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Realizing Health Reform's Potential

Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change

Pamela Farley Short, Katherine Swartz,
Namrata Uberoi, and Deborah Graefe

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For more information about this study, please contact:

Pamela Farley Short, Ph.D.
Professor of Health Policy and Administration
Pennsylvania State University
PamShort@psu.edu

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Abstract: The Affordable Care Act builds on existing sources of public and private health insurance, while creating new health insurance exchanges and subsidies. A potential disadvantage of preserving many sources of health insurance is the likelihood of abrupt changes in coverage or financial responsibility when individual circumstances change. This brief describes four policy challenges related to such changes: adjusting premium and cost-sharing subsidies when incomes change; coordinating eligibility for premium credits, Medicaid, and the Children's Health Insurance Program; encouraging and facilitating continuous coverage; and minimizing transitions between individual and small-business exchanges. Policy recommendations to reduce uncertainty, simplify coverage decisions, and minimize insurance transitions include extending coverage to the open enrollment period at the end of the year, generous treatment of income gains in correcting premium tax credits, and unifying the small-business and individual exchanges.

OVERVIEW

The national health insurance reforms enacted in March 2010, referred to as the Affordable Care Act of 2010, build on existing sources of public and private health insurance.[1] This strategy reduced the risks associated with reform and was consistent with President Obama's promise: "If you like your health care plan, you can keep your health care plan." The reform law also emphasized affordability of coverage and shared responsibility for paying for it.

A possible disadvantage of preserving many sources of insurance that are tailored to different individual circumstances is the potential for abrupt changes in coverage or financial responsibility when circumstances change. This brief focuses on the policy challenges that arise when individuals and families experience major life changes over a year. In particular, the brief examines the following four policy challenges related to health insurance coverage:

- adjusting premium and cost-sharing subsidies when incomes change;
- coordinating eligibility for premium credits, Medicaid, and the Children's Health Insurance Program (CHIP);

- encouraging and facilitating continuous coverage; and
- minimizing transitions between individual and small-business exchanges.

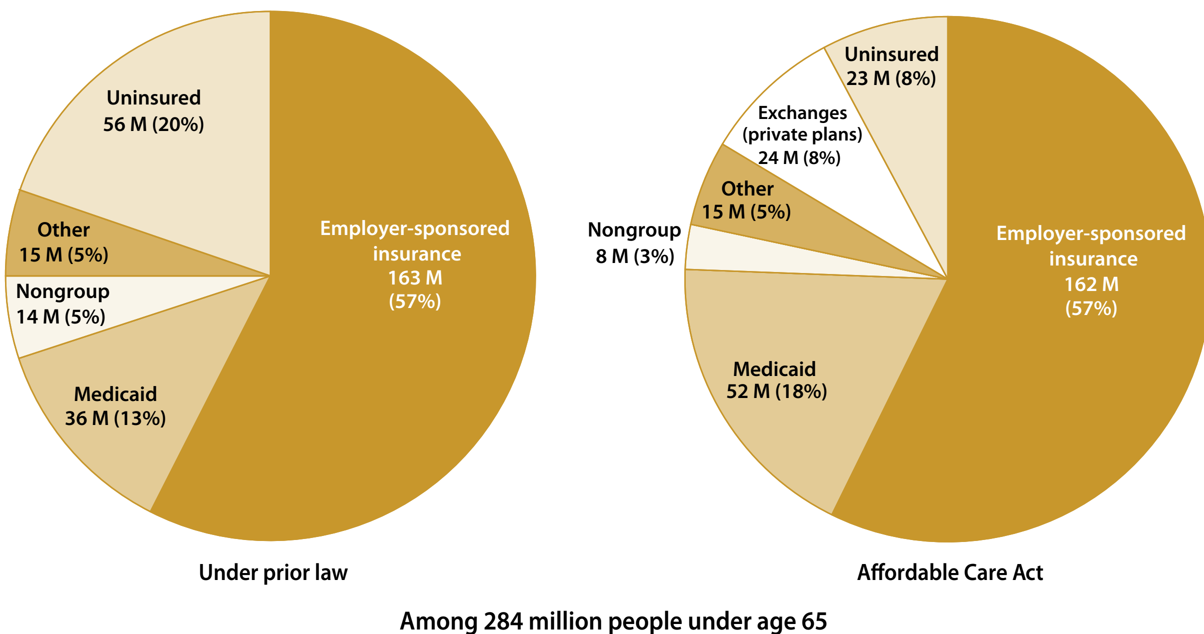
The brief concludes with policy strategies for addressing each of these challenges, with the objective of reducing uncertainty, simplifying coverage decisions, and minimizing transitions among health plans and publicly supported programs that will exist under the Affordable Care Act.

BACKGROUND

By drawing on multiple sources of insurance, the reforms in the Affordable Care Act are projected to insure an additional 34 million Americans in 2020, leaving only 8 percent of legal nonelderly residents uninsured (Exhibit 1).[2] Employers will continue to cover about three of five Americans under age 65. Medicaid's share will increase from 13 percent to 18 percent, and the new health insurance exchanges will cover 8 percent.

But changes in people's lives (e.g., starting or quitting a job, changing jobs, getting married or divorced) that currently cause gaps in health insurance coverage, churning in and out of public health insurance programs, and unexpected shifts in household premiums could continue to be problematic.[3,4,5] After January 2014, when the health reform law is fully implemented, access to specific sources of coverage will be based on characteristics that frequently change (including family income, family size, and access to employer plans). The new system must be designed to handle these life transitions effectively, or the instability and insecurity of the current system will persist. Another consideration is the opportunity for policymakers to promote participation in the new system by smoothly and generously accommodating changes in individual circumstances. More people will enroll in health insurance coverage if they know they will not have to scramble for replacement coverage if their lives change. Further, enrollment numbers will be higher if the economic consequences of participation or nonparticipation (i.e., out-of-pocket premiums, tax credits,

Exhibit 1. Sources of Insurance Coverage Pre-Reform and Under the Affordable Care Act, 2020



Notes: Employees whose employers provide coverage through the exchange are shown as covered by their employers; "Other" includes Medicare.
Source: Testimony Statement of Douglas W. Elmendorf, Director, Congressional Budget Office, before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," March 30, 2011, http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.

