

Affordability of Marketplace Coverage: Challenges to Enrollment and State Options to Lower Consumer Costs

December 2014

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Robert Wood Johnson
Foundation


URBAN
INSTITUTE
HEALTH
POLICY CENTER

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in case study states. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

EXECUTIVE SUMMARY

Open enrollment in 2014 exceeded expectations for consumer participation. Even at this early stage, the Patient Protection and Affordable Care Act (ACA) has significantly reduced the number of uninsured. Nevertheless, many consumers remain without coverage despite eligibility for Medicaid or subsidies to lower the cost of qualified health plans (QHPs) offered in health insurance marketplaces.

One serious obstacle to enrollment is many consumers' belief that QHP coverage, even with federal subsidies, is not affordable. In early June 2014, this was by far the most frequent reason that uninsured adults who visited a health insurance marketplace gave for not enrolling in marketplace coverage. According to the Urban Institute's Health Reform Monitoring Survey (HRMS), 58 percent of these adults cited their inability to afford coverage as a reason for failing to enroll, compared with 29 percent and 20 percent who mentioned ineligibility for financial assistance and technical or time barriers to participation, respectively—the second and third most frequently cited reasons. These findings are consistent with our interviews with application assisters from multiple states, who reported that even with subsidies, many uninsured found coverage too expensive to purchase.

Most uninsured adults who visited a marketplace (64 percent) reported hearing “some or a lot” about subsidies. On the other hand, some concerns about affordability may reflect a lack of information. Most

uninsured consumers who did *not* visit a marketplace (72 percent) heard “little or nothing” about subsidies.

Altogether, 68 percent of the consumers who remained uninsured after open enrollment in 2014 had not visited a marketplace. It may therefore be important for states to address not just the actual affordability of coverage, but also public education about available subsidies. The latter topic is not explored here, but it is addressed as part of another paper in this series.

To improve QHP affordability for low- and moderate-income consumers, several states appeared to achieve success taking two distinct approaches:

- *Minnesota uses a Medicaid waiver to provide more affordable coverage outside the marketplace to consumers with incomes up to 200 percent of the federal poverty level (FPL). An adult with income at 170 percent of FPL, for example, pays \$33 a month for MinnesotaCare (MNCare), compared with \$80 that would be charged for subsidized QHP coverage. Based on several projections, MNCare has achieved more than two or three times the level of enrollment, relative to its target population (eligible consumers with incomes under 200 percent of FPL), that was achieved by QHP subsidies, relative to their target population (eligible consumers with incomes above 200 percent of FPL). However, factors other than greater affordability may have contributed to*

MNCare's high enrollment levels, such as many consumers' greater familiarity with and positive regard for MNCare than QHP coverage. One cannot conclusively declare MNCare to be a success until several other states have reported detailed enrollment information for comparison.

Minnesota plans to convert MNCare into a Basic Health Program (BHP) in 2015, the first year BHPs are allowed. This will increase the state's federal funding, but Minnesota will still need to contribute significant amounts. New York is also planning to implement a BHP.

- *Vermont supplements federal subsidies inside the marketplace* to improve affordability for consumers with incomes up to 300 percent of FPL. For example, single adults with incomes of 170 percent of FPL

pay \$60 in premiums rather than \$80 a month; and those at 250 percent of FPL pay \$161 instead of \$193. Vermont's enrollment of subsidy recipients as a percentage of QHP-eligible consumers exceeds every other state's enrollment of subsidized and unsubsidized QHP enrollees combined. However, high enrollment resulted from factors in addition to greater affordability, such as the state's ability to shift numerous eligible consumers from pre-ACA Medicaid coverage into subsidized QHPs.

