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More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods

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Timely Analysis of Immediate Health Policy Issues

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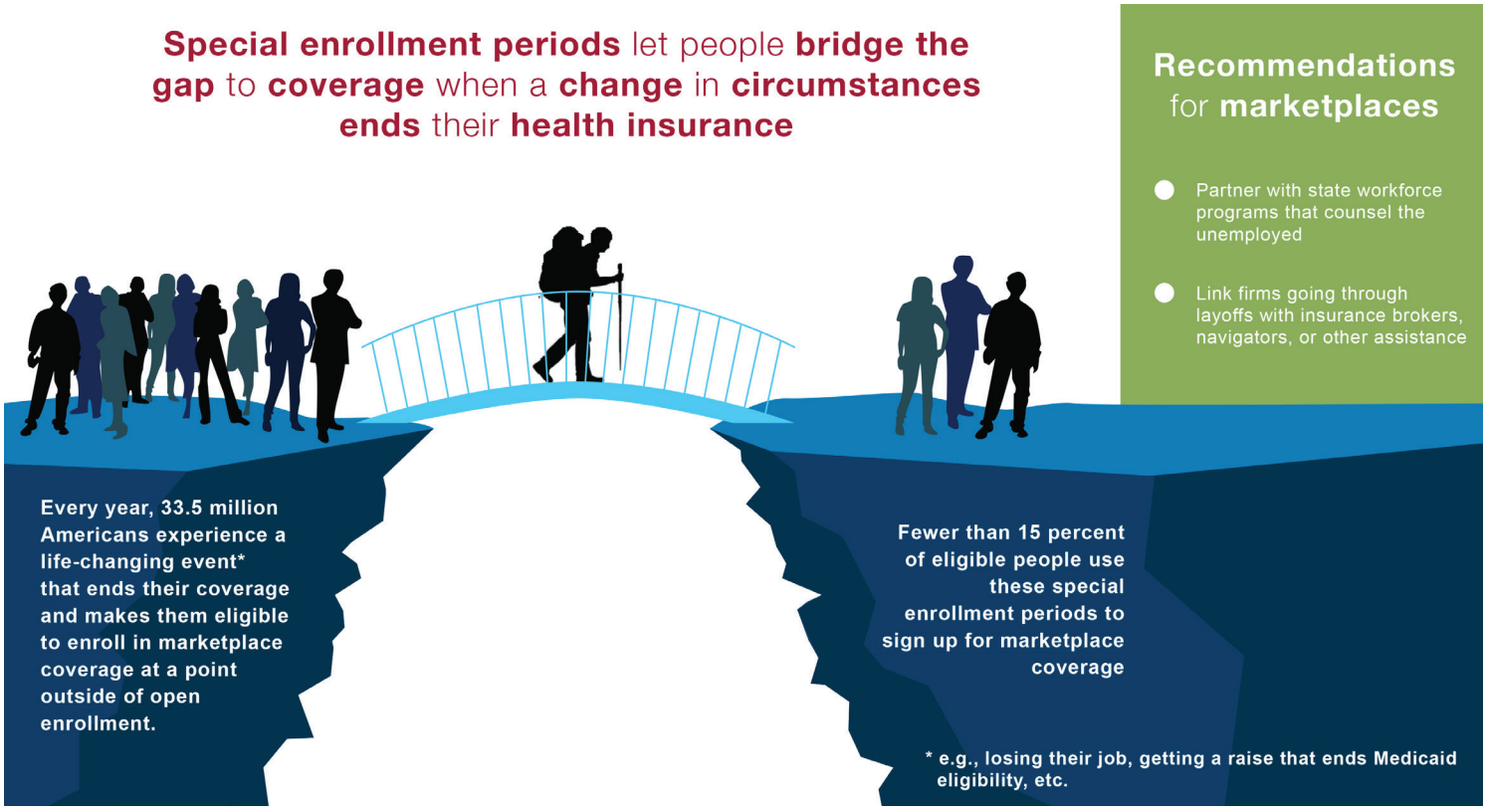
In-Brief

Enrollment in health insurance marketplaces is generally limited to annual open enrollment periods (OEPs). However, some events, such as termination of health coverage due to job loss, can qualify consumers for special enrollment periods (SEPs) that let them sign up for marketplace plans at other times. We estimate the following for each year:

- Roughly 12.9 million people could enroll using SEPs who would otherwise lose coverage and be uninsured at the end of the year (and potentially beyond). Of this 12.9 million, 9.7 million qualify for SEPs because of job loss that terminates employer-sponsored insurance (ESI).
- An additional 20.6 million could use SEPs to prevent temporary coverage gaps. Most of them (18.2 million people) would otherwise be uninsured while they transition between the end of one job and the start of another during the same calendar year.

