



# Response to the Heritage Foundation's Criticisms of the Urban Institute's King v. Burwell Analyses

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In January and February 2015, we released three studies estimating the implications of a Supreme Court ruling for the plaintiffs in King v. Burwell (Buettgens et al. 2015; Blumberg, Buettgens, and Holahan 2015a, 2015b). A finding for the plaintiffs would eliminate the premium tax credits and cost-sharing reductions currently being provided under the Affordable Care Act (ACA) in the states where the federal government is playing a role in operating the new nongroup insurance Marketplaces established under the law. In these studies, we

- quantified the effects of eliminating the financial assistance on the number of people uninsured,
- estimated average premiums in the nongroup insurance markets inside and outside the Marketplaces following a win for the plaintiffs compared with under current implementation of the law,
- summarized the characteristics of the individuals who would be affected,
- estimated the increased financial burdens facing those attempting to retain the same coverage they would have had otherwise as the law is currently implemented, and
- quantified the reduction in health care spending by sector for those becoming uninsured as a consequence of a ruling for the plaintiffs.

In an issue brief released on February 20, 2015, Edmund Haislmaier of the Heritage Foundation criticizes the validity of some of these estimates, as well as related analyses released by researchers at the RAND Corporation and the Commonwealth Fund (Haislmaier 2015). Here, we respond to each of his criticisms levied at our work and at our colleagues.

# Heritage Foundation Criticism #1 Ignores New Enrollment during the 2016 Open Enrollment Period and Ignores That the Increase in Coverage Resulting from the ACA Phases Up Over Time

The Urban Institute projects that, in 2016, 9.3 million individuals in federally facilitated Marketplace (FFM) states would receive tax credits under the ACA as currently implemented; all of these individuals would lose tax credits (and those with income below 250 percent of the federal poverty level enrolled in silver-level coverage would also lose cost-sharing reductions) if the Court finds for the plaintiffs. Haislmaier states, “Based on existing enrollment trends, this projection for 2016 is highly unlikely. A more realistic estimate is that around 5.5 million individuals could lose subsidies in 2015.” He bases his skepticism on the information that there was attrition in enrollment between the end of the 2014 open enrollment period and the end of the 2014 plan year, because some did not pay premiums and some left coverage midyear.

Though, as expected, there was attrition between the number of people choosing a plan during 2014 open enrollment and the number finishing the year with coverage, Haislmaier’s extrapolation of that attrition into the future is faulty. He applies a 16.5 percent attrition rate to the US Department of Health and Human Services’ 2015 figure of tax credit-eligible enrollees in the FFM states (6.6 million people), an attrition rate that is consistent with that seen for all Marketplace enrollees between open enrollment 2014 and the end of the 2014 plan year. He states that his 5.5 million estimate ( $6.6 \text{ million} \times (1 - 0.165) = 5.5$ ) is a projection of 2016 enrollment, but in doing so he has ignored that more enrollees will sign up for coverage in 2016, just as was the case in 2015. He is, in effect, taking into account one side of churn in the nongroup market (some people moving out of nongroup coverage in a year) while not taking the other side of churn into account (some people moving into nongroup coverage throughout the year and in the next open enrollment period). In addition, he ignores the fact that policy analysts, based on experience with previous coverage expansions under programs such as Medicaid, CHIP, and the Massachusetts state reforms, recognize that the first three to five years after ACA implementation are actually phase-in years. This means that enrollment in Medicaid and nongroup insurance will continue to expand over this period in each new open enrollment period as individuals learn more about the coverage options and financial assistance now available to them, and as more people become aware of and respond to the increasing individual mandate penalties by moving from being uninsured to being insured.

In fact, the net number of people enrolled in subsidized Marketplace enrollment through the FFMs increased 43 percent between the 2014 and 2015 open enrollment periods.<sup>1</sup> If 2016 sees a similar relative increase, the number of people enrolled in Marketplace coverage with tax credits in these states would be 9.4 million, compared with our projection (which predated the conclusion of the 2015 open enrollment) of 9.3 million. Thus, current enrollment statistics strongly suggest that our projection is the more realistic one.

