

RESEARCH REPORT

# Enrollment Periods in 2015 and Beyond

Potential Effects on Program Participation and Administration

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*February 2015*



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# Acknowledgements

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The author appreciates the financial support of the California HealthCare Foundation, which made this research possible. In addition, the author thanks the following for their thoughtful comments on earlier drafts and on the concepts in this paper: Zachary Baron, Enroll America; Brian Haile and George Brandes, formerly of Jackson Hewitt Tax Service, Inc. (Jackson-Hewitt); Elaine Maag of the Urban Institute/Brookings Institution Tax Policy Center; Gabriel McGlamery of the Florida Blue Center for Health Policy; Katherine Swartz of the Harvard School of Public Health; and Catherine Teare of the California HealthCare Foundation. Neither the California HealthCare Foundation, those individuals, nor their affiliated organizations are responsible for the views expressed in this report, which are the author's.

# Executive Summary

**Several leading experts believe that allowing enrollment in qualified health plans (QHPs) during late winter and early spring could yield major reductions in the number of uninsured and an improved risk pool under the Patient Protection and Affordable Care Act (ACA).**

That timetable would require a change. The 2015 open enrollment period (OEP) is slated to end on February 15, 2015. For 2016, the Centers for Medicare and Medicaid Services (CMS) propose an OEP lasting from October 1 through December 15, 2015. If enrollment was instead scheduled for late winter and early spring, overlapping with much of tax filing season, more eligible uninsured would probably gain coverage, particularly among those without serious health problems. Several factors play a role:

1. *Penalties for going without coverage would likely prompt more uninsured to enroll when the previous year's penalties are fresh in their minds—right after they have filed tax returns and lost their tax refunds.* If the uninsured must instead wait until October to enroll, behavioral economics research suggests that a more distant memory of loss will motivate fewer to act.
2. *The proposed 2016 OEP overlaps with the holiday season's financial pressures, which are likely to undermine QHP enrollment. February and March, after those pressures are gone, historically see much higher sales of products like insurance.* Consumer debt rises in October through December, falls in January, and reaches its lowest levels in February to April. In the \$20,000 to \$50,000 income range typical of QHP subsidy eligibility, 85 percent of taxpayers receive tax refunds, averaging nearly \$2,700; two-thirds of refunds arrive by the end of March. Sales of all kinds of insurance, as shown by broker revenue, are thus lowest in the year's final quarter, when consumer finances are most constrained, and highest in the year's first two quarters, when household balance sheets are more favorable. Sales of autos and new homes, which like insurance require regular monthly payments, similarly peak in March through June, after recovering from annual lows during November through January (figure ES-1).
3. *Brokers and tax preparation services could help more consumers sign up for coverage.* Participation levels rise when application assisters relieve consumers of the need to fill out paperwork. If QHP enrollment occurred in late winter and early spring, more insurance brokers could help with Insurance Affordability Program (IAP) applications. In October through December, Medicare Advantage and most employer plans hold open enrollment, which pulls brokers away from QHP sign-ups.

Tax preparers could also help consumers apply for IAPs if QHP enrollment overlapped with tax season. More than 74 percent of the IAP-eligible uninsured, including 89 percent of those who qualify for QHP subsidies, file federal income tax returns, typically using paid tax preparers. Uninsured,

subsidy-eligible tax filers are relatively low risk: 43 percent are adults under age 35 and 13 percent are age 55-64, compared to 28 percent and 25 percent, respectively, among QHP enrollees. After clients provide tax information, just six minutes of additional questions are needed, on average, to finish an IAP application. More than 700,000 tax preparers are registered with the Internal Revenue Service—nearly 20 times the 38,000 full-time staff who provided application assistance during the 2014 OEP.

There is a reasonable chance (though not a certainty) that tax preparation services could transition into a major new role helping uninsured clients enroll into IAPs, greatly improving overall coverage and risk levels. However, that transition could be prevented unless OEPs overlap with tax season.

4. *Fewer consumers would probably be denied subsidies for failing to file timely tax returns.* When people who receive advance payment of tax credits (APTCs) in one year do not file returns by the following April 15, they become ineligible for subsidies. If QHP enrollment overlaps with tax season, Marketplaces and application assisters could focus on the few subsidy applicants who do not file early returns, intervening to ensure that they preserve eligibility by filing before April 15. With an October to December OEP, by contrast, Marketplaces can do little more than include notices about the importance of April 15 filing along with other information they send to all beneficiaries; such notices can easily be forgotten or overlooked. And by October it is too late to meet the previous April's tax filing.
5. *Consumers could change plans rather than be forced to drop coverage if they learn, during tax filing, that they must lower their APTC amount to prevent later reconciliation problems.* If the OEP overlapped with tax season, they could switch to a cheaper plan. If the OEP is over, however, they cannot change plans. Consumers who must cut their APTCs could face increased premium costs they perceive as unaffordable. Some may be forced to drop coverage, at least until the next OEP.
6. *More consumers could receive the full subsidies for which they qualify.* For example, tax preparers could inform the self-employed that they can receive additional subsidies by deducting from their taxable income QHP premiums not covered by APTCs.

## Different approaches could apply in 2015 and in the future

### **In 2015, a federal or state special enrollment period (SEP) could help the uninsured**

Uninsured consumers who pay a tax penalty for failing to get coverage in 2014 could enroll into QHPs for 2015. As proposed by Families USA and Timothy Jost, such an SEP would last from February 16 through April 15. It would help consumers who might otherwise be surprised to find themselves doubly disadvantaged when they file their returns after February 15. Such consumers would: (1) be penalized for

lacking coverage in 2014; and (2) face a larger penalty for lacking coverage in 2015, which they would be powerless to avoid if they filed returns after rather than before February 15. During the 2015 tax filing season, when the ACA's penalties for uninsurance will first be applied, such an SEP can be supported on equitable grounds, in addition to the enrollment advantages described above.

This SEP would have trade-offs. For example, while it would improve QHP risk pools by letting many healthy consumers enroll, it would also create offsetting adverse selection. Some uninsured consumers would sign up for QHPs after getting sick or injured between February 16 and April 15. It would also worsen communications challenges facing Marketplaces that encourage enrollment by emphasizing the general unavailability of coverage after February 15.

### **After 2016, OEPs could take place early in each calendar year**

Health plans, regulators, and Marketplaces do not have enough time to prepare for a 2016 OEP that would be rescheduled for late winter or early spring. But after 2016, the OEP could run from January 20 or February 1 through March 31. The QHP plan year could then begin on May 1. During open enrollment, subsidy applicants would project their incomes for the remainder of the calendar year. Subsidy eligibility would be based on calendar year income, as it is now. **Such an OEP, scheduled for late winter and early spring, could yield advantages in addition to the participation gains and risk pool improvements noted earlier:**

- *Subsidies could be determined more accurately and reconciliation problems could decrease.*
  - The OEP would take place after the year begins. Final annual income could thus be predicted more accurately than during October through December the previous year.
  - If enrollment overlaps with tax filing, last year's tax return could begin the eligibility process. In October through December, the process starts with a return showing income two years before the subsidy period, which is more likely to be outdated.
  - If more consumers received expert help in applying for subsidies, applications overall would be more accurate, based on experience with pre-ACA programs.
  - All else equal, APTC amounts are likely to be most outdated in the final months of QHP plan years, when the longest time has passed since Marketplaces determined income in processing initial applications. During that time, inertia could prevent consumers from reporting changes and correcting APTC amounts. If the QHP plan year starts in May, APTC errors in the final months of the plan year would occur early in the calendar year. To keep such errors from causing reconciliation problems, consumers could adjust their APTC amounts later in the calendar year. This cannot happen with the current schedule, since the QHP plan year ends with the calendar year's final months.

However, APTCs paid between the start of the calendar year and the OEP would continue at the same level as in the prior year unless beneficiaries report income changes to the Marketplace. To adjust subsidies for the new calendar year, Marketplaces could institute an income updating process in November or December. Such a process could range from: (1) simply reminding APTC beneficiaries of their duty to notify the Marketplace about income changes that could affect subsidy eligibility, including at the start of the new calendar year; to (2) providing beneficiaries with revised income estimates that incorporate available third-party data. Those revised estimates would request confirmation or correction and make clear that APTC amounts do not change unless beneficiaries confirm the accuracy of Marketplace revisions. Decisions about such income updating procedures involve a trade-off between improving subsidy accuracy and risking adverse selection by triggering SEPs through significant changes to subsidy eligibility.

- *Administrative burdens could lighten for carriers, brokers, and employers.* With an OEP early in the calendar year, premium calculations, bid negotiations, and development of marketing materials for QHPs and other individual plans could happen at different times than for Medicare Advantage, Medigap, and most employer-sponsored insurance (ESI), which hold open enrollment in the October to December period. Carrier enrollment staff and brokers could likewise respond to demands from QHP and individual market enrollees at different times from Medicare beneficiaries and most ESI recipients. This would make workloads more manageable by spreading burdens over the calendar. Employers could also incur fewer administrative costs if QHP enrollment overlapped with tax filing. Most workers learn about employer identification numbers (EIN) from tax forms. More applicants know their current employers' EINs during tax season, when tax forms show the previous year's employer, than during October to December, when tax forms show the employer from two years ago. If more applicants provided current EINs, more applicants' ESI information could be verified via electronic data matches, rather than paperwork from employers.
- *The calendar would be less politically charged.* New QHP premiums would be announced around the late January start of open enrollment, rather than, as under the current schedule, near October 1, approximately one month before Election Day in even-numbered years. Also, state and federal officials would no longer be tempted to delay the announcement of important rules until after Election Day; currently, such delays can compress insurance product development and regulatory review to the point of placing the adequacy of QHP coverage at risk.

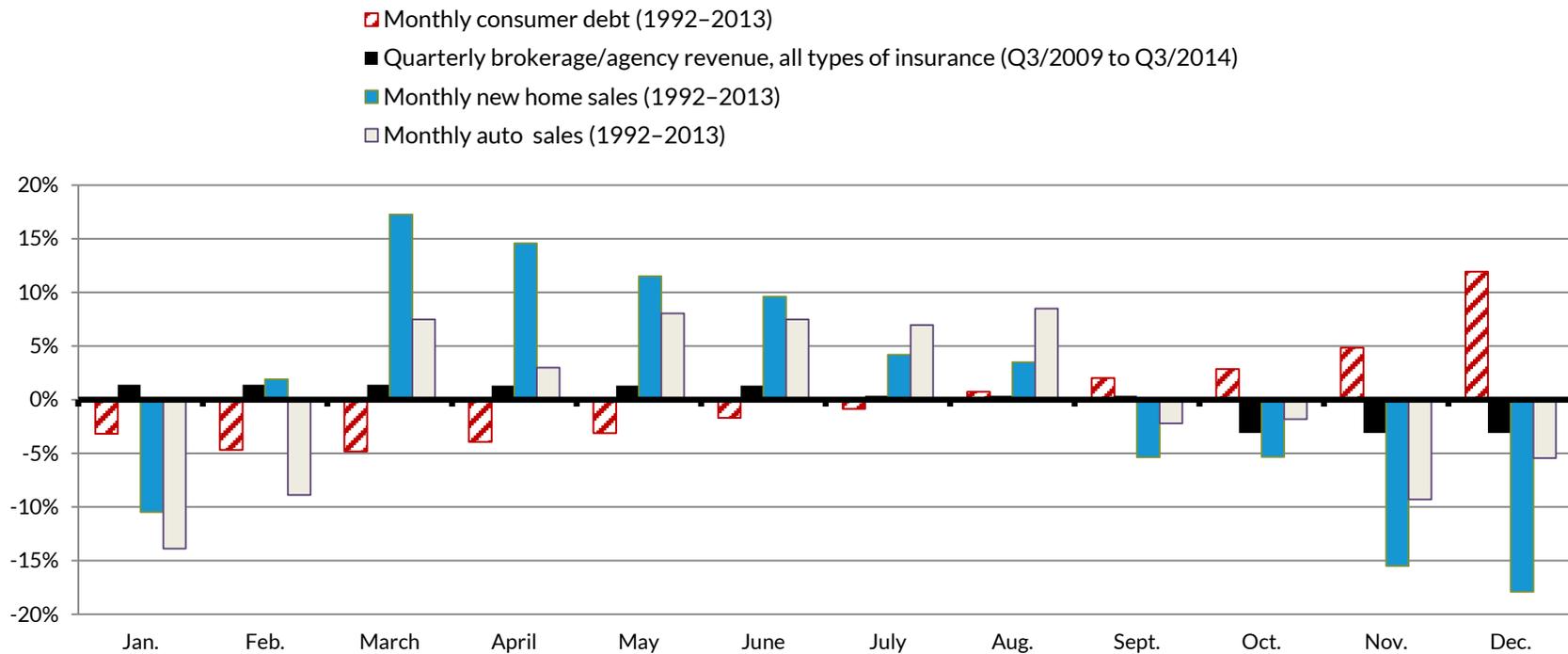
**However, an OEP early in the calendar year would also create disadvantages:**

- *Shifting to QHP plan years that start in May could involve a costly and disruptive transition* for carriers, regulators, and Marketplaces that have built an extensive infrastructure around coverage years for QHPs and individual plans that begin in January. Transitioning to a plan year that starts in May would also require a bridge coverage period that lasts for something other than 12 months. Federal agencies would need to adjust their rules for such things as paying QHPs for cost-sharing reductions given to low-income consumers, risk-adjustments, actuarial value calculators, and medical loss ratios, which now assume 12-month coverage periods. After those adjustments were finalized, plans would need to develop new insurance products. The resulting costs could not be recouped during a four-month period of bridge coverage from January 2017 to April 2017. Such a brief coverage period, with a new OEP in its midst, would also risk adverse selection. Less disruption would result from one 16-month or two eight-month bridge periods from January 2017 to April 2018 or two 14-month periods from January 2017 to April 2019.
- *Consumer confusion.* Families who face complex insurance choices under the ACA would find planning even more confusing if the QHP year began in May, since each calendar year would contain portions of two QHP plan years. However, some consumers' understanding would improve, since more consumers would likely receive help from brokers and tax assistance services. In theory, some clarifying simplicity might be lost if QHP schedules differed from those used for Medicare and most employer plans. In practice, however, there is almost no overlap between consumers who qualify for QHP subsidies and those with ESI or Medicare. And tax reconciliation should not confuse consumers, despite the start of a new QHP plan year on May 1. Each January, Marketplaces are required to provide information about monthly coverage in the prior year that makes reconciliation calculations possible, even with mid-year changes. Typically handled by tax preparation services rather than consumers themselves, reconciliation would proceed as if, in May, a subsidy beneficiary moved to a new county where QHPs charged different premiums.

Put simply, there are good reasons why a number of experts have concluded that important gains could result from letting consumers enroll into QHPs early during the calendar year, rather than on the same schedule as Medicare and most employer plans. Several options are available for making this shift, in 2015 and beyond. Each option has accompanying advantages and disadvantages, which policymakers must carefully weigh before deciding whether, how, and when to make a change.

FIGURE ES.1.

### How Total Consumer Debt, Revenue for Insurance Brokerages and Agencies, and Sales of New Homes and Autos Varies from the Average in Particular Months or Quarters



**Source:** Board of Governors of the Federal Reserve System 2014; U.S. Census Bureau, Quarterly Services Survey 2014, Monthly Retail Trade Survey 2014, Survey of Construction 2014.

**Note:** Bars falling below the 0% line indicate months with lower than average values while bars above the line indicate higher than average values. For each year: (1) average amounts per month (or quarter, in the case of brokerage/agency revenue) were calculated, and (2) the difference between that average and the amount for each specific month (quarter, in the case of brokerage/agency revenue) was estimated. The latter estimate, for each specific month (quarter, in the case of brokerage/agency revenue), was averaged for all years covered by the figure. Insurance revenue data are available only by quarter, shown here as identical monthly amounts within each quarter. For more information, see figures 2, 4, and 5, below.

## Acronym glossary

ACA	Patient Protection and Affordable Care Act
AGI	Adjusted gross income
APTC	Advance premium tax credit
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CSR	Cost-sharing reduction
CY	Calendar year
EITC	Earned Income Tax Credit
EIN	Employer identification number
ESI	Employer-sponsored insurance
FPL	Federal poverty level
HRMS	Health Reform Monitoring Survey
IAP	Insurance affordability program
IRS	Internal Revenue Service
MAGI	Modified adjusted gross income
OEP	Open enrollment period
PTC	Premium tax credit
QHP	Qualified health plan
SEP	Special enrollment period
SLCSP	Second-lowest cost silver plan



“Right timing is in all things the most important factor.”

-Hesiod

“Strategy and timing are the Himalayas of marketing. Everything else is the Catskills.”

