Downgrading the Affordable Care Act: Unattractive Health Insurance and Lower Enrollment

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ABSTRACT

When the Patient Protection and Affordable Care Act (ACA) was signed into law in 2010, many groups projected how many people would enroll in health insurance plans satisfying the law's new rules and requirements (ACA plans). Nearly six years later, enrollment in health insurance exchange plans is far short of initial projections, particularly for people who earn too much to qualify for subsidies to reduce high ACA plan deductibles. The dearth of exchange enrollees with at least a middle-class income indicates that the individual mandate is not motivating as many people, particularly younger, healthier, and wealthier people, to purchase coverage as was originally expected. Large insurer losses on ACA plans show that the overall risk pool is sicker and much more costly than originally projected, and are an indication that the law may require significant revision in order to avoid causing an adverse-selection spiral.

JEL codes: I11, I13, I18

Keywords: Affordable Care Act, health insurance, exchange, uninsured, enrollment, CBO, premium, deductibles, subsidy, individual mandate, risk corridors, adverse selection

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Projections constructed in 2010 by both the federal government and private research organizations overestimated 2014 and 2015 health insurance exchange enrollment by several million people. Those estimates also projected about 10 million more exchange enrollees for 2016 than is now widely predicted. The models erred the most in projecting the number of unsubsidized enrollees (i.e., enrollees not eligible for subsidies because of their higher incomes). Two years into implementation of the central coverage provisions of the Patient Protection and Affordable Care Act (ACA), it appears that a large majority of people who do not qualify for large subsidies to offset premiums and reduce deductibles have decided not to purchase a health insurance exchange plan.

A recent analysis by three University of Pennsylvania Wharton School economists—Mark Pauly, Adam Leive, and Scott Harrington—shows that most people who were uninsured before the ACA are worse off buying an ACA plan (an insurance plan that satisfies the requirements of the law) than remaining uninsured.[1] This finding is particularly true for people earning at least twice the poverty level. Exchange plans have large deductibles and narrow networks that limit their appeal, and the Pauly, Leive, and Harrington study shows that the uninsured—even the higher-income uninsured—spend less than $500 on healthcare services each year.

When the ACA was signed into law in March 2010, most experts and economic models projected that the ACA's individual mandate provision, along with the new subsidies, would induce enough relatively healthy people to enroll in an ACA plan to produce a stable risk pool. Most people buy ACA plans through newly created health insurance exchanges, largely because subsidies are only available for people who purchase plans through an

1. Mark Pauly, Adam Leive, and Scott Harrington, "The Price of Responsibility: The Impact of Health Reform on Non-poor Uninsureds" (NBER Working Paper 21565, National Bureau of Economic Research, Cambridge, MA, September 2015).

exchange. ACA plans are also available for people to buy off the exchange, meaning directly from an insurer. The ACA requires that insurers selling ACA plans consider all enrollees as part of a single risk pool for pricing purposes.

Early data, however, show that insurers have enrolled a disproportionate number of older and sicker people.[2] Despite an $8 billion subsidy through a reinsurance program to pay the majority of the expenses for high-cost ACA plan enrollees, insurers' 2014 losses on ACA plans equaled about 12 percent of the premiums collected.[3] Of the 23 healthcare cooperatives (co-ops) that were initiated with ACA start-up loans, 12 have already gone out of business or are shutting down at the end of 2015 because of massive losses from ACA plans. Part of the reason for a worse-than-expected risk pool is that the individual mandate appears to be leading fewer relatively healthy people to enroll than was expected.

Diminished exchange enrollment of both subsidized and unsubsidized people will undoubtedly cause the Congressional Budget Office (CBO) to significantly lower the projected budgetary cost of the law, at least in the next few years. Although a lower budgetary cost can be viewed as a positive development, it will primarily occur only because far fewer relatively young and healthy people are enrolling than was originally projected.

As insurers have learned that their expanded risk pools are more adverse than anticipated, those continuing to offer coverage appear to be raising premiums significantly and increasing deductibles, and becoming more restrictive about the choice of providers. As premiums rise, ACA plans will look even worse to younger and healthier people who do not qualify for large subsidies. If the trends

"As premiums rise, ACA plans will look even worse to younger and healthier people who do not qualify for large subsidies."

2. Centers for Medicare and Medicaid Services, "The Three Rs: An Overview," October 1, 2015, Washington, DC, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html.
3. Brian Blase, "New Data Shows Large Insurer Losses on Obamacare Plans," *Forbes*, October 12, 2015, http://www.forbes.com/sites/theapothecary/2015/10/12/new-data-shows-large-insurer-losses-on-obamacare-plans/.

continue and far fewer younger and healthier people enroll in ACA plans than expected, there will be an increasing need to revisit the law, as well as many of the assumptions made by health policy experts and economic modelers.

HOW THE ACA CHANGED THE CALCULUS FOR PURCHASING INSURANCE

In deciding whether to purchase insurance and what type of plan to choose, people generally compare the expected benefit, which accounts for their risk preference and a plan's design, to premiums and expected out-of-pocket expenses. All else being equal, people in relatively poor health or with expensive conditions value health insurance more highly than do relatively healthy people. Policies that affect premiums or the costs of being uninsured affect people's demand for insurance, and the ACA contains several such policies.

The ACA requires that all plans cover a prescribed set of benefits and, with limited exceptions, exceed an actuarial value of 60 percent.[4] These new requirements have raised average premiums considerably[5] and in isolation would likely lead fewer people to buy health insurance. However, the ACA also included the individual mandate, the employer mandate, and subsidies for lower-income people (to reduce their share of premiums and out-of-pocket expenses), as well as many other provisions that also change the calculus for purchasing insurance.

The individual mandate penalty essentially represents a tax for people who choose to go without ACA-compliant health insurance. Because the individual mandate makes the decision not to purchase coverage more expensive, the mandate causes a greater number of people to purchase coverage or to seek an employer that offers coverage (and to accept the coverage offered) than would do so in the absence of the penalty, all else being equal. Although such penalties raise revenue for the federal government, the purpose of the mandate is to induce relatively healthy and young people to purchase insurance that is actually priced well above an actuarially fair amount in an effort to maintain a balanced risk pool and prevent extremely high average premiums.

The individual mandate penalties, shown in table 1, are the greater of a specified flat fee or a percentage of household income above the tax filing

4. A plan's actuarial value represents the average percentage of healthcare expenses covered by the plan.

5. Avik Roy, "3,137-County Analysis: Obamacare Increased 2014 Individual-Market Premiums by Average of 49%," *Forbes*, June 18, 2014, http://www.forbes.com/sites/theapothecary/2014/06/18/3137-county-analysis-obamacare-increased-2014-individual-market-premiums-by-average-of-49/.

threshold. After 2016, the penalties are indexed to inflation. At an annual income of about $26,400 for a single person in 2015 and about $38,400 in 2016, the penalty for being uninsured is the same under the flat fee and the percentage of household income calculation. People with household income above those amounts will face a penalty equal to a percentage of their income. Several exemptions—many outlined in the ACA and others put in place by the Department of Health and Human Services (HHS)—allow millions of people to remain uninsured without penalty.[6]

TABLE 1. INDIVIDUAL MANDATE PENALTY

Year	Flat fee	Percentage of household income
2014	$95 per person ($47.50 per child), up to maximum family penalty of $285	1.0% of yearly household income, above the tax filing threshold
2015	$325 per person ($162.50 per child), up to maximum family penalty of $975	2.0% of yearly household income, above the tax filing threshold
2016	$695 per person ($347.50 per child), up to maximum family penalty of $2,085	2.5% of yearly household income, above the tax filing threshold

Note: The penalty is the greater of the flat fee and the percentage of household income calculation and is capped at the national average premium for Bronze-level coverage (60 percent actuarial value).

Source: Department of Health and Human Services, "The Fee for Not Having Health Insurance," accessed November 16, 2015, https://www.healthcare.gov/fees/fee-for-not-being-covered/.

Although the individual mandate represents a tax on people who choose to remain uninsured and do not qualify for an exemption, the ACA's subsidies, which take the form of premium tax credits and cost-sharing reduction payments, are intended to encourage uninsured people who qualify for subsidies to purchase an exchange plan. The tax credits are available to most people with incomes between 100 and 400 percent of the federal poverty level (FPL).[7] The credits phase out as household income increases, with an extra $1,000 in household income generally reducing the credit by about $150.