Based on an August 2015 report from the Centers for Medicare and Medicaid Services (CMS), we estimate that fewer than 15 percent of these uninsured consumers are enrolling through SEPs for which they qualify.



Introduction

Like most ESI plans, marketplaces have annual OEPs, which are the only time consumers can generally enroll into qualified health plans (QHPs). This restriction prevents people from waiting to get sick before signing up for coverage; if such delays were allowed, average health care costs per enrollee would rise in the individual market, leading to higher premiums. However, changed household circumstances after the OEP ends, such as job loss and divorce, can create a need for coverage. Enrollment opportunities at such times are particularly important in marketplaces, where consumers can qualify for financial assistance based on income and the absence of ESI offers.

In this brief, we estimate the number of people who would qualify during 2016 for the most common SEPs, which are triggered by[1]

- losing employment and ESI;[2]
- losing Medicaid eligibility;
- getting married;
- adding a child to the family through birth, adoption, or foster-child placement;
- losing health coverage through divorce or separation;
- moving between counties or states;
- gaining citizenship;
- turning 26 and losing coverage from parental ESI; and
- in a state that has not expanded adults' Medicaid eligibility under the Patient Protection and Affordable Care Act (ACA) to 138 percent of the federal poverty level (FPL), qualifying for QHP tax credits by going from below 100 percent of FPL to above 100 percent of FPL.

We conclude by describing current use of SEPs, the potential benefits of SEP participation, and strategies for increasing SEP enrollment.

Methods

Our Health Insurance Policy Simulation Model (HIPSM) uses data from the 2012 and 2013 American Community Survey (ACS). The ACS provides annual snapshots but does not follow the same people over time, so it does not show life changes that trigger SEPs. We thus augment HIPSM with data from the Survey of Income and Program Participation (SIPP), which follows respondents over time.[3] We analyze waves 12 through 15 of the 2008 SIPP panel. These were the latest available data at the time of analysis, covering May 2012 through August 2013.

We simulate the main coverage provisions of the ACA, trending HIPSM's ACS data forward to 2016,[4] and simulating the full impact of the ACA on individual health coverage and employer health benefit decisions. HIPSM incorporates each state's eligibility rules for Medicaid and imputes immigration status and unaccepted offers of ESI based on matches with sources of data outside SIPP and ACS. We estimate each family's eligibility for insurance affordability programs throughout the year, assuming state decisions about Medicaid expansion as of July 2015.[5] We determine the probability that each family qualifies for an SEP and estimate coverage without the SEP. People age 65 and older who qualify for Medicare are excluded from the analysis.

We separate people experiencing SEP-qualifying events into three groups, based on the coverage they are simulated to have at the year's end:

- Members of the first group experience an SEP-qualifying event and end the year without ESI or public coverage. They would have to take advantage of the SEP to avoid finishing the year uninsured. We refer to this group as qualifying for "SEPs that can prevent longer-term uninsurance."
- In the second group, people (1) experience an SEP-qualifying event that involves coverage loss,[6] such as when ESI ends because of a layoff, but (2) are estimated to gain ESI or Medicaid at the end of the year. This group's SEPs are termed, "SEPs that can prevent shorter coverage gaps."
- Members of the third group (1) experience an SEP that does not involve a loss of coverage and (2) end the year with ESI or public coverage. People in this group are unlikely to use the SEP to enroll in the marketplace, as explained in the next section.

The distinction between first two groups is based on coverage at the end of the year, not how long the coverage gap would last for each person. For example, a worker who loses coverage because of an SEP-qualifying event in June is classified as experiencing (1) "longer-term uninsurance" if the worker is uninsured in December but (2) a "shorter coverage gap" if the worker has ESI in December from a new employer. Accordingly, someone gaining coverage just before the end of the year is in the "shorter coverage gap" group; another who lost coverage at that same point and regained it soon after the following year began is in the "longer-term uninsurance" group. The latter group also includes individuals who, during a single year, lose coverage through an SEP-qualifying event, regain coverage, and then lose coverage again.

