reflect current market conditions and the risk mix of those in the individual market, including some of the factors mentioned above. However, even states with high premium rates can expect to see increases in the ranges projected in this issue brief, which would exacerbate the price sensitivity of consumers and increase their likelihood of going uncovered due to lack of affordability.

Figure 1: National Overview — State-by-State Interactive Mapping of Premium Increase and Instability Risk



Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States

Based on this analysis, every state has a high risk level of seeing significant premium increases over the next three years:

- Significant marketplace risk of three-year cumulative premium increases of ~35 percent: These are states that have historic enrollment or market characteristics that indicate their individual markets are likely to be have "lower than average" premium increases above medical trend. Given the range of premium-increase forecasts from other analyses for 2019 and beyond, these states are likely to have a cumulative increase over the next three years of ~35 percent.
- High marketplace risk of three-year cumulative premium increases of more than 50 percent: These are states that have historic enrollment or market characteristics that indicate their individual markets are likely to have "market average" premium increases above medical trend. Given the range of premium-increase forecast for 2019 and beyond, these states are likely to have a cumulative increase over the next three years of more than 50 percent.
- Catastrophic marketplace risk of three-year cumulative premium increases of 90 percent or more: These are states that reflect historic enrollment or market characteristics that indicate their individual markets are likely to be subject to higher premium increases or instability in the form of risk of market exit by carriers. Given the range of premium increases forecast for 2019 and beyond, these states are likely to have a cumulative increase over the next three years of 90 percent.

In addition to providing an indication for each state's likelihood of having significant, high or catastrophic risks for premium increases and instability, the data interactive map function allows each state's comparative data to be easily reviewed (see for example Figure 2, which shows the state profiles for Oregon and Pennsylvania).

Figure 2: **State Profiles of Premium Increase and Instability Risk for Oregon and Pennsylvania**

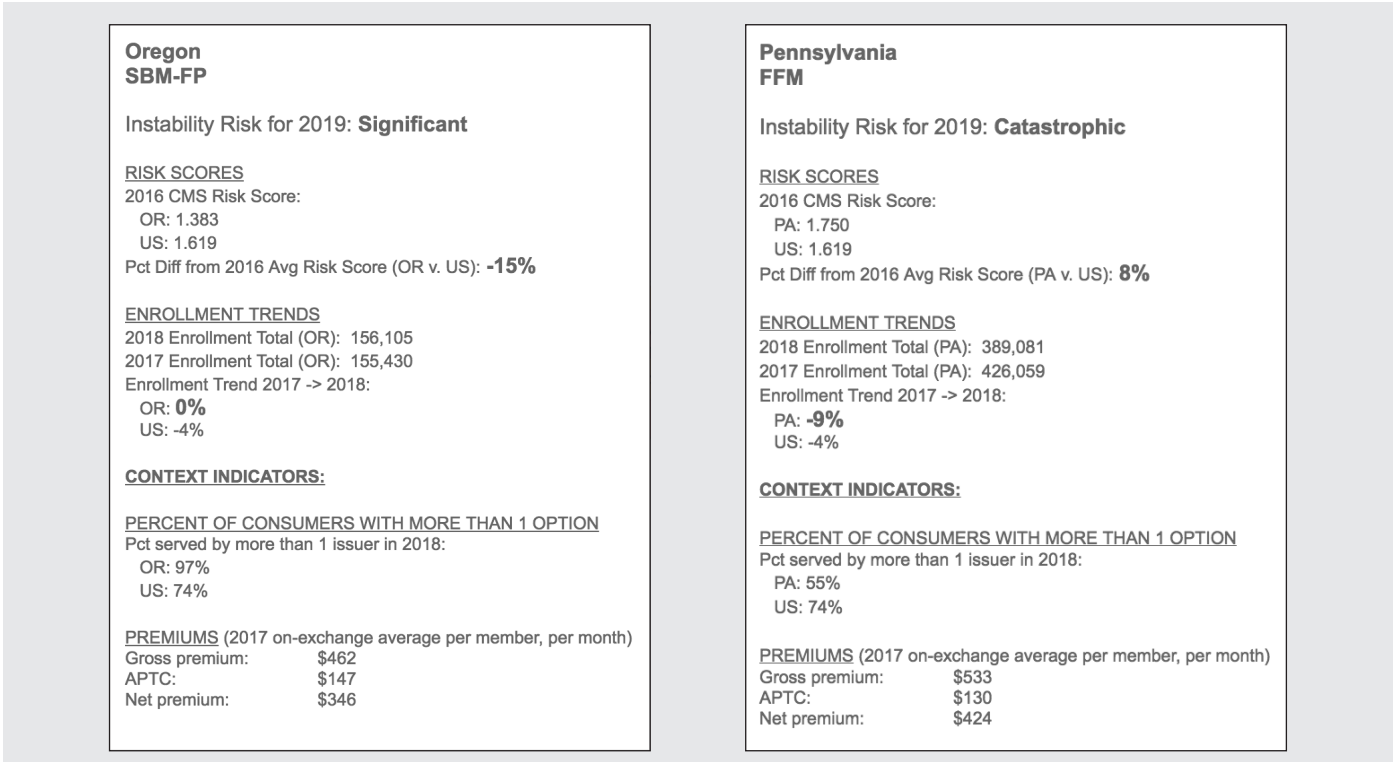


Table 3: **State-by-State Cumulative Summary of Risk for Instability and Premium Increases**

	Key Indicators for Premium / Instability				Marketplace Context Data			
State	2016 CMS Risk Score Difference from National Average	Trend in Marketplace Plan Selections 2017->18	Summary Cumulative Premium Risk	Type	Percent of Enrollees served by more than 1 QHP in 2018	Average On-Exchange Gross Premium for 2017 ($)	Average On-Exchange APTC for 2017 ($)	Average On-Exchange Net Premium for 2017 ($)
AK	-9%	-4%	High	FFM	0%	1,041	958	93
AL	24%	-5%	Catastrophic	FFM	19%	575	515	72
AR	27%	-3%	Catastrophic	SBM-FP	100%	420	272	159
AZ	-6%	-16%	High	FFM	0%	611	521	104
CA	-16%	-2%	Significant	SBM	97%	448	325	131
CO	-22%	3%	Significant	SBM	94%	454	366	129
CT	-5%	2%	Significant	SBM	100%	537	608	134
DC	-4%	0%	Significant	SBM	100%	NR	NR	NR
DE	8%	-11%	Catastrophic	FFM	0%	569	418	162
FL	7%	-3%	High	FFM	87%	442	360	84
GA	-2%	-3%	High	FFM	61%	431	355	87
HI	18%	5%	High	FFM	100%	477	357	141
IA	6%	3%	High	FFM	0%	526	422	132
ID	-7%	-6%	High	SBM	100%	426	573	94
IL	-4%	-6%	High	FFM	82%	517	364	174
IN	3%	-5%	High	FFM	64%	420	262	170
KS	2%	-1%	High	FFM	100%	476	378	110
KY	7%	10%	Significant	SBM-FP	0%	406	289	144
LA	11%		Catastrophic	FFM	100%	552	435	127
MA		2%	Significant	SBM	100%	290	127	126
MD	-3%	-3%	High	SBM	89%	431	404	147
ME	-7%	-5%	High	FFM	100%	518	414	118
MI	2%	-9%	Catastrophic	FFM	96%	402	264	152
MN	-15%	6%	Significant	SBM	99%	566	NR	185
MO	7%	0%	High	FFM	55%	483	398	100
MS	19%	-5%	Catastrophic	FFM	0%	455	373	88
MT	-16%	-9%	High	FFM	100%	581	481	115
NC	6%	-5%	Catastrophic	FFM	15%	662	589	87
ND	-12%	2%	Significant	FFM	35%	399	288	124
NE	-4%	5%	Significant	FFM	0%	595	507	100
NH	0%	-7%	Catastrophic	FFM	100%	399	249	171
NJ	4%	-7%	Catastrophic	FFM	100%	479	349	148
NM	-4%	-9%	High	SBM-FP	100%	366	279	111
NV	-5%	2%	Significant	SBM-FP	91%	379	286	105
NY	12%	4%	High	SBM	100%	NR	NR	NR
OH	8%	-4%	Catastrophic	FFM	86%	413	265	168
OK	13%	-4%	Catastrophic	FFM	0%	620	550	79
OR	-15%	0%	Significant	SBM-FP	97%	462	346	147
PA	8%	-9%	Catastrophic	FFM	55%	533	424	130
RI	-1%	12%	Significant	SBM	100%	365	344	136
SC	15%	-6%	Catastrophic	FFM	100%	512	418	101
SD	-2%	0%	Significant	FFM	100%	541	444	108
TN	17%	-2%	Catastrophic	FFM	34%	587	529	79
TX	0%	-8%	Catastrophic	FFM	89%	404	328	85
UT	-12%	-2%	Significant	FFM	100%	319	234	89
VA	1%	-3%	High	FFM	44%	405	318	97
VT	-6%	-12%	High	SBM	100%	488	333	159
WA	-10%	8%	Significant	SBM	88%	NR	NR	NR
WI	5%	-7%	Catastrophic	FFM	86%	514	399	131
WV	27%	-19%	Catastrophic	FFM	64%	702	559	161
WY	1%	-1%	High	FFM	0%	614	506	113
National Average	N/A	- 4%	N/A	ALL	74%	468	370	111

Key: **Catastrophic** (premium increases of more than 90%) **High** (premium increases of ~ 50%) **Significant** (premium increases of ~ 35%)

Methods for Summarizing Marketplace Risk by State

For this analysis, states were ranked on both of the indicators (CMS risk score and marketplace enrollment trend) and for each area scored on a percentile basis compared to all other states. A composite score was then made by summing each indicator percentile. Adjustments were made wherever a metric was not valid for a state in that year (e.g., Louisiana was still expanding its Medicaid program in 2018, explaining part of the "loss" of marketplace enrollment compared to 2017).

Based on this methodology, the worst possible "score" a state could get would be zero if it were the lowest ranked state on both indicators. If it were the highest ranked state in each of the indicators, the best possible "score" a state could get would be 200. To group states by rough marketplace risk, the 200-point range was divided into three groups: Zero to 75 (catastrophic risk), 75 to 125 (high risk) and 125 to 200 (significant risk). While these categorizations cannot be considered predictors of specific premium increases for 2019 and beyond, they serve as important indicators of potential range of future premiums.

[1] Covered California - "The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies"

[2] America's Health Insurance Plans –Factors Influencing 2019 Premiums in the Individual Market. February 2018 - https://www.ahip.org/wp-content/uploads/2018/02/FactorsInfluencing2019Premiums_IssueBrief_2.7.18.pdf; Mendelson, Dan, Chris Sloan, and Chad Brooker. Association Health Plans Projected to Enroll 3.2 Million Individuals. February 28, 2018 - http://avalere.com/expertise/managed-care/insights/association-health-plans-projected-to-enroll-3.2m-individuals; Hsu, John, Vicki Fung, Michael E. Chernew, Alan M. Zaslavsky, William Dow, and Joseph P. Newhouse. Eliminating the Individual Mandate Penalty in California: Harmful But Non-Fatal Changes in Enrollment and Premiums. March 1, 2018 - https://www.healthaffairs.org/do/10.1377/hblog20180223.551552/full/; and Blumberg, Linda J., Matthew Buettgens, and Robin Wang. The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. February 26, 2018 - https://www.urban.org/research/publication/potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending.

[3] The projections reflected in Tables 1 is the product of expert review, informed by a review of the literature, and engaging actuaries and academic experts. Among those who informed the development of this table were actuaries at AHIP member companies, Covered California's Chief Actuary and actuaries with Milliman.

[4] Covered California. Reducing Premiums and Maximizing the Stabilization of Individual Markets for 2019 and Beyond: State Invisible High Risk Pools/Reinsurance. January 10, 2018. http://hbex.coveredca.com/data-research/library/CoveredCA_Reducing_Premiums_1-10-18.pdf

[5] Covered California. Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets. September 2017. See Table 4 - http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf

[6] Massachusetts Health Connector. The Massachusetts Individual Mandate: Design, Administration, and Results. November 2017 - https://www.mahealthconnector.org/wp-content/uploads/Individual-Mandate-Report-Nov2017.pdf.

[7] American Enterprise Institute. June 5, 2017 - http://www.aei.org/publication/the-senate-should-build-automatic-enrollment-into-health-reform-heres-how/

[8] The projections in the Report are the product of expert review, informed by a review of the literature, and engaging actuaries and academic experts, with the leadership on the analysis provided by Covered California's Chief Actuary, John Bertko. Among those who informed the development of the report were actuaries at health plans, and academics at the University of California Los Angeles and Harvard University. In addition, Milliman provided actuarial modeling related to the potential impact of the instituting a federal state-based invisible high risk pool or reinsurance (Milliman's complete report related to the potential impact of reinsurance is available at http://hbex.coveredca.com/data-research/library/Milliman_Reinsurance_Program_Estimates_2-14-2018.pdf.

[9] Centers for Medicare and Medicaid Services. Appendix A to June 30, 2017 Summary Report – HHS Risk Adjustment Program State-Specific Data - https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-2017-Summary-Report-Data.xlsx

[10] Centers for Medicare and Medicaid Services. Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for

the 2016 Benefit Year. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

[11] Data on off-marketplace enrollment in 2018 was not available at the time of publication of this report.

[12] Kaiser Family Foundation. Number of Issuers Participating in the Individual Health Insurance Marketplaces, 2014-2018 - https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/

[13] https://www.washingtonpost.com/national/health-science/aetna-exiting-all-aca-insurance-marketplaces-in-2018/2017/05/10/9dedbeea-35d4-11e7-b373-418f6849a004_story.html

[14] Holahan, John, Linda J. Blumberg, and Erik Wengle. What Characterizes the Marketplaces With One or Two Insurers. May 2017 - https://www.rwjf.org/en/library/research/2017/05/what-characterizes-marketplaces-with-one-or-two-insurers.html

[15] Kaiser Family Foundation. Insurer Participation on ACA Marketplaces, 2014-2018 - https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/

[16] Note: For the purpose of this analysis, the percent of consumers with more than one insurer option is used to broadly examine state risks. In some areas of the country a single insurer option may be the the result of concentrated provider markets where reduced provider competition allows certain providers to have greater leverage in setting favorable reimbursements. In these types of situations, more plan competition might not lead to lower premiums on its own.

[17] To demonstrate the state-by-state variation in premiums, we present on-exchange marketplace average premiums from 2017: Centers for Medicaid and Medicare Services, Center for Consumer Information and Insurance Oversight (2017). "2017 Marketplace Open Enrollment Period Public Use Files: 2017 OEP State-Level Public Use File (tab 5)" (modified May 11, 2017): https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html 2018 data was not yet available at the time of publication. Note that this data is for on-exchange enrollees only; premiums paid by off-exchange members may differ, but no comprehensive source for off-exchange premium data is publicly available at this time.

About Covered California

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

Towards Universal Health Coverage:

California Policy Options for Improving Individual Market Affordability and Enrollment

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California Health Care Foundation

Executive Summary

California has made historic progress under the Affordable Care Act (ACA) by cutting the uninsurance rate by more than half, resulting in approximately 93% of Californians now having health insurance. Health coverage affordability has improved for many, especially for those who became newly eligible for Medi-Cal or subsidized coverage through Covered California. For those who purchase coverage individually, the ACA has not only provided financial assistance to help eligible low- and middle-income individuals afford premiums and out-of-pocket costs, but has also provided crucial protections to individual market enrollees of all income levels. These protections include requiring insurers to offer insurance to all without charging higher premiums for those with pre-existing conditions, setting a floor for the share of costs that insurers cover, and establishing a ceiling on enrollees' out-of-pocket costs.

However, many Californians continue to face difficulties in affording premium and out-of-pocket costs. Affordability challenges can deter enrollment in and retention of coverage, cause financial difficulties for those struggling to pay premiums or medical bills, and decrease access to care. In this report, we focus specifically on the affordability challenges for the 2.3 million Californians who purchase private insurance individually and for many of the 1.2 million Californians who are eligible to purchase insurance through Covered California but remain uninsured.

We also explore state policy options for improving affordability of individual market premiums and out-of-pocket costs, and consequently helping move the state closer to universal coverage. This set of policy options was developed based on analysis of the available evidence on affordability concerns in California's individual market, as well as on a review of policies used by other states and localities to improve affordability. The options include:

- Adding state premium subsidies to the federal ACA subsidies to further reduce enrollees' premium contributions;
- Providing financial assistance to further reduce deductibles, co-payments, and other cost sharing for some Californians already receiving ACA cost sharing subsidies, and making more Californians eligible for this assistance;
- Capping the percentage of income spent on premiums by Californians who earn too much for ACA premium assistance by providing state-funded premium subsidies;
- Establishing a state reinsurance program to lower premiums for unsubsidized individual market enrollees; and
- Extending eligibility for state-funded premium and cost sharing subsidies to children and spouses affected by the ACA "family glitch."

These policy options assume Covered California and its partners will continue the state's strong outreach and marketing efforts to increase awareness of the financial assistance available.

State policies to improve individual market affordability can help counteract the loss of insurance projected to occur beginning in 2019 as a result of the elimination of the ACA individual mandate penalty. Survey data indicates that subsidies are an even bigger driver of enrollment than penalties. Improved affordability would help to ensure strong enrollment by a broad population and help to minimize the growth in premiums that could occur if healthier people leave the market. Combining improve affordability with a state-level insurance requirement would further secure the stability of the insurance market.

These policy options could help Californians afford health coverage in the near-term in our existing health care system with its current cost structure. High and rapidly growing health care costs are a major driver of the affordability challenges facing Americans with all types of health coverage. Policies to reign in underlying medical costs, which are not the focus of this report, are also necessary.

* * *

The evidence on the extent and nature of Californians' affordability concerns underscores the need for state policy interventions. Based on our examination of survey data, analysis of Covered California enrollment data and premiums, and synthesis of the existing research on affordability, we found that:

Affordability concerns are a barrier to individual market enrollment and renewal of coverage

- Affordability is the top reason that those eligible for Covered California lack insurance, regardless of income level.
- Californians who were potentially eligible for ACA premium subsidies based on income were more likely to be uninsured and more likely to have paid the federal tax penalty for lacking insurance in 2015, compared to those with higher income.
- Many Californians enrolled in the individual market report difficulties affording premiums and out-of-pocket costs.

High out-of-pocket costs can be a barrier to care, cause financial problems, and potentially dissuade enrollment

- Even with ACA subsidies, combined premium and out-of-pocket spending in the individual market can exceed 10% of income for some Californians with median out-of-pocket spending, and can reach 20% to 30% of income for some with very high medical use.
- More than one-third of Covered California enrollees with incomes between $24,120 and $48,240 for a single individual are enrolled in Bronze plans with a $6,300 individual annual deductible.

- The vast majority of Americans eligible for ACA premium subsidies based on income do not have liquid assets sufficient to cover a $6,300 deductible.
- Research has shown that high out-of-pocket costs can be a barrier to care and cause financial problems. Out-of-pocket costs are a major consideration in individuals' enrollment decisions.

The high cost of living in California and broader financial insecurity may exacerbate health insurance affordability concerns for some individuals

- ACA premium subsidies are based on the Federal Poverty Level, but the higher cost of living in California may squeeze some families' ability to afford healthcare.
- The upper income limit for premium subsidies under the ACA—four times the Federal Poverty Level—is equivalent to five times that level in California and six times that level in San Francisco.
- In all California counties, some individuals face an affordability gap in that they earn too much to qualify for Medi-Cal with no premiums or cost sharing, but do not earn enough to afford Covered California insurance even with subsidies, based on a household budget analysis.

Some citizens and lawfully present immigrants lack access to coverage that meets ACA affordability standards

- Affordability can be a challenge for people who earn too much to be eligible for premium subsidies, especially for those age 50 or older and those who have family income between $48,240 and $72,360 for a single individual. In every region of California, premiums for some of these individuals exceed the standard of affordability under the ACA individual mandate.
- Some Californians have access to neither affordable employer-sponsored insurance nor affordable individual market coverage. Under the ACA "family glitch," they are ineligible for subsidies through Covered California because they have an offer of employer-sponsored coverage through a parent or spouse, but that employer-sponsored dependent coverage is unaffordable.

Concerns about affording health insurance and care are common among Americans with all types of health insurance, but affordability challenges are especially prevalent among those who rely on the individual insurance market. California's high cost of living makes affording health care even more challenging for some. California has substantially narrowed its coverage gaps as a result of the state's effective implementation of the ACA. Building on that momentum, California policymakers could take additional steps to make individual market insurance more affordable in the near-term, moving the state closer to universal and affordable coverage.

Contents

Background

California has made substantial gains in individual market enrollment and affordability under ACA

The percentage of Californians with health insurance has grown dramatically under the Affordable Care Act (ACA), from 83% in 2013 to 93% in 2016, the largest increase in coverage of any state.[1] These coverage gains were due in part to substantial growth in the state's individual market, in which individuals without job-based coverage purchase private insurance either through the state's health insurance Marketplace, called Covered California, or directly from an insurer.

Enrollment in the individual market grew from 1.5 million in 2013 to 2.3 million in 2016[2] due to several provisions in the ACA as well as California's extensive and effective implementation of the law. Particularly important were:

- Federal premium subsidies and financial assistance to reduce deductibles, co-payments, and other cost sharing, depending on income;
- The requirement that insurers cannot deny coverage or charge higher premiums for applicants with pre-existing conditions;
- Improved ability of consumers to shop for coverage and compare plans owing to the creation of the state marketplace and the standardization of plan benefit designs;
- Strong state-level investment in outreach, advertising, and enrollment assistance to help individuals understand their options and apply for coverage; and
- The requirement that individuals have insurance or pay a penalty.

Improved affordability is likely one of the biggest factors explaining the net enrollment gain of 800,000 Californians in the individual market. A survey conducted for Covered California found that 70% of respondents receiving premium subsidies in 2015 said that the availability of subsidies was a very or extremely important factor in their decision to purchase a plan. In fact, subsidies were a bigger driver of enrollment than the ACA individual mandate penalty, which was cited by 44% of subsidized respondents as a very or extremely important motivator.[3]

In addition to providing financial assistance with premiums and out-of-pocket costs, the ACA also established new consumer protections that help to limit out-of-pocket liability for individuals of all income levels:

- The ACA set a floor for the share of medical costs that individual market plans must cover —60% of costs across an average population.[4] Before the ACA floor was implemented, half of Americans with individual market coverage were in plans that paid less than 60% of costs.[5] The higher share of costs paid by individual market insurers in California under the ACA[6] improves financial protection for families and reduces barriers to care due to cost.
- The ACA set a ceiling on out-of-pocket costs paid by households ($7,350 for individuals and $14,700 for families in 2018).[7] While many of the households that incur high

healthcare expenses likely struggle to pay out-of-pocket costs even with these maximum limits, no limits existed before passage of the ACA, and some families with individual market coverage spent as much as $27,000 on out-of-pocket costs in 2010.[8]

- The ACA banned insurers from limiting the amount of medical benefits covered for an enrollee over a lifetime or during any given year.

As a result of the financial assistance and consumer protections established by the ACA, enrollees reported improved affordability. A longitudinal study by the Kaiser Family Foundation followed a panel of Californians who were uninsured prior to the first ACA open enrollment period. Respondents who had gained private insurance or Medi-Cal by the time of the second ACA open enrollment period in 2015 were far less likely to report difficulty for their family in affording health insurance (49%) than they had been prior to the ACA (86%). These respondents were about half as likely report problems paying medical bills (23%) as they had been prior to the ACA (45%), and more than half (53%) reported that having health insurance made them feel more financially secure.[9]

Additionally, the share of Californians in the individual market who reported spending more than 10% of their family income on premiums and out-of-pocket costs fell from 43% in 2013 to 34% in 2015, according to analysis of Current Population Survey data by the State Health Access Data Assistance Center.[10]

Affordability is the main reason that those eligible for Covered California remain uninsured

However, there are at least 1.2 million Californians who remain uninsured despite being eligible to purchase insurance through Covered California, with or without subsidies (Exhibit 2, page 9). This is the second largest group of uninsured residents in the state, after undocumented residents who are excluded from the ACA and Medicaid under federal law.[11]

In 2014 through 2016, cost was identified as the top reason for lacking insurance among uninsured citizens in California, regardless of income level, according to the California Health Interview Survey. The vast majority of citizens who tried to purchase insurance through Covered California but ultimately remained uninsured said they found it difficult to find an affordable plan.[12]

Affordability is more of a challenge for those with individual market coverage than for most other insurance types

Among California citizens with individual market coverage, nearly half (45%) reported finding it very or somewhat difficult to find an affordable plan through Covered California in 2014 through 2016.[13]

Individuals with all types of health insurance can face difficulties affording insurance and care, but the challenges are greatest for those with individual market coverage, and, by some measures, Medicare. A national study by the State Health Access Data Assistance Center found that in 2015, 39% of those with individual market insurance spent in excess of 10% of family income on premiums and out-of-pocket costs, compared to 26% of those with Medicare, 20% of those with employer-sponsored insurance, and 16% of those with Medicaid.[14] National analysis by the

In discussing affordability concerns and potential state policy solutions, this report references various levels of income as they relate to the Federal Poverty Level (FPL). For reference, Exhibit 1 shows the FPL thresholds most frequently discussed in this report for the most common household sizes.

:

Annual Income as a Percentage of the Federal Poverty Level (FPL), 2017

FPL	Household size			
	1	2	3	4
139%	$ 16,760	$ 22,570	$ 28,380	$ 34,190
150%	$ 18,090	$ 24,360	$ 30,630	$ 36,900
200%	$ 24,120	$ 32,480	$ 40,840	$ 49,200
250%	$ 30,150	$ 40,600	$ 51,050	$ 61,500
267%	$ 32,200	$ 43,360	$ 54,520	$ 65,680
300%	$ 36,180	$ 48,720	$ 61,260	$ 73,800
400%	$ 48,240	$ 64,960	$ 81,680	$ 98,400
500%	$ 60,300	$ 81,200	$ 102,100	$ 123,000
600%	$ 72,360	$ 97,440	$ 122,520	$ 147,600

Notes: Under the ACA, 2017 FPLs are used to determine eligibility for premium and cost sharing subsidies in plan year 2018. Income amounts in this exhibit are rounded to the nearest $10.

Commonwealth Fund found that the rate of "underinsurance," the term for the situation in which insured individuals face out-of-pocket costs that are high relative to income, was higher for those with coverage in the individual market (44%) and for the non-elderly disabled enrolled in Medicare (47%) than for those with employer-sponsored insurance (24%) and Medicaid (26%) in 2016.[15]

Ensuring affordable individual market coverage is one potential state response to the elimination of the ACA individual mandate penalty

The enrollment and uninsurance estimates in this report reflect current policy, but trends could change starting in 2019, when the ACA penalty for lacking insurance will be eliminated. Under this federal policy change, the number of uninsured Americans is projected to grow and the number enrolled in individual market coverage, Medicaid, and employer-sponsored insurance is projected to decline. Individual market premiums are expected to increase as healthier people become less likely to purchase insurance, and the resulting premium increases would cause even more people to not purchase insurance.[16] The amount by which individual market enrollment will decline in California is uncertain. Some estimates indicate that several hundred thousand fewer Californians could enroll in the individual market in the initial year of the penalty elimination.[17] Most of the enrollment reduction is likely to occur among subsidized enrollees.[18] The coverage losses are expected to grow over the first few years without a penalty, then level off, according to Congressional Budget Office estimates.[19]

California could take steps to mitigate the coverage losses by enacting its own individual mandate, continuing and expanding its strong outreach efforts, and adopting policies that improve affordability, like those described in this report. Implementing all of these policies in combination

Defining "affordable"

Affordable health insurance is difficult to define using a one-size-fits-all standard. The amount that is "affordable" to an individual or family for the purchase and use health insurance depends on a constellation of factors including income, age, family size, medical use, cost of living, and the family's budget for other household expenses or outstanding debts. However, several different approaches have been developed and can be useful in evaluating health insurance affordability. Affordability can be evaluated using a household budget approach—at each level of income, are sufficient funds available to pay for healthcare after accounting for spending on other essentials like housing, food, transportation, and childcare? Another approach is to examine how much households currently spend on health care as an indicator of the level of spending that is feasible. Finally, benchmarks from public programs, such as Medicaid premium and cost sharing limits, could be used.

Each of these approaches to measuring affordability has advantages and limitations.[20] This report does not rely on a single standard of affordability, but instead presents evidence that reveals the concerns and challenges with affordability in the individual market in California, and outlines state-level policy options for improving affordability of coverage for those at all income levels without necessarily meeting one standard definition of affordability.

The ACA set various standards of affordability; these provide useful context for understanding the progress made under the law toward making affordable health coverage available, as well as the gaps that remain:

- Premium affordability standards are implied for individuals who are eligible for subsidies to purchase insurance through the Marketplaces. Enrollee premium contributions vary on a sliding scale from 3.38% of household income at 139% of the Federal Poverty Level to 9.56% of household income at 300% to 400% of the FPL.[21]
- Out-of-pocket affordability standards are implied by the level of cost sharing assistance for those under 250% FPL, which is based on a sliding scale. For low-income enrollees, insurers must cover between 73% and 94% of medical costs, on average, depending on the exact income level. When insurers pay a higher share of costs, families pay less in deductibles, copayments and other cost sharing.
- Individuals are exempt from the ACA individual mandate if they lack access to affordable coverage, defined as costing less than 8.16% of household income in 2018.
- Employer-sponsored insurance is considered affordable if a household's premium contributions to cover only the worker cost less than 9.56% of household income and if the insurer covers at least 60% of medical costs, on average. (See page 17 for further details.)

Affordability remains a concern for many Californians with access to individual market insurance that meets these ACA standards of affordability, but understanding these standards is important for understanding the affordability gaps discussed in this report.

would have the strongest impact in counteracting the loss of individual market coverage and increase in individual market premiums expected to occur without a federal mandate.

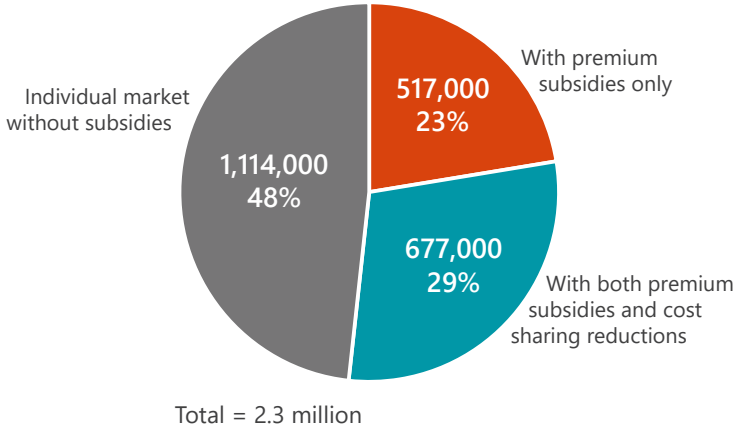
Affordability concerns among Californians eligible for or enrolled in the individual market

When premiums are affordable, individuals are more likely to enroll in and retain coverage over time. Younger individuals' and low-income individuals' decisions to enroll in Covered California are especially sensitive to the price of health insurance.[22] When health insurance is affordable, a broader population enrolls, supporting a balanced risk mix, a more stable market, and lower premiums.

This section summarizes the existing evidence on the extent and nature of affordability concerns among the 2.3 million Californians already enrolled in the individual market (Exhibit 2) and the approximately 1.2 million uninsured Californians who are likely eligible to enroll in Covered California (Exhibit 3).[23]

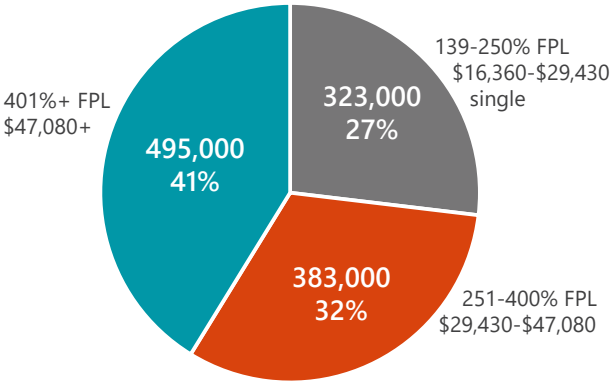
We consider first the affordability concerns of Californians with household incomes at or below 400% FPL, the upper eligibility threshold for premium subsidies under the ACA. Then, the affordability concerns of Californians not eligible for subsidies based on income are discussed. This section will last explore the health insurance affordability concerns of Californians caught in the ACA "family glitch," in which they are ineligible for subsidies through Covered California because they have an offer of employer-sponsored family coverage through a parent or spouse, but that employer-sponsored dependent coverage is unaffordable.

Exhibit 2:
Individual market enrollment, California, 2016



Source: Katherine Wilson, California Health Insurers Hold on to Previous ACA Gains, California Health Care Foundation Blog, July 13, 2017, https://www.chcf.org/blog/california-health-insurers-hold-on-to-previous-aca-gains/. Covered California, Active Member Profile, June 2016, http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2016_06.xlsx

Exhibit 3:
Uninsured citizens ages 0-64 with household income above Medi-Cal eligibility threshold, California, 2016



Note: Due to data limitations, this chart does not include lawfully present immigrants, though they are also eligible to enroll in Covered California and receive subsidies if eligible based on income.[24] This chart excludes uninsured citizen adults ages 19-64 in households with income below 139% FPL and uninsured citizen children ages 0-18 in households with income below 267% FPL because they are eligible for Medi-Cal.

Source: 2016 California Health Interview Survey

Affordability concerns for Californians currently eligible for subsidies

Approximately half of individual market enrollees in California, or nearly 1.2 million, receive ACA subsidies (Exhibit 2, page 9). Of those who are eligible for Covered California but remain uninsured,[25] six out of ten, or more than 700,000, may be eligible for subsidies based on income. Approximately half of this uninsured subsidy-eligible group may be eligible for premium subsidies and the other half may be eligible for both premium and cost sharing subsidies (Exhibit 3, page 9). Not every individual with income at or below 400% FPL is necessarily eligible for subsidies: they may have an offer of employer-sponsored insurance that disqualifies them from subsidies, or they may have an unsubsidized premium that falls below the maximum required premium contribution under
the ACA.

Premium affordability concerns remain in spite of ACA subsidies

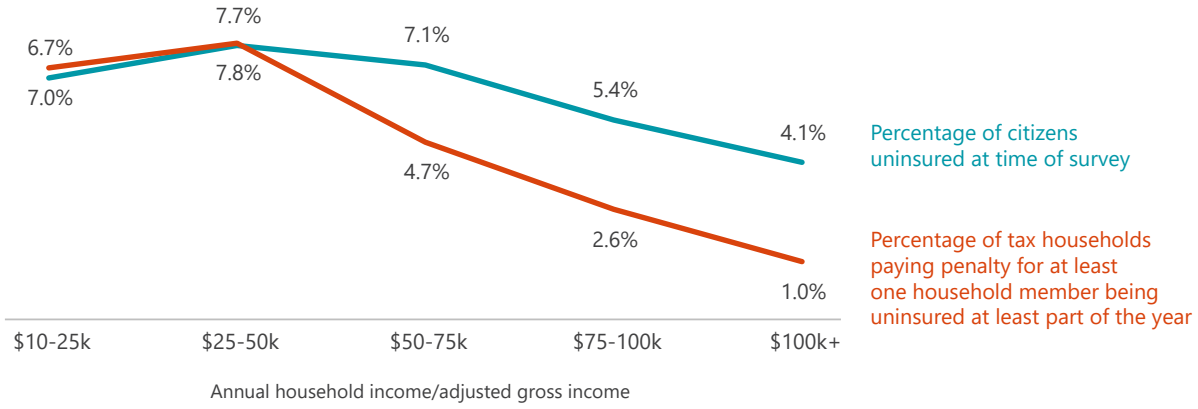
Under the ACA, citizens and lawfully present immigrants are eligible for premium subsidies if their household income is at or below 400% FPL, which is $48,240 annually for a single individual or $98,400 for a family of four. Premium subsidies are calculated on a sliding scale such that households pay between 2.01% and 9.56% of income (further details are shown in Appendix Exhibit A1). For individuals who receive premium subsidies, in 2017 the federal government paid on average 71% of premium costs, reducing average annual premium contributions per subsidized California household by over $6,000.[26] In 2018, monthly premium payments for Covered California enrollees receiving premium subsidies are between $47 and $384 for a single individual, depending on income, and up to $784 for a family of four.[27] By contrast, Californians with employer-sponsored insurance paid on average $85 per month for single coverage and $410 per month for family coverage in 2016.[28]

In 2015, Californians with incomes in the subsidy-eligible range were more likely to be uninsured and more likely to have paid the tax penalty for lacking insurance than those with higher income (Exhibit 4, page 11).[29] As a result, uninsured households in the subsidy-eligible income range comprised at least three-quarters of Californian households paying the tax penalty for not having insurance in 2015.[30] The higher rates at which Californians in this income range are uninsured and paying the tax penalty, coupled with survey data showing that affordability is the top reason for uninsurance among citizens at all income levels, indicates that significant affordability challenges remain for Californians with incomes in the subsidy-eligible range.

Non-elderly adults potentially eligible for Covered California subsidies are more likely to remain unenrolled than adults eligible for Medi-Cal. More than 1.1 million adults ages 19 to 64 with incomes at or below 400% FPL were enrolled in Covered California with subsidies in 2016,[31] compared to 671,000 uninsured working age citizens with incomes between 139% and 400% FPL,[32] some of whom may not have been eligible for subsidies due to an offer of employer-sponsored insurance.[33] By contrast, nearly 5.7 million adults ages 21 to 64 were enrolled in comprehensive Medi-Cal benefits,[34] compared to 379,000 uninsured working age citizens with incomes below 139% FPL in 2016.[35] Given that Medi-Cal has no premiums or cost sharing for adults, the higher level of enrollment in Medi-Cal is another indicator that affordability is a barrier to enrollment for some who lack insurance and are eligible for Covered California with subsidies.

Exhibit 4:

Uninsurance rate among citizens and percentage of households paying penalty for lacking insurance, by household income, California, 2015



Note: $50,000 in annual income is equivalent to approximately 410% FPL for a single individual and approximately 200% FPL for a family of four. $75,000 in annual income is equivalent to approximately 620% FPL for a single individual and approximately 300% FPL for a family of four. Graph excludes households with income below $10,000 because they are likely eligible for Medi-Cal, as well as often exempt from the individual mandate due to their income being below the tax filing threshold.

Sources: UC Berkeley analysis of American Community Survey (ACS) 2015 data; U.S. Internal Revenue Service (IRS), California Individual Income Tax Returns: Selected Income and Tax Items by State, County, and Size of Adjusted Gross Income, Tax Year 2015.

One survey found that affordability concerns are common even among Californians enrolled in the individual market. At least four out of ten surveyed non-elderly adults enrolled in the California individual market had some or a lot of difficulty paying their premiums in 2014, and a similar share had difficulty affording out-of-pocket costs. The prevalence of affordability concerns was relatively similar between individuals with incomes below 250% FPL and those with incomes between 250% and 400% FPL. The study found that premium affordability difficulties were worse for those who purchased insurance through the off-Exchange market where federal subsidies are not available.[36]

Premium affordability may be especially concerning to the lowest-income Covered California enrollees. Approximately 25,000 lawfully present immigrants enrolled in Covered California have incomes below 139% FPL.[37, 38] Additionally, some Medi-Cal enrollees experiencing an increase in income may face challenges transitioning from zero premiums in Medi-Cal to monthly premium contributions of at least $46 in Covered California, given the low income of those who earn a little too much to qualify for Medi-Cal (approximately $1,400 per month for a single individual or $2,850 for a family of four).

A number of studies have shown how premiums can hamper enrollment and retention of coverage for low-income individuals.[39] One recent study found that "near poor" non-elderly adults who were eligible for Marketplace coverage because they lived in a state that did not expand Medicaid were more likely to be uninsured than their counterparts in expansion states.[40] Medicaid generally requires no premiums while single Marketplace enrollees with incomes between 100% and 138% FPL pay between $20 and $46 on monthly premiums after subsidies. In many states, including California, Medicaid requires no cost sharing.

High out-of-pocket costs can hinder access to care, cause financial problems, and potentially deter enrollment

Research has also shown that high deductibles and other cost sharing can create barriers to care. Insured Americans with deductibles and out-of-pocket costs that meet the Commonwealth Fund's standard for "underinsurance" are more likely to: forgo seeing a doctor when they have a medical problem; leave a prescription unfilled, skip a medical test, and decline doctor-recommended treatment or follow-up; and forgo seeing a specialist despite a doctor's recommendation.[41] According to the California Health Interview Survey, in 2014 through 2016, two-thirds (67%) of non-elderly Californians in the individual market reported delaying care due to cost, a lower rate than among the uninsured (81%) but a higher rate than among those with employer-sponsored insurance (35%). For the subset of Californians with incomes at or below 400% FPL, the relative rates of delaying access to care due to cost by coverage type were similar.[42]

Underinsurance does not just impede access to care; it also increases the prevalence of difficulties paying medical bills and the likelihood of related financial problems such as taking on credit card debt or using up savings.[43]

Out-of-pocket costs that are high relative to income "will likely dissuade many individuals from enrolling or re-enrolling" in coverage, according to Linda Blumberg and John Holahan of the Urban Institute.[44] According to one national survey that asked uninsured individuals who tried to purchase insurance why they decided not to enroll, out-of-pocket costs were the second most important factor named after premiums. As a decision-making consideration, out-of-pocket costs ranked higher in importance than covered benefits, the individual mandate penalty, and the availability of doctors in the plan network.[45]

Under the ACA, eligible individuals with incomes at or below 250% FPL ($30,150 for a single individual or $61,500 for a family of four) are offered cost sharing reductions, which provide federal financial assistance to reduce deductibles, co-payments, and other costs, on top of premium subsidies. Cost sharing subsidies had an average value of nearly $1,500 annually per subsidized California household in 2016.[46] Eligible Californians continue to receive this financial assistance in spite of President Trump's decision in October 2017 to discontinue federal payments to insurers for cost sharing reductions[47] because insurers are still legally required to provide cost sharing reductions and California insurers have raised the premiums for certain Silver plans to reflect the reduction in federal payments.

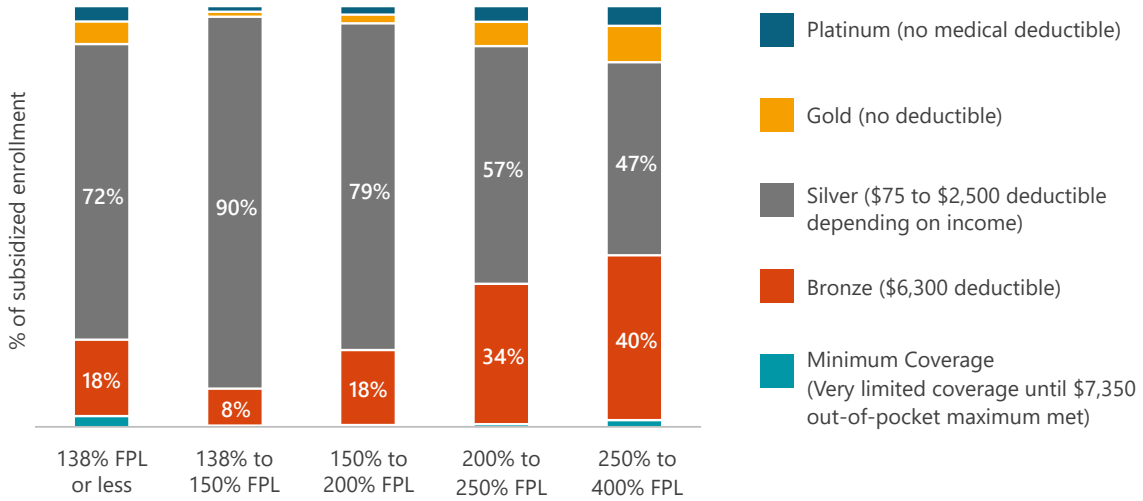
Cost sharing reductions have greatly improved out-of-pocket affordability for many Californians. Those in the individual market have also benefited from the state's decision to standardize benefit designs for plans offered through Covered California, and the subsequent efforts by Covered California, in partnership with stakeholders, to design benefits to maximize value and access to care. In Silver plans offered through Covered California, doctor visits, emergency room care, lab tests, x-rays, and imaging are not subject to medical deductibles. The annual medical deductible of $2,500 in the Silver plan only applies to hospital care. (See Appendix Exhibit A2 for further details on Covered California standardized benefit designs, including the deductibles, co-payments, and other cost sharing under each plan type.)

Nonetheless, one-quarter of Covered California enrollees with incomes at or below 400% FPL were enrolled in Bronze plans in 2017, which offer the least financial protection of the plans offered through Covered California. The rate of Bronze enrollment was even higher (37%) among Covered California enrollees with incomes between 200% and 400% FPL.[48] These rates of Bronze enrollment for low- and middle-income Covered California enrollees are significantly higher than those for Californians with employer-sponsored insurance: 11% of Californians with insurance through a small employer and only 1% of those with insurance through a large employer had coverage equivalent to or somewhat better than a Bronze plan in 2016.[49] Individuals who have difficulty affording premiums for Silver plans may opt to enroll in a Bronze plan because of the lower premiums. Covered California estimated that while 60% of subsidized enrollees could purchase a Silver plan for less than $100 per month in plan year 2018, nearly three-quarters (74%) could purchase a Bronze plan for less than $10 a month.[50]

While Bronze premiums are lower than Silver premiums, individuals who enroll in Bronze plans are at significant risk of out-of-pocket costs due to the plans' $7,000 out-of-pocket maximum and $6,300 individual medical deductible, which applies to all services except the first three doctor visits. Individuals eligible for cost sharing reductions only receive that financial assistance if they enroll in a Silver plan, and the level of financial assistance provided is most substantial for people with incomes below 200% FPL (Appendix Exhibit A2). This may be one explanation for lower Bronze enrollment among those in the lower income range compared to enrollment among those with incomes between 200% and 400% FPL (Exhibit 5).

Although some middle-income individuals who enroll in Bronze plans may feel confident that they can afford the deductible and out-of-pocket limit if they were to incur high health care

Exhibit 5:
Covered California enrollment distribution by metal tier and income level under 400% FPL, June 2017



Source: Covered California Active Member Profile, June 2017

costs, this sentiment is likely shared by only a minority of enrollees. Research by the Kaiser Family Foundation found that American non-elderly households with incomes between 150% and 400% FPL had median liquid assets of $1,902 for single-person households and $2,811 for multi-person households in 2016. These numbers reflect the potential for severe affordability challenges for those enrolled in Bronze plans, given their deductible of $6,300 for all care other than the first three doctor visits. Liquid assets sufficient to cover a Bronze deductible were found to be available to fewer than one out of three American households with incomes between 150% and 400% FPL. The affordability risk associated with the Bronze deductible was even higher for U.S. households with incomes at or below 150% FPL, which had median liquid assets of approximately $500 in 2016. Only approximately one in ten of these low-income households had liquid assets sufficient to cover a Bronze deductible.[51]

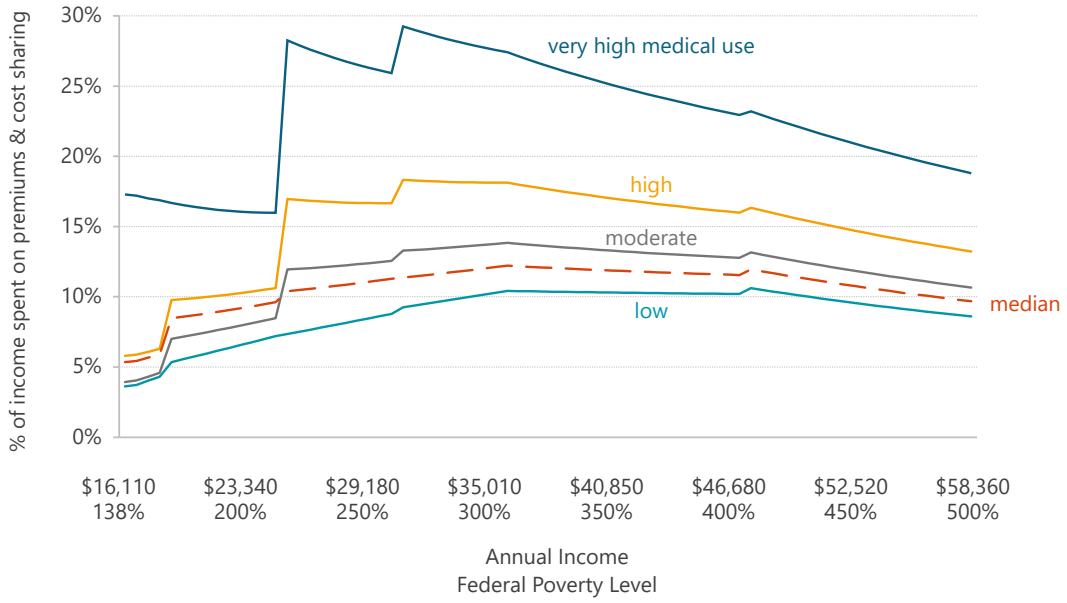
Combined premium and out-of-pocket spending can reach 10% to 30% of income for some Californians

The affordability problem is compounded when premium and out-of-pocket costs are considered in combination. As shown in Exhibit 6, a single 40-year old in San Francisco with median health care use and with an income level between approximately 200% and 485% FPL would have spent more than 10% of income on Silver plan premiums and out-of-pocket costs in 2015 after subsidies. San Franciscans with similar demographics but very high medical use would have spent more than 20% percent of annual income at income levels between approximately 200% and 470% FPL, with some individuals spending nearly 30% of their income on health insurance and care.[52]

Exhibit 6:

Total expected health spending for single 40-year old, San Francisco, 2015

Premium & out-of-pocket spending after subsidies for second lowest cost Silver plan through Covered California



Source: UC Berkeley analysis excerpted from Health Management Associates, Addressing Affordability of Health Insurance in San Francisco, Technical Report Presented to San Francisco Department of Public Health, June 2015, https://www.sfdph.org/dph/files/uhc/HMA-FinalReport-SFDPH-PublicBenefitProgram-June2015.pdf.

While the range of health spending is relatively similar across all regions in the state (more than 10% of income for some with median health use and as much as 20% to 30% of income for some with high medical use), the specific spending levels at each income level may vary slightly by region. This is especially the case for individuals who earn too much to receive premium subsidies and who therefore are not shielded from regional premium differences.[53]

High cost of living and general financial insecurity exacerbate affordability concerns

Concerns about health insurance affordability do not necessarily stem solely from premium and out-of-pocket costs. For many, these concerns may also reflect broader financial insecurity related to living expenses and other factors. The high cost of living in certain regions of California undoubtedly leave little room in some families' budgets for health insurance.

ACA premium subsidies are set on a sliding scale based on the Federal Poverty Level, but the cost of living in much of California is higher than in most other parts of the U.S., primarily due to high housing costs. Using the California Poverty Measure, an unofficial measure that accounts for cost of living and a range of family needs and resources, the 400% FPL upper limit for eligibility for ACA premium subsidies is equivalent to approximately 500% FPL statewide in California, and up to 600% FPL in a high-cost region like San Francisco.[54]

Previous analysis by the UC Berkeley Labor Center estimated the minimum household income needed to pay Covered California premiums for a Silver plan and out-of-pocket costs after federal subsidies, while also meeting other basic needs. The analysis found that in every California county there is an affordability gap for some residents who earn too much to qualify for zero-premium Medi-Cal, but not enough to be able to afford Covered California insurance and care while also covering their other basic needs.

The income level at which health care costs could be considered affordable varied by county based on cost of living. A typical family of four in the highest-cost region, Marin County, might be able to afford premiums and out-of-pocket costs with earnings of $110,300, or 455% FPL, in 2016. This is compared to a typical family of four in the California county with the lowest cost of living, Modoc, where $54,600 in annual income, or 225% FPL, might be sufficient for a family of four to afford healthcare costs through Covered California. These estimates were conservative in that they assumed low medical use by all household members and a minimal household budget for other expenses, based in part on the California Budget & Policy Center's "Making Ends Meet" household budget estimates by county. (An interactive map with estimates for all 58 California counties and further information about this analysis is available on the California Health Care Foundation website.[55])

More than one-third (36%) of California non-elderly adults newly insured through Covered California in 2014 reported feeling financially insecure in general, according to a survey conducted by the Kaiser Family Foundation. Four out of ten (41%) reported that it was somewhat or very difficult to pay for necessities, two-thirds (66%) reported that it was somewhat or very difficult to save money, and more than half (54%) reported that it was somewhat or very difficult to pay off debt.[56] A national survey of uninsured adults in 2015 found that more than half (58%) had $100 or less left over each month after paying bills, and more than half (56%) had less than $100 in

CASE STUDY:

High Housing Costs in Certain Regions Squeeze Household Budgets, Exacerbating Heath Insurance Affordability

A single 40-year old man with income of $3,015 per month (300% FPL) living in San Mateo, California, where the median rent for a studio apartment is over $2,000 a month[58] would have approximately $1,000 left each month after paying rent to cover food, transportation, utilities, taxes, other expenses, and health care. In 2018, he would face the following health coverage choices if he were not offered affordable insurance through his job.

- He could pay $280 per month in premiums, after subsidies, for the lowest cost Silver plan, leaving a little over $700 per month after housing for all other expenses including taxes. This might cause difficulty affording other basic needs.
- He could pay $95 per month, after subsidies, for the lowest cost Bronze plan, which may be more manageable than Silver premiums but would put him at greater risk of high out-of-pocket costs. He has $2,000 in savings, which would only partially cover the $6,300 deductible if he incurred high medical expenses. If he were to select this plan, he might forgo needed care due to cost.
- He could remain uninsured and pay approximately $58 per month in penalties for the 2018 tax year.[59] In 2019, he would not owe a penalty for lacking insurance unless the state enacts its own mandate.

The evidence shows that Californians in situations like this are making all three of these choices, depending on their individual circumstances.

savings.[57] This broader financial insecurity may make it difficult for some Californians to afford health insurance even with subsidies.

Affordability concerns for Californians not eligible for subsidies based on income

Affordability is also a challenge for people who earn too much to qualify for premium subsidies: more than $48,240 for a single individual or $98,400 for a family of four. Covered California estimates that nationally the median household income of off-Marketplace individual market enrollees was approximately $75,000 in 2016.[60] While the typical unsubsidized Marketplace enrollee is not poor, they are also generally not high-income individuals.

The ACA exempts uninsured individuals from paying a penalty if the lowest cost Bronze plan available to them costs more than 8.16% of income, but no financial assistance is available to individuals with incomes above 400% FPL to make insurance more affordable for them. Many of the approximately 1 million California individual market enrollees in households earning more than 400% FPL[61] face Bronze premiums that cost more than 8.16% of income. Some individuals face premiums for a Bronze plan that are equal to more than 20% of their income.[62]

Affordability challenges for those seeking unsubsidized coverage are most likely to affect those age 50 or older.[63] The ACA limited the allowable variation in premiums based on age so that older individuals pay no more than three times the amount younger individuals pay—but this still results in older people facing significantly higher premiums than younger people. Even so, Bronze plans can fail to meet the individual mandate affordability exemption standard (8.16% of income) for single individuals as young as age 36 in San Mateo County, the pricing region with the highest 2018 Bronze premium. In the lowest premium region of California, Los Angeles, only older single individuals—those at least 51 years old— may be subject to Bronze premiums that cost more than 8.16% of income (Appendix Exhibit A3).

All other things equal, premiums constitute a higher share of income for married couples than for single individuals of the same age; this is because unsubsidized premiums for a couple are double those for a single individual, while the Federal Poverty Level for a couple is only 35% higher than for a single individual. As shown in Appendix Exhibit A4, in some parts of Northern California, couples as young as age 18 would pay Bronze premiums that fail to meet the individual mandate affordability standard. As a percentage of income, unsubsidized Bronze premium spending for families with children (not shown) generally falls in between spending by single individuals and married couples without children.

Among unsubsidized enrollees, individuals with incomes between 400% and 600% FPL (between $48,240 and $72,360 for a single individual) are the most likely to pay a higher percentage of income on premiums,[64] but even higher-income individuals sometimes face premiums that fail to meet the individual mandate affordability standard. Bronze premiums exceed the individual mandate affordability exemption standard for single 64-year olds with incomes up to 652% FPL in Los Angeles (Region 15) and up to 982% FPL in San Mateo (Appendix Exhibit A3). The problem of high premium spending relative to income extends higher up the income scale for married 64-year old couples: 968% FPL in Los Angeles (Region 15) and 1,458% FPL in San Mateo (Appendix Exhibit A4).

Appendix Exhibits A3 and A4 show the results of our analysis on the full range of ages and income levels for which Bronze premiums may be unaffordable for individuals with incomes above 400% FPL. Our analysis found that while it is possible for some Californians as young as 18 or with incomes well above 1000% FPL to face unaffordable Bronze premiums, it is older and middle-income Californians who are the most likely to face these affordability challenges.

Californians lacking access to affordable employer-sponsored and individual market coverage due to the "family glitch"

In order to curb "crowd out," or the reduction of enrollment in employer-sponsored insurance as a result of the expansion of publicly-subsidized coverage options, the ACA requires large employers to offer coverage to full-time employees and their dependent children or pay a penalty. No penalty is owed for not offering coverage to spouses. Large employers that offer unaffordable coverage to full-time employees may owe a penalty, but the ACA imposes no penalty for offering unaffordable coverage to dependent children and spouses.[65]

To maintain the primary role of employer-sponsored insurance in the U.S. health coverage system, the ACA also prohibits individuals with an offer of affordable employer-sponsored insurance from receiving subsidies to purchase coverage through the Marketplaces. Because of this provision,

CASE STUDY:
Older Individuals Ineligible for Subsidies based on Income

A married couple, both age 55 and self-employed, living in San Mateo, California, and earning $73,080 annually (450% FPL) would pay $1,200 per month total for the lowest cost Bronze plan offered in that region. Premium spending would equal nearly 20% of the couple's income, before any out-of-pocket spending on health care costs under the plan's $6,300 deductible.

CASE STUDY:
"Family Glitch" Affected Households

A married California couple with two children earns $66,420 (270% FPL), a little too much for the children to be eligible for Medi-Cal. One spouse works full time and the other spouse is the primary caregiver for the family's young kids. The worker's employer offers health insurance requiring an employee premium contribution of $140 per month for worker-only coverage and $810 per month for coverage for the whole family. This family would pay 2.5% of income to enroll the worker and 14.7% of income to enroll the entire family in employer-sponsored insurance. The worker's spouse and children are not eligible for premium subsidies through Covered California because the worker-only premiums are affordable under the ACA definition for the purposes of determining premium subsidy eligibility. Some families in this scenario may struggle to pay the employer-sponsored premiums for the whole family, while other families may be unable to do so, leaving some family members uninsured.

In a second example, a married couple without children earns $24,360 (150% FPL). One spouse is offered employer-sponsored insurance requiring an employee premium contribution of $140 per month for worker-only coverage and $400 per month for the couple. This household would pay 6.9% of income to enroll the worker in employer-sponsored insurance and 19.7% of income to enroll the couple.

workers with an offer of insurance coverage that costs less than 9.56% of household income cannot receive subsidies through the Marketplaces. The ACA statute was unclear, however, on the affordability standard for coverage offered to dependents and spouses of a worker.[66] In 2013, the Internal Revenue Service (IRS) decided to define affordability using the cost of worker-only coverage, meaning dependent children and spouses of workers with affordable worker-only coverage would also be ineligible for subsidies, regardless of the cost of family coverage.[67]

The IRS's decision was significant because, in many cases, worker-only coverage through an employer may be affordable while family coverage is not. Premiums for employer-sponsored family coverage are much higher than premiums for worker-only coverage, and the share of premiums that employees are required to contribute for family coverage is often higher than for worker-only coverage.[68] Some employers that cover a significant portion of their employees' premiums allow the employees to include their dependent children and spouses on the plan but do not cover any of their premiums.

For "family glitch" affected households, purchasing individual market coverage without subsidies is an option under current policy. However, in those circumstances when a spouse requires coverage, this option may be particularly formidable since the cost of coverage for spouses, which varies by age, is higher than for children.

If children and spouses caught in the family glitch choose not to enroll in a health insurance plan, most are exempt from the individual mandate and do not face a penalty for not having coverage.[69] Despite the exemption from the individual mandate penalty, many individuals affected by the family glitch maintain unaffordable insurance.

State policy options to improve individual market affordability

States can play a role in further improving affordability of individual market coverage beyond the standards set by the ACA. Several states and localities have already enacted policies that reduce premium and/or out-of-pocket costs for some residents. Massachusetts provides additional premium and cost sharing subsidies to eligible individuals with incomes at or below 300% FPL who enroll in Commonwealth Care, a program that began under the state's health reform efforts enacted in 2006 and was modified under the ACA. The Vermont Premium Assistance program provides premium and cost sharing assistance to eligible individuals with incomes at or below 300% FPL. Under the San Francisco Health Care Security Ordinance, some San Franciscans with incomes at or below 500% FPL receive premium and cost sharing subsidies through the Covered San Francisco MRA program if they have an employer that fulfills the law's health care spending requirement by contributing to the City Option program.[70] Finally, three states—Alaska, Minnesota, and Oregon—have received federal approval for state reinsurance programs that will reduce premiums for unsubsidized enrollees, most of whom have incomes above 400% FPL.

These programs serve as examples for some of the five state policy options explored in this report:

1. Adding state premium subsidies for those who are already eligible for federal ACA subsidies;
2. Increasing the level of financial assistance to reduce deductibles, co-payments, and other cost sharing, and expanding eligibility for this assistance;
3. Limiting premium contributions for individuals not eligible for ACA premium subsidies based on income;
4. Establishing a state reinsurance program that would reduce premiums for unsubsidized individual market enrollees; and
5. Extending eligibility for state-funded premium and cost sharing subsidies to children and spouses affected by the ACA "family glitch."

These policy proposals are discussed as separate options, but implementing them in combination would likely produce effects that are greater than the sum of the effects of each policy in isolation. Implementing these policies in concert would increase enrollment in the individual market to an extent exceeding the pooled effect of each individual policy. Correspondingly, the state cost to implement these policies in combination could be higher than the sum of the cost of each policy on its own. The potential for these policies to result in lower premiums due to the enrollment of a healthier population would be greater if these policies were implemented in combination,[71] thereby further improving affordability for unsubsidized enrollees, further reducing federal spending on premium subsidies, and helping to limit some of the state cost associated with any new premium subsidies provided. Implementing a package of these policies in combination may also potentially "crowd out" enrollment in employer-sponsored insurance beyond the sum of the effects of each policy.[72]

Enhance premium subsidies for those already eligible

California could consider using state funds to increase premium subsidies for eligible individuals with incomes at or below 400% FPL in order to improve affordability and increase enrollment.

Policy design considerations:

The state could increase premium subsidies for Californians under 400% FPL in a variety of ways. Premium contributions could be reduced proportionally for all enrollees in this income range, or premium contributions could be reduced by differing amount at various income levels. For example, California could add state premium subsidies that result in households with incomes under 139% FPL paying zero premiums, households with incomes between 300% and 400% FPL paying no more than 8% of income on premiums, and improved affordability scaled to income for households in between. This could improve premium affordability both for those who currently receive subsidies through Covered California as well as for those eligible but not enrolled.

Programs in Massachusetts, Vermont, and San Francisco provide examples of various standards for premium affordability that California policymakers could consider. (See Appendix Exhibit A5 for details.)

One potential element of a policy to improve premium affordability for those already eligible would be to eliminate premium contributions for the 25,000 lawfully present immigrants in Covered California who have incomes below 139% FPL but are not eligible for Medi-Cal.[73] As described earlier in this report, these individuals, who earn less than $1,400 per month if single, face premiums of up to $46 per month for a single individual. Eliminating premiums for this population, as Massachusetts has done (for those with incomes at or below 150% FPL), would improve affordability and create parity with the other Californians in this income range who are eligible for Medi-Cal and pay no premiums.

Number of Californians affected:

If state premium subsidies were provided to all Californians currently eligible for ACA premium subsidies, affordability would improve for the 1.2 million Californians already enrolled in subsidized coverage (Exhibit 2, page 9). The projected increase in enrollment would depend on the size of the reductions in premium contributions. A 15% decrease in net premium contributions would be estimated to increase individual market enrollment by tens of thousands, and a 50% decrease in net premiums would result in an increase in enrollment that is in the low hundreds of thousands.[74] These estimates do not take into account the elimination of the ACA individual mandate penalty, which is expected to reduce enrollment. Providing state premium subsidies would help to counteract the reduction in individual market enrollment that would occur when the ACA individual mandate penalty is eliminated, but we have not quantified how many Californians would retain coverage if the state provides premium subsidies in the absence of a penalty for lacking insurance.

Impact on premiums:

Under this policy option, the new enrollees in the individual market would likely be somewhat healthier on average than existing enrollees, which could slightly reduce premiums across the whole market. This, in turn, would result in unsubsidized enrollees paying less than they otherwise

would have, and the federal government spending less on premium tax credits for subsidized enrollees. RAND estimated that reducing subsidized premium contributions by 15% under a federal policy would decrease Silver premiums by 0.2% in 2020.[75] A larger reduction in premium contributions for subsidized enrollees, or enhancing premium subsidies in combination with other policies to improve affordability, would likely yield higher premium reductions across the market.

Funding considerations:
California would likely need to rely solely on state funding to further improve premium subsidies beyond ACA standards. If this policy were pursued under a 1332 State Innovation Waiver, federal deficit neutrality calculations would be unlikely to result in federal pass-through savings to the state, though the exact impact would depend on the specifics of the proposal and projections of how much enrollment and premiums would change as a result. Although federal spending on premium subsidies per enrollee could be reduced by enrollment of a broader, healthier population, those federal savings might be offset by an increase in federal spending resulting from higher enrollment with improved affordability.[76]

Impact on employer-sponsored insurance:
In determining the level of state premium subsidies to provide, policymakers might consider the impact that improving the affordability of coverage offered to individuals without employer-sponsored insurance would have on the offer of and enrollment in employer-sponsored insurance. A national analysis by RAND indicated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 2,800 more people enrolled in individual market coverage, under a federal policy scenario in which net enrollee premium contributions would be 15% lower than under the ACA.[77]

Enhance cost sharing subsidies and expand eligibility

California policymakers could consider improving financial assistance for out-of-pocket costs (cost sharing reductions) to lower deductibles, co-payments, and other costs in order to improve access to care, reduce financial problems related to medical bills, and potentially increase enrollment.

Policy design approach:
Improving affordability of co-pays, deductibles, and other costs could involve providing additional financial assistance to those currently eligible for ACA out-of-pocket assistance as well as providing financial assistance to those with incomes above 250% FPL. Massachusetts and Vermont have reduced out-of-pocket costs for eligible individuals with incomes at or below 300% FPL and San Francisco provides financial assistance to reduce out-of-pocket costs to certain residents with incomes at or below 500% FPL in recognition of the city's high cost of living. Further details about these programs are provided in Appendix Exhibit A6.

Number of Californians affected:
This policy option would improve out-of-pocket affordability for some of the 680,000 Californians already receiving cost sharing reductions (Exhibit 2, page 9), depending on the income levels for which additional financial assistance is provided. If California used state funds to extend eligibility for cost sharing reductions to Covered California enrollees with incomes up to 400% FPL, as many

as 320,000 additional individuals could benefit from increased out-of-pocket affordability, based on the current number of Covered California enrollees in that income range.[78]

Under this policy option, all individuals receiving state-funded cost sharing subsidies would pay lower co-payments, which could improve access to care and reduce financial burdens. This policy would especially improve affordability for Californians with the highest health care use because it could reduce their deductibles and out-of-pocket maximums by hundreds or thousands of dollars annually, depending on the specific policy design. State spending on such a policy would be most concentrated on the Californians who need the most care.

Enhanced cost sharing could also potentially increase enrollment among the uninsured, for whom out-of-pocket costs are one of the most important considerations in their enrollment decisions. It is not known how many Californians would be likely to become newly insured if out-of-pocket costs were reduced. This policy option also could also potentially improve retention of coverage, which is particularly important in the context of the elimination of the ACA individual mandate penalty.

Impact on premiums:
The impact of state-funded enhanced on premiums would depend on the extent to which reducing out-of-pocket costs changes the amount and mix of health services used by enrollees, and whether the average risk mix in the market would change as a result of any new enrollment under this policy. No existing research was found that could be used to predict these impacts.

Funding considerations:
This policy would likely need to be completely funded using state funds.

Impact on employer-sponsored insurance:
In determining the level of state financial assistance to provide for enhanced cost sharing subsidies, policymakers might consider the impact that reducing out-of-pocket costs for individuals without employer-sponsored insurance would have on the offer of and enrollment in employer-sponsored insurance. For Californians who have insurance through a small employer, insurers paid 79% of medical costs, on average, and enrollees paid the other 21% in 2016. For Californians with insurance through a large employer, insurers paid between 86% and 90% of costs, on average, in 2016.[79] Marketplace Silver plans for individuals with incomes above 200% FPL pay a lower share of costs, on average, compared to the amount paid by employer-sponsored plans.

Cap premium contributions for individuals not currently eligible for subsidies

State policymakers could consider limiting premium contributions for all individuals eligible for Covered California to a certain percentage of income and providing a state tax credit for the amount by which premiums exceed this standard.

Policy approach:

Under the ACA, individuals are exempt from paying a penalty for lacking insurance if they have no offer of affordable coverage, defined as premiums costing no more than 8.16% of income, but premium subsidies are only provided to households with annual income equivalent to or below 400% FPL, or $48,240 for a single person. To make coverage more affordable to Californians with incomes above 400% FPL, premiums could be capped at 8.16% of income for the lowest cost Bronze plan. The ACA individual mandate affordability standard is just one example of a standard that policymakers could consider in making coverage more affordable for Californians in this income range. Policymakers could design the policy using a different affordability standard, tying the affordability standard to a different benchmark plan, or applying the policy to a more limited income range, such as 400% to 600% FPL or 400% to 800% FPL. Assistance could be provided through a refundable income tax credit or through another mechanism.

One consideration in developing a mechanism for financial assistance with premiums for those over 400% FPL is that some individuals in this income range may lack the liquid assets to pay premiums upfront and then receive a tax credit when they file their taxes. The ability to pay premiums upfront will also depend on how much financial assistance a particular individual needs to make coverage affordable. A Kaiser Family Foundation analysis indicated that in 2016, the vast majority (93%) of U.S. households with incomes between 400% and 800% FPL had liquid assets of at least $1,000, while more than two-thirds (68% to 73% depending on household size) had at least $5,000, and over half (53% to 54%) had at least $10,000.[80]

Number of Californians affected:

A policy capping premiums for Californians with incomes above 400% FPL at 8.16% of income for the lowest cost Bronze plan would improve affordability for those who are already enrolled in individual market coverage that exceeds this affordability standard. Out of the approximately 1 million California individual market enrollees with incomes at or above 400% FPL, the number currently enrolled in coverage that is unaffordable by this standard is estimated to be in the low hundreds of thousands.[81] This policy would be especially likely to improve affordability for Californians ages 50 and older who have incomes between 400% and 600% FPL, or $48,240 to $72,360 for a single individual.[82] Improved affordability for those already enrolled could lead to greater retention of coverage.

In addition, individual market enrollment could increase by tens of thousands as a result of such a policy, as some Californians would likely become newly insured as a result of the more affordable options that this policy would yield.[83] This estimate does not take into account the elimination of the ACA individual mandate penalty.

Impact on premiums:

RAND estimated that capping premium contributions at 9.95% of income based on the second-lowest cost Silver plan would be projected to reduce Silver premiums across the individual market by 2.5% for a 40-year old in 2020 as a result of enrollment by individuals who are healthier, on average, than existing enrollees.[84]

Funding considerations:
State policymakers could consider applying for a 1332 State Innovation Waiver in order to try to obtain federal pass-through funding to help offset a fraction of state costs for this proposal. This policy has the potential to reduce federal spending on premium tax credits as a result of new enrollment by healthier individuals who are not eligible for ACA subsidies, which would reduce premiums across the market. The policy is unlikely to substantially increase enrollment among those eligible for ACA premium subsidies and therefore would likely not result in increased federal spending on premium tax credits.

Impact on employer-sponsored insurance:
In evaluating the impacts of this policy, policymakers might consider how it could affect the role of employer-sponsored insurance. Under one federal policy scenario that would cap premium contributions for individuals with incomes above 400% FPL, RAND estimated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 4,000 more people enrolled in individual market coverage.[85]

Reduce premiums for unsubsidized enrollees via state reinsurance

Another approach to improving affordability for individuals not currently eligible for premium subsidies based on income would be to establish a state-level reinsurance program to help insurers pay for high-cost claims or high-cost enrollees. This would result in reduced premiums across the individual market and improved affordability for unsubsidized enrollees, most of whom have incomes above 400% FPL. Premium contributions paid by subsidized enrollees would generally remain constant because they are based on a percentage of income, but federal spending on premium tax credits for subsidized enrollees would be reduced. Reinsurance programs also help to maintain a stable market and increase insurer participation.

Policy approach:
The ACA established a temporary reinsurance program from 2014 through 2016. Under this program, insurance plans received payments when the costs for a particular enrollee exceeded a certain initial amount (the "attachment point") and payments continued until the costs for that enrollee exceeded a higher amount (the "cap"). Specifically, federal funding covered 100% of individual market insurers' costs between $45,000 and $250,000 in claims in the first year of the program, approximately half of claims between those claims amounts in the second year, and approximately half of insurers' costs between $90,000 and $250,000 in claims in the last year.[86] The ACA reinsurance program reduced premiums by an estimated to 10% to 14% in the first year.[87] The Medicare Part D program also has a reinsurance program.

In 2017, three states—Alaska, Minnesota, and Oregon—received federal approval for 1332 State Innovation Waivers for their reinsurance programs. The Minnesota and Oregon programs will provide payments to insurers to cover a percentage of costs for claims within a certain dollar range, while Alaska covers all claims costs for enrollees that have one of 33 designated health conditions.

Number of Californians affected:
This policy option has the potential to reduce premiums for the approximately 1.1 million Californians enrolled in the individual market without subsidies (Exhibit 2, page 9). It could also increase enrollment among the uninsured who are eligible for Covered California without subsidies. A 7% premium reduction (see discussion of premium impact below) would be estimated to result in an increase in unsubsidized enrollment that is in the low tens of thousands.[88] This estimate does not take into account the elimination of the ACA individual mandate penalty.

Impact on premiums:
For every $1 billion in gross reinsurance payments in California, individual market premiums would be reduced by approximately 7%, on average, in 2019.[89] Alaska and Minnesota each aim to reduce premiums by 20%, on average, while Oregon is targeting a premium reduction of approximately 7%.[90] Premium reductions may vary by issuer and region depending on the risk mix of each plan, but premium reductions would not vary based on how much financial assistance each enrollee needs to make premiums affordable. As a result, this policy option is less targeted to the unsubsidized Californians with the greatest affordability challenges than the policy option that would cap premium contributions as a percentage of income.

Funding considerations:
Ongoing state funding would be required for a state reinsurance program. The three states with 1332 Waiver approval will receive federal pass-through funding to offset a share of the state payments to insurers for reinsurance. The most dominant factor in the calculation of federal pass-through funding under a Waiver is the estimated reduction in federal spending on premium tax credits as a result of lower premiums. Federal funding will offset an estimated 80% of the gross reinsurance spending in Alaska, 51% in Minnesota, and 33% in Oregon. The states remain responsible for the remainder of the cost.

