EXCHANGE ENROLLMENT

AN OPPORTUNITY FOR REFORM

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COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

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ABOUT US

The Council for Affordable Health Coverage (CAHC) is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. CAHC members believe that the cost of health coverage is too high and growing too fast. We promote policies that lower health costs through increased competition, informed consumers, and more choices.

CAHC would like to thank Avalere for their help in completing the data analysis comparing the potential and enrolled exchange population contained in this report.

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INTRODUCTION

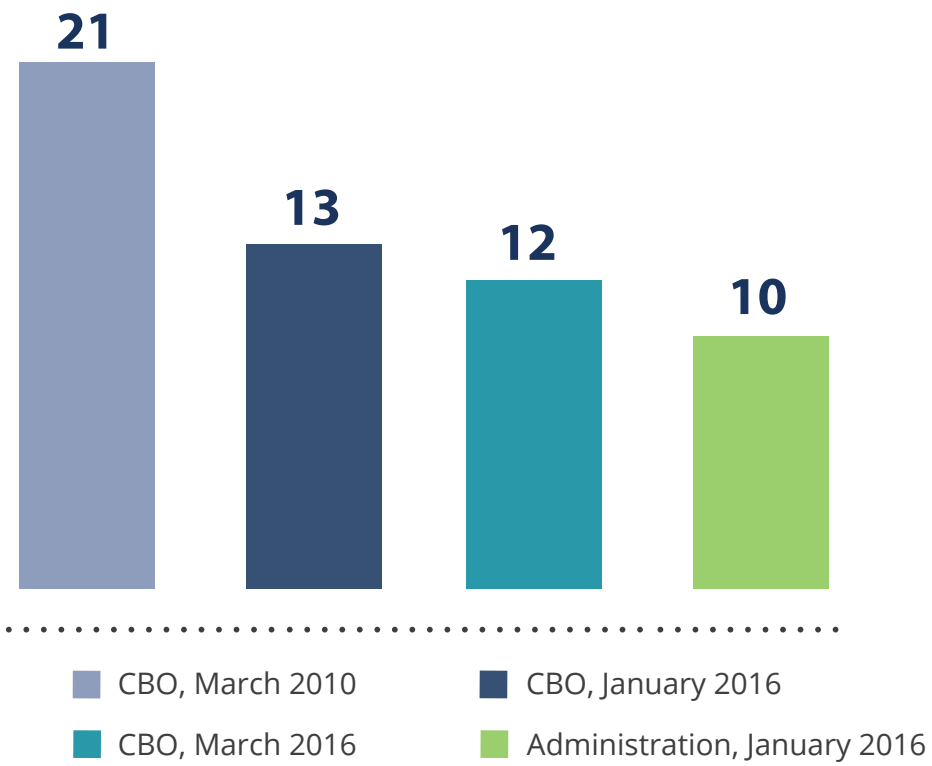
The Affordable Care Act (ACA) created health insurance exchanges to facilitate consumer choice of health plans for individuals, families, and small businesses. Together with the Medicaid expansion, exchanges were projected to help achieve the ACA's goal of near-universal coverage. While exchanges have realized success in helping expand access to care for millions of Americans, enrollment has fallen well short of projections. This issue brief explores current exchange enrollment trends, compares the demographics of current exchange enrollment to expectations, and considers recommendations that could increase coverage.

THE NUMBER OF INDIVIDUALS ENROLLED IN EXCHANGES IS LOWER THAN ORIGINALLY PROJECTED

To date, exchanges have not achieved the level of enrollment projected when the ACA was enacted in 2010. Specifically, in March 2010, the Congressional Budget Office (CBO) projected that 21 million individuals would enroll in exchanges by 2016.[i] Since that time, the CBO has downgraded its 2016 estimates to 13 million and 12 million in its January 2016 and March 2016 projections, respectively.[ii, iii] The Obama Administration projects enrollment below CBO's estimates. Indeed, as shown in Figure 1, the Administration projects that 10 million people will be enrolled in exchanges by the end of 2016.[iv]