Recently, Hartman and colleagues used SIPP data to estimate SEP eligibility. They found that more than 8.4 million adults qualify for SEPs who would otherwise be uninsured or receive nongroup coverage.[7] This population roughly corresponds to our first group, SEPs that prevent longer-term coverage gaps. Their estimate is lower than ours, perhaps because of the following methodological differences:[8]

- Hartman and colleagues examined SIPP data for two months alone, April 2012 and January 2013. Their estimates thus did not include anyone who experienced an SEP-qualifying event during May through December. By contrast, we included people experiencing SEP-qualifying events throughout the year outside

the OEP.
- Their estimates were limited to adults, while ours included children as well.
- They did not consider several SEP categories we included in our analysis, such as for people who move between counties or states.

Also, the Hartman team did not estimate the number of people who experience temporary gaps in coverage that SEPs could prevent; we refer to these as SEPs that could prevent coverage gaps of shorter duration. In later sections, we explain the policy importance of this group.

Results

We estimate that 46.5 million people will experience an SEP-qualifying event during 2016, representing about 17 percent of the nonelderly population (data not shown). To identify those who need SEPs to prevent coverage gaps losses and gaps, we estimate the number of SEP-qualifying consumers in the three groups described earlier (Table 1):

1. **SEPs that can prevent longer-term uninsurance.** About 12.9 million SEP-eligible people would lose coverage during the SEP-qualifying event and, at the end of the year, receive neither ESI nor Medicaid unless they take advantage of the SEP. They include 7.2 million individuals in nonexpansion and 5.7 million in expansion states (data about expansion vs. nonexpansion states not shown).[9]

2. **SEPs that can prevent coverage gaps of shorter duration.** Roughly 20.6 million people would lose coverage during an SEP event but have ESI or Medicaid at the year's end (10.3 million in nonexpansion states and 10.3 million in expansion states). For this group, SEPs could prevent shorter coverage gaps. (Consumers experiencing SEP-qualifying events, such as job loss, do not typically know how long their coverage gap will last. The outreach and enrollment strategies we describe below thus focus on SEP events such as job loss and do not attempt to distinguish the target groups based on duration of uninsurance.)

3. **Other SEPs.** The remaining 13.0 million could switch from existing coverage to QHPs but are unlikely to do so (5.5 million in nonexpansion states and 7.5 million in expansion states). These consumers qualify for SEPs, like those triggered by marriage or childbirth, that may not involve a loss of coverage and so are unlikely to result in marketplace enrollment. For example, a family with ESI typically adds a newborn baby to existing coverage, rather than leave ESI for the marketplace.

The rest of this brief focuses on the 33.5 million people in the first two groups.

SEPs That Can Prevent Long-Term Uninsurance

Table 1 shows eligibility for specific SEPs that could help consumers who would otherwise be uninsured at the end of the year:[10]

- The most common such SEP is caused by job loss that terminates ESI; this category is estimated to affect 9.7 million people.[11]
- Medicaid loss triggers SEPs for an estimated 1.8 million people, including 600,000 in expansion states and 1.2 million in nonexpansion states (data not shown). Medicaid loss is more common in nonexpansion states because of narrower Medicaid eligibility, which in turn increases the likelihood of qualifying for marketplace coverage. Medicaid eligibility varies widely among nonexpansion states, so the prevalence of Medicaid loss likewise varies.
- Other important SEPs in this group are those caused by moving (500,000), getting married (400,000), and adding a new child to the family (200,000).
- In nonexpansion states, about 200,000 people who would be uninsured without the SEP are estimated to qualify for marketplace subsidies when their incomes rise from below to above 100 percent of FPL. Before that change, they were estimated to be within the "coverage gap," ineligible for both Medicaid and QHP financial assistance.

SEPs That Can Prevent Coverage Gaps of Shorter Duration

As noted, we estimate that 20.6 million people will qualify for SEPs because of circumstances that involve the loss or absence of coverage but will then receive Medicaid or ESI at the end of the year. For these consumers, QHPs offer short-term protection by providing access to care while shielding enrollees from financial losses that otherwise could result from unforeseen medical problems.