Massachusetts is taking an approach like that used by Vermont. Both states fund subsidies with a combination of state dollars and federal matching payments through Medicaid waivers. It is not clear whether other states can obtain similar waivers; if not, any new supplementation efforts will be entirely state-funded.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) created two insurance affordability programs to help the low- and moderate-income uninsured obtain coverage:

- Expanded Medicaid eligibility to serve adults with incomes up to 138 percent of the federal poverty level (FPL), which the Supreme Court effectively changed into a state option; and
- A combination of premium tax credits and cost-sharing reductions to subsidize the purchase of private, qualified health plans (QHPs) in health insurance marketplaces. Subsidies are available to consumers who
 - are ineligible for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP);
 - are not offered employer-sponsored insurance the ACA classifies as affordable; and
 - have incomes between 100 and 400 percent of FPL. In states with expanded Medicaid eligibility, the lower income bound rises to 138 percent of FPL for most consumers.¹

The end of the ACA's first open enrollment period has seen better-than-expected participation² and a significant drop in the number of uninsured, particularly

in states that expanded Medicaid.³ However, many eligible uninsured have not yet signed up. Based on the country's experience with CHIP, years may be needed to accomplish the ACA's enrollment goals as states learn from each other's successes and failures, eventually migrating toward a general consensus about effective practice.⁴

This paper focuses on one factor that has emerged as a challenge to marketplace enrollment: namely, consumers' perception that, even with federal subsidies, QHPs are not affordable. We begin by analyzing how this factor played out during the open enrollment season for 2014, relying on two primary sources of information:

- *Health Reform Monitoring Survey (HRMS) results from the first two quarters of 2014.* HRMS is a quarterly national survey of the nonelderly population conducted to analyze the ACA's effects. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation (RWJF), the Ford Foundation, and the Urban Institute. For further information, see <http://hrms.urban.org/>.
- *State-level interviews* with policy-makers, consumer advocacy groups, navigators, application assisters and insurance brokers and agents. Based on semistructured interview protocols, researchers from the Urban Institute and, in some cases, Georgetown

University's Health Policy Institute and the Institute for Health Policy Solutions spoke with stakeholders in 22 states with state-based or partnership marketplaces, as well as several states with federally facilitated marketplaces (namely, Alabama and Virginia).

After exploring affordability issues that emerged during the 2014 open enrollment period, the report describes promising practices implemented by particular states to improve the affordability of coverage.

AFFORDABILITY OF QHPS AS AN OBSTACLE TO PARTICIPATION

One of the most serious obstacles to enrollment in QHPs is the perceived cost of coverage, even taking into account available federal subsidies. According to HRMS results for the second quarter of 2014, financial barriers were the most frequent reason that uninsured adults who visited the marketplace gave for not enrolling. Unaffordable costs were mentioned by 58 percent of such adults, compared with 29 percent and 20 percent who cited ineligibility for financial assistance and technical or time barriers to participation, respectively the second and third most common reasons for not enrolling in marketplace coverage (Figure 1).

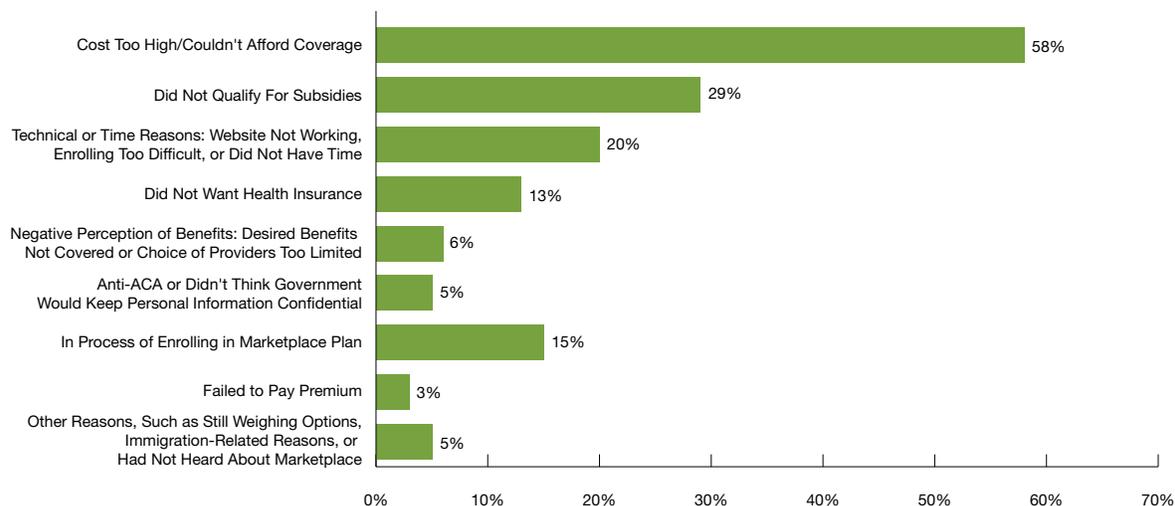
Unfamiliarity with subsidies did not appear to be the main reason why consumers who visited the marketplace found coverage unaffordable. Among those who visited the marketplace but remained uninsured, nearly two-thirds (64 percent) reported hearing “some or a lot” about subsidies, according to HRMS data for June 2014.