Figure 1

2016 ENROLLMENT PROJECTIONS, IN MILLIONS

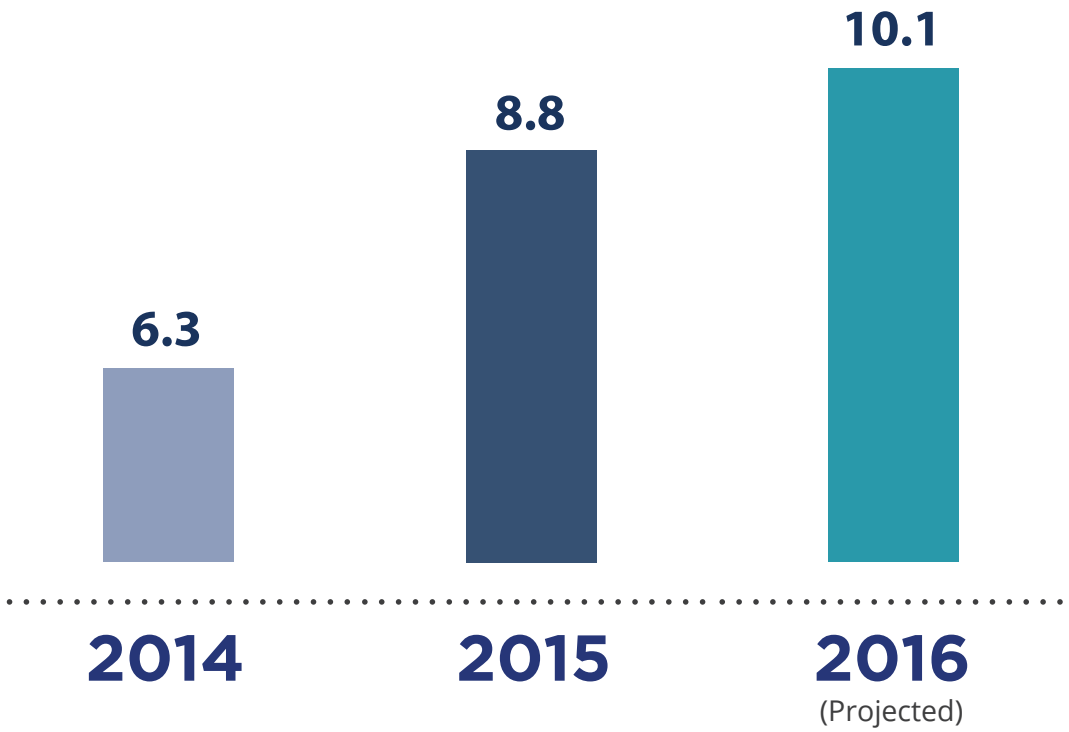


Source: Avalere Analysis, May 2016

While enrollment has grown each year—from 6.3 million enrollees in 2014, to 8.8 million in 2015, and a projected 10.1 million in 2016—enrollment is likely to be less than half of what was originally projected by the ACA.[v]