ESI termination caused by job loss is by far the most common such SEP event, estimated to affect 19.2 million people.[12] Within this group, 18.2 million are estimated to receive ESI before the next year begins, typically from a new employer (data not shown). In the second-largest category, about 800,000 people are estimated to lose Medicaid eligibility and regain some form of coverage by the end of the year (most often through Medicaid).[13] We estimate that the rest (approximately 600,000) either (1) become uninsured through divorce, separation, or loss of parental ESI upon turning 26 or (2) were uninsured before the SEP because they were in the coverage gap of a state that did not expand Medicaid.

Table 1 shows that consumers who are estimated to experience coverage gaps of shorter duration have higher incomes than SEP–eligible people who are estimated to face longer-term uninsurance. In the short-term group, 80 percent are estimated to end the year with incomes above 200 percent of FPL, including 41 percent above 400 percent of FPL. For the longer-term uninsured, those proportions are 54 percent and

Table 1. Eligibility for SEPs That Can Prevent Coverage Gaps

	SEPs that can prevent longer-term uninsurance		SEPs that can prevent coverage gaps of shorter duration	
	Thousands of nonelderly	Percentage	Thousands of nonelderly	Percentage
Total	**12,860**	**100%**	**20,610**	**100%**
Type of Event				
Formerly Eligible for Medicaid, Newly Eligible for Tax Credits	1,800	14%	830	4%
New Citizen	-	0%	n/a	
Household Member Loses Job and ESI	9,690	75%	19,150	93%
Household Member is Newly Married	390	3%	n/a	
New Child in Household	170	1%	n/a	
Household Member Loses Coverage at Separation or Divorce	40	0%	540	3%
Moved County or State	510	4%	n/a	
Former Coverage Gap, Newly Eligible for Tax Credits	210	2%	50	0%
Turn 26 and Lose Parent's Coverage	50	0%	40	0%
Income				
<138% of FPL	3,520	27%	2,480	12%
138 - 200% of FPL	2,350	18%	1,630	8%
200 - 400% of FPL	4,780	37%	7,960	39%
400%+ of FPL	2,210	17%	8,540	41%
Age				
0 - 18	920	7%	3,440	17%
19 - 24	2,250	17%	2,290	11%
25 - 34	2,870	22%	3,220	16%
35 - 44	2,130	17%	3,640	18%
45 - 54	2,490	19%	4,340	21%
55 - 64	2,200	17%	3,680	18%
Race/Ethnicity				
White, non-Hispanic	7,900	61%	14,600	71%
Black, non-Hispanic	1,630	13%	2,200	11%
Hispanic	2,250	17%	2,270	11%
Asian/Pacific Islander	690	5%	1,010	5%
Other	390	3%	530	3%
Education [a]	**11,940**	**100%**	**17,170**	**100%**
Less than High School	1,590	13%	890	5%
High School Graduate	4,860	41%	5,680	33%
Some College	3,160	26%	5,000	29%
College Graduate	2,320	19%	5,600	33%
Employment Status [a]	**11,940**	**100%**	**17,170**	**100%**
Full Time	5,270	44%	11,730	68%
Part TIme	2,120	18%	2,250	13%
Unemployed	4,550	38%	3,190	19%

Source: Health Insurance Policy Simulation Model—American Community Survey 2015 and the Survey of Income and Program Participation, simulating ACA implementation as of 2016.

Notes: FPL = federal poverty level; SEP = special enrollment period; ESI = employer-sponsored insurance. All characteristics except type of SEP-qualifying event are estimated as of the end of the year. Households are tax units used to determine eligibility for tax credits and Medicaid. "Income" is modified adjusted gross income, estimated as of the end of the calendar year. Consumers eligible for SEPs that can prevent longer-term uninsurance are estimated to lack coverage at the end of the calendar year unless they enroll during the SEP. SEPs that can prevent coverage gaps of shorter duration are available to consumers who, without the SEP, are estimated to lose or lack coverage during the SEP event but regain coverage by the end of the calendar year. Estimates use state Medicaid expansion decisions as of July 2015. Data in columns may not sum to totals because of rounding.

[a] *Adults Only*

17 percent, respectively. Related to these income differences, the two SEP categories differ in their estimated racial and ethnic mix (22 percent Black or Hispanic in the short-term group versus 30 percent in the longer-term group), education level (in estimates for the short-term group, 5 percent of adults did not finish high school and 33 percent graduated college; for the longer-term group, those numbers are 13 and 19 percent, respectively), and employment status (in estimates for the short-term group, 68 percent of adults were employed full time at the end of the year and 19 percent were then unemployed; for the longer-term group, those numbers are 44 and 38 percent, respectively).

