



March 2015

# PRIVATE HEALTH INSURANCE

Early Evidence Finds  
Premium Tax Credit  
Likely Contributed to  
Expanded Coverage,  
but Some Lack  
Access to Affordable  
Plans

Accessible Version

# GAO Highlights

Highlights of [GAO-15-312](#), a report to congressional committees

## Why GAO Did This Study

The number of uninsured individuals and the rising cost of health insurance have been long-standing issues. PPACA mandated that most individuals have health insurance that provides minimum essential coverage or pay a tax penalty. To make health insurance more affordable and expand access, PPACA created the APTC to subsidize the cost of exchange plans' premiums for those eligible. PPACA used two standards for defining affordability of health insurance: 8 percent of household income for the purposes of minimum essential coverage and 9.5 percent for APTC eligibility for individuals offered employer-sponsored plans.

PPACA mandated that GAO review the affordability of health insurance coverage. GAO examined (1) what is known about the effects of the APTC and (2) the extent to which affordable health benefits plans are available and individuals are able to maintain minimum essential coverage. GAO conducted a structured literature search to identify studies on the rate of uninsured individuals, among other topics, and interviewed experts from HHS, the Internal Revenue Service (IRS), and 11 research and industry organizations to understand factors affecting affordability. GAO also analyzed the variation in the affordability of exchange plan premiums nationwide using 2014 data—the most recent data available at the time of GAO's analysis.

GAO received technical comments on a draft of this report from HHS and IRS and incorporated them as appropriate.

View [GAO-15-312](#). For more information, contact John E. Dicken at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

March 2015

## PRIVATE HEALTH INSURANCE

### Early Evidence Finds Premium Tax Credit Likely Contributed to Expanded Coverage, but Some Lack Access to Affordable Plans

#### What GAO Found

Early evidence suggests that the advance premium tax credit (APTC)—the refundable tax credit that can be paid on an advance basis—likely contributed to an expansion of health insurance coverage in 2014 because it significantly reduced the cost of exchange plans' premiums for those eligible. Although there are limitations to measuring the effects of the APTC using currently available data, surveys GAO identified estimated that the uninsured rate declined significantly among households with incomes eligible for the APTC. For example, one survey found that the rate of uninsured among individuals with household incomes that make them financially eligible for the APTC fell 5.2 percentage points between September 2013 and September 2014. This expansion in health insurance coverage is likely partially a result of the APTC having reduced the cost of health insurance premiums for those eligible. Among those eligible for the APTC who the Department of Health and Human Services (HHS) initially reported selected a plan through a federally facilitated exchange or one of two state-based exchanges, the APTC reduced premiums by 76 percent, on average. As of January 2015, data were not yet available on the extent to which the APTC reduced 2015 premiums, although studies have found that, on average, premiums (before applying the APTC) changed only modestly from 2014 to 2015, though some areas saw significant increases or decreases.

Most nonelderly adults had access to affordable health benefits plans—as defined by the Patient Protection and Affordable Care Act (PPACA)—but some may face challenges maintaining coverage. Most nonelderly adults had access to affordable plans through their employer, Medicaid, the exchanges, or other sources as of March 2014, although about 16 percent of nonelderly adults remained uninsured. While there are many reasons people remain uninsured, some people may not have access to affordable coverage, including (1) low-income nonelderly adults—those with household income below 100 percent of the federal poverty level—who live in one of the 23 states that chose not to expand Medicaid and (2) some nonelderly adults who do not have affordable employer-sponsored insurance and who were not eligible for the APTC. For those with incomes too high to qualify for the APTC, the affordability of health insurance coverage available in the individual exchanges in 2014 varied by age, household size, income, and location. For example, a 60-year-old with an income of 450 percent of the federal poverty level would have had to spend more than 8 percent of their household income for the lowest-cost plan in 84 percent of all health insurance rating areas in the United States, but a 27-year-old had access to an affordable plan in all but one. Regardless of the affordability of premiums, some may face challenges in maintaining coverage that qualifies under PPACA as minimum essential coverage; for example, changes in income can result in changes in APTC eligibility.

This report provides an early look at the effect of the APTC and the affordability of health insurance under PPACA. However, it is important to note that these findings about the first year of the exchanges cannot be generalized to future years. Numerous factors, including additional data and changes in trends in health care costs, could affect the affordability of health insurance going forward.

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# Contents

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Letter	1
Background	6
Early Evidence Suggests That While the APTC Likely Contributed to an Expansion of Coverage, the Small Employer Tax Credit Has Had Little Effect	12
While Most Nonelderly Adults Had Access to Affordable Health Insurance Coverage, Maintaining Minimum Essential Coverage May Be Challenging for Some	25
Concluding Observations	36
Agency Comments	36

---

Appendix I: Potential Effects of Changing the Affordability Threshold for Employer-Sponsored Insurance	39
Appendix II: Objectives, Scope and Methodology	42
Appendix III: Affordability of the Lowest-Cost Bronze Plan, by Rating Area	47
Appendix IV: GAO Contact and Staff Acknowledgments	57
GAO Contact	57
Staff Acknowledgments	57

---

Tables	
Table 1: 2013 Federal Poverty Level (FPL) for an Individual and a Family of Four in the 48 Contiguous States	8
Table 2: Percentage of Household Income Enrollee Is Required to Contribute for Reference Plan Premiums, after Applying the APTC	9
Table 3: Survey Estimates of the Change in the Percent of Uninsured Nonelderly Adults by Household Income As a Percent of the Federal Poverty Level (FPL)	14
Table 4: Average Monthly Advance Premium Tax Credit (APTC) Amount and Percent Reduction in Premiums after APTC for Individuals Who Selected a Plan through a Federally Facilitated Exchange or a State-Based Exchange that Used the Federal Website for Enrollment in 2014 and Were Deemed Eligible for the APTC in 2014, by Metal Tier <sup>17</sup>	
Table 5: Methodological Information for Surveys That Estimated the Change in the Rate of Uninsured Nonelderly Adults	43

---

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Figures

Figure 1: Number of Employers That Claimed the Small Employer Tax Credit, 2010-2012	22
Figure 2: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan by Household Characteristics and Income As a Percent of the Federal Poverty Level (FPL) (2014)	31
Figure 3: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 60-Year-Old Individual with Household Income at 450 Percent of the Federal Poverty Level (2014)	47
Figure 4: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 60-Year-Old Individual with Household Income at 500 Percent of the Federal Poverty Level (2014)	48
Figure 5: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 60-Year-Old Individual with Household Income at 600 Percent of the Federal Poverty Level (2014)	49
Figure 6: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 27-Year-Old Individual with Household Income at 450 Percent of the Federal Poverty Level (2014)	50
Figure 7: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 27-Year-Old Individual with Household Income at 500 Percent of the Federal Poverty Level (2014)	51
Figure 8: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 27-Year-Old Individual with Household Income at 600 Percent of the Federal Poverty Level (2014)	53
Figure 9: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 40-Year-Old Married Couple with Two Children Under 21-Years-Old and Have Household Income at 450 Percent of the Federal Poverty Level (2014)	54
Figure 10: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 40-Year-Old Married Couple with Two Children Under 21-Years-Old and Have Household Income at 500 Percent of the Federal Poverty Level (2014)	55

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Figure 11: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 40-Year-Old Married Couple with Two Children Under 21-Years-Old and Have Household Income at 600 Percent of the Federal Poverty Level (2014)

56

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**Abbreviations**

AHRQ	Agency for Healthcare Research and Quality
APTC	Advance Premium Tax Credit
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
ESI	employer-sponsored insurance
FPL	federal poverty level
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
KFF	The Henry J. Kaiser Family Foundation
MEPS	Medical Expenditure Panel Survey
PPACA	Patient Protection and Affordable Care Act
SHOP	Small Business Health Option Programs

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# Letter

March 23, 2015

## Congressional Committees

The number of uninsured individuals and the rising cost of health insurance have been long-standing issues. From 1997 through 2013, the number of nonelderly uninsured in the United States fluctuated between about 30 and 42.5 million and was about 20.4 percent of the nonelderly population in 2013.<sup>1</sup> Many of these uninsured individuals were not eligible for public insurance, such as Medicaid—the joint federal-state health coverage program for certain low-income individuals—nor were they offered employer-sponsored insurance (ESI). Before 2014, their remaining option was to purchase a plan on the private, individual market, but these plans were often difficult to afford given that the uninsured typically have low incomes. In 2013, 85 percent of the uninsured were in households earning less than about 400 percent of the federal poverty level (FPL).<sup>2</sup>

The Patient Protection and Affordable Care Act (PPACA) included a number of provisions to address these challenges. Among other things, PPACA mandated that, with some exceptions, individuals must have health insurance that provides “minimum essential coverage” or pay a tax penalty, a requirement many refer to as the individual mandate.<sup>3</sup> Health

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<sup>1</sup>M. E. Martinez and R. A. Cohen, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2014* (Hyattsville, Md.: National Center for Health Statistics, 2014); and *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January – March 2009*, (Hyattsville, Md.: National Center for Health Statistics, 2009).

The “nonelderly” refers to adults under age 65. In this report, we refer to nonelderly adults when we discuss those who are uninsured.

<sup>2</sup>The Henry J. Kaiser Family Foundation, *Distribution of the Nonelderly Uninsured by Federal Poverty Level*, accessed Jan. 5, 2015, <http://kff.org/uninsured/state-indicator/distribution-by-fpl-2>.

The FPL is an amount updated annually by the Department of Health and Human Services (HHS) to set eligibility for various means-tested programs.

<sup>3</sup>Pub. L. No. 111-148, §§ 1501, 10106, 124 Stat. 119, 242, 907 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, §§ 1002, 1004, 124 Stat. 1029, 1032, 1034 (2010) (codified at 26 U.S.C. § 5000A). In this report, references to PPACA include any amendments made by HCERA.

insurance that meets the minimum essential coverage standard includes certain types of government-sponsored coverage (such as Medicare Part A or Medicaid) as well as most types of private insurance plans (such as ESI) that provide health benefits consistent with the law.<sup>4</sup>

To expand access to health insurance that qualifies as minimum essential coverage, PPACA created the premium tax credit to subsidize premium costs for plans purchased by eligible individuals and families through the exchanges—marketplaces where participating private issuers offer consumers a variety of qualified health plans that constitute minimum essential coverage.<sup>5</sup> Certain low- and moderate-income individuals and families may be eligible for this credit, which is refundable and can be paid to insurance companies in advance to reduce enrollees' premium

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<sup>4</sup>Health insurance coverage that provides limited benefits, such as dental-only coverage, or Medicaid coverage that provides less than full benefits, such as Medicaid plans that cover only family planning, does not constitute minimum essential coverage.

Medicare is a federal health insurance program for individuals aged 65 and older, individuals under age 65 with certain disabilities, and individuals diagnosed with end-stage renal disease. Medicare Part A covers inpatient medical benefits. Other Medicare programs cover different goods and services.

<sup>5</sup>PPACA required the establishment of exchanges in each state by Jan. 1, 2014. In states that did not elect to operate their own state-based exchange, PPACA required the federal government to establish and operate an exchange in the state, known as federally facilitated exchanges. Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 119 at 173, 186.

Our report assumed that individuals in all states could potentially be eligible for the premium tax credit, regardless of whether they purchased insurance through a state-based exchange or a federally facilitated exchange, consistent with the final rule issued by the Internal Revenue Service. See Health Insurance Premium Tax Credit, preamble 1.f and regulations to be codified at 26 C.F.R. §§ 1.36B-0 et seq.; 77 Fed. Reg. 30377, 30378, 30385 (May 23, 2012). The U.S. Supreme Court will consider whether PPACA authorizes the premium tax credit for individuals who purchase coverage through federally facilitated exchanges. See *King v. Burwell*, 759 F.3d 358 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (Nov. 7, 2014) (No. 14-114).

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costs for exchange plans. In this report, we refer to advance payments of the credit as advance premium tax credits (APTC).<sup>6</sup>

In addition, PPACA required the establishment of small business health option programs (SHOP) in each state to allow small employers to compare available health insurance options in their states and facilitate the enrollment of their employees in qualifying coverage. To provide an incentive for them to do so, PPACA established the small employer health insurance tax credit (referred to in this report as the small employer tax credit).<sup>7</sup> It subsidizes the share of the premiums small employers pay for their employees' health insurance.

Individuals are exempt from the requirement to have minimum essential coverage when such coverage is not "affordable," as defined by PPACA. In general, plans are considered affordable if their cost does not exceed 8 percent of household income. In addition, for purposes of determining eligibility for the APTC, PPACA considers ESI affordable if an employee's share of a qualifying self-only plan costs no more than 9.5 percent of household income.<sup>8</sup> Individuals with an offer of ESI that meets or is below this threshold are not eligible to receive the APTC.

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<sup>6</sup>Individuals who receive APTC must file federal income tax returns to reconcile the amount of the premium tax credit allowed based on reported income with the amount of the premium tax credit received in advance (APTC). An individual whose premium tax credit for the taxable year exceeds the individual's APTC payments may receive the excess as an income tax refund. An individual whose APTC payments for the taxable year exceed the individual's premium tax credit owes the excess as an additional income tax liability, subject to certain caps. 26 C.F.R. § 1.36B-4.

<sup>7</sup>Pub. L. No. 111-148, §§ 1421, 10105, 124 Stat. 119 at 237, 906 (codified at 26 U.S.C. § 45R).

<sup>8</sup>PPACA adjusts the thresholds at which premiums become unaffordable to reflect the excess of the rate of premium growth over the rate of income growth for the preceding calendar year. In 2015, the threshold at which premiums are unaffordable for purposes of determining an exemption from the requirement to have minimum essential coverage rose from 8 percent of household income to 8.05 percent. Similarly, the threshold at which an employee's share of ESI premiums are considered unaffordable for purposes of APTC eligibility rose from 9.5 percent to 9.56 percent.

PPACA mandated that GAO review the affordability of health insurance coverage 5 years after enactment.<sup>9</sup> Specifically, in this report we examine

1. what is known about the effects of the APTC and the small employer tax credit on health insurance coverage; and
2. the extent to which affordable health benefits plans are available and individuals are able to maintain minimum essential coverage.

