

## HEALTH POLICY REPORT

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## Health Care Coverage under the Affordable Care Act — A Progress Report

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With politicians and pundits clamoring in the background, the first open-enrollment period — created by the Affordable Care Act (ACA) for Americans seeking insurance coverage in the new individual marketplaces — came to a close on March 31. There were last-minute extensions by the Department of Health and Human Services and by certain states, but for most insurance seekers, March 31 was the last chance to enroll through the individual marketplaces until the next open-enrollment period launches in November.

Americans who did not have qualified health insurance when open enrollment ended and who do not qualify for an exemption will incur a penalty of \$95 or 1% of their income over the tax-filing limit (whichever is greater) when they file income taxes on April 15, 2015. Those with incomes between 100% and 400% of the federal poverty level are eligible for subsidies to help purchase insurance, but they must purchase plans from the marketplaces to get these funds.

If this combination of penalties and incentives did not stimulate substantial numbers of previously uninsured Americans to obtain coverage, opponents would have had strong new arguments against the ACA's viability. As proponents and many experts predicted, however, a late surge pushed the number of enrollees through individual marketplaces to 8 million, which exceeded the much cited predictions by the Congressional Budget Office (CBO).

Controversy continues, however, about the importance of this and virtually every other number associated with the ACA. This report aims to help readers understand recently announced enrollment numbers, as well as other numbers that have received less attention, and assess their importance for the future of the ACA and our health care system. Ultimately, the

success of the coverage expansions of the law will be judged by their effect on a set of variables: the numbers of uninsured Americans, the adequacy of insurance (which will perhaps best be judged by the number of people who remain underinsured), and the affordability of private coverage.<sup>1</sup> It may take years, however, before we can render a considered judgment on these critical outcomes. In the meantime, an impatient public and battling politicians want progress reports.

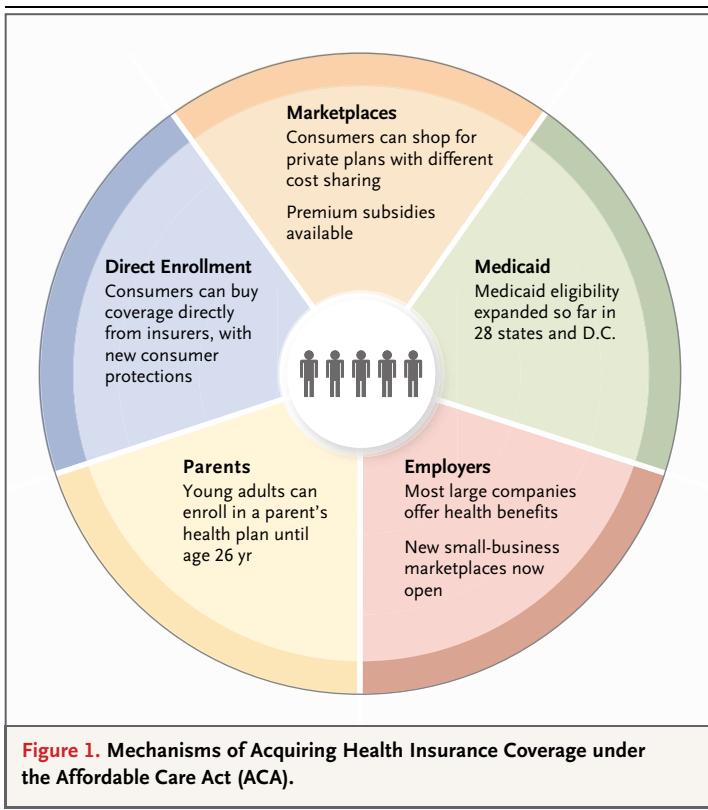
In assessing the record of the ACA to date, we comment on enrollment not only through the individual marketplaces but also through other critical vehicles for extending coverage: the requirement that private insurers cover children of enrollees until the age of 26 years, the expansion of Medicaid eligibility, new insurance-market rules that enable people to more easily buy plans directly through insurance companies outside the individual marketplaces, and marketplaces created for small businesses, known as the Small Business Health Options Program (SHOP) (Fig. 1). We also report on early survey data about recent trends in rates of insurance since the passage of the ACA.

