

RESEARCH REPORT

After *King v. Burwell*: Next Steps for the Affordable Care Act

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August 2015



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Acknowledgments

This report was funded with internal Urban Institute funds.

The authors are grateful for comments and suggestions on an earlier draft of this paper from Judy Feder, Liz Fowler, Chris Jennings, Genevieve Kenney, Karen Pollitz, Bob Reischauer, and Steve Zuckerman. We appreciate the simulation estimates included in this paper that were produced by Matthew Buettgens using the Health Insurance Policy Simulation Model and research assistance from Erik Wengle.

Executive Summary

With the Supreme Court deciding the *King v. Burwell* case in favor of the government, premium tax credits and cost-sharing subsidies for the purchase of private health insurance policies remain available to residents in all states, including those with federally facilitated health insurance marketplaces (FFMs). Now that this important issue is settled, policymakers can move forward to complete the implementation of the law and fix several of the problems that have emerged. In this paper, we discuss several outstanding problems and then propose solutions.

The Affordable Care Act (ACA) has achieved substantial successes in its first two years of implementation, despite a difficult launch. Many people are newly enrolled in Medicaid or in subsidized health plans in marketplaces, the uninsured rate has fallen significantly, and the reformed nongroup market has seen many insurers enter, strong competition, and unexpectedly low premiums. Evidence clearly shows that employer coverage is remaining stable despite fears of widespread dropping. As a nation, we are spending far less than originally expected on health care in total, despite a major coverage expansion, in part because of various ACA provisions. For example, the Centers for Medicare and Medicaid Services (CMS) actuaries originally forecast that the ACA would add \$575 billion to national health expenditures between 2014 and 2019. The most recent forecast is that we will spend \$2.5 trillion less than originally forecast over that period.

At the same time, the ACA faces significant challenges going forward. Specifically, the ACA was passed under tight budgetary constraints given its ambitious coverage goals, and it is essentially underfunded in multiple ways. This underfunding has implications for health care affordability for families, and it also means that administration of the law has been shortchanged.

Affordability Concerns and Strategies to Address Them

Even with the ACA, consumers with relatively low incomes may face very high costs for premiums and out-of-pocket costs relative to incomes. This may result in substantially lower enrollment in the new marketplaces over time. Although coverage has increased significantly thus far, fewer people than expected may sign up in the future if they determine that they are paying premiums for plans that require substantial amounts of cost-sharing. For many moderate-income people, particularly those in good health, the high cost-sharing requirements may not seem worth the premiums paid to get them. This may prove true even for some of those eligible for tax credits and cost-sharing reductions.

Others may find that the policies do not provide them with the access to care that they expected because they cannot afford such sizable deductibles. As a result, many consumers could become disillusioned, and disenrollment rates could increase over time. If enrollment falls below expected levels, the nongroup insurance pools may become less healthy over time, leading to higher premiums. It is too soon to know the magnitude of these effects on enrollment, but growing evidence indicates that there are significant reasons for concern.

The premium and cost-sharing structures established under the law were delineated with the intention of meeting specific budget targets that now seem overly constraining. As a result, several problems occurred. Premium tax credits are substantial, but they are still inadequate for many individuals and families, given their incomes. Similarly, many individuals with modest incomes may struggle to afford the level of cost-sharing required in the plans for which the premium tax credits are pegged. Premium tax credits are tied to a product with cost-sharing requirements that significantly exceed the typical large employer-sponsored plan. In particular, older individuals with incomes just above the current tax credit eligibility range face high premiums relative to their incomes, and because they tend to use more medical care than do their younger counterparts, they face a total bill for premiums plus out-of-pocket spending that can be very high.

Table ES.1 shows the combined burdens of nongroup insurance premiums and out-of-pocket costs relative to income under the ACA. The table shows spending at the median and at the 90th percentile. Spending is over 20 percent of income at the 90th percentile for individuals with incomes over 200 percent of the federal poverty level (FPL). Other issues include the fact that family members are denied access to financial assistance if one worker in the family has an offer of employer sponsored insurance for single coverage that is deemed adequate and affordable. This barrier to assistance creates significant financial problems for some modest income families. The law also indexes premium caps as a percentage of income with the consumer price index, thus increasing family health insurance premium burdens over time.

In this paper, we propose ways to improve the premium tax credit schedule and reduce the amount of cost-sharing that individuals face at different income levels. We provide a revised premium schedule that requires individuals at each income level to pay less as a percentage of their income than they do with the current law. The ACA's premium schedule and our proposed modified schedule are shown in Table ES.2. We also would link these subsidized premiums to plans in the gold metal tier instead of to plans in the ACA's silver tier, a change that would reduce the average cost-sharing requirements that households face. Furthermore, we propose increasing cost-sharing subsidies for some income groups and extending them to individuals with incomes up to 300 percent of FPL. Finally, we would eliminate

the practice of indexing premium tax credits and would thereby hold constant the percentage of income that individuals are expected to contribute to the cost of their insurance.

Looking Beyond *King v. Burwell*: Next Steps for the ACA

Accomplishments
<ul style="list-style-type: none"> ▪ Newly enrolled 13 million into Medicaid and enrolled 9 million into subsidized marketplace coverage ▪ Reduced the number of uninsured people by 15 million between October 2013 and March 2015 ▪ Created health insurance marketplaces with strong competition leading to moderate premiums ▪ Contributed to the slowdown in national health expenditure growth ▪ Eliminated discrimination by health status in the nongroup and fully insured small-group health insurance markets ▪ No loss of employer coverage and no adverse effects on employment
Remaining Problems
<ul style="list-style-type: none"> ▪ A continued lack of affordability for some leads to high financial burdens and limits enrollment and reductions in the number of uninsured people ▪ The employer-based insurance “family glitch” prevents some families from getting affordable coverage ▪ Twenty-one states have not expanded Medicaid eligibility, creating a substantial coverage gap for poor residents of those states ▪ Administrative functions have been underfunded
Proposed Solutions
<ul style="list-style-type: none"> ▪ Improve premium tax credits and cost-sharing reductions ▪ Ease access to marketplace financial assistance for those affected by the “family glitch” ▪ Allow states the option to expand Medicaid to 100 percent of the federal poverty level instead of 138 percent ▪ Increase federal grants for information technology development and operation; education, outreach, and enrollment activities; and oversight and enforcement of insurance regulations
Financing
<ul style="list-style-type: none"> ▪ Extend Medicaid drug rebate to low-income Medicare beneficiaries ▪ Increase cigarette and alcohol taxes ▪ Small increase in Medicare hospital insurance tax on wages ▪ Replace the “Cadillac tax” with a cap on the tax exclusion for contributions to employer-based health insurance
Spending in Context
<ul style="list-style-type: none"> ▪ The US is expected to spend significantly less on health care between 2014 and 2019 than was originally projected after the ACA’s passage. CMS actuaries now project national health expenditures for that period to be \$2.5 trillion below what they had projected for that same period in August 2010. These unanticipated savings exceed many times over the additional 10-year investment proposed here. ▪ Our rough estimate of additional investments necessary to ensure the long-term success of the ACA amount to 0.20 to 0.24 percent of GDP (\$453 to \$559 billion over 10 years). To put this in perspective, total GDP between 2016 and 2025 is estimated to be \$230 trillion.

Note: ACA = Affordable Care Act; CMS = Centers for Medicare and Medicaid Services; GDP = gross domestic product.

We also suggest an approach for providing access to tax credits for certain families caught in the employer-based insurance “glitch.” The reform would not require Congressional action but would require a change in the current Internal Revenue Service interpretation of the ACA and its associated regulations. Essentially, this would allow family members to enter the marketplace and obtain premium tax credits if employer insurance coverage for the family (not just the worker) is deemed unaffordable. Workers would pay the required employee contribution for their work-based coverage. That contribution would be counted against the family’s financial obligation for coverage in the marketplace. Thus, a family that would otherwise be required to pay 7 percent of income for marketplace coverage would deduct the contribution it makes for the worker’s employer coverage (for example, 4 percent of family income) and then cover the rest of the family through the marketplace for 3 percent of family income.

In addition, more needs to be done to address coverage gaps in the states that are not adopting the Medicaid expansion. Medicaid expansions have had a big effect on the uninsured rate. Eventually, all states may expand Medicaid eligibility under the ACA because the financial incentives are so strong and support for expansion from business and provider groups is growing. Such an outcome cannot be guaranteed but the federal government may encourage more states to adopt the Medicaid expansion if it offered states the option of extending Medicaid to only individuals with incomes up to 100 percent of FPL. In states taking this option, individuals with incomes between 100 and 138 percent of FPL could obtain coverage in the marketplaces with tax credits and cost-sharing reductions, regardless of whether they have access to an adequate, affordable offer of employer-based health insurance. With our enhanced premium tax credit schedule, people between 100 percent and 138 percent of FPL would face financial burdens only modestly higher than under Medicaid. The effect on federal expenditures would be the cost of the coverage expansion in states that would not have otherwise expanded in the 10-year budget window plus the difference between the additional marketplace subsidy costs and the reduced Medicaid costs in the states decreasing eligibility to 100 percent of FPL.

Concerns Related to Underfunding of Administrative Needs and Strategies to Address Them

We also argue that administration of the ACA has been underfunded. Despite significant investments, more needs to be done to improve the information technology (IT) systems at the federal level and in selected states. IT systems need to be able to accurately determine eligibility for financial assistance, to provide coordination with applications for both qualified health plans (QHPs) and Medicaid, to provide

adequate consumer support during the application process, to provide real-time enrollment data and other system performance data to marketplace officials, to provide accurate and understandable plan information to consumers, and to provide accurate enrollment and financial data to insurers. Current systems are falling well short for many of these needs. Some state systems will not warrant further investment, however, and those states should migrate to the federal system or another state's system for efficiency.

More ongoing investment is needed to support outreach, education, call centers, and application assistance nationwide. Substantial resources were initially made available to state-based marketplace states, but little funding was made available to FFMs. Consumer assistance, particularly in the form of human assistance, was often underappreciated and underfunded, and, in some cases, performance standards were lacking. This is particularly true in FFM states, and it will become increasingly true for state-based marketplaces as the federal funds they received are expended. Greater support for oversight and enforcement of the insurance market regulatory reforms also is critical to ensure that the promised consumer protections are appropriately implemented. State departments of insurance have more resources than in prior years because of new federal support, but states remain understaffed, and the regulations to enforce some of the ACA's original intentions are often weak or absent at both the state and federal levels.

Costs of Policy Proposals

Some of the necessary increased investment in administrative costs could be borne by states, either through broad-based assessments on insurance plans (not just marketplace plans), with general revenues, or a combination. However, these administrative functions may well remain underfunded if left to the states alone, given the political challenges of raising additional targeted revenue at the state level. For the ACA to be successful, federal resources are needed to support state efforts that would otherwise be inadequate. It is not equitable or even feasible to subsidize only the states that are most likely to underinvest, and as such, all states require additional funds.

Taken together, we estimate that our suggested reforms would cost \$453 billion to \$559 billion over 10 years. The new expenditures are significant relative to the current spending projections for the ACA, but they amount to only 0.20 percent to 0.24 percent of gross domestic product and reflect the fact that such a complicated law was never adequately funded. In fact, the cost of these enhancements is much smaller than the estimated savings in national health expenditures relative to projections made before ACA implementation. The changes would help ensure that the ACA's coverage goals are met and

probably exceeded over the long term; without them, the ACA could well fall short. The changes would also provide financial relief to low-income families that are now expected to pay significant amounts of their income toward health insurance, improving access to care simultaneously.

Financing Options

We provide an illustrative set of options for financing these additional expenses using Congressional Budget Office (CBO) revenue estimates. Applying the Medicaid drug rebate to Medicare's dual eligibles could yield \$103 billion over 10 years. Increases in cigarette and alcohol taxes have been shown to lead to less use of both products and can generate a significant amount of revenue (\$34.7 billion and \$66 billion, respectively, over 10 years). The Medicare payroll tax could be increased somewhat (a 0.2 percent increase yields \$160 billion over 10 years).

Another possibility is to eliminate the excise or "Cadillac" tax on high-cost employer health plans and instead limit the exclusion of employer contributions from taxation by capping it at, say, the 70th or 75th percentile. The current exclusion provides a significant tax break, primarily to higher income individuals. Capping the exclusion not only provides additional revenue (CBO estimates that a cap at the 50th percentile, replacing the ACA's high-cost plan excise tax, yields \$537 billion over 10 years, after accounting for higher marketplace subsidy and Medicaid costs), but also is an efficient way to redistribute income from higher-income individuals to those low- and modest- income individuals that would benefit from marketplace coverage.