## Heritage Foundation Criticism #2 Relies on an Erroneous Interpretation of Information Regarding Recent Coverage in Employer-Sponsored Insurance

The RAND analysis, consistent with ours, finds that a decision for the plaintiffs would “undermine the ACA’s current and future success in reducing the number of uninsured Americans, which dropped by an estimated 8 to 10 million during the first open enrollment period” (Saltzman and Eibner 2015). In response, Haislmaier claims that 85 percent of the increase in nongroup insurance coverage under the ACA amounted to a crowding out of employer-sponsored insurance (ESI). In other words, he states that the vast majority of the increase in nongroup insurance coverage was offset by a decline in ESI. Consequently, he believes that reversing coverage gains via the ACA’s Marketplaces would not significantly affect the number uninsured, because he hypothesizes that almost 90 percent of the expansion of coverage under the law is attributable to the Medicaid expansion. His interpretation of the changes in ESI coverage between 2013, 2014, and 2015 are, however, inconsistent with the broad array of research evidence. His misinterpretation is likely the consequence of using multiple datasets that measure insurance coverage from different sources differently, resulting in an inconsistent understanding of coverage dynamics overall. The data source he uses for fully insured employer coverage is a different one from what he uses for a source of data on self-insured employer coverage. Consequently, he may well be missing a movement from fully insured to self-insured products. In addition, the data sources he uses are plagued by problems of large insurers with many enrollees not appearing in the data consistently over time, with the coverage continuing but not always captured by the data (Blewett et al. 2014).

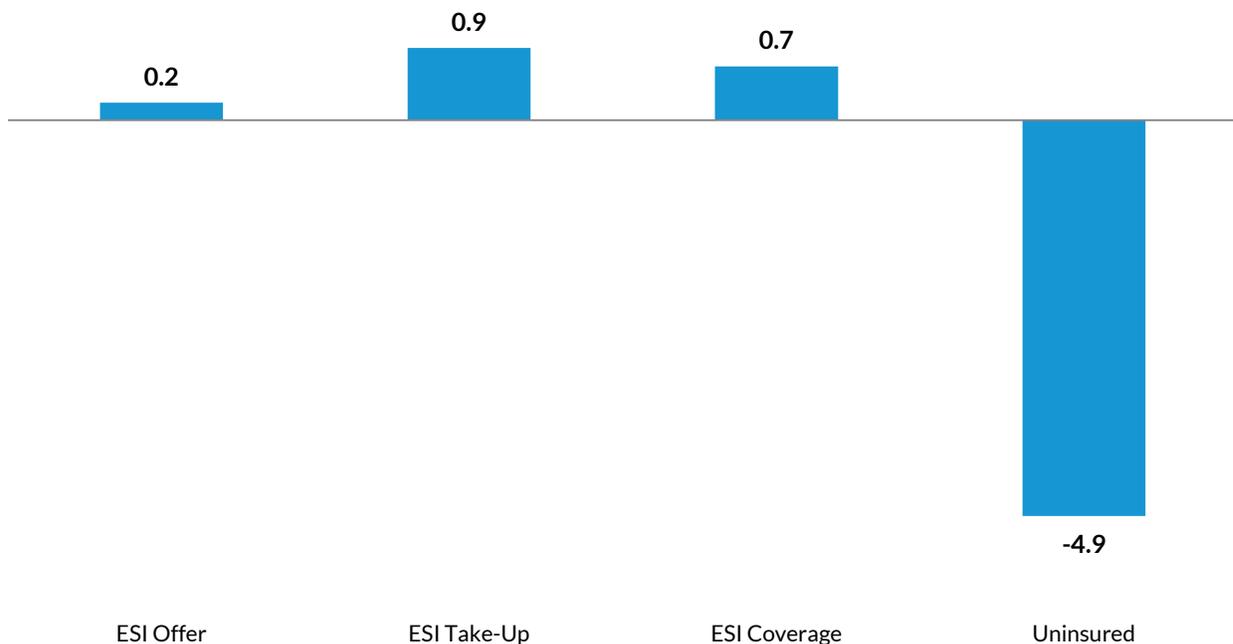
Available evidence from consistent sources of data through 2014 demonstrates that ESI has remained stable in the early years of ACA implementation. A study by the Urban Institute found no significant changes in ESI offer rates, take-up, and coverage between June 2013 and September 2014 for all workers, workers in small firms, or low-income workers (Blavin, Shartzter, and Holahan 2015). Additional estimates from the Urban Institute show no change in employer offer rates, take-up, or coverage and a significant decline in uninsurance for nonelderly adults in FFM/partnership states with family income in the range targeted by Marketplace subsidies between September 2013 and December 2014 (figure 1). Similarly, data from Gallup show ESI held relatively steady for nonelderly adults between quarter 3 2013 and quarter 4 2014 (44.4 percent compared with 43.4 percent, respectively), with a 5.7 percentage-point decline in the uninsured rate and increases in nongroup insurance (which Gallup refers to as “self-paid”), Medicaid, and Medicare.<sup>2</sup> Estimates from the National Health Interview Survey show an overall increase from quarter 4 2013 to quarter 2 2014 in the share of the nonelderly population with any private coverage from 60.5 to 63.8 percent, including ESI and directly purchased coverage (National Health Interview Survey Early Release Program 2014).