By contrast, among the uninsured who had not visited a

marketplace, only 26 percent had heard “some or a lot” about subsidies; 72 percent had heard “little or nothing.” Altogether, 68 percent of consumers who had been uninsured at some point during the previous 12 months and who remained uninsured in June 2014 did not visit a marketplace during 2014 open enrollment. This suggests that, in addition to addressing the actual affordability of QHP coverage, policy-makers seeking to increase enrollment levels could consider public education strategies. The latter topic is not addressed here, but it is included as part of another paper in this series.

The HRMS survey results showing that consumers familiar with marketplace coverage frequently chose not to enroll because they viewed costs as unaffordable are consistent with our interviews in many states. Application assisters and navigators often reported that many consumers who had not previously purchased individual coverage found subsidized QHP coverage very costly. Sometimes these consumers enrolled in plans with higher out-of-pocket cost-sharing levels than they would

Figure 1. Why Uninsured Adults Who Visited the Marketplace Did Not Enroll in Marketplace Coverage: June 2014



Source: HRMS, Quarter 2, 2014.

Note: Respondents could give more than one answer, so total answers exceed 100 percent.

have preferred, but many simply did not enroll. On the other hand, consumers who had previously purchased individual coverage were often pleased with the options made available by QHP subsidies, according to our interviewees. The same was true of consumers who had attempted to buy individual coverage in the past but could not do so because of preexisting conditions.

Premium charges can vary for many reasons.⁵ When a subsidy beneficiary buys so-called “benchmark coverage”—that is, the second-lowest-cost silver plan—FPL and household size determine the consumer’s payments. At the same time, out-of-pocket costs grow along with income as cost-sharing subsidies diminish in value. A single adult enrolling in benchmark silver-level coverage would pay the following annual amounts:

- At 150 percent of FPL, \$684 in premiums for a plan with 94 percent actuarial value (AV). Using QHPs available in Vermont as examples, plans with such AV could have annual deductibles of \$100 or \$450.⁶
- At 200 percent of FPL, \$1,452 in premiums for a plan with 87 percent AV, which could involve annual deductibles of \$750 or \$1,000.⁷
- At 250 percent of FPL, \$2,328 in premiums for a plan with 73 percent AV, which could involve annual deductibles of \$1,400 or \$1,900.⁸

These are significant costs for people earning \$17,505, \$23,340 and \$29,175, respectively, in annual pretax income.

STATE STRATEGIES TO IMPROVE AFFORDABILITY

The first year of full ACA implementation saw a few states appear to achieve success using two very different strategies to improve the affordability of QHP coverage for low- and moderate-income consumers.