The share of state reinsurance payments that would be offset by federal funding in California would be dependent on actuarial analysis and the state's negotiations with the U.S. Department of Health and Human Services on the calculations of federal deficit neutrality. One key driver of the level of federal pass-through funding is the state's share of the individual market enrollment that is subsidized. A higher share of the market receiving premium subsidies yields greater opportunity for federal savings to offset the state's costs. In California, approximately 52% of individual market enrollees received premium subsidies in 2016 (Exhibit 2, page 9), compared to 23% in Minnesota,[91] 39% in Oregon,[92] and 66% in Alaska in 2016.[93]

Impact on employer-sponsored insurance:
In evaluating the impacts of this policy, policymakers might consider how it could affect the role of employer-sponsored insurance. Under two federal reinsurance scenarios with varying levels of funding, RAND estimated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 2,350 to 3,000 more people enrolled in individual market coverage.[94]

Extend ACA affordability standards to Californians with unaffordable employer-sponsored insurance for dependents

California policymakers could consider offering state-funded premium and cost sharing subsidies to Californians in households with incomes at or below 400% FPL who have an offer of unaffordable employer-sponsored insurance through a parent or spouse. These individuals are currently excluded from subsidy eligibility under the ACA "family glitch."

Policy approach:

Our analysis focuses on a policy option under which children and spouses caught in the family glitch would become eligible for subsidies through Covered California and workers with an affordable offer of employer-sponsored insurance would continue to be ineligible for subsidized coverage. An alternate option for fixing the family glitch, which would affect more Californians and would require greater state funding, would allow the workers to enroll in subsidized coverage through Covered California, along with their dependents, even if the worker has an offer of affordable worker-only coverage.

Number of Californians affected:

This proposal would improve affordability for an estimated 110,000 Californians who would be expected to switch from employer-sponsored insurance to more affordable subsidized insurance through Covered California, according to estimates by the UC Berkeley Labor Center and UCLA Center for Health Policy Research in 2011.[95] National estimates by the Urban Institute also suggest that, if the family glitch were fixed in this way, most new enrollees in subsidized coverage would have already been insured through unaffordable employer-sponsored insurance.[96] RAND estimates that most who would newly enroll in subsidized coverage under this policy would have had employer-sponsored insurance or unsubsidized individual market coverage.[97] Families purchasing unaffordable private or employer-sponsored insurance have less room in their budgets for other essentials, and some go into debt to pay their premiums.[98]

According to national analysis by the Urban Institute, employer-sponsored insurance costs for households that fall into the family glitch average 15.8% of household income. If these households became eligible for subsidized marketplace coverage, their average premiums could fall to a more affordable 9.3% of income in combined costs for subsidized marketplace coverage and employer-sponsored insurance.[99]

In addition, an estimated 30,000 Californians would become newly insured under this proposal, according to the 2011 UC Berkeley–UCLA estimates. Approximately half of the 140,000 Californians who would be projected to newly enroll in Covered California under this proposal are children and half are adult dependents, primarily spouses but also adult children.[100]

Impact on premiums:

The Californians who would be projected to enroll under this proposal would be younger and healthier than existing enrollees, which could slightly reduce average premiums across the market, with the potential to slightly improve affordability for unsubsidized enrollees.[101] RAND estimates that allowing dependents with unaffordable employer-sponsored insurance offers to be eligible

for ACA subsidies would result in Silver premiums for a 40-year old that are approximately 1% lower than they otherwise would be, due to the shift in enrollment of some relatively healthy workers from employer-sponsored coverage to Marketplace coverage.[102]

Funding considerations:
This policy option would rely completely on the use of state funds.

Impact on employer-sponsored insurance: Approximately 110,000 fewer Californians would be expected to have employer-sponsored insurance under this policy option because they would switch to subsidized insurance through Covered California, according to estimates by the UC Berkeley Labor Center and UCLA Center for Health Policy Research in 2011.[103]

Continue strong outreach and marketing efforts to improve awareness of financial assistance available

The policy options discussed above, individually and collectively, would reduce the amount that Californians struggling to afford coverage and care would spend, but perceived unaffordability can also be a barrier to enrollment in the individual market. A recent survey conducted for Covered California by Greenberg Strategy found that nearly three-quarters of uninsured Californians eligible for subsidized coverage either did not know they were eligible for subsidies or falsely believed they were ineligible. This finding is important because the same survey also found that uninsured people who expected to be eligible for subsidies were twice as likely to plan to enroll.[104] While California has been a leader among states in conducting strategic outreach campaigns and investing in marketing and enrollment assistance to help individuals understand their coverage options, more work is needed to ensure that people understand their eligibility and shop for coverage at the time that they are eligible. These efforts are not a focus of this report, but will always be needed as people churn in and out of needing individual market coverage as their income fluctuates, as their access to job-based coverage changes, or as they undergo other life transitions. Ensuring awareness of the financial assistance available would become even more important if California enacted policies to make coverage more affordable.

Conclusion

The ACA has significantly improved the affordability of and enrollment in coverage among Covered California-eligible individuals who lack access to employer-sponsored insurance or Medi-Cal. However, at least 1.2 million Californians eligible for Covered California, with or without subsidies, remain uninsured, with affordability concerns being the leading reason for lacking insurance. Many of the 2.3 million Californians enrolled in individual market coverage struggle to afford premiums, causing financial problems and putting retention of coverage at risk. Many Californians also face high out-of-pocket costs, which can cause financial hardship, result in delay or avoidance of necessary care, and potentially serve as a deterrent to enrollment. The evidence from California indicates that affordability is a concern for both those already eligible for ACA premium subsidies and those who earn too much to qualify.

Policies to improve affordability of individual market coverage are an important and necessary component to making health coverage more universal and affordable in this state. Affordability concerns are one of the biggest drivers of uninsurance in California, second only to the exclusion of undocumented immigrants from coverage options.

California policymakers could consider improving premium subsidies and cost sharing assistance for those already eligible under the ACA, and expanding cost sharing assistance to individuals who are not currently eligible based on income. Massachusetts, Vermont, and San Francisco have implemented policies that could serve as models. These policies have the potential, especially if implemented in combination, to improve affordability, enrollment, and access to care, while reducing premiums for unsubsidized enrollees if a broader and healthier population enrolls.

California could also limit premium spending as a share of income for individuals who earn too much to be eligible for ACA premium subsidies. A state reinsurance program would be another way to reduce premiums for unsubsidized enrollees. Both of these options would improve affordability for individuals who are ineligible for ACA premium subsidies based on income, though the affordability help provided under a cap on premium spending as a share of income would be more targeted to those with affordability concerns than would be the case under a reinsurance program. Both of these options also have the potential to increase enrollment, leading to a broader and healthier enrollment population that would consequently result in lower premiums.

Providing state-funded premium and cost sharing subsidies mirroring the ACA subsidies would benefit Californians caught in the ACA "family glitch"—in which children and spouses have an offer of family coverage through a parent's or spouse's job, rendering them ineligible for ACA subsidies, but whose family coverage offer is unaffordable. This policy option would reduce spending on health care by families caught up in this glitch by allowing them to switch from unaffordable employer-sponsored coverage to subsidized coverage through Covered California. It would also result in new enrollment in subsidized coverage among some who remain uninsured due to this eligibility gap in the ACA.

Consideration and adoption of policy options to increase health care affordability takes on greater importance with the elimination of the federal individual mandate penalty starting in 2019, which threatens to reduce individual market enrollment and increase individual market premiums. However, survey data indicate that affordability considerations are a bigger driver of the enrollment decision than concern over the penalty for not having insurance.

With these improvements to individual market affordability, California could continue to build upon the progress it has made under the ACA by bringing the state even closer to universal coverage. The state has already served as a national model for successful implementation of the ACA. Implementation of these policies could further expand the state's role as a model for how states can go beyond the ACA.

Appendix

Exhibit A1:
Premium contributions under ACA by income level, 2018

Income as a percent of the federal poverty level (FPL)	Maximum premium contributions for second-lowest cost silver plan		
	As percentage of income	Monthly $ (single)	Monthly $ (family of 4)
Less than 139% FPL	2.01% – 3.32%	$ 0 – 47	$ 0 – 96
At least 139% but less than 150%	3.38% – 4.03%	$ 47 – 61	$ 96 – 124
At least 150% but less than 200%	4.03% – 6.34%	$ 61 – 127	$ 124 – 260
At least 200% but less than 250%	6.34% – 8.10%	$ 127 – 204	$ 260 – 415
At least 250% but less than 300%	8.10% – 9.56%	$ 204 – 288	$ 415 – 588
At least 300% but less than 350%	9.56%	$ 288 – 336	$ 588 – 686
At least 350% but not more than 400%	9.56%	$ 336 – 384	$ 686 – 784

Exhibit A2:

Excerpts from Covered California Standardized Benefit Designs, 2018

Benefits in blue are not subject to a deductible

Coverage category	Bronze	Silver	Enhanced Silver 73 200–250% FPL	Enhanced Silver 87 150–200% FPL	Enhanced Silver 94 100–150% FPL	Gold	Platinum
Primary care visit	$75*	$35	$30	$10	$5	$25	$15
Specialist visit	$105*	$75	$75	$25	$8	$55	$30
Generic drugs	Full cost until drug deductible is met	$15 after drug deductible is met	$15 after drug deductible is met	$5 or less	$3 or less	$15 or less	$5 or less
Emergency room	Full cost until deductible is met	$350	$350	$100	$50	$325	$150
Hospital facility fee	100% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	10% coinsurance	$600 per day up to 5 days	$250 per day up to 5 days
Individual Medical deductible	$6,300	$2,500	$2,200	$650	$75	N/A	N/A
Individual Pharmacy deductible	$500	$130	$130	$50	N/A	N/A	N/A
Individual Out-of-pocket maximum	$7,000	$7,000	$5,850	$2,450	$1,000	$6,000	$3,350

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

For a fuller description of cost sharing by metal tier and service see Covered California's Standardized Benefit Design chart here https://www.coveredca.com/PDFs/2018-Health-Benefits-table.pdf. More details are available from Covered California at http://hbex.coveredca.com/stakeholders/plan-management/PDFs/2018-Covered-California-Patient-Centered-Benefit-Plan-Designs.pdf?v=2.0.

Exhibit A3:

Characteristics of **single individuals** in California with incomes above 400% FPL for whom lowest cost Bronze premium exceeds ACA individual mandate affordability standard, by Covered California pricing region, 2018

Covered California Pricing Region	Lowest cost Bronze premium exceeds ACA individual mandate affordability standard (8.16% of income), 2018	
	For this age range, depending on income	For this income range as a percentage of the Federal Poverty Level, depending on age
1 – Northern Counties	Age 43+	401% – 888% FPL
2 – North Bay Area	41+	401% – 935%
3 – Greater Sacramento	43+	401% – 888%
4 – San Francisco County	38+	401% – 969%
5 – Contra Costa County	43+	401% – 888%
6 – Alameda County	42+	401% – 912%
7 – Santa Clara County	47+	401% – 795%
8 – San Mateo County	36+	401% – 982%
9 – Santa Cruz, Benito, Monterey	42+	401% – 912%
10 – Central Valley	47+	401% – 795%
11 – Fresno, Kings, Madera Counties	48+	401% – 758%
12 – Central Coast	44+	401% – 874%
13 – Eastern Counties	46+	401% – 829%
14 – Kern County	47+	401% – 794%
15 – Los Angeles County (partial)	51+	401% – 652%
16 – Los Angeles County (partial)	48+	401% – 738%
17 – Inland Empire	49+	401% – 708%
18 – Orange County	49+	401% – 731%
19 – San Diego County	47+	401% – 788%

Source: Authors' analysis of Covered California rates, 2018.

Exhibit A4:

Characteristics of **married couples** in California with incomes above 400% FPL for whom lowest cost Bronze premium exceeds ACA individual mandate affordability standard, by Covered California pricing region, 2018

Note: Examples assume spouses are the same age for simplicity.

Covered California Pricing Region	Lowest cost Bronze premium exceeds ACA individual mandate affordability standard (8.16% of income), 2018	
	For this age range, depending on income	For this income range as a percentage of the Federal Poverty Level, depending on age
1 – Northern Counties	Age 18+	401% – 1320% FPL
2 – North Bay Area	18+	401% – 1389%
3 – Greater Sacramento	18+	401% – 1320%
4 – San Francisco County	18+	401% – 1439%
5 – Contra Costa County	18+	401% – 1320%
6 – Alameda County	18+	401% – 1354%
7 – Santa Clara County	26+	401% – 1181%
8 – San Mateo County	18+	401% – 1458%
9 – Santa Cruz, Benito, Monterey	18+	401% – 1354%
10 – Central Valley	26+	401% – 1181%
11 – Fresno, Kings, Madera Counties	28+	401% – 1125%
12 – Central Coast	19+	401% – 1298%
13 – Eastern Counties	21+	401% – 1232%
14 – Kern County	26+	401% – 1179%
15 – Los Angeles County (partial)	38+	401% – 968%
16 – Los Angeles County (partial)	29+	401% – 1096%
17 – Inland Empire	31+	401% – 1052%
18 – Orange County	29+	401% – 1085%
19 – San Diego County	27+	401% – 1171%

Source: Authors' analysis of Covered California rates, 2018.

Exhibit A5:
Premium Affordability Programs in Other States and Localities

Program	Eligibility	Premium Contributions for second-lowest cost Silver plan	Reduction in premiums compared to under ACA
Commonwealth Care (Massachusetts)	Eligible for ACA premium subsidies and income at or below 300% FPL	No premiums for those at or below 150% FPL, premium contributions of between 2.90% and 7.45% of income between 150% and 300% FPL, compared to between 4.03% and 9.56% of income under the ACA	100% reduction for those with incomes at or below 150% FPL Varies from 0% to 54% reduction for those with incomes 150-300% FPL
Vermont Premium Assistance	Eligible for ACA premium subsidies and income at or below 300% FPL	Reduces premiums by 1.5% of income on top of ACA subsidies (e.g., maximum required contribution under ACA is 4.03% at 150% FPL and in Vermont it is 2.53%)	Sliding scale from 75% reduction below 133% FPL to 16% reduction at 300% FPL
Covered San Francisco MRA	Adult residing in San Francisco with income at or below 500% FPL, enrolled in Covered California, not eligible for Medi-Cal or Medicare, employer meets City health spending requirement by contributing to City Option	For individuals with subsidized coverage, enrollee pays 40% of net premium after ACA subsidies For individuals with unsubsidized coverage, enrollee pays 40% of total premium	60% reduction

Sources: Massachusetts Health Connector, Final Affordability Schedule for Calendar Year 2018, Board of Directors Meeting, April 13, 2017, https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/04-13-2017/CY2018-Final-Affordability-Schedule-VOTE-041317.pdf. Correspondence with Department of Vermont Health Access, January 2018. Ken Jacobs (UC Berkeley Labor Center), Universal Access to Care: Lessons from San Francisco, Testimony to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, December 11, 2017, http://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Ken%20Jacobs%20powerpoint%20presentation%20Lessons%20from%20San%20Francisco.pdf.

Exhibit A6:

Actuarial value of plans offered to eligible individuals by household income level under ACA and programs in states and localities that provide additional financial assistance with out-of-pocket costs

Note: Actuarial value is a measure of the percentage of claims an insurer pays, on average, across a population, with enrollees paying the remainder of costs. Deductibles and other cost sharing amounts can vary even among plans with the same actuarial value.

	Household income as a percentage of the Federal Poverty Level (FPL)					
Program	**At or below 100% FPL**	**100–150% FPL**	**150–200% FPL**	**200–250% FPL**	**250–300% FPL**	**300–500% FPL**
Affordable Care Act	94%	94%	87%	73%	70%	70% if enrolled in benchmark plan
Commonwealth Care (Massachusetts)	99%	97%	97%	95%	95%	
Vermont Premium Assistance	94%	94%	87%	77%	73%	
Covered San Francisco MRA	Financial assistance is not directly tied to actuarial value: cost sharing assistance is provided to keep deductible below 5% of income (after ACA cost sharing reductions when applicable)					

Sources: Suzanne Curry, Maintaining Affordable Health Coverage in Massachusetts, Presentation to Families USA Health Action 2015, January 2015, http://slideplayer.com/slide/4103559/. Correspondence with Department of Vermont Health Access, January 2018. Ken Jacobs (UC Berkeley Labor Center), Universal Access to Care: Lessons from San Francisco, Testimony to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, December 11, 2017, http://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Ken%20Jacobs%20powerpoint%20presentation%20Lessons%20from%20San%20Francisco.pdf.

Endnotes

[1] U.S. Census Bureau, American Community Survey, 2013 and 2016.

[2] Wilson K. July 13, 2017. California Insurers Hold on to Previous Gains. California Health Care Foundation Blog. https://www.chcf.org/blog/california-health-insurers-hold-on-to-previous-aca-gains/.

[3] NORC at the University of Chicago. October 22, 2015. Covered California Overview of Findings from the Third California Affordable Care Act Consumer Tracking Survey. http://hbex.coveredca.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf.

[4] Individuals under age 30 also have the option of a "Minimum Coverage" that offers limited coverage before the deductible is reached. Approximately 12,000 Covered Californians were enrolled in these plans in June 2017. (Covered California. September 1, 2017. Active Member Profile June 2017. http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2017_06.xlsx.)

[5] Gabel JR, Lore R, McDevitt RD, et al. June 2012. More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges As Of 2014. *Health Affairs* 31(6): 1339-1348.

[6] In California prior to the ACA, many individual market plans covered less than 60% of costs and some plans paid as little as 32% of medical costs. (McDevitt R. October 2008. Actuarial Value: A Method for Comparing Health Plan Benefits. Prepared for California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2017/12/PDF-HealthPlanActuarialValue.pdf.) After the ACA, insurers paid 78% of medical costs for subsidized enrollees in Covered California, on average, and 71% for unsubsidized enrollees in 2016. (UC Berkeley analysis of data from: Covered California. March 14, 2017b. Bringing Financial Assistance Within Reach. http://hbex.coveredca.com/data-research/library/Bringing_Health_Care_Coverage_Within_Reach_Data_Sheet_2016.xlsx.) Data is not available for the individual market outside of Covered California.

[7] In Covered California, maximum out-of-pocket spending is limited to $7,000 for an individual and $14,000 for a family in 2018, with lower spending limits for individuals receiving financial assistance to reduce out-of-pocket costs and for those enrolled in Gold or Platinum plans. After this out-of-pocket limit is reached, insurers must pay for all covered care without any enrollee contributions. Most families do not use enough care to reach this out-of-pocket spending limit.

[8] Gabel et al. 2012.

[9] DiJulio B, Firth J, and Brodie M. July 2015. California's Previously Uninsured after the ACA's Second Enrollment Period, Kaiser Family Foundation. Kaiser Family Foundation. https://www.kff.org/health-reform/report/californias-previously-uninsured-after-the-acas-second-open-enrollment-period/.

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Education, and UCLA Center for Health Policy Research. http://laborcenter.berkeley.edu/pdf/2016/Preliminary-CalSIM-20-Regional-Remaining-Uninsured-2017.pdf.

[12] California Health Interview Survey, pooled 2014-2016 data.

[13] California Health Interview Survey, pooled 2014-2016 data.

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[15] Collins SR, Gunja MZ, Doty MM. October 2017. How Well Does Insurance Coverage Protect Consumers from Health Care Costs? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016. Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2017/oct/insurance-coverage-consumers-health-care-costs.

[16] Congressional Budget Office. November 8, 2017. Repealing the Individual Health Insurance Mandate: An Updated Estimate. https://www.cbo.gov/publication/53300.

[17] Approximately 378,000 fewer Californians would be estimated to enroll in the individual market without an individual mandate, based on a survey in which 18% of respondents enrolled in the California individual market reported that they would not have purchased insurance in 2017 if the penalty had not existed. (Hsu J, Fung V, Chernew ME, et al. March 1, 2018. Eliminating the Individual Mandate Penalty in California: Harmful but Non-Fatal Changes in Enrollment and Premiums. *Health Affairs Blog*. https://www.healthaffairs.org/do/10.1377/hblog20180223.551552/full/.) Using the Congressional Budget Office's national estimates of individual market coverage losses in 2019 (Congressional Budget Office 2017), and assuming that the coverage loss in California would be proportionate to California's share of the national individual market enrollment in 2016, we estimate that 440,000 fewer Californians would be enrolled in the individual market in 2019.

[18] Prior estimates by Covered California, with PricewaterhouseCoopers, projected that if the individual mandate was not enforced, 280,000 fewer Californians would be enrolled in subsidized individual market insurance and 60,000 fewer Californians would be enrolled in unsubsidized individual market coverage in 2018. (Bertko J and Hunt S. April 27, 2017. Analysis of Impact to California's Individual Market if Federal Policy Changes are Implemented. http://hbex.coveredca.com/data-research/library/CoveredCA_Impact_to_CA_ind_market_4-27-17%20(1).pdf.) This is consistent with the more recent estimate that of the approximately 378,000 fewer Californians expected to enroll in individual market coverage due to the elimination of the individual mandate penalty (Hsu et al. 2018), 250,000 are currently insured through Covered California. Given that the vast majority of Covered California enrollees are subsidized, most of the enrollment loss would also be likely to be among subsidized enrollees. These projections are also consistent with research by Evan Saltzman. He concluded from his analysis of data from Covered California that "individuals with income above 400 percent of FPL are not sensitive to the existence of the mandate, compared to those with income below 400 percent of FPL." (Saltzman E. 2017. Demand for Health Insurance, Evidence from the California and Washington ACA Marketplaces. Wharton Health Care Management. https://repository.upenn.edu/cgi/viewcontent.cgi?article=1140&context=hcmg_papers.)

[19] Congressional Budget Office 2017.

[20] Blumberg LJ, Holahan J, Hadley J, and Nordahl K. 2007. Setting a Standard of Affordability for Health Insurance Coverage. *Health Affairs* 26(4): w463-473.

[21] Individuals with incomes at or below 133% FPL pay 2.01% of income on premiums under the ACA. This applies to a subset of lawfully present immigrants who are not eligible for Medi-Cal.

[22] Saltzman 2017.

[23] Throughout this report, due to data limitations, data on uninsured citizens is referenced as a proxy for those eligible for Covered California but lawfully present immigrants are also eligible to enroll in Covered California and receive subsidies. Undocumented Californians are not eligible to purchase insurance through Covered California under federal law, but are eligible to purchase private insurance directly from insurers in the individual market.

[24] Non-citizens made up approximately 15% of enrollees with individual market coverage through Covered California in 2015 through 2016, according to the California Health Interview Survey. However, it is not known how many uninsured Californians with incomes at or above 139% FPL are lawfully present immigrants.

[25] Adults with household incomes below 139% FPL are covered by Medi-Cal, with zero premiums and zero cost sharing. Children are also eligible for Medi-Cal if they are in households with incomes below 267% FPL. Depending on income, some children have zero premiums and no cost sharing, while others have modest premiums and co-pays.

[26] Covered California, Active Member Profile June 2017.

[27] These are premium contributions for the benchmark plan, the second-lowest cost Silver plan. Premium contributions are lower for individuals purchasing the lowest cost Silver plan or a Bronze plan.

[28] Whitmore H and Gabel J. March 14, 2017. California Employer Health Benefits: Prices Up, Coverage Down. California Health Care Foundation. https://www.chcf.org/publication/california-employer-health-benefits-prices-up-coverage-down/.

[29] 2015 is the most recent tax data available for California at the time of this report's publication. The number of California households paying the penalty may have been lower in 2016 as uninsurance rates in the state continued to decline. Nationally, the number of households paying the penalty declined 26.8% between tax year 2015 and tax year 2016. (U.S. Treasury Inspector General for Tax Administration. January 31, 2018. Results of the 2017 Filing Season. https://www.treasury.gov/tigta/auditreports/2018reports/201840012fr.pdf.)

[30] 76% of Californians paying the tax penalty for not having insurance in 2015 had household income between $10,000 and $50,000, which in most cases would make them eligible for subsidies through Covered California. Another 14% of Californians paying the tax penalty had income between $50,000 and $75,000 and in some cases could have been eligible for subsidies based on income, depending on household size. (Internal Revenue Service (n.d.). Individual Income Tax Returns: Selected Income and Tax Items by State, County, and Size of Adjusted Gross Income, Tax Year 2015. https://www.irs.gov/pub/irs-soi/15incyca.xls.)

[31] Covered California. September 1, 2017b. Active Member Profile June 2016. http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2016_06.xlsx.

[32] California Health Interview Survey 2016.

[33] In 2014, fewer than one in five (18%) of uninsured citizen adults in the subsidy-eligible income range had an offer of employer-sponsored insurance that they declined. It is not known to what extent these offers of employer-sponsored insurance met the ACA affordability standards for the purpose of determining subsidy eligibility. (California Health Interview Survey 2014.)

[34] Excludes nearly 1 million undocumented enrollees who had coverage for emergency and pregnancy-related services only. (California Department of Health Care Services, Research and Analytic Studies Division. December 2016. Medi-Cal Monthly, Enrollment Fast Facts September 2016. http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Sept_16_ADA.pdf.)

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[37] Covered California, Active Member Profile June 2017.

[38] Under federal law, only a subset of lawfully present immigrants are considered "qualified" immigrants eligible for Medi-Cal. Certain other immigrants are eligible for Medi-Cal using state funds, such as Lawful Permanent Residents who are subject to the federal "five-year bar." Lawfully present immigrants who are not eligible for Medi-Cal under federal or state law— such as those with Temporary Protective Status (TPS), individuals with work visas, student visas, or certain other visas, or individuals applying for certain statuses —are eligible for Marketplace coverage and subsidies (depending on income). (National Immigration Law Center, Center on Budget and Policy Priorities, and the Georgetown Center for Children and Families. September 19, 2014. Overview of Immigrant Eligibility Policies for Health Insurance Affordability Programs. https://www.nilc.org/wp-content/uploads/2015/12/CMS-Immigrant-Eligibilty-Presentation-2014-09-19.pdf.)

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[41] The Commonwealth Fund considers an individual underinsured if actual spending on out-of-pocket costs, not including premiums, exceeds 10% of income (or 5% of income for those with household incomes below 200% FPL) or if one's deductible exceeds 5% of income, regardless of how much is actually spent on healthcare. (Collins et al. 2017).

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[48] Covered California, Active Member Profile June 2017.

[49] These estimates include employer-sponsored insurance plans with an actuarial value of between 60% and 69%. The large group plans in this estimate include only those that are fully insured. Large group estimates based on analysis of California SB 546 filings. (California Labor Federation (n.d.). California's Fully Insured Large Group Market: Findings from the First Year of SB 546 Filings. http://calaborfed.org/californias-fully-insured-large-group-market-findings-from-the-first-year-of-sb-546-filings/.) Small group enrollment distribution by actuarial value is based on the PricewaterhouseCoopers (PWC) analysis for California Health Benefits Review Program (CHBRP) of the 2016 distribution of enrollees by benefit plan type obtained through PWC surveys of health plans, CHBRP's estimate of the 2018 population split by market and broad plan type, and the calculated weighted average actuarial values.

[50] Covered California. October 11, 2017. Press Release: Covered California Keeps Premiums Stable by Adding Cost-Sharing Reduction Surcharge Only to Silver Plans to Limit Consumer Impact.

[51] Liquid assets sufficient to cover a Bronze deductible are available for between 27% and 29% of American households with incomes between 150% and 400% FPL, and between 7% and 11% of households with incomes under 150% FPL, depending on household size. (Rae M, Claxton G, and Levitt L. November 2017. Do Health Plan Enrollees have Enough Money to Pay Cost Sharing? Kaiser Family Foundation Issue Brief. https://www.kff.org/report-section/do-health-plan-enrollees-have-enough-money-to-pay-cost-sharing-issue-brief/.)

[52] These estimates for San Francisco are consistent with a national analysis by the Urban Institute, which estimated that individual market enrollees with incomes between 200% and 500% FPL and median health use spent more than 10% of income on premiums and out-of-pocket costs, on average, in 2016. Combined premium and out-of-pocket spending exceeded 20% of income for individuals in the same income range with health spending at the 90th percentile. The Urban Institute concluded that under the ACA the burden of premium and out-of-pocket costs in the individual market is highest among individuals with incomes between 200% and 500% FPL. (Blumberg LJ, Holahan J, and Buettgens M. December 2015. How Much Do Marketplace and Other Nongroup Enrollees Spend on Health Care Relative to Their Income? Urban Institute. https://www.urban.org/sites/default/files/publication/76446/2000559-How-Much-Do-Marketplace-and-Other-Nongroup-Enrollees-Spend-on-Health-Care-Relative-to-Their-Incomes.pdf.)

[53] An individual living in Los Angeles with the same demographics as the individual in the Exhibit 6 example would have spent the same percentage of income as someone in San Francisco through approximately 285% FPL. Between 286% and 500% FPL, a single 40-year old in Los Angeles would have spent 6.9% to 11.9% of income on combined premium and out-of-pocket spending in 2015 with median health use, and 16.0% to 27.6% of income with very high health use. These ranges are slightly lower than in San Francisco, where combined health spending for an individual with these demographics would have been 9.7% to 12.0% of income with median health use and 18.8% to 27.7% with very high health use.

[54] Authors' analysis extrapolating from the California Poverty Measure (CPM), produced by Public Policy Institute of California and the Stanford Center on Poverty and Inequality, https://inequality.stanford.edu/publications/research-reports/california-poverty-measure. These estimates are based specifically on CPM data, which are averaged over 2013 to 2015 and show the resources required by

county for a family of four to live out of poverty assuming they do not own their home. (Public Policy Institute of California and Stanford Center on Poverty and Inequality (n.d.). California Poverty by County, 2013-2015. http://www.ppic.org/data-set/california-poverty-by-county-and-legislative-district/.)

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[60] This is only somewhat higher than the overall U.S. median income of $66,000 for all Americans ages 19 through 64. (Covered California. January 18, 2018. The Roller Coaster Continues—The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies. http://board.coveredca.com/meetings/2018/01-18/CoveredCA-Roller_Coaster_Continues_1-18-18.pdf.)

[61] Over 1.0 million individual market enrollees were in households with incomes above 400% FPL in 2016, according to the California Health Interview Survey.

[62] UC Berkeley Labor Center analysis using Covered California 2018 rates by age.

[63] UC Berkeley Labor Center analysis using Covered California 2018 rates by age. These findings are consistent with national analysis by RAND. (Eibner C and Liu J. October 2017. Options to Expand Health Insurance Enrollment in the Individual Market. Commonwealth Fund. http://www.commonwealthfund.org/publications/fund-reports/2017/oct/expand-insurance-enrollment-individual-market.)

[64] Ibid.

[65] The ACA requires employers with an average of 50 or more full-time employees to offer these full-time employees affordable health insurance, with "affordability" defined as not costing the employee more than 9.56% of his or her income. The plan must also meet a minimum value standard under which it covers 60% of medical costs, on average. Coverage must also be offered to employees' children under age 26. If employers do not make such an offer, employers may owe a penalty to the IRS. See the IRS's website for more information about Employer Shared Responsibility Provisions, https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions.

[66] Interpretations of the text of the ACA varied on whether the cost of worker-only coverage or family coverage should be compared against household incomes to determine eligibility for subsidies. The Joint Committee on Taxation (JCT) interpreted the statute to define affordability using the cost of worker-only coverage, but some experts argued that there was a strong legal basis for interpreting

the statute to define affordability using the cost of family coverage for determining eligibility for dependents. (Internal Revenue Service. November 17, 2011. Public Hearing on Proposed Regulations 26 CFR Part 1. http://www.taxhistory.org/www/features.nsf/Articles/1C04199B199E24678525794C00541F-D8?OpenDocument.)

[67] IRS Code Title 26, Chapter 1, Subchapter A, Part 1 §1.36b-3.

[68] In 2016, the average monthly premium for worker-only coverage was $597 in California while the average premium for a family of four was $1,634. Employers in California contributed 86% of premiums for worker-only coverage, on average, and 75% for family coverage. (Whitmore and Gabel 2017.)

[69] These dependents are exempt from the individual mandate if the cost of purchasing overage for all family members would exceed 8.13% of household income.

[70] For more information about San Francisco's City Option program see: http://sfcityoption.org/whatiscityoption/.

[71] For example, a national analysis by RAND estimated that a particular federal policy option to improve premium subsidies for those with incomes at or below 400% FPL would decrease Silver premiums for a 40-year old by 0.2%, another policy option to extend premium subsidies to those with incomes above 400% FPL would decrease premiums by 2.5%, but in combination the policies would decrease premiums by 4.8%. (Eibner and Liu, October 2017.)

[72] The term "crowd-out" describes when enrollment in private coverage decreases because of the expansion of publicly-subsidized coverage options. This can occur in a variety of ways, including employers no longer offering coverage or workers and/or their dependents no longer enrolling in employer-sponsored insurance in response to the availability of publicly subsidized programs.

[73] Covered California, Active Member Profile June 2017.

[74] These are order-of-magnitude estimates by the authors based on a working paper by Evan Saltzman of the University of Pennsylvania Wharton School estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians not offered or eligible for employer-sponsored insurance, by income level, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.)

[75] Eibner and Liu, October 2017.

[76] Manatt Health. February 2018. Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California. California Health Care Foundation Publication. https://www.chcf.org/wp-content/uploads/2018/02/UnderstandingTheRules-FederalLegalConsiderations.pdf.

[77] Eibner and Liu, October 2017.

[78] Covered California, Active Member Profile June 2017.

[79] The large group plans in this estimate include only those that are fully insured. Large group estimates based on analysis of California SB 546 filings. (California Labor Federation (n.d.).) Small group enrollment distribution by actuarial value is based on the PricewaterhouseCoopers (PWC) analysis for the California Health Benefits Review Program (CHBRP) of the 2016 distribution of enrollees by benefit

plan type obtained through PWC surveys of health plans, CHBRP's estimate of the 2018 population split by market and broad plan type, and the calculated weighted average actuarial values.

[80] Correspondence with Matthew Rae, Kaiser Family Foundation, October 2017.

[81] UC Berkeley analysis of Covered California 2018 rates by age and region, compared to analysis of individual market enrollment by age, income, and region using data from the California Health Interview Survey, 2016.

[82] RAND also estimated that people age 50 and over and people with incomes between 400% and 600% FPL would disproportionately benefit from a similar policy option at the federal level. (Eibner C and Liu J. July 2017. Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults. Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2017/jul/marketplace-tax-credit-extension.)

[83] These are order-of-magnitude estimates by the authors in part based on a working paper by Evan Saltzman, The Wharton School, estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians with demographics that would make them potentially eligible for this state policy option, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.) RAND projected that a potential federal policy that would cap premiums for individuals with incomes at or above 400% FPL at 9.95% of income based on the second-lowest cost Silver plan (a more affordable standard than 8.16% of income based on lower-cost Bronze) in 2020 would result in 1.6 million additional individual market enrollees. (Eibner and Liu, October 2017.)

[84] Eibner and Liu, October 2017.

[85] The federal policy scenario would cap premium contributions for the second-lowest cost Silver plan at 9.95% of income in 2020. (Eibner and Liu, October 2017)

[86] Harrington SE. September 11, 2017. Stabilizing Individual Health Insurance Markets with Subsidized Reinsurance. University of Pennsylvania Leonard Davis Institute of Health Economics Issue Brief. https://ldi.upenn.edu/brief/stabilizing-individual-health-insurance-markets-subsidized-reinsurance.

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[88] These are order-of-magnitude estimates by the authors based on a working paper by Evan Saltzman, The Wharton School, estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians not offered or eligible for employer-sponsored insurance, by income level, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.)

[89] Gross reinsurance spending of $1 billion in 2019 would be approximately 7% of estimated aggregate individual market premiums in that year, using 2015 actual aggregate premiums from Milliman adjusted up by 7% annually to estimate premium growth. (Milliman. April 2017. Individual Health Insurance Market Profile: State of California, 2015. http://www.milliman.com/uploadedFiles/insight/2017/state-profiles/CA-summary-april-17.pdf.)

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[101] Jacobs et al. 2011.

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[104] Greenberg Strategy. October 5, 2017. Covered California Sentiment Research, Wave 2: A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage. https://www.coveredca.com/PDFs/October_2017_Covered_California_Sentiment_Survey_FINAL.pdf.

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Eliminating The Individual Mandate Penalty In California: Harmful But Non-Fatal Changes In Enrollment And Premiums

John Hsu, Vicki Fung, Michael E. Chernew, Alan M. Zaslavsky, William Dow, Joseph P. Newhouse

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The federal tax reform act of December 2017 eliminated the penalty for noncompliance with the Affordable Care Act's (ACA) individual mandate (also known as the shared responsibility requirement) starting in 2019. This legislative change has highlighted uncertainty about the penalty's importance in inducing lower-risk individuals to purchase insurance, and the potential for higher premiums in the individual insurance market should they not do so.

The Congressional Budget Office and the Joint Committee on Taxation (CBO/JCT) estimated that within one year, eliminating the penalty would leave four million fewer individuals insured nationwide, including three million fewer with individual market insurance. Moreover, the higher risk profile of the remaining insured would drive up individual insurance market premiums by 10 percent. CBO/JCT also predicted that over time more enrollees would drop out of the insurance market, partly due to the rising premiums, resulting in five million fewer insured in 2027 compared with baseline estimates without the repeal.

Proponents of the mandate repeal suggested that the CBO/JCT methodology is flawed because it overstates the importance of the mandate for coverage. Another recent analysis suggests that the size of the mandate penalty had little effect on coverage in 2014 and 2015, but ignores any generalized "woodwork" effect of the mandate. Importantly, the effect of eliminating the penalty on market stability depends both on 1) the number of people who no longer purchase insurance, and 2) whether these people are healthier than those retaining insurance and thus have below-average medical costs. If most enrollees continue to purchase insurance, or if those who do not purchase have similar average risk to those who do purchase, there will be less impact on premiums.

Below we show that 18 percent of enrollees in California's individual market in 2017 say they would not have purchased insurance in the absence of a penalty, but that the substantial majority of lower-risk enrollees would still have purchased. Based on this changing risk mix, we estimate that eliminating the mandate penalty would have caused premiums to rise 5 percent to 9 percent in California's individual insurance market plans.

An Estimate From California

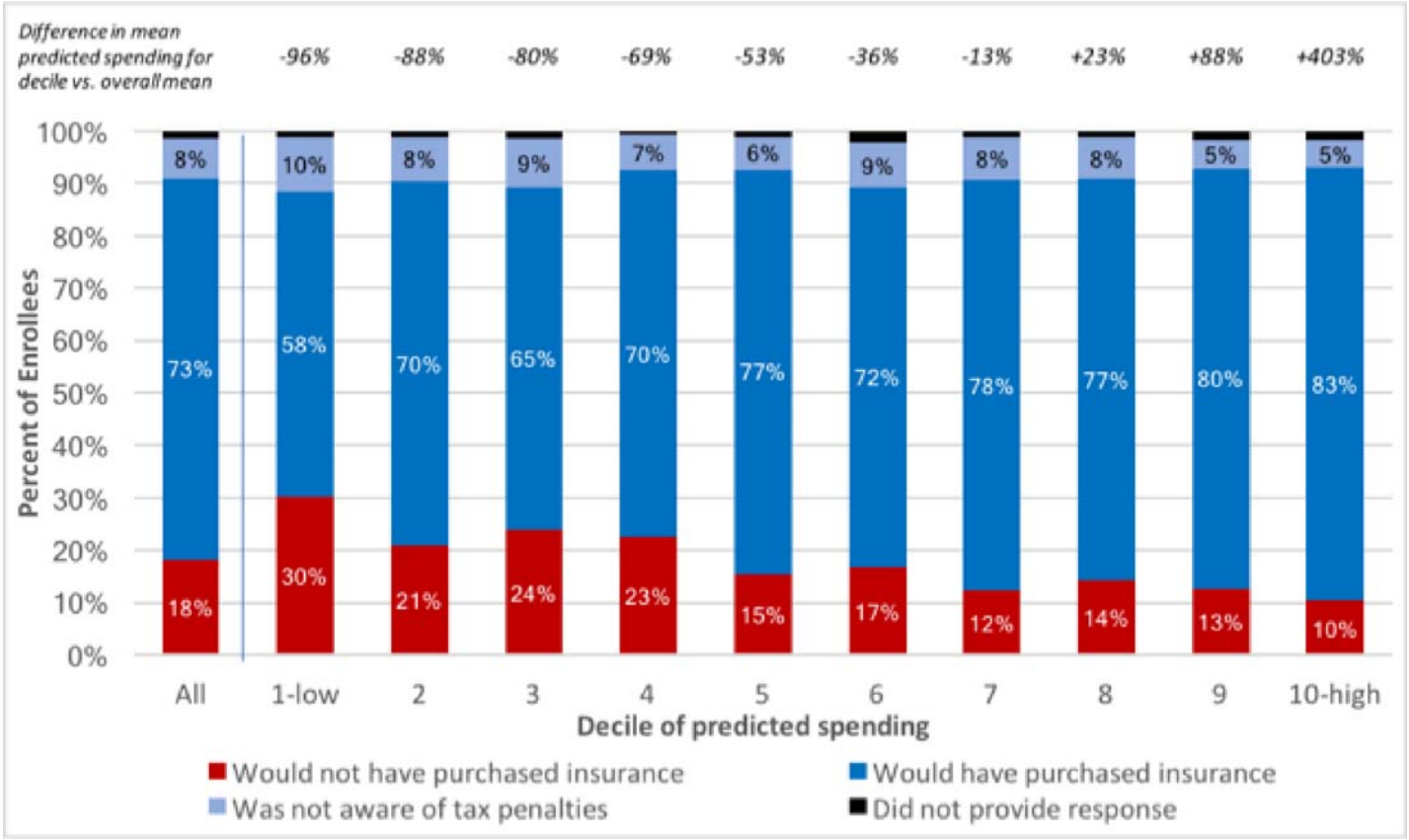
We asked a random sample of adult enrollees in the 2017 California individual insurance market about the extent to which eliminating the mandate penalties might have altered their decision to purchase insurance. The 3,010 respondents represented enrollees who purchased individual insurance market plans through the Covered California marketplace as well as those who purchased outside of the marketplace or "off-exchange."

Overall, 91 percent of individual market enrollees in this California sample were aware that there was a mandate penalty, and 18 percent (or almost one in five enrollees) said they would not have purchased insurance in

2017 if the penalty had not existed. This reduction (about 378,000 fewer enrollees in California) is comparable to the CBO/JCT estimate of enrollment reductions nationally in the first year following the elimination of the mandate penalty, but larger than the 7 percent reported in an October 2017 nationwide Kaiser Health Tracking Poll.

Not surprisingly, enrollees with the lowest levels of predicted medical spending were more likely to say they would not have purchased insurance in 2017 in the absence of the penalty, compared with those at higher levels of predicted spending. For example, 30 percent and 21 percent of those in the lowest two deciles of predicted spending said they would not have purchased insurance in the absence of the penalty, compared to 13 percent and 10 percent of those in the top two deciles of predicted spending (Exhibit 1). At each level of predicted spending, the majority of respondents (70 percent to 90 percent) would likely have purchased insurance in the absence of the mandate penalty.

Exhibit 1: Awareness Of Mandate Penalties And Respondents' Self-Reported Insurance Purchasing Decisions In The Absence Of Mandate Penalties In 2017



Source: Authors' analyses of surveys of individual market enrollees in California in 2017. Note: We asked respondents whether they knew that they would have to pay a tax penalty if they did not have insurance coverage, and if so, whether they would have purchased health insurance coverage this year (2017) if there were no penalty. We conducted the survey between May and September 2017, prior to the passage of the tax reform bill. To examine how these decisions varied by risk level, we predicted annual medical spending for each enrollee based on the following characteristics: age, sex, race/ethnicity, education, household income, self-rated health status, indicators for five chronic conditions, smoking status, and body mass index. We used a two-part model calibrated to the Medical Expenditure Panel Survey. Further details are available from the authors upon request; neither the survey instrument nor our analysis was subject to peer review for this blog post.

On average, enrollees who said they would not have purchased insurance had about 36 percent lower predicted spending compared with those who still would have purchased insurance or were unaware of the mandate

penalty (95 percent confidence interval: 25 percent to 46 percent lower spending). We used these results to predict the potential relative change in premiums if the 18 percent of respondents who said they would not have purchased insurance in the absence of the mandate penalty were not in the risk pool.

We estimate that due to elimination of the mandate penalty, premiums would increase by an additional 7 percent per enrollee (95 percent confidence interval: 5 percent to 9 percent) in California, which is somewhat lower than the CBO/JCT 10 percent estimate. Importantly, there is uncertainty around all estimates, including from CBO/JCT, beyond that captured in the confidence interval because of assumptions implicit in the spending models and forecast approaches. Moreover, the CBO estimate represents a national average across all states, and there are likely to be differences across states in the potential effects of eliminating the mandate penalty depending on other policies or efforts that states may have already adopted or could adopt that encourage individuals to buy insurance.

Implications

Premiums for individual insurance plans have increased substantially since 2014 for many reasons, including the expiration of the ACA's reinsurance program after 2016. In California, premiums for unsubsidized beneficiaries have risen an average of 8.5 percent per year between 2014 and 2018. Despite the increase, Covered California enrollment remained stable and even grew slightly over that time period, suggesting that an additional 7 percent premium increase would be unlikely to destabilize the California market, particularly since the premium tax credits (PTCs) that most enrollees receive would absorb the premium increase.

Our estimates rely on self-reported assessments of the likely impact of eliminating the mandate penalties on enrollees' purchasing decisions in

2017, which we assessed prior to the actual elimination of the mandate penalty. The actual effects in 2019 will differ because of other changes in the market and the details concerning this policy change. For example, our estimates assume that all the enrollees who reported knowing about the mandate when interviewed, also would know about the current repeal of the mandate penalty. Short-term effects on exits from the market likely would be smaller if many are unaware of the policy change or unclear about the details and how it might affect them personally. In a recent Kaiser Health Tracking Poll, only about one-third of those polled were aware that the mandate penalty had been eliminated.

Similarly, inertia in insurance choices could mitigate initial coverage losses. In short, it seems likely that the individual market in California would remain reasonably stable and not suffer an immediate downward spiral under a scenario where only the mandate penalty is eliminated, despite the potential for roughly an 18 percent drop in individual market enrollment.

Other possible changes could alter these predictions. We assumed that there are no changes in insurer participation, but several additional federal policy changes could alter insurer and consumer behavior. In October 2017, the Centers for Medicare and Medicaid Services halted federal cost-sharing reduction (CSR) payments to insurers, which led to premium increases in all states for 2018. The federal government also reduced outreach and marketing, and shortened the 2018 open enrollment period in federally facilitated marketplaces. It has proposed rule changes for Association Health Plans and short-term health insurance plans that, if implemented, could unfavorably impact the risk pool.

Given these other policy changes, the effects of eliminating the mandate penalties could be more severe. Moreover, the interactive effects between these changes are difficult to predict and will require continued assessment. For example, the approaches taken by individual states for

adjusting premium rates following the CSR payment elimination affect the magnitude of the premium tax credits and, in some cases, could even result in lower premiums for non-Silver plans. Alternatively, policies leading to large premium changes in a state could be exacerbated by the lack of the mandate penalty.

New state-level policies also could mitigate the potential impact of eliminating the penalty on coverage. For example, according to a recent report, several states are considering introducing a state mandate such as the one in Massachusetts. Other potential efforts include increasing marketing and outreach, requiring auto-enrollment for renewals, and improving enforcement of special enrollment period criteria.

Lastly, eliminating the mandate penalty could matter less in California than in other states because California has one of the most stable individual markets in the nation with a more favorable risk mix than other states, as reflected in average risk scores published by the Center for Consumer Information & Insurance Oversight. California has implemented a number of policies to reduce adverse selection into and within the market. For example, California was one of 11 states that prohibited the sale of ACA non-compliant plans in 2014, which likely improved the favorability of the individual market risk pool. It was one of five states to mandate some alignment of plans sold on and off of the public marketplace by requiring that all plans sold on-marketplace have a mirrored product sold off-marketplace.

Relative to other states, California has invested heavily in outreach and education efforts to increase insurance uptake, emphasizing reasons other than the mandate for buying insurance such as financial and health protection. Reflecting these efforts, premium rates and year-to-year growth in premiums have been lower in California compared with other states. In sum, our estimates could represent a best-case scenario for the potential

effects of the mandate repeal on the individual insurance market elsewhere.

Authors' Note

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MEMO

February 14, 2018

To:	John Bertko, FSA, MAAA Chief Actuary Covered California
From:	Bob Cosway, FSA, MAAA, Principal and Consulting Actuary Barbara Dewey, FSA, MAAA, Consulting Actuary Matt Schoonmaker, FSA, MAAA, Actuary
Re:	**Reinsurance Program Estimates for 2019-2021**

Covered California retained Milliman, Inc. to provide estimates of the effect of various reinsurance proposals on health insurance premiums in the overall U.S. individual market. This report contains an overview of the U.S. federal legislative bills with reinsurance proposals along with estimates of the per member per month (PMPM) costs, reductions in premium levels, and total annual costs associated with various reinsurance plan designs. Our understanding is that Covered California will include our estimates of the effect of reinsurance proposals in a larger analysis that provides projections of premiums into 2019, 2020, and 2021.

OVERVIEW OF BILLS WITH REINSURANCE PROPOSALS

Our understanding is that there are multiple reinsurance proposals that have been introduced in the U.S. federal legislature in the past few months. The purpose of these proposals is to stabilize health insurance premiums in the individual market.

One bill, H.R. 4666: Premium Relief Act of 2017,[1] introduced by Ryan Costello (R-Pa.) in the House of Representatives, allocates $10 billion per year from 2019 to 2021 for this reinsurance program and has the following preliminary reinsurance program parameters:

Attachment point: $50,000
Maximum charge subject to reinsurance: $350,000
Coinsurance: 75%

These program parameters can be interpreted as, assuming there are sufficient funds, that the federal government will reimburse health plans 75% of the cost between $50,000 and $350,000 for each individual enrolled in a health insurance plan in the individual market in a given calendar year. The table in Figure 1 shows the calculation of the reinsurance amount for a few sample patients.

[1] Available online at: https://www.govtrack.us/congress/bills/115/hr4666/text.

Figure 1: Sample Calculations for a Reinsurance Plan Design With a $50,000 Attachment Point, $350,000 Maximum Charge Subject to Reinsurance, and 75% Coinsurance

Patient Plan-Paid Annual Charges	Calculation of Reinsurance Amount	Reinsurance Amount
$25,000	Patient has not reached the attachment point.	$0
$100,000	75% x ($100,000 - 50,000)	$37,500
$500,000	75% x (MIN [$350,000, $500,000] - $50,000)	$225,000

Covered California provided us with estimated Qualified Health Plan (QHP) enrollment numbers for the nationwide individual market of approximately 18 million for 2016 and 17 million for 2017. Assuming enrollment in the 2019-2021 period continues to decrease at a rate of 1 million members per year, the $10 billion per year funding for the Costello bill's reinsurance program would translate to approximately $56 per member per month (PMPM) for the 2019 plan year. Our analysis in this report evaluates whether this funding level is sufficient for the proposed plan design, and presents alternative plan designs for consideration.

A second bill, S. 1835: Lower Premiums Through Reinsurance Act of 2017, introduced by Susan Collins (R-Maine) and Bill Nelson (D-Fla.) in the Senate, uses 1332 waivers to let states draw from a $2.25 billion pool for their own reinsurance programs each year for two years. Using the same enrollment estimates as before, and assuming that the funding would be allocated to each state based on its exchange enrollment, the Collins bill provides approximately $13 PMPM.

Covered California asked us to model a plan design with a $50,000 attachment point, $250,000 maximum charge subject to reinsurance, and 80% coinsurance.

FINDINGS

We modeled a number of different plan designs using the silver-level combined medical and pharmacy claims probability distribution (CPDs) underlying the 2019 actuarial value (AV) calculator, with observed trends from the 2016-2019 actuarial value calculators. Figure 2 shows the results of our modeling for Covered California's proposed plan design with a $50,000 attachment point, $250,000 maximum charge subject to reinsurance, and 80% coinsurance. The figure shows the plan design, the estimated PMPM reinsurance payments to insurers, the percentage of premium reduction due to the reinsurance payments, and the estimated total annual cost for this program.

As shown in the tables in this report, any reinsurance plan design will result in lower premiums. This, in turn, will result in a lower federal budget for advance premium tax credits (APTCs). It is not yet clear whether the funding for the proposed bills will be the stated budgets (of $10 billion per year or $2.25 billion per year) plus all or a portion of the related reduction in the required APTC budget or will be limited to just the stated budgets (of $10 billion per year or $2.25 billion per year). For the purpose of the estimated total annual costs shown in the tables in this report, we show the full amount that would be needed to fund each reinsurance plan design, regardless of the funding sources.

Figure 2: Estimated 2019-2021 Values for Covered California's Proposed Nationwide Reinsurance Plan Design

Reinsurance Plan Designs	Covered California's Proposed Nationwide Reinsurance Plan Design
Attachment Point	$50,000
Maximum Charge Subject to Reinsurance	$250,000
Coinsurance Percentage	80%
PMPM Reinsurance Payments to Insurers Using CPDs From AV Calculator	
2019	$81
2020	$89
2021	$98
Percentage Premium Reduction Using CPDs From AV Calculator	
2019	17.2%
2020	17.8%
2021	18.3%
Total Annual Nationwide Reinsurance Cost, Expressed in Billions	
2019 (assuming 15 million members)	$14.6
2020 (assuming 14 million members)	$15.0
2021 (assuming 13 million members)	$15.3

Note: Values have been rounded.

Figure 2 shows that the proposed plan design is expected to result in approximately $81 PMPM in reinsurance payments to insurers, with an estimated total annual nationwide cost of approximately $14.6 billion for the 2019 plan year. The program cost rises to approximately $98 PMPM in reinsurance payments to insurers, with a total annual nationwide cost of approximately $15.3 billion for the 2021 plan year, using the underlying trend assumptions in the 2016 to 2019 actuarial value calculators.

We compared the PMPM results from Figure 2 to historical values from Covered California's data warehouse, which indicate that the same reinsurance plan design applied to the 2016 data would result in reinsurance payments to insurers of approximately $45 PMPM. This is directionally consistent with the higher values presented in Figure 2 because the California risk pool is thought to be healthier than the nationwide pool and the $45 PMPM does not include an additional three to five years of trend that are included in the 2019-2021 values in Figure 2.

Figure 3 shows the results of our modeling for the transitional reinsurance program parameters that were in place for the 2014-2016 plan years. This figure provides a range of sample plan designs that have been used in the individual market in prior years, and shows how different plan designs can achieve different target annual budget amounts.

Figure 3: Estimated 2019-2021 Values Under Historical 2014-2016 Transitional Reinsurance Parameters[2]

Reinsurance Plan Designs	2014 Transitional Reinsurance Parameters	2015 Transitional Reinsurance Parameters	2016 Transitional Reinsurance Parameters
Attachment Point	$45,000	$45,000	$90,000
Maximum Charge Subject to Reinsurance	$250,000	$250,000	$250,000
Coinsurance Percentage	100%	55%	53%
PMPM Reinsurance Payments to Insurers Using CPDs From AV Calculator			
2019	$111	$61	$28
2020	$122	$68	$31
2021	$134	$74	$33
Percentage Premium Reduction Using CPDs From AV Calculator			
2019	23.5%	13.0%	5.9%
2020	24.3%	13.4%	6.1%
2021	25.1%	13.8%	6.2%
Total Annual Nationwide Reinsurance Cost, Expressed in Billions			
2019 (assuming 15 million members)	$20.0	$11.0	$5.0
2020 (assuming 14 million members)	$20.6	$11.3	$5.2
2021 (assuming 13 million members)	$20.9	$11.6	$5.2

Note: Values have been rounded.

We compared the results in Figure 3 to historical values that the carriers provided to Covered California as part of the 2014 to 2017 bid processes. These values are available publicly on the California Department of Managed Healthcare and California Department of Insurance rate review websites. The comparison of Figure 3 to the estimated reinsurance recoveries provided by the carriers in their bids shows that, as expected, the same plan designs are worth more in 2019 to 2021 than they were in 2014 to 2016, but that the relative value of each plan design is generally consistent with the carrier estimates.

Figures 4 to 6 show the proposed plan design from the Costello bill, which has a $50,000 attachment point, $350,000 maximum charge subject to reinsurance, and 75% coinsurance. The three figures also show how changes to the various levers of the reinsurance plan design could affect the estimated premium reductions and total annual budget.

Figure 4 shows how changes to the attachment point affect the estimated premium reductions and the total annual budget.

[2] Reinsurance payment parameters from CMS reports on the 2014-2016 benefit years. "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year" Revised September 17, 2015. "Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year" Released December 6, 2016. "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year" Released June 30, 2017. Reports are available online at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/.

Figure 4: Estimated 2019-2021 Values for Costello-Proposed Plan Design With Variations on Attachment Point

Reinsurance Plan Designs	Costello-Proposed Plan Design	Costello Plan Attachment Point Variant #1	Costello Plan Attachment Point Variant #2	Costello Plan Attachment Point Variant #3
Attachment Point	*$50,000*	*$65,000*	*$70,000*	*$75,000*
Maximum Charge Subject to Reinsurance	$350,000	$350,000	$350,000	$350,000
Coinsurance Percentage	75%	75%	75%	75%
PMPM Reinsurance Payments to Insurers Using CPDs From AV Calculator				
2019	$82	$62	$56	$54
2020	$91	$70	$63	$58
2021	$100	$79	$72	$66
Percentage Premium Reduction Using CPDs From AV Calculator				
2019	17.4%	13.1%	11.9%	11.4%
2020	18.1%	14.0%	12.6%	11.6%
2021	18.8%	14.8%	13.5%	12.2%
Total Annual Nationwide Reinsurance Cost, Expressed in Billions				
2019 (assuming 15 million members)	$14.8	$11.1	$10.1	$9.7
2020 (assuming 14 million members)	$15.3	$11.8	$10.7	$9.8
2021 (assuming 13 million members)	$15.7	$12.4	$11.3	$10.2

Note: Values have been rounded.

Figure 5 shows how changes to the maximum charge amount affect the estimated premium reductions and the total annual budget.

Figure 5: Estimated 2019-2021 Values for Costello-Proposed Plan Design With Variations on Maximum Charge Amount

Reinsurance Plan Designs	Costello-Proposed Plan Design	Costello Plan Maximum Charge Variant #1	Costello Plan Maximum Charge Variant #2	Costello Plan Maximum Charge Variant #3
Attachment Point	$50,000	$50,000	$50,000	$50,000
Maximum Charge Subject to Reinsurance	*$350,000*	*$300,000*	*$250,000*	*$200,000*
Coinsurance Percentage	75%	75%	75%	75%
PMPM Reinsurance Payments to Insurers Using CPDs From AV Calculator				
2019	$82	$79	$76	$69
2020	$91	$88	$84	$76
2021	$100	$97	$92	$85
Percentage Premium Reduction Using CPDs From AV Calculator				
2019	17.4%	16.8%	16.1%	14.7%
2020	18.1%	17.4%	16.7%	15.2%
2021	18.8%	18.2%	17.2%	15.8%
Total Annual Nationwide Reinsurance Cost, Expressed in Billions				
2019 (assuming 15 million members)	$14.8	$14.3	$13.7	$12.5
2020 (assuming 14 million members)	$15.3	$14.7	$14.1	$12.8
2021 (assuming 13 million members)	$15.7	$15.2	$14.4	$13.2

Note: Values have been rounded.

Figure 6 shows how changes to the coinsurance amount affect the estimated premium reductions and the total annual budget.

Figure 6: Estimated 2019-2021 Values for Costello-Proposed Plan Design With Variations on Coinsurance Amount

Reinsurance Plan Designs	Costello-Proposed Plan Design	Costello Plan Coinsurance Variant #1	Costello Plan Coinsurance Variant #2	Costello Plan Coinsurance Variant #3
Attachment Point	$50,000	$50,000	$50,000	$50,000
Maximum Charge Subject to Reinsurance	$350,000	$350,000	$350,000	$350,000
Coinsurance Percentage	*75%*	*70%*	*60%*	*50%*
PMPM Reinsurance Payments to Insurers Using CPDs From AV Calculator				
2019	$82	$77	$66	$55
2020	$91	$85	$73	$61
2021	$100	$94	$80	$67
Percentage Premium Reduction Using CPDs From AV Calculator				
2019	17.4%	16.3%	13.9%	11.6%
2020	18.1%	16.9%	14.5%	12.1%
2021	18.8%	17.5%	15.0%	12.5%
Total Annual Nationwide Reinsurance Cost, Expressed in Billions				
2019 (assuming 15 million members)	$14.8	$13.8	$11.8	$9.9
2020 (assuming 14 million members)	$15.3	$14.2	$12.2	$10.2
2021 (assuming 13 million members)	$15.7	$14.6	$12.5	$10.4

Note: Values have been rounded.

It is not yet clear whether the funding for the Costello bill's proposed reinsurance program would be $10 billion per year plus all or a portion of the related reduction in the required APTC budget, or would be limited to just $10 billion per year. If the funding for Costello's proposed reinsurance program is $10 billion per year plus the funds reallocated from the lower APTC payments, then the proposed plan design may be achievable. If the funding is limited to $10 billion per year, a review of Figures 4 to 6 concludes that the Costello bill would likely need a leaner reinsurance plan design to meet the $10 billion target costs or a larger budget in order to offer the stated reinsurance plan design.

A comparison of the proposed Collins bill's total annual budget to the total annual costs in Figures 2 to 6 above shows that implementing the Collins bill would require a lean reinsurance plan design, possibly similar to the plan design in place in the 2016 plan year.

DATA SOURCES AND METHODOLOGY

We estimated the value of each reinsurance plan design using the CPDs underlying the actuarial value calculator (AV calculator) provided by the U.S. Department of Health and Human Services (HHS). The AV calculator contains a number of CPDs, including separate CPDs for each metallic level and separate CPDs for medical, pharmacy, and combined plan designs. For the purpose of the calculations shown in this report, we used the silver-level CPD for medical and pharmacy combined.

For each plan design, we calculated the PMPM reinsurance payments to insurers and estimated the percentage premium reduction using the CPDs from the 2019 plan year. We trended the 2019 CPD to 2020 and 2021 using observed trends from the 2016 to 2019 AV calculators, then applied the reinsurance parameters to estimate the reinsurance PMPMs. We assumed a paid-to-allowed ratio of 87% and a non-benefit expense percentage of 12% of premiums. For the purpose of the calculations provided in this report, we have assumed that the reinsurance would not affect the non-benefit expenses when expressed as a percentage of premium.

We compared the results to three separate sources to assess the reasonableness of the results. First, we compared the estimated reinsurance recoveries calculated using the silver-level combined medical and pharmacy CPD from the 2019 AV calculator to the estimated reinsurance recoveries calculated using observed 2016 costs from Covered California's data warehouse. Then we compared the estimated values of the 2014-2016 reinsurance plan designs using the silver-level combined medical and pharmacy CPD from the 2019 AV calculator to observed carrier-reported experience from Covered California carrier rate filings provided on the California Department of Managed Healthcare and California Department of Insurance rate review websites. Finally, we compared the estimated premium reductions to the same values estimated using the Milliman Health Cost Guidelines™ commercial CPDs. All three reasonableness checks support the decision to use the CPD from the 2019 AV calculator as the basis for the calculations shown in this report.

Covered California provided us with estimated QHP enrollment numbers for the U.S. individual market of approximately 18 million for 2016 and 17 million for 2017. As a simplified but still reasonable assumption, we have assumed that enrollment in the 2019-2021 period continues to decrease at a rate of 1 million members per year. We used these enrollment estimates to convert the PMPM reinsurance payments to insurers to total annual nationwide budgets for each reinsurance plan design.

LIMITATIONS

The information contained in this report has been prepared for Covered California for the purpose of estimating the effect of various reinsurance proposals on health insurance premiums in the overall U.S. individual market. The information contained within the report may not be appropriate for other purposes.

It is our understanding that the information contained in this report will be released publicly. Any distribution of the information should be in its entirety. Summaries of this report, such as a standalone executive summary or section, must still cite the full report. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

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In compiling this report we relied upon data and information from various sources, as documented within the report. We have not audited or verified the data and information other than reviewing it for general reasonableness. Whenever the underlying data or information is inaccurate, incomplete, or misleading, the results of our analysis may likewise be inaccurate or incomplete. The results of the financial analysis are estimates based upon chosen assumptions. Actual experience will differ from these estimates.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The services provided for this project were performed under the signed Agreement Number 15-C-074 between Milliman and Covered California signed May 10, 2016.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

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United States of Care

February 2018

STATE EFFORTS TO CLOSE THE HEALTH COVERAGE GAP

This review examines prominent state efforts to expand health coverage to the remaining uninsured. It analyzes and compares efforts in Massachusetts, Vermont, Colorado, California, and Nevada and highlights insights and themes that emerge. It explores the context and climate for reform within the state, stakeholder involvement, political coalitions, financing, and possible opposition. As such, it serves as a case study in how different states build, or fail to build, the popular and political will towards health care coverage for all residents. This is the first in a series of reports that will monitor and analyze developments at the state level to expand coverage and improve access to care.

There is a health coverage gap in the United States, with nearly 28 million individuals lacking health insurance coverage. While health insurance is not a guarantee of affordable health care or better health outcomes, recent evidence indicates that expanding coverage increases patients' access to primary care, preventive care, chronic illness treatment, medications, and surgery. State and federal governments have grappled with their role in ensuring coverage, attempting to close the coverage gap with a mix of public and/or private programs.

The Affordable Care Act (ACA) of 2010 was the most recent federal attempt to fill gaps in health coverage, and it made significant progress in reducing the uninsured rate. It is notable that as a compromise agreement, the ACA focused on incremental improvements rather than large-scale overhaul, particularly in the expansion of Medicaid and changes to the individual insurance market. Even if the ACA had been implemented as originally written, the Congressional Budget Office (CBO) projected that it would have left 23 million nonelderly people uninsured in 2019.

Overall, the goal of expanding coverage to the remaining uninsured enjoys general public support, but there is little consensus around policies to get us there. Further federal movement in that direction is unlikely in the immediate future, given the recent gridlock of the federal government. However, there has been activity at the state level toward this goal in recent years.

This review focuses on prominent state efforts that have, or had, as their primary goal to close the coverage gap, and highlights insights and themes that emerge. Other states have targeted important and relevant issues such as controlling health care costs, stabilizing private markets, improving choice, and increasing price transparency, all of which may help to expand coverage, but these efforts are beyond the scope of this review.

Overall, this review serves as a case study in how different states build, or fail to build, the popular and political will towards health care coverage for all residents. What might we learn across the experience of very different states, proposing very different solutions? We explore the importance of the current coverage gap within the state, building public will, stakeholder involvement, political coalitions, financing, and possible opposition.

MASSACHUSETTS (2006)

Massachusetts passed a health care reform bill in 2006 that became a model for the national effort that resulted in the ACA. It achieved nearly universal coverage in the state, covering 97% of all residents as of 2009.

Elements of Reform. The Massachusetts reform expanded Medicaid coverage; created state-subsidized insurance for low-income people not eligible for Medicaid; merged the individual and small-group insurance markets; instituted an employer "fair share assessment" and an individual mandate; and created the Commonwealth Connector, an insurance marketplace that also set coverage and affordability standards.

Climate for Reform. It is important to realize that Massachusetts was building on prior reforms to the individual marketplace, including guaranteed issue and community rating, and that the state had already broadened Medicaid eligibility under an 1115 waiver. The uninsured rate among the non-elderly was relatively low before the reform (10.9%, about 532,000 people), which dropped to 5.5% in the year after implementation. Massachusetts had other characteristics conducive to successful reform: it had a relatively high per capita income and large rate of employer-sponsored coverage. Massachusetts had also created an uncompensated care pool in 1985, to help compensate hospitals for otherwise unpaid care.

A motivating factor in reform was revenue shortfalls and projected state budget deficits that confronted the newly elected Governor Romney in 2003. Medicaid provider payments were cut an average of 3%-5% for hospitals, nursing homes, physicians, pharmacists, and managed care organizations. Enrollment and eligibility cutbacks were in the works as well. The existing system seemed fiscally unsustainable. One other immediate motivation was the impending expiration of the Medicaid waiver, which put more than $385 million in federal funds at risk without further reforms.

Political Support. The plan was introduced by a Republican governor, and endorsed by prominent Democrats, business leaders, consumer advocates, insurance executives, clergy, and hospital CEOs. The plan was three years in the making, beginning with a Blue Cross Blue Shield Foundation-funded initiative that developed a comprehensive "Roadmap to Coverage." Developed over two years with multi-stakeholder involvement, the Roadmap presented a plan that minimized 1) disruption to the employer market; 2) the need for new revenues; and 3) expansion of the government's role. A central theme in the political debate was the need for "shared responsibility"— the idea that individuals, employers, and government would all need to contribute to achieving access to health care for all residents. A survey conducted six months after passage (but before implementation) found that 64% of Massachusetts residents were largely supportive of the new law.

Financing. In keeping with the theme of shared responsibility, the plan was financed by raising the level of funding from both the public and private sector. The financing of the plan "worked" because the new burden on taxpayers was presented as primarily a redirection of existing funding, with minimal impact on the state budget. After reform, with revenues redirected as shown in Figure 1, the net new spending was $591 million, of which $172 million — less than 1% of the state budget — came from the state's general fund.

"Shared responsibility" was more than a slogan —a 2009 report found that the overall distribution of spending on health insurance by employers, individuals, and government remained essentially the same between 2005 and 2007. Only about half of the more than 400,000 residents who gained coverage by the end of 2008 were publicly subsidized. In 2009, two Massachusetts officials noted that "the individual mandate and employer incentives have provided good value for Massachusetts taxpayers, costing about $1,060 in net new spending per newly covered resident in 2008. The state succeeded in enacting a government program that stimulated private parties to use private dollars to help fulfill a public good."

Governing/Decisionmaking Body. The statute established the quasi-public Commonwealth Connector, an insurance-purchasing exchange, led by the Connector Board, composed of various stakeholders, including consumers, business, and labor. The board was charged with defining affordability, negotiating premium rates with health plans, developing consumers' cost-sharing provisions, and defining the minimum benefits package. Significantly, Massachusetts did not include cost-control mechanisms such as rate setting or restrictions on cost growth.

KEY INSIGHTS:

- The Massachusetts reforms were built on pre-ACA scaffolding that included a low proportion of uninsured residents, a highly regulated insurance market, and significant state spending on an uncompensated care pool.
- Most of the residents that gained insurance did so through employers, thereby avoiding the political problems that a massive growth in government spending might produce.
- Bipartisanship—with support from a Democratic legislature and a Republican governor—reduced partisan divides and minimized entrenched opposition by party lines.
- The reform maintained the balance of funding across sectors, thereby minimizing narratives about "winners" and "losers."

FIGURE 1
The Financing of Massachusetts Health Care Reform*

Source	Financing before Reform	Financing after Reform			Additional Financing, Fiscal Years 2006-2009
	Fiscal Year 2006, Actual	Fiscal Year 2007, Actual	Fiscal Year 2008, Actual	Fiscal Year 2009, Estimated	
	millions of dollars				
Spending					
MassHealth	770	511	642	795	
Commonwealth Care	0	133	628	805	
UCP-HSTNF	656	665	416	417	
Total	1,426	1,309	1,686	2,017	
Additional, 2006-2009					591
Revenues					
UCP-HSNTF provider assessments and insurer surcharges	320	320	320	320	
Local contribution to MCO supplemental payments	385	0	0	0	
Federal financial participation	688	816	888	1,272	
Dedicated revenues	0	7	21	219	
Total	1,393	1,143	1,229	1,811	
Additional, 2006-2009					418
Difference					
General fund share	33	166	457	205	
General fund share of net new annual spending, 2006-2009					172

* Data are from the Massachusetts Executive Office of Health and Human Services. No enrollment increases besides those directly attributable to eligibility changes have been included in this analysis. Commonwealth Care spending is net of enrollee contributions. Dedicated revenues include new taxes and penalties dedicated to paying for health care reform. Some differences appear not to be exact, because of rounding. MCO denotes managed-care organization, and UCP-HSNTF uncompensated care pool—Health Safety Net Trust Fund (as the pool is called under health care reform).

SOURCE: Massachusetts Health Care Reform — Near-Universal Coverage at What Cost? NEJM 2009; 361:2012-2015

VERMONT (2011)

The most comprehensive state attempt to achieve universal health coverage in recent U.S. history occurred in Vermont. Its reform bill, Act 48, was enacted in 2011, with reformers wanting to improve upon the ACA to cover the entire population while simultaneously containing costs.

Elements of Reform. Act 48 instructed the state to develop a single-payer, government-financed system, called Green Mountain Care, to provide universal coverage, replacing most health insurance in Vermont except for Medicare and Tricare. Employees could choose to keep employer-sponsored health insurance, with Green Mountain Care as secondary coverage, but the Act anticipated replacing most employer-sponsored coverage. Non-residents working for Vermont-based companies would also be covered. The plan offered a broad array of services, designed to mirror or improve upon existing coverage for most Vermonters. It required that hospitals and providers accept 105% of Medicare reimbursement rates for their privately insured populations, and set an overall cost growth cap of 4%.

Climate for Reform. In 2007, Vermont had enacted a package of health reforms, including a new program for covering the uninsured known as Catamount Health. This earlier reform was a product of political compromise, with private, subsidized coverage offered to low-income uninsured people. Catamount Health experienced higher-than-expected costs, the state had less revenue because of the recession, and the ACA catalyzed advocates who had pushed for more radical reform in the earlier efforts. Before Act 48 was enacted, 7.6% of non-elderly residents were uninsured in 2009. After the ACA was implemented, the uninsured rate dropped to 6% (second lowest in the U.S.), about 31,200 people.

Political Support. In 2010, Peter Shumlin, a progressive Democrat with a close alliance with Senator Bernie Sanders, ran on a single-payer platform and won election as Governor. State legislators also wanted to go beyond the ACA, and push for radical reform. The plan was bolstered by a strong "Healthcare Is a Human Right" campaign, and the involvement of well-known health economists William Hsiao and Jonathan Gruber. Hsiao had experience developing universal health coverage programs in other countries.

FIGURE 2
Financial Estimates from Three Projections for a Vermont Single-Payer Health Plan*

Variable	2011, Harvard	2013, UMass	2014, State of Vermont
Estimated savings (%)	8-12% short term; 24-25% long term	1.5% over 3 yr	1.6% over 5 yr
Estimated new taxes			
Employers	9.4% of payroll	Not estimated	11.5% of payroll
Employees	3.1% of household income	Not estimated	Sliding scale up to 9.5% of household income
Cost gap to be state financed	NA	$1.6 million	$2.5 billion
New federal revenues from ACA Section 1332	$420 million	$267 million	$106 million
Total cost of Green Mountain Care	NA	$3.5 billion	$4.3 million

* ACA denotes Affordable Care Act, NA not applicable, and UMass University of Massachusetts

SOURCE: The Demise of Vermont's Single-Payer Plan. NEJM 2015; 372:1584-1585

However, in 2014, Gov. Shumlin won re-election by a single percentage point margin, which left him without a strong mandate to implement the single-payer promise he had run on. In addition, the political will to enact the plan waned in the absence of a clear financing mechanism.

Political Opposition. "Partners for Health Care Reform," a coalition of the Vermont Medical Society, Fletcher Allen Health Care, Blue Cross/Blue Shield, Vermont Association of Hospitals and Health Systems, Vermont Business Roundtable. Vermont Chamber of Commerce, and the Vermont Assembly of Home Health Agencies, did not come out explicitly against the plan, but challenged some of the assumptions regarding provider payments and administrative savings. The group commissioned a report that estimated the plan would amount to a 16% cut in payments to doctors and hospitals (something the state disputed). Public opinion polling in 2011 found that residents were divided in their support for the law, with 40% supporting it, 35% opposing it, and 25% unsure. In 2014, polls showed that the public remained divided, with 40% supporting the plan, 39% opposing it, and 21% undecided.