Figure 2

YEAR-END EXCHANGE ENROLLMENT, IN MILLIONS



Source: Avalere Analysis, May 2016

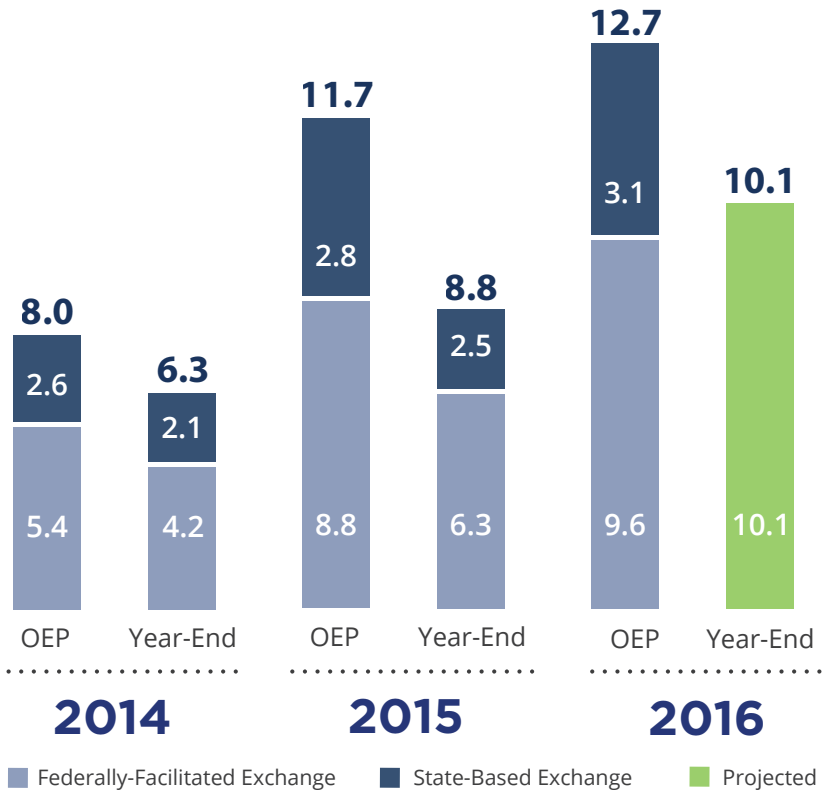
There are a variety of factors that may contribute to lower-than-projected exchange enrollment, including more individuals than expected retaining their previous sources of coverage (e.g., employer-sponsored coverage, off-exchange individual market coverage).[vi] In addition, the individual mandate penalty may be too low relative to the cost of coverage for some individuals to attract enrollment, particularly for middle-income, healthy individuals.[vii] Exchange coverage may simply be too expensive for people to afford without a premium or cost sharing subsidy. Finally, the early technological glitches associated with the launch of exchanges, the lack of education around the availability of financial assistance, and language barriers, may also dissuade consumers from enrolling.

EXCHANGE ATTRITION IS NEAR 20 PERCENT

One factor driving lower-than-expected exchange enrollment and threatening market stability is the sizeable number of individuals who select a plan but who do not pay their first month's premium or stay enrolled throughout the course of the year. As shown in Figure 3, exchanges face significant attrition throughout the plan year.[viii] In fact, enrollment at the end of the year is typically about 20 percent lower than at the close of the annual open enrollment period (OEP).[ix] This figure also accounts for consumers enrolling through special enrollment periods (SEP) throughout the year. In the first half of 2015, approximately 940,000 individuals enrolled in exchange coverage through a SEP, most often due to loss of other coverage (50 percent of consumers) or ineligibility for Medicaid/CHIP coverage (19 percent).[x]