Some mix of this set of revenue proposals or others could fund the enhancements proposed here, and investing in improved affordability and administration would increase the likelihood that the ACA will be successful in the long term. Furthermore, these revenues can be raised without placing inordinate burdens on any single group of individuals.

Conclusion

A number of other components of the law could be changed to improve its chances of success. One provision that cannot be changed, however, is the individual mandate. It is simply not possible to have guaranteed issue of insurance providing adequate benefits with no discrimination by health status without both adequate subsidies for low-income individuals and a mandate to obtain coverage. The

need for what is effectively a mandate is also recognized in Medicare Parts B and D and even in recent proposals by Republican legislators.

The case for the employer mandate is less compelling. It contributes little to expanding coverage, can create labor market distortions, and has resulted in significant business opposition to the ACA in general. Eliminating the employer mandate could improve support for the law from an important constituency without compromising the law’s central goals.

The ACA is an attempt to build on and fill the gaps between existing public programs and private insurance. Maintaining as much as possible of the system that was already in place while correcting its central failings introduced considerable complexity into the health insurance system, and thus the changes require significant infrastructure development and maintenance to be successful in the long term. While the cost of appropriate levels of investment in the law is significant, financing it is entirely feasible.

TABLE ES.1

Healthcare Financial Burdens (Premiums plus Out-of-Pocket Costs Relative to Income) under the ACA after Taking Tax Credits and Cost-Sharing Reductions into Account, among Individuals Purchasing Marketplace Nongroup Insurance Plans, Median and 90th Percentile, 2016

Income Relative to the Federal Poverty Level Group (% of FPL)	Median (%)	90th Percentile (%)
<200	6.2	17.3
200–300	10.2	20.6
300–400	13.3	20.6
400–500	18.1	25.2
500 and above	15.5	22.2

Source: Health Insurance Policy Simulation Model (HIPSM) 2015.

Note: ACA = Affordable Care Act; FPL = federal poverty level. Sample with income below 400 percent of FPL includes only individuals eligible for tax credits; individuals purchasing nongroup coverage who are ineligible for tax credits because they have access to an affordable alternative offer of health insurance are excluded from these income groups.

TABLE ES.2

Premium Tax Credit Caps as a Percentage of Income and Cost-Sharing Reductions under the ACA and under the Proposed Schedules

Income Relative to Federal Poverty Level (% of FPL)	Premium Tax Credit Schedule: Household Premium as Percentage of Income for the Applicable Income Category		Cost-Sharing Reduction Schedule: Actuarial Value Level of Plan Provided to Eligibles Enrolling in Specified Level of Coverage	
	2015 ACA Schedule: Pegged to Silver Level (70% AV) Premium, Indexed ^a (%)	Proposed Schedule: Pegged to Gold Level (80% AV) Premium, Not Indexed (%)	ACA Schedule: Level of Coverage Provided to those Purchasing a Silver Plan (%)	Proposed Schedule: Level of Coverage Provided to those Purchasing a Gold Plan (%)
≤ 100-138	2.01	0-1.0	94	94
138-150	3.02-4.02	1.0-2.0	94	94
150-200	4.02-6.34	2.0-4.0	87	90
200-250	6.34-8.10	4.0-6.0	73	85
250-300	8.10-9.56	6.0-7.0	70	85
300-400	9.56	7.0-8.5	70	80
400 and higher	n.a.	8.5	70	80

Source: Health Insurance Policy Simulation Model (HIPSM) 2015.

Note: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; n.a. = not applicable.

^a Premium tax credits under the ACA are indexed to grow as a function of health care costs increasing faster than general inflation. Our proposal would eliminate the indexing, keeping the percent-of-income caps fixed.

Introduction

The Affordable Care Act (ACA) has had considerable success thus far in getting people enrolled in Medicaid and in private health plans in the insurance marketplaces despite its turbulent initial months. The number of uninsured has fallen (Long et al. 2014), health care costs are lower than expected at least in part because of the ACA (Holahan and McMorro 2015), and nongroup insurers can no longer discriminate against individuals based on their health status, an enormous change in almost every state and one which was implemented without reports of significant difficulty (Corlette and Lucia 2014). The new insurance marketplaces have had high participation by health insurance carriers and significant enrollment (Gunja and Gee 2014), while premium growth has been moderate (Holahan, Blumberg, and Wengle 2015).

Although the successes signify substantial accomplishments for the first years of the ACA, insufficient funding poses significant challenges to providing affordability and administrative capacity. Choosing not to address those issues will hinder the law's ability to achieve its objectives to broadly improve access to adequate, affordable insurance coverage in the long term. Coverage will likely increase by less than could otherwise be achieved, financial burdens for those individuals with modest incomes will remain higher than many will feel is affordable (particularly if they have serious health problems), and some individuals will become more difficult to enroll and retain in the marketplaces over time. For example, 2015 marketplace enrollment increased only modestly relative to 2014 enrollment in a number of states, including California, Colorado, New York, and Rhode Island, and marketplace enrollment actually decreased modestly in Vermont and Washington.¹ This paper will delineate the concerns and outline potential strategies for addressing them.

Our primary concern is that the law is underfunded in two central areas:

- Affordability for the modest-income population: individuals whose income is above Medicaid eligibility levels but who still possess low means relative to the cost of their insurance and direct costs of care, plus individuals who would be eligible for Medicaid but who live in states that have chosen not to expand their programs.
- Administration of several aspects of the reforms.

The affordability issue manifests itself in three areas. First, the financial assistance provided through the marketplaces to those people earning above Medicaid eligibility levels is insufficient to make coverage affordable for many. The most obvious shortfall is that some individuals are expected to

pay too much in premiums relative to their income. Moreover, direct out-of-pocket costs for those above 200 percent of the federal poverty level (FPL) can be very high, particularly for families with significant health care needs. The premiums and potential out-of-pocket costs are not currently considered as two pieces of a whole in setting affordability standards, a flaw in their conceptualization. Second, inequities persist in the eligibility determination for assistance, such that, for example, tax credits are unavailable to working families in which an employer offers one member affordable individual insurance but not affordable family coverage (a problem often referred to as the “family glitch”).

Finally, an ongoing, critical affordability problem is that, at this time, 21 states have chosen not to expand Medicaid eligibility under the ACA. Some states may eventually decide to do so on their own, but others could reverse their coverage decision. Whether Medicaid would eventually be extended in all states and when that might occur is highly uncertain, even though the fiscal imperative to do so is strong (Dorn, McGrath, and Holahan 2014). If Medicaid eligibility is not expanded in all the states, the fundamental goals of the reforms cannot be achieved in the affected states, and the types of improvements we suggest here would be unable to bridge the shortfall.

The second category of ACA responsibilities that were underfunded, the administration of the reforms, also arises in multiple contexts. First, seamless transitions across programs and recruitment and retention of enrollees in Medicaid/Children’s Health Insurance Program and the marketplaces require state-of-the-art information technology (IT) systems; additional funding will be required to get these systems where they need to be and to assure they are upgraded over time. Second, there have not been sufficient resources under the law devoted to outreach, education, and enrollment assistance, all necessary components for reform’s success. Although the issue is growing in all states as federal and state funding for these efforts decrease, shortfalls are especially large in the 34 states that rely on the federal government to administer their insurance marketplaces. Many states, including those operating their own marketplaces, may well underinvest in this area, for example setting premium assessments that are inadequate to sufficiently support the outreach and assistance functions. Not letting the shortfall happen is in the federal interest because inadequate support would severely hamper the ability of the ACA to meet its coverage goals. Third, precious little funding has been allocated to the oversight and enforcement of private insurance market reforms, reforms made necessary because of the many pre-ACA flaws in the individual and small group markets; resources are not sufficient to ensure the effective implementation of these consumer protections provided under the ACA.

Several controversial components of the law also could be modified to potentially increase political support without adversely affecting the ACA’s ability to achieve its central objectives. Chief among

these potential changes is elimination of the employer mandate and, with it, any potential associated labor market distortions (Blumberg, Holahan, and Buettgens 2014).

What cannot be changed, however, is the individual mandate. The ACA's individual responsibility requirement is critical to broadly sharing health care risk and to maintaining stable, reasonably priced insurance pools outside of the employment context (Blumberg and Holahan 2013). Without significant financial assistance for modest-income earners coupled with a requirement that most people obtain insurance or incur a penalty, one cannot meet the goals of guaranteed issue of insurance that provides adequate benefits, eliminates discrimination in premiums by health status and maintains a pool of insured individuals with an average level of health care needs. Other examples of health insurance-related individual mandates are already in place that were implemented without controversy – one in Medicare Part B and one in Medicare Part D (Holahan and Blumberg 2015). In addition, what is essentially an individual mandate has more recently been included in the Patient Choice, Affordability, Responsibility, and Empowerment Act proposal put forward by three Republican members of Congress (Holahan and Blumberg 2015).

The case for the employer mandate is much less compelling. It could be eliminated without causing significant harm to coverage under the law (Blumberg, Holahan, and Buettgens 2014). Opponents of the employer mandate argue that the added cost of providing health insurance or paying the penalty will destroy jobs and otherwise distort the labor market, that firms, for example, will avoid expanding the size of their businesses beyond 49 workers or move to a more part-time workforce to avoid penalties. And although no evidence suggests such distortions have occurred thus far (Garrett and Kaestner 2015), the employer mandate is one example of a possible trade-off that could be made to engender support for additional investment in the ACA without undermining its foundation.

The Achievements of the Affordable Care Act

The law has had a number of substantial, measurable accomplishments. As of the most recent report, approximately 11.7 million people were enrolled in the nongroup marketplaces (ASPE 2015a). This enrollment level is a significant achievement given the problematic 2014 rollout of the federal marketplaces and many state marketplace IT systems. The 2015 open enrollment period proceeded much more smoothly, bringing in additional enrollees as familiarity with the law, its requirements, and the coverage options increased, along with improvements in the IT and other administrative systems. Another 12.8 million individuals enrolled in Medicaid since the reforms were implemented, even though only 29 states have implemented the Medicaid expansion (CMS 2015a). Those numbers also should increase in 2015 because of growing awareness of the expanded eligibility and because more states could expand Medicaid.

As of March 2015, the number of uninsured Americans had fallen by about 15 million adults since September 2013 (Long et al. 2015). Several household surveys consistently find that the number of uninsured has fallen appreciably since implementation of the ACA. The most recent Gallop survey estimated that 17.3 percent of adults were uninsured in full year 2013, with the percentage falling to 11.7 percent in the first half of 2015 (Witters 2015). The Urban Institute's Health Reform Monitoring Survey estimated that 10.1 percent of adults were uninsured in the first quarter of 2015 (Long et al. 2015). This was 7.5 percentage points lower than the uninsured rate in the third quarter of 2013, a relative decrease of 42.5 percent. The decrease represents a reduction of 15 million in the number of uninsured people.

The reduction in the number of uninsured individuals has led to reductions in uncompensated care. A report released on March 23, 2015, by the Department of Health and Human Services projects that hospitals will save \$7.4 billion in formerly uncompensated care because of expanded coverage under the ACA in 2014 (ASPE 2015b). States that have expanded Medicaid have accrued 68 percent of the total savings nationally, with hospitals in those 28 states projected to save \$5.0 billion (ASPE 2015b). The 22 states that had not adopted the Medicaid expansion in 2014 are projected to save \$2.4 billion collectively that year (ASPE 2015b).²

Since January 1, 2014, considerable improvements have been made in the nongroup (individual) insurance market, the market most transformed under the ACA. No longer can insurers discriminate on

the basis of gender or health status, either by excluding enrollees, charging them differentially, or offering different benefits or cost-sharing structures. Premiums in that market and the small group market can vary only by age and smoking status, with those variations limited under the law.³ The law has imposed minimum medical loss ratios (MLR), which reduced nongroup insurer administrative costs (including profits) relative to benefits paid for many insurers nationally (Clemans-Cope et al. 2013). The MLR rules collectively resulted in rebates to 28.1 million individuals between 2011 and 2014 (CMS 2014; National Conference of State Legislatures 2014). The ACA also prohibits dollar limits on annual or lifetime benefits provided by insurers in all markets and requires all insurers to provide a list of preventive services to enrollees at no out-of-pocket cost. The ACA has allowed young adults to remain on their parents' employer policies until the age of 26, regardless of their status as students or not, and this provision alone was estimated to increase insurance coverage among young adults by about two million in 2011 (Antwi, Moriya, and Simon 2012). Finally, the law has provided additional benefits to Medicare beneficiaries, including first-dollar coverage for many preventive services. In addition, the prescription drug donut hole, a gap of reimbursement for expenditures in a certain range, is being phased out.