Exhibit 2. Using Multiple Sources of Coverage to Achieve Universal Access to Affordable Health Insurance

Private health insurance

- Exchanges
  - → Individual exchanges are available to all. Premium credits are restricted to individuals and families with incomes from 133 percent to 399 percent of the federal poverty level and without access to employer plans.
  - → Small-employer exchanges
- Employer groups
  - → Large employers
  - → Small employers (outside exchange)
- Individual (outside exchange)

Public health insurance

- Medicaid (children and adults below 133 percent of poverty)
- Children's Health Insuance Program (children, 133 percent of poverty to state income limit)
- Medicare (people with disabilities)

Source: Authors' analysis.

and tax penalties) are as predictable as possible—especially for people facing a lot of other changes and uncertainties.

Additional reasons for policymakers to focus on the issue of continuity of coverage include the potential effects on continuity of care and administrative costs. Because most health insurance plans have provider networks, people who are forced by life changes to shift to different plans may also have to change providers or pay more for out-of-network care. Minimizing turnover in enrollment will reduce administrative costs for exchanges, state and federal agencies determining eligibility for public programs and subsidies, and private health plans.

UNIVERSAL ACCESS TO AFFORDABLE INSURANCE

The Affordable Care Act brings together coverage from a multitude of sources to offer universal access to affordable health insurance (Exhibit 2). At the heart of this strategy are the health insurance exchanges that each state must establish for individuals and small businesses.[6] The exchanges will offer easy access to qualified health plans, with customer service and "navigator" programs to answer questions and facilitate enrollment.[7] The exchanges will maintain Web sites with price and quality information about plans to encourage comparison shopping and competition among insurers.

Individual Exchanges

All United States citizens and legal immigrants will be able to enroll in any qualified health plan offered in the individual exchanges.[8] For people without access to public insurance or affordable employment-based insurance, and with incomes from 100 percent to 399

Exhibit 3. Limits on Out-of-Pocket Premiums

Income level	Premium as a percent of income
<133% FPL	2% of income
133%–149% FPL	3% to 4% of income
150%–199% FPL	4% to 6.3% of income
200%–249% FPL	6.3% to 8.05% of income
250%–299% FPL	8.05% to 9.5% of income
300%–399% FPL	9.5% of income

Note: FPL = federal poverty level.
Source: Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111–148 and 111–152), www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

percent of the federal poverty level, the Act provides tax credits to reduce premium costs for insurance purchased in the exchanges.[9] People who meet income eligibility requirements and who have employer plans that cover less than 60 percent of insured expenses or employee premiums that exceed 9.5 percent of income are also eligible for the tax credits.[10]

The tax credit is tied to the premium for the second-least expensive, "silver" plan in the exchange, which covers 70 percent of covered expenses.[11,12] The tax credit limits each taxpayer's out-of-pocket premium contribution to a specified percentage of adjusted gross income that varies with income from 133 percent to 399 percent of the federal poverty level (Exhibit 3).[13,14]

In addition to subsidizing premiums, the federal government will subsidize a reduction in cost-sharing for individuals with incomes below 250 percent of the poverty level who purchase silver plans from the individual exchange. The cost-sharing reduction depends on a person's income as a percentage of poverty and is mainly accomplished by lowering the limit on out-of-pocket expenditures.[15]

Small Business Exchanges

Starting in 2014, businesses with fewer than 100 employees will be able to purchase coverage for employees through state-based Small Business Health Options Program (SHOP) exchanges, although states may limit participation to employers with 50 or fewer employees until 2016.[16] The SHOP exchange can be separate from the individual exchange or combined with it. In 2017, states will have the option of opening the exchange to employers with more than 100 employees.[17,18]

Private Insurance Purchased Outside the Exchanges

Both small and large employers may continue to offer health insurance to employees outside the exchange. However, none of this coverage will be publicly subsidized, with the exception of small-business tax credits that will be available for eligible small employers through 2015. Except for new consumer protections that will apply to all health insurance plans, individuals will be able to retain the same group health plans and benefits from before the legislation was enacted. Such plans are referred to as "grandfathered health plans."[19] To remain in grandfathered status, plans must meet certain requirements including not increasing coinsurance or out-of-pocket spending limits.[20]

As before, under COBRA, employees at firms with more than 20 employees (and dependents) who would otherwise lose coverage will be allowed to extend their coverage by paying 102 percent of the total premium.[21] The 2009 American Recovery and Reinvestment Act temporarily offered a 65 percent subsidy to workers exercising COBRA rights, but the Affordable Care Act does not provide COBRA subsidies.[22]

Public Health Insurance Programs

The Affordable Care Act also expands eligibility for public insurance. In particular, anyone under age 65 with family income below 133 percent of poverty will become eligible for Medicaid, except for people on Medicare.[23] States are required to maintain current eligibility and income requirements for CHIP, which covers middle- and low-income children ineligible for Medicaid, until October 1, 2019. The law gives states the option of creating a basic health plan for individuals not eligible for Medicaid with incomes from 133 percent to 199 percent of the poverty level, by pooling 95 percent of the federal premium credits and cost-sharing subsidies. If a state creates a basic health plan, individuals enrolled in it will not be eligible for premium tax credits or cost-sharing subsidies for insurance purchased through the state's exchange.[24]