-Al Ries

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## Introduction

Despite daunting obstacles, the first open enrollment period under the Patient Protection and Affordable Care Act (ACA) ushered in a substantial reduction in the number of uninsured, with more Americans receiving coverage in health insurance Marketplaces than many observers expected.<sup>1</sup> Replicating that feat could prove challenging. Fewer resources will be available to provide critically important hands-on application assistance;<sup>2</sup> mass media is paying less attention to Marketplaces; many of those easiest to reach have presumably already signed up for coverage; and the second open enrollment period (OEP) lasts just three months—November 15, 2014, through February 15, 2015—half the first period’s duration. The Centers for Medicare and Medicaid Services (CMS) has proposed an 11-week OEP for 2016, from October 1 to December 15, 2015.<sup>3</sup>

Regardless of the length of open enrollment, several experts believe that changing its timing could greatly increase participation. Katherine Swartz of the Harvard University School of Public Health and Vanderbilt University’s John Graves conclude that “holding open enrollment just before or during the holiday season is a mistake;” and that “the ACA’s goals of maximizing enrollment ... and maintaining a healthy balance of enrollees with low and high risks ... are more likely to be achieved” if the annual OEP were shifted to February 15 through April 15.<sup>4</sup> Washington and Lee University’s Timothy Jost describes a similar policy of letting the uninsured enroll into qualified health plans (QHPs) during February through April 2015 as a “vitally important step that the administration could take to substantially increase 2015 open enrollment,” as it would “extend coverage to many otherwise uninsured individuals and draw into the exchanges a group that is likely to be relatively low risk.”<sup>5</sup> Leading behavioral economists suggest that, with benefit programs that have seasonal applications, enrollment gains might result from “synchronizing the timing” of applications “with the tax season,” because “much of the information needed for determining eligibility ... is already contained on the tax return” and could be used to apply for benefits.<sup>6</sup>

The first part of this paper examines these conclusions by exploring factors that could enhance participation if QHP enrollment took place in late winter and early spring. The paper then explores the feasibility of modifying the 2015 open enrollment period and structuring future OEPs to incorporate such a

schedule. It concludes that significant gains would likely result; that several approaches are possible to achieve those gains; but that each approach has trade-offs that require careful thought.

## QHP Enrollment in Late Winter and Early Spring Could Increase Participation and Improve Risk Pools

This analysis assumes that, despite subsidies and the ACA's individual coverage requirement, a key challenge for the foreseeable future will involve persuading relatively healthy uninsured consumers to enroll into subsidized QHPs. Affordability appeared to be the most important factor limiting QHP participation among uninsured consumers who examined Marketplace options in 2014 and chose not to sign up.<sup>7</sup> In lowering enrollment projections for the 2015 OEP, federal officials noted the country's experience with the Children's Health Insurance (CHIP) program and other initiatives, suggesting that a five- or six-year ramp-up may be a realistic trajectory to steady-state enrollment under the ACA.<sup>8</sup> Factoring in the ACA's coverage mandate, independent estimates project that, after the initial transition period, approximately 27.2 million Americans will remain uninsured, of whom 4.1 million will qualify for QHP subsidies but not enroll.<sup>9</sup> For reasons discussed below, QHP sign-ups in late winter and early spring could increase participation among the relatively healthy, eligible uninsured, lowering risk levels and supporting the sustainability of Marketplaces that are funded based on the number of QHP enrollees.

### The tax penalty may be more effective in motivating action when it is being applied, not just remembered

Beginning in 2014, the ACA requires most individuals to obtain health insurance coverage or pay a tax penalty, with the size of the penalty phasing up between 2014 and 2016. These penalties are likely to have the largest effects on healthy consumers, who do not have health problems that motivate them to purchase health insurance. However, the Internal Revenue Service (IRS) can collect penalties only by reducing or denying tax refunds. If consumers can enroll immediately after that occurs, a tax preparer could say to an uninsured client, "You just lost \$98 in refunds because you were uninsured. Next year, you will lose \$325. You can reduce that penalty by enrolling into coverage right now, which I can help with." By contrast, if enrollment is not possible during tax season, the uninsured can only resolve to act during the following open

enrollment period, at least six months in the future. By then, the memory of the previous year's penalty will be less likely to prompt action.

When loss is being experienced, the prospect of a similar future loss seems more vivid, and action is more likely than when losses are merely remembered from the past. Behavioral economics findings about “availability” repeatedly show that the ease with which something comes to mind—because of recent timing, personal experience, or other factors—can make it seem more probable and increase its likelihood of motivating action.<sup>10</sup> Observing that, “The impact of seeing a house burning ... is probably greater than the impact of reading about a fire in the local paper,” one leader in the field illustrated the role of timing in insurance decisions with several research findings: “If floods have not occurred in the immediate past, people who live on flood plains are far less likely to purchase insurance. In the aftermath of an earthquake, many more people buy insurance for earthquakes, but the number declines steadily from that point, as vivid memories recede.”<sup>11</sup>

Another example of this effect involved a randomized, controlled trial with participants who served as jurors on a simulated products liability trial. All participants received the same written set of facts and jury instructions. Two groups were shown a news article about a \$14 million award in a similar case. One group saw it three days before the simulated trial, and the other saw the article three weeks in advance. Members of the first group awarded plaintiffs an average of \$1.3 million. Those in the second group awarded an average of \$226,000—less than one-fifth the first group's award, even though the only difference involved the time since seeing the news article.<sup>12</sup>

None of these studies involved the precise equivalent of QHP enrollment, but each showed that the recent timing of events can be irrationally influential in shaping decisions. This suggests that the ACA's penalty for remaining uninsured could be much more effective in motivating action if enrollment can occur immediately after the penalty is imposed.

## Consumers are more likely to buy insurance when their credit balances have recovered from the holidays and they are receiving tax refunds

Swartz and Graves, examining internet search patterns, found that financial anxieties are highest during the November to December holiday period and do not significantly recede until February and March. Citing behavioral economics research showing that such stresses can prevent effective decisionmaking, the authors suggested that more uninsured are likely to buy health insurance during late February and March,

when many receive tax refunds, rather than November through mid-February, which “are particularly financially stressful for many people.”<sup>13</sup>

These research findings and conclusions are consistent with seasonal patterns of consumer purchases and credit balances. Sales of such items as clothing, sporting goods, and electronics, which are often bought as holiday gifts, typically peak during the final quarter of the year then plummet during the year’s initial months. Census Bureau data show that, during the average year from 1992 through 2013 (figure 1):

- Sales at clothing stores, sporting goods/hobby/book/music stores, gift/novelty/souvenir stores, electronic shopping and mail-order houses, and electronics and appliances stores are 9 to 20 percent above average levels in November and 47 to 96 percent above average in December; while
- Sales at such stores are below average monthly levels by 9 to 31 percent in January; 11 to 23 percent in February; and 4 to 19 percent in March.

Federal Reserve data about consumer credit show a corresponding worsening of consumer debt during the year’s last few months, with major improvements after the holidays. During the average year from 1992 through 2013, consumer debt exceeded the year’s average by ever-increasing amounts from August through December, peaking at 2.9 percent, 4.8 percent and 11.9 percent above average levels in October, November, and December, respectively (figure 2).<sup>14</sup> After the holiday season, consumer credit improves, reaching its most favorable levels in February, March, and April. During those months, total consumer debt falls below annual average amounts by 4.7 percent, 4.8 percent, and 3.9 percent, respectively (figure 2).<sup>15</sup>

At the same time that credit balances have recovered from holiday purchases, many consumers claim tax refunds, starting in late January. As figure 3 shows, half of all refunds are in hand after the first week in March, and 66 percent are received by the end of that month. In 2013, 114.8 million out of 144.9 million federal income tax returns (79 percent) involved refunds or overpayments.<sup>16</sup>

Most people who are financially eligible for QHP subsidies receive significant tax refunds. Precise percentage estimates are not easy to provide, however. IRS data show tax filers in terms of adjusted gross income (AGI), and subsidy eligibility is based on income as a percentage of the federal poverty level (FPL), which reflects household size as well as dollar income. The typical eligibility range for subsidies, 138 to 400 percent of FPL,<sup>17</sup> equals \$16,105 to \$46,680 for a single adult and \$32,913 to \$95,400 for a family of four. Among all filers with AGI between \$20,000 and \$50,000, 85 percent received refunds in 2013, averaging \$2,690; in the \$50,000 to \$75,000 range, 76 percent received refunds, averaging \$2,852 (table 1).<sup>18</sup>

This analysis suggests that consumers are better positioned to buy insurance in February, March, and April than during October through December. Census data confirm that agencies and brokerages receive their greatest earnings for selling all types of insurance (not just health coverage) during the first half of the

year and their least in the final quarter. During the average year from 2009 through 2014 (the period for which data are available), agency and brokerage income was 3.1 percent below average in the final calendar quarter—the holidays, when consumer credit was most over-extended. It was 1.4 percent and 1.3 percent *above* average levels during the first and second calendar quarters, respectively (figure 4).

While suggestive, this finding does not resolve the timing of insurance sales to consumers, since agent and broker revenue comes from employers as well. Other data, involving auto and new home sales, does focus specifically on consumers. Like buying insurance, purchasing autos and homes typically involves committing to future monthly payments. As with broker revenue, auto and new home sales typically decline in the final calendar quarter and rise in the year's first half. According to Census Bureau data, during the average year from 1992 through 2013 auto sales were at their lowest levels from November through February and their highest levels in March, May, June, and August; and new home sales were similarly at their lowest levels in October through January and their peak during March through May (figure 5).

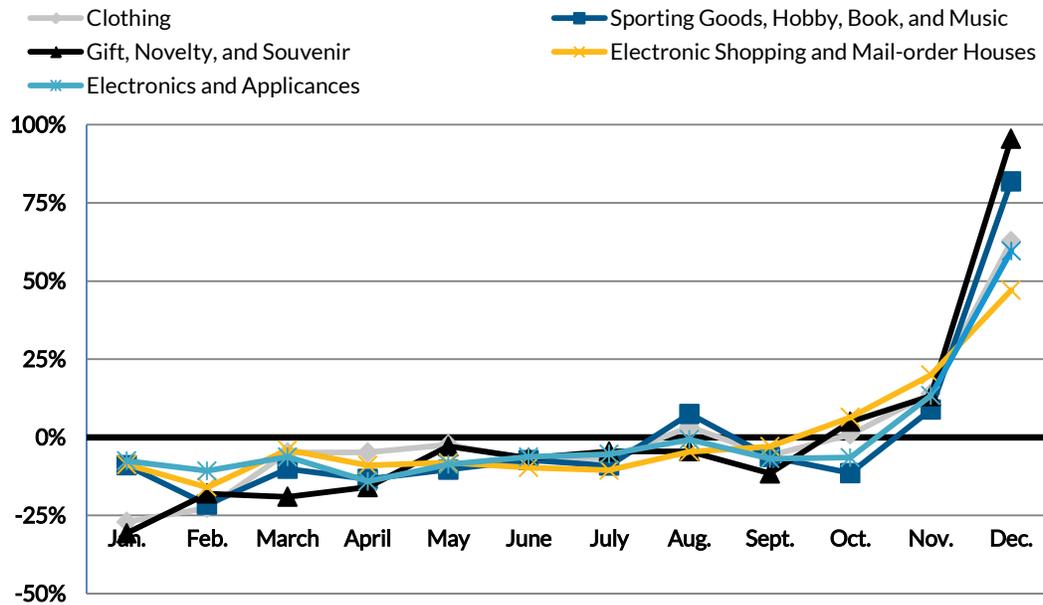
With homes, climate also affects sales. Spring weather makes house-hunting more appealing, and winter weather dampens sales. However, the same patterns for new home purchases are present in the Western U.S. (figure 5), where nearly 3 in 5 home sales (59 percent) occur in California, Arizona, and Hawaii,<sup>19</sup> states with seasonal weather patterns that differ greatly from those elsewhere in the country.

Unique dynamics affect seasonality of sales in each market. None of these metrics—earnings by insurance brokerages and agencies, auto sales, or new home sales—is a precise match for QHP purchases. But they form a coherent pattern. During the year's final months, sales of gift items spike, consumer debt reaches its highest levels, and sales of products that can seem more mundane and that require ongoing financial commitments reach their lowest points of the year. In February and March, by contrast, gift sales have plummeted, consumer debt reaches its lowest point, consumers receive significant tax refunds, and sales of autos, new homes, and insurance sold by brokers and agents are at or near peak levels. This suggests that QHP sales to relatively healthy consumers, which could present a challenge at any point on the calendar, will likely be highest during the same part of the year when similar costly necessities have historically been easiest to sell, for understandable reasons.

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FIGURE 1

**How Sales Amounts in Particular Months Differ from Average Monthly Sales: Consumer Goods Sold by Various Types of Stores, 1992–2013**



Source: U.S. Census Bureau, Monthly Retail Trade Survey 2014.<sup>20</sup>

Note: For each calendar year, (1) average sales per month were calculated, and (2) the difference between that average and the sales for each specific calendar month in the year was estimated. The latter estimate, for each specific calendar month, was then averaged for all of the years covered by the figure.

TABLE 1

**Percentage of Individual Income Tax Returns Filed in 2013 That Received Refunds and Average Refund per Return, by Adjusted Gross Income**

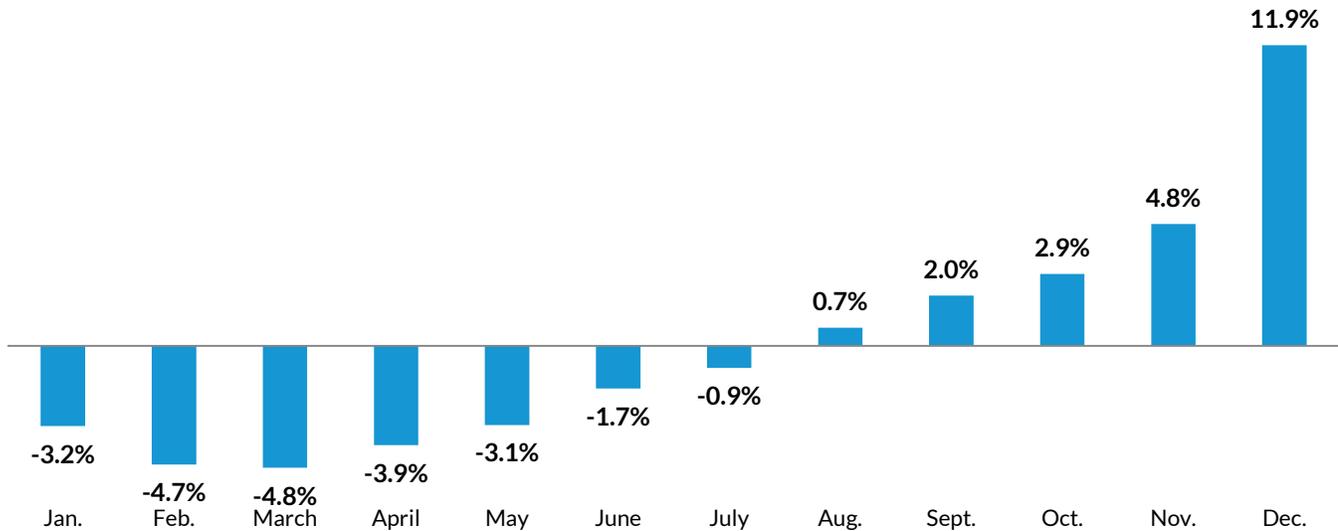
Adjusted Gross Income	Percentage of returns with refunds	Average refund per return
<\$20,000	81%	\$1,918
\$20,000 to \$49,999	85%	\$2,690
\$50,000 to \$74,999	76%	\$2,852
\$75,000 to \$99,999	73%	\$3,354
\$100,000+	55%	\$5,762

Source: IRS, Statistics of Income Division, Publication 1304, July 2014.<sup>21</sup>

Note: Average refunds are among returns claiming refunds.

FIGURE 2

How Total Consumer Debt in Particular Months Differs from Average Monthly Debt: 1992–2013

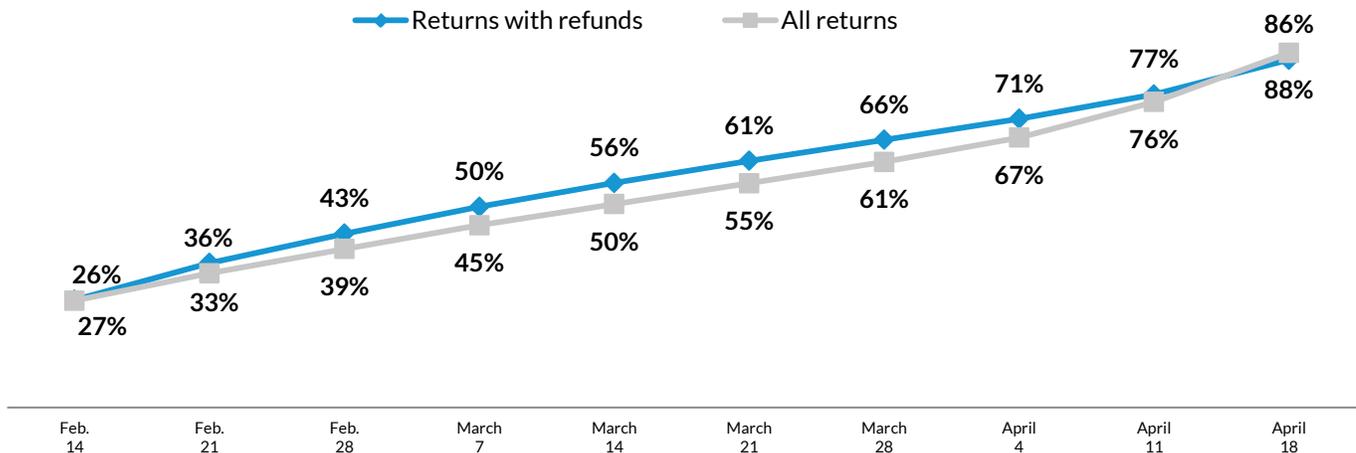


Source: Board of Governors of the Federal Reserve System, 2014.<sup>22</sup>

Note: For each calendar year, (1) total consumer debt was calculated for the average month, and (2) the difference between that average and total consumer debt for each specific calendar month in the year was estimated. The latter estimate, for each specific calendar month, was then averaged for all of the years covered by the figure.