In addition to stable ESI coverage rates through 2014, evidence suggests employer offer rates have been relatively stable. The 2014 Kaiser Family Foundation/Health Research and Education Trust survey of employers found no significant change from 2013 in the share of employers offering health

benefits to at least some workers (55 percent) and the percentage of workers covered at those firms (62 percent; Claxton et al. 2014).

FIGURE 1

Percentage-Point Change in ESI and Uninsurance between Quarter 3 2013 and Quarter 4 2014 among Nonelderly Adults in FFM States with Family Income between 138 and 400 Percent of FPL



Source: The Urban Institute’s Health Reform Monitoring Survey.

Note: ESI = employer-sponsored insurance; FFM = federally facilitated Marketplace; FPL = federal poverty level.

## Heritage Foundation Criticism #3 Erroneously Assumes That Almost All of Those Becoming Uninsured Would Enroll in ESI once Nongroup Insurance Became Unaffordable

We estimated that if the Supreme Court finds for the plaintiffs, an additional 8.2 million people would be uninsured at a point in time in 2016 than would otherwise have been the case. The comparable RAND estimate is an additional 8.0 million uninsured. Haismaier believes our estimated increase in the uninsured to be too high. He claims that, “Given their predisposition to obtain coverage, many would probably respond to a loss of subsidies by seeking new coverage, most likely under employer plans.” Though he acknowledges that some would be uninsured, at least initially, the number would be far below the additional 8.0 million that the RAND analysts estimated or the 8.2 million that we estimated.

His conclusion rests on two misperceptions. The first misperception is that, as described in our response to his second criticism, the vast majority of nongroup insurance enrollees had ESI before 2014. As we have shown, that is not true based on multiple reliable sources of data. Second, he must be assuming that individuals enrolled in Marketplace coverage have access to affordable offers of ESI that they are declining. However, we know that 77 percent of Marketplace enrollees in states that would be affected by a *King v. Burwell* ruling are tax credit-eligible<sup>3</sup> and that, by law, individuals cannot have access to affordable ESI as a precondition of eligibility for tax credits. Thus, at a minimum, more than three-quarters of Marketplace enrollees do not have access to affordable coverage through an employer or a family member's employer.

It is also unlikely that more than a small percentage of the other 25 percent of Marketplace enrollees paying the full premium for their coverage (due to not being tax credit-eligible) have access to ESI either. In the vast majority of cases, employer options are less expensive to the worker for comparable benefits than nongroup coverage. Administrative costs are lower for large employer groups than is the case for nongroup insurance, and employers usually contribute a significant share of the premium, making the direct out-of-pocket cost to workers lower than purchasing a nongroup policy with their own funds. As such, a very small share of workers would find purchasing nongroup insurance independently preferable to an employer offer of coverage if they had one.

## Heritage Foundation Criticism #4 Misunderstands the Unified Risk Pool Nature of the Reformed Nongroup Insurance Market

RAND estimated that the changes in the nongroup insurance market resulting from a finding for *King* would increase the cost of identical coverage for an unsubsidized 40-year-old nonsmoker by 47 percent. Our most comparable estimate is modestly higher; we find that for the median individual purchasing nongroup coverage without a tax credit, buying the same coverage after a Supreme Court decision in favor of the plaintiffs would cost 55 percent more than under current implementation of the law (Blumberg, Buettgens, and Holahan 2015a). Haislmaier criticizes the RAND estimate, and by extension our estimate, of the effect on premiums as being too high. He does not believe that enrollment in the nongroup insurance market would fall by 9.6 million (RAND's estimate), or 9.8 million (our estimate). If the decline in nongroup coverage is much smaller than that, he suggests, the effect on premiums should be much smaller. He indicates that the number losing nongroup insurance coverage should be more akin to his 5.5 million figure that we previously demonstrated was incorrect. However, it is not just that his 5.5 million number is much too low that is the problem with his argument; he is making the case that only tax credit recipients would be affected by a change in the nongroup insurance risk pools, and this is not consistent with the law.