SHARED RESPONSIBILITY FOR FINANCING HEALTH INSURANCE

Individuals

Beginning in 2014, the Affordable Care Act requires all U.S. citizens and legal residents to be covered by health insurance. Anyone who does not comply will pay a penalty through the federal income tax system that phases in until 2016, when it will be the greater of $695 annually for individuals ($2,085 for families) or 2.5 percent of household income.[25] Exemptions will be granted if the cheapest plan in the exchange costs more than 8 percent of an individual's income or for uninsured periods of three months or less.[26]

Employers

Employers that do not offer insurance and have 50 or more full-time equivalent employees must contribute toward the government costs associated with full-time employees receiving premium tax credits. The contribution will be $2,000 for each full-time employee (not including the first 30 employees).[27,28] Employers that offer coverage but have employees receiving premium tax credits through the exchanges must pay the lesser of $3,000 for each full-time worker who receives a tax credit or $2,000 for each full-time worker (not including the first 30 employees). Employers with fewer than 50 full-time employees are not subject to any of these requirements.

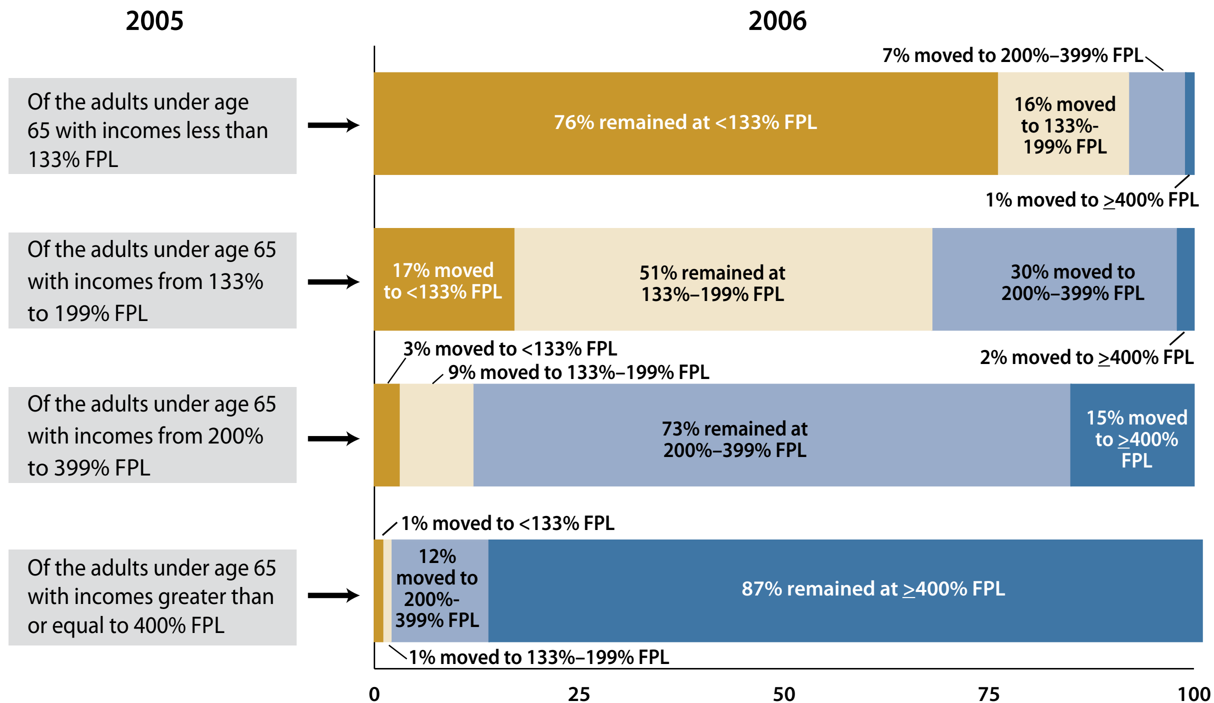
State and Federal Government

The funding of Medicaid and CHIP remains a joint responsibility of federal and state governments. To finance the expansion of Medicaid to all adults below 133 percent of the poverty level, the federal government will match state funds at 100 percent from 2014 through 2016. This funding will begin to phase down after 2016 until it reaches 90 percent in 2020. States that have already expanded Medicaid eligibility for low-income adults will receive a phased-in increase in federal assistance to 90 percent. The federal match for CHIP will increase by 23 percentage points (with the total not to exceed 100%), beginning in 2016 and extending through 2019.[29,30]

COMMON LIFE CHANGES WILL AFFECT ELIGIBILITY FOR SUBSIDIZED INSURANCE

Significant changes in family income from one year to the next are common even in normal economic times, especially for people with annual incomes below 400 percent of the federal poverty level. This is illustrated in Exhibit 4, which shows national estimates using data from the Survey of Income and Program Participation of year-to-year changes in family income for 2005 and 2006, before the beginning of the recession in 2007. One of four individuals with 2005 incomes below 133 percent of the poverty level—who would have qualified for Medicaid under the Affordable Care Act—would not have qualified for Medicaid based on annual income in 2006. Incomes were even less stable just above Medicaid eligibility (i.e., 133% to 199% of the federal poverty level), where premium credits are the most generous under the Act. Of people who were in this category in 2005, slightly over half were in the same category in 2006, 17 percent dropped below 133 percent of poverty and would have qualified for Medicaid, and 30 percent moved up a category where they would not have qualified for a state basic health

Exhibit 4. Changes in Family Income, U.S. Population Under Age 65, 2005 to 2006



Note: FPL = Federal poverty level.
Source: Authors' tabulations of the 2004 Survey of Income and Program Participation.

plan but would have remained eligible for premium credits at reduced levels. The incomes of people at the highest level were the most stable: 87 percent of individuals above the threshold for premium credits (400% of poverty) in 2005 would have remained ineligible in 2006 as well. A study that analyzed monthly income changes in the same survey concluded that income changes were likely to produce a good deal of churning between Medicaid and the insurance exchanges under the Affordable Care Act, with more than 35 percent of adults below 200 percent of the poverty level crossing the eligibility threshold in at least one month out of six.[31]