The nongroup health insurance marketplaces introduced in 2014 have functioned well outside of the initial IT challenges that many people experienced. A large number of competitors are available in most markets, particularly in more populous areas (Gunja et al. 2014; Holahan, Blumberg, and Wengle 2015). Blue Cross plans participate broadly, and many other commercial plans also are participating, depending largely on their pre-ACA presence in the market. Some previously Medicaid-only plans have participated as well, and co-ops have emerged with a strong presence in many states (Blumberg, Holahan, and Wengle 2015). The ACA ties the level of premium tax credits to the second-lowest-cost silver plan in the resident's area. An individual wanting a more expensive plan in any tier must pay the full difference in premium; someone choosing a less expensive plan pays lower premiums. That incentive structure has produced considerable price competition among insurers. Insurers have responded by developing more limited and lower-cost provider networks and have engaged in intense negotiations with providers over payment rates (Corlette et al. 2014). In many areas, premiums were surprisingly low in 2014 and have either fallen or increased slowly in most markets (Holahan, Blumberg, and Wengle 2015).

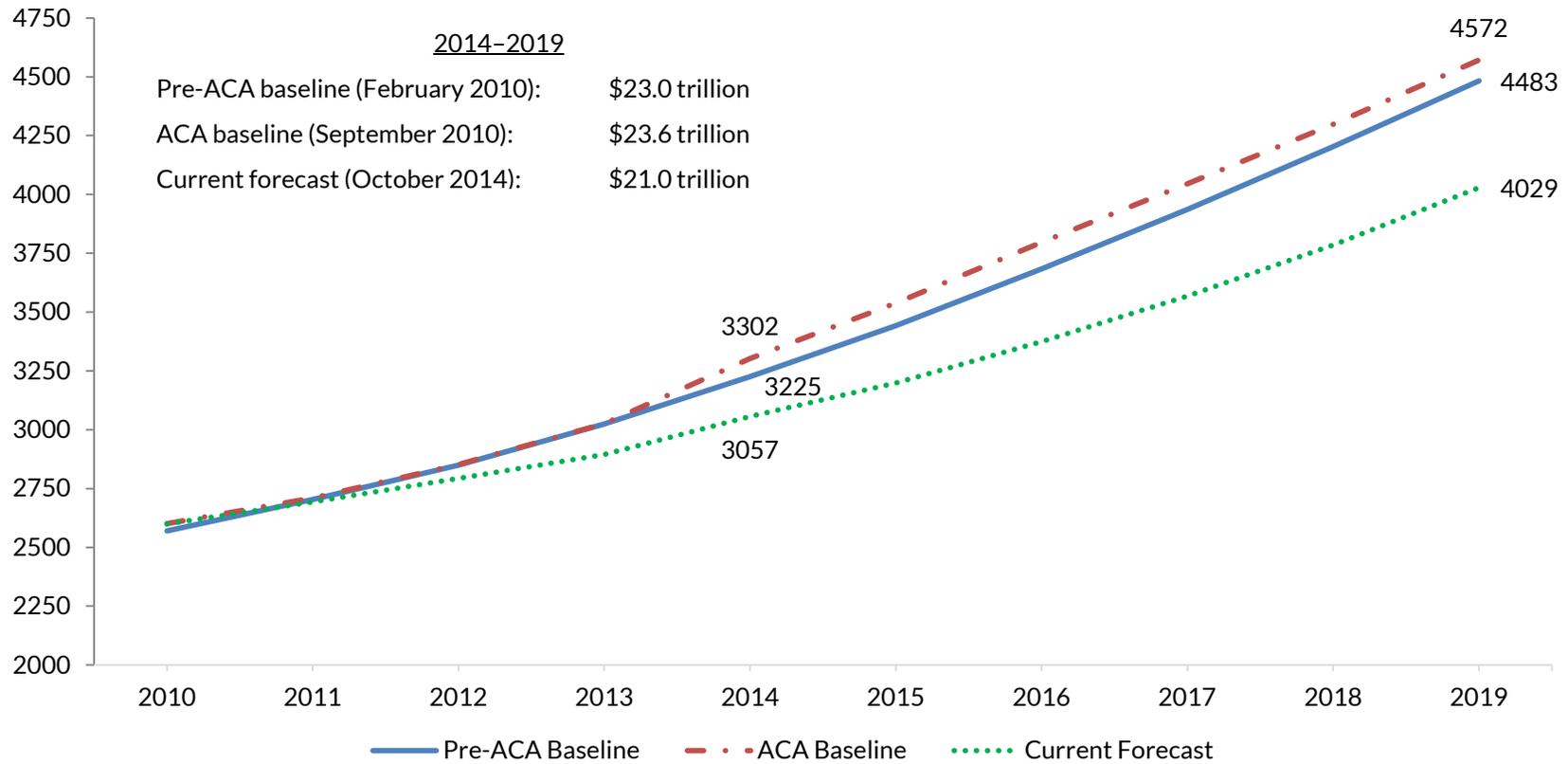
National health expenditure growth has slowed considerably, with the result that new cost estimates are well below projections made in 2010 (figure 1 and table 1) (Holahan and McMorro 2015). In 2010, CMS actuaries projected that national health expenditures would increase by \$577 billion between 2014 and 2019. Because of slower than expected health care cost growth, some of

which may be attributable to the ACA, more recent national health expenditure projections made in 2014 for the 2014 to 2019 period are over \$2.5 trillion below the August 2010 estimates (Holahan and McMorrow 2015). Medicare expenditures are now projected to be \$384 billion lower over the same period. Medicaid expenditures are now estimated to be \$927 billion lower, with \$210 billion of that reduction due to the Supreme Court decision to allow states to opt out of the Medicaid expansion. Subtracting the Court decision effect, Medicaid spending is projected to be \$717 billion lower than originally estimated over this period. Thus, overall, Medicare and Medicaid expenditures are projected to be \$1.1 trillion lower from 2014 to 2019 than the projections made just four years ago. The reasons for lower aggregate health expenditures are complex and include (1) the slow growth in the economy and incomes, (2) the greater use of higher cost-sharing requirements in private insurance policies, (3) lower-cost provider networks in commercial insurance plans, (4) the Medicare payment reductions made under the ACA and subsequent legislation, (5) the lower than expected premiums in marketplace plans, and (6) slower growth in Medicaid. Thus the fears of accelerating health care costs because of the law have simply not been realized, nor has the ACA added to the federal deficit. In fact, through its contribution to health care cost reductions, the ACA is helping to reduce the nation's deficit (CBO 2015a).

FIGURE 1

National Health Expenditure Projections (\$ billions)

Billions of Dollars



Source: Centers for Medicare and Medicaid Services, Office of the Actuary. All projections include the cuts to physician reimbursement required by the sustainable growth rate formula.
Note: ACA = Affordable Care Act.

TABLE 1

Cumulative Spending Projections, 2014–2019

	Pre-ACA Baseline	ACA Baseline	Current Forecast	Original Estimated Impact of ACA for 2014–2019		Current Forecast (2014–2019) Relative to Pre- ACA Baseline		Current Forecast (2014–2019) Relative to ACA Baseline	
	A	B	C	B-A	% change	C-A	% change	C-B	% change
	(in \$billions)								
NHE	22,973	23,550	21,012	577	2.5%	-1,961	-8.5%	-2,538	-10.8%
Medicare	4,863	4,554	4,170	-309	-6.4%	-693	-14.3%	-384	-8.4%
Medicaid	4,003	4,567	3,640	564	14.1%	-363	-9.1%	-927	-20.3%
Private Health Insurance	7,102	7,694	7,006	592	8.3%	-96	-1.3%	-688	-8.9%
OOP	2,438	2,237	2,217	-202	-8.3%	-222	-9.1%	-20	-0.9%
Other	4,567	4,498	3,979	-69	-1.5%	-587	-12.9%	-519	-11.5%

Source: Centers for Medicare and Medicaid Services Office of the Actuary.

Note: ACA = Affordable Care Act; NHE = National Health Expenditure; OOP = out-of-pocket.

The ACA has been criticized by its opponents for concerns beyond those previously noted related to health care cost growth and increases to the federal deficit. Much of the criticism has been through strong, though vague, rhetoric, with descriptions such as “a disaster” and “a monstrosity” (Newsmax 2013; Hogberg 2014). The main criticisms are that the law would have an adverse effect on the economy and employment and that it would lead to labor market distortions, discouraging hiring, increasing part-time work, and ultimately leading to reductions in employer-based offers of insurance and coverage. At this time, no empirical evidence supports those dire predictions (Garrett and Kaestner 2015, Garrett and Kaestner 2014a, 2014b; Garrett and Buettgens 2011; Blavin et al. 2014). The same is true of predictions of soaring health care cost growth. However, some individuals have had to give up nongroup insurance policies that favored them, leading to criticism of President Barack Obama’s pledge that if you liked your insurance plan, you could keep it. Some insurers eliminated grandfathered plans beginning in 2014 and some states chose not to extend so-called grandmothers plans after those extensions were permitted.⁴ Still other consumers found the new ACA-compliant plans and their coverage of essential health benefits and cost-sharing limits, as well as the financial assistance provided to some for their purchase, more attractive than the plans they had previously held, and they switched voluntarily.⁵

Addressing the ACA's Funding Shortfalls: Affordability and Administrative Capacity

Although the ACA's accomplishments are already measurable and significant, the program's long-run sustainability and growth are vulnerable because of underinvestments in the areas of affordability and administration, each of which is discussed in turn in this section.

Despite its goals of reducing the uninsured by about 25 million Americans and reducing large financial burdens on many others, the ACA was never particularly well-funded. As the law moved through the legislative process, the goal was to keep the federal cost under \$1.0 trillion over the 10-year budget window (Obama 2009). CBO's original estimate was that spending for the period 2010–2019 would be \$872 billion. Over the 2014–2019 portion of that period, during which the bulk of the law would be implemented, spending would be \$855 billion, which amounted to 0.73 percent of gross domestic product (GDP) (CBO 2009 and CBO 2010). The more recent CBO estimate of the cost of the coverage provisions over the 10-year budget window of 2016–2025 is \$1.7 trillion or 0.74 percent of GDP (CBO 2015b and CBO 2015c). (GDP is estimated to be \$230 trillion over the 2016–2025 period.) Not only are these cost estimates small in comparison to GDP, but they are also low relative to projected spending on Medicare and Medicaid. Over the same period, Medicare was projected to cost \$9.6 trillion or 4.2 percent of GDP, and Medicaid federal and state spending (excluding the ACA expansion population) was estimated to be \$6.6 trillion or 2.9 percent of GDP (CMS 2015c). The foregone federal tax revenue attributed to the exclusion of contributions to employer-based health insurance is estimated to be \$3.4 trillion between 2014 and 2023, or 1.5 percent of GDP (CBO 2013).