To examine what is known about the effects of the APTC and the small employer tax credit on health insurance coverage, we conducted a structured literature search to identify relevant studies.<sup>10</sup> To conduct this review, we searched over 30 reference databases for studies published on these topics. Two analysts independently reviewed each of the results for relevance. To supplement this search, we performed further Internet searches and asked experts we interviewed to recommend literature. We interviewed experts from 11 research or industry organizations as well as officials from the Department of Health and Human Services' (HHS) Center for Consumer Information and Insurance Oversight, Assistant Secretary of Planning and Evaluation, and the Chief Actuary; and from the Internal Revenue Service (IRS). We identified the experts through their published or other work, and we asked them about how the tax credits were likely to affect health insurance coverage. We also reviewed laws, regulations, and guidance related to PPACA's individual mandate, the APTC, the small employer tax credit, individual exchange regulation, and the ESI affordability threshold. To further analyze the effects of the small employer tax credit on health insurance coverage, we incorporated summary data from our previous report on this topic and requested updated summary data from the IRS on claims for tax years 2011 and

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<sup>9</sup>PPACA also mandated that GAO review what is known about the effects of lowering the employer-sponsored insurance (ESI) affordability threshold. We discuss this topic in appendix I.

<sup>10</sup>This report discusses the advance premium tax credit rather than the premium tax credit because complete information on the premium tax credit was not available during the period of our review. In particular, individuals who received the APTC must, when filing their 2014 federal income tax returns, reconcile the amount of the premium tax credit allowed based on their reported income with the amount of the premium tax credit received in advance based on their anticipated income at the time of enrollment. Because our work preceded the reconciliation process, the only data available for our analysis was APTC data, not the reconciled amounts.

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2012, the most current years available at the time of our analysis.<sup>11</sup> To assess the reliability of the data, we reviewed the data and supporting documentation for obvious errors, as well as IRS's internal controls for producing the data. We found the data to be sufficiently reliable for our purposes.

To examine the extent to which affordable health benefits plans are available and individuals are able to maintain minimum essential coverage, we reviewed studies resulting from our literature review, as well as interviewed experts as described above. We asked experts about the types of individuals that may have more or less difficulty accessing affordable coverage and maintaining minimum essential coverage. In addition, we analyzed 2014 premium data—the most recent data available at the time of our analysis—from the federally facilitated exchanges and state-based exchanges to determine the percent of household income that households would have had to spend on premiums for the lowest-cost plans available. We obtained these premium data from The Henry J. Kaiser Family Foundation (KFF) and from the state of New York. To assess these data for reliability, we interviewed key officials, checked the data for outliers and validated selected data. We found both datasets to be reliable for our purposes. A more extensive discussion of our scope and methodology appears in appendix II.

We conducted this performance audit from July 2014 through March 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>11</sup>GAO, *Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity*, [GAO-12-549](#) (Washington, D.C.: May 14, 2012).

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## Background

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### PPACA Health Insurance Requirements and Subsidies

Beginning January 1, 2014, PPACA required most citizens and legal residents of the United States to maintain health insurance that qualifies as minimum essential coverage for themselves and their dependents or pay a tax penalty. Individuals are exempt from this requirement if they would have to pay more than 8 percent of their household income for the lowest-cost self-only health plan that is available to the individual.<sup>12</sup>

Beginning October 1, 2013, individuals were able to shop for private health insurance coverage that qualifies as minimum essential coverage through marketplaces, also referred to as exchanges, which offer choices of qualified health plans.<sup>13</sup> In 34 states, the federal government operated the individual exchanges, known as federally facilitated exchanges, while 17 states operated state-based exchanges in 2014.<sup>14</sup> Individuals can purchase self-only plans, or they can purchase family plans for themselves, their spouses, and their dependents.

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<sup>12</sup>Similarly, families are exempt when the lowest-cost health plan available to the family exceeds 8 percent of household income. For purposes of the individual mandate, household income is the taxpayer's modified adjusted gross income, plus that of every other individual in a family for whom an individual can properly claim a personal exemption deduction and who is required to file a federal income tax return. Modified adjusted gross income is a tax-based definition of income established in PPACA. See 26 U.S.C. § 5000A(c)(4)(B). Other exemptions may be available for certain eligible individuals, such as those determined to have suffered certain hardships, members of Native American tribes, and those who qualify for an exemption for religious reasons.

<sup>13</sup>PPACA requires the insurance plans offered under an exchange, known as qualified health plans, to provide a package of essential health benefits—including coverage for specific service categories, such as ambulatory care, prescription drugs, and hospitalization. In addition to these categories, states may require or restrict coverage of other benefits by qualified health plans. Pub. L. No. 111-148, §§ 1311(d), 10104(e)(1), 124 Stat. 119 at 176, 900.

<sup>14</sup>Some states that elected not to establish a state-based exchange entered into a partnership with the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services in which HHS establishes and operates the exchange while states assist HHS in carrying out certain functions of the exchange. Because a partnership exchange is a variation of a federally facilitated exchange, we include partnership states as federally facilitated exchange states in this report. In addition, in 2014, two states—Idaho and New Mexico—operated their own exchange, but enrollees signed up for health insurance through the federal website, <http://www.healthcare.gov>. The term "state" in this report includes the District of Columbia.

Qualified health plans on the exchanges may provide minimum essential coverage at one of four levels of coverage that reflect out-of-pocket costs that may be incurred by an enrollee. The four levels of coverage correspond to a plan's actuarial value—the percentage of the total average costs of allowed benefits paid by a health plan—and are designated by metal tiers: 60 percent (bronze), 70 percent (silver), 80 percent (gold), and 90 percent (platinum).<sup>15</sup> For example, a gold plan with an 80 percent actuarial value would be expected to pay, on average, 80 percent of a standard population's expected medical expenses for the essential health benefits. The individuals covered by the plan would be expected to pay, on average, the remaining 20 percent of the expected cost-sharing expenses in the form of deductibles, copayments, and coinsurance.<sup>16</sup>

Under PPACA, issuers are allowed to adjust premium rates within specified limits for plans, based on the number of people covered under a particular policy and the covered individuals' age, tobacco use, and area of residence.<sup>17</sup> Each state must divide its state into one or more rating areas that all issuers must use in setting premium rates. The rating area is the lowest geographic level by which issuers can vary premiums.

Individuals obtaining insurance through the exchanges may be eligible for the APTC under PPACA if they meet applicable income requirements and are not be eligible for coverage under another qualifying plan or program, such as ESI or Medicaid. To meet the APTC's income requirements,

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<sup>15</sup>42 U.S.C. § 18022(d). In addition to these metal tiers, catastrophic plans are available to those under 30 years of age or to those who are exempt from the requirement to have minimum essential coverage because of a hardship or because the lowest-cost plan available would cost more than 8 percent of one's household income. Catastrophic plans' actuarial value must be lower than that of a bronze plan, so these plans have the highest level of cost sharing, although they cover preventive care at no cost. Enrollees are not eligible for the APTC.

<sup>16</sup>These cost-sharing provisions apply only to the essential health benefits and other goods and services that insurers cover. Goods and services that are not covered may cause additional expenses to be incurred.

<sup>17</sup>In 2013 in most states, applicable laws allowed broader variation for age and also allowed variation for other factors, such as health status and gender, which PPACA prohibited in 2014. See GAO, *Private Health Insurance: The Range of Base Premiums in the Individual Market by County in January 2013* (Washington D.C., Sept. 5, 2014) [GAO-14-772R](#).

individuals must have household incomes between 100 and 400 percent of the FPL (see table 1).<sup>18</sup>

**Table 1: 2013 Federal Poverty Level (FPL) for an Individual and a Family of Four in the 48 Contiguous States**

Percentage of Poverty	Poverty level for single person	Poverty level for family of four
100	\$11,490	\$23,550
133	\$15,282	\$31,322
200	\$22,980	\$47,100
300	\$34,470	\$70,650
400	\$45,960	\$94,200

Source: Department of Health and Human Services. | GAO-15-312

Note: The U.S. Department of Health and Human Services publishes separate FPL guidelines for Alaska and Hawaii that are higher than for the 48 continuous states, reflecting higher cost-of-living allowances.

The amount of the APTC is calculated based on an eligible individual’s household income relative to the cost of premiums for the “reference plan,” even if the individual chooses to enroll in a different plan. The reference plan is the second-lowest-cost silver plan available.<sup>19</sup> The APTC in effect caps the maximum amount of income that an individual would be required to contribute to the premiums for the reference plan. The capped amount varies depending on the enrollee’s household income relative to the FPL and is less for enrollees with lower household income. Table 2 shows the maximum percentage of household income a qualifying enrollee would have to pay if they enrolled in the reference plan. If the enrollee chooses a more expensive plan, such as a gold or

<sup>18</sup>Household income is the taxpayer’s modified adjusted gross income, plus that of every other individual in a family for whom an individual can properly claim a personal exemption deduction and who is required to file a federal income tax return. For purposes of the premium tax credit, and in contrast to the individual mandate, modified adjusted gross income includes nontaxable Social Security benefits. See 26 U.S.C. § 36B(d)(2)(B); 26 U.S.C. § 5000A(c)(4)(C).

Certain lawfully present immigrants with incomes below 100 percent of FPL who would be eligible for Medicaid but for their immigration status are eligible for the APTC.

<sup>19</sup>The second-lowest-cost silver plan available is the plan that applies to a taxpayer’s “coverage family.” Members of the coverage family are those for whom a taxpayer claims a personal exemption and who are enrolled in a qualified health plan through an exchange and not eligible for other minimum essential coverage.

platinum plan, they would pay a higher percentage of their income. If the enrollee chooses a less expensive plan, such as a bronze plan, they would pay less.<sup>20</sup> The amount of the APTC is determined based on an enrollee’s family size and anticipated household income for the year, which is subject to adjustment—or reconciliation—the following year. Specifically, the final amount of the credit is determined when the enrollee files an income tax return for the taxable year, which may result in a tax liability or refund if the enrollee’s actual, reported household income amount is greater or less than the anticipated income on which the amount of APTC was based.

**Table 2: Percentage of Household Income Enrollee Is Required to Contribute for Reference Plan Premiums, after Applying the APTC**

Percentage of the FPL	Premium contribution as a percentage of income
0 to less than 100%	Generally does not qualify for APTC
At least 100 but less than 133%	2%
At least 133 but less than 150%	3-4%
At least 150 but less than 200%	4-6.3%
At least 200 but less than 250%	6.3-8.1%
At least 250 but less than 300%	8.1-9.5%
At least 301 but less than 400%	9.5%
Over 400%	Does not qualify for APTC

Source: IRS and 26 C.F.R. §§ 1.36B-2(b), 1.36B-3(g)(2) (2012). | GAO-15-312

To further improve access to care, certain low-income individuals may also be eligible for an additional type of income-based subsidy established by PPACA, known as cost-sharing subsidies, which reduce out-of-pocket costs for such things as copayments for physician visits or prescription drugs.<sup>21</sup> To be eligible for these cost-sharing subsidies, individuals must have household incomes between 100 and 250 percent of the FPL, not be eligible for coverage under another qualifying plan or program such as Medicaid or ESI, and be enrolled in a silver plan through

<sup>20</sup>If the amount of the credit is larger than the premium itself, the enrollee pays no premium. Conversely, if the premium cost is less than the percentage of household income an individual is required to contribute based on FPL, then the individual will not receive a tax credit.

<sup>21</sup>42 U.S.C. § 18071.

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an exchange.<sup>22</sup> Cost-sharing subsidies effectively raise the actuarial value of the silver plan.

As a practical matter, because individuals eligible for Medicaid are not eligible for the APTC, the minimum income level for these subsidies differs between states that chose to expand Medicaid under PPACA and those that did not.<sup>23</sup> In states that chose to expand Medicaid under PPACA, nonelderly adults are eligible for Medicaid when their household income is less than 138 percent of the FPL. Because those eligible for Medicaid are not eligible for the APTC, the minimum income level for the APTC in Medicaid expansion states is effectively 138 percent of the FPL. In states that chose not to expand Medicaid, the minimum income level for individuals to qualify for APTC and cost-sharing subsidies is 100 percent of the FPL, as specified in PPACA, assuming the state's Medicaid eligibility threshold is at or below this level.<sup>24</sup> As of January 2015, 27 states and the District of Columbia opted to expand Medicaid under PPACA.

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## Employer-Sponsored Insurance under PPACA

Under PPACA, employers that meet certain conditions must offer health insurance to some employees. Employers with at least 50 full-time equivalent employees—which includes employees whose hours average at least 30-hours per week—must offer qualifying health insurance to their

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<sup>22</sup>American Indians and Alaska Natives are eligible for cost-sharing assistance up to 300 percent of the FPL.

<sup>23</sup>Specifically, PPACA authorizes states to expand eligibility for Medicaid to most non-elderly adults whose income is at or below 133 percent of the FPL. PPACA also specifies that an income disregard in the amount of 5 percent of the FPL be deducted from an individual's income when determining Medicaid eligibility, which effectively raises the income eligibility threshold for newly eligible Medicaid recipients in expansion states to 138 percent of the FPL.

<sup>24</sup>See 26 U.S.C. § 36B(c)(1)(A). The minimum income levels applicable to APTC also apply to federal cost-sharing subsidies, which reduce out-of-pocket costs for such things as copayments for physician visits or prescription drugs. See 42 U.S.C. § 18071(b)(2).

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full time employees or face tax penalties if at least one full-time employee receives the APTC.<sup>25</sup>

In contrast to PPACA's affordability threshold of 8 percent of household income for the purpose of assessing penalties for failure to maintain minimum essential coverage, PPACA requires ESI to meet two different affordability tests for the purposes of determining eligibility for the APTC. First, the employee's share of the ESI premiums covering an individual, also referred to as a self-only plan, must not exceed 9.5 percent of the employee's household income. Second, the insurance offered must cover 60 percent of the actuarial value of health care for the average person to qualify as affordable for purposes of the APTC. Employees who are offered ESI that meets both of these tests are not eligible for the APTC. Some employees may be offered qualifying ESI that costs between 8 and 9.5 percent of household income. If these individuals do not have access to insurance on an individual exchange that costs less than 8 percent of household income, they are exempt from the individual mandate and will not have to pay a tax penalty if they forgo coverage. However, these individuals are not eligible for the APTC.