Under the ACA, the entire nongroup insurance market (inside and outside the Marketplaces) in each geographic rating area is treated as a single risk pool, with the exception of a small percentage of

plans that were grandfathered (plans held continuously since the date of enactment of the ACA in March 2010). Premium rating rules and risk adjustment mechanisms are in place so that no insurer or its enrollees is penalized financially by enrolling a higher medical need group of individuals than the others. As such, a change in the expected average health expenditures of those with coverage (whether previously purchasing with a tax credit or not) in the Marketplace will affect the premiums faced by everyone in the same manner, both inside and outside the Marketplaces.

Haislmaier also assumes that only young adults will drop their insurance coverage once they lose their tax credits; another mistake as shown by the Urban Institute and RAND microsimulation models. As we have estimated, fully 99 percent of all individuals otherwise purchasing nongroup insurance with a tax credit would face post-King premiums that exceed the ACA's affordability standard of 8 percent of income. Thus virtually all of them, not just the young, would be exempt from the ACA's individual mandate, a component of the law that further encourages enrollment. In fact, the lost tax credits are significantly larger for older adults because of the higher premiums they face under age rating in the nongroup market, so they would be significantly affected as well. As such, the healthier and lower income individuals of all ages would drop their coverage as soon as they received their next bill charging them for the full cost of nongroup coverage absent tax credits. The increased cost of the average individual remaining in the nongroup market in each affected state would increase premiums in the entire (non-grandfathered) nongroup insurance market as soon as insurers were permitted to adjust premiums. This price increase would cause more individuals, including those not previously receiving tax credits, to drop their coverage. Many of those never eligible for tax credits would also become exempt from the individual mandate due to the increased cost of coverage. The more the healthier individuals exit the pool, the more the premiums would be driven upward.

The issue is not whether premiums for identical coverage would be driven up as high as 47 to 55 percent as RAND and the Urban Institute, respectively, have estimated; the question is whether these nongroup markets can sustain themselves without falling into a full-fledged death spiral. Our estimates indicate the possibility that much smaller markets could survive with some individuals shifting from more comprehensive coverage down to bronze level coverage, as long as the individual mandate is not eliminated. The RAND analysis is less sanguine and sees a higher likelihood that these nongroup markets would not be sustainable. Both are reasonable scenarios based upon microsimulation results incorporating the best economic understanding of individual behavior within the insurance context.

## Heritage Foundation Criticism #5 Indicates a Lack of Understanding of Competitive Dynamics in the Nongroup Insurance Markets since Implementation of the ACA

Haislmaier disputes our suggestion that, under a finding for King, “areas experiencing increased insurer competition under the ACA's initial years are likely to revert to smaller numbers of insurers.” He states

that “there has been almost no increase in insurer competition in response to the ACA—and thus, no reason to believe that, absent subsidies, insurer competition would decrease.” Oddly, to support his claim, he cites a GAO study that examined the concentration of enrollees in insurers over the period 2010 through 2013 (US Government Accountability Office 2014), stating that it shows there was a decline in 2015. However, that cannot be possible because the GAO analysis did not cover 2014 or 2015. Heritage’s own study compares the entire 2013 market to the Marketplace market only; they make no mention of the off-Marketplace number of insurers (Senger 2014). Comparing the number of nongroup insurers in total to the number of Marketplace insurers is an apples- to-oranges comparison. Because the insurance risk pools inside and outside the Marketplaces are tied to each other, as explained previously, pricing and competitive dynamics in the Marketplace also affect those of insurers outside it.