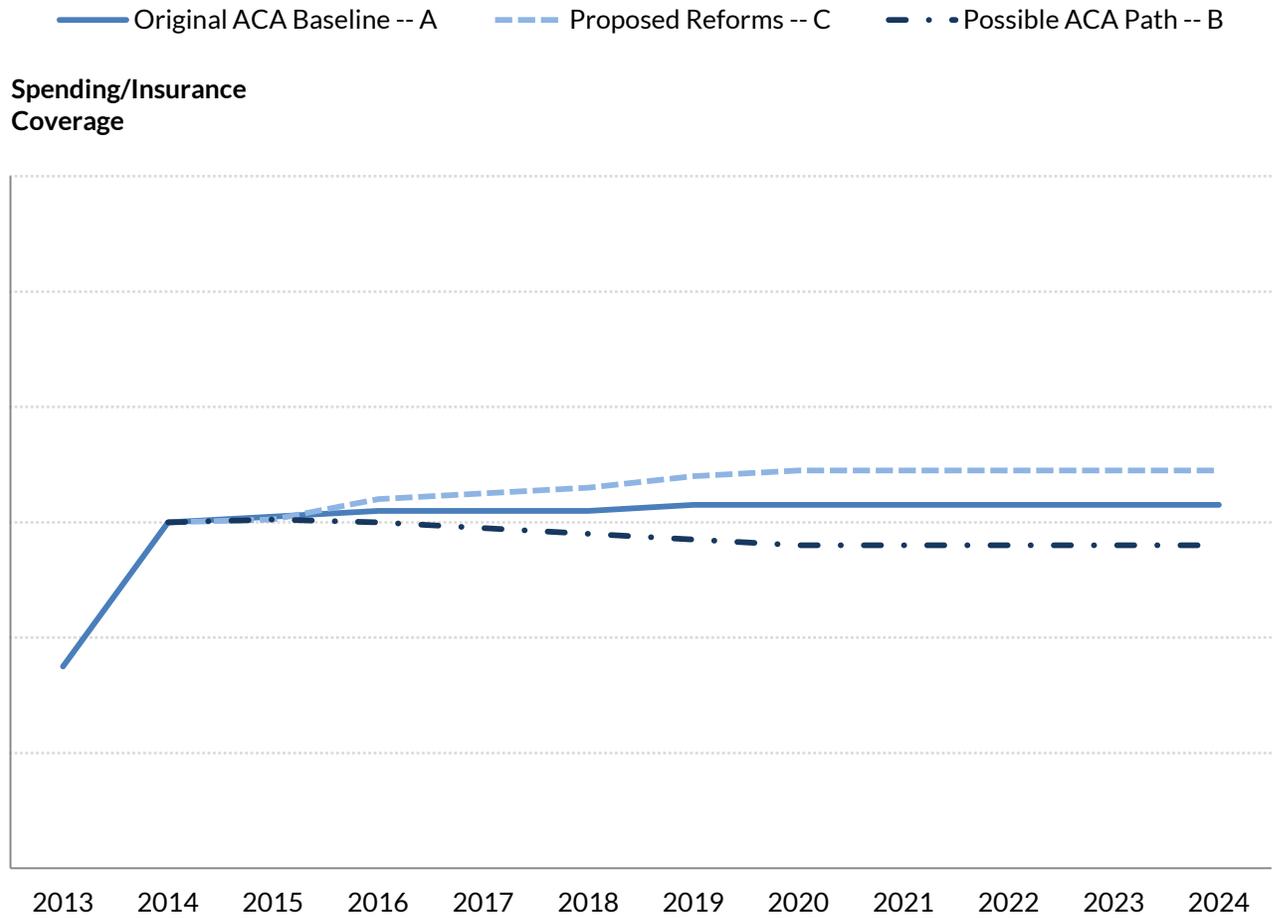
Thus, the ACA is a small expense relative to GDP, and it is small relative to long-standing public health insurance programs. As previously discussed, health spending under the ACA also has been substantially lower than originally anticipated, not only because of the decision of 21 states not to participate in the Medicaid expansion, but also because of slower growth in health care costs overall. This context is critical to keep in mind as we discuss the importance of additional investments in components of the ACA, as it means that the reforms proposed here could be implemented and that the nation would still spend considerably less than was originally forecast.

Our overall premise is that, because of the issues we raise, the enrollment and cost estimates of the ACA's coverage provisions published by the Urban Institute, CBO, and others may not be realized. Reports that are beginning to emerge (see, for example, Eisenberg 2015; Ehley 2014; Goodnough and Pear 2014) suggest that many individuals eligible for financial assistance are remaining uninsured because they find the cost of the available plans still too high, even after taking the tax credits and cost-sharing reductions into account.⁶ And, among those individuals who find the post-tax credit premiums affordable, anecdotal reports indicate that many may be finding the deductibles and other cost-sharing responsibilities too high to make access to necessary care affordable. In addition, insufficient continued funding of outreach and enrollment activities suggests that enrolling the remaining, presumably harder-to-reach, uninsured Americans may slow enrollment growth appreciably in future years. As a consequence, we are concerned that the actual enrollment time path for marketplace plans may already be leveling off, with some evidence of this situation already observed in states such as California, Colorado, New York, Rhode Island, Vermont, and Washington and with the additional future possibility that maintaining current levels of enrollment will be difficult.

If our concerns are warranted, then the main ACA enrollment and cost estimates for future years (both ours and CBO's represented in the theoretical framework in figure 2 as line A) are overstated, as lower than projected enrollment in subsidized insurance would mean lower costs. In that case, the nation would be at spending and coverage levels represented by line B instead of line A. We argue that the reforms we propose may be necessary to bring enrollment to line A and may well bring us to a higher level, represented by line C in the figure. In other words, the additional investment we propose and that is reflected in the cost estimates that we will present will lead to insurance coverage levels equal to and at least somewhat greater than those that have been projected previously. But these proposals also require a higher level of spending than had been previously anticipated. Without that additional spending, we may not be able to stay on the coverage path that is represented by line A and that reflects the long-term objectives of the law. In addition to increasing insurance coverage, the additional spending proposed would further reduce medical financial burdens on low- and modest-income families, simultaneously increasing their effective access to care further and likely generating positive health outcomes as a result.

FIGURE 2

Conceptual Representation of the Possible Baseline Coverage and Spending Path under ACA Compared with Proposed Enhanced Approach



Note: ACA = Affordable Care Act.

Affordability: Lack of an Internally Consistent Definition of Affordability and Sufficient Funding to Meet an Appropriate Standard

The issue of affordability is perhaps more important than any other factor in increasing insurance coverage and access to medical care. Individuals eligible for Medicaid under the ACA have the most affordable coverage available to them; the program provides comprehensive coverage at little or no premium to the individual and with little to no cost-sharing responsibilities. Financial burdens that face

other individuals vary considerably and, for some, remain high relative to income. Although affordability is inherently subjective—what seems affordable to some may not seem affordable to others of similar means, for example—any health care reform requiring premium or out-of-pocket contributions from individuals and families must set standards for affordability. Unlike a government-run health care system designed to provide care to all citizens, the ACA is structured to increase affordability without guaranteeing affordability, even by the law’s own standards of what is affordable. For example, the law exempts people from the individual requirement to obtain coverage or pay a penalty if they are unable to obtain insurance compliant with the law’s requirements at a cost of 8 percent or less of family income. While 8 percent of family income devoted to health insurance coverage is explicitly defined as affordable under the law, the law recognizes that not everyone will be able to access insurance coverage at that level of financial burden.

Many modest-income individuals eligible for federal premium tax credits through the marketplaces—those with incomes of 250 to 400 percent of FPL—still do not receive sufficient financial assistance to meet that 8 percent affordability standard. For example, those at 250 percent of FPL had the premium for their benchmark coverage capped at 8.10 percent of family income in 2015, and that income cap increases linearly until it reaches 9.56 percent of income for those at 300 to 400 percent of FPL.⁷As a result, the schedule for financial assistance in purchasing premiums is inconsistent with the affordability standard in the law itself. Although the law perceives those individuals between roughly 250 and 400 percent of FPL to warrant financial assistance, it does not provide them with financial assistance that is sufficient to make coverage affordable according to the law’s definition of what is affordable. In other words, individuals in this income range are required to pay 8.10 to 9.56 percent of income to obtain coverage under a 70 percent actuarial value marketplace plan, but the ACA itself exempts them from the individual mandate to obtain coverage if their cost is more than 8.0 percent of their income. The number of people exempted from the coverage requirement because they do not have access to affordable coverage will increase over time because the income cap percentages are designed to increase as health care costs grow faster than general inflation.

Aside from that inconsistency, the financial burdens associated with post-tax credit marketplace premiums are considerably higher than those associated with the Massachusetts state reforms (particularly for those individuals between 200 and 300 percent of FPL), with the Massachusetts contribution requirements widely seen as affordable and participation rates remaining very high as a consequence. Table 2 shows how the original Massachusetts financial assistance schedule compares with that under the ACA.

TABLE 2

Individual Contributions to Subsidized Coverage under the 2006 Massachusetts Reforms Compared with the ACA, for Select Levels of Income Relative to the Federal Poverty Level

Income Relative to Poverty selected points for comparison, (%)	Massachusetts—Required contribution to subsidized single coverage as share of income (%)	ACA—Required contribution to subsidized coverage as a share of income, 2015 (%)
100	0	2.01
150	0	4.02
200	2.1	6.30
250	3–4	8.10
300	4.2	9.56
350	No cap	9.56
400	No cap	9.56
Over 400	No cap	No cap

Note: ACA = Affordable Care Act.

At every income level at or below 300 percent of FPL, the Massachusetts schedule requires individuals to pay less for their health insurance coverage than does the ACA's schedule. Case study work, household surveys, and evidence from enrollment patterns all indicate that many of those individuals who continue to be uninsured under the ACA perceive the direct cost of health insurance, even with the available financial assistance, still out of their financial reach (Dorn 2014a, 2014b, 2014c).

Likely exacerbating the sense of some consumers that coverage is still unaffordable is the fact that the affordability standards implicit in the ACA do not take into account out-of-pocket spending burdens. As we have noted elsewhere, a standard that ensures effective affordability of coverage, particularly for those with modest incomes, must take both premiums and potential out-of-pocket costs into account (Blumberg et al 2007). A premium may be reasonably low relative to income, but if that coverage comes with large deductibles, copayments, and out-of-pocket limits, those features can serve as barriers to accessing necessary care and will likely dissuade many individuals from enrolling or re-enrolling. Cost-sharing reductions for marketplace-based coverage are available under the ACA, but they are limited to those individuals below 250 percent of FPL, and the assistance is so small for those between 200 and 250 percent of FPL that it does little to reduce households' costs.

TABLE 3

ACA Marketplace Premium Cap Schedule as a Percentage of Income and Cost-Sharing Reductions

Family Income Range Relative to the Federal Poverty Level (% of FPL)	Household Premium Contributions as Percentage of Income for the Applicable Income Category, 2015 (%)	CSR Schedule: AV Provided for Silver Plan Premium
Up to 138	2.01	94% AV
138–150	3.02–4.02	94% AV
150–200	4.0–6.3	87% AV
200–250	6.34–8.10	73% AV
250–300	8.10–9.56	70% AV (standard silver, no CSR)
300–400	9.56	70% AV (standard silver, no CSR)
400 and higher	No cap	70% AV (standard silver, no CSR)

Note: ACA = Affordable Care Act; AV = actuarial value; CSR = cost-sharing reduction; FPL = federal poverty level.

Under the ACA, cost-sharing reductions are provided to income-eligible subsidized enrollees purchasing silver plans (those with actuarial value [AV] of 70 percent, that is, plans that reimburse 70 percent of covered benefit costs across an average population). (See table 3.) The cost-sharing reductions are designed to increase AV to 94 percent for those up to 150 percent of FPL, to increase AV to 87 percent for those between 150 and 200 percent of FPL, and to 73 percent for those between 200 and 250 percent FPL. Silver-tier cost-sharing structures vary across plans and insurance carriers, but absent cost-sharing reductions, the median deductible is \$2,900 for single coverage in 2015 (double that for family coverage), or even higher if there are no cost-sharing requirements after the deductible is met. The median silver plan's out-of-pocket maximum is \$6,350 for single policies, \$12,700 for family policies. We have found 73 percent cost-sharing reduction plans for individuals with deductibles of \$5,000 and out-of-pocket limits of \$5,000, leaving people at 225 percent of FPL with a potential premium plus out-of-pocket financial burden of 26.3 percent of their yearly income.⁸ Out-of-pocket maximums for those ineligible for cost-sharing reduction plans are limited under federal law to \$6,600 for single policies and \$13,200 for family policies in 2015, extremely large financial burdens that would be imposed on those with high medical needs but still modest incomes and that could be added to their premium payments. Median and 90th percentile health care financial burdens, taking both premiums and out-of-pocket spending into account, under current law are shown in table 4, for those estimated to purchase marketplace-based nongroup insurance coverage in 2016.⁹

TABLE 4

Health Care Financial Burdens (Premiums plus Out-of-Pocket Costs Relative to Income) Under the ACA after Taking Any Tax Credits and Cost-Sharing Reductions into Account, among Those Purchasing Marketplace Nongroup Insurance Plans, Median and 90th Percentile, 2016

Income Relative to the Federal Poverty Level (% of FPL) Group	Median (%)	90th Percentile (%)
<200	6.2	17.3
200–300	10.2	20.6
300–400	13.3	20.6
400–500	18.1	25.2
500 and above	15.5	22.2

Source: Health Insurance Policy Simulation Model, HIPSM, 2015.

Note: ACA = Affordable Care Act; FPL = federal poverty level. Sample with income below 400 percent of FPL includes only those individuals eligible for tax credits; those purchasing nongroup insurance who are ineligible for tax credits because they have access to an affordable offer of health insurance are excluded from these income groups.

Proposal

We propose a new subsidy schedule designed to address the shortfall in affordability in both premium costs and out-of-pocket cost-sharing burdens. The modified premium tax credit schedule would be pegged to the second-lowest-cost gold level (80 percent actuarial value) plan, rather than the current policy that ties the schedule to the second-lowest-cost silver level (70 percent AV) plan. The gold-level plans have significantly lower out-of-pocket cost-sharing requirements, by definition. The median deductible for single coverage is \$1,000 in 2015, with the median out-of-pocket maximum at \$4,000, compared with \$2,900 and \$6,350, respectively, for single silver-level coverage.¹⁰ In addition, we propose lowering the percent-of-income caps defining maximum required premium payments under the premium tax credit schedule and improving the cost-sharing reduction schedule as well. The percent-of-income schedules under the ACA currently and as proposed here are shown in table 5.

