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POLICY BRIEF

The Promise of the Affordable Care Act, the Practical Realities of Implementation:

Maintaining Health Coverage During Life Transitions

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This brief is the second in a series discussing seamless health care insurance coverage for families lacking coverage due to work or life transitions. Our initial brief, Maximizing Health Care Enrollment through Seamless Coverage for Families in Transition: Current Trends and Policy Implications (*by Ken Jacobs, Laurel Lucia, Ann O'Leary, and Ann Marie Marciarille, released in March 2011), reviewed the literature on the prevalence of uninsurance caused by work or life transitions, and provided initial policy recommendations. In this brief, we provide a more detailed set of recommendations for state and federal policymakers on how best to ensure seamless health coverage under the Affordable Care Act for individuals and families who lose health insurance because of a work or life transition.*

INTRODUCTION

The promise of the Affordable Care Act (ACA) is that if someone loses a job or gets divorced, they can still have affordable health coverage. If someone is forced to retire early for whatever reason, they don't have to wait for Medicare to get health coverage. If a young adult graduates from school and is no longer covered on a parent's plan, and she does not have a good job with benefits, she will not be left without health insurance.

Making this promise a reality is one of the key challenges of implementation. Past experience with the state Children's Health Insurance Program (CHIP), Medicaid expansions, the recent implementation of

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the federal high risk pools (PCIP), and other public programs demonstrates that while outreach and education are essential, such efforts alone are not sufficient to assure that those eligible will enroll in the program. In contrast, very high proportions of those eligible for job-based coverage enroll (over 80% of those eligible)[1] and even higher proportions of those eligible for Medicare enroll (95% or higher).[2]

Why is take-up of employment-based coverage and Medicare so much higher? Two major factors are the automatic or nearly automatic nature of enrollment, and the widespread knowledge of the availability of benefits. In the case of employment-based coverage, the institutional connection between employer and employee facilitates take-up. Payment is done through a payroll deduction and enrollment is simple and generally occurs at the time of initial employment. For Medicare Part B, individuals are automatically enrolled when they turn 65, unless they return a form declining coverage.[3] Eligibility is straightforward, there is no income test to qualify, and there is widespread cultural knowledge about the program. Most Americans know that people over age 65 get Medicare.

This policy brief is one element of an implementation effort designed to ensure that individuals who lose employment-based insurance or for whom insurance in the individual market is no longer affordable can easily transition to other coverage. This brief builds on earlier efforts to provide seamless coverage among public programs, but recognizes that less work has been devoted to maintaining health coverage in the private insurance markets.[4] The policy work behind this paper began with this question: How can implementation of the Affordable Care Act build on institutional connections and develop widespread cultural knowledge of the availability of coverage during life transitions that precipitate the loss of private coverage?

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EXECUTIVE SUMMARY

Americans' health insurance coverage is not static. People cycle in and out of coverage and between sources of coverage. Gaps in coverage have real effects on American families; even short bouts of uninsurance can have long-term impacts on health and family finances.

Loss of coverage frequently coincides with life transitions like losing a job, changing jobs, moving, or divorce. The main option for those who lose employment-based coverage, COBRA, is often priced out of reach for families that have suffered a major loss of income.

The Affordable Care Act creates an unprecedented opportunity to address the gaps in health coverage caused by life transitions. Achieving this promise will require attention in federal regulations and actions by the new health insurance exchanges as well as public health coverage programs, particularly Medicaid and the Children's Health Insurance Program (CHIP). Just as the ACA relies on the health insurance exchanges as a single portal to connect individuals to the exchanges, Medicaid, and CHIP, throughout this paper we refer to the "exchanges" in discussing how to connect those who lose employment-based coverage to subsidized and unsubsidized coverage through the exchange as well as Medicaid/CHIP. While we mainly focus on the loss of employment-based coverage, the same considerations will hold for people who purchase coverage in the individual market outside of the exchanges and later face changing economic or life circumstances that make them eligible to receive subsidized coverage through the exchanges.

This paper makes the following policy recommendations to ensure that all Americans can maintain health coverage under the ACA—even during complicated life transitions:

Use existing institutions to inform Americans about—and enroll them in—the health insurance exchanges.

The triggering events that cause people to lose employer-based coverage often put them into contact with institutions that can serve as gateways for enrollment into the health insurance exchanges. These include: the insurance company terminating coverage, the unemployment insurance system or other public programs, the educational system, state and local courts in the case of divorce, and departments of motor vehicles for those who move. Auto-application systems should be implemented by partnering with these institutions where possible.

Ensure individuals are able to make informed choices between COBRA and the health insurance exchanges, and can access the exchanges with no gaps in coverage.

Consumers must be informed of the option of enrolling in COBRA or the exchanges at the time of loss of coverage, and be provided the tools to determine the best choice for their family. Entities currently required to provide COBRA notification should be required to provide similar notification about the

availability of health coverage through the exchanges. Individuals who drop COBRA should be able to take-up coverage in the exchange, and do so without a gap in coverage. State should ultimately encourage insurers to offer plan options within the exchanges with similar provider networks to the most common group plans to ensure continuity of care.

Protect families from having to make unanticipated repayments to the IRS.

The ACA uses advance tax credits to make health insurance widely affordable, but requires that individuals refund the government if their income increases during the year. The health insurance exchanges should provide tools to families to best determine subsidy amounts at the time of initial application, re-determination for the subsequent calendar years, and re-determination during the year due to changes in circumstances. Exchanges should educate enrollees about the importance of promptly reporting changes in income, and consider the use of government data sources to trigger reminders.

BACKGROUND

It is well-documented that one of the major sources of gaps in health insurance coverage is work or life transitions that lead to the loss of employment-based coverage, including unemployment, a reduction in work hours, divorce, widowhood, and aging off of one's parents' coverage.[5] Individuals who lose employment-based insurance risk having a gap in coverage as they transition to a new health plan. In addition, they risk an interruption in the continuity and quality of health care resulting from changing health plans or providers. Both problems lead to negative health outcomes as well as the risk of serious financial consequences.

The Patient Protection and Affordable Care Act of 2010 (ACA) aims to address these gaps in coverage in several ways, including by providing individuals with affordable coverage options when they are without employment-based coverage, and by requiring states to create single points of entry and seamlessness between public programs and the health insurance exchanges. A major emphasis of the ACA and the accompanying state implementation efforts is to ensure seamlessness primarily among public health programs, such as Medicaid and CHIP, and the health insurance exchanges. This policy brief will argue that, in addition, the federal government and states must work together to ensure seamlessness for those individuals shifting from employment-based coverage or coverage in the individual market to the new health insurance exchanges and the re-invented Medicaid program.

This brief will start with a review of the data establishing that individuals facing major life transitions such as unemployment or the shift from full-time to part-time work often lose health coverage and will be in need of assistance from the health insurance exchanges. In order to maximize enrollment in coverage, the federal regulations and state policies must provide for notice and create mechanisms to proactively enroll these individuals in the health insurance exchanges or relevant public program. One policy challenge will be to ensure that individuals who are experiencing a major work or life transition that results in a loss of coverage are informed of their options, and understand the pros and cons of maintaining coverage through COBRA versus enrolling in insurance through the exchanges, both subsidized and unsubsidized. Finally, given that life transitions are also associated with income volatility, individuals will need to be assisted to ensure the subsidies they may receive are adequate to enable them to purchase coverage at a time of economic hardship without creating undue liability for repayment when they file their taxes in the subsequent year, or to assist in enrolling in Medicaid if eligible.

We will make recommendations for federal regulations that minimize barriers to access and affordability along with state policies to build the architecture needed to create seamlessness between private coverage (both employment-based coverage and individual coverage) and the health insurance exchanges (or other state subsidized health programs).