Current Use of SEPs

On August 13, 2015, CMS reported SEP enrollment from February 23, 2015, to June 30, 2015. In 37 states using the federal healthcare.gov platform, nearly 944,000 enrolled using an SEP. Two SEP categories in the CMS report, a tax-filing SEP and an SEP for consumers who apply for Medicaid but are found eligible for QHP tax credits, are not included in our estimates. Enrollment into the remaining categories totaled 619,666,[14] which is the rough equivalent of 1.7 million annual SEP enrollees nationally.[15] This extrapolated number of SEP enrollees equals 5 percent of the estimated 33.5 million people for whom SEP enrollment is needed to prevent short- or longer-term coverage gaps. Considering just the 12.9 million with longer-term uninsurance, estimated SEP enrollees represent 13 percent of SEP-eligible consumers.

This extrapolation has limitations, but it is clear that only a small fraction of eligible consumers, almost certainly fewer than 15 percent, are using SEPs to avoid coverage gaps.[16]

An analysis of five states' approaches to SEPs identified several factors underlying SEPs' limited use in 2014.[17] With states prioritizing other aspects of ACA implementation, intensive outreach and enrollment efforts had generally not focused specifically on SEPs. Moreover, states had not implemented systems to move consumers losing Medicaid eligibility into marketplace coverage. Factors that complicated SEP outreach included conflicts with the message that uninsured consumers must sign up by the end of open enrollment; the many types of SEP-qualifying events, which made it difficult to focus a simple marketing message; the brief window of time during which SEP enrollment is permitted (generally 60 days following the SEP-qualifying event); and eligible consumers' lack of relevant knowledge, including Medicaid beneficiaries' unfamiliarity with private coverage and uninsured consumers' unawareness of SEPs.

The Impact of Higher SEP Take-Up

Increasing eligible consumers' use of SEPs could have several advantages:

- **Reducing the number of people who are uninsured at some point during the year.** Even brief coverage disruptions can have significant medical and financial consequences, particularly for those with chronic conditions.[18]

- **Furnishing interim health coverage while workers and their families move between jobs.** This could help create a constituency for marketplaces by filling a structural gap in the country's health care system, which does not currently take an organized approach to providing transitional coverage.[19] Among those who qualify for an SEP that involves short-term coverage gaps, 18.2 million lose ESI and then regain it within the same year.

- **Promoting marketplace sustainability.** SEPs can increase marketplace enrollment. For administrative funding, most marketplaces surcharge each enrollee's premium.

Outreach and Enrollment Strategies

Marketplaces could consider outreach and enrollment strategies tailored to the circumstances of particular SEP-qualifying events, including those for the two most widely applicable SEPs:[20]

- **Job-loss SEP**. Past coverage expansions that targeted laid-off workers failed to reach most eligible people.[21] One contributing factor was that many laid-off workers find it hard to absorb all of the information they receive about unemployment insurance and other benefits.[22] The few successful efforts gave workers one-on-one help with enrollment into health programs.[23] That history is consistent with more recent evidence showing the importance of application assistance to ACA enrollment.[24] Marketplaces interested in furnishing application assistance to newly uninsured, SEP-eligible workers could

  - use publicly financed navigators or application assistance programs to serve laid-off workers, with Medicaid providing partial funding;[25]

  - link firms undergoing layoffs to brokers who help departing employees enroll, relying on commissions from insurers rather than public funding to support such individual assistance; and/or

  - partner with state workforce agency programs that already counsel the unemployed. Such programs could be equipped to help their clients enroll into health coverage.

- **The Medicaid-termination SEP**. Such an SEP could engage automatically whenever Medicaid ends because of increased earnings, and Medicaid's income determination could establish financial eligibility for QHP tax credits. Consumers could be asked about ESI offers (which affect tax credit eligibility) while they are already interacting with the state, during either Medicaid redetermination or QHP enrollment.