TABLE 5

ACA Premium Tax Credit Caps as a Percentage of Income Compared with Proposed Caps

Income Relative to Federal Poverty Level (% of FPL)	ACA: Household Premium Contribution as Percentage of Income for the Applicable Income Category, Pegged to Silver Level Plan, 2015 (%)	Proposed Schedule: Household Premium Contribution as Percentage of Income for the Applicable Income Category, Pegged to Gold Level Plan (%)
≤ 100–138	2.01	0–1.0
138–150	3.02–4.02	1.0–2.0
150–200	4.02–6.34	2.0–4.0
200–250	6.34–8.10	4.0–6.0
250–300	8.10–9.56	6.0–7.0
300–400	9.56–9.56	7.0–8.5
400 and higher	No cap	8.5

Note: ACA = Affordable Care Act; FPL = federal poverty level.

The proposed schedule lowers the premium contributions relative to income for all income groups eligible for them under the ACA and adds an 8.5 percent cap for those at or above 400 percent of FPL. The 8.5 percent cap for the higher income group would not affect many of the higher income individuals potentially eligible for it because premiums would not reach that level relative to income for most of them. However, it would provide additional protection, particularly for those older adults between 400 and 500 percent of the federal poverty level who face the full effect of the 3-to-1 age rating under the law and who have incomes that are still modest relative to those high costs. Younger adults in this income range are unlikely to receive financial assistance under this new cap because they benefit from the 3-to-1 age rating and face significantly lower premiums.

We also would eliminate the current indexing of the caps over time, so that they would not grow as health care cost growth exceeds the consumer price index. In addition, we would move the affordability test, which determines whether an individual or family faces insurance costs sufficiently high to exempt them from possible individual mandate penalties, from the ACA's 8.0 percent to 8.5 percent, making the percentage slightly higher but consistent with the maximum percent-of-income cap for marketplace coverage. This test would, however, continue to be tied to bronze-level coverage as it is under current law.

Our next proposed change to financial assistance is a modification to the actuarial level of coverage subsidized for those eligible for cost-sharing reductions. To receive a cost-sharing subsidy under the ACA, an income-eligible person pays the premium (less premium tax credits) for a silver-level (70 percent AV) plan and then receives a corresponding plan from that insurer that has a higher actuarial value level. For example, an enrollee with income below 150 percent of FPL would pay the specified

portion of a silver plan premium but then be enrolled in a 94 percent actuarial value plan instead of a 70 percent one. The old actuarial value schedule and the proposed one are shown in table 6:

TABLE 6

Actuarial Values Associated with ACA Cost-Sharing Reductions Compared with Proposed Levels

Income Relative to Federal Poverty Level (% of FPL)	ACA: Actuarial Value Level Plan Provided to Eligibles Paying for a Subsidized Silver Level Premium	Proposed Schedule: Actuarial Value Level Plan Provided to Eligibles Paying for a Subsidized Gold Level Premium
≤ 150	94%	94%
150–200	87%	90%
200–250	73%	85%
250–300	n.a.	85%

Note: ACA = Affordable Care Act; FPL = federal poverty level; n.a. = not applicable because cost sharing reductions are not available.

The proposed schedule would keep the ACA’s most generous cost-sharing reduction plan at its current level, but increase it for the 150 to 250 percent of FPL group and extend it to the 250 to 300 percent of FPL population. Those individuals who receive premium tax credits but who are not eligible for cost-sharing reductions would be subsidized to gold-level, 80 percent AV coverage. In this way, the proposed approach would address the linked affordability issues of premiums and out-of-pocket costs. Individuals would still be required to make significant contributions toward the costs of their health insurance coverage and when they directly access care, yet the combined financial burdens of premiums and out-of-pocket costs would be less onerous than under current law (see table 7).

TABLE 7

Health Care Financial Burdens (Premiums plus Out-of-Pocket Costs Relative to Income) Under the ACA and Proposed Changes, after Taking Any Tax Credits and Cost-Sharing Reductions into Account, among Those Purchasing Marketplace Nongroup Insurance Plans, Median and 90th Percentile, 2016

Income Relative to Federal Poverty Level (% of FPL)	Median		90th Percentile	
	Current ACA (%)	Proposed (%)	Current ACA (%)	Proposed (%)
< 200	6.2	4.3	17.3	14.8
200–300	10.2	7.8	20.6	16.6
300–400	13.3	11.8	20.6	19.2
400–500	18.1	12.4	25.2	19.0
500 and over	15.5	11.5	22.2	16.4

Source: Health Insurance Policy Simulation Model (HIPSM)

Note: ACA = Affordable Care Act; FPL = federal poverty level.

We estimate that the combination of the enhanced premium tax credits pegged to gold- instead of silver-level coverage, the improved cost-sharing reductions, and the elimination of indexing the premium caps would cost an additional \$221 billion over the 10 years 2016–2025, \$39 billion of which is attributable to increasing the cost sharing reductions and extending them to 300 percent of FPL.¹¹ The Urban Institute’s most recent 10-year cost estimates for the ACA’s coverage provisions as currently implemented are \$444 billion. If the proposed changes were in effect during that 10-year window instead, the 10-year costs would be \$665 billion.

Affordability: Inequities Resulting from Differential Treatment across Work and Family Circumstances

Although clearly increasing affordability for many consumers relative to the pre-reform situation, the ACA also created inequities across people with different employment and family circumstances. Those inequities were most certainly introduced as a mechanism for reducing the federal government’s cost of financial assistance provided through the marketplaces, but they adversely affect affordability for some people. Eligibility for financial assistance via the marketplaces is restricted to those individuals (1) who are not eligible for public insurance, (2) are legal residents of the United States, and (3) who do not have themselves nor does an immediate family member have an offer of employer-based health insurance at a direct cost of less than 9.5 percent of family income for worker-only coverage. This 9.5 percent employer-sponsored insurance affordability standard signifies yet another inconsistency in the law, a

departure from the 8.0 percent affordability standard that exempts individuals and families from the individual mandate penalties.

In addition to that inconsistency, linking tax credit eligibility to worker-only coverage rather than to family coverage creates affordability inequities by work and family status. A single adult may find worker-only coverage through her employer affordable, but the family coverage contribution may not be affordable. For example, the average contribution that workers make to single coverage through their employer is estimated to be \$1,290 in 2015, with the corresponding average contribution to family coverage estimated to be \$4,874.¹² Using these averages to illustrate, a single adult with income of 150 percent of FPL (\$17,655) would have to contribute 7 percent of income to obtain coverage through her employer. Because 7 percent of income is less than the 9.5 percent exclusion threshold, that worker with that employer offer would not be eligible for financial assistance through the marketplaces.

A family of three making 150 percent of FPL with the same employer offer would have to pay \$4,874 for family coverage, which would amount to over 16 percent of their family income. However, that large financial burden is irrelevant to their eligibility for financial assistance through the marketplaces, because, according to the current federal regulations, the family's eligibility is a function of the contribution for single coverage, which amounts to less than 5 percent of their income. A similar family without access to this "affordable" employer offer would be eligible for full family coverage under a 94 percent actuarial value plan through their marketplace for a contribution of just four percent of income. This family/work status inequity not only causes financial hardship for some individuals and families relative to others of similar means, but also has the potential to cause labor market distortions. Those individuals seeking truly affordable access to health insurance may look for jobs that do not offer health insurance coverage so they can access coverage at a more reasonable out-of-pocket cost.

Proposal

We propose a two-pronged fix to the firewall between employer-sponsored insurance offers and eligibility for premium tax credits through the nongroup marketplaces. First, a single adult with an employer-sponsored insurance offer for which his direct cost exceeds 8.5 percent of income would be eligible for tax credits through the marketplace. This change reduces the firewall threshold from 9.5 percent and would be consistent with the highest percent-of-income cap in our proposed premium tax credit schedule and our proposed change to the affordability threshold. Ideally, we would also eliminate the inconsistency between the affordability standard for workers offered employer sponsored

insurance and the percent of income caps for which they would otherwise be eligible in the nongroup marketplace. For example, a worker who would be eligible for nongroup coverage at a direct cost of 4 percent of income through the marketplace should have access to that financial assistance if the contribution required for employer-based coverage exceeds 4 percent of his income, not 8.5 percent. However, the government cost of eliminating this inequity would be large, and therefore, while recognizing this as a problem, we are not proposing to correct it at this time.

Second, because many legal experts believe that the family glitch is a regulatory, not a legal issue (“Health Policy Brief” 2014), we encourage the US Internal Revenue Service leadership to reconsider their interpretation of the statute and to rewrite the associated regulations to address the problem by applying the employer-sponsored insurance affordability threshold equitably to the cost of single and family policies. Alternatively, the problem could be addressed through legislation, such as that proposed by US Senator Al Franken’s “Family Coverage Act;”¹³ however, taking the legislative approach likely would require raising additional revenues whereas the regulatory approach would not.

Our proposed approach is as follows. If at least one family member has an employer offer for family coverage, the minimum direct cost of which exceeds the employer-sponsored insurance affordability threshold (8.5 percent of income under our modified policy), the family members would be eligible for financial assistance through the marketplace. Contributions that the worker makes to the employer’s plan for single coverage would count against the amount the family members would be required to contribute for marketplace coverage. For example, if the worker contributed 4.0 percent of family income for a single policy through his employer but family coverage would cost 12 percent of his family income, the family members (the worker’s spouse and children) could be eligible for financial assistance if they obtain their coverage through the marketplace. Given their income, if the family would otherwise be expected to contribute 7.0 percent of their income for marketplace coverage, this amount would be reduced by the 4.0 percent the worker was paying for single employer-based coverage, and the family would pay the additional 3.0 percent for family coverage through the marketplace.

Eliminating the family glitch alone through revisions of existing regulations does not require additional revenues to be raised because, if properly interpreted originally, any associated costs would be incorporated in the ACA’s baseline. However, because we are proposing to enhance the tax credits and cost-sharing reductions through the marketplace, there would be an additional cost. In addition, even though a regulatory change would incorporate the costs into the baseline, fixing this problem would increase federal spending relative to the current level; as a consequence, we provide an estimate of both the cost associated with correcting the problem within the context of current law and the marginal cost of doing so with our proposed, enhanced financial assistance. We estimate that the base

increase in spending of addressing the problem through changes in regulation would be \$78 billion over 10 years; an additional \$39 billion over 10 years is needed to adjust for our proposed improvements to the premium tax credits and cost-sharing reductions.¹⁴

Affordability: The 21 States That Have Chosen Not to Expand Medicaid Eligibility under the ACA

Although not directly an issue of underfunding, at this time 21 states do not participate in the ACA's Medicaid eligibility expansion for all individuals up to 138 percent of FPL. The expansion has had a substantial effect on the number of uninsured people in states that have taken up the option. The uninsured rate has fallen by about one-third in nonexpanding states but has fallen by almost half in expanding states (Long et al. 2015). The states that have not adopted Medicaid generally have strongly opposed the ACA and argue that ongoing federal funding cannot be counted on. Meanwhile, their lack of participation significantly impedes the law's ability to meet its objectives in those states.

Proposal

Although some of the currently nonexpanding states may choose to participate in the future, many others may continue to refuse to do so, maintaining the tremendous inequity that provides federal financial assistance to some people with incomes at or above the federal poverty level but denies assistance to many adults who are actually poor. One option to address this hole in the ACA's reach is to give states the option of expanding Medicaid coverage up to 100 percent of FPL rather than requiring them to expand to 138 percent of FPL if they expand at all.

That approach was originally considered as the law moved through the legislative process, but it was rejected because of the higher projected federal expenditures it was projected would be required. Subsidizing more people through the marketplace plans increased projected expenditures because those plans were presumed to pay higher provider payment rates than Medicaid plans do. However, having the choice to limit the Medicaid expansion population to 100 percent of FPL would reduce the financial risk that the nonexpanding states seem to fear. It would mean fewer people in the public program, often a goal of political leadership in the nonexpanding states. It also would shift the total financial burden for assisting the population with incomes of 100 to 138 percent of FPL to the federal government because marketplace assistance is fully federally funded.