State Public Health Insurance Programs and Public Subsidies for Private Coverage: An Eligibility Roadmap

Under the ACA, affordable coverage will be provided through a multitude of public programs and the health insurance exchanges. Starting in 2014 those adults and families without employment-based coverage will be able to access health insurance through:

Medicaid: Beginning January 1, 2014, federal law will require coverage of all individuals under age 65 (children, parents, and childless adults) with incomes *at or below 133 percent of the FPL* regardless of disability or other categories.[6] The result is an increased number of individuals eligible for Medicaid. By 2016, approximately 16 million additional Americans will qualify for the expanded Medicaid program and CHIP.[7]

Subsidized Coverage through Health Insurance Exchanges: Individuals without an offer of affordable employment-based coverage will be able to obtain private health insurance through health insurance exchanges. In a state that does not create a Basic Health Plan, adults over age 18 with incomes 133–400 percent of the FPL will be eligible for cost-sharing and premium subsidies. Children under age 18 with incomes 133–400 percent of the FPL will be eligible either for CHIP or exchange subsidies (see below). Adults and children above 400 percent of the FPL will be able to purchase private coverage through the health insurance exchanges, but will not be eligible for subsidies.

Premium tax credits (provided in advance in order to allow individuals to purchase health insurance when they need it) will be available to those individuals who purchase health insurance through the exchanges, earn up to 400 percent of the FPL, and are not otherwise eligible for other coverage.[8] The tax credits will be available on a sliding scale based on income, providing limits on the percentage of income that people are required to pay for their health premiums for the year.[9] The credits are designed to reduce the premium payments to a pre-determined percentage of participants' annual income. Additional subsidies will reduce the out-of-pocket costs (such as co-payments and deductibles) to further reduce the financial burden on individuals receiving health care. By 2016, approximately 18 million Americans will qualify for such subsidies through the exchange.[10]

Unsubsidized Coverage through Health Insurance Exchanges: Individuals without an offer of affordable employment-based coverage and with incomes above 400 percent of the FPL will also be able to obtain private health insurance through the exchanges. The extent to which higher income individuals do so is expected to vary by state and over time, depending on the nature of the market outside the exchange as well as the ability of the exchange to provide insurance products and customer service appealing to higher income individuals who lack employment-based coverage.

Basic Health Plan: Adults *between 133–200 percent of the FPL* could qualify for coverage through the proposed Basic Health Plan (BHP) if a state chooses to adopt such a plan.[11] States choosing to do so will receive 95 percent of what the federal government would have paid for their coverage through the exchange.[12] The remaining 5 percent would presumably be covered by subscriber premiums or by reducing provider reimbursement.[13] A state could choose to administer a Basic Health Plan as an extension of its Medicaid program or as a third program administered by the exchange, along with the individual market exchange and the SHOP exchange.[14]

Public Programs for Children: Children in low and moderate income families may qualify either for Medicaid or the Children's Health Insurance Program (CHIP). In some states, the CHIP program operates as a Medicaid extension. In other states, such as California, there is a separate CHIP program (Healthy Families). Income eligibility varies from state to state in terms of both the minimum income eligibility for the CHIP program as well as the upper limit on income eligibility. In addition, in many states income eligibility varies by age so that a family may have one child in Medicaid and another child in CHIP.

A FOCUS ON WHO IS LOSING COVERAGE AND THE IMPLICATIONS FOR THE HEALTH INSURANCE EXCHANGE

"The uninsured" is not a static population. A study by the U.S. Treasury estimates that nearly half of the non-elderly population can be expected to go without coverage for some period of time over a decade.[15] Individuals may go on and off coverage for a variety of reasons, including gain or loss of employment, changes in income, moving, and changes in family status.

Many people cycle in and out of coverage over a short period of time. One-half to two-thirds of those who are uninsured in any given year move into or out of coverage in that year.[16] In Massachusetts, approximately one-quarter of individual market enrollees in the state's health insurance exchange, the Connector, enrolled and terminated their coverage within 12 months.[17]

This is a major design challenge for exchanges: individuals can be expected to shift between the employment-based insurance market and the exchanges, and to do so for varying lengths of time. Many will remain in the exchange for less than a year during a transitional period. For others it will be their stable source of coverage for a number of years. This has important implications for the health insurance exchanges across a wide range of issues, from the design of the eligibility and enrollment system to the plan choices and provider networks.

Understanding the prevalence of the life transitions that lead to loss of coverage can help determine how policy interventions could be targeted to most effectively ensure maintenance of coverage following these transitions.

New research by economist Lara Shore-Sheppard of Williams College identifies the prevalence of life transitions at the time of health insurance loss. She analyzed the incidence of certain transitions among those who have lost coverage and those who maintain coverage. The analysis is based on a sample of adults ages 19–64 using 2002 data from the 2001 Survey of Income and Program Participation (SIPP) by the U.S. Census Bureau. Although the SIPP does not directly identify the cause of coverage loss, Shore-Sheppard's analysis indicates the changes that occurred in an individual's life around the time of the loss of coverage.

Shore-Sheppard finds that over the year, 76.6 percent of the individuals surveyed were always insured, 8.4 percent experienced at least one loss of coverage, 10.4 percent were never insured, and 4.6 percent gained coverage. As shown in Table 1, a loss in coverage frequently coincided with job loss, change in employment, or moving. Among months in which a coverage loss was observed, 16.2 percent of individuals had lost a job in the past four months, 22.9 percent were in families in which any family member lost a job, and 14.2 percent were in families in which the owner of insurance lost a job. Other common life transitions observed during the four months prior to a coverage loss were changing employers (14.0%), moving (9.6%), and switching from full-time to part-time work (9.0%). The likelihood of having lost a job, changed employers, or moved was significantly lower in months in which a coverage loss was not observed, but the

Table 1. Incidence of Life Transitions

	Life transition in past 4 months	Month in which a coverage loss was observed	Month in which a coverage loss was not observed
Any family member	Lost job	22.9%	10.1%
Owner of insurance	Lost job	14.2%	2.5%
Individual	Lost job	16.2%	4.6%
	Changed employers	14.0%	5.4%
	Moved	9.6%	5.5%
	Switched to part-time work	9.0%	7.2%
	Not re-enrolled	5.3%	3.3%
	Divorced	0.4%	0.3%
	Widowed	0.2%	0.1%

Source: Lara Shore-Sheppard, unpublished article "Correlates and Triggers of Losing or Changing Insurance" based on analysis of 2002 data from the 2001 Survey of Income and Program Participation (SIPP) by the U.S. Census Bureau.

NOTE: This data predates the Great Recession; transitions are likely to be greater during economic downturns.

likelihood of having switched from full-time to part-time work was relatively similar regardless of whether or not a coverage loss was observed.

For those individuals whose incomes would qualify them for either a public health insurance program or health insurance premium subsidies in the health insurance exchange, income fluctuations are quite dramatic even in non-recessionary times. People who purchased insurance in the individual market may find the cost of that coverage out of reach and will need access to subsidized coverage through the exchange in order maintain insurance. Individuals covered through the exchange may experience changes in both program eligibility and subsidy eligibility due to income fluctuations.

The Commonwealth Fund recently analyzed data from the Survey of Income and Program Participation (SIPP) and found that there is great fluctuation from year to year for individuals who would qualify for varying public programs or subsidies through the health insurance exchange.[18] The data show that in non-recessionary times (from 2005 to 2006), 17 percent of individuals who had been eligible for subsidized health coverage through the exchange would lose their eligibility due to an increase in family income (15 percent if the state has a Basic Health Plan) and another 14 percent who had not been eligible due to family incomes above the income threshold would become eligible either for subsidized coverage through the exchange (12%), the Basic Health Plan (1%), or Medicaid (1%), (Table 2). The majority of individuals who would be income-eligible for subsidies would remain in the same income level category, but many of these individuals could experience income fluctuations within the 133–399 percent FPL income range that would change the level of subsidies for which they are eligible.