Financing. The initial Act provided no financial details, but directed that a financing plan be produced by 2013. Initial estimates predicted immediate and longer term savings for the health system (see Figure 2), and concluded that a new payroll tax of 9.4% for employers and new income taxes of 3.1% for individuals would replace health insurance premiums. However, other estimates were not so optimistic, and Gov. Shumlin did not produce the report of how much the act would cost until long after it was introduced, which may have contributed to its failure. Projections kept changing because anticipated federal revenues from Medicaid and the ACA declined in the interim, and because the new plan offered 'platinum' level insurance (94% actuarial value) rather than the 87% actuarial value of the initial estimate. Yet policymakers refused to reduce the offering to gold-tiered benefits because that would have been a downgrade in coverage for many Vermont citizens. The plan was also expensive because it tried to replace federally-subsidized insurance with state-subsidized insurance. In the final, official analysis, the plan would require raising payroll taxes by 11.5% and income tax by up to 9%, with lower predicted savings to the health system of 1.6%.

Governing/Decisionmaking Body. Act 48 created the Green Mountain Care Board with unprecedented, centralized responsibility for benefits design, coverage, and premiums. It was tasked with controlling the rate of growth in health care costs and "improving the health of Vermonters" through a variety of regulatory and planning tools. These tools included all-payer rate setting and an explicit cost growth cap (4%). The Board consisted of five Vermonters, nominated by a broad-based committee and appointed by the Governor.

Outcome. Citing the risk of "economic shock," Gov. Shumlin pulled the plan in December 2014, stating that it was not the time to move forward with a publicly-financed health care system in Vermont. "Our current way of paying for health care is inequitable. I wanted to fix this at the state level, and I thought we could. I have learned that the limitations of state-based financing – limitations of federal law, limitations of our tax capacity, and sensitivity of our economy – make that unwise and untenable at this time."

KEY INSIGHTS:

- The public was divided in its support for radical health reform when it passed. Three years later, it was just as divided, in the absence of any sustained effort to educate the public about what the act did and how it would affect people's lives. Thus, there was no groundswell of support when estimates were much higher than anticipated. Health reform needs significant time and energy devoted to educating the public about the plan and its financing.
- The state government did not produce a competing narrative to the complaint about big-government expansion.
- States must work with hospitals and providers at the table for buy-in and to develop all-payer rates and limits on cost growth. Vermont's inability to bring these players together in support of the bill likely contributed to its failure.
- It is important to think about the behavioral economics of how a plan will be received. For example, workers might fail to notice their employer-based health insurance premiums, but would notice an increase in their tax bill.

COLORADO (2016)

Through a ballot initiative in 2016, Colorado was the next state to try to pass an ambitious, universal health coverage plan (ColoradoCare). The plan would have replaced most employer-sponsored insurance coverage, individual market plans, Medicaid, and CHIP with a single-payer system.

Elements of Reform. ColoradoCare was a taxpayer-financed system of universal health coverage for all Colorado residents. It would be created by the state constitution (through Amendment 69), but largely beyond the control of the governor and legislature. It would replace Medicaid (but not Medicare) and private insurance. It featured broad coverage, no restrictions on provider networks, no deductibles, and some copayments.

It would have also replaced the medical care portion of workers' compensation insurance. Beneficiaries that would have been eligible for Medicaid or the Children's Basic Health Plan would have received benefits required by federal law, in addition to ColoradoCare's standard benefits. The wording of Amendment 69, as presented to the voters on the ballot, is below:

> SHALL STATE TAXES BE INCREASED $25 BILLION ANNUALLY IN THE FIRST FULL FISCAL YEAR, AND BY SUCH AMOUNTS THAT ARE RAISED THEREAFTER, BY AN AMENDMENT TO THE COLORADO CONSTITUTION ESTABLISHING A HEALTHCARE PAYMENT SYSTEM TO FUND HEALTHCARE FOR ALL INDIVIDUALS WHOSE PRIMARY RESIDENCE IS IN COLORADO, AND, IN CONNECTION THEREWITH, CREATING A GOVERNMENTAL ENTITY CALLED COLORADOCARE TO ADMINISTER THE HEALTHCARE PAYMENT SYSTEM; PROVIDING FOR THE GOVERNANCE OF COLORADOCARE BY AN INTERIM BOARD OF TRUSTEES UNTIL AN ELECTED BOARD OF TRUSTEES TAKES RESPONSIBILITY; EXEMPTING COLORADOCARE FROM THE TAXPAYER'S BILL OF RIGHTS; ASSESSING AN INITIAL TAX ON THE TOTAL PAYROLL FROM EMPLOYERS, PAYROLL INCOME FROM EMPLOYEES, AND NONPAYROLL INCOME AT VARYING RATES; INCREASING THESE TAX RATES WHEN COLORADOCARE BEGINS MAKING HEALTHCARE PAYMENTS FOR BENEFICIARIES; CAPPING THE TOTAL AMOUNT OF INCOME SUBJECT TO TAXATION; AUTHORIZING THE BOARD TO INCREASE THE TAXES IN SPECIFIED CIRCUMSTANCES UPON APPROVAL OF THE MEMBERS OF COLORADOCARE; REQUIRING COLORADOCARE TO CONTRACT WITH HEALTHCARE PROVIDERS TO PAY FOR SPECIFIC HEALTHCARE BENEFITS; TRANSFERRING ADMINISTRATION OF THE MEDICAID AND CHILDREN'S BASIC HEALTH PROGRAMS AND ALL OTHER STATE AND FEDERAL HEALTHCARE FUNDS FOR COLORADO TO COLORADOCARE; TRANSFERRING RESPONSIBILITY TO COLORADOCARE FOR MEDICAL CARE THAT WOULD OTHERWISE BE PAID FOR BY WORKERS' COMPENSATION INSURANCE; REQUIRING COLORADOCARE TO APPLY FOR A WAIVER FROM THE AFFORDABLE CARE ACT TO ESTABLISH A COLORADO HEALTHCARE PAYMENT SYSTEM; AND SUSPENDING THE OPERATIONS OF THE COLORADO HEALTH BENEFIT EXCHANGE AND TRANSFERRING ITS RESOURCES TO COLORADOCARE?

Climate for Reform. In 2013, 14% of Colorado's non-elderly residents, approximately 646,200 people, were uninsured. After implementation of the ACA, the uninsured rate decreased to 10% (469,600 people), but parts of Colorado (rural areas with few providers and little insurer competition) faced skyrocketing premiums and growing cost-sharing.

Political Support. The initiative was shepherded by physician and Colorado State Sen. Irene Aguilar, a Democrat, and had the support of slightly more than half of the Democratic-controlled legislature. It garnered the necessary 100,000 signatures to put it on the ballot by tapping into public frustrations over rising out-of-pocket costs and limited coverage. It was supported by ColoradoCareYES, a community-based organization.

Political Opposition. The Denver Metro Chamber of Commerce coordinated opposition through a campaign group called Coloradans for Coloradans. State Treasurer Walker Stapleton, a Republican, and former Governor Bill Ritter, a Democrat, co-chaired the group. Gov. John Hickenlooper, a Democrat, also opposed the proposal, stating, "Our reforms are just beginning to bear fruit...and it would be premature to dramatically remake our health care system at this time." Strong bipartisan political opposition included four U.S. representatives, more than a dozen state senators, and more than a dozen state representatives. Sen. Bennet and three former governors spoke out against it, while candidates up for re-election found it risky to support the plan. Additionally, influential industries including realtors, bankers, farmers, contractors, and especially health insurance companies opposed it.

The measure lost the support of important women's health groups due to a fear that because the Colorado state constitution bans the use of 'public funds' for abortion, women covered by ColoradoCare would not be covered for abortions. By August 2016, the liberal group ProgressNow Colorado announced its opposition to the measure.

Financing. Unlike Vermont, Colorado did propose a financing plan: a payroll tax of 10% (pre-tax payroll premiums of 3.33% for employees and 6.67% for employers), and 10% of all non-payroll income, such as self-employment and capital gains. The tax would apply to individual income below $350,000 for a single person, or $450,000 for married couples filing jointly. Business owners said the extra taxes would have been burdensome and unpopular, driving business from the state. When fully implemented, the plan would cost $36 billion, more than the state's present budget. An independent, nonpartisan analysis concluded that the proposed revenue to pay for ColoradoCare would not keep up with increasing health care costs, resulting in growing deficits each year.

Governing Body/Decisionmaking. The Amendment proposed an interim board of 15 members appointed by the Governor and legislative leaders, followed by a permanent 21-person board of trustees elected from seven districts across the state. That board would set benefits and budgets. There was a great deal of fear that the board would have too much control over health care, and voters would not have been able to recall the elected board members. Detractors also said that health care providers could be inadequately reimbursed under the new system, causing them to stop providing care in Colorado and, thus, decreasing Coloradans' health care choices.

Outcome. When Colorado put single payer on the ballot as Amendment 69 in 2016, it failed badly, with 79% voting against it. Opponents (Coloradans for Coloradans) outspent supporters

(ColoradoCareYES) by more than five to one, with messages focused on the increased tax burden on employees and employers, and claiming that inadequate reimbursement would lead to a decrease in health choices.

KEY INSIGHTS:

- A ballot initiative, because the language is set early, does not lend itself well to the process of building support over time for large-scale reforms.
- It is clear that tax shock is a severe obstacle to such efforts. Support for single-payer dramatically drops if a tax hike is imposed. "Shall state taxes be increased $25 billion annually..." is not likely to be positively received without a major initiative to educate the public about savings in the long-term.
- Fear of diminished or constrained choices in providers or coverage proved to be a powerful drawback. There was little appetite for delegating choices to a board, even an elected one; the public's distrust of such governing bodies runs deep.
- Fractured coalitions with the loss of women's health groups proved problematic.
- Without unified support from either party's officials, building political will for large-scale reform is unlikely.

CALIFORNIA (2017)

The next state to attempt universal health coverage was California. In June 2017, the California State Senate passed a bill to create "Healthy California"—a program to create a single health care market in the state.

Elements of Reform. The bill would create the "Healthy California Trust Fund" in the State Treasury. Federal and state funds previously allocated to Medicaid, CHIP, Medicare, ACA subsidies, and others would be deposited in the trust fund. Under the Healthy California plan, individuals would not be subject to premiums, copayments, or deductibles. Medical, pharmaceutical, dental, vision, and long-term care would be provided to all residents—including undocumented immigrants—free of charge. Providers would be paid Medicare rates.

Climate for Reform. In 2013, 16% of California's non-elderly residents, approximately 5.47 million people, were uninsured. After implementation of the ACA (and Medicaid expansion), the uninsured rate dropped to 10% (2.95 million people) in 2016. One in three of California's remaining uninsured are non-citizens who are not eligible for any public program of coverage. California has a long history of campaigns and political leaders who have espoused universal coverage.

Financing. The bill required the legislature to develop a revenue plan for Healthy California. Experts estimate the program would cost about $400 billion per year—double California's current budget. California could cover about $200 billion from current federal and state spending—including Medicaid and Medicare. An additional $100 to $150 billion could be captured from what employers are already spending. The additional funding needed could involve a 15% payroll tax, a 2.3% sales tax, and/or a business tax increase.

Political Support. The powerful California Nurses Association led the campaign for the bill, with other support from labor unions and consumer groups. Public support in California for single payer is 65%, yet drops to 42% if such a plan requires an increase in taxes. Lt. Gov. Gavin Newsom supports single payer and is running for governor in 2018.

Political Opposition. A wide array of business groups opposed the measure, including health insurers, manufacturers and the California Chamber of Commerce, which called the bill a "job killer" because of the tax burden it would impose on responsible employers. Opponents also pointed to the lack of cost containment measures that would lead to budget shortfalls, requiring drastic cuts in services or long waits for providers.

Governing Body/Decisionmaking. An independent public entity called the Healthy California Board would govern the program. The nine-member board would have representatives from the health care sector, labor, and the general public, and include individuals with health care experience. The Governor, Senate Committee on Rules, and Speaker of the Assembly would appoint the board members, and each member would serve four-year terms. The board would be responsible for negotiating contracts and payment methods with health care providers and health care systems, and for seeking necessary waivers and approvals to allow existing federal health-related payments to be made directly to the program.

Outcome. California Assembly Speaker Anthony Rendon shelved the plan in June 2017, citing a lack of a funding mechanism that would allow it to deliver the care and coverage that it promised. The measure is likely to be reconsidered in the 2018 legislative session.

KEY INSIGHTS:

- The California plan is about as ambitious, and disruptive, as has been introduced.
- The plan faced significant hurdles both politically and practically. It would require a variety of federal waivers of existing Medicaid and Medicare regulations, and the financing mechanism would need to be developed.
- The lack of a defined financing mechanism for California's proposal left even its supporters unable to proceed.
- Because the plan would create a true single-payer market (replacing all present insurance, both public and private) it faced predictable

continued on next page ▸

and well-funded opposition from those whose livelihoods were at stake (such as health insurers).

- California is one of the success stories in terms of implementing the ACA and creating a robust individual market. The fact that many of its remaining uninsured cannot obtain coverage through ACA-related provisions (due to citizenship status) provides incentive to pursue disruptive change.

NEVADA (2017)

In 2017, the Nevada legislature passed a plan to take the state closer to universal health coverage by building on the existing multi-payer model. It leverages the structure and negotiated rates of Medicaid to create a "public option" plan on the state exchange. It should be noted that although the plan would be available to all, it would not be subsidized—making it a vehicle for incremental progress, while unlikely to achieve universal coverage on its own.

Elements of Reform. The Medicaid-buy in model —known as "Sprinkle Care" after its namesake and champion, State Rep. Mike Sprinkle, a Democrat – would have been the first state program to allow individuals of all incomes to buy into Medicaid, at full cost; low-income people who qualify for tax credits under the ACA would have the option to use those credits to buy Medicaid-style coverage on the state's Health Insurance Exchange. Employer-sponsored insurance and Medicare would have been maintained, but a commercial insurance product resembling the state's Medicaid coverage would have provided consumers a new option and leveraged the state's lower Medicaid reimbursement rates. The bill was only four pages long, and provided limited information on costs, premiums, and cost-sharing.

Climate for Reform. Prior to the implementation of the ACA, 22% of Nevada's non-elderly population (522,200 people) were uninsured in 2013, one of the highest rates in the nation. A number of factors accounted for the high rate of uninsured, including Nevada's high rate of service sector jobs and low-wage jobs without health benefits, as well as a high level of unemployment.

Under the ACA, that percentage was cut in half, primarily because of Nevada's Medicaid expansion, in which enrollment grew by 90%. Nevada's Gov. Brian Sandoval was the first Republican Governor to choose to expand Medicaid after the Supreme Court made it optional. According to Rep. Sprinkle, the idea for the bill sprung from two dynamics: first, the new Administration's support for a greater state role in health reform decisions, and second, ambiguity and uncertainty around whether the ACA would continue to exist. A primary motive to move the bill was to give the Medicaid expansion population an option to buy-in if the ACA were repealed and the state lost the significant federal subsidy that enabled it to expand Medicaid in the first place.

Political Support. In 2017, Democrats controlled both chambers of the Nevada Legislature, which meets every other year. During floor votes on the House and Senate floors, there was no debate even as the bill passed along largely party lines. Nearly one in four Nevada residents is insured by Medicaid, which enjoys broad popular support.

Political Opposition. The Nevada Hospital Association, along with other health care providers, voiced concerns about the new plan reimbursing them at lower rates. However, they remained neutral, given the lack of detail about whether the plan might displace private payers or primarily be an option for people who were uninsured or at risk of losing their existing Medicaid coverage.

Financing. No details. According to Rep. Sprinkle, the state insurance commissioner was prepared to obtain an actuarial estimate of the premiums and costs once the bill was signed. The goal, he said, was to offer a premium that "is affordable, but that is also not going to cause such marketplace disruption that we lose a private insurance industry that we obviously need in the state." Because the bill included no state subsidies for the plan, its effect on taxpayers would be minimal, with administrative costs built into the premium calculation.

Governing Body/Decisionmaking. The Nevada Medicaid Department would manage the new program, which would be separate from the Medicaid program. The department would have the option to contract with managed care organizations (MCOs), as it does with four MCOs in the Medicaid program in the more populous areas of Nevada.

Outcome. In June 2017, Gov. Sandoval, a Republican, vetoed the plan, writing that the legislation was "an undeveloped remedy to an undefined problem." He also expressed concern that many people buying into the plan would be those with private insurance, rather than the uninsured. Proponents vowed to bring the plan back for consideration in the next legislative session in 2019.

KEY INSIGHTS:

- A Medicaid buy-in approach made sense in a state that saw its uninsured rate decline significantly through Medicaid expansion.
- The bill passed quickly in reaction to the threat of ACA repeal and particularly threats to federal Medicaid funding.
- The plan had a short timeline for start-up, with a target date of January 2019, with few details on how the plan would actually work. This likely contributed to its failure.
- The plan sought to build upon Nevada's existing framework, which includes four managed care companies with Medicaid contracts. In so doing, it attempted to avoid severe pushback from the insurance industry.

EMERGING QUESTIONS AND THEMES

This review summarizes prominent recent attempts at the state level to adopt health reforms that could improve health care access through expanding coverage to all residents. As such, each state operates as a case study in building, or failing to build, the popular and political will towards reform. What might we learn across the experience of very different states, proposing very different solutions?

GETTING TO THE FINISH LINE

States that have pursued universal health coverage often have relatively low percentages of uninsured residents, meaning that the gaps in coverage they have to fill may be small. But paradoxically, it may be harder to build the support to pass a broad proposal when the coverage problem is limited. In the face of small coverage gaps, disruptive reforms may encounter majorities of the public fearful of changes to their existing coverage and thus more skeptical of change.

BUILDING PUBLIC SUPPORT

Educating the public about present health care costs and existing financing mechanisms is key. An understanding of this dynamic is essential to understanding the "problem" and countering the message of higher taxes. Financing through taxes leaves taxpayers (and the proposals) vulnerable to health care costs that grow at greater rates than revenue sources.

FINANCING

These proposals had varying levels of information as to the financing for the reforms. Some efforts floundered by either not offering information about how their policy would be fiscally sustainable, or by proposing drastic tax increases that faced backlash from the public and business community. Massachusetts found success by demonstrating the program could be paid for by reallocating existing funding sources and would require minimal new state funds, in the "shared responsibility" model.

STAKEHOLDER INVOLVEMENT

Building a broad stakeholder coalition in support of coverage expansion proposals is an important element of success in swaying public opinion and political support. Influential stakeholders who feel left out, or who feel their interests may be threatened, are likely to galvanize opposition to efforts to expand coverage. In particular, hospitals and other providers should be brought in early to address concerns about the long-term adequacy of payments.

BUILDING POLITICAL COALITIONS

Although universal health care is often considered a Democratic issue, the example of Massachusetts shows that it can be a Republican one as well. Conversely, the example of Colorado shows that health reform can cause intraparty division and bipartisan opposition, especially if it conflicts with other party priorities.

COUNTERING THE OPPOSITION

Single-payer proposals create the impression of larger government at the expense of the private sector, while an all-payer model raises the specter of price setting and price caps. In either case, getting the language right is essential, to avoid concepts that prompt immediate opposition. The example of Massachusetts shows that messaging such as "shared responsibility" can be used to counter these objections effectively.

DETAILS

One unanswered question is whether including details in an initial proposal is a help or hindrance to initial buy-in. It may be the case that when building upon existing frameworks, detailed plans are not needed for buy-in; but when planning for disruptive change, detailed financing and payment plans are essential in fully educating the public, or opponents may fill the void with scare tactics.

THE IMPORTANCE OF THE FEDERAL GOVERNMENT

Implementing universal coverage in a state, by almost any mechanism, must involve buy-in from the federal government in terms of waiver approvals. It is important for proponents to understand what the parameters of that approval might be, and to frame state debates within the context of the federal government's likely reaction.

FUTURE STATE EFFORTS

Expanding health coverage to all people is a popular idea, but not a monolithic one. In the coming years, many states will consider a variety of approaches specific to their needs, population, economic characteristics, and political will for reform. Some state leaders are pursuing a single-payer model, and others are looking to find market-based solutions with a mix of public and private payers.

Our future analyses will examine and track developments at the state level to catalogue and share lessons learned, and inform state lawmakers as they consider alternatives. As they do, we will update this review and build on the foundation of both the successes and the failures.

This review was prepared by Janet Weiner, Rebecka Rosenquist, and Erin Hartman at Penn LDI. It was produced as part of a research partnership between United States of Care and Penn LDI, and we thank reviewers from both organizations for their valuable input.

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The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies

Executive Summary

- Issuers and states faced considerable challenges in 2018 due to federal policy changes and uncertainty, including reduced carrier participation and the need to make premium work-arounds to address the removal of direct federal funding for the cost-sharing reduction ("CSR") program. For those receiving subsidies, their premium cost fell on average 3 percent in federally facilitated marketplace (FFM) states, while on average the premium for the lowest-cost Silver plan for those who did not receive subsidies increased 32 percent.
- Reductions to marketing and outreach for the federally facilitated marketplace began in the final week of open enrollment 2017 and have continued into the 2018 open-enrollment period. Total enrollment in the federally facilitated marketplace in 2018 closed with 8.7 million, down 9 percent from the 2016 level. To the extent a risk pool is shrinking, it is very likely to be getting "less healthy" and more expensive for all those insured, especially for the 6 million unsubsidized individuals who do not receive the Advanced Premium Tax Credit to offset the premium increases.
- The 2019 plan year has the potential to be just as uncertain and volatile as 2018 due to major policies changes that include (1) the removal of the individual mandate tax penalty, (2) the potential continuation of reduced marketing spending for the federal marketplace, and (3) implementation of association health plans and short-term, limited-duration plans.
- Statewide average premium increases in 2019, absent federal policies to stabilize these markets, could range from 16 to 30 percent — with some carriers in certain states having even higher rate increases, depending on state factors.
- Action on three federal policy options in early 2018 could significantly mitigate the potential 2019 rate increases, with reductions felt most directly by the 6 million consumers who purchase individual coverage without subsidies on-exchange or in the off-exchange Affordable Care Act-compliant market:
  1. Funding state-based invisible high-risk pools or reinsurance programs could produce an average rate reduction of 12 percent with a range of 9 to 16 percent depending on the state;
  2. Restoring marketing and outreach funding in the FFM in 2019 could reduce rates between 2 and 4 percent; and
  3. Reinstituting the health insurance tax "holiday" for 2019 could reduce rates between 1 to 3 percent.

Introduction

Issuers and states faced considerable challenges preparing for the 2018 plan year due to federal policy uncertainty. During the course of 2017, federal executive action shortened the open-enrollment period for the 2018 plan year, reduced the marketing and outreach budget for the 39 states in the federally facilitated marketplace by 90 percent, and ended cost-sharing reduction payments to issuers in October. The 2019 plan year has the potential to be just as uncertain and volatile, if not more so. Major policy changes for 2019 include setting the individual mandate tax penalty to zero for plan years 2019 and beyond, potential continuation of the minuscule marketing spending for the federal marketplace and the implementation of association health plans (AHPs) and short-term, limited-duration insurance plans, which could affect the market as early as 2019.

The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies

This document provides a brief summary of what occurred in 2018 and an overview of the potential impacts for 2019, along with a review of some of the major mitigating policies that could be adopted. We estimate that statewide average premium increases in 2019, absent federal policies to stabilize these markets, could range from 15.6 to 30.2 percent — with some carriers in certain states having even higher rates increases, depending on state factors. Given the continued uncertainty, while it appears most health plans participating in individual markets are themselves stable, a risk remains that parts of the nation could have no carriers interested in participating, or markets that now have two or three carriers could have only one carrier. We also estimate the impact of three federal policy options that could partially mitigate 2019 rate increases and promote carrier participation: reinsurance, increased marketing and outreach to promote enrollment in FFM states, and a reinstitution of the health insurance tax (HIT) holiday.

Market Factors and 2018 Enrollment

The prospects for the 2019 individual market are directly affected by the premiums, and in turn, new enrollment and renewal in the individual market for 2018. The individual market is composed of the on-exchange market (which is about 85 percent subsidized) and the off-exchange market (which is entirely unsubsidized). The individual market includes roughly 6 million Americans who are unsubsidized and bear the full brunt of premium increases (see the Six Million Americans Impacted Most Directly by Premium Increases on page 4). These are the people who benefit most from policies that foster better enrollment with an improved risk mix. In state-based marketplaces and the FFM, over 8 million Americans receive subsidies and are largely shielded from the effect of premium increases by increased federal subsidies. The data below on enrollment reflects only the on-exchange enrollment, and only the data from the federally facilitated marketplace, since in some states operating state-based marketplaces — such as California — open enrollment for 2018 does not close until Jan. 31, 2018. Off-exchange enrollment is not readily available because no single agency is tasked with compiling these numbers for all states in a systematic and timely fashion.

The factors that likely contributed to changes in enrollment and rates for 2018 include:

1. **Changes in products and their pricing to address the removal of direct cost-sharing reduction (CSR) funding contributed to lower premiums for most individuals receiving subsidies:** Most states across the nation implemented a "consumer-centric work-around" to allow health plans to fund the required CSR subsidy program by loading the costs on Silver or on-exchange Silver products only. There were many implications of this policy, but for the majority of states including those in the FFM, net premiums remained the same or decreased for subsidized enrollees, while unsubsidized individuals could avoid net premium increases due to how health plans funded the required CSR program. For the states in the FFM, this meant that on average net premiums for the benchmark Silver plans were about 3 percent lower in 2018 than they were in 2017.[1] In a few states, unsubsidized individuals may have faced a "CSR surcharge" in addition to the other reasons for premium increases if their state did not provide an off-exchange option without an additional premium increase for the CSR.

2. **Reduction in FFM Marketing for Plan Years 2017 and 2018:** Reduced marketing and outreach spending by the FFM actually began in the final week of open enrollment for 2017 when the Trump administration pulled $5 million in planned paid advertising.[2] Before this decision, total cumulative 2017 plan selections for the week of Jan. 1 to 14, 2017, was outpacing the prior year.[3] Given this trend, projections were that the final week of enrollment would match or even surpass the over 680,000 plan selections that were made in the final week of the open enrollment for 2016.[4] What actually occurred was that the final week's enrollment report for Jan. 15 to 31, 2017, showed only 376,260 plan selections — an estimated drop of over 300,000 enrollees.[5] In the end, total 2017 plan selections decreased by a little over 420,000, down 5 percent from 2016 (see Table 1. Annual Enrollment: FFM and Covered California — 2015 to 2018). The federal government

continued the policy of reduced marketing spending for the FFM states for the 2018 open-enrollment period with a 90 percent decrease for FFM states, leaving just $10 million for 39 states, as well as a reduction in support for Navigators doing outreach from $63 to $37 million.[6] (See the next section for continued discussion of the impact on sign-ups for 2018.) We estimate the potential range of 2019 premium impacts of these administration decisions will result in the risk mix in the individual markets to continue to get less healthy and more expensive.

3. **Shortened Open-Enrollment Period:** The open-enrollment period for FFM states — and some state-based marketplaces — was cut in half for plan year 2018. Taken together with the reduction in marketing for the 2018 plan year, the likely impact in many states will be a reduction in the number of healthy new sign-ups.

Table 1. Annual Enrollment: FFM and Covered California — 2015 to 2018

Total Plan Selections	2015	2016	2017	2018
Federal Marketplace	8,838,291	9,625,982	9,201,805	8,743,642
Covered California	1,412,200	1,575,340	1,556,676	*

* Please note final 2018 plan selection data for Covered California will not be available until after Jan. 31, 2018

Early Market Impacts for 2018

Early signs of the 2018 market impact of federal policy changes and uncertainty include changes in carrier participation in 2018 and premium increases for Patient Protection and Affordable Care Act-compliant plans around the nation. Carrier participation and premium increases are important not only for understanding what happened in 2018 but also because they may foreshadow what could occur in 2019. With continued policy and rate uncertainty, the two major actions that carriers could take for 2019 are to (1) decline to continue participating (potentially resulting in more "one plan" counties or even leading to "bare counties"), or (2) raise premiums to accommodate the anticipated cost of covering their on- and off-exchange individual market risk pools.

- **Carrier Participation:** Although no counties were left without an issuer in 2018, data compiled by the Kaiser Family Foundation show that the percent of enrollees with only one issuer to choose rose from 21 percent in 2017 to 26 percent in 2018.[7] These data also show that the average number of plans per state dropped from 4.3 to 3.5 between 2017 and 2018, and the number of states with only one issuer rose from 5 in 2017 to 8 in 2018. (See the Kaiser Family Foundation for additional county-level issuer participation data and maps: http://kaiserf.am/2DHyocF.)
- **Premium Increases:** A Kaiser Family Foundation analysis shows that issuers added cost-sharing reduction surcharges ranging from 7 to 38 percent to 2018 premiums.[8] Independent of the cost-sharing reduction surcharge, statewide premium increases averaged 32 percent for the lowest-cost Silver plans.[9] Uncertainty about enforcement of the individual mandate, enrollment projections related to the shorter enrollment period and the anticipated drop in marketing and other factors likely also contributed to rate increases above the expected medical trend increase. While subsidized enrollees will generally see their 2018 tax credit increase, more than offsetting the premium increase, unsubsidized consumers both on- and off-exchange will bear the full weight of those premium increases. The effect on enrollment for those not receiving subsidies is not clear at this point, but what is certain is that to the extent there is a drop in coverage due to higher premiums, it will result in a worsening of the risk pool and higher premiums for the entire market in future years.

  Average premium increases in 2018 for key products are higher in states with only one carrier, which is an important consideration for 2019. Among states with more than one issuer in 2018, the average premium increase from 2017 to 2018 for the second-lowest-cost Silver plan for a 27-year-old was 36 percent compared to 44 percent in regions with one issuer.[10] Among states with more than one issuer in 2018, the average premium increase from 2017 to 2018 for the lowest-cost Bronze plan for a 27-year-old was 21 percent compared to 29 percent in states with one issuer.[11]

The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies

- **Enrollment Changes for the Federally Facilitated Marketplace:** Overall, enrollment in the states served by the FFM for 2018 was 8.7 million, including both renewing individuals and those newly signing up for coverage (see Table 1. Annual Enrollment: FFM and Covered California — 2015 to 2018), which reflects a decrease of 5 percent from 2017. Given the fact that reduced marketing and outreach spending began in the final week of open enrollment for 2017, it may be more appropriate to compare open enrollment performance for 2018 to the 2016 open-enrollment period. Over the past three years — from 2016 to 2018 — the number of sign-ups in states served by the FFM declined by 882,340 (a 9 percent decline). Importantly, however, this count does not include changes in the off-exchange individual market, which is likely to have even greater declines because those unsubsidized individuals do not have the Advanced Premium Tax Credit to offset the premium increases. In contrast, in California, on-exchange enrollment has remained stable during this three-year period. Covered California's relative stability comes in the context of the fact that there is substantial churn in the individual market, with about 40 percent of enrollees leaving Covered California each year, the vast majority of whom get coverage elsewhere.

  One of the lessons of the past five years is that the individual market is characterized by "churn" — many people come and go from the individual market due to changes in life circumstance (e.g., getting or losing job-based coverage, moving, aging into Medicare). Another lesson that is fundamental to maintaining a stable risk pool and keeping premiums low is that while constant net growth is not necessary to maintain a stable risk mix, to the extent a risk pool is shrinking, it is very likely to be getting "less healthy" and more expensive for all those insured.

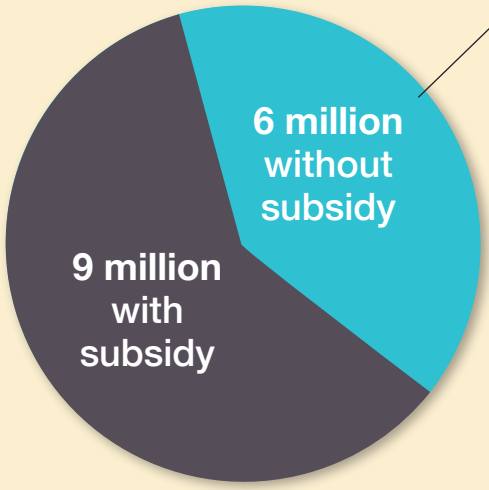
The Six Million Americans Impacted Most Directly by Premium Increases

The individual (or "nongroup") market is composed of approximately 15 million Americans.[12] Roughly 6 million individual market enrollees who do not receive subsidies are directly affected by premium rate increases. The vast majority of these individuals (approximately 75 percent) obtain insurance in the off-exchange individual market. This means they purchase directly from health plans, but they are still purchasing Affordable Care Act-compliant policies and they are all part of the "common risk pool" that serves as the basis for health plans' pricing.

The median household income estimated in the 2016 National Health Interview Survey for off-exchange consumers was approximately $75,000, compared to a median income of $66,000 for those aged 19 to 64 (regardless of coverage).[13] For many of these consumers, double-digit premium increases could lead them to drop coverage. The off-exchange market does have a somewhat higher proportion of high-income individuals — with 10 percent having an estimated household income of $200,000 or more, compared to 6 percent of all individuals regardless of coverage source — however, these are a distinct minority of those getting insurance in the individual market.

An independent review that compared off-exchange enrollees to their Marketplace counterparts in 2015 found that while off-exchange enrollees' age distributions were not meaningfully different, the off-exchange are more likely to be: (1) middle or upper-middle class; (2) college graduates; (3) male; (4) white; (5) citizens; and (6) in better self-reported health status.[14]

Figure 1: Premium Increases Directly Affect Unsubsidized Consumers



- Unsubsidized consumers have an estimated median income of $75,000, compared to $66,000 for all individuals aged 19 to 64.
- Most are NOT high income individuals and the existing premiums are struggle for many.

Total individual market of 15 million people

The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies

Potential 2019 Premium Impacts of Known Risk Factors and Uncertainty

As the regional variation in carrier participation and premium increases in 2018 shows, health care is local and what will happen in terms of carrier participation, rates and enrollment varies considerably on a state-by-state basis. Factors that affect state-specific circumstances include whether the state is supported by the FFM (and its decisions on marketing) or by a state-based marketplace (SBM) making independent investments in marketing, the state insurance-regulatory environment and what that means for potential products or policies that siphon risk out of the individual market, and other market factors. The 2019 premium impact of several policies are estimated and discussed below. All impacts are summarized in Table 2: 2019 Premium Driver Estimates and Mitigation Options.

1. **Elimination of the Individual Mandate Penalty:** The Tax Cuts and Jobs Act eliminated the individual mandate penalty, effective January 2019. In November 2017, the Congressional Budget Office estimated that elimination of the individual mandate could drive a rate increase of 10 percent on average.[15] The impact within each state will vary based on a variety of factors, including the health of the state's risk pool, carrier competition and the strength of marketing and outreach efforts. Considering these factors, we would expect variation across states with a low impact of 8 percent and a high impact of 13 percent depending on state-specific factors.

2. **Premium Increases Caused by Enrollment Reductions and Deteriorating Risk Pool (Marketing and Other Factors) in Federally Facilitated Marketplace States:** Even in the face of net premium reductions for the majority of consumers who receive premium subsidies, the FFM states in the 2018 plan year had 5 percent fewer new sign-ups compared to 2017 and a reduction of 9 percent compared to FFM enrollment in 2016 (see Table 1). The individuals who did sign up were likely less healthy on average than new enrollees in 2017. Some of the decline in enrollment is attributable to the federal decisions to reduce marketing — both at the end of the open-enrollment period for plan year 2017 and for the recently completed enrollment period. Using an assumption that the individuals who — for whatever reason — were not persuaded to sign up are on average 25 percent less costly than the average enrollee, we estimate that premiums in FFM states will increase by about 1.3 percent in 2019 due to the decreased marketing for the 2018 plan year.[16] The dollar value of this 1.3 percent premium load is about $1 billion nationally, which contrasts to the $90 million "savings" attributed to reducing marketing spending.[17] The impact in any given FFM state may vary depending on the existing risk pool in that state and the change in enrollment between 2017 and 2018. We believe states with relatively unhealthy risk pools and lower 2018 enrollment compared to 2017 could see as much as a 6.3 percent rate increase in 2019 attributable to the marketing reduction and other factors that resulted in decreases in net enrollment for plan year 2018. On the other hand, states with higher enrollment in 2018 — including some SBM states — may see a slight downward pressure of up to 2.3 percent of their 2019 rates.

3. **Impact of FFM and SBM Open Enrollment 2019 Marketing Decisions:** A continued policy of not using collected health plan user fees to promote enrollment for the 2019 plan year will likely result in lower enrollment, a worse risk mix and carriers that will price for this expectation with further increased premiums. While we note that issuers' load for lack of marketing will vary, we use an estimate of 2.6 percent, which builds on prior work on the impact of marketing on enrollment and risk mix.[18]

   According to research commissioned by Covered California, some of the impacts to reduced marketing and outreach investments for 2018 may have been offset by substantial increases in media coverage generated by proposals to repeal and replace the Affordable Care Act and administration decisions regarding open enrollment 2018. During Oct. 1, 2017, through Dec. 15, 2017, the topics of "enrollment" and "enrollment period" and "deadline" were more frequently mentioned in news articles, increasing by 53 percent, 125 percent and 129 percent, respectively, when compared to the same period last year. Past

research by Covered California has documented that both news coverage and paid advertising prompt action by consumers.[19] This increased coverage of the shorter deadline and enrollment opportunities may have partially offset the absence of national or broadcast TV advertising for healthcare.gov, but it is unlikely to continue in 2019.

4. **Association Health Plans and Short-Term, Limited-Duration Plans:** Assuming that federal regulations are finalized in time for the 2019 plan year, we estimate that Association Health Plans (AHPs) and short-term plans will result in a modest premium increase for 2019. Assuming that the individuals who leave will be 25 percent less costly than the average enrollees in the common risk pool, we estimate that AHPs and short-term plans together will increase rates between 0.3 and 1.3 percent in Affordable Care Act-compliant plans.

5. **Medical Trend:** We assume an increase in medical costs of 7 percent based on current national averages.

While actual impacts at the issuer level could vary significantly depending on state factors and policy decisions made in 2018, we estimate that the addition of the factors listed above to the expected cost of medical inflation could produce 2019 average statewide premium increases between 15.6 and 30.2 percent. We would also expect that multiple states would be at risk for having the remaining carriers exit as well as a continued increase in both the number of states or parts of states with only one issuer and the number of individuals with only one issuer from which to choose. Given the fact that areas served by only one carrier generally face higher premiums, it is likely that in many parts of the nation these estimates understate the impacts that will be felt by consumers.

Potential 2019 Premium Stabilization Actions

Plan year 2019 has the potential for significant rate increases. Federal policy action in early 2018 could significantly mitigate the potential 2019 rate increases estimated above. Funding state-based invisible high-risk pools or reinsurance programs at a nominal level of $15 billion (which would be a $5 billion cost to the federal budget after Advanced Premium Tax Credit offsets) in 2019, and the same amount in 2020 — if not made permanent — could produce an average rate reduction of 12 percent with a range of 9 to 16 percent depending on the state. Reinsurance would also likely have the effect of fostering health plan participation.[20] A restoration of marketing and outreach funding in the FFM in 2019 could lead issuers to reduce rates between 2 and 4 percent, because of their understanding that the enhanced marketing would increase the proportion of healthy individuals who will sign up for coverage. Federal spending to promote enrollment using the health plan user fee would likely have a distinctly positive return on investment. Support for marketing could be either done through national marketing and promotion sponsored by the U.S. Department of Health and Human Services (HHS), using the assessment on health plans collected for that purpose, or the same funds could be distributed to states or other local entities to promote enrollment in FFM states. And finally, an additional 1 to 3 percent rate reduction — depending on the issuer — could be achieved by reinstituting the health insurance tax holiday for 2019. These reductions would be felt most directly by the 5 to 6 million consumers who purchase individual coverage without subsidies on-exchange or in the off-exchange Affordable Care Act-compliant market.

Conclusion

Going into 2017, the individual insurance markets were largely stabilizing in terms of enrollment and issuer profitability.[21] Yet the 2018 rate increases were significantly above medical cost, and the prospects of another year of such increases raises the stakes for policies that foster a strong individual market. Year-to-year policy actions or market uncertainty leads to both wide variation in premium impacts and carrier decisions that the

market is not worth the risk. Both of these choices have negative consequences for enrollees, particularly those who do not qualify for premium subsidies. Policymakers now have a short window of time to enact stabilization measures, some of which we have described above, that could mitigate a significant share of the 2019 premium increase and may keep issuers in the individual market that would otherwise exit in the current environment.[22]

Table 2. 2019 Premium Driver Estimates and Mitigation Options

PREMIUM-INCREASE DRIVERS
Estimates reflect potential state average increases; some states and individual carriers could be higher or lower. Premium estimates reflect gross premiums; for those receiving subsidies, premium increases would likely be far less.

	Low	Medium	High
Premium Drivers on Top of Medical Trend	**8.6%**	**14.7%**	**23.2%**
Individual Mandate Premium Impact	8%	10%	13%
2018 Enrollment Change Premium Impact	-2.3%	1.3%	6.3%
2019 Ongoing Marketing Reduction Premium Impact	2.6%*	2.6%	2.6%
Short-Term and Association Health Plans	0.3%	0.8%	1.3%
Medical Trend	**7.0%**	**7.0%**	**7.0%**
Total Potential 2019 State-Level Premium Rate Increase	**15.6%**	**21.7%**	**30.2%**

OPTIONS TO MITIGATE PREMIUM INCREASES
Estimates reflect the range of how each stabilizing policy would after states based on their circumstances. The effect on premium in some states for individual carriers could be greater.

	Low	Medium	High
Reinsurance (see Covered California reinsurance analysis)	**-9%**	**-12%**	**-16%**
Gross reinsurance funding level (billions)	$12	$12	$12
Net federal cost of reinsurance	$5	$5	$5
Enhance Marketing and Outreach	**0.0%**	**-2.3%**	**-4.2%**
Health Insurance Tax Holiday	**-1.0%**	**-2.0%**	**-3.0%**

* State-based marketplaces (SBMs) that continue outreach and marketing to promote enrollment for 2019 will likely mitigate this additional premium increase driver.

This analysis was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally. This policy report is the product of the plan management and policy staff of Covered California, led by Chief Actuary John Bertko and informed by review by outside academic and policy experts. For questions, please contact Vishaal Pegany at vishaal.pegany@covered.ca.gov

[1] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE). "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange." (Oct. 30, 2017) https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf. See Table 6 on page 10, comparing change in net premiums after APTC. A recent Covered California analysis also found that the net monthly premiums for enrollees who receive financial help are on average 10 percent lower than what new and renewing consumers paid last year (https://coveredcanews.blogspot.com/2017/12/covered-california-looks-ahead-to-2019.html).

[2] Politico. "With less fanfare, Obamacare sign-ups roll to a finish." (Jan. 31, 2017). https://www.politico.com/story/2017/01/obamacare-health-care-signup-234459.

[3] Centers for Medicaid and Medicare Services. Biweekly Enrollment Snapshot for Jan 1-14, 2017. (Jan. 18, 2017). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-18.html.

[4] Centers for Medicaid and Medicare Services. Biweekly Enrollment Snapshot for Jan 24, 2016 - Feb 1, 2016. (Feb 4, 2016). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html.

[5] Centers for Medicaid and Medicare Services. Biweekly Enrollment Snapshot for Jan 15-31, 2017. (Feb 3, 2017). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-02-03.html)

[6] Centers for Medicaid and Medicare Services (Aug. 31, 2017) "CMS Announcement of ACA Navigator Program and Promotion for Upcoming Open Enrollment." https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-31-3.html. See also the CMS fact sheet: http://big.assets.huffingtonpost.com/cms-fact-sheet.pdf.

[7] Kaiser Family Foundation. "Issuer Participation on ACA Marketplaces, 2014-2018." (Nov. 10, 2017.) https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/.

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

[9] Kaiser Family Foundation. "How Premiums Are Changing In 2018." (Nov. 29, 2017) https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/.

[10] These rates include the "CSR surcharge" that resulted in increased premium tax credits, meaning the net premium went down for many subsidy eligible individuals.

[11] ASPE Research Brief. "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange." (Oct. 30, 2017) https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.

[12] It is difficult to obtain administrative data about the entire individual market. For this analysis, we estimate the size of the market based on 2016 enrollment data based on Centers for Medicaid and Medicare Services (CMS) data releases. The reports suggest that in 2016 there were roughly 14.3 million enrollees in the single risk pool, which does not include enrollees in Massachusetts or Vermont, or the individual market enrollees in plans that are not part of the single risk pool (e.g. "grandfathered" plans). CMS reports that approximately 10 million were enrolled on-exchange, with about 8.4 million receiving tax credits. For total single risk pool size and average monthly enrollment, see Centers for Medicaid and Medicare Services, Center for Consumer Information and Insurance Oversight (2017). "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year." (June 30, 2017): https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf. For on-exchange and tax credit average monthly enrollment for 2016, see Centers for Medicaid and Medicare Services (2017). "Effectuated Enrollment Snapshot." (June 12, 2017): https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf.

[13] National Health Interview Survey (NHIS) 2016, using Lynn A. Blewett, Julia A. Rivera Drew, Risa Griffin, Miram L. King, and Kari C. W. Williams. IPUMS Health Surveys: National Health Interview Survey, Version 6.2. Minneapolis: University of Minnesota, 2016. http://doi.org/10.18128/D070.V6.2. Datasets available at http://www.nhis.ipums.org. Due to high rates of missing data for income in the NHIS, for this analysis we relied on the NHIS imputed income point estimates, and all analyses were restricted to ages 19 to 64 (inclusive). See Division of Health Interview Statistic, National Center for Health Statistics (2016). "Multiple Imputation of Family Income and Personal Earnings in the National Health Interview Survey: Methods and Examples." Available at: https://www.cdc.gov/nchs/data/nhis/tecdoc15.pdf.

[14] Goddeeris, John, Stacey McMorrow and Genevieve Kenney. 2017. "Off-Marketplace Enrollment Remains An Important Part of Health Insurance Under the ACA." Health Affairs. 36(8): 1489-1494.

[15] Congressional Budget Office. "Repealing the Individual Health Insurance Mandate: An Updated Estimate." (November 2017.) https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

[16] Covered California. "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets." (September 2017.) http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf. See page 21 for a discussion of the relationship between marketing, individuals' health status and enrollment.

[17] This number was derived as follows: The 2016 actual aggregate individual market gross premiums of $49 billion was inflated by 48 percent, which was the average rate change reported by ASPE for the lowest-cost marketplace plan between the 2016 and 2018 plan years (see Table 4, page 8). This calculated to $72 billion, which was then inflated by a 7 percent medical trend to equal $78 billion. We then multiplied 1.3 percent by $78 billion. This method is a conservative estimate as we modeled it based on the rate change for the lowest-cost plan.

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

[19] NORC (2015) "Final Report: Covered California – Overview of Main Findings from the Third California Affordable Care Act Consumer Tracking Survey. (October 22, 2015) http://hbex.coveredca.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf

[20] For a description of potential ways to structure financial support for state-based invisible high-risk pools or reinsurance, see "Reducing Premiums and Maximizing the Stabilization of Individual Markets for 2019 and Beyond: State Invisible High-Risk Pools/Reinsurance." http://hbex.coveredca.com/data-research/library/CoveredCA_Reducing_Premiums_1-10-18.pdf.

[21] Kaiser Family Foundation. "Individual Insurance Market Performance in Late 2017." (Jan. 4, 2018.) https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-late-2017. S&P Global Ratings. "The U.S. ACA Individual Market Showed Progress in 2016 But Still Needs Time to Mature." (April 7, 2017.) https://www.spglobal.com/our-insights/The-US-ACA-Individual-Market-Showed-Progress-In-2016-But-Still-Needs-Time-To-Mature.html.

[22] We note that this estimate does not take into account the potential premium impacts of restoration of direct funding for cost-sharing reductions. In particular, unsubsidized enrollees in states that did not take mitigating actions by encouraging the CSR premium increases to be loaded on the Silver plans could see a significant rate reduction in 2019. But for most consumers in most states, the restoration of direct funding of cost-sharing reductions would likely have little, if any, impact (depending on state and carrier pricing to protect consumers).

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Individual Market Stabilization Proposals Should Avoid Raising Costs for Consumers

Proposals Should Also Address Greatest Risks to the Market

By Aviva Aron-Dine

Policymakers of both parties have resumed discussions about legislation to strengthen the individual market for health insurance, reportedly with the goal of reaching an agreement by March 23, the deadline for Congress to pass new appropriations legislation.[1] A starting point for these discussions has been two bipartisan bills negotiated last fall: legislation introduced by Senators Lamar Alexander and Patty Murray that would restore cost-sharing reduction (CSR) payments to insurers, among other changes, and legislation introduced by Senators Susan Collins and Bill Nelson that would provide federal funding for state reinsurance programs.[2] But the health insurance landscape has shifted since last year, and simply adopting last year's bipartisan bills, without significant changes, would do more harm than good.

Since these proposals were initially negotiated, there have been a number of important developments:

- Congress repealed the Affordable Care Act's (ACA) individual mandate (the requirement that most people have health insurance or pay a penalty) beginning in 2019. By reducing incentives for healthier people to sign up for coverage, repeal of the mandate will weaken the individual market risk pool, raise premiums, and increase the number of uninsured.
- The Trump Administration has proposed new regulations that would further weaken the individual market risk pool and increase premiums. Most significant, it is proposing to let insurers offer "short-term" health plans lasting up to one year that are exempt from the ACA's consumer protections, including its prohibition on discrimination based on pre-existing conditions and its requirement to cover essential health benefits.

[1] Adam Cancryn and Jennifer Haberkorn, "Alexander, Murray Aim to Wrap Obamacare Stabilization Into Spending Deal," Politico, February 28, 2018.

[2] The Alexander-Murray Bipartisan Health Care Stabilization Act of 2017 is available at https://www.help.senate.gov/download/bill-text-; the Collins-Nelson Lower Premiums through Reinsurance Act of 2017 is available at https://www.congress.gov/bill/115th-congress/senate-bill/1835/text.

- The market has largely adjusted to the Trump Administration's decision to end CSR payments, and the transition went considerably more smoothly than many experts anticipated. Ironically, ending CSR payments has helped the market weather some of the Administration's other harmful actions. That's because, as explained below, eliminating CSR payments resulted in increased subsidies for many consumers, making coverage more affordable and more attractive.

The sponsors of last year's bipartisan stabilization bills generally agreed that the goals of the legislation were to make coverage more affordable for consumers, including by strengthening the individual market risk pool, and to maintain or increase consumer choice, including by encouraging insurers to participate in the market. In adapting last year's bills to the current environment, policymakers must meet three tests to advance these goals.

- **Avoid making coverage more expensive for moderate-income consumers.** Now that the market has adapted to the Administration's decision not to pay CSRs, restoring these payments — without compensating adjustments in consumer subsidies, as Senator Murray has proposed — would increase premiums or cost sharing for up to 3.3 million moderate-income consumers (up to 36 percent of all HealthCare.gov consumers), in many cases by over $1,000 per year. In addition to the direct harm to those affected, making coverage less affordable would likely decrease enrollment, further weakening the individual market risk pool and compounding the damage from mandate repeal.

  Meanwhile, the reinsurance funding that the Collins-Nelson bill would provide would be beneficial on its own, but House Republicans are reportedly proposing to offset its cost by restoring CSRs.[3] To be sure, such a package would make coverage more affordable for people with incomes above 400 percent of the poverty level. But it would do so *at the expense* of those with incomes below 400 percent of the poverty level — a harmful and unnecessary tradeoff.

- **Address the greatest risks to the individual market.** Without changes, neither Alexander-Murray nor Collins-Nelson would address the most serious outstanding threat to the individual market, the Administration's recent regulatory actions expanding insurance plans that operate outside the ACA's rules and protections. The short-term plans rule, in particular, may not only raise premiums but also risks leading some insurers to pull out of the individual market. Failing to block the proposed expansion of short-term plans would result in a "stabilization" package that ignores the major near-term risk to individual market stability.
- **Avoid weakening consumer protections or coverage.** The Administration is reportedly demanding that any stabilization bill include a measure allowing insurers to charge older people higher premiums. There is also a risk that policymakers may seek to offset the cost of federal reinsurance funding with policies that would make it harder for individual market consumers to access or maintain coverage, such as those House Republicans proposed as offsets for children's health coverage last year. But a stabilization bill should not be used as a vehicle for policy changes or offsets that would weaken the ACA's protections for people with serious health needs or make it harder to access coverage. Not only would such changes directly harm those affected, some could undermine the goals of a stabilization bill. Policies

[3] Peter Sullivan, "GOP Eyes Budget Maneuver to Pay for ObamaCare Funds," *The Hill*, March 1, 2018, http://thehill.com/policy/healthcare/376145-gop-eyes-budget-maneuver-to-pay-for-obamacare-funds.

that make it harder for people to enroll in coverage tend to disproportionately discourage healthier consumers, worsening the individual market risk pool and increasing premiums.

Beyond these principles, there are larger opportunities to build on the ACA's progress in expanding coverage, improving affordability, and strengthening consumer protections, as a number of recently introduced bills aim to do.[4] But whether a limited, bipartisan stabilization bill advances the goal of strengthening the individual market will depend on whether it meets the tests above.

Avoid Making Coverage Less Affordable for Moderate-Income Consumers

This principle might seem non-controversial: policymakers of both parties agree that the goal of a stabilization bill is to make coverage more affordable, not less. Yet, one of the major proposals on the table — restoring CSR payments to insurers — would result in higher premiums, higher cost sharing, or both for millions of moderate-income consumers. That's because the Trump Administration's decision to stop these payments has had the effect of making coverage more affordable for many consumers who are eligible for premium tax credits.

Under the ACA, insurers are required to provide reduced cost sharing (lower deductibles, co-pays, and coinsurance) to lower-income consumers who enroll in "silver" tier marketplace plans; CSR payments are supposed to compensate insurers for providing this reduced cost sharing. With the Administration having halted these payments, insurers in most states are instead defraying their costs by charging higher silver plan premiums (a practice referred to as "silver loading").

Because of the structure of the ACA's subsidies, that shift in how insurers are compensated for cost-sharing assistance results in more affordable coverage options for many consumers. The ACA's premium tax credits are based on the "sticker price" premium of a typical silver plan where a person lives, but consumers can also use these tax credits to purchase bronze (lower sticker price, higher deductible) or gold (higher sticker price, lower deductible) plans. Their net premium is the difference between the sticker price premium for the plan they select and their tax credit.[5] Because of the Administration's decision to halt CSR payments, silver plan premiums — and therefore premium tax credits — increased more rapidly than bronze or gold plan premiums for 2018. The result is that

[4] For example, one bill introduced this week would improve and expand subsidies and prevent expansions of sub-standard plans (the Undo Sabotage and Expand Affordability of Health Insurance Act of 2018, H.R. 5155); another would extend the ACA's major consumer protections to short-term plans, going beyond reversing the Trump Administration's proposed regulation (the Fair Care Act, S. 2494); and a third would improve premium tax credits for young adults (the Advancing Youth Enrollment Act).

[5] Silver plans have an "actuarial value" of about 70 percent, meaning that, on average, 70 percent of total covered health costs are paid for by the insurance plan and 30 percent by consumer cost sharing (deductibles, coinsurance, and co-pays). Bronze plans have an actuarial value of about 60 percent, while gold plans have an actuarial value of about 80 percent. (Consumers can also select platinum plans, with an actuarial value of about 90 percent, but these are significantly less common.) For 2018, deductibles average $6,002 in bronze plans, $4,034 in silver plans (for consumers not eligible for additional cost sharing assistance), and $1,194 in gold plans. Kaiser Family Foundation, "Cost-Sharing for Plans Offered in the Federal Marketplace for 2018," November 3, 2017, https://www.kff.org/health-reform/fact-sheet/cost-sharing-for-plans-offered-in-the-federal-marketplace-for-2018/.

many subsidized consumers can now purchase bronze plans with very low net premiums, or can purchase lower-deductible gold plans for less than they paid last year for silver plans.[6]

Most consumers with incomes below 200 percent of the poverty line are still better off purchasing silver plans, because that lets them take advantage of the generous cost-sharing assistance they are eligible for in those plans. But people who are eligible for tax credits but not for significant cost-sharing assistance — those with incomes between 200 and 400 percent of the poverty line (about $24,000 to $48,000 for a single adult) — can now purchase plans with lower premiums, lower cost sharing, or both, as a result of the Administration's decision. Meanwhile, unsubsidized consumers can largely avoid the premium increases resulting from that decision by purchasing bronze or gold or, in most states, by purchasing silver plans outside of the ACA marketplaces. (In most states, insurers increased premiums only for *marketplace* silver plans to account for the loss of CSRs, leaving similar plans offered outside the marketplaces unaffected.) Even before the Administration's decision to end CSR payments, most unsubsidized ACA individual market consumers enrolled outside of the marketplaces, and the majority of on-marketplace unsubsidized consumers enrolled in non-silver plans.

This dynamic was understood prior to the Administration's decision to stop CSR payments, with the Department of Health and Human Services, Urban Institute researchers, the Congressional Budget Office (CBO), and others all predicting that ending CSR payments would *ultimately* reduce costs for consumers.[7] But most experts predicted an extended and disruptive transition before those gains would be realized. For example, CBO forecast that halting CSR payments would result in "about 5 percent of people liv[ing] in areas that would have no insurers in the nongroup market in 2018." The bipartisan Alexander-Murray bill, introduced about a week after the Administration's decision, aimed to restore CSR payments quickly enough to avoid these consequences.

But Senate leadership declined to bring the Alexander-Murray bill to a vote at that time. And — thanks in large part to state regulators' timely intervention — the market adjusted to the loss of CSRs more quickly and smoothly than most experts anticipated. Insurers in states accounting for about 85 percent of marketplace enrollees incorporated the loss of CSRs into their silver plan

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[6] See for example 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/; Emily Gee, "Health Insurance Marketplaces Offer More Low-Cost Options Than Ever Before," November 1, 2017, https://www.americanprogress.org/issues/healthcare/reports/2017/11/01/441915/health-insurance-marketplaces-offer-more-low-cost-options-than-ever-before/; and Hannah Recht, "For Many Obamacare Enrollees, 2018 Will Be Cheapest Year Ever," October 31, 2017, https://www.bloomberg.com/graphics/2017-marketplace-premiums-affordable/?utm_content=graphics&utm_campaign=socialflow-organic&utm_source=twitter&utm_medium=social&cmpid%3D=socialflow-twitter-graphics.

[7] Department of Health and Human Services Assistant Secretary for Planning and Evaluation, "Potential Fiscal Consequences of Not Providing CSR Reimbursements," December 2015, https://aspe.hhs.gov/system/files/pdf/156571/ASPE_IB_CSRs.pdf; Linda J. Blumberg and Matthew Buettgens, "The Implications of a Finding for the Plaintiffs in House v. Burwell," Urban Institute, January 26, 2016, https://www.urban.org/research/publication/implications-finding-plaintiffs-house-v-burwell; and Congressional Budget Office, "The Effects of Terminating Payments for Cost-Sharing Reductions," August 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf.

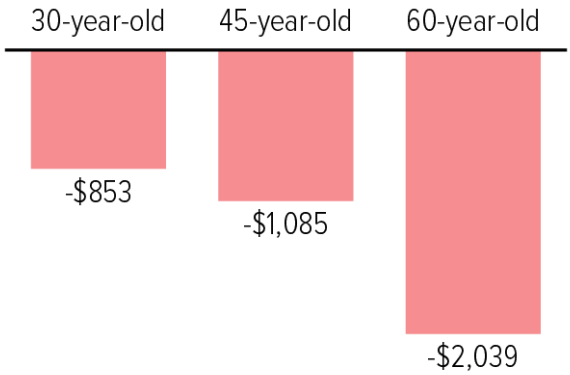
premiums for 2018, and more states will likely follow this approach for 2019.[8] Contrary to concerns about bare counties, consumers everywhere in the country have 2018 coverage options through the marketplace.

Now that the market has adjusted to the loss of CSRs, restoring these payments — without compensating improvements in subsidies — would have significant adverse effects for consumers. Based on 2017 enrollment patterns, between 1.6 million and 3.3 million consumers in HealthCare.gov states — or between 18 percent and 36 percent of all marketplace consumers in these 39 states — could face higher costs if CSR payments are restored next year.[9] (See the appendix for an explanation of these estimates and state-by-state data.)

FIGURE 1

Moderate-Income Consumers Benefit From Non-Payment of Cost Sharing Reductions

Estimated reduction in premiums for typical subsidy-eligible consumers buying bronze or gold plans in 2018



Source: CBPP calculations based on average HealthCare.gov benchmark premiums and Kaiser Family Foundation projected impact of loss of CSR payments

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And the amounts at stake are sizable. Based on Kaiser Family Foundation estimates of the impact of CSRs on silver plan premiums, the Administration's cut-off of CSRs is saving a typical subsidy-eligible 45-year-old $1,085 in premiums this year, provided that he or she purchases either a bronze or gold plan.[10] Savings are larger for older people, who face higher base premiums; for example, a typical subsidy-eligible 60-year-old is saving $2,039 this year, and would see a premium increase of similar magnitude next year if CSR payments were restored. (See Figure 1.) CBO estimated that halting CSR payments would cost the federal government more than $10 billion per year, and the

[8] Sabrina Corlette, Kevin Lucia, and Maanasa Kona, "States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments," Commonwealth Fund, October 27, 2017, http://www.commonwealthfund.org/publications/blog/2017/oct/states-protect-consumers-in-wake-of-aca-cost-sharing-payment-cuts.

[9] Caitlin Owens, "More Losers Than Winners If Congress Funds Disputed ACA Program," Axios, January 29, 2018, https://www.axios.com/winners-and-losers-under-the-aca-market-stabilization-ill-1516912820-703db250-7bd1-4869-a941-2966416ebb85.html. For an explanation of these estimates and the comparable state-by-state estimates, see the appendix.

[10] Estimates reflect average HealthCare.gov benchmark premiums, as reported by the Department of Health and Human Services, and Kaiser's estimate that silver plan premiums would increase 19 percent due to loss of CSRs: Kaiser Family Foundation, "Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19 Percent to Compensate for Lack of Funding for Cost-Sharing Subsidies," April 6, 2017, https://www.kff.org/health-reform/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/. Kaiser's estimate is in line with the observed gap between benchmark silver and the lowest-cost bronze plans in 2018 (20 percentage points) and with CBO's projected increase in silver plan premiums due to loss of CSRs in 2018 (20 percent).

Administration is touting the federal savings that would result from reversing its decision.[11] But these savings would come from reducing total subsidies (tax credits plus cost-sharing assistance), and therefore increasing total costs, for moderate-income consumers.[12]

Of course, halting CSR payments was not anyone's preferred strategy for making coverage more affordable for consumers. Among other problems, the resulting affordability improvements are inconsistent across and within states, depending on state actions and insurer pricing decisions, and many consumers were likely confused about what plan they should select given premium changes, although consumers are likely to understand their options better with time.

Senator Murray has proposed a preferable alternative, in which CSR payments would be restored, but the federal savings would be used to directly improve affordability for moderate-income consumers.[13] For example, legislation restoring CSR payments could expand and improve cost-sharing assistance for people with incomes between 200 and 400 percent of the poverty line, ensuring that these consumers retain access to more affordable, lower-deductible plans even if premium tax credits fall. Or, it could increase premium tax credits, for example, by basing them on the cost of gold rather than silver plan coverage, maintaining the higher subsidies resulting from silver loading, but with more consistent increases across the country. (Bills taking these approaches have been introduced in both the House and Senate.[14])

Absent such an approach, however, restoring CSR payments would likely harm millions of people. It would also undermine the goals of stabilization legislation by harming the individual market risk pool. This year, higher subsidies helped make up for the Trump Administration's outreach cuts and other actions undermining the marketplaces, contributing to keeping total marketplace enrollment nearly stable despite unprecedented challenges.[15] Shrinking subsidies next year would likely lead to lower enrollment, especially among healthier people, compounding the damage from individual mandate repeal.

Of particular importance, using the savings from restoring CSR payments to pay for federal reinsurance funding — as House Republicans are reportedly contemplating — would be a harmful

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[11] Caitlin Owens and Jonathan Swan, "OMB: Funding Insurer Subsidies Will Lower ACA Premiums 15-20%," Axios, March 6, 2018, https://www.axios.com/white-house-aca-subsidies-lower-premiums-1520352713-cf2b15f9-9d5e-4e1b-b736-23cfc15cef67.html.

[12] These estimates predate repeal of the individual mandate; updated estimates would likely be lower but still show sizable increases in subsidies from the Administration's decision.

[13] Caitlin Owens, "Democrats Want to Increase ACA Subsidies in Stabilization Bill," Axios, February 7, https://www.axios.com/democrats-want-to-increase-aca-subsidies-in-stabilization-b-1518018808-cde0887d-1bf2-4f17-b634-b94778e276be.html.

[14] H.R. 5155 (https://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Bill%20Text_0.pdf) would restore CSRs while also increasing both tax credits and cost sharing assistance for subsidized consumers who would otherwise lose from ending silver loading; S. 1462 (https://www.congress.gov/bill/115th-congress/senate-bill/1462/text) would increase cost-sharing assistance.

[15] Aviva Aron-Dine and Tara Straw, "The Outlook for Marketplace Open Enrollment," Center on Budget and Policy Priorities, October 31, 2017, https://www.cbpp.org/research/health/the-outlook-for-marketplace-open-enrollment.

and unnecessary transfer of resources from people below 400 percent of the poverty line to people at higher income levels.[16] On their own, well-designed proposals for federal reinsurance funding would strengthen the individual market: by reimbursing insurers for some of the costs associated with high-cost enrollees, reinsurance allows them to charge lower premiums.[17] But because reinsurance lowers *sticker price* premiums, it only helps the minority of individual market consumers with incomes too high to qualify for subsidies — not those with incomes below 400 percent of the poverty level, who are eligible for premium tax credits. For consumers qualifying for tax credits, net premiums are determined based on their income, and the premium tax credits adjust automatically to make up the difference between the percentage of income the consumer is expected to pay for premiums and the sticker price. This means that, if a reinsurance program lowers sticker price premiums, premium tax credits will decline accordingly, and the amount subsidized consumers pay in net premiums will stay the same. These consumers would see no benefit from reinsurance, but would lose from reinstating CSR payments to offset a reinsurance program's cost.

Restoring CSRs and using the resulting federal savings to fund reinsurance would thus entail cutting subsidies for people below 400 percent of the poverty line to pay for lowering premiums for people with incomes above those levels. Of course, many middle-income consumers also face challenges paying premiums. But assistance for these consumers should not come at the expense of people at lower income levels, who also face serious affordability challenges.

Address the Greatest Risks to the Individual Market

Stabilization legislation will also fail to achieve its goals if it ignores the greatest outstanding risk to the individual market: the Administration's recent executive actions.

As of 2017, the ACA individual market was on track for greater price stability and competition going forward. After experiencing losses for 2014 through 2016 and increasing premium significantly for 2017, insurers were on track to break even or better on their individual market business, with recent data showing loss ratios in line with or lower than pre-ACA levels.[18] Marketplace enrollment remained robust despite the premium increases, with 12.2 million people signing up for 2017 plans (only slightly below the previous year).[19] And average 2017 individual market premiums were similar to average premiums for comparable employer market coverage,

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[16] Peter Sullivan, "GOP Eyes Budget Maneuver to Pay for ObamaCare Funds," *The Hill*, March 1, 2018, http://thehill.com/policy/healthcare/376145-gop-eyes-budget-maneuver-to-pay-for-obamacare-funds.

[17] Sarah Lueck, "Policymakers Should Craft Reinsurance Proposals to Lower Premiums, Help More People," Center on Budget and Policy Priorities, February 8, 2018, https://www.cbpp.org/blog/policymakers-should-craft-reinsurance-proposals-to-lower-premiums-help-more-people.

[18] Matthew Fiedler, "Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market Through 2017," Brookings Institution, October 27, 2017, https://www.brookings.edu/research/taking-stock-of-insurer-financial-performance-in-the-individual-health-insurance-market-through-2017/, and Cynthia Cox, Ashley Semanskee, and Larry Levitt, "Individual Insurance Market Performance in Late 2017," Kaiser Family Foundation, January 4, 2018, https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-late-2017/.

[19] While complete data are not available, it's likely that off-marketplace individual market enrollment fell more than marketplace enrollment. However, the significant improvement in insurer financial performance in 2017 indicates that enrollment did not fall enough to significantly impact the risk pool.

indicating that 2017 increases brought individual market premiums roughly in line with underlying market-wide health care costs.[20]

Absent policy changes, improving finances for insurers should have translated into slower premium growth for consumers in 2018, keeping individual market premiums in line with employer premiums.[21] Instead, policy actions and the uncertainty created by multiple attempts to repeal the ACA contributed to another year of high premium increases and insurer market exits.[22] The repeal of the individual mandate will likely result in additional premium increases in 2019 that also could have been avoided.

Yet even with the mandate repealed, the individual market is showing some positive signs for 2019. For example, Anthem, a major insurer that withdrew from a number of state markets last year, recently indicated that it is considering re-entering them, and Wellmark, a major Iowa insurer whose exit from Iowa's market caused significant concern last year, has announced that it will re-enter, assuming there aren't additional "significant changes to the Affordable Care Act."[23] While premiums will be higher than they would have been without harmful policy actions, these statements point to continued market stability and suggest that consumer choice might even increase.

The Administration's new rules threaten this progress. Most damaging to the individual market, the Administration is proposing to allow insurers to sell "short-term, limited duration" health plans lasting up to 364 days. Short-term plans are exempt from the ACA's consumer protections, which means that these plans can deny coverage or charge higher premiums to people with pre-existing conditions; exclude essential health benefits such as maternity care, mental health and substance use treatment, and prescription drugs; and impose annual and lifetime limits on benefits. If finalized, the proposed rule would in effect allow a parallel insurance market — governed by pre-ACA rules — to operate alongside the ACA market, similar to the approach proposed by Senator Ted Cruz and rejected by Congress during the ACA repeal debate last year.[24]

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[20] John Holahan *et al.*, "The Evidence on Recent Health Care Spending Growth and the Impact of the Affordable Care Act," Urban Institute, May 2017, https://www.urban.org/sites/default/files/publication/90471/2001288-the_evidence_on_recent_health_care_spending_growth_and_the_impact_of_the_affordable_care_act.pdf.

[21] See for example Kurt Giesa, "Analysis: Market Uncertainty Driving ACA Rate Increases," Oliver Wyman, June 14, 2017, http://health.oliverwyman.com/content/oliver-wyman/hls/en/transform-care/2017/06/analysis_market_unc.html.

[22] For insurer and state regulator statements attributing 2018 premium increases and market exits to policy actions and uncertainty, see Protect Our Care, "New Report: Vast Majority of States Attribute Health Insurance Rate Increases to Trump Sabotage," October 5, 2017, https://medium.com/@protectourcare2017/new-report-vast-majority-of-states-attribute-health-insurance-rate-increases-to-trump-sabotage-e37250c8009c and Center on Budget and Policy Priorities, "Sabotage and Uncertainty Jeopardizing ACA Marketplaces, Insurers and Regulators Confirm," https://www.cbpp.org/sabotage-and-uncertainty-jeopardizing-aca-marketplaces-insurers-and-regulators-confirm.

[23] Anthem Quarterly Earnings Call, January 29, 2018, https://seekingalpha.com/article/4141685-anthems-antm-ceo-gail-boudreaux-q4-2017-results-earnings-call-transcript and "Wellmark Commits to Re-Entering ACA Market in Iowa in 2019," February 8, 2018, https://www.wellmark.com/about/newsroom/2018/02/08/wellmark-commits-to-re-entering-the-aca-market-in-iowa-in-2019.

[24] For additional detail, see Sarah Lueck, "Trump Proposal Expanding Short-Term Health Plans Would Harm Consumers," Center on Budget and Policy Priorities, February 20, 2018, https://www.cbpp.org/blog/trump-proposal-expanding-short-term-health-plans-would-harm-consumers.

The expansion of short-term plans will be harmful to some of the people who buy them, who then find themselves without coverage they need when they become seriously ill. But it will also harm people seeking comprehensive health plans in the ACA individual market. Because short-term plans can charge different rates based on health status and exclude the medical services needed by people with serious health conditions, they will be able to offer cheaper coverage to healthy people, pulling them out of the ACA risk pool. The Urban Institute estimates that the short-term plans rule will reduce the number of people purchasing comprehensive individual market coverage by 2.1 million, shrinking the ACA market in affected states by an average of almost 20 percent.[25] (See Figure 2.) Those dropping coverage will be healthier than average, raising average costs and premiums for those remaining in the ACA market.[26] This will make coverage less affordable — or unaffordable — for middle-income people with pre-existing conditions, for whom short-term plans won't be a viable option, but who also aren't eligible for marketplace subsidies that would shield them from premium increases.

Potentially even more damaging, the short-term plans rule significantly increases uncertainty about the individual market risk pool, making it more difficult for insurers to predict costs and set prices. While the Urban Institute's analysis provides a best estimate of the number of people who will exit the ACA individual market in 2019, there is considerable uncertainty about how attractive short-term plans will be to consumers and how quickly the market for these plans will ramp up. Insurers will have to predict these outcomes for every market they participate in, while also forecasting how much healthier than average short-term plan enrollees will be. (This uncertainty comes on top of uncertainty created by repeal of the individual mandate.)

Under plausible assumptions, the short-term plans rule could raise average per-enrollee costs in the ACA market in the near term from less than 5 percent to 25 percent.[27] Faced with such substantial uncertainty — and the associated risk of substantial losses — some insurers may opt to protect themselves by pricing for the high end of the range, even if they expect costs will likely be lower. There is also a risk that some might decide to simply exit the ACA individual market until they see how things play out. As the Urban Institute study notes, "insurers will by necessity reexamine the profitability of remaining in the [ACA] compliant markets. This may well lead to more insurer exits from the compliant markets in the next years, reducing choice for the people remaining and ultimately making the markets difficult to maintain." Even the Administration's own analysis of the proposed rule raised this concern, noting "this proposed rule may further reduce choices for individuals remaining in [the] individual market single risk pool."[28]

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[25] Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "The Potential Impact of Short-Term, Limited Duration Policies on Insurance Coverage, Premiums, and Health Spending," Urban Institute, February 2018, https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf. The 2.1 million people dropping coverage also include those who are priced out of the market and become uninsured.

[26] Urban estimates that the combination of repeal of the individual mandate and the short-term plans rule will cause an 18 percent premium increase in affected states.

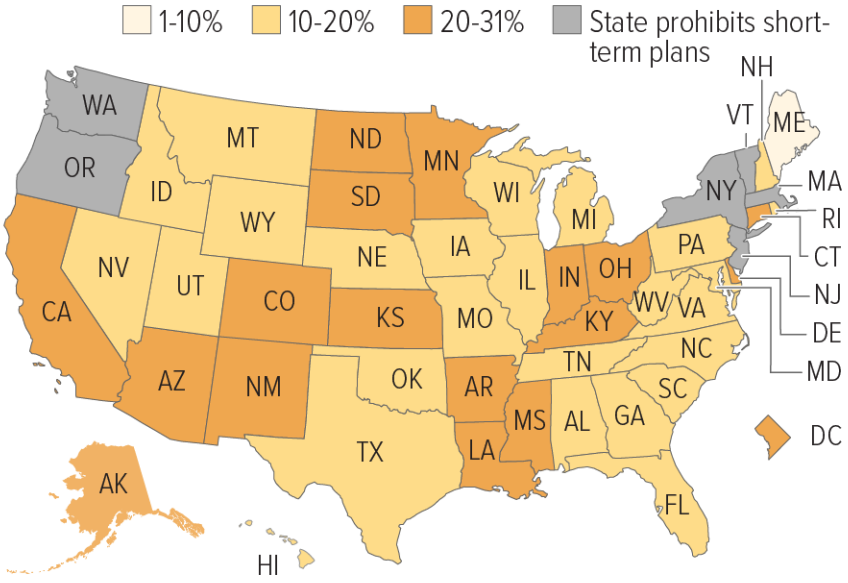
[27] The low (high) end of this range assumes that 25 (75) percent of unsubsidized ACA individual market enrollees purchase short-term plans and that those exiting the ACA market have average costs 25 (50) percent below those who stay. These calculations assume that about 55 percent of current ACA individual market enrollees are subsidized.