The cost-sharing subsidies are available for people with household income between 100 and 250 percent of the FPL if they select a Silver plan.[8] The subsidies are paid directly by the government to insurers to decrease plan deductibles, cost-sharing amounts, and out-of-pocket limits. The cost-sharing

6. HealthCare.gov, "Exemptions from the Requirement to Have Health Insurance," accessed November 2, 2015, https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee/.
7. For 2015, 100 percent of the FPL equals $11,770 for a single person and $24,250 for a family of four; 400 percent of the FPL equals $47,080 for a single person and $97,000 for a family of four.
8. Silver plans are the most common type of exchange plan purchased. They have an actuarial value of 70 percent.

subsidies increase the actuarial value of Silver plan coverage to 94 percent for people with household income between 100 and 150 percent of the FPL, to 87 percent for people with household income between 150 and 200 percent of the FPL, and to 73 percent for people with household income between 200 and 250 percent of the FPL. Since the cost-sharing subsidy amounts drop in cliffs, particularly at 200 percent of the FPL, Silver plan coverage is much more attractive for people earning just below 200 percent of the FPL than for people earning just above 200 percent of the FPL.

Table 2 illustrates the effect of cost-sharing subsidies with an example from the Kaiser Family Foundation for a person with single coverage.[9] Simple differences show that the deductible and out-of-pocket limit are $1,341 and $2,931 less, respectively, for a person with an income between 150 and 200 percent of the FPL compared to a person with an income between 200 and 250 percent of the FPL.

TABLE 2. EFFECT OF COST-SHARING SUBSIDIES

Indicator	Income level as a percentage of federal poverty level			
	Above 250%	200–250%	150–200%	100–150%
Plan actuarial value	70%	73%	87%	94%
Deductible	$2,559	$2,078	$737	$229
Primary care provider co-pay	$28	$23	$17	$14
Out-of-pocket limit	$5,824	$4,622	$1,691	$879

Source: Gary Claxton and Nirmita Panchal, "Cost-Sharing Subsidies in Federal Marketplace Plans," Kaiser Family Foundation, February 11, 2015, http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans/.

Note: Cost-sharing subsidies are available to people who select a Silver exchange plan.

Although the individual mandate and subsidies were meant to increase the enrollment of relatively healthy people, other key provisions of the law discourage people from purchasing coverage. For example, in an attempt to protect people from escalating premiums or from loss of coverage on diagnosis of an expensive illness or medical condition, the ACA prohibits insurers from varying premiums on the basis of health status (a *modified community rating* provision) and requires insurers to offer coverage to any applicant regardless of preexisting conditions (a *guaranteed issue* provision). These provisions

9. Gary Claxton and Nirmita Panchal, "Cost-Sharing Subsidies in Federal Marketplace Plans," Kaiser Family Foundation, February 11, 2015, http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans/.

produce an unintended incentive for uninsured people to wait until they learn of a health condition before purchasing insurance. The ACA also requires a 90-day grace period for subsidized enrollees that guarantees uninterrupted insurance coverage for up to three months when they fail to pay their share of premiums.[10]

Annual open enrollment periods attempt to limit people's ability to sign up for insurance only when they anticipate seeking medical care. The open enrollment period for 2016 is November 1, 2015, through January 31, 2016. An exchange plan can be purchased outside the yearly open enrollment period only when there is a so-called qualifying life event, such as a change in family size or loss of workplace insurance.[11] Although people who fail to obtain insurance during open enrollment face the risk of needing medical services before the start of the next plan year, most health conditions are not urgent matters of life and death, so many people, knowing they cannot be denied coverage at standard rates during the next open enrollment period, have an incentive under the ACA to forgo health insurance.

INITIAL PROJECTIONS SIGNIFICANTLY OVERSTATED EXCHANGE ENROLLMENT

The ACA contains hundreds of provisions with complicated interactions that experts and modelers needed to understand in order to develop estimates of the law's effects. Although economic models produce precise estimates, potential errors were significant in this case because of the magnitude of the changes made by the law. It turns out that exchange enrollment in both 2014 and 2015 was a few million people below initial expectations. The initial projections look even worse for the years after 2015. On October 15, 2015, the Obama administration announced that it expects about 11 million to 14 million people to enroll in an exchange plan during the 2016 open enrollment period and that a total of 9.4 million to 11.4 million people will be enrolled in an exchange plan by the end of 2015.[12] These projections for 2016 are roughly 10 million fewer enrollees than were projected when the ACA became law.

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10. Rachana Dixit Pradhan, "The Ninety-Day Grace Period" (Health Policy Brief, Robert Wood Johnson Foundation, Princeton, NJ, October 16, 2014).
11. Louise Norris, "Qualifying Events That Can Get You Coverage," February 21, 2015, http://www.healthinsurance.org/obamacare/qualifying-events-that-can-get-you-coverage/.
12. Department of Health and Human Services, "10 Million People Expected to Have Marketplace Coverage at End of 2016," Washington, DC, October 15, 2015, http://www.hhs.gov/about/news/2015/10/15/10-million-people-expected-have-marketplace-coverage-end-2016.html.

Projections of Exchange Enrollment for 2014–2016

Table 3 shows exchange enrollment projections made in 2010 by CBO, the Office of the Actuary at the Centers for Medicare and Medicaid Services, the RAND Corporation, and the Urban Institute.

TABLE 3. PROJECTIONS OF EXCHANGE ENROLLMENT

	2014 projection (millions)	2015 projection (millions)	2016 projection (millions)	Projection date
Congressional Budget Office	8.0	13.0	21.0	March 20, 2010
Centers for Medicare and Medicaid Services, Office of the Actuary	16.9	18.6	24.8	April 22, 2010
RAND Corporation	16.0	24.0	27.0	February 16, 2010
Urban Institute*			23.1	December 2010

* By using its Health Insurance Policy Simulation Model, the Urban Institute simulated the ACA's provisions as if fully implemented in 2010.

Sources: Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)," Washington, DC, March 20, 2010; Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Washington, DC, April, 22, 2010; Jeanne S. Ringel et al., "Analysis of the Patient Protection and Affordable Care Act (H.R. 3590)" (RAND Corporation, Santa Monica, CA, 2010); Matthew Buettgens, Bowen Garrett, and John Holahan, "America under the Affordable Care Act" (Urban Institute and Robert Wood Johnson Foundation, December 2010).

Of these four organizations, CBO updates its estimates on the most regular basis, at least once a year when it produces its revised baseline for the federal budget. The first significant change in its estimates occurred following the 2012 US Supreme Court decision in *National Federation of Independent Business v. Sebelius*. Although the decision generally upheld the ACA, it made Medicaid eligibility expansion optional for the states. Because the ACA authorizes premium tax credits for people with incomes between 100 and 400 percent of the FPL, the court's decision allowed people in non–Medicaid expansion states earning between 100 percent and 138 percent of the FPL—people who would have been covered by Medicaid under the ACA's Medicaid eligibility expansion provision—to qualify for the law's premium tax credits and cost-sharing subsidies. After the court's decision, CBO increased its projected 2014 exchange enrollment to 9 million people (up 1 million people from the March 2010 estimate), increased the projected 2015 enrollment to 14 million people (up 1 million people), and increased the projected 2016 enrollment to 23 million people (up 2 million people).[13]

13. CBO, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," Washington, DC, July 24, 2012.

"CBO is not the only organization to project, as of earlier in 2015, upwards of 20 million exchange enrollees for 2016."