Table 2. Income Fluctuations by Percent of Federal Poverty Level

Year 1	Year 2						
Income Level	No Change in Income	Decreases in Income ↓			Increases in Income ↑		
		Below 133%	133–199%	200–399%	133–199%	200–399%	Above 400%
Below 133% of FPL	76%				16%	7%	1%
133–199% FPL	51%	17%				30%	2%
200–399% FPL	73%	3%	9%				15%
Above 400% FPL	87%	1%	1%	12%			

Source: Table created by authors based on data from Pamela Farley Short, et al., *Realizing Health Reform's Potential: Maintaining Coverage, Affordability and Shared Responsibility When Income and Employment Change*, THE COMMONWEALTH FUND, May 2011.

The data underscore that the health insurance exchange participants should not be thought of as a stable population. While many will continue from year to year, others will transition in and out of the exchange due to changes in employment status, family status, or income, while others will move up and down on the scale of subsidy eligibility.

THE PRACTICALITIES OF IMPLEMENTATION: HOW TO CONNECT INDIVIDUALS TO COVERAGE?

The availability and affordability of health coverage is the first step in providing coverage to individuals who would otherwise be uninsured. But it is only a first step. We posit that the following must occur for eligible individuals to obtain coverage through the exchanges or Medicaid/CHIP:

- Coverage must be available and affordable. The ACA provides for this with various limits and constraints.
- Individuals must be aware that coverage is available and affordable. The ACA provides for outreach and education. We suggest numerous instances in which notice to those affected by a life transition or loss of coverage is appropriate and necessary to build awareness of the availability of health insurance exchanges and a re-invented Medicaid program.
- Individuals must have the opportunity to connect to coverage. The ACA begins this work by providing for a web portal and real-time determination of eligibility but there is much more to do in state and federal implementation to enroll people who would benefit from coverage.
- Individuals must understand the implications of their choices. The ACA creates a framework for accomplishing this through the web portal, navigators, and other devices; we suggest that among

Health Coverage Options Prior to 2014: COBRA, Private Insurance, and Public Programs

Prior to the 2014 effective date of most of the ACA provisions, individuals who lose employment-based coverage have limited options for continuing health coverage: (1) use COBRA to maintain existing coverage through an employer's group health insurance plan, and pay the full cost of the insurance premium; or (2) find an alternative form of insurance such as through a spouse's plan, the individual health insurance market, or a public program such as Medicaid or CHIP. Many individuals are not eligible for coverage through these options, because they are not eligible for COBRA, dependent coverage, Medicaid or CHIP, or they are denied private insurance coverage in the individual, non-group market. Even among those who are eligible for other coverage, many cannot afford coverage, whether it is the spouse's share of the premium or the full cost of the premium for COBRA or individual coverage. This will change significantly under the ACA.

COBRA

COBRA (or the Consolidated Omnibus Budget Reconciliation Act) was enacted in 1986 to address the disproportionately high cost of purchasing individual insurance compared to insurance purchased through a large group, usually an employer.[19] This high cost, and a general lack of portability of coverage from employer-to-employer, made it difficult for individuals transitioning between jobs to maintain health coverage.[20] COBRA's solution is to provide many (but not all) employees (and their spouses and dependent children) with a right to coverage at the group rate secured by their employer if they experience a "qualifying event."

Eligibility: COBRA only applies to coverage provided by group health plans for employers with 20 or more employees. Many states, including California, have laws similar to COBRA which apply to employers with fewer than 20 employees.[21]

A qualified beneficiary is, generally speaking, an employee (or dependent of an employee) receiving eligible plan coverage on the day of a qualifying event. Employees (and their dependents) that are not covered on the date of a qualifying event are not eligible for COBRA. For employees, qualifying events include termination of employment for reasons other than gross misconduct, and the reduction in the number of hours of employment. Other qualifying events include those for spouses—the termination or reduction in hours of a spouse who is a qualified beneficiary, the person's spouse becoming eligible for Medicare, divorce, separation, or death of a spouse who is a qualified beneficiary. Dependent children that lose their dependent status can also use COBRA to maintain their coverage. COBRA is not available if an employer no longer offers coverage or goes out of business.

Duration: Individuals eligible for COBRA may continue to maintain their group insurance for 18 to 36 months depending on the qualifying event.[22] If the loss of coverage was due to a job loss or reduction in hours, the beneficiaries are only entitled to 18 months of continued coverage under the group health plan. If, however, the loss of coverage was due to a divorce, death, or loss of dependent child status, the beneficiary is entitled to 36 months of coverage. In California, all beneficiaries are entitled to 36 months of coverage.[23]

Affordability: Individuals who qualify for COBRA must pay the full cost of the health insurance premiums under the group health plan. Not only have these individuals lost their employer's contribution to offset the cost of their health care premiums, they often have also lost their job or had a significant reduction in their income. As a result, COBRA coverage is often unaffordable to those that are eligible for it.[24]

No subsidies are currently available to assist with payment of COBRA coverage. In 2009 the American Recovery and Reinvestment Act (ARRA) provided premium subsidies for COBRA for a short time. Studies of the subsidy showed that it dramatically increased enrollment in COBRA for those that were eligible to receive it.[25] The program ended in May of 2010 and there are no current plans to provide a similar subsidy program on a continuing basis.

Due to the lack of affordability of COBRA, recent estimates indicate that as few as 14 percent of those eligible for COBRA coverage accept that coverage.[26]

the implications that are worthy of consideration are the choice between COBRA and the exchange (or Medicaid) as well as the consequences of reconciliation in a subsequent tax year.

- Finally, we suggest that, in some instances where there is likely to be a high correlation between an event and lack of coverage or unaffordability of coverage, an application for ACA coverage through an exchange or Medicaid be automatically initiated on behalf of a potentially eligible individual.

OPTIONS FOR MAINTAINING HEALTH COVERAGE DURING LIFE TRANSITIONS UNDER THE ACA

For individuals facing the loss of employment-based coverage due to a major life or work transition, the ACA provides an alternative to COBRA to obtain affordable health coverage: Enrolling in health insurance offered through a health insurance exchange or Medicaid/CHIP, with subsidies scaled to income for those below 400 percent of the federal poverty level.

There are four distinct policy challenges that the federal government and the states must address in helping individuals find and maintain affordable health coverage after losing employment-based coverage:

- First, individuals who are experiencing a major work or life transition, and the resulting loss of coverage, must be informed about the availability of health insurance through the exchanges and the availability of premium and cost-sharing subsidies (or public programs like Medicaid).
- Second, federal regulations and state action must provide notice to those likely to be eligible and create mechanisms to proactively enroll these individuals in the health insurance exchange (or public programs).
- Third, individuals must understand the pros and cons of maintaining their current health coverage through COBRA versus enrolling in insurance through the health insurance exchanges.

