

Health Status of Exchange Enrollees: Putting Rate Shock in Perspective

Timely Analysis of Immediate Health Policy Issues

July 2013

Linda J. Blumberg and John Holahan

Summary

Recent news reports have focused on the health insurance premiums that will be available to those purchasing nongroup insurance under the Affordable Care Act's (ACA) reforms that will be implemented in 2014. Many stories originally focused on "rate shock"—the concern of insurers and others that some of those with current nongroup coverage will face significantly higher premiums once the nongroup market becomes more accessible and affordable for those with health problems. More recently, however, stories have focused on premiums made public in some states, where several insurers (although not all) are identifying the reforms as a significant expansion opportunity and are setting premiums competitively in order to continue to attract lower-cost enrollees, whose enrollment decisions are the most sensitive to high prices. While some have been surprised at the lower premium bids in light of the pervasive "rate shock" warnings in political circles, these premiums are consistent with the findings of the analysis presented here.

We compare the population most likely to enroll in the ACA's nongroup market exchanges to those who now have employer coverage, focusing on characteristics related to their health risks. This comparison seems apt, since there is widespread agreement that the large population enrolled in employer-based insurance coverage constitutes an actuarially sound, long-term sustainable risk pool. To the extent that the population likely to enroll in the nongroup exchange and nonexchange markets under the ACA is similar in health-related characteristics to the larger employer-based market, unsubsidized premiums in the reformed nongroup market should be set at reasonable levels.

While individuals with higher-than-average health care needs may be somewhat more likely to enroll in the nongroup market in the first year, once past the transition period, the health characteristics of nongroup enrollees can be expected to be quite similar to those with employer-based insurance. The exchange target population is slightly less likely to report excellent, very good or good physical and mental health; less likely to report any of several chronic conditions; more likely to be smokers (although the simulated enrollment population is less likely to smoke); and less likely to be obese than those with employer insurance. Many exchange enrollees will receive subsidies—premiums paid by enrollees will be based on a percentage of income—so the availability of subsidies will reduce any impact of total premiums being somewhat higher in the first year of implementation. If the exchange target population does not participate at the rates predicted given their characteristics, however, premiums could be higher than what we observe in the employer-based market.

Background

Beginning January 1, 2014, the Affordable Care Act (ACA) will bring significant changes to the private nongroup insurance market, including new prohibitions on health status–related discrimination in pricing, enrollment and benefits provided. The law also creates nongroup health insurance exchanges in each state designed to increase competition and transparency in insurance, and provides financial assistance for nongroup insurance purchasers with modest incomes. These reforms constitute significant changes to the currently small

and generally exclusive nongroup insurance market. And with major change often comes uncertainty and concern over the implications.

Recent months have seen a mix of news reports, ranging from insurers and others worried that the premiums charged for nongroup exchange enrollees under reform would be very high—sometimes characterized as "rate shock"—to more positive stories of late reported on some lower than expected insurance premium

bids in particular states. Generally, concerns center around whether some of those with current nongroup coverage will face significantly higher premiums than they do today once the nongroup market becomes more accessible and affordable for those with health problems. Specifically, many have raised concerns that some young adults with very low cost limited-benefit policies today who are not eligible for subsidies will see significant increases in premiums. Policy-maker and stakeholder worries over premiums also reflect



Robert Wood Johnson Foundation

 **Urban Institute**

carriers' fears of adverse selection—that those with higher medical needs will be overrepresented in particular health plans or markets, or that, in the beginning of implementation, those in worse health, for example, will be the first to enroll in the new exchanges while those in good health will delay enrolling.

For these reasons, some insurers could set premiums at relatively high levels in the first year of health reform implementation. However, within an indeterminate but likely short period, large numbers of more moderate-risk individuals are expected to enroll in the nongroup exchanges because of the existence of a more stable, reliable, and adequate source of coverage outside the workplace; the income-related subsidies to lower the cost of premiums and cost-sharing for many; and the new requirement that most individuals obtain insurance coverage or pay a tax.¹ In fact, the federal subsidies, structured to limit the share of income an eligible enrollee must contribute toward his/her own insurance, will shield most exchange enrollees from transitional turbulence in premiums. We are already seeing that, in some states, several insurers (although not all) are identifying the reforms as a significant expansion opportunity and are setting premiums competitively in order to continue to attract lower-cost enrollees, whose enrollment decisions are the most sensitive to high prices.² While some in the media have been surprised at the lower premium bids in light of the pervasive “rate shock” warnings in political circles, these premiums are consistent with the findings of the analysis presented here.

This paper examines the larger picture: what is the post-transition pool of individuals insured in the reformed nongroup market likely to look like? We examine the health-related characteristics of those likely to enroll in exchanges. We focus primarily on those who have nongroup coverage or are uninsured prior to reform. These individuals will make up the bulk of nongroup market enrollment, both inside and outside exchanges. A very small share of those with current employer or Medicaid coverage will obtain nongroup coverage under the ACA, but they are estimated to make up a very small

percentage of this market.³ Consequently, the key analytic question we address here is how those with current nongroup coverage and those currently uninsured compare in health risk to those who now have employer coverage. This comparison seems apt, since there is widespread agreement that the large population enrolled in employer-based insurance coverage constitutes an actuarially sound, long-term sustainable risk pool. (Employer premiums themselves are higher than many would like but this is an overall health system issue; there are many provisions of the ACA that address cost containment.⁴) To the extent that the population likely to enroll in the nongroup exchange and nonexchange markets under the ACA is similar in health-related characteristics to the larger employer-based market, unsubsidized premiums in the reformed nongroup market should be set at reasonable levels.