FIGURE 3

Percentage of Federal Income Tax Returns Filed by Various Dates, 2013–14

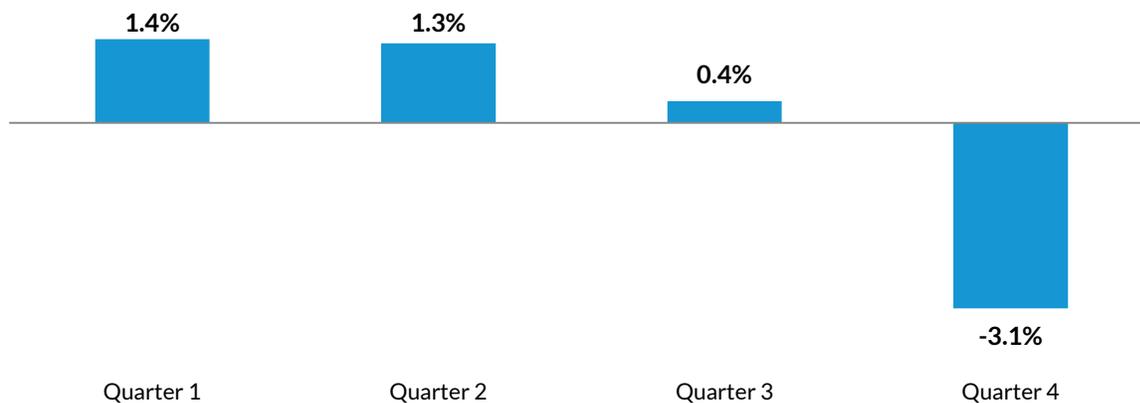


Source: Internal Revenue Service, 2013 and 2014 Filing Season Statistics.<sup>23</sup>

Notes: Return filing information is shown only through the date immediately following the April 15 end of non-extended federal income tax filing, by which APTC claimants are required to file federal income tax returns.<sup>24</sup> The displayed percentages represent averages of data from 2013 and 2014. As of this writing, the most recent available 2014 tax filing data ends with May 16 filing. The numbers displayed assume that the same percentage of all returns filed in 2014 will be filed by May 16, 2014, as were filed in 2013 by May 17, 2013.

FIGURE 4

How Insurance Agency and Brokerage Revenue in Particular Calendar Quarters Differs from Average Quarterly Revenues: Quarter 3, 2009 through Quarter 3, 2014

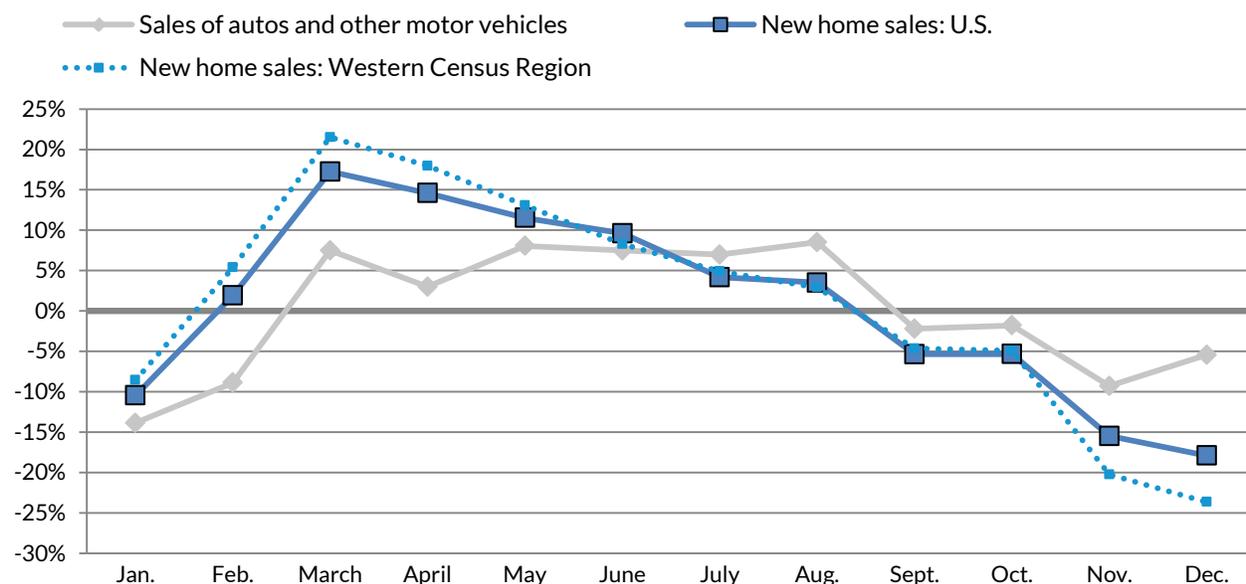


Source: U.S. Census Bureau, Quarterly Services Survey, 2014.<sup>25</sup>

Note: For each four quarter period (1) average revenue per quarter was calculated, and (2) the difference between that average and the revenue for each specific quarter in the year was estimated. The latter estimate was then averaged for all of the four-quarter periods covered by the figure. Because the available data cover five years and one quarter, averages were calculated for Q3 2009 through Q2 2014, with average revenue per quarter calculated over four-quarter periods beginning in the third quarter, and for Q4 2009 through Q3 2014, with such revenue calculated over periods beginning in the fourth quarter. The figure displays the average of the two results.

FIGURE 5

How Sales of Autos and New Homes in Particular Months Differ from Average Monthly Sales: 1992–2013



Source: U.S. Census Bureau, Monthly Retail Trade Survey 2014,<sup>26</sup> Survey of Construction 2014.<sup>27</sup>

Note: For each calendar year, (1) average sales per month were calculated, and (2) the difference between that average and the sales for each specific calendar month in the year was estimated. The latter estimate, for each specific calendar month, was then averaged for all of the years covered by the figure. The Census Bureau’s Western region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, New Mexico, Oregon, Utah, Washington, and Wyoming.

## More consumers could receive application assistance

Behavioral economists studying application procedures in public and private benefit programs repeatedly find that adding even minor steps can greatly reduce participation levels.<sup>28</sup> Simple “human frailties—procrastinating filing a form, or being put off by the tediousness or hassle of completing it, or failing to understand program rules” can “lead qualifying individuals to forgo benefits.”<sup>29</sup> Conversely, participation can greatly rise when people receive assistance that, while providing information and guidance, eliminates the need for consumers themselves to complete paperwork.<sup>30</sup> The 2014 OEP provided additional evidence that consumers are much more likely to enroll if someone else completes the necessary forms:

- A national survey by Enroll America found that, compared to those who received no help, uninsured consumers who received in-person application assistance were approximately twice as likely to receive coverage—31 percent, compared to 16 percent.<sup>31</sup>
- Data from the Urban Institute’s Health Reform Monitoring Survey (HRMS), a quarterly national survey tracking the ACA’s effects, showed that, among previously uninsured adults who visited Marketplaces, 54 percent of those who enrolled by June 2014 used application assistance, compared with 32 percent of those who did not enroll.<sup>32</sup>

Unfortunately, state-based Marketplaces are likely to provide much less application assistance than in the past, because federal grants are no longer available to pay Marketplace administrative costs, including for application assistance. Marketplaces must now be financially self-sufficient, so application assistance is competing with other functions for the limited administrative dollars that Marketplaces must raise. Each Marketplace is legally obliged to provide Navigators, but the resources devoted to this function could fall short of what is needed to maximize participation by the eligible uninsured.<sup>33</sup> If enrollment into QHPs and other individual plans occurs in late winter and early spring, two sources of application assistance could potentially help fill this gap: insurance brokers and tax preparation services.

## More insurance brokers could help consumers with QHPs and other individual plans

In late winter and early spring, brokers and agents will not face conflicting demands from Medicare Advantage, which holds open enrollment during October through December, and the many employer plans that conduct open enrollment late in the year. Brokers often see these alternative sources of business as more profitable than individual coverage. This is particularly true with QHPs, where applications for insurance affordability programs (IAPs) can consume considerable broker time without providing additional compensation. If QHP enrollment takes place when these more remunerative alternatives are unavailable, additional brokers are likely to help consumers enroll into QHPs and other individual plans.

In some states, brokers made important contributions enrolling consumers into coverage during the 2014 OEP, even though completing IAP applications was a new role. For example, they were responsible for more than 40 percent of Marketplace enrollees in Kentucky and more than 46 percent of subsidized Marketplace enrollees in California.<sup>34</sup> Nationally, adults reported that brokers and agents were more useful than any other source in providing information about and help with Marketplace coverage.<sup>35</sup>

## Tax preparation services could help with IAP applications

If the OEP overlaps with tax filing season, tax preparation services could more easily transition into a new role of helping their clients qualify for IAPs. If that became a regular part of tax preparers' work, a considerable coverage increase could result. Federal income tax returns are filed by more than 74 percent of IAP-eligible uninsured consumers, including more than 88 percent of those who qualify for QHP subsidies.<sup>36</sup> The "tax filing moment" is almost certainly the single setting with the largest number of IAP-eligible uninsured. By comparison, only 55.8 percent of the uninsured obtained health care in 2012 from any source, many fewer than file federal income tax returns.<sup>37</sup>

Tax preparation services enjoy considerable efficiency advantages in helping the uninsured apply for IAPs. Not only do they have a client service infrastructure in place, they have already gathered, for tax purposes, most of the necessary information. Jackson-Hewitt found that, by asking their tax clients an average of five to six additional minutes of questions,<sup>38</sup> they could gather all the information needed to complete IAP applications.

Most low-income tax filers use in-person tax preparers, the vast majority of whom are paid.<sup>39</sup> Among taxpayers who claimed earned income tax credits (EITC) in 2007–08, 68 percent used paid preparers, and 3 percent used volunteer or free services provided by IRS-sponsored or other programs.<sup>40</sup>

A considerable work force provides these services. Altogether, more than 700,000 tax preparers were registered with the IRS as of December 1, 2014.<sup>41</sup> If only 1 in 10 helped their uninsured clients enroll in IAPs, that would roughly double the approximately 38,000 full-time-equivalent staff who provided application assistance during 2014 OEP as certified Navigators, In-Person Application Assistants, or Certified Application Counsellors.<sup>42</sup>

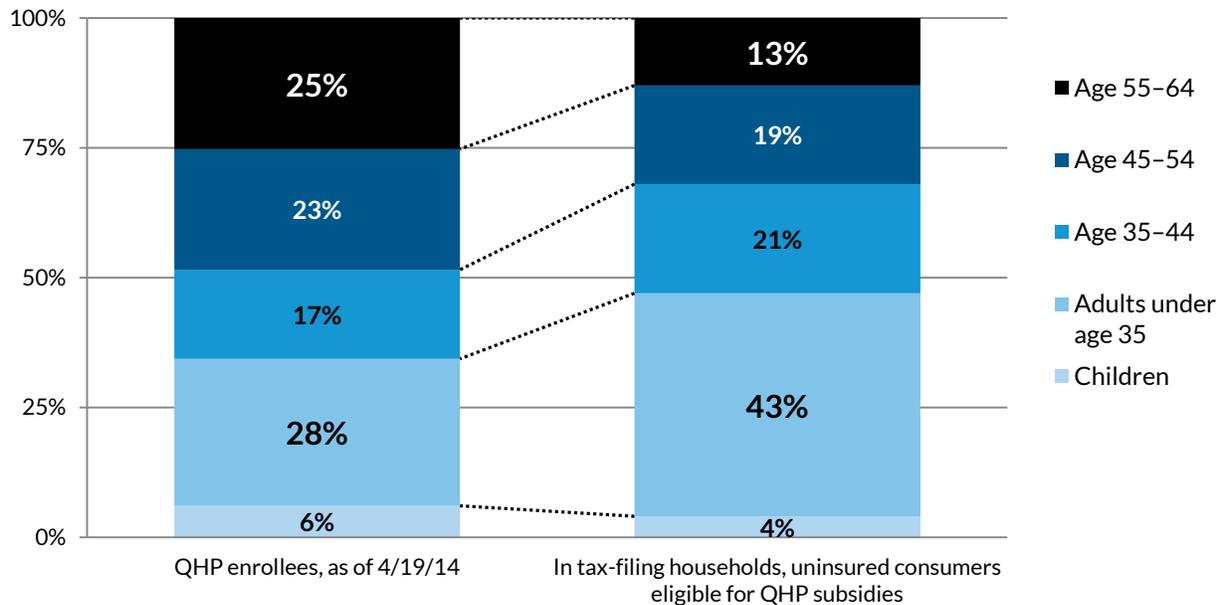
If the tax filing setting can be effectively leveraged for IAP enrollment, the resulting coverage increase would improve the individual market's risk pool. Compared to Marketplace enrollees after the 2014 OEP, uninsured tax filers eligible for QHP subsidies include more young adults and fewer older ones (figure 6):

- Adults under age 35 comprise 43 percent of uninsured tax filers who qualify for QHP subsidies but just 28 percent of all consumers who enrolled in QHPs by mid-April 2014.

- Adults ages 55 through 64 made up a quarter (25 percent) of QHP members after the 2014 OEP, compared to just 13 percent of uninsured, subsidy-eligible tax filers.

FIGURE 6

**Age Distribution of QHP Enrollees after 2014 Open Enrollment vs. Uninsured Consumers in Tax-Filing Households Who Qualify for QHP Subsidies**



Sources: HHS 2014,<sup>43</sup> Health Insurance Policy Simulation Model 2014.<sup>44</sup>

Notes: The QHP enrollment estimates (left bar) classify as children people under age 18. The tax filing estimates (right bar) count 18-year-olds as children, consistent with the definition used for purposes of Medicaid and CHIP. QHP enrollment counts are as of April 19, 2014, including from both open enrollment and special enrollment periods.

Tax preparation services will thus encounter the bulk of the eligible uninsured—especially among those who are young adults and eligible for QHP subsidies. Tax preparers will also have the capacity to efficiently enroll them into IAPs. That said, it is unknown how much of the industry would likely transition to playing this new role, given the opportunity. During the 2014 open enrollment period, national tax preparation services provided considerable information about the ACA on their websites and in their offices, but most helped only a limited number of uninsured clients qualify for IAPs.<sup>45</sup> On the other hand, California’s Marketplace, which provides unusually detailed information about individual application assisters, reports that, among the state’s 30 most productive assisters during the 2014 OEP, four were tax preparers—more than 1 in 8.<sup>46</sup> Helping clients apply for IAPs and accurately calculate APTC amounts could present a business opportunity for additional tax preparers, because of several factors:

- *Cost avoidance with repeat clients.* Ensuring that that a tax client receives health coverage and claims an appropriate APTC during one tax season could reduce the need for a tax preparer to spend significant uncompensated time the following tax season addressing that client's non-compliance with the ACA's individual coverage requirements or handling the client's tax reconciliation problems.
- *Revenue.* Tax preparers can receive revenue from fee-splitting arrangements with insurance brokers, through which brokers share the commissions they receive from insurers with the tax preparers who referred clients to the brokers. Also, in states like California, Medicaid agencies pay tax preparers, along with others, for each successful Medicaid application. Some Marketplaces also pays tax preparers as certified Navigators.
- *Customer service and market share.* Helping clients qualify for IAPs, claim appropriate APTCs, and avoid future tax problems could help tax preparation services furnish good service and gain customer loyalty. The resulting market share gains could be particularly important to in-person preparers, since it might help them counter recent years' losses to software vendors. Moreover, avoiding future tax reconciliation problems and uninsurance penalties can preserve market share by preventing repeat clients from going elsewhere out of frustration and anger.

When tax preparers sought to help clients apply for IAPs during the 2014 OEP, unfamiliarity with health issues was not a major barrier. Some preparers became certified assisters or Navigators.<sup>47</sup> Other preparers partnered with health experts:

- For clients who qualified for QHP subsidies, the enrollment process that followed the initial determination of IAP eligibility, including the often arduous step of plan selection,<sup>48</sup> was handled by licensed insurance brokers or certified assisters who partnered with tax preparation services.
- For clients who were eligible for Medicaid or CHIP, one major tax preparer mailed the clients' applications to the relevant state agency, after which the Medicaid/CHIP program completed the clients' enrollment.<sup>49</sup>

We do not yet know what role has been played by tax preparation services during the 2015 OEP. For those services to transition into a major new role of helping millions of uninsured tax clients qualify for IAPs, work would likely be needed to overcome challenges like the following:

- *Taxpayers must consent before their tax information can be used for non-tax purposes.* The IRS has released guidance explaining how preparers can obtain such consent without risking criminal liability.<sup>50</sup> However, some preparers find that significant time is required to obtain consent. It will be important to develop consent procedures that (1) satisfy legal requirements and policy reasons

to safeguard taxpayer privacy while (2) effectively and efficiently educating consumers about the reasons why providing consent may be to their advantage in this context.