Option 1: Providing low-income consumers with more affordable coverage outside the marketplace

Minnesota sidestepped affordability problems for consumers with incomes at or below 200 percent of FPL. Rather than QHP subsidies, such consumers received coverage through a modified version of the state’s longstanding MinnesotaCare (MNCare) program.⁹ Funded through a Medicaid waiver, MNCare charges much less than subsidized QHPs. For example, a single adult at 170 percent of FPL

- pays premiums of \$33 a month for MNCare, compared with \$80 that would have been charged for subsidized QHP coverage at that same FPL level;¹⁰ and
- has coverage with a \$2.75 monthly deductible and \$3 office visit copays.¹¹ In the marketplace, a typical plan for such an adult receiving cost-sharing subsidies might have, for example, a \$750 annual deductible and office copays of \$10 and \$30 for primary and specialty care office visits, respectively.¹²

Navigators and consumer groups reported that, because

of MNCare’s greater affordability, it received a much more positive response than subsidized QHP coverage. Many who qualified for the latter found coverage unaffordable and chose to pay the penalty for being uninsured; no such responses were reported for consumers who qualified for MNCare.¹³ (Of course, Minnesota navigators could not describe consumers’ reactions to QHP subsidies below 200 percent of FPL, since Minnesota consumers with incomes below 200 percent of FPL were not offered QHPs.)

From the start of open enrollment on October 1, 2013, through June 10, 2014,

- 51,558 individuals enrolled in Minnesota QHPs, of whom 41 percent (approximately 21,000) purchased coverage with the aid of premium tax credits; and
- 49,115 individuals enrolled in MNCare.¹⁴

These enrollment results can be compared to forecasts from several microsimulation models, which estimated Minnesota’s participation levels once coverage transitions are complete and enrollment reaches steady-state levels. Such models distinguished (1) enrollment in subsidized QHP coverage below 200 percent of FPL, the income level served by MNCare; from (2) enrollment between 200 and 400 percent of FPL, the income level served by subsidized QHPs. Jonathan Gruber of MIT and Bela Gorman of Gorman Actuarial, LLC, estimated that, at steady-state levels, 153,000 tax credit recipients

below 200 percent of FPL would enroll in QHPs, as would 217,000 recipients with incomes between 200 and 400 percent of FPL.¹⁵ Urban Institute researchers using the Health Insurance Policy Simulation Model (HIPSM) projected enrollment of approximately 138,000 and 125,000 tax credit recipients with incomes below and above 200 percent of FPL, respectively.¹⁶

The actual June 2014 enrollment levels of roughly 49,000 and 21,000 in those two income categories equal 32 percent and 10 percent, respectively, of the expected, final, steady-state levels forecast by Gruber and Gorman and 36 and 17 percent of such levels estimated by HIPSM.¹⁷ Accordingly, if projected QHP participation within each income range is used to provide relative benchmarks for comparison, MNCare achieved more than two or three times the enrollment success attained by QHP subsidies.

MNCare thus enjoyed an apparent success, relative to expectations defined by HIPSM and the Gruber/Gorman estimates. MNCare's greater affordability, relative to subsidized QHPs, may have been one cause of that apparent success, as suggested by the application assisters we interviewed. However, other factors may have also contributed, such as low-income consumers' prior familiarity with and generally high regard for MNCare. Moreover, until information about the income distribution of subsidized QHP enrollment in a number of other states can be compared with enrollment patterns in Minnesota,¹⁸ the judgment of MNCare's apparent success needs to be somewhat tentative, rather than conclusive.

State officials view the current Medicaid waiver as a bridge to Minnesota's implementation of the Basic Health Program (BHP) option under the ACA, which will start in 2015, the first year that federal regulations allow BHP implementation. With BHP, states cover consumers with incomes at or below 200 percent of FPL through state-contracting plans, rather than the marketplace. The federal government provides funding equal to 95 percent of what it would have spent on tax credits and cost-sharing reductions for BHP consumers if they had enrolled in QHPs.¹⁹

State officials expect BHP to significantly increase the state's receipt of federal funding, compared with the current Medicaid waiver, which provides Minnesota's standard federal medical assistance percentage (FMAP).²⁰ However, Minnesota's combination of low benchmark QHP premiums (the basis on which federal

BHP funding is determined), high per capita Medicaid costs, and policy-makers' determination to keep consumer costs low will likely mean significant (albeit reduced) state costs under BHP. New York also plans to implement BHP, anticipating that it will achieve net state budget savings by transferring state-funded health care costs for indigent immigrant adults to federally funded BHP, without the affected consumers losing services or incurring increased costs.²¹