We also compare the characteristics of those likely to enroll in the ACA's nongroup market to those in public coverage programs. This comparison provides some insight into the risk pool implications of moving significant portions of Medicaid enrollees into the exchange-based risk pools, an idea that is being considered in some states but is not an explicit component of the ACA.⁵ As reported in Appendix Table 1, there are some differences in health status measures between those with nongroup coverage and the uninsured in the exchange target population. For example, nongroup enrollees are more likely to report being in excellent, very good or good physical and mental health than the uninsured but are also more likely to have certain chronic conditions such as arthritis, asthma and high blood pressure. However, exchange enrollees will make up one unified risk pool, regardless of pre-reform insurance status, and as such we combine them into one group here.

We conclude that:

- Any “rate shock” that occurs will be a transitional phenomenon; competition will result in average premiums in the nongroup exchanges at reasonable levels;
- The health status of those expected to enroll in the nongroup exchanges is

similar to those in the employer market today: they are slightly less likely to report being in excellent, very good or good health (92.3 percent versus 93.8 percent), but they are also less likely to report a number of chronic conditions, including arthritis, high blood pressure, diabetes and heart disease;

- Those expected to enroll in the nongroup exchange are significantly less likely than those with employer coverage to smoke (13.7 percent versus 16.8 percent) and are significantly less likely to be obese (23.7 percent versus 27.2 percent);
- While we focus on individual characteristics related to expected use of health care services and do not estimate premiums explicitly, premiums in the reformed nongroup market will reflect the health status similarities with the employer-based insurance pool while differing in administrative costs, cost-sharing and benefits; and
- Enrolling the Medicaid *expansion* population in nongroup exchanges will have little effect on average health risk, although including the pre-ACA Medicaid eligible population would increase the average risk of exchange enrollees significantly.

Data and Approach

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) data file, including data from the Medical Expenditure Panel Survey–Household Component (MEPS-HC), in our descriptive analyses comparing the characteristics of likely nongroup exchange enrollees and employer-based insurance enrollees. HIPSM is a detailed microsimulation model of the health care system. It estimates the cost and coverage effects of proposed health care policy options. HIPSM simulates the decisions of employers, families and individuals to offer and enroll in health insurance coverage. The model predicts the impact of policy on changes in government and private health care spending, uncompensated care costs, health insurance premiums in employer and nongroup health insurance risk pools, rates of employer offers of coverage, and health insurance coverage.⁶

Table 1: Demographic Characteristics of Adults 19–64 with MAGI Above 138% of FPL Without an Affordable Employer-Sponsored Insurance Offer in the Health Insurance Unit (HIU)

	Exchange Target Population: MAGI Above 138% of FPL Without an Affordable Employer-Sponsored Insurance Offer in the HIU				All with Current Employer Sponsored Insurance	
	Current ESI		Current Nongroup/Uninsured			
	N	%	N	%	N	%
Total (19–64)	5,312,200	100.0%	16,197,300	100.0%	110,777,200	100.0%
Age						
19–34	819,900	15.4%*	5,550,700	34.3%	31,517,300	28.5%*
35–54	2,187,100	41.2%*	7,395,100	45.7%	56,597,300	51.1%*
55–64	2,305,200	43.4%*	3,251,500	20.1%	22,662,600	20.5%*
Gender						
Male	2,657,300	50.0%*	9,168,200	56.6%	53,646,300	48.4%*
Female	2,654,900	50.0%*	7,029,100	43.4%	57,131,000	51.6%*
Race/Ethnicity						
Non-Hispanic White	4,494,100	84.6%*	10,612,900	65.5%	80,572,400	72.7%*
Non-Hispanic Black	263,600	5.0%*	1,668,500	10.3%	11,055,400	10.0%
Hispanic	272,900	5.1%*	2,748,100	17.0%	11,574,600	10.4%*
Non-Hispanic Other	281,600	5.3%*	1,167,800	7.2%	7,574,900	6.8%*
Modified Adjusted Gross Income as % of FPL						
Under 138% of FPL	0	0.0%	0	0.0%	7,424,500	6.7%*
138 to 199% of FPL	610,900	11.5%*	4,700,400	29.0%	7,059,300	6.4%*
200 to 299% of FPL	888,600	16.7%*	4,707,000	29.1%	16,237,700	14.7%*
300 to 399% of FPL	740,600	13.9%	2,296,400	14.2%	17,148,800	15.5%*
400% of FPL and Above	3,072,100	57.8%*	4,493,400	27.7%	62,906,900	56.8%*
Employment Status						
Full-Time, Full-Year Worker in HIU	3,204,100	60.3%*	10,422,700	64.3%	95,202,000	85.9%*
Less Than Full-Time, Full-Year Worker in HIU	799,800	15.1%*	4,712,500	29.1%	12,236,100	11.0%*
No Worker in HIU	1,308,300	24.6%*	1,062,100	6.6%	3,339,200	3.0%*
Education Status						
Less Than High School	169,900	3.2%*	1,828,300	11.3%	5,637,100	5.1%*
High School Graduate	1,266,500	23.8%*	5,412,000	33.4%	28,987,500	26.2%*
Some College	1,490,100	28.1%*	5,063,000	31.3%	33,970,100	30.7%*
College Graduate	2,385,700	44.9%*	3,893,900	24.0%	42,182,500	38.1%*