[28] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-03208.pdf

FIGURE 2

Trump Proposal to Expand Short-Term Plans Will Shrink ACA Individual Market Enrollment

Projected drop in Affordable Care Act individual market enrollment due to proposed rule to expand short-term, limited-benefit plans, 2019



Source: Urban Institute

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The Administration's proposal to expand Association Health Plans (AHPs) would create similar problems, although the impact on the individual market likely would be smaller. As with the short-term plans proposed rule, the proposed AHP rule would give insurers more latitude to offer plans not subject to ACA rules, including to small businesses and self-employed individuals. While short-term plans are likely to be the more attractive options for healthy consumers seeking cheaper, limited-benefit plans, growth in AHPs may disrupt the individual market in states that have taken or take steps to prevent the expansion of short-term plans, or where associations aggressively recruit individual market enrollees. It may also disrupt states' small group markets.[29] (Some provisions of the Administration's proposed 2019 Notice of Benefit and Payment Parameters, the annual rule updating provisions governing the ACA marketplaces, could also harm the individual market risk pool, for example by imposing new verification requirements that make it harder for consumers to maintain coverage.)

Any stabilization bill that fails to address the proposed expansion of non-ACA-compliant plans will leave the greatest new risk to the individual market untouched. Notably, simply providing reinsurance funding would *not* address the uncertainty and risk of insurer exits from the proposed

[29] See Sarah Lueck, "Trump Rule on Association Health Plans Could Devastate Small-Group Markets," Center on Budget and Policy Priorities, January 5, 2018, https://www.cbpp.org/blog/trump-rule-on-association-health-plans-could-devastate-small-group-markets.

short-term plans rule. While reinsurance relieves insurers of some of the costs associated with high-cost enrollees, to set premiums insurers still must be able to predict how many people — including how many healthier people — will enroll. Thus, a reinsurance program does not change the fact that insurers will be at risk of large losses if their assumptions about how many people (and how many healthy people) will leave the market in response to the expansion of short-term plans (or AHPs) prove too sanguine.

Avoid Weakening Consumer Protections or Coverage

A final important principle for a stabilization package is simple: do no harm. Despite challenges, 11.8 million people signed up for 2018 coverage through the ACA marketplaces; millions more purchase comprehensive coverage subject to ACA rules and protections outside the marketplaces. More than 80 percent of marketplace consumers describe themselves as satisfied or very satisfied with their coverage, and many say it allows them to access critical health care they could not otherwise afford.[30] A stabilization package should not be an excuse to undo the coverage gains or improvements in coverage quality achieved under the ACA.

While the Alexander-Murray bill included various compromise provisions in addition to reinstating CSRs, and some elements raised concerns, these provisions retained the ACA's core consumer protections and did not reduce coverage.[31] Now, however, some policymakers and outside interests are attempting to modify the Alexander-Murray and Collins-Nelson bills in ways that would violate those basic criteria.

In particular, policymakers should resist efforts to:

- **Use reinsurance funding to open the door to high-risk pools.** Some reinsurance proposals appear to let states use the federal reinsurance funds for high-risk pools, which segregate people with high-cost conditions into separate insurance markets or plans rather than pooling risks. That approach has a very poor track record: prior to the ACA, high-risk pools generally offered limited, unaffordable coverage or were not accessible to many people.[32] Other members of Congress have proposed letting states operate "invisible high-risk pools," under which insurers are compensated for insuring people with high-cost conditions, rather than based on the actual costs of high-cost enrollees. In some cases (though not all),

[30] 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?" Commonwealth Fund, September 2017, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/sep/collins_2017_aca_tracking_survey_ib_v2.pdf and Commonwealth Fund, "Affordable Care Act Tracking Survey," http://acatracking.commonwealthfund.org/.

[31] Center on Budget and Policy Priorities, "Greenstein: Alexander-Murray Agreement an Important Step Toward Bipartisanship on Health Care," October 18, 2017, https://www.cbpp.org/press/statements/greenstein-alexander-murray-agreement-an-important-step-toward-bipartisanship-on.

[32] See Sarah Lueck, "Policymakers Should Craft Reinsurance Proposals to Lower Premiums, Help More People," Center on Budget and Policy Priorities, February 8, 2018, https://www.cbpp.org/blog/policymakers-should-craft-reinsurance-proposals-to-lower-premiums-help-more-people.

such programs require applicants to provide health status information before enrolling in coverage, creating barriers to signing up for plans.

- **Use a stabilization bill as a vehicle to weaken consumer protections.** For example, the Administration is reportedly arguing that a stabilization bill "must… include" changes allowing insurers to charge higher premiums to older adults and codify the expansion of short-term health plans.[33] The Administration and other policymakers are also seeking to use stabilization legislation as a vehicle for new, unrelated restrictions dealing with abortion services.
- **Offset the cost of federal reinsurance funding by making it harder for people to get health coverage.** Some members of Congress have sought to pay for other health care policies by making it harder for people to obtain or maintain coverage through the ACA marketplaces. Last year, for example, House Republicans proposed to pay for extending funding for children's health coverage and community health centers in part by shortening the "grace period" during which marketplace enrollees can catch up on past-due premiums, a change that would have caused up to 688,000 people to lose coverage.[34]

  Not only would such proposals directly harm those affected, but some could undermine the goals of a stabilization bill. Policies that make it harder for people to enroll in coverage tend to disproportionately discourage healthier consumers, worsening the individual market risk pool and thus increasing premiums.

[33] Paul Demko, "White House Seeks Controversial Policies in ACA Stabilization Package," Politico, March 6, 2018.

[34] Tara Straw, "Up to 688,000 Would Lose Insurance Under House Bill," Center on Budget and Policy Priorities, October 31, 2017, https://www.cbpp.org/blog/up-to-688000-would-lose-insurance-under-house-bill.

Appendix: Consumers Facing Higher Costs if CSR Payments Are Reinstated

As discussed in the main text, many subsidized consumers will face higher costs if CSR payments are reinstated. How many consumers fall into this category depends on how many subsidy-eligible consumers will enroll in non-silver plans in 2019, assuming silver loading continues.

The best available proxy for that number comes from 2017 enrollment data. (2017 is the latest year for which the Centers for Medicare & Medicaid Services has released detailed enrollment data by income and plan tier.[35] These data are only available for the 39 states using the HealthCare.gov eligibility and enrollment platform, and so this analysis is limited to these states, which account for about three-quarters of marketplace consumers.)

Nationwide, 1.6 million subsidized consumers, or 18 percent of all HealthCare.gov consumers, enrolled in non-silver plans (this was before the Administration's decision not to pay CSRs increased silver plan premiums). This presumably represents a lower bound on the number of consumers who would enroll in non-silver plans once silver loading made doing so more advantageous. Another 1.7 million consumers with incomes between 200 and 400 percent of the poverty line selected silver plans in 2017, but would see lower premiums, cost sharing, or both as a result of silver loading if they switched to another metal tier. Adding these two groups together gives a total of 3.3 million consumers, or 36 percent of all HealthCare.gov consumers. This is an upper bound on those who benefit from silver loading and could lose if CSR payments were restored.

Consumers not included in these totals are:

- Subsidized consumers below 200 percent of the federal poverty line who enrolled in silver plans in 2017. Such consumers are generally better off remaining in silver plans and taking advantage of the cost-sharing assistance available to them in these plans. They pay neither more nor less under silver loading.
- Marketplace and off-marketplace consumers with incomes too high to qualify for subsidies. These consumers will pay more as a result of silver loading if they enroll in marketplace silver plans, but they can avoid these cost increases if they enroll in non-silver or — in most states — off-marketplace silver plans. Even in 2017, before silver loading, most unsubsidized consumers enrolled in coverage outside the marketplace, and the majority of unsubsidized marketplace consumers enrolled in a plan tier other than silver.

[35] This analysis is similar to Caitlin Owens, "More Losers Than Winners If Congress Funds Disputed ACA Program," Axios, January 29, 2018, https://www.axios.com/winners-and-losers-under-the-aca-market-stabilization-ill-1516912820-703db250-7bd1-4869-a941-2966416ebb85.html. Data are available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html.

TABLE 1

Consumers Who Could Face Higher Costs From Restoring Cost-Sharing Reductions and Ending "Silver Loading"*

Based on Centers for Medicare & Medicaid Services 2017 Plan Selection Data for HealthCare.gov States

	Lower Bound on Number Facing Higher Costs			Upper Bound on Number Facing Higher Costs	
	Subsidized Consumers Selecting Non-Silver Plans in 2017, Before Silver Loading	As share of Marketplace Consumers	Additional Consumers Who Could Benefit from Silver Loading if They Switch to Non-Silver Plan	Total Number of Subsidized Consumers Potentially Benefiting from Silver Loading	As share of Marketplace Consumers
Alaska	8,499	44%	2,903	11,402	60%
Alabama	14,194	8%	35,765	49,959	28%
Arkansas	13,568	19%	17,495	31,062	44%
Arizona**	35,235	18%	51,542	86,777	44%
Delaware**	6,734	24%	6,719	13,453	49%
Florida	260,257	15%	183,197	443,454	25%
Georgia	59,323	12%	72,541	131,864	27%
Hawaii**	3,281	17%	2,980	6,261	33%
Iowa	11,390	22%	13,698	25,088	49%
Illinois	84,211	24%	73,395	157,607	44%
Indiana**	28,157	16%	42,978	71,134	41%
Kansas	23,458	24%	15,536	38,994	39%
Kentucky	13,958	17%	22,496	36,454	45%
Louisiana	32,059	22%	27,507	59,566	41%
Maine	17,781	22%	18,178	35,958	45%
Michigan	78,990	25%	72,839	151,829	47%
Missouri**	58,928	24%	38,070	96,998	40%
Mississippi**	8,190	9%	11,548	19,738	22%

TABLE 1

Consumers Who Could Face Higher Costs From Restoring Cost-Sharing Reductions and Ending "Silver Loading"*

Based on Centers for Medicare & Medicaid Services 2017 Plan Selection Data for HealthCare.gov States

	Lower Bound on Number Facing Higher Costs			Upper Bound on Number Facing Higher Costs	
	Subsidized Consumers Selecting Non-Silver Plans in 2017, Before Silver Loading	As share of Marketplace Consumers	Additional Consumers Who Could Benefit from Silver Loading if They Switch to Non-Silver Plan	Total Number of Subsidized Consumers Potentially Benefiting from Silver Loading	As share of Marketplace Consumers
Montana**	18,917	36%	9,627	28,544	54%
North Carolina	87,759	16%	116,146	203,905	37%
North Dakota**	7,066	32%	4,921	11,987	55%
Nebraska	23,485	28%	17,397	40,882	48%
New Hampshire	10,697	20%	10,478	21,175	40%
New Jersey	37,717	13%	84,467	122,184	41%
New Mexico	9,887	18%	12,567	22,454	41%
Nevada	19,271	22%	18,786	38,057	43%
Ohio	51,285	21%	57,204	108,489	45%
Oklahoma**	43,640	30%	21,273	64,913	44%
Oregon	37,460	24%	38,307	75,767	49%
Pennsylvania	48,916	11%	127,234	176,150	41%
South Carolina	17,697	8%	52,575	70,272	31%
South Dakota**	6,406	22%	7,950	14,356	48%
Tennessee	46,691	20%	40,232	86,924	37%
Texas	227,751	19%	169,863	397,614	32%
Utah	37,910	19%	40,239	78,149	40%
Virginia	64,556	16%	75,951	140,507	34%

TABLE 1

Consumers Who Could Face Higher Costs From Restoring Cost-Sharing Reductions and Ending "Silver Loading"*

Based on Centers for Medicare & Medicaid Services 2017 Plan Selection Data for HealthCare.gov States

	Lower Bound on Number Facing Higher Costs			Upper Bound on Number Facing Higher Costs	
	Subsidized Consumers Selecting Non-Silver Plans in 2017, Before Silver Loading	As share of Marketplace Consumers	Additional Consumers Who Could Benefit from Silver Loading if They Switch to Non-Silver Plan	Total Number of Subsidized Consumers Potentially Benefiting from Silver Loading	As share of Marketplace Consumers
Wisconsin**	50,085	21%	49,793	99,878	41%
West Virginia**	7,792	23%	8,803	16,594	49%
Wyoming	6,089	25%	5,961	12,049	49%
HealthCare.gov total^	**1,621,325**	**18%**	**1,706,781**	**3,328,106**	**36%**

* "Silver loading" refers to building the cost of CSRs into silver plan premiums, resulting in higher tax credits.

** Some or all insurers in state did not adopt silver loading for 2018. Some states that did not silver load in 2018 are likely to follow other states' lead and silver load in 2019.

Source for state approaches is: http://www.commonwealthfund.org/publications/blog/2017/oct/states-protect-consumers-in-wake-of-aca-cost-sharing-payment-cuts.

^ State data do not add to HealthCare.gov totals due to rounding in underlying CMS state data.

Kaiser Health Tracking Poll – February 2018: Health Care and the 2018 Midterms, Attitudes Towards Proposed Changes to Medicaid

Ashley Kirzinger (https://www.kff.org/person/ashley-kirzinger/) (https://twitter.com/AshleyKirzinger),

Bryan Wu (https://www.kff.org/person/bryan-wu/), and

Mollyann Brodie (https://www.kff.org/person/mollyann-brodie/) (https://twitter.com/Mollybrodie)

Published: Mar 01, 2018

FINDINGS

KEY FINDINGS:

- Medicaid continues to be seen favorably by a majority of the public (74 percent) and about half (52 percent) believe the Medicaid program is working well for most low-income people covered by the program.
- When asked about proposed changes to the Medicaid program, attitudes are largely driver by party identification. A large majority of Democrats (84 percent) and most independents (64 percent) oppose lifetime limits for Medicaid benefits, while Republicans are more divided in their views with half (51 percent) believing Medicaid should only be available for limited amount of time.

ng (41%) or lifting people out of poverty (33%) *(http://twitter.com/share?*
-%2841%25%29+or+lifting+people+out+of+poverty+%2833%25%29+&url=http%3A%2F%2Fkaiserf.am%2F2FC9qft)

- Party identification also drives views on what individuals believe is the main reason behind some states imposing Medicaid work requirements. A larger share of Democrats and independents believe the main reason for these work requirements is to reduce government spending (42 percent and 45 percent, respectively) than believe it is to help lift people out of poverty (26 percent and 31 percent). On the other hand, a similar share of Republicans say it is to reduce government spending (40 percent) as say it is to help lift people out of poverty (42 percent). Individuals living in states pursuing Medicaid work requirements are also divided on the main reason for these limits, even when controlling for party identification.

  The February Kaiser Health Tracking Poll finds a slight increase in the share of the public

the highest share in more than 80 tracking polls *(http://twitter.com/share?*
%E2%80%93+the+highest+share+in+more+than+80+tracking+polls+&url=http%3A%2F%2Fkaiserf.am%2F2FC9qft)

- who say they have a favorable view of the Affordable Care Act (ACA), from 50 percent in January 2018 to 54 percent this month. This is the highest level of favorability of the ACA measured in more than 80 Kaiser Health Tracking Polls since 2010. This change is largely driven by independents, with more than half (55 percent) now saying they have a favorable opinion of the law compared to 48 percent last month. Large majorities (83 percent) of Democrats continue to view the law favorably (including six in ten who now say they hold a "very favorable" view, up from 48 percent last month) while nearly eight in ten Republicans (78 percent) view the law unfavorably (unchanged from last month).
- The majority of the public are either unaware that the ACA's individual mandate has been repealed (40 percent) or are aware that it has been repealed but incorrectly think the requirement is not in effect in 2018 (21 percent). Few (13 percent) are aware the requirement has been repealed but is still in effect for 2018.
- More than twice as many voters mention health care costs (22 percent) as mention repealing/opposing the ACA (7 percent) as the top health care issue they most want to hear 2018 candidates discuss in their campaigns. Health care costs are the top issue mentioned by Democratic voters (16 percent) and independent voters (25 percent), as well as one of the top issues mentioned by Republican voters (22 percent), followed by repealing or opposing the ACA (17 percent).

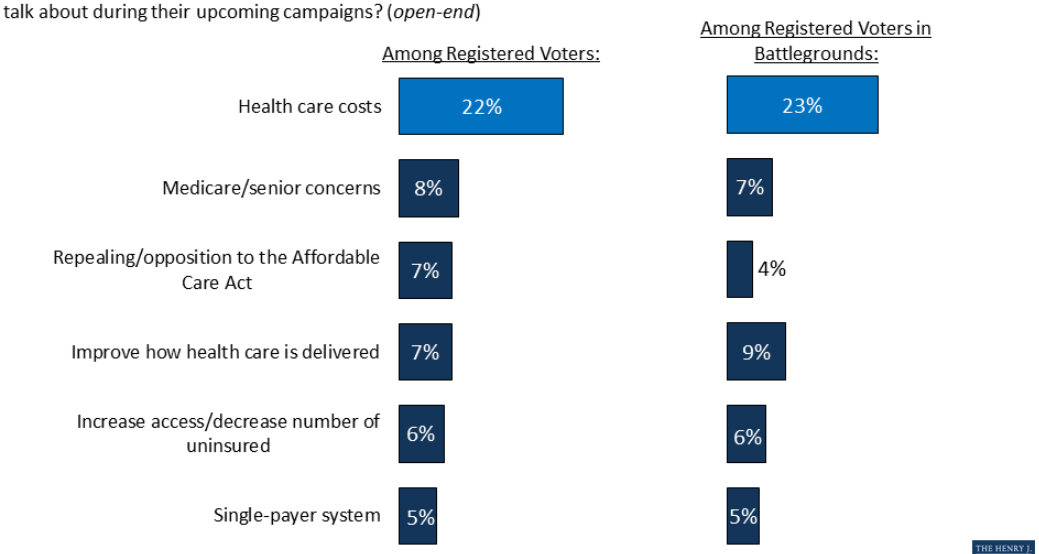
2018 Midterm Elections

With still a few months until the midterm elections are in full swing, the latest Kaiser Health Tracking Poll finds health care costs as the top health care issue mentioned by voters when asked what they want to hear 2018 candidates discuss. When asked to say in their own words what health care issue they most want to hear the candidates talk about during their upcoming campaigns, one-fifth (22 percent) of registered voters mention health care costs. This is followed by a series of other health care issues, such as Medicare/senior concerns (8 percent), repealing or opposition to the Affordable Care Act (7 percent), improve how health care is delivered (7 percent), increasing access/decreasing the number of uninsured (6 percent), or a single-payer system (5 percent). Health care costs is the top issue mentioned by Democratic voters (16 percent) and independent voters (25 percent), as well as one of the top issues mentioned by Republican voters (22 percent), followed by repealing or opposing the ACA (17 percent).

Figure 1

Health Care Costs Are Top Health Care Issue Voters Want 2018 Candidates to Talk About During Their Campaigns

While this year's election is still a long way off, what health care issue do you most want to hear candidates talk about during their upcoming campaigns? (*open-end*)



NOTE: Only top six responses listed.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

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Figure 1: Health Care Costs Are Top Health Care Issue Voters Want 2018 Candidates to Talk About During Their Campaigns

Battleground Voters

Health care costs are also the top issue mentioned by voters living where there are competitive House, Senate, or Governor races. One-fourth (23 percent) of voters in areas with competitive elections mention health care costs when asked what health care issue they most want to hear candidates talk about. Fewer mention other health care issues such as improve how health care is delivered (9 percent) or increasing access/decreasing the number of uninsured (6 percent).

2018 Midterm Election Analysis

As part of Kaiser Family Foundation's effort to examine the role of health care in the 2018 midterm elections, throughout the year we will be tracking the views of voters – paying special attention to those living in states or congressional districts in which both parties have a viable path to win the election. This group, referred to in our analysis as "voters in battlegrounds" is defined by the 2018 Senate, House, and Governor ratings provided by *The Cook Political Report*. Congressional and Governor races categorized as "toss-up" were included in this group. A complete list of the states and congressional districts included in the comparison group is available in Appendix A (http://files.kff.org/attachment/Appendix-Kaiser-Health-Tracking-Poll-February-2018).

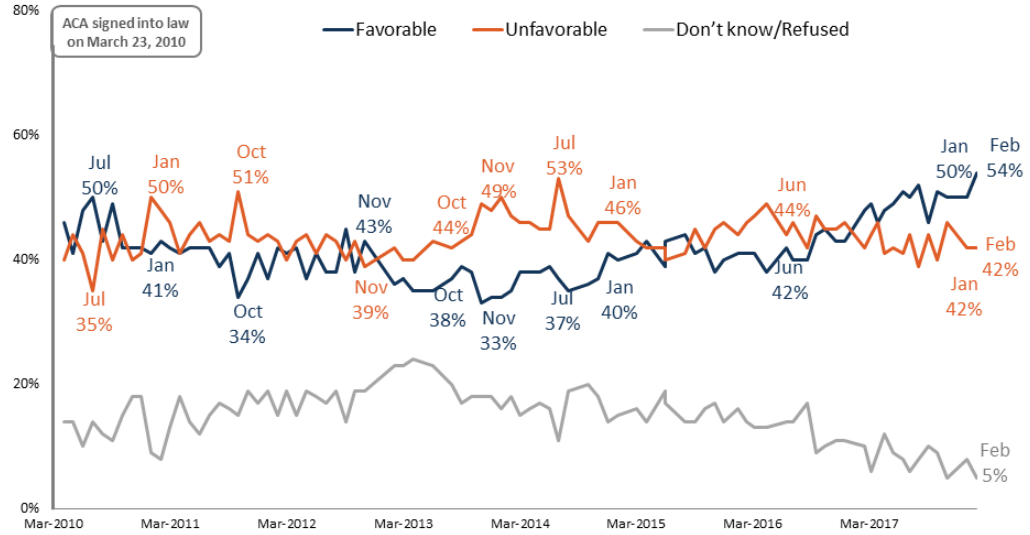
The Affordable Care Act

This month's Kaiser Health Tracking Poll finds a slight increase in the share of the public who say they have a favorable view of the 2010 Affordable Care Act (ACA). The share of the public who say they hold a favorable view of the law has increased to 54 percent (from 50 percent in January 2018) while 42 percent currently say they hold an unfavorable view. This is the highes level of favorability of the ACA measured in more than 80 Kaiser Health Tracking Polls since 2010. This change is largely driven by independents, with more than half (55 percent) now saying they have a favorable opinion of the law compared to 48 percent last month. Large majorities (83 percent) of Democrats continue to view the law favorably (including six in ten who now say they hold a "very favorable" view, up from 48 percent last month) while nearly eight in ten Republicans (78 percent) view the law unfavorably (unchanged from last month).

Figure 2

More of the Public Hold a Favorable View of the ACA

As you may know a health reform bill was signed into law in 2010, known commonly as the Affordable Care Act or Obamacare. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?



SOURCE: Kaiser Family Foundation Health Tracking Polls

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Figure 2: More of the Public Hold a Favorable View of the ACA

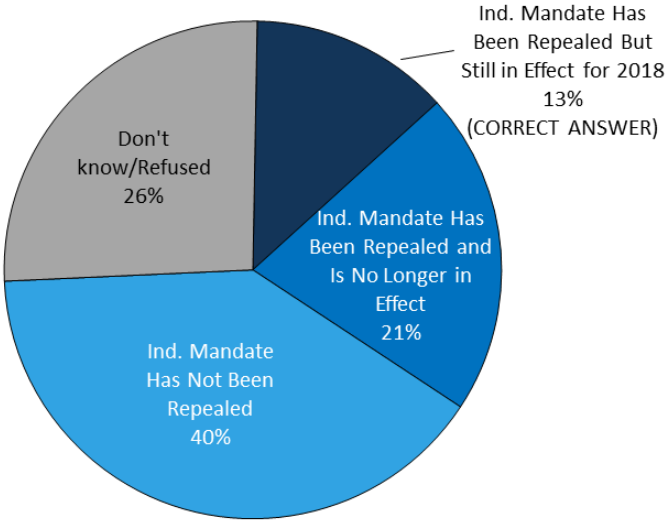
Public Awareness of the Repeal of the ACA's Individual Mandate

The February Kaiser Health Tracking Poll finds a slight uptick (from 36 percent in January 2018 to 41 percent this month) in the share of the public who are aware that the ACA's requiremen that nearly all individuals have health insurance or else pay a fine, known commonly as the individual mandate, has been repealed. Yet, misunderstandings persist. The majority of the public (61 percent) are either unaware that this requirement has been repealed (40 percent) or are aware that it has been repealed but incorrectly think the requirement is not in effect in 2018 (21 percent of total). Few (13 percent) are aware the requirement has been repealed but is still in effect for 2018.

Figure 3

Confusion Remains on the Status of the ACA's Individual Mandate

As you may know, the Affordable Care Act required nearly all Americans to have health insurance, or else pay a fine. As far as you know, has Congress repealed this requirement, or not? Do you happen to know if this requirement is still in effect for 2018, or is this requirement no longer in effect?



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

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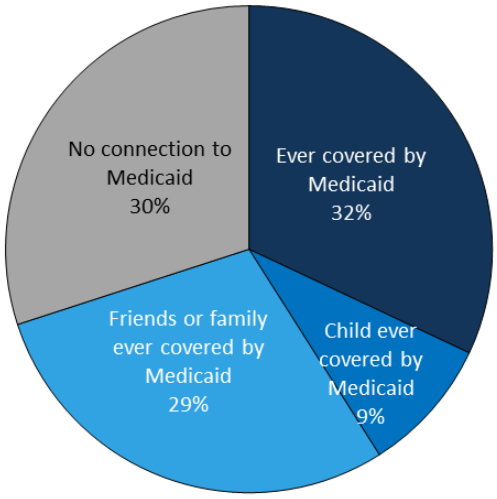
Figure 3: Confusion Remains on the Status of the ACA's Individual Mandate

Medicaid

In recent months, President Trump's administration has supported state efforts to make changes to their Medicaid programs, the government health insurance and long-term care program for low-income adults and children. Seven in ten Americans say they have ever had a connection to the Medicaid program either directly through their own health insurance coverage (32 percent) or their child being covered by the program (9 percent), or indirectly through a friend or family member covered by the program (29 percent).

Figure 4

Seven in Ten Americans Say They Have Ever Had A Connection to Medicaid



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

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Figure 4: Seven in Ten Americans Say They Have Ever Had A Connection to Medicaid

Majority of the Public Holds Favorable Views of Medicaid and Thinks the Program is Working Well

Overall, the majority of the public (74 percent) holds favorable views of Medicaid, including four in ten who have a “very favorable” view. About one-fifth of the public (21 percent) hold unfavorable views of the program. Unlike attitudes towards the ACA, opinions towards Medicaid are not drastically different among partisans and majorities across parties report favorable views. However, a larger share of Republicans do hold unfavorable views (29 percent) compared to independents (21 percent) or Democrats (13 percent).

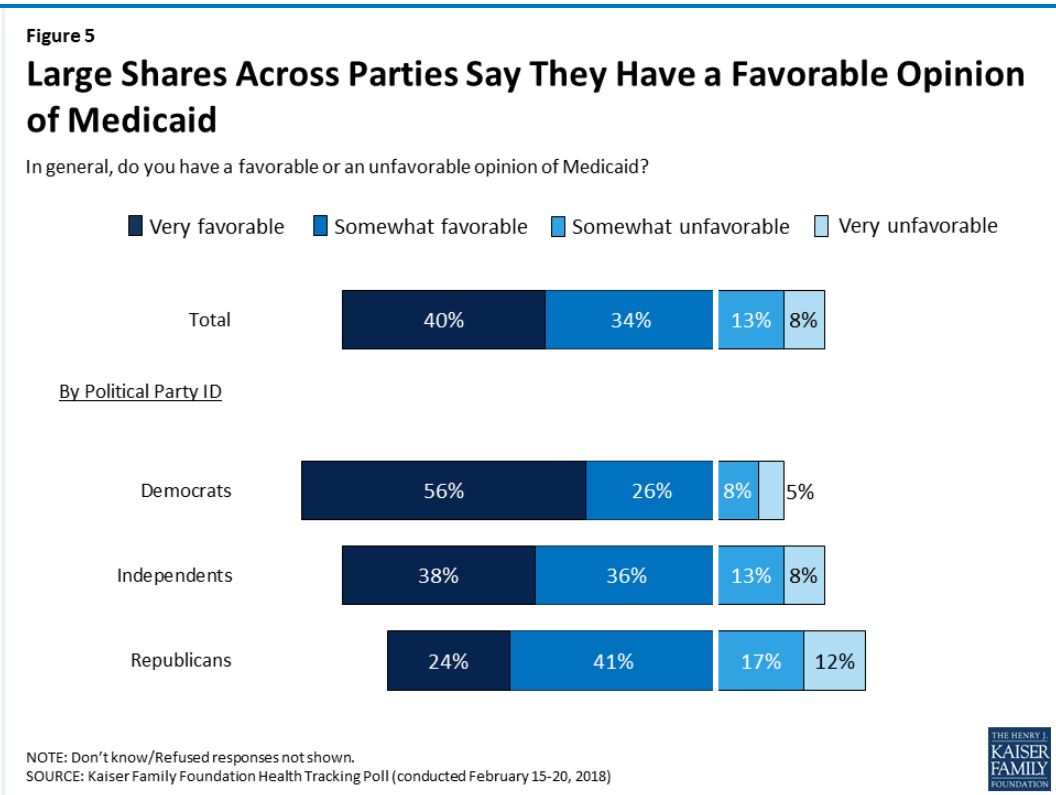


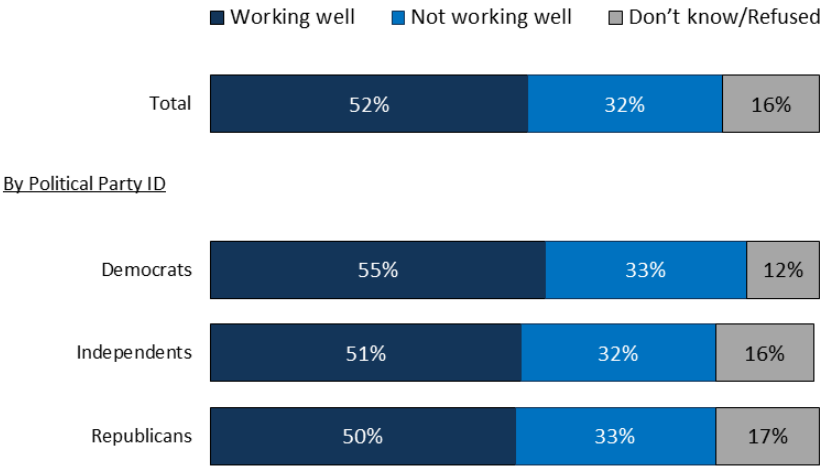
Figure 5: Large Shares Across Parties Say They Have a Favorable Opinion of Medicaid

In addition, more believe the program is working well than not working well for most low-income people covered by the program. This holds true across partisans with about half saying the Medicaid program is "working well" and about one-third saying it is "not working well."

Figure 6

Larger Shares Say Medicaid Is Currently Working Well for Most Low-Income People Covered by the Program

Would you say the current Medicaid program is working well for most low-income people covered by the program, or not?



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

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Figure 6: Larger Shares Say Medicaid Is Currently Working Well for Most Low-Income People Covered by the Program

Support for Medicaid Expansion in Non-Expansion States

One of the major changes brought on by the ACA was the option for states to expand Medicaid to cover more low-income people. As of February 2018, 18 states have not expande their Medicaid programs.

Figure 7

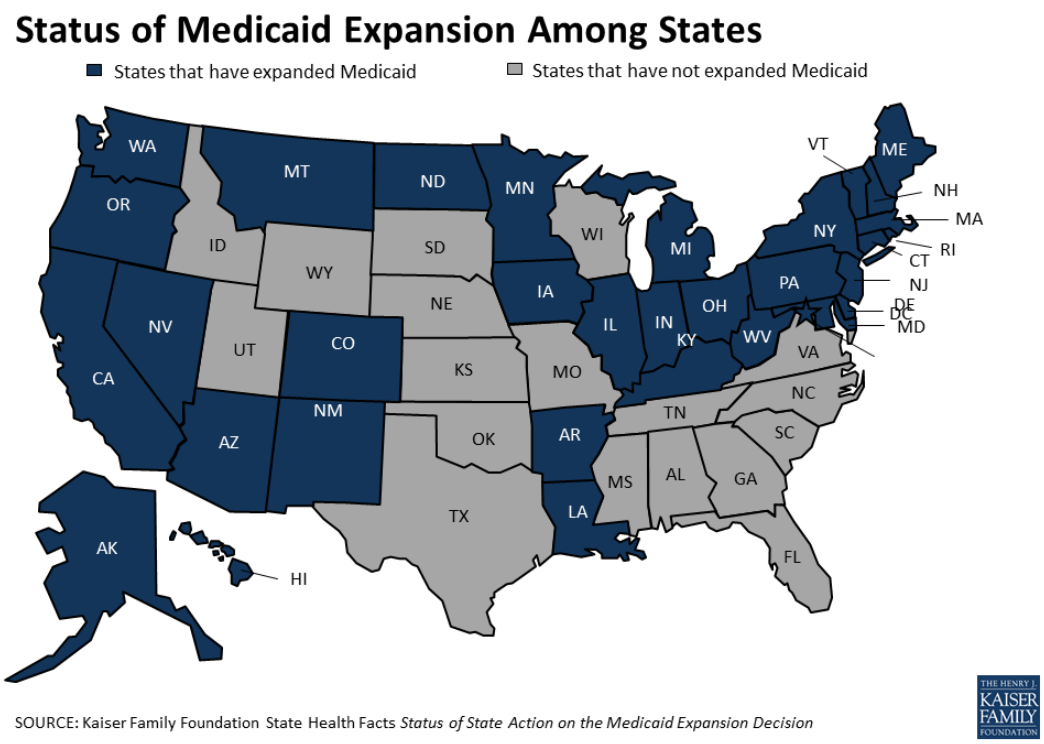


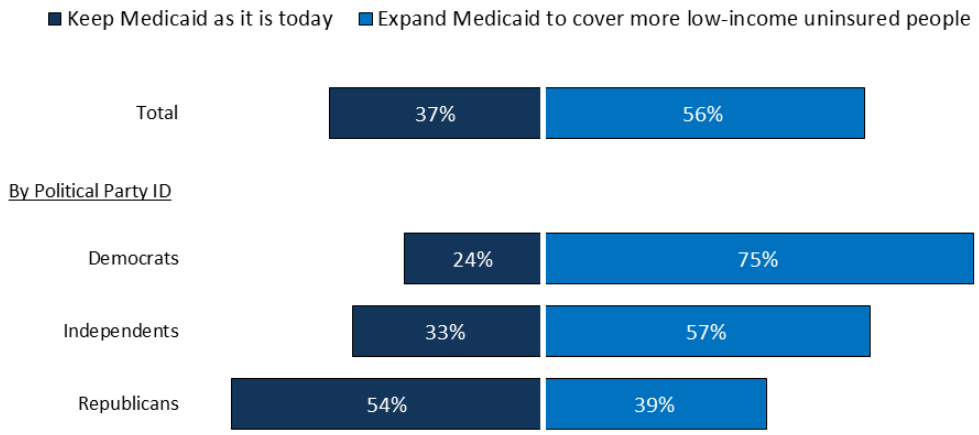
Figure 7: Status of Medicaid Expansion Among States

Among individuals living in states that have not expanded their Medicaid programs, most (56 percent) say they think their state should expand Medicaid to cover more low-income uninsured people while four in ten (37 percent) say their state should keep Medicaid as it is today. Slightly more than half of Republicans living in non-expansion states say their state should keep Medicaid as it is today (54 percent) while four in ten (39 percent) say their state should expand their Medicaid program. Majorities of Democrats (75 percent) and independents (57 percent) say their state should expand their Medicaid program.

Figure 8

Democrats and Independents Are More Likely to Want Their State to Expand Medicaid Than Republicans

AMONG THOSE LIVING IN STATES THAT HAVE NOT EXPANDED MEDICAID: Do you think your state should keep Medicaid as it is today or expand Medicaid to cover more low-income uninsured people?



NOTE: Other/Neither (Vol.) and Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

Figure 8: Democrats and Independents Are More Likely to Want Their State to Expand Medicaid Than Republicans

Proposed Changes to Medicaid

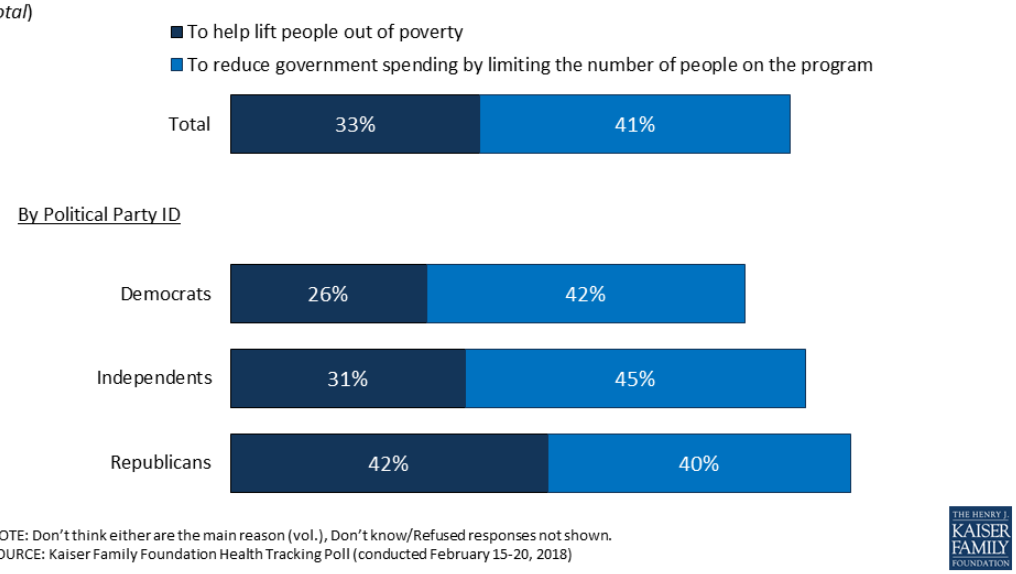
SECTION 1115 WORK REQUIREMENT WAIVERS

In January, the Centers for Medicare and Medicaid Services (CMS) provided new guidance for Section 1115 waivers, which would allow states to impose work requirements for individuals to be covered by Medicaid benefits. As of February 21, CMS has approved work requirement waivers in two states (KY and IN) and eight other states have pending requests.[1] (https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/view/footnotes/#footnote-250521-1) When asked what they thin the reasoning is behind these proposed changes to Medicaid, a larger share of the public (41 percent) believe the main reason is to reduce government spending by limiting the number of people on the program than say the main reason is to help lift people out of poverty (33 percent). There are differences among demographic groups with a larger share of Democrats and independents believing the main reason is to reduce government spending, while Republicans are more divided with similar shares saying the main reason is to lift people out of poverty (42 percent) as reduce government spending (40 percent).

Figure 9

Republicans Are Divided on the Main Reason Behind the Trump Administration Permitting Work Requirements

As you may know, the Trump administration is allowing some states to change their Medicaid program to require adults without disabilities to be working or looking for work in order to have health insurance through Medicaid. Which of these do you think is the MAIN reason behind these proposed changes to Medicaid? (*percentages based on total*)



NOTE: Don't think either are the main reason (vol.), Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

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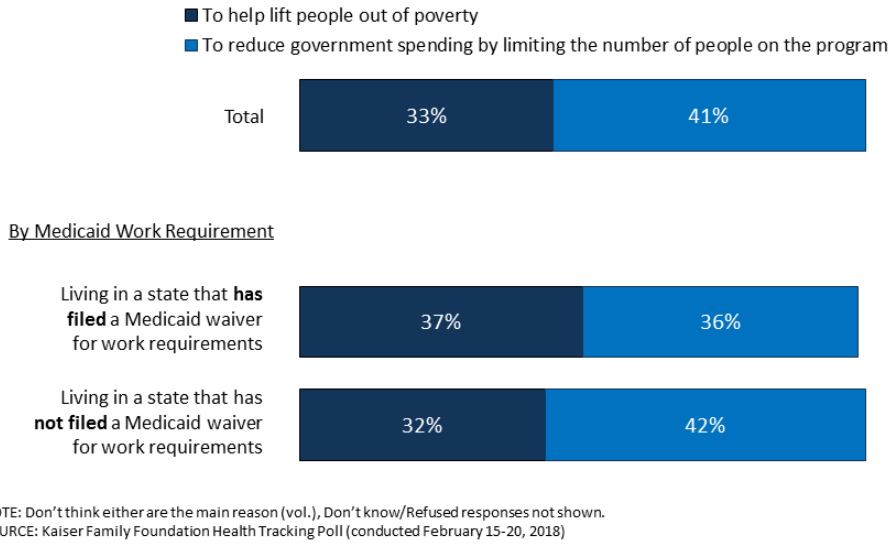
Figure 9: Republicans Are Divided on the Main Reason Behind the Trump Administration Permitting Work Requirements

There are also differences between individuals living in states that have either filed a Medicaic waiver for a work requirement or have had a waiver approved and those living in states that do not have Medicaid work requirement waivers pending or approved.[2] (https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/view/footnotes/#footnote-250521-2) Individuals living in states with pending or approved Medicaid work requirements are divided on whether the main reason for these limits is to lift people out of poverty (37 percent) or reduce government spending (36 percent). This holds true even when controlling for other demographic variables such as party identification and income that may influence beliefs.

Figure 10

Those in States with Medicaid Work Requirements Are Divided on the Main Reason Behind Them

As you may know, the Trump administration is allowing some states to change their Medicaid program to require adults without disabilities to be working or looking for work in order to have health insurance through Medicaid. Which of these do you think is the MAIN reason behind these proposed changes to Medicaid? (*percentages based on total*)



NOTE: Don't think either are the main reason (vol.), Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

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Figure 10: Those in States with Medicaid Work Requirements Are Divided on the Main Reason Behind Them

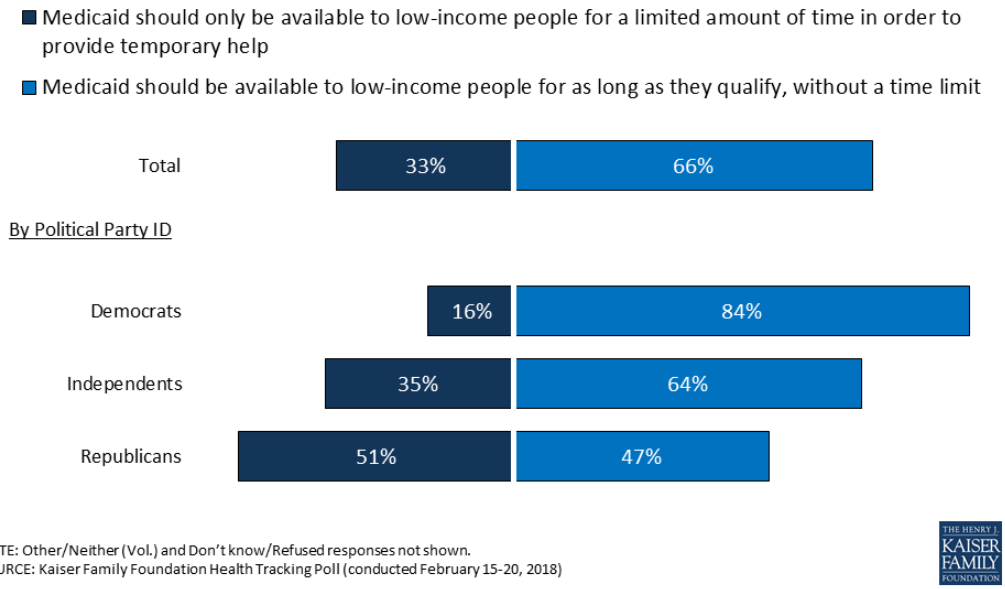
SECTION 1115 LIFETIME LIMIT WAIVERS

In addition to work requirement waivers, five states are currently seeking waivers from the Trump administration to impose Medicaid coverage limits. These "lifetime limits" would cap Medicaid health care benefits for non-disabled adults. When asked how they think Medicaid should work, two-thirds of the public say Medicaid should be available to low-income people for as long as they qualify, without a time limit, while one-third say it should only be available to low-income people for a limited amount of time in order to provide temporary help. The vast majority of Democrats (84 percent) and most independents (64 percent) say Medicaid should be available without lifetime limits, while Republicans are divided with similar shares saying they favor time limits (51 percent) as saying they do not favor such limits (47 percent). Seven in ten (71 percent) of individuals who have ever had a connection to Medicaid say they do not support lifetime limits compared to three in ten (28 percent) who say it should only be available for a limited amount of time in order to provide temporary help.

Figure 11

Majorities of Democrats and Independents Say Medicaid Should Be Available Without a Time Limit; Republicans Are Divided

Which of the following comes closer to your view of how Medicaid should work?



NOTE: Other/Neither (Vol.) and Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

Figure 11: Majorities of Democrats and Independents Say Medicaid Should Be Available Without a Time Limit; Republicans Are Divided

METHODOLOGY (HTTPS://WWW.KFF.ORG/REPORT-SECTION/KAISER-HEALTH-TRACKING-POLL-FEBRUARY-2018-HEALTH-CARE-AND-THE-2018-MIDTERMS-ATTITUDES-TOWARDS-PROPOSED-CHANGES-TO-MEDICAID-METHODOLOGY/)

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A Century of Advancing Health Care for All

TO THE POINT
Quick Takes on Health Care Policy and Practice

Health Insurance Markets Perform Better in States That Run Their Own Marketplaces

Wednesday, March 7, 2018


By Mark A. Hall (/about-us/experts/hall-mark) and Michael J. McCue (/about-us/experts/mccue-michael)

In spite of actions by Congress and President Trump that undermine parts of the Affordable Care Act (ACA), reports of the law's death are greatly exaggerated, as Mark Twain might have said. Enrollment in the ACA's subsidized marketplace exchanges remains strong, and coverage remains available throughout the country. Not all insurance markets have remained as resilient as others, however. It appears that attempts to undermine the ACA have had greater effects in some locations than in others. In particular, analysts have noted (https://nashp.org/unpacking-the-state-based-marketplaces/) that insurance markets remain healthier (http://www.commonwealthfund.org/publications/blog/2018/jan/insurer-participation-in-aca-marketplaces) in the 17 states that run their own insurance marketplaces than in those that rely on the federal marketplace. We use newly released federal data to explore this difference between states.

Lower ACA Individual Market Premiums, Claims, and Costs in States with State-Run Marketplaces

averaged 21 percent higher ($633 per month vs. $526 per month) in states using the federal marketplace than in those running their own marketplaces. Comparing these numbers to those from last year, insurers' premium projections increased 68 percent more on average in federal marketplace states than in states with their own marketplaces ($135 per month vs. $82 per month).

Projected Premiums, Medical Claims, Administrative Costs, and Profit for 2018 in the ACA Individual Market

Note: Dollar figures are expressed as per-member, per-month averages weighted by projected enrollment. Percent figures are the percentage of average premiums for each cost or profit element.
Data: Authors' analysis of 2018 Uniform Rate Review Template data for the individual market.

Source: M. A. Hall and M. J. McCue, "Health Insurance Markets Perform Better in States That Run their Own Marketplaces," *To the Point*, The Commonwealth Fund, Mar. 5, 2018.

Difference in Projected Premiums, Medical Claims, Administrative Costs, and Profit in the ACA Individual Market, 2018 vs. 2017

These greater projected premiums in federal marketplace states continue a trend that has existed since near the beginning of the marketplaces. During the second year of the ACA marketplaces (2015), rate increases between the two sets of states were similar, but thereafter they began to diverge. In 2016, 2017 and 2018, insurers had greater premium increases in states using the federal marketplace than in states operating their own, with differences averaging 6 percentage points a year . Notably, the differences in rate increases were substantially greater for 2018 (11 percentage points) than for the prior two years (3 percentage points), as the stability of health care markets was thrown into question in the wake of the Trump administration's pronouncements and policies.

For 2018, the difference in premiums between the two sets of states is based in part on greater projected medical claims in federal marketplace states. Insurers in federal marketplace states projected claims for 2018 that were 14 percent greater ($478 per month vs. $419 per month) than in states with their own marketplaces. Insurers in the federal marketplace states also projected higher administrative costs and operating profits per member, resulting in a substantially higher proportion of premiums (24.7% vs. 20.2%) going to overhead rather than to medical claims.

States That Run Their Own Marketplaces Are Better Positioned for Negative Impacts of ACA Changes

As insurers were adjusting to recent changes in administrative policy as well as market conditions, insurance markets in states with their own marketplaces appear to be more resilient than those in states using the federal marketplace. Under state-based marketplaces, insurers were able to project lower claims costs and keep administrative and overhead costs lower than in other states.

ombination of factors (http://www.milliman.com/insight/2016/A-financial-post-mortem-Transitional-olicies-and-the-financial-implications-for-the-2014-ACA-individual-market/) that these data do not lluminate, but which other analysts (noted above, and here (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1456)) have suggested. Principally, states with their own marketplaces have a more proactive engagement with the ACA, which is likely to ranslate into a more balanced risk pool and a greater willingness of insurers to enter or remain in the market. For example, when the Trump administration shortened the open-enrollment period and reduced advertising for the federal marketplace, states with their own marketplaces (http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf) extended heir open-enrollment periods and supplemented federal funds for outreach and assistance.

Other factors may well be at play in this observed difference between states.[1](#/#1) But the consistently and increasingly lower premiums in state-based marketplace states suggest that, as additional changes are made to the ACA, these states may be better situated and more motivated to buffer the potential negative impacts. States that wish to avoid the worst effects of market destabilization flowing from the most recent set of federal health policy reversals might want to follow the lead set by states that operate heir own marketplaces.[2](#/#2)

Study Methods

Data come from the 2018 Uniform Rate Review Template (URRT), which insurers filed in mid-2017, to establish compliance with the ACA's rating rules. The URRT reports amounts that insurers' actuaries anticipate in the coming year for enrollment, premiums, medical claims, administrative costs, and profits. We refer to these as "projected" amounts.

We initially examined 238 insurers in the individual market that projected having at least 1,000 members in 2018, and we weighted most financial performance indicators according to each insurer's projected enrollment. (The only exception is for insurers' historical rate increases which, in the final exhibit above, are weighted according to each product's projected premium volume.) To account for rate filings that had not been updated to reflect the Trump administration's cancellation of cost-sharing reduction (CSR) payments in October 2017, we excluded 8 insurers that projected CSR payments greater than 10 percent of their total premiums, resulting in a final sample of 230.

In categorizing states between federal vs. state-based marketplaces, some states are regarded as "partnership" states because they assume some of the exchange's regulatory functions while still using the federal exchange. Financial indicators in these partnership states were substantially similar to the pure federal marketplace states, so we combine their experience with the other federal exchange states.

Notes

For instance, states with their own marketplaces were also those that tended to disallow the sale of non-conforming "transitional" policies, whereas federal marketplace states more often allowed the continued renewal of these policies, which tends to fragment the insurance market. K. Hempstead, *Marketplace Pulse: Leaky Risk Pools Sink Markets (https://www.rwjf.org/en/library/research/2017/08/marketplace-pulse--leaky-risk-pools-sink-markets.html)* (Robert Wood Johnson Foundation, Aug. 16, 2017). And states with exchanges are also those that expanded Medicaid, whereas most federal exchange states did not. Expansion removes the lowest-income segment of the population from the marketplaces — those between 100 percent and 133 percent of poverty — which, because of their worse health, lowers somewhat the average claims costs for the private insurance market. A. P. Sen and T. DeLeire, *The Effect of Medicaid Expansion on Marketplace Premiums (https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf)*, ASPE Issue Brief (U.S. Dept. of Health and Human Services, Sept. 6, 2016).

For instance, states can opt for tighter regulation of non-complying short-term plans and association health plans. Georgetown University Center on Health Insurance Reforms, *State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Association Health Plans (https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf442346)* (Georgetown University Health Policy Institute, Dec. 2017); and Georgetown University Center on Health Insurance Reforms, *State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Short-Term Health Plans (https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf441920)* (Georgetown University Health Policy Institute, Dec. 2017). And states could implement their own version of, replacement for, the individual mandate. N. Bagley, "The Tax Bill Destroys an Important Part of Obamacare. The States Can Save It. (https://www.vox.com/the-big-idea/2017/12/14/16773294/obamacare-aca-states-protect-coverage-after-tax-bill)," *Vox,* Dec. 14, 2017.

Competition and Premium Costs in Single-Insurer Marketplaces: A Study of Five Rural States

March 6, 2018

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Abstract

- **Issue:** In 2017, five states — Alabama, Alaska, Oklahoma, South Carolina, and Wyoming — had only one issuer participating in their health care marketplaces, limiting consumer choice and competition among insurers.
- **Goal:** Examine the history of participation in the individual market from 2010 (before the Affordable Care Act was enacted) to 2017, and analyze premium changes among marketplace plans.
- **Methods:** Robert Wood Johnson Foundation's HIX Compare, which provides national data on the marketplaces from 2014 to 2017.
- **Findings and Conclusions:** In 2010, the individual insurance market was already concentrated in the five study states, with Blue Cross and Blue Shield (BCBS) plans covering the majority of enrollees. By 2015, with the marketplaces in full swing, more issuers were competing in the five states. But by 2016, co-ops were facing bankruptcy and left the marketplaces in these states; and in 2017, citing large financial losses, national

Policy options with bipartisan support, such as resuming cost-sharing reduction payments and reestablishing reinsurance and risk corridors, could help attract new or returning issuers to marketplaces in these states.

Background

Uncertainty over the Trump administration's approach to the Affordable Care Act marketplaces and the repeal of the individual mandate penalties has increased fears of insurers exiting the marketplaces. This action would in turn create a lack of competition and, potentially, an increase in premiums because of adverse selection. In 2017, while some states had just one insurer participating, others had more than 10. Similarly, some states experienced large premium increases while others saw small increases and, in some cases, even decreases.

This issue brief examines the five states — Alabama, Alaska, Oklahoma, South Carolina, and Wyoming — that had only one insurer participating in the marketplaces in 2017. Understanding the experiences of competition and consumer choice in these states may help policymakers strengthen and improve the stability of markets going forward.[1 (#/#1)] We look at the history of the individual market in these five largely rural states beginning in 2010, before the passage of the ACA, and then track the entry and exit of issuers from the marketplaces from 2014 to 2017. Our analysis also examines how premiums changed over this time period as the number of issuers declined.

Findings

Marketplace Entries and Exits

In 2010, before the law was passed, the individual markets were relatively concentrated in the five study states. Blue Cross and Blue Shield (BCBS) plans held more than 50 percent of the market in each state; Blue Cross and Blue Shield of Alabama held an 86 percent market share.[2 (#/#2)] Assurant and HealthMarkets competed in the individual markets in four states (Exhibit 1), but both have since left the individual market nationwide.[3,4 (#/#3)]

Exhibit 1

Insurer Marketplace Participation in Five Study States, 2010–2017

All state marketplaces included a number of miscellaneous legacy insurers in 2010 — we list only carriers with at least a 5 percent share of he market.

Data: April 2011 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE); and Robert Wood Johnso Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017).

Source: J. R. Gabel, H. Whitmore, M. Green et al, *Competition and Premium Costs in Single-Insurer Marketplaces: A Study of Five Rural States*, T Commonwealth Fund, February 2018.

When the marketplaces became operational in 2014, Alabama, Alaska, and Wyoming each had just two issuers participating (Exhibit 2). Four issuers competed in South Carolina (two were Blue Cross corporate entities) and six competed in Oklahoma.[5](#/#5) Newly established co-ops competed in Oklahoma, South Carolina, and Wyoming.[6](#/#6) These plans originated in the ACA's Consumer Operated and Oriented Plan Program, intended to encourage the creation of qualified nonprofit health insurers to compete in the individual and small-group markets.

Exhibit 2

Number of Participating Marketplace Insurers in Five Study States, 2014 to 2017

All state marketplaces included a number of miscellaneous legacy insurers in 2010 — we list only carriers with at least a 5 percent share of he market.

Data: April 2011 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE); and Robert Wood Johnso Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017).

Source: J. R. Gabel, H. Whitmore, M. Green et al, *Competition and Premium Costs in Single-Insurer Marketplaces: A Study of Five Rural States*, T Commonwealth Fund, February 2018.

Co-ops had the largest 2014 enrollment in South Carolina and Wyoming (Consumers' Choice Health Plan and WINhealth Partners, respectively) and a Medicaid managed care plan, Moda Health, had the largest enrollment in Alaska (Exhibit 3). Two of these three plans also had the lowest premiums for silver plans, and Consumers' Choice was within a few dollars of the least expensive option. In 2015, Moda and Consumers' Choice retained the largest market shares in their states; WINhealth Partners held a 41 percent market share in Wyoming. In South Carolina and Wyoming, the co-op underpriced the BCBS plans by 13 percent and 15 percent, respectively. In Alaska in 2014, Moda underpriced BCBS by 10 percent. In Alabama and Oklahoma, BCBS was price-competitive with the other issuers that year, and retained a dominant market share.

Exhibit 3

Market Share and Silver Plan Premiums in Five Study States, 2014 and 2015

lote: Premium prices are for individual coverage for a 40-year-old nonsmoking adult.
Data: Center for Consumer Information and Insurance Oversight, *Issuer Level Enrollment Data, 2014 and 2015* (CCIIO, n.d.); and Robert Wood ohnson Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017).

ource: J. R. Gabel, H. Whitmore, M. Green et al, *Competition and Premium Costs in Single-Insurer Marketplaces: A Study of Five Rural States*, T ommonwealth Fund, February 2018.

n 2015, the number of issuers competing in each state changed little, but in 2016, participation declined (Exhibit 2) Co-ops went out of business in Oklahoma, South Carolina, and Wyoming. In most states throughout the country, co ops lacked the capital to sustain financial losses from a sicker-than-expected enrollee population. Legislation passed y Congress required that the law's risk-corridor program (which was designed to help protect insurers against very arge financial losses) be budget neutral. This left issuers with less than one-third of the funds they had expected to e available.[7 (#/#7)] In South Carolina, Coventry was acquired by Aetna.[8 (#/#8)] UnitedHealthcare entered the Oklahoma and South Carolina marketplaces.

n 2017, participation declined even further. National commercial issuers UnitedHealthcare, Aetna, and Humana xited the marketplaces in the study states (as well as in other states across the nation). Specifically, UnitedHealthcare left Alabama, Oklahoma, and South Carolina; Aetna exited from South Carolina; and Humana

ts ability to sell insurance because of solvency concerns.[9 (#/#9)]

Trends in Premiums

The average annual premium increases from 2014 to 2017 in three of five study states substantially outpaced the national average (Exhibit 4). Alabama averaged 21 percent annual increases, and Alaska and Oklahoma had 27 percent and 26 percent increases, respectively. The average annual premium increase nationwide was 11 percent. Wyoming was the sole single-issuer state with annual premium increase growth (7%) below the national average, while South Carolina was nearly the same as the national average. Premium increases were particularly large from 2016 to 2017 in Alabama (43%) and Oklahoma (58%).[10 (#/#10)] In these two states, BCBS controlled overwhelming shares of the market for all study years.

Exhibit 4

Average Statewide Marketplace Premiums for Silver Plans in Five Study States, 2014 to 2017

Average premiums for single coverage, 40-year-old nonsmoking adult

Note: All premium figures weighted by population of the geographic rating area in which the plan is sold.
Data: Robert Wood Johnson Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017).

Source: J. R. Gabel, H. Whitmore, M. Green et al, *Competition and Premium Costs in Single-Insurer Marketplaces: A Study of Five Rural States*, T Commonwealth Fund, February 2018.

Share

Conclusions and Next Steps

The five study states, which were all left with a single issuer by 2017, experienced similar cycles from 2014 to 2017. In 2010, before passage of the ACA, the individual insurance market was already concentrated in all five states. By 2014, two insurers, Assurant and HealthMarkets, which each had a presence in four states, left the health

eft the marketplaces in these states. In 2017, citing large financial losses, large national issuers UnitedHealthcare, Aetna, and Humana exited these marketplaces. Despite the withdrawal of these three large insurers, a 2017 report rom Standard & Poor's observed trends towards stabilization in the individual health insurance market, but noted hat these markets still need more time to mature.[11 (#/#11)]

From 2014 to 2017, three of the five single-issuer states experienced substantially higher rates of annual premium ncreases than the federally facilitated marketplace average. The other two states had rates comparable to the ationwide figure. Limited competition was a likely factor behind the higher premium increases.[12,13 (#/#12)] In ddition, the elimination of many lower-cost options, with co-ops exiting the market, also contributed to larger remium increases. Moreover, none of these states opted to expand Medicaid, so they may have experienced dverse selection as individuals with incomes between 100 percent and 138 percent of poverty enrolled in the narketplaces. States that did not expand Medicaid had marketplace premiums that were 7 percent higher than states hat did.[14 (#/#14)] Generally speaking, lower-income people have poorer health status than moderate- and high- ncome people.[15 (#/#15)]

Historically, competition among issuers in the five single-issuer states — and in rural states generally — has been imited. In these states, marketplace enrollees have less choice, and, in many cases, the approximately 20 percent of nrollees who are not eligible for premium tax credits have higher premium costs. But the experience and policies f other states offer insights and ideas that could help. For example, Minnesota recently enacted its own reinsurance rogram, and state officials and issuers there have stated that premiums for 2018 are 20 percent lower as a result.[16 #/#16)] Federal programs to reestablish risk corridors, or reimburse issuers for previous losses under the program, ould also reduce premiums and make market entry more appealing.[17 (#/#17)] And resuming cost-sharing reduction ayments to issuers also could help to encourage participation and foster lower premiums.[18 (#/#18)] Many of these roposals have bipartisan support in Congress.[19 (#/#19)]

The measures Congress legislated to ensure issuer participation in the Medicare Part D prescription drug program ould be extended to the marketplaces, as some have also suggested.[20 (#/#20)] Under such a plan, if no issuers articipate in a county, the U.S. Department of Health and Human Services would contract with an issuer to dminister a plan. Alternatively, the two largest insurers participating in the Federal Employees Health Benefits FEHB) Program in the county could be required to offer a silver plan. This participation would be a requirement or the plans to be included in the FEHB Program.[21 (#/#21)] Insurers regard FEHB as providing high value, given the rogram's very large enrollment; in fact, every U.S. county has at least one participating plan.

n 2017 and 2018, the Trump administration and Congress took a number of actions to scale back the ACA that ould also potentially affect the stability of the marketplaces. These include: 1) repealing the individual mandate enalties, which is projected to increase the number of uninsured Americans by 13 million by 2027; 2) ending unding for cost-sharing reduction payments; and 3) proposing new rules that would increase the proliferation of ssociation health plans and short-term insurance policies that do not meet many ACA requirements, such as ssential health benefits.[22 (#/#22)] The effect of these changes on issuer participation and premiums likely will be the

egislative or administrative changes, or both. States also could take steps — as Alaska, Minnesota, and Oregon have done — to establish reinsurance programs to stabilize the individual market.[23,24 (#/#23)]

How We Conducted This Study

Our primary data source is the Robert Wood Johnson Foundation's HIX Compare, which provides national data on the marketplaces from 2014 to 2017.[a] Data elements include premiums, deductibles, and out-of-pocket limits. A second database used in the study is the April 2011 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) that provides names of issuers offering coverage in each state in 2010 in the individual market. Lastly, we used the Center for Consumer Information and Insurance Oversight (CCIIO) Issuer Level Enrollment Data for 2014 and 2015.

In our analysis of trends from 2014 to 2017, readers should be aware that these calculations are heavily dependent on the premiums and cost-sharing requirements of the remaining issuer in 2017. In all five states this issuer is the local Blue Cross Blue Shield plan.

The HIX Compare dataset presents premium information for single enrollees at age 27 and age 50 and for family enrollees with adults at age 30. In order to present consistent estimates by age group, all premium figures were scaled to reflect 40-year-old adults, using both federal and state-specific age-rating ratios.[b]

We use weighting to present estimates to provide a more accurate picture of the market as a whole. Using simple averages would treat all premium changes equally, even if they occur among plans that have low enrollment or are offered in areas with low population. We chose to weight premium and cost-sharing figures by the population of the rating area in which the plan is sold. The CCIIO has released plan-level enrollment data in states with federally facilitated marketplaces for 2014 and 2015, but since these data were not available for all plan years, we did not use them to calculate premium or cost-sharing figures. We did use them, however, to calculate market share information in 2014 and 2015.

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SURVEY BRIEF
MARCH 2018

Americans' Views on Health Insurance at the End of a Turbulent Year

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The Affordable Care Act's 2018 open enrollment period came at the end of a turbulent year in health care. The Trump administration took several steps to weaken the ACA's insurance marketplaces. Meanwhile, congressional Republicans engaged in a nine-month effort to repeal and replace the law's coverage expansions and roll back Medicaid.

Nevertheless, 11.8 million people had selected plans through the marketplaces by the end of January, about 3.7 percent fewer than the prior year.[1] There was an overall increase in enrollment this year in states that run their own marketplaces and a decrease in those states that rely on the federal marketplace.

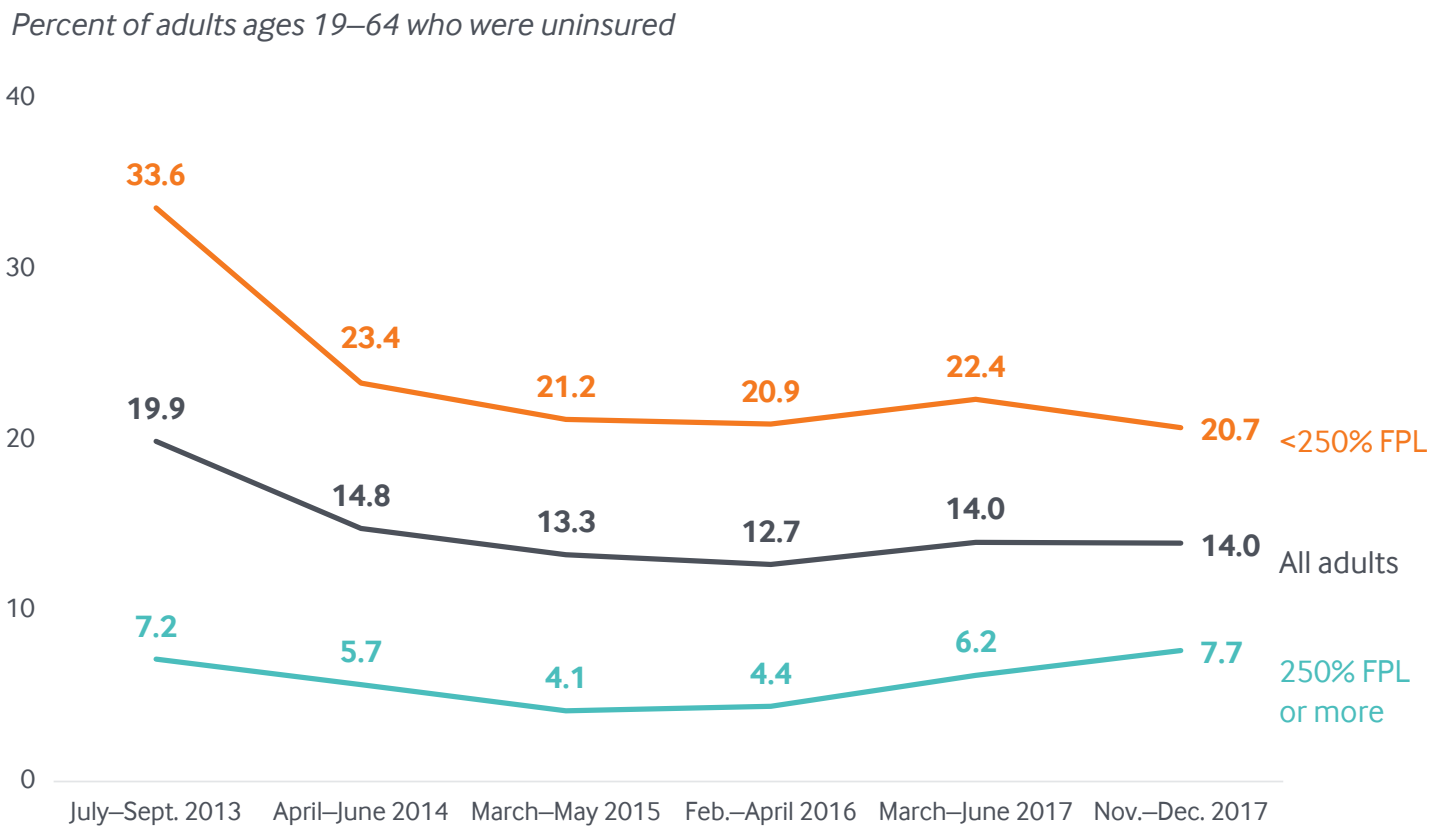
To gauge the perspectives of Americans on the marketplaces, Medicaid, and other health insurance issues, the Commonwealth Fund Affordable Care Act Tracking Survey interviewed a random, nationally representative sample of 2,410 adults ages 19 to 64 between November 2 and December 27, 2017, including 541 people who have marketplace or Medicaid coverage. The findings are compared to prior ACA tracking surveys, the most recent of which was fielded between March and June 2017. The survey research firm SSRS conducted the survey, which has an overall margin of error is +/– 2.7 percentage points at the 95 percent confidence level. See How We Conducted This Study to learn more about the survey methods.

HIGHLIGHTS

Adults were asked about:

- **INSURANCE COVERAGE** 14 percent of working age adults were uninsured at the end of 2017, unchanged from March–June 2017.
- **AWARENESS OF THE MARKETPLACES** 35 percent of uninsured adults were not aware of the marketplaces.
- **REASONS FOR NOT GETTING COVERED** Among uninsured adults who were aware of the marketplaces but did not plan to visit them, 71 percent said they didn't think they could afford health insurance, while 23 percent thought the ACA was going to be repealed.
- **CONFIDENCE ABOUT STAYING COVERED** About three in 10 people with marketplace coverage or Medicaid said they were not confident they would be able to keep their coverage in the future. Of those, 47 percent said they felt this way because either the Trump administration would not carry out the law (32%) or Congress would repeal it (15%).
- **SHOULD AFFORDABLE HEALTH CARE BE A RIGHT?** 92 percent of working-age adults think that all Americans should have the right to affordable health care, including 99 percent of Democrats, 82 percent of Republicans, and 92 percent of independents.

The uninsured rate among working-age adults held steady at 14 percent.



Note: FPL refers to federal poverty level; 250% FPL is about $31,150 for an individual and $61,500 for a family of four.

Data: The Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013, April–June 2014, March–May 2015, Feb.–April 2016, March–June 2017, and Nov.–Dec. 2017.

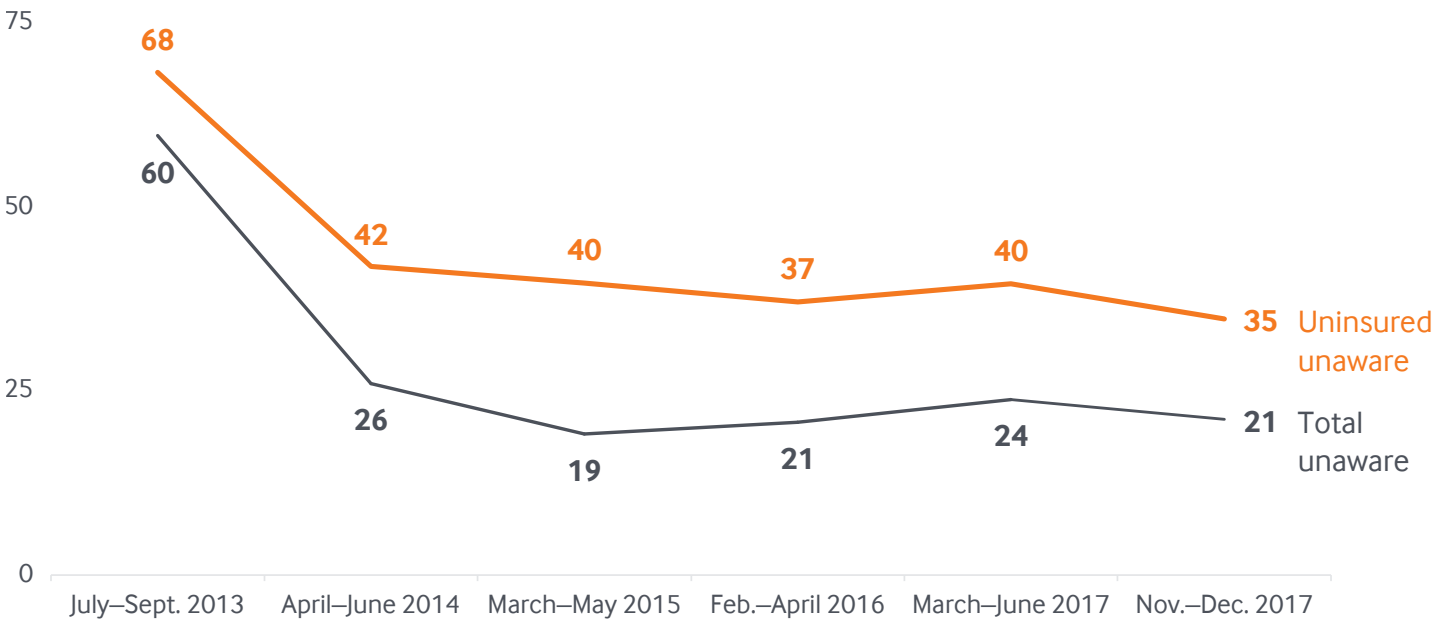
At the end of 2017, 14 percent of adults ages 19 to 64 were uninsured, the same as six months earlier. (See the Appendix for a comparison with other recent federal and private survey estimates.) This remains above the lowest rate in 2016, although the difference is not statistically significant. Still, it is well below the 20 percent uninsured rate seen just prior to the ACA's first open enrollment period.

Uninsured rates are highest among low-income adults, Latinos, the unemployed, employees of small firms, and residents of states that have yet to expand Medicaid. (See Tables 1–3 for complete data.)

Most adults are aware of the marketplaces, but uninsured adults remain less aware.

Are you aware of the marketplaces also known as HealthCare.gov or the marketplace in your state?

Adults ages19–64 who responded "no"



Data: The Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013, April–June 2014, March–May 2015, Feb.–April 2016, March–June 2017, and Nov.–Dec. 2017.

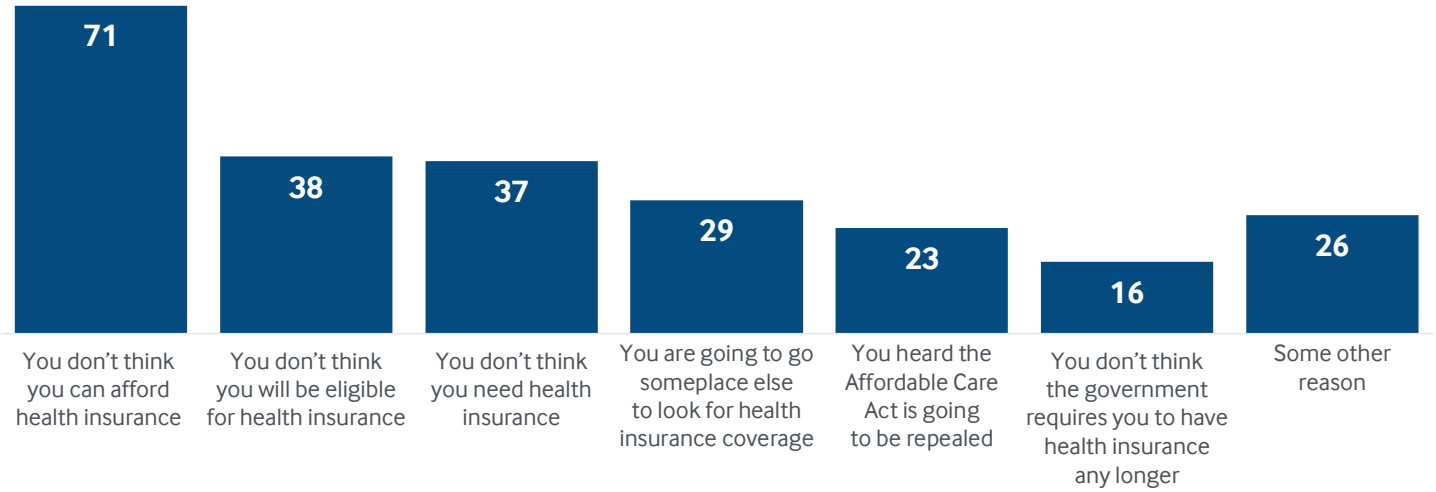
Five years after the rollout of the health insurance marketplaces, most of the public is aware that people who don't have employer coverage can get a plan through the marketplaces. Lack of awareness is higher among uninsured adults, and though there has been some improvement over the last year, the change is not statistically significant.