Although the court's decision boosted exchange enrollment, a "transition" policy of the Obama administration depressed exchange enrollment in the near term. In response to the millions of people slated to lose their existing insurance plans because those plans did not comply with the ACA, the Obama administration, in the fall of 2013, decided to permit state insurance commissioners to allow insurers to extend noncompliant plans for one year.[14] In March 2014, the administration extended this policy through September 30, 2017,[15] and 35 states are allowing these transitional policies to remain in force.[16]

Although the transition policy undoubtedly reduced exchange enrollment, it likely had a relatively small effect because of the transient nature of the individual market and because it applied only to people who enrolled in an insurance plan after the ACA was signed into law in 2010. (The grandfathering provision in the law allows people enrolled in plans before the ACA became law to keep those plans as long as significant changes are not made to the plans.) In April 2014, CBO estimated that the March 2014 transition policy would slightly reduce enrollment in exchange plans but did not specify by how much.[17]

Table 4 shows CBO projections of exchange plan enrollment for 2015, 2016, and 2017. CBO has repeatedly downgraded the estimates. In projections made in April 2014—after the disastrous initial performance of Health Care.gov—CBO's estimates of enrollment were 6 million

14. White House Office of the Press Secretary, "Statement by the President on the Affordable Care Act," Washington, DC, November 14, 2013, https://www.whitehouse.gov/the-press-office/2013/11/14/statement-president-affordable-care-act.
15. Centers for Medicare and Medicaid Services, "HHS 2015 Health Policy Standards Fact Sheet," Washington, DC, March 5, 2014, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-03-05-2.html.
16. Louise Norris, "Like Your Grandmothered Health Plan?," September 16, 2015, https://www.healthinsurance.org/blog/2015/09/16/like-your-grandmothered-health-plan/.
17. CBO, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," Washington, DC, April 2014.

people in 2014, 13 million in 2015, and 24 million in 2016.[18] Between April 2014 and March 2015, CBO further downgraded its estimates of 2015 and 2016 exchange enrollment to 11 million and 21 million, respectively.[19] CBO has consistently projected that net enrollment will remain fairly constant after 2017.

TABLE 4. THE CONGRESSIONAL BUDGET OFFICE'S PROJECTIONS OF EXCHANGE ENROLLMENT, 2014–2017

Estimate date	2014 (millions)	2015 (millions)	2016 (millions)	2017 (millions)
July 2012	9	14	23	25
February 2014	↓6	↓13	↓22	↓24
April 2014	6	13	↑24	↑25
January 2015	–	↓12	↓21	25
March 2015	–	↓11	21	↓24
June 2015	–	–	↓20	↓23

Note: The Congressional Budget Office's June 2015 estimate was of ACA repeal and did not include an estimate of 2015 exchange enrollment.

Sources: For July 2012, Congressional Budget Office (CBO), "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," Washington, DC, July 2012. For February 2014, CBO, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," Appendix B, Washington, DC, February 2014. For April 2014, CBO, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," Washington, DC, April 2014. For January 2015, CBO, "Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline," January 2015, Washington, DC. For March 2015, CBO, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015, Washington, DC. For June 2015, CBO, "Budgetary and Economic Effects of Repealing the Affordable Care Act," Washington, DC, June 2015.

CBO is not the only organization to project, as of earlier in 2015, upwards of 20 million exchange enrollees for 2016. In its estimate of the impact of the US Supreme Court decision for the plaintiffs in *King v. Burwell*, the RAND Corporation projected that 19.8 million people would be enrolled in exchange plans in 2015—about double the actual number.[20]

In its work on potential implications of a ruling for the plaintiffs in *King v. Burwell*, the Urban Institute estimates that 13.6 million people will be enrolled in 2016 in federal exchange plans in the 34 states that chose not to establish their own exchanges.[21] Because these states encompass about 65 percent of

18. Ibid.
19. CBO, "Insurance Coverage Provisions of the Affordable Care Act: CBO's March 2015 Baseline," Washington, DC, March 2015.
20. Evan Saltzman and Christine Eibner, "The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces" (RAND Corporation, Santa Monica, CA, 2015).
21. Linda J. Blumberg, Matthew Buettgens, and John Holahan, "The Implications of a Supreme Court Finding for the Plaintiff in *King vs. Burwell*: 8.2 Million More Uninsured and 35% Higher Premiums" (In-Brief, Urban Institute and Robert Wood Johnson Foundation, Washington, DC, January 2015).

the nation's population, extrapolating the Urban Institute's estimate to the entire country equates to about 21 million people nationwide—only 2 million fewer than its original projection of 23 million enrollees when the law was fully implemented. The similarity of the Urban Institute's estimates is an indication that the organization, like both CBO and RAND, did not meaningfully change its assumptions or underlying elasticities from its 2010 model.

Exchange Enrollment Was Below Both 2014 and 2015 Projections

At the conclusion of the 2014 open enrollment period, about 8.1 million people were enrolled in an exchange plan.[22] However, many people failed to make any premium payments—or stopped making payments—and were dropped from coverage. Throughout the year, other people with a qualifying life event signed up for coverage. By the end of 2014, paid exchange enrollment reportedly dropped to about 6.3 million, as far more people dropped coverage during the year than signed up.[23] Charles Gaba, a statistical expert who closely monitors ACA developments, estimates that 2014 exchange enrollment averaged 5.5 million people.[24] Average yearly exchange enrollment is the metric that CBO uses in its budgetary estimates.

On September 8, 2015, HHS announced that 9.9 million people were enrolled in an exchange plan as of June 30, 2015.[25] That was about 2 million fewer people than signed up for an exchange plan at the conclusion of open enrollment in mid-February 2015 and about 300,000 fewer than were enrolled on March 31. Assuming net attrition similar to 2014, average exchange enrollment will likely be 9.0 million to 9.5 million people for 2015. Comparing actual enrollment to CBO's initial projections, as shown in table 3, demonstrates that CBO overestimated exchange enrollment by about 2.5 million people for 2014 and 3.5 million people for 2015. The other organizations' estimates were off by considerably more.

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22. Office of the Assistant Secretary for Planning and Evaluation (ASPE), "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," Washington, DC, May 1, 2014.
23. Centers for Medicare and Medicaid Services, "March 31, 2015 Effectuated Enrollment Snapshot," Washington, DC, June 2, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html.
24. Charles Gaba, "Updated: ACA Surpassed CBO Target without Achieving CBO Target; Seriously," *ACASignups.net*, September 24, 2015, http://acasignups.net/15/09/25/updated-aca-surpassed-cbo-target-without-achieving-cbo-target-seriously.
25. Centers for Medicare and Medicaid Services, "June 30, 2015 Effectuated Enrollment Snapshot," Washington, DC, September 8, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html.

Off-Exchange Plan Enrollment

ACA plans are also available for people to buy directly from insurers off the exchange. For pricing purposes, exchange enrollees are in the same risk pool as people who buy ACA off-exchange plans. The number of people buying ACA off-exchange plans is not a data point collected by HHS and is not commonly estimated by either CBO or other organizations.

In 2014, several insurers released information showing the number of exchange plan enrollees relative to off-exchange plan enrollees.[26] Those estimates show that insurers enrolled about a quarter as many off-exchange enrollees as exchange enrollees. A recent Commonwealth Fund study observes that "insurers projected that only 21 percent of their anticipated 14 million ACA-compliant subscribers will be in plans sold only off the exchanges" in 2014.[27] Assuming a similar ratio of exchange plan enrollees to off-exchange plan enrollees in 2014 and 2015 means that average annual enrollment in off-exchange plans probably totaled about 2 million people in 2014 and about 3 million in 2015.

Many Enrollees Risk Loss of Coverage Because of Tax Filing Mistakes

Exchange enrollment in 2016 may suffer because many people who have received advanced premium tax credits (APTCs) may lose eligibility for an APTC in 2016 because of a failure to file required 2014 tax information. As of mid-July 2015, nearly 2.0 million of the 4.8 million people who claimed an APTC in 2014 had not filed the necessary forms to reconcile the amount they received with the actual amount to which they were entitled.[28] More than 700,000 of these people failed to file a tax return for 2014, and most of the remainder failed to file all necessary forms.[29] People who received an APTC in 2014 but failed to reconcile their APTC are supposed to lose eligibility for an

26. Steve Davis, "Blues Plans Report Big Enrollment Both on and off Public Insurance Exchanges," Atlantic Information Services, Washington, DC, April 23, 2014, https://aishealth.com/archive/nblu0414-02.
27. Michael J. McCue and Mark Hall, "Comparing Individual Health Coverage On and Off the Affordable Care Act's Insurance Exchanges," Commonwealth Fund, August 18, 2015, http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/comparing-coverage-on-off-aca-exchanges.
28. John Koskinen, IRS Commissioner, letter to members of Congress, July 17, 2015, https://www.irs.gov/pub/irs-utl/CommissionerLetterlwithcharts.pdf.
29. Ibid.