Figure 3

2014, 2015, AND 2016 EXCHANGE ENROLLMENT, END OF OEP AND YEAR-END ENROLLMENT, IN MILLIONS



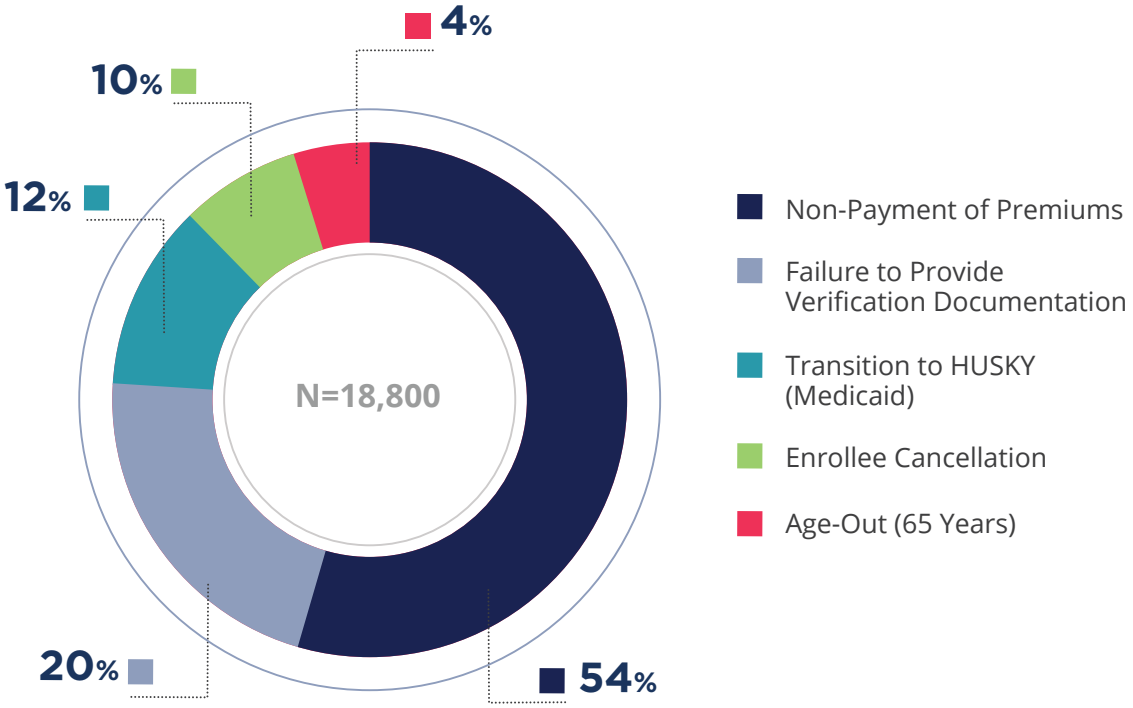
Source: Avalere Analysis, May 2016

In some cases, attrition is a result of individuals securing other forms of coverage, such as employer-sponsored insurance. In many cases, however, individuals stop paying insurance premiums mid-year. National data is not publicly available on this trend. However, for example, in Connecticut, the majority (54 percent) of the approximately 19,000 disenrollments following the 2016 OEP were due to non-payment of premiums. As shown in Figure 4, another 20 percent were due to failure to provide verification documentation. In addition, 12 percent of enrollees transitioned into Medicaid coverage and 10 percent requested a cancellation of coverage, often due to securing other forms of coverage or moving out of state.[xi]

Figure 4

2016 DISENROLLMENT BY REASON, CONNECTICUT EXCHANGE

AS OF APRIL 21, 2016



Source: Access Health CT, April 2016

HISPANICS AND HIGHER INCOME POPULATIONS ARE UNDERREPRESENTED IN EXCHANGES

In addition to overall enrollment figures falling below projections, certain populations are underrepresented in the market relative to the population who could potentially choose exchange coverage. In particular, the exchange-enrolled population is disproportionately older and lower-income, as compared to the potential exchange population.[1] In addition, males and Hispanics have enrolled at lower rates. These findings reinforce the need for targeted outreach efforts to better attract underrepresented populations and consideration of other exchange reforms that could expand the population enrolled.

METHODOLOGY

To evaluate exchange enrollment across demographic groups, the following analysis examines the pre-ACA "potential" exchange population relative to the population that enrolled. The potential population includes individuals who were uninsured or who purchased health insurance in the non-group market in 2013, prior to the implementation of the exchanges.[1]

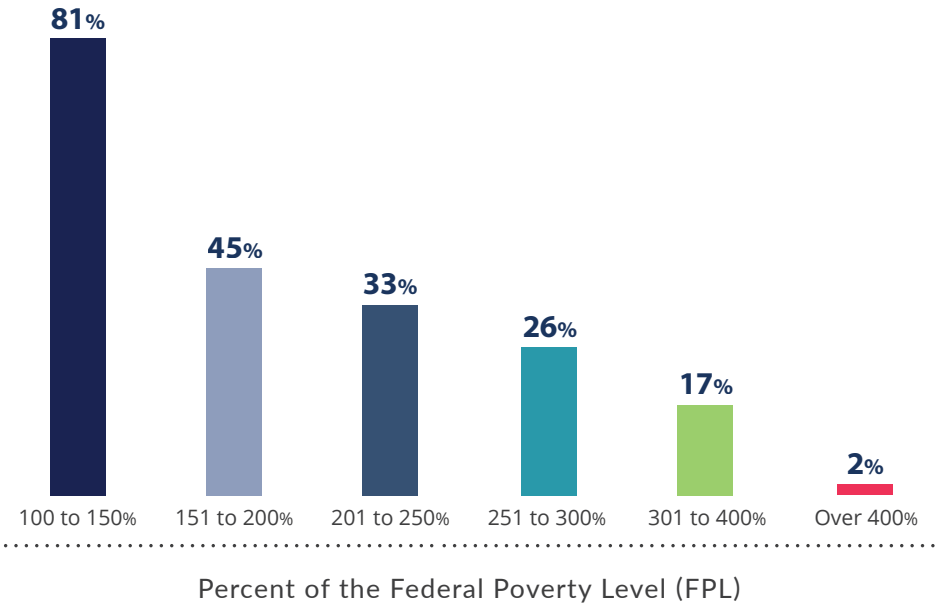
[1] The potential population includes individuals without employer-sponsored coverage, Medicare, or Medicaid in 2013; specifically, those who were uninsured or who purchased health insurance in the non-group market in 2013, prior to the implementation of the exchanges.The analysis includes the 38 states relying on healthcare.gov in 2016, and considers state Medicaid expansion decisions in determining eligibility for exchange coverage. This analysis does not account for citizenship status.