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### COVERAGE GAINS FOR YOUNG ADULTS BEFORE 2014

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Though the major coverage expansions began this year, the law launched reforms in 2010 that were designed to improve health insurance and expand coverage to high-risk groups. Among the most visible of these provisions is the requirement that all health plans offering dependent coverage allow young adults to enroll in a parent's policy until they turn 26 years of age. Last year, a Commonwealth Fund survey showed that 7.8 million adults between the ages of 19 and 25



years were enrolled in a parent's plan — and that most of these enrollees would not have been eligible to do so before the passage of the law.<sup>2</sup> Federal surveys suggest that the number of young adults without health insurance has declined by 1 million to 3 million since the provision took effect.<sup>3-5</sup>

The young-adult provision has been popular across the political spectrum. The Commonwealth Fund survey showed that young adults who identified themselves as Republicans were enrolled through their parents' policies in greater numbers than were those who identified themselves as Democrats.

#### MAJOR COVERAGE EXPANSIONS UNDER THE ACA

The major coverage provisions of the ACA went into effect in January 2014. First, the law instituted new national standards for private insurance sold to individuals and small groups in the United States. Insurers selling health plans in these markets can no longer set prices on the

basis of health or exclude coverage of preexisting health conditions, and they are limited in what they can charge older adults as compared with younger adults. In addition, all plans that are sold in these markets must meet comprehensive benefit standards. Cost sharing such as deductibles may vary across plans, but to aid consumer decision making, health plans must be sold at four distinct levels of actuarial value (i.e., the share of medical costs covered on average). For example, on average, bronze plans must cover at least 60% of medical costs, silver 70%, gold 80%, and platinum 90%.

Second, the law created new private insurance marketplaces in all 50 states and the District of Columbia to sell subsidized insurance to individuals and small groups. Fourteen states and the District of Columbia chose to run these marketplaces themselves in 2014. The rest of the states left this wholly or partly to the federal government.

Third, the ACA substantially expanded eligibility for the Medicaid program. The 2012 Supreme Court decision made state participation in the law's expansion optional. As of now, 28 states and the District of Columbia are moving forward on expansion, including 6 states that are pursuing customized approaches requiring federal approval.

#### INDIVIDUAL MARKETPLACES

The experience with individual marketplaces has received disproportionate attention in the media and in political debate. The enrollment figure of 8 million that was announced in late spring with such fanfare refers exclusively to new enrollees in these marketplaces. The overwhelming focus on this particular aspect of the ACA became inevitable as soon as the troubled launch of the individual marketplaces created an irresistible narrative of government incompetence and seemed to confirm opponents' predictions of the law's failure. As a result, rightly or wrongly, the experience with individual marketplaces has become a kind of acid test for the success or failure of the ACA as a whole.

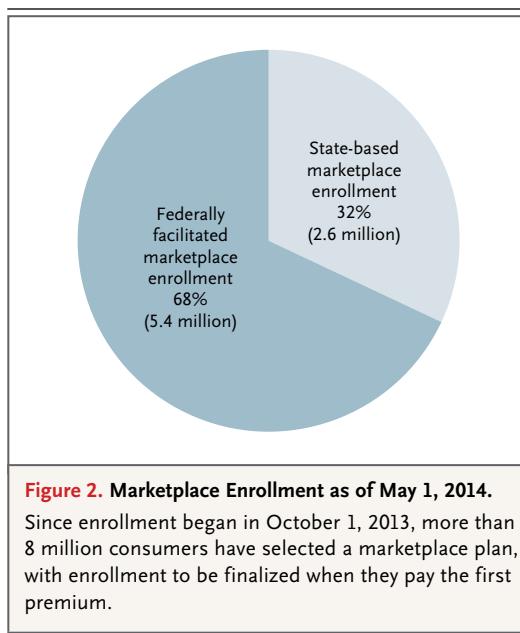
Several aspects of the individual marketplaces deserve attention as we judge their past and prospective performance. First, enrollment is not the same as insurance. Critics have questioned whether enrollees will actually pay their pre-