- *IAP forms and procedures could be streamlined for tax preparers.* A tax software vendor cannot automatically complete and file an IAP application form unless the vendor knows that a properly completed form will be accepted by the relevant Marketplace. Income tax agencies thus publish final tax forms well in advance of each tax filing season, which lets tax software vendors prepare and file tax returns; something similar would be needed for IAP applications. In addition to making advance copies of final forms available, Marketplaces could operate portals through which approved tax preparation firms, whether software vendors or in-person assisters, submit IAP applications. After using their own procedures to gather client information, firms meeting data security and privacy requirements could send that information through these portals to Marketplaces in electronic form. That would address current inefficiencies that sometimes: (1) require preparers to manually reenter on a Marketplace website client data that the preparers already entered into their systems for tax purposes; or (2) require Marketplace staff to enter or scan information into the Marketplace's eligibility system from a written IAP application the tax preparer printed out and mailed to the Marketplace.

Policymakers incorporating tax preparers into ACA enrollment strategies would also need to face the serious past problems that have been reported with some preparers' competence and ethics. Returns filed by preparers often contain significant errors.<sup>51</sup> Mistakes are least frequent among volunteer tax preparers and most common among paid preparers who are not Certified Public Accountants (CPAs), attorneys, affiliated with national tax preparation companies, or otherwise formally registered with the IRS.<sup>52</sup> Ethical problems reported by the IRS Office of the Taxpayer Advocate include "misconduct cases in which the return preparers have altered return information without their clients' knowledge or consent in an attempt to obtain improperly inflated refunds or divert refunds for [preparers'] personal benefit."<sup>53</sup> To address such problems, agreement to a code of conduct could be a precondition of tax preparation services receiving the kind of favorable treatment, described above, that would facilitate their clients' enrollment into IAPs. A code of conduct might include elements like (1) joining the IRS's voluntary initiative to improve tax preparer competence and enforceable agreement to ethical standards;<sup>54</sup> (2) providing clients with Marketplace-certified application-assistance, either themselves or through a contracting partner (which could include a broker that does not preferentially provide information about plans based on the broker's potential compensation); and (3) helping uninsured clients apply to any IAP for which they appear to qualify.

In sum, there is a reasonable chance (though not a certainty) that tax preparation services could significantly improve overall coverage and risk levels by transitioning into a major new role helping their clients participate in IAPs. According to some knowledgeable observers, perhaps the most important

current limitation on the industry's willingness to invest in making this transition has been the absence of a future overlap between OEPs and tax filing season.<sup>55</sup> If there is no such overlap, the opportunity for tax preparation services to develop this new capacity is likely to be substantially constrained.

## Fewer consumers would be denied APTCs for failing to file timely tax returns

If a consumer receives any APTCs, even for a month, during one calendar year, the consumer must, by April 15 the following year, file an individual income tax return. Someone who fails or whose spouse fails to file such a timely return and use it to reconcile APTCs with actual income becomes ineligible for later APTCs.<sup>56</sup>

As noted earlier, most subsidy-eligible uninsured already file tax returns, and the majority of returns that claim refunds are filed well before April 15. Most APTC beneficiaries will thus meet this requirement, even though few are probably aware of it.<sup>57</sup> That said, some APTC recipients may not file returns by April 15. Some may face difficult life circumstances that lead them to extend their tax filing until October 15 or to forget tax filing altogether; some may not read the notices they receive from the Marketplace or fail to receive them because of address changes; some may forget APTCs they or their spouse received the prior year, perhaps during a short period of transitioning between non-Marketplace sources of coverage; still others may have incomes below the mandatory threshold for income tax filing and, particularly if they are childless adults, may not qualify for sufficiently large EITCs to warrant the work needed to file a return.<sup>58</sup>

Many fewer consumers would probably lose APTC eligibility for failure to file by April 15 if open enrollment overlapped with tax filing. During tax season, Marketplaces and application assisters could greatly increase the likelihood that IAP applicants who received APTCs the previous year file their returns on time. They could (1) ask applicants and beneficiaries whether they have filed their tax returns; (2) explain to those who not done so that failing to file by April 15 will make them ineligible for subsidies; (3) focus on the minority of late filers by sending them reminders until they file; and (4) even make referrals to approved tax preparers, with discount coupons, as one state-based Marketplace did during the 2014 OEP.<sup>59</sup> By contrast, with enrollment in October to December, Marketplaces and assisters cannot focus their efforts on the small proportion of applicants who do not file early returns. Instead, they can do little more than include notices about the obligation to file by April 15 along with other information they furnish to all APTC beneficiaries. Such notices can easily be forgotten or overlooked; and by October it is too late to meet the requirement to have filed tax returns by the previous April 15.

## Consumers could change plans rather than be forced to drop coverage if they learn, during tax filing season, that they enrolled in the wrong QHPs based on mistaken income projections

Tax filing season is when most Americans, after receiving W-2s, 1099 forms, and other tax records, gain the clearest picture of their financial situation. A consumer who has been receiving APTCs may realize, for the first time, that too much is being claimed. If QHP enrollment is open when the consumer learns this, the consumer can change to a plan with lower premiums. But if open enrollment is over, plan changes are not allowed based on a clearer understanding of household circumstances. An APTC reduction could nevertheless be needed to avoid tax reconciliation problems. It may also be required to avoid misleading the Marketplace, as failing to correct APTCs that the beneficiary knows are excessive can lead to up to \$25,000 in civil penalties.<sup>60</sup> If consumers cut their APTCs at tax time but cannot change QHPs, some will feel forced by the resulting increased premium costs to drop coverage entirely until the next OEP.

## More consumers could receive the full subsidies for which they qualify

Some consumers would be more likely to enroll because, with tax preparation services' advice, consumers would receive additional financial help for which they qualify. For example, consumers with self-employment income may learn that they can deduct from that income the portion of QHP premiums not covered by tax credits—potentially a significant supplemental subsidy for many such consumers.<sup>61</sup> Conversely, in states that have not expanded Medicaid eligibility, some uninsured IAP applicants could learn about tax planning strategies that project annual income as exceeding rather than falling below 100 percent of FPL, thereby qualifying for subsidies that help pay for coverage.<sup>62</sup> So long as the Marketplace qualifies a consumer for APTCs based on annual income that is reasonably projected between 100 and 400 percent of FPL, no penalty applies at reconciliation if the consumer turns out to earn less than 100 percent of FPL.<sup>63</sup>

# A Special Enrollment Period in 2015

Special enrollment periods (SEPs) let consumers who meet specified conditions join QHPs after open enrollment ends. Families USA<sup>64</sup> and Timothy Jost<sup>65</sup> have proposed an SEP that would run from February 15, 2015 (the end of the 2015 OEP), through April 15, 2015 (the end of the standard tax filing period), to let uninsured consumers who pay their tax penalty for lacking coverage in 2014 enroll into QHPs for 2015. Such an SEP could be established nationally<sup>66</sup> or by states.<sup>67</sup> Here, we explore this approach's advantages and disadvantages.

## Advantages

In addition to increased enrollment, as described earlier, the proposed SEP would prevent consumers from being surprised by penalties that they have no ability to avoid.

Many uninsured lack basic knowledge about the ACA. A Kaiser Family Foundation poll found that, in early November 2014, just 11 percent of the uninsured knew open enrollment would begin within weeks.<sup>68</sup> In June 2014, shortly after the 2014 OEP ended, uninsured adults surveyed by HRMS reported that<sup>69</sup>

- 40 percent had heard little or nothing about Marketplaces;
- 60 percent had heard little or nothing about subsidies to help pay for Marketplace coverage; and
- 42 percent had heard little or nothing about requirements to purchase coverage or pay a fine.

Penalties for uninsurance have not yet been applied. Many uninsured will thus learn the facts relevant to their situations only when they file 2014 federal income tax returns, in early 2015. Jost explains:

*"Many will become aware at that point for the first time that they will have to pay a penalty for not having had minimum essential coverage for 2014. These penalties are relatively small—for 2014, [the higher of] \$95 per adult or 1 percent of income over the filing limit. Penalties for 2015 will be much higher, \$325 per adult and 2 percent. But many will discover that they owe the penalty after February 15 when open enrollment closes and it is no longer possible to enroll for 2015.... [A] special enrollment period lasting through April 15 for anyone who has to pay a shared responsibility penalty for 2014 could diminish hostility to the ACA, which will surely increase if individuals are blind-sided by a penalty they can do nothing to avoid."<sup>70</sup> (Emphasis added)*

In the future, most Americans will presumably understand the relationship between enrollment periods and the ACA's penalties for lacking coverage. During tax season 2015, however—the first time penalties are applied—many of those affected will lack that understanding. A one-year, transitional SEP that lets the uninsured who pay their penalty for 2014 enroll into QHPs after February 15, thereby reducing their 2015 penalties, would serve the appearance of fairness and, arguably, the reality of it as well.

## Disadvantages

The proposed SEP would have several disadvantages. First, some adverse selection would offset the influx of healthy enrollees resulting from February through April enrollment. A number of uninsured consumers who began the open enrollment period in good health, not intending to enroll, will contract an illness or experience an accident between February 16 and April 15 that leads them to sign up. For example, data from the National Center for Health Statistics suggest that, during the average two-month period,

- approximately 0.17 percent of adults ages 18–44 and 0.11 percent of adults age 45–64 experience a non-fatal auto accident;<sup>71</sup> and
- cancer in some form is diagnosed for an estimated 0.07 percent of adults ages 20–49 and 0.27 percent of adults ages 50–65.<sup>72</sup>

It is not clear whether, on balance, bad risks like these would outweigh the good risks joining the individual market's risk pool as a result of the SEP.

Second, an SEP that allows enrollment after February 15 could undermine the credibility of Marketplace messages stressing the need to enroll by February 15. Experience with 2014 open enrollment suggests the potential effectiveness of such messages.<sup>73</sup> Of course, Marketplaces using those messages will face credibility challenges, with or without the suggested SEP. After February 15, eligible consumers can still join Medicaid and CHIP. Also, nationally applicable SEPs let QHPs enroll many who experience events like job loss or divorce. That said, the suggested SEP could further complicate this communications task.

Third, Marketplaces may need to develop SEP verification procedures. For example, applicants could be asked to upload signed and dated copies of their tax returns showing they paid the penalty for lacking coverage in 2014. Marketplaces could not immediately verify with IRS whether those copies were accurate. However, consumers would know that, eventually, Marketplaces would learn from IRS the facts of their tax filing. Much evidence shows that when taxpayers know that reports like W-2s will permit the later detection of falsehoods, returns are nearly always accurate.<sup>74</sup>

Fourth, some uninsured would be treated unfairly. For example, the SEP would not help consumers who were exempt from penalty in 2014 or who did not lose coverage until 2015. Policymakers concerned about those limitations could expand the SEP's scope.<sup>75</sup> However, the above limits would probably not exclude numerous people. Many consumers exempt from penalties in 2014—for example, because their state did not expand Medicaid or they lacked affordable access to coverage—will continue to be exempt in 2015, and most uninsured in early 2015 previously lacked coverage in 2014.

The fifth and final problem is the flip side of the fourth problem. An SEP cannot be defined so broadly that, as a practical matter, open enrollment never ends.<sup>76</sup> The SEP under discussion here thus has limits. It helps only consumers who are uninsured, not those with individual coverage or unaffordable employer-sponsored insurance (ESI). Among the uninsured, it covers only those who were also uninsured in 2014 and who were subject to and paid a penalty. It also ends on April 15. Policymakers could impose additional limits:

- *Enrollment could be required immediately after paying the penalty*—perhaps within days. This restriction would constrain opportunities for adverse selection. It would also fit the SEP's purpose of permitting uninsured consumers, at one stroke, to pay the penalty for being uninsured in 2014 while enrolling into 2015 coverage to limit the application of additional penalties.
- *The SEP could end on March 31 rather than April 15.* That would prevent this SEP from extending beyond the end date for 2014 open enrollment and slightly reduce opportunities for adverse selection. However, it would also limit the number of uninsured who could receive coverage.<sup>77</sup>
- *The SEP could be limited to people with incomes at or below 400 percent of FPL,* the maximum income level for subsidy eligibility. The assumption underlying this limit is that consumers with incomes too high for subsidies, who are in the top 37 percent of the U.S. income distribution for the nonelderly,<sup>78</sup> generally have the financial capacity to purchase coverage. The disadvantage of this limitation is that some older adults with incomes over 400 percent of FPL may have difficulty affording coverage, because individual premiums in most states are higher for older adults. However, this limitation would improve the SEP's risk pool effects. Adults over age 44 are 40 percent of nonelderly people above and just 26 percent of those below 400 percent of FPL.<sup>79</sup>

Adding limits to the SEP could make it more complicated to administer. For a one-year transitional policy, policymakers need to carefully consider whether such complications yield commensurate gains.

# Open Enrollment Periods After 2015

As noted earlier, CMS has proposed a 2016 OEP that runs from October through December 2015. Here, the paper explores how an OEP could instead operate early in the calendar year, along with the potential advantages and disadvantages of such a change.

## How an OEP could operate early in the calendar year

Certain features of such an OEP schedule seem clear:

- The OEP could start on January 20 or February 1 and end on March 31; and the QHP plan year could begin on May 1.<sup>80</sup> That schedule reflects the following facts: February and March is when most tax refunds are received and consumer credit balances are strongest; longer OEPs increase adverse selection risks, but also opportunities for enrollment; and increasing the gap between the OEP's conclusion and the plan year's start reduces adverse selection dangers, stresses on Marketplaces and plans, and the likelihood of enrollment "snafus" experienced by consumers.<sup>81</sup>
- During the OEP, consumers would project their incomes for the calendar year that had already begun. Such projections would be the basis for their IAP applications and Marketplace determinations of APTC eligibility. Income projections would not reach the next calendar year.
- Tax reconciliation would take place on a calendar year basis, as with the current OEP schedule. However, the 12 months of APTCs that are reconciled would be paid during two QHP plan years: four months during the plan year that ends in April, and eight months of APTCs during the plan year that starts in May. For a beneficiary who stays in the same plan, the following would typically change in May: the QHP premium, the second-lowest-cost silver premium, and the appropriate APTC amount. Reconciliation would be calculated much as if, under the current schedule, a beneficiary moved to a new location in May where QHPs charged different premiums.
- A long transition to the new schedule would be required. Moving the start of the QHP plan year from January to May would require "bridge" coverage that lasts for something other than twelve months. Federal policies currently predicated on 12-month coverage periods—such as those involving risk-adjustment, cost-sharing reductions, medical loss ratios, and the actuarial value calculator— would require modification. After such modifications are proposed and finalized, plans would prepare premium bids for bridge coverage, which regulators and marketplaces would review, and then conduct negotiations around those bids. Only after those negotiations are complete could

QHP consumers be presented with their bridge plan choices. Insufficient time remains for this to take place before January 2016. For the first bridge coverage period to begin in January 2017, a decision to move in this direction probably needs to be made in the next few months, after which federal regulators would begin revising current policies to fit the bridge coverage period.

Other issues about how best to structure an OEP in late winter and early spring are less clear:

- What transition approach, including bridge coverage periods, would be least costly and disruptive?
- Late in the calendar year, should Marketplaces encourage APTC beneficiaries to evaluate their incomes to see if they need to change APTC amounts when the new calendar year begins? If so, what form should that encouragement take?
- Should states be allowed to depart from the national schedule for the OEP and QHP plan year?

These issues are generally addressed later, in the context of analyzing the relevant advantages and disadvantages of shifting to a new schedule for open enrollment.

Figure 7 shows how an OEP ending in March, following by a QHP plan year starting in May, could operate in calendar year (CY) 2019, assuming that this new schedule began in 2018.

FIGURE 7

Operation of an OEP Ending in March, with a QHP Plan Year Starting in May (CY 2019, Assuming Prior Operation in 2018)

Jan 2019	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec 2019
Final four months of plan year 2018-19				Plan year begins 5/1. First eight months of plan year 2019-20; benchmark premiums and APTCs different from January through April.							
Employers and insurers mail forms showing coverage offered and received in CY 2018	Open enrollment; consumer projects total income for CY 2019										[Optional: Marketplace initiates income-updating process for the first months of 2020]
Marketplace mails 1095-A forms showing APTCs and benchmark premiums in CY 2018	Income tax filing reconciles CY 2018 APTCs with CY 2018 income										

# Advantages

An OEP in late winter and early spring could yield advantages in addition to the enrollment and risk pool gains discussed earlier.