These findings suggest that more advertising and outreach could help lower the uninsured rate.

Uninsured adults most often cite concerns about affordability as the reason why they didn't plan to shop for marketplace coverage.

You said that you do not intend to visit the marketplace to shop for health insurance this fall. What are the reasons you do not plan to visit the marketplace? Is it because...?

Percent of uninsured adults ages 19–64 who were aware of the marketplaces but did not intend to visit



Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

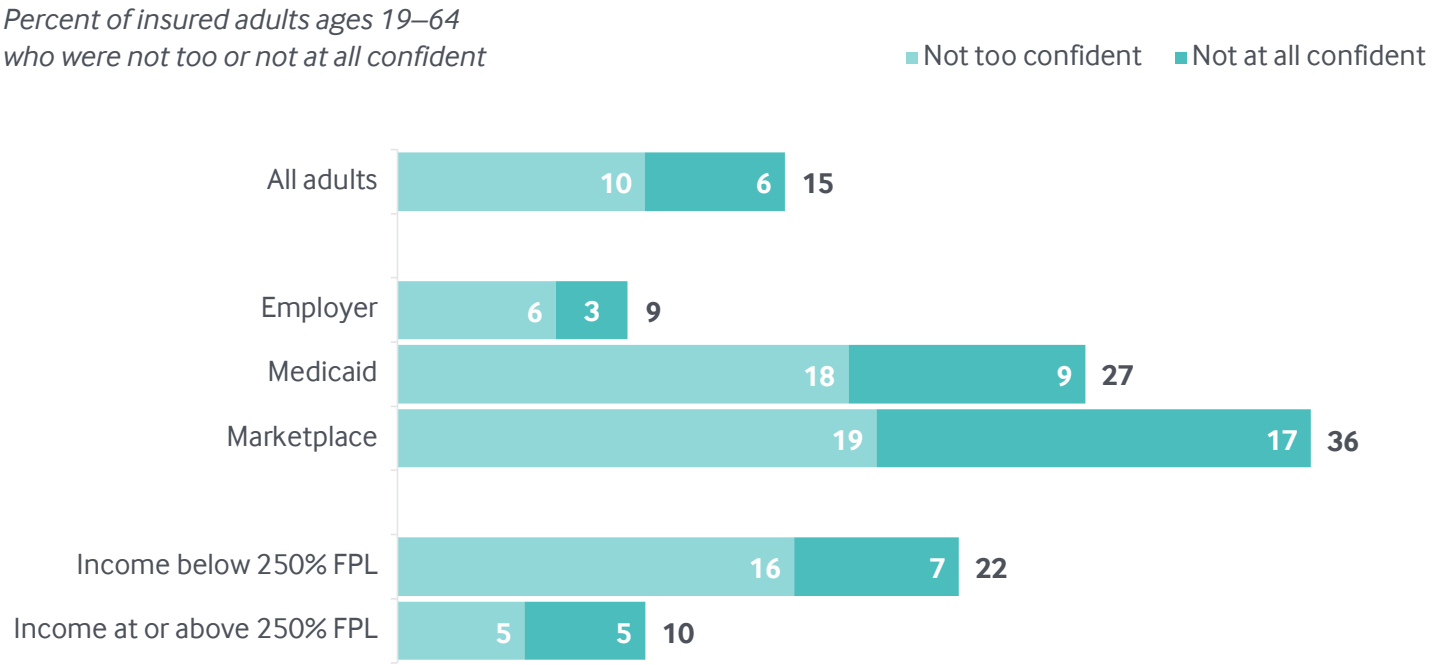
About half (47%) of uninsured adults were aware of the marketplaces but said they did not intend to visit them last fall to buy health insurance. When asked what the reasons were, 71 percent said they didn't think they could afford coverage. About one-third said they didn't think they would be eligible, while a similar share said they didn't think they needed health insurance.

Last year's debate over the ACA likely affected some uninsured adults' decisions not to shop for marketplace coverage: 23 percent said they thought the law was going to be repealed, and 16 percent said they thought the government no longer required them to have health insurance.

Adults with marketplace plans or Medicaid express the least confidence in being able to keep their coverage in the future.

You said you currently have health insurance. How confident are you that you will be able to keep this health care coverage in the future?

Percent of insured adults ages 19–64 who were not too or not at all confident



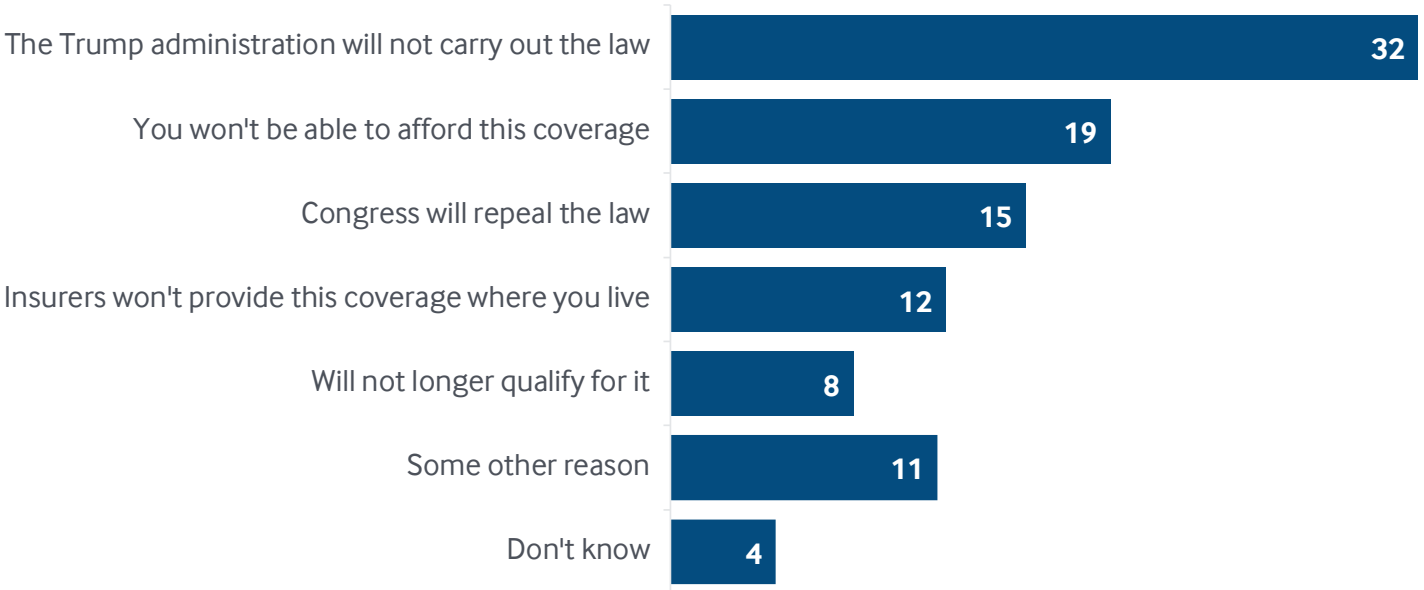
Notes: Segments may not sum to indicated total because of rounding. FPL refers to federal poverty level; 250% FPL is about $31,150 for an individual and $61,500 for a family of four.

Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

People with marketplace plans or Medicaid are significantly less likely than those with employer benefits to be confident that they will be able to keep their health insurance in the future. About one-third of marketplace enrollees and one-quarter of Medicaid beneficiaries were not confident they could keep their plans in the future; just 9 percent of those with employer plans were not confident. (See Table 4 for complete data.)

Among Medicaid or marketplace enrollees who lacked confidence about keeping their plans, nearly half said the Trump administration wouldn't carry out the ACA or Congress would repeal it.

What is the main reason you are not confident you will be able to keep this coverage in the future?



*Adults ages 19–64 with marketplace or Medicaid coverage who were **not confident** they would be able to keep health care coverage in the future*

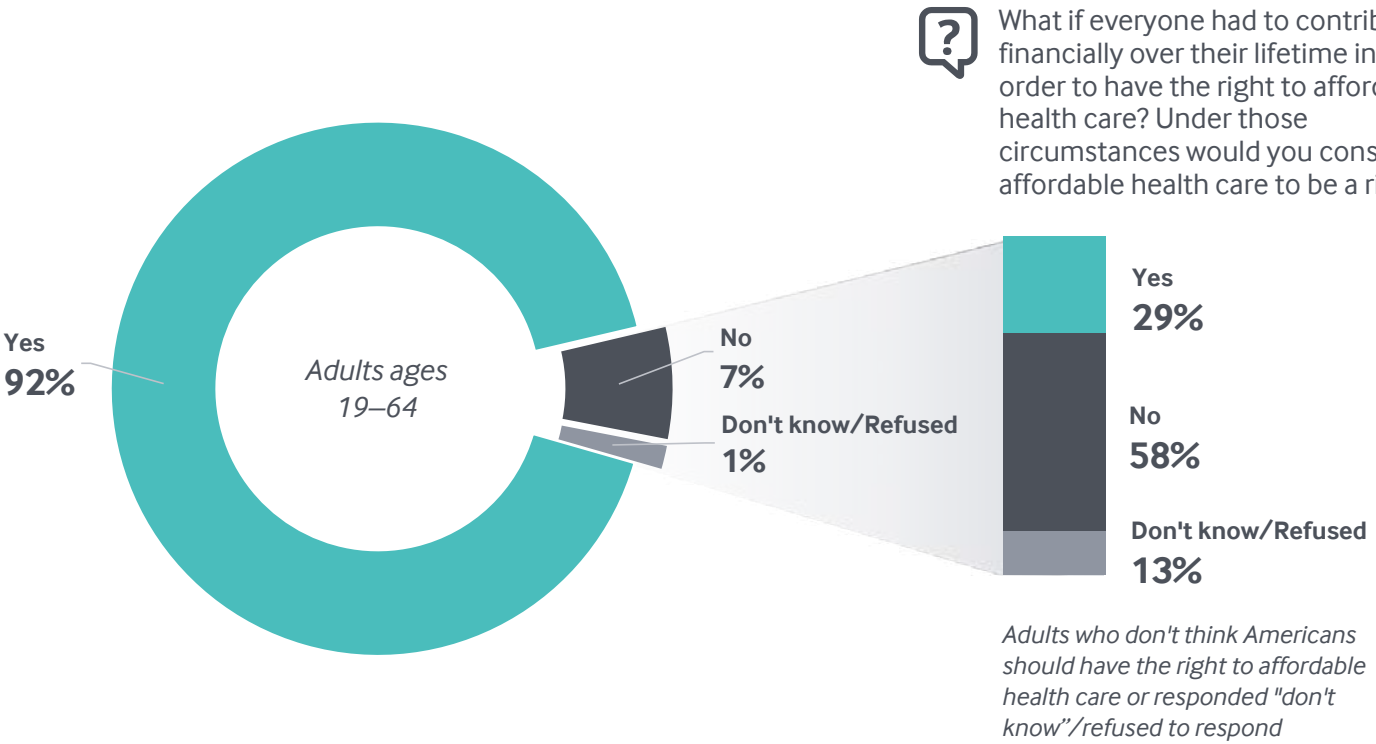
When asked why they weren't confident they could keep their health insurance in the future, 32 percent of marketplace and Medicaid enrollees said they didn't think the Trump administration would carry out the ACA, while 15 percent expected Congress to repeal the law. About one in five didn't think they would be able to afford their insurance, and 12 percent thought insurers might not offer it where they live.

Note: Categories may not sum to 100 percent because of rounding.

Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

Most people think all Americans should have the right to affordable health care.

Do you think all Americans should have the right to affordable health care?



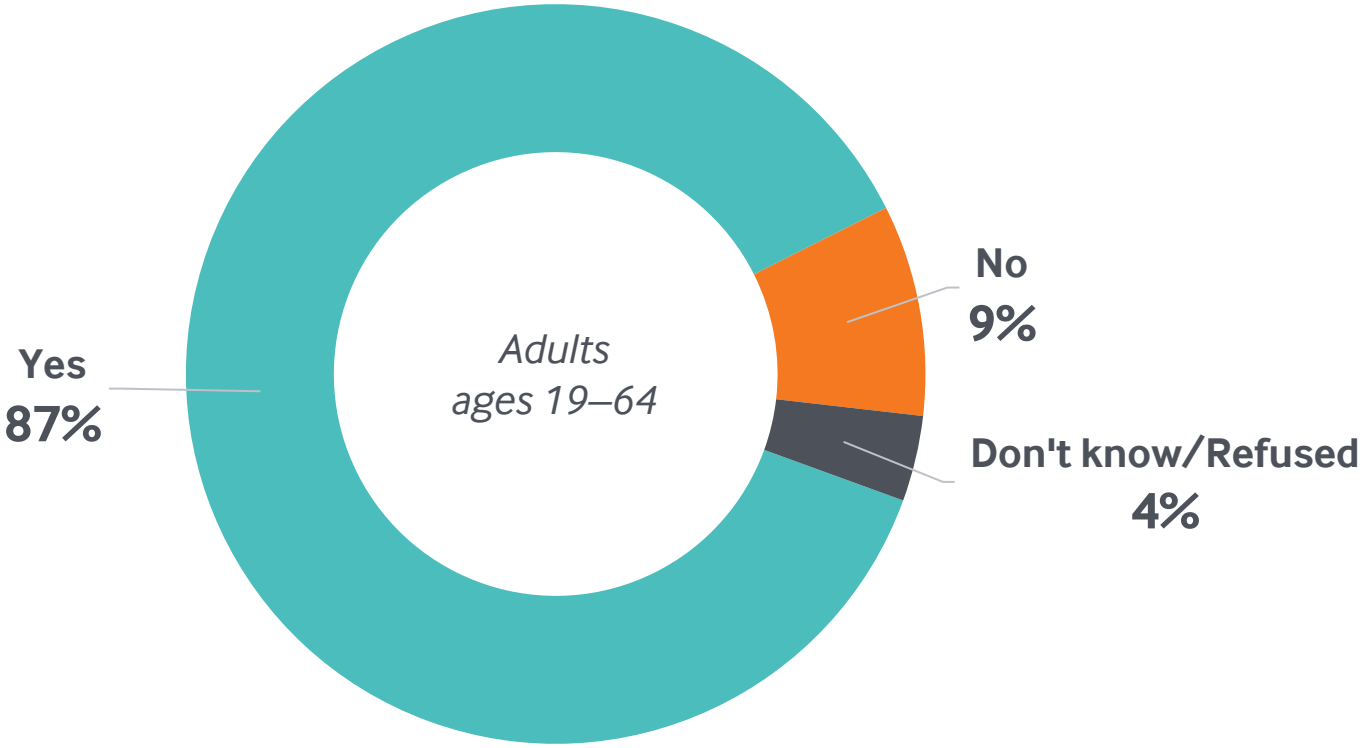
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

Nearly all U.S. adults, regardless of political affiliation or income, think all Americans should have the right to affordable health care. This includes 99 percent of Democrats, 82 percent of Republicans, and 92 percent of independents. (See Table 5 for complete data.)

Of the 8 percent of adults who either don't think Americans should have the right to affordable health care, or didn't know or refused to respond, 29 percent said they would consider health care a right if people had to contribute financially over their lifetime.

Most think paying into Medicare over a lifetime is a fair way to ensure everyone has access to care at age 65.

Most people contribute financially to Medicare over their lifetime through payroll taxes. Do you think this is a fair way to help ensure everyone has access to Medicare when they become eligible at age 65, or not?



Medicare requires lifetime financial contributions. Workers pay into Medicare through payroll taxes. When people were asked whether they thought this was a fair way to ensure everyone has access to Medicare when they turn 65, 87 percent of respondents said yes. This included 92 percent of Democrats, 84 percent of Republicans, and 87 percent of independents. (See Table 6 for complete data.)

Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

POLICY IMPLICATIONS

This survey, along with other recent federal and private surveys, indicate that gains in coverage post-ACA have leveled out, and uninsured rates may even be ticking up slightly. As our findings suggest, policy changes could increase coverage, including greater outreach and advertising in all states and reforms to improve plan affordability.

Analysts Christine Eibner and Jodi Liu modeled six options to increase affordability of marketplace coverage, including extending tax credits to people who are above the income eligibility threshold and instituting a federal reinsurance program.[2] Medicaid expansion, however, remains the most obvious means for expanding coverage nationwide: this and other surveys show that uninsured rates in the 19 states that have not expanded Medicaid are higher than in expansion states.[3]

Among survey respondents who were extremely pessimistic about their ability to maintain their marketplace or Medicaid coverage going forward, nearly half pointed to actions by the Trump administration and Congress as the main source of their unease. It seems clear that signals of support for this coverage from both branches of government would reassure consumers about their access to health care. Such a shift also would provide a more stable regulatory environment for insurers participating in both the marketplaces and Medicaid.

The absence of such signals from Washington may fuel an emerging debate over how best to insure that all Americans have coverage that provides them with access to affordable health care. Some proposals call for building on the ACA to achieve this goal. Others would allow people to buy in to Medicare or Medicaid. Still others would replace the ACA with a Medicare for all approach, while others would provide funds to states to design their own systems. This survey's finding that strong majorities of U.S. adults, regardless of party affiliation, believe that all Americans should have a right to affordable health care suggests there may be popular support for a discussion over our preferred path.

HOW WE CONDUCTED THIS STUDY

The most recent Commonwealth Fund Affordable Care Act Tracking Survey was conducted by SSRS from November 2 to December 27, 2017. The survey consisted of telephone interviews in English or Spanish and was conducted among a random, nationally representative sample of 2,410 adults, ages 19 to 64, living in the United States. Overall, 122 interviews were conducted on landline telephones and 2,288 interviews on cell phones.

This survey is the sixth in a series of Commonwealth Fund surveys to track the implementation and impact of the ACA. The first was conducted by SSRS from July 15 to September 8, 2013, by telephone among a random, nationally representative U.S. sample of 6,132 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 1.8 percent at the 95 percent confidence level.

The second survey in the series was conducted by SSRS from April 9 to June 2, 2014, by telephone among a random, nationally representative U.S. sample of 4,425 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 2.1 percent at the 95 percent confidence level. The sample for the April–June 2014 survey was designed to increase the likelihood of surveying respondents who were most likely eligible for new coverage options under the ACA. As such, respondents in the July–September 2013 survey who said they were uninsured or had individual coverage were asked if they could be recontacted for the April–June 2014 survey. SSRS also recontacted households reached through their omnibus survey of adults who were uninsured or had individual coverage prior to the first open enrollment period for 2014 marketplace coverage.

The third survey in the series was conducted by SSRS from March 9 to May 3, 2015, by telephone among a random, nationally representative U.S. sample of 4,881 adults, ages 19 to 64. The March–May 2015 sample was also designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. SSRS recontacted households reached through their omnibus survey of adults between November 5, 2014, and February 1, 2015, who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. The survey had an overall margin of sampling error of +/– 2.1 percentage points at the 95 percent confidence level.

The fourth survey in the series was conducted by SSRS from February 2 to April 5, 2016, by telephone among a random, nationally representative U.S. sample of 4,802 adults, ages 19 to 64. The February–April 2016 sample was also designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. Interviews in wave 4 were obtained through two sources: 1) stratified RDD sample, using the same methodology as in waves 1–3; and 2) households reached through the SSRS Omnibus, where interviews were previously completed with respondents ages 19 to 64 who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. The survey had an overall margin of sampling error of +/– 2.0 percentage points at the 95 percent confidence level.

The fifth survey in the series was conducted by SSRS from March 28 to June 20, 2017, by telephone among a random, nationally representative U.S. sample of 4,813 adults, ages 19 to 64. The March–June 2017 sample was also designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. Interviews in wave 5 were obtained through two sources: 1) stratified RDD sample, using the same methodology as in waves 1–4; and 2) households reached through the SSRS Omnibus where interviews were previously completed with respondents ages 19 to 64 who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. The survey had an overall margin of sampling error of +/– 1.8 percentage points at the 95 percent confidence level.

The November–December 2017 sample was also designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. Interviews in wave 6 were obtained through two sources: 1) stratified RDD sample, using the same methodology as in waves 1–5; and 2) households reached through the SSRS Omnibus, where interviews were previously completed with respondents ages 19 to 64 who were uninsured, had individual coverage, had a marketplace plan, or had public insurance.

As in all waves of the survey, SSRS oversampled adults with incomes under 250 percent of the federal poverty level to further increase the likelihood of surveying respondents eligible for the coverage options as well as to allow separate analyses of responses from low-income households.

The data were weighted to correct for oversampling uninsured and direct purchase respondents, the stratified sample design, the overlapping landline and cell phone sample frames, and disproportionate nonresponse that might bias results. New to this wave's sample design, the weights also corrected for oversampling respondents with a prepaid cell phone. The data are weighted to the U.S. 19-to-64 adult population by age by state, gender by state, race/ethnicity by state, education by state, household size, geographic division, and population density using the U.S. Census Bureau's 2015 American Community Survey. Data were weighted to household telephone use parameters based on the CDC's 2016 National Health Interview Survey (NHIS).

The resulting weighted sample is representative of the approximately 190 million U.S. adults ages 19 to 64. Data for income, and subsequently for federal poverty level, were imputed for cases with missing data, utilizing a standard general linear model procedure. The survey has an overall margin of sampling error of +/– 2.7 percentage points at the 95 percent confidence level. The overall response rate, including the prescreened sample, was 7.0 percent.

Table 1. Demographics of Overall Sample, Uninsured Adults, and Adults by Coverage Source

	Total adults (ages 19–64)	Uninsured adults	Total current marketplace and Medicaid enrollees	Enrolled in a private health plan through the marketplace	Enrolled in Medicaid	Enrolled in employer-sponsored insurance
Percent distribution	100%	14%	19%	7%	12%	54%
Age						
19–34	33	40	30	24	33	35
19–25	15	17	12	13	12	15
26–34	18	23	18	10	22	19
35–49	32	33	31	31	31	34
50–64	33	27	36	43	33	30
Race/Ethnicity						
Non-Hispanic White	61	44	54	64	49	68
Black	13	10	17	13	19	12
Latino	18	36	21	15	24	13
U.S.-born Latino	9	11	11	9	11	8
Foreign-born Latino	9	25	10	5	13	5
Asian/Pacific Islander	4	5	4	4	3	4
Other/Mixed	3	3	4	3	4	2
Poverty status						
Below 250% poverty	48	72	76	54	88	29
250% poverty or more	52	28	24	46	12	71
Health status						
Fair/Poor health status, or any chronic condition or disability^	50	47	62	53	67	43
No health problem	50	53	38	47	33	57
Political affiliation						
Democrat	29	19	34	33	35	31
Republican	19	18	13	20	9	21
Independent	26	26	26	27	25	25
Something else	17	18	18	15	19	17
State Medicaid expansion decision*						
Expanded Medicaid	61	49	72	59	79	60
Did not expand Medicaid	38	51	28	41	21	39
Region						
Northeast	17	12	18	14	20	18
Midwest	20	18	20	20	20	20
South	38	47	30	38	25	38
West	25	23	33	28	35	23
Adult work status						
Full-time	56	40	28	47	18	75
Part-time	14	18	22	22	23	9
Not working	29	40	50	31	59	15
Employer size^^						
1–24 employees	28	57	46	60	34	16
25–99 employees	13	17	14	18	11	11
100–499 employees	12	5	4	3	5	15
500 or more employees	44	15	28	17	38	55
Education level						
High school or less	37	52	46	30	54	30
Some college/technical school	31	33	36	40	34	27
College graduate or higher	32	12	18	30	12	43

NOTES

* The following states expanded their Medicaid program and began enrolling individuals by the time of the survey: AK, AR, AZ, CA, CO, CT, DE, HI, IA, IN, IL, KY, LA, MA, MD, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, WV, and the District of Columbia. All other states were considered to have not expanded.

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

^^ Base: full- and part-time employed adults ages 19–64.

Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

Table 2. Uninsured Rates Among Adults, 2013–2017

	July–Sept. 2013	April–June 2014	March–May 2015	Feb.–April 2016	March–June 2017	Nov.–Dec. 2017
Percent distribution	19.9%	14.8%	13.3%	12.7%	14.0%	14.0%
Age						
19–34	28	18	19	18	16	17
19–25	31	19	16	17	14	15
26–34	26	18	23	19	18	18
35–49	18	15	13	11	15	15
50–64	14	11	8	9	10	11
Race/Ethnicity						
Non-Hispanic White	16	12	9	9	10	10
Black	21	20	18	13	17	10
Latino	36	23	26	29	30	28
U.S.-born Latino	24	*	*	14	17	18
Foreign-born Latino	47	*	*	43	42	38
Asian/Pacific Islander	18	10	8	9	5	*
Other/Mixed	23	12	14	11	13	—
Poverty status						
Below 250% poverty	34	23	21	21	22	21
250% poverty or more	7	6	4	4	6	8
Health status						
Fair/Poor health status, or any chronic condition or disability^	20	16	14	13	13	13
No health problem	20	14	13	12	15	15
Political affiliation						
Democrat	18	13	10	10	10	9
Republican	11	11	8	8	10	13
Independent	19	14	15	12	15	14
Something else	28	19	17	16	17	15
State Medicaid expansion decision**						
Expanded Medicaid	18	12	10	10	11	11
Did not expand Medicaid	23	19	18	16	19	18
Region						
Northeast	13	12	8	10	9	10
Midwest	17	13	8	8	9	13
South	24	19	18	16	19	17
West	21	12	13	13	14	13
Adult work status						
Full-time	14	12	10	9	11	10
Part-time	29	19	14	17	20	18
Not working	25	17	18	17	17	19
Employer size^^						
1–24 employees	32	25	21	24	25	23
25–99 employees	20	17	17	14	13	16
100–499 employees	13	8	9	6	8	5
500 or more employees	7	6	4	3	5	4
Education level						
High school or less	28	23	22	22	23	20
Some college/technical school	19	14	11	11	11	15
College graduate or higher	10	5	5	3	6	5

NOTES

* Not applicable.

— Sample size limitations.

** We categorize states as expansion states if their state expanded their Medicaid program and were enrolling people by the time of the survey.

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

^^ Base: full- and part-time employed adults ages 19–64.

Data: The Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013, April–June 2014, March–May 2015, Feb.–April 2016, March–June 2017, and Nov.–Dec. 2017.

Table 3. Demographics of Total Adults and Uninsured Adults, July–Sept. 2013 and Nov.–Dec. 2017

	Total adults (ages 19–64)		Uninsured adults (ages 19–64)	
	July–Sept. 2013	Nov.–Dec. 2017	July–Sept. 2013	Nov.–Dec. 2017
Percent distribution	100%	100%	100%	100%
Age				
19–34	32	33	46	40
19–25	15	15	23	17
26–34	18	18	23	23
35–49	32	32	29	33
50–64	33	33	23	27
Race/Ethnicity				
Non-Hispanic White	63	61	50	44
Black	12	13	13	10
Latino	16	18	29	36
U.S.-born Latino	7	9	9	11
Foreign-born Latino	9	9	20	25
Asian/Pacific Islander	4	4	3	5
Other/Mixed	2	3	3	3
Poverty status				
Below 250% poverty	48	48	81	72
250% poverty or more	52	52	19	28
Health status				
Fair/Poor health status, or any chronic condition or disability^	47	50	47	47
No health problem	53	50	53	53
Political affiliation				
Democrat	30	29	28	19
Republican	20	19	11	18
Independent	24	26	22	26
Something else	16	17	22	18
State Medicaid expansion decision*				
Expanded Medicaid	59	61	53	49
Did not expand Medicaid	41	38	46	51
Region				
Northeast	17	17	12	12
Midwest	22	20	18	18
South	38	38	46	47
West	23	25	25	23
Adult work status				
Full-time	53	56	39	40
Part-time	12	14	18	18
Not working	33	29	42	40
Employer size^^				
1–24 employees	26	28	48	57
25–99 employees	17	13	19	17
100–499 employees	15	12	11	5
500 or more employees	41	44	17	15
Education level				
High school or less	39	37	56	52
Some college/technical school	30	31	29	33
College graduate or higher	29	32	14	12

NOTES

* We categorize states as expansion states if their state expanded their Medicaid program and were enrolling people by the time of the survey.

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

^^ Base: full- and part-time employed adults ages 19–64.

Data: The Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013 and Nov.–Dec. 2017.

Table 4. You said you currently have health insurance. How confident are you that you will be able to keep this health care coverage in the future?
Base: Insured adults ages 19–64

	Very confident	Somewhat confident	Very or somewhat confident	Not too confident	Not at all confident	Not too or not at all confident
Percent distribution	57%	25%	83%	10%	6%	15%
Age						
19–34	57	26	83	11	5	16
35–49	59	24	84	10	5	15
50–64	56	26	82	8	6	15
Gender						
Men	63	22	85	6	7	13
Women	53	28	81	13	5	18
Race/Ethnicity						
White	61	25	85	7	6	13
Black	56	28	83	10	6	15
Hispanic	44	27	71	22	5	27
Income						
Below 250% poverty	47	29	76	16	7	22
250% poverty or more	66	23	89	5	5	10
Insurance status						
Employer	67	22	90	6	3	9
Medicaid	34	36	70	18	9	27
Medicare	44	26	71	13	8	22
Marketplace	32	31	63	19	17	36
Region						
Northeast	56	25	81	12	6	18
Midwest	60	25	86	9	4	13
South	63	22	85	8	6	13
West	49	30	79	12	6	18
Political affiliation						
Democrat	57	26	83	11	5	16
Republican	65	20	85	7	8	15
Independent	56	28	84	9	5	14
Voter registration status						
Not registered	62	22	84	9	5	14
Registered	58	27	85	8	6	14

Notes: Segments may not sum to indicated total because of rounding. "Very or somewhat confident" and "Not too or not at all confident" categories may not sum to 100 percent because of "Don't know" responses or refusal to respond.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

Table 5. Do you think all Americans should have the right to affordable health care?
Base: Adults ages 19–64

	Yes	No
Percent distribution	92%	7%
Age		
19–34	94	4
35–49	91	8
50–64	91	8
Gender		
Men	89	9
Women	95	4
Race/Ethnicity		
White	90	9
Black	97	2
Hispanic	97	2
Income		
Below 250% poverty	96	2
250% poverty or more	88	11
Insurance status		
Uninsured	91	7
Employer	91	8
Medicaid	98	1
Medicare	96	1
Marketplace	93	7
Region		
Northeast	93	5
Midwest	91	8
South	91	7
West	92	6
Political affiliation		
Democrat	99	1
Republican	82	17
Independent	92	6
Voter registration status		
Not registered	95	4
Registered	91	8

Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

Table 6. Most people contribute financially to Medicare over their lifetime through payroll taxes. Do you think this is a fair way to help ensure everyone has access to Medicare when they become eligible at age 65, or not?
Base: Adults ages 19–64

	Yes	No
Percent distribution	87%	9%
Age		
19–34	87	9
35–49	84	12
50–64	89	7
Gender		
Men	85	10
Women	89	8
Race/Ethnicity		
White	87	9
Black	85	12
Hispanic	91	7
Income		
Below 250% poverty	87	10
250% poverty or more	87	9
Insurance status		
Uninsured	84	11
Employer	88	9
Medicaid	86	9
Medicare	87	10
Marketplace	93	5
Region		
Northeast	85	10
Midwest	86	12
South	89	8
West	87	9
Political affiliation		
Democrat	92	6
Republican	84	13
Independent	87	10
Voter registration status		
Not registered	82	12
Registered	88	9

Data: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

NOTES

[1] National Academy for State Health Policy, *Individual Marketplace Enrollment Remains Stable in the Face of National Uncertainty* (NASHP, Feb. 7, 2018), https://nashp.org/individual-marketplace-enrollment-remains-stable-in-the-face-of-national-uncertainty/.

[2] C. Eibner and J. Liu, *Options to Expand Health Insurance Enrollment in the Individual Market* (The Commonwealth Fund, Oct. 2017), http://www.commonwealthfund.org/publications/fund-reports/2017/oct/expand-insurance-enrollment-individual-market.

[3] S. L. Hayes, S. R. Collins, D. C. Radley, and D. McCarthy, *What's at Stake: States' Progress on Health Coverage and Access to Care, 2013–2016* (The Commonwealth Fund, Dec. 2017), http://www.commonwealthfund.org/publications/issue-briefs/2017/dec/states-progress-health-coverage-and-access.

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About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

APPENDIX

Survey Estimates of Changes in U.S. Uninsured Rates Since 2013

Survey	Pre-implementation uninsured rate (%) [95% CI]	Current uninsured rate (%) [95% CI]	Millions of uninsured
The Commonwealth Fund Affordable Care Act Tracking Survey[1]	19.9% [18.5%–21.4%]	14.0% [12.3%–15.8%]	—
National Health Interview Survey[2]	20.4% [19.7%–21.1%]	12.5% [11.7%–13.3%]	24.7 million
Gallup-Sharecare Well-Being Index[3]	20.7%	14.8%	—

Notes: Confidence intervals are shown where they were reported out by the organization. Percent estimates were not reported.

[1] The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

[2] E. P. Zammitti, R. A. Cohen, and M. E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, Jan.–June 2017* (National Center for Health Statistics, Nov. 2017), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201711.pdf.

[3] Z. Auter, "U.S. Uninsured Rate Steady at 12.2% in Fourth Quarter of 2017," Gallup-Sharecare Well-Being Index, Jan. 16, 2018, http://news.gallup.com/poll/225383/uninsured-rate-steady-fourth-quarter-2017.aspx.

Methodological Differences Between Surveys

Survey	Population	Time frame	Sample frame	Response rate
The Commonwealth Fund Affordable Care Act Tracking Survey[1]	U.S. adults ages 19–64	July–Sept. 2013 to Nov.–Dec. 2017	Dual-frame, RDD telephone survey	2013: 20.1% 2017: 7%
National Health Interview Survey[2,3]	U.S. adults ages 18–64	2013 to Jan.–June 2017	Multistage area probability design	80%
Gallup-Sharecare Well-Being Index[4]	U.S. adults ages 18–64	2013 to Oct.–Dec. 2017	Dual-frame, RDD telephone survey	7%–9%

[1] The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

[2] E. P. Zammitti, R. A. Cohen, M. E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, Jan.–June 2017* (National Center for Health Statistics, Nov. 2017), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201711.pdf.

[3] National Center for Health Statistics, *About the National Health Interview Survey* (NCHS, July 2017), https://www.cdc.gov/nchs/nhis/about_nhis.htm.

[4] Z. Auter, "U.S. Uninsured Rate Steady at 12.2% in Fourth Quarter of 2017," Gallup-Sharecare Well-Being Index, Jan. 16, 2018, http://news.gallup.com/poll/225383/uninsured-rate-steady-fourth-quarter-2017.aspx.

The Commonwealth Fund

commonwealthfund.org

Association Health Plans: Projecting the Impact of the Proposed Rule

Prepared for America's Health Insurance Plans | 02.28.18

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Avalere

Executive Summary

Association Health Plans (AHPs) are health insurance arrangements sponsored by an industry, trade, or professional association that provide health coverage to their members—typically small businesses and their employees. Health insurance coverage offered through AHPs aims to make coverage available and affordable for small groups and individual employees. Importantly, these arrangements are currently governed by state and federal requirements and are subject to state oversight, including standards related to premiums and benefit requirements.

A recent Department of Labor's (DOL) proposed regulation would seek to broaden access to AHPs by expanding eligibility and potentially allowing a larger number of these arrangements to be exempt from certain Affordable Care Act insurance protections—including coverage for essential health benefits and community rating requirements.

The proposed AHP changes are expected to have an impact on enrollment and premiums for existing individual and small group market plans. Individuals and small businesses shifting out of their respective markets into AHPs are expected to be healthier than average, fueling adverse selection. This adverse selection could increase individual and small group market premiums and could lead to decreased competition in those markets due to changes in issuer participation.

The report that follows estimates the premium and coverage impact of the DOL proposed rule over a 5-year period (2018-2022). If the rule is finalized as proposed, we estimate the following impacts on the individual and small-group markets:

- **Higher premiums in both the individual and small-group markets.** If the proposed AHP rule is finalized, Avalere projects premiums would rise in the current individual (2.7% to 4.0%) and small group (0.1% to 1.9%) markets relative to current law, largely due to healthier enrollees shifting into AHPs. This trend will lead to the individual and small group market risk scores rising.
- **Increase in the number of uninsured Americans.** The proposed rule is projected to lead to 130,000 - 140,000 additional individuals becoming uninsured by 2022, compared to current law. The increased number of uninsured is largely caused by premium increases in the individual market as healthier enrollees shift into AHPs.
- **An additional 2.4M to 4.3M peopled enrolled in AHPs.** This figure represents people switching out of the individual market (0.7M to 1.2M) and small group market (1.7M to 3.2M) into the expanded AHPs.
- **Lower premiums for enrollees that enroll in AHPs.** Premiums in the new AHPs are projected to be between $1,900 to $4,100 lower than the yearly premiums in the small group market and $8,700 to $10,800 lower than the yearly premiums in the individual market by 2022, depending on the generosity of AHP coverage offered. While AHPs will likely offer lower premiums for many enrollees, the largest premium differences assume

AHPs offer less-generous benefits than current markets, which could expose some enrollees to high out-of-pocket costs, particularly those that have significant healthcare needs.

The AHP proposed rule continues a trend under the current administration toward increased regulatory flexibility. While this flexibility may lead to lower premiums for some (particularly younger, healthier individuals and small groups), it is likely to further adverse selection out of the individual and small group markets that could lead to increased premiums in those markets and create additional market instability.

Overview of Association Health Plans and the Proposed Rule

AHPs Today

AHPs provide an additional option for individuals and small businesses seeking to obtain affordable healthcare coverage.[1] Managing a group health plan can be administratively complex and costly for certain small businesses—especially those lacking formal or expansive human resource departments. By allowing small businesses to band together under association health plan group coverage, these arrangements aim to achieve economies-of-scale advantages to be more effective in coverage negotiations and bargaining with private payers.

Today, most AHPs limit their enrollment to specific employer groups—individual enrollees who are sole proprietors and small employers who are engaged in a specific trade or business. These limitations make many individuals and employers ineligible to participate in certain AHPs that may operate in their area and help the AHP control its enrollment and the associated risk of enrollees.

Regulation of AHPs

Compared to the large group market, there are more extensive benefit and coverage requirements in the individual and small group market. These include requirements to offer benefits in each of the 10 essential health benefit (EHB) categories, community rating standards, network adequacy requirements, and state review of issuer rate and form filings.[I] Many of these requirements, including the EHBs, do not apply to or are not as strict for large group plans.

AHPs may obtain the same benefit flexibility and coverage choices as the large group market if they are able to self-insure (where the AHP itself takes on the insurance risk of the individuals

1 According to the Employee Retirement Income Security Act (ERISA) of 1974, ERISA defines an employer-based AHP (also known as a Multiple Employer Welfare Arrangement (MEWA)) as any arrangement through which two or more employers and/or self-employed individuals obtain health insurance coverage." This analysis focuses on those AHPs which can be classified as MEWAs.

enrolling in the AHP) or if they can be classified as a single-employer large group plan.[ii] However, the small size of the risk pool in most AHPs, creating non-diversified risk, can make it financially challenging or impossible for many AHPs to self-insure. In addition, current ERISA rules make it challenging for AHPs to achieve the single employer classification.

Specifically, guidance notes that it should be "rare" that an AHP is deemed the "employer," and is treated as sponsoring a single group health plan.[vi] In order to be classified as a single large group, the AHP must be constructed so that:

- All employer members are in the same profession or industry, or are members of the same employee organization;
- Access to the AHP is not the only purpose for becoming a member of the association;
- The AHP is owned and managed (directly or through elected representatives) by its member employers; and
- There must be at least 51 employees of the employers participating in the plan.

As a result of these requirements, very few AHPs are classified as single-employer large group plans and therefore do not have access to the regulatory flexibility described above.

January 2018 AHP Proposed Rule

On January 4, DOL issued a proposed rule that seeks to expand access to and increase regulatory flexibility for AHPs.[iii] The proposed rule follows an executive order (EO) by President Trump on October 12, 2017, and is designed to streamline the ability of small employers, including sole proprietors, to enroll and seek coverage for their employees through AHPs.[iv] Indeed, the DOL's proposed rule would broaden access to AHPs and make it easier for an AHP to be classified as a single-employer plan under ERISA. As explained above, such a classification would allow the AHP to have greater benefit and coverage flexibility, leading to potentially less generous, but also less-expensive, coverage offerings through the AHP. While the DOL did include AHP anti-discrimination provisions that are designed to prevent misuse of AHPs, there are still potential concerns that the flexibility provided to AHPs to regulate their membership could be used to discriminate against higher cost enrollees and groups.

i. Expanding Access to AHPs

The proposed rule seeks to expand access to AHPs by clarifying DOL rules around eligibility for sole proprietors (self-employed without non-family employees). AHP rules already allow self-employed individuals to participate in AHPs.[v] However, the DOL sought to align regulations throughout different parts of ERISA to ensure that a working owner without employees, regardless of the legal form in which the business is operated, may choose to participate in a AHP.

ii. Reducing Barriers to Single Employer Classification

The DOL also sought to make it easier for more AHPs, including those with participants from a diverse range of businesses or industries, to potentially be classified as a single employer group

plan. As previously noted, today, it is difficult for a AHP to be classified as a single employer group.

a. Same Industry or Business Requirement

One of the obstacles to the single-employer classification is the requirement that members of the same AHP be in the same trade or business. In the proposed rule, the DOL seeks to remove this limitation in situations where all members of the AHP are in the same state or metropolitan area. The proposed rule specifically notes that this flexibility will allow local chambers of commerce to sponsor a AHP and make it open to all members of the chamber. In addition, it could allow for the sale across state lines if the metropolitan area in which the AHP is offered occupies multiple states.

b. Sole Purpose of AHP Membership

The proposed rule also would ensure that employers can pursue AHP membership solely for access to health coverage without jeopardizing the ERISA status of the plan. The DOL proposes to do this by removing the ERISA AHP requirement that membership in the AHP must not be the sole relationship or purpose for members joining the association. In addition to expanding access, this could also make it easier for AHPs to form, as they would no longer have to offer additional benefits, such as advocacy or representation, to be able to access the coverage flexibility of a single large employer AHP.

c. Joint Control

The DOL did not recommend changes to the joint control requirement that exists for an AHP to be considered a single-employer group. Joint control requires the group or association to have a formal organizational structure with a governing body where member employers control the establishment and maintenance of the group health plan—either directly or through elected representatives. The purpose of these requirements is to ensure that the organization acts as a single unit and in the interests of its members. This requirement is cited as one of the most significant barriers to a AHP being classified as a single employer group. The fact that it was not altered could impact how many AHPs can take advantage of the additional benefit flexibility.

iii. Nondiscrimination

The proposed rule specifically applies many of the nondiscrimination provisions of the Affordable Care Act (ACA) and Health Insurance Portability and Accountability Act (HIPAA) to AHPs. Specifically, AHPs must not restrict membership or impose differential premiums based on health status, medical condition (including both physical and mental illnesses), claims experience, medical history, genetic information, evidence of insurability, or disability. However, AHPs may impose different non-health-related eligibility terms and premiums based on factors such as full-time versus part-time status, different geographic locations, membership in a collective bargaining unit, date of hire, length of service, current versus former employee status, occupation, and relationship to employee member (for dependent coverage).

Potential Implications of AHP Proposed Rule

As proposed, the rule may allow some employers to access less expensive, less generous health insurance coverage or may allow them to pursue different insurance structures, such as self-insured and fully-insured AHPs. In addition, reducing the barriers to a AHP being classified as a single large group could allow some employers to access additional benefit flexibility, which could lead lower premiums and reduced benefits for some members. Importantly, this increased flexibility creates adverse selection incentives for many sole proprietors and small businesses, particularly those who are healthier than average, to shift into AHPs. As healthier sole proprietors and small businesses shift toward AHPs, premiums are projected to rise for the remaining enrollees in the individual and small group markets. Below are some of the potential implications of the AHP proposed rule if finalized as proposed.

Table 1: Expected Policy Impacts of the AHP Proposed Rule

	Positive	Negative
Coverage	Additional coverage options and benefit flexibilities Lower administrative costs	Increased number of uninsured Potential instability if new AHPs are unprepared to effectively manage risk for their enrollees
Premiums	Lower premiums for enrollees compared to current markets	Higher premiums for existing individual / small group market enrollees
Benefit Flexibility	More benefit flexibility, which can be used to tailor benefits to meet the needs of enrollees	Higher out-of-pocket costs for enrollees with significant healthcare needs Return of potentially discriminatory insurance practices

Projected Impact of AHP Proposed Rule

Key Modeling Takeaways

The proposed rule on AHPs would lead to a substantive shift, within the first four years, of enrollees in both the individual and small group markets into the new AHPs. Avalere modeled three scenarios, a “High”, “Moderate”, and “Low” scenario. The scenarios vary based on the initial availability of AHPs in 2019, the average generosity of coverage offered by AHPs, and the projected level of risk selection by small businesses (i.e., healthier on average small businesses choosing to move into AHPs for lower premiums, less generous coverage). The “High” scenario assumes the highest availability of AHPs starting in 2019 of all the scenarios, a low projected level of generosity of AHP coverage (and thereby low premiums), and significant risk selection by small businesses. Conversely, the “Low” scenario assumes limited availability of AHPs in

2019, generosity of AHP coverage more akin to small group coverage today, and limited risk selection by small businesses.

Avalere projects 2.4M to 4.3M enrollees to shift into AHPs by 2022. If the proposed AHP rule is finalized, premiums would rise in both the individual (2.7% to 4.0%) and small group markets (0.1% to 1.9%) relative to current law, as healthier enrollees and small businesses in both markets self-select into AHPs. Premiums in the new AHPs are projected to be $1,900 to $4,100 lower than the yearly premiums in the small group market and $8,700 to $10,800 lower than the yearly premiums in the individual market by 2022, depending on the generosity of AHP coverage offered. Additionally, 130,000 - 140,000 individuals are expected to become uninsured by 2022 due to the proposed rule.

The further expansion of the AHP market is constrained by the number of eligible sole proprietors and small groups, as well as the availability of AHPs offered in the area. Despite these constraints, enrollment in AHPs is expected to continue to grow in future years. In total, the proposed rule is projected to shift 0.7M to 1.2M individuals out of the individual market and 1.7M to 3.2M out of the small group market by 2022.

Table 2: Projected Impact of AHP Proposed Rule by Scenario, 2022

	Low Scenario	Moderate Scenario	High Scenario
Enrollment			
New AHP Enrollment	2,360,000	3,180,000	4,310,000
From Individual Market into AHPs	(710,000)	(950,000)	(1,110,000)
From Small Group Market	(1,650,000)	(2,230,000)	(3,200,000)
Premiums			
Change in Individual Market Premiums	2.7%	3.5%	4.0%
Average Individual Market Premiums[2]	$14,900	$15,000	$15,000
Change in Small Group Market Premiums	0.1%	0.5%	1.9%
Average Small Group Market Premiums	$8,100	$8,200	$8,300
Average AHP Premiums	$6,200	$5,300	$4,200

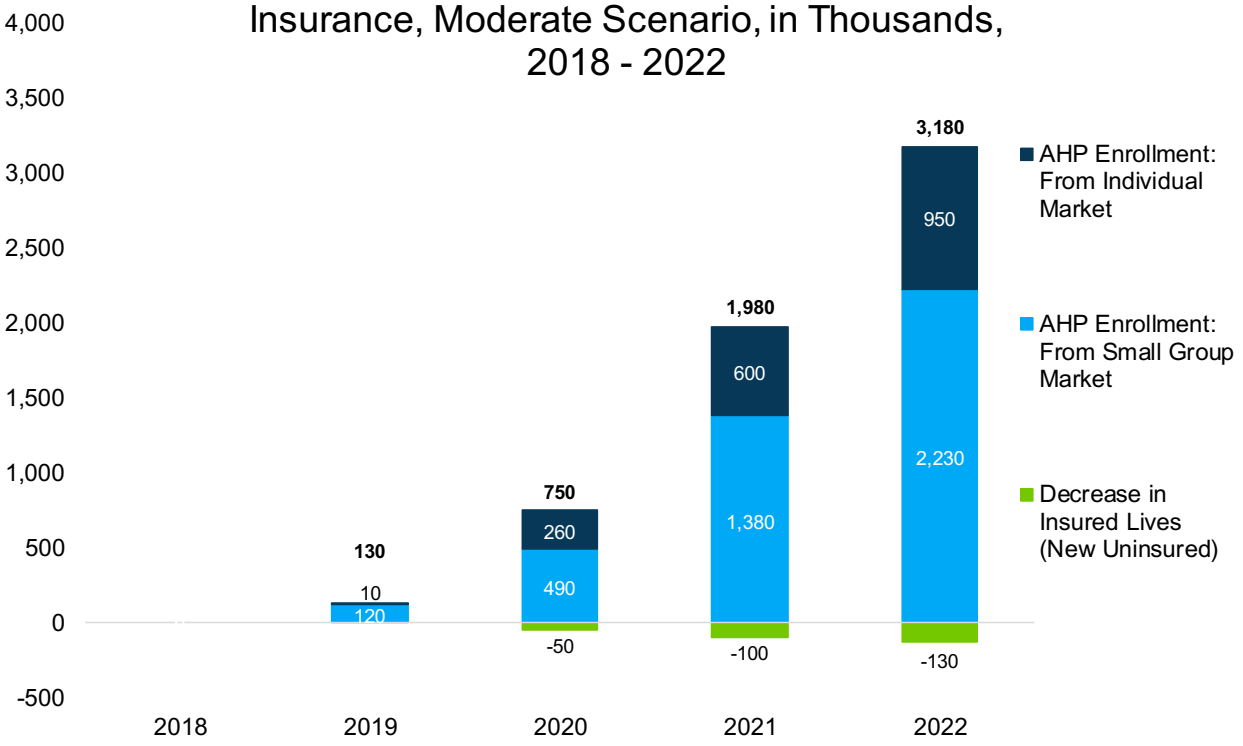
2 Average individual market unsubsidized premiums.

Model Findings

New AHP Enrollment: New AHP enrollment is projected to range from 2.4M to 4.3M under the high and low scenarios.

Source of AHP Enrollment: Enrollment in AHPs is projected to come from currently insured individuals and small businesses. Small groups would see the largest shifts into the new AHPs, comprising approximately 70% to 75% of the new AHP enrollment. The magnitude of this movement is largely due to the pool of eligible small groups substantially outweighing the eligible sole proprietors in the individual market.

Figure 1: Projected Enrollment in AHPs and Change in Insurance, Moderate Scenario, in Thousands, 2018 - 2022



AHP Premiums: Premiums in the new AHP market are expected to range $1,900 to $4,100 lower than the small group market average yearly premiums and $8,700 to $10,800 below the individual market average yearly premium by 2022. Sole proprietors in the individual market are projected to enroll at a much higher rate than small groups, particularly due to the larger differences between the premiums in the individual market and the new AHPs. The “High” scenario, which projects the largest premium differences between the new AHPs and individual and small group market premiums, assumes AHPs provide less generous coverage than currently offered in the individual and small group markets, while covering fewer benefits. This, coupled with aggressive risk selection out of the individual and small group markets into AHPs leads to substantial premium differences between the markets. The “Low” and “Moderate”

scenarios have less aggressive assumptions on the reductions in benefit generosity for AHPs and therefore have lower estimates of the premium differences between the markets.

Risk Scores: Risk scores are a measure of the "risk" of the insured population. The risk scores in the existing individual and small group markets will see an increase as a result of the proposed rule. Individual market average risk scores will increase 2.7% to 4.0%, while average small group risk scores are projected to increase 0.1% to 1.9%.

Table 3: Average Risk Scores Under AHP Proposed Rule, Moderate Scenario, 2022

Average Risk Scores	Individual Market	Small Group Market	New AHP Market
Current Law	1.277	1.159	-
Under AHP Proposed Rule: Moderate Scenario	1.321	1.165	0.905

Uninsured: The proposed AHP rule is projected to increase the number of uninsured in the US by 130,000 to 140,000 by 2022, largely because of the premium increases for those in the individual market who are ineligible to purchase coverage through an AHP. Over 80% of the newly uninsured come from the individual market.

Other Results Considerations

Avalere projected the expected enrollment growth in AHPs over the next 5 years, through 2022, as the result of the proposed rule. Given the uncertainty around the number of AHPs created, the propensity of small employers and sole proprietors to shift into AHPs, and the availability of AHPs in all regions of the country, Avalere modeled 3 scenarios projecting eventual enrollment into the market.

These scenarios were informed by the universe of sole proprietors and small businesses deemed eligible and likely to enroll, expected adverse selection by small employers, and generosity of AHP benefits. According to survey data, approximately 8% of the current individual market is self-employed in industries most likely to participate in an AHP. For the small group market, approximately 42% of the current small group market is in an industry deemed most likely to participate in an AHP.

Projecting the impact of the AHP proposed rule requires projecting a variety of decisions, from enrollee uptake, to eligibility, to availability of AHPs, and the generosity of the benefits that they offer. Below are some key factors that Avalere considered when building the model:

Initial Enrollment: Under the scenarios, Avalere varies the number of new AHP enrollees in the first year. The 3 scenarios are based off, in part, the phase-in experience of the healthcare sharing ministries (HCSM), another alternative to ACA coverage that has been growing substantially since 2013. Avalere used the share of HCSM enrollment compared to total individual enrollment during 2013 to inform the share of the eligible enrollees who move into the

new AHPs during 2019. These numbers are varied in the scenarios to provide a range of outcomes. The risk mix of the initial enrollment is projected to be similar to that of the demographics of the eligible sole proprietors in the individual market and the small groups in industries more likely to participate in an AHP.

Benefit Generosity: Much of the criticism of the AHP proposed rule has focused around the potential for a "race to the bottom" in benefit generosity, which would further exacerbate the adverse selection concerns for both the individual and small group markets. To model the impacts, the scenarios model different benefit amounts, ranging from Bronze levels (60% actuarial value) for the "High" scenario to Gold levels (80% actuarial value) for the "Low" scenario. Importantly, while single-employer insured AHPs may be exempted from certain individual and small group market rules, they are still subject to many state laws and large group requirements. As such, Avalere selected a reasonable range of benefit generosity for purposes of these scenarios.

Small Group Market Selection: Unlike the individual market, shifts into AHPs from the small group market will happen at the group level, rather than at the individual level. This makes self-selection more difficult and less likely to be as dramatic a risk shift as the enrollees shifting from the individual market. To better account for small group behavior, Avalere varied the levels of self-selection on the part of the small group market, with the "High" scenario assuming the highest level of self-selection and the "Low" scenario assuming the lowest amount (i.e., the shifts from the small group market more closely align to the risk of the entire market).

Eligibility Categories: Interestingly, the overall risk of small groups most likely to shift into AHPs is projected to be higher than the average risk of the small group market, due to the demographic make-up (particularly the age mix) of their employees. While small groups still are projected to shift into AHPs, the lower risk and premiums in the new AHP market is largely driven by the low-risk sole proprietors shifting into AHPs from the individual market. Effectively, the incentives for small groups to shift into AHPs are substantially lower than those for sole proprietors exiting the individual market.

Conclusion

The recent AHP proposed rule is expected to incentivize a larger number of healthy sole proprietors and groups to access the more affordable, potentially less generous coverage that could be available through an AHP. Conversely, those who remain in the individual and small group markets will pay more for their coverage, with an additional 130,000 to 140,000 individuals projected to become uninsured.

Importantly, this proposed rule on AHPs is one in a series of expected proposed regulations from the Administration that are projected to increase benefit flexibility and coverage options for healthier enrollees in the individual and small group markets. However, changes that allow or incentivize healthier individuals to exit the individual and small group market to pursue other,

sometimes non-ACA-compliant coverage offerings, could lead to higher costs for those sicker, less healthy individuals and groups who remain behind in the ACA regulated markets. For example, the Administration recently released a proposed rule increasing the availability of short-term limited duration insurance (which is exempted from many of the ACA's requirements)—which could similarly incent healthier individuals to exit the individual market, further increasing premiums for those remaining in ACA markets. Importantly, the potential effects of the short-term plan proposed rule are not considered here.

Methodology

The AHP proposed rule modeling results are the output of Avalere's proprietary models of individual and small group market health insurance coverage. The underlying data in the models are drawn from the American Community Survey (ACS), Current Population Survey (CPS), Centers for Medicare & Medicaid Services (CMS) exchange enrollment reports, yearly premium data from Healthcare.gov, and general exchange market demographic data released by the United States Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE). In addition, Avalere utilizes Inovalon's proprietary MORE2 claims database of individual and small group market enrollees. This allows the model to take into account underlying risk scores for purposes of modeling behavior, premiums (premiums in the model are a weighted market average by age and metal level), and risk selection by metal level, age, and gender.

Avalere determined the number of individuals in both the individual and group markets receiving coverage who would be eligible for AHPs under the proposed rule based on survey data from ACS (for the individual market) and CPS (for the small group market).

For the individual market, eligibility was determined by the number of enrollees who are sole proprietors. This data was then segmented by age and income. Income data was used to exclude those individuals who are current heavily subsidized (defined as below 250% of the federal poverty level) and who Avalere deemed will be unlikely to shift into AHPs. Similarly, Avalere analyzed the industries for sole proprietors to determine those most likely to participate in an AHP. Avalere used the 2012 IND codes for this purposes in ACS and defined those industries as likely to participate in an AHP as Construction, Transportation and Utilities, Professional (Professional, Scientific, Management, Administrative, and Waste Management Services), and Other Services (Except Public Administration). This group of individuals most likely to join AHPs was segmented by age to match up with the MORE2 risk scores and better project the expected risk shifting into the AHPs.

For the small group market, eligibility was determined by the size of the small group market and the same industry segmentation as the individual market. Employer size is available in CPS with the same industry segmentation measures as those used in ACS for the individual market. Similarly, Avalere segmented the eligible population receiving small group coverage into age groupings to match the MORE2 risk scores in the model.

Using the total eligible enrollees in AHPs as an "upper bound", Avalere assumed an enrollment phase-in based on the trend of healthcare sharing ministries enrollment growth post-2010. The trend provides the best available proxy of enrollment in an alternative form of coverage to the ACA while also providing an approximation of enrollment being constrained by availability.

With a base of enrollees in 2019, Avalere's proprietary models of individual and small group coverage model the elasticity of demand for eligible individuals and small groups to shift into

AHP coverage. These elasticity of demand assumptions are based on published literature from the Congressional Budget Office (CBO).

For the individual market, Avalere assumed that the chronically ill, defined as the top 10% of the individual market by risk score and based on Avalere analysis of the Medical Expenditure Panel Survey (MEPS), are inelastic and remain in the individual market. Essentially, the healthier individuals are more likely to shift into an alternate form of coverage with fewer covered benefits. Additionally, Avalere assumed that the heavily subsidized population does not shift into AHPs. This is defined as those individuals below 250% of the federal poverty level (FPL).

Avalere constructed three scenarios that varied based on the initial availability of AHPs in 2019, the average generosity of coverage offered by AHPs, and the projected level of risk selection by small businesses. For the initial availability of AHPs, Avalere used a high, medium, and low, based on the initial enrollment of healthcare sharing ministries in the early years of the ACA, as a percentage of the total individual market. For the average generosity of coverage, Avalere projected that AHP benefits in the “Low”, “Moderate”, and “High” scenarios had an average actuarial value approximating 60%, 70%, and 80%, respectively. Importantly, that actuarial value is based off the estimated cost of claims for the small group market.

References

i. 45 CFR § 147.150 requires individual and small group market health insurance issuers to offer coverage that at least covers the EHB package as defined in section 1302(a) of the Affordable Care Act (ACA). This includes the 10 categories of EHBs. However, large group plans are not required to adhere to these EHB standards.

ii. Id.; 45 CFR § 147.130 requires a group health plan, or a health insurance issuer offering group health insurance coverage, to provide coverage, without cost-sharing for 1) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force), 2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and 3) evidence-informed preventive care and screenings for infants, children, and adolescents that are supported by the Health Resources and Services Administration. That coverage requirement is echoed in 29 CFR § 2590.715-2713 (Section 2713 of the Public Health Services Act).

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About Us

Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. As an Inovalon company, we prize insights and strategies driven by robust data to achieve meaningful results. For more information, please contact info@avalere.com. You can also visit us at **avalere**.com.

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The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending

Linda J. Blumberg, Matthew Buettgens, and Robin Wang

February 2018

In Brief

On February 20, 2018, the Departments of Treasury, Labor, and Health and Human Services released a proposed regulation that would increase the maximum length of short-term, limited-duration insurance policies to one year. These plans, sold to individuals and families, are not federally required to comply with the Affordable Care Act regulations that prohibit annual and lifetime benefit limits, require coverage of all essential health benefits, and otherwise prohibit insurers from setting premiums or choosing whether to sell coverage to particular people based on applicants' health status and health history. As such, these plans do not meet minimum essential coverage standards under the law; thus, the Congressional Budget Office does not consider them private insurance. If implemented, the rule would permit these plans to compete against the ACA-compliant plans.

Importantly, this change would be implemented on top of an array of other significant policy changes made since the beginning of 2017. We analyze the implications of the 2017 policy changes relative to the ACA as originally designed and implemented (prior law), in addition to the potential consequences of the proposed expansion of short-term limited-duration policies. In estimating the effects of these changes on insurance coverage, premiums, and federal spending, we take into account the variations in state circumstances and state-specific laws on short-term plans.

Key findings include the following:

- The elimination of the individual-mandate penalties and the other policy changes, such as the withdrawal of cost-sharing reduction payments and the diminution of federal investments in advertising and enrollment assistance during 2017 that affected the 2018 open enrollment period, will lead to an additional 6.4 million people uninsured in 2019 compared with prior law (12.5 percent of the nonelderly population uninsured compared with 10.2 percent).
- The introduction of expanded short-term, limited-duration policies, consistent with proposed regulations, would increase the number of people without minimum essential coverage by 2.5 million in 2019. Of the 36.9 million people without minimum essential coverage, 32.6 million would have no coverage at all (completely uninsured), and 4.2 million would enroll in expanded short-term limited-duration plans.
- The combined effect of eliminating the individual-mandate penalties and expanding short-term limited-duration policies would increase 2019 ACA-compliant nongroup insurance premiums 18.2 percent on average in the 43 states that do not prohibit or limit short-term plans.
- Federal government spending in 2019 will be an estimated 9.3 percent higher than under prior law, owing to the combined effect of expanding short-term limited-duration policies, eliminating the individual-mandate penalties, and other recent policy changes. This increase in federal spending is lower than the overall increase in premiums because of cost reductions caused by decreases in enrollment.

Introduction

The October 2017 executive order calls for the Departments of Treasury, Labor, and Health and Human Services to consider new regulations that would increase the maximum length of short-term limited-duration coverage. Such policies are not regulated by the Affordable Care Act's (ACA's) reform of the private nongroup insurance market; as such, they are exempt from guaranteed issue, guaranteed renewal, modified community rating, essential health benefit requirements, prohibitions on preexisting condition exclusions, annual and lifetime limit prohibitions, and other protections. In addition, these policies are not part of the ACA's risk-adjustment system that spreads the costs associated with large claims across all nongroup insurers in a state. Recently, enrollment in these policies has been limited by two factors. First, someone buying a short-term policy without other coverage would not satisfy the ACA's individual responsibility requirement (the individual mandate) and would be subject to a financial penalty. Second, regulations promulgated by the Departments of Labor, Treasury, and Health and Human Services in 2016 prohibited short-term policies sold in April 2016 or later from coverage exceeding three months. The regulations also required the companies selling short-term policies to clearly warn potential purchasers that the policies do not satisfy the individual mandate.

The expansion of short-term, limited-duration policies would be implemented on top of other significant changes to the ACA's private nongroup insurance markets since early 2017. These include

cessation of federal reimbursement for cost-sharing reductions, shortened open enrollment periods in most states, substantially reduced federal funding for outreach and enrollment assistance, and the elimination of the individual=mandate penalty beginning in 2019. If, consistent with the proposed rule released on February 20, 2019,[1] new regulations allow short-term policies to be sold for coverage lasting as long as a year, these policies could compete as medically underwritten, largely unregulated alternatives to the products sold in the ACA's private nongroup insurance markets (both inside and outside Marketplaces). In this way, they could pull healthier people out of the ACA-compliant nongroup insurance market, leaving an enrollee population with higher average health care needs in the regulated insurance pool. The elimination of the individual-mandate penalties must be accounted for when assessing the potential impact of the expansion of short-term limited-duration policies, as these two changes intrinsically interact. The state-specific implications of this policy change vary and should also be taken into account, since some states have their own laws and regulations limiting sales of short-term policies, and other states may be interested in developing some in response to the federal change in policy.

We analyze the national and state-specific effects of ending the individual mandate and loosening limits on short-term, limited-duration policies on insurance coverage, premiums in the ACA-compliant nongroup insurance market, and federal spending in 2019. Our analysis relies on the Urban Institute's Health Insurance Policy Microsimulation Model (HIPSM), which is used extensively to estimate the cost and coverage implications of the ACA, reforms to the ACA, and repeal and replace proposals. We provide 2019 estimates of the coverage and costs under three scenarios:

1. the trend preceding the 2017 policy changes introduced by the current administration (prior-law ACA);
2. the collective policy changes introduced by the current administration in 2017 that have affected Marketplace and nongroup insurance enrollment in 2018 (as evidenced by enrollment data and premium changes), as well as the elimination of penalties for the ACA's individual mandate (current-law ACA); and
3. current-law ACA plus the expansion of short-term limited-duration, or STLD, policies (current law plus expansion of STLD).

Methodological Approach

The Health Insurance Policy Simulation Model 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 a representative sample of families that is large enough for us to produce estimates for individual states. 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. As described below, 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.

HIPSM is unique among microsimulation models of health coverage and costs because individual and family decisions combine the two most common types of microsimulation decisionmaking: elasticity and expected utility. Decisionmaking follows an expected-utility framework that captures factors such as individual health risk, but we add a latent preference term for each observation that represents factors involved in their observed choices that the expected-utility approach alone could not capture. These terms are set so the model leads to each person in the data making the choice they reported in the survey, and the distribution of latent preference terms is set so the model replicates premium elasticity targets from the literature. This approach makes it easier to simulate novel policies consistently while calibrating the model to a wide range of real-world data, such as Medicaid and Marketplace enrollment.

Prior- and Current-Law ACA Scenarios

Our prior-law and current-law ACA simulations for 2019 are based on real-world snapshots of Marketplace enrollment in each state under two different policy regimes: (1) that of the Obama administration, culminating in the 2017 open enrollment period (OEP), and (2) that of the Trump administration for the 2018 OEP. The current-law simulation also eliminates the ACA's individual-mandate penalties; the prior-law scenario includes them. The collective effect of the policy changes implemented by the Trump administration are captured 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. To simulate the effect of the individual mandate, 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 were to become uninsured. Other exemptions, such as those for individual hardship circumstances and religious conscience objections, cannot be modeled. However, our estimates of the number of families paying the tax penalty are similar to published IRS estimates, so the missing exemptions do not appear to affect our results substantially.

Based on the coverage gains resulting from the 2006 Massachusetts health reform law, we assume that the mandate would have an impact larger than the dollar amount of the penalties would suggest. Recent research using ACA-era data has confirmed that this assumption is appropriate (Salzman 2017). To estimate the size of 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 (which is generally considered the most reliable national measure of enrollment in major health coverage types) combined with reported Marketplace enrollment. Specifically, 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 levels of coverage to benchmarks based on Marketplace enrollment and the National Health Interview Survey. The difference between coverage

levels based on financial factors and the benchmarks is attributed to the nonfinancial effect of the individual mandate, and the model's simulated coverage is calibrated to hit those benchmarks in the 2017 prior-law scenario.

As of February 2018, no data are available on nongroup enrollment outside the Marketplaces in 2018, so this was simulated by HIPSM. The increases in nongroup premiums from 2017 to 2018 are estimated to reduce enrollment among people not eligible for tax credits in 2018, an effect that increases further in 2019 once the individual-mandate penalties are eliminated.

Short-Term Limited-Duration Policy Expansion

For our third simulation, we start with the current-law ACA framework described above, based on evidence from 2018 coverage decisions and premiums plus the elimination of individual-mandate penalties, and we assume that access to STLD plans is expanded. However, a change in federal regulations to expand STLDs would not preempt state laws regarding such plans. Based on preliminary analysis of state regulations by Georgetown University's Center on Health Insurance Reforms (Lucia et al., forthcoming), we categorize states into three groups: those that have regulations that would effectively prohibit the expansion of STLD policies, those that would significantly reduce the expansion of STLD policies but would not eliminate them, and those where the new regulations would effectively allow STLD policies to compete with ACA-compliant policies without further state action.[2]

Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington have laws that would prevent an expansion of STLDs. Results for these six states are the same as in the current-law scenario. Michigan and Nevada have laws that would limit STLD policy expansion. In these two states, we reduce the incentives to choose STLDs by roughly half. The remaining states either have no regulations that would substantially limit STLD policy expansion or have regulations that would allow sales, renewals, or extensions of STLD policies for 12 months or more. 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 the ability of a person to enroll in and extend or renew a STLD plan for up to 12 months.[3]

Within HIPSM, in states whose laws would not prevent STLD plan expansion, people would now have a choice between ACA-compliant nongroup coverage and STLD plans. We assume that full-year STLD coverage would differ from ACA-compliant coverage because such coverage would have a lower actuarial value (approximately 50 percent) and, in general, health status, gender rating, and broad age rating variations would be allowed when setting premiums. 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 will tend to have lower expected health care needs, since high premiums for those with greater needs as well as higher cost-sharing requirements associated with STLD plans would dissuade enrollment by those with serious health conditions. As more people enroll in STLD plans who would otherwise have chosen ACA-compliant coverage, premiums for ACA-compliant policies will rise. These price increases lead to more people choosing STLD policies, and HIPSM captures this adverse selection behavior until coverage and premium changes stabilize in successive iterations.

Short-term limited-duration plans would not meet the standards of minimum essential coverage. The Congressional Budget Office's definition of private insurance would not include these plans.[4] Consequently, we group STLD purchasers with the completely uninsured (those with no coverage whatsoever) as people without minimum essential coverage.

Results

National Distribution of Health Insurance Coverage

Table 1 shows the estimated 2019 national distribution of insurance coverage under prior law, current law, and current law plus the expansion to the availability of STLD policies. We estimate that the percentage of nonelderly people uninsured will be 2.3 percentage points higher in 2019 (12.5 percent uninsured versus 10.2 percent uninsured) as a consequence of the combined 2017 policy changes as well as elimination of the individual-mandate penalties. (Consumer confusion about whether the ACA is still in place[5] may also contribute to lower enrollment.) This is equivalent to an additional 6.4 million uninsured people, with 3.7 million of that increase resulting from reduced nongroup coverage purchased without tax credits, 1.8 million people fewer enrolling in nongroup coverage with tax credits, and roughly 500,000 and 400,000 fewer people with employer-sponsored insurance coverage and Medicaid/CHIP, respectively. The reduction in Medicaid/CHIP coverage is largely attributable to reductions in coverage for children whose parents would, under prior law, learn of their children's eligibility for public insurance when applying for Marketplace coverage. Because fewer people would apply for nongroup coverage, fewer would find out their children are eligible. The reduction in employer-sponsored insurance is largely attributable to the elimination of the individual-mandate penalties.

We estimate that once the rules limiting STLD policies are loosened, ACA-compliant nongroup coverage would decrease by another 2.1 million people. About 70 percent of that decrease (1.5 million people) comes from fewer people buying ACA-compliant coverage without a tax credit, and about 30 percent of the decrease (about 600,000 people) comes from fewer people buying nongroup insurance with a tax credit. Employer coverage would fall by an additional 230,000 people and Medicaid/CHIP by an additional 150,000 people. Approximately 36.9 million people would be without minimum essential coverage, an increase of 9.0 million people over prior law and 2.5 million people over current law. Of that number, 32.6 million people would be uninsured (no coverage at all) and 4.2 million people would be enrolled in the expanded STLD policies. About 1.7 million of the people buying STLD policies would have been uninsured (in the traditional sense) under current law, and 2.5 million STLD policy holders would otherwise have had insurance of some type.

TABLE 1

Distribution of Health Insurance Coverage among the Nonelderly under Prior-Law, Current-Law, and Current Law with Expanded Short-Term Limited-Duration (STLD) Policies, 2019

Thousands of people

	Prior Law		Current Law				Current Law with Expanded STLD Policies					
					Difference from Prior Law				Difference from Prior Law		Difference from Current Law	
	Number	Percent	Number	Percent	Number	Pct.-pt.	Number	Percent	Number	Pct.-pt.	Number	Pct.-pt.
Insured	**246,415**	**89.8%**	**239,988**	**87.5%**	**-6,427**	**-2.3%**	**237,465**	**86.6%**	**-8,950**	**-3.3%**	**-2,523**	**-0.9%**
Employer	149,115	54.4%	148,580	54.2%	-535	-0.2%	148,346	54.1%	-769	-0.3%	-234	-0.1%
Nongroup (with tax credits)	9,748	3.6%	7,990	2.9%	-1,758	-0.6%	7,373	2.7%	-2,375	-0.9%	-617	-0.2%
Nongroup (without tax credits)	9,700	3.5%	6,002	2.2%	-3,698	-1.3%	4,484	1.6%	-5,217	-1.9%	-1,519	-0.6%
Medicaid/CHIP	69,278	25.3%	68,842	25.1%	-436	-0.2%	68,688	25.0%	-590	-0.2%	-154	-0.1%
Other (including Medicare)	8,574	3.1%	8,574	3.1%	0	0.0%	8,574	3.1%	0	0.0%	0	0.0%
Without minimum essential coverage	**27,901**	**10.2%**	**34,328**	**12.5%**	**6,427**	**2.3%**	**36,851**	**13.4%**	**8,950**	**3.3%**	**2,523**	**0.9%**
Uninsured	27,901	10.2%	34,328	12.5%	6,427	2.3%	32,646	11.9%	4,745	1.7%	-1,682	-0.6%
Expanded STLD plans	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	4,205	1.5%	4,205	1.5%	4,205	1.5%
Total	**274,316**	**100.0%**	**274,316**	**100.0%**	**0**	**0.0%**	**274,316**	**100.0%**	**0**	**100.0%**	**0**	**0.0%**

Source: Urban Institute analysis based on HIPSM 2018. Reform simulated in 2019.

Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing levels of laws governing short-term limited-duration policies. "Prior law" refers to what would have been the case had the trends in place before January 2017 persisted. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. n.a. = not applicable; pct.-pt. = percentage-point.

State-by-State Findings

ACA-Compliant Nongroup Insurance Coverage. Table 2 shows the effect of current-law changes and expanded STLD policies on ACA-compliant nongroup coverage (Marketplace and non- arketplace combined) in each state. Findings are shown for the three state categories described earlier: those that would experience the full impact of expanded STLD, those where state laws and regulations would effectively prohibit the expansion, and those with a moderated effect.