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## Small Employer Tax Credit

Because small employers are not required to offer health insurance and have been less likely to offer health insurance than large employers, PPACA established a small employer tax credit as an incentive for them to provide insurance by making it more affordable.<sup>26</sup> The credit is available to certain employers—small business and tax-exempt entities—with employees earning low wages and that pay at least half of their employees' health insurance premiums. To qualify for the credit, employers must employ fewer than 25 full-time equivalent employees (excluding certain employees, such as business owners and their family

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<sup>25</sup>26 U.S.C. § 4980H. These requirements are being phased in over time. In 2015, employers with between 50 to 99 full-time equivalent employees are exempt from the requirement. Employers with more than 100 full-time equivalent employees must offer qualifying health insurance coverage to 70 percent of full-time employees in 2015. In 2016, employers with 50 or more full-time equivalent employees will be required to offer qualifying coverage to 95 percent of their full-time employees. Employers out of compliance will be subject to an annual tax penalty of \$2,000 times the number of full-time employees minus 30, if one of their full-time employees receives the APTC to purchase health insurance through the individual exchanges. See *Shared Responsibility for Employers Regarding Health Coverage*, 79 Fed. Reg. 8544 (Feb. 12, 2014).

<sup>26</sup>26 U.S.C. § 45R.

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members), and pay average annual wages per employee of less than \$50,800 per year in 2014. The amount of the credit depends on several factors, such as the number of full-time equivalent employees and their total annual wages. In addition, the amount of the credit is limited if the premiums paid by an employer are more than the state's average small group market premiums, as determined by HHS.

Employers may claim the small employer tax credit for up to 6 years—the initial 4 years from 2010 through 2013 and, starting in 2014, any 2 consecutive years if they buy insurance through the Small Business Health Option Programs (SHOP). PPACA required the establishment of SHOPS in each state by January 1, 2014, to allow small employers to compare available health insurance options in their states and facilitate the enrollment of their employees in coverage. In states electing not to establish and operate a state-based SHOP, PPACA required the federal government to establish and operate a federally facilitated SHOP in the state.<sup>27</sup> Starting in 2014, employers that wanted to claim the small employer tax credit had to enroll their employees through the SHOP exchanges.

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## Early Evidence Suggests That While the APTC Likely Contributed to an Expansion of Coverage, the Small Employer Tax Credit Has Had Little Effect

Early evidence suggests that the APTC likely contributed to an expansion of health insurance coverage because it significantly reduced the cost of premiums for those eligible, though there are limitations to measuring the effects of the APTC using currently available data. In contrast, few employers claimed the small employer tax credit, limiting its effect on health insurance coverage.

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<sup>27</sup>In 2014, 18 states chose to operate state-based SHOPS while 33 states opted for a federally facilitated SHOP.

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The APTC Likely Contributed to an Expansion of Coverage by Reducing the Cost of Health Insurance Premiums to Those Eligible

Early evidence suggests that the APTC likely contributed to an expansion in health insurance coverage. We identified three surveys that estimated the uninsured rate by household income. Although limitations exist in measuring the direct, causal effects of the APTC on health insurance coverage using currently available data, these surveys can be used to make early observations about changes in the rate of uninsured. They found that the uninsured rate declined among households with incomes between 139 and 400 percent of the FPL—that is, households financially eligible for the APTC in all states (see table 3). For example, one study found that the rate of uninsured among individuals with household incomes between 139 and 400 percent of the FPL fell 9 percentage points between January 1, 2012, and June 30, 2014, in Medicaid expansion states.<sup>28</sup> Further, the results from this survey found that gains in insurance coverage were statistically significant for individuals in this income bracket regardless of the states' Medicaid expansion decisions.

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<sup>28</sup>B. D. Sommers, T. Musco, K. Finegold, M. Z., Gunja, et al. "Health Reform and Changes in Health Insurance Coverage in 2014," *The New England Journal of Medicine*, vol. 371, no. 9 (Aug. 28, 2014).

**Table 3: Survey Estimates of the Change in the Percent of Uninsured Nonelderly Adults by Household Income As a Percent of the Federal Poverty Level (FPL)**

Survey	States covered	Time period	Income categories, as a percent of the FPL	Percentage point change in the rate of uninsured
Gallup-Healthways Well-Being Index <sup>a</sup>	Medicaid nonexpansion states	January 1, 2012, to June 30, 2014	Less than 139 percent of the FPL	-3.1
			139 to 400 percent of the FPL	-5.5
			Greater than 400 percent of the FPL	-1.0
	Medicaid expansion states	January 1, 2012, to June 30, 2014	Less than 139 percent of the FPL	-6.0
			139 to 400 percent of the FPL	-9.0
			Greater than 400 percent of the FPL	-0.7
The Commonwealth Fund Affordable Care Act Tracking Survey <sup>b</sup>	All states	July 15 to September 8, 2013, versus April 9 to June 2, 2014	Less than 138 percent of the FPL	-11.0
			138 to 249 percent of the FPL	-10.0
			250 to 399 percent of the FPL	-2.0
			400 percent of the FPL or greater	-1.0
The Urban Institute Health Reform Monitoring Survey <sup>c</sup>	All states	September 2013 to September 2014	Less than 139 percent of the FPL	-12.0
			139 to 399 percent of the FPL	-5.2
			400 percent of the FPL or greater	-0.2

Source: GAO analysis. | GAO-15-312.

Notes: The three surveys cannot be compared directly because each survey covered different time periods, categorized respondents in slightly different income categories, and asked questions about individuals' health insurance coverage slightly differently.

<sup>a</sup>B. D. Sommers, T. Musco, K. Finegold, M. Z. Gunja, et al., "Health Reform and Changes in Health Insurance Coverage in 2014," *The New England Journal of Medicine*, vol. 371, no. 9 (2014).

<sup>b</sup>S. R. Collins, P. W. Rasmussen, and M. M. Doty. *Gaining Ground: Americans' Health Insurance Coverage and Access to Care after the Affordable Care Act's First Open Enrollment Period* (New York: The Commonwealth Fund, 2014).

<sup>c</sup>S. K. Long, M. Karpman, A. Shartzter, D. Wissoker, et al., *Taking Stock: Health Insurance Coverage under the ACA as of September 2014* (Washington, D.C.: The Urban Institute, 2014).

This expansion in health insurance coverage is likely partially a result of the APTC having reduced the cost of health insurance premiums for those deemed eligible.<sup>29</sup> As of April 19, 2014, HHS initially estimated that 8 million individuals (including dependents) had selected a health plan through either a state-based exchange or a federally facilitated exchange,

<sup>29</sup>Other factors or provisions in the PPACA could have also affected changes in the rate of uninsured, including the requirement to maintain minimum essential coverage or pay a tax penalty (i.e., the individual mandate), the requirement that some large employers offer health insurance to full-time employees, or individual market reforms that prohibited issuers from denying individuals coverage and setting rates based on individuals' health status.

and most of them (85 percent) were deemed eligible for the APTC at the time that they selected a health plan.<sup>30</sup> Among those who selected a plan through 1 of the 34 federally facilitated exchanges or the 2 state-based exchanges that used the federal website for enrollment in 2014 and were deemed eligible for the APTC (4.7 million individuals), the APTC reduced premiums by 76 percent, on average (see table 4).<sup>31</sup> For those who selected a silver plan through these 36 exchanges and were deemed eligible for the APTC, the APTC reduced premiums the most—an 80 percent reduction.<sup>32</sup> Overall, most individuals who selected a plan through these 36 exchanges and received the APTC (69 percent) saw their premiums reduced to \$100 per month or less (\$1,200 annually or less), and nearly half (46 percent) had their monthly premiums reduced to

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<sup>30</sup>Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Open Enrollment Period* (Washington, D.C.: May 1, 2014). As of November 2014, HHS reported that 6.7 million individuals had enrolled in a health plan through the individual exchanges, after accounting for effectuated enrollment—that is, individuals who had selected a plan and paid their premiums—and excluding enrollment in dental plans. Of these individuals, 85 percent were deemed eligible for the APTC. As of January 2015, however, HHS had not revised its summary statistics on the amount of APTC that eligible individuals had received or the amount that the APTC reduced premiums for those eligible.

<sup>31</sup>Department of Health and Human Services, *Health Insurance Marketplace*; and Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Premium Affordability, Competition, and Choice in Health Insurance Marketplace, 2014* (Washington, D.C.: June 18, 2014). In its analysis of the amount of APTC that individuals received and the extent to which it reduced premiums, HHS included data from the 34 federally facilitated exchanges as well as 2 state-based exchanges—Idaho and New Mexico—that used the federal website, <http://www.healthcare.gov>, for exchange enrollment in 2014.

<sup>32</sup>Department of Health and Human Services, *Premium Affordability*. Of those who were deemed eligible for an APTC when they selected a health plan through 1 of the 34 federally facilitated exchanges or 1 of the 2 state-based exchanges that used the federal website, <http://www.healthcare.gov>, for enrollment in 2014, most (76 percent) selected a silver plan, followed by 15 percent who selected a bronze plan, 6 percent who selected a gold plan, and 3 percent who selected a platinum plan. Department of Health and Human Services, *Health Insurance Marketplace*. Individuals with household incomes between 100 and 250 percent of the FPL—those eligible to receive both the APTC and the cost-sharing reduction subsidies—may have been encouraged to select silver because, by selecting a bronze plan, they would have become ineligible to receive the cost-sharing reduction subsidies.

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\$50 or less (\$600 annually or less).<sup>33</sup> However, results from an early survey and experts we interviewed suggested that the APTC may have been less effective in expanding health insurance coverage for individuals financially eligible for a smaller APTC amount and ineligible for cost-sharing reduction subsidies than for individuals eligible for a larger APTC amount as well as for cost-sharing reduction subsidies.<sup>34</sup>

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<sup>33</sup>Thirteen percent of individuals who selected a health plan through 1 of the 34 federally facilitated exchanges or 1 of the 2 state-based exchanges that used the federal website, <http://www.healthcare.gov>, for enrollment in 2014 and were deemed eligible for the APTC had their monthly premiums reduced to between \$101 and \$150 (\$1,212 to \$1,800 annually), and 18 percent had an after-APTC monthly premium amount greater than \$150 (greater than \$1,800 annually). Department of Health and Human Services, *Premium Affordability*.

<sup>34</sup>The survey examined changes in the rate of nonelderly uninsured adults by income and found that, between 2013 and 2014, the uninsured rate declined by 2 percentage points among those with household incomes between 250 and 399 percent of the FPL—individuals eligible for a smaller APTC amount and ineligible for cost-sharing reduction subsidies. By comparison, the uninsured rate declined by 10 percentage points among those with household incomes between 138 and 249 percent of the FPL—individuals eligible for a larger APTC amount as well as cost-sharing reduction subsidies. S. R. Collins, P. W. Rasmussen, and M. M. Doty, *Gaining Ground: Americans' Health Insurance Coverage after the Affordable Care Act's First Open Enrollment Period* (New York: The Commonwealth Fund, 2014).

**Table 4: Average Monthly Advance Premium Tax Credit (APTC) Amount and Percent Reduction in Premiums after APTC for Individuals Who Selected a Plan through a Federally Facilitated Exchange or a State-Based Exchange that Used the Federal Website for Enrollment in 2014 and Were Deemed Eligible for the APTC in 2014, by Metal Tier**

Metal tier	Average monthly premium amount before APTC	Average monthly APTC	Average monthly premium amount after APTC	Average percent reduction in premiums after APTC
Bronze	\$289	\$221	\$68	76
Silver	\$345	\$276	\$69	80
Gold	\$428	\$220	\$208	51
Platinum	\$452	\$232	\$220	51
<b>All metal tiers</b>	<b>\$346</b>	<b>\$264</b>	<b>\$82</b>	<b>76</b>

Source: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014* (Washington, D.C.: June 18, 2014). | GAO-15-312

Notes: In its analysis of the amount of APTC that individuals received and the extent to which it reduced premiums, HHS included data from the 34 federally facilitated exchanges as well as 2 state-based exchanges—Idaho and New Mexico—that used the federal website, <http://www.healthcare.gov>, for exchange enrollment in 2014. Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent.

As of January 2015, data were not available on the extent to which the APTC reduced 2015 premiums for enrollees. Studies that examined changes in premiums between 2014 and 2015 found that, on average, premiums changed modestly. For example, HHS reported that premiums for the reference plan (before applying the APTC) increased by 2 percent, on average, between 2014 and 2015, and premiums for the lowest-cost silver plan increased by an average of 5 percent.<sup>35</sup> However, studies found variation across rating areas, and some rating areas had significant increases or decreases in average premiums.<sup>36</sup> Further, premiums are

<sup>35</sup>Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace* (Washington, D.C.: Dec. 4, 2014).

<sup>36</sup>For example, one study that measured the change in premiums between 2014 and 2015 found that, while premiums for the lowest-cost bronze plan increased by an average of 4 percent, they increased by up to 43 percent in western counties of Minnesota and declined by at most 40 percent in Summit County, Colorado. C. Cox, L. Levitt, G. Claxton, R. Ma, and R. Duddy-Tenbrunsel, *Analysis of 2015 Premium Changes in the Affordable Care Act’s Health Insurance Marketplaces* (Menlo Park, Calif.: Jan. 6, 2015).

likely to continue to change in future years as issuers gain more data about enrollees in the exchanges and how they compare to enrollees previously purchasing individual insurance or ESI.<sup>37</sup> In addition, while the APTC helps protect eligible individuals from large increases in premiums by capping the amount of household income individuals have to pay for the reference plan, some who reenrolled in their health plan in 2015, rather than shopping for and switching to a lower cost plan, may find that their premiums, after accounting for the APTC, increased substantially. HHS estimated that more than 7 in 10 current exchange enrollees could find a lower-cost plan within the same metal level as they selected in 2014 if they selected the new lowest-cost plan in 2015, rather than reenroll in their same 2014 plan, but the extent to which this occurred was not yet known as of January 2015.<sup>38</sup>

According to results from four early surveys of nonelderly adults and one group of experts we interviewed, lack of awareness of the APTC may have limited take-up of health insurance coverage among some individuals likely eligible for the APTC. Three of the four surveys estimated that, of those who remained uninsured in 2014, between 59 and 60 percent cited affordability or the cost of premiums as the reason for not purchasing health insurance coverage.<sup>39</sup> However, less than half—between 38 and 47 percent—of the uninsured surveyed were aware of

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<sup>37</sup>Also, as premiums are influenced by underlying costs of health care, there remains uncertainty as to whether lower than historical trends in health care cost growth in recent years will continue in future years.