Alternative Insurance Options

Individuals who lose employment-based coverage and either are not eligible for COBRA or cannot afford COBRA have limited options for obtaining insurance elsewhere. Some may be able to obtain coverage through a public program, the individual market, or a spouse's employment-based plan. But economists analyzing data from the 1996 Medical Expenditure Survey Panel of the unemployed found that few individuals take up these alternative options.[27]

Less than 1 percent of COBRA-eligible individuals and only 8 percent of all job losers had enrolled in a public health plan within three months of losing a job.[28] One of the reasons for this low-take up is that many individuals are simply not eligible for these programs. Prior to the ACA reforms, public programs for low-income individuals, such as Medicaid, have been available only for parents and children; adults without children under 18 at home are not eligible under most circumstances in most states. Similarly, only 3 percent of COBRA-eligible individuals and 10 percent of all job losers had enrolled in another private health insurance plan.[29] This low take-up is due to the serious barriers in the individual insurance market—barriers that the ACA attempts to address. For example, prior to the ACA, in most states, insurers could deny coverage in the individual market due to pre-existing conditions or impose limitations on coverage that preclude coverage for the pre-existing condition, sometimes indefinitely. Finally, even when an individual has a working spouse with access to job-based coverage, the cost of enrolling in that private coverage may be out of reach.

- Finally, upon entering the exchange individuals must be helped so that they receive the necessary subsidies to purchase coverage but do not become liable for a large amount of repayment at the end of the year due to changes in income.

(1) More than Just Outreach and Public Education: Institutional Connection Points and Automatic Initiation of Application

In considering how best to raise awareness about the health exchanges and connect individuals in life transitions to coverage, we can learn from the experience of past public health programs. For example, maximizing children's enrollment in CHIP and Medicaid programs involved not only extensive outreach and education about the availability of coverage, but also identifying and utilizing key institutions connected to kids. To this end, a number of states used "express lane" eligibility to connect kids on school lunch programs to Medicaid and CHIP coverage.[30] States also encouraged or required K–12 educational institutions to provide enrollment materials.[31] Churches and other religious institutions in many areas reached out to their congregations.[32]

In thinking about how to reach individuals when they face life transitions that may result in a loss of health coverage, we identified key institutions that connect to individuals with private coverage or with which they are likely to interact when going through a life transition. These include:

- Employers for employment-based coverage;
- Insurers for both employment-based coverage and individual coverage;
- Unemployment insurance agencies for the unemployed;
- Educational institutions, both K–12 and higher education, annually at times of enrollment and graduation;
- State or local courts for those facing life changes such as divorce or adoption; and
- Departments of motor vehicles and the U.S. Postal Service for movers.

In some instances, we suggest that these institutions provide notice. In other instances, we suggest that these institutions provide a link through their websites to the web portal for health insurance coverage. In a few instances, we propose that an application for coverage be automatically initiated.

One of the ways to determine how such efforts should be targeted is to understand where individuals who are losing health coverage go for other public benefits and services. Economist Lara Shore-Sheppard analyzed participation rates in public programs, which suggest potential points for enrollment or notification of coverage options. As shown in Table 3, during nearly one-quarter (23.5%) of months in which a coverage loss was observed, a family member was enrolled in Medicaid. The rate of Medicaid participation by any family member was similar during uninsured months (24.8%). School food program participation by a child in the household was also common during months in which a coverage loss was observed (21.9%) and during uninsured months (24.9%). While a smaller share of those losing coverage

Table 3. Participation in Public Programs

	Public Program	Month in which a coverage loss was observed	Month in which uninsurance was observed	Month in which private coverage (job-based and individual market) was observed
Any family member	Medicaid	23.5%	24.8%	4.5%
	Women, Infants and Children	9.7%	8.4%	1.9%
	Unemployment Insurance	7.0%	4.4%	2.2%
	Social Security Insurance	4.2%	4.3%	1.1%
	TANF	0.9%	0.7%	0.1%
Child in household	School food	21.9%	24.9%	5.7%
Individual	Housing	4.9%	4.3%	0.9%
	Energy assistance	2.8%	2.2%	0.3%

Source: Lara Shore-Sheppard, unpublished article "Correlates and Triggers of Losing or Changing Insurance" based on analysis of 2002 data from the 2001 Survey of Income and Program Participation (SIPP) by the U.S. Census Bureau.

were on unemployment insurance (7.1%), UI can provide an important portal for reaching individuals who lose coverage due to job loss. Another promising point of connection not covered in this analysis is new enrollment in the Supplemental Nutrition Assistance Program (SNAP) (formerly known as food stamps), which in nearly all cases will coincide with eligibility for Medicaid.

By first focusing on key life events and existing paperwork, we can then modify current procedures to better identify the uninsured.[33] These could include COBRA notices, other insurance notices, applications for UI and public benefit programs, applications for community college, divorce, W-4 forms for withholding of earnings, state income tax forms, health care visits, the annual start of school, change of address, and children aging off Medicaid/SCHIP.[34] During these events, the uninsured individual could be allowed to indicate: (1) their lack of coverage; (2) a request for the state's help to obtain coverage; (3) a request for the state to access otherwise confidential data to determine eligibility; and (4) permission to be contacted if necessary to establish eligibility.[35] A sign-off procedure is necessary to address privacy concerns and comply with HIPAA requirements for individual consent before data is transferred.

At a minimum, each of the entry points described above should provide notices on how to obtain health coverage. Where online applications are used for other public programs, they should include a question on health insurance and a link directly into the online portal for signing up for coverage in the health insurance exchanges to the extent permitted by federal law.

California has pending legislation that would provide notice, web portal links, and, in some instances, semi-automatic initiation of an application for health coverage through the health insurance exchange web portal, using some of the institutional connection points described in this section.

Laboratory of the States: California Explorations, Opportunities for Other States

California, like many other states, has faced past challenges in assuring that those who were eligible became enrolled in public programs, including CHIP/Healthy Families, PCIP (the new federal high risk pool), and Medicaid/Medi-Cal. Outreach and public education have been helpful but not sufficient to achieve take-up comparable to employment-based coverage or Medicare. Discussion on these issues arose in California during 2007 when the state attempted to enact comprehensive reform on its own. In 2009–2010, as federal health reform took shape, the urgency of realizing the promise of health reform pushed Health Access California and other stakeholders to explore opportunities to maximize enrollment in the health insurance exchanges and Medicaid/Medi-Cal after 2014.

In 2011, Health Access California sponsored AB 792 by Assemblymember Susan Bonilla, which is designed to take advantage of institutional connection points for Californians at risk of losing private coverage. This legislation requires:

- Notice about the availability of coverage through the health insurance exchange and Medicaid/Medi-Cal;
- Website linkage to the health insurance exchange web portal; and
- Automatic filing of an application for coverage (with opt-out opportunities).

The ACA requires the creation of a single web portal that allows individuals to enroll in health insurance exchange coverage, subsidized and non-subsidized, as well as in Medicaid or CHIP if the individual is eligible for those programs. The trick is to connect individuals who are losing coverage to that process.

AB 792 establishes notification requirements about the availability of coverage through the health insurance exchange and Medicaid, creates web portal linkages between state agencies and the exchange web portal, and in some instances requires the initiation of automatic applications for health coverage through the exchange web portal. The primary focus is on individuals experiencing certain life transitions such as loss of employment or loss of health insurance, but it also addresses additional opportunities to connect persons who have individual coverage to coverage through the health insurance exchange (or public programs).

Insurers—Loss of Employment-Based Health Insurance: State governments regulate a substantial share of health insurance sold to employers. AB 792 requires state-regulated insurers to provide notice and, with the consent of the individual, initiate an application for coverage to the health insurance exchange when there is a loss of employer-based health insurance. The list of qualifying events is similar but not identical to COBRA qualifying events and applies to employees and dependents. In California alone, there were an estimated 6.5 million job terminations in 2010,[35] with a substantial share of these individuals losing employment-based coverage at least for a period of time between jobs. As currently drafted, the notice states:

> "In March of 2010, the federal government passed national health care reform. Because of this, you may be eligible for reduced-cost comprehensive health care coverage through the California Health Benefit Exchange. Because you are losing your coverage from your employer or the employer of a family member, an application will be sent to the California Health Benefit Exchange to make it easier for you to get health care coverage. Eligibility for reduced-cost coverage through the California Health Benefit Exchange or no-cost coverage through Medi-Cal is based on your income. You will be contacted by the Exchange to complete the application. You are not required to accept coverage from the Exchange. To learn more, or to contact the Exchange, visit www.healthexchange.ca.gov or call 1-888-(insert telephone number)."