As noted earlier, nongroup insurance coverage is estimated to decrease by 5.5 million people, or 28.1 percent, under current law compared to prior law in 2019. This estimated decrease includes all the policy changes made beginning in 2017, including the elimination of the individual mandate. The smallest effect of these policy changes is seen in Massachusetts, which has its own individual mandate that will remain in place even after the federal penalties are eliminated. Massachusetts also saw smaller 2018 premium increases than many other states. The effect in New York is also much smaller than others, as recent large gains in insurance coverage there are attributable to the implementation of the Essential Plan, a basic health program for people with incomes between 138 and 200 percent of the federal poverty level; those gains resulted from affordability improvements and would not be reversed when the individual-mandate penalties are eliminated.

We estimate that ACA-compliant markets in Alaska, Arizona, Iowa, Louisiana, Mississippi, Oklahoma, West Virginia, and Wyoming will lose more than 40 percent of their enrollment because of policy changes made beginning in 2017. The magnitude of the effects varies across states because of premium levels, differences in characteristics of those in the private nongroup insurance market, and different state Marketplace policies. For example, states with more aggressive outreach and enrollment strategies or with active community organizations involved in outreach and enrollment, and which kept longer open enrollment periods than the federal government, have been shown to have more continuing robust participation (e.g., New York, Vermont, and Connecticut). States with smaller nongroup markets, where exits resulting from the end of the individual-mandate penalties are likely to have larger effects on premiums, are expected to lose larger shares of their markets. The simplest changes to understand are those that correspond with large reported premium differences between 2017 and 2018 and states with high premium levels. Among the states listed above that would lose the most nongroup insurance enrollment, Iowa, Mississippi, and Wyoming had exceptionally large 2018 premium increases; those increases have the strongest effect on those not eligible for tax credits. In contrast, Arizona, Louisiana, and West Virginia had disproportionately large declines in 2018 Marketplace nongroup enrollment among people who are eligible for tax credits.

The effects of the expansion of STLD policies on nongroup coverage also vary widely across states. The six states prohibiting their expansion would experience no change relative to current law. However, on average, the states experiencing the full effect of expanded STLD policies would lose an additional 18.6 percent of their nongroup policies, or 2.1 million nongroup insurance enrollees. Compared with prior law, these states' ACA nongroup markets would decrease by 7.0 million people, or 43.3 percent of the people that would have been covered in these markets under prior law. The expansion of STLD

policies alone would reduce the Washington, DC, nongroup market 30.5 percent and the Arkansas nongroup market 25.0 percent, absent city- or state-specific legal changes to prevent such a reduction. We estimate expanded STLD policies would reduce nongroup coverage by only 10.8 percent in Michigan and 13.2 percent in Nevada because of some moderating state laws in each.

TABLE 2

ACA-Compliant Nongroup Coverage by State under Prior Law, Current Law, and Expansion of Short-Term Limited-Duration (STLD) Policies, 2019

Thousands of people

	Prior Law	Current Law			Current Law Plus Expanded STLD Policies				
	Number with compliant nongroup insurance	Number with compliant nongroup insurance	Change from Prior Law		Number with compliant nongroup insurance	Change from Prior Law		Change from Current Law	
State			Number	Percent		Number	Percent	Number	Percent
Full-impact states	**16,091**	**11,209**	**-4,882**	**-30.3%**	**9,127**	**-6,963**	**-43.3%**	**-2,081**	**-18.6%**
Alabama	266	176	-90	-33.7%	145	-121	-45.4%	-31	-17.6%
Alaska	32	15	-17	-53.4%	12	-21	-64.0%	-3	-22.8%
Arizona	318	180	-138	-43.4%	128	-190	-59.7%	-52	-28.8%
Arkansas	120	75	-44	-37.1%	57	-63	-52.8%	-19	-25.0%
California	2,514	1,843	-671	-26.7%	1,456	-1,058	-42.1%	-387	-21.0%
Colorado	283	191	-92	-32.4%	142	-141	-49.8%	-49	-25.7%
Connecticut	178	143	-34	-19.4%	112	-66	-36.9%	-31	-21.8%
Delaware	42	27	-15	-36.3%	21	-21	-49.5%	-6	-20.7%
District of Columbia	25	17	-9	-35.0%	11	-14	-54.8%	-5	-30.5%
Florida	2,166	1,729	-437	-20.2%	1,461	-705	-32.6%	-268	-15.5%
Georgia	697	458	-240	-34.4%	388	-309	-44.3%	-69	-15.1%
Hawaii	50	37	-13	-26.2%	30	-20	-40.0%	-7	-18.7%
Idaho	154	113	-41	-26.9%	91	-63	-40.7%	-21	-18.8%
Illinois	662	497	-165	-25.0%	403	-259	-39.1%	-94	-18.9%
Indiana	306	194	-112	-36.5%	155	-151	-49.2%	-39	-20.0%
Iowa	135	79	-56	-41.6%	63	-71	-52.9%	-15	-19.4%
Kansas	176	126	-50	-28.2%	101	-75	-42.8%	-26	-20.4%
Kentucky	132	106	-26	-19.7%	84	-48	-36.3%	-22	-20.6%
Louisiana	243	139	-103	-42.6%	109	-133	-54.9%	-30	-21.6%
Maine	94	68	-25	-27.2%	61	-32	-34.4%	-7	-9.9%
Maryland	276	221	-56	-20.1%	181	-96	-34.7%	-40	-18.3%
Minnesota	282	170	-112	-39.8%	132	-150	-53.3%	-38	-22.5%
Mississippi	129	75	-53	-41.6%	59	-69	-53.8%	-16	-21.0%
Missouri	365	253	-113	-30.9%	209	-157	-42.9%	-44	-17.4%
Montana	76	51	-25	-33.3%	41	-35	-46.0%	-10	-19.1%
Nebraska	151	105	-46	-30.3%	89	-61	-40.8%	-16	-15.0%
New Hampshire	69	48	-22	-31.2%	40	-30	-42.8%	-8	-16.9%
New Mexico	77	51	-26	-34.4%	40	-37	-48.6%	-11	-21.6%

State	Prior Law	Current Law			Current Law Plus Expanded STLD Policies				
	Number with compliant nongroup insurance	Number with compliant nongroup insurance	Change from Prior Law		Number with compliant nongroup insurance	Change from Prior Law		Change from Current Law	
			Number	Percent		Number	Percent	Number	Percent
North Carolina	758	496	-263	-34.6%	418	-340	-44.8%	-77	-15.6%
North Dakota	51	40	-11	-22.0%	30	-21	-40.8%	-10	-24.1%
Ohio	445	305	-141	-31.6%	242	-203	-45.6%	-62	-20.5%
Oklahoma	227	135	-93	-40.7%	113	-114	-50.4%	-22	-16.3%
Pennsylvania	688	480	-209	-30.3%	392	-296	-43.0%	-87	-18.2%
Rhode Island	51	42	-9	-17.5%	34	-17	-33.1%	-8	-18.9%
South Carolina	307	198	-109	-35.6%	165	-142	-46.1%	-32	-16.4%
South Dakota	66	42	-24	-36.3%	32	-34	-51.0%	-10	-23.0%
Tennessee	373	244	-128	-34.5%	198	-175	-47.0%	-47	-19.2%
Texas	1,737	1,095	-642	-37.0%	884	-854	-49.1%	-211	-19.3%
Utah	291	221	-70	-24.0%	178	-113	-38.9%	-43	-19.7%
Virginia	615	418	-197	-32.1%	355	-260	-42.2%	-62	-14.9%
West Virginia	50	26	-24	-47.9%	22	-28	-55.9%	-4	-15.4%
Wisconsin	368	258	-110	-29.8%	220	-147	-40.1%	-38	-14.6%
Wyoming	45	24	-21	-47.0%	20	-25	-54.9%	-4	-15.0%
States prohibiting STLD plans	**2,656**	**2,303**	**-353**	**-13.3%**	**2,303**	**-353**	**-13.3%**	**0**	**0.0%**
Massachusetts	380	367	-13	-3.3%	367	-13	-3.3%	0	0.0%
New Jersey	456	350	-106	-23.2%	350	-106	-23.2%	0	0.0%
New York	1,240	1,168	-72	-5.8%	1,168	-72	-5.8%	0	0.0%
Oregon	216	158	-58	-26.8%	158	-58	-26.8%	0	0.0%
Vermont	38	34	-5	-12.4%	34	-5	-12.4%	0	0.0%
Washington	326	226	-100	-30.6%	226	-100	-30.6%	0	0.0%
States with moderate STLD impact	**701**	**480**	**-221**	**-31.5%**	**426**	**-275**	**-39.2%**	**-54**	**-11.3%**
Michigan	551	383	-168	-30.5%	342	-209	-38.0%	-41	-10.8%
Nevada	150	97	-53	-35.2%	85	-66	-43.8%	-13	-13.2%
Total	**19,448**	**13,992**	**-5,456**	**-28.1%**	**11,857**	**-7,592**	**-39.0%**	**-2,136**	**-15.3%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing laws governing STLD policies. "Prior law" refers to what would have been the case had the trends in place before January 2017 persisted. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. The District of Columbia is considered a state in this analysis.

Those without Minimum Essential Coverage. Table 3 shows the number of uninsured (those with no coverage at all) in each state under prior law, current law, and current law with expansions of STLD policies. In the third scenario, we also show the number of people with short-term, limited-duration policies—a group, as explained earlier, that does not meet the current Congressional Budget Office definition of private health insurance because the coverage does not meet minimum essential coverage standards. We estimate that the number of people uninsured under current law in 2019 will increase by 23 percent on average compared with prior law. The percentage increases in the uninsured will be above 10 percent in all but six states, with the largest effects in states that had the biggest decreases in 2018 Marketplace enrollment and the largest 2018 nongroup premium increases.

Once STLD plans are expanded, 8.3 million fewer people would have insurance compared with prior law, and 2.5 million fewer people would have insurance compared with current law in the 43 states that do not prohibit or limit STLD plan expansion. The STLD expansion alone would decrease the number of those completely uninsured by 5.4 percent in these states (1.7 million people) compared with current law, although these new purchasers would have significantly narrower coverage than that offered in the ACA-compliant nongroup insurance market. Enrollment in the short-term limited-duration plans would total 4.1 million people in those states. The isolated effect of the STLD expansion compared with current law in the states fully affected ranges from a 4.4 percent increase in those without minimum essential coverage in Texas (a state with a high current-law uninsurance rate) to a 23.4 percent effect in North Dakota (a state with a particularly extreme mixture of young adults and older, higher-risk adults). States with the largest effects will tend to be those with high unsubsidized ACA-compliant premiums and those with low Marketplace participation. Health status and socioeconomic characteristic differences also affect the ability of state residents to enroll in STLD plans and their preferences for doing so.

States with the largest absolute numbers of enrollees in STLD plans have the largest populations, including 620,000 people in California, 421,000 people in Texas, and 394,000 people in Florida. These totals include people who would otherwise be uninsured, an even larger number of people opting for these policies instead of enrolling in ACA compliant nongroup insurance, and a considerably small number of people enrolling in the plans instead of employer-sponsored insurance.

TABLE 3

People without Minimum Essential Coverage by State, under Prior Law, Current Law, and Current Law Plus Expanded Short-Term Limited-Duration (STLD) Policies, 2019

Thousands of people

	Prior Law	Current Law			Current Law Plus Expanded STLD Policies						
			Change from Prior Law					Change from Prior Law		Change from Current Law	
State	Uninsured	Uninsured	Number	Percent	STLD policies	Uninsured	Total without MEC	Number	Percent	Number	Percent
Full-impact states	**24,415**	**30,238**	**5,823**	**23.9%**	**4,127**	**28,581**	**32,707**	**8,293**	**34.0%**	**2,470**	**8.2%**
Alabama	510	715	206	40.4%	90	677	767	258	50.6%	52	7.3%
Alaska	97	94	-3	-3.3%	30	77	107	10	9.8%	13	13.6%
Arizona	717	841	124	17.3%	167	772	939	222	31.0%	98	11.6%
Arkansas	160	285	125	78.1%	36	271	307	147	91.6%	22	7.6%
California	2,972	4,626	1,654	55.7%	620	4,439	5,059	2,087	70.2%	433	9.4%
Colorado	390	484	94	24.1%	108	433	540	150	38.4%	56	11.6%
Connecticut	159	193	34	21.1%	52	176	228	69	43.5%	36	18.5%
Delaware	61	70	9	15.5%	9	67	76	15	25.4%	6	8.6%
District of Columbia	26	34	8	32.3%	5	34	38	13	49.3%	4	12.9%
Florida	2,220	2,532	312	14.1%	394	2,435	2,829	609	27.4%	297	11.7%
Georgia	1,619	1,778	159	9.9%	172	1,689	1,861	242	15.0%	83	4.7%
Hawaii	93	104	11	12.0%	12	99	111	19	20.0%	7	7.2%
Idaho	177	213	36	20.1%	39	199	238	60	34.1%	25	11.7%
Illinois	961	1,193	233	24.2%	157	1,131	1,288	327	34.1%	94	7.9%
Indiana	482	663	181	37.5%	74	628	702	220	45.6%	39	5.9%
Iowa	151	206	54	35.8%	41	182	223	71	47.2%	17	8.4%
Kansas	313	363	50	16.0%	50	343	393	80	25.5%	30	8.2%
Kentucky	200	222	22	11.0%	38	208	246	46	23.2%	24	10.9%
Louisiana	325	434	109	33.6%	64	403	467	143	43.9%	33	7.7%
Maine	77	120	42	55.0%	22	106	128	51	66.0%	9	7.1%
Maryland	355	407	52	14.7%	63	384	447	92	26.0%	40	9.8%
Minnesota	325	411	85	26.3%	97	365	463	137	42.2%	52	12.6%
Mississippi	383	448	65	17.0%	47	425	472	89	23.2%	24	5.4%
Missouri	556	723	167	30.0%	96	683	779	223	40.2%	57	7.8%
Montana	74	87	13	17.8%	21	79	100	26	35.0%	13	14.6%
Nebraska	159	197	38	23.7%	43	172	216	57	35.5%	19	9.5%
New Hampshire	58	80	21	36.9%	18	70	87	29	49.9%	8	9.5%
New Mexico	169	200	31	18.4%	20	192	211	42	25.0%	11	5.5%

	Prior Law	Current Law			Current Law Plus Expanded STLD Policies						
			Change from Prior Law					Change from Prior Law		Change from Current Law	
State	Uninsured	Uninsured	Number	Percent	STLD policies	Uninsured	Total without MEC	Number	Percent	Number	Percent
North Carolina	1,144	1,430	287	25.1%	221	1,325	1,546	402	35.1%	115	8.1%
North Dakota	43	46	3	7.3%	15	41	57	14	32.4%	11	23.4%
Ohio	576	713	137	23.7%	116	661	776	200	34.7%	63	8.9%
Oklahoma	561	668	107	19.1%	70	633	703	142	25.3%	35	5.2%
Pennsylvania	542	702	160	29.6%	165	644	810	268	49.5%	108	15.4%
Rhode Island	47	51	4	7.9%	11	48	60	12	26.2%	9	17.0%
South Carolina	549	660	111	20.1%	76	627	704	154	28.1%	44	6.6%
South Dakota	85	109	24	27.9%	23	98	121	36	42.0%	12	11.0%
Tennessee	653	769	115	17.7%	120	713	833	180	27.5%	64	8.4%
Texas	4,731	5,304	573	12.1%	421	5,117	5,538	807	17.1%	234	4.4%
Utah	298	373	75	25.3%	67	352	419	121	40.6%	46	12.3%
Virginia	912	1,069	157	17.2%	137	1,003	1,141	229	25.1%	72	6.7%
West Virginia	74	101	27	36.5%	21	91	112	38	51.6%	11	11.1%
Wisconsin	348	441	93	26.8%	58	420	478	130	37.5%	37	8.5%
Wyoming	61	78	17	27.5%	19	67	86	24	39.6%	7	9.5%
States prohibiting STLD plans	**2,643**	**3,040**	**397**	**15.0%**	**0**	**3,040**	**3,040**	**397**	**15.0%**	**0**	**0.0%**
Massachusetts	96	103	7	7.5%	0	103	103	7	7.5%	0	0.0%
New Jersey	589	681	92	15.6%	0	681	681	92	15.6%	0	0.0%
New York	1,222	1,315	94	7.7%	0	1,315	1,315	94	7.7%	0	0.0%
Oregon	241	293	52	21.8%	0	293	293	52	21.8%	0	0.0%
Vermont	24	43	19	78.8%	0	43	43	19	78.8%	0	0.0%
Washington	473	605	133	28.1%	0	605	605	133	28.1%	0	0.0%
States with moderate STLD impact	**843**	**1,050**	**207**	**24.6%**	**78**	**1,025**	**1,103**	**261**	**30.9%**	**54**	**5.1%**
Michigan	497	662	165	33.2%	54	646	700	203	40.9%	38	5.8%
Nevada	346	388	42	12.1%	25	379	403	57	16.5%	15	4.0%
Total	**27,901**	**34,328**	**6,427**	**23.0%**	**4,205**	**32,646**	**36,851**	**8,950**	**32.1%**	**2,523**	**7.4%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing levels of laws governing STLD policies. "Prior law" refers to what would have been the case had the trends in place before January 2017 persisted. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. Minimum essential coverage (or MEC) refers to any insurance plan that satisfies the ACA's requirement to have health insurance coverage. STLD plans do not meet that standard and are thus not considered private insurance coverage by the Congressional Budget Office. The District of Columbia is considered a state in this analysis.

Effect of Expanded STLD Plans on Premiums in the ACA-Compliant Nongroup Insurance Market. We estimate that average premiums in the ACA-compliant nongroup insurance market would increase approximately 18 percent in the states that do not prohibit or limit expanded STLD plans (table 4). This premium increase includes the expansion of the STLD plans and the elimination of the individual-mandate penalties. The premium effect varies modestly across states, with the clear majority falling in the 17 to 21 percent range. States like Alaska and Minnesota that have reinsurance mechanisms in place in the ACA-compliant market, would experience still significant (but smaller premium) increases. The same is true for Michigan and Nevada (12.2 and 15.2 percent increases, respectively), where state law would significantly limit enrollment in STLD plans. Massachusetts is the only state with its own individual mandate and effective prohibitions on expansions of STLD policies and thus no measurable premium effect. The premium effects in the other five states prohibiting STLD plan expansion are attributable to the elimination of the individual-mandate penalties alone.

TABLE 4

Percent Change in ACA-Compliant Premiums because of Expanded Short-Term Limited-Duration (STLD) Policies and Loss of Individual Mandate, Compared with Current Law, 2019

State	Change	State	Change
Full-impact states	**18.2%**	**Full-impact states (cont'd)**	
Alabama	21.6%	New Mexico	9.1%
Alaska	8.5%	North Carolina	17.8%
Arizona	20.6%	North Dakota	20.8%
Arkansas	18.8%	Ohio	16.8%
California	17.8%	Oklahoma	18.7%
Colorado	18.3%	Pennsylvania	19.2%
Connecticut	16.5%	Rhode Island	20.7%
Delaware	19.9%	South Carolina	17.2%
District of Columbia	13.6%	South Dakota	21.7%
Florida	16.9%	Tennessee	18.1%
Georgia	19.5%	Texas	20.2%
Hawaii	17.5%	Utah	18.5%
Idaho	17.5%	Virginia	19.1%
Illinois	19.4%	West Virginia	20.0%
Indiana	19.6%	Wisconsin	20.0%
Iowa	15.8%	Wyoming	18.6%
Kansas	19.2%	**States prohibiting STLD plans**	**8.3%**
Kentucky	18.7%	Massachusetts	0.0%
Louisiana	14.0%	New Jersey	10.9%
Maine	15.9%	New York	8.8%
Maryland	18.4%	Oregon	9.1%
Minnesota	11.1%	Vermont	12.2%
Mississippi	17.2%	Washington	13.6%
Missouri	18.3%	**States with moderate STLD impact**	**12.8%**
Montana	19.8%	Michigan	12.2%
Nebraska	20.4%	Nevada	15.2%
New Hampshire	19.6%		
		Total	**16.4%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.
Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing laws governing STLD policies. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. The District of Columbia is considered a state in this analysis.

Federal Health Care Spending. Table 5 provides estimates of federal health care spending (acute care spending for the nonelderly through Medicaid and CHIP plus Marketplace premium tax credits) in each state under prior law, current law, and current law plus the expanded STLD plans in 2019. The largest effect on federal spending is attributable to the policy changes made since early 2017, particularly the elimination of the individual-mandate penalties. The federal spending effect of the expanded STLD policies alone is negligible, a decrease of roughly 0.2 percent, or $686 million, in 2019. This stability in federal spending is the consequence of the offsetting effects of reducing the number of people receiving ACA premium tax credits by about 600,000 while increasing private nongroup premiums approximately 16 percent on average nationally. With the expanded STLD policies in place, however, federal spending is estimated to be 9.3 percent or $33.3 billion higher than under prior law. This higher spending takes

into account lower enrollment in subsidized Marketplace coverage and Medicaid along with higher Marketplace premiums stemming from a worsened nongroup insurance risk pool caused the individual-mandate penalties being eliminated and other 2017 policy changes. The higher average-cost insurance pool leads to significantly higher premium tax credits per enrollee.

Variation across states in the federal spending effects of expanded STLD policies alone is driven by interactions between reductions in Marketplace subsidized enrollment and premium increases. For example, Virginia has more modest losses of nongroup coverage than many other states; as such, the increase in average premium tax credits received by Virginia residents due to higher premiums significantly outweighs the federal savings from reduced enrollment. In Arkansas, however, the federal savings from larger reductions in Marketplace enrollment create small net reductions in federal spending even in the face of premium increases.

TABLE 5

Federal Costs by State under Prior Law, Current Law, and Current Law Plus Expanded Short-Term Limited-Duration (STLD) Policies, 2019

Millions of dollars

State	Prior Law	Current Law			Current Law Plus Expanded STLD Policies				
	Total federal spending	Total federal spending	Difference from Prior Law		Total federal spending	Difference from Prior Law		Difference from Current Law	
			Amount	Percent		Amount	Percent	Amount	Percent
Full-impact states	**289,499**	**317,356**	**27,857**	**9.6%**	**316,646**	**27,147**	**10.9%**	**-710**	**-0.2%**
Alabama	4,581	5,009	428	9.3%	4,986	405	8.8%	-24	-0.5%
Alaska	1,045	1,183	138	13.2%	1,165	120	11.5%	-17	-1.5%
Arizona	10,145	10,458	313	3.1%	10,396	251	2.5%	-62	-0.6%
Arkansas	5,185	5,152	-33	-0.6%	5,128	-57	-1.1%	-24	-0.5%
California	46,027	49,521	3,494	7.6%	49,299	3,272	7.1%	-222	-0.4%
Colorado	5,449	5,839	390	7.2%	5,834	384	7.1%	-6	-0.1%
Connecticut	4,402	4,871	469	10.7%	4,871	470	10.7%	1	0.0%
Delaware	1,222	1,388	166	13.6%	1,368	145	11.9%	-20	-1.5%
District of Columbia	1,360	1,417	56	4.1%	1,417	57	4.2%	1	0.0%
Florida	20,359	23,380	3,020	14.8%	23,321	2,961	14.5%	-59	-0.3%
Georgia	9,063	10,697	1,634	18.0%	10,662	1,599	17.6%	-35	-0.3%
Hawaii	992	1,089	97	9.8%	1,097	105	10.6%	8	0.7%
Idaho	1,791	1,981	190	10.6%	1,982	191	10.6%	1	0.0%
Illinois	8,864	9,834	970	10.9%	9,821	957	10.8%	-13	-0.1%
Indiana	8,433	8,538	104	1.2%	8,521	87	1.0%	-17	-0.2%
Iowa	2,997	3,608	611	20.4%	3,598	601	20.1%	-10	-0.3%
Kansas	1,857	1,985	128	6.9%	2,005	148	8.0%	20	1.0%
Kentucky	8,088	8,831	744	9.2%	8,830	742	9.2%	-2	0.0%
Louisiana	6,620	7,036	416	6.3%	7,017	397	6.0%	-19	-0.3%
Maine	1,710	1,939	229	13.4%	1,937	227	13.2%	-2	-0.1%
Maryland	6,112	6,878	765	12.5%	6,868	755	12.4%	-10	-0.1%
Minnesota	6,146	6,838	692	11.3%	6,804	658	10.7%	-34	-0.5%
Mississippi	4,237	4,411	173	4.1%	4,404	166	3.9%	-7	-0.2%
Missouri	7,559	8,182	623	8.2%	8,227	669	8.8%	45	0.6%
Montana	1,868	2,243	375	20.1%	2,215	347	18.5%	-28	-1.3%
Nebraska	1,303	1,864	562	43.1%	1,853	551	42.3%	-11	-0.6%
New Hampshire	908	1,062	153	16.9%	1,063	154	17.0%	1	0.1%
New Mexico	5,060	5,168	108	2.1%	5,173	113	2.2%	5	0.1%
North Carolina	14,045	15,155	1,110	7.9%	15,148	1,103	7.9%	-7	0.0%

State	Prior Law	Current Law			Current Law Plus Expanded STLD Policies				
	Total federal spending	Total federal spending	Difference from Prior Law		Total federal spending	Difference from Prior Law		Difference from Current Law	
			Amount	Percent		Amount	Percent	Amount	Percent
North Dakota	514	558	45	8.7%	561	47	9.2%	3	0.5%
Ohio	14,021	14,697	676	4.8%	14,716	695	5.0%	19	0.1%
Oklahoma	4,046	4,724	678	16.8%	4,658	612	15.1%	-66	-1.4%
Pennsylvania	14,848	16,507	1,659	11.2%	16,414	1,566	10.5%	-93	-0.6%
Rhode Island	1,100	1,234	133	12.1%	1,232	132	12.0%	-2	-0.2%
South Carolina	4,812	5,185	373	7.7%	5,208	396	8.2%	23	0.4%
South Dakota	683	784	101	14.8%	785	102	14.9%	1	0.2%
Tennessee	8,390	9,541	1,151	13.7%	9,585	1,194	14.2%	43	0.5%
Texas	27,340	29,219	1,878	6.9%	29,234	1,893	6.9%	15	0.1%
Utah	2,819	3,618	799	28.4%	3,588	769	27.3%	-30	-0.8%
Virginia	5,448	6,852	1,404	25.8%	6,854	1,406	25.8%	2	0.0%
West Virginia	2,850	2,959	109	3.8%	2,907	57	2.0%	-52	-1.8%
Wisconsin	4,729	5,355	626	13.2%	5,329	600	12.7%	-26	-0.5%
Wyoming	467	567	100	21.5%	567	100	21.5%	0	0.0%
States prohibiting STLD plans	**52,461**	**57,310**	**4,849**	**9.2%**	**57,310**	**4,849**	**10.0%**	**0**	**0.0%**
Massachusetts	6,971	6,530	-441	-6.3%	6,530	-441	-6.3%	0	0.0%
New Jersey	6,719	6,995	276	4.1%	6,995	276	4.1%	0	0.0%
New York	23,970	28,110	4,140	17.3%	28,110	4,140	17.3%	0	0.0%
Oregon	5,693	6,217	525	9.2%	6,217	525	9.2%	0	0.0%
Vermont	1,207	1,261	55	4.5%	1,261	55	4.5%	0	0.0%
Washington	7,902	8,197	294	3.7%	8,197	294	3.7%	0	0.0%
States with moderate STLD impact	**16,175**	**17,440**	**1,265**	**7.8%**	**17,464**	**1,289**	**8.6%**	**24**	**0.1%**
Michigan	13,109	14,180	1,071	8.2%	14,206	1,096	8.4%	25	0.2%
Nevada	3,066	3,260	194	6.3%	3,258	193	6.3%	-2	-0.1%
Total	**358,135**	**392,106**	**33,971**	**9.5%**	**391,420**	**33,285**	**9.3%**	**-686**	**-0.2%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing laws governing STLD policies. "Prior law" refers to what would have been the case had the trends in place before January 2017 persisted. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. The District of Columbia is considered a state in this analysis.

Discussion

The expansion of short-term limited-duration policies implied in the current administration's proposed rule has significant implications, particularly for insurance coverage and premiums in the remaining ACA-compliant insurance market. We estimate that ACA-compliant private nongroup coverage would fall by 2.1 million people in 2019 from the expansion of STLD policies alone, exacerbating the nongroup market decline of 5.5 million people already anticipated in 2019 because of the elimination of the individual-mandate penalties and other policy changes made since early 2017. The effects will vary across the states given differences in state laws and regulations as well as differences in health care costs and population characteristics. In the 43 states most affected, premiums in the ACA-compliant nongroup insurance market would increase 18 percent on average owing both to the expansion of the short-term plans and elimination of the individual-mandate penalties. This premium effect would be 20 percent or higher in nine states. Those affected by these large premium increases would be disproportionately middle-income people with health problems because they prefer health insurance that covers essential health benefits, are unlikely to have access to medically underwritten short-term limited-duration policies, and are not financially protected by the ACA's premium tax credits. For people who have ACA-compliant coverage and are eligible for premium tax credits, these higher premiums translate into higher premium tax credits per enrollee paid by the federal government. In total, 9.0 million fewer people would have insurance (minimum essential coverage) compared with prior law.

Several issues cannot be captured through a microsimulation analysis. First, as the ACA-compliant nongroup insurance markets decrease and as healthier enrollees exit for short-term plans, insurers will by necessity reexamine the profitability of remaining in the compliant markets. This may well lead to more insurer exits from the compliant markets in the next years, reducing choice for the people remaining and ultimately making the markets difficult to maintain. Second, STLD policies are generally not subject to the ACA's medical loss ratio requirements,[6] and therefore the companies that sell them can pay higher commissions to their brokers than they can for ACA-compliant plans. As a result, brokers are likely to market these plans very aggressively, and consumers may purchase them without understanding how they differ from compliant plans. If this is the case, more people may be pulled out of the compliant market than we have estimated here, increasing the effects of the policy change. Third, some people buying the narrower STLD polices will incur serious health problems once enrolled, and find that their plans do not meet their medical needs. This could lead to increases in unmet medical need and uncompensated care. Finally, states can impose regulations that would limit the types of short-term plans that could be sold, and they can effectively prohibit them. While only a small number of states have done so thus far, more could make such legal and/or regulatory changes and thereby significantly reduce or even eliminate the effects estimated here.

Notes

[1] "A Proposed Rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department," 83 Fed. Reg. 7437 (Feb. 21, 2018).

[2] Our three categories differ from the five categories that the Center on Health Insurance Reforms developed. We use the detailed information in their analysis to assess the practical outcome of state regulatory approaches.

[3] For example, Minnesota limits the duration of these policies to 185-day contracts, but they can be renewed for as many as 365 days of coverage in a 555-day period (Dania Palanker, Kevin Lucia, Sabrina Corlette, and Maanasa Kona, "Proposed Federal Changes to Short-Term Health Coverage Leave Regulation to States," *To the Point* (blog), The Commonwealth Fund, February 20, 2018, http://www.commonwealthfund.org/publications/blog/2018/feb/short-term-health-plan-proposed-changes.

[4] Jared Maeda and Susan Yeh Beyer, "How Does CBO Define and Estimate Health Insurance Coverage for People under Age 65?" Congressional Budget Office blog, December 20, 2016, https://www.cbo.gov/publication/52352.

[5] Harriet Sinclair, "Trump Claims Obamacare is 'Dead' and 'You Shouldn't Even Mention It'," *Newsweek*, October 16, 2017, http://www.newsweek.com/trump-claims-obamacare-dead-686219.

[6] The one exception seems to be Rhode Island.

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Blue Cross Of Idaho Takes The Plunge To Sell Non-ACA-Compliant Plans

Katie Keith

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On February 13, 2018, Blue Cross of Idaho filed five new individual market plans that will not comply with federal law under the Affordable Care Act (ACA). These new "Freedom Blue" plans were filed in response to an executive order signed by Governor C.L. "Butch" Otter and implementing guidance issued by the Idaho Department of Insurance (DOI) in January 2018. Because the plans do not comply with the ACA, insurers that offer them are opening themselves up to significant legal risk and generating additional uncertainty for the market. To avoid this (and attempts by other states that to replicate Idaho's path), the Department of Health and Human Services (HHS) could step in to enforce the ACA's consumer protections, as the agency is required to do so under the Public Health Service Act and federal regulations.

What's In The New Plans?

Gov. Otter's executive order and the bulletin issued by the DOI essentially authorize a state-level version of the "Cruz amendment," which Senator Ted Cruz (R-TX) offered to the Better Care Reconciliation Act during efforts to repeal the ACA last year. The amendment—which would have allowed insurers to offer non-ACA-compliant plans in the individual market so long as they offered plans through the marketplace—was criticized for its potential to increase premiums in the ACA-compliant market and erode protections for consumers with preexisting conditions.

Idaho's approach—which creates an uneven playing field of market rules—and the decision by Blue Cross of Idaho to offer these non-ACA-compliant "state-based plans" is likely to have similar effects on the Idaho market. Blue Cross will continue to offer marketplace plans that comply with the ACA through Your Health Idaho, the Idaho marketplace. However, they will also sell new "Freedom Blue" plans which are currently under review by the DOI. Blue Cross of Idaho hopes to begin selling the new plans in early March, with coverage going into effect in early April. These plans would be available on a year-round basis (rather than offered during an open enrollment period like ACA plans) and sold directly from Blue Cross.

Some media outlets are reporting that the state-based plans are similar to Blue Cross' marketplace plans, but this is very misleading. The plans are quite dissimilar. They must be, or else the average rate for these plans would not be 25 to 50 percent lower than the rate of Blue Cross of Idaho's bronze marketplace plans. These differences may not be immediately apparent from Blue Cross marketing materials; however, if they follow the DOI's guidance, consumers who enroll in these plans may find themselves paying higher premiums based on health status, facing preexisting condition exclusions and benefit caps, and needing to pay much more money out-of-pocket before being protected financially.

The first major difference is that Blue Cross would take health status into consideration before calculating a consumer's final premium—a significant

return to the pre-ACA era. Under the DOI guidance, Blue Cross could charge individuals with a personal or family medical history up to 50 percent more in premiums based solely on health status. These plans could also exclude coverage for preexisting conditions unless a consumer had continuous coverage (meaning they were enrolled in health insurance before they enrolled in this policy without more than a 63-day break). Older Idahoans could also be charged more relative to the ACA and those who use tobacco could face heftier surcharges as well.

Some additional differences are highlighted in Blue Cross marketing materials; consumers could see significant increases in their medical costs thanks to dollar caps on benefits and caps on annual out-of-pocket expenses that are nearly twice as high as under the ACA. The state-based plans have an annual benefit cap of $1 million and dollar caps on certain benefits such as physical therapy, both of which are prohibited under the ACA. The state-based plans also have significantly higher annual out-of-pocket maximums relative to ACA plans: up to $12,000 for an individual and $24,000 for a family. There is also what appears to be a separate annual out-of-pocket maximum of $6,500 for prescription drugs. These changes alone could more than double the cost of medical care for an individual or family. And, although some press reports suggest that most plans will cover maternity care, there is no detail in the Blue Cross marketing materials and nothing to suggest that other benefit categories that are missing under state law (such as pediatric vision and dental care) would be covered.

The DOI and Blue Cross of Idaho argue that the state-based plans offer new, more affordable coverage options to middle-class uninsured Idahoans who are not eligible for subsidies through the marketplace. However, these benefit, cost-sharing, and rating changes are designed to make Freedom Blue plans more attractive to healthier, younger individuals who can pass medical underwriting. This will have the effect of leaving sicker, older individuals to the ACA-compliant market, resulting in higher

premiums for those purchasing coverage through the marketplace. It also does not appear that the state-based plans will be subject to risk adjustment requirements; without this requirement, insurers that do not offer state-based plans would be financially disadvantaged for taking on higher-risk enrollees.

Federal Enforcement Of ACA Requirements

Under Sections 2723 and 2761 of the Public Health Service Act (PHSA), states are the primary regulators of federal health insurance requirements. However, if a state fails to substantially enforce federal requirements, HHS must step in to enforce the law within that state. This federal-state framework was adopted under HIPAA in 1996 and was extended by the ACA. This same framework is used for enforcement of a variety of federal health insurance requirements, including the Mental Health Parity Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998. HHS regularly uses this enforcement authority and is currently enforcing the ACA in four states.

This framework is not new and HHS has a long history of implementing the PHSA's enforcement standards. In 1997, HHS (then the Health Care Finance Administration) published regulations to implement HIPAA and included general enforcement provisions. These regulations were revisited in 1999 after HHS gained more experience with direct federal enforcement and again in 2005 under the Bush administration. In 2013, HHS made non-substantive, technical amendments to the regulations; doing so helped ensure that the regulations are fully inclusive of the parts of the ACA in the PHSA.

In the 1999 regulations, HHS adopted fairly extensive rules governing when HHS steps in to enforce federal law. Under 45 C.F.R. 150.203, the agency laid out the circumstances in which HHS would step in to enforce, including when a state notified HHS that it was not enforcing federal law or

if HHS made its own determination based on information it had received or obtained. HHS also outlined the different sources of information that might trigger an investigation of state enforcement. These include complaints, information learned during contact between HHS and state officials, media reports, information from governors and insurance commissioners, and "any other information that indicates a possible failure to substantially enforce." These provisions remain in effect today.

Given this authority, the widespread news coverage of Idaho's approach, and a letter yesterday from patient advocates, HHS Secretary Alex Azar has more than enough grounds to initiate an investigation into whether the DOI is substantially enforcing the ACA. If the DOI is not doing so, HHS is obligated under federal law and its own regulations to step in and do so. HHS must then follow the procedures outlined in 45 C.F.R. 150 Subparts B and C to make a preliminary determination of noncompliance, provide notice to the state, and then make a final determination. States can resume enforcement responsibilities if they enact and implement legislation and if HHS determines that it is appropriate to do so.

It is generally in insurers' interest not to be subject to federal enforcement because of HHS' authority to impose steep civil monetary penalties. Although HHS has some discretion in calculating the amount of the penalty (it can weigh, for instance, the gravity of the violation and the insurer's previous record of compliance), the agency can impose a penalty of up to $100 each day for each individual affected by the violation. This could be a very high penalty if even a fraction of Blue Cross' estimated 110,000 uninsured middle-class Idahoans enroll in state-based plans.

Under these same regulations, HHS has the authority to perform market conduct examinations to investigate insurers' practices and, if warranted, assess civil monetary penalties. These examinations are used by federal regulators to examine insurer operations, business affairs, or both to verify compliance with federal law. There does not appear to be a "look back"

restriction on market conduct examinations under the PHSA. Thus, even if HHS under the Trump administration does not step in to enforce the ACA in Idaho, a future HHS under a different administration or different leadership could conceivably initiate a multi-year market examination of Blue Cross of Idaho's conduct here and potentially assess penalties. As a practical matter, to avoid HHS penalties, Blue Cross of Idaho could be forced to reprocess multiple years of claims to ensure that payments are consistent with ACA requirements and take other actions to remediate its failure to comply with the ACA.

What Happens Next?

If these plans move forward, Blue Cross of Idaho is likely to face significant legal liability and consumers could be harmed. The threat of litigation and steep civil monetary penalties may continue to keep other insurers away from this new state-based plan market. In a press comment, Regence BlueShield of Idaho stated that the ACA is "still valid law, and we do not see how the guidance … fits within that framework." Other insurers, such as PacificSource, noted similar concerns about "the potential for federal objections or fines and the impact that these plans could have on the ACA risk pool."

HHS can step in to enforce federal law before (or if and when) the Freedom Blue plans are approved by the Idaho DOI. So far, however, HHS has been largely silent. When asked about Idaho's new guidance during testimony before the House Ways and Means Committee on February 14, 2018, Secretary Azar did not take a definitive position on Idaho. He pledged to enforce federal law, noting that "there is a rule of law that we need to enforce," but offered nothing more specific.

Secretary Azar also suggested yesterday that he was not aware that HHS had yet been asked about Idaho. He made this statement despite widespread press coverage and on the same day that 15 patient advocacy

organizations—including the American Cancer Society Cancer Action Network, the American Heart Association, the March of Dimes, and the Cystic Fibrosis Foundation—sent a letter to him raising concerns about Idaho's approach. The groups note that the new proposal "would seriously injure Idaho patients and consumers and significantly destabilize Idaho's entire health insurance market." These organizations urged Azar to address this issue quickly, to uphold federal law, and to clarify that the DOI's bulletin is legally invalid.

The DOI and Blue Cross are taking these steps at a time when there is already uncertainty for insurers heading into the filing season for the 2019 plan year. Insurers are looking at whether to participate in the marketplaces in 2019 following repeal of the individual mandate and the Trump administration's efforts (or anticipated efforts) to make it easier to sell other types of non-ACA-compliant plans, such as association health plans and short-term limited duration insurance.

The ball now appears to be squarely in HHS' court. What was once a theoretical legal question about Idaho's authority to approve non-ACA-compliant plans has become a very real risk to the market now that Blue Cross has filed its plans. Other significant questions remain: Will HHS take action or at least initiate an investigation? Will other insurers join Blue Cross? And will other states follow in Idaho's footsteps?

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Norm Spier • a month ago

Thanks to the Vox newsletter people for pointing me to this article. (Health Affairs is almost always the most detailed source of info.)

I wonder if people can be charged that up to 50% more even if they maintained continuous prior coverage? (The wording in the post kind of suggests that they can, but I don't find it absolutely specific about that. It's of course relevant to the degree of instability in the market.)

Throw in the instability from non-coverage penalty removal federally, which was already too small to be truly effective, and we see lots of possible instability. But it's tricky: people with incomes 100% to 400% of the Federal Poverty level all get reasonable cost plans through the exchange, so they are protected. People at above 400% may be able to afford the 50% extra, and need to carry coverage if sicker and pay lower prices if not sick could conceivably lower prices and the effect of the loss of the Federal mandate. It would seem to be hard to say exactly what will happen to people over 400% of FPL -- it might kind of work for them, or it might really fail.

Poor slobs in Idaho who are not dirt poor, and are under 100% of FPL, of course are in trouble, as they were without this. (No Medicaid expansion in Idaho.)

As for the million dollar cap: I guess life in the U.S. has a certain amount of risk of bankruptcy. For example, most people don't carry long term care insurance, and thus are exposed to health-related bankruptcy risk, and this just adds to it.

With the weakening of Obamacare, it's own prior instability issues not fixed, and the fact that there is no end in sight for U.S. health care costs coming from anywhere, it's a time for pessimism..

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Katie Keith ➚ Norm Spier • 25 days ago

Hi Norm - the answer to your question about the 50% surcharge based on health status is yes, per guidance from the Idaho Department of Insurance. The insurer

can charge this even if someone had continuous coverage. The continuous coverage component is separate from the rating rule - but does affect whether a person would face an exclusion for preexisting conditions. If they had continuous coverage, then preexisting conditions would be covered. If not, coverage for preexisting conditions could be excluded for up to a year. That's in addition to the 50% surcharge based solely on health status. We don't yet know exactly how Blue Cross of Idaho will do its rating, but we know that is what they are allowed to do under guidance

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February 2018 | Issue Brief

Understanding Short-Term Limited Duration Health Insurance

Karen Pollitz

Short-term, limited duration (STLD) health insurance has long been offered to individuals through the non-group market and through associations. The product was designed for people who experience a temporary gap in health coverage.[1] Unlike other products that are considered "limited benefit" or "excepted benefit" policies – such as cancer-only policies or hospital indemnity policies that pay a fixed dollar benefit per inpatient stay – short-term policies are generally considered to be "major medical" coverage; however short-term policies are distinguished from other comprehensive major medical policies because they only provide coverage for a limited term, typically less than 365 days. Short-term policies are also characterized by other significant limitations.

Late last year, Congress repealed the individual mandate penalty under the Affordable Care Act (ACA), the requirement that individuals have minimum essential health coverage or face a tax penalty. Starting in 2019, the tax penalty will be reduced to $0. It is possible this change could lead more consumers to consider purchasing short-term policies. In addition, late last year, President Trump issued an executive order directing the Secretary of Health and Human Services to take steps to expand the availability of short-term health insurance policies, and a proposed regulation to increase the maximum coverage term under such policies was published this month. This brief provides background information on short-term policies and how they differ from ACA-compliant health plans.

Background

As the name suggests, short-term health insurance policies are not renewable. Whereas federal law since 1996[2] has required all other individual health insurance to be guaranteed renewable at the policyholder's option, coverage under a short-term policy terminates at the end of the contract term. To continue coverage beyond that date requires applying for a new policy. As a result, an individual who buys a short-term policy and then becomes seriously ill will not be able to renew coverage when the policy ends.[3]

The Affordable Care Act (ACA) exempted short-term policies from market rules that apply to most major medical health insurance policies sold to individuals in the non-group market: rules that prohibit medical underwriting, pre-existing condition exclusions, and lifetime and annual limits, and that require minimum coverage standards. By contrast, short term policies:

- are often medically underwritten – applicants with health conditions can be turned down or charged higher premiums, without limit, based on health status, gender, age, and other factors;

- exclude coverage for pre-existing conditions – policyholders who get sick may be investigated by the insurer to determine whether the newly-diagnosed condition could be considered pre-existing and so excluded from coverage;[4]
- do not have to cover essential health benefits – typical short-term policies do not cover maternity care, prescription drugs, mental health care, preventive care, and other essential benefits, and may limit coverage in other ways;
- can impose lifetime and annual limits – for example, many policies cap covered benefits at $1 million or less; (Table 1)
- are not subject to cost sharing limits – some short term policies, for example, may require cost sharing in excess of $20,000 per person per policy period, compared to the ACA-required annual cap on cost sharing of $7,350 in 2018 (Table 1); and
- are not subject to other ACA market requirements – such as rate review or minimum medical loss ratios; for example, while ACA compliant non-group policies are required to pay out at least 80% of premium revenue for claims and related expenses, the average loss ratio for individual market short-term medical policies in 2016 was 67%; while for the top two insurers, who together sold 80% of all short-term policies in this market, the average loss ratio was 50%.[5]

How Short-Term Policies Compare to Minimum Essential Coverage

Due to these limitations in coverage, short-term policies, not surprisingly, cost less than ACA-compliant major medical health insurance policies. A review of short-term policies offered on two websites, ehealthinsurance.com and agilehealth.com, shows it is not uncommon to find the cheapest short-term policy priced at 20% or less of the premium for the lowest cost ACA-compliant bronze plan in an area. (Table 1)

Because of their coverage limitations, short-term policies also are not considered minimum essential coverage (MEC) for purposes of satisfying the ACA individual mandate. Individuals who are covered only under short-term policies for a year and who do not otherwise qualify for exemptions from the mandate could face a tax penalty in 2018 – the greater of $695 or 2.5% of income above the tax filing threshold. However, even taking the tax penalty into account, short-term policies can be cheaper for individuals healthy enough to qualify to purchase them. Once ACA market rules took effect in 2014, some short-term policy marketing materials specifically highlighted this differential.[6] Once the individual mandate penalty drops to $0 in 2019, the cost differential between short-term policies and ACA-compliant policies will be even greater.

The number of short-term policies in effect today is not known. Most such policies appear to be sold through associations, though a small number are sold directly through the non-group market. News reports suggest short-term policy sales may have grown since ACA market reforms were implemented. One industry survey found that more purchasers (51%) cited lower price, vs. the need for temporary coverage (39%) as the primary reason for buying short-term policies.[7]

Concerned that short-term policies were becoming an alternative to ACA compliant major medical policies, and not just a bridge for short coverage gaps, the Obama Administration published new rules for such policies in 2016. The final regulation defined short-term policies as those with an expiration date specified in the contract, taking into account any extension that may be elected by the policyholder with or without the issuer's

consent, which is less than 3 months after the original effective date of the contract. This new maximum policy term was consistent with the ACA individual mandate exemption for short periods (defined as less than 3 months) of uninsurance. The final regulation also required short-term policies to include prominent consumer notices that coverage does not constitute qualifying health coverage (MEC) for purposes of satisfying the individual mandate. These rules took effect for short-term policies sold on or after January 1, 2017.

Since the 2016 rule took effect, short-term policy terms appear to now be limited to less than 3 months; however, some issuers offer "four-packs" of short-term policies with sequential effective dates scheduled 3-months apart, enabling consumers to continue to buy up to a year of short-term coverage at a time.[8]

Table 1: ACA Marketplace Plans vs. Short-Term Health Insurance Plans in Selected Cities, 40-year-old male

City	Monthly Premium for Lowest Cost Bronze Marketplace Plan (unsubsidized)	Range of Monthly Premiums for Short-Term Plans	Range of Out-of-Pocket Cost Sharing Maximums for Short-Term Plans	Range of Policy Coverage Caps for Short-Term Plans
Phoenix, AZ	$405	$36 - $437	$500 – $30,000	$250,000 – $2 million
Los Angeles, CA	$264	$141-$566	$2,500 – $10,000	$750, 000 – $2 million
Denver, CO	$338	$35-$262	$2,000 – $20,000	$250,000 – $1.5 million
Miami, FL	$297	$46 - $983	$250 – $22,500	$250,000 – $2 million
Atlanta, GA	$371	$47 - $503	$1,000 – $22,500	$250,000 – $2 million
Chicago, IL	$305	$55 - $573	$250 – $22,500	$250,000 – $2 million
St. Louis, MO	$281	$38 - $423	$1,000 – $20,000	$250,000 – $2 million
Columbus, OH	$289	$25 - $305	$250 - $20,000	$250,000 – $2 million
Houston, TX	$270	$55 - $644	$250 - $22,500	$250,000 – $2 million
Virginia Beach, VA	$479	$44 - $583	$250 - $20,000	$250,000 – $2 million

Source: KFF Subsidy Calculator for ACA compliant plan premiums; ehealthinsurance.com and agilehealth.com for short-term policy premiums and features.

Monthly premiums for Marketplace plans do not reflect discounts for premium tax credits. Monthly premiums for short-term plans reflect prices posted online; these rates are not guaranteed and may be adjusted after medical underwriting. Short-term monthly premiums also do not all reflect association membership fees, generally required to purchase

Out-of-pocket cost sharing maximum for short-term plans applies to 3-month term of coverage; by contrast, out-of-pocket cost sharing maximum max for an ACA compliant plan in 2018 is $7,350 for the calendar year

This month, the Trump Administration published a proposed regulation amending the definition of short-term policies to include those offering a maximum coverage period of less than 12 months. The proposed rule also sought public comment on other regulation or guidance that could be issued to ease the sale of such policies.

Discussion

Short-term health insurance policies offer lower monthly premiums compared to ACA-compliant plans because short-term policies offer less insurance protection. Medically underwritten policies can only be purchased by people when they are healthy. Individuals who buy short-term policies and then develop health conditions will lose coverage when the contract ends. Short-term policies typically do not cover essential benefits, such as prescription drugs, and often apply higher deductibles and dollar caps on coverage that are no longer allowed under ACA-compliant individual market and group health plans. As a result, people who buy short-term policies today in order to reduce their monthly premiums take a risk that, if they do need medical care, they could be left with uncovered bills and/or find themselves "uninsurable" under such plans in the future (though they would be able to buy ACA-compliant policies at the next open enrollment period).

To the extent that healthy individuals opt for cheaper short-term policies instead of ACA-compliant plans, such adverse selection contributes to instability in the reformed non-group market and raises the cost of coverage for people who have health conditions. Income-related premium subsidies in the non-group market offset the cost differential, and so help correct for adverse selection to a significant extent. Lower-income people would be protected by the premium subsidies, but middle-income people not eligible for subsidies who buy ACA-compliant plans would likely see premium increases. So far, the individual mandate penalty also has helped offset the cost differential between short-term plans and ACA-compliant plans, though this will disappear starting in 2019. Whether administration efforts to promote the sale of short-term policies will add further instability to the ACA-reformed market remains to be seen.

Endnotes

[1] For example, a newly hired employee who must complete a probationary period before becoming eligible for group health benefits might seek coverage through a short term policy during the probationary period.

[2] The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

[3] See, for example, *Time Magazine,* "The Health Care Crisis Hits Home," March 5, 2009, available at http://www.pnhp.org/news/2009/march/the_healthcare_cris.php

[4] Short-term policies commonly exclude coverage for pre-existing conditions, often defined as conditions (1) for which medical advice, diagnosis, care or treatment was recommended or received preceding the date the covered person became insured under the policy, or (2) that was not diagnosed but manifested symptoms that would have caused an ordinarily prudent layperson to seek medical advice, diagnosis, care or treatment.

[5] National Association of Insurance Commissioners, Accident and Health Policy Experience Report for 2016, available at http://www.naic.org/prod_serv/AHP-LR-17.pdf

[6] See, for example, https://www.agilehealthinsurance.com/health-insurance-learning-center/term-insurance-costs-less-for-26-year-olds-with-penalty-and-subsidies

[7] *Wall Street Journal*, "Sales of Short-Term Policies Surge," April 10, 2016. Available at https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539

[8] See, for example, brochure for one currently-marketed short-term policy explaining the length of coverage, "Current federal regulations limit short term medical plans to 90 days under one certificate of insurance. However, [we offer] you the convenient opportunity to apply for up to four back-to-back certificates at one time. You do not have to qualify again for the three additional certificates, and you can cancel at any time." https://www.pivothealth.com/_assets/pdf/Pivot_Health-Short_term_medical_brochure-20161027.pdf

Consumerism and Disruption: Lessons from Florida Blue

Print this Page

Hospitals and Health Networks, February 2018

How a health insurer became consumer-friendly

By Ian Morrison

As we enter a new year, the healthcare industry is once again all atwitter about the megatrends of the year. Chief among them is the rise of consumerism. I've been in the health futures business for over 30 years; Dude, every year is the start of the rise in consumerism. It's been the future for a long time.

But there is some validity to the argument that we have reached a tipping point in the role of consumers in healthcare, not the least of which is the increasing responsibilities consumers have for selecting plans, providers and treatment options and more importantly in paying out of pocket for the privilege of choosing.

Consumer "empowerment" to make selection plan and provider decisions is a major shift that has occurred not just in ACA Marketplaces but in Medicare Advantage (which continues to grow rapidly and accounts for a third of all Medicare enrollees) in managed Medicaid where in many states enrollees must make choices, and in the employer-sponsored market where more of the decision-making and economic burden is placed on consumers through higher deductibles and copayments.

Some conservative observers say this latter trend toward rising out of pocket costs is overplayed and cite the fact that relative share of out-of-pocket expenditures as a total of national healthcare expenditures is actually going down over time not up). Nevertheless, the prevailing sense in the marketplace is that consumers are paying more out-of-pocket in absolute terms and perceive themselves to be paying a bigger share of costs (certainly in the employer-sponsored market). Consumers are increasingly responsible for choices and are often ill-equipped to make those choices in a way that best serves their health. (For example, there is a massive body of evidence that now that supports the obvious that high deductible care is a blunt instrument that causes patients to forego both necessary and unnecessary care in almost equal measure).

All actors in the healthcare system are trying to deal with consumerism in their own way. With mega deals such as the CVS acquisition of Aetna being consummated and as healthcare stakeholders anxiously eye Amazon, Apple, Google and Facebook as they lurk on the edge of the healthcare system. There is considerable anxiety in the healthcare ecosystem about consumerist led disruption of conventional healthcare.

What is Consumerism?

Consumerism means different things to different people. One angle is the increased use of transparency and consumer navigation tools to guide choices particularly when those choices have significant financial incentives attached such as in narrow networks, reference pricing, high deductible health plans, tiered benefit designs and so forth.

A second dimension of consumerism is the sheer importance of consumer experience to providers and plans both in terms of patient acquisition, retention and loyalty as well as patient satisfaction (which increasingly carries dollars with it in terms of patient experience measures in value-based payment under Medicare and in Medicare Advantage).

Third, consumerism in healthcare is seen as a strategic imperative of meeting consumers' expectations (particularly tech-savvy millennials) who increasingly have ever higher expectations of service industries driven by their positive experience with high technology enabled consumer offerings such as Netflix, Amazon, Uber and Air BNB.

Fourth, is the notion that consumers need to be more proactive and engaged in their own health and wellness and take more personal responsibility for health and lifestyle choices. As one doctor asked me recently "when are the patients going to be accountable?"

Finally, perhaps the most significant dimension of healthcare consumerism is the economic out-of-pocket costs burden being placed on consumers going forward and the battle that ensues for wallet share in the wellness, health and healthcare industries that are now colliding.

We will cover all five of these threads in this discussion but it is important to recognize that they are different and in some senses complementary.

Healthcare Stakeholders on the Consumerism Journey

Hospitals are behind the curve in their understanding of consumers. (They are quite advanced in their understanding of patients but that isn't always the same thing). Most Americans don't get admitted to hospital in a year (only about 14%) while 80% of Americans visit a doctor, 90% now have a health plan relationship and probably even higher percentage visit a retail facility with a pharmacy. Hospitals should know the answer to the basic consumer questions: how many unique consumers do you touch, who are they, what do you do for them, and how is that working for them and you? As hospitals integrate across the continuum of care, absorb more risk and pursue population health initiatives, these questions become increasingly important.

With close to 90% of Americans having some relationship with health insurers, health plans have made significant strides to be more consumer friendly by improving their navigation tools, their customer service and support functions and their outreach to consumers. Let's be clear, health insurers are coming from a difficult position at the bottom of the heap of consumer ratings.

Technology leaders like Apple and elite retail and fast food outlets enjoy Net Promoter Scores in the 70s which are considered world class (Net Promoter Score is a measure of consumer loyalty and willingness to recommend a product or service on a scale of plus 100 to minus 100, a high positive score is desirable, 70-80 is considered world class). Most of healthcare ranks pretty low in net promoter scores but there are exceptions like Kaiser and the Mayo Clinic. The health insurance industry generally has negative or low double digit net promoter scores (just ahead of Al Qaeda in their trustworthiness and popularity), but progress is being made and many large insurers now tie executive compensation partly to improvement in net promoter scores and other consumer measures (United, Aetna, And Anthem in particular).

The Case of Florida Blue

So insurers, like others in the health industry are trying hard to reach out to consumers in new ways to enhance the experience. Perhaps one of the most interesting examples is from Florida Blue (the Blue Cross Blues Shield Plan of Florida) who have a strong consumer focus and indeed have built a significant retail presence over the last few years.

I reached out to Patrick Geraghty, Florida Blue CEO, who was kind enough to walk me through his perspectives on consumerism and disruption from a health insurance point of view.

By way of context, Florida Blue operates under the umbrella of GuideWell Mutual Holding company (that Geraghty also leads) whose combined businesses have a current run rate of $16 billion in revenue with Florida Blue comprising almost 90% of that revenue base. They operate or joint venture in a number of related business entities in both the insurance space, (such as Florida True Health, a joint venture a Medicaid managed care organization) as well as a portfolio of direct healthcare delivery operations such as medical clinics and freestanding emergency services.

Over the last decade GuideWell built capabilities in consumer navigation and population health acquiring a number of businesses that they seek to expand nationally. Indeed, despite their obvious focus on the Florida market with 5 million members (almost a third of all Floridians) many of their businesses operate nationwide or in multiple states. For example, their traditional Medicare business is the fee-for-service Medicare administrator for Medicare jurisdictions which account for 11 states, the District of Columbia, the Indian Health Service at the VA thereby being the back-office processor for millions of Medicare recipients. GuideWell is interacting with millions of consumers in a lot of different ways.

Pat Geraghty who came to lead Florida Blue from Minnesota is an industry veteran with great experience and enthusiasm for the positive role consumerism can play in transforming healthcare. He was kind enough to share his insights about Florida Blues' pioneering experience in opening retail outlets in support of the core health insurance function and how it relates to the consumerism agenda.

In the last few years Florida Blue has opened 20 retail centers around the state (providing access to 80% of the population of Florida within a 30-mile radius of the centers). These retail centers are conceived much in the way as an Apple store supports Apple products not just as a sales channel but as a service center, brand presence and product support function.

Geraghty told me: "health care is a system, from coverage to care, and many consumers need support in navigating the system," much in the way many of us Apple users struggle to get the most out of our seemingly simple devices. In some sense the Florida Blue retail centers are the "Genius Bar of Health Insurance".

In exploring the contribution that retail centers have made to Florida Blues strategy, Geraghty laid out the importance of complementing not cannibalizing existing distribution and service channels. "These retail centers are just one of many channels that support our products and services" he said.

In particular, when the two pilot retail stores were opened some years ago, brokers reacted negatively to the potential of them cannibalizing or undercutting traditional distribution channels to individual and small group purchasers. Since then, the retail centers were recast and repositioned to supplement and partner with brokers rather than to supplant them.

When I asked Geraghty how Florida Blue got into the retail business he pointed to their analysis of the Massachusetts market (the early pioneer of exchanges) as a harbinger of what might happen under the Affordable Care Act. Florida Blue examined the experience with the Massachusetts Connector (the pioneering Romney Care Exchange) where consumers would go online to select insurance but many people needed support in making decisions and customizing their selections. Selecting health insurance is a complex choice "it's not like buying an appliance" Geraghty said, "there's a lot of complexity to the product and it is highly personal."

The Florida Blue retail centers were conceived as a place to help navigate health insurance and healthcare choices and answer customer questions, but increasingly the retail centers integrate and co-locate other health services such as physician groups and wellness.

The retail concept has met with considerable positive feedback from consumers. In the last year, 300,000 unique customers have visited across the 20 retail sites with customer satisfaction scores of 92% overall and 97% where clinical services are co-located.

The stereotypical user is not a confused, less well-educated, older, non-tech savvy customer as you might imagine. Florida Blue executives were pleasantly surprised to find that a wide cross section of consumers were using their retail facilities for sales, service and product support such as Florida Blue's "know before you go" tools that they provide to consumers who are embarking on significant interactions with the medical care system. Indeed, Geraghty told me that a significant segment of retail customers were younger couples just starting a family who were seriously engaging with health insurance for the first time.

Florida is a particularly interesting state in terms of providing retail choice to individual health insurance consumers because it is home to the largest individual market in the country as measured by exchange enrollment. Approximately 1.7 million Floridians have signed up for exchanges in 2018 according to CMS, and although, final numbers aren't yet verified for Florida Blue, a good

estimate is that one million members will be enrolled with Florida Blue through the exchange. With this scale and good operational discipline Geraghty told me with regard to the individual market: “we operate in the black”.

In the last year, the entire health insurance industry has experienced the roller coaster of withdrawal of Cost-Sharing Reduction (CSR) support causing strategic chaos and impairing the finances of most insurers in the individual market and accelerating exit from state markets by national players such as United and Anthem for 2018. Removing CSR funding late in 2017 resulted in 15-30% increase in rates for 2018 in many states. This is ameliorated for those lower income exchange customers (some 87% of people buying on the exchanges) who are getting some form of subsidy that insulates them from these rate increases (but doesn’t insulate the government from paying even more in premium subsidies). Perversely, the withdrawal of CSR support in many states has led to bronze plans being even cheaper than 2017 for the lowest income consumers.

For non-subsidy consumers (those over 400% of FPL) rates have increased on average by 30% in Florida as in many states as the elimination of CSRs are priced in for 2018, and similar effects will be likely in 2019 as the repeal of the individual mandate takes effect.

The gap between the subsidy population and non-subsidy consumers will continue to widen in terms of what consumers actually pay with younger, lower income consumers getting plans that are almost free to them while upper and middle income older consumers in the non-subsidized individual market paying more than $1,500 per month (as I was going to do this year in California before getting on full blown fee for service Medicare at about a third of the cost, Yay! Another column for another time).

The rules of engagement in the individual market must be resolved one way or another politically and economically in the twenty four months preferably to the benefit of all consumers and taxpayers. The lack of clarity is frustrating health insurance industry leaders and making the lives of actuaries increasingly difficult. As one CEO of a major national insurer told me recently: “This industry can change dramatically with just one stroke of a pen in Washington”. The ultimate disruption.

No matter what the political and policy rollercoaster, part of the success Florida Blue has experienced in enrollment is the ability for these retail outlets to provide consumers of all types with an opportunity to truly understand the product and engage with confidence in their choices.

Sparked by the ACA and the rise of individual market Florida Blue deems their retail initiative a success and a key part all of an overall strategy of assisting all consumers in making informed choices. Recently, these retail centers have been expanded to include other services such as health risk appraisals, on site clinical services co-located with partners, and even providing consumers access to “test drives” and advice on selection of “wellness wearables” such as Fit Bits and smart watches. Florida Blue continues the path of integrating complementary clinical services as their consumer facing strategy develops.

While focused on individual market consumers, members in other lines of business particularly the small group market also make use of these retail centers even though they may have a relationship with agents and brokers but use the retail center to complement the advice. (Most of their self-insured employer customers have their internal employee benefit tools and navigation aids that are complementary).

Geraghty also told me of a recent acquisition PopHealthCare, a Nashville based company with presence in multiple states. Geraghty sees this new asset as an exciting opportunity to expand the retail platform to help identify chronically patients in need of clinical services who could potentially have them delivered and managed through a combination of retail clinical offerings and home-based services. This is not dissimilar to the vision that CVS and Aetna’s merger hopes to yield by combining a physical retail presence locally with a sophisticated set of relationships and data analytics tools to identify high-cost populations that may be better treated with chronic care services in the retail and home-based setting.

It is important to point out that retail strategy is by no means the only method of communication with consumers. Florida Blue (like most insurers) have extremely sophisticated in-bound and outbound call center operations, web-based solutions and digital outreach using multiple technology platforms, all supported by data analytics to help engage with consumers in all of their lines of business from Medicare to the individual market.

Dealing with Disruption

When I asked Geraghty about what keeps him up at night in terms of disruption and where that disruption may come from whether it be Silicon Valley, retail giants like CVS or Amazon or some other weird new upstarts, he adroitly pointed out: “anyone who isn’t paranoid isn’t paying attention.”

“Our goal is to try and disrupt ourselves”, he said which I think is wise advice. I wrote a book The Second Curve more than 20 years ago about change in business generally (the first curve being the incumbent the second curve being the disruptor). Great companies that endure like IBM have been successful in disrupting themselves but it is not an easy thing to do. Certainly other leaders in healthcare such as Providence-St Joseph and Kaiser are pursuing a strategy of self-disruption as a motivation for their teams to continuously innovate. See a previous column http://www.hhnmag.com/articles/7165-lessons-from-a-health-care-system-that-disrupts-itself

As Geraghty told me, while healthcare seems ripe for disruption it is not necessarily true that everyone wants to be an insurance company. I’ve described before what I call the mutual disrespect problem within healthcare: everybody thinks everybody else’s job is easy and anyone can do what an insurance company does. It turns out it’s not that easy to be an insurer as provider sponsored health plans and venture capital backed insurance upstarts alike are finding out.

The real growth and potential disruption is in adjacent services. A good example is the rapid growth of the Optum division of United Health. Optum now has annual revenues in excess of $80 billion much of it related to PBM activity. Similarly, the CVS-Aetna deal is spun around at its core a massive PBM operation. Incumbents such as Optum, Anthem, Aetna, Cambia and other insurers have significant service and technology businesses and population health offerings. At the same time, there are a

myriad of health 2.0. offerings being developed to compete in these adjacent services. Geraghty argues that the more intense disruptive activity will occur among these related service offerings beyond traditional insurance.

It makes sense to anticipate that the core health insurance functions of claims processing, network development and customer service and support and so forth will see continue consolidation with more horizontal rather than vertical integration to the degree that regulators allow it. At the same time, we will see increased competition and disruption and a great sorting out of all of the peripheral service businesses to health insurance. But no matter what, as we have argued in these columns before, innovation by itself is not enough, Innovation at scale is required.

Lessons Learned

The case for Florida Blue provides insights on the rapidly changing field of consumerism in health. It also spurred me to think about where we are headed with consumerism in health. My takeaways:

Meet people in their lives. Florida Blue is meeting people in their lives, in retail environments and on-line with services and support, and navigation tools that enhance the overall healthcare consumer experience.

Make the Complex Simple. Healthcare is complex it needs to be made more simple and even if we have simpler designs we need to build better support tools for consumers that may involve more retail handholding and decision support. Health insurance is a complex product and even tech savvy millennials struggle with it, indeed in a recent Aon Consumer Survey found 41% of Millennials say: “I have stopped trying to figure out what I should pay for medical services and just pay the bill when it comes.”

Scale and Local Market Penetration Matter. Insurers with significant market share in local markets such as regional Blues plans can have significant influence on provider systems and population health in their geography. Powerful local plans have an opportunity to set the standards and change the rules of engagement for the entire local health system.

Use Multiple Channels. Consumers, even millennials are not all digital all the time, sometimes we need a little real help, face to face.

Technology and Policy will expand Digital Consumer Facing Services. Recent policy and technology changes such as Fast Healthcare Interoperability Resource standards (FHIR), Open Application Programming Interfaces (APIs) and Blockchain tools are all likely to promote inter-operability and create a rich and rapidly evolving environment of consumer facing digital offerings. This new frontier is not without challenges such as cyber security, data privacy, and fraud and abuse potential, but overall we will see an acceleration in the number, range and hopefully the quality of digitally enabled, consumer facing solutions. Expect continued competition and disruption in this space.

Navigation tools need work. In the early 2000s we asked a series of questions in Harris Interactive Surveys about consumers use of report cards on health plans, hospitals, and doctors. We asked are you aware of them, do you ever use the report card, and did you actually make a change on the basis of the report card. We did the surveys every year for 10 years and the square root of zero humans ever changed a decision-based on the report card (actually 1%). I am sure it’s better now (we’ll check this year). Consumers do want information to make comparisons on cost and quality of plans, providers and treatment options, but we need to get better in consumer decision support.

Free. Great consumer service brands such as Google and Facebook are popular partly because they are free. (Actually not really free since we users are getting bombarded with commercial messages as you surf, post and like). In health insurance, there are actually some free or close to free offerings such as Medicaid, zero premium Medicare Advantage and highly subsidized exchange offerings, but generally health insurance carries a consumer cost that is more visible and economically painful every year. We may not all get to free, but the ultimate goal is to get health insurance and healthcare affordable for all concerned. Let’s work on that.

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Government As Innovation Catalyst: Lessons From The Early Center For Medicare And Medicaid Innovation Models

ABSTRACT Congress established the Center for Medicare and Medicaid Innovation (CMMI) to design, test, and spread innovative payment and service delivery models that either reduce spending without reducing the quality of care or improve the quality of care without increasing spending. CMMI sought to leverage these models to foster market innovation and accelerate the transformation of payment and care delivery to achieve the Triple Aim of better health, better care, and lower cost. This article provides a perspective on the design and execution of CMMI's five initial models, the resulting outcomes and lessons, and how their core concepts evolved within and spread beyond CMMI. This experience yields three key insights that could inform future efforts by CMMI and public and private payers, including model designs and policy decisions. These insights center on the need for iterative testing and learning guided by market feedback, more realistic time frames to demonstrate impact on cost and quality, and greater integration of models.

For decades the Centers for Medicare and Medicaid Services (CMS) has spearheaded innovation in provider reimbursement systems to improve quality and reduce costs, with diagnosis-related groups in the 1980s, resource-based relative value scales in the 1990s, ambulatory payment classification for outpatient services in the 2000s, and value-based purchasing in the 2010s. Private payers typically followed, incorporating the new methodologies into their provider contracts. These innovations involved congressional action and were informed by policy makers, researchers, and at times pilot programs from CMS's Office of Research, Development, and Information.

By 2011 it was widely believed that systemic transformation, including accelerated payment and delivery reform, was necessary to address escalating health care expenses and lapses in quality. The increased federal and state expenditures expected to result from the Affordable Care Act (ACA) created additional pressure to find new ways to improve care delivery outcomes and efficiency. Section 3021 of the ACA created and funded the Center for Medicare and Medicaid Innovation (CMMI) within CMS, allocating $10 billion over ten years to "test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care." To enable timely action, the ACA provided the health and human services secretary with the authority to scale to the national level new payment approaches that demonstrably reduced costs without adversely affecting quality or that improved quality without significantly increasing costs.

CMMI's initial strategy focused on testing new payment and delivery models in acute care, population health management, and community

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health; testing methods to spread these innovations; and spurring payers, entrepreneurs, clinical innovators, and states to likewise develop and test alternative payment and delivery models. CMMI intended these strategies to demonstrate to the market the inevitability of care transformation and start a wildfire of innovation, testing, and learning.

In 2011 the Department of Health and Human Services created a CMS team to explore and develop alternative payment and care delivery models that would operationalize that agency's Triple Aim of lower cost, better health, and better care.[1] CMS launched five early models: the Pioneer and Advance Payment Accountable Care Organization (ACO) initiatives, the Bundled Payments for Care Improvement initiative, the Comprehensive Primary Care Initiative, the Partnership for Patients initiative, and the Health Care Innovation Awards (exhibit 1).

This article discusses the design choices that were made as these early models were developed, key implementation challenges and lessons learned, the models' early results, and the models' impact (exhibit 2). Our work yielded three key insights that could inform future efforts by CMMI and public and private payers to design payment models and make related policy decisions.

Case Study 1: Accountable Care Organizations

In 2011 CMS announced the Pioneer ACO Model (born out of CMS's Physician Group Practice Demonstration) and the Medicare Shared Savings Program. These models aimed to support groups of health care providers to better coordinate care, thereby improving quality and reducing costs. The ACOs assumed some financial risk for their patient populations, with those in the Medicare Shared Savings Program assuming lower risk than those in the Pioneer model. Value-based payment models were virtually nonexistent at the time. Private payers' investment in ACOs was limited to a handful of contracts, largely among local and regional health plans. Most Pioneer ACO applicants cited Medicare Advantage risk contracts as evidence of their experience in outcomes-based arrangements.

Early results were mixed. ACOs that had succeeded under Medicare Advantage's local benchmarking for cost and utilization faced challenges achieving the further efficiencies required to meet the Pioneer ACO national benchmarks. As a result, some ACOs struggled to deliver the degree of savings they had anticipated. Nonetheless, this model provided crucial lessons about how (and how not) to implement effective ACOs. The Pioneer ACOs gained valuable experience in managing fee-for-service Medicare patients,

EXHIBIT 1

Role of the Centers for Medicare and Medicaid Services (CMS) in scaling health care delivery innovations

Case study	Primary role of CMS	Path to scale and sustainability
ACO	To engage health systems and providers in the transformation to a population-focused, risk-based arrangement.	State and federal funding sources have seen the value of early CMMI demonstration; alternative payment models continue to grow among commercial health plans.
BPCI	To serve as a contracting partner with providers.	Continued participation in voluntary bundles from the federal government, expanding presence of bundles in private payers, and integration of episode payments within ACO models will all contribute.
CPC	To serve as a convener of payers and to prioritize the role of primary care.	Many states are currently pursuing multipayer initiatives, such as Delivery System Reform Incentive Payment and the State Innovation Models initiative, which build on the lessons learned by CMMI in administering CPC.
PfP	To engage providers in and create a mechanism for the dissemination of delivery system improvements.	Hospital Engagement Networks were consolidated with the CMS-funded Quality Improvement Organizations Program.
HCIA, round 1	To catalyze innovation across the health care marketplace.	Applicants included formal sustainability plans that often leveraged risk arrangements to offset losses in fee-for-service payments.

SOURCE Authors' analysis. **NOTES** ACO is accountable care organization, which in this instance comprises the Pioneer and Advanced Payment initiatives. CMMI is Center for Medicare and Medicaid Innovation. BPCI is Bundled Payments for Care Improvement initiative. CPC is Comprehensive Primary Care Initiative. PfP is Partnership for Patients initiative. HCIA is Health Care Innovation Awards.