miums and become insured. State and federal officials, using data provided by insurance companies, estimate that 80 to 90% of enrollees have paid their first month's premiums. But it will be important over time to assess whether individuals using the 51 marketplaces pay their premiums each month. The fact that 85% of people who selected a plan during open enrollment were eligible for premium subsidies will undoubtedly influence this outcome, since the subsidies dramatically lower their premium contributions, but so will other factors, such as premium levels, cost-sharing obligations, and restrictions on provider choice, which will influence purchasers' perception of the value of the insurance they are buying.

Second, the 8-million enrollment figure is just the beginning for the individual marketplaces. The CBO projects that 25 million people will have insurance through the marketplaces by 2017. Although ongoing outreach efforts will be critical to inform those eligible about their coverage options, it is easy to see how the current number will grow. There will be annual open-enrollment periods, with the next one scheduled for November 2014 through February 2015. Individuals can also enroll at any time they lose insurance as a result of an important life event, such as marriage, or a job change. An estimated 4 million people may gain health insurance this way this year during the months between the open-enrollment periods.<sup>6</sup>

Third, despite the media focus on federally run marketplaces, the 14 states running their own systems will have a major influence on the numbers of people gaining coverage. States with well-functioning systems, such as California, New York, Rhode Island, Connecticut, and Kentucky, contributed substantially to the enrollment numbers (Fig. 2).

But HealthCare.gov was not the only malfunctioning website. Several states, including Hawaii, Minnesota, Maryland, Massachusetts, and Oregon, had severe technical failures with their online-enrollment mechanisms that have left some of these systems still largely inoperable. Maryland is replacing its online platform with Connecticut's much-lauded technology; Oregon may adopt the federal platform for 2015 enrollment. If these states overcome their technical difficulties, they will provide another boost to enrollment.



#### ENROLLMENT OUTSIDE THE NEW ACA MARKETPLACES

Preoccupation with the individual marketplaces obscured another important effect of the ACA: increased enrollment outside the marketplaces. The law's new regulations affecting private health insurance that is sold to individuals and small employers in the United States protect consumers and small companies, whether they buy plans in the new ACA marketplaces or outside them in traditional insurance markets. This creates another entry point to coverage for people who previously would have faced exorbitant premiums or been shut out of the market altogether because of age or preexisting health conditions. And of course, the individual mandate creates added incentives for individuals to sign up. Recent CBO estimates project that 5 million people may gain coverage this year directly from insurers.<sup>7</sup>

#### CANCELED POLICIES

A political firestorm erupted last fall when people with individual market coverage that did not meet the law's minimum standards received notices from their insurance carriers that their policies would be canceled for the 2014 coverage year. The law had clear provisions that only people with insurance policies that were active when

the law was signed in March 2010 would be “grandfathered” — that is, allowed to keep coverage that did not comply with the ACA’s new regulatory requirements. This exemption did not extend to individuals who purchased coverage thereafter. In advocating for the ACA before its passage, President Barack Obama promised that anyone who liked their insurance would be able to keep it under the new law. In hindsight, his assurances should have been more nuanced.

Nevertheless, some of the cancellations would have occurred in the absence of the ACA. Health-policy expert Benjamin Sommers and colleagues point out that there was significant turnover in the individual market before the ACA went into effect: between 2008 and 2011, only 42% of people who started out with such coverage still had it after 1 year.<sup>8</sup> Nevertheless, some plans were probably canceled because they did not meet the ACA standards requiring that all insurance products provide minimal levels of coverage and benefit. A December 2013 Commonwealth Fund survey reported that one in five adults with individual insurance had received a cancellation notice from their insurer.<sup>9</sup> The Obama administration sought to mitigate the political fallout by giving states discretion to allow insurers to renew health plans that were not compliant with the law’s standards. A total of 38 states have decided to allow renewals.<sup>10</sup> Estimates by RAND suggest that about 500,000 people may have renewed noncompliant policies.