Source: HIPSM 2011

Note: An ESI offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from Nongroup/Uninsured is statistically significant at the $p < .05$ level. This test is not carried out for the exchange target ESI versus all current ESI groups.

Health Insurance Unit (HIU) refers to the family members who can be covered by a single private insurance policy.

HIPSM, which has the Current Population Survey (CPS) as its core, statistically matches data from the MEPS-HC to CPS observations. The current version of HIPSM relies on merged data from the 2009 and 2010 CPS and 2006 to 2008 MEPS-HC, aged to 2011. The MEPS-HC is a longitudinal survey that contains data on insurance coverage, medical expenditures and a large number of health status measures for a large, nationally representative population.⁷ The population of central interest for this analysis is made up of those with current nongroup insurance and those currently uninsured, both groups with incomes above 138 percent of the federal poverty level

(FPL) (i.e., those who will not qualify for Medicaid under the ACA's public program expansion) and who do not have access to an affordable employer-sponsored insurance (ESI) offer in their household. Those with access to an affordable ESI offer (direct premium cost facing the worker for single coverage being less than 9.5 percent of family income) are not eligible for subsidized coverage in the new nongroup exchanges and are much more likely to obtain coverage through the offering employer as opposed to entering the exchange.

We use HIPSM's ACA simulation results of post-reform premiums and insurance offers

in conjunction with family income data to identify the target population for exchange enrollment. The test of access to affordable employer insurance offers eliminates from subsidy eligibility about 95 percent of all workers with employer-sponsored insurance offers and with incomes above 138 percent of FPL. Undocumented immigrants are also excluded from the exchange target population, consistent with provisions of the ACA.

In later results we use HIPSM to assess the health status-related characteristics of the population that the model's full simulation specifically predicts to enroll in the nongroup exchanges under the

Table 2: Health Characteristics of Adults 19–64 with MAGI Above 138% of FPL Without an Affordable Employer-Sponsored Insurance Offer in the Health Insurance Unit

	Exchange Target Population: MAGI Above 138% of FPL Without an Affordable Employer-Sponsored Insurance Offer in the Health Insurance Unit				All with Current Employer Sponsored Insurance	
	Current ESI		Current Nongroup/Uninsured			
	N	%	N	%	N	%
Total (19–64)	5,312,200	100.0%	16,197,300	100.0%	110,777,200	100.0%
General Health						
Excellent/Very Good/Good	4,919,600	92.6%*	14,828,700	91.6%	103,940,100	93.8%*
Fair/Poor	392,600	7.4%*	1,368,600	8.4%	6,837,100	6.2%*
Mental Health						
Excellent/Very Good/Good	4,945,300	93.1%*	14,300,700	88.3%	104,886,000	94.7%*
Fair/Poor	366,900	6.9%*	1,896,600	11.7%	5,891,200	5.3%*
Chronic Physical Conditions						
Arthritis	1,209,700	22.8%*	2,283,900	14.1%	17,011,000	15.4%*
Asthma	497,600	9.4%*	1,180,900	7.3%	9,975,700	9.0%*
Diabetes	446,100	8.4%*	909,300	5.6%	6,653,300	6.0%*
Emphysema	39,000	0.7%*	208,500	1.3%	513,500	0.5%*
Heart Disease ¹	505,300	9.5%*	1,005,000	6.2%	7,003,100	6.3%
High Blood Pressure	1,560,000	29.4%*	3,244,400	20.0%	24,905,500	22.5%*
Stroke	94,300	1.8%*	192,200	1.2%	1,080,600	1.0%
Current Smoker						
Yes	858,800	16.2%*	4,382,400	27.1%	18,599,500	16.8%*
No	4,453,400	83.8%*	11,814,900	72.9%	92,177,700	83.2%*
BMI						
Underweight (< 18.5)	45,600	0.9%*	295,300	1.8%	1,482,100	1.3%*
Normal Weight (18.5–24.9)	1,733,600	32.6%*	6,039,400	37.3%	39,916,200	36.0%*
Overweight (25.0–29.9)	2,016,100	38.0%	6,089,700	37.6%	39,204,900	35.4%*
Obese (30.0+)	1,516,800	28.6%*	3,772,800	23.3%	30,174,100	27.2%*
Limitation in Physical Functioning ²	536,800	10.1%	1,524,800	9.4%	6,615,800	6.0%*

Source: HIPSM 2011

Note: An ESI offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from Nongroup/Uninsured is statistically significant at the $p < .05$ level.