## Fewer subsidy errors and tax reconciliation problems for consumers

If QHP enrollment occurs early during the year—such as February and March—subsidy eligibility for the year would be determined more accurately than during the previous October through December, safeguarding program integrity and reducing tax reconciliation risks. Several factors play a role:<sup>82</sup>

- *The year would have started.* In February and March, one or two months of the year's income have already been received, so applicants would need to project income for only ten or 11 months. Also, no uncertainty would be caused by delay between the application and the period covered by the projection. Projections made during October 1 to December 15 are more likely to err, as two weeks to three months must pass before the year starts, and estimates are needed for all 12 months.
- *A more recent tax return may be available.* Financial eligibility determination for QHP subsidies begins with the most recent tax return.<sup>83</sup> If enrollment occurred in tax filing season, IAP applications could be completed simultaneously with or immediately after the filing of tax returns that describe the year ending just before the subsidy period. If enrollment takes place during October through December, the most recent return will describe the year ending 12 months before the subsidy period. Significant income fluctuations affect many subsidy-eligible people,<sup>84</sup> so using a more recent return as the starting point for eligibility determination should improve accuracy.
- *More applicants are likely to get help.* As noted earlier, more brokers would likely help with IAP applications when brokers face fewer competing demands from Medicare Advantage and employer plans. Also, during tax season tax preparers would be more likely to help QHP-enrolled clients estimate APTCs.<sup>85</sup> Experience with Massachusetts' reforms suggests that applications are generally more accurate when consumers receive knowledgeable help than when they apply on their own.<sup>86</sup>
- *APTC errors could be prevented from causing reconciliation problems.* QHP plan years can end as many as 15 months after subsidy applications. Because of fluctuating incomes, the correct APTC amount is more likely to vary from the amount determined at application, all else equal, at the end of the QHP plan year than in earlier months. APTC beneficiaries may not make the adjustments needed to prevent their APTCs from drifting out of touch with changing household circumstances.<sup>87</sup>

The resulting errors at the end of the QHP plan year will occur at the start of the calendar year if the plan year begins in May. To prevent those mistakes from causing reconciliation problems, consumers could make offsetting adjustments to APTCs for subsequent months in the calendar year. Such adjustments are not possible under the current schedule, since the end of the QHP plan year coincides with the end of the calendar year.<sup>88</sup>

On the other hand, if a February to March OEP is when consumers project their income for the rest of the calendar year, several months of APTCs could remain on “automatic pilot” at the start of the following calendar year, before the next OEP begins. One might think unreported raises in January could create later reconciliation problems, but that seasonal pattern does not typify the low- and moderate-income workers who are most likely to qualify for QHP subsidies. For production and non-supervisory employees, average employment fell by 3.2 percent and average wages fell by 0.8 percent during January in the average year from 1993 through 2014 (table 2). For the many APTC beneficiaries whose income falls in January, keeping APTCs unchanged in January would thus reduce rather than increase their reconciliation risks.

TABLE 2

**Monthly Changes to Average Weekly Payroll and Average Weekly Earnings of Production and Nonsupervisory Employees (Average for 1993–2014)**

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
<b>Employment</b>	-3.2%	0.7%	0.9%	1.4%	1.1%	1.4%	0.1%	0.7%	0.0%	0.4%	0.2%	0.4%
<b>Earnings</b>	-0.8%	0.4%	0.2%	0.5%	0.3%	0.5%	0.1%	0.6%	0.4%	0.2%	0.0%	0.5%

**Source:** Bureau of Labor Statistics, Employment, Hours, and Earnings from the Current Employment Statistics survey, Feb. 1993–Nov. 2014 (National, Not Seasonally Adjusted).

Despite this pattern, an OEP that leaves the initial months of the calendar year without an income projection could trouble some policymakers. That gap could be filled by an income updating process in November or December. Using a range of possible procedures, Marketplaces could either:

- Remind consumers of the obligation to report changes in income or other household circumstances that could affect APTC eligibility, including during the first months of the next calendar year;
- Couple such a reminder with a statement of household income as previously estimated by the Marketplace; or
- Couple such a reminder with an updated income estimate based on matches with available data, such as state workforce agency quarterly wage records, while asking beneficiaries to confirm or correct those estimates. Such updated estimates would not take effect until they are confirmed.<sup>89</sup>

In deciding whether and how to implement such an income revision procedure, policymakers face a trade-off. Notices that effectively encourage consumers to reexamine their financial circumstances at the start of the calendar year could lead to more accurate APTCs. However, changes to subsidy eligibility that move household income above or below 150, 200, or 250 percent of FPL, thereby changing eligibility for cost-sharing reductions, trigger SEPs,<sup>90</sup> which risk adverse selection. It is unclear how many consumers would be affected by these trade-offs, however. Marketplaces send enrollees numerous notices, and inertia or inattention could prevent beneficiaries from reporting even income changes that increase subsidies.<sup>91</sup>

## **Reduced administrative burdens for carriers and brokers**

The 2014 OEP, which began in October 2013, overlapped with the October-December OEP for Medicare and the late-year OEP used by much ESI. Some carriers and brokers were overwhelmed by the resulting combined requests for help with enrollment assistance, problem-solving, and answers to questions. Some bottlenecks resulted that affected customer service. Because Marketplace OEPs apply to individual insurance sold outside the Marketplace, these issues involved both QHPs and other individual plans.<sup>92</sup>

To prevent a recurrence, some insurers hired additional staff to help during the 2015 QHP OEP.<sup>93</sup> If the QHP OEP for future years continues to coincide with OEPs for Medicare and most ESI, carriers could face the need for annual December employment spikes. Brokerages, many of which are less flexible than carriers in changing employees and contractors, could find it hard to adjust to such heightened seasonal variation. By contrast, an OEP in late winter and early spring would spread the demand for help over a longer period, reducing burdens for insurers and brokers while potentially improving consumer service.

By having QHPs and other individual plans operate on a different calendar than most ESI, Medicare Advantage, and Medigap, this schedule would yield other administrative gains for carriers. For multiple markets, carriers would use different rather than the same time frames to estimate premiums, prepare bids, negotiate with payors, develop marketing plans and materials. This could provide a more manageable overall workload for insurers' staff responsible for these functions.

## **Reduced administrative burdens for employers**

Scheduling open enrollment to overlap with tax filing could reduce the amount of manual verification employers must provide about the health coverage they do or do not offer. Compared to October through December of the previous year, tax season will provide more subsidy applicants with tax documents that contain up-to-date information about their companies' employer identification numbers (EINs). ESI

information could then be verified through data-matching rather than firms' completion of questionnaires or manual provision of documents or answers to Marketplace queries.

To qualify for QHP subsidies, one must be without an offer of ESI that the ACA classifies as affordable and offering minimum value (that is, having an actuarial value of at least 60 percent). The ACA creates systems through which, starting in 2015, larger employers (i.e., those with 50 or more full-time-equivalent employees) will provide the federal government with data about the health coverage they do or do not offer; information about the health coverage provided by firms with fewer than 50 workers will be reported either by the employer or the firm's health insurer.<sup>94</sup> In the meantime, subsidy applicants who are offered ESI give their employers a document to complete—"Appendix A" to the family application, which requests:<sup>95</sup> employer name, EIN, address, and phone number; contact person for ESI information, including phone number and email address; whether the employee is currently eligible for ESI or is in a waiting or probationary period and, if the latter, the date on which such period ends; all family members who are eligible for ESI; whether the employer offers a plan that meets the ACA's minimum value standard; the premium cost to the employee of the lowest-cost plan that meets the minimum value standard, assuming that the employee receives the maximum tobacco-related discount and no other wellness discounts; the frequency with which the employee would make premium payments for such a plan; changes the employer will make for the new plan year, including whether the employer will begin or stop offering coverage, or whether the employer will change the premium for the lowest-cost plan that meets the minimum value requirement; if the employer will make changes for the new plan year, the date the change becomes effective, the amount the employee would then have to pay in premiums for the lowest-cost plan that meets the ACA's minimum value requirement, and the frequency of such payments.

Even after employers and their plans provide the federal government with data about ESI, the information will not always be sufficient to verify eligibility. Presumably, applicants will be asked to use burdensome forms like Appendix A in seeking documentation from employers when electronic data-matching proves insufficient. If no verification is available from any source, Marketplaces will determine access to ESI based on applicant attestations, according to CMS regulations. Among applications granted based on these attestations, the Marketplace will seek verification from a sample of employers.<sup>96</sup>

The ground rules for employers' future documentation of ESI are not entirely clear. But it seems likely that if Marketplaces are limited in their ability to verify applicants' eligibility by matching with sources of electronic data provided by firms or their insurers, employers will need to shoulder additional burdens, by completing forms for employees, by responding to government queries, or both.

For a Marketplace to verify an applicant's eligibility based on data employers or their insurers have already provided, the Marketplace must match the employer's EIN with an EIN listed on the subsidy application. As a practical matter, most people know their employers' EINs only through the forms they

receive for tax purposes. If open enrollment takes place in October to December, tax returns from two years in the past will provide the EIN. Such EINs will not fit current employers for applicants who changed jobs during the past two years. If the OEP overlaps with during tax filing season, only one year's job changes will have occurred since the period covered by the return.<sup>97</sup> An OEP early during the year should thus increase the number of applications with up-to-date EINs. As a result, more ESI-related eligibility should be verified through data matches, reducing employers' verification burdens.

## A less politically charged calendar

Changing the schedule for open enrollment and QHP plan years could mitigate some potentially harmful political pressures that now focus on ACA implementation.

Under the current schedule, premiums for QHPs and other individual plans are announced around the October 1 start of open enrollment—approximately one month before Election Day in every even-numbered year. Such announcements could have unpredictable political effects out of proportion to their policy relevance. By analogy, imagine the political impact if gas prices changed once a year, and the change was announced every October.

Another implication of the current calendar is that officials can be tempted to delay the release of “potentially costly or otherwise controversial rules during an election year.”<sup>98</sup> Some observers suggest that, to avoid political risks, HHS delayed issuance of key ACA rules in 2012 from September until after the Presidential election, creating a “time crunch” that contributed to later problems with Marketplace roll-outs.<sup>99</sup> Whether or not that observation was accurate, an October OEP start date in future years risks delays to annual Notices of Benefit and Payment Parameters. These notices can govern key elements of Marketplace operations. The notice for 2016, for example, addresses risk adjustment, reinsurance, and risk corridors programs; cost sharing rules for QHPs by metal tier; cost-sharing reductions for low-income consumers; user fees for federally-facilitated Marketplaces (FFMs); OEP timing; standards for Essential Health Benefits; network adequacy standards; etc.<sup>100</sup> These notices are supposed to be published as proposed rules by mid-October, two calendar years before the applicable benefit year, with comments due two months later, and final rules published by mid-January.<sup>101</sup> This should leave two to three months for plans to develop products in time for submission to FFMs by the proposed mid-April due date. Marketplaces and regulators can then complete the lengthy review and negotiation required for plan submissions to be approved and QHPs offered by the October 1 start of open enrollment.<sup>102</sup> If the Notice of Benefit and Payment Parameters is delayed—for example, the proposed rule for 2016 was not published until November 26, 2014, and the final rule had not been published at this writing in early February 2015—the

time for product development and review is shortened. This could create serious problems in the coverage offered to consumers.

Suppose the OEP was instead scheduled for late January through March and the QHP plan year started in May. In December 2018, for example, CMS could announce proposed rules for the QHP plan year that would begin in May 2020. Electoral considerations would not interfere with the timing of this announcement. CMS could finalize those rules by mid-March 2019, leaving ample time for plans, regulators, and Marketplaces to develop and approve coverage before open enrollment began in late January 2020.

Under such an alternative calendar, new QHP premiums would be announced every year in late January, around the time the CMS Office of the Actuary releases its annual analysis of overall health care spending.<sup>103</sup> This timing might enrich the public conversation about health care costs. Most important, annual changes to QHP premiums would no longer be announced during the heat of political campaigns.

## Disadvantages

### Transition costs

Since CMS's July 2011 announcement of Marketplace OEP and plan year schedules,<sup>104</sup> a considerable private and public infrastructure has developed around a plan year that starts in January for QHPs and other individual plans. This infrastructure involves carrier rate and form filing, review by insurance regulators, data provision to FFMs, state statutes governing the individual market, and federal regulations.<sup>105</sup> Changing this infrastructure could involve considerable work.

Moreover, a period of bridge coverage would be required to transition from a plan year that starts in January to one that begins in May. To illustrate, Massachusetts' 2006 reforms used a plan year that began in July, the start of the state's fiscal year. In moving to the ACA's QHP plan year that began in January 2014, the state provided six months of bridge coverage from July 2013 through December 2013. Deductibles were reduced on a pro-rata basis, reflecting six- rather than 12-month coverage. No serious disruptions were reported.<sup>106</sup>

An analogous approach, in this context, would involve four months of bridge coverage from January through April 2017. However, such a short transition would likely prove more costly and disruptive than Massachusetts's six-month bridge. QHP plan design is much more diverse nationally than was plan design in Massachusetts. QHP deductibles and limits on consumer costs can be prorated from annual to part-year coverage, but copayments and coinsurance would presumably be unchanged, whether coverage lasts for

four or 12 months. Technical revisions to the CMS actuarial value calculator would thus be needed to square the resulting hybrid cost-sharing structures with the actuarial value standards that, under the ACA, define both the metal tiers into which all QHP consumers enroll and cost-sharing reductions (CSRs) for low-income enrollees. Examples of other necessary changes required by shifting from 12-months to four-months of coverage include medical loss ratio rules, risk-adjustments, and CSR payment procedures.<sup>107</sup>

Carriers would likely need to undertake considerable work developing products that conform to revised federal specifications. The reward for offering those new products would be limited, consisting of four months of premiums. Moreover, the risks of offering such products could be considerable; plans have no prior experience with insurance that operates in this way, and the combination of a new OEP early during bridge coverage and the ACA's rules for three-month grace periods following non-payment of premiums could present significant opportunities for "gaming" and adverse selection.<sup>108</sup>

Any bridge coverage would last for something other than 12 months and so require a recalibration of federal rules. However, a transition that lasts longer than four months could reduce adverse selection risks and increase plans' ability to recoup the investments required to respond to changed federal standards. To reduce overall disruption, policymakers could use either:

- A single, 16-month period of bridge coverage (January 2017 through April 2018);
- Two eight-month bridge periods (January 2017 through August 2017 and September 2017 through April 2018); or
- Two 14-month periods (January 2017 through February 2018 and March 2018 through April 2019).

Each of these schedules has its trade-offs. The third would entail a longer delay before realizing the enrollment and risk pool gains of an OEP scheduled for late winter and early spring. On the other hand, it would also provide coverage periods closest to 12 months in length, which could simplify the necessary federal modifications and make claims easier to predict, based on carriers' prior experience with annual coverage periods. Generally speaking, shorter bridge periods would reduce carriers' risks of mispriced products and give uninsured consumers more chances to enroll; longer periods of time with a single type of bridge coverage would increase plans' opportunities to recoup the cost of product development.

## Consumer confusion

Changing the QHP plan year from the annual accounting period used for tax credit calculation could further complicate already difficult decisions that face some families. For example, an APTC-beneficiary family may

have an 18-year-old child who is considering leaving home mid-year, which would reduce household size. That would increase the FPL that determines the family's year-end tax credit, since such FPL is generally<sup>109</sup> based on household size as of December 31.<sup>110</sup> If this occurs, APTCs claimed appropriately based on circumstances before the child left home could create income tax liabilities at reconciliation.

Choices like these would become harder if QHP plan years began in May. Families would need to think about each option's effects through multiple time periods, each less than a year in length, each involving various combinations of QHP plan years and calendar years. By contrast, if the QHP plan year remains aligned with the calendar year, the analysis would be simpler, proceeding one calendar year at a time.

Consumers who make such decisions on their own would experience increased confusion. However, the ACA will be dauntingly complex, no matter what. As noted earlier, an OEP early during the calendar year would let more consumers get help from brokers and tax preparation services. Less overall confusion, not more, could result if additional consumers receive assistance in navigating the ACA's complexities.<sup>111</sup>

## Other concerns

Two concerns often raised about a QHP plan year that differs from the calendar year should not worry policymakers. The first is the prospect of tax reconciliation that encompasses two different QHP plan years. Carefully analyzed, a mid-year change between QHP plan years would be no harder for reconciliation to handle than a subsidy beneficiary's mid-year move from one county to another.

If the QHP plan year began in May, reconciliation would not straddle two calendar years or become a two-year process. Consumers would still claim APTCs during a single calendar year based on income projections for that year. Taxpayers would still reconcile APTCs received during a calendar year with final annual income shown on their tax return for that year. When a new QHP plan year began in May, monthly benchmark premiums and APTCs would change, just as if the APTC beneficiary had moved to a new county.

The benchmark premium—that is, the premium charged by the second-lowest-cost silver plan (SLCSP) available to QHP enrollees—affects the taxpayer's tax credit amount. That amount equals the difference between (1) the SLCSP and (2) the taxpayer's income-based payment. Today, when a QHP beneficiary moves mid-year to a place where the SLCSP charges a different amount, the benchmark premium and APTC amount change. The same thing would happen if the start of a new QHP plan year in May changed the SLCSP because of adjustments to local QHP offerings combined with the beneficiary being one year older than at the start of the previous QHP plan year.

Mid-year changes to SLCSPs and APTCs do not greatly worsen reconciliation's complexities. Reconciliation requires adding up all of a taxpayer's monthly APTCs. When SLCSPs change mid-year, one

likewise adds all 12 months' SLCSPs to calculate the annual tax credit amount.<sup>112</sup> Marketplaces are required to send APTC recipients "1095-A forms" in late January that provide all the information needed to do the arithmetic of reconciliation. These forms list, from the prior year, each month's APTC and SLCSP (figure 8). Most APTC beneficiaries are likely to use tax preparation services to completing tax reconciliation forms. It seems highly unlikely that reconciliation would become more complex in a way that many taxpayers would notice if, because the QHP plan year started in May, mid-year changes to APTCs and SLCSPs became essentially universal rather than occasional.

FIGURE 8

Excerpts from the 1095-A Marketplace Reporting Form

<b>Part III Household Information</b>			
Month	A. Monthly Premium Amount	B. Monthly Premium Amount of Second Lowest Cost Silver Plan (SLCSP)	C. Monthly Advance Payment of Premium Tax Credit
21 January			
22 February			
32 December			
33 Annual Totals			

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60703Q Form **1095-A** (2014)

Source: IRS 2014.