<sup>38</sup>For 78 percent of individuals who selected a silver plan in 2014, the lowest-cost silver plan in 2015 cost less than their 2014 plan. Similarly, for 78 percent of who selected a bronze plan in 2014, the lowest-cost bronze plan in 2015 was cheaper than their 2014 plan. Department of Health and Human Services, *Health Plan Choice*.

<sup>39</sup>L. Hamel, B. DiJulio, J. Firth, M. Brodie, *Kaiser Health Tracking Poll: November 2014* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 2014); A. Bhardwaj, E. Coe, J. Cordina, and R. Saha, *Individual Market: Insights Into Consumer Behavior at the End of Open Enrollment* (New York: McKinsey Center for U.S. Health System Reform, 2014); and A. Schatzer, G. M. Kenney, S. K. Long, K. Hemstead, et al. *Who Are the Remaining Uninsured As of June 2014?* (Washington, D.C.: The Urban Institute, 2014). In addition, publicly available summary results from the fourth survey showed that of all nonelderly adults surveyed who reported that they shopped on an exchange for a health insurance plan, 54 percent said that it was “very difficult or impossible” or “somewhat difficult” to find a plan they could afford. P. W. Rasmussen, S. R. Collins, M. M. Doty, and S. Beutel, *Are Americans Finding Affordable Coverage in the Health Insurance Marketplaces? Results from the Commonwealth Fund Affordable Care Act Survey* (New York: The Commonwealth Fund, September 2014).

the availability of financial assistance to purchase insurance through the individual exchanges.<sup>40</sup>

When interpreting data on the effect of the APTC on changes in health insurance coverage, there are several limitations to consider:

- Large-scale, rigorous survey data are needed to more accurately measure the direct, causal effect of the APTC on changes in health insurance coverage. While early survey data provide some indications of the effect of the APTC on coverage, these surveys generally have lower response rates and smaller sample sizes, which could cause large margins of error when examining changes in health insurance coverage by subgroups, such as by household income.<sup>41</sup> However, results from larger, more rigorous surveys are not expected to be available until the summer of 2015 at the earliest.<sup>42</sup>
- Available summary data from HHS on those who received the APTC are limited and subject to change because the data:
  - Did not account for effectuated enrollment—that is, whether those who initially selected a health plan paid their premium—nor did it account for individuals who did not submit required documentation

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<sup>40</sup>Collins et al., *Gaining Ground*; L. Hamel, J. Firth, B. DiJulio, and K. Brodie, *Kaiser Health Tracking Poll: October 2014* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 2014); and Schatzer et al., *Who Are the Remaining Uninsured*. In addition, publicly available summary results from the fourth survey found that 44 percent of the uninsured surveyed who were likely eligible for financial assistance were aware of the APTC. Bhardwaj et al., *Individual Market*.

<sup>41</sup>See appendix II for additional information about the response rates, sample sizes, and margins of error of early surveys cited in this report.

<sup>42</sup>The first large data set that covers the full first year of enrollment in the exchanges will become available in June 2015 with the release of complete 2014 National Health Interview Survey data, though precise income data in this survey will not become available until August 2015.

to verify their eligibility for the exchanges or the APTC, or those who may have selected a plan after open enrollment ended.<sup>43</sup>

- Did not include the amount of APTC that individuals in 15 state-based exchanges received.<sup>44</sup> Although 15 state-based exchanges reported to HHS's Centers for Medicare & Medicaid Services (CMS) the number of individuals who were deemed eligible for the APTC at the time that they selected a plan, CMS officials we spoke with stated that voluntary reporting on the amount of APTC individuals received was limited and variable across states.
- Did not account for adjustments to the amount of APTC that may occur when the amount of APTC received is reconciled against enrollees' actual income reported in their 2014 income tax returns, which will begin to occur when individuals start to file their income tax returns in 2015.<sup>45</sup>

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<sup>43</sup>As of September 15, 2014, HHS officials reported that at least 363,000 individuals who selected a health plan through the exchanges had not yet submitted required documentation. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), *CMS Update on Consumers Who Have Data Matching Issues*, Press Release (Washington, D.C.: Sept. 15, 2014). Individuals may enroll in coverage through an exchange during a special enrollment period outside of open enrollment due to a qualifying life event, such as a change in family status (e.g., marriage or birth of a child) or the loss of other health coverage, such as ESI.

<sup>44</sup>HHS included data from 2 of the 17 state-based exchanges—Idaho and New Mexico—in its summary data on the amount of APTC received by individuals who selected a health plan and were deemed eligible for the APTC. These two state-based exchanges used the federal website, <http://www.healthcare.gov>, for their 2014 exchange enrollment.

<sup>45</sup>Individuals who receive APTC must file federal income tax returns in order to reconcile the amount of the premium tax credit allowed based on reported income with the amount of the premium tax credit received in advance (APTC). An individual whose premium tax credit for the taxable year exceeds the individual's APTC payments may receive the excess as an income tax refund. An individual whose APTC payments for the taxable year exceed the individual's premium tax credit owes the excess as an additional income tax liability, subject to certain caps. 26 C.F.R. § 1.36B-4.

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## Few Employers Claimed the Small Employer Tax Credit, Limiting Its Effect on Health Insurance Coverage

Take-up of the small employer tax credit has continued to be lower than anticipated, limiting the effect of the credit on expanding health insurance coverage. About 167,600 employers claimed the credit in 2012 (the most recent year for which data were available), slightly fewer than the 170,300 employers that claimed the credit in 2010 (see fig. 1).<sup>46</sup> These figures are low compared to the number of employers eligible for the credit. In 2012, we found that selected estimates of the number of employers eligible ranged from about 1.4 million to 4 million.<sup>47</sup> Although about the same number of small employers claimed the credit in 2012 as in 2010, these employers paid all or some of the premiums for more employees in 2012 (900,800 employees) than in 2010 (770,000 employees).<sup>48</sup>

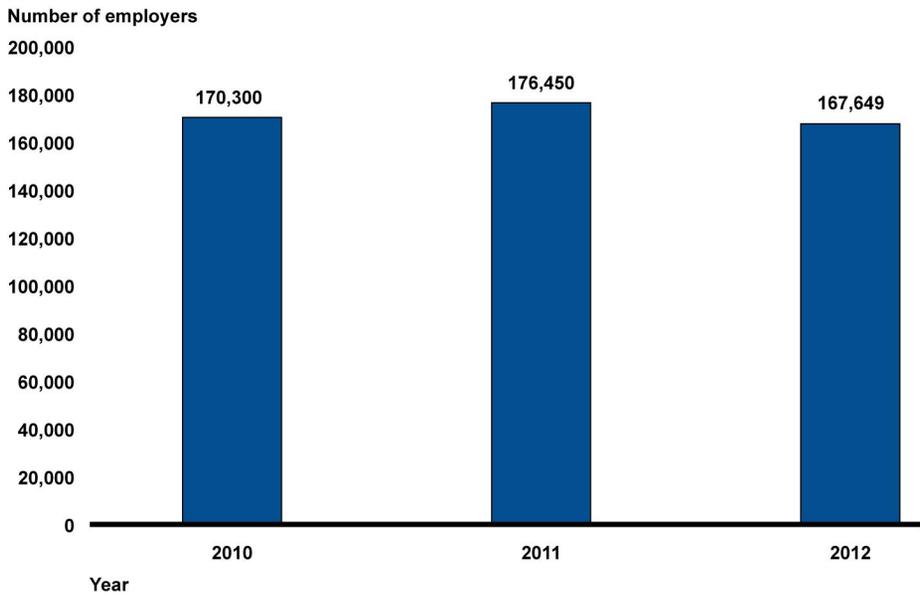
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<sup>46</sup>Complete data on the number of entities that claimed a tax credit are generally not available until sometime after the tax year in question because of the complex nature of filing and reconciling taxes.

<sup>47</sup>Data limitations made these estimates necessarily rough. See [GAO-12-549](#), 9.

<sup>48</sup>The total amount of credit claimed by employers continued to be lower than experts had projected. In March 2012, the Congressional Budget Office (CBO) and the Joint Committee on Taxation estimated that the cost of the credit would be \$1 billion in 2012. This estimate was previously \$5 billion in 2012. In 2012, employers claimed about \$507 million in credits compared to \$645 million in 2011 and \$468 million in 2010.

**Figure 1: Number of Employers That Claimed the Small Employer Tax Credit, 2010-2012**



Source: IRS. | GAO-15-312

As we found in 2012, experts we interviewed for this report generally told us that features of the small employer tax credit did not provide a strong enough incentive to employers to begin to offer or to continue offering health insurance.<sup>49</sup> First, experts explained that the maximum amount of the credit is targeted to very small employers, most of which do not offer health insurance, and experts told us the size of the credit is not large enough to be an incentive to employers to offer or maintain insurance. The maximum amount of the small employer tax credit is available to for-profit employers with ten or fewer full-time equivalent employees that pay an average of \$25,400 or less in wages.<sup>50</sup> Such an employer could be eligible for a credit worth up to 50 percent of the employer contributions to

<sup>49</sup>See [GAO-12-549](#), 12. In addition, we found no peer reviewed studies that examined whether or not the small employer tax credit affected employers' decisions to offer health insurance or lowered the costs of ESI in the last four years.

<sup>50</sup>The average annual wages were \$25,000 or less through 2013. The maximum average wage limit is indexed for inflation beginning in 2014.

premiums in 2014.<sup>51</sup> The credit amount “phases out” to zero as employers employ up to 25 full-time equivalent employees at higher wages—up to an average of \$50,000. For example, employers with 24 full-time equivalent employees are only eligible for the credit if they paid wages that averaged \$25,400 or less; such employers may be eligible for a credit worth up to 2.2 percent of employer contributions to premiums.<sup>52</sup> Second, the limited availability of the credit—employers can claim it for only two consecutive years after 2013—further detracts from any potential incentive for small employers that do not offer coverage to begin offering coverage. Experts we interviewed told us that employers are reluctant to provide a benefit to employees that would be at risk of being taken away later when the credit is no longer available.<sup>53</sup> Finally, experts told us that the complexity of applying for the credit outweighed its benefit. According to tax preparers and other stakeholders we interviewed for this and our previous report, the complexity of the paperwork required to claim the credit was significant, and small employers likely did not view the credit as a sufficient incentive to begin offering health insurance, given the time required to claim it.<sup>54</sup>

The trend in low take-up of the small employer tax credit is likely to continue given the low enrollment in SHOPs, and thus it is unlikely that its effects on coverage will change in the near future. This is because employers were required to offer health insurance coverage through SHOP exchanges to be eligible for the small employer tax credit

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<sup>51</sup>Through 2013, small for-profit employers could receive up to 35 percent (nonprofit entities up to 25 percent) of their base payments for employee health insurance premiums. These portions rose to 50 percent and 35 percent, respectively, starting in 2014.

<sup>52</sup>The Medical Expenditure Panel Survey (MEPS) estimated that in 2013, 86 percent of employers who may otherwise be eligible for the full credit did not offer health insurance. This MEPS statistic is based on employers—both for profit and nonprofit—with fewer than 10 employees that pay annual wages of \$24,000 or less to over half of their employees. Further, 76 percent of employers that may be eligible for the partial credit did not offer insurance. This MEPS statistic is based on employers—both for profit and nonprofit—with 10 to 24 employees that pay annual wages of \$24,000 or less to over half of their employees. Because the employers eligible for the partial credit can pay up to \$50,000 in wages, this is a less precise estimate than using MEPS to estimate insurance offerings for the full credit.

<sup>53</sup>See also [GAO-12-549](#), 12.

<sup>54</sup>See [GAO-12-549](#), 12-13.

beginning in 2014.<sup>55</sup> We previously found that 2014 enrollment in SHOP was significantly below expectations. Specifically, we found that as of June 2014, the 18 state-based SHOP exchanges had enrolled about 76,000 employees through nearly 12,000 small employers,<sup>56</sup> although not all of these employers were eligible for the credit.<sup>57</sup> Enrollment in states with federally facilitated SHOPS was not known as of January 2015, although CMS officials said they did not have reason to expect significant differences in enrollment trends for 2014 between the state-based SHOPS and the federally facilitated SHOPS.<sup>58</sup> In comparison, the Congressional Budget Office (CBO) had estimated that, in 2014, 2 million employees would enroll in coverage through either state-based or federally facilitated SHOP exchanges.<sup>59</sup>

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<sup>55</sup>The IRS has stated that in 2014, small employers in certain counties in Wisconsin and Washington where SHOP plans are not offered may be eligible for the tax credit if they offer coverage that would have qualified for the credit prior to January 1, 2014. See Internal Revenue Service, Section 45R – *Transition Relief with Respect to the Tax Credit for Employee Health Insurance Expenses of Certain Small Employers*, Internal Revenue Bulletin: 2014-2 (Washington, D.C.: Jan. 6, 2014). Similarly, the IRS has stated that in 2015, small employers in certain counties in Iowa where SHOP plans are not offered may be eligible for the tax credit if they offer coverage that would have qualified for the credit prior to January 1, 2014. See Internal Revenue Service, Section 45R-2015 – *Guidance with Respect to the Tax Credit from Employee Health Insurance Expenses of Certain Small Employers*, Internal Revenue Bulletin: 2015-6 (Washington, D.C.: Feb. 9, 2015).

<sup>56</sup>GAO, *Small Business Health Insurance Exchanges: Low Initial Enrollment Likely due to Multiple, Evolving Factors*, [GAO-15-58](#) (Washington, D.C.: Nov. 13, 2014), 12.

<sup>57</sup>Until 2016, states have the option to define small employers either as employers with 100 or fewer full-time equivalent employees or employers with 50 or fewer full-time equivalent employees. In contrast, to qualify for the small employer tax credit, employers must employ fewer than 25 full-time equivalent employees in the tax year (excluding certain employees, such as business owners and their family members).

<sup>58</sup>[GAO-15-58](#), 15.