¹ Heart disease includes heart attack, coronary heart disease, angina and other heart disease as defined in the MEPS-HC.

² Includes difficulty lifting 10 pounds, walking up 10 steps, walking 3 blocks, walking a mile, standing for 10 minutes, bending over or stooping, reaching overhead, and using fingers to grasp.

Health Insurance Unit refers to the family members who can be covered by a single private insurance policy.

ACA. The model predicts employer offer decisions and household/individual coverage decisions given the options and incentives available under different policy environments. People can enter exchanges by leaving employer plans, moving from current nongroup coverage to exchange-based nongroup coverage, or by gaining coverage after having been uninsured. If some of the small number of states that have already expanded Medicaid eligibility above ACA levels eliminate Medicaid eligibility for groups with incomes above 138 percent of FPL in response to the reforms, some people will switch from Medicaid to exchange coverage.

HIPSM considers various characteristics, such as age, health status, health expenditures, socioeconomic information, and preferences revealed by pre-reform

coverage choices to predict who will enroll in coverage. Thus, this approach provides a more nuanced alternative for predicting the characteristics of those who will enroll in exchange-based coverage post-reform, compared to the first set of results presented in the paper that focus on a larger group of potential enrollees. HIPSM simulates the effects of policy changes in equilibrium, and as such the results presented do not represent short-term effects that may occur during a transition period.

Finally, there has been an interest on the part of several states in potentially enrolling their Medicaid expansion populations—those with incomes below 138 percent of FPL—in private plans in the exchanges rather than through traditional Medicaid programs and exclusive Medicaid managed care plans. One important concern with such an approach is

the implication of merging at least a portion of the Medicaid eligible population into the insurance risk pool with the exchange enrollees.⁸ Does the Medicaid expansion population tend to be sicker than those with incomes above 138 percent of FPL who are likely to enroll in the exchanges? How would the risk pool differ if all nonelderly Medicaid enrollees are placed into exchange plans? If Medicaid enrollees' health profiles differ significantly from the profile of expected exchange enrollees, merging the pools together could have significant premium implications for the exchange populations, with particularly significant financial implications for those enrolling without federal subsidies. Again, we use HIPSM simulations of Medicaid eligibility and enrollment under the ACA to identify the appropriate populations for analysis.

Table 3: Health Characteristics of Adults 19–64 Simulated to Enroll in Nongroup Exchange Under ACA

	Simulated Nongroup Exchange Enrollment, Above 138% of FPL, Without Affordable Employer Offer ³		All with Current Employer-Sponsored Insurance	
	N	%	N	%
Total (19–64)	9,186,500	100.0%	110,777,200	100.0%
General Health				
Excellent/Very Good/Good	8,476,300	92.3%	103,940,100	93.8%*
Fair/Poor	710,200	7.7%	6,837,100	6.2%*
Mental Health				
Excellent/Very Good/Good	8,351,700	90.9%	104,886,000	94.7%*
Fair/Poor	834,800	9.1%	5,891,200	5.3%*
Chronic Physical Conditions				
Arthritis	1,255,000	13.7%	17,011,000	15.4%*
Asthma	672,400	7.3%	9,975,700	9.0%*
Diabetes	486,100	5.3%	6,653,300	6.0%
Emphysema	87,100	0.9%	513,500	0.5%*
Heart Disease ¹	481,600	5.2%	7,003,100	6.3%*
High Blood Pressure	1,725,100	18.8%	24,905,500	22.5%*
Stroke	84,500	0.9%	1,080,600	1.0%
Current Smoker				
Yes	1,257,200	13.7%	18,599,500	16.8%*
No	7,929,300	86.3%	92,177,700	83.2%*
BMI				
Underweight (< 18.5)	169,100	1.8%	1,482,100	1.3%*
Normal Weight (18.5–24.9)	3,396,700	37.0%	39,916,200	36.0%
Overweight (25.0–29.9)	3,443,300	37.5%	39,204,900	35.4%*
Obese (30.0+)	2,177,400	23.7%	30,174,100	27.2%*
Limitation in Physical Functioning ²	742,100	8.1%	6,615,800	6.0%*

Source: HIPSM 2011

Note: An ESI offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from Nongroup Exchange is statistically significant at the $p < .05$ level.

¹ Heart disease includes heart attack, coronary heart disease, angina and other heart disease as defined in the MEPS-HC.

² Includes difficulty lifting 10 pounds, walking up 10 steps, walking 3 blocks, walking a mile, standing for 10 minutes, bending over or stooping, reaching overhead, and using fingers to grasp.

³ A small percentage of simulated nongroup exchange enrollees have MAGI below 138% of FPL due to immigration status and length of residence in the US, and a small percentage of enrollees will opt for exchange coverage even though they have affordable offers of employer-sponsored insurance. These small groups are excluded from this table for comparability with the other tables in this analysis.