Conclusion

Every year, millions of consumers will become uninsured unless they take advantage of SEPs. The most significant SEPs involve termination of health coverage due to job loss and, in a distant second place, loss of Medicaid. Based on data for SEP take-up through June 2015 in states served by healthcare.gov, it appears that only a small fraction of those who qualify for SEPs are actually signing up for marketplace plans. Marketplaces could consider targeted strategies, focused on the most common SEPs, both to enroll the longer-term uninsured and to play a currently unfilled role in the country's health care system by furnishing interim coverage when workers move between jobs.

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ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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Notes

1 Some SEPs could not be modeled. These SEPs are triggered by gaining legal residence, membership in a federally recognized Indian or Alaska native tribe, leaving incarceration, navigator misconduct, plan noncompliance, and applying for Medicaid and being found eligible for QHP tax credits. New York has recently added pregnancy as an SEP-qualifying event; it is the only state to do so.

2 Any loss of employment within the tax unit, and consequent loss of ESI, can trigger this SEP.

3 For more detailed descriptions of our methodology, see "Further Methodological Information for 'Tax Preparers Could Help Most Uninsured Get Covered,'" Urban Institute, http://www.urban.org/policy-centers/health-policy-center/publications/further-methodological-information-tax-preparers-could-help-most-uninsured-get-covered (Accessed September 2015) and Buettgens M, Resnick R, Lynch V and Carroll C. "Documentation on the Urban Institute's American Community Survey Health Insurance Policy Simulation Model (ACS-HIPSM)." Washington: Urban Institute, 2013, http://www.urban.org/research/publication/documentation-urban-institutes-american-community-survey-health-insurance (Accessed September 2015).

4 We age the data to 2016 using the population projections of the Urban Institute's Mapping America's Futures project, which match Census projections on the national level.

5 HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, tax credits for the purchase of health insurance, and insurance market reforms. The model estimates changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. For more about HIPSM's capabilities and a list of recent research papers and reports using it, see "The Urban Institute's Health Microsimulation Capabilities," http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html. Families in the SIPP are interviewed three times during the course of a year. Monthly income responses are more accurate for actual interview months than for other months during the year, a problem known as "seam bias" in the literature. As a result, we only use reported income for these three months during the year to determine eligibility.

6 This group also includes some who are uninsured at the time of the SEP-qualifying event, namely those who live in states that have not expanded Medicaid and that transition from the "coverage gap" (having income below 100 percent of FPL but without any eligibility for insurance affordability programs) to qualifying for QHP tax credits (by having income between 100 and 400 percent of FPL and being without an offer of ESI that meets the ACA's standards for affordability and minimum value). The coverage-gap SEP is discussed in more detail below.

7 The study also analyzed two other groups of SEP-eligible adults, estimating that (1) roughly 8.3 million adults experience SEP-qualifying events that do not involve uninsurance and so are unlikely to prompt movement to marketplace plans; and (2) up to 3.7 million qualify for a different kind of SEP—one that lets marketplace enrollees change QHPs when a shift in household income triggers a significant modification in eligibility for tax credits or cost-sharing reductions. Hartman L., Espinoza G.A., Fried B., and Sonier J. 2015. "Millions Of Americans May Be Eligible For Marketplace Coverage Outside Open Enrollment As A Result Of Qualifying Life Events." Health Affairs 34(5), http://content.healthaffairs.org/content/early/2015/04/16/hlthaff.2014.0932.full.pdf+html.

8 Other departures from their methodology that could introduce differences in estimated SEP eligibility are noted here. (1) Our estimates reflect each state's Medicaid eligibility rules. Hartman and colleagues did not consider such state-by-state variation. Instead, they (a) relied on self-reported Medicaid coverage in non-expansion states; and (b) assumed that in expansion states all adults under 138 percent of FPL received Medicaid. (2) We imputed into the SIPP data estimates of immigration status and unaccepted ESI offers. They did not. Both of these factors can affect tax credit eligibility.

9 We exclude from this group people whose SEP permits ongoing enrollment into nongroup coverage or ESI (that is, SEPs triggered by marrying, adding a child to the family, gaining citizenship, and moving between counties or states) and people whom HIPSM projects will end the year with nongroup coverage. Some within this group may experience coverage gaps and be unable to enroll into marketplace coverage without an SEP. Accordingly, our approach may slightly underestimate the number of SEP-eligible consumers who, unless they sign up for marketplace coverage during the SEP, will be uninsured at the end of the calendar year.