INCOME

While eligibility for exchange subsidies is limited to individuals between 100 percent ($11,880 in 2016) and 400 percent ($47,520 in 2016) of the federal poverty level (FPL), exchanges were projected to enroll both subsidized and non-subsidized individuals, including subsidized individuals at various incomes along the eligibility scale. However, as shown in Figure 5, exchange participation rates decline dramatically as incomes increase and subsidies decrease. Specifically, exchanges have enrolled more than 80 percent of the potential exchange population with incomes below 150 percent of the federal poverty level (FPL), but only 2 percent of individuals with incomes above 400 percent of the FPL. In addition, only 17 percent of potential exchange enrollees with incomes between 301 and 400 percent of the FPL selected coverage through an exchange, even though they may be eligible for premium subsidies.

Figure 5

PERCENT OF POTENTIAL EXCHANGE POPULATION MAKING MARKETPLACE PLAN SELECTIONS IN 2016, BY INCOME



Source: Avalere Analysis, May 2016

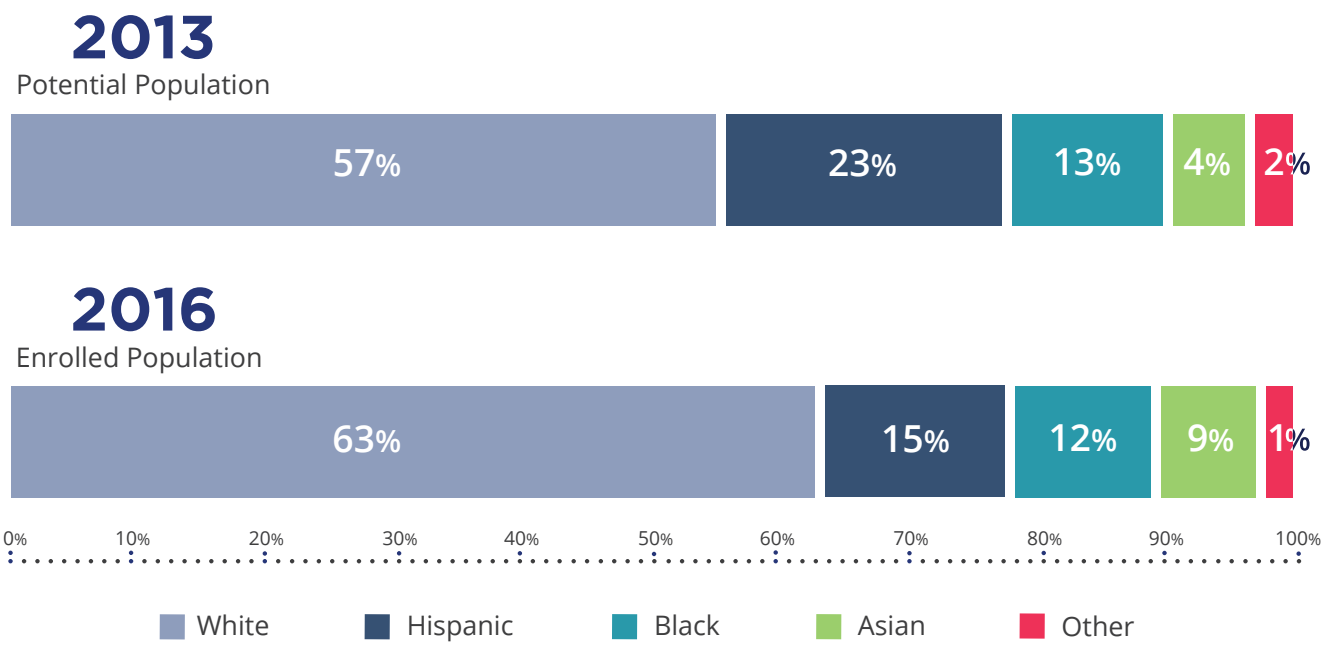
Consumers with lower incomes have the greatest incentive to enroll in coverage, since they benefit from higher subsidies and more generous coverage. To ensure the sustainability and stability of the exchange market into the future, exchanges will need to attract individuals across income levels.