Throughout the analysis, family income is defined at the health insurance unit (HIU) level⁹ using the modified adjusted gross income (MAGI)¹⁰ computation consistent with income eligibility definitions in the ACA. This analysis also focuses exclusively on nonelderly adults, excluding the population age 65 and above as well as children age 18 or under. The vast majority of the elderly population will be excluded from the exchanges due to Medicare eligibility, and the expected health care costs of children do not vary as much as they do for adults across population groups, meaning their inclusion could complicate identifying risk differences central to this analysis.

A number of recent studies have shown that self-reported health status has strong predictive power in identifying individuals

at risk for high health expenditures.¹¹ As a result, assessing differences in such measures across population groups can provide insights into the expected health care costs associated with different pools of insured individuals.

Results

Demographic Characteristics of the Potential Exchange Population. Table 1 allows us to compare the socioeconomic characteristics of those nonelderly adults with current employer-sponsored insurance (the rightmost set of columns) with nonelderly adults who constitute the target population for the new nongroup exchanges. These target populations include those with incomes above 138 percent of FPL (the ACA's Medicaid expansion eligibility level) without affordable offers

of coverage through an employer once the ACA is fully implemented. We separate this target population into its two component groups: those with current ESI coverage (many of whom are already paying more on their own than what the ACA deems as its threshold of affordability) and those who have either nongroup coverage today or are uninsured. More than three-quarters of the target population is composed of the nongroup/uninsured (approximately 16.2 million people, compared to about 5.3 million people with current ESI coverage that costs the worker more than 9.5 percent of family income). We separate these two groups since those with current ESI are significantly less likely to leave that coverage and enroll in the exchanges than are their counterparts with current nongroup coverage or who are currently uninsured.

Table 4: Health Characteristics of Adults 19–64, Comparing Current Medicaid Enrollees, Medicaid Expansion Target Population, and the Nongroup Exchange Target Population

	Adults (19–64)					
	Current Medicaid Under 138% of FPL Nondisabled		Medicaid Expansion Target Population: Current Nongroup/Uninsured Under 138% of FPL		Exchange Target Population: Nongroup/Uninsured Above 138% of FPL Without Affordable Employer Offer	
	N	%	N	%	N	%
Total (19–64)	8,836,400	100.0%	20,941,000	100.0%	16,197,300	100.0%
General Health						
Excellent/Very Good/Good	6,135,500	69.4%*	17,480,900	83.5%*	14,828,700	91.6%
Fair/Poor	2,700,900	30.6%*	3,460,100	16.5%*	1,368,600	8.4%
Mental Health						
Excellent/Very Good/Good	7,044,900	79.7%*	19,116,800	91.3%*	14,300,700	88.3%
Fair/Poor	1,791,500	20.3%*	1,824,200	8.7%*	1,896,600	11.7%
Chronic Physical Conditions						
Arthritis	1,510,000	17.1%*	1,994,600	9.5%*	2,283,900	14.1%
Asthma	1,124,500	12.7%*	1,362,300	6.5%*	1,180,900	7.3%
Diabetes	906,900	10.3%*	808,900	3.9%*	909,300	5.6%
Emphysema	92,400	1.0%	127,900	0.6%*	208,500	1.3%
Heart Disease ¹	640,300	7.2%*	786,800	3.8%*	1,005,000	6.2%
High Blood Pressure	1,985,200	22.5%*	2,766,200	13.2%*	3,244,400	20.0%
Stroke	206,600	2.3%*	162,200	0.8%*	192,200	1.2%
Current Smoker						
Yes	2,638,000	29.9%*	5,285,400	25.2%	4,382,400	27.1%
No	6,198,400	70.1%*	15,655,600	74.8%	11,814,900	72.9%
BMI						
Underweight (< 18.5)	237,400	2.7%*	549,600	2.6%*	295,300	1.8%
Normal Weight (18.5–24.9)	2,918,400	33.0%*	7,752,600	37.0%*	6,039,400	37.3%
Overweight (25.0–29.9)	2,450,700	27.7%*	7,543,700	36.0%	6,089,700	37.6%
Obese (30.0+)	3,229,900	36.6%*	5,095,100	24.3%*	3,772,800	23.3%
Limitation in Physical Functioning ²	1,410,700	16.0%*	1,248,500	6.0%*	1,524,800	9.4%

Source: HIPSM 2011

Note: An ESI offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from Nongroup/Uninsured Above 138% of FPL is statistically significant at the p < .05 level.

¹ Heart disease includes heart attack, coronary heart disease, angina and other heart disease as defined in the MEPS-HC.

² Includes difficulty lifting 10 pounds, walking up 10 steps, walking 3 blocks, walking a mile, standing for 10 minutes, bending over or stooping, reaching overhead, and using fingers to grasp.

The data in Table 1 show that the current nongroup/uninsured population with income above the ACA's Medicaid eligibility level is younger and more likely to be male than the full employer-sponsored insurance population.¹² For example, 34.3 percent of the nongroup/uninsured population is between the ages of 19 and 34 versus 28.5 percent of the full ESI population. Similarly, 56.6 percent of the nongroup/uninsured population is male versus 48.4 percent of the ESI population. They are also more likely to be Hispanic (17.0 percent versus 10.4 percent) and less likely to be non-Hispanic white. This target group has, on average, significantly lower income; about 57 percent of the full ESI population has family income at 400 percent of FPL or above versus about 28 percent for the nongroup/uninsured

target population. The target population of nongroup/uninsured also has lower levels of full-time employment.