APTC in 2016.[30] If a large number of these people fail to file the required tax information and the Obama administration follows the law and rescinds their eligibility for APTCs, exchange plan enrollment will suffer.

PROJECTIONS SIGNIFICANTLY OVERESTIMATED UNSUBSIDIZED EXCHANGE ENROLLMENT

As table 3 shows, estimates of exchange enrollment for 2014 and 2015 were overly optimistic. The major mistake was in overestimating how many people with incomes above 200 percent of the FPL—people not eligible for large cost-sharing subsidies—would enroll in an exchange plan.

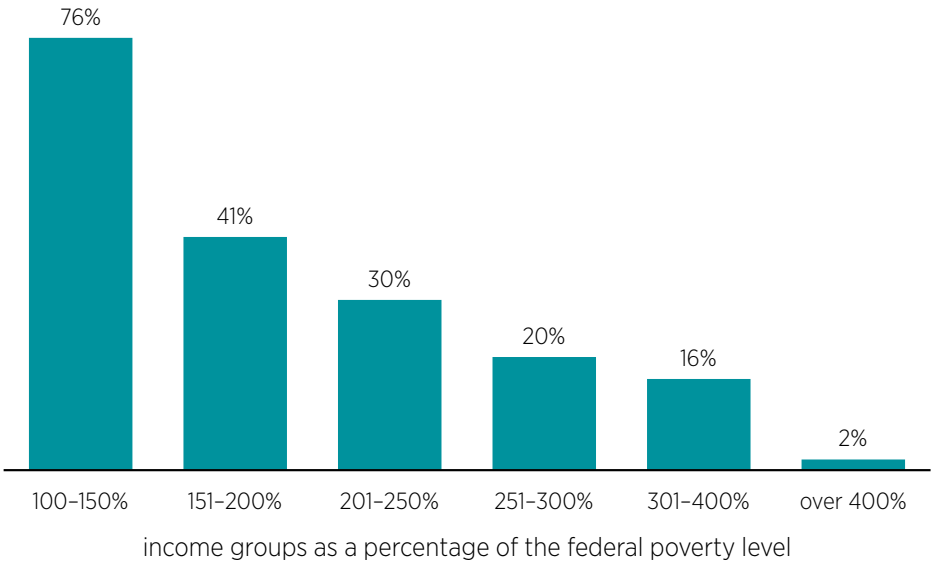
People without Large Cost-Sharing Subsidies Are Largely Shunning the Exchanges

Several pieces of data released in 2015 shed light on why exchange enrollment projections have been too high. On March 10, 2015, roughly one month after the 2015 open enrollment period closed, HHS released data on exchange enrollees in the 37 states using HealthCare.gov for enrollment.[31] (Three states—New Mexico, Nevada, and Oregon—used HealthCare.gov for enrollment even though their exchanges were considered state exchanges.) Although half of all uninsured people eligible for exchange plans had incomes above 250 percent of the FPL,[32] only about 17 percent of exchange enrollees had greater incomes.[33] Nearly 70 percent of enrollees had incomes below 200 percent of the FPL.

Also in March 2015, Avalere Health released numbers showing the percentages of eligible people, by income group, who enrolled in exchange plans.[34] (People are generally eligible for exchange coverage if they do not receive an offer of affordable coverage[35] by an employer or are not covered by a government program, such as Medicaid.) Avalere's analysis, shown in figure 1, demonstrates that exchange coverage has generally lacked appeal for eligible

30. Ibid.
31. Office of the Assistant Secretary for Planning, "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," Washington, DC, March 10, 2015.
32. Pauly, Leive, and Harrington, "Price of Responsibility."
33. ASPE, "Health Insurance Marketplaces 2015 Open Enrollment Period."
34. Caroline F. Pearson, "Exchanges Struggle to Enroll Consumers as Income Increases," Avalere Health, Washington, DC, March 25, 2015, http://avalere.com/expertise/managed-care/insights/exchanges-struggle-to-enroll-consumers-as-income-increases.
35. According to the ACA, *affordable coverage* is defined as coverage that costs no more than 9.5 percent of household income, after any employer contribution.

FIGURE 1. PERCENTAGE OF ELIGIBLE INDIVIDUALS ENROLLED IN EXCHANGE PLANS IN 2015



Note: 100% of the federal poverty level equals $11,770 for a single person.

Source: Brian Blase, "Examining Plummeting Obamacare Enrollment, Part I," *Forbes*, October 19, 2015. The chart is based on a chart in Caroline F. Pearson, "Exchanges Struggle to Enroll Consumers as Income Increases" (Avalere Health LLC, March 25, 2015), and uses data from the Centers for Medicare and Medicaid Services.

people with incomes above 200 percent of the FPL. Eligible individuals who do not purchase exchange coverage are not necessarily uninsured; they may be enrolled in grandfathered plans, plans allowed to continue because of the Obama administration's transition policy, or off-exchange ACA plans.

Fewer than 20 percent of eligible people with incomes between 250 and 400 percent of the FPL—people who generally qualify for a premium tax credit—were enrolled in exchange plans in 2015. Thus far, eligible people who do not qualify for cost-sharing subsidies have generally found exchange plans not to be worth the cost. Moreover, only 1 in 50 eligible people who do not qualify for any financial assistance bought an exchange plan in 2015. Although some of these people purchased off-exchange ACA plans directly through an insurer, the fact that only 2 percent of eligible people above 400 percent of the FPL purchased an exchange plan signals that the plans are generally unattractive to people who are not eligible for subsidies.

On September 8, 2015, HHS released information on the 9.9 million people throughout the country enrolled in exchange plans as of June 30. The data showed that about 84 percent of enrollees were receiving an APTC to reduce their out-of-pocket premium share and only 16 percent were not.

Quantifying the Exchange Enrollment Errors

Exchange enrollment data show that CBO, the RAND Corporation, and the Urban Institute all significantly overestimated the expected number of unsubsidized exchange enrollees (i.e., higher-income enrollees who do not qualify for a premium tax credit). CBO expected twice as many unsubsidized enrollees in 2015 as actually enrolled. CBO also projected that there would be about 3 million unsubsidized exchange enrollees in 2015, but as of June 30 only about 1.6 million exchange enrollees were not receiving subsidies.[36]

Table 5 shows CBO's enrollment projections by year for subsidized and unsubsidized exchange enrollees. Because CBO rounds its enrollment numbers to the nearest million, the agency overestimated the number of unsubsidized 2015 exchange enrollees by between 1 million and 2 million.

TABLE 5. CONGRESSIONAL BUDGET OFFICE PROJECTIONS FOR SUBSIDIZED AND UNSUBSIDIZED EXCHANGE ENROLLEES, 2015–2025

	Subsidized and unsubsidized exchange enrollees (millions)										
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Subsidized enrollees	8	15	18	18	17	17	17	17	17	16	16
Unsubsidized enrollees	3	6	6	6	6	6	6	6	6	6	6

Source: Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015, Washington, DC.

In its 2010 estimate, RAND projected about 15 million subsidized enrollees and 13 million unsubsidized enrollees in 2019.[37] RAND's estimate of 27 million exchange enrollees in 2016 is similar to its 2019 enrollment projection and shows that RAND also significantly overestimated the number of unsubsidized enrollees.

The Urban Institute's December 2010 report provides a detailed breakdown of its enrollment projections, including estimates by income group.[38] At the time, the institute projected that nearly as many people earning above 400 percent of the FPL would enroll in exchange coverage as people earning below 200 percent of the FPL. Broken into four income groups, table 6 shows the percentage of exchange enrollees for the institute's December 2010 estimate, the January 2015 estimate, and the actual enrollment data provided by HHS in

36. CBO, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline."
37. Jeanne S. Ringel et al., "Analysis of the Patient Protection and Affordable Care Act (H.R. 3590)" (RAND Corporation, Santa Monica, CA, 2010).
38. Matthew Buettgens, Bowen Garrett, and John Holahan, "America under the Affordable Care Act" (Urban Institute and Robert Wood Johnson Foundation, December 2010).