People at low income levels are more likely to work for small firms, which will add to movement among small-business exchanges, subsidized participation in individual exchanges, and Medicaid under health reform. According to our estimates, using data from the Survey of Income and Program Participation, 57 percent of individuals below 133 percent of poverty worked for firms with fewer than 100 employees in 2006 (data not shown). The percentage of individuals in smaller firms decreases as people move up the income ladder: 46 percent with incomes from 133 percent to 199 percent of poverty, 39 percent with incomes from 200 percent to 399 percent of poverty, and 32 percent with incomes at or above 400 percent of poverty. Only 79 percent of workers with incomes below 133 percent of poverty who worked for small firms in January 2005—that is, those who could have enrolled in a small-business exchange—were still working for small firms in January 2006. At the next higher income level, from 133 percent to 1999 percent of poverty, 83 percent were still working for small firms in January 2006.

These statistics illustrate that many people at lower income levels experience changes in income or employment that could affect the continuity of their coverage and their out-of-pocket expenses for health care and health insurance over a year. One of the challenges in implementing the Affordable Care Act is to decide on a fair way of applying its concepts of affordability and shared responsibility when people's ability to pay for insurance changes.

AVOIDING INSURANCE GAPS AND AWKWARD TRANSITIONS WHEN LIVES CHANGE

Changing life circumstances could easily cause people to be confused about their eligibility for premium credits or Medicaid, and create uncertainty about the ultimate out-of-pocket costs of enrolling in coverage purchased through an exchange or the likelihood of remaining in a plan for a full year. This confusion and uncertainty could discourage people from signing up for insurance. If people who sign up for insurance face the hassle of switching plans because of life changes, they may default to becoming uninsured.

Furthermore, income fluctuations around the thresholds that limit eligibility for Medicaid (<133% of the poverty level) and premium tax credits (<400% of poverty) could cause abrupt changes in the affordability of health insurance and health care. To avoid these changes, people at risk of crossing either threshold will have strong incentives to decline opportunities for earning more or to hide additional income. Furthermore, the incentive to game the system could be quite different for people with identical annual incomes, depending on whether their usual weekly or monthly income is above or below the threshold. Such asymmetries have been observed in the food stamp program.[32]

In the following section, we briefly describe four policy challenges related to accommodating changes in people's lives in the context of health reform. Each of these challenges involves issues that could make decisions about buying insurance more uncertain or difficult and could lead to gaps in coverage. To address these issues, we suggest some basic policy approaches for reducing uncertainty, simplifying coverage decisions, and minimizing transitions between plans and programs. These policy strategies could be complementary or could overlap with each other; they are not mutually exclusive.

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CHALLENGES IN IMPLEMENTING REFORMS FOR PEOPLE WITH INCOME AND EMPLOYMENT CHANGES

Adjusting Subsidies for Premiums and Cost-Sharing When Incomes Change

Timing of federal tax returns will complicate the calculation of subsidies for people with income changes. The new law calls for the U.S. Department of the Treasury to advance credits to the exchanges on behalf of people eligible for premium assistance, rather than make them pay the entire premium initially and wait to be reimbursed. To help people plan their insurance for the coming year during an open enrollment season, the exchanges will determine everyone's premium credits for the coming year just before the open enrollment season.[33] Unfortunately, the timing of the credit determination means that income reported on tax returns will not be accurate for people with recent changes in income. For example, if the open enrollment season for health insurance in 2014 is held in November 2013, then the most recently filed tax returns (for the April 15, 2013, deadline) will report income for 2012. Recognizing this issue, the Affordable Care Act requires the secretary of Health and Human Services (HHS) to specify additional procedures for determining advance credits for taxpayers with significant income changes in 2013 and for people who did not

file returns for 2012. Premium credits will be affected by changes in family size and filing status (e.g., single vs. married), as well as income changes, because the federal poverty level depends on family size.

Given the lags in reporting income on tax returns, people with significant income changes will have to go through a more complicated and demanding administrative process to determine their advance premium credits. The burden of that process will likely discourage participation. The challenge for the government in designing the updating process is to balance issues of fairness, administrative costs, and applicant burden.

Insurance decisions during open enrollment will have to anticipate changes in tax credits that could result from future changes in income. The final determination of tax credits for the coverage year will be based on actual income reported on tax returns at the end of the year. Uncertainty about the ultimate out-of-pocket costs of coverage could lead people to delay enrolling in a plan or to ignore the insurance requirement altogether. Either response will lessen participation in health insurance and the continuity of coverage.

In our example with 2014 as the coverage year, when tax returns for 2014 are filed by April 2015, the credits advanced for 2014 will be reconciled against credits computed from income reported on the return.[34] Taxpayers with less income than anticipated will receive additional credits in the form of a larger tax refund or smaller tax payment, if they enrolled in a plan in the exchange. Taxpayers with more income than anticipated will have to pay back the advanced credits, as a smaller tax refund or larger tax payment. The Affordable Care Act limited the repayment to $450 for couples and $250 for single individuals with incomes remaining below 400 percent of the poverty level, but required taxpayers with incomes that go to 400 percent of poverty or higher to repay the entire credit. In 2010, to partially offset the cost of postponing scheduled reductions in Medicare physician payments, the Medicare and Medicaid Extenders Act (P.L. 111–309, Sec. 208) increased the payback requirement to as much as $2,500 for people approaching 400 percent of the poverty level. The effective increase in out-of-pocket premiums will be $1,800, for example, for a single adult initially at 200 percent of the poverty level who experienced an $11,500 increase in pretax income to reach 300 percent of poverty. Such sizeable repayments could easily discourage people either from earning additional income or reporting it, or from relying on the advance credits in deciding to buy insurance in the first place.