Option 2. Supplementing subsidies in the marketplace

Taking a different approach to improving affordability, Vermont supplements exchange subsidies for consumers with incomes up to 300 percent of FPL. For example:

- Single adults with incomes at 170 percent of FPL pay \$60 in monthly premiums rather than the \$80 that would ordinarily be charged at that income level, those at 200 percent of FPL pay \$96 rather than \$121, and those at 250 percent of FPL pay \$161 instead of \$193.²²
- Vermont does not reduce out-of-pocket cost-sharing for consumers with incomes below 200 percent of FPL. Instead, the state modestly increases AV for consumers between 200 and 300 percent of FPL, smoothing out what would otherwise be an abrupt drop in AV. Between 201 and 250 percent of FPL, the state's supplement could lower an individual deductible, for example, from \$1,900 to \$1,500; and between 251 and 300 percent of FPL, it might reduce the out-of-pocket maximum for medical care from \$5,100 to \$4,000.²³

Vermont achieved remarkably high QHP enrollment levels. April 2014 QHP participation in Vermont exceeded by 9.8 percent the final, steady-state levels forecast by HIPSM for 2016. Vermont's tax credit beneficiaries by themselves represented 73.6 percent of all QHP enrollees HIPSM forecast for 2016, subsidized and unsubsidized combined. By contrast, in the second-highest state, Florida, all QHP participants, with and without tax credits, together reached just 68.5 percent of forecast 2016 levels—well below the enrollment achieved in Vermont by tax credit beneficiaries alone.²⁴

The generosity of subsidized coverage in Vermont likely played a role contributing to such high participation levels among Vermont's subsidy-eligible consumers. However, other factors may have been involved as

well—notably, the state’s pre-ACA coverage, through its “Catamount Health” Medicaid waiver, of adults with incomes up to 300 percent of FPL. This existing coverage facilitated enrollment by providing a “target list” of consumers who typically qualified for subsidized QHP coverage, many of whom had current contact information on file, and who were already known to want subsidized health insurance.

The ACA specifically permits states to supplement federal QHP subsidies.²⁵ In the case of Vermont, the federal government, via Medicaid waiver, has gone further and shares the cost of supplementing tax credits, paying standard FMAP.²⁶ This waiver does not, however, contribute to the cost of supplementing cost-sharing reductions. Massachusetts, which also covered adults with incomes up to 300 percent of FPL before the ACA, is now implementing a policy like Vermont’s, supplementing both premium tax credits and cost-sharing reductions in the marketplace. As in Vermont, Massachusetts’s federal Medicaid waiver helps cover the cost of the former (but not the latter).

It is not at all clear that the federal government would grant similar waivers to other states that did not cover adults with incomes above 138 percent of FPL in the past and so do not need supplemental QHP subsidies to shield consumers from increased health care costs under the ACA. Without such a waiver, a state that supplements federal QHP subsidies would need to finance its supplement with state-only dollars.

Comparing the two options

Both approaches increased participation by making coverage more affordable. However, in neither case can one be certain about causation, since other factors were also in play.

CONCLUSION

With insurance affordability programs starting in January 2014, the ACA’s main coverage expansion has just begun. The cost of QHP coverage, even with federal subsidies, appears to be deterring many uninsured consumers from enrollment. Several states offer promising examples that suggest contrasting strategies for overcoming this obstacle.

One difference between these approaches is that Minnesota provides more affordable coverage by moving low-income consumers outside the marketplace into more affordable plans, which means that its marketplace contains fewer participants. Vermont keeps consumers within the marketplace and increases subsidy levels, lowering consumer costs while they remain enrolled in QHPs.

Also, Minnesota’s approach is limited to consumers with incomes up to 200 percent of FPL. This limitation likely results from the state’s intent to transition to BHP, which is not available above that income threshold. By contrast, Vermont’s Medicaid waiver extends to consumers with incomes up to 300 percent of FPL.