March 2015, which are also separated into whether states using HealthCare .gov for enrollment expanded Medicaid eligibility or not.

TABLE 6. SHARE OF EXCHANGE ENROLLEES BY INCOME GROUP

FPL group	Urban Institute		Department of Health and Human Services		
	2010 projection, 50 states	2015 projection, 34 states with federal exchanges	All states using HealthCare.gov for enrollment, 37 states	Medicaid expansion states, 16 states	Non–Medicaid expansion states, 21 states
Below 200%	35%	36%	68%	56%	73%
200–300%	21%	25%	23%	30%	20%
300–400%	12%	14%	8%	11%	6%
Above 400%	32%	25%	2%	3%	2%

Note: The Urban Institute's 2010 estimates projected 8.2 million exchange enrollees with incomes less than 200 percent of the FPL (federal poverty level), 4.8 million enrollees with incomes between 200 and 300 percent of the FPL, 2.7 million enrollees with incomes between 300 and 400 percent of the FPL, and 7.4 million enrollees with incomes above 400 percent of the FPL throughout the country. These estimates were simulated as if the law would be fully implemented in 2010. The institute's 2015 estimates projected 4.9 million exchange enrollees with incomes less than 200 percent of the FPL, 3.5 million enrollees with incomes between 200 and 300 percent of the FPL, 1.9 million enrollees with incomes between 300 and 400 percent of the FPL, and 3.4 million enrollees with incomes above 400 percent of the FPL in 2016 in the 34 states classified as federal exchange states. (Three states—New Mexico, Nevada, and Oregon—used HealthCare.gov for enrollment, but their exchanges were considered state exchanges.)

Sources: Matthew Buettgens, Bowen Garrett, and John Holahan, "America under the Affordable Care Act" (Urban Institute and Robert Wood Johnson Foundation, December 2010); Linda J. Blumberg, Matthew Buettgens, and John Holahan, "The Implications of a Supreme Court Finding for the Plaintiff in *King vs. Burwell*: 8.2 Million More Uninsured and 35% Higher Premiums" (In-Brief, Urban Institute and Robert Wood Johnson Foundation, Washington, DC, January 2015); Office of the Assistant Secretary for Planning, "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," Washington, DC, March 10, 2015.

Table 6 provides some perspective on how exchange enrollment has been affected by states' decision whether to expand Medicaid eligibility under the ACA. Nearly three-quarters of exchange enrollees in states that did not expand Medicaid have earned incomes between 100 and 200 percent of the FPL, compared to 56 percent of exchange enrollees in nonexpansion states. In both Medicaid expansion states and non–Medicaid expansion states, however, very few exchange enrollees had incomes above 400 percent of the FPL.

It is most appropriate to use the Medicaid expansion states as a comparison for the Urban Institute's 2010 estimate[39] because it was assumed at the time that all states would expand Medicaid eligibility. Even using the Medicaid expansion state grouping as a comparison shows that the Urban Institute's estimates will likely be significantly off base. Moreover, although table 6 makes it appear that the institute predicted too few lower-income enrollees, only the *share* of lower-income enrollees was underestimated since overall exchange

39. Ibid.

enrollment was significantly overestimated. The projections for 2010, simulated as if the law would be fully implemented in 2010, were for 8.2 million enrollees below 200 percent of the FPL, 4.8 million enrollees between 200 and 300 percent of the FPL, 2.7 million enrollees between 300 and 400 percent of the FPL, and 7.4 million enrollees above 400 percent of the FPL.

Although the Urban Institute's projections likely overestimate the number of 2016 enrollees in every income group, the errors appear most significant for the higher-income groups. The March 2015 HHS data indicate that fewer than 500,000 people enrolled nationally in 2015 exchange plans have incomes above 400 percent of the FPL—a small fraction of what the Urban Institute predicted.[40]

By early 2015, many states had decided not to expand Medicaid eligibility, and 2014 exchange enrollment data provided some indication that 2015 exchange enrollment would not be as robust as had been widely predicted. Yet the Urban Institute's January 2015 estimated distribution of exchange enrollees,[41] although somewhat more accurate than its December 2010 estimates, also appears substantially off the mark—an indication that assumptions about the actions of unsubsidized enrollees need to be adjusted significantly.

A SICKER RISK POOL THAN EXPECTED

For the ACA to work as intended, the individual mandate and the subsidies need to induce enough relatively young and healthy people into the ACA plan risk pools to cross-subsidize the artificially low premiums for relatively older and less healthy people. Early results, including data compiled by McKinsey & Company[42] and risk corridor data,[43] show that not enough young and healthy people, at least thus far, have enrolled in coverage for there to be a stable risk pool for insurers.

The risk corridor program is a three-year program intended to transfer funds from insurers with lower-than-expected medical claims on ACA plans, including both exchange and off-exchange plans, to insurers with higher-than-expected claims on these plans. On October 1, 2015, the Obama administration released risk corridor data, showing that many insurers lost significant money in 2014 on ACA plans and that only a few made money.[44] In 2014, the risk corridor

40. Office of the Assistant Secretary for Planning, "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," Washington, DC, March 10, 2015.
41. Blumberg, Buettgens, and Holahan, "Implications of a Supreme Court Finding for the Plaintiff."
42. McKinsey & Company, "Health Insurance Enrollment and Revenue Shifts 2013–2014: An Emerging Story," November 2015, http://healthcare.mckinsey.com/health-insurance-enrollment-and-revenue-shifts-2013-2014-emerging-story.
43. Centers for Medicare and Medicaid Services, "Three Rs."
44. Ibid.

shortfall exceeded $2.5 billion, as insurers with lower-than-anticipated medical claims owed about $360 million under the program, and insurers with higher-than-anticipated medical claims requested transfers of about $2.9 billion.

The risk corridor data demonstrate that CBO—the only organization that produced risk corridor estimates—has been overly optimistic about insurer profitability on ACA plans. In February 2014, CBO estimated that risk corridor payments would yield net savings to the federal government of $8 billion between 2015 and 2017. By projecting such large net savings, CBO expected that insurers would make positive overall profits on exchange plans. In its February 2014 report, CBO wrote,

> Plans' premium bids in the ACA's exchanges will probably exceed their costs by a few percent. Despite the technical problems that have impeded enrollment in exchanges—and the resulting reduction in CBO and JCT's [Joint Committee on Taxation's] projection of enrollment for 2014—CBO expects that premium bids will still exceed costs, and, as a result, collections from insurers for the risk corridor program will exceed payments.[45]

By the time it next estimated the ACA's effect in April 2014, CBO zeroed out the budgetary effect of the risk corridor program, citing a final HHS regulation in March 2014 that the department intended to implement the risk corridor program in a budget-neutral manner.[46] It is important to note that CBO did not revise its earlier projection that insurers would, on net, profit from selling exchange plans from 2014 to 2016.

In January 2015, CBO released estimates that risk corridor payments and collections would each equal about $5 billion over the three-year period—$1 billion for fiscal year (FY) 2015, $1.5 billion for FY 2016, and $2.5 billion for FY 2017.[47] The actual risk corridor data show that, for 2014, CBO underestimated insurers' expected payments from the program (i.e., payments to unprofitable insurers) by a factor of three and overestimated insurers' payments into the program (i.e., payments by profitable insurers) by a factor of nearly three.[48]

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45. CBO, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," Washington, DC, March 4, 2014.
46. CBO, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," Washington, DC, April 2014.
47. CBO, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," Appendix B, January 2015, Washington, DC.
48. Centers for Medicare and Medicaid Services, "Three Rs."

The large risk corridor deficit means that, on average, ACA plan premiums in 2014 were substantially too low to cover claims. The data also strongly suggest that the average health of ACA plan enrollees is significantly worse than CBO has assumed. Liquidation of 12 of the 23 new healthcare co-ops, started with federal loans authorized by the ACA, also indicates how badly insurers have underpriced ACA plan premiums. A Standard & Poor's report shows that the risk corridor program is also likely to run a significant deficit for 2015.[49]

UNATTRACTIVE ACA PLANS

A recent assessment of the benefits and costs of ACA plans shows that purchasing an ACA plan makes most people currently without insurance worse off, principally because the uninsured spend less than an average of $500 on health care each year.[50] ACA plans also tend to have very high deductibles without being accompanied by health savings accounts, as well as extremely narrow provider networks.