Cost-sharing subsidies may not reflect income changes. The Affordable Care Act specified that eligibility for cost-sharing subsidies available to individuals enrolled in silver plans in the individual exchanges "shall be made on the basis of the taxable year for which the advance determination is made." In our example, a strict interpretation of the legislative language would use income in 2012 as the basis for determining eligibility for cost-sharing assistance in 2014.[35] Implementing regulations could probably adopt a looser interpretation, and account for income changes in 2013 that are built into the advance credits for 2014. However, the law does not allow cost-sharing subsidies to be updated for income changes during the coverage year (2014, in this example). This could be especially important for anyone forced to shift from Medicaid to purchasing subsidized insurance through an exchange as a result of income gains during the year, because Medicaid cost-sharing is much less than the 30 percent required by the silver plan without cost-sharing subsidies.

Policy Suggestions

Create special decision-making supports for people experiencing or anticipating major economic changes. The exchanges could design interactive computer programs and train personnel to guide people through the extra procedures required to update the advance credits and cost-sharing subsidies for major economic changes occurring before the open enrollment season. People also will need assistance with "what if" scenarios for the coming year, so they can

explore the implications of a range of future income possibilities and coverage choices on out-of-pocket expenses for premiums, cost-sharing, and penalties for being uninsured. Long before the end of the coverage year, the Internal Revenue Service could alert people to the likelihood of corrections to their premium credits. An early warning system would allow individuals to contact the exchange or tax professionals for help in projecting their income and premium credits for the year and to adjust their tax withholding accordingly. If people could be assured of quick and effective help when their economic situation changes, anxiety about relying on credits to buy insurance would be reduced.

Downplay recent changes in income, which could be temporary, in advancing premium credits. A study that simulated advance premium subsidies with and without full reconciliation at the end of the year concluded that less correction is needed when income is initially measured over a longer time period that gives less weight to temporary fluctuations.[36]

Err on the side of generosity in correcting premium credits for income changes during the coverage year. The same study concluded that "excess" premium credits that taxpayers do not have to repay are particularly effective in promoting voluntary insurance purchases, because people who anticipate income gains are especially likely to use the extra income combined with the extra credits to buy insurance. Conversely, the effect on participation of initially offering too little help to people with income losses cannot be undone if they failed to buy insurance during the open enrollment season and then are not eligible for premium credits. If taxpayers are allowed to keep their advance premium credits, they will have more incentive to pursue income opportunities and fewer disincentives to report income gains.

A full accounting of government costs and benefits associated with reclaiming credits should take account of tax revenues that may be lost because of forgone earning opportunities or unreported income gains, as well as increased administrative and enforcement costs. In addition, reclaiming credits could have adverse effects on enrollment if people fear that increases in earnings could subject them to unexpectedly large tax bills at the end of the year. It could be more cost-effective for the government to reduce the stated generosity of the subsidy schedule slightly and forgo repayments from taxpayers with income gains, rather than state a more generous schedule and require repayments.

Coordinating Eligibility for Premium Credits, Medicaid, and the Children's Health Insurance Program

Coordination is critical for several reasons. First, most transitions in and out of these programs will occur between programs, and the variability of incomes near the Medicaid income eligibility limit implies that changes in eligibility will happen frequently. Second, the financial implications for families are significant. Medicaid requires no premium and minimal cost-sharing for medical services, while coverage through CHIP or the exchange involves out-of-pocket premium contributions and modest cost-sharing. Third, the premium credits will be federally financed and administered through the federal income tax system, while the states will share responsibility for financing and operating Medicaid and CHIP. The difference in federal and state roles adds to the potential for confusion and highlights the need for coordinating eligibility determination for the three programs. Finally, decades of experience with eligibility expansions involving Medicaid and CHIP have demonstrated that participation in public programs is far from automatic. Simplified eligibility rules, administrative streamlining, and outreach are necessary for achieving high levels of participation in the eligible population.[37,38,39]

Coordination will be complicated by differences in the timing of income considered in determining eligibility for Medicaid and tax credits. To better coordinate with tax-based premium credits, the income definition used to determine Medicaid eligibility was changed to a modification of adjusted gross income as defined in the federal tax system.[40] Medicaid asset

tests also were eliminated.[41] However, in determining Medicaid eligibility, states will continue to evaluate income at the time of application.[42] Existing state procedures for periodically redetermining income eligibility for Medicaid will continue. Consequently, the enrollment churning that currently occurs in Medicaid because of income gains or failure to comply with income reporting requirements could be perpetuated in a new form. Families with incomes around the Medicaid eligibility limit may get caught in a revolving door between Medicaid and the individual exchange.

Policy Suggestions

Federal and state authorities should assign a high priority to coordinating eligibility for the premium credits with eligibility for Medicaid and CHIP. To jump-start the coordination process, the Affordable Care Act requires the HHS secretary to develop and provide states with a unified system for determining eligibility for Medicaid, CHIP, and tax credits for plans purchased in the exchange. The secretary (in consultation with the states) also must create a single Internet portal that identifies all public and private health insurance options that are relevant for individual residents in each state.[43] Exchanges will engage “navigators” to assist consumers in identifying and enrolling in affordable plans.[44]

Eligibility determination, out-of-pocket premium calculators, portals, and navigators must all be designed to help consumers cope with changes in subsidy eligibility. Making the exchanges responsible for determining and coordinating eligibility across programs, as well as for enrollment in the exchanges, would facilitate more flexible and coordinated responses to income fluctuations around the limits for Medicaid and CHIP eligibility. If gaps in coverage are to be avoided, recruiting and retention strategies to increase participation in Medicaid and CHIP must be adapted to help encourage people who are no longer eligible for one program to switch to another.