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#### THE RISK POOL AND 2015 PREMIUMS

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Even with subsidies, buying insurance can be a stretch for many individuals. Premiums in 2014 were 16% lower than predicted by the CBO.<sup>11</sup> But the new insurance-market reforms under the law certainly had different effects on different people and small businesses, depending on how they were rated in the individual and small-group markets under pre-ACA pricing practices. Healthy and young people and businesses may have seen their rates increase under the ACA, whereas those in poorer health probably had lower premiums for more comprehensive coverage. The questions are, What will happen to premiums in 2015, and what will be the effect on coverage?

One of the most important determinants of premiums is how insurance companies project

medical expenses that will be incurred by their members. To make these projections, actuaries assess the health care risks in the pool of customers they insure, known as a risk pool. Projected 2015 premiums, which are already being released in some states, will reflect company estimates of their 2015 risk pools. The age of enrollees has attracted the most attention from the media as a determinant of risk, but age is just a proxy for health status.

As expected, enrollment among 18-to-34-year-olds surged as the March 31 deadline approached, climbing from 27% of total enrollment in February to 31% in the month of March. It is widely agreed that there is no single desired rate of young-adult participation. What really matters is whether the observed rate turns out to be consistent with the projections of insurance companies for any period — that is, whether the 31% participation is about what the companies expected for 2014. If young-adult participation fell short of expectations, this could prompt rate increases in 2015. However, even if participation in the pools skews to an older age than companies predicted, an analysis by the Kaiser Family Foundation showed that 2015 premiums might increase by only 1 to 2% to offset higher-than-expected costs.<sup>12</sup> This modest projected effect of an older pool reflects the fact that under the law, health plans can still charge an older person a higher premium than a younger person.

Another factor that will militate against dramatically increased 2015 rates is the risk-sharing programs of the ACA, including the so-called transitional-reinsurance and risk-corridor programs, which protect insurers and consumers against dramatic premium hikes.<sup>13</sup> Carriers with higher-than-expected claims will receive reinsurance payments, for example. This factor alone reduced premiums by 10% in 2014 and will continue to play an important role in limiting premium increases in 2015.

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#### NARROW NETWORKS

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One explanation for relatively modest premiums in 2014 was the widespread use of restricted or “narrow” provider networks in marketplace plans. Such narrow networks require that enrollees use lower-price providers and often charge patients more when they go out of network.

Insurers are likely to continue to use narrow

networks as a strategy to keep premiums affordable. The question is how these restrictions on choice affect the actual or perceived value of the insurance products that are sold in the marketplaces. If the quality is lower as a result of such restrictions or consumers feel they cannot get the care they need, they may stop purchasing new insurance plans, thus defeating the purpose of the law. The federal government is aware of this problem and recently announced it would examine the adequacy of narrow-network plans in the federally run marketplaces for the enrollment period next year. Several states are also developing regulations or legislation to address the issue.

The unavoidable truth is that the growth of premiums will continue as long as health care costs grow.<sup>14</sup> Narrow networks are just one solution that health plans are likely to use. The long-term success of the ACA is linked inextricably to the affordability of health care in the United States, a larger problem that the law addresses through other provisions that have drawn far less attention than the enrollment numbers.