Most Uninsured People Are Better Off by Remaining Uninsured

Contrary to the prior expectations of multiple forecasters, the Pauly, Leive, and Harrington study indicates that consumers appear to be acting as economic theory would predict. These researchers find that the ACA has made most uninsured people worse off and "those formerly uninsured at higher incomes [and] not in poor health [are] consistently . . . worse off from purchasing coverage regardless of the assumptions made regarding spending increase and risk aversion."[51] They write,

> At all income levels, the premiums will still represent positive payments for those who (by definition) previously paid nothing for insurance, while the effect of coverage in reducing out-of-pocket payments tends to be modest. At higher income levels, small or zero subsidies and currently modest penalties will not be enough to affect the larger welfare losses that the middle

49. Standard & Poor's Financial Services, "The ACA Risk Corridor Will Not Stabilize the U.S. Health Insurance Marketplace in 2015," *Global Credit Portal*, November 5, 2015, https://www.globalcreditportal.com/ratingsdirect/renderArticle.do?articleId=1476233&SctArtId=352088&from=CM&nsl_code=LIME&sourceObjectId=9401106&sourceRevId=5&fee_ind=N&exp_date=20251105-19%3A10%3A01.
50. Pauly, Leive, and Harrington, "Price of Responsibility."
51. Ibid.

> class uninsured would experience were they to buy coverage. The minority of high risks among the middle class uninsured may gain, but most uninsured will lose and, according to our estimates, will prefer to remain uninsured at the current penalty levels for violating the individual mandate.[52]

For example, they calculate that a typical single person making $40,000 is worse off by about $2,900 from purchasing a Bronze plan[53] and $3,500 from purchasing a Silver plan.[54]

High Deductibles and Narrow Provider Networks

Although premiums are a significant factor in the decision to purchase health insurance, plan design is also important. All else being equal, relatively healthy people find plans with high deductibles less attractive than do relatively unhealthy people, particularly if the plans are not accompanied by a health savings account. Relatively healthy people are more likely to believe that they will not incur expenses close to a plan's deductible. For people who do not qualify for a cost-sharing subsidy, ACA plans tend to have very high deductibles. For 2015, these deductibles average $2,927 for Silver plan single coverage[55] and $5,181 for Bronze plan single coverage[56]—the two most popular categories of plans. Deductibles for family coverage are roughly double these amounts.

ACA plans also tend to have narrow provider networks. An analysis by Avalere Health of average provider network size in 2015 found that exchange plan networks have about 34 percent fewer providers than the average commercial off-exchange plan.[57] A Robert Woods Johnson Foundation study classified 41 percent of Silver plan physician networks for exchange plans as "small"

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52. Ibid.
53. Bronze plans are the second-most-common type of exchange plan purchased. They have an actuarial value of 60 percent.
54. As noted earlier, Silver plans are the most common type of exchange plan purchased. They have an actuarial value of 70 percent..
55. HealthPocket Inc., "Silver Plan—Affordable Care Act (Obamacare)," https://www.healthpocket.com/individual-health-insurance/silver-health-plans#.VeczlvlVikp.
56. HealthPocket Inc., "Bronze Plan—Affordable Care Act (Obamacare)," https://www.healthpocket.com/individual-health-insurance/bronze-health-plans#.Vec0RPlVikp.
57. Chris Sloan and Elizabeth Carpenter, "Exchange Plans Include 34 Percent Fewer Providers Than the Average for Commercial Plans," Avalere Health, July 15, 2015, http://avalere.com/expertise/managed-care/insights/exchange-plans-include-34-percent-fewer-providers-than-the-average-for-comm.

or "extra small," meaning that the plans covered less than 25 percent of physicians in the plan area.[58]

Insurance plan design changes for 2016 generally make ACA plans less attractive even if premiums remain flat. First, out-of-pocket limits and deductibles will generally increase from 2015.[59] Second, these plans are becoming more restrictive overall. For example, from 2015 to 2016, the number of preferred provider organization (PPO) plans available in the 37 states using HealthCare.gov for enrollment will drop by 41 percent, from 1,899 plans to 1,123. As plans that offer greater freedom to choose providers disappear, the number of health maintenance organization (HMO) plans will increase by 9 percent, from 2,008 plans to 2,181.[60] With an HMO plan, people pick a primary care physician and generally all services are coordinated through this physician using a prescribed network of providers. People with a PPO plan do not need a primary care physician, and they can go to doctors both inside and outside their network.

ASSUMPTIONS REGARDING EFFECT OF THE INDIVIDUAL MANDATE

The economic effect of the ACA's individual mandate becomes larger as more people change their behavior and purchase health insurance than would have done so in the absence of the mandate. In their models, CBO, the RAND Corporation, and the Urban Institute all place a large weight on the effect of the individual mandate in convincing people to obtain health insurance. For example, according to a 2010 RAND paper, "The individual mandate has the largest independent effect on increasing coverage; if enacted alone, it would reduce the number of uninsured in 2019 to 31 million [from 53 million]."[61]

In a 2012 paper on the effect of eliminating the individual mandate, Urban Institute researchers Matthew Buettgens and Caitlin Carroll estimate that the

58. Daniel Polsky and Janet Weiner, "The Skinny on Narrow Networks in Health Insurance Marketplace Plans," Robert Wood Johnson Foundation, June 2015, http://www.rwjf.org/en/library/research/2015/06/the-skinny-on-narrow-networks-in-health-insurance-marketplace-pl.html.
59. HealthPocket Inc, "2016 Affordable Care Act Market Brings Higher Average Premiums for Unsubsidized," November 2, 2015, https://www.healthpocket.com/healthcare-research/infostat/2016-obamacare-premiums-deductibles#.VkC04rerS03.
60. Charles Gaba, "Total Number of HC.gov Plans Down 12% for 2016, but It's Not All Bad News," *ACASignups.net*, October 29, 2015, http://acasignups.net/15/10/31/total-number-hcgov-plans-down-12-2016-its-not-all-bad-news.
61. Ringel et al., "Analysis of the Patient Protection and Affordable Care Act."

individual mandate's marginal effect will be to reduce the number of uninsured people by between 13.4 million and 15.8 million:[62]

> The mandate is more than a dollar amount; it is a legal requirement. Desire to comply with the law, aversion to an income tax penalty, and the new social norm to have health coverage can lead to behavioral responses much stronger than the nominal amount of the penalty would suggest. We operationalize this by making being uninsured less attractive to families affected by the mandate.

A 2010 CBO working paper outlines how the agency used health, tax compliance, and behavioral economics to develop its model of how the individual mandate would affect coverage.[63] CBO noted that estimating the effect "is challenging, partly because there is so little empirical evidence concerning individual people's responsiveness to health insurance mandates." Also discussed is how CBO's model accounts for factors beyond the monetary benefits and costs of obtaining coverage, such as a sense of shame or guilt that people might have from not complying with the mandate. CBO concludes by indicating that the ACA's individual mandate will significantly increase coverage relative to an otherwise comparable overall policy but without a mandate.

On June 19, 2015, in a closed-door presentation to congressional staff, CBO presented the agency's estimate of the economic, budgetary, and coverage impacts of repealing the ACA. At the meeting, CBO's experts were asked about their projection that exchange enrollment would nearly double between 2015 and 2016. They answered that the increase in the size of the individual mandate penalty in 2016, along with people's increasing awareness of the penalty, would lead to significantly greater demand for health insurance coverage and thus a large increase in exchange enrollment.[64]

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62. Matthew Buettgens and Caitlin Carroll, "Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care," Urban Institute, Washington, DC, January 12, 2012, http://www.urban.org/research/publication/eliminating-individual-mandate-effects-premiums-coverage-and-uncompensated-care.
63. CBO, "Will Health Insurance Mandates Increase Coverage? Synthesizing Perspectives from the Literature in Health Economics, Tax Compliance, and Behavioral Economics" (Working Paper 2010-05, Washington, DC, August 2010).
64. Author's notes from June 19, 2015, meeting.