It may be easier for states to coordinate eligibility for Medicaid, CHIP, and premium subsidies by creating a state basic health plan for residents from 133 percent to 199 percent of poverty instead of enrolling that income group in the exchange with premium credits. States with a state basic health plan would not have to interact with the Internal Revenue Service and federal tax policy for people with incomes below 200 percent of poverty. These states could standardize eligibility rules, benefit designs, plan selection, and administrative procedures across Medicaid, CHIP, and the state basic health plan.

Extend eligibility for Medicaid and CHIP until the next open enrollment period at the end of the year. This option would ease uncertainty and minimize coverage changes for people with incomes around the thresholds separating eligibility for premium credits from eligibility for Medicaid or CHIP. For example, people receiving premium credits for coverage from an exchange may not want to switch to Medicaid when temporary income losses make them eligible for Medicaid, especially if they expect the drop in income to be temporary. These individuals could delay declaring eligibility for Medicaid with a resulting lapse in coverage.

Facilitating Continuous Coverage

Penalties for initially going without coverage are uncertain and confusing. The individual insurance mandate is a monthly requirement. One-twelfth of the annual penalty will be assessed for each month that taxpayers or their dependents are uninsured in a calendar year, although one uninsured period lasting three months or less will be forgiven each year.[45] The first three months will not be forgiven if the coverage gap lasts more than three months, so the penalty for a fourth uninsured month spikes abruptly.[46] In keeping with the three-month forgiveness period, the Affordable Care Act guarantees that new employees will not have to wait more than 90 days to qualify for employer insurance.[47] However, the 90-day limit will not protect new hires who were uninsured before the waiting period; their gap in coverage will exceed three months and cause them to be penalized during the waiting period.

Short-term enrollment will raise costs in the exchanges because of adverse selection and increased administrative overhead per premium dollar. Research indicates that about half of people who become uninsured regain insurance within six months or less.[48,49,50,51] Anticipating only a short gap in coverage, many people (especially younger or healthy people) might not see the financial risk as warranting the hassle of obtaining and then cancelling a plan to fill the gap. Although there is a monthly penalty for being uninsured, especially for overshooting the three-month limit, the penalty is mild. Consequently, without a process to make it very easy for healthy people to fill short gaps (or without harsher penalties for being uninsured), the people who are motivated to obtain short-term coverage through the exchange will mostly be unhealthy. This form of adverse selection will raise premiums and the cost of premium credits in the exchanges, as will the high administrative costs associated with rapid turnover among exchange enrollees.

Policy Suggestions

Simplify the exemption for short gaps in coverage, so there is no doubt about the number of uninsured months (if any) that will be forgiven each year. When initially contemplating a gap in coverage, people may discount the possibility of being penalized after three months. In addition, they cannot do anything about the earlier uninsured months when they face the retroactive penalty at four months. As a result, the retroactive penalty may do little to discourage uninsured gaps. By the same reasoning, monitoring gaps across tax years may do little to discourage gaps, but will add administrative cost and complexity to the enforcement of the individual coverage requirement.

Allow and encourage extensions of existing coverage, rather than expect people to default to the individual exchange to fill short gaps. The federal COBRA law, as well as state laws extending COBRA to smaller employers, allows the continuation of employment-based insurance to workers and their families who lose their jobs and, consequently, their health benefits. However, to make COBRA extensions appealing to workers who have left their jobs, the federal government would likely need to offer premium tax credits to offset the loss of employer premium contributions. For public insurance, there is precedent for coverage extensions. For instance, "transitional medical assistance" allows otherwise ineligible Medicaid enrollees with new earnings or child support to continue in the program for an additional four to 12 months.[52]

Guarantee a full year of coverage from the public or private plan that each person chooses during the open enrollment period, with adjustments in financing to reflect life changes. This approach would synchronize coverage extensions with the annual redetermination of eligibility for premium subsidies and public insurance during the open enrollment season, so that most coverage changes would occur between calendar years. Eliminating enrollment changes during the year would reduce administrative costs and adverse selection, thereby reducing premiums and government program costs.

The administrative mechanisms for financing coverage extensions to the end of the year could draw on existing precedents for sharing premium costs between employers and Medicaid (i.e., Medicaid "premium assistance") or subsidizing COBRA. The payments required from employers with employees in the exchange could be prorated as contributions toward coverage extended to the end of the year.

Minimizing Transitions Between Individual and Small Business Exchanges

There is likely to be a lot of movement between the separate exchanges for individuals and small businesses. Employees of small firms who lose their jobs will have to transition to the individual exchange and will likely apply for premium credits. Individuals who start new jobs with small firms that offer health insurance will often come from the individual exchange. Because the creation of separate exchanges results in separate risk pools, it creates the potential for much

higher premiums for individuals than for employees of small firms. As a result, job changes may cause big changes in family out-of-pocket premiums.

Policy Suggestions

Make the exchanges as large as possible by drawing individuals and small businesses into a unified exchange and encouraging small employers to join. Within a unified exchange, people would retain coverage through the same insurers and plans when moving in and out of jobs with small employers in the exchange. The total cost of the coverage would remain the same, although the out-of-pocket contribution might change, depending on the amount of employer premium contributions compared with premium credits. A unified exchange would be well-positioned to counsel households facing changes in their out-of-pocket costs because of changes in employment, as well as to facilitate a quick and smooth change in the financing of the rest of the premium by employers or government sources.

In addition, administrative costs for states and insurers would be reduced by unifying the exchanges. State expenses related to managing the exchanges would be less, and employment changes would not require insurers to add or remove people from their enrollment records. Even the billing for premiums would be simpler, since the same exchange would be responsible for collecting and distributing premiums to all insurers.

Creating a single exchange that encompassed as many individuals and small firms as possible would reduce adverse selection against the individual exchange, which will be the insurer of last resort in the reformed system. Minimizing adverse selection will reduce premiums by reducing insurer risk; lower premiums in the exchange that serves individuals will reduce federal expenditures for premium credits.