<sup>59</sup>In a previous report, we found that the reasons for the low enrollment included the delay of some expected SHOP features. For example, online enrollment was not available for states with federally facilitated SHOP exchanges, and few SHOP exchanges offered employees a choice of plans. In addition, we reported that the small employer tax credit provided an insufficient incentive for employers to sign up. [GAO-15-58](#), 20.

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## While Most Nonelderly Adults Had Access to Affordable Health Insurance Coverage, Maintaining Minimum Essential Coverage May Be Challenging for Some

Most nonelderly adults had access to affordable minimum essential coverage through their employer, Medicaid, the exchanges, or other sources, although about 16 percent of nonelderly adults remained uninsured as of March 2014. While there are many reasons people remain uninsured, some—including certain families or individuals not eligible for the APTC—may not have access to affordable coverage. The affordability of health insurance coverage obtained through the exchanges varied depending on one’s age, household size, income, and place of residence. Regardless of the affordability of premiums, some may face challenges in maintaining their insurance.

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## Most Nonelderly Adults Had Access to Affordable Coverage

Most nonelderly adults had access to affordable minimum essential coverage through their employer, Medicaid, the exchanges, or other sources. While specific data on individuals’ access to affordable coverage is not available, estimates of the number of nonelderly adults who are insured through various types of coverage indicate that most have access to coverage that would be considered affordable under PPACA. For example, one survey estimated that, as of March 2014, 59 percent of nonelderly adults had obtained coverage through an employer.<sup>60</sup> For most individuals with ESI, the coverage would be considered affordable under PPACA—that is, premiums for the self-only ESI plan offered cost less

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<sup>60</sup>K.G. Carman and C. Eibner, *Changes in Health Insurance Enrollment Since 2013: Evidence from the RAND Health Reform Opinion Study* (Santa Monica, Calif.: RAND Corporation, 2014).

ESI generally qualifies as minimum essential coverage. However, according to experts we interviewed, some employers may offer plans with few benefits that do not meet the requirement that ESI cover 60 percent of the actuarial value of health care for the average person. Such plans generally cover only preventive services, according to these experts. Employees and their families who enroll in such plans are not subject to the penalty for failing to maintain minimum essential coverage. However, ESI plans that do not cover the minimum 60-percent actuarial value of health care costs are not affordable for purposes of determining eligibility for the APTC, and employers offering only these plans may be subject to a penalty if an employee obtains health insurance through an exchange and receives the APTC.

than 9.5 percent of their household income.<sup>61</sup> Individuals who are offered ESI that does not meet this affordability threshold may be eligible, depending on their household income, to receive the APTC to instead purchase an affordable exchange plan.<sup>62</sup> As of March 2014, an estimated 2 percent of nonelderly adults purchased coverage through an exchange—an estimated 85 percent of whom received the APTC. An additional 9 percent of nonelderly adults were enrolled in Medicaid coverage, which requires either no or minimal premiums.<sup>63</sup> Finally, an estimated 14 percent of nonelderly adults had other sources of coverage, such as TRICARE for certain members of the armed forces, or health plans sold off the exchanges.<sup>64</sup>

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<sup>61</sup>CBO estimated that up to 500,000 of an estimated 156 million individuals were offered unaffordable ESI in 2014 and enrolled in plans through the exchanges, suggesting that most with access to ESI are offered affordable coverage. Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (Washington, D.C., April 2014). Other researchers have reported similar estimates. See appendix I for more information.

<sup>62</sup>With financial assistance from the APTC, the cost of health insurance premiums for those eligible is reduced to an amount considered affordable—that is, the cost of premiums for the second lowest-cost silver plan are capped at between 2 and 9.5 percent of household income, depending on one's income.

<sup>63</sup>Carman and Eibner, *Changes in Health Insurance*; and Department of Health and Human Services, *Health Insurance Marketplace*. Minimum essential coverage generally includes Medicaid. However, some Medicaid enrollees may have had coverage under limited benefit plans that do not qualify as minimum essential coverage, such as Medicaid plans that cover only family planning. In addition, minimum essential coverage generally includes health plans offered through the exchanges with the exception of catastrophic plans.

<sup>64</sup>Carman and Eibner, *Changes in Health Insurance*. TRICARE plans require no premiums or up to \$548 annually for a family plan, depending on the individuals' military status, type of TRICARE plan, and where they choose to receive their care. Four percent of nonelderly adults—which is included in the 14 percent of nonelderly adults who were insured through other sources—obtained their coverage through the individual market outside the exchanges. Information about the affordability of such plans is not available.

## Some Groups of Nonelderly Adults May Lack Access to Affordable Health Insurance Coverage

An estimated 16 percent of nonelderly adults (31.4 million) were uninsured as of March 2014, according to one early survey.<sup>65</sup> CBO estimated that, in 2016, most of those who will remain uninsured—at least 77 percent—will likely be exempt from the requirement to maintain minimum essential coverage because, for example, they are undocumented immigrants or lack access to health insurance coverage that is considered affordable under PPACA.<sup>66</sup> While there are many reasons people remain uninsured, some individuals may not have access to affordable health insurance coverage.<sup>67</sup> For example, some may be low-income and live in a Medicaid nonexpansion state or they may lack access to affordable ESI yet are also ineligible for the APTC to instead purchase affordable coverage through the individual exchanges.

## Low-Income Individuals Living in Medicaid Nonexpansion States

Nonelderly adults with household incomes less than 100 percent of the FPL are not eligible for the APTC and, if their state chose not to expand Medicaid to low-income adults, they may not be eligible for Medicaid.<sup>68</sup> Without financial assistance from an APTC, coverage available through

<sup>65</sup>Carman and Eibner, *Changes in Health Insurance*. Results from early surveys have estimated that between 12.4 and 17.0 percent of nonelderly adults were uninsured as of early 2014, though all surveys consistently show that the rate of uninsured has declined since 2013, ranging from a decline of 3.4 to 5.3 percentage points. See Long et al., *Taking Stock*; Collins, et al., *Gaining Ground*; Sommers et al., *Health Reform and Changes*; and Martinez and Cohen, *Health Insurance Coverage*.

<sup>66</sup>Individuals qualify for the affordability exemption if the required amount that they would have to contribute for the lowest-cost, self-only plan available to them costs more than 8 percent of their household income. Individuals could also be exempt from the requirement to maintain minimum essential coverage because they were members of Native American tribes, individuals with qualifying religious exemptions, or received a hardship exemption. In addition to those exempt, CBO also estimated that some people who lack minimum essential coverage will try to avoid penalties when filing their income tax returns. Congressional Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update* (Washington, D.C.: June 2014).

<sup>67</sup>Some of the uninsured may have access to affordable coverage but chose not to take-up that coverage. For example, one study estimated that 3 percent of the uninsured (8.1 million) were eligible for Medicaid and 4 percent (10.9 million) were eligible for the APTC. Another 2 percent (7.3 million), though they had access to affordable coverage, would have to pay a penalty for failing to maintain minimum essential coverage. L. J. Blumberg, M. Buettgens, J. Feder, *The Individual Mandate in Perspective: Timely Analysis of Immediate Health Policy Issues* (Washington, D.C.: The Urban Institute, 2012). In addition, some people who were insured in 2014 may have had coverage that did not qualify as minimum essential coverage, such as Medicaid partial-benefit coverage.

<sup>68</sup>Some states permit certain nonelderly adults with incomes greater than 100 percent of the FPL to enroll in Medicaid, such as those who are pregnant or disabled.

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the individual exchanges was likely unaffordable for these uninsured individuals. For example, an individual age 27 with household income at 99 percent of the FPL in a Medicaid nonexpansion state would have had to spend between 10 and 32 percent of their household income on the lowest-cost bronze plan, depending on their place of residence.<sup>69</sup> One study estimated that roughly 4 million nonelderly adults with household incomes below 100 percent of the FPL living in a Medicaid nonexpansion state were uninsured in 2014.<sup>70</sup>

### Some Families with ESI

Although some families have access to ESI that is considered affordable under PPACA, they may have to spend more than 9.5 percent of their household income on such coverage. The ESI affordability threshold is based on the cost of a self-only plan even though premiums for a family plan are typically more expensive, requiring them to spend more than they would on a self-only plan. Because the family would be considered to have access to affordable ESI under PPACA based on the self-only plan, it would not be eligible to receive financial assistance through the APTC to purchase a family plan through the individual exchanges. This has created a situation that some have referred to as “the family glitch,” where families offered ESI may find that coverage to be unaffordable yet they are ineligible for the APTC. The Agency for Healthcare Research and Quality (AHRQ) recently estimated that 10.5 million adults and children may be in this situation.<sup>71</sup>

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<sup>69</sup>Individuals are eligible to purchase a catastrophic plan if they are under age 30 or the lowest-cost bronze plan available costs more than 8 percent of their household income. In Medicaid nonexpansion states where a catastrophic plan was available, a 27-year-old individual with household income at 99 percent of the FPL would have had to spend between 8.4 and 27.5 percent of household income on the cheapest catastrophic plan. A 27-year-old individual with lower household income would have had to spend an even larger percentage of their household income on such a plan. In addition, insurers are permitted to charge higher premiums based on age and family size, so older individuals or individuals with a larger family would have had to spend an even larger percentage of their household income on either the lowest-cost catastrophic or bronze plan.

<sup>70</sup>R. Garfield, A. Damico, J. Stephens, and S. Rouhani, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid—An Update* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 2014).

<sup>71</sup>Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: March 2014). AHRQ’s estimate was conducted at the request of the Medicaid and CHIP Payment and Access Commission and published in its report.

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Some Individuals without Affordable ESI Who Are Not Financially Eligible for the APTC

Some nonelderly adults who lack access to affordable coverage elsewhere, such as through an employer, and instead shop for health insurance coverage on the individual exchanges may find this insurance unaffordable without financial assistance from the APTC—those with household incomes greater than 400 percent of the FPL.<sup>72</sup> Results from one early survey suggest that about 6 percent of nonelderly adults were uninsured in 2014 and had household income greater than 400 percent of the FPL.<sup>73</sup> In addition, based on nine household scenarios we examined, the affordability of the lowest-cost bronze plans available in the individual exchanges for such individuals varied by age, household size, income, and location in 2014.<sup>74</sup> For example, in most rating areas in 2014 the lowest-cost bronze plan available would have been considered unaffordable to older individuals with household income between, for example, 401 and 500 percent of the FPL. However, in nearly all rating areas such coverage was likely affordable for younger individuals regardless of their household income.<sup>75</sup> The affordability of the lowest-

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<sup>72</sup>In addition, for some individuals, even with financial assistance from the APTC, premiums for the lowest-cost bronze plan available in the individual exchanges may have exceeded 8 percent of household income in 2014, depending on the difference in the cost of premiums from the reference plan. However, this may have only occurred in some rating areas. For example, in just 8 out of the 501 rating areas (2 percent), a 60-year-old individual with household income at 400 percent of FPL would have had to pay greater than 8 percent of their household income on the lowest-cost bronze plan after accounting for the APTC. And, in 52 of 501 rating areas (10 percent), a family of four with two parents aged 40 years old and two children under 21 years of age with household income at 400 percent of the FPL would have had to spend greater than 8 percent of its household income on the lowest-cost bronze plan after accounting for the APTC.

<sup>73</sup>Shartzter et al., *Who Are the Remaining Uninsured*. Some individuals without affordable ESI who have household incomes greater than 400 percent of the FPL may have been able to afford health insurance coverage but chose instead to pay the penalty.

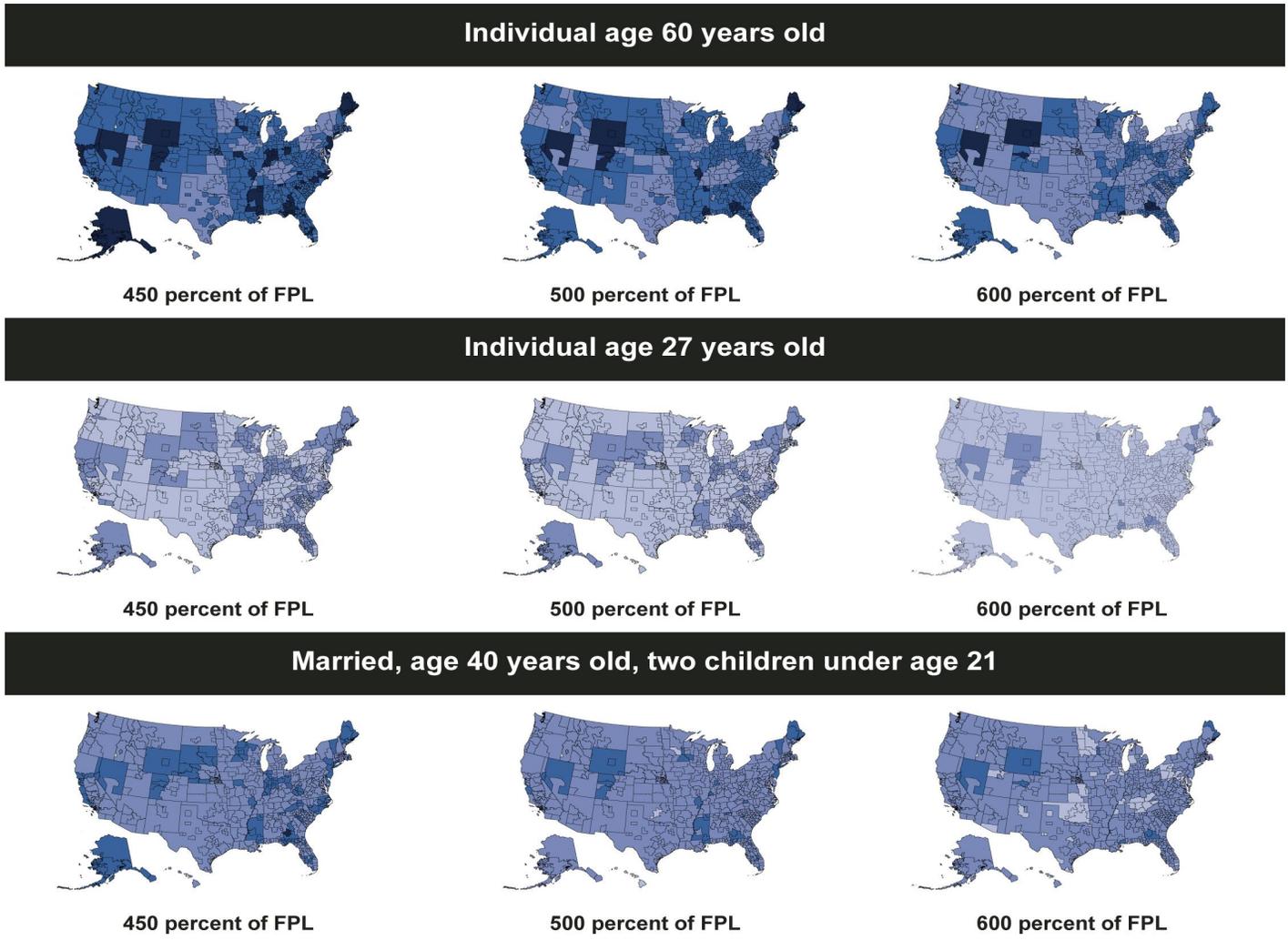
<sup>74</sup>Among individuals who selected a health plan without financial assistance from the APTC through 1 of the 34 federally facilitated exchanges or the 2 state-based exchanges that used the federal website, <http://www.healthcare.gov>, for enrollment in 2014, they were most likely to select a bronze plan than any other metal tier. For example, 33 percent of those who selected a health plan without financial assistance from the APTC through these 36 exchanges selected a bronze plan while 25 percent selected a silver plan and 12 percent selected a catastrophic plan. Of those who selected a catastrophic plan through these 36 exchanges, most (85 percent) were under age 35. Department of Health and Human Services, *Health Insurance Marketplace*.