We analyzed insurance dynamics in 18 ACA Marketplaces that approved 2015 premium rates early (Holahan et al. 2014). We found clear evidence of competitive dynamics in many of the rating areas within the Marketplaces, frequently resulting in small relative premium increases or decreases in each insurer’s lowest cost silver offerings in 2015. Often, those that were high relative to their competitors in 2014 brought premiums down in 2015. Those in markets with competitors clustered close together in premiums had very small or no premium increases in the second year. Large relative increases tended to occur when insurers had 2014 premiums that were quite low relative to their competitors. We also found that in some areas, new private market entrants such as co-ops and previously Medicaid-only managed-care plans were playing an important role in catalyzing price competition.

In addition, a McKinsey study that looked at rate filings in every rating area in the country found that “competition and choice are increasing nationwide. In most counties, consumers shopping for coverage on the 2015 public exchanges have more carriers and more products from which to choose. Nationwide, the number of carriers participating on the exchanges has increased 19 percent since the 2014 OEP (open enrollment period), and the number of products has increased 27 percent” (Bello et al. 2014). The McKinsey study also noted that “just over half of new price leaders are either recent or new entrants (i.e., carriers that entered the individual exchange market in one or more states last year or this year). In many counties, there is a significant change in competitive price positions.”

The US Department of Health and Human Services provided estimates for Marketplace participation as well. They note that “at least 67 issuers in the FFM and 10 issuers in the SBMs (state-based Marketplaces) will be new to the Marketplaces in 2015.” Also, based on preliminary data, they found that across the 44 states for which they had information at the time, there would be a “25 percent increase in the number of health insurance issuers offering Marketplace coverage in 2015 compared to 2014” (Gunja and Gee 2014).

# Heritage Foundation Criticism #6 Ignores the Interconnectedness of the Nongroup Market inside and outside the Marketplaces as Well as the Profitability of Nongroup Business for Many Insurers

Haislmaier criticizes the Commonwealth Fund claim that a victory for the plaintiff would lead to “major financial losses for the insurance industry.” Haislmaier claims that since nongroup insurance constitutes a small share of private market coverage and since the largest insurer with nongroup as its principal business did not offer coverage in the Marketplaces, the post-King effect would not be substantial for the industry. First, his argument that Assurant, the largest insurer for which its insurance business is predominately in the nongroup market, would not be significantly affected by a King victory ignores the fact, as explained previously, that changes to premiums in the Marketplaces affect the non-Marketplace plans commensurately. As such, nongroup coverage as a whole would fall, according to our estimates, 69 percent. This decline would not be confined to the Marketplace plans as the premiums would be increasing by the same relative amounts both inside and outside the Marketplaces. It is hard to imagine insurers being unconcerned with their nongroup market enrollment falling by almost 70 percent, on average.

In addition, Haislmaier again incorrectly assumes that nongroup coverage merely offsets declines in ESI in supporting his criticism. As we have explained, the increase in nongroup insurance is not simply a wash with declines in ESI. And regardless of the share of their business that nongroup coverage makes up, many insurers are participating in the Marketplaces and the number has grown 19 percent in 2015, according to McKinsey. These firms must see at least long term profitability from these markets, otherwise they would not be expanding their business into them.

## Notes

1. “Open Enrollment Week 13: February 7, 2015 – February 15, 2015,” US Department of Health and Human Services, accessed February 25, 2015, <http://www.hhs.gov/healthcare/facts/blog/2015/02/open-enrollment-week-thirteen.html>.
2. Jenna Levy, “In U.S., Uninsured Rate Sinks to 12.9%,” *Gallup*, January 7, 2015, <http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx>.
3. US Department of Health and Human Services. Open Enrollment Week 13: February 7, 2015 – February 15, 2015.

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**Linda J. Blumberg** is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and

implementation efforts at the state level, analyzing competition in insurance marketplaces and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in select states and nationally. Examples of other research include codirecting 22 state case studies of stakeholder perspectives on ACA implementation, assessing the implications of self-insurance among small employers on insurance reforms, and comparing the importance of employer and individual mandates in reaching ACA objectives. She also led the quantitative analysis supporting the development of a “Roadmap to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state.

**Matthew Buettgens** is a senior research associate in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban’s Health Insurance Policy Simulation Model (HIPSM). The model has been used to provide technical assistance for health reform implementation in many states, among them Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage.

**John Holahan** is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, he directed the “Roadmap to Universal Coverage” project which informed the state health care reform process in Massachusetts. His current work examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including state and federal government costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and their implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.



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