10 Further data not shown in the text demonstrate how this group of SEP eligibles differs between expansion and non-expansion states. 5.7 million live in the former and 7.2 million in the latter states—respectively 3.5 and 6.6 percent of those states' non-elderly residents. In non-expansion states, 43 percent of longer-term SEP eligibles have incomes below 138 percent of FPL, compared to 7 percent in expansion states—a disparity that reflects different eligibility rules for assistance. In non-expansion states, citizens and lawfully present non-citizens can qualify for QHP tax credits with incomes between 100 and 138 percent of FPL. In expansion states, by contrast, QHP tax credit eligibility extends below 138 percent of FPL only for lawfully present non-citizens whose immigration status disqualifies them from Medicaid. Different financial eligibility rules relate to other contrasts, such as SEP eligibles' lower educational attainment and reduced levels of full-time employment in non-expansion states.

The racial and ethnic distribution of SEP eligibles likewise varies between expansion and non-expansion states. Non-Hispanic blacks make up 17 percent of longer-term SEP eligibles in non-expansion states, vs. 8 percent in expansion states; and Asian-Americans and Pacific Islanders (AAPI) are more prevalent in expansion states (8 percent vs. 3 percent in non-expansion states).To some degree, this variation reflects different tax credit eligibility in expansion and non-expansion states, but it primarily involves underlying population differences, such as the AAPI community's disproportionate representation in West Coast states, all of which expanded Medicaid. http://www.urban.org/research/publication/racialethnic-differences-uninsurance-rates-under-aca

11 The table rounds off to the nearest 10,000, but in the text we round to the nearest 100,000.

12 This number differs from the estimate in the table because of rounding.

13 Out of the roughly 800,000 in this group, approximately 700,000 would receive Medicaid by the end of the year (data not shown).

14 Centers for Medicare and Medicaid Services. "2015 Special Enrollment Period Report – February 23 – June 30, 2015." Baltimore: Centers for Medicare and Medicaid Services, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-13.html (Accessed September 2015).

15 As of February 22, 2015, 76 percent of all marketplace enrollees obtained coverage via healthcare.gov. If that same share applies to SEP enrollment, then more than 800,000 people used these SEPs nationally from February 23 through June 30, 2015. The 127 days from February 23 through June 30 represent 47 percent of the nine months to which our eligibility estimates apply. If SEP enrollment continues at the same pace for nine months, about 1.7 million people will enroll in SEPs outside the OEP.

16 Several limitations are noted here. SEP utilization levels may differ between state-based marketplaces and marketplaces using the healthcare.gov platform; SEP enrollment may be faster or slower during February 23 through June 30 than at other periods; some consumers in the two CMS-reported categories we exclude from this analysis (the tax-filing SEP and Medicaid applications that lead to tax credit eligibility) may have also experienced SEPs in other categories (either by (1) living in a non-expansion state and, within the past 60 days, experiencing an increase in income from under to over 100 percent FPL or (2) applying for Medicaid because of an SEP-qualifying event that terminates prior coverage, then being found eligible for tax credits); and our extrapolation overstates enrollment in that the CMS report includes all who selected a plan, whether or not they effectuated enrollment by paying premiums. Also, our SEP eligibility number could be too low, relative to participants, since some of the SEP enrollees in the CMS report may be in SEP categories outside our eligibility estimates.

17 Wishner, JB, Ahn, S, Lucia, K. and Gadsden, S. "Special Enrollment Periods in 2014: A Study of Select States." Washington, DC: Urban Institute, 2015, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000122-Special-Enrollment-Periods-in-2014.pdf (Accessed October 2015).

18 Gulley, SE. "Ongoing Coverage for Ongoing Care: Access, Utilization, and Out-of-Pocket Spending Among Uninsured Working-Age Adults With Chronic Health Care Needs." *American Journal of Public Health*, 101 (2): 368–375, 2011; Olson F., Tang S and Newacheck P. "Children in the United States With Discontinuous Health Insurance Coverage." *New England Journal of Medicine*, 353 (4): 382–391, 2005. In addition, a useful summary of the literature, prepared by Daniel Liebman of "The Incidental Economist," is available at "Consequences of Gaps in Insurance Coverage," the Incidental Economist, http://theincidentaleconomist.com/wordpress/wp-content/

uploads/2014/01/Gaps-in-Coverage-Lit-Review.pdf (Accessed September 2015). See also the Incidental Economist, "The Consequences of Health Insurance Coverage Gaps," Academy Health Blog, Monday, January 6, 2014, http://blog.academyhealth.org/the-consequences-of-health-insurance-coverage-gaps/ (Accessed September 2015).