INDIVIDUAL MANDATE EFFECT OVERSTATED

It is certainly possible that the individual mandate lost some of the "social norm" force when the US Supreme Court interpreted it as a tax and not a mandate. There are several reasons to be skeptical that the individual mandate will cause exchange enrollment to substantially accelerate in 2016: (1) more people paid the individual mandate penalty in 2014 than the federal government had projected; (2) relatively few people purchased insurance from the exchanges during a special enrollment period that was allowed because millions of people had learned that they would owe a penalty for 2014 for noncompliance with the mandate after the 2015 open enrollment period closed; (3) the relative size of the penalty increased more from 2014 to 2015 than it will from 2015 to 2016; and (4) more of the public, particularly people most likely to be uninsured, will learn of the many exemptions that allow people to remain uninsured and avoid the mandate penalty as well as the IRS's limited ability to collect mandate penalties.

More People Paid the Mandate Penalty than Expected

In June 2014, CBO forecast that 3.9 million people, including dependent children who have payments made on their behalf, would pay the individual mandate penalty in 2016.[65] CBO did not publish an estimate of the number of people that it thought would owe the individual mandate penalty for 2014. However, the Obama administration significantly underestimated the number of people who would forgo coverage for 2014 and then pay the penalty.

In January 2015, the Department of the Treasury projected that between 2 percent and 4 percent of all tax filers (3 million to 6 million filers) would owe an individual mandate penalty for 2014.[66] Tax data for 2014 show that 7.5 million filers—about 6 percent of all filers—paid the penalty.[67] Accounting for the fact that some of these filers have dependent children or spouses (if they filed jointly) without the required health insurance means that likely more than 8 million people paid the penalty or had the penalty paid on their behalf for 2014.

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65. CBO, "Payments of Penalties for Being Uninsured under the Affordable Care Act: 2014 Update," Washington, DC, June 2014, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45397-IndividualMandate.pdf.
66. Elise Viebeck, "Feds: Up to 6 Million Will Face ObamaCare Penalty," *The Hill*, January 28, 2015, http://thehill.com/policy/healthcare/231018-feds-15-to-30-million-exempt-from-obamacare-penalty.
67. Dan Mangan, "IRS: More Paid Obamacare Fine than Expected," CNBC, July 20, 2015, http://www.cnbc.com/2015/07/20/irs-more-paid-obamacare-fine-than-expected.html.

Few People Enrolled during the Special Enrollment Period

HHS allowed a special enrollment period from March 15, 2015, through April 30, 2015, for people who were required to pay the individual mandate penalty in 2014. The department made this allowance because the open enrollment period, which went from November 15, 2014, through February 15, 2015, ended before the 2014 tax return filing season and before many people had learned that they would be subject to the penalty. Of the roughly 8 million people who were required to pay the individual mandate penalty for 2014, only about 200,000 used the special enrollment period to sign up for 2015 exchange coverage.[68] This number was far below the 600,000 to 1.2 million additional sign-ups that had been estimated, even though the estimate was based on fewer people paying the individual mandate penalty than actually did.[69] Although some of those 8 million people may have already signed up for some other type of coverage, most probably chose to remain uninsured.

The Penalty Is Not Much Greater in 2016 Than in 2015

CBO projected that exchange enrollment would increase by nearly 10 million people from 2015 to 2016. However, the size of the individual mandate penalty more than doubled between 2014 and 2015, and even with increased awareness of the penalty, along with relatively low average premium increases from 2014 to 2015, average net exchange enrollment increased by only 4 million people. Table 7 shows that the penalty will increase by a lower percentage from 2015 to 2016 than it did from 2014 to 2015. This is particularly true for people with incomes above about 300 percent of the FPL, whose payment will be calculated according to a percentage of their household income.

68. Charles Gaba, "Updated: #ACATaxTime Wrap-Up: ~210K QHPs Should Put the Kibosh on the 'Move Open Enrollment to Spring' Movement," *ACASignups.net*, May 20, 2015, http://acasignups.net/15/05/20/acataxtime-wrap-200k-qhps-should-put-kibosh-move-open-enrollment-spring-movement.
69. Charles Gaba, "#ACATaxTime: Let the Speculation Begin . . . How Many More Will Enroll by April 30?," *ACASignups.net*, March 15, 2015, http://acasignups.net/15/03/15/acataxtime-let-speculation-beginhow-many-more-will-enroll-april-30.

TABLE 7. YEAR-TO-YEAR PERCENTAGE INCREASE IN INDIVIDUAL MANDATE PENALTY BY METHOD OF CALCULATION

Years	Increase in penalty	
	Flat fee method	Percentage of household income method
2014–2015	242%	100%
2015–2016	114%	25%

Source: Author's calculations using data from table 1.

Mandate Exemptions and IRS Limitations in Collecting Penalties

The ACA contains several exemptions to the individual mandate, including a religious exemption, an exemption for people who are incarcerated, and an affordability exemption for people whose required premium contribution exceeds about 8 percent of household income, as well as hardship exemptions. HHS has wide discretion to define hardship exemptions, and the Obama administration has fashioned 12.[70] For example, hardship exemptions are granted to victims of domestic violence, for the death of a close family member, after receipt of a shutoff notice from a utility company, and for medical expenses that could not be paid in the past two years. People can also qualify for an exemption if they have had an insurance plan canceled and think that an exchange plan is unaffordable. In addition, HHS allows people to apply for an exemption if they experience a hardship obtaining insurance because of something other than the 12 exemptions.

In addition to the numerous exemptions, the public will likely become more aware that the IRS has limited ability to collect individual mandate penalties. Because Congress knew the mandate would be unpopular, the IRS is generally limited to reducing the amount of a tax refund that an uninsured tax filer would otherwise receive in order to collect the penalty. If a person underwithholds during a given year, the IRS can send notices that the person owes money but cannot take any proactive enforcement actions to collect the penalty. As the many hardship exemptions become better known, along with the IRS's limited ability to collect penalties, the mandate will likely lose effectiveness over time.

PREMIUMS RISING MORE THAN EXPECTED

Premiums are rising to a greater degree than CBO predicted. In its March 2015 estimate, CBO lowered its projection of expected exchange premiums by about

70. HealthCare.gov, "Exemptions from the Requirement to Have Health Insurance," https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee/.

10 percent.[71] CBO attributed the reduction mainly to slower growth in overall healthcare spending during the preceding period as well as to exchange plan networks being more restrictive than CBO had earlier projected. CBO projected that private health insurance spending per exchange enrollee would grow by an average of 4.3 percent per year over the 2014–2018 period and that exchange plan premium increases would "generally reflect the underlying trend in spending by private health insurers."[72] CBO also projected that the average cost of the benchmark exchange plans—the second-lowest-cost Silver plans—would increase at an average annual rate of 8.5 percent between 2016 and 2018.[73] CBO's particular interest in benchmark plans' premiums is the result of the ACA pegging subsidy amounts to the second-lowest-cost Silver plan. Although CBO did not offer an explanation for expecting benchmark premiums to increase more than average exchange premiums, it seems plausible that the agency expects the differences across exchange plan premiums to narrow over time as lower-priced plans, which have thus far attracted more enrollees, increase premiums to a greater extent than higher-priced plans.

Insurers have finalized the premiums they will charge for 2016 ACA plans, and premiums will increase more than CBO had expected. In general, plans with the greatest market shares requested, and subsequently received, the largest premium increases. For example, BlueCross BlueShield of Tennessee has hiked 2016 premiums by 36.3 percent, Oregon's Moda Health Plan has increased premiums by 25.6 percent,[74] and Blue Cross Blue Shield has increased premiums 32.5 percent.[75] These insurers had the largest share of people enrolled in exchange plans in their state.

Avalere Health analyzed premium increases released by HHS for the 37 states using HealthCare.gov for enrollment, finding that the average lowest-cost Silver plan will rise by 13 percent in 2016 and that the average lowest-price Bronze plan will rise by 16 percent in 2016.[76] According to Avalere Health, the average lowest-price Silver plan will increase by at least 10 percent in 20 states,

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71. CBO, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," Washington, DC.
72. CBO, "Updated Budget Projections: 2015 to 2025," Washington, DC.
73. Ibid.
74. Louise Radnofsky and Stephanie Armour, "Insurers Win Big Health-Rate Increases," *Wall Street Journal*, August 27, 2015, http://www.wsj.com/articles/insurers-win-big-health-rate-increases-1440628848.
75. John Murawski, "ACA premiums in NC to rise sharply in 2016," *News & Observer*, October 30, 2015, http://www.newsobserver.com/news/business/article41993349.html.
76. Caroline F. Pearson, "Avalere Analysis: 2016 Exchange Premiums," Avalere Health, October 30, 2015, http://avalere.com/expertise/managed-care/insights/avalere-analysis-2016-exchange-premiums.

and the average lowest-price Bronze plan will increase by at least 10 percent in 25 states.