HIPAA and privacy laws more generally are a challenge in automatic initiation of an application since HIPAA requires consent of the individual to have information transferred from the insurer or employer to the exchange. As currently drafted, AB 792 requires the insurer to receive the consent of the enrollee to transfer any information. If the information is transferred, it will trigger the initiation of an application for enrollment in coverage.[37] This has the felicitous effect of sorting out those who believe themselves at risk of being uninsured from those who expect to have continuous coverage (for example, an employee who is going from a job with coverage to a different employer that also provides coverage). However, obtaining consent creates a barrier to application that may diminish take-up by those who need coverage.

Insurers—Health Coverage in the Individual Market: Research by the California Health Care Foundation undertaken to support the work of the California Health Benefits Exchange, done while AB 792 was pending, indicates that 58 percent of the 2.2 million Californians with individual insurance coverage are income-eligible for subsidies through the health insurance exchange or Medicaid/Medi-Cal.[38] Once reform is implemented, individuals who are initially not eligible for subsidies may choose

coverage in the private market where subsidies are not available. If earnings decline, they may choose to terminate coverage due to financial hardship. AB 792 requires insurers to provide notice of the availability of subsidies to every purchaser of individual coverage. AB 792 also requires that when an individual terminates individual coverage, with the consent of the individual, the insurer must initiate an application for coverage through the health insurance exchange web portal by transferring the individual's information to the exchange. Over a million Californians could get more affordable coverage through the exchange or Medicaid/Medi-Cal as a result of this provision alone.

Unemployment Insurance Agency—Application for UI: This provision would require California's Employment Development Department (the state agency that administers the Unemployment Insurance system) to provide notice of the availability of coverage through the health insurance exchange and Medicaid as well as initiate an application to the exchange automatically whenever an individual applies for Unemployment Insurance. The initial response by the state agency responsible for UI turned on a very narrow interpretation of federal law governing the use of UI funds, resulting in a cost estimate of millions of dollars to the state budget. Further work with the U.S. Department of Labor and the State is needed to determine whether a linkage can be created similar to what exists between the Social Security Administration and the Medicare program in which consumers who apply for one are educated about the availability of the other and the websites provide easy links from one program to the other.

Family Courts—Change in Family Status: Under AB 792, family courts would be required to provide a notice regarding the availability of affordable health insurance through California's health insurance exchange to individuals petitioning for or responding to dissolution of marriage or legal separation and to those petitioning for the adoption of a child. The state courts worked collaboratively on this effort, perhaps because health insurance is often an issue for those undergoing divorce, legal separation, or adoption.

Application for State Disability Insurance: When an individual files a claim for disability benefits, the state would be required to provide a notice to the individual regarding the availability of affordable health insurance through California's health insurance exchange.

K–12 Educational Institutions: The CHIP programs (Healthy Families in California) have explored various means of connecting kids to coverage through K–12 schools. Some school districts provide CHIP/Medicaid applications for those in the lower grades. Some states, including California, have a version of "express lane" eligibility in which kids enrolled in school lunch programs are offered an opportunity to enroll in CHIP/Medicaid. Similar efforts should be undertaken to reach not only the parents and other family members of kids on CHIP/Medicaid but also young adults graduating from high school, a life transition highly correlated with lack of coverage. Health Access is working on further legislative and administrative efforts to accomplish this in California. One barrier that may be particular to California is that a state law requiring a school district to take action is a state-mandated local cost that the state budget must pay, a difficult hurdle in these tough budget times for California. However, both the school lunch program and many California school districts connect kids to CHIP/Healthy Families and Medicaid/Medi-Cal.

Higher Educational Institutions: Because CHIP eligibility cuts off prior to higher education for most young adults and because Medicaid in most states does not cover adults without children under 18 at home, little attention has been paid to institutions of higher education as an institutional point of connection for health coverage programs. Both the creation of health insurance exchanges and the expansion of Medicaid to adults without children at home mean this is now a fertile area for exploration.

Further work at the state level is needed to explore how best to connect students in institutions of higher learning with coverage. Given budget cuts to the higher education programs in California, this would need to be done at little or no cost to the higher education systems. At least some of the institutions of higher education already determine whether a student has coverage or not.

Department of Motor Vehicles: Moving is another important indicator of loss of health coverage. The DMV could be another point of connection to information about the health insurance exchange when individuals file for change of address. This was not included in the draft legislation, but is worth further exploration.

Not every institutional point of connection will work or will be effective enough to be worth the effort. Health Access California began with the model of COBRA because the system is in place and it provides an easy foundation upon which to build with little additional cost. The requirements on individual insurance are an extension of practices already in place with COBRA. Unemployment Insurance provides an obvious point of entry due to the correlation of job loss with lack of health coverage. Building on the work of linking children to CHIP (and Medicaid), the role of educational institutions as connection points for individuals in life transition is worth exploring as well.

Recommendation:

Exchanges should work with existing institutions that reach individuals at the time of life transitions to ensure that these individuals are notified of the opportunities for affordable coverage made possible through the ACA and connected to enrollment. Where online applications are used for public services individuals are likely to touch during transitions that lead to a loss of health insurance, direct links should be provided to online portals for applying for coverage in the exchange, Medicaid, or CHIP. States should require state-regulated insurers to provide notification to consumers about the option of enrolling in Medicaid and the exchange when job-based coverage is terminated. Auto-application should be used to the extent practicable.

(2) Staying Covered: COBRA or the Health Insurance Exchange?

When an employee or dependent loses employment-based coverage, most employees will have the choice of either continuing group coverage through COBRA (if eligible) or enrolling in health insurance through the exchanges or Medicaid/CHIP. In order to ensure awareness and appropriate uptake of coverage through the exchanges, four barriers to enrollment must be addressed:

COBRA should not close the door to enrollment in coverage through a health insurance exchange.

When an individual experiences a loss of health coverage due to a life transition, such as job loss, reduction in hours, or divorce, the ACA provides a special enrollment period to allow these individuals to enroll in health insurance through the exchanges.[39] Many of these individuals will qualify for both COBRA and health insurance through the exchanges, and so will need to choose one or the other forms of coverage. If an individual chooses COBRA, the proposed regulations seem to indicate that the individual may not be able to enroll in the exchange until the exhaustion of the COBRA period.[40] The problem posed by the current draft of the regulations is further exacerbated by the fact that when an individual enrolls in health insurance through the exchange, the effective date of coverage is either the first day of the following month or the first day of the second month if enrollment occurs after the 22nd of the month.[41] This means that an individual who cannot go without health insurance (e.g., an individual receiving cancer treatments) may choose to enroll in COBRA, but could then be precluded from enrolling in health insurance through the exchange.

Furthermore, the proposed regulations allow individuals to enroll in health insurance through the health insurance exchange if the employee's eligible employer-sponsored health coverage is no longer affordable.[42] But the regulations are not clear on whether individuals who take advantage of COBRA after losing a job, rather than immediately enrolling in health insurance through the exchange, would be allowed to later enroll in health insurance through the exchange if the coverage is no longer affordable.