A second frequently expressed concern involves simplicity and clarity. Aside from the difference between plan years and tax credit accounting periods, some suggest that consumers would be less confused with a simpler system where QHPs used the same OEP and plan year as Medicare and most ESI.<sup>113</sup>

Such simplicity may be more symbolic than consequential. Populations do not greatly overlap between QHP subsidies, on the one hand, and Medicare or ESI, on the other. Medicare-eligible consumers cannot receive QHP subsidies. And only 22 percent of QHP-eligible uninsured adults work or have spouses who work for firms that offer ESI.<sup>114</sup> Even among adults (1) who work or whose spouses work at firms offering ESI and (2) whose income is in the range that qualifies for subsidies (138 to 400 percent of FPL), ESI and subsidy eligibility rarely coincide:

- Between 97.8 and 99.8 percent of ESI recipients in this group are ineligible for QHP subsidies because the ACA classifies their ESI as affordable.
- Between 96.5 and 99.6 percent of those who do *not* receive ESI within this group are either (1) not offered ESI because of part-time employment or other reasons; or (2) offered ESI that makes them ineligible because it is deemed affordable.<sup>115</sup> The latter have rejected these disqualifying ESI offers.

Massachusetts's 2006 reforms, which used a plan year that began in July, reduced the percentage of uninsured residents below 3 percent—the lowest level of any state.<sup>116</sup> While that state's experience does not shed light on the impact of departing from the calendar-year period used for tax credits under the ACA, Massachusetts's track record suggests that uninsured consumers can easily comprehend the difference between a subsidy system's enrollment schedule and the schedule used by Medicare and most ESI.

## Conclusion

**For Medicare, federal employees, and most ESI, the same basic schedule applies: open enrollment takes place near the end of the year, and coverage begins the following January.**

In some observers' view, common sense calls for comparable treatment of Marketplace plans. QHPs are health insurance, like employer plans and Medicare Advantage—why time QHP enrollment any differently? Aligning the plan year with the calendar year seems, on its face, particularly logical with QHPs, since the premium tax credits that help fund most QHP coverage are based on the income that taxpayers earn during the calendar year. Furthermore, many consumers are already confused about the ACA; why compound the confusion by arranging a plan year that differs from the calendar year used for tax credit accounting and an enrollment schedule that differs from Medicare and most employer coverage?

More than common sense is needed, however, to resolve this issue wisely. Even with the ACA's subsidies, QHP costs can be much higher, relative to income, than those imposed on Medicare beneficiaries and most ESI enrollees. Affordability has already emerged as perhaps the most important factor deterring QHP enrollment among uninsured consumers who examined their Marketplace options in 2014 and chose not to sign up. Unless they suffer from health problems that motivate participation, consumers eligible for Marketplace coverage must be persuaded to enroll. Compared to October through December, February and March are likely to be much more successful months for such persuasion. Scheduling enrollment for late winter and early spring could also improve subsidies' accuracy, lower tax reconciliation risks, lighten administrative burdens for carriers, brokers, and employers, and reduce political pressures on key features of the health insurance cycle.

From February 16 through April 15, 2015, an SEP could let uninsured consumers who pay their penalty for lacking coverage in 2014 quickly enroll into QHPs for the remainder of 2015. Not only would enrollment of young and healthy consumers increase (albeit with some offsetting enrollment of consumers who experience an injury or are diagnosed with an illness during the SEP), uninsured consumers would not feel unfairly blindsided by the application of unexpected penalties for uninsurance in 2015 that they cannot avoid if they file returns after rather than before February 15.

For future years, policymakers seeking the benefits of an OEP early in late winter and early spring would need to analyze the cost of moving to a QHP plan year that starts in May and select the least disruptive transition schedule. Policymakers would also need to weigh the benefits of change against the confusion that some consumers would experience if the QHP plan year diverges from the calendar year that determines subsidy eligibility.

In his novel, *The Alloy of Law*, Brendan Sanderson stressed the importance of knowing “when to set aside the important things in order to accomplish the vital ones.” Those who believe the ACA’s vital goals involve enrolling the eligible uninsured into coverage thus face three questions:

1. If the OEP is scheduled for early in the year, is there a good chance that significantly more eligible uninsured would receive coverage? If so:
2. What combination of transition schedule and other policies, along with an OEP early in the year, would produce the most favorable overall results, considering both advantages and disadvantages?
3. How does that policy combination’s likely gains compare to its expected losses? Which of those anticipated results are vital and which are merely important?

# Notes

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<sup>1</sup> Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H and Zuckerman S. Measuring Marketplace Enrollment Relative to Enrollment Projections: Update. Washington, DC: Urban Institute, 2014, <http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf>. Several months ago, federal officials announced that their early estimates of enrollment were too high because they included recipients of dental-only coverage. Nevertheless, survey data, independent of HHS administrative reports, show considerable reductions in uninsurance since the start of the 2014 open enrollment period. Long SK, Kenney GM, Zuckerman S, Wissoker D, Shartz A, Karpman M, Anderson N and Hempstead K. Taking Stock at Mid-Year: Health Insurance Coverage under the ACA as of June 2014. Washington, DC: Urban Institute, July 29, 2014, <http://hrms.urban.org/briefs/taking-stock-at-mid-year.pdf>. Long SK, Karpman M, Shartz A, Wissoker D, Kenney GM, Zuckerman S, Anderson N and Hempstead K. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. Washington, DC: Urban Institute, December 2014, <http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.pdf>.

<sup>2</sup> Jost T. "Implementing Health Reform: Medicaid Eligibility, 2015 Navigator Grants, And FAQs (Updated)." *Health Affairs Blog*, Sept. 8, 2014, <http://healthaffairs.org/blog/2014/09/08/implementing-health-reform-medicaid-eligibility-2015-open-enrollment-and-faqs/>.

<sup>3</sup> CMS. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016." *Federal Register*, Feb. 26, 2014, <http://s3.amazonaws.com/public-inspection.federalregister.gov/2014-27858.pdf>. This followed CMS's earlier statement, "we intend to propose open enrollment dates for the 2016 plan year in the 2016 draft Payment Notice. Finalizing open enrollment dates for the 2016 plan year in the 2016 Payment Notice will allow an additional year's experiences to inform the finalization of realistic enrollment dates." CMS. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule. 79 Fed. Register 13744, 13797 (March 11, 2014).

<sup>4</sup> Swartz K and Graves JA. "Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices." *Health Affairs*, July 2014, 33 (7):1-8.

<sup>5</sup> Jost, T, "Implementing Health Reform: New HHS 2015 Marketplace Enrollment Estimates," *Health Affairs Blog*, November 11, 2014, <http://healthaffairs.org/blog/2014/11/11/implementing-health-reform-new-hhs-2015-marketplace-enrollment-estimates/>.

<sup>6</sup> Congdon W, Kling JR, and Mullainathan S. "Behavioral Economics and Tax Policy." *National Bureau of Economic Research Working Paper 15328*. September 2009.

<sup>7</sup> Dorn, S. *Affordability of Marketplace Coverage: Challenges to Enrollment and State Options to Lower Consumer Costs*, December 2014, Washington, DC: Urban Institute, <http://www.urban.org/UploadedPDF/2000039-Affordability-of-Marketplace-Coverage.pdf>.

<sup>8</sup> ASPE/HHS. How Many Individuals Might Have Marketplace Coverage after the 2015 Open Enrollment Period? November 10, 2014, [http://aspe.hhs.gov/health/reports/2014/Targets/ib\\_Targets.pdf](http://aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf), citing U.S. Department of Health and Human Services, Health Insurance Marketplace: November Enrollment Report," Nov. 13, 2013, p. 20-25. Available at: [http://aspe.hhs.gov/health/reports/2013/marketplaceenrollment/rpt\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2013/marketplaceenrollment/rpt_enrollment.pdf).

<sup>9</sup> Buettgens M, Kenney GM, and Recht H. *Eligibility for Assistance and Projected Changes in Coverage under the ACA: Variation across States*, May 2014 Update. Washington, DC: Urban Institute, <http://www.urban.org/UploadedPDF/413129-Eligibility-for-Assistance-and-Projected-Changes-in-Coverage-Under-the-ACA-Variation-Across-States.pdf>.

<sup>10</sup> See studies described in Kahneman K. "Maps of Bounded Rationality: Psychology for Behavioral Economics." *The American Economic Review*, Dec. 2003, 93 (5)1449-75; Sunstein CR. "What's Available? Social influences and behavioral economics." *Northwestern University Law Review*. Spring 2003. 97(3): 1295-1314; Shams, Michele A., "The Availability Heuristic in Judgments of Research Findings: Manipulations of Subjective Experience" (2002). All Volumes (2001-08). Paper 112, [http://digitalcommons.unf.edu/ojii\\_volumes/112](http://digitalcommons.unf.edu/ojii_volumes/112).

<sup>11</sup> Sunstein, What's Available? Social influences and Behavioral Economics. Another study involved a randomized, controlled trial that tested the impact of timing by creating a computer-operated video game that, during each round, let participants observe the game and then "bet" on what would happen next. Participants were informed that, throughout

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each round, fixed rules determined what would occur. Although participants knew all observations were equally relevant, 59 percent of their bets reflected observations in the first half of each round, while 75 percent reflected the second, more recent half. Hertwig R, Barron G, Elke U, Weber, Erev I. "Decisions from Experience and the Effect of Rare Events in Risky Choice." *Psychological Science*, Vol. 15, No. 8 (Aug., 2004), pp. 534-9.

<sup>12</sup> Platania J and Crawford J. "Media Exposure, Juror Decision-Making, and the Availability Heuristic." *The Jury Expert*, November/December 2012, Volume 24, Issue 5, 1-6.

<sup>13</sup> Swartz K and Graves JA. "Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices." *Health Affairs*, July 2014, 33 (7):1-8.

<sup>14</sup> For the sake of consistency, we analyze data for consumer credit and new home sales from 1992 to 2013, even though data in these two categories are readily available for earlier periods. Data regarding sales in other categories shown here, including new cars, are readily available from the Census Bureau's Retail Trade Survey in comparable fashion, over time, starting in 1992.

<sup>15</sup> Along similar lines, the Harris poll found that, in November 2014, households earning between \$50,000 and \$75,000 a year expected to take an average of 2.6 months to pay off their holiday debts, and those earning less than \$50,000 expected to require an average of two months. Glazer J, "Middle Class Families Will Have the Hardest Time Paying Off Holiday Debt," *Five Thirty Eight*, Dec. 1, 2014, <http://fivethirtyeight.com/datalab/middle-class-families-paying-off-holiday-debt/>.

<sup>16</sup> Refunds are likely to be received even earlier during 2015, as the tax filing season began on January 20. During the two previous years, data from which was the basis for figure 3, that season began at the very end of January or the beginning of February.

<sup>17</sup> In states that do not expand Medicaid, the lower end of financial eligibility for subsidies drops to 100 percent of FPL. In all states, non-citizens who are lawfully present in the U.S. but are not qualified aliens eligible for federal Medicaid funding can qualify for QHP subsidies with incomes below otherwise applicable minimums.

<sup>18</sup> Overall employment and wage levels for non-supervisory and production workers are also slightly higher in the spring than during the final months of the year, as shown later.

<sup>19</sup> Of all existing home sales in the Census Bureau's Western Region during 2010 through 2010, 45 percent, 12 percent, and 2 percent took place in California, Arizona, and Hawaii, respectively. Author's calculations, National Association of Realtors, Washington, DC, *Real Estate Outlook; Market Trends & Insights*, "Table 979. Existing Home Sales by State: 2000 to 2010," <https://www.census.gov/compendia/statab/2012/tables/12s0979.xls>. The Census Bureau does not make available state-level data about new home sales.

<sup>20</sup> Author's calculations, U.S. Census Bureau, Monthly Retail Trade and Food Services. Not Seasonally Adjusted Sales - Monthly [Millions of Dollars], 1992-2014. "443: Electronics and Appliance Stores: U.S. Total," <https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=443&dataType=SM&geoLevel=US&notAdjusted=1&submit=GET+DATA>; "4481: Clothing Stores: U.S. Total," <https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=4481&dataType=SM&geoLevel=US&notAdjusted=1&submit=GET+DATA>; "451: Sporting Goods, Hobby, Book, and Music Stores: U.S. Total," <https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=451&dataType=SM&geoLevel=US&notAdjusted=1&submit=GET+DATA>; "45322: Gift, Novelty, and Souvenir Stores: U.S. Total," <https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=45322&dataType=SM&geoLevel=US&notAdjusted=1&submit=GET+DATA>; "4541: Electronic Shopping and Mail-order Houses: U.S. Total," <https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=4541&dataType=SM&geoLevel=US&notAdjusted=1&submit=GET+DATA>.

<sup>21</sup> Author's calculations. IRS. "Table 3.3 All Returns: Tax Liability, Tax Credits, and Tax Payments, by Size of Adjusted Gross Income, Tax Year 2012." *SOI Tax Stats - Individual Income Tax Returns Publication 1304*. Washington, DC: IRS, 2014. [http://www.irs.gov/file\\_source/pub/irs-soi/12in33ar.xls](http://www.irs.gov/file_source/pub/irs-soi/12in33ar.xls).

<sup>22</sup> Author's calculations, Federal Reserve Board, "Revolving consumer credit owned and securitized, not seasonally adjusted level," *The G.19 Statistical Release*,

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[http://www.federalreserve.gov/releases/g19/HIST/cc\\_hist\\_r\\_levels.html](http://www.federalreserve.gov/releases/g19/HIST/cc_hist_r_levels.html)[http://www.federalreserve.gov/releases/g19/HIST/cc\\_hist\\_r\\_levels.html](http://www.federalreserve.gov/releases/g19/HIST/cc_hist_r_levels.html)

<sup>23</sup> <http://www.irs.gov/uac/2014-and-Prior-Year-Filing-Season-Statistics>.

<sup>24</sup> 26 CFR 1.6011-8(a).

<sup>25</sup> Author's calculations, U.S. Census Bureau, "5242: Agencies, Brokerages, and Other Insurance Related Activities: U.S. Total, Not Seasonally Adjusted Total Revenue [Millions of Dollars], 2003-2014," <https://www.census.gov/econ/currentdata/dbsearch?program=QSS&startYear=2003&endYear=2014&categories=5241T&dataType=QREV&geoLevel=US&notAdjusted=1&submit=GET+DATA>.

<sup>26</sup> Author's calculations, U.S. Census Bureau, "Monthly Retail Trade and Food Services, 4411,4412: Auto and Other Motor Vehicles: U.S. Total, Not Seasonally Adjusted Sales - Monthly [Millions of Dollars], 1992-2014," <https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=441X&dataType=SM&geoLevel=US&notAdjusted=1&submit=GET+DATA>.

<sup>27</sup> Author's calculations, U.S. Census Bureau, "New Single-family Houses Sold: United States — Not Seasonally Adjusted All Houses [Thousands of Units], 1963-2014," <https://www.census.gov/econ/currentdata/dbsearch?program=RESSALES&startYear=1963&endYear=2014&categories=SOLD&dataType=TOTAL&geoLevel=US&notAdjusted=1&submit=GET+DATA>.

<sup>28</sup> Laibson D, "Impatience and Savings," *NBER Reporter Online* (2005). <http://www.nber.org/reporter/fall05/laibson.html>; Laibson D, "Golden Eggs and Hyperbolic Discounting," *The Quarterly Journal of Economics* 112, no. 2 (1997): 443-78; Thaler R, "Mental Accounting and Consumer Choice," *Marketing Science* 4, no. 3 (1985): 199-214; O'Donoghue T and Rabin R, "Procrastination in Preparing for Retirement," in *Behavioral Dimensions of Retirement Economics*, edited by Aaron H (Washington, DC: Brookings Institution and Russell Sage, 1998): 125-56; Baicker K., Congdon W J, and Mullainathan S, "Health Insurance Coverage and Take-Up: Lessons from behavioral economics," *The Milbank Quarterly* 90, no. 1 (2012): 107-34; Choi J J, Laibson D, and B C Madrian. \$100 Bills on the Sidewalk: Suboptimal Investment in 401(K) Plans. *NBER Working Paper 11554*. August. 2005. [http://www.nber.org/papers/w11554.pdf?new\\_window=1](http://www.nber.org/papers/w11554.pdf?new_window=1); Beshears J, Choi J J, Laibson D, and Madrian B C, "The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States," *National Bureau of Economic Research Working Paper Series* (Cambridge, MA: NBER, 2006); Madrian B C and Shea D F, "The Power of Suggestion: Inertia in 401(k) participation and savings behavior," *The Quarterly Journal of Economics* 116, no. 4 (2001): 1149-87; Dorn S, Wilkinson M, and Benatar S. "Case Study of Louisiana's Express Lane Eligibility: Final Report." *CHIPRA Express Lane Eligibility Evaluation*. Washington, DC: Urban Institute, January 2012; Johnson, E.J., and D.G. Goldstein. "Defaults and Donation Decisions." *Transplantation*. 78 (12): 1713-1716. December 27, 2004.

<sup>29</sup> Congdon W, Kling JR, and Mullainathan S. "Behavioral Economics and Tax Policy." *National Bureau of Economic Research Working Paper 15328*. September 2009.