RACE AND ETHNICITY

The population enrolled in exchanges does not represent a proportionate distribution of individuals across races and ethnicities in the target exchange population. As shown in Figure 6, a significant portion of Hispanics have not enrolled in exchange coverage, while White and Asian populations have enrolled at higher rates.[2] While Hispanics have experienced the largest increase in coverage among racial and ethnic groups under the ACA, millions still remain uninsured.[xiii, 3]

Figure 6

2013 POTENTIAL EXCHANGE POPULATION VS. 2016 ENROLLED POPULATION, BY RACE/ETHNICITY



Source: Avalere Analysis, May 2016

[2] CMS updated the methodology for identifying Latinos applying for 2016 coverage by incorporating the selection of "Other" ethnicity as Latino. Specifically, all consumers who selected "Other ethnicity" on their application are now counted as Latino. This has led to an increase in the number of reported Latinos compared to previous years.
[3] Estimates indicate over 20 percent, or 10.8 million, of Hispanics remain uninsured and also comprise a large proportion of unauthorized immigrants, who are ineligible for Medicaid or exchange coverage.[xvii]

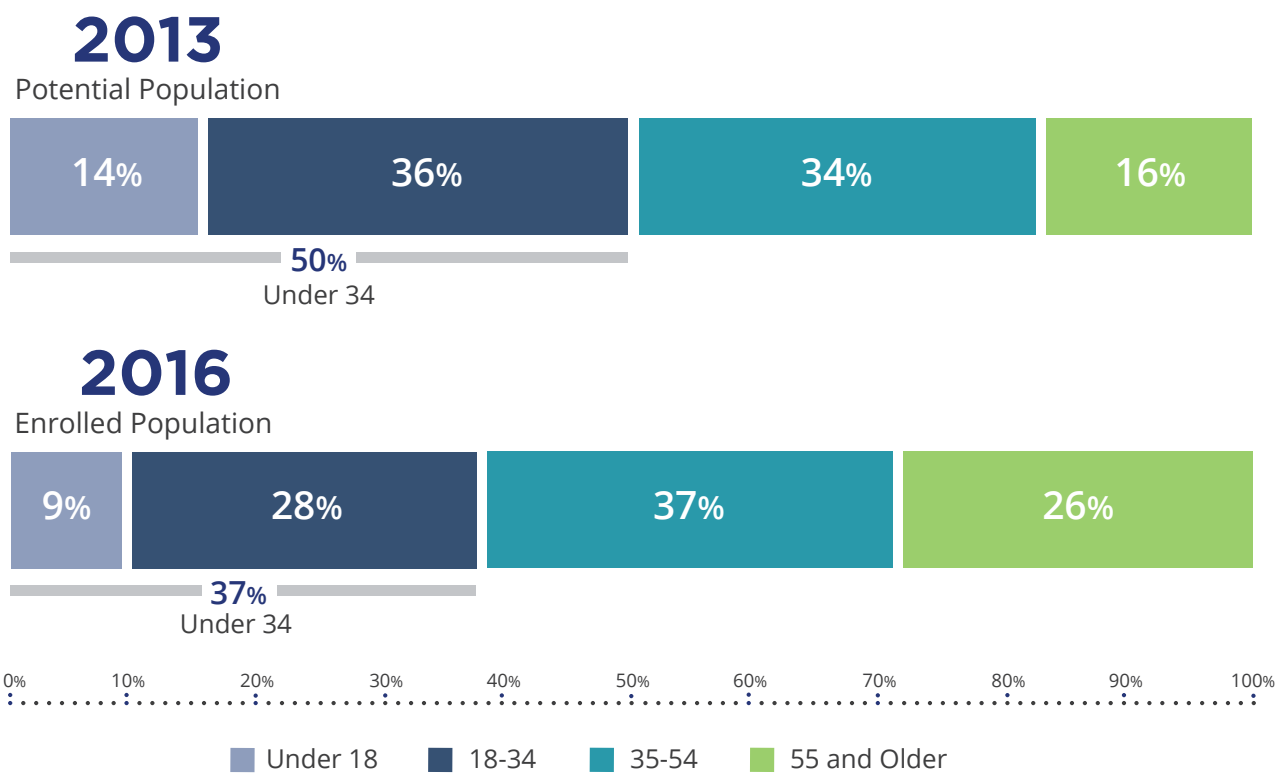
AGE