<sup>75</sup>Under PPACA, issuers are prohibited from setting premium rates based on an individual's health status. However, issuers are permitted to set rates based on one's age, though rates based on age cannot vary by more than a 3:1 ratio under PPACA. States may have additional restrictions. For example, New York and Vermont have a 1:1 age rating ratio.

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cost bronze plans also varied by location and income for a family of four with two parents aged 40 years old and two children under 21 years of age. (See fig 2. For a more detailed version of the maps included in fig. 2, see appendix III.)

**Figure 2: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan by Household Characteristics and Income As a Percent of the Federal Poverty Level (FPL) (2014)**



Percent of household income that would have been spent on premiums for the lowest-cost bronze plan



Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines in each of the maps depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

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Based on nine household scenarios we examined, the affordability of the lowest-cost bronze plans available varied across different demographic subsets in the United States, for example:

- **Individual age 60-years-old:** A 60-year-old individual with household income at 450 percent of the FPL would have had to spend greater than 8 percent of their household income for the lowest-cost bronze plan in most (84 percent) of the 501 rating areas in the United States.<sup>76</sup> Specifically, in 17 percent of rating areas such an individual would have had to spend greater than 12 percent of their household income, in nearly two-thirds (67 percent) of rating areas they would have had to spend greater than 8 through 12 percent, and in 16 percent of all rating areas they would have had to spend from 4 through 8 percent of their household income on the lowest-cost bronze plan.<sup>77</sup> Even with somewhat higher household income at 500 percent of the FPL, the lowest-cost bronze plan would be considered unaffordable for older individuals in most rating areas (72 percent). Moreover, in the most expensive rating area for a 60-year-old individual (counties near Albany, GA), the lowest-cost bronze plan had an annual premium of \$9,487. Among those with income too high to receive the APTC, this plan would have been considered unaffordable for a 60-year-old individual if they earned between \$46,797 (401 percent of the FPL) and \$118,588 (1,016 percent of the FPL) in that rating area.<sup>78</sup>

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<sup>76</sup>Under PPACA, the rating area is the lowest geographic level by which health insurance premiums are permitted to vary. However, according to one expert we interviewed, plans may not be offered in all service areas throughout a rating area. For example, a health insurer could offer a health plan in all but one or two counties within a rating area. As a result, the lowest-cost plan available could vary within a rating area.

<sup>77</sup>Early survey data has shown the largest declines in the rate of uninsured between 2013 and early 2014 occurred among younger adults. See Martinez and Cohen, *Health Insurance Coverage*; Collins et al., *Gaining Ground*; Sommers et al., *Health Reform and Changes*; and Long et al., *Taking Stock*. However, most of the uninsured in 2014 were age 18 to 34 (42 percent) followed by individuals aged 35 to 44 (19 percent) and individuals age 45 to 64 (12 percent). Martinez and Cohen, *Health Insurance Coverage*.

<sup>78</sup>In contrast, in the least expensive rating area for a 60-year-old individual (counties near Rochester, NY), the annual premium for the lowest-cost bronze plan was \$2,575, which would have been considered affordable for a 60-year-old individual at any income level over 400 percent of the FPL.

- **Individual age 27-years-old:** The lowest-cost bronze plan would have been considered affordable in all but one rating area for a 27-year-old with income too high to receive the APTC. In nearly half (47 percent) of all rating areas, such individuals with household income at 450 percent of the FPL, for example, would have had to spend from 4 through 8 percent of their income on the lowest-cost bronze plan, and in 53 percent of rating areas they would have had to spend less than 4 percent of their income. There is only one rating area where 27-year-olds with household income greater than 400 percent of the FPL would have had to spend greater than 8 percent of their household income on the lowest-cost bronze plan. In the most expensive rating area for a 27-year-old (the state of Vermont), the lowest-cost bronze plan had an annual premium of \$4,032. Among those with income too high to receive the APTC, this plan would have been considered unaffordable for a 27-year-old individual if they earned between \$46,797 (401 percent of the FPL) and \$50,400 (432 percent of the FPL) in that rating area.<sup>79</sup>
- **Married couple age 40-years-old with two children under 21-years-old:** In 75 percent of all rating areas such a family with household income at 450 percent of the FPL would have had to spend from 4 through 8 percent of its household income on the lowest-cost bronze plan, and in 25 percent of all rating areas it would have had to spend greater than 8 through 12 percent of its household income. In one rating area such a family would have had to spend greater than 12 percent of its household income. In the most expensive rating area for a married couple aged 40 with two children and household income too high to receive the APTC (counties near Albany, GA), the lowest-cost bronze plan had an annual premium of \$13,374, which would have been considered unaffordable for such a family if it earned between \$95,639 (401 percent of the FPL) and \$167,176 (701 percent of the FPL) in that rating area.<sup>80</sup>

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<sup>79</sup>In contrast, in counties near Minneapolis and St. Paul, MN, the least expensive rating area for such an individual, the annual premiums for the lowest-cost bronze plan were \$1,132, which would have been affordable for such a family any income level.

<sup>80</sup>In contrast, in Comanche County, OK, the least expensive rating area for such a family, the annual premiums for the lowest-cost bronze plan were \$4,397, which would have been affordable for such a family at any income level greater than 400 percent of the FPL.

Changes in premiums for plans offered on the individual exchanges between 2014 and 2015 likely affected variation in the affordability of lowest-cost bronze plans by rating area in 2015. Studies have estimated that, while the average cost of premiums for the reference or lowest-cost plans have changed only modestly between 2014 and 2015, average premiums increased significantly in some rating areas and decreased significantly in others.

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**Even Those with Affordable Premiums Could Face Challenges Maintaining Minimum Essential Insurance Coverage and Paying for High Out-of-Pocket Costs**

Regardless of the affordability of premiums, some may face challenges in maintaining minimum essential coverage, and for those who retain insurance, obtaining health care may be costly. For example, among those eligible for the APTC, some may experience changes in their income that affect their eligibility, which may lead to coverage gaps or discontinuity in coverage.<sup>81</sup> It is too soon to know how many people became ineligible for the APTC in 2014, but experts we interviewed and studies of past years' data indicate that income changes are fairly common, particularly among those with lower incomes.<sup>82</sup>

Changes in employment status and family composition can change enrollees' eligibility for certain types of insurance, which could lead to challenges maintaining health insurance. For example, a change in employment status can affect eligibility for ESI, the most common form of insurance for the nonelderly. One survey found that among nonelderly adults who reported having had a gap in ESI coverage in 2011,

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<sup>81</sup>Enrollees who experience changes can file with an exchange to report that their income has changed. Alternatively, when enrollees file taxes, the APTC amount will be reconciled with their actual income for the preceding year.

GAO is currently examining issues related to individuals' movement between the exchanges and Medicaid.

<sup>82</sup>For example, one study examined changes in household income. It found that 2 percent of adults in households with incomes between 133 and 199 percent of the FPL in 2005 had incomes over 400 percent in the following year, and 15 percent of adults with incomes between 200 and 399 percent of the FPL had incomes over 400 percent in the following year. If the same income changes occurred in 2014, those households would be ineligible for the APTC. See P. Farley Short, K. Swartz, N. Uberoi, and D. Graefe, *Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change* (Washington, D.C.: The Commonwealth Fund, May 2011). Some of these households may enroll in ESI, even if they are income-eligible for the APTC or Medicaid.

67 percent reported that it was due to a change in employment status.<sup>83</sup> Changes in family composition can also cause challenges for people seeking to maintain health insurance. For example, divorce can cause one spouse to lose access to the other's ESI, or may change household income such that eligibility changes for federal subsidies or Medicaid.

Even if individuals are able to maintain health insurance that meets the criteria for minimum essential coverage, obtaining medical care may be costly. When enrollees receive health care services, they are often responsible for cost-sharing payments such as copayments or coinsurance. Enrollees' cost-sharing responsibilities for silver, gold, and platinum plans are lower than for bronze plans, but out-of-pocket costs for all plans can be considerable depending on an enrollee's health care needs and the structure of one's health plan. Insurers can structure plans to charge more or less for certain services or medications, as long as the out-of-pocket costs are limited to no more than \$6,350 per year for in-network goods and services for single coverage of those with incomes above 250 percent of FPL.<sup>84</sup> For an enrollee with income of 251 percent of FPL (\$28,725), \$6,350 represents about 22 percent of their annual income.<sup>85</sup>

Experts we interviewed stated that all exchange enrollees are vulnerable to high out-of-pocket costs, particularly if they seek care from out-of-network health care providers. Costs incurred by using out-of-network providers do not count toward a plan's out-of-pocket maximum, are not

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<sup>83</sup>S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Gaps in Health Insurance: Why So Many Americans Experience Breaks in Coverage and How the Affordable Care Act Will Help* (Washington, D.C.: The Commonwealth Fund, April 2012).

<sup>84</sup>This limit does not include premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits that are not covered by the plan.

<sup>85</sup>Exchange enrollees with incomes between 100 and 250 percent of the FPL are eligible for cost-sharing subsidies that reduce their maximum out-of-pocket costs if they are enrolled in a silver plan. Because silver plan premiums are higher than bronze plan premiums, some enrollees with low out-of-pocket costs may pay less overall by enrolling in a bronze plan without cost-sharing subsidies. Others with higher out-of-pocket costs would likely pay less overall in a silver plan with cost-sharing subsidies.

Insurers can choose one of two ways to reduce out-of-pocket spending for cost-sharing subsidy-eligible enrollees. Insurers can either reduce the total out-of-pocket spending limit to specified amounts, or insurers can design plans to meet higher actuarial values.

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required to contribute toward a plan's deductible, and are ineligible for federal cost-sharing subsidies. Furthermore, experts told us that some insurers have limited the networks of providers covered by the plans offered on the exchanges. Experts explained that restricting networks allows insurers to reduce premiums by limiting the number of provider choices, but increases the possibility that a provider sought by an enrollee will be out-of-network.

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## Concluding Observations

This report provides an early look at the effect of the tax credits and affordability of health insurance under PPACA, finding that evidence suggests that the APTC likely contributed to an expansion of health insurance coverage because it significantly reduced the cost of premiums for those eligible. However, the effects of the APTC and the affordability of health insurance in 2014 and beyond is uncertain for several reasons. First, complete data on the number of people who claimed the APTC in 2014 and the amount of the APTC claimed are not yet available because of the limited data reported from most state-based exchanges as well as the lag time during which enrollees file taxes and IRS completes reconciliation. Second, insurers will likely adjust premiums in exchange plans as more data become available about enrollees in the exchanges, including how the health profiles of exchange enrollees compares to that of enrollees previously purchasing individual insurance or ESI. Thus, trends for premiums in exchange plans may not stabilize for several years, although PPACA established certain requirements intended to reduce variation. Third, health insurance premiums are in large part driven by the underlying costs of health care. While the rate of growth of health care costs has slowed in recent years, there is no guarantee that such a trend will continue. As a result, it is important to note that our findings about the first year of the exchanges cannot be generalized to future years.

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## Agency Comments

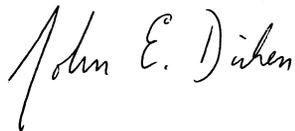
We received technical comments on a draft of this report from HHS and IRS and incorporated them as appropriate.

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We are sending copies of this report to the appropriate congressional committees, the Secretary of the Department of Health and Human Services, the Commissioner of the Internal Revenue Service, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

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If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or [DickenJ@gao.gov](mailto:DickenJ@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.



John E. Dicken  
Director, Health Care

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*List of Committees*

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# Appendix I: Potential Effects of Changing the Affordability Threshold for Employer-Sponsored Insurance

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In addition to the two objectives we addressed in this report, PPACA mandated that GAO review what is known about the potential effects of lowering the employer-sponsored insurance (ESI) affordability threshold.<sup>1</sup> Under the 2014 income threshold, “affordable” means that employees’ premium contribution for a self-only plan must cost no more than 9.5 percent of their household income.

Our literature review found no peer-reviewed studies that have examined the effects of lowering the ESI affordability threshold below 9.5 percent of household income.<sup>2</sup> However, experts to whom we spoke described mixed potential effects. Lowering the ESI affordability threshold would shift more of the cost of premiums onto employers—that is, employers would have to increase their contribution towards employees’ premiums. Some experts stated that such a shift could encourage some employers to discontinue offering health insurance. In particular, experts told us that employers most likely to discontinue are those that employ a low-wage workforce. These employers face less competition in attracting lower-paid workers than higher-paid workers, so they have less incentive to offer health insurance coverage to attract workers. Employers with more than 50 full-time equivalent employees that do not provide health insurance coverage would be subject to the tax penalty on employers if any of their employees obtain health insurance coverage through the exchanges with assistance from the advance premium tax credit (APTC).<sup>3</sup> One expert commented that employers that cease offering health insurance may also choose to compensate employees for the loss of health insurance by increasing wages. Alternatively, one expert told us that employers that choose to continue offering health insurance might adjust employees’ compensation packages to account for an increase in the employer contribution to health insurance premiums. These employers would avoid the tax penalty on employers that fail to offer affordable health insurance to employees.