19 Curtis R., Institute for Health Policy Solutions, personal communication, 2015.

20 Outreach and enrollment strategies are also available for smaller SEPs: (1) With the "new child SEP," states could engage hospitals. At labor and delivery, hospitals commonly cover some uncompensated costs by qualifying newborns for Medicaid. They could be encouraged to simultaneously help uninsured parents sign up for IAPs, thus building good will among potential future patients. Also, adoption agencies could help enroll into IAPs what is probably a small population of uninsured adoptive parents. (2) With the marriage SEP, marketplaces could engage issuers of marriage licenses and clergy associations in linking uninsured newlyweds to sources of application assistance. (3) With the moving SEP, post office data show geographic moves, but no existing infrastructure gives movers individual assistance of any kind, as far as the authors are aware. (4) Family or divorce courts could be a nexus for enrolling divorced adults into health coverage.

21 Dorn S. "Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons." Washington: Urban Institute, 2008, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411608-Health-Coverage-Tax-Credits.PDF (Accessed September 2015); Office of Economic Policy. "COBRA Insurance Coverage Since the Recovery Act: Results From New Survey Data." Washington: U.S. Treasury Department, 2010, http://www.treasury.gov/resource-center/economic-policy/Documents/cobra%20final%20report.pdf (Accessed September 2015). An important factor constraining participation in these earlier subsidy programs was the limited affordability of coverage, even with subsidies. See Berk J and Rangarajan A. "Evaluation of the ARRA COBRA Subsidy: Final Report." Washington: Mathematica Policy Research, 2015, http://www.dol.gov/asp/evaluation/completed-studies/COBRA_FinalReport_toDOL.pdf (Accessed September 2015).

22 Dorn S, Aug. 2004, "Health Coverage Tax Credits in North Carolina: Heroic Efforts, Modest Results," Economic and Social Research Institute; Government Accountability Office, Jan. 2006, "Trade Adjustment Assistance: Most Workers in Five Layoffs Received Services, but Better Outreach Needed on New Benefits," GAO-06-43, http://www.gao.gov/assets/250/248989.pdf.

23 The Health Coverage Tax Credit (HCTC) program, enacted as part of the Trade Act of 2002, provided subsidies to laid-off workers displaced by international trade agreements (along with certain other populations). Nationally, only 13 to 21 percent of HCTC-eligible workers enrolled into coverage. However, a few enrollment assistance efforts greatly increased participation levels. For example, union-sponsored efforts in West Virginia enrolled between 43 and 59 percent of eligible beneficiaries; a state-sponsored project in Virginia enrolled more than 90 percent of HCTC-eligible callers; and HCTCs covered 53 percent of eligible Bethlehem Steel retirees who received union assistance. These individual assistance initiatives were accompanied by efforts to address affordability issues and other concerns that limited national HCTC enrollment. Dorn S. "Take-Up of Health Coverage Tax Credits: Examples of Success in a Program with Low Enrollment," Washington: Urban Institute, 2006 http://www.urban.org/research/publication/take-health-coverage-tax-credits (accessed September 2015).

24 See, e.g., Dorn S. "Public Education, Outreach and Application Assistance," Washington, DC: Urban Institute, 2014, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000037-Public-Education-Outreach-and-Application-Assistance.pdf (Accessed October 2015); Zuckerman, S., et al. "Navigating the Marketplace: How Uninsured Adults Have Been Looking for Coverage, Washington, DC: Urban Institute, 2014, http://hrms.urban.org/briefs/navigating-the-marketplace.html (Accessed October 2015).

25 Such efforts would likely enroll laid-off workers and their dependents into both QHPs and Medicaid. Under federal cost-allocation rules, Medicaid would contribute to the cost of such programs in proportion to Medicaid's benefit. CMS has already specified that such cost allocation should occur with similar functions, for example, call centers and eligibility and enrollment systems that benefit both Medicaid and marketplaces. See CMS. "Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems: Questions and Answers." Baltimore: Centers for Medicare and Medicaid Services, 2012, http://medicaid.gov/AffordableCareAct/Provisions/Downloads/Key-Cost allocation-QAs-10-05-12.pdf (Accessed September 2015).