Provide broad access to the same insurance plans through different sources. Even if the two exchanges are not combined, states could smooth transitions between the exchanges by ensuring plenty of overlap in the health plans offered by each exchange. In this scenario, people who chose plans available in both exchanges could move between exchanges without changing plans.

The same strategy could be applied in contracting with private plans to serve the populations enrolled in CHIP or Medicaid. Exchanges could be required to offer at least one of the health plans contracting with Medicaid or CHIP, or plans contracting with Medicaid or CHIP could be required to participate in the exchanges. Although most large employers are self-insured and their health plans do not correspond to plans offered in the small-group or individual markets, states could require health plans that contract as third-party administrators of self-insured firms to offer plans with similar networks through the exchanges.[53]

Through regulations, administrative policies, and existing state options, the states and the federal government have the ability to smooth many transitions in coverage and financial responsibility from one open enrollment season to the next.

CONCLUSIONS

Because the Affordable Care Act leaves many details to be specified by the executive branch, a number of the policy recommendations suggested here could be implemented in federal regulations or administrative policies over the next several years (Exhibit 5). Other suggestions could be implemented by states under options already available under the Act or existing Medicaid and CHIP policies. A few suggestions (e.g., simplifying the exemption for short gaps in coverage, reconsidering the payback of advanced credits, subsidizing COBRA extensions with premium credits) would require new federal legislation. Yet through regulations, administrative policies, and existing state options, the states and the federal government have the ability to smooth many transitions in coverage and financial responsibility from one open enrollment season to the next. In terms of administrative cost and complexity, the best way to ease transitions may be to eliminate them entirely, by postponing most changes in coverage and financial responsibility until the next open enrollment season's choices go into effect.

Exhibit 5. Potential Mechanisms for Implementing Policy Suggestions

	Through federal regulations implementing the Affordable Care Act	Through state options under the Affordable Care Act or other federal policies	Requires new federal legislation
Adjusting premium and cost-sharing subsidies when incomes change			
Provide special decision-making supports for people experiencing or anticipating major economic changes	X	X	
Update cost-sharing subsidies for income changes between April tax filing and open season	X		
Downplay recent income fluctuations in advancing premium credits	X		
Err on the side of generosity in correcting premium credits at end of coverage year			X
Coordinating eligibility for premium credits, Medicaid, and CHIP			
Design portals, eligibility calculators, and navigators to assist with transitions between subsidy programs during a calendar year	X	X	
Extend eligibility for Medicaid and CHIP to the end of the calendar year		X (transitional medical assistance)	
Encouraging and facilitating continuous coverage			
Simplify the three-month exemption for short gaps in coverage			X
Allow and encourage extensions of existing coverage		X (transitional medical assistance)	X (premium credits for COBRA)
Guarantee a full year of coverage from the public or private plan chosen during annual open enrollment period, with adjustments in financing to reflect life changes		X	X
Minimizing transitions between individual and small-business exchanges			
Make exchanges as large as possible; create a single, unified exchange		X	
Provide access to same insurance plans in both exchanges (and in Medicaid and CHIP)		X	

Source: Author's tabulations of the 2004 Survey of Income and Program Participation.

As they try to recover from the economic recession, Americans are acutely aware of the uncertainties of life; many are anxious about their future employment and income prospects. As national reform is implemented, procedures and policies should be developed for managing life changes that will help to insulate health and health insurance from other economic uncertainties. This will involve policies for handling the effects of economic gains, as well as losses. Many economists do not expect a substantial reduction in the unemployment rate for several years, around the time the Affordable Care Act goes into full effect. Most people who are still unemployed or underemployed at that point will have incomes below 400 percent of the federal poverty level and will qualify for health insurance premium subsidies through tax credits, or will be eligible for Medicaid or CHIP. If and when their circumstances improve, they may resent abrupt cuts in their subsidies that penalize their economic efforts and make it harder to recover from the losses they have suffered.

To achieve high rates of enrollment in the exchanges, as well as almost universal participation among people eligible for Medicaid and CHIP, the implementation of the new law must take the guesswork and uncertainty out of health insurance decisions. The success of the new law depends on creating financial and administrative mechanisms that will coordinate the availability of subsidized coverage through individual exchanges, Medicaid, and CHIP when incomes change, while leaving little doubt about the costs and benefits of signing up for insurance or going without it. Government officials and citizens are understandably concerned about the overall cost of insurance subsidies. Even so, erring on the side of generosity and stability in guaranteeing affordable coverage will increase enrollment in health insurance and encourage the successful implementation of the Affordable Care Act.

Notes

1. More formally, the reforms are contained in the Patient Protection and Affordable Care Act (PPACA, P.L. 111–148), as amended by the Affordable Care and Education Reconciliation Act (ACERA, P.L. 111–152).

2. Congressional Budget Office, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Statement of Douglas W. Elmendorf, Director, before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011, http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.

3. P. F. Short, D. Graefe, and C. Schoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem* (New York: The Commonwealth Fund, Nov. 2003).

4. P. F. Short, J. Cantor, and A. Monheit, "The Dynamics of Medicaid Enrollment," *Inquiry*, Winter 1998 25(4):504–16.

5. L. Ku and D. C. Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families* (New York: The Commonwealth Fund, Dec. 2002).

6. T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).

7. Sec. 1311(d)(4), pp. 58–59; Commonwealth Fund Health Reform Resource Center, What's in the Affordable Care Act? (Public Law 111–148 and 111–152), www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

8. Sec. 1312(f), pp. 65–66.

9. Sec. 36B(c), pp. 97–98.

10. Sec. 1411(a), p. 106.

11. Sec. 36B(b), pp. 96–97.

12. Sec. 1302(d), pp. 49–50.

13. Sec. 36B(b), pp. 95–96.

14. Henry J. Kaiser Family Foundation, *Explaining Health Care Reform: Questions about Health Insurance Subsidies* (Menlo Park, Calif.: Kaiser Family Foundation, April 2010).