As shown in Figure 7, exchange enrollees are older than the available exchange population. Specifically, individuals 55 years and older comprise more than one-quarter (26 percent) of exchange enrollees compared to 16 percent of the target population. While half (50 percent) of the potential exchange population was under the age of 35, only 37 percent of 2016 exchange enrollees are in that age bracket.

Young adults, commonly characterized as "young invincibles," often consider themselves healthy with few perceived health needs and therefore forgo purchasing health insurance.[xiv] In order to grow and balance the market moving forward, exchanges will likely need to better attract and retain younger enrollees.

Figure 7

2013 POTENTIAL EXCHANGE POPULATION VS. 2016 ENROLLED POPULATION, BY AGE



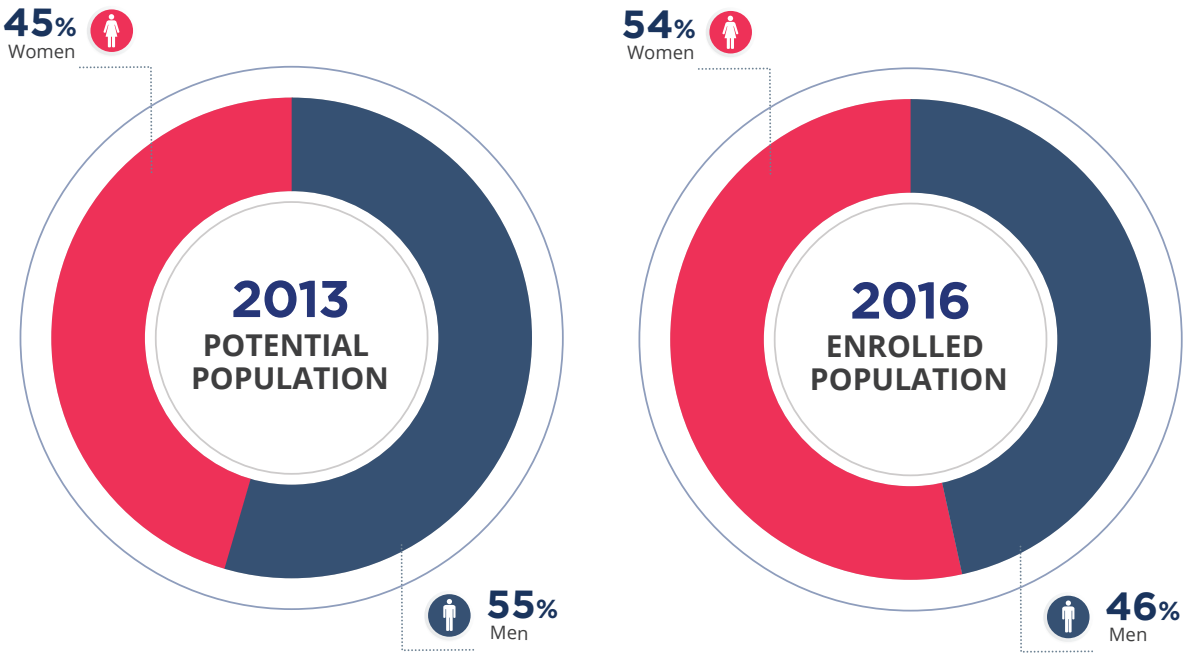
Source: Avalere Analysis, May 2016

GENDER

Additionally, many men eligible to enroll in exchange coverage have not yet picked a plan. As shown in Figure 8 below, women comprise just 45 percent of the potential exchange population; however, 54 percent of 2016 enrollees are female. Research indicates that women utilize more healthcare services than men and also tend to be the healthcare decision-makers for themselves and their families.[xv, xvi] As a result, it is likely that future outreach efforts will need to target men specifically.