Experts to whom we spoke stated that if the threshold were lowered, overall, federal costs would likely increase, although the magnitude of

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<sup>1</sup>Pub. L. No. 111-148, § 1401(c), 124 Stat. 119, 220 (2010).

<sup>2</sup>See appendix II for details on our search for studies.

<sup>3</sup>Employers out of compliance will be subject to an annual fine of \$2,000 times the number of full-time employees minus 30. For example, in 2016, an employer with 50 full-time equivalents that did not offer insurance would be penalized \$40,000.

such an increase is unclear. Federal costs would increase if employers stop offering health insurance and employees that subsequently seek exchange coverage are eligible for and claim the APTC and cost-sharing subsidies. At the same time, federal tax revenue may also increase if employers dropping health insurance raised taxable wages and paid employer penalties because of their failure to offer health insurance. However, experts told us this increase in tax revenue would likely not be high enough to offset the increase in federal costs from employees' APTC and cost-sharing subsidy claims.

Because studies have estimated that relatively few people have an offer from their employer of self-only health insurance coverage that exceeds the affordability threshold of 9.5 percent of household income, relatively few are likely to be affected if the threshold were lowered. Three studies varied in their estimates, with the highest estimating up to 1 million people may have such an offer.<sup>4</sup> In comparison, the Congressional Budget Office (CBO) estimates that in 2014, 156 million nonelderly people received ESI coverage. The three studies found:

- The Agency for Healthcare Research and Quality (AHRQ) estimated that about one million people with household incomes between 139 to 400 percent of the federal poverty level (FPL) have an unaffordable offer.<sup>5</sup>
- CBO estimated that between 0 and 500,000 people had an unaffordable offer in 2014 and sought coverage on an exchange.<sup>6</sup>

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<sup>4</sup>In contrast, another study separately estimated that about 10.5 million people are subject to the “family glitch”—that is, they are not eligible for the APTC or cost sharing subsidies because one household member has an offer of self-only coverage that is affordable, as discussed earlier. Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: March 2014). This study was conducted at the request of the Medicaid and CHIP Payment and Access Commission and published in its report.

<sup>5</sup>Agency for Healthcare Research Quality, *Employer and Worker Incentives in the Affordable Care Act: Insights from a Linked Employer-Employee Data Set* (Washington, D.C.: June 23, 2013). Using Medical Expenditure Panel Survey (MEPS) Household Component data, authors created synthetic workforces for each establishment in the MEPS Insurance Component. Estimates may be imprecise due to multiple sources of errors, including the error stemming from linking household and establishment data.

<sup>6</sup>Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (Washington, D.C.: Congressional Budget Office, April 2014).

- Another study combined different data sets to generate estimates of the number of households that had an unaffordable ESI offer.<sup>7</sup> The study found that if employers keep employee contributions at the national average (which the study authors calculated as 20 percent for self-only coverage in 2009), no employees' contribution would have exceeded the ESI affordability threshold in 2009.

These studies estimated that a relatively low number of people are offered ESI coverage that exceed 9.5 percent of their income because generally, employee contributions for self-only ESI coverage are small compared to income. The average ESI premiums in 2014 were \$6,025 per year for single coverage, and employees contributed about \$1,081, on average.<sup>8</sup> Employees with household income of more than \$11,380 would be considered to have affordable premiums.

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<sup>7</sup>Researchers merged data from the MEPS Insurance Component, the March Current Population Survey as well as other data, and The Henry J. Kaiser Family Foundation premium data. This study has limitations as well, such as potential biases from various simplifying assumptions used for the analysis. For example, the researchers assumed that if an employee no longer received ESI, employers would fully pass on the savings from premiums to the employees. R. V. Burkhauser, S. Lyons, K. I. Simon, "The Importance of the Meaning and Measurement of 'Affordable' In the Affordable Care Act" (Cambridge, Mass.: National Bureau of Economic Research, Working Paper 17279, 2011).

<sup>8</sup>The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2014 Annual Survey* (Washington, D.C.: The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, 2014).

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# Appendix II: Objectives, Scope and Methodology

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To describe what is known about the effects of the Advance Premium Tax Credit (APTC) and the small employer tax credit on health insurance coverage, as well as what is known about the potential effects of changing the employer-sponsored insurance (ESI) affordability threshold, we conducted a structured literature search for studies. To conduct this review, we searched over 30 bibliographic databases, including ABI/INFORM Global, MEDLINE, and WorldCat, for studies on these topics published between January 1, 2010, and November 12, 2014. Two analysts independently reviewed each of the results for relevance and then reconciled differences. We determined that a study was directly relevant to our objectives if it: (1) included empirical analysis related to the effects of the APTC or the small employer tax credit on the provision of health insurance or maintenance of health insurance; or (2) analyzed the effects of changing the ESI affordability threshold on the actions of employers, employees, or the federal budget. To supplement our search of reference databases, we:

- searched the Internet using Google.com and terms such as “APTC maintain health insurance” and “surveys insurance Patient Protection and Affordable Care Act (PPACA)”;
- searched the websites of health policy research organizations such as the Henry J. Kaiser Family Foundation (KFF), the Urban Institute, and the American Enterprise Institute; and
- asked the experts we interviewed to recommend sources of literature that would address our objectives.

Through all of these literature searches, we identified 23 studies that were useful for the objectives of our report.<sup>1</sup> Among these studies, we identified summary results from three surveys that estimated the change in the rate of uninsured nonelderly adults between 2013 and 2014 by household income amounts comparable to APTC eligibility limits.<sup>2</sup> These surveys generally had low response rates and small sample sizes, which can introduce potential errors in estimating individuals’ health insurance

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<sup>1</sup>For these and all studies cited in our report, we reviewed the methodologies of the studies to ensure they were sound and determined that they were sufficiently reliable for our purposes.

<sup>2</sup>Larger, more rigorous survey data that can be used to more accurately estimate individuals’ health insurance status were not yet available at the time that we conducted our analyses.

status, especially by population subgroups, such as by individuals' household income or type of health insurance coverage. Table 5 provides a summary of the response rate, sample size, and margin of error for these three surveys. To improve the reliability of estimates produced from the survey results, the studies' authors used certain sampling methodologies, such as stratified sampling to over-sample populations commonly underrepresented in such surveys (e.g., low-income populations), and weighted regression models. In addition, the authors validated their estimates against prior estimates from larger, more rigorous surveys, such as the American Community Survey, and found their estimates to be generally comparable, though with small differences in some cases. Because of these approaches to improve reliability, we determined the studies were sufficiently reliable for our purposes.

**Table 5: Methodological Information for Surveys That Estimated the Change in the Rate of Uninsured Nonelderly Adults**

Survey	Time period surveyed	Survey response rate	Sample size	Sampling error (at 95 percent confidence interval) <sup>a</sup>
Gallup Healthways Well-Being Index	January 2012 to June 2014	11%	420,449	+/-1.0
The Commonwealth Fund Affordable Care Act Tracking Survey	July 15 to September 8, 2013 and April 9 to June 2, 2014	14%	4,425	+/- 2.1
The Urban Institute Health Reform Monitoring Survey	September 2013 to September 2014	5%	7,500 <sup>b</sup>	+/-1.3

Source: GAO analysis. | GAO-15-312

Notes:

<sup>a</sup>Sampling error is the extent to which the survey results differ from what would have been obtained if the whole population had been observed.

<sup>b</sup>The Urban Institute's Health Reform Monitoring Survey (HRMS) samples approximately 7,500 nonelderly adults each quarter. HRMS data from the third quarter of 2013 and the third quarter of 2014 were used to estimate changes in the rate of uninsured nonelderly adults between September 2013 through September 2014.

We also reviewed laws, regulations, and guidance related to PPACA's individual mandate, the APTC, the small employer tax credit, individual exchange regulation, and the ESI affordability threshold. We also reviewed the legislative history of the ESI affordability threshold.

We interviewed a range of experts to explore what is known about the effects of the APTC and the small employer tax credit on health insurance coverage and what is known about the extent to which health benefit plans are available and individuals are able to maintain minimum essential coverage, as well as what is known about the potential effects of changing the ESI affordability threshold. We asked experts at 11 research and industry organizations, in addition to officials at the Department of

Health and Human Services (HHS) and the Internal Revenue Service (IRS), about their work related to the potential effect of tax credits on health insurance coverage, the types of individuals that may have more or less difficulty maintaining minimum essential coverage, and the potential effects on employers, employees, and federal costs of changing the ESI affordability threshold (we did not ask every question of every expert). We chose these experts based on relevance of their published or other work to our objectives.<sup>3</sup>

To further analyze what is known about the effects of the small employer tax credit on health insurance coverage, we requested summary data from the IRS on small employer tax credit claims, the number of employee premiums covered, and the total cost of the credit that IRS provided for tax years 2011 and 2012. Data on tax year 2013 and 2014 were not available at the time of our analysis. To assess the reliability of the data, we reviewed the data and supporting documentation for obvious errors, as well as IRS's internal controls for producing the data.<sup>4</sup> We found the data to be sufficiently reliable for our purposes. To supplement these data, we also incorporated summary data from our previous report on this topic.<sup>5</sup>

To describe the extent to which affordable health benefits plans are available and individuals are able to maintain minimum essential coverage, we analyzed 2014 premium data—the most recent data available at the time of our analysis—for health benefit plans offered through the exchanges. We obtained data from two sources. First, The Henry J. Kaiser Family Foundation (KFF) provided us with data on premiums for all health plans offered in the individual health insurance

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<sup>3</sup>Experts we interviewed included representatives from: American Enterprise Institute; The Center for Health Insurance Reforms at Georgetown University; HHS's Agency for Healthcare Research and Quality, Center for Consumer Information and Insurance Oversight, Office of the Assistant Secretary of Planning and Evaluation, and the Office of the Actuary; the Congressional Budget Office; IRS; National Business Group on Health; National Federation of Independent Businesses; Pennsylvania State University; The Commonwealth Fund; The Henry J. Kaiser Family Foundation; The Urban Institute; and the University of Minnesota.

<sup>4</sup>Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

<sup>5</sup>See GAO, *Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity*, [GAO-12-549](#) (Washington, D.C.: May 14, 2012).

exchanges by rating area, excluding New York. KFF compiled the data using HHS's Centers for Medicare & Medicaid Services' Landscape file, which, for 2014, captured data on premiums for plans participating in the 34 federally facilitated exchanges and 2 state-based exchanges that used the federal website, <http://www.healthcare.gov>, for enrollment.<sup>6</sup> KFF supplemented the Landscape file data with data on premiums for plans offered in the other 15 state-based exchanges, which it acquired by reviewing health insurance companies' rate filings in each state and validating these data through state exchange websites when possible. We assessed the reliability of these data by: interviewing KFF officials about how they compiled and validated the data as well as their internal controls, testing the data for duplicate data and outliers, and comparing the publicly available Landscape data on federally facilitated exchanges to the KFF data. Second, from the state of New York, we obtained premium data for plans offered through the state's individual exchange during the initial open enrollment period (October 1, 2013, through March 31, 2014). To assess these data for reliability, we checked the data for outliers and validated selected data through the New York state exchange website. We found both the KFF data and the New York data to be sufficiently reliable for our purposes.

Using the data from these sources, we calculated the percent of household income that nine hypothetical individuals or households would have had to spend on premiums for the lowest cost bronze plans in each rating area in the United States in 2014, assuming different levels of household income as a percentage of the federal poverty level.<sup>7</sup> We also calculated the amount of household income that each hypothetical individual or household would need in order to pay 8 percent of

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<sup>6</sup>PPACA required the establishment of exchanges in each state by January 1, 2014. In states that did not elect to operate their own state-based exchange, PPACA required the federal government to establish and operate an exchange in the state, known as federally facilitated exchanges. Some states that elected not to establish a state-based exchange entered into a partnership with the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS), in which HHS establishes and operates the exchange while states assist HHS in carrying out certain functions of the exchange. A partnership exchange is a variation of a federally facilitated exchange. In addition, in 2014, two states—Idaho and New Mexico—operated their own exchange but enrollees signed up for health insurance through the federal website, <http://www.healthcare.gov>, which populates CMS's Landscape file.

<sup>7</sup>We used the 2013 federal poverty level because 2014 eligibility for APTC and Medicaid was based on the 2013 level.