Minnesota’s approach brings in a greater total amount of federal funding, which lets the state provide more affordable coverage. On the other hand, the state’s financial responsibility is potentially greater and less defined under Minnesota’s approach:

- Minnesota furnishes all care. Under BHP, federal funding will be based on subsidies that would have been furnished in the marketplace, so the extent (if any) to which the state is ultimately responsible for paying health care costs will largely reflect the relationship between benchmark QHP premiums and the cost of state-furnished BHP coverage.
- Vermont’s approach limits the state’s financial responsibility to supplementing QHP subsidies.

These states have been willing to commit resources to making coverage more affordable to their low- and moderate-income residents. Before other states embrace similar efforts, they would need to carefully consider what costs might be involved, what offsets might be available, and what gains and trade-offs might result.

These conclusions are necessarily somewhat preliminary at this early point in ACA implementation. The coming years will provide more experience with the ACA, and more data documenting its effects will become available. Observers will gain an increased capacity to definitively assess the significance of QHP costs as a barrier to enrollment as well as the impact of alternative state strategies aimed at making coverage more affordable for the low- and moderate-income uninsured.

ENDNOTES

1. In states that expand Medicaid, the lower threshold of financial eligibility for QHP subsidies generally rises to 138 percent of FPL because consumers with incomes at or below that level qualify for Medicaid, with one exception. Certain lawfully present noncitizens are ineligible for Medicaid because of their immigration status and so qualify for QHP subsidies, notwithstanding income below the ordinarily applicable lower-income threshold for such subsidies.
2. Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H and Zuckerman S. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update*. Washington, D.C.: Urban Institute, May 1, 2014, <http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf>.
3. 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, D.C.: Urban Institute, 2014, <http://hrms.urban.org/briefs/taking-stock-at-mid-year.pdf>.
4. Along with Medicaid coverage of children, CHIP is now one of the country's most successful need-based programs, reaching an estimated 87 percent of its target population. (Kenney GM, Anderson N and Lynch V. "Medicaid/CHIP Participation Rates among Children: An Update." Washington, D.C.: Urban Institute, 2013, <http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf> [accessed February 7, 2014].). During its first few years, however, CHIP was viewed with "general disappointment ... due to low enrollment rates," according to the Congressional Research Service (Herz E and Baumrucker EP. "Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?" Washington, D.C.: Congressional Research Service, 2001, <http://www.policyarchive.org/handle/10207/bitstreams/1043.pdf> [accessed February 7, 2014].).
5. According to the U.S. Department of Health and Human Services, the average premium paid by subsidy recipients in federally facilitated marketplaces is \$82 a month, or \$984 a year. (Burke A, Misra A and Sheingold S. *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014*. Washington, D.C.: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2014, <http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf>.) However, we do not know what premiums were charged to consumers who chose not to enroll. Premiums charged to nonenrollees are presumably higher, on average, than for those who sign up for coverage, since higher premiums are associated with a reduced likelihood of taking up insurance. See, for example, Gresenz CR, Edgington SE, Laugesen MJ and Escarce JJ. "Income Eligibility Thresholds, Premium Contributions, and Children's Coverage Outcomes: A Study of CHIP Expansions." *Health Services Research* 48(2) 884–904, April 2013; Guy GP, Adams EK and Atherly AJ. *The Impact of Public and Private Health Insurance Premiums on the Health Insurance Status of Low Income Childless Adults*, Washington, D.C.: AcademyHealth, 2011, http://www.academyhealth.org/files/2011/monday_guy.pdf; and Dushi I and Honig M. "Price and Spouse's Coverage in Employee Demand for Health Insurance." *The American Economic Review*, 93(2): 252–256, May 2013.