The ESI target population—those enrolled in employer coverage but whose premium under the ACA would not be deemed affordable—are considerably older, are much more likely to be non-Hispanic white, have substantially higher incomes, and tend to be significantly more highly educated than their counterparts who are currently nongroup-covered or uninsured.

Health Status of the Potential Exchange Population. We find that the combined nongroup/uninsured target population is slightly less likely to report excellent, very good or good health than the ESI population: 91.6 percent versus 93.8 percent, respectively (Table 2). The target

population is also less likely to report excellent, very good or good mental health: 88.3 percent versus 94.7 percent. On the other hand, the nongroup/uninsured are less likely to report chronic conditions. This includes arthritis (14.1 percent versus 15.4 percent), asthma (7.3 percent versus 9.0 percent), diabetes (5.6 percent versus 6.0 percent), and high blood pressure (20.0 percent versus 22.5 percent). These differences in chronic conditions between the groups diminish considerably within age group (data not shown), meaning that the exchange target population has lower rates of prevalence of chronic conditions largely due to the population being younger.

The nongroup/uninsured are, however, far more likely to be smokers than the

full ESI population: 27.1 percent versus 16.8 percent, respectively. The nongroup/uninsured are very similar to the full ESI population in body mass index (BMI), with a lower share of the nongroup uninsured being obese (23.3 percent versus 27.2 percent of the full ESI group). The nongroup/uninsured are more likely to have a limitation in physical functioning (9.4 percent versus 6.0 percent).

The ESI target population reports similar general health and mental health as the full ESI population (92.6 percent versus 93.8 percent, a statistically significant difference, but small in magnitude), but higher rates of some chronic conditions, for example arthritis, diabetes, heart disease, high blood pressure and stroke. They are slightly less likely to be normal weight or underweight compared to the full ESI population, but they have statistically identical smoking rates to that group. Ten percent of the target ESI population has a limitation in physical functioning, compared to 6 percent of the full ESI population.

Thus, we conclude that the population likely to enter the exchange—those with nongroup coverage or who are uninsured without affordable employer offers—look quite similar to those who now have employer-sponsored insurance. (A major reason for this is that those with the most severe health problems are already covered by Medicare or Medicaid—data not shown.) It is also possible that those uninsured today have some characteristics not measured here that make them even less likely to use medical care than is suggested here, characteristics that are associated with their uninsured status. Regardless, the results shown here mean that, all else being equal, average premiums for this population should not differ markedly from the ESI market overall. But not all is equal; administrative costs should be higher in the nongroup exchange, while nongroup plans are likely to have fewer benefits and more cost-sharing than many employer plans, all of which will determine premiums along with the average health status of the populations enrolled.

Simulating Exchange Enrollment.

Table 3 represents the results of a full simulation of exchange enrollment using

HIPSM. As noted earlier, we used HIPSM to predict who would enroll in nongroup coverage in the exchange, including those moving from existing nongroup coverage to exchange enrollment, those gaining coverage after being uninsured, or those switching from employer coverage into the exchange. This allows us to take advantage of the sophisticated behavioral modeling incorporated in HIPSM to predict more precisely who will enroll, as opposed to the broader population targeted by the policies. For example, the model considers factors such as age and health status—those with greater needs for care would be more likely to sign up as would those qualifying for larger premium tax credits.

When we compare results of the simulated enrollment with the ESI population, we find again that the simulated nongroup exchange enrollees are only slightly less likely to report excellent, very good or good general and mental health—in fact, the simulated enrollment group looks slightly more similar to the ESI group than did the broader target group on these measures. While the differences are statistically significant, they are not substantially different in absolute magnitude.

In contrast, when we look at chronic conditions, the simulated nongroup exchange enrollees remain less likely to have arthritis, asthma, heart disease and high blood pressure than the ESI population. Notably, the simulated exchange enrollees are significantly *less* likely to be smokers than the ESI population, even though the broader target nongroup/uninsured population is considerably *more* likely to smoke. This is the consequence of the ACA's rules allowing insurers to charge tobacco users up to 1.5 times the premium of non-tobacco users of the same age for the same coverage; the higher premiums will dissuade smokers from obtaining coverage. Simulated exchange enrollees are also less likely to be obese than those with ESI coverage but again have higher rates of physical functioning limitations. Thus, again, the results are somewhat mixed but there are strong similarities between the expected exchange enrollees and the population with ESI in characteristics that are likely to be associated with health

care costs. Thus, we would expect the average premiums in nongroup exchange plans to be similar to what we observe in the employer market today, other than presumably somewhat higher administrative costs and differences in benefits provided and cost-sharing options chosen.

Merging Medicaid and Exchanges.