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#### MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

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In analyses of the success of the ACA in reducing the number of uninsured Americans, the Medicaid provisions of the law are likely to prove to be as important as its private insurance-market programs. The expansion of eligibility for Medicaid to people with incomes up to 138% of the poverty level is the largest such expansion since the inception of the program in 1965. Before this expansion, only people with low incomes who fell into certain categories (children, parents, pregnant women, people with disabilities, and those >65 years of age) were eligible. The expansion in Medicaid eligibility is also well financed from the perspective of the states. The federal government is covering 100% of the costs for most states through 2016, before gradually reducing its contribution to 90% for all states by 2020. This new financing translates into an infusion of federal dollars into states to the tune of \$800 billion through 2022.<sup>15</sup>

Despite the economic and health care rationale for expanding Medicaid, state officials who are opposed to the ACA have refused to allow this expansion in many states. In such states,

people with incomes at or above 100% of the federal poverty level can apply for subsidies for private plans in the marketplaces. But those with incomes below the poverty level cannot apply for such subsidies, since drafters of the ACA assumed that the poor would be eligible for Medicaid. In the states that have not yet expanded their programs, nearly 5 million uninsured people with low incomes are expected to be left out of the new coverage options this year.

Despite these facts, 6 months after the launch of the coverage provisions of the ACA, 6 million people had enrolled in Medicaid or the Children's Health Insurance Program (CHIP). This tally includes people who were found to be eligible as they sought insurance through federal and state marketplaces or through other means. Many individuals who went to online marketplaces were informed of their Medicaid eligibility. Consequently, this figure also includes people living in nonexpansion states who were found to be eligible under their state's preexisting Medicaid and CHIP programs. The CBO is now projecting that new enrollment in Medicaid and CHIP will reach 7 million this year and 13 million eventually. Even with uncertainty about state participation, this means that 46 million people — or 17% of the nonelderly U.S. population — could be enrolled in Medicaid or CHIP by 2018.

If history is a guide, most states will ultimately expand their programs. The fiscal benefits to states are enormous, and hospitals and other providers generally favor participation. Medicaid was launched in 1966, but it took until 1972 for participation to become widespread. Arizona held out until 1982.

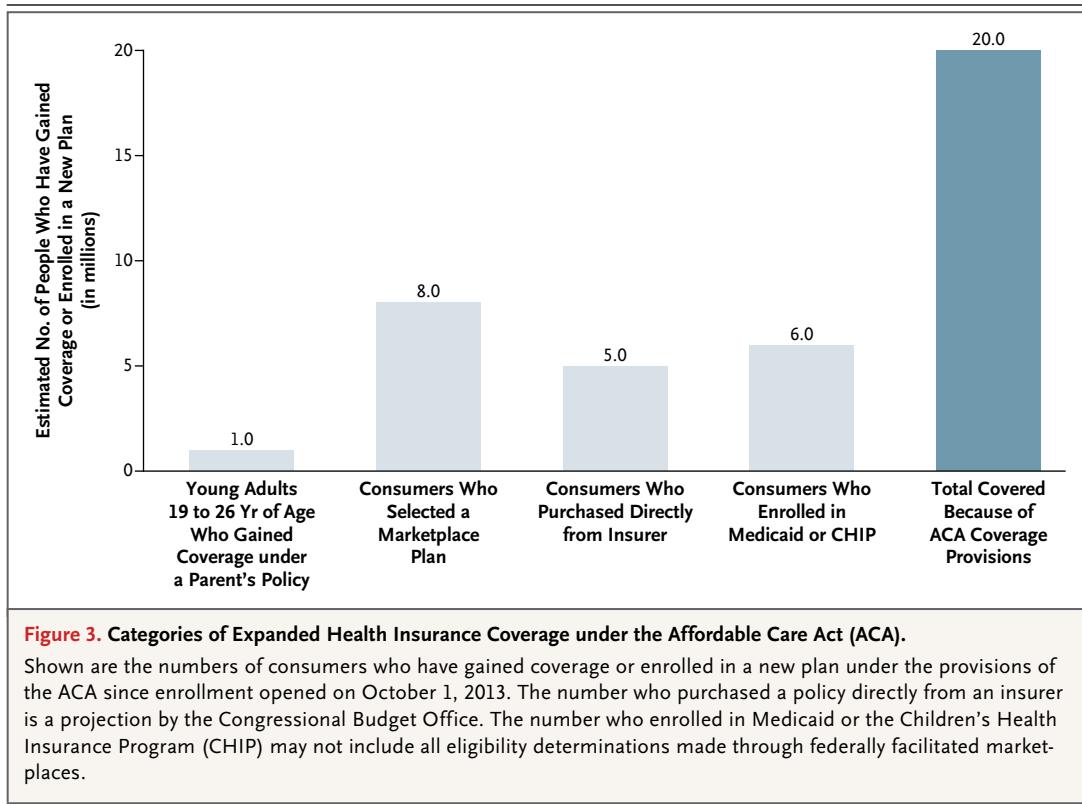
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#### REFORMS FOR SMALL BUSINESSES