Recommendation:

In order to maximize affordable enrollment options for those individuals losing employment-based coverage, the regulations should be clarified to ensure that individuals who choose COBRA may later enroll in health insurance through the exchange—via a special enrollment period —if the individual drops enrollment in COBRA coverage or if COBRA is deemed unaffordable. Further, the timing of the effective date of enrollment should be modified to avoid any gaps in coverage. This could be achieved through two changes: First, by making coverage retroactive to the enrollment date, and second by allowing for pre-enrollment in advance of a known qualifying event while an individual still retains insurance, with the effective date of coverage in the health insurance exchange starting at the time coverage through the current source ends.

Consumers must be informed of the option of enrolling in the health insurance exchange and understand the implications of choosing COBRA rather than enrolling in health insurance through an exchange.

Recommendation:

Federal regulations and state laws (or regulations) should be revised to require that consumers who would otherwise receive federal or state COBRA notice also receive notice of the availability of coverage through an exchange. Such notices should further alert consumers that if they choose COBRA, there may be limitations on the circumstances under which they can enroll in the health insurance exchange and what those limitations are. In addition, states should incorporate this message into public education campaigns about enrolling in health insurance through the exchanges.

Consumers must be provided with information to make an informed choice about the cost implications and the implications for maintaining coverage after loss of employment-based coverage.

The ACA requires health insurance exchanges to develop an Internet portal that will provide information about health insurance plans available through the exchange and the premium tax credits and cost-sharing reductions.[43] In addition, the ACA requires health insurance exchanges to make available an electronic calculator to help individuals determine the actual cost of coverage after the premium tax credit and cost-sharing reductions.[44] If health insurance exchanges are going to effectively serve individuals losing employment-based coverage, exchanges should help individuals losing employment-based coverage determine the cost-benefit calculation of choosing COBRA coverage over choosing subsidized coverage through the exchanges.

Recommendation for health insurance exchanges:

Exchanges should provide information that will guide individuals in choosing COBRA or insurance offered through the exchanges. Individuals will need information about the comparison of costs between the two options, but will also need information to determine whether insurance offered through the exchange will allow them to continue to see the same providers. This information should be incorporated into their exchange Internet portal, exchange calculator, and outreach and education campaign as appropriate.

Recommendation for federal regulators:

The federal regulations should be modified to encourage health insurance exchanges to provide information on comparisons between COBRA and coverage offered through the exchanges, both subsidized and unsubsidized. Even higher income consumers, those above 400 percent of the FPL, will be able to obtain coverage through a health insurance exchange, but a silver plan with an actuarial value of 70 percent will have very different cost sharing than the typical employer plan, which has an actuarial value closer to 83 percent.[45] Consumers will need to be educated about these basic parameters in addition to having available more precise details for those consumers who find it useful.

States should consider whether they can encourage or drive insurance carriers to offer to individuals within the health insurance exchanges some plan options with similar networks to those offered in the employer group markets.

The most seamless option for individuals losing employment-based coverage would be a product with a similar or identical provider network found through the health insurance exchange. Given the disparity in the actuarial value between the exchange silver plan and the average employer plan, as well as the cost sharing and premium subsidies that vary based on income, it is unlikely that consumers will have precisely the same product with the same cost sharing that they had with their employer, but it is more likely that they will have the same or similar networks of providers. States will face design choices in balancing seamlessness between Medicaid coverage and the health insurance exchange, and between employment-based coverage and exchange coverage. Provider networks can vary significantly between Medicaid managed care plans and group coverage even within the same commercial insurer.[46] For example, in California, major commercial insurers that contract with Medicaid/Medi-Cal use different provider networks for Medicaid managed care than for commercial business, and a major integrated health plan, Kaiser Permanente, has a very small share of the Medicaid managed care market but a very large share of the commercial market. Because of low Medicaid reimbursement rates, other states may also face a mismatch between Medicaid managed care provider networks and provider networks for commercial plans. One possible solution is for those states with licensed Medicaid managed care plans to include both the dominant such plan in each geographic area in the exchange as well as the commercial insurers with the networks used for employment-based coverage.

(3) Getting the Subsidies Right—Creating a System to Allow Individuals to Qualify for Premium Subsidies Based on Existing Circumstances and Incomes

Once an applicant reaches a state health exchange, the health insurance exchange will assist the individual in enrolling in a health insurance plan that best meets the need of that individual and his or her family, and will also work to ensure that the individual receives health insurance premium subsidies in order to afford health insurance.

Federal subsidies are a centerpiece of the ACA's mission to improve the affordability of health care by providing financial assistance to Americans purchasing health insurance through the exchanges.[47] It is estimated that up to 20 million people will receive subsidies through the health insurance exchanges by 2021.[48] Health insurance exchange subsidies are provided in the form of advanced payments on tax credits. Any advance payment received in a given year must then be reconciled with the tax credits for which they are found eligible after they have reported their income on their tax return.[49] Depending on family income, a portion or all of the overpayment must be re-paid when taxes are filed (see box below for amounts).

Determining eligibility for advance premium tax credits under the ACA is based on the prior year's income as reported on the prior year's tax return, or projected annual income if there has been a change in income from the prior year.[50] The ACA required the U. S. Secretary of Health and Human Services to develop procedures for making premium tax credit eligibility determinations based on changed circumstances, which include the types of life and work transitions we are focused on here: substantial changes in income, changes in family size or household circumstances, changes in tax filing status, and the filing of an application for unemployment insurance.[51]

The potential for overpayment or underpayment will be especially acute for individuals who lose or gain employment during the course of the year or have major changes in income or changes in family size. If an individual has a significant increase in earnings or a child leaves home and is no longer a dependent and it is not reported and processed in a timely manner, they may face a large repayment at the end of the year. This is especially acute for those near the 400 percent of the federal poverty level threshold. If an individual has a decrease in income or adds a dependent, reporting changes will have in important impact on the affordability of coverage and their ability to access better cost-sharing subsidies through insurance plans in the exchange that are available to people with lower income levels. If an individual is unemployed at the start of the year and obtains a new job and job-based coverage later in the year, they could face a repayment if they do not take the subsidies they have already received into account in determining their tax withholding at the new job. COBRA coverage may be more appropriate for those with higher incomes who face a relatively brief transition between one source of coverage and another because the individual would not face a repayment penalty; the individual needs to be able to make an accurate determination as to the relative costs of such a choice.

Federal regulations and state implementation of the health insurance exchanges should work to minimize repayment shocks while maximizing coverage.

Health Insurance Exchange Subsidies and Tax Liabilities

Under the ACA, health insurance exchange subsidies are advanced payments on tax-credits. The ACA further requires that any advance payment received in a given year must then be reconciled with the tax credits that they are found eligible for after they have reported their income on their tax return.[52] Cost-sharing reductions in the exchange are not subject to reconciliation. Tax liability arises if the advance payments exceed the credit for which individuals are ultimately found eligible, as the ACA requires a portion of the overpayment (or potentially the entire amount) to be repaid.[53] This is particularly troubling as many individuals' incomes fluctuate during the year, and certain job losses or gains can be unpredictable.[54] Congress has changed the law twice since the passage of the ACA with respect to subsidy reconciliation. The most recent change in April 2011 raised the repayment caps for those under 400 percent of the federal poverty level, and removed the cap entirely on those over 400 percent of the federal poverty level. The final changes were made in order to cover the cost of repealing a business tax reporting requirement included in the original legislation.

Under the current repayment requirements, families with incomes below 200 percent of the FPL will be required to pay back up to $600 in premium tax credit overpayments; families with incomes between 200 and 300 percent of the FPL will be required to pay back up to $1,500 in overpayments; families with incomes between 300 and 400 percent of the FPL will be required to pay back up to $2,500 in overpayments; and those making above 400 percent of the FPL will have to pay back the entire amount of overpayment regardless of the amount. Individuals will be required to pay back up to half the amount families owe.