Table 4 compares the ACA's exchange target population of nongroup/uninsured with the population targeted by the Medicaid expansion, and those currently enrolled in Medicaid and not disabled. This indicates the implications for risk pools of merging the Medicaid expansion population into exchanges. The ACA's exchange target population of nongroup/uninsured report better general health

(91.6 percent being in excellent, very good or good health) than those in the Medicaid expansion target population (83.5 percent in excellent, very good or good health). On the other hand, the Medicaid expansion target population is slightly more likely to report excellent, very good or good mental health—91.3 percent versus 88.3 percent—a significant but probably not meaningful difference. In general, the lower income Medicaid expansion target population is less likely to have chronic conditions, including being less likely to suffer from arthritis, asthma, diabetes, emphysema, heart disease, high blood pressure and stroke. Also, there is no significant difference between the two groups in the likelihood of being a smoker, their BMI profiles are very similar, and the Medicaid expansion population is less likely to have a limitation in physical functioning. Again this is a slightly mixed picture, but it suggests that bringing the Medicaid expansion population into the exchanges would not significantly affect the risk pool.

Bringing the entire currently enrolled Medicaid population with incomes below 138 percent of FPL into the exchange is a very different story, even excluding current enrollees with disabilities. The current nonelderly nondisabled Medicaid population is substantially less likely to report being in excellent, very good or good health—69.4 percent versus 91.6 percent in the exchange target population. They are also less likely to report excellent, very good, or good mental health—79.7 percent

versus 88.3 percent. They are more likely to have several chronic conditions, including arthritis, asthma, diabetes, heart disease, high blood pressure or stroke. They are also more likely to be smokers and are substantially more likely to be obese. Thus, bringing in the entire Medicaid population would affect risk pools significantly, increasing federal subsidy costs due to the resulting higher average premiums for all subsidized enrollees and increasing costs for the unsubsidized population within the exchanges, in particular, but also having potential implications for the subsidized enrollees as well.

Conclusion

While individuals with higher than average health care needs may be somewhat more likely to enroll in the nongroup market

in the first year, once past the transition period, the health characteristics of nongroup enrollees can be expected to be quite similar to those with employer-based insurance. The exchange target population is slightly less likely to report excellent, very good or good physical and mental health; less likely to report any of several chronic conditions; more likely to be smokers (although the simulated enrollee population is less likely to smoke); and less likely to be obese than those with employer insurance. Many exchange enrollees will receive subsidies; because premiums paid by enrollees will be based on a percentage of income, the availability of subsidies will reduce any impact of total premiums being somewhat higher in the first year of implementation. If the exchange target population does

not participate at the rates predicted given their characteristics, however, premiums could be higher than what we observe in the employer-based market.

Analyses using microsimulation models incorporating the best economic research on behavioral responses to health insurance at different prices predict considerable participation in exchanges under the ACA by a diverse group of individuals, with the availability of federal subsidies and the new requirement that most people obtain health insurance coverage being important factors. Well-funded and well-executed efforts at outreach and enrollment are critical to obtaining these predicted enrollment levels, and increased funding for additional subsidies beyond the ACA's schedule would also increase participation by healthy individuals.

Appendix Table 1: Comparison of Health Characteristics of Adults 19–64 in the Nongroup Exchange Target Population with Current Nongroup Insurance or Currently Uninsured

	Nongroup Exchange Target Population: MAGI Above 138% of FPL Without an Affordable Employer Offer in the Health Insurance Unit					
	Current Nongroup		Current Uninsured		Combined	
	N	%	N	%	N	%
Total (19–64)	3,754,800	100.0%	12,442,400	100.0%	16,197,300	100.0%
General Health						
Excellent/Very Good/Good	3,557,000	94.7%*	11,271,700	90.6%	14,828,700	91.6%
Fair/Poor	197,800	5.3%*	1,170,800	9.4%	1,368,600	8.4%
Mental Health						
Excellent/Very Good/Good	3,455,000	92.0%*	10,845,700	87.2%	14,300,700	88.3%
Fair/Poor	299,800	8.0%*	1,596,800	12.8%	1,896,600	11.7%
At Least One Physical Chronic Condition	1,436,100	38.2%*	4,189,600	33.7%	5,625,700	34.7%
Chronic Physical Conditions						
Arthritis	621,100	16.5%*	1,662,800	13.4%	2,283,900	14.1%
Asthma	353,300	9.4%*	827,600	6.7%	1,180,900	7.3%
Diabetes	155,900	4.2%*	753,400	6.1%	909,300	5.6%
Emphysema	31,900	0.9%*	176,600	1.4%	208,500	1.3%
Heart Disease ¹	228,100	6.1%	776,900	6.2%	1,005,000	6.2%
High Blood Pressure	817,500	21.8%*	2,426,900	19.5%	3,244,400	20.0%
Stroke	43,700	1.2%	148,500	1.2%	192,200	1.2%
Current Smoker						
Yes	539,600	14.4%*	3,842,800	30.9%	4,382,400	27.1%
No	3,215,300	85.6%*	8,599,600	69.1%	11,814,900	72.9%
BMI						
Underweight (< 18.5)	54,200	1.4%	241,200	1.9%	295,300	1.8%
Normal Weight (18.5–24.9)	1,555,800	41.4%*	4,483,700	36.0%	6,039,400	37.3%
Overweight (25.0–29.9)	1,447,500	38.6%	4,642,200	37.3%	6,089,700	37.6%
Obese (30.0+)	697,400	18.6%*	3,075,400	24.7%	3,772,800	23.3%
Limitation in Physical Functioning²	329,700	8.8%	1,195,100	9.6%	1,524,800	9.4%

Source: HIPSM 2011

Note: An employer-sponsored insurance offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from uninsured is statistically significant at the p <.05 level. This test is not carried out for the combined nongroup/uninsured group.