6. See Vermont Health Connect, *Cost-Sharing Reduction (CSR) Tier I (94% AV) Silver Plans*.
7. See Vermont Health Connect, *Cost-Sharing Reduction (CSR) Tier II (87% AV) Silver Plans*.
8. See Vermont Health Connect, *Cost-Sharing Reduction (CSR) Tier IV (73% AV) Silver Plans*.
9. Although Minnesota's coverage was provided pursuant to state waiver, Medicaid coverage for adults over 138 percent of FPL can also be implemented through state plan amendment, pursuant to 42 CFR 435.21.
10. At 140 percent of FPL, MNCare premiums are \$21 per adult, compared with \$46 and \$94 in subsidized QHP coverage for 1- and 4-person households, respectively; at 150 percent of FPL, MNCare premiums are \$25, compared with \$57 and \$118; and at 200 percent of FPL, a MNCare adult pays \$50 a month, compared with \$121 and \$247 for a subsidy-eligible QHP enrollee in a 1- and 4-person household, respectively. *MinnesotaCare Premium Estimator Table, Effective January 1, 2014 – December 31, 2014*. <https://edocs.dhs.state.mn.us/lfs/Server/Public/DHS-4139A-ENG>.
11. Minnesota Department of Human Services. *Minnesota Health Care Programs: Summary of Coverage, Cost Sharing and Limits (Effective January 1, 2014)*. DHS-3860-ENG.
12. See, for example, Vermont Health Connect. *Cost-Sharing Reduction (CSR) Tier II (87% AV) Silver Plans*.
13. Several broker interviewees suggested that some consumers, such as those with serious health problems who were formerly covered by the state's high-risk pool, would be better off in QHPs than in MNCare because of broader provider networks in QHPs. However, this concern was not reported by consumer advocacy groups, navigators or application assisters we interviewed; brokers receive commissions for QHP enrollees but not for MNCare enrollees, raising questions about their objectivity.
14. MNSure. "MNSure Metrics Dashboard: Prepared for Board of Directors Meeting, June 18, 2014." <https://www.mnsure.org/images/bd-2014-06-18-dashboard.pdf>.
15. Gruber J, Gorman B, Gorman D and Smagula J. "The Impact of the ACA and Exchange on Minnesota: Updated Estimates." St. Paul, MN: prepared for the State of Minnesota, February 2013, <https://www.mnsure.org/images/Report-GruberGormanUpdate-2013-02-28.pdf>.
16. See table 3 in Buettgens M, Holahan J and Carroll C. *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid*. Washington, D.C.: Urban Institute 2011, <http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf>. The estimates in the text result from multiplying the projected number of marketplace participants statewide by the estimated percentage of such participants with incomes at applicable levels.
17. If one analyzes enrollment estimates available soon after the March conclusion of open enrollment, rather than enrollment estimates as of mid-June, similar conclusions follow. As of April 13, 2014—the earliest date following the end of open enrollment for which enrollment estimates are available—37,985 individuals had enrolled in MNCare and 47,902 in QHPs (MNSure. "MNSure Metrics Dashboard: Prepared for Board of Directors Meeting, April 16, 2014." <https://www.mnsure.org/images/bd-2014-04-16-dashboard.pdf>.) These estimates did not state the percentage of QHP enrollees receiving tax credits, which is why the text uses the June estimates. Applying to these mid-April results the June 2014 finding that 41 percent of Minnesota's QHP enrollees received tax credits, approximately 19,640 tax credit beneficiaries above 200 percent of FPL would be estimated to have enrolled in QHPs by mid-April. Using the Gruber/Gorman estimates of "steady state" QHP enrollment, MNCare had reached 25 percent of target levels by the end of open enrollment, compared with 9 percent of tax credit beneficiaries enrolling into QHP coverage. Using HIPSM estimates as the benchmark, MNCare enrolled 19 percent, and QHP subsidies 9 percent, of projected steady-state enrollees by the end of open enrollment.