EXHIBIT 2

Reach of the models of the Center for Medicare and Medicaid Innovation

Model	Engagement with government	Impact on marketplace
ACO	As of April 2017, there were 563 Medicare and 88 Medicare contracts accounting for over 13 million covered lives.	As of April 2017, there were 715 commercial contracts covering over 19 million lives.
BPCI	315 acute care hospitals, 567 skilled nursing facilities, 228 physician group practices, 76 home health agencies, and 9 inpatient rehabilitation facilities.	Bundled payments remain central to conversations about the transition from fee-for-service reimbursements to value-based care.
CPC	2,188 providers served roughly 410,000 Medicare and Medicaid beneficiaries.	Those same providers served approximately 2,290,000 commercial health plan members.
PfP	Over 3,700 US hospitals participated.	Numerous learning and dissemination models are prevalent in the commercial marketplace.
HCIA, round 1	Over 7,000 letters of intent were received, approximately 3,000 applications were submitted, and 107 contracts were issued.	Anecdotal feedback suggests that many of the proposals that did not receive contracts were independently pursued.

SOURCE Authors' analysis. **NOTES** ACO is accountable care organization, which in this instance comprises the Pioneer and Advanced Payment initiatives. BPCI is Bundled Payments for Care Improvement initiative. CPC the Comprehensive Primary Care Initiative. PfP is Partnership for Patients. HCIA is Health Care Innovation Awards.

integrating and analyzing data, designing and targeting clinical interventions for complex and high-need patients, and communicating about their work. These ACOs disseminated learning from this experience to other providers. For example, one ACO improved care coordination by giving emergency departments (EDs) photographs of its primary care physicians to help beneficiaries identify their own physicians—which in turn allowed the emergency department to contact physicians more quickly.

Furthermore, Pioneer ACOs tested key design elements, such as the prospective attribution of patients (that is, identifying which patients an ACO would be accountable for at the performance year's outset, instead of changing the patient population throughout the year), a waiver of the three-day hospitalization rule for skilled nursing facility admissions (to allow for direct admission to such a facility, thus avoiding inpatient admission costs), and high levels of shared risk and reward (the percentages of savings or losses that an ACO could earn or owe). These elements were subsequently incorporated into the Medicare Shared Savings Program and other CMS ACO initiatives. Other design elements were rejected or modified. For example, CMS retired the Pioneer ACO Model's complex methodology for setting spending targets.

In 2015 the Office of the Actuary at CMS certified that the Pioneer ACO Model improved quality without increasing cost—required by statue if the Department of Health and Human Services wished to expand the model. CMS incorporated key elements of the model into the Medicare Shared Savings Program's track 3, which included additional performance-based risk. For example, the program's ACOs were given discretion to identify as ACO members individual providers in a group, rather than the whole group. This gave the track 3 ACOs greater flexibility to choose providers based on performance, as Pioneer ACOs had had. Lessons from CMMI's early ACO pilots also informed the design of its subsequent Next Generation ACO Model (for example, by using regional rather than national benchmarks to reward ACOs that were already efficient) and the Health Care Payment Learning and Action Network's recommendations on how to design ACO initiatives.

CMS's ACO initiatives, especially the Medicare Shared Savings Program, significantly accelerated the growth of commercial ACOs, from 75 in 2011 to 842 in 2016.[2] As CMMI launched ACO models for specific populations, such as the Medicare-Medicaid ACO Model and the Comprehensive ESRD Care Model (for patients with end-stage renal disease), other payers did the same. Ten states now have Medicaid ACOs, and another thirteen are developing them.[3] ACOs are recognized as a dominant vehicle for health reform: Approximately thirty-two million lives are covered under 1,366 active ACO contracts, more than half of which belong to commercial payers.[2] Investors and entrepreneurs recognize ACOs as a rapidly growing opportunity to develop products catering to providers in value-based payment arrangements.[4] Venture capital firms have invested directly in ACOs, recognizing the organizations' challenges in accessing capital to invest in care management infrastructure.

Yet challenges remain for ACOs. Entities that

started with efficient utilization patterns may struggle to continuously achieve additional savings.[5] Furthermore, it is difficult to manage care, absent strong incentives for beneficiaries to engage with providers and their recommendations. CMS continues to struggle with constraints on how it can offer beneficiaries lower cost sharing for obtaining services from ACO providers rather than from other providers, as a result of the prevalence of Medigap coverage and legacy data systems that make it challenging to reduce deductibles on a rolling basis. Also, CMMI cannot reduce benefits within a payment model because its authorizing legislation restricts enacting any model design that would reduce benefits; this requirement creates a critical barrier to implementing benefit designs aligned with the goals of the model. Indeed, some commercial ACOs now have features (such as narrow provider networks and increased copayments for low-value care) that reduce costs more than CMS ACOs do. Ultimately, ACOs' impact on cost, quality, and patient experience outcomes will be difficult to judge unless CMS and commercial payers continue to test and learn from ACO models and invest in and share the results of formal evaluations.

Case Study 2: Bundled Payments For Care Improvement Initiative

Bundled payments, also called episode-based payments, reimburse providers based on a full episode of care rather than for each individual service within an episode. Doing so encourages efficiency and eliminates fee-for-service incentives to provide unnecessary care to produce additional revenue opportunities. CMS began experimenting with episode-based payment starting in the 1980s, with the inpatient prospective payment system—which reimbursed hospitals for a patient's full stay based on the patient's diagnosis-related group. CMS also piloted the Physician Hospital Collaboration Demonstration in 2007 and the Medicare Acute Care Episode Demonstration in 2009, both of which were bundled payment initiatives that reimbursed providers based on defined clinical episodes. Despite both models' limited size and scope, evaluators determined that they had the potential to reduce variability, improve quality, and create savings that could be shared with providers.

On this basis, CMMI developed the Bundled Payments for Care Improvement initiative, a set of episode-based models that providers could voluntarily participate in. In each case, CMS contracted directly with providers for one of forty-eight possible episodes of care, and providers offered a discounted rate from their historical performance. Model 1 in the initiative limited episodes to the inpatient length-of-stay and included an inpatient payment that decreased over the duration of the model.[6] This decrease made physician engagement and enrollment challenging: Most of the twenty-four awardees exited the demonstration early.[6] The narrow definition of the episode restricted providers' ability to transform delivery, improve quality, and reduce cost, which made this model unattractive to the marketplace.

By contrast, models 2, 3, and 4 included choices of episodes that lasted from the inpatient admission or from discharge, and continued for thirty, sixty, or ninety days after discharge and of either prospective or retrospective payments based on reconciled fee-for-service payments. Prospective payments are more predictable, but they require changes in billing and workflow that proved challenging for many providers. These models encouraged participating providers to focus on quality and cost management during the episode, and tailor postdischarge care to the patients' needs.[7] These three models began with nineteen participants; a second phase from July 2015 to September 2018 yielded dramatically increased enrollment.[8] CMS reported that there were 1,191 participants in models 2, 3, and 4 through October 1, 2017.[8] Participants found the greatest opportunities for quality improvement and cost reduction in managing surgical and procedural care, care transitions, and postacute care.

Early results from models 2, 3, and 4 were promising. While the initiative did little to influence utilization rates, it reduced episode costs—with the greatest savings from reductions in the cost of postacute care.[7] The initiative also highlighted business and operational barriers to implementing this approach. These included managing cash flows, developing budgets for episodes paid prospectively (rather than retrospectively), and reliably tracking providers' enrollment in a bundled payment model. Convening organizations (such as Premier or Remedy Partners, which brought multiple providers together to support implementation and sometimes shouldered some financial risk), could bring bundles to scale faster but introduced the additional complexity of a three-way arrangement among payer, convener, and provider.

These findings informed CMMI's development of the Oncology Care Model, a voluntary bundled payment model for cancer care, and the mandatory Episode Payment Models for joint replacement. In April 2016 CMMI launched the mandatory Comprehensive Care for Joint Replacement model.[9] By July 2016 the Department

of Health and Human Services proposed bundled payment models for acute myocardial infarction, coronary artery bypass graft, and surgical hip and femur fracture treatment that would begin in July 2017.[10] Some providers rejected a mandatory model, given the considerable investments that a hospital or provider group had to make to be successful. For example, when the Comprehensive Care for Joint Replacement model was announced, community hospitals expressed concern about being responsible for managing the risk for episode length, while having limited ability to manage postacute care providers' performance and quality.

In August 2017 the Department of Health and Human Services announced that the model will be scaled back to thirty-four of sixty-seven metro areas and that other mandatory models will be canceled.[9] This likely reflected concerns voiced by some providers and hospitals that there is broad adoption of voluntary models as well as the position of the new administration that mandatory models provide additional burden to hospitals and reduce flexibility.[11] The rule change might slow the expansion of bundled payment, but interest in voluntary participation is likely to continue, especially if bundled payment complements other payment reforms. Providers that assume meaningful population-level risk for the cost and care of their patients increasingly recognize that the methods to standardize care that drive success under bundled payment can also be applied to improve quality and reduce costs in other payment models, such as ACOs.[11] Moreover, while we are aware of no survey that quantified adoption, we know anecdotally that many commercial payers have implemented bundled payments for discrete conditions or are considering doing so.

Case Study 3: Comprehensive Primary Care Initiative

The Comprehensive Primary Care Initiative (CPC) was a CMMI model that organized private insurers and state Medicaid programs to support primary care practices in providing higher-value primary care. CPC addressed three challenges to transforming primary care: Payment is critical to successful primary care transformation, primary care providers function in a heterogeneous payment environment, and payers in the same primary care geographical region have varying reimbursement expectations. A federally led multipayer payment model could address these challenges to promote primary care transformation and population health management.

In CPC, CMMI defined the elements of transformed primary care that evidence suggested would support the Triple Aim—elements codified as milestones that practices had to achieve within a year.[12] CMMI paid a $20 per member per month premium to each practice (on average, 40 percent more for the primary care services it delivered than the practice would have received under normal Medicare rules) that demonstrated a commitment to high-value, team-based care—including meeting the prerequisite of achieving meaningful use of its electronic health record (EHR). CMMI targeted seven regions across the country where qualified insurers offered enhanced payment for over 70 percent of covered lives. Forty-three insurers, including national and regional plans and state Medicaid agencies, submitted bids to provide participating practices with enhanced support such as augmented payments and access to data for measuring and improving performance. This ensured that the practices would be eligible to receive higher compensation from a substantial majority of their payers, thus providing a sufficiently reliable and predictable revenue stream to deliver transformed care.

Within two years CPC yielded improved patient experience ratings and essentially resulted in the same amount of spending when the care management fee was factored in, although this result did not reach significance.[12] As with the Bundled Payments for Care Improvement initiative, some practices had steep learning curves for operational capabilities such as budget development, accounting, and risk stratification to target interventions and resources to patients with the greatest need and utilization patterns. CMMI invested in learning system support[13] and national webinars and "boots on the ground" technical assistance to help practices develop these capabilities. Practices found it hard to convince their electronic health record (EHR) vendors to make the technical changes needed to support direct reporting of quality data from the records. As a consequence, CMS did not receive sufficient, reliable EHR data to properly measure and report back to practices how they performed. The quality and volume of data that CMS received in the first two years were inadequate for calculating reliable performance benchmarks.

With this early lesson, CMMI launched Comprehensive Primary Care Plus (CPC+), a larger initiative in eighteen regions with sixty-one payers in two rounds. Round 1 had 2,850 practices, and round 2 will have up to 1,000 additional practices.[14] CPC+ engages payers in a way similar to CPC but sets higher qualification standards for practices to reduce the time it takes them to develop the necessary capabilities for improving cost and quality outcomes. CPC+ also sets more-specific patient targets and provides

higher care coordination fees. In CPC, the market made clear that offering shared savings to an aggregation of small, unrelated practices did not provide sufficient motivation or financial incentives for practices to fully engage. CPC+ instead offers performance payments based on practice-specific utilization and quality metrics and on screening patients for unmet social needs.

States attempting to transform care and align incentives have adopted the multipayer approach and benefited from the lessons learned from the CPC and /CPC+ models. Thirteen states have formed Delivery System Reform Incentive Payment programs (using section 1115 demonstration waivers); and thirty-four states, three territories, and the District of Columbia have partnered with CMS in CMMI'S State Innovation Models initiative. Both the programs and the initiative contain multipayer coordination as a critical element.

Case Study 4: Partnership For Patients Initiative

Launched in April 2011, the Partnership for Patients initiative (PfP) was a model that focused on reducing patient harm and its associated costs. It was designed to test the effectiveness of networked learning approaches, public-private partnerships, and new models of care delivery (such as the Community-based Care Transitions Program) in making these improvements.

Specifically, PfP enlisted provider organizations, federal and state agencies, hospital associations, insurers, and large employers as participants and partners to commit to achieving two aims: a 40 percent decrease in the number of cases of preventable harm to hospital patients, and a 20 percent decrease in hospital readmissions. Both aims were to be achieved by the end of 2013, with progress measured against a 2010 baseline.[15]

To inform the spread of other CMMI models, PfP examined which dissemination methods (for example, campaigns, collaboratives, and communities of practice) could effectively orchestrate performance improvement activities at hospitals and in care transitions. It also asked how hospital systems, hospital associations, implementation and research organizations, and state and federal governments could best coordinate their efforts, engaging stakeholders across the Department of Health and Human Services (for example, the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention) and private-sector partners (such as patient and consumer organizations and employers) in the process.

Central to the initiative, PfP funded twenty-six intermediary Hospital Engagement Networks—consisting of state and national hospital associations and private health systems—to coordinate providers' improvement activities. HENs designed and oversaw the learning and exchange of best practices, delivered technical assistance, and supported progress measurement for over 3,700 constituent hospitals, working under contracts that allowed the networks to rapidly learn and make data-informed adjustments in support of participants.

To track improvement, the Hospital Engagement Networks and program evaluators collected qualitative and quantitative data on improvement, using surveys, site visits, and key-informant interviews. Evaluators also used other analytic methods, including difference-in-differences regression modeling and propensity scoring. Progress was evaluated against targeted outcomes as well as implementation and process measures (for example, the degree of success in implementing harm reduction strategies, the degree of engagement in learning activities, and whether changes to practice were hospital wide or unit specific).[16]

Through this mixed-methods approach, PfP revealed variations in performance across the Hospital Engagement Networks and the characteristics of the highest performing networks, including management to achieve clear aims, coordinating incentives and technical assistance thoughtfully to support change, regularly engaging with participating hospitals, and making rapid adjustments in strategy and tactics based on timely hospital performance data. One key implementation challenge was the management of multiple competing priorities, such as implementing new EHR systems during PfP's harm reduction work.[16]

Participating hospitals fell short of achieving the specified aims during the initial campaign period but an evaluation of PfP from 2015 demonstrated significant national reductions over time in several forms of hospital-based harm (for example, adverse drug events, central line–associated bloodstream infections, ventilator-associated pneumonia, readmissions, and early elective deliveries), for a cumulative reduction of over 1.6 million adverse events (representing a savings of roughly $8.6 billion).[16] Critics questioned the lack of standardized measures across the Hospital Engagement Networks, as well as the inability to isolate the impacts of PfP from those of other patient safety efforts.[17] However, PfP suggested that networked learning and support structures can support multiple actors to make progress toward shared aims.

CMS leveraged insights from PfP and the Hos-

pital Engagement Networks to inform the subsequent design of its learning networks. In September 2016, CMS made competitive awards to create a new Hospital Improvement and Innovation Network (awarding $347 million to sixteen intermediary organizations) as part of its existing Quality Improvement Organizations Program.[18]

Case Study 5: Health Care Innovation Awards, Round 1

With the Health Care Innovation Awards, CMMI moved away from a government-defined, prescriptive model of innovation and testing. The awards recognized and sought to accelerate the creativity of private- and public-sector innovators by enabling them to compete for funds to test models that would improve health and health care while reducing the total cost of care.

CMMI received over seven thousand letters of intent, and approximately three thousand clinicians, entrepreneurs, health centers, hospitals, and community-based organizations submitted applications. Over a hundred organizations, representing every state, received funding across eight project domains to implement 135 interventions—some of which were new, and others of which extended existing efforts to new populations or settings. Exhibit 3 shows funding amounts and geographic reach by domain.

For recipients of a Health Care Innovation Award, a key challenge was integrating new approaches and workflows into existing systems that had to provide ongoing care.[19] Many awardees struggled to establish new partnerships, enroll participants, and formalize staff working relationships, though by the second year most were using improvement strategies to achieve progress. For example, seventy-seven awardees identified health information technology (IT) as a challenge in the first year, but most had adapted and reported limited health IT challenges by the end of the second year.[19]

Several awards had a large-scale impact. After demonstrating that the National Diabetes Prevention Program led to weight loss, decreased ED visits and hospitalizations, and decreased total costs, the YMCA of the USA was approved for a reimbursable Medicare billing code for the program. The Guide to Community Preventive Services and the US Preventive Services Task Force also found sufficient evidence to recommend the program as a routine, reimbursable preventive service.

The impact of other Health Care Innovation Awards also extended beyond CMS's funding period. Among community-based programs, approximately half of the awardees formalized plans with community partners and funders to sustain adaptations to organizational cultures and workflows. Other awardees secured follow-on funding from states and other federal sources. For example, Northeastern University received funding from the Agency for Healthcare Research and Quality to continue testing the use of systems and industrial engineering principles in improving care delivery. Other awardees further developed their innovations via value-based payment models. To promote sustainability, round 2 of the Health Care Innovation Awards required applicants to include a payment model to support their service delivery innovations.[20]

Ultimately, the awards' greatest impact may have been the applicants' initial ideation and proposal-writing process. The large number of applicants provided evidence of the receptive-

EXHIBIT 3

Health Care Innovation Awards, by domain

Domain	Number of awards	Funding	Number of states or territories with an awardee
Behavioral health and substance abuse	10	$84,373,959	21
Community resource planning and prevention	24	$155,093,945	26
Complex, high-risk patient targeting	23	$215,002,440	24
Disease-specific interventions	18	$119,680,733	27
Hospital care	9	$88,661,705	12
Primary care redesign	14	$190,842,854	33
Medication management	6	$42,500,615	12
Shared decision making	3	$42,271,992	17
Total	107	$938,428,243	52

SOURCE Authors' analysis of information from the website of the Center for Medicare and Medicaid Innovation. **NOTES** In all, 107 awardees received contracts for 135 interventions. Twenty-two awardees piloted multiple interventions.

ness of the innovation environment. Although fewer than 4 percent of the applicants received an award, all of them had to design their innovation and engage new partners. In doing so, market adversaries found common innovative solutions to improve the health and reduce the cost of care of the populations they serve together. Anecdotally, many of these proposals were pursued even without CMMI funding—an example, we believe, of the wildfire of innovation that CMS envisioned.

Discussion

As the largest purchaser of health care in the United States, CMS is uniquely positioned to be a first mover and accelerator of innovation. CMMI's early years elucidate how the federal government can spur innovation and how it can get in the way. Lessons derived from its efforts are as much about how the government engages and catalyzes the market as they are about the mechanics of new delivery and payment models. They reveal three related insights that could inform future efforts by both CMMI and public and private payers, including their model designs and policy decisions. The latest Request for Information from CMMI suggests that the next group of models may focus more on market forces and informed consumers. While this may be a new direction for CMMI, the lessons learned from early model implementation should be valuable in developing and implementing future models.

First, CMMI created an organizing framework for iterative testing and learning. Target results were not achieved for every model, but the resulting learning would not have occurred as early, as fast, or at the same scale without public-sector leadership to synthesize the market's reactions and feedback and iterate based on this leadership and its influence in the market. Participants spurred adjustments to the models when they dropped out (as with model 1 of the Bundled Payments for Care Improvement initiative), defected to other models (as when early Pioneer ACOs transitioned to the lower-risk Medicare Shared Savings Program), or remained in a model and provided feedback (as with CPC+, which altered CPC's shared savings methodology).

Second, in retrospect, this iterative learning made it unrealistic to assume that any new model or combination of models would rapidly achieve the Triple Aim. Given the size, complexity, and competing interests in health care, the expedited timetable for demonstrating cost savings and system transformation was too ambitious. This will be true for any new CMS model. Innovation at a regional or national scale requires adequate time to operationalize the changes required to achieve the desired cost savings and to respond to unanticipated consequences, such as overlapping payment models that make evaluations of specific models difficult and create financial distortions. For example, episode-based savings realized from bundled payments may have diminished ACOs' potential for shared savings.[21] Even the Bundled Payments for Care Improvement initiative and Pioneer ACOs—the early CMMI models that built on successful prior demonstrations—required significant adjustments. Furthermore, voluntary programs (such as the Bundled Payments for Care Improvement initiative) will take longer than mandatory programs to have an effect, absent a compelling business case to drive rapid and widespread change. Major change takes time, and voluntary programs will typically take longer.

Third, innovation is not always about creating new models; sometimes it is about better integrating and coordinating existing models. If CMMI's first phase aimed to start a wildfire of innovation, the second phase presents opportunities to build on lessons learned, to achieve greater efficiency. For example, ACOs are the dominant alternative payment model, yet other complementary CMMI models have been pursued in parallel with them (for example, the CPC's medical home model and the Accountable Health Communities Model that addresses social needs). Each model has its own goals, measures, technical specifications, and contracts. Integration of these and other CMMI models can produce higher-quality care for patients and reduce burdens on providers.

Conclusion

The federal government is a key actor in the health care market. The question is how the government-market relationship can best accelerate innovation and learning to achieve the Triple Aim. CMMI's early models demonstrated the importance of testing a diverse set of approaches to pay for and deliver care, the catalytic role of government in spurring market adoption and innovation, and the importance of the government's learning from the private sector. Because every provider, practice, and system has a unique set of concerns, priorities, and resources, the diversity of CMMI's models enabled significant learning and innovation. The lessons learned can drive greater efficiency and impact as CMMI enters its next phase of development and funding. ■

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New Risk-Adjustment Policies Reduce But Do Not Eliminate Special Enrollment Period Underpayment

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ABSTRACT Millions of uninsured Americans do not sign up for available coverage despite job loss or other factors that would make them eligible for special enrollment periods (SEPs). Such periods let people enroll in nongroup insurance outside the usual open enrollment period for Marketplace coverage. Concerned that risk adjustment results in underpayment for the health risks associated with SEP enrollees, carriers rarely market their products to consumers eligible for SEPs, and many do not pay agents and brokers to enroll such consumers. To address the apparent underpayments, federal officials added enrollment duration factors that, starting in 2017, increased risk scores for SEP enrollees and other part-year members. Using individual-market claims data for 2015 from two large carriers, we found that risk adjustment did, in fact, undercompensate plans for part-year members. However, underpayment was much larger for SEP enrollees than for part-year members who joined during open enrollment periods. Short-term, urgent health problems appeared to drive enrollment more for SEP enrollees than for part-year members who signed up during open enrollment. We also found that the federal government's enrollment duration factors will remedy underpayment for part-year members whose coverage begins during open enrollment but leave carriers significantly underpaid for SEP enrollees. For carriers to recruit rather than avoid SEP enrollees, further increases to risk adjustment for such enrollees are likely needed.

Under the Affordable Care Act (ACA), consumers in the nongroup market can generally enroll in Marketplace plans only during annual open enrollment periods (OEPs). However, certain life events, such as losing employer-sponsored insurance because of involuntary unemployment, create special enrollment periods (SEPs) that briefly permit consumers to sign up outside of open enrollment periods.

A year after the ACA Marketplaces became operational, SEPs took on unexpected importance. Several insurers that stopped participating in nongroup markets cited losses due to SEP enrollment as a major contributing factor.[1] Other insurers continued offering coverage but cut their SEP losses by avoiding marketing outside of open enrollment periods.[2] Some even denied commissions to agents and brokers who sold insurance during SEPs.[3]

The implications for coverage were significant. One study estimated that between open enrollment periods, more than thirty million people a year experienced periods without insurance as a result of job loss or other reasons that qualified them for SEPs but that fewer than 5 percent of such people enrolled in available cover-

age.[4] Another study found that, unlike other groups, people who lost insurance because of unemployment experienced almost no increased coverage under the ACA.[5]

In 2016–17 the Department of Health and Human Services (HHS) sought to address insurers' concerns about SEPs. One important step involved risk adjustment for people who enrolled for less than a full year. Risk adjustment was previously based primarily on age, sex, and chronic conditions listed in the Hierarchical Condition Categories (HCCs) defined by HHS.[6] Within each state's individual market, carriers enrolling people with below-average risks contributed to a transfer system that paid carriers whose enrollees had above-average risks.

HHS changed risk adjustment effective in 2017 (and continuing without much alteration in 2018) by adding enrollment duration factors that reflect the length of time a person has been a plan member. Such factors increased carriers' payments for members covered for less than a year, including both people who enrolled during an SEP and those who enrolled during open enrollment but dropped or lost coverage later during the year.[7] HHS based this change on findings that the previous risk-adjustment model underpaid for part-year enrollees. HHS found that compared to full-year members, part-year members were less likely to have diagnosed conditions that would raise risk-adjustment payments, because such conditions were either underreported or less frequent; in the latter case, part-year members would have higher claims costs than other enrollees for conditions that do not trigger risk-adjustment payments. HHS also found that part-year members' covered claims were more likely to be clustered together soon after enrollment, which aligned poorly with risk-adjustment payments that presumed claims were evenly distributed throughout the year.

HHS's new enrollment duration factors have increased members' risk scores based on two characteristics: brevity of enrollment and the metal tier of the plan. The shortest-term members and highest-tier plans received the greatest score increases. Crucially, whether enrollment began during an open enrollment period or SEP did not affect enrollment duration factors.

HHS also announced that starting in 2018, enrollees' risk scores are to increase not just for part-year enrollment but also on the basis of prescription drug category factors. Such factors reflect members' use of prescription drugs that signal the existence of HCCs or severity of conditions that might not be fully captured in the claims on which such risk factors are based. If members enrolled for a short time are more likely than full-year members to have conditions go undiagnosed, HHS hoped that these new drug factors might supplement enrollment duration factors in remedying the previous underpayment of such members' costs.[7]

Effective risk adjustment is crucial to achieving a core goal of insurance market reform: incentivizing insurers to compete by offering value to consumers, rather than by avoiding high-cost members.[8,9] With SEP enrollees, such adjustment is also important to accomplishing the even more fundamental goal of expanding coverage. As long as carriers believe that they will lose money on SEP enrollees, they are unlikely to aggressively market outside of open enrollment periods and may resist policy makers' efforts to enroll SEP-eligible consumers. A risk-adjustment methodology that adequately captures the risk posed by SEP enrollees is necessary for accomplishing those goals.

In this study we used claims data from two large nongroup carriers to analyze whether the 2015 risk-adjustment methodology in fact underpaid for SEP enrollees and other part-year members, relative to full-year members. We further assessed whether enrollment duration factors and other risk-adjustment changes since 2015 are likely to remedy such underpayment. We conclude that while recent policy changes appear to solve the problem of underpayment for part-year OEP enrollees, further efforts are needed to avoid significant undercompensation for SEP enrollees.

Study Data And Methods

To assess the relative adequacy of risk adjustment for full-year and part-year members, we examined individual-market data from two carriers. For part- and full-year members at each insurer, we compared the relationship between paid claims and the plan risk scores that dictated risk-adjustment payments.

ANALYSIS OF DATA FROM TWO CARRIERS Two carriers with large nongroup memberships both in and out of the Marketplaces provided data about all of their 2015 nongroup members. These insurers differ considerably. One operates in many states, while the other primarily serves residents of a single state; they have different payment arrangements for agents and brokers; and the states they cover vary in terms of Medicaid eligibility, application assistance networks, federally facilitated versus state-based Marketplaces, and underlying demographics.

To protect proprietary and confidential data, we refer to the two carriers as "Insurer A" and "Insurer B." We also state results for part-year cohorts relative to full-year members, rather than in absolute terms. For example, if a carrier's

full-year members and a certain part-year cohort had medical loss ratios (MLRs) of 80 percent and 100 percent, respectively, we would describe the part-year cohort's MLR as 125 percent of the MLR for full-year members.

For various cohorts, each insurer provided the per member per month cost of paid claims; average duration of enrollment; number of member-months; average risk scores (which largely determine risk-adjustment payments)[8] and medical loss ratios before and after risk adjustment.

Member cohorts were defined in terms of the calendar quarter in which coverage began; whether enrollment lasted for 1–6 months, 7–9 months, or 10–12 months; whether members were assigned one or more HCCs and so qualified for a higher risk score based on health conditions; and plan metal tier. SEP enrollees accounted for 8 percent of member-months at Insurer A and 15 percent at Insurer B (data not shown). For part-year OEP enrollees (those with 1–9 months of coverage), proportions were 12 percent and 15 percent, respectively.

For each carrier we used two metrics to compare the adequacy of risk adjustment for part-year members to adequacy for full-year members. The first involved the ratio of paid claims to risk score, or the claims-to-risk ratio. We calculated relative claims-to-risk ratios to show how the claims-to-risk ratio for each part-year cohort compared to the ratio for the insurer's full-year enrollees. For example, if a carrier's full-year members had per member per month paid claims of $375 and an average risk score of 1.5, this group's claims-to-risk ratio would have been 250 ($375 divided by 1.5). If one of the carrier's part-year cohorts had claims of $360 and an average risk score of 1.2, yielding a claims-to-risk ratio of 300 ($360 divided by 1.2), its claims-to-risk ratio of 300 would have been 20 percent higher than the full-year cohort's ratio of 250, so its relative claims-to-risk ratio would have been 120 percent.

The 20 percent increased claims-to-risk ratio in our example represents the portion of paid claims for which risk adjustment fails to compensate among part-year enrollees relative to compensation for full-year enrollees. If a part-year cohort has a relative claims-to-risk ratio of 100 percent, the same proportion of paid claims would be covered by risk adjustment as for the carrier's full-year cohort.

Our second metric was the medical loss ratio after risk adjustment. If one cohort had a higher medical loss ratio after risk adjustment than another cohort did, a higher percentage of the carrier's premium dollars remaining after risk adjustment were consumed by paid claims for the former than for the latter cohort. We calculated the MLR after risk adjustment for a part-year cohort as a percentage of the analogous MLR for the carrier's full-year cohort.

For example, suppose premiums for a carrier's full-year cohort average $250 a month, with average paid claims of $230 and risk-adjustment receipts averaging $10 per member per month. The MLR for full-year members would be 92 percent ($230 divided by $250), and the MLR after risk adjustment would be 88 percent ($230 divided by $260). Consider a part-year cohort at that same carrier with average monthly premiums of $240, claims of $235, and risk-adjustment contributions of $10. That cohort would have a 98 percent MLR ($235 divided by $240), but a 102 percent MLR ($235 divided by $230) after risk adjustment. The part-year cohort's MLR after risk adjustment, relative to the full-year cohort, would be 115 percent (102 divided by 88). When MLRs are higher after risk adjustment, carriers experience less favorable financial results.

We used members with 10–12 months of enrollment as a proxy for full-year members. We classified consumers whose coverage began after March as SEP enrollees for that year. Since the 2015 open enrollment period ended on February 15, 2015, and coverage began no earlier than fifteen days after enrollment, nearly all insurance with an effective date in January through March took place through the 2015 period. Our data did not separately identify those who were already enrolled in the prior year.

To assess the impact of enrollment duration factors in equalizing the adequacy of risk adjustment between part-year and full-year members, we applied HHS's enrollment duration factors for 2018 based on each part-year cohort's average duration of enrollment. We then compared the computed enrollment duration factors to the risk-score increase required to bring the cohort's relative claims-to-risk ratio to 100 percent, thus equalizing risk-adjustment adequacy for the cohort and the carrier's full-year members.

ANALYSIS OF SUPPLEMENTAL DATA PROVIDED BY ONE CARRIER Insurer B provided additional information that divided cohorts more finely than we were provided in the two-carrier data described above. This supplemental information distinguished between people enrolled for 12 months, 10–11 months, 7–9 month, 4–6 months, and 1–3 months. The supplemental data also showed per member per month covered claims amounts for each month of coverage, combining plan payments with enrollees' cost sharing. And the supplemental data identified members with and without prescription drug category factors, which Insurer B imputed based on members' drug claims. To assess whether adding these

factors could shrink the gap in risk-adjustment adequacy between SEP enrollees and full-year members, we compared the prevalence of prescription drug category factors in the two groups.[10] Insurer B also provided information about members with pregnancy-related claims.

LIMITATIONS Our approach had several limitations. First, we did not assess the absolute adequacy of risk adjustment, only its relative adequacy for full- and part-year members. Put differently, we did not ask whether carriers received sufficient risk-adjusted payments for either full- or part-year members, only whether each carrier received less adequate compensation for part-year than for full-year members.

Second, we did not analyze risk adjustment across the overall nongroup market; rather, we focused on the relative compensation of full- and part-year members at two particular carriers. Because of these and other limitations discussed in the online appendix,[11] our analysis indicated the general nature and direction, rather than the specific amount, of changes needed to adequately compensate for risk selection associated with part-year members in the nongroup market.

One limitation deserves special attention. Our data came from the 2015 market. The nongroup market in 2017 and beyond is likely to differ from that in 2015 for many reasons, including greatly increased requirements for verification of SEP eligibility. The most likely result is that fewer consumers will enroll through SEPs, but average SEP enrollee risk levels will rise. Initial efforts to strengthen verification of eligibility for special enrollment lowered SEP enrollment by 20 percent, with 46 percent of applicants ages 18–24 failing to meet procedural requirements—compared to just 27 percent of those ages 55–64.[12] As with similar verification procedures used in Medicaid, increasing the effort required to enroll may be deterring younger and healthier eligible adults from applying.[4] Nonetheless, changes in SEP verification and eligibility rules appear unlikely to change the fundamental dynamic that we identify of short-term, urgent medical needs driving SEP selection in ways that risk adjustment does not fully capture.[13]

Study Results

2015 RISK ADJUSTMENT We found that the 2015 risk-adjustment approach underpaid carriers for part-year members and that the degree of underpayment was greater for SEP enrollees than for part-year OEP enrollees. We reached these results with both carriers and both measures of relative payment adequacy (exhibit 1). For all cohorts, relative claims-to-risk ratios and relative MLRs after risk adjustment were greater than 100 percent and higher for SEP enrollees than for corresponding part-year OEP enrollees. For example, for Insurer A, the relative claims-to-risk ratio was 119 percent for part-year OEP enrollees and 133 percent for SEP enrollees—which indicates relative underpayment for both part-year groups, but more so for SEP enrollees. We found a similar pattern for Insurer B, whose relative claims-to-risk ratios were 110 percent for part-year OEP enrollees and 116 percent for SEP enrollees.

These data suggest that the degree of underpayment, independent of enrollment duration, depended on whether coverage began during the open enrollment period or an SEP. On average, part-year OEP enrollees were enrolled for shorter periods than SEP enrollees were. If shorter enrollment duration by itself, regardless of when coverage began, were associated with relative underpayment, the underpayment would likely be greater for part-year OEP enrollees than for SEP enrollees. Instead, for both insurers, we found that the reverse was true. For Insurer A, for example, average duration of enrollment was 3.8 months for part-year OEP enrollees, compared with 4.5 months for SEP enrollees.

Supplemental data from Insurer B corroborated this inference. Among members with the same coverage duration, underpayment was larger for SEP enrollees than for part-year OEP enrollees (exhibit 2). These gaps increased as duration shortened, for both measures of risk-adjustment adequacy. For example, relative claims-to-risk ratios were 104 percent for OEP enrollees and 107 percent for SEP enrollees for members with 7–9 months of coverage; 109 per-

EXHIBIT 1

Average duration of enrollment, claims-to-risk ratio, and medical loss ratio (MLR) after risk adjustment for part-year members, by enrollment during open enrollment periods (OEPs) or special enrollment periods (SEPs)

	OEP enrollment	SEP enrollment
INSURER A		
Average duration of enrollment (months)	3.8	4.5
Relative claims-to-risk ratio	119%	133%
Relative MLR after risk adjustment	118%	132%
INSURER B		
Average duration of enrollment (months)	5.1	5.8
Relative claims-to-risk ratio	110%	116%
Relative MLR after risk adjustment	113%	121%

SOURCE Authors' analysis of individual-market claims data for 2015 from two large insurers ("Insurer A" and "Insurer B"). **NOTES** Part-year OEP enrollees have 1–9 months of enrollment. Members with 10–12 months of enrollment are used as a proxy for full-year members. The claims-to-risk ratio is the ratio of per member per month paid-claim costs to the average risk score. The MLR after risk adjustment takes risk-transfer payments into account. Ratios are shown relative to the carrier's full-year members.

EXHIBIT 2

Claims-to-risk ratio and medical loss ratio (MLR) after risk adjustment, by duration of enrollment and type of enrollment period, Insurer B only

	Average duration of enrollment							
	7–9 months		4–6 months		1–3 months		1 month[a]	
	OEP	SEP	OEP	SEP	OEP	SEP	OEP	SEP
Relative claims-to-risk ratio	104%	107%	109%	119%	119%	134%	106%	118%
Relative MLR after risk adjustment	107%	111%	114%	124%	120%	143%	100%	123%

SOURCE Authors' analysis of individual-market claims data for 2015 from one large insurer ("Insurer B"). **NOTES** Part-year OEP enrollees have 1–9 months of enrollment. The claims-to-risk ratio is the ratio of per member per month paid-claim costs to the average risk score. The MLR after risk adjustment takes risk-transfer payments into account. Ratios are shown relative to the carrier's members with 12 months of enrollment. OEP and SEP are explained in exhibit 1. [a]Subcategory of "1–3 months" (preceding two columns).

cent and 119 percent, respectively, for members with 4–6 months of coverage; and 119 percent and 134 percent, respectively, for members with 1–3 months of coverage.

Data from Insurer B on covered claims by month of enrollment, including both plan payments and members' cost sharing, provided important clues about the reasons for these differences between part-year OEP enrollees and SEP enrollees. As shown in exhibit 3, full-year OEP enrollees (those with 10–12 months of coverage) incurred first-month claims that were below average monthly amounts. Compared to full-year members, part-year OEP enrollees showed slightly higher first-month costs, relative to average monthly claims.

The experience for SEP enrollees was quite different. Claims during the first month of coverage were 13–20 percent higher than average monthly levels for these enrollees, depending on the length of enrollment. Short-term care needs were apparently a more powerful driver of enrollment decisions for this cohort than for either full-year members or part-year members whose coverage began during open enrollment.

EXHIBIT 3

Covered claims in the first month of coverage as a percentage of average monthly covered claims, by duration of coverage and type of enrollment period, Insurer B only

Duration of coverage (months)	OEP	SEP
12	92%	—[a]
10–11	88	—[a]
7–9	100	113%
4–6	94	120
1–3	97	117

SOURCE Authors' analysis of individual-market claims data for 2015 from one large insurer ("Insurer B"). **NOTES** Claims are all those covered as essential health benefits. They include both expenses within enrollees' cost share and those paid by the plan. OEP and SEP are explained in exhibit 1. [a]SEP enrollment in 2015 did not begin before March, so no SEP enrollees received 12 months or 10–11 months of coverage.

Data reported in the appendix[11] show that risk adjustment underpaid for part-year enrollees both with and without health conditions as captured by HCCs, and did so by larger margins with SEP enrollees than with part-year OEP enrollees. For Insurer A's SEP enrollees, for example, the claims-to-risk ratio was 133 percent for those with health conditions and 132 percent for those without. These findings suggest that the short-term risks driving SEP enrollment involve both HCCs reflected in insurers' claims records and other health conditions. The latter could include chronic health conditions that fall within HCCs but are not recorded in members' claims records. They could also include acute conditions or other health problems that fall outside HCCs.

ENROLLMENT DURATION AND PRESCRIPTION DRUG CATEGORY FACTORS We found that the enrollment duration factors for 2018 would remedy the underpayment that existed in 2015 for part-year members who enroll during OEPs. However, such factors would fall significantly short for SEP enrollees.

Exhibit 4 shows that enrollment duration factors would increase average risk scores for part-year OEP members by at least the amount needed to equalize claims-to-risk ratios for such members and full-year enrollees. For Insurer A, enrollment duration factors would increase part-year OEP enrollees' risk scores by 0.23—the same amount needed to equalize relative payment adequacy. For Insurer B, the enrollment duration factors would increase part-year OEP enrollees' risk scores by 0.22—a little more than the 0.18 increase needed to equalize relative payment adequacy.

By contrast, enrollment duration factors raised risk scores for both insurers' SEP enrollees by substantially less than the amount required for equalization (exhibit 4). Enrollment duration factors would raise risk scores for Insurer A's SEP enrollees by 0.21—just half of the 0.42 increase needed to equalize relative pay-

ment adequacy. For Insurer B, the enrollment duration factors would raise risk scores by 0.20, whereas an increase of 0.31 would be required to equalize relative payment adequacy.

Discussion

In 2015, risk scores reflected two characteristics of plan members: demographics (age and sex) and certain health conditions.[8] We found that risk adjustment based on such scores underpaid insurers for part-year relative to full-year members. This relative underpayment was much larger for part-year members who signed up during SEPs than for those whose coverage began during open enrollment.

HHS's new enrollment duration factors, which do not distinguish between SEP and OEP enrollees, appear to bring compensation for part-year OEP enrollees to a level comparable to that for full-year members. However, these factors fall well short with SEP enrollees. It seems likely that compared to part-year members who sign up during open enrollment, more SEP enrollees seek to address short-term, pressing care needs. A telling sign is that unlike part-year OEP enrollees, SEP enrollees incur more paid claims during their first month of enrollment than during their average month of coverage.

This stands to reason. Many people who enroll during open enrollment and plan to retain ongoing coverage could drop coverage mid-year for reasons unrelated to the end of a short-term need for care. Some of them may get new jobs that offer employer-sponsored insurance. Others may incur unexpected costs outside the health care arena—for example, they may need to repair a broken boiler or auto—that displace premium payment as a priority.

That said, a different potential contributor to greater risk-adjustment underpayment for SEP enrollees involves undiagnosed HCCs. Many OEP enrollees, whose coverage begins in January, were already enrolled during prior years. Their carriers may be better positioned to learn about their health conditions, compared to the conditions of SEP enrollees whose coverage begins mid-year and whom the carrier did not previously insure.

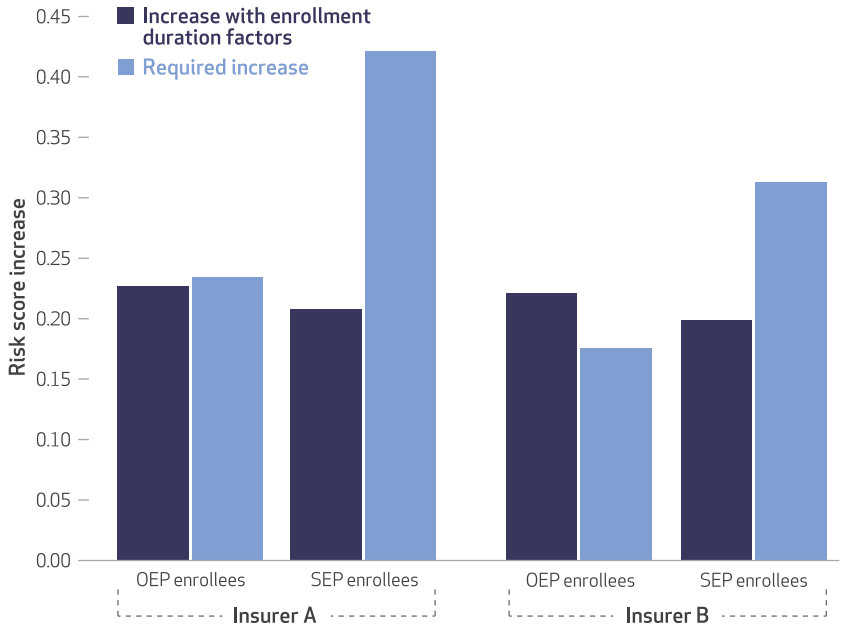
If so, by flagging the otherwise undiagnosed existence or severity of HCCs, prescription drug category factors might, in theory, narrow the relative payment gap between SEP enrollees and full-year members. Unfortunately, that gap is likely to increase rather than shrink as prescription drug category factors go into effect for 2018. Supplemental data from Insurer B show that the percentage of member-months with drug factors is 23 percent smaller among SEP enrollees than among full-year members, and paid claims for member-months with drug factors as a percentage of all paid claims are 22 percent lower for SEP enrollees than for full-year members (data not shown). When drug category factors supplement enrollment duration factors starting in 2018, carriers will get a greater increase in compensation for full-year members than for SEP enrollees. Accordingly, the current payment-adequacy gap between full-year members and SEP enrollees is likely to grow, rather than shrink.[14]

This surprising result suggests that undiagnosed conditions are more common among full-year members or less frequent among SEP enrollees than expected. It is possible that acute conditions not reflected in the current adjustments contribute to the relative costliness of SEP enrollees.

For risk adjustment to adequately compensate carriers for the selection risks associated with SEP enrollment, policy makers may need to increase enrollment duration factors that apply to SEP enrollees.[15] Increased payments for SEP enrollees would be calibrated based on claims experience in the nongroup market, using a

EXHIBIT 4

Increases in risk scores with 2018 enrollment duration factors and increases required to end risk-adjustment underpayment



SOURCE Authors' analysis of individual-market claims data for 2015 from two large insurers ("Insurer A" and "Insurer B"). **NOTES** The enrollment duration factor for each cohort was imputed based on average months of enrollment. The risk-score increase required to end risk-adjustment underpayment is the amount that, for the carrier's part-year and full-year cohorts, would equalize the ratio between per member per month paid claims and risk score. Part-year open enrollment period (OEP) enrollees have 1–9 months of enrollment. Members with 10–12 months of enrollment are used as a proxy for full-year members. SEP is special enrollment period; explained in exhibit 1.

data-analysis capacity that HHS anticipates bringing fully on line in 2019.[7] However, as with all determinations of risk-adjustment factors using data from claims records that must be analyzed and "cleaned," this calibration will lag several years behind the changing characteristics of the nongroup market. Such changing characteristics may eventually give way to relatively stable ones if the policy-making environment in which the individual market is defined becomes more stable.

Moreover, providing extra risk-adjustment payments to carriers for SEP enrollees may be necessary, but it might not be sufficient to provide carriers with adequate payment. As explained above, risk adjustment merely transfers premium dollars from nongroup carriers with healthier-than-average members to those with sicker-than-average members within a state's nongroup market. It does not affect the total amount of nongroup premiums in a state's market, which must be high enough to cover incurred claims for all members—regardless of when they enroll and how long they retain coverage. Moreover, carriers have stressed the importance of limiting SEP enrollment to consumers who meet its qualifications.

Recent developments have addressed the last two factors. Average monthly benchmark premiums in health insurance Marketplaces rose from $276 in 2015 to $355 in 2017 (29 percent) and $481 in 2018 (74 percent).[16] Moreover, HHS is requiring more documentation of SEP eligibility from consumers who seek SEP coverage.[17–19] At this juncture, modifying risk adjustment to provide adequate payment for SEP enrollees is likely to be the most important incremental step that can be taken to increase carriers' interest in serving this population.

Increased verification requirements for eligibility will likely result in fewer SEP enrollees, but the risk level of those who enroll despite higher barriers would likely rise. When HHS began testing such increased verification methods, it reported that younger adults were deterred more than older adults, as explained earlier.[12] While the overall impact of SEP-related policy changes remains to be seen, it appears doubtful that changes in this policy would alter the overall direction of our main findings. While the composition of SEP and other enrollee cohorts may shift over time, short-term urgent medical needs are likely to continue driving enrollment during SEPs in ways that require additional risk adjustment.

Several health insurance Marketplaces have found that brokers and agents can be important and effective sources of enrollment assistance.[20,21] If carriers encouraged agents and brokers to enroll eligible consumers outside open enrollment, significant coverage gains might result among the more than thirty million people who lose health insurance during a given year for reasons that qualify them for special enrollment in Marketplace coverage.

Conclusion

The past failure of risk adjustment to account for the distinctive risk profile of Marketplace enrollees during special enrollment periods has contributed to carriers' avoidance of this population. Recent policy changes represent important steps that partially rectify this shortfall. However, further increases to risk-adjustment payments for SEP enrollees are probably needed to enable carriers to compete by offering value to all eligible consumers throughout the year, rather than by avoiding the many uninsured consumers who qualify for special enrollment. ■

Some material in this article was presented to staff members of the Center for Consumer Information and Insurance Oversight in November 2016 (in Bethesda, Maryland) and June 2017. It was also presented to officials and staff members at America's Health Insurance Plans and the BlueCross BlueShield Association in December 2016 and staff members in the Federal Health Practice Group at KPMG in July 2017. The Urban Institute hosted a briefing on the findings presented in this article for consumer groups in January 2017; representatives from the National Health Law Program, Families USA, the Center on Budget and Policy Priorities, and Consumers Union were present. AcademyHealth hosted a grantee research briefing in September 2017, at which the findings were presented. They were also presented at the Fall Research Conference of the Association for Public Policy Analysis and Management in Chicago, Illinois, in November 2017. All meetings were held in Washington, D.C., except as noted. This work was funded by the Robert Wood Johnson Foundation through its Policy Relevant Insurance Studies initiative, administered by AcademyHealth. The authors are grateful to the foundation and to AcademyHealth for supporting this research and for helpful comments and suggestions. The authors thank the two insurers and their staff members who contributed data to the project. The authors are grateful to John Holahan for helpful comments and suggestions. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

NOTES

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10 With both two- and one-carrier data, when we combined part-year cohorts we weighted by member-months.
11 To access the appendix, click on the Details tab of the article online.
12 Centers for Medicare and Medicaid Services. Pre-enrollment verification for special enrollment periods [Internet]. Baltimore (MD): CMS; [cited 2017 Dec 28]. Available from: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Pre-Enrollment-SEP-fact-sheet-FINAL.PDF
13 HHS has also announced changes in SEP eligibility rules involving categories—such as people who move between states—with relatively few SEP enrollees. Those changes do not affect people who lose minimum essential coverage as a result of involuntary job loss, who constitute by far the largest group of SEP-eligible consumers. See note 4.
14 We found similar results when our analysis was limited to members for whom prescription drug category factors signal otherwise undiagnosed chronic conditions. In terms of member-months, the proportion of members with drug factors and no related Hierarchical Condition Categories documented in office-visit claims was 12 percent smaller for SEP enrollees than for full-year enrollees (data not shown). As a percentage of paid claims, the proportion was 23 percent smaller for SEP enrollees than for full-year enrollees. This suggests that drug factors will not solve the problem of SEP underpayment by addressing what some observers postulate is a disproportionately high percentage of undiagnosed chronic conditions among SEP enrollees.
15 A separate risk-adjustment factor for SEP enrollees with condition categories involving pregnancy could reduce the adjustment needed for other SEP enrollees. Based on supplemental data from Insurer B, we found that if risk scores for SEP enrollees with pregnancy-related conditions were raised so that their relative claims-to-risk ratio was 100 percent, the total gap in risk-adjustment payment adequacy between full-year members and SEP enrollees would fall by 28 percent (data not shown). Put differently, for Insurer B, unpaid costs associated with pregnancy, labor, and delivery were responsible for slightly more than a quarter of all underpayment for SEP enrollees. Enrollees with pregnancy-related conditions accounted for 3.74 percent of member-months for SEP enrollees, compared to 1.44 percent for full-year members.
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Association Health Plan Proposed Rule: Summary and Implications for States

Authored by The Center on Health Insurance Reforms at Georgetown University

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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In response to President Trump's October 12 executive order (EO), the U.S. Department of Labor (DOL) has published proposed rules to expand the availability of health coverage sold through associations to small businesses and self-employed individuals. The public has until March 6, 2018 to submit comments on these proposed rules.

What's in the Association Health Plan Proposed Rule?

The President's EO asks DOL to expand the conditions under which a group of employers can join together to be considered a single employer under the Employee Retirement Income Security Act (ERISA). The proposed rule has the primary aim of allowing more groups to form association health plans (AHPs) so that they can offer coverage that is regulated under federal law as large-group coverage. As a result, such arrangements would be exempt from Affordable Care Act (ACA) requirements, such as the essential health benefits standard, premium rating restrictions, the single risk pool requirement, and the risk adjustment program, and would raise new challenges for states attempting to regulate this business under state law. See Table 1.

Table 1. Application of ACA Insurance Protections by Market Segment (Fully Insured)

ACA Market Reform	Description	Individual Market*	Small-Group Market*	Large-Group Market*
Guaranteed Issue	Insurers must accept every individual or employer that applies for coverage, regardless of their health status or claims experience	Yes	Yes	Yes**
Essential Health Benefits	Insurers must provide coverage that includes 10 categories of defined benefits***	Yes	Yes	No
Rating Rules	Insurers cannot vary rates based on health status or gender; age rating is limited to 3:1	Yes	Yes	No
Single Risk Pool	Insurers must consider claims experience of all enrollees in all plans in setting premium rates	Yes	Yes	No
Risk Adjustment Program	Transfers funds from insurers with relatively low-risk enrollees to insurers with relatively high-risk enrollees	Yes	Yes	No

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

**The ACA requires insurers that market in the large-group market to accept all employers that apply for coverage.

***The 10 categories of benefits outlined in the ACA are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive services and chronic disease management, and pediatric services, including vision and oral care.

Gaining "Large-Group" Status Under ERISA: Proposed Change

Under current DOL rules and guidance, the criteria for determining whether a group of employers can be considered a bona fide single employer group focus on three key issues:

1. Whether the group or association is a bona fide organization with a purpose and function other than the provision of benefits;

2. Whether the employers share some commonality and organizational relationship unrelated to the provision of benefits; and
3. Whether the employers that participate in the benefit program either directly or indirectly exercise control over the program.

Furthermore, guidance issued by the Obama administration in 2011 clarifies that coverage sold via AHPs to small-group employers must be regulated under small-group market rules; coverage sold through AHPs to individuals must be regulated under individual market rules. DOL refers to the 2011 policy as the "look through" guidance. In other words, the size of each individual employer determines whether the AHP is subject to large-group market or small-group market rules, not the size of the AHP as a whole.

Under the proposed rule, AHPs could form an association solely to provide insurance benefits and gain the regulatory advantages of being treated as a large group. Additionally, DOL proposes to expand what it means for employers to "share some commonality." To be considered a single employer AHP, employer-members could be either: (1) in the same trade, industry, line of business, or profession; or (2) have their principal place of business in the same geographic region, either within a state or a metropolitan area that includes more than one state, such as the Washington, D.C., New York, or Kansas City metropolitan areas. If the former, the AHP could sell coverage nationwide, so long as its members are in the same trade, industry, line of business, or profession.

DOL proposes to retain the third criteria, requiring that the employer-members exercise control over the program. Furthermore, the AHP must have a "formal organizational structure," governing body, and by-laws in order to ensure that the AHP is acting "in the interest" of participating employers.

Expanding AHPs to the Individual Market: Membership for the Self-Employed

Under current federal rules, employers who want to purchase small-group coverage must have at least one employee who is not a spouse. The proposed rule reverses the DOL's past interpretation of ERISA, providing that the self-employed can elect to be treated as "employers" in order to join the association and at the same time be treated as "employees" in order to be covered under the benefit plan. The proposed rule would require "worker-owners" to earn a minimum income from the relevant trade or business, or work a minimum number of hours. However, AHPs could rely solely on a written attestation from the individual that he or she meets these requirements.

Health Nondiscrimination Protections

Currently, federal rules allow AHPs that achieve bona fide large-group status to separately rate each employer member of the AHP based on its claims experience or other rating factors. In expanding the ability of AHPs to achieve large-group status, however, DOL is proposing new rules that would prohibit discrimination between employer-members based on health status. Specifically, DOL is proposing that AHP membership, eligibility for benefits, benefit designs, and premiums cannot be based on any health factor. However, as a large group exempt from the ACA's rating restrictions, AHPs could charge different premiums to small groups or individuals based on age, industry, gender, or other non-health factors. Furthermore, AHPs would not be required to cover the ACA's essential health benefits and could establish different membership criteria or plan benefit designs based on other classifications, such as full-time versus part-time status, date of hire, and different occupations. For example, the rules appear to allow an AHP to offer a plan that covers maternity services to small employers and one that does not to self-employed individuals, because the separate classification would not be based on a health factor. The DOL is seeking comment on whether these nondiscrimination requirements could result in "involuntary cross-subsidization" across firms, discouraging their formation.

On the Horizon: Potential Broad Preemption of State AHP Regulation

The preamble to the proposed rule includes a "Request for Information" on whether DOL should exempt certain self-insured AHPs from state insurance regulation. This federal exemption authority could preempt state benefit standards, rating rules, and marketing restrictions, but would not preempt states' authority over AHPs' financial solvency. DOL says it is interested in "the potential for such exemptions to promote health care consumer choice and competition…as well as in the risk such exemptions might present to appropriate regulation and oversight of AHPs…" DOL further notes that, in the event of such an exemption, AHPs would continue to be subject to federal regulatory standards governing ERISA plans and AHPs.

Implications for States

States are the primary regulators of health insurance, and have broad authority to regulate AHPs, including financial solvency, marketing and rating practices, and insurance contracts. The proposed rule raises several issues likely to be of interest to states seeking to retain that authority and potentially amend their current rules and standards related to AHPs; DOL specifically asks for comments on the interaction and consequences of the proposed rule for other state and federal laws.

Who Decides? Determining Which AHPs Meet New Federal Standard

The proposed rule does not lay out a process by which AHPs would apply for or receive a federal designation as a bona fide employer sponsor of a "single multiple employer" health plan. Currently, an AHP seeking such a designation can request a DOL Advisory Opinion, a process that can take many months, if not years. In some cases, state departments of insurance (DOIs) have required AHPs to receive a formal DOL designation before being allowed to operate in the state; other DOIs have made their own determination of whether the entity meets the federal criteria for single employer, large-group status. Without a clear, new process for AHP certification prescribed by DOL, state DOIs may be on the front lines for determining whether AHPs meet the new criteria.

Potential Preemption of State Insurance Oversight: How Far Can States Go in Regulating AHPs?

The preamble to the proposed rule states that it would have a "limited" effect on state regulation because it would not modify states' authority to regulate insurers or the policies they sell to AHPs. AHPs may be "self-insured," meaning that the employer-members bear the risk of paying employees' medical claims. In other cases, the AHP is "fully-insured," meaning that it purchases insurance from an insurance company. In either case, states currently have broad authority to regulate the coverage sold through AHPs.

For the first time, DOL has signaled that it could exercise its authority to exempt certain self-insured AHPs from most insurance regulation. If it does, DOL would be the primary regulator of coverage marketed through AHPs. States would not be permitted to require AHPs to meet state rating, insurance contract, or marketing standards, and consumers who run into problems with their AHP would need to appeal to a federal agency, not their DOI, for help.

Additionally, while DOL states that the rule in its current form would not affect state regulatory authority over AHPs, there are some questions about how far state regulation could go. The proposed rule notes that state regulation must not be "inconsistent with ERISA." It is thus not clear whether a state's law or standard could be in jeopardy if it runs counter to DOL's new interpretation of ERISA for AHPs. For example, some states currently prohibit new self-insured AHPs from operating. Other states require all AHPs marketing coverage to small businesses to comply with small-group regulations and standards. A critical question for these states is whether they could be sued for having laws that are now deemed "inconsistent with ERISA."

Impact on State Premium Tax Revenue

Finally, to the extent that AHPs gain significant membership and shift small businesses and individuals away from the state-regulated group or individual markets, states could experience a resultant decline in revenue from premium taxes. This shortfall could impact state budgeting and planning.

Conclusion

The proposed rule could dramatically expand the number of AHPs that market insurance to small businesses and individuals but are regulated as large-group, single employer health plans. It will have significant implications for the small businesses and individuals enrolled through these AHPs, as well as for the markets subject to the ACA and state small-group and individual market standards. It further raises questions about the extent of state authority to assess whether AHPs meet the new federal test for single employer status, as well as states' ability to subject AHPs to small-group or individual market rules. It also raises the prospect of future federal rules that could broadly preempt state regulation of AHPs.

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ABOUT THE CENTER ON HEALTH INSURANCE REFORMS AT GEORGETOWN UNIVERSITY

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

Change in Marketplace Enrollment, 2017-2018 | The Henry Family Foundation

Timeframe: 2017-2018

Location	Marketplace Type	Number of Individuals Who Selected a Marketplace Plan, 2018	Number of Individuals Who Selected a Marketplace Plan, 2017	Percent Change, 2017-2018
United States	**12 State-based; 5 SBM using Healthcare.gov; 39 Healthcare.gov**	**11,760,533**	**12,216,003**	**-3.7%**
Alabama	Healthcare.gov	170,211	178,414	-4.6%
Alaska	Healthcare.gov	18,313	19,145	-4.3%
Arizona	Healthcare.gov	165,758	196,291	-15.6%
Arkansas	SBM using Healthcare.gov	68,100	70,404	-3.3%
California	State-based Marketplace	1,521,524	1,556,676	-2.3%
Colorado	State-based Marketplace	165,777	161,568	2.6%
Connecticut	State-based Marketplace	114,134	111,542	2.3%
Delaware	Healthcare.gov	24,500	27,584	-11.2%
District of Columbia	State-based Marketplace	22,584	21,248	6.3%
Florida	Healthcare.gov	1,715,227	1,760,025	-2.5%
Georgia	Healthcare.gov	480,912	493,880	-2.6%
Hawaii	Healthcare.gov	19,799	18,938	4.5%
Idaho	State-based Marketplace	94,507	100,082	-5.6%
Illinois	Healthcare.gov	334,979	356,403	-6.0%
Indiana	Healthcare.gov	166,711	174,611	-4.5%
Iowa	Healthcare.gov	53,217	51,573	3.2%
Kansas	Healthcare.gov	98,238	98,780	-0.5%
Kentucky	SBM using Healthcare.gov	89,569	81,155	10.4%
Louisiana	Healthcare.gov	109,855	143,577	-23.5%
Maine	Healthcare.gov	75,809	79,407	-4.5%
Maryland	State-based Marketplace	153,584	157,832	-2.7%
Massachusetts	State-based Marketplace	270,688	266,664	1.5%
Michigan	Healthcare.gov	293,940	321,451	-8.6%
Minnesota	State-based Marketplace	116,358	109,974	5.8%
Mississippi	Healthcare.gov	83,649	88,483	-5.5%
Missouri	Healthcare.gov	243,382	244,382	-0.4%
Montana	Healthcare.gov	47,699	52,473	-9.1%
Nebraska	Healthcare.gov	88,213	84,371	4.6%
Nevada	SBM using Healthcare.gov	91,003	89,061	2.2%
New Hampshire	Healthcare.gov	49,573	53,024	-6.5%
New Jersey	Healthcare.gov	274,782	295,067	-6.9%
New Mexico	SBM using Healthcare.gov	49,792	54,653	-8.9%
New York	State-based Marketplace	253,102	242,880	4.2%
North Carolina	Healthcare.gov	519,803	549,158	-5.3%
North Dakota	Healthcare.gov	22,486	21,982	2.3%
Ohio	Healthcare.gov	230,127	238,843	-3.6%

Oklahoma	Healthcare.gov	140,184	146,286	-4.2%
Oregon	SBM using Healthcare.gov	156,105	155,430	0.4%
Pennsylvania	Healthcare.gov	389,081	426,059	-8.7%
Rhode Island	State-based Marketplace	33,021	29,456	12.1%
South Carolina	Healthcare.gov	215,983	230,211	-6.2%
South Dakota	Healthcare.gov	29,652	29,622	0.1%
Tennessee	Healthcare.gov	228,646	234,125	-2.3%
Texas	Healthcare.gov	1,126,838	1,227,290	-8.2%
Utah	Healthcare.gov	194,118	197,187	-1.6%
Vermont	State-based Marketplace	28,762	30,682	-6.3%
Virginia	Healthcare.gov	400,015	410,726	-2.6%
Washington	State-based Marketplace	242,850	225,594	7.6%
West Virginia	Healthcare.gov	27,409	34,045	-19.5%
Wisconsin	Healthcare.gov	225,435	242,863	-7.2%
Wyoming	Healthcare.gov	24,529	24,826	-1.2%

NOTES

Notes

The Affordable Care Act established Health Insurance Marketplaces where individuals can purchase health insurance during an annual open enrollr in this table show the change in Marketplace enrollment between 2017 and 2018.

Sources

2018: Final Weekly Enrollment Snapshot for 2018 Open Enrollment Period, CMS, Department of Health and Human Services, for states using health Marketplace websites and ACAsignups.net, for state-based Marketplace states

2017: 2017 Marketplace Open Enrollment Period Public Use Files, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department c Services (HHS).

Definitions

Number of Individuals Who Selected a Marketplace Plan represents the total number of people who selected or were automatically reenrolled i medical plan (regardless of whether the consumer paid the premium) as of the end of the open enrollment period.

State-based Marketplace: state operates its own Marketplace eligibility and enrollment platform.

SBM using Healthcare.gov: state operates a state-based Marketplace, but relies on the Healthcare.gov eligibility and enrollment platform.

Healthcare.gov: State relies on the federal Healthcare.gov Marketplace eligibility and enrollment platform; Healthcare.gov Marketplaces may be fu operated as a partnership between the federal government and the state.

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Health Coverage by Race and Ethnicity: Changes Under the ACA

Samantha Artiga, Julia Foutz, and Anthony Damico

Key Takeaways

People of color historically have been more likely to be uninsured and to face more barriers accessing care than Whites. The Affordable Care Act (ACA) health coverage expansions provided an opportunity to help reduce these disparities. This brief examines changes in health coverage under the ACA by race and ethnicity and discusses the implications for health coverage disparities. Based on Kaiser Family Foundation analysis of Current Population Survey data for the nonelderly population, it finds:

- **People of color have had larger gains in coverage compared to Whites since implementation of the ACA, helping to narrow racial and ethnic disparities in coverage.** All racial and ethnic groups had coverage gains. Gains were largest for nonelderly Hispanics, whose uninsured rate decreased from 26% to 17%, reducing the number of uninsured by 4.0 million. The number of nonelderly uninsured Asians fell by 0.9 million, and their uninsured rate decreased by almost half from 15% to 8%. Among nonelderly Blacks, the number of uninsured fell by 1.8 million and the uninsured rate decreased from 17% to 12%. Nonelderly Whites had a smaller change in their uninsured rate, which fell from 12% to 8%, but the largest decrease in the number of uninsured (6.7 million), reflecting their larger overall population size.
- **Despite larger coverage gains for people of color, disparities in coverage persist, particularly for Hispanics.** Medicaid plays a key role helping to fill gaps in private coverage for nonelderly Hispanics and Blacks, but they remain more likely to be uninsured than Whites. Hispanics are at the highest risk of being uninsured, with nonelderly adult Hispanics nearly two and half times as likely to be uninsured than nonelderly adult Whites (22% vs. 9%). Uninsured rates for children are lower than rates for adults, but Hispanic children are still twice as likely a White children to be uninsured (8% vs. 4%).
- **Opportunities remain to increase coverage through enrollment of eligible but uninsured individuals in Medicaid or subsidized Marketplace coverage, but eligibility for coverage varies by race and ethnicity.** Nonelderly uninsured Blacks are more likely than nonelderly uninsured Whites to be ineligible for coverage because they fall into the coverage gap in states that have not implemented the Medicaid expansion. Nonelderly uninsured Asians and Hispanics have lower eligibility rates because they include higher shares of noncitizens, and some are ineligible due to immigration status.
- **Progress reducing coverage disparities could be eroded by recent cuts to outreach funding, changes to Medicaid, and repeal of the individual mandate**. These changes could limit enrollment of eligible people and lead to coverage losses that would disproportionately affect people of color.

Introduction

Despite improvements in population health and continued efforts to reduce disparities in health and health care, people of color remain more likely to be uninsured and to face increased barriers accessing care compared to Whites.[1] People of color also have lower utilization of care compared to Whites and have worse measures of health status and health outcomes.[2] As the United States population becomes more racially and ethnically diverse, with people of color projected to constitute over half of the population in 2045,[3] disparities have growing implications for the nation. The Affordable Care Act (ACA) coverage expansions offered an opportunity to increase coverage among people of color and address the longstanding racial and ethnic disparities in health coverage. This brief examines changes in health coverage by race and ethnicity under the ACA and discusses the implications for health coverage disparities.

The ACA Health Coverage Expansions

The ACA established new coverage options for low- and moderate-income individuals. The ACA included an expansion of Medicaid to low-income adults with incomes up to 138% of the federal poverty level (FPL) ($28,676 for a family of three in 2018).[4] The ACA also established health insurance Marketplaces through which individuals can purchase insurance coverage and provides tax credits to individuals with incomes between 100% and 400% FPL ($20,780 to $83,120 for a family of three in 2018).[5]

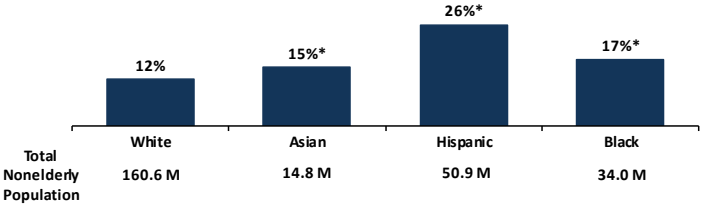
Under the ACA, these expansions became effective as of January 2014. As enacted, the Medicaid expansion to low-income adults was to be implemented nationwide; however, it was effectively made a state option by the 2012 Supreme Court ruling on the ACA. As of January 2018, 33 states, including the District of Columbia, had adopted the expansion, although it had not yet been implemented in Maine. In the 19 states that have not implemented the expansion, an estimated 2.4 million poor adults fall into a coverage gap.[6] These adults did not gain access to an affordable coverage option because they earn too much to qualify for Medicaid but not enough to receive tax credits for Marketplace coverage, which become available at 100% FPL.

Changes in Health Coverage by Race/Ethnicity under the ACA

Prior to the ACA, people of color were more likely to be uninsured than Whites. As of 2013, a total of 41.1 million nonelderly individuals were uninsured, including 18.7 million Whites, 2.2 million Asians, 13.1 million Hispanics, and 5.8 million Blacks. While nearly half of the uninsured were Whites (46%)[7], people of color had a higher risk of being uninsured than Whites (Figure 1). Hispanics were at the highest risk of being uninsured with over one in four lacking coverage.

Figure 1

Uninsured Rates Among Nonelderly Individuals by Race/Ethnicity, 2013

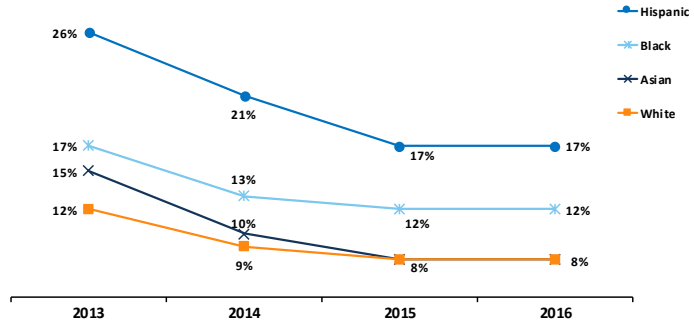


* Indicates statistically significant difference from the White population at the p < 0.05 level.
Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age.
Source: Kaiser Family Foundation analysis of March 2014 Current Population Survey, Annual Social and Economic Supplement.

People of color have experienced larger gains in coverage compared to Whites since ACA implementation. All racial and ethnic groups experienced reductions in their uninsured rate between 2013 and 2016, with coverage remaining largely steady between 2015 and 2016 (Figure 2). Decreases in the uninsured rate were larger among communities of color compared to Whites, which helped narrow disparities in coverage (Figure 3). Coverage gains were particularly large for Hispanics, who experienced a 4.0 million decline in the number of uninsured and a 9 point decline in their uninsured rate over the period. Asians and Blacks also had larger percentage point reductions in their uninsured rate compared to Whites, resulting in the numbers of uninsured Asians and Blacks decreasing by 0.9 and 1.8 million, respectively. Though Whites had a smaller change in their uninsured rate, they had the largest decrease in the number of uninsured over the period (6.7 million), reflecting their larger overall population size.

Figure 2

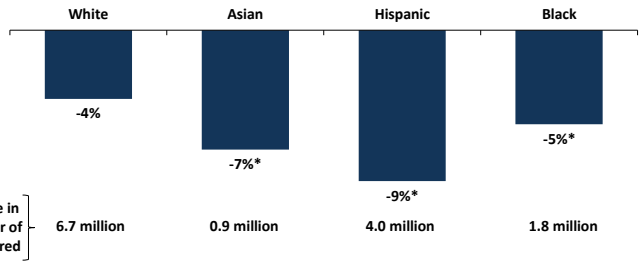
Uninsured Rate Among Nonelderly Individuals by Race/Ethnicity, 2013-2016



Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are nonHispanic.
Includes nonelderly individuals 0-64 years of age.
Source: Kaiser Family Foundation analysis of March 2014-2017 Current Population Survey, Annual Social and EconomicSupplement.

Figure 3

Percentage Point Change in Uninsured Rate among the Nonelderly Population by Race/Ethnicity, 2013-2016

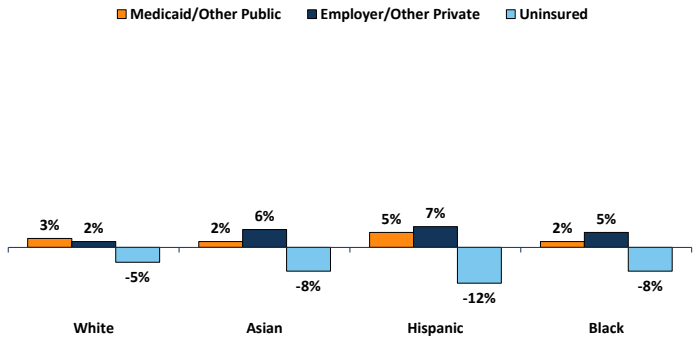


* Indicates statistically significant difference from the White population at the p < 0.05 level.
Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.
Includes nonelderly individuals 0-64 years of age.
Source: Kaiser Family Foundation analysis of March 2014 and 2017 Current Population Survey, Annual Social and Economic Supplement.

Coverage gains for adults were driven by increases in both Medicaid and private coverage. Medicaid and private coverage increased for White, Hispanic, and Black nonelderly adults between 2013 and 2016, which led to the drops in their uninsured rates, while gains in private coverage drove most of the decline in the uninsured rate for nonelderly adult Asians (Figure 4). Coverage changes for children were smaller over the period. Private coverage for Asian, Hispanic, and Black children increased and there was a small increase in Medicaid coverage for White children (data not shown).

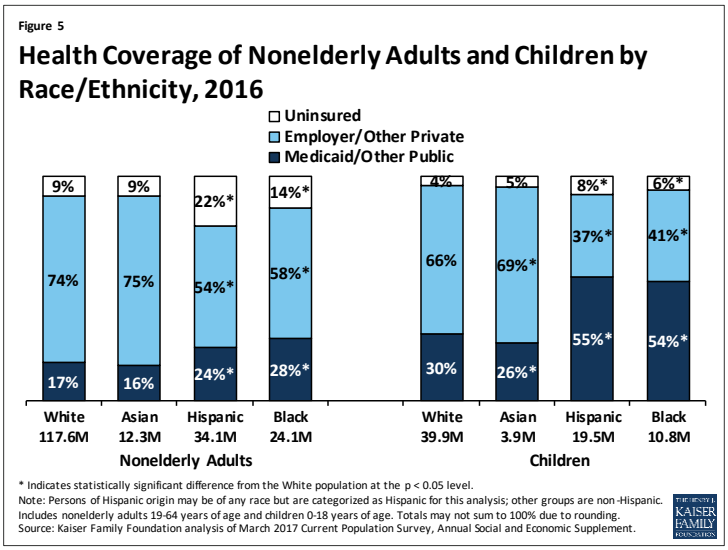
Figure 4

Percentage Point Change in Health Coverage for Nonelderly Adults by Race/Ethnicity, 2013-2016

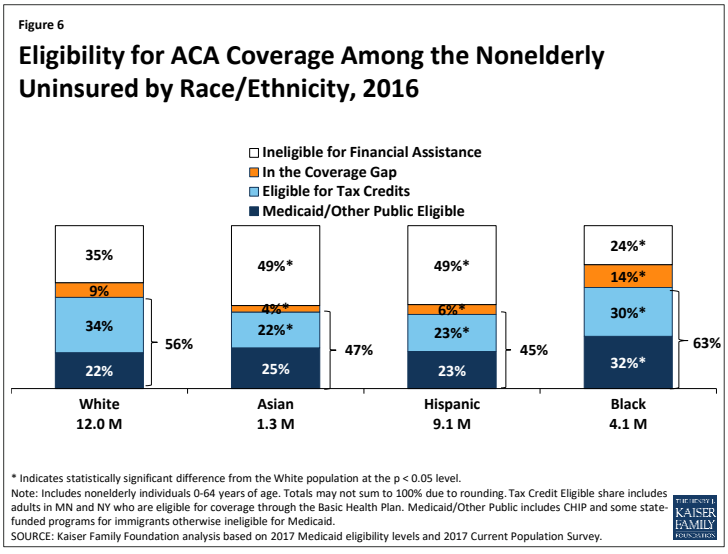


Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.
Includes nonelderly adults 19-64 years of age.
Source: Kaiser Family Foundation analysis of March 2014 and 2017 Current Population Survey, Annual Social and Economic Supplement.