Changes in marital status could also result in overpayments requiring reconciliation. The proposed IRS regulations recognize that there may be a need to provide relief to individuals who owe an overpayment because their household income increased due to a marriage during that tax year and one or both individuals received subsidies prior to marriage. The regulations also propose special rules for taxpayers who divorce. Taxpayers who divorce during the tax year may agree to allocate premiums and subsidies between themselves. If the taxpayers do not agree on an allocation, the default is that 100 percent of the premiums and subsidies are allocated to the enrolled spouse in cases in which only one of the former spouses was enrolled and the allocation is split between spouses in all other cases.[55]

The repayment requirements create a challenge for health insurance exchange eligibility and enrollment. If a family's income increases even modestly over the course of the year, the family may be at potential risk of a financial shock at the time of tax filing. In case of non-payment of the overage, a three-month grace period is allowed before coverage would be discontinued. The IRS has also indicated that penalties may be charged along with the repayment amount in accordance with current law on underpayment of taxes.

Those likely to receive the greatest income shocks due to underestimation of income are those whose incomes go over the 400 percent FPL "cliff," since they will be liable for the entire cost of the subsidy, and older families, since the cost of coverage and amount subsidized at any given income level increases with age.

The Center on Budget and Policy Priorities estimates that a middle-class family of four with an income between 350 and 400 percent of federal poverty, one member of which is 55 years old, would receive a subsidy of $11,400 toward the cost of coverage.[56] A small increase in income would result in a required full repayment of the subsidy, which is equivalent to 13 to 15 percent of their annual income. At the other end of the income spectrum, a required repayment of $600 may be a significant sum for a family with an income under 200 percent of the federal poverty level.

The perceived risk of being required to repay subsidies may result in reduced take-up of coverage in the health insurance exchange, especially for lower income families. Concern about repayment risk has been cited[57] as one of the reasons for low take-up rates for the Advance Earned Income Tax Credit (AEITC). A study from the U.S. Government Accountability Office found that from 2002 through 2004 both the use of AEITC and the amount paid out by employers was quite low: Only about 3 percent of those potentially eligible claimed advance payments, and about half of those received $100 per year or less.[58]

The individuals or families who are most likely to decline insurance in favor of paying a lesser penalty for non-coverage are also the ones most likely to be in good health at the time that insurance is declined. Removing healthy people from the health insurance exchanges' insurance pools will make the pools less healthy in general, and that effect could drive up premium rates overall.[59] Large repayments could also undermine public support for the ACA.

Addressing this issue will be important for the success of ACA implementation and for supporting seamless access to health coverage through life transitions.

The federal regulations proposed by the Department of Health and Human Services (HHS) seek to minimize overpayments "through a strong initial eligibility process that maximizes accuracy and a strong process by which individuals can report changes that occur during the year." The regulations contribute to that goal by allowing an applicant to accept subsidies that are lower than the amount they are eligible for, in order to reduce the risk of overpayment. When individuals attest that their annual household income has increased or is reasonably expected to increase (compared to prior tax returns), exchanges will accept their application without further verification required.[60]

However, the regulations must be further strengthened and exchanges should take additional steps in order to reduce the prevalence of overpayments. The re-determination process in the proposed HHS regulations "relies primarily on the individual to provide the exchange with updated information during the benefit year, as opposed to having the exchange examine electronic data sources and/or contact the individual in order to determine whether a change has occurred during the year."[61] The exchanges should play a more active role in identifying individuals with changes in income or household members, encouraging those individuals to report changes and helping them to make appropriate timely adjustments to their subsidies.

Recommendations:

- The health insurance exchanges should provide tools to families to assist in projecting annual income at the time of initial application and to re-determine amounts over the course of the year as circumstances change, as is done with federal tax withholding and estimated taxes. The exchanges should make calculators available that take into account current income and earnings during the year prior to unemployment or a major change in income or in family status. The exchanges' help lines, navigators, and brokers should be trained to aid individuals in understanding their options and determining their projected income. Exchanges will need to have the agility to re-determine subsidy levels over the course of the year upon request of the consumer. The process for making changes should be simple and the exchanges should be required to act on reported changes in a timely manner.

- Consumers with subsidized coverage will need to know to report changes in income to the health insurance exchange. Exchanges should educate enrollees about the importance of promptly reporting changes in income. Along with notifying participants at the time of enrollment, this will need to be a broader focus of public education about the exchanges. As considered in the proposed HHS regulations, exchanges should offer enrollees the option to be periodically reminded to report any changes that have occurred. Individuals should be able to report income changes at any time by logging in to the exchange website and providing updated information. Individuals should be able to report changes in income that are below the 20 percent threshold required in law. Regulations should clarify that changes in family size can be reported mid-year and advanced tax payments and cost-sharing subsidies adjusted accordingly.

- Government data sources could be used to trigger reminders to report significant income changes. States have data on individuals' employment and earnings through filings to state employment agencies, and exchanges should be authorized to use this data. Research is needed to investigate the prevalence of the problem and the cost-effectiveness of data matching to identify individuals who could face potential overpayments.

CONCLUSION

The ACA offers great promise for expanding access to health coverage and minimizing the gaps in coverage caused by changes in life circumstances. Much attention has been paid to ensuring seamless coverage between Medicaid and the health insurance exchanges. Less attention has been paid to the transitions between the exchanges and employment-based coverage. COBRA does not provide a viable alternative for many of those who lose job-based coverage due to its high cost in a time of reduced income.

In order to maximize coverage under the ACA, federal regulations should be modified to ensure that the health insurance exchanges are viable options for individuals who lose job-based coverage while liabilities for repayment are minimized. Health insurance exchanges will need to insure that individuals are aware of their options and have the information, tools, and supports they need to make informed decisions.

Analyzing triggering events of loss of coverage will help in developing strategies to identify and enroll individuals who lose coverage. Notification will not be enough. States must also create mechanisms for auto-application to maximize enrollment. Finally, states will need systems in place to aid individuals in correctly determining subsidy levels and minimizing repayments.

By doing so, implementation of the health insurance exchanges can meet the promise of the ACA.

ENDNOTES

[1] *Employer Health Benefits: 2011 Annual Survey*, Henry J. Kaiser Family Found. and Health Research Educational Trust, (Sept. 2011), http://ehbs.kff.org/pdf/2011/8225.pdf.

[2] Dahlia K. Remler and Sherry A. Glied, *What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs*, Am J Public Health 2003 93: 67–74.

[3] *Id.*

[4] Stan Dorn, *Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals*, ROBERT WOOD JOHNSON FOUND.: STATE COVERAGE INITIATIVES, 8 (Aug. 2007), http://www.statecoverage.org/files/Automatic%20Enrollment%20Strategies%20-%20Helping%20State%20Coverage%20Expansions%20Achieve%20Their%20Goals.pdf.

[5] Ken Jacobs, et al., *Maximizing Health Care Enrollment through Seamless Coverage for Families in Transition: Current Trends and Policy Implications*, UNIVERSITY OF CALIFORNIA, BERKELEY (March 2011), *available at* http://www.laborcenter.berkeley.edu/healthcare/seamless_coverage11.pdf.