<sup>30</sup> Such assistance played an important role in the success achieved by Massachusetts's 2006 reforms; more than half of successful applications came, not from consumers themselves, but from providers and community organizations acting on consumers' behalf. Dorn S, Hill I, and Hogan S. *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, November 2009, Washington, DC: Urban Institute, [http://www.urban.org/uploadedpdf/411987\\_massachusetts\\_success.pdf](http://www.urban.org/uploadedpdf/411987_massachusetts_success.pdf). Along similar lines, a randomized, controlled experiment involved the tax preparation firm H&R Block, which used tax return data and interviews to complete and submit SNAP application forms on behalf of low-income clients. Among those in that group, 80 percent more SNAP applications were filed than with a control group that received only basic SNAP information and a blank SNAP form. By contrast, no statistically significant effects were observed, compared to the control group, when H&R Block completed SNAP forms, handed them to families, and explained where and how to file them. Schanzenbach W D. "Experimental Estimates of the Barriers to Food Stamp Enrollment." Institute for Research on Poverty, Discussion Paper no. 1367-09. Sept. 2009. A comparable H&R Block experiment involving applications for college student aid found similar results. Bettinger, EP, Long BT, Oreopoulos P, and Sanbonmatsu L, "The Role of Simplification And Information In College Decisions: Results From The H&R Block FAFSA Experiment," National Bureau of Economic Research Working Paper 15361 (September 2009). As another example, a randomized, controlled experiment in a low-income, predominantly Latino community in Boston compared Massachusetts's normal Medicaid outreach methods with having case managers from a community-based organization file applications for children, then following up over time to address emerging problems. The state's normal outreach methods involved mailings, door-to-door canvassing, radio advertisements in Spanish, grants to community organizations, and a toll-free call center. Among the children who received assistance from community-based case managers, 96 percent enrolled in Medicaid, and 78 percent retained coverage continuously

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throughout the study's one-year follow-up period. By contrast, only 57 percent of the children receiving the state's standard outreach enrolled, and just 30 percent retained coverage continuously throughout the following year. Flores G, et al. "A randomized, controlled trial of the effectiveness of community-based case management in insuring uninsured Latino children." *Pediatrics*. 2005; 116: 1433–41. <http://pediatrics.aappublications.org/content/116/6/1433.full.pdf>.

<sup>31</sup> Baron Z. *In-Person Assistance Maximizes Enrollment Success*. March 2014, Washington, DC: Enroll America, <https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf>.

<sup>32</sup> Dorn S. *Public Education, Outreach and Application Assistance*. November 2014, Washington, DC: Urban Institute. HRMS is funded by the Robert Wood Johnson Foundation, the Ford Foundation, and others.

<sup>33</sup> Marketplaces typically fund administration through QHP surcharges, which increase QHP premiums. If administrative costs, hence surcharges, rise, the resulting premium increase could disadvantage QHPs in competing against individual plans outside the Marketplace. Both competitive dynamics and worries about Marketplaces' sustainable financing of ongoing operations pressure Marketplaces to limit administrative costs, including for application assistance. See KPMG Government Institute, "The Market Model for Sustainable ACA State Exchanges," *KPMG Government Institute Issue Brief*, January 2014, <http://www.kpmg-institutes.com/content/dam/kpmg/governmentinstitute/pdf/2014/market-model-for-sustainable-aca-state-exchanges-1.pdf>.

<sup>34</sup> Dorn S., Public Education, *Outreach and Application Assistance*, December 2014, Washington, DC: Urban Institute, <http://www.urban.org/UploadedPDF/2000037-Public-Education-Outreach-and-Application-Assistance.pdf>; author's calculations, Covered California, "Ethnic Race by Service Channel - Subsidized Only," *2014 Open Enrollment Data Book*, June 18, 2014 (enrollment data from October 1, 2013, through April 15, 2014), <http://hbex.coveredca.com/data-research/2014-Open-Enrollment-Data-Book/Income%20Category%20by%20Service%20Channel.xlsx>.

<sup>35</sup> Blavin F, Zuckerman S, and Karpman M. *Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources*. June 9, 2014, Washington, DC: Urban Institute, <http://hrms.urban.org/briefs/obtaining-information-on-marketplace.html>.

<sup>36</sup> Dorn S, Buettgens M, and Dev J. *Tax Preparers Could Help Most Uninsured Get Covered*. Feb. 2014, Washington, DC: Urban Institute, <http://www.urban.org/UploadedPDF/413029-Tax-Preparers-Could-Help-Most-Uninsured-Get-Covered.pdf>.

<sup>37</sup> Agency for Healthcare Research and Quality. Total Health Services-Mean and Median Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2012. Medical Expenditure Panel Survey Household Component Data. Generated interactively. (December 11, 2014) [http://meps.ahrq.gov/mepsweb/data\\_stats/tables/compendia\\_hh\\_interactive.jsp?\\_SERVICE=MEPSSocket0&\\_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012\\_PLEXP\\_%40&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&\\_Debug=](http://meps.ahrq.gov/mepsweb/data_stats/tables/compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_PLEXP_%40&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug=)

<sup>38</sup> Brian Haile, Jackson-Hewitt, personal communication, 2014.

<sup>39</sup> Dorn, Buettgens, and Dev 2014, Tax Preparers Could Help Most Uninsured Get Covered.

<sup>40</sup> Marcuss R, Dubois A, Hedemann H, Risler M-H, and Leibel K. August 2014. *Compliance Estimates for the Earned Income Tax Credit Claimed on 2006–2008 Returns*, Research, Analysis, and Statistics Report, Publication 5162, Washington, DC: Internal Revenue Service.

<sup>41</sup> IRS. "Number of Individuals with Current Preparer Tax Identification Numbers (PTINs) for 2014/2015," *Return Preparer Office Federal Tax Return Preparer Statistics*, Data current as of 12/1/2014, <http://www.irs.gov/Tax-Professionals/Return-Preparer-Office-Federal-Tax-Return-Preparer-Statistics>.

<sup>42</sup> Karen Pollitz, Jennifer Tolbert, and Rosa Ma. *Survey of Health Insurance Marketplace Assister Programs: A First Look at Consumer Assistance under the Affordable Care Act*, July 2014, Washington, DC: Kaiser Family Foundation, <http://files.kff.org/attachment/survey-of-health-insurance-marketplace-assister-programs-report>.

<sup>43</sup> Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*, For the period: October 1, 2013 – March 31, 2014 (Including Additional Special Enrollment Period Activity Reported through 4-19-14), May 1, 2014.

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<sup>44</sup> Unpublished tabulations from Dorn, Buettgens, and Dev 2014, Tax Preparers Could Help Most Uninsured Get Covered.

<sup>45</sup> Brian Haile, 2014.

<sup>46</sup> Covered California. *All Certified Enrollment Counselors (CEC) Production (Data from Oct. 1, 2013 – April 15, 2014)*, June 5, 2014, <http://hbex.coveredca.com/data-research/library/CEC%20ID%20Number%20Production%20Report%20Final.pdf>.

<sup>47</sup> Kelly Rolfe Financial Services, for example, California's top-ranked tax preparer is a certified enrollment counsellor. See <http://krfs.org/>.

<sup>48</sup> In many states, QHP plan selection was the most time-consuming part of the enrollment process for subsidy-eligible consumers. Dorn, Public Education, Outreach and Application Assistance.

<sup>49</sup> Brian Haile, 2014. Typically, Medicaid and CHIP agencies contract with private vendors to help newly enrolling consumers select a managed care plan. In many states, those who fail to choose a plan within a specified period of time are assigned to a plan that is selected automatically.

<sup>50</sup> IRS. "IRC § 7216 Questions and Answers Related to the Affordable Care Act," February 3, 2014, <http://www.irs.gov/uac/IRC-%C2%A7-7216-Questions-and-Answers-Related-to-the-Affordable-Care-Act>.

<sup>51</sup> Government Accountability Office. *Paid Tax Return Preparers: In a Limited Study, Preparers Made Significant Errors*, April 8, 2014, GAO-14-467T, <http://gao.gov/assets/670/662356.pdf>.

<sup>52</sup> Marcus, et al., Compliance Estimates for the Earned Income Tax Credit Claimed on 2006–2008 Return.

<sup>53</sup> IRS National Taxpayer Advocate. "Most Serious Problem #5: Regulation of Return Preparers: Taxpayers and Tax Administration Remain Vulnerable to Incompetent and Unscrupulous Return Preparers While the IRS Is Enjoined From Continuing its Efforts to Effectively Regulate Unenrolled Preparers," *2013 Annual Report to Congress, Volume I*, December 31, 2014, <http://www.taxpayeradvocate.irs.gov/userfiles/file/2013FullReport/Volume-1.pdf>.

<sup>54</sup> The IRS has developed a voluntary Annual Filing Season Program designed to encourage tax return preparers who are not attorneys, CPAs, or enrolled agents to complete continuing education courses and to agree to abide by requirements that govern representation of taxpayers before the IRS. Such non-enrolled preparers can receive an Annual Filing Season Program Record of Completion by meeting specified education requirements and agreeing to comply with various provisions within Treasury Department Circular No. 230, including 31 CFR § 10.51. The latter prohibits, among other things, "[g]iving false or misleading information, or participating in any way in the giving of false or misleading information" on "Federal tax returns;" "willfully evading, attempting to evade, or participating in any way in evading or attempting to evade any assessment or payment of any Federal tax;" "[w]illfully assisting, counseling, encouraging a client or prospective client in violating, or suggesting to a client or prospective client to violate, any Federal tax law, or knowingly counseling or suggesting to a client or prospective client an illegal plan to evade Federal taxes or payment thereof;" or "[g]iving a false opinion, knowingly, recklessly, or through gross incompetence, including an opinion which is intentionally or recklessly misleading, or engaging in a pattern of providing incompetent opinions on questions arising under the Federal tax laws." For a more detailed explanation of the Annual Filing Season Program, see IRS, *Annual Filing Season Program*, Rev. Proc. 2014-42, July 1, 2014, <http://www.irs.gov/pub/irs-drop/rp-14-42.pdf>.

<sup>55</sup> George Brandes, formerly of Jackson-Hewitt, personal communication, 2014.

<sup>56</sup> 26 CFR 1.6011-8(a) provides: "A taxpayer who receives advance payments of the premium tax credit under section 36B must file an income tax return for that taxable year on or before the fifteenth day of the fourth month following the close of the taxable year." According to 45 CFR 155.305 (f)(4), "The Exchange may not determine a tax filer eligible for advance payments of the premium tax credit if HHS notifies the Exchange ... that advance payments of the premium tax credit were made on behalf of the tax filer or either spouse ... and the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit for that period."

<sup>57</sup> Most QHP subsidy beneficiaries are unaware even of the more basic requirement that they must reconcile ATPCs on annual federal income tax returns. Dorn S. *Public Education, Outreach and Application Assistance*, November 2014, Washington, DC: Urban Institute.

<sup>58</sup> Among taxpayers who qualify for EITCs, childless adults are much less likely to file returns and claim credits, compared to families with children. Plueger, D., "Earned Income Tax Credit Participation Rate for Tax Year 2005," Internal Revenue Service, 2009, <http://www.irs.gov/pub/irs-soi/09resconeitcpart.pdf>.

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<sup>59</sup> The New Mexico Marketplace arranged referrals to Jackson Hewitt, which offered discounts to help consumers with income tax-filing, and which helped interested taxpayers apply for IAPs.

<sup>60</sup> ACA §1411(h)(1)(A)(i)(I), cross-referencing §1411(b); ACA §1411(b)(c)(B), cross-referencing §1412(b)(2).

<sup>61</sup> 26 CFR 1.162(l)-1T.

<sup>62</sup> It is also possible that if the OEP begins in February, the current year's FPL guidelines, rather than guidelines for the previous year, would determine subsidy eligibility. Eligibility for premium tax credits and cost-sharing reductions is based on federal poverty level (FPL) guidelines in effect at the start of open enrollment. Internal Revenue Code § 36B(d)(3)(B), 45 CFR §155.300(a). Each January, HHS releases an updated set of FPL guidelines, reflecting changes in the Consumer Price Index since the previous calendar year. When OEPs begin in October, QHP subsidy eligibility reflects FPL guidelines from the previous calendar year. If the OEP starts in February, the higher, current-year FPL guidelines may apply, which would lower each household's FPL level. If inflation remains low, tax credit amounts would not change much. However, consumers with incomes that would otherwise be slightly above 150, 200, or 250 percent of FPL could move into a different category that qualifies for additional cost-sharing reductions. Particularly for those slightly above the two lowest thresholds, a small drop in family FPL could significantly lower their out-of-pocket costs, thus improving their access to care. Cost-sharing reductions raise actuarial value in silver plans from 70 percent to 94 percent for consumers with incomes at or below 150 percent of FPL; to 87 percent for those with incomes between 151 and 200 percent of FPL; and to 73 percent for those with incomes between 201 and 250 percent of FPL.

<sup>63</sup> In fact, such a consumer would receive additional credits at reconciliation, as the tax return for the year would show lower income than was projected in determining APTC eligibility. 26 CFR 1.36B-2(b)(7).

<sup>64</sup> Pollack R and Klein R. *Accelerating the Affordable Care Act's Enrollment Momentum: 10 Recommendations for Future Enrollment Periods*. April 2014, Washington, DC: Families USA, <http://familiesusa.org/product/10-enrollment-fixes>.

<sup>65</sup> Jost 2014. *Implementing Health Reform: New HHS 2015 Marketplace Enrollment Estimates*.

<sup>66</sup> See the "exceptional circumstances" SEP in 45 CFR 155.420(d)(9).

<sup>67</sup> CMS explained the following in a regulatory preamble: "[Our] final rules do not preclude the application of stronger consumer protections provided by state law including, for example, open enrollment periods that allow individuals to purchase coverage more frequently than the federal standards.... We note that states may create special enrollment periods or limited open enrollment periods in addition to those established by this final rule." Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule. 78 Fed. Register 13406, 13417-13418 (February 27, 2013). By July 2014, eight states (including D.C.) had created new SEPs or extended federally-created SEPs beyond parameters established by federal regulations. To illustrate the latter, some states lengthened federally-defined SEPs or required additional notices beyond those mandated by federal regulations. Giovannelli J, Lucia KW, and Corlette S. "Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market." New York, New York: The Commonwealth Fund (July 2014), Center on Health Insurance, Reforms Georgetown University Health Policy Institute.

<sup>68</sup> *Kaiser Health Tracking Poll*, November 2014, <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2014/>.

<sup>69</sup> Unpublished data from Dorn, Public Education, Outreach and Application Assistance.

<sup>70</sup> Jost, *Implementing Health Reform: New HHS 2015 Marketplace Enrollment Estimates*.

<sup>71</sup> Centers for Disease Control and Prevention. National Center for Health Statistics. Health Indicators Warehouse. [www.healthindicators.gov](http://www.healthindicators.gov). Rates of non-fatal auto accidents per 100,000 are available by age group for 2011 at [http://www.healthindicators.gov/Indicators/Motor-vehicle-injuries-nonfatal-per-100000\\_1078/Profile/ClassicData](http://www.healthindicators.gov/Indicators/Motor-vehicle-injuries-nonfatal-per-100000_1078/Profile/ClassicData). The two-month estimates in the text divided these annual totals by six.

<sup>72</sup> DevCan 6.8.0, August 2014, National Cancer Institute (<http://surveillance.cancer.gov/devcan/>), "Table 2.12. All Cancer Sites (Invasive), Risk of Being Diagnosed With Cancer in 10, 20 and 30 Years, Lifetime Risk of Being Diagnosed with Cancer Given Alive and Cancer-Free at Current Age, and Lifetime Risk of Dying from Cancer Given Alive at Current Age, Both Sexes, 2009-2011 By Race/Ethnicity." [http://seer.cancer.gov/csr/1975\\_2011/results\\_merged/topic\\_lifetime\\_risk.pdf](http://seer.cancer.gov/csr/1975_2011/results_merged/topic_lifetime_risk.pdf). The estimates of being diagnosed with cancer during each 10-year period from ages 20 through 60 were divided by 60 to develop estimates of being diagnosed with cancer during a two-month period. An estimated risk of cancer diagnosis between ages 60 and 65 was developed

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using Surveillance, Epidemiology, and End Results (SEER) Program ([www.seer.cancer.gov](http://www.seer.cancer.gov)) DevCan database: "SEER 18 Incidence and Mortality, 2000–2011, with Kaposi Sarcoma and Mesothelioma". National Cancer Institute, DCCPS, Surveillance Research Program, Surveillance Systems Branch, released August 2014, based on the November 2013 submission. Underlying mortality data provided by NCHS ([www.cdc.gov/nchs](http://www.cdc.gov/nchs)). Results are available at [http://canques.seer.cancer.gov/cgi-bin/cq\\_submit?dir=devcan2011&db=1&rpt=TAB&sel=1^4^1^1^59^12^13&dec=2&template=null](http://canques.seer.cancer.gov/cgi-bin/cq_submit?dir=devcan2011&db=1&rpt=TAB&sel=1^4^1^1^59^12^13&dec=2&template=null). That six-year estimate was then divided by 36 to yield a two-month estimate for the likelihood of a new cancer diagnosis among 60–65 year olds. The estimates in the text combine the risks of each applicable age group into larger age bands.

<sup>73</sup> Dorn, Public Education, Outreach and Application Assistance.

<sup>74</sup> The Government Accountability Office thus explained as follows: "The extent to which individual taxpayers accurately report their income is related to the extent to which the income is reported to them and IRS by third parties or taxes on the income are withheld. For example, for types of income for which there is little or no information reporting, such as business income, individual taxpayers tend to misreport over half of their income. In contrast, employers report most wages, salaries, and tip compensation to employees and IRS through Form W-2. Also, banks and other financial institutions provide information returns (Forms 1099) to account holders and IRS showing the taxpayers' annual income from some types of investments. Findings from IRS's study of individual tax compliance indicate that nearly 99 percent of these types of income are accurately reported on individual tax returns." Government Accountability Office. *Tax Gap: Sources of Noncompliance and Strategies to Reduce It*. GAO-12-651T, Apr 19, 2012. <http://www.gao.gov/products/GAO-12-651T>.