¹ Heart disease includes heart attack, coronary heart disease, angina and other heart disease as defined in the MEPS-HC.

² Includes difficulty lifting 10 pounds, walking up 10 steps, walking 3 blocks, walking a mile, standing for 10 minutes, bending over or stooping, reaching overhead, and using fingers to grasp.

Health Insurance Unit refers to the family members who can be covered by a single private insurance policy.

Endnotes

- ¹ See, for example, Blavin F, Buettgens M and Roth J. “State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain.” Washington: The Urban Institute, 2012. <http://www.urban.org/publications/412485.html>; and Congressional Budget Office. “CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010.” Washington: Congressional Budget Office, 2010. <http://www.cbo.gov/publication/22077>.
- ² Kingsdale J and Aurori J. “Impact of National Health Reform and State-Based Exchanges on the Level of Competition in the Nongroup Market.” Princeton: Robert Wood Johnson Foundation, 2013. <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/06/impact-of-national-health-reform-and-state-based-exchanges-on-th.html>; Holahan J, Lucia K, Peters R, et al. “Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States.” (Forthcoming 2013).
- ³ Unpublished HIPSM results, 2013.
- ⁴ Zuckerman S and Holahan J. “Despite Criticism, The Affordable Care Act Does Much to Contain Health Care Costs.” Washington: The Urban Institute, 2012.
- ⁵ Rovner J. “Arkansas Medicaid Expansion Attracts Other States’ Interest.” National Public Radio, March 26, 2013. <http://www.npr.org/blogs/health/2013/03/26/175301509/arkansas-medicaid-expansion-attracts-other-states-interest>.
- ⁶ For more about HIPSM’s capabilities and a list of recent research using it, see “The Urban Institute’s Health Microsimulation Capabilities,” <http://www.urban.org/publications/412154.html>. A more technical description of the construction of the model can be found at <http://www.urban.org/publications/412471.html>.
- ⁷ For more information on the MEPS-HC, see http://meps.ahrq.gov/mepsweb/survey_comp/household.jsp.
- ⁸ Another central issue in the discussion of this option is the relative cost of coverage in private plans relative to current Medicaid plans, since private plans today tend to pay providers at higher rates and are thus more expensive than Medicaid. The expected price differential under reform is difficult to predict for two reasons. First, while the research evidence on the current system is clear that private insurance plans are considerably more expensive than Medicaid holding health status and other characteristics constant, incentives under the ACA mean that exchanges in at least some areas are expected to offer some lower-cost commercial plans that use more limited provider networks and pay lower provider payments than is the commercial norm today. Second, with a larger Medicaid-eligible population that must be served under the ACA, state programs may start to pay somewhat higher reimbursement rates in order to attract a broader network of providers willing to participate in the program. As a result of the unpredictability of these dynamics and how pervasive they are likely to be, we do not address the Medicaid versus exchange cost differential here.
- ⁹ A health insurance unit includes the members of a nuclear family who can be covered under one health insurance policy. A policyholder may cover his or her spouse, all children under 18, and children between 18 and 23 who are full-time students.
- ¹⁰ Under the ACA, income eligibility is based on the IRS tax definition of modified adjusted gross income, which includes the following types of income for everyone who is not a tax-dependent child: wages, business income, retirement income, investment income, Social Security, alimony, unemployment compensation, and financial and educational assistance.
- ¹¹ See, for example, DeSalvo KB, Jones TM, Peabody J, et al. “Health Care Expenditure Prediction with a Single Item, Self-Rated Health Measure.” *Medical Care*, 47(4): 440–447, 2009; and Fleishman JA, Cohen JW, Manning WG, et al. “Using the SF-12 Health Status Measure to Improve Predictions of Medical Expenditures.” *Medical Care*, 44(5) (Suppl.): 154–163, 2006.
- ¹² The full ESI population includes those with current ESI that are part of the “target” population in Table 1 due to the premium they pay directly exceeding the ACA’s threshold for affordability.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgments

Linda Blumberg is a senior fellow and John Holahan is an institute fellow in the Urban Institute's Health Policy Center. This research was funded by the Robert Wood Johnson Foundation. The authors are grateful for research assistance by Chris Hildebrand and Caitlin Carroll and the comments and suggestions made by Genevieve Kenney, Larry Levitt, Tim Waidmann, and Steve Zuckerman. Matthew Buettgens' contributions to the development of the HIPSM model allowed us produce the estimates in this paper.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. For more information, visit <http://www.urban.org>. Follow the Urban Institute on Twitter www.urban.org/twitter or Facebook www.urban.org/facebook.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter www.rwjf.org/twitter or Facebook www.rwjf.org/facebook.