As we have discussed previously, we propose reducing marketplace premium contributions for those with incomes between 100 and 138 percent of FPL, with no contributions to premiums required at or below 100 percent of FPL, phasing up to a maximum of 1 percent of income at 138 percent of FPL. As a result, there would be little to no increase in premium-related financial burdens for eligible individuals relative to Medicaid. However, a 94 percent actuarial value plan through the marketplace might lead to some additional out-of-pocket costs relative to a Medicaid plan. Plus, premium tax credit eligibles could only enroll in nongroup coverage during an annual open enrollment period whereas Medicaid eligibles can enroll at any time during the year. Private plans do not generally cover some benefits included in Medicaid, eg. transportation; however private plans may provide access to a broader array of health care providers. In addition, those individuals in this income group could be made eligible for financial assistance regardless of any available employer-based insurance, thus resolving another difference with Medicaid and ensuring access to comprehensive low cost-sharing coverage for this very low income population.

The federal costs of this option depend on how many otherwise nonexpanding states take up the option to expand eligibility to 100 percent of FPL and how many already-expanding states decrease eligibility from 138 percent to 100 percent of FPL. If some of the currently nonexpanding states would have decided to expand under current law, that also reduces the additional federal costs that would need to be financed, as the costs of those states would already be included in the baseline ACA cost estimates. Because of the uncertainty around state participation under current law and under the proposed approach, we estimate a range of \$100 to \$200 billion in additional federal costs over 10 years, including an increase in marketplace subsidy costs and Medicaid savings in states reducing eligibility from 138 percent of the FPL to 100 percent of the FPL. The high end of the range assumes all currently nonexpanding states take up the new expansion option at some point during the 10-year budget window and that most already expanding states decrease eligibility to 100 percent of FPL. The lower end of the range assumes a smaller response by both nonexpanding and expanding states.

The change would increase costs to the federal government by eliminating the state contribution for those individuals between 100 and 138 percent of FPL. The additional cost to the federal government from increased marketplace enrollment would depend on the premiums for the second-lowest-cost gold plans to which premium tax credits would be tied in each rating region under our proposed changes. Because marketplace benchmark premiums have been relatively low in many areas, the difference in cost between Medicaid plans and marketplace benchmark plans might be smaller than originally estimated by CBO. Plans that are at or near the benchmark often have limited provider networks and in many cases are the same plans as those participating in the state's Medicaid program.

Administrative Capacity: The IT System

The ACA builds on the existing private insurance system, filling in coverage gaps through tax credits and cost-sharing reductions available in the new health insurance marketplaces. The law provides such financial assistance through an array of private plans that allow individuals opportunities to enroll in coverage options that vary in price and benefit generosity. However, this structure creates significant difficulties as well, particularly because it is partnered with requirements to provide estimated income data and to eventually reconcile tax credits with full-year income. Together, these characteristics of the financial assistance structure demand an IT system that allows a broad array of data to be collected and stored on income (for tax credit eligibility determination and reconciliation purposes), employment, citizenship, payments from various sources (federal government, private, and state government for states supplementing tax credits), plan choices, metrics for assessing insurers and plans (including provider network details, quality data, administrative cost information), and measures of health status of enrollees by insurer (for risk adjustment purposes). Some of these data must be transferred from other government IT systems, such as state Medicaid systems, federal social security systems, and the Immigration and Naturalization Service, while other data must be entered directly into the marketplace system. In addition, the system has to be sufficiently flexible to effectively handle the consequences of income fluctuations, which are common in this income group, such that payment from the multiple sources can be adjusted quickly and electronic records are able to reflect them.

Data being entered directly into the system also can come from an array of possible sources at different times and must be integrated effectively, with information coming from the enrollees and assisters of different types (publicly funded navigators, in-person assisters, agents, brokers, call center personnel). In addition, the system must provide sufficient guidance so that the different parties can complete the enrollment processes effectively, including for individuals with complex family situations related to immigration, anticipated changes in income or family status, and so on. Data on attribution of enrollment must be maintained so that brokers and agents can be compensated for their work, including in circumstances in which assisters allow consumers to complete the enrollment process.

In short, the complexity of demands to create an IT system that effectively supports the policies of broad private plan choice, complex eligibility rules, and reconciliation are enormous. As such, the investment necessary to further develop and refine an IT system to meet those numerous operational challenges must be commensurate for the ACA to be successful. And although significant progress has been made since the 2014 open enrollment period, some of the needs have yet to be met by the existing IT infrastructure, and current funding levels seem inadequate given the challenges faced.

Many of the websites for marketplaces are not as consumer friendly as they ought to be, and the lack of insurer and provider network transparency means that information necessary to promote effective competition across insurers is still lacking (Blumberg, Peters et al. 2014). Consumers are not given “receipts” from the system that allow them to see the accuracy of the income that has been attributed to them for tax credit eligibility determinations, and applicants receive no information on reasons if the system denies their tax credit eligibility. These “notice” failings are due to funding limitations. The back-end interactions between the marketplaces and the insurers continue to have problems in many of the systems. Integration is lacking in many states between Medicaid and marketplace IT systems, a situation which has created enrollment delays in some areas. Fixing those components of marketplace IT systems is critical for the long-term success of the reforms.

Proposal

Additional funding is necessary to complete the job begun through healthcare.gov and a number of state-based marketplaces. Some share of these additional funds should be devoted to the federal IT system, which, after its challenging start, has come a long way to operating effectively with most front-end functions. Additional investment is needed on the back end, however. State-based marketplaces without their own well-functioning IT systems should be encouraged to join the healthcare.gov platform or to use a highly functioning system developed by another state rather than investing in new systems or major repairs.¹⁵ States that have already developed their own successful IT systems but that need some additional support should receive funds to allow them to complete the job they began. However, investing in new state-based systems for state-based marketplaces with failed systems is not cost-efficient.

CMS or perhaps an independent body should be tasked to articulate specific policy and performance goals and then to offer a thoughtful strategic plan and cost estimate for achieving those goals and updating them over time. In general, marketplace IT systems should (1) accurately determine eligibility; (2) achieve single streamlined application and enrollment in the marketplace and Medicaid; (3) provide adequate, accurate, and timely notices to applicants and enrollees; (4) provide adequate consumer support during application processes (such as pop-up windows to explain questions being asked); (5) enable assisters to securely access client files; (6) enable marketplace officials and call center personnel to query the system in real time; (7) provide real time enrollment data and other system performance data to marketplace officials; (8) provide accurate and understandable plan information to

consumers; (9) provide effective plan comparison tools; and (10) provide consumer information in multiple languages.

We also propose that federal funds be available to support the remaining development of healthcare.gov and some share of ongoing operating costs. Similarly, somewhere between 6 and 10 states have well-functioning IT systems. These states also need additional support for infrastructure development as well as ongoing operational expenses. Estimating the true need for funding over a 10-year period is very difficult. After a review of spending levels to date, we derived a rough, place-holder estimate of \$4–6 billion over 10 years in additional federal funds required for both the federal system and those in selected states (about 10 states). However, CMS or an independent body should be tasked to develop a framework for defining a successful IT system, accurately estimate the cost of modifying existing systems to meet those defined standards, identify for which state systems the additional investment is appropriate (in addition to greater investment in healthcare.gov), and establish an accountable process for moving the systems there.

Administrative Capacity: Outreach and Enrollment Assistance

Outreach, education, and enrollment assistance efforts continue to be fundamental to further expanding insurance coverage and to retaining gains that were achieved in the first two years. However, funding allocated to these efforts is already decreasing and was underfunded from the beginning in many areas. During the first open enrollment period, there was a significant shortfall in available assister funding and staff, and, as a result, nearly half of all marketplace assister programs reported having to turn away at least some consumers who sought help during the final weeks of the first open enrollment period (Pollitz, Tolbert, and Ma 2014). Additionally, the call centers, designed to aid individuals enrolling in coverage, may have been underfunded to some extent. Many states and the federal government appeared to have underestimated the time it would take to complete the enrollment process and the level of training call center staff would require, and if that was the case, at least some of the centers were underfunded (Dorn 2014c). Furthermore, accountability requirements are needed.

Outreach resources vary substantially across states, with enrollment levels reflecting public and private efforts made (Blumberg, Holahan et al. 2014; Blumberg, Kenney et al. 2014; Wishner, Spencer, and Wengle 2014). In some states, resources were concentrated in urban centers; that strategy often

made sense in the first year because of large numbers of uninsured persons being contacted. However, harder to reach populations in rural areas, those not speaking English, and others with cultural sensitivities requiring additional assistance and contact from community members to enroll often did not get sufficient attention as a consequence. Each year, the remaining uninsured are likely to be more challenging to enroll, and thus resources required to enroll each person still uninsured are likely to be higher, not lower, over time. In addition, changes to premiums, plan offerings, financial assistance eligibility, and life circumstances mean that the modest-income individuals already insured will continue to need assistance if they are to stay covered. Many of those not used to having private insurance are likely to need assistance to understand how to use the coverage they have gained; if that assistance is provided, it is likely to increase coverage retention rates.

It is unclear what the plan is for future federal funds devoted to outreach and enrollment; if they decline, it would hamper future enrollment and retention. The ACA requires that navigators be funded through marketplace operating revenues. However, outside of New York, it is not apparent that any of the marketplaces (including FFMs) have committed core funding to this purpose as is required. Already there has been a dramatic decline in private funding efforts, such as Enroll America.

However, the need continues. The Urban Institute's Health Reform Monitoring Survey found that large numbers of people lacked understanding of basic health insurance terms, including deductible, co-payment, co-insurance, premiums, and out-of-pocket maximums (Blumberg, Long et al. 2013). And, although health insurance literacy should properly be addressed on its own, it certainly adds to the challenge that navigators and assisters face in enrolling members. The broad array of plan options available in many areas and the complexity of the financial implications of choosing among them mean that many of those individuals eligible for marketplace financial assistance would benefit from knowledgeable assistance and many will not enroll or will not stay enrolled without it. And, as noted, more effective targeting of these resources to hard-to-reach populations is necessary.

Proposal

Sufficient funding is critical to maintain well-trained and -operated in-person assistance and call centers throughout the year. Treating these personnel, who are as critical to the ACA success as the IT system, as temporary or intermittent employees available during open enrollment periods ignores the importance of their knowledge and expertise in handling complicated situations that they gain through experience each year. Systems designed to save money by releasing trained, experienced staff during months of low enrollment activity are short sighted. Also, the effort in many states during the special

enrollment period has been insufficient. Many marketplaces seem not to have engaged brokers in outreach and enrollment activities to the extent advantageous.¹⁶ Some of the lower-than-desirable level of broker involvement relates to the IT system shortfalls discussed earlier, but in some marketplaces, it also relates to the lack, or belated realization, of the contributions that brokers can make to achieving marketplace goals. As has been demonstrated in particular circumstances, those issues can be overcome.

We propose ongoing federal support for all forms of customer service, including call centers, application assistance by navigators and brokers, advertising and outreach, and eligibility determination in both state-based marketplaces (SBMs) and FFMs. The federal government partially recognized this need when it recently announced additional navigator grants for FFMs and state partnership marketplaces in the amount of \$67 million for 2016, with grants renewable for two additional 12-month periods (CMS 2015b). Funds should be allocated on the basis of the number of uninsured and marketplace enrollment. Fiscal incentives are likely to lead to underinvestment in these activities in many states, as some states fear the consequences of increasing premium assessments or general revenues when their neighbors do not. As a result, the amount of revenue from premium assessments will likely be insufficient to cover all of the necessary costs. The federal government has a strong continuing interest in maximizing enrollment and reducing the number of uninsured, and achieving these goals will require some ongoing funding to ensure adequate outreach and enrollment efforts. It is important to build a core infrastructure of skilled, professional consumer assistance personnel. Doing so requires more investment than has been made to date. Once established, an ongoing commitment must be made to fund the staff through the operational funds of the marketplace.

In FFM states, funds could be made available to states that apply and meet specified federal standards. The standards might include standards for (1) competency and continuing education, (2) the establishment of strong ties with the communities they serve, (3) accessibility for persons with disabilities and other limitations, (4) bilingual skills and cultural competency, (5) work with targeted vulnerable subpopulations, (6) effective partnerships and referral networks, (7) outreach and assistance for people experiencing mid-year changes in circumstances, and others. Or, the funds could be used by the federal government to conduct the same activities in states that do not apply or meet federal standards. SBM states would also have to apply and meet the same federal standards for how the funds are employed. Emphasis of the standards would be placed on improving and maintaining call center functions, all forms of application assistance, and continued outreach and education, including a focus on harder-to-reach populations. Again, estimating the appropriate level of financial support is very difficult, but we believe, based on spending levels in several states, that a rough estimate of the ongoing

requirements is about \$16–20 billion over 10 years. We assume that about half of this would come from states through premium assessments or general revenues. Thus the amount that would be required in a new federal grant program would be \$8–10 billion over 10 years. Again, experts experienced in this area should be tasked by CMS to delineate necessary requirements and resources and develop a strategy for putting them in place to maximum effectiveness.