[6] Despite the expansion of Medicaid, the Affordable Care Act does not change the five-year waiting period before legal immigrants can be eligible for Medicaid and CHIP. And undocumented immigrants are unable to enroll in Medicaid, receive subsidies, or even use the exchanges to purchase insurance with their own resources. *See* Maria C. Abascal, *Reform's Mixed Impact on Immigrants*, The American Prospect (August 2010), http://prospect.org/cs/articles?article=reforms_mixed_impact_on_immigrants; Stephen Zuckerman, Timothy Waidmann and Emily Lawton, *Undocumented Immigrants, Left Out of Health Care Reform, Likely to Continue to Grow As Share of the Uninsured*, 30 HEALTH AFFAIRS 10: 1997–2004 (2011).

[7] Douglas W. Elmendorf, Congressional Budget Office, *Testimony: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, before the Subcommittee on Health Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011.

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1413 (amending Internal Revenue Code to provide such credits), 124 Stat. 119, 175 (2010).

[9] *Id.*

[10] Congressional Budget Office, CBO's March 2011 Baseline: Health Insurance Exchanges, March 18, 2011, http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceExchanges.pdf.

[11] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1331, 124 Stat. 119, 175 (2010).

[12] *Id.*

[13] *Basic Health Plan in California?*, Insure the Uninsured Project, http://itup.org/blog/2011/04/27/basic-health-plan-in-california/ (last visited October 14, 2011).

[14] Many states administer the CHIP program as a Medicaid expansion. In California, the CHIP program, Healthy Families, is administered by a separate state agency with an independent governing board, the Major Risk Medical Insurance Board (MRMIB). MRMIB also administers a program for moderate income pregnant women and infants (AIM), a state high risk pool, and the federal high risk pool, and in the past administered a small group purchasing pool, which failed due to adverse selection.

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[16] Pamela Farley Short and Deborah R. Graefe, *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, 22 HEALTH AFFAIRS 6: 244–255 (2003).

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[18] Pamela Farley Short et al., *Realizing Health Reform's Potential: Maintaining Coverage, Affordability and Shared Responsibility When Income and Employment Change,* THE COMMONWEALTH FUND, May 2011, *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1503_Short_maintaining_coverage_affordability_reform_brief.pdf.

[19] Current COBRA provisions are found in three places: the Public Health Services Act, 42 U.S.C. §§ 300bb-1 et seq., (group health for public employees); 29 U.S.C. §§ 1161 et seq. (group health for private employees); and I.R.C. § 4980B.

[20] *See, e.g.,* David W. Baker et al., *Lack of Health Insurance and Decline in Overall Health in Late Middle Age*, 345 NEW ENG. J. MED. 1106 (2001).

[21] Cal. Health & Safety Code § 1366.20 et seq.

[22] United States Department of Labor, Fact Sheet: Consolidated Omnibus Budget Reconciliation Act (COBRA), http://www.dol.gov/ebsa/newsroom/fscobra.html.

[23] Cal. Health & Safety Code § 1366.27.

[24] *See, e.g.,* Mark C. Berger et al., *Health Insurance Coverage of the Unemployed: COBRA and the Potential Effects of Kassebaum-Kennedy*, 18 J. POL'Y ANALYSIS & MGMT. 430 (1999) (finding that COBRA eligibility only increases the probability of securing health insurance coverage by 9.5 percent); Jonathan Gruber and Brigitte C. Madrian, *Employment Separation and Health Insurance Coverage*, 66 J. PUB. ECON. 349 (1997) (finding that COBRA laws only increase the probability that an unemployed worker secures health insurance by 6.7 percent).

[25] *E.g.,* Randall R. Bovbjerg et al., *Federal Subsidy for Laid-Off Workers' Health Insurance: A First Year's Report Card for the New COBRA Premium Assistance*, 3 URBAN INSTITUTE (2010); U.S. Treasury Department Office of Economic Policy, COBRA Insurance Coverage since the Recovery Act: Results from New Survey Data 1 (2010).

[26] Pamela Farley Short, *supra* note 18.

[27] Kanika Kapur and M. Susan Marquis, *Health Insurance for Workers Who Lose Jobs: Implications for Various Subsidy Schemes*, 22 HEALTH AFFAIRS 3: 203, 208 (2003).

[28] *Id.*

[29] *Id.*

[30] Centers for Medicare & Medicaid Services Webinar Transcript, "Getting Eligible Children Enrolled in Medicaid and CHIP: School-Based Outreach Strategies that Make the Grade," July 29, 2010, *available at* http://www.insurekidsnow.gov/professionals/outreach/webinars/schoolbased_transcript.pdf.

[31] *Id.*

[32] *See, e.g.,* Aitebureme Oare Aigbe, Faith-Based Outreach to Uninsured Children (May 2010) (M.P.H. thesis) (on file with Drexel University School of Public Health); *Enrollment in CHIP/Medicaid Is Up in Tarrant County*, Tarrant County CHIP Coalition, http://tarrantcountychip.com/2010/08/08/enrollment-in-chipmedicaid-is-up-in-tarrant-county/ (last visited October 17, 2011).

[33] Dorn, *supra* note 4.

[34] *Id.* at 10–11.

[35] *Id.* at 10.

[36] Annual job separations rate was 41% in 2009. Mark K. deWolf and Katherine Klemmer, *Job Openings, Hires, and Separations Fall During the Recession*, MONTHLY LABOR REVIEW, May 2010, accessed http://www.bls.gov/opub/mlr/2010/05/art3full.pdf. In March 2011, California had 15.9 million employed workers. California Employment Development Department, *Quick Statistics*, accessed http://www.edd.ca.gov/About_EDD/Quick_Statistics.htm.

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[39] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(c)(6), 124 Stat. 119, 175 (2010).

[40] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. at 41,883.

[41] *Id.* at 41,917.

[42] *Id.* at 41,918 (proposing that "[t]he Exchange must permit an individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan").

[43] § 1311(d)(4)(C) and proposed regs § 155.205(b)

[44] § 1311(d)(4)(G) and proposed regs § 155.205(c)

[45] Jon Gabel et al., *Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down*, 25 HEALTH AFFAIRS 3: 832–843 (2006).

[46] *Public Partner: The California Health Benefit Exchange Aligned with Medi-Cal*, California Health Care Foundation (Oct. 2011), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CAExchangePublicPartner.pdf.

[47] *Reconciliation of Advance Payments for Health Insurance Subsidies*, Henry J. Kaiser Family Found., 1 (Feb. 2011), http://www.kff.org/healthreform/upload/8154.pdf.

[48] CBO *supra* note 10.

[49] *Id.* § 1401(a) (revising Internal Revenue Code to incorporate provisions on reconciliation).

[50] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1411(b)(3), 124 Stat. 119, 225 (2010); Patient Protection and Affordable Care Act; Exchange Function in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, 76 Fed. Reg. at 51,232–234

[51] *Id.* § 1412(b)(2).

[52] *Id.*

[53] *Id.*

[54] *Id.*

[55] Health Insurance Premium Tax Credit, 76 Fed. Reg. at 50931 (proposed August 17, 2011) (to be codified at 26 C.F.R. pt. 1).

[56] Judith Solomon, *House Ways and Means Offset for Repealing Affordable Care Act's Tax Reporting Requirement Would Weaken Health Reform*, CTR. ON BUDGET & POLICY PRIORITIES, 4 (Mar. 2, 2011), www.cbpp.org/files/3-1-11health.pdf.

[57] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-1110, ADVANCE EARNED INCOME TAX CREDIT: LOW USE AND SMALL DOLLARS PAID IMPEDE IRS'S EFFORTS TO REDUCE HIGH NONCOMPLIANCE 1 (2007), *available at* http://www.gao.gov/new.items/d071110.pdf.

[58] *Id.*

[59] Solomon *supra* note 56.

[60] Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, 76 Fed. Reg. at 51202 (proposed August 17, 2011) (to be codified at 45 C.F.R. pt. 155 and 157).

[61] *Id.*

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