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The final way in which Americans will gain coverage under the ACA is through their employers. The law imposes penalties on employers with 50 or more full-time employees who do not offer health insurance, or who offer inadequate health insurance, if an employee becomes eligible for subsidized coverage through the marketplaces. This so-called employer mandate was delayed to 2015 for employers with 100 or more employees and to 2016 for those with 50 to 99 employees.

But although the majority of large employers offer health insurance, small employers have



struggled to offer affordable coverage to employees, paying on average 18% more in premiums than large employers.<sup>16</sup> Similar to individuals who had to buy coverage on their own, small businesses that sought coverage in the small-group market were often charged higher premiums because of the health of their workforces and other factors. Many small employers, particularly those with older workforces or those in industries in which workers are exposed to health risks, could find private insurance easier and cheaper to buy under the ACA. The reforms in the small-group market are similar to those in the individual market. The law also requires that each state have a SHOP, a small-business marketplace designed to meet the needs of small employers. This year, small employers can buy plans through the SHOPS in most states, but the small-business marketplaces are not fully operational in some states because the federal government delayed certain aspects of the SHOP implementation until 2015. So far, there are no national estimates of enrollment in the SHOPS. A similar set of provisions under the Massachu-

setts reform law led to an increase in the share of small employers who offered coverage. It is too early to tell how many people may be gaining coverage through employers because of these new provisions.

#### THE RECORD TO DATE

Taking all existing coverage expansions together, we estimate that 20 million Americans have gained coverage as of May 1 under the ACA (Fig. 3). We do not know yet exactly how many of these people were previously uninsured, but it seems certain that many were. Recent national surveys seem to confirm this presumption. The CBO projects that the law will decrease the number of uninsured people by 12 million this year and by 26 million by 2017. Early polling data from Gallup, RAND, and the Urban Institute indicate that the number of uninsured people may have already declined by 5 million to 9 million and that the proportion of U.S. adults lacking insurance has fallen from 18% in the third quarter of 2013 to 13.4% in May 2014.

However, these surveys may underestimate total gains, since some were fielded before the late March enrollment surge and do not include children. With continuing enrollment through individual marketplaces, Medicaid, and SHOP, the numbers of Americans gaining insurance for the first time — or insurance that is better in quality or more affordable than their previous policy — will total in the many tens of millions.

As we look to the future of the coverage provisions of the ACA and their effect on the U.S. health care system, several observations seem justified. First, as the number of individuals benefiting from the law grows, its wholesale repeal will grow less likely, although the law could still be importantly modified in the future.

Second, experience with the ACA will vary enormously among states. Those deciding not to expand Medicaid will benefit far less from the law, and since many of these states have high rates of uninsured residents and lower health status, the ACA may have the paradoxical effect of increasing disparities across regions, even as it reduces disparities between previously insured and uninsured Americans as a whole.<sup>17</sup>

Third, the sustainability of the coverage expansions will depend to a great extent on the ability to control the overall costs of care in the United States. Otherwise, premiums will become increasingly unaffordable for consumers, employers, and the federal government. Insurers who seek to control those costs through increasingly narrow provider networks across all U.S. insurance markets may ultimately leave Americans less satisfied with their health care. Developing and spreading innovative approaches to health care delivery that provide greater quality at lower cost is the next great challenge facing the nation.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Commonwealth Fund, New York.

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