Administrative Capacity: Regulatory Oversight and Enforcement

Finally, regulatory oversight by private insurance markets is also underfunded. Regulatory loopholes and the lack of diligent regulatory oversight can undermine the goals of reform. A central premise of the ACA is that coverage would continue to rely in large part on private insurance markets but that states and the federal government would regulate them to assure that the markets treat all individuals without regard to health status and risk and to ensure sufficient provider networks to adequately meet enrollee needs. State departments of insurance have more resources than previously because of federal rate review grants. But states remain understaffed, and the regulations to enforce some of the ACA's original policy intentions in this area can be weak or absent at both the state and federal levels.

Regulatory oversight, tracking, and analysis of network adequacy, discriminatory policy designs, insurer transparency, compliance with essential health benefit requirements, and meaningful difference rules are likely not receiving sufficient attention in most states, potentially leading to problems for those with serious health conditions down the road. In addition, five states (Alabama, Missouri, Oklahoma, Texas, and Wyoming) chose not to enforce the ACA's market regulatory reforms, leaving that responsibility to the federal government (Keith and Lucia 2014). Regulatory loopholes, such as self-insurance and ERISA bona fide association health plans, have the potential to undermine market reforms, especially in small group markets in many states, yet extremely little activity has been undertaken to track the extent to which these loopholes are being employed.

Very little federal resources were given to support oversight and enforcement functions at the state level, although some marketplace establishment grants went to state departments of insurance and some of the funds might have been used for additional hiring. However, in general, states do not have substantial resources for these purposes. Thus, significant investment is needed to enhance efforts in the states with both SBMs and FFM.

In addition, the federal government itself needs additional resources to fulfill its role in oversight functions. Federal agencies, including the CMS (responsible for oversight of HIPAA private health insurance protections) and the Department of Labor (responsible for oversight of self-insured employer-sponsored health plans) were already understaffed for their pre-ACA regulatory responsibilities (Block 2008; Berg 1997), and the new ACA-related responsibilities are most certainly underfunded as well. The federal agencies have yet to issue regulations to implement the insurer transparency requirements provided for in *Section 2715A of the Public Health Service Act* and *Section 1311(e) of ACA*, information critical to appropriately monitoring insurer practices under the act. Data collection under this section includes claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of claims that are denied, data on rating practices, information on cost-sharing and payments with respect to out-of-network coverage, information on enrollee and participant rights under the title, and other information as determined appropriate by the Secretary of Health and Human Services (HHS). Not only must regulations be issued to implement the data requirements of this section, but funds must be provided to do timely analysis of the data provided by insurers under the section as a necessary component for oversight and enforcement of the market rules.

Proposal

Although the ACA provided states with short-term rate review grants that allowed many state departments of insurance to hire their own actuaries for the first time, funds were not provided to extend capacity in other areas of import to the ACA, such as form review, consumer support, market conduct, or data collection and analysis. To support rate review and these other critical functions on an ongoing basis, we suggest providing a new grant program to states. As above, states could be required to support a share of the costs by using some of their premium assessments or using general revenues. This amount would significantly increase state regulatory capacity but would still require additional funds from states to meet all the new needs. The federal government could take on those responsibilities in states in which adequate effort is absent. Federal insurance regulation and oversight funds should be increased, totaling about \$3–5 billion over 10 years.

As already noted, however, funding is not the only need for improvement in this area. New and better data requirements are critical. In addition to regulations to implement the 2715a transparency requirements, the secretary of HHS should commit to sharing data with state and federal regulators, creating a system of cooperative oversight. And if federal regulation is an effective fallback option, the

federal government needs to have accurate information on the states' regulatory processes, with some capacity to verify how those systems are working in practice and a commitment of resources to provide for direct oversight and regulation when warranted.

Additional Funding Necessary to Address the Shortfalls in the Current System

We see the following additional funding needs:

- Decrease the premium tax credit percent-of-income caps, eliminate indexing of the caps, and extend the highest income cap to those above 400 percent of FPL, change the reference premium to gold rather than silver coverage, and make further adjustments to reduce cost-sharing burdens on modest-income individuals and families;
- Move the affordability threshold (exemption level for the individual mandate penalty) to 8.5 percent of income, making the employer-sponsored insurance firewall for single coverage consistent with the affordability threshold, and adding an employer-sponsored insurance firewall threshold for family coverage;
- Permit states to expand their Medicaid programs to 100 percent of FPL instead of 138 percent and accommodate in the marketplaces all of those individuals in the 100–138 percent of FPL income group who otherwise would have been eligible for Medicaid;
- Provide additional investment in IT systems at the state and federal levels, additional and ongoing funding for outreach and enrollment assistance through in-person assisters and call centers, and additional funding to improve regulatory oversight and enforcement at the state and federal levels;

Our preliminary estimates of the federal costs of those proposed changes are summarized in table 8. The estimates of appropriate levels of spending on enhanced administrative capacity are challenging to develop, and further analysis with inputs from state marketplace administrators, IT experts, in-person assisters, and insurance regulators is clearly warranted. In addition, it is worth exploring the potential for tying at least some of the proposed grants to additional contributions to these specific functions by states to increase the likelihood that the total investments in these areas will reach sufficient levels to meet the goals and objectives of the law.

TABLE 8

Summary of Preliminary Federal Cost Estimates Associated with Proposed Changes, 2016–2025

Cost Estimates	Amount (\$ billions)
Improving Premium and Cost Sharing Subsidies	\$221
Increasing State Medicaid Expansion Options	\$100-\$200
Federal Grants for IT	\$4-\$6
Federal Grants for Outreach and Enrollment	\$8-\$10
Federal Grants for Insurance Regulation	\$3-\$5
Total Costs of Financial Assistance Enhancements and Administrative Upgrades	\$336-442
Fixing the Family Glitch ^a	\$117
Grand Total, Including Increased Spending due to Regulatory Correction to Family Glitch	\$453-\$559

^a Fully \$78 billion of the increased federal spending associated with this fix could be addressed without Congressional action through Internal Revenue Service regulatory authority. As such, Congress would not have to raise additional revenues to finance it. The remaining \$39 billion is the additional costs of fixing the family glitch in the context of our proposed enhanced premium tax credits and cost-sharing reductions.

Ways to Pay for the Reforms

We estimate that making the changes discussed in the previous section would cost about \$453–559 billion over 10 years, with \$78 billion of this amount not requiring additional revenues to finance it as noted in the previous section. Although seemingly a large sum, it is actually a relatively small amount if the goal is to have the ACA succeed. To put the amount in perspective, \$453–559 billion is 0.20–0.24 percent of GDP over 10 years. Clearly, it is a manageable amount; the problem is the political will to raise the additional revenue. It is also worth reiterating that the ACA, along with health care spending overall, is considerably lower than originally anticipated. As noted previously, the CMS actuaries originally estimated that national health expenditures would increase by \$575 billion between 2014 and 2019—the cost of the coverage expansions less cuts in Medicare and Medicaid. More recent estimates show reductions in health spending growth; national health expenditures are now forecast to be \$2.5 trillion below the forecast made just four years ago for the period 2014 to 2019 (Holahan and McMorro, 2015). Thus, the lower than expected health care spending is more than enough to compensate for the increased investments in the program that we propose.

Although it is feasible to pay for these changes, increasing revenues is obviously politically challenging. CBO routinely provides a range of options for raising revenue and addressing the nation's debt. Even if we limit the discussion to health-related revenue options, a range of possibilities exist. However, the options delineated here are meant to be illustrative; many more sources of revenue could be considered, particularly sources unrelated to health per se. Any could be used as substitutes or complements to these options.

Increase Drug Rebates for Dual Eligibles

One option is to increase the minimum rebate on drugs covered under Medicare Part D for low-income beneficiaries. With the establishment of Medicare Part D in 2006, Medicaid dual eligible beneficiaries became eligible for Medicare drug benefits. That meant that drug manufacturers no longer had to pay the significant rebate on drug purchases by Medicaid enrollees—currently 23.1 percent of the average manufacturer's price for sales to retail pharmacies. With the establishment of part D, drug purchases by dual eligible beneficiaries (low-income individuals eligible for both Medicare and Medicaid) receive the same rebates as other Medicare beneficiaries which are dependent upon negotiations between part D plans and drug manufacturers. This option would extend the 23.1 percent Medicaid drug rebate to dual

eligibles. Any other rebates provided to part D plans would be subtracted from the 23.1 percent rebate. This approach would reduce federal outlays by \$103 billion between 2015 and 2024.

Additional Cigarette and Alcohol Taxes

According to recent CBO estimates, increases in these taxes would reduce cigarette and alcohol consumption and thus provide health benefits as well as revenues. Increasing the cigarette tax by 50 cents per pack would yield \$34.7 billion over the 2015–2024 period. Increasing the tax on alcoholic beverages by \$16 dollars per proof gallon would increase federal revenues over the same period by \$66 billion.

Increase in the Medicare Hospital Insurance Tax

A third option is to increase the Medicare hospital insurance tax by 0.2 percentage points, 0.1 percent on employers and the same on employees. This would increase the combined hospital insurance tax on most workers from 2.9 percent to 3.1 percent of earnings, yielding \$160 billion over 10 years, according to CBO. There is precedent for using the Hospital Insurance Tax for ACA funding. Also, evidence indicates that individuals' Medicare tax contributions do not fully pay for their future part A expenses (CBO 2014); there is also evidence that increases in insurance coverage before age 65 reduce Medicare spending (Hadley and Waidmann 2006), so there is an economic case for using the hospital tax revenues to support expanded coverage under the ACA.

Replace the ACA's High Cost Plan Tax with a Cap on the Tax Exclusion for Employer-Sponsored Insurance

A fourth option is to cap the current tax exclusion of employer-sponsored insurance premiums and medical benefits from taxation. The current exclusion reduced federal income and payroll taxes by \$335 billion in 2013 (US Department of Treasury 2016). It is by far the largest tax expenditure in the US tax system and has been criticized for providing far greater benefits to high-income individuals than to low-income individuals, for encouraging overly comprehensive coverage, and for contributing to high

health care costs. If a cap were implemented, it would work best as a replacement for the ACA's excise tax on high cost employer-sponsored insurance plans.

The ACA currently has an excise tax on a portion of certain high cost employer-sponsored insurance plans. The excise tax is 40 percent on the difference between the total value of employer and employee contributions and the applicable thresholds—\$10,200 for single coverage and \$27,500 for family coverage—and will apply to individuals regardless of income. The excise tax begins in 2018 and is scheduled to bring in \$87 billion between 2018 and 2025, largely because of expected increases in taxable compensation (wages and salaries) as employers reduce nontaxable compensation (health insurance) (CBO 2015b). Because the thresholds are set at high levels, the new tax affects relatively small numbers of people in the early years, but the number of people affected grows over time because the thresholds are indexed to the consumer price index and this becomes increasingly binding over time if health care costs grow faster than general inflation. Thus, how much the number of people affected increases depends on the level and growth in health care premiums; the slowdown in health care costs has caused CBO to reduce its revenue estimates. Revenues from the excise tax, however, are still modest relative to the overall size of the employer exclusion's total value.

CBO has looked at a range of alternative proposals, including lowering the thresholds for the excise tax. However, a better alternative is to eliminate the excise tax and place a limit on the amount of employer-paid health insurance premiums and contributions to Flexible Spending Accounts, Health Reimbursement Accounts, and Health Savings Accounts that can be excluded from income and payroll taxation.

CBO estimated the revenues from a cap that would be set at the 50th percentile of health insurance premiums paid by employers in 2015, with the thresholds indexed using the CPI-U (consumer price index for all urban consumers). These caps would be \$7,000 for individual coverage and \$17,000 for family coverage in 2019 rather than \$10,550 and \$28,400, respectively, for the excise tax in 2019. The policy would increase revenues by \$537 billion between 2015 and 2023. This accounts for the loss in revenue from the elimination of the excise tax and for the fact that some employers would drop coverage and some individuals would enroll in Medicaid or purchase subsidized coverage through the marketplaces. That amount is more revenue than needed to cover the costs of all the ACA fixes proposed in this paper. And there are other possible sources of revenue which could also be used and could allow the cap to be set at a higher threshold, say, the 70–75th percentile of health insurance premiums or to exempt some lower-income workers from the tax.