Figure 8

2013 POTENTIAL EXCHANGE POPULATION VS. 2016 ENROLLED POPULATION, BY GENDER



Source: Avalere Analysis, May 2016

ADDITIONAL REFORMS COULD IMPROVE THE FUNCTIONALITY AND SUSTAINABILITY OF THE EXCHANGE MARKET

As a result of low exchange enrollment and other factors, such as coverage gaps created in states that have not expanded Medicaid under the ACA, approximately 33 million people in the U.S. remain uninsured. More than one-third of this population, or 11 million individuals, may be eligible to enroll in exchange coverage, and most of these individuals will also qualify for exchange tax credits.[xvii] This presents a significant opportunity to grow and balance the market and to extend coverage to millions of eligible, but currently uninsured, individuals.

In addition to traditional enrollment and outreach efforts, policymakers may consider improvements to exchange functionality as a means of increasing enrollment, reaching new and underrepresented populations, and reducing taxpayer and per enrollee subsidy costs.

CAHC encourages policymakers to consider what the next generation of exchanges might look like. Currently, most exchange functions, such as providing premium subsidies, are exclusively provided by the federal and state governments. We suggest ending this public monopoly and allow the private sector to take on more responsibility for certain exchange functions. Specifically, the Next Generation Exchange Model consists of four parts, as outlined below.

Figure 9

NEXT GENERATION EXCHANGE MODEL

NEXT GENERATION EXCHANGE MODEL

Private shopping websites that compete directly with public websites for consumers based on the user experience and key-decision support tools, such as out-of-pocket cost calculators, plan finder tools to prioritize and quickly highlight best-fit options, integrated and searchable provider networks and drug directories, and easy-to-understand cost information for common services and procedures.

A modern subsidy process that allows the federal government to contract with at least one private vendor to set-up a "PayPal"-like system for subsidies. A "PayPal"-like icon would be displayed on each shopping website. Consumers could use this icon to create an online account and input necessary information, such as income. The system would interface with federal/state programs to verify a consumer's ability to purchase health insurance coverage on the exchange, determine eligibility for programs like Medicaid or CHIP, and determine the consumer's eligibility for premium subsidies. Once the consumer has selected health insurance coverage and is ready to make a purchase online, he or she could click on the PayPal-like icon and use that subsidy to make a purchase. This would allow subsidies to become portable so that low-income consumers could purchase coverage from any website.

Simplified small employer shopping that would allow small employers to purchase traditional small group coverage on private shopping websites. In addition, processes could be improved to create administrative efficiencies for employers. For example, systems could be improved to allow employers to upload demographic information in a single file that could be used to facilitate enrollment across multiple issuers.

A revamped state certification process whereby each state would certify that there is at least one website that allows for the purchase of health insurance, shows the pricing of all insurers offering individual market and small group coverage in the state, and offers a "PayPal"-like system for subsidies.

CONCLUSION

While the ACA exchanges have upped their e-commerce game since 2014, most still lag behind the state of the art. In the recently closed open enrollment season, only three exchange websites (out of 14 total) allowed consumers to quickly search and identify plans that cover their prescribed medications. Only six allowed consumers to identify those plans with their favorite doctors covered in-network. Only seven had easily accessible out-of-pocket cost calculators designed to compute expected annual outlays—each with questionable dependability.

Fortunately, the private sector is already shifting its focus to these areas. For example, employers increasingly are turning to private exchanges, which are helping to both bring the focus back to consumer empowerment and foster more predictable costs for employers. New software apps now make it possible to match enrollees with those plans best-suited to their unique preferences and needs—which is one key to improving satisfaction with insurance coverage while also making access to health care more affordable for patients.

Will Congress and the Administration follow the private sector's lead? Considering current exchange enrollment, what do we have to lose?

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