18. The only state to report the income distribution of subsidy-eligible QHP enrollees is New York. There, 53 percent of such enrollees had incomes at or below 200 percent of FPL (NY State of Health: The Official Health Plan Marketplace. *2014 Open Enrollment Report*, Albany, NY: New York Department of Health, June 2014.). In Minnesota, by contrast, MNCare enrollees made up 70 percent of all mid-June enrollees who otherwise may have qualified for QHP subsidies (that is, 70 percent of all consumers who received either MNCare or subsidized QHP coverage). If one uses the method described above to estimate QHP-subsidy eligibility for the end of Minnesota open enrollment, then MNCare enrollees made up 66 percent of all such subsidy-eligible enrollees—well above New York's 53 percent level.
19. For more information about the BHP option, see Dorn S and Tolbert J. *The ACA's Basic Health Program Option: Federal Requirements and State Trade-Offs*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured (publication pending). Beginning in 2017, states interested in this general approach may be able to go beyond BHPs by implementing broad state innovation waivers under ACA Section 1332, which will let states rearrange the ACA's architecture of federal health spending and coverage. This is the section that has authorized Vermont's implementation of a single payer system, which the state plans to begin implementing in 2017. A state implementing a Section 1332 waiver must ensure that, compared with standard ACA implementation, total federal spending does not increase and consumers neither lose benefits nor are charged higher premiums or out-of-pocket cost-sharing. Such a waiver might allow a state to implement a BHP-like approach while gaining access to more generous federal funding—providing 100 percent rather than 95 percent of subsidies that would otherwise have been paid. A waiver approach could also let consumers with incomes above 200 percent of FPL enroll in state-contracting plans outside the marketplace. However, no federal guidance or regulations have defined the substantive ground rules for such waivers, so whether and, if so, under what terms such a "BHP-plus" approach will be allowed is currently unknown.
20. Schwartz, S. "Two States on the Path to the Basic Health Program." *CHIRblog*, Georgetown University Health Policy Institute, Center for Health Insurance Reform, April 4, 2014, <http://chirblog.org/two-states-on-the-path-to-the-basic-health-program/>.
21. Affected adults in New York are lawfully present immigrants with incomes below 138 percent of FPL who are ineligible for federally matched Medicaid that goes beyond emergency services.
22. At 140 percent of FPL, single adults in Vermont pay \$30 rather than \$46; at 150 percent, they pay \$39 rather than \$57 (Vermont Health Connect Subsidy Calculator, http://info.healthconnect.vermont.gov/tax_credit_calculator).
23. Between 201 and 250 percent of FPL, Vermont's supplements increase AV from 77 to 73 percent, and between 251 and 300 percent of FPL, the state boosts AV from 70 to 73 percent. See Vermont Health Connect. Cost-Sharing Reduction (CSR) Tier III (77% AV) Silver Plans; *Cost-Sharing Reduction (CSR) Tier IV (73% AV) Silver Plans*; *Vermont Health Connect Silver Plans*.
24. This analysis is premised on the fact that 67 percent of Vermont's QHP enrollees receive tax credits. *Vermont Health Connect. Vermont Health Connect Update, Medicaid and Exchange Advisory Board, Monday, May 12, May 12, 2014*, http://info.healthconnect.vermont.gov/sites/hcexchange/files/Vermont%20Health%20Connect%20Update_MEAB_5%2012%202014.pdf. For interstate comparisons, see Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H, and Zuckerman S. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update*. Washington, D.C.: Urban Institute, 2014, <http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf>. The same results follow when other metrics are used to compare states. For example, one can compare April 2014 enrollment to the total population eligible to enroll in QHPs, defining the latter to include (1) people who qualify for tax credits, (2) the uninsured who are ineligible for IAPs, and (3) the individually insured who are ineligible for insurance affordability programs. Using this metric, Vermont enrolled 73.5 percent of QHP-eligible consumers by April 2014, compared with 42.2 percent in California, the second-highest state; the national average was 24.5 percent. Among tax credit beneficiaries alone, Vermont's enrollees represented 49.2 percent of the state's entire QHP-eligible population—still higher than California's 42.2 percent level, which counts both subsidized and unsubsidized enrollees as participants.
25. ACA §1412(e).
26. The total amount of federal payments for this purpose is capped, and these payments fall within the Vermont global waiver's total budget neutrality requirements.

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About the Authors and Acknowledgements

Stan Dorn is a senior fellow at the Urban Institute’s Health Policy Center. The author appreciates the comments, suggestions and other assistance of the Urban Institute’s Linda Blumberg, John Holahan, Michael Karpman and Genevieve Kenney. The author is grateful to the Robert Wood Johnson Foundation for supporting this research.

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