15. The standard limits on out-of-pocket spending for all plans will be $5,950 for an individual and $11,900 for a family in 2014, and these limits will grow over time. For people with incomes from 100% to 199% of the federal poverty level, the out-of-pocket limit will be one-third of the standard limit; for people with incomes from 200% to 299% of the poverty level, the limit will be half of the standard limit; and for people with incomes from 300% to 399% of poverty level, the limit will be two-thirds the standard limit.

16. Sec. 1312(a)(2), p. 64.

17. Sec. 1312(f)(2), p. 66.

18. S. R. Collins, K. Davis, J. L. Nicholson, and K. Stremikis, *Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Sept 2010.

19. Sec. 1251, pp. 43–44.

20. Department of the Treasury, Department of Labor, Department of Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," http://www.hhs.gov/ociio/regulations/grandfather/index.html; S. R. Collins, "Grandfathered vs. Non-Grandfathered Health Plans Under the Affordable Care Act: Striking the Right Balance," Commonwealth Fund Blog, June 22, 2010.

21. Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act."

22. Subsidies to cover 65% of the cost of premiums under COBRA were available to workers who were involuntarily terminated from September 1, 2008, to December 31, 2009. The subsidies were available for up to nine months and were extended for people who lost their jobs through May 31, 2010, for a period of up to 15 months. See U.S. Department of Labor, *Fact Sheet: COBRA Premium Reduction,* April 26, 2010, http://www.dol.gov/ebsa/newsroom/fsCOBRApremiumreduction.html; R. R. Bovbjerg, S. Dorn, and J. Macri et al., *COBRA Subsidies for Laid-Off Workers: An Initial Report Card* (New York: The Commonwealth Fund, Dec. 2009).

[23] Sec. 2001(a)(1), p. 153.

[24] Sec. 1331, pp. 81–85.

[25] The penalty increases from $95 or 1% of taxable income in 2014, to $325 or 2% of taxable income in 2015, and $695 or 2.5% of taxable income in 2016.

[26] Sec. 5000A, pp. 126–131.

[27] H. Darling, "Health Care Reform: Perspectives from Large Employers," *Health Affairs,* June 2010 29(6):1220–24.

[28] Sec. 4980H, pp. 135–138.

[29] With the CHIP matching rate currently ranging from 65% to 83%, depending on the state, the increase in federal match scheduled for 2016 means that the program will become mostly a federally funded program, although it will remain a block-grant program and not an entitlement.

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[33] Sec. 1412(b), pp. 289–290.

[34] Sec. 1401(f), pp. 253–255.

[35] Sec. 1402(f)(3), p. 267.

[36] P. F. Short, "Hitting a Moving Target: Income-Related Subsidies for the Uninsured," *Journal of Policy Analysis and Management*, Summer 2000 19(3):383–405.

[37] J. B. Herndon, W. B. Vogel, R. Bucciarelli et al., "The Effect of Renewal Policy Changes on SCHIP Disenrollment," *Health Services Research,* Dec. 2008 43(6): 2086–2105.

[38] Kaiser Commission on Medicaid and the Uninsured, *Expanding Medicaid to Low-Income Childless Adults Under Health Reform: Key Lessons from State Experiences* (Menlo Park, Calif.: Kaiser Family Foundation, July 2010).

[39] Kaiser Commission on Medicaid and the Uninsured, *Enrolling Uninsured Low-Income Children in Medicaid and SCHIP* (Menlo Park, Calif.: Kaiser Family Foundation, Jan. 2009).

[40] Sec. 2002, pp. 414–22.

[41] Sec. 2002, p. 414.

[42] Sec. 2002, p.422.

[43] Sec. 1103a, p. 58; Sec. 1311(c)(5), p. 136.

[44] Sec. 1311(i), p. 150.

[45] Sec. 5000A(b), p. 322.

[46] Additionally, the three-month limit extends across years, so a gap extending from November of one year through February of the next year, for example, will trigger a penalty for all four months—although the person was uninsured for only two months in each year.

[47] Sec. 2708, p. 43.

[48] K. Swartz and T. D. McBride. "Spells Without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry*, Fall 1990 27(3):281–88.

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About the Authors

Pamela Farley Short, Ph.D., is professor of health policy and administration at Pennsylvania State University, where she is also director of the Center for Health Care and Policy Research. She has written extensively on health insurance dynamics, policy strategies for insuring the uninsured, and public and private insurance. Much of her research is concerned with changes in individuals' health, health insurance, income, and employment over time. In 1994, during congressional consideration of national coverage reform, Dr. Short worked in the White House as senior staff economist on health care for the Council of Economic Advisers. She received her Ph.D. in economics from Yale University.

Katherine Swartz, Ph.D., is professor of health economics and policy at the Harvard School of Public Health. Professor Swartz's research interests have long focused on people without health insurance, dynamics of insurance coverage, and ways to increase access to health insurance. She has written two reports on New York's Healthy New York program for The Commonwealth Fund and she is the author of *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do* (Russell Sage Foundation Press, 2006). She is a member of the Institute of Medicine and a past president of the Association for Public Policy and Management. She received her Ph.D. in economics from the University of Wisconsin.

Namrata Uberoi, M.P.H., is a Ph.D. candidate in the department of health policy and administration at Penn State. Ms. Uberoi worked at the Centers for Disease Control and Prevention on the Healthy People 2020 program before enrolling at Penn State University. She holds a master's degree in public health from the University of Florida.

Deborah R. Graefe, Ph.D., is a research associate in Penn State's Population Research Institute. She received her Ph.D. in sociology and demography from Penn State University.

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