Racial and ethnic disparities in coverage persist despite recent coverage gains and Medicaid's role filling gaps in private coverage for adults and children of color. Even with the recent gains coverage, Hispanic and Black nonelderly adults and children remain significantly less likely to have private coverage compared to Whites. Medicaid helps fill these gaps in coverage, covering over one in four Hispanic and Black nonelderly adults and over half of Hispanic and Black children. However, it does not fully offset the difference, leaving Hispanics and Blacks at higher risk of being uninsured. Hispanics are at the highest risk of being uninsured, with nonelderly adult Hispanics nearly two and half times as likely to be uninsured than nonelderly adult Whites (22% vs. 9%). Uninsured rates for children are lower than rates for adults, but Hispanic children are still twice as likely a White children to be uninsured (8% vs. 4%).



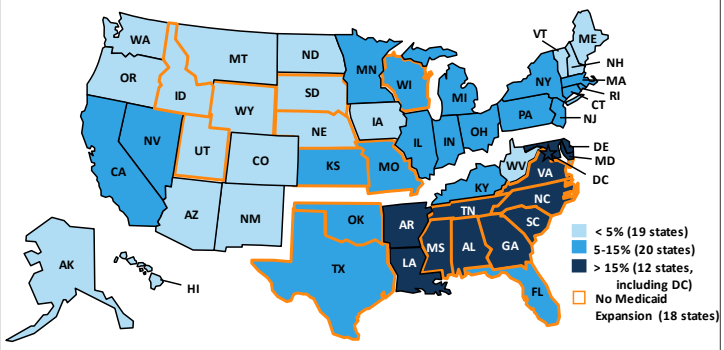
Opportunities remain to increase coverage through enrollment of eligible but uninsured individuals in Medicaid or subsidized Marketplace coverage, but eligibility for coverage varies by race and ethnicity. In 2016, 27.5 million nonelderly people lacked health insurance. Overall, an estimated 53% of this population is eligible for financial assistance for coverage.[8] This includes one in four (25%) who are eligible for Medicaid and nearly a third (29%) who are eligible for premium tax credits to purchase coverage through the Marketplaces.[9] However, eligibility for financial assistance for coverage among the uninsured varies substantially across racial and ethnic groups (Figure 6).



Uninsured nonelderly Blacks are more likely than Whites to fall in the coverage gap because a greater share live in states that have not implemented the Medicaid expansion. While over 6 in 10 (63%) uninsured nonelderly Blacks are eligible for Medicaid or subsidies for Marketplace coverage, they are more likely than uninsured nonelderly Whites to be ineligible for assistance because they fall into the coverage gap in states that did not expand Medicaid (14% vs. 9%). This finding reflects that Blacks make up a greater share of the population in the South, where most states have not expanded Medicaid (Figure 7).

Figure 7

Share of Total Population that is Black by State and Medicaid Expansion Status, 2016

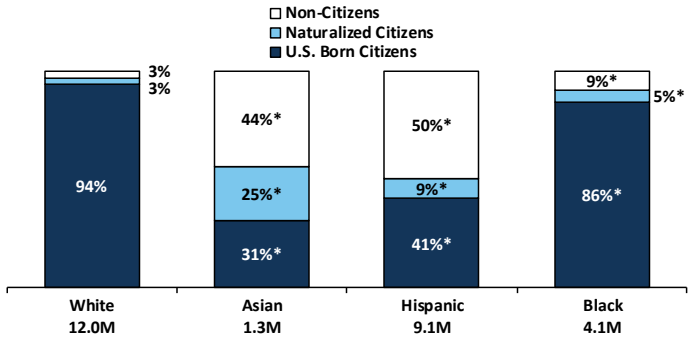


NOTE: Blacks are non-Hispanic. States outlined in orange have not adopted Medicaid expansion. Expansion has not yet been implemented in Maine.
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey, Annual Social and Economic Supplement.

Uninsured nonelderly Asians and Hispanics are less likely than Whites to be eligible for financial assistance for coverage, because they include larger shares of noncitizens and some do not qualify due to immigration status. Less than half nonelderly uninsured Asians (47%) and Hispanics (45%) are eligible for financial assistance for coverage compared to over half of uninsured Whites (56%). This, in part, reflects that noncitizens account for higher shares of nonelderly uninsured Asians and Hispanics compared to Whites (Figure 8), and some of those noncitizens remain ineligible for assistance due to their immigration status.

Figure 8

Citizenship Status of Nonelderly Uninsured Population by Race/Ethnicity, 2016



* Indicates statistically significant difference from the White population at the p < 0.05 level.
Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age. Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey, Annual Social and Economic Supplement.

Discussion

These findings show that the ACA has contributed to large coverage gains among people of color, which have narrowed coverage disparities and will likely lead to improved access to care and utilization. The coverage gains have helped reduce longstanding disparities in coverage faced by people of color, particularly for Hispanics. These coverage gains are expected to reduce disparities in access to and use of health care as well as health outcomes over the long-term. Research shows that health insurance makes a key difference in whether, when, and where people get medical care and ultimately how healthy they are.[10]

Although the ACA coverage expansions have helped narrow disparities in health coverage for people of color, disparities persist. Hispanics adults and children, in particular, remain at higher risk of being uninsured. These ongoing coverage disparities contribute to greater barriers to accessing care and at risk for unaffordable medical bills that could lead to medical debt and financial instability.

Opportunities remain to increase coverage and further reduce coverage disparities by enrolling individuals who are eligible for financial assistance for coverage but remain uninsured. However, the extent to which enrollment can increase coverage varies by race/ethnicity since eligibility for coverage among the remaining uninsured varies substantially across racial and ethnic groups. Some uninsured individuals remain ineligible for assistance for coverage because they fall into the coverage gap in states that did not expand Medicaid or do not qualify based on immigration status. Further, recent cuts in funding to Navigator programs that conduct outreach and provide enrollment assistance and a shorter open enrollment period may limit progress reaching the remaining eligible but uninsured population.

Recent progress reducing coverage disparities could be eroded by changes to Medicaid and repeal of the individual mandate. Although efforts to repeal and replace the ACA and cut federal financing for Medicaid failed last year, in 2018, there may be changes in Medicaid through waivers to impose work requirements and other restrictions and proposals to reduce federal Medicaid funding may reemerge. Reductions or limits in Medicaid would disproportionately affect people of color and widen coverage disparities. The repeal and replace debate and elimination of the individual mandate may also contribute to coverage losses that would widen disparities. In fact, recent data from other survey data point to increases in the uninsured rate during 2017, with larger increases for Blacks and Hispanics compared to Whites.[11]

Data and Methods

This brief is based on Kaiser Family Foundation analysis of Current Population Survey data for the nonelderly population between ages 0-64. See, "Estimates of Eligibility for ACA Coverage among the Uninsured in 2016," for more information on methods used to estimate eligibility for coverage among the uninsured. Throughout the brief, individuals of Hispanic origin may be any race but are classified as Hispanic for this analysis; all other groups are limited to non-Hispanic individuals. Due to sample size limitations data could not be reported for American Indians and Alaska Natives or Native Hawaiians and Other Pacific Islanders. (See the following infographics based on American Community Survey data for information for American Indians and Alaska Natives and Native Hawaiians and Pacific Islanders.)

Samantha Artiga and Julia Foutz are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

Endnotes

[1] Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity*, (Washington, DC: Kaiser Family Foundation, June 2016), http://files.kff.org/attachment/Chartpack-Key-Facts-on-Health-and-Health-Care-by-Race-and-Ethnicity.

[2] Ibid.

[3] "Projections of the Population by Sex, Hispanic Origin, and Race for the United States 2015 to 2060," U.S. Census Bureau, accessed November 10, 2017, https://www.census.gov/data/tables/2014/demo/popproj/2014-summary-tables.html.

[4] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2017 Poverty Guidelines. Available at: https://aspe.hhs.gov/poverty-guidelines.

[5] Ibid.

[6] Rachel Garfield and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, (Washington, DC: Kaiser Family Foundation, November 2017), http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

[7] Kaiser Family Foundation, *Key Facts about the Uninsured Population* (Washington, DC: Kaiser Family Foundation, September 2017), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[8] Rachel Garfield, et al., *Estimates of Eligibility for ACA Coverage among the Uninsured in 2016*, (Washington, DC: Kaiser Family Foundation. October 2017), http://kff.org/uninsured/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/.

[9] Ibid.

[10] Kaiser Commission on Medicaid and the Uninsured, *Key Facts About the Uninsured Population, (Washington, DC: Kaiser Family Foundation, September 2016), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/*.

[11] Zac Auter, "U.S. Uninsured Rate Steady at 12.2% in Fourth Quarter of 2017," *Gallup News* (January 16, 2018), http://news.gallup.com/poll/225383/uninsured-rate-steady-fourth-quarter-2017.aspx

By Fredric Blavin, Michael Karpman, Genevieve M. Kenney, and Benjamin D. Sommers

Medicaid Versus Marketplace Coverage For Near-Poor Adults: Effects On Out-Of-Pocket Spending And Coverage

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ABSTRACT **In states that expanded Medicaid eligibility under the Affordable Care Act, nonelderly near-poor adults—those with family incomes of 100–138 percent of the federal poverty level—are generally eligible for Medicaid, with no premiums and minimal cost sharing. In states that did not expand eligibility, these adults may qualify for premium tax credits to purchase Marketplace plans that have out-of-pocket premiums and cost-sharing requirements. We used data for 2010–15 to estimate the effects of Medicaid expansion on coverage and out-of-pocket expenses, compared to the effects of Marketplace coverage. For adults with family incomes of 100–138 percent of poverty, living in a Medicaid expansion state was associated with a 4.5-percentage-point reduction in the probability of being uninsured, a $344 decline in average total out-of-pocket spending, a 4.1-percentage-point decline in high out-of-pocket spending burden (that is, spending more than 10 percent of income), and a 7.7-percentage-point decline in the probability of having any out-of-pocket spending relative to living in a nonexpansion state. These findings suggest that policies that substitute Marketplace for Medicaid eligibility could lower coverage rates and increase out-of-pocket expenses for enrollees.**

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The Affordable Care Act (ACA) expanded eligibility for Medicaid for near-poor nonelderly adults—those with family incomes below 138 percent of the federal poverty level. However, the US Supreme Court's 2012 ruling allowed states to opt out of the Medicaid expansion. In the nineteen states that had chosen not to expand Medicaid as of October 2017, most adults with family incomes of 100–400 percent of poverty[1]—but generally not those with family incomes below 100 percent of poverty—may qualify for tax credits to purchase Marketplace plans if they do not have access to affordable employer-sponsored coverage.

Important differences exist in the cost-sharing provisions applicable to various groups of people with incomes of 100–138 percent of poverty, depending upon Medicaid expansion status. In nonexpansion states, premium tax credits for people in this income range cap premiums for the second-lowest-cost silver plan at 2.0 percent of income, and cost-sharing reduction subsidies increase the actuarial value of a silver plan to 94 percent. In contrast, in expansion states, adults with incomes below 138 percent of poverty typically face no premiums and minimal cost-sharing requirements.[2]

In addition to lower premiums and cost-sharing requirements, Medicaid expansion could also affect consumers' financial situation through higher take-up and coverage eligibility compared to Marketplace coverage. In contrast to subsidized Marketplace coverage, Medicaid enroll-

ment typically does not require premiums, is available on a retroactive basis, and can occur year-round with no restrictions (that is, there is no open enrollment period)—all of which may contribute to higher take-up of Medicaid than of Marketplace coverage.[3–6] Moreover, in contrast to people with Medicaid, those with access to employer-sponsored coverage with out-of-pocket premiums totaling less than 9.5 percent of their income (adjusted annually) are not eligible for Marketplace subsidies. Thus, fewer people with incomes of 100–138 percent of poverty are eligible for insurance with financial assistance in states that did not expand Medicaid.

While no published research, to our knowledge, has quantified differences in out-of-pocket spending in Medicaid relative to that in Marketplace plans, several studies have evaluated the effects of Medicaid on financial well-being. Adults in Medicaid expansion states experienced larger reductions in the probability of having any out-of-pocket spending compared to Marketplace enrollees but faced greater difficulty in accessing physician care.[7] The Oregon Health Insurance Experiment found that Medicaid coverage reduced the likelihood of borrowing money or skipping bills to pay for medical care by 40 percent and reduced the probability of having a medical debt collection by 25 percent.[8] A national study also found that Medicaid expansion reduced difficulty paying medical bills among low-income parents.[9] Meanwhile, another study found that adults in Kentucky (a traditional Medicaid expansion state) with incomes below 138 percent of poverty experienced a greater reduction in problems paying medical bills than comparable adults in Arkansas, a "private option" expansion state that features the maximum allowable cost sharing under Medicaid rules.[10]

For this study we used data from the Census Bureau's Current Population Survey (CPS) and the American Community Survey (ACS) to analyze out-of-pocket health spending and insurance coverage of near-poor nonelderly adults in Medicaid expansion states compared to near-poor nonelderly adults in nonexpansion states with potential access to subsidized Marketplace plans. Throughout the remainder of this text, we state "Medicaid expansion relative to Marketplace coverage" as shorthand for this comparison. This research is important for states as they consider expansion and make design choices in their Medicaid programs in the coming years. Six states have received section 1115 Medicaid expansion waivers allowing Medicaid to charge premiums for people with incomes of 100–138 percent of poverty.[11] Moreover, Arkansas, which—as noted above—has implemented a "private option" for Medicaid, has submitted a waiver request to lower the eligibility level to 100 percent of poverty from the current 138 percent, while at least five other states have drafted plans to place other limits on existing Medicaid expansions.[11,12] Understanding how out-of-pocket spending and coverage rates differentially changed for nonelderly adults who had incomes of 100–138 percent of poverty and who were eligible for either Medicaid or Marketplace coverage is important to informing pending state and federal policy decisions.

Study Data And Methods

DATA AND SAMPLE We used data for 2011–16 from the CPS Annual Social and Economic Supplement to assess out-of-pocket spending levels in 2010–15. Information covering 2010–13 and 2014–15 provide data for the periods before and after the ACA Medicaid expansion, respectively. The CPS collects individual-level data on income, health insurance coverage, state of residence, and demographic and socioeconomic characteristics. CPS data also include detailed information on out-of-pocket premium and nonpremium medical spending.[13] We refer to nonpremium out-of-pocket medical spending as *cost sharing*. The CPS sample is nationally representative and includes an annual sample of more than 7,000 nonelderly adults with incomes of 100–138 percent of poverty.

We did not use the CPS's insurance information in our main model because of a fundamental redesign of the health insurance questionnaire in 2014 that precludes direct comparisons to estimates from prior years.[14] Instead, we used data for 2010–15 from the ACS to assess the impacts of Medicaid expansion on coverage status in this income group. The ACS surveys approximately three million people each year and, in contrast to the CPS, asked a consistent set of insurance questions over the study period.

We limited our analytic sample to adults ages 19–64 with incomes of 100–138 percent of poverty, and we took into account immigration requirements for eligibility.[15] To approximate ACA-related eligibility for Medicaid and Marketplace coverage, we constructed health insurance units and a measure of Modified Adjusted Gross Income to define income groups. We also imputed documentation status on the CPS for noncitizens using a method developed by the Pew Research Center.[16] For the ACS sample, we excluded noncitizens and people with Medicare.

Our sample for both analyses included forty-four states. We excluded four states that expanded Medicaid after mid-2014 and before 2016 (Alaska, Indiana, New Hampshire, and Pennsyl-

vania) because post-ACA data for those states would contain a mixture of expansion and nonexpansion periods. We also excluded two states (Massachusetts and Vermont) and the District of Columbia—all of which expanded public coverage to childless adults with incomes of up to 138 percent of poverty before 2014—because they were significantly less affected by the 2014 expansion. As sensitivity tests, we included and excluded various combinations of states. For example, we excluded other states that expanded Medicaid under the ACA before 2014 and states that had expanded Medicaid for some adults before the ACA.

As an alternative specification for the CPS analysis, we use a shorter pre-2014 period (2013 only), because of changes made by the Census Bureau to the income questions on the 2014 survey designed to improve the accuracy of reporting. The change created a split-sample design in which about 30 percent of the sample received the redesigned questions and the remaining 70 percent received the traditional income questions. For our alternative specification test, we included the 2014–15 sample and the portion of the 2013 sample that received the redesigned income questions.

STATISTICAL ANALYSES We estimated difference-in-differences models to compare key coverage and spending outcomes for people with incomes of 100–138 percent of poverty in Medicaid expansion states versus those in nonexpansion states. The key independent variables in each model included an indicator set to 1 for people who lived in Medicaid expansion states (Medicaid), a variable set to 1 for all observations in 2014 or later (Post), and an interaction term (Post*Medicaid) that measured the change in the outcome in expansion states relative to the change in nonexpansion states.

For the ACS coverage analysis, we estimated linear probability difference-in-differences models in which the dependent variables were indicators for being uninsured, being covered by Medicaid, having employer-sponsored insurance (including military coverage), and having direct-purchase coverage (inside or outside the Marketplaces).[17] Given potential concerns about measurement error in the specific type of coverage reported in the ACS,[18] we placed greater credence in our estimates of the impacts on any coverage than in coverage type.

For the CPS out-of-pocket spending analysis, we analyzed three general outcomes: total out-of-pocket spending, out-of-pocket premium spending, and cost sharing. For each of these outcomes, we estimated the following models: an ordinary least squares regression model in which the dependent variable was the person's level of expenses, a linear probability model in which the dependent variable was equal to 1 if the person's family out-of-pocket spending exceeded 10 percent of the family income (high out-of-pocket burden),[19] and a two-part model to account for the large share of zeros in the data. For the two-part model, we estimated linear probability models in the first stage, in which the dependent variable was equal to 1 for people with nonzero expenses, and ordinary least squares models in the second stage, in which the dependent variable was the level of expenses among those with nonzero spending. We adjusted out-of-pocket premium and medical spending for inflation using the Consumer Price Index, and all spending estimates are in 2015 dollars.

For both analyses, each model controlled for several individual and household characteristics—age, sex, race/ethnicity, educational attainment level, work status, citizenship status, and family structure—that could affect coverage or out-of-pocket spending. We also controlled for fixed differences across years (year fixed effects) and geographic areas (state fixed effects for the CPS and Public Use Microdata Area fixed effects for the ACS). For the CPS analysis, we also included an indicator of whether respondents received the traditional or redesigned income questions, to control for changes in the CPS income definition during the analysis period.

We also used various sensitivity tests and subgroup analyses to help identify causal effects and verify the robustness of our models, as further described in the online appendix.[20] We made changes to the income bands to address potential measurement error in income, reestimating the main model to include people with incomes slightly below (75–100 percent of poverty) and slightly above (138–150 percent of poverty) the income band of those in the main model. As a falsification test, we also estimated out-of-pocket spending and coverage impacts among families in higher income bands (150–200 percent and 200–400 percent of poverty), because the ACA coverage provisions for this income group are, for the most part, the same in expansion and nonexpansion states.[21] To formally test for differences in trends, we estimated models in which a 2010–13 linear time trend was interacted with the Medicaid expansion dummy variable.

For the CPS analysis, we used replicate weights designed by the Census Bureau to generate empirically derived standard error estimates. For the ACS analysis, we report robust standard errors clustered at the state level.

LIMITATIONS There were several limitations to this study. First, there was potential for recall error and other forms of measurement error in annual income, as respondents reported multi-

ple sources of income for themselves and members of their households.[22,23] In part, we addressed this concern by changing the income band definition as a sensitivity test. Similarly, the presence of income "churn" could influence the interpretation of the results, because some people who had full-year incomes of 100–138 percent of poverty may have had incomes below 100 percent or above 138 percent of poverty for part of the year. Since we might have misclassified people's eligibility for subsidized coverage in both expansion and nonexpansion states because of imperfectly measured income and lack of information on offers of affordable employer-sponsored coverage, the net effect of that measurement error would likely be to bias our estimates toward the null (that is, no difference).

Second, between March 2013 and March 2014 there were changes to the CPS in the wording of the questions about out-of-pocket spending and the imputation process for missing responses.[24] The new questions were ordered differently, were shortened to reduce respondent burden, and included a reference to the respondent's employer contribution to the premium, when applicable. We addressed this concern by limiting our sample to data for the period 2013–15, during which the questions on out-of-pocket spending and the imputation process were unchanged.

Third, the 2013 income data for the portion of the sample receiving redesigned CPS income questions can be consistently compared with income data for 2014 and 2015, but not earlier years. We addressed this by estimating a sensitivity model limited to those in the 2013–15 sample who received the redesigned income questions. The concern was also mitigated by the fact that the new income questions were primarily designed to improve the capture of retirement and asset income,[25] changes that were unlikely to have a significant impact on our sample of low-income, nonelderly adults.

Finally, as with any quasi-experimental analysis, time-varying unobservable factors might have biased our estimated effects. For example, Medicaid expansion states might have done a better job with outreach and enrollment efforts, which could have further boosted take-up relative to nonexpansion states. While our falsification tests, pre-2014 trend analyses, and sensitivity analyses were designed to minimize these risks, some potential for bias remains.

Study Results

COVERAGE CHANGES FROM THE AMERICAN COMMUNITY SURVEY Low-income adults experienced unprecedented changes in health insurance coverage in both expansion and nonexpansion states between 2010–13 and 2014–15. The uninsurance rate among adults with incomes of 100–138 percent of poverty declined by 16.4 percentage points in Medicaid expansion states and by 11.7 percentage points in nonexpansion states during this period (exhibit 1 and appendix exhibit A15).[20] The adjusted difference-in-differences estimates show that Medicaid expansion was associated with a 4.5-percentage-point reduction in the probability of being uninsured among sample adults, other things being equal.

This significant decline in the uninsurance rate in expansion states relative to that in nonexpansion states was primarily driven by larger increases in Medicaid coverage in expansion states. Between 2010–13 and 2014–15, the share of sample adults in expansion states covered by Medicaid increased by 11.9 percentage points, while the share covered by Medicaid in nonexpansion states increased by less than 1.0 percentage point. This increase in Medicaid coverage in expansion states was partially offset by a relative decline in private coverage, particularly directly purchased coverage—which is by design. Employer-sponsored insurance and directly purchased private insurance coverage rates increased in both expansion and nonexpansion states during this period, but significantly larger increases occurred in nonexpansion states.

Estimates from sensitivity analyses were generally consistent with the overall findings. First, difference-in-differences estimates from the CPS coverage model were similar to the ACS findings (appendix exhibit A1).[20] Second, the ACS difference-in-differences uninsurance estimates were significantly smaller among people with incomes of 200–400 percent of poverty (appendix exhibit A2).[20] However, we found similar, yet slightly smaller, difference-in-differences estimates among those with incomes of 150–200 percent of poverty, which points to the potential presence of measurement error in income or unmeasured factors correlated with Medicaid expansion that increased take-up among people in that income band beyond differences between Medicaid and the Marketplace. Finally, we found no evidence of differential trends driving the overall coverage findings (appendix exhibit A3).[20]

CHARACTERISTICS OF THE CURRENT POPULATION SURVEY STUDY SAMPLE Appendix exhibit A4 compares sample characteristics from the CPS for people with incomes of 100–138 percent of poverty in expansion states and nonexpansion states in the 2010–13 and 2014–15 periods.[20] People in expansion and nonexpansion states were generally similar in terms of sex, age, work status, family structure, and levels of educational

EXHIBIT 1

Difference-in-differences in health insurance coverage of adults ages 19–64 with family incomes of 100–138 percent of the federal poverty level in Medicaid expansion versus nonexpansion states, from 2010–13 to 2014–15

	Unadjusted mean		Difference	Difference-in-differences	
Type of coverage	2010–13	2014–15	between periods	Unadjusted	Adjusted
UNINSURED					
Expansion states	0.352	0.188	–0.164	–0.047***	–0.045***
Nonexpansion states	0.429	0.311	–0.117		
MEDICAID					
Expansion states	0.176	0.294	0.119	0.112***	0.111***
Nonexpansion states	0.099	0.106	0.007		
EMPLOYER SPONSORED OR MILITARY					
Expansion states	0.394	0.418	0.024	–0.020***	–0.023***
Nonexpansion states	0.403	0.447	0.044		
DIRECT PURCHASE					
Expansion states	0.078	0.099	0.021	–0.046***	–0.043***
Nonexpansion states	0.069	0.136	0.067		

SOURCE Authors' analysis of data for 2010–15 from the American Community Survey. **NOTES** Medicaid expansion states include those that expanded eligibility for Medicaid in the first half of 2014 or earlier. The estimates exclude states that expanded Medicaid in late 2014 or 2015 (Alaska, Indiana, New Hampshire, and Pennsylvania) and the District of Columbia, Massachusetts, Vermont—all of which expanded Medicaid to childless adults before the ACA was implemented. Adjusted differences-in-differences are estimated controlling for age, sex, race/ethnicity, educational attainment, work status, family structure, urban versus rural residence, activity limitations, and Public Use Microdata Area and year fixed effects. Coverage type estimates are based on the following hierarchy: Medicare, employer-sponsored insurance or military insurance, Marketplace or direct purchase, Medicaid or other public, and uninsured. Regression models are estimated using ordinary least squares. Estimates exclude noncitizens and adults with Medicare or Supplemental Security Income. ***$p < 0.01$

attainment. Adults in expansion states were more likely to be noncitizens and Hispanic and less likely to be non-Hispanic blacks than those in nonexpansion states.

CHANGES IN OUT-OF-POCKET SPENDING In Medicaid expansion states, average total out-of-pocket spending decreased by $42, from $1,014 in 2010–13 to $972 in 2014–15 (exhibit 2 and appendix exhibit A15).[20] In contrast, among the same income group in nonexpansion states, average total out-of-pocket spending increased by $326, from $1,086 to $1,412.[26] Overall, estimates from the regression-adjusted difference-in-differences model show that the Medicaid expansion, relative to Marketplace coverage, reduced average total out-of-pocket spending by $344.

The regression-adjusted difference-in-differences estimates in exhibit 2 also show that relative to available Marketplace coverage in nonexpansion states, Medicaid expansion was associated with a 4.1-percentage-point reduction in the probability of having a high total out-of-pocket spending burden and a 7.7-percentage-point reduction in the probability of having any out-of-pocket spending. These changes were primarily driven by significant increases in these spending outcomes in nonexpansion states. The difference-in-differences estimate for average total out-of-pocket expenses among those with any spending was not significant at the 10 percent level, a finding that is consistent in the remaining exhibits.

The impacts from the total out-of-pocket spending models were generally driven by differential changes in both out-of-pocket premiums and cost sharing in expansion and nonexpansion states. For the first three models (average premium spending, high premium spending burden, and any premium spending), out-of-pocket premium spending increased among sample adults in both expansion and nonexpansion states (exhibit 3). However, these increases were significantly higher in nonexpansion states. The regression-adjusted difference-in-differences estimates show that relative to access to subsidized Marketplace coverage in nonexpansion states, Medicaid expansion was associated with lower average out-of-pocket premium spending (–$125), a lower probability of having a high out-of-pocket premium spending burden (that is, premium spending more than 10 percent of income) (–2.6 percentage points), and a lower probability of having any out-of-pocket premium spending (–7.5 percentage points).

Consistent with the outcomes discussed above, Medicaid expansion was associated with lower average cost-sharing spending (–$218) and a lower probability of having any cost shar-

EXHIBIT 2

Difference-in-differences in total out-of-pocket spending of adults ages 19–64 with family incomes of 100–138 percent of the federal poverty level in Medicaid expansion versus nonexpansion states, from 2010–13 to 2014–15

	Unadjusted mean		Difference	Difference-in-differences	
	2010–13	2014–15	between periods	Unadjusted	Adjusted
AVERAGE OUT-OF-POCKET SPENDING					
Expansion states	$1,014	$972	–$42	–$368***	–$344**
Nonexpansion states	$1,086	$1,412	$326		
HIGH OUT-OF-POCKET SPENDING BURDEN[a]					
Expansion states	0.211	0.212	0.001	–0.048***	–0.041***
Nonexpansion states	0.229	0.278	0.049		
ANY OUT-OF-POCKET SPENDING					
Expansion states	0.593	0.574	–0.019	–0.089***	–0.077***
Nonexpansion states	0.615	0.685	0.070		
AVERAGE OUT-OF-POCKET SPENDING, CONDITIONAL ON ANY OUT-OF-POCKET SPENDING					
Expansion states	$1,711	$1,694	–$17	–$312	–$295
Nonexpansion states	$1,766	$2,061	$295		

SOURCE Authors' analysis of data for 2011–16 from the Current Population Survey's Annual Social and Economic Supplement. **NOTES** Total out-of-pocket spending includes out-of-pocket premium spending and cost sharing (in 2015 dollars). The estimates exclude immigrants imputed as undocumented. Medicaid expansion states include those that expanded Medicaid in the first half of 2014 or earlier. The estimates exclude the states listed in the notes to exhibit 1 and the District of Columbia. Adjusted differences-in-differences are estimated controlling for age, sex, race/ethnicity, educational attainment, work status, citizenship status, family structure, state and year fixed effects, and an indicator of whether the respondent received the traditional or redesigned income questions if they were in the March 2014 sample. Standard errors are calculated using CPS replicate weights. All models are estimated using ordinary least squares. [a]Family out-of-pocket spending exceeded 10 percent of family income. $^{**}p < 0.05$ $^{***}p < 0.01$

ing (–7.0 percentage points) (exhibit 4). However, the 0.9-percentage-point decline in high cost-sharing spending burdens (that is, cost sharing more than 10 percent of income) was not significant at the 10-percent level.

To summarize, Medicaid expansion (relative to Marketplace access) reduced the uninsurance rate by 4.5 percentage points, the share of people

EXHIBIT 3

Difference-in-differences in out-of-pocket premium spending of adults ages 19–64 with family incomes of 100–38 percent of the federal poverty level in Medicaid expansion versus nonexpansion states, from 2010–13 to 2014–15

	Unadjusted mean		Difference	Difference-in-differences	
	2010–13	2014–15	between periods	Unadjusted	Adjusted
AVERAGE OUT-OF-POCKET PREMIUM SPENDING					
Expansion states	$544	$579	$36	–$141***	–$125**
Nonexpansion states	$546	$722	$176		
HIGH OUT-OF-POCKET PREMIUM SPENDING BURDEN[a]					
Expansion states	0.117	0.124	0.007	–0.030***	–0.026**
Nonexpansion states	0.127	0.164	0.037		
ANY OUT-OF-POCKET PREMIUM SPENDING					
Expansion states	0.211	0.253	0.042	–0.081***	–0.075***
Nonexpansion states	0.231	0.354	0.123		
AVERAGE OUT-OF-POCKET PREMIUM SPENDING, CONDITIONAL ON ANY OUT-OF-POCKET PREMIUM SPENDING					
Expansion states	$2,571	$2,289	–$282	$38	$85
Nonexpansion states	$2,359	$2,039	–$320		

SOURCE Authors' analysis of data for 2011–16 from the Current Population Survey's Annual Social and Economic Supplement. **NOTES** Spending is in 2015 dollars. The estimates exclude immigrants imputed as undocumented. Medicaid expansion states include those that expanded Medicaid in the first half of 2014 or earlier. The estimates exclude states listed in the notes to exhibit 1 and the District of Columbia. Adjusted differences-in-differences are estimated controlling for the characteristics listed in the notes to exhibit 2. Standard errors are calculated using successive difference replication methods using CPS replicate weights. All models are estimated using ordinary least squares. [a]Family out-of-pocket premium spending exceeded 10 percent of family income. $^{**}p < 0.05$ $^{***}p < 0.01$

EXHIBIT 4

Difference-in-differences in cost sharing of adults ages 19–64 with family incomes of 100–138 percent of the federal poverty level in Medicaid expansion versus nonexpansion states, from 2010–13 to 2014–15

	Unadjusted mean		Difference between periods	Difference-in-differences	
	2010–13	2014–15		Unadjusted	Adjusted
AVERAGE COST SHARING					
Expansion states	$470	$393	–$78	–$227*	–$218*
Nonexpansion states	$540	$689	$149		
HIGH COST-SHARING SPENDING BURDEN[a]					
Expansion states	0.091	0.082	–0.008	–0.012	–0.009
Nonexpansion states	0.111	0.115	0.004		
ANY COST SHARING					
Expansion states	0.543	0.500	–0.042	–0.082***	–0.070***
Nonexpansion states	0.555	0.595	0.040		
AVERAGE COST SHARING, CONDITIONAL ON ANY COST SHARING					
Expansion states	$867	$785	–$82	–$268	–$274
Nonexpansion states	$972	$1,158	$186		

SOURCE Authors' analysis of data for 2011–16 from the Current Population Survey's Annual Social and Economic Supplement. **NOTES** Spending is in 2015 dollars. Cost sharing includes spending for the person's medical care, such as doctor and dentist visits, hospital visits, diagnostic tests, prescription medicine, glasses and contacts, and medical supplies. The estimates exclude immigrants imputed as undocumented. Medicaid expansion states include those that expanded Medicaid in the first half of 2014 or earlier. The estimates exclude states listed in the notes to exhibit 1 and the District of Columbia. Adjusted differences-in-differences are estimated controlling for the characteristics listed in the notes to exhibit 2. Standard errors are calculated using successive difference replication methods using CPS replicate weights. All models are estimated using ordinary least squares. [a]Family cost-sharing exceeded 10 percent of family income. *$p < 0.10$ ***$p < 0.01$

with high out-of-pocket spending burdens by 4.1 percentage points, and the share with any out-of-pocket spending by 7.7 percentage points. Additionally, Medicaid expansion was associated with a $344 decline in average total out-of-pocket spending, a $125 decline in average out-of-pocket premium spending, and a $218 decline in average cost-sharing spending, relative to Marketplace access. Relative to 2010–13 means in expansion states, these last three changes represent declines of 33.9 percent, 23.0 percent, and 46.4 percent, respectively.

OUT-OF-POCKET SPENDING SENSITIVITY ANALYSES When we expanded the income band to include people with incomes slightly below (75–138 percent of poverty) or slightly above (100–150 percent of poverty) the Medicaid income eligibility thresholds, the estimated effects were roughly the same or smaller in magnitude compared to those of the main model, as one would expect (appendix exhibit A5).[20] Similarly, the estimated impacts among people in higher-income bands (150–200 percent and 200–400 percent of poverty) were significantly smaller in magnitude compared to those of the main model, and only some of the first-stage linear probability model estimates were significant.

There were similar trends for most spending outcomes in expansion and nonexpansion states before 2013, which offers support for our study design (appendix exhibit A6).[20] We found no evidence of differential trends in the total out-of-pocket spending and premium models. While we did find some evidence of differential trends in average cost sharing, we found no evidence of such trends in any other model. For a further discussion of our sensitivity analyses, see the appendix.[20]

Discussion

We examined the impacts on out-of-pocket spending and health insurance coverage for near-poor adults who gained access to different types of health insurance under the ACA: Medicaid coverage in expansion states and subsidized Marketplace coverage in nonexpansion states.

We found that Medicaid expansion lowered out-of-pocket health spending burdens for people with incomes of 100–138 percent of poverty, relative to not expanding Medicaid. This key finding was likely driven by lower out-of-pocket premiums and cost-sharing requirements in Medicaid, combined with higher overall coverage take-up in expansion states relative to nonexpansion states. While uninsurance rates declined significantly in both expansion and nonexpansion states, the difference-in-differences estimates indicate that, relative to Marketplace coverage, Medicaid expansion was associated with nearly a 5-percentage-point reduction

in the probability of being uninsured. This finding implies that more restrictive eligibility and enrollment policies, combined with higher premiums for Marketplace coverage relative to Medicaid, were associated with lower take-up rates among people with incomes of 100–138 percent of poverty.

Despite gaining coverage, adults in that group in nonexpansion states experienced significant increases in out-of-pocket spending in 2014–15, while spending declined among people in nonexpansion states. In terms of magnitude, Medicaid expansion was associated with a reduction in average total out-of-pocket spending of $344, high out-of-pocket spending burdens of 4.1 percentage points, and the probability of having any out-of-pocket spending of 7.7 percentage points. The $344 decline in out-of-pocket spending corresponds to 2 percent of the average income for adults with incomes of 100–138 percent of poverty, which is consistent with the amount that low-income people would have to pay out of pocket for a Marketplace plan in nonexpansion states. However, the impact for those who were newly enrolled in Medicaid, relative to those who were newly enrolled in Marketplace coverage, was likely to be much higher—particularly among those with high out-of-pocket expenses before the ACA (for example, high-cost uninsured adults and those with expensive employer-sponsored plans).

Policy Implications

These findings have important implications for state and federal policy makers focused on increasing coverage or lowering out-of-pocket spending burdens among low-income uninsured people. This analysis suggests that nonexpansion states that choose to expand Medicaid under the ACA will see an increase in coverage among people with incomes of 100–138 percent of poverty and a reduction in out-of-pocket spending burdens, particularly if premiums are not included under the expansion. It also suggests that states that drop Medicaid expansion could see an increase in uninsurance and underinsurance for people with incomes of 100–138 percent of poverty, unless the states further subsidize premiums and cost sharing for Marketplace plans. Massachusetts's recent proposed section 1115 waiver does just that, using state funds to subsidize cost sharing for Marketplace enrollees in that income band at a level greater than current federal requirements. Waivers that allow Medicaid to charge premiums for people in this income band could also deter enrollment among the remaining uninsured, while increasing out-of-pocket spending burdens among enrollees.

To increase take-up and lower spending burdens among the population with incomes of 100–138 percent of poverty in both expansion and nonexpansion states, policy makers could reduce or eliminate premium requirements, increase targeted outreach efforts, or increase the value proposition of coverage relative to being uninsured by improving the quality of coverage (for example, by increasing provider participation in Medicaid through higher reimbursements and improving network adequacy in the Marketplace).[27] Future research should focus on the relative effectiveness of these different strategies.

Moving forward, it will be important to consider other factors that could influence coverage take-up and out-of-pocket spending among the population with incomes of 100–138 percent of poverty in expansion and nonexpansion states. These factors include the elimination of cost-sharing reduction subsidies, the availability of zero-premium bronze Marketplace plans in some states, repeal of the individual mandate penalty in the 2017 tax bill, and differences in outreach efforts among late-expansion states compared to those that expanded in 2014. ■

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NOTES

1 In 2017, 100–138 percent of poverty corresponded to $12,060–$16,643 for a single person and $24,600–$33,948 for a family of four. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs [Internet]. Washington (DC): ASPE; [cited 2017 Dec 13]. Available from: https://aspe.hhs.gov/poverty-guidelines

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12 McIntyre A, Joseph AM, Bagley N. Small change, big consequences—partial Medicaid expansions under the ACA. N Engl J Med. 2017;377(11): 1004–6.

13 Nonpremium out-of-pocket medical spending includes spending for the individual's medical care, such as doctor and dentist visits, hospital visits, diagnostic tests, prescription medicine, glasses and contacts, and medical supplies. Individuals may have paid out of pocket for this care because it was not a covered service under their health plan or because they were spending toward their deductible, copayments, or coinsurance for the medical care. This measure does not include spending for nonprescription health care products.

14 Pascale J, Boudreaux M, King R. Understanding the new current population survey health insurance questions. Health Serv Res. 2016; 51(1):240–61.

15 Our sample included people in nonexpansion states who had offers of affordable employer-sponsored insurance, since this information is not available in the CPS data. This may have created some biases in our estimates, since these people were not eligible for Marketplace subsidies (for example, including them might have reduced the insurance effect in nonexpansion states, compared to expansion states).

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20 To access the Appendix, click on the Details tab of the article online.

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25 Czajka JL, Rosso R. Redesign of the income questions in the Current Population Survey Annual Social and Economic Supplement: further analysis of the 2014 split-sample test [Internet]. Washington (DC): Mathematica Policy Research; 2015 Sep 27 [cited 2017 Dec 13]. Available from: https://www.mathematica-mpr.com/our-publications-and-findings/publications/redesign-of-the-income-questions-in-the-current-population-survey-annual-social-and-economic

26 This increase in total out-of-pocket spending in nonexpansion states could be driven by uninsured people moving into Marketplace coverage with some out-of-pocket premium and cost-sharing requirements

27 One potential way to improve network adequacy is through the use of telemedicine. See Ahn S, Corlette S, Lucia K. Can telemedicine help address concerns with network adequacy? Opportunities and challenges in six states [Internet]. Washington (DC): Urban Institute; 2016 Apr 6 [cited 2017 Dec 13]. Available from https://www.urban.org/research/publication/can-telemedicine-help-address-concerns-network-adequacy-opportunities-and-challenges-six-states

The Affordable Care Act and Insurance Coverage Changes by Sexual Orientation

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DATA NOTE

The Affordable Care Act (ACA) has provided millions of Americans with new access to insurance coverage, in some cases for the first time. While a significant body of research has explored how the law has affected different populations, limited information has been available on insurance coverage changes by sexual orientation, in part due to the dearth of available nationally representative data about lesbian, gay, bisexual, and transgender (LGBT) individuals and insurance status.[1] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-1)

This data note provides the most up to date nationally representative estimates of insurance coverage changes among self-identified lesbian, gay and bisexual adults (LGB) under the ACA. It compares survey responses of nonelderly adults using the Sample Adult component from the Centers for Disease Control and Prevention's (CDC) National Health Interview Survey (NHIS), 2013 and 2016 cycles.[2] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-2) We find that rates of uninsurance decreased significantly among LGB adults after the implementation of the ACA's major coverage changes. There was also a significant increase in Medicaid coverage We were unable to examine changes in private insurance coverage due to sample size limitations.

Background

Historically, lesbian, gay, and bisexual individuals have faced barriers in accessing healthcare.[3] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-3) Challenges result from stigma and discrimination, inequality in the workplace, refusal of care, and denial of coverage related to sexual orientation or gender identity. Prior to the ACA, insurance companies could deny LGBT individuals insurance coverage, exclude certain services (e.g. those related to gender transition), or charge higher rates based on sexual orientation or gender identity. Issuers were also able to deny insurance coverage or charge higher rates to people with health conditions that disproportionally affect LGBT individuals such as HIV, mental illness, and substance use disorders.[4] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-4)

Under the ACA, insurers are no longer permitted to consider health status when setting rates or issuing coverage. Further, issuers are prohibited from discriminating on the basis of sexual orientation or gender identity in coverage subject to the Essential Health Benefits, including plans sold on the health insurance marketplaces. (The law and implementing regulations also include additional protections that prohibit discrimination based on sex, defined to include gender identity and sex stereotypes, in any health program receiving federal funds, including: Medicaid, Medicare, the marketplaces, and providers who receive federal funds. However, as part of an ongoing lawsuit, a federal court has issued an injunction halting enforcement of this provision's protections around gender identity.[5] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-5)

In addition to non-discrimination protections, the ACA introduced two main coverage pathways. The first is the Medicaid expansion, which provides Medicaid coverage to eligible individuals below 138% of FPL, basing eligibility on income and residency status alone rather than categorical eligibility (e.g. requiring disability or pregnancy in addition to being low-income). As a result of a Supreme Court decision, Medicaid expansion is effectively a state option and to date, 33 states (including DC) have expanded their programs.[6] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-6) Second, legal US residents are now able to purchase private coverage through insurance Marketplaces with subsidies available to most between 100% and 400% of the federal poverty level (FPL).

In order to assess changes in coverage among LGB individuals under the ACA, we analyzed data for non-elderly adults from the NHIS, a nationally representative survey conducted by CDC on health and health behaviors. We compared data from 2013, prior to the implementation of major ACA insurance expansions to 2016, after implementation. We were not able to examine coverage among transgender individuals as the NHIS instrument category does not include transgender as a stand-alone category.

Findings

Using the 2013 and 2016 NHIS cycles, we estimate that there were 4.8 million U.S. adults between the ages of 18-64 who identified as lesbian, gay or bisexual in 2013, and 5.5 million ir 2016. Based on both cycles, we estimate that LGB individuals in this age group make up abou 3% of the US population. This is similar to estimates found in other research.[7] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-7) Uninsurance declined and Medicaid coverage increased significantly for this population after the implementation of the ACA, as follows. (We are unable provide private insurance due to sample size limitations.):

The Uninsured

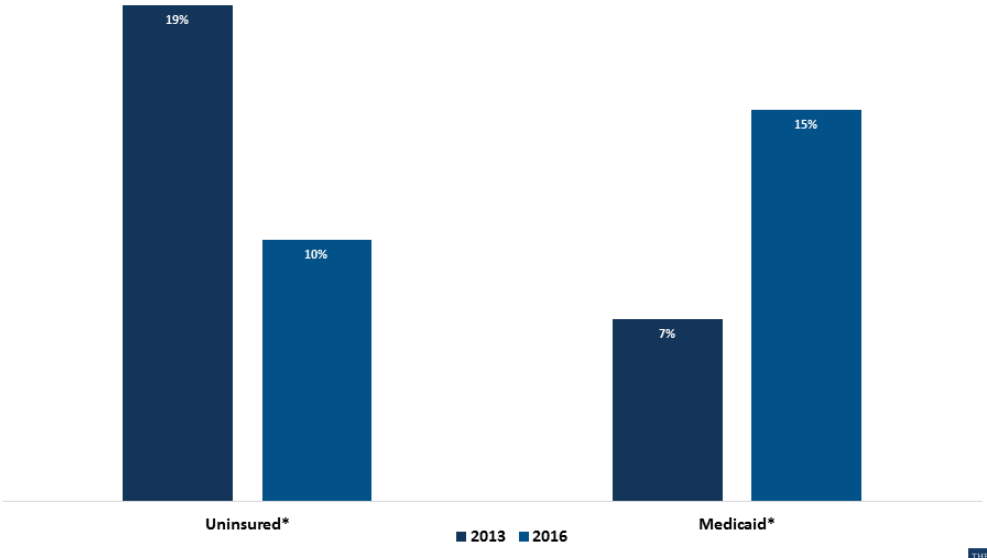
During the early years of ACA implementation, the rate of uninsurance among LGB individuals fell by almost half (from 19% in 2013 to 10% in 2016), representing an estimated 369,000 fewer uninsured LGB individuals in 2016 compared to 2013. The drop in the uninsurance rate experienced by LGB groups was similar to that seen among heterosexuals over this period.[8] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-8)

Medicaid

LGB individuals saw significant gains in Medicaid coverage between 2013 and 2016 (increasing from 7% to 15%), likely due to Medicaid expansion.[9] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-9) This increase represents an estimated 511,000 more LGB individuals with Medicaid coverage in 2016 compared to 2013. Increases in Medicaid coverage over this period were no significantly different when comparing LGB individuals to heterosexual individuals.[10] (https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/view/footnotes/#footnote-247691-10)

Figure 1

Changes in Uninsurance Rate and Medicaid Coverage, Among Lesbian, Gay, and Bisexual Individuals, 2013-2016



** denotes statistically significant at p<.05.*
Source: KFF analysis of NHIS, 2013 and 2016.

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Figure 1: Changes in Uninsurance Rate and Medicaid Coverage, Among Lesbian, Gay, and Bisexual Individuals, 2013-2016

Discussion

The ACA has played a significant role in increasing insurance coverage and reducing the rate of uninsurance for people in the United States and many of these gains have translated to the LGB population. Under the ACA, LGB people experienced reductions in the uninsurance rate between 2013 and 2016. Gains in Medicaid coverage have driven this trend, though it is also likely that some uptick in private insurance coverage contributed to declines in the share uninsured as well. As the Administration, Congress, and states, continue to make changes to the health landscape, including to protections for LGBT individuals, it will be important to monitor these trends in future years.

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TO THE POINT
Quick Takes on Health Care Policy and Practice

Insurer Participation in ACA Marketplaces: Federal Uncertainty Triggers Diverging Business Strategies

Friday, January 5, 2018



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

A reliable indicator of health insurance markets' stability is insurer participation, including the number of insurers that elect to sell individual plans and whether they participate over subsequent years. This analysis looks at insurer participation in the state-based Affordable Care Act (ACA) marketplaces from 2014 to 2018 — shedding light on how state marketplaces have maintained competition despite uncertainty about the law's future.

In the months leading up to the 2018 open enrollment period, there was widespread concern (https://www.urban.org/sites/default/files/publication/87816/2001126-uncertain-future-for-affordable-care-act-leads_insurers-to-rethink-participation-prices_1.pdf) that the administration's lack of commitment to implementing the ACA, including ending federal funding for cost-sharing subsidies, would lead many insurers to exit the marketplaces. Some insurers, including large publicly traded companies like Aetna (https://www.washingtonpost.com/national/health-science/aetna-exiting-all-aca-insurance-marketplaces-in-2018/2017/05/10/9dedbeea-35d4-11e7-b373-418f6849a004_story.html?utm_term=.2e302fbb12ef) and Humana (https://www.nytimes.com/2017/02/14/health/humana-plans-to-pull-out-of-obamacares-insurance-exchanges.html), did announce in early spring 2017 that they would leave some states or markets. However, every county ultimately retained at least one insurer, and nearly half (https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/) of marketplace enrollees can choose among three or more insurers in 2018. Overall, insurer participation in the state-based marketplaces was more stable than in the federally facilitated marketplace.

he repeal of the individual mandate and loosening of requirements for short-term policies and association health plans—likely to affect markets in 2019.

State-Based Marketplace Participation Remains More Stable Than the Federal Marketplace

While most of the states using the federally run marketplace lost between one to four insurers from 2017 to 2018, more than half of the state-based marketplaces (nine of 17) held steady with the same number of insurers.[1 (#/#1)]

State-Based Marketplace Insurer Participation, 2014–18

State	2014 total	2015 total	2016 total	2017 total	2018 total	Change from 2017	Insurer changes
Arkansas	3	4	4	3	3	None	
California	11	10	12	11	11	None	
Colorado	10	10	8	7	7	None	
Connecticut	3	4	4	2	2	None	
District of Columbia	3	3	2	2	2	None	
Idaho	4	5	5	5	4	-1	BridgeSpan exits
Kentucky	3	5	7	3	2	-1	Humana exits
Maryland	4	5	5	3	2	-1	Cigna exits
Massachusetts	10	11	11	10	8	-2	CeltiCare Health exits, Minuteman Health Co-Op closes
Minnesota	5	5	5	4	4	None	
Nevada	4	5	3	3	2	-1	Anthem and Prominence exit, Centene enter
New Mexico	5	6	4	4	4	None	
New York	16	16	15	14	12	-2	Affinity Health and CareConnect exit
Oregon	11	10	10	6	5	-1	ATRIO Health exits
Rhode Island	2	3	3	2	2	None	
Vermont	2	2	2	2	2	None	
Washington	8	10	11	9	7	-2	Community Health Plan and Group Health Cooperative exit
TOTAL	103	112	109	90	79		

Source: E. Curran, J. Giovannelli, and K. Lucia, "Insurer Participation in ACA Marketplaces: Federal Uncertainty Triggers Diverging Business Strategies," *To the Point,* The Commonwealth Fund, January 5, 2018.

http://www.commonwealthfund.org/publications/blog/2017/nov/state-based-marketplaces-push-ahead) that they worked closely with insurers to secure participation.[2](#/#2) When an insurer indicated it was contemplating scaling back participation, state marketplaces responded by promoting enrollment. For example, these states invested in marketing, bolstered relationships with agents and brokers, and engaged stakeholders in discussions when deciding the length of open enrollment (http://www.commonwealthfund.org/publications/blog/2017/nov/state-based-marketplaces-push-ahead).

Insurers' Marketplace Participation Reflects Different Business Strategies

While the average number of insurers participating by state has gradually declined (https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/), insurers' perspectives on participation have varied. Many insurers that exited for 2018 cited federal uncertainty as a driving factor, while others left states where they were unable to make their businesses work. For instance, in Maryland, Massachusetts, and New York, insurers left after capturing only 1 to 5 percent of overall enrollment, and the nonprofit Boston-based insurer Minuteman Health exited when it was unable (https://www.bostonglobe.com/business/2017/08/16/minuteman-health-fails-raise-enough-money-relaunch-for-profit/afD6dHCvRkrxsLcg4OhxeK/story.html) to raise sufficient funding to convert to a for-profit.

Still, many insurers now participating in the marketplaces remain optimistic that their investments will pay off and stepped up to promote enrollment following federal cuts to marketing and outreach. Centene, which expanded (http://www.healthcarefinancenews.com/news/centene-expand-exchange-footprint-offering-plans-three-additional-states) into three new states for 2018, reported (https://seekingalpha.com/article/4115981-centenes-cnc-ceo-michael-neidorff-q3-2017-results-earnings-call-transcript?part=single) that it ramped up advertising, while Florida Blue hired (http://www.stltoday.com/business/local/insurers-step-up-pitch-for-obamacare-as-government-slashes-its/article_725e19ea-7509-5997-9654-0a26c2302ecb.html) 700 temporary employees to take part in 1,000 enrollment events. Even Anthem, which scaled back participation this year, expects (https://seekingalpha.com/article/4116262-anthem-antm-q3-2017-results-earnings-call-transcript?auth_param=19al7m:1cv1fes:cda308b74fef99f01929e2dc17eabc8b&uprof=14&dr=1) its remaining ACA membership to be slightly profitable and believes the business is "viable."

Some Insurers Are Exploring Alternatives to Capture Marketplace Enrollment

Some insurers that exited early on are now looking for ways to capture healthy marketplace enrollment, through association health plans (http://www.commonwealthfund.org/publications/blog/2017/oct/association-health-plans-executive-order) and short-term limited duration policies (http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans). The Trump administration yesterday released proposed rules lifting restrictions on association health plans and recently

https://seekingalpha.com/article/4114057-unitedhealths-unh-ceo-david-wichmann-q3-2017-results-earnings-call-ranscript?uth_param=19al7m:1cucjoc:202b02c7448f46b39163dfff2cfebb4c&dr=1&uprof=14&utoken=f0e207892b7edb5ff6632a96d57f0d8) that it has 300,000 members in association plans and is eager to see short-term limited duration olicies extended to a full year. Aetna, which completely exited (https://www.washingtonpost.com/national/health-cience/aetna-exiting-all-aca-insurance-marketplaces-in-2018/2017/05/10/9dedbeea-35d4-11e7-b373-18f6849a004_story.html?utm_term=.e75826bba523) the marketplaces this year, expressed https://seekingalpha.com/article/4118741-aetna-aet-q3-2017-results-earnings-call-transcript?uth_param=19al7m:1cvhii3:5d7ab5b9493936d21944b47a34a2c609&uprof=14&dr=1) the same interest.

State regulators (https://www.insurance.ca.gov/0400-news/0100-press-releases/2017/statement104-17.cfm) have ew regulations on short-term policies and have raised concerns https://www.nytimes.com/2017/10/12/us/politics/trump-obamacare-executive-order-health-insurance.html) that uch strategies threaten to carve up the individual market and adversely impact the risk pool by drawing healthy ndividuals out with the promise of cheaper premiums. While these alternatives may benefit some consumers, short-erm and association plans do not cover essential services or comply with many traditional insurance rules and tend o create further instability, as those with greater health care needs are left behind.

Takeaway

While insurers have called for clarity from the federal government about the direction of the health insurance narketplaces, their participation in 2018 largely reflects diverging business strategies in response to a changing olicy environment. Some insurers continue to view the marketplaces as a viable business and are working to attrac ew membership, while others are recovering from early losses and attempting to capture healthy enrollment hrough non-marketplace alternatives.

While some consumers may find these alternatives to be a helpful bridge between coverage options, segmenting the nsured pool can lead to higher premiums and fewer plans http://www.commonwealthfund.org/publications/blog/2017/oct/association-health-plans-executive-order) for those uying regulated coverage, particularly without an individual mandate. Such segmentation cuts against what most tates are working to achieve and could lead to further declines in insurer participation. States may opt to head off his segmentation through regulation, since even modest federal efforts to stabilize https://www.usnews.com/news/national-news/articles/2017-12-20/collins-alexander-withdraw-demand-for-obamacare-fix-in-spending-bill) the markets have stalled.

Authors' analysis of: Kaiser Family Foundation, Insurer Participation on ACA Marketplaces, 2014-2018, November 10, 2017.

We interviewed executives of 15 marketplaces, including CEOs, executive directors, and directors of communications. Arkansas and Kentucky did not participate n this research.

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January 2018 | Issue Brief

Individual Insurance Market Performance in Late 2017

Cynthia Cox, Ashley Semanskee and Larry Levitt

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

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

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

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

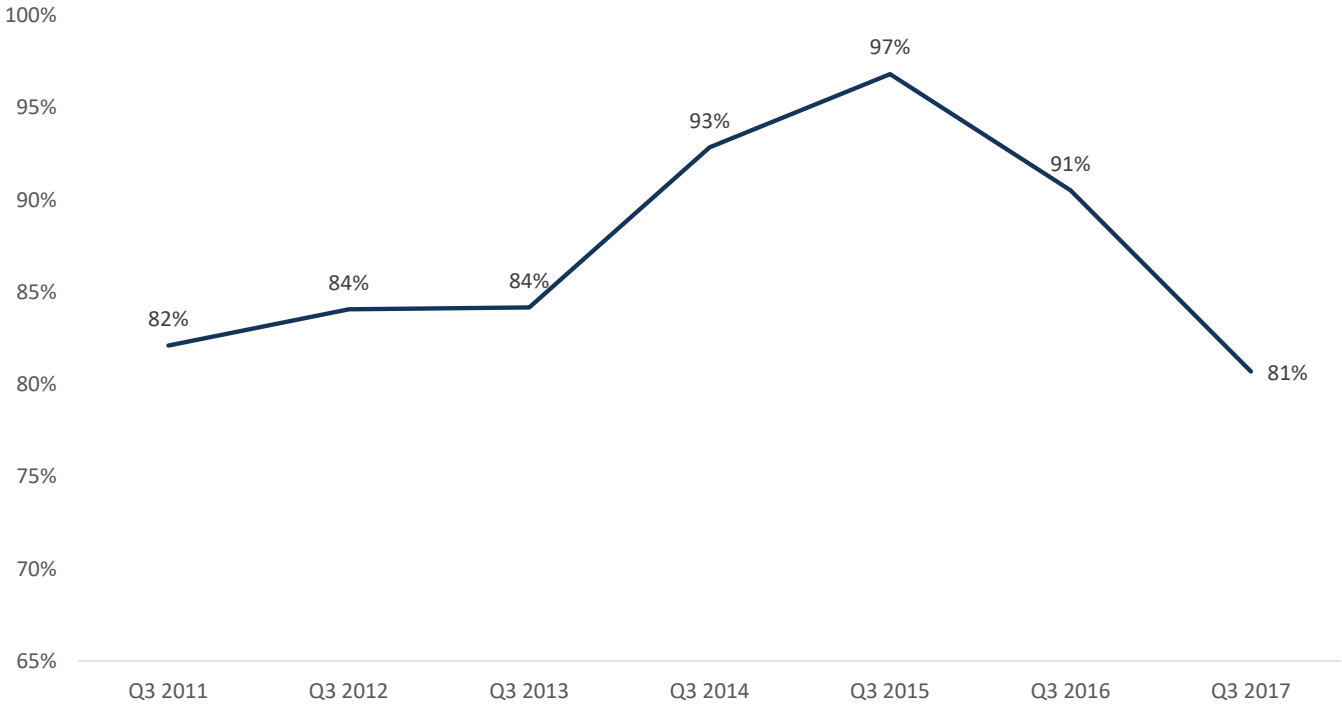
Medical Loss Ratios

As we found in our previous analysis, insurer financial performance as measured by loss ratios (the share of health premiums paid out as claims) worsened in the earliest years of the Affordable Care Act Marketplaces, but began to improve more recently. This is to be expected, as the market had just undergone significant regulatory changes in 2014 and insurers had very little information to work with in setting their premiums, even going into the second year of the exchange markets.

Loss ratios began to decline in 2016, suggesting improved financial performance. In 2017, following relatively large premium increases, individual market insurers saw significant improvement in loss ratios, averaging 81% through the third quarter. Third quarter loss ratios tend to follow the same pattern as annual loss ratios, but in recent years have been lower than annual loss ratios.[2] Though 2017 annual loss ratios are likely to be impacted by the loss of cost-sharing subsidy payments during the last three months of the year, this is nevertheless a sign that individual market insurers on average were beginning to stabilize in 2017.

Figure 1

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



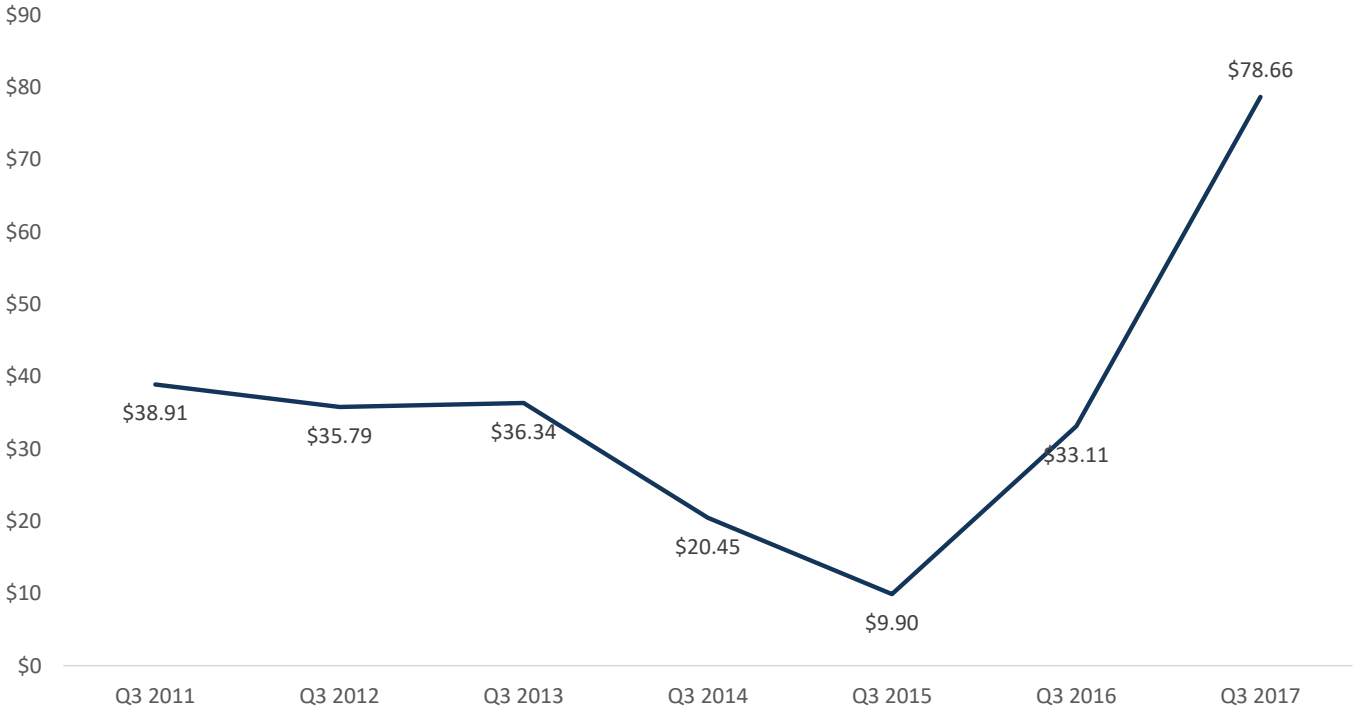
Note: Q3 data is year-to-date from January 1 – September 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM. Note: Figures above represent simple loss ratios and differ from the definition of MLR in the Affordable Care Act

Margins

Another way to look at individual market financial performance is to examine average gross margins per member per month, or the average amount by which premium income exceeds claims costs per enrollee in a given month. Gross margins are an indicator of performance, but positive margins do not necessarily translate into profitability since they do not account for administrative expenses. As with medical loss ratios, third quarter margins tend to follow a similar pattern to annual margins, but generally look more favorable as enrollees are still paying toward their deductibles in the early part of the year, lowering claims costs for insurers.

Figure 2

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



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

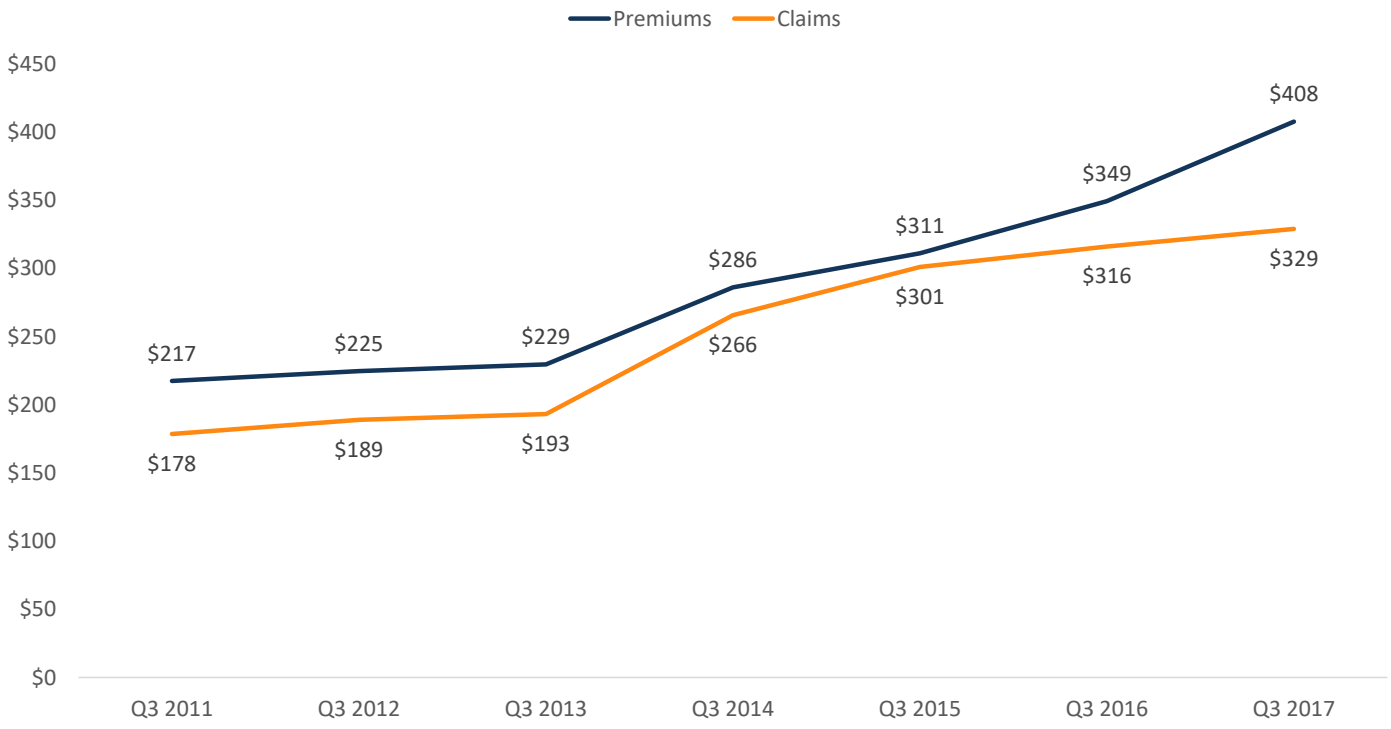
Looking at gross margins, we see a similar pattern as we did looking at loss ratios, where insurer financial performance improved dramatically through the third quarter of 2017 (increasing to $79 per enrollee, from a recent third quarter low of $10 in 2015). Again, third quarter data tend to indicate the general direction of the annual trend, and while annual 2017 margins are unlikely to end as high as they are in the third quarter, these data suggest that insurers in this market are on track to reach pre-ACA individual market performance levels.

Underlying Trends

Driving recent improvements in individual market insurer financial performance are the premium increases in 2017 and simultaneous slow growth in claims for medical expenses. On average, premiums per enrollee grew 17% from third quarter 2016 to third quarter 2017, while per person claims grew only 4%.

Figure 3

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



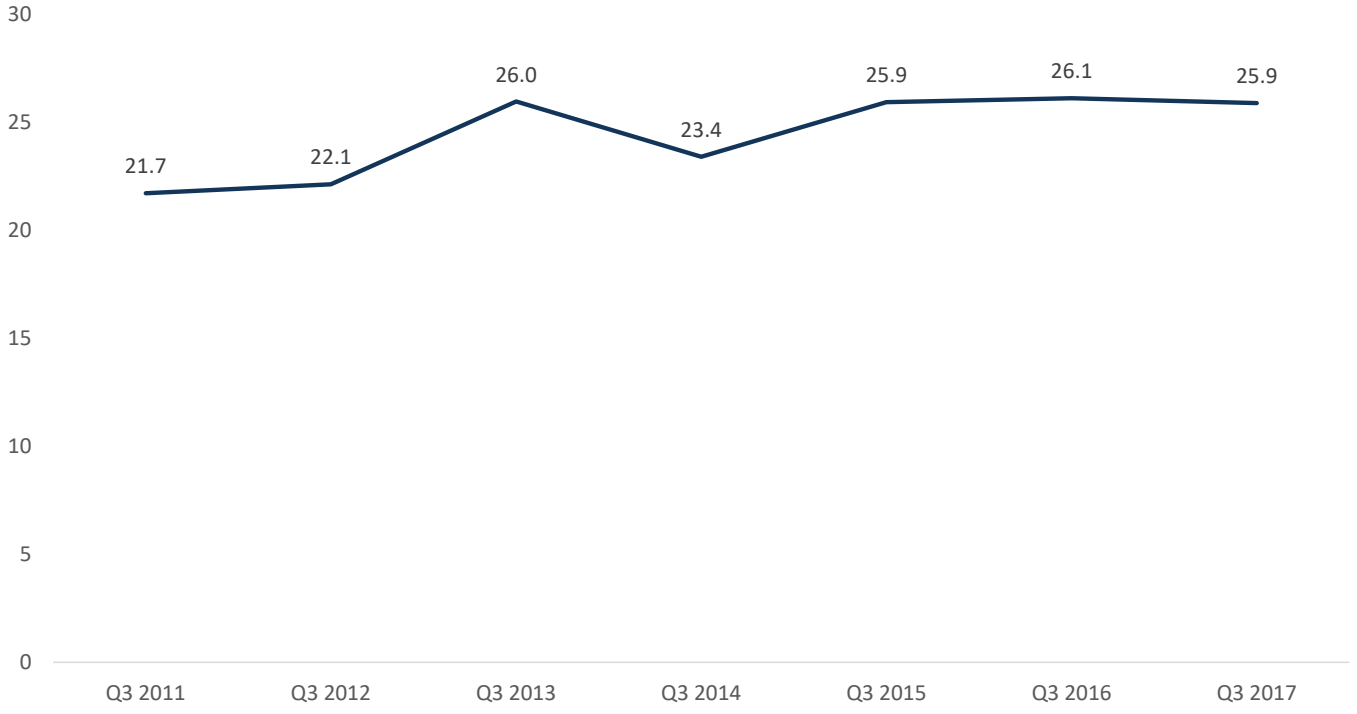
Note: Q3 data is year-to-date from January 1 – September 30
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

One concern about rising premiums in the individual market was whether healthy enrollees would drop out of the market in large numbers rather than pay higher rates. While the vast majority of exchange enrollees are subsidized and sheltered from paying premium increases, those enrolling off-exchange would have to pay the full increase. As average claims costs grew very slowly through the third quarter of 2017, it does not appear that the enrollees today are noticeably sicker than last year.

On average, the number of days individual market enrollees spent in a hospital through the third quarter of 2017 was similar to third quarter inpatient days in the previous two years. (The third quarter of 2014 is not necessarily representative of the full year because open enrollment was longer that year and a number of exchange enrollees did not begin their coverage until mid-year 2014).

Figure 4

Average Third Quarter Individual Market Monthly Hospital Patient Days Per 1,000 Enrollees, 2011 - 2017



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

Taken together, these data on claims and utilization suggest that the individual market risk pool is relatively stable, though sicker on average than the pre-ACA market, which is to be expected since people with pre-existing conditions have guaranteed access to coverage under the ACA.

Discussion

Third quarter results from 2017 suggest the individual market was stabilizing and insurers in this market were regaining profitability. Insurer financial results as of the third quarter 2017 – before the Administration's decision to stop making cost-sharing subsidy payments and before the repeal of the individual mandate penalty in the tax overhaul – showed no sign of a market collapse. Third quarter premium and claims data from 2017 support the notion that 2017 premium increases were necessary as a one-time market correction to adjust for a sicker-than-expected risk pool. Although individual market enrollees appear on average to be sicker than the market pre-ACA, data on hospitalizations in this market suggest that the risk pool is stable on average and not getting progressively sicker as of late 2017. Some insurers have exited the market in recent years, but others have been successful and expanded their footprints, as would be expected in a competitive marketplace.

While the market on average is stabilizing, there remain some areas of the country that are more fragile. In addition, policy uncertainty has the potential to destabilize the individual market generally. The decision by the

Administration to cease cost-sharing subsidy payments led some insurers to leave the market or request larger premium increases than they would otherwise. A few parts of the country were thought to be at risk of having no insurer on exchange, though new entrants or expanding insurers have since moved in to cover all areas previously at risk of being bare. Signups through the federal marketplace during the recently completed open enrollment period were higher than many expected, which could help to keep the market stable. However, continued policy uncertainty and the repeal of the individual mandate as part of tax reform legislation complicate the outlook for 2018 and beyond.

Methods

We analyzed insurer-reported financial data from Health Coverage Portal TM, a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners. The dataset analyzed in this report does not include NAIC plans licensed as life insurance or California HMOs regulated by California's Department of Managed Health Care; in total, the plans in this dataset represent at least 80% of the individual market. All figures in this data note are for the individual health insurance market as a whole, which includes major medical insurance plans sold both on and off exchange. We excluded some plans that filed negative enrollment, premiums, or claims and corrected for plans that did not file "member months" in the third quarter but did file third quarter membership.

To calculate the weighted average loss ratio across the individual market, we divided the market-wide sum of total incurred claims by the sum of all health premiums earned. Medical loss ratios in this analysis are simple loss ratios and do not adjust for quality improvement expenses, taxes, or risk program payments. Gross margins were calculated by subtracting the sum of total incurred claims from the sum of health premiums earned and dividing by the total number of member months (average monthly enrollment) in the individual insurance market.

Endnotes

[1] The loss ratios shown in this data note differ from the definition of MLR in the ACA, which makes some adjustments for quality improvement and taxes, and do not account for reinsurance, risk corridors, or risk adjustment payments. Reinsurance payments, in particular, helped offset some losses insurers would have otherwise experienced. However, the ACA's reinsurance program was temporary, ending in 2016, so loss ratio calculations excluding reinsurance payments are a good indicator of financial stability going forward.

[2] Although third quarter loss ratios and margins generally follow a similar pattern as annual data, starting in 2014 with the move to an annual open enrollment that corresponds to the calendar year, third quarter MLRs have been lower than annual loss ratios in the same year. This is because renewing existing customers, as well as new enrollees, are starting to pay toward their deductibles in January, whereas pre-ACA, renewals would occur throughout the calendar year.