Each Option Varies in Its Distributional Implications

The four options presented here vary greatly in their incidence. The increase in drug rebates would fall on the drug manufacturers and potentially their consumers. The cigarette and alcohol taxes tend to be regressive. The Medicare hospital tax would be roughly proportional in incidence. Eliminating the tax exclusion from employer contributions to health insurance would be more progressive; about 80 percent of benefits of the exclusion currently accrue to the top three income quartiles. Placing a cap on employer contributions to health insurance has been very controversial politically, but it is hard to justify a tax benefit that so disproportionately benefits the highest income Americans. Reallocating a fairly small amount of resources to support lower income groups seems appropriate.

Table 9 sums up the revenue estimates of each option. More revenue is available from these options than is needed to fund the changes to the ACA discussed in this paper. Some mix of these revenue sources at appropriate levels or in some combination with others options may be the best solution.

TABLE 9

Examples of Financing Options for Proposed Reforms

Financing Options	Amount (\$ billions)	Years
Capping the Tax Exclusion of Employer Contributions at 50th Percentiles	\$537.0	2014–2023
Increase Cigarette Tax by \$0.50 Per Pack	\$34.7	2015–2024
Increase Alcohol Tax by \$16 Per Proof Gallon	\$66.0	2015–2024
Increase Medicare Hospital Insurance Tax by 0.2%	\$160.0	2015–2024
Impose Higher Minimum Rebate on Drugs Covered Under Part D of Medicare for Low Income Beneficiaries	\$103.0	2015–2024

Source: Congressional Budget Office 2013 and 2014.

Conclusion

In this paper we have argued that the ACA has already achieved some major milestones. The law has reduced the number of uninsured Americans by about 15 million people. It has reformed the nongroup insurance market, no longer allowing insurers to discriminate against high-risk individuals.

Furthermore, the marketplace has been structured to assure considerable competition and has resulted in surprisingly moderate premiums in 2014 and 2015. Health care growth has been slow by historical standards, in part because of policies adopted in the ACA. In contrast to fears of widespread employer dropping of insurance coverage, there appears to have been no loss in employer-sponsored insurance. Finally, there have been no adverse effects on employment.

But at the same time, there are many reasons to believe the law is underfunded. The original budgetary cost for the ACA's coverage expansion was under \$1 trillion, with financing coming from a combination of cuts in Medicare and Medicaid and new taxes. The amount that many individuals are expected to pay in premiums is still relatively high as a percentage of income. Further, premium subsidies were tied to silver-level (70 percent AV) plans, a metal tier that has relatively high deductibles and other forms of cost-sharing. The high premiums coupled with high cost-sharing not only can lead to substantial financial burdens for some people, but also may have an adverse effect on enrollment. Further, the premium tax credit caps are indexed to increase over time as medical costs grow faster than general inflation, meaning that household financial burdens will increase over time as well. Another problem is that families that include a worker who has an affordable employer offer are typically not eligible for financial assistance in the marketplaces, even if the cost of family coverage through the employer is very high. Finally, as of this date, 21 states are not participating in Medicaid, leaving large numbers of very low income individuals without coverage.

In addition, the administrative functions in the law have been underfunded considerably. IT systems continue to need upgrades and ongoing operational support. Efforts at education, outreach, and enrollment assistance are in need of more federal financial support. Finally, increased support is needed at the federal and state levels for oversight and enforcement of insurance regulations; the premise of the law is that we can build upon a regulated private insurance market and doing so requires adequate resources.

Given this set of problems, we propose reducing the amount of nongroup insurance premiums that individuals are expected to pay at each income level to make coverage more affordable. We would tie premium tax credits to gold plans rather than to silver (80 percent AV rather than 70 percent) and

improve cost-sharing subsidies for low-income people. Further, we propose eliminating the indexing of premiums tax credits so that their value does not erode over time. We would fix the family glitch by allowing family members to obtain subsidized coverage through the marketplaces even if one of the adults has an affordable offer of single coverage. We would modify the ACA's affordability standard to make it consistent with the highest nongroup premium tax cap that we propose and the employer-sponsored insurance firewall exemption level.

Next, we would address the reluctance of the 21 states to expand Medicaid up to 138 percent of FPL by giving all states the option of extending coverage up to 100 percent of FPL. Many states that have ideological reasons for opposing expansion of Medicaid are more comfortable covering individuals below the poverty level in public insurance programs, and thus this option may induce many of the remaining states to participate. It may also result in many states that are already covering individuals up to 138 percent of FPL reducing coverage levels to those technically in poverty. Moving some current Medicaid enrollees into marketplace plans clearly comes with trade-offs. For example, some consumers would have modest increases in out-of-pocket costs, although our improved subsidy schedule would limit that exposure. All enrollees would be subject to open enrollment period requirements, which Medicaid does not have. Some states provide additional services through Medicaid (e.g., transportation to providers) that may not be covered in marketplace plans, but some people would gain access to a broader set of providers than they have in the Medicaid program. States with Medicaid expansions are clearly experiencing larger increases in coverage than nonexpansion states (Long et al. 2015), and if the approach moves more states to participate, it would go a long way toward redressing the indefensible inequity of subsidizing higher-income individuals while providing no assistance to many of the nation's poorest residents.

Taken together, these measures designed to improve affordability would increase enrollment to levels at least commensurate with original projections and likely to even higher levels. We also propose additional funds to support IT system development and ongoing improvements, support for state education, outreach and enrollment assistance efforts, and for increased oversight and enforcement of federal and state insurance regulations.

Our preliminary estimate of the total cost of these reforms is \$453–559 billion over the 10-year period 2016–2025, with \$78 billion of this amount not requiring additional revenues to finance it as noted previously. We estimate that improving the premium and cost-sharing subsidies would cost \$221 billion. Fixing the family glitch would add another \$117 billion, although fixing this problem through federal regulations means having to raise revenue for only a fraction of that cost. The option to extend Medicaid to 100 percent of FPL would cost \$100–200 billion in new Medicaid and subsidy costs,

depending on how nonexpanding and expanded states respond to the new option. A rough estimate for increasing the financing of administrative functions (IT, outreach and enrollment, oversight and enforcement of insurance regulations) is an additional \$15–21 billion. Although a large sum taken together, these additional investments would add only 0.20 to 0.24 percent of GDP to the cost of the program. The current costs of the coverage expansions in the program have been estimated to be 0.74 percent of GDP. Even expenditures of 0.94–0.98 percent of GDP to solve a major national problem do not seem excessive. As we have pointed out, national health expenditures over the period 2014–2019 were projected in 2014 to be \$2.5 trillion less than originally projected in 2010, and thus these proposed investments would cost substantially less than national savings resulting from lower than expected national health expenditures.

We propose several ways in which these costs could be paid for. The first option is to extend Medicaid drug rebates to all dual eligibles, providing \$103 billion over 10 years. Increases in cigarette and alcohol taxes, a second option, have been estimated by CBO to result in \$34–66 billion, respectively, over 10 years. Increasing the Medicare hospital insurance tax on wages by 0.2 percent would yield another \$160 billion, a third financing option. Finally, eliminating the excise or “Cadillac” tax and replacing it with a cap on the employer-sponsored insurance tax exclusion for health care costs above a certain threshold would yield a large sum of money. For example, a cap at the 50th percentile of employer-based insurance costs would yield \$537 billion over 10 years, even after accounting for added Medicaid and subsidy costs resulting from some employer dropping of coverage. If a mix of the other aforementioned revenue sources or others not mentioned here were used, nowhere near this much money would be required from the employer exclusion. Setting the cap, for example, somewhere between the 70th–75th percentile of employer-based insurance costs and combining that revenue with some of the other possible revenue sources would yield sufficient funds.

We have not attempted to address all of the important issues related to the ACA and health insurance affordability here. For example, low-income workers with access to employer-based coverage deemed affordable under the ACA are not currently provided financial assistance, yet many face high cost-sharing requirements that could limit their access to necessary care. Providing cost-sharing subsidies to this population is another area worthy of analysis and policy development. Some controversial components of the ACA which do not play a fundamental role in the coverage expansions could be debated as possible trade-offs for further investments like those proposed here. Such components include the employer mandate and the Independent Payment Advisory Board (IPAB). As we have shown elsewhere, the employer mandate contributes little to coverage but has resulted in considerable business opposition to the law overall. Given IPAB’s limited authority to control Medicare

costs and the slowdown in Medicare cost growth to levels below the targets which would trigger action by the IPAB, it may be another candidate for tradeoffs.

However, it is essential that policymakers preserve the structural pillars of the ACA while taking steps necessary to redress the underinvestment in the commitments it represents. Affordability of insurance coverage remains a significant barrier for many of the remaining uninsured and some of those already covered. Both premiums and out-of-pocket costs for the entire family unit must be considered in combination to ensure effective access to necessary medical care. Although the ACA has made substantial advances in this regard, we have further to go to ensure that the law meets its objectives of providing access to adequate and affordable coverage for all Americans. Failing to do so will likely inhibit the law from meeting its insurance coverage goals over time and will leave many low-income and middle-income Americans with heavy health care financial burdens.

And while affordability remains a substantial barrier to coverage, one cannot overestimate the importance of a sufficiently funded administrative structure to support the processes of enrolling individuals in coverage and ensuring that the consumer protections promised by the ACA are implemented effectively. Private insurance markets provide choices in cost-sharing options, provider networks, and benefit design that many consumers value. However, these options require sufficient numbers of well-trained assisters to ensure the health insurance programs reach the intended populations and allow them to make effective insurance decisions; a smoothly operating IT system with an easily managed consumer interface and an underlying set of complex functions serving government, insurers, and assisters of different types; and an effective level of oversight and enforcement such that competition between insurers flourishes on quality and efficiency instead of on the history of enrolling individuals with the best possible health care risks.

It is too much to expect that a single piece of legislation could address the many challenges of our health care system. All developed countries continue to modify their health care policies over time, addressing issues and concerns as they are identified. The ACA has been a critical first step in improving the US system. The proposals outlined here represent important subsequent steps that can be implemented well within the national health expenditures originally envisioned when the ACA was passed. The hard work of reform has begun and it has accomplished much in a short period of time, but there is more to do.

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Notes

1. State by state data on marketplace enrollment by year are available at <http://datatools.urban.org/features/marketplace-enrollment/>.
2. Pennsylvania and New Hampshire were excluded from the analysis because they chose to expand Medicaid but had not yet enrolled individuals into Medicaid.
3. The premium charged for a 64-year-old cannot be more than three times that of the youngest adult, and a smoker cannot be charged more than 1.5 times the premium of a nonsmoker of the same age.
4. Dan Mangan, "Feds Give 2-Year Grace Period for Non-Obamacare Plans," *CNBC*, March 5, 2014, <http://www.cnn.com/id/101469265#>.
5. Those paying more now due to ACA policies that prohibit price and benefit discrimination based on health status and limit price differences based upon age tend to be young, healthy adults who are likely to benefit financially and via increased access to care due to these new policies as they age and incur health problems.
6. Michael Ollove, "Is Affordable Care Act Really Affordable for All?" *USA Today*, January 14, 2014, <http://www.usatoday.com/story/news/nation/2014/01/14/stateline-obama-health-care/4471957/>.
7. Each year the caps are indexed to increase as a function of health care cost growth relative to general inflation. As a consequence, the caps are already slightly higher in 2015 than they were in 2014.
8. Calculations based upon the second lowest cost silver plan available in Chicago. Source: healthcare.gov.
9. Estimates of household health care financial burdens under the ACA were produced by Matthew Buettgens using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).
10. Estimated by Matthew Buettgens using the Urban Institute's HIPSM.
11. Cost-estimates for these changes were produced by Matthew Buettgens using the Urban Institute's HIPSM.
12. Authors' calculation based on MEPS-IC 2013 averages, assumes 5 percent growth in average contributions per year for both single and family coverage.
13. S.2434 (113th): Family Coverage Act, available at <https://www.govtracks.us/congress/bills/113/s2434>.
14. Estimates of the cost of eliminating the family glitch were produced by Matthew Buettgens using the Urban Institute's HIPSM.
15. We hesitate to propose that all of these states with insufficient systems join healthcare.gov until it is clear that system will be able to interact seamlessly with state Medicaid enrollment processes in the future.
16. Sabrina Corlette, Linda J. Blumberg, and Erik Wengle, *Insurance Brokers and the ACA: Early Barriers and Options for Expanding Their Role* (Washington, DC: Urban Institute, 2015).

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Linda Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decision-making and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in select states and nationally. Examples of other research include codirecting 22 state case studies of stakeholder perspectives on ACA implementation, assessing the implications of self-insurance among small employers on insurance reforms, and comparing the importance of employer and individual mandates in reaching ACA objectives. She also led the quantitative analysis supporting the development of a “Roadmap to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

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