Charles Gaba calculated a weighted average premium increase across ACA plans under the assumption that all people continue in their current plans. He calculated a national weighted average rate increase of 13 percent.[77] In 33 states, the average weighted premium increase for 2016 will be at least 10 percent. In 17 states, the average weighted increase will exceed 20 percent.

Although CBO's annual premium growth estimates are averaged over a three-year period and only the projected increase for 2016 is known, the agency appears to have considerably underestimated the average increase for 2016. The weighted national average increase in exchange plan premiums for 2016 is roughly three times higher than CBO's projection for annual increases in premiums and nearly 50 percent higher than its projection for the benchmark premium increase.

Although enrollees who receive tax credits are protected somewhat from rising exchange plan premiums in that their out-of-pocket premium payment is capped at a percentage of their income for a benchmark plan, enrollees who do not qualify for a tax credit will pay the full increase. Moreover, the ACA's reinsurance program, which HHS's own experts estimate reduced 2014 ACA plan premiums by 10 to 15 percent, is phasing down and is supposed to end after 2016.[78] As premiums rise to account for both a sicker-than-expected risk pool and the loss of reinsurance program support for enrollees with high claims, ACA plans will likely look even worse to both middle-class and upper-income people who are already largely shunning them.

ANTICIPATING A REVISED ACA BASELINE BY CBO

Because CBO sets the official baseline for government spending as well as for the ACA, the changes that the agency makes to its estimates going forward are important. For CBO's previous exchange enrollment estimates to closely approximate reality in 2016, about 6 million unsubsidized people (about four times as many as in 2015) will have to be enrolled in an exchange plan for

77. Charles Gaba, "Final Projection: 2016 Weighted Avg. Rate Increases: 12–13% Nationally," *ACASignups.net*, October 15, 2015, http://acasignups.net/15/10/29/final-projection-2016-weighted-avg-rate-increases-12-13-nationally.

78. Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F)," regulatory impact analysis, March 2012.

2016. Moreover, nearly 7 million more people, on net, with subsidized coverage will need to enroll for 2016 than 2015. According to the Pauly, Leive, and Harrington findings, many if not most of these people will generally have to act against their economic self-interest if they buy an exchange plan.

Given that such robust growth in exchange enrollment seems implausible for 2016 and that the Obama administration now estimates there will be just 9.4 million to 11.4 million exchange enrollees at the end of 2016, CBO's next update will most likely project fewer exchange enrollees than its most recent estimate (for June 2015)—and probably substantially fewer for at least the next two or three years. It is possible that CBO will project a permanently lower level of exchange enrollment or that the agency will just downgrade projected enrollment for the next few years.

CBO will also have to account for the risk corridor data and 2016 exchange plan premium increases, both of which the agency significantly misestimated in the past. Since it is clear from these data that CBO assumed a healthier overall risk pool than has thus far proved to be the case, CBO will almost certainly have to project higher exchange plan premiums moving forward.

The degree to which CBO downgrades the number of expected exchange enrollees, particularly subsidized enrollees, will be a key factor in how the annual federal budget estimate for the ACA changes. Fewer people with subsidized coverage will cause a drop in the law's budgetary cost, mainly by less government spending, all else being equal. Gaba predicts that about 13.2 million exchange enrollees will effectuate coverage by paying their first premium and that there will be about 12.2 million exchange enrollees at the end of 2016.[79] Assuming his prediction (an average yearly enrollment of about 12.7 million people)

"The degree to which CBO downgrades the number of expected exchange enrollees, particularly subsidized enrollees, will be a key factor in how the annual federal budget estimate for the ACA changes."

79. Charles Gaba, "Prediction: QHP Enrollment Will Swell by 25 Percent," October 15, 2015, https://www.healthinsurance.org/blog/2015/10/15/prediction-qhp-enrollment-will-swell-by-25-percent/.

comes true, as well as the same ratio of subsidized-to-unsubsidized enrollees for 2016 as in 2015, means there will be about 10.6 million subsidized exchange enrollees and about 2.1 million unsubsidized enrollees, on average, in 2016. This would mean about 4.5 million fewer subsidized enrollees and 4 million fewer unsubsidized enrollees for 2016 than CBO predicted in March 2015.

If CBO's estimate of exchange enrollment declines as significantly as Gaba projects, CBO's budgetary cost estimate of the ACA for 2016 will almost certainly decrease as well because of the magnitude of the exchange enrollment downgrade. In March 2015, CBO assumed a total average subsidy of $4,040 per enrollee for 2016. That amount, combined with 4.5 million fewer subsidized enrollees, will mean federal budget savings of about $18 billion for 2016. It is worth noting that if CBO revises the average subsidy amount for 2016 and beyond, it will more likely go up than down because of higher-than-projected premiums and relatively more exchange enrollees with larger overall subsidies (people with incomes less than 200 percent of the FPL) relative to people with smaller subsidies (people with incomes between 200 and 400 percent of the FPL).

Although this study focuses on exchange enrollment and not Medicaid enrollment, there is some evidence that more people have enrolled in the ACA's Medicaid expansion than CBO most recently projected.[80] In addition, the Centers for Medicare and Medicaid Services has reported that government spending on adult Medicaid enrollees in states that expanded eligibility is about 19 percent higher than government spending on adult Medicaid enrollees in states that did not expand eligibility.[81] These new data points indicate that CBO will likely raise the ACA budgetary cost for Medicaid expansion in its next projection.

Several other estimates will be affected if CBO downgrades its exchange enrollment projection. Depending on CBO's assumptions about the degree to which uninsured people actually pay the individual mandate penalty, CBO may project increased revenue from mandate penalties as fewer people than expected enroll in exchange plans.

Because exchange plans have proved more undesirable than CBO assumed, people who have incomes above 200 percent of the FPL—and who thus do not qualify for the generous cost-sharing subsidies—should be somewhat more likely to seek jobs from employers offering health insurance and to

80. Centers for Medicare and Medicaid Services, "Medicaid and CHIP: June 2015 Monthly Applications, Eligibility Determinations and Enrollment Report," Washington, DC, August 31, 2015.
81. Centers for Medicare & Medicaid Services, "2014 Actuarial Report on the Financial Outlook for Medicaid," Washington, DC, .

take such jobs relative to CBO's previous estimates. Therefore, CBO's estimates will probably include more people with workplace coverage and show a decline in employer mandate penalties collected relative to its most recent projection (for June 2015). More people covered by employer-sponsored insurance than CBO originally anticipated will somewhat increase the law's projected impact on the budget deficit. All else being equal, the greater the number of people covered by employer-sponsored insurance, the lower federal tax revenue will be because less wage income will be subject to taxation.

CONCLUSION

CBO's next estimate will likely show a lower federal budget ACA cost principally because ACA plans are much less desirable than was widely assumed and also because the individual mandate does not appear to be as effective as was expected. Ultimately, the key to how the ACA functions in 2016 and beyond is how many people with incomes above 200 percent of the FPL enroll in ACA plans. As the law's reinsurance program phases out completely after 2016 and premiums reflect the true cost of enrollees, health insurance coverage will likely look even less attractive to people who do not qualify for large subsidies to purchase it. Higher premiums will, in turn, make plans even more unattractive to people in the middle class and could lead to, or at least form the beginnings of, an adverse selection spiral—a cycle of increasing premiums and disproportionate enrollment of sicker and older people—in the individual market. Thus far, the extremely high percentage of eligible people with incomes above 200 percent of the FPL who have decided not to purchase an ACA plan and the new research discussed in this paper showing that purchasing a plan is against their economic self-interest are strong negative indications about the likelihood that the ACA will continue to be viable without significant revision.

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