<sup>75</sup> For example, the SEP could expand to include people who were uninsured in 2014 but not penalized based on exemptions that may not continue in 2015, such as income below federal income tax filing requirements or health insurance costs exceeding 8 percent of income.

<sup>76</sup> As noted earlier, the legal basis for a national SEP could be "exceptional circumstances." The circumstances discussed here could be exceptional in the sense that they could be characterized as highly unfair, denying an opportunity for those who have rectified a past period of uninsurance to sign up for coverage in time to avoid a new and more severe penalty of which they were unaware during the first year of the penalty's application. That said, if most who want to enroll into QHPs can do so under a particular SEP, one could argue that, by definition, the SEP is not "exceptional."

<sup>77</sup> During the past two years, 69 percent of all returns filed by April 15 were filed by the end of March; but among those that claimed refunds, which are more likely to be submitted by low- and moderate-income taxpayers, 77 percent were filed by the end of March (figure 1). Author's calculations, Internal Revenue Service, 2013 and 2014 Filing Season Statistics, <http://www.irs.gov/uac/2014-and-Prior-Year-Filing-Season-Statistics>.

<sup>78</sup> Author's calculations, CPS-ASEC data for 2013, [http://www.census.gov/hhes/www/cpstables/032014/pov/pov01\\_400\\_1.xls](http://www.census.gov/hhes/www/cpstables/032014/pov/pov01_400_1.xls).

<sup>79</sup> Limiting the analysis to non-elderly *adults*, rather than *all non-elderly residents*, those ages 45–64 are 50 percent of people with incomes above 400 percent of FPL but 37 percent of adults with incomes at or below 400 percent of FPL. Author's calculations, CPS-ASEC data for 2013, [http://www.census.gov/hhes/www/cpstables/032014/pov/pov01\\_400\\_1.xls](http://www.census.gov/hhes/www/cpstables/032014/pov/pov01_400_1.xls).

<sup>80</sup> A QHP plan year that begins in June, leaving a two-month gap between the end of the OEP and the start of the QHP plan year, would reduce the odds of enrollment "snafus" and lessen selection risks. However, such a prolonged delay could prove unacceptable to much of the public, given our culture of increasingly brief periods between order and delivery of consumer goods. It could also reduce plans' ability to price products effectively, since fewer claims would be available between the end of one QHP plan year and the time when QHP bids must be submitted for the following year.

<sup>81</sup> Brian Haile, a respected analyst who has thought deeply about this issue, suggests that the QHP plan year could begin in January even if the OEP overlapped with tax filing. It is hard to see how such an alternative could work effectively in practice, however. If the OEP runs from February through April, for example, existing enrollees would need the opportunity to change plans during November or December, before the QHP plan year begins. Otherwise, they could wait to see whether health problems develop in January through March, after which they could switch to a comprehensive plan, creating significant selection problems. But if enrollees could switch plans during November or December, plans would need to prepare QHP bids at roughly the same time as for Medicare Advantage and Medigap open enrollment, which begins in October, forfeiting important administrative advantages of a late winter-early spring OEP. If the QHP calendar year begins in January and the OEP starts in December, existing enrollees would need to change plans up by December 15, which would place a tremendous stress on carrier enrollment staff and brokers during

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the final days of Medicare open enrollment, again forfeiting important administrative advantages of a changed QHP OEP. Moreover, to gain the participation advantages of a late winter/early spring OEP, it would need to last until March or April; if the OEP starts in November or December, it would be lengthy, created opportunities for adverse selection that could greatly trouble carriers.

<sup>82</sup> One other factor could lessen reconciliation risks if open enrollment beginning in February resulted in the use of current-year FPL guidelines, thereby lowering consumers' FPL levels, as explained earlier. For APTC beneficiaries whose annual income would otherwise be slightly above 200, 300, or 400 percent of FPL, this would reduce their maximum reconciliation-based tax liability, because they would move from slightly above to slightly below those FPL levels. Reconciliation liability is capped, for single adults and other filers, at \$300 and \$600, respectively, if income is below 200 percent of FPL; at \$750 and \$1,500 if income is between 200 and 299 percent of FPL; and at \$1,250 and \$2,500 if income is between 300 and 399 percent of FPL. 25 CFR 1.36B-4(a)(3).

<sup>83</sup> See 45 CFR §155.320.

<sup>84</sup> Buettgens M, Nichols A, and Dorn S. *Churning Under the ACA and State Policy Options for Mitigation*. Prepared by the Urban Institute for the Robert Wood Johnson Foundation. June 2012. <http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf>; Curtis R and Graves J. "Open Enrollment Season Marks the Beginning (Not the End) of Exchange Enrollment." *Health Affairs Blog*. November 26th, 2013. <http://healthaffairs.org/blog/2013/11/26/open-enrollment-season-marks-the-beginning-not-the-end-of-exchange-enrollment/>.

<sup>85</sup> Only during an OEP that overlaps with tax filing would the prospective APTC amount be relevant to a decision that clients face at tax time. If QHP enrollment is not taking place during tax filing, tax preparers' ACA-related services are likely to be limited to (1) showing compliance with, making a case for falling within exceptions to, or completing forms and calculating penalties for violating the coverage mandate; and (2) reconciliation. Both of these topics arise in the context of preparing the tax return. Brian Haile, op cit. Determining APTC amounts, by contrast, would be comparable to revising withholding on W-4 forms, which is not typically undertaken by tax preparation services during tax filing season.

<sup>86</sup> Massachusetts officials reported that applications filed on consumers' behalf by trained and certified providers and consumer groups contained many fewer errors than those filed by consumers themselves. Dorn S, et al., *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*.

<sup>87</sup> One illustration is provided by the National School Lunch Program (NSLP), which, before 2004 legislation, required participants to report all income changes of \$50 or more; few met those requirements. Families applied in August, without documenting income. A small sample of applications would be selected for verification in December. Unreported income changes and other differences from household circumstances reported at the time of application would frequently result in findings of error. Ralston K et al. *The National School Lunch Program: Background, Trends, and Issues*. July 2008. Economic Research Report Number 61. Economic Research Service, U.S. Department of Agriculture (ERS/USDA), [http://www.ers.usda.gov/media/205594/err61\\_1\\_1.pdf](http://www.ers.usda.gov/media/205594/err61_1_1.pdf). Notably, this even occurred with NSLP applications where eligibility was granted, not based on parents' unverified income attestations, which were sometimes erroneous, but on so-called "categorical eligibility"—that is, receipt of benefits like food stamps or cash assistance, for which other public agencies had verified income. One analysis of verification outcomes in large metropolitan school districts found that, among sampled NSLP children granted benefits in August based on receipt of other benefits, 10 percent were found to qualify for fewer benefits and 24 percent were eligible for additional benefits based on their circumstances in December. Author's calculation, table III 3, bottom panel, Burghardt J, Silva T, and Hulseley L. "Case Study of National School Lunch Program Verification Outcomes in Large Metropolitan School Districts." *Special Nutrition Program Report Series, No. CN-04-AV3*. Prepared by Mathematica Policy Research, Inc., for USDA Food and Nutrition Service, April 2004, <http://www.fns.usda.gov/sites/default/files/NSLPCasestudy.pdf>.

<sup>88</sup> Regardless of when the OEP is scheduled, tax reconciliation risks could be mitigated if, during the OEP, consumers can adjust their APTC claims for the final months of the QHP plan year. However, such adjustments are limited by consumers' inability to change QHPs at that point in the plan year, unless a special enrollment period is triggered by a change in eligibility for cost-sharing subsidies. See 45 CFR 155.420(d)(6)(i) and (ii). An APTC reduction may not be feasible if it would leave the consumer exposed to an unaffordable premium payment. By contrast, an APTC adjustment made at the start of a QHP plan year can be accompanied by a choice of plan that fits the modified APTC.

<sup>89</sup> 45 CFR 155.330 (e)(2)(ii)(C).

<sup>90</sup> 45 CFR 155.420(d)(6).

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<sup>91</sup> In the past, inertia has prevented consumers from changing plans when such changes would have been favorable. Neuman T. Open Enrollment: Insights from Medicare for Health Insurance Marketplaces. October 23, 2014, Washington, DC: Kaiser Family Foundation, <http://kff.org/health-reform/perspective/open-enrollment-insights-from-medicare-for-health-insurance-marketplaces/>. That said, reporting income changes to Marketplaces would take much less work. However, as suggested by the above NSLP findings, families do not always report changed circumstances that qualify them for additional benefits.

<sup>92</sup> See 45 CFR 147.104(b)(1)(ii).

<sup>93</sup> Herman B. "Insurers Ramp Up Staffing ahead of Obamacare Open Enrollment," *Modern Healthcare*, November 5, 2014, <http://www.modernhealthcare.com/article/20141105/NEWS/311059984/insurers-ramp-up-staffing-ahead-of-obamacare-open-enrollment>.

<sup>94</sup> IRS. Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055), Page Last Reviewed or Updated: 09-Dec-2014, <http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055>; IRS, Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056), Page Last Reviewed or Updated: 09-Dec-2014, <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Reporting-of-Offer-of-Health-Insurance-Coverage-by-Employers-Section-6056>.

<sup>95</sup> CMS. "Appendix A: Health Coverage from jobs," *Application for Health Coverage & Help Paying Costs*, Family Application Form (English), <https://Marketplace.cms.gov/applications-and-forms/Marketplace-application-for-family.pdf>.

<sup>96</sup> See 45 CFR 155.320(d)(3)(iii).

<sup>97</sup> Tax preparation services may also be able to find the current employer's EIN and use it on the consumer's IAP application, even if the consumer recently changed jobs and the previous year's tax form is no longer timely for this purpose.

<sup>98</sup> Copeland CW. *Length of Rule Reviews by the Office of Information and Regulatory Affairs*. December 2, 2013, draft report for the Administrative Conference of the United States, <https://www.acus.gov/sites/default/files/documents/Draft%20OIRA%20Report%20120213.pdf>.

<sup>99</sup> Attkisson S. "Did White House Obamacare guidance stop ahead of 2012 election?" *CBS News*, October 24, 2013, 8:56 PM, <http://www.cbsnews.com/news/did-white-house-obamacare-guidance-stop-ahead-of-2012-election/>.

<sup>100</sup> 79 Fed. Reg. 70674 (Nov. 26, 2014).

<sup>101</sup> HHS, "Patient Protection and Affordable Care Act: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (Final Rule)," 77 *Fed. Register* 17220, 17223 (March 23, 2012).

<sup>102</sup> CCIIO. *DRAFT 2016 Letter to Issuers in the Federally-facilitated Marketplaces*. Dec. 19, 2014, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016DraftLettertoIssuers12-19-2014.pdf>.

<sup>103</sup> See Hartman M., et al., "National Health Spending In 2013: Growth Slows, Remains In Step With The Overall Economy," *Health Affairs*. *January 2015* 34:150-160;

<sup>104</sup> CMS. "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule." *Federal Register*. July 15, 2011, Vol. 76, No. 136: 41866- 41927, <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>.

<sup>105</sup> Federal regulations of the individual market include many explicit and implicit references to the January start date of QHP coverage. States with unified small group and individual markets are currently required to have plan years that coincide with the calendar year. 45 CFR 147.104 (b)(2). Also, current regulations forbid insurers, from November 15 through December 15 of each year, from denying offers to small firms based on failure to meet minimum participation requirements. 45 CFR 147.104 (b)(1)(i)(B). To the extent the policy judgment underlying the choice of the latter dates reflected the open enrollment period for individual coverage or the QHP plan year, federal policymakers may need to revise the period during which non-participation requirements are effectively suspended for small group coverage.

<sup>106</sup> Brian Rossman, Massachusetts Health Care for All, personal communication, 2014; Katherine Swartz, Harvard School of Public Health, personal communication, 2015.

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<sup>107</sup> See 45 CFR § 156.430 for a description of how CMS provides QHPs with advance payments to cover the estimated cost of CSRs the plans provide to eligible consumers; how QHPs report CSRs' actual cost; and how those advance payments are reconciled with actual costs. For examples of the detailed calculations that apply, see Center for Consumer Information and Insurance Oversight, CMS. Cost-Sharing Reductions Reconciliation, March 2013, [https://www.cms.gov/CCIIO/Resources/Files/Downloads/pages\\_from\\_csr\\_recon\\_cleared-a.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/pages_from_csr_recon_cleared-a.pdf).

<sup>108</sup> For example, a healthy consumer already enrolled in a plan from the prior calendar year could stop paying premiums in January and wait to see whether he or she gets sick by March. If so, the consumer could make back-payments of premiums to the start of the year and remain insured through the end of April. If the consumer does not get sick, he or she could avoid paying premiums for the four-month bridge plan, instead enrolling only into coverage that starts in May. CCIIO. *Revised Bulletin #10 on Grace Periods Related to Terminations for Non-Payment of Premiums and Enrollment through the Federally-facilitated Marketplace across Benefit Years*. September 12, 2014. [https://www.regtap.info/uploads/library/REVISED\\_Bulletin10GracePeriods\\_5CR\\_091214.pdf](https://www.regtap.info/uploads/library/REVISED_Bulletin10GracePeriods_5CR_091214.pdf).

<sup>109</sup> When death, divorce, or marriage occurs mid-year, special rules determine household size for purposes of calculating FPL and the annual tax credit. See, 26 CFR 1.36B-4(b).

<sup>110</sup> 26 CFR §§1.36B-4(a)(2), 1.36B-4T(a)(4), Example 4.

<sup>111</sup> Under the schedule discussed here, another factor would lessen consumer confusion if a February rather than October start to the OEP would result in the use of current-year FPL guidelines, rather than prior-year FPL guidelines, to determine eligibility for QHP subsidies. This change would better align QHP subsidies with Medicaid and CHIP, which use current-year rather than prior-year FPL guidelines. See 42 CFR 435.4 (definition of "Federal poverty level (FPL)"). Such alignment would prevent confusion that otherwise results when consumers learn, in some cases as they shift between programs, that they have one FPL level for purposes of QHP subsidies but a different FPL level for Medicaid purposes. Unlike the theoretical alignment of QHP subsidies and Medicare/ESI, which affects very few consumers, aligning Medicaid and QHP subsidies would affect numerous consumers. Among consumers who qualify for QHP subsidies in a two-year period, 38 percent qualify for Medicaid during one of those years. Buettgens M, Nichols A, and Dorn S. *Churning Under the ACA and State Policy Options for Mitigation*, June 2012, Washington, DC: Urban Institute, <http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf>.

<sup>112</sup> The text is consistent with IRS regulations, although the latter are framed in terms of annual rather than monthly premiums. Such regulations provide that the annual benchmark premium is calculated using an average of the different annual benchmark premiums that were charged during the year. The latter premiums are weighted based on the number of months to which they applied. For example, if a \$6,000 annual benchmark premium applied to one-third of the year, and a \$9,000 annual benchmark premium applied to the other two-thirds, an \$8,000 benchmark premium would be used to determine the year's premium tax credit ( $1/3 \times \$6,000 + 2/3 \times \$9,000 = \$8,000$ ). See Example 7 in 26 CFR §1.36B-4(a)(4). Translating this example into monthly terms, if a monthly \$500 benchmark premium (the monthly equivalent to a \$6,000 annual premium) is charged for 4 months (one-third of the year) and a \$750 benchmark premium (the monthly equivalent to an \$8,000 annual premium) is charged for 8 months (two-thirds of the year), the annual benchmark premium is calculated as follows:  $(\$500 \times 4) + (\$750 \times 8) = \$8,000$ .

<sup>113</sup> Moreover, if an employer's open enrollment period overlaps with QHP open enrollment, workers who move from ESI into QHPs will do so at the start of the employer's plan year. By contrast, if QHP open enrollment is at a different time, such workers could leave ESI in the middle of the employer's plan year. That would not be unprecedented; employees leave or begin ESI mid-year for many reasons, including job changes. Nevertheless, coverage changes initiated mid-year could be more disruptive to employers than changes at the start of the employer's plan year. This problem could be prevented if CMS established a SEP allowing QHP enrollment when an employer's OEP differs from the Marketplace OEP. Such a SEP would be analogous to the existing SEP for consumers whose individual coverage ended in 2014 at a time that was off-cycle for QHP open enrollment. 45 CFR 155.420 (d)(1)(ii).

<sup>114</sup> Urban Institute Health Insurance Policy Simulation Model 2014.

<sup>115</sup> Buettgens M, et al., Access to Employer-Sponsored Insurance and Subsidy Eligibility in Health Benefits Exchanges: Two Data-Based Approaches.

<sup>116</sup> Blue Cross and Blue Shield of Massachusetts Foundation. *Health Reform in Massachusetts Expanding Access to Health Insurance Coverage: Assessing the Results*, March 2014, Boston, MA, [http://bluecrossmafoundation.org/sites/default/files/download/publication/Monitoring%20MA%20Reform%20March%202013\\_0.pdf](http://bluecrossmafoundation.org/sites/default/files/download/publication/Monitoring%20MA%20Reform%20March%202013_0.pdf).