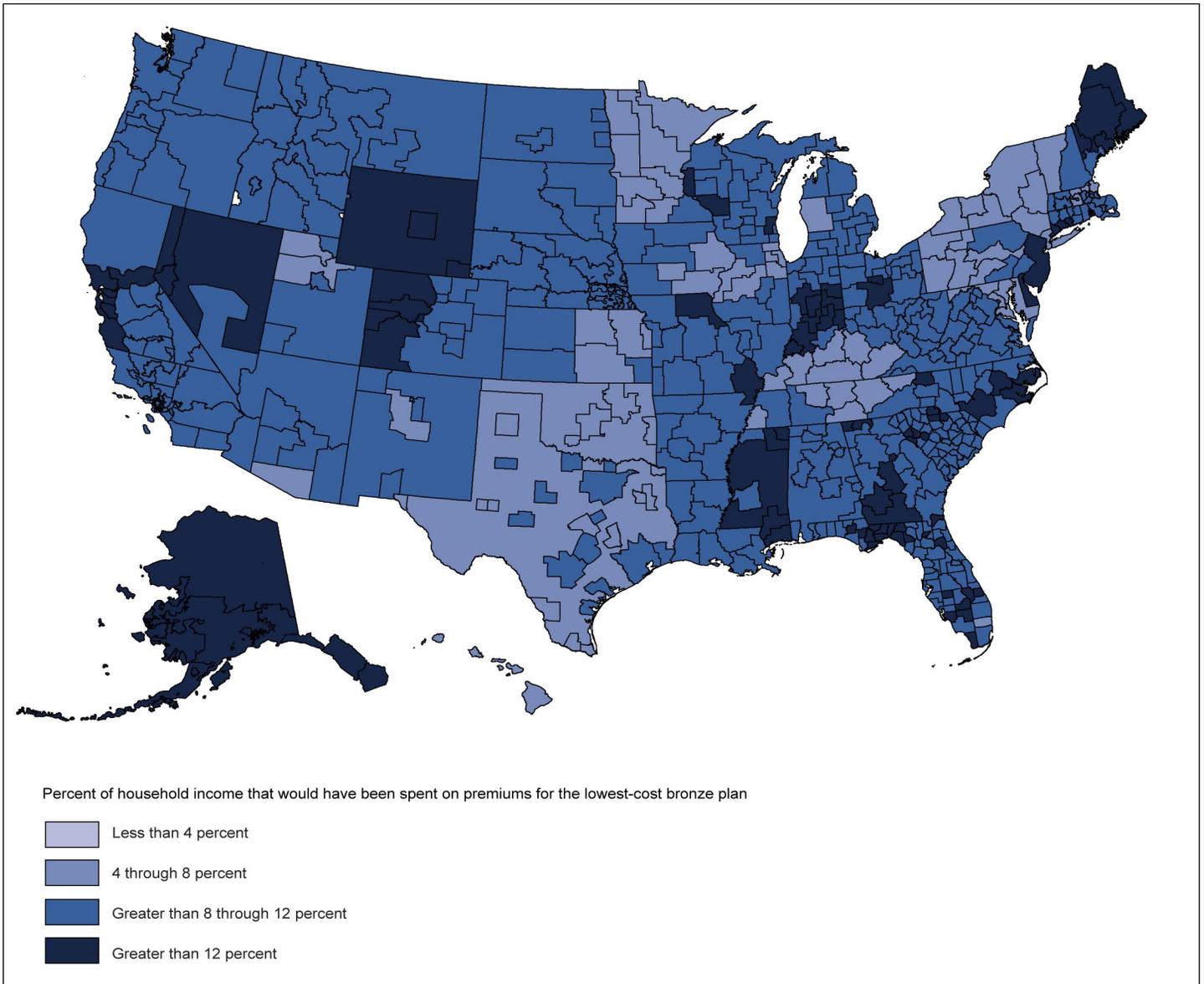
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household income for the lowest-cost bronze plan available by rating area.

We conducted this performance audit from July 2014 through March 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# Appendix III: Affordability of the Lowest-Cost Bronze Plan, by Rating Area

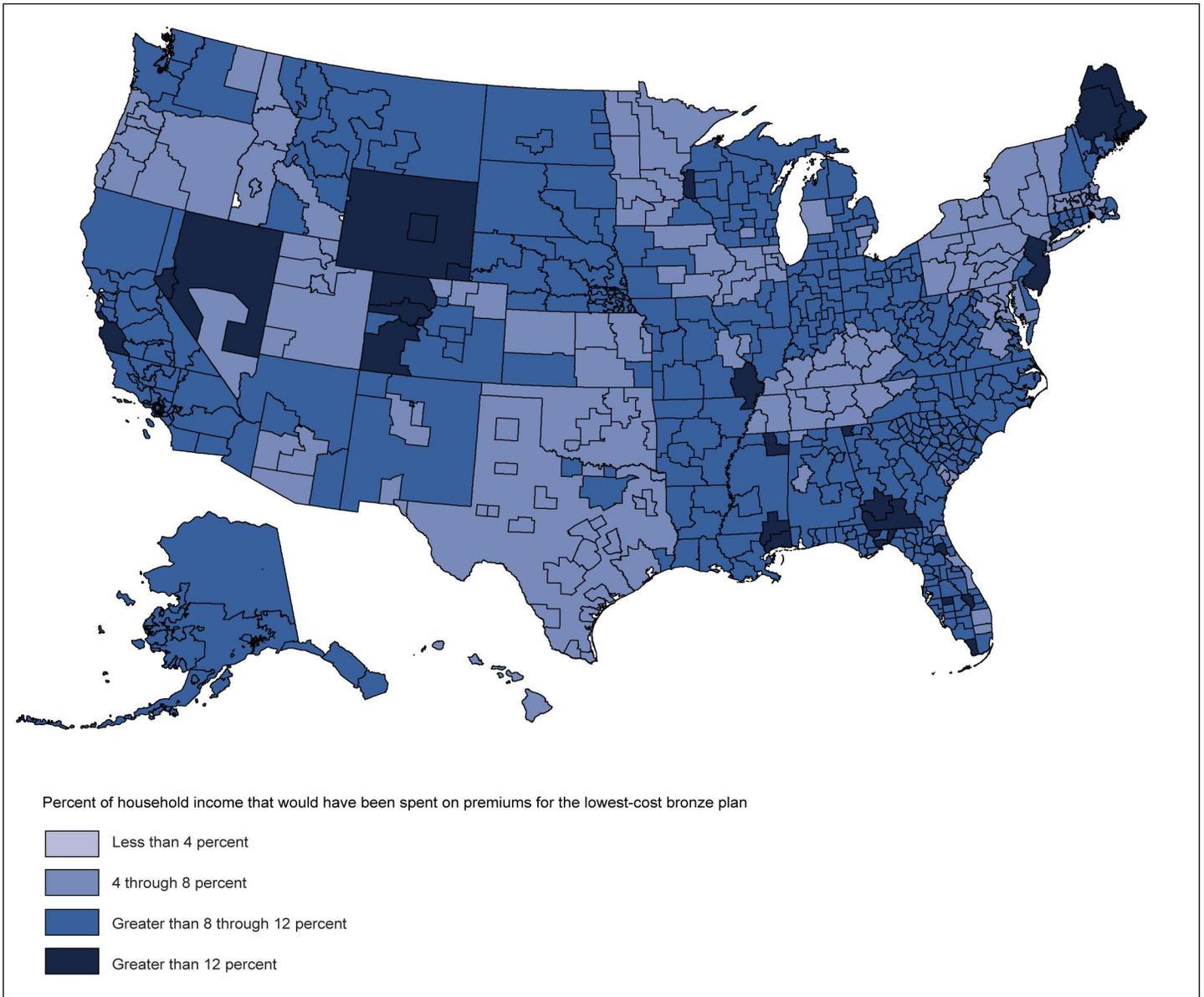
**Figure 3: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 60-Year-Old Individual with Household Income at 450 Percent of the Federal Poverty Level (2014)**



Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

Figure 4: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 60-Year-Old Individual with Household Income at 500 Percent of the Federal Poverty Level (2014)



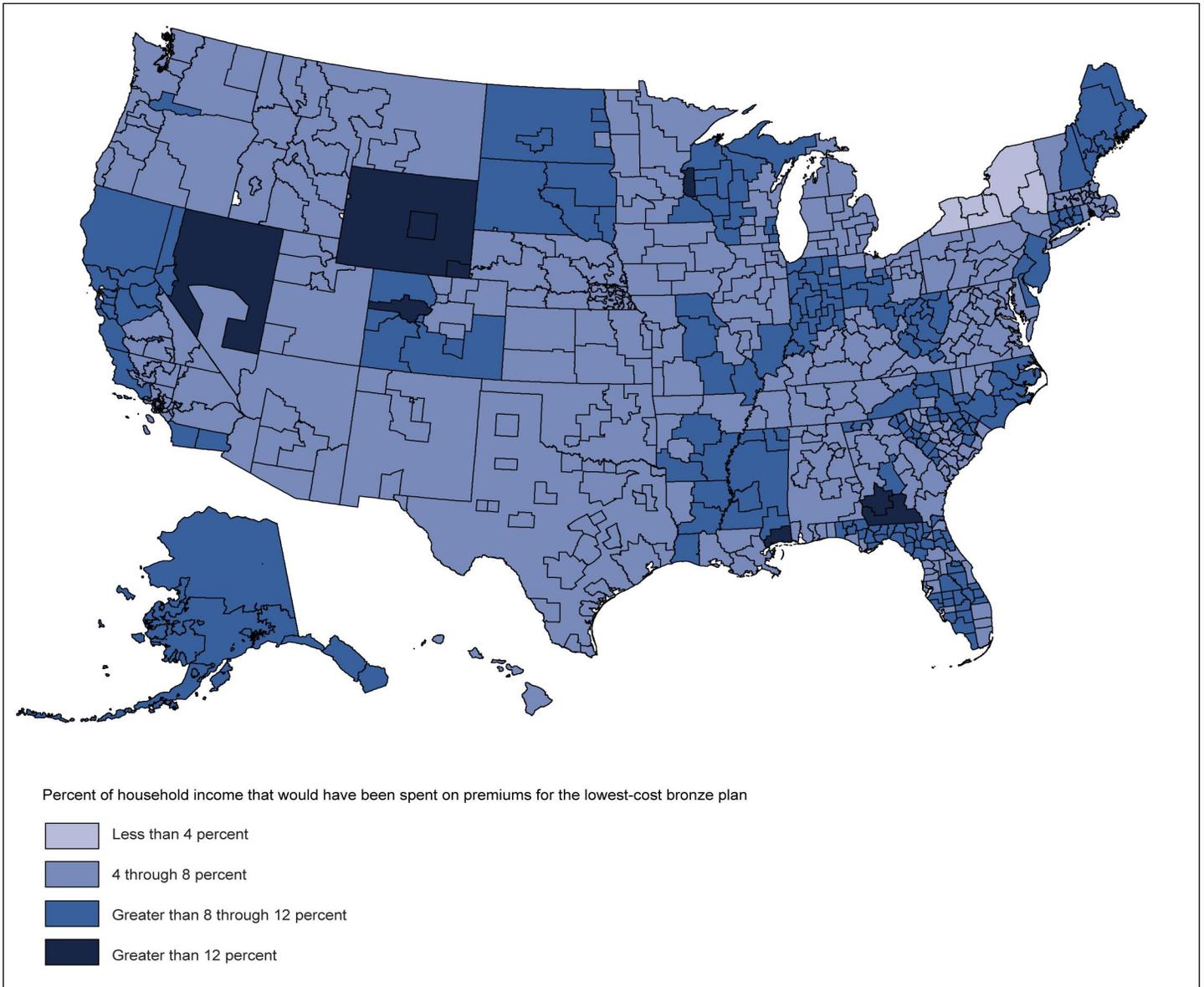
Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip

Appendix III: Affordability of the Lowest-Cost Bronze Plan, by Rating Area

codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

Figure 5: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 60-Year-Old Individual with Household Income at 600 Percent of the Federal Poverty Level (2014)



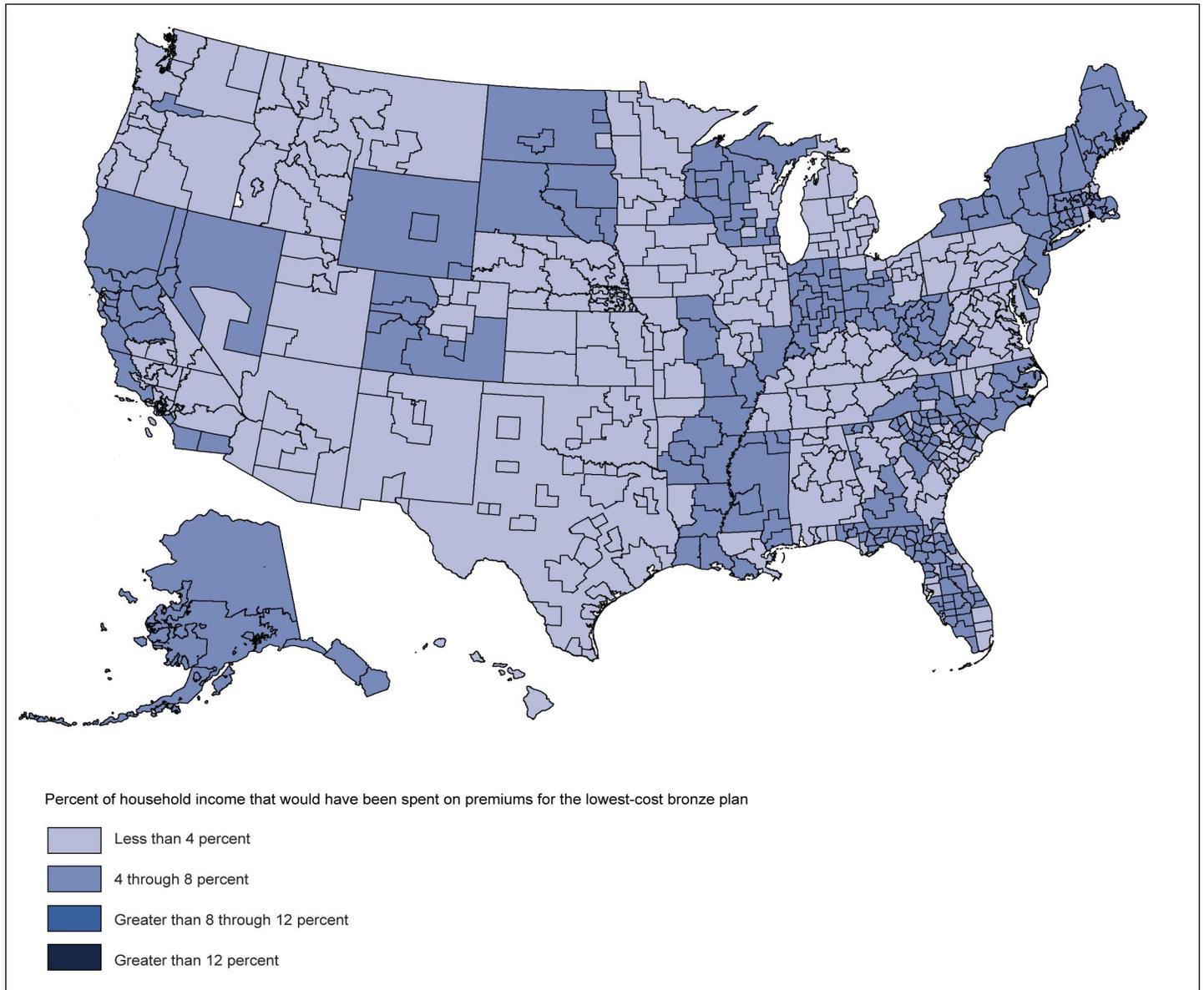
Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating

**Appendix III: Affordability of the Lowest-Cost Bronze Plan, by Rating Area**

areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

**Figure 6: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 27-Year-Old Individual with Household Income at 450 Percent of the Federal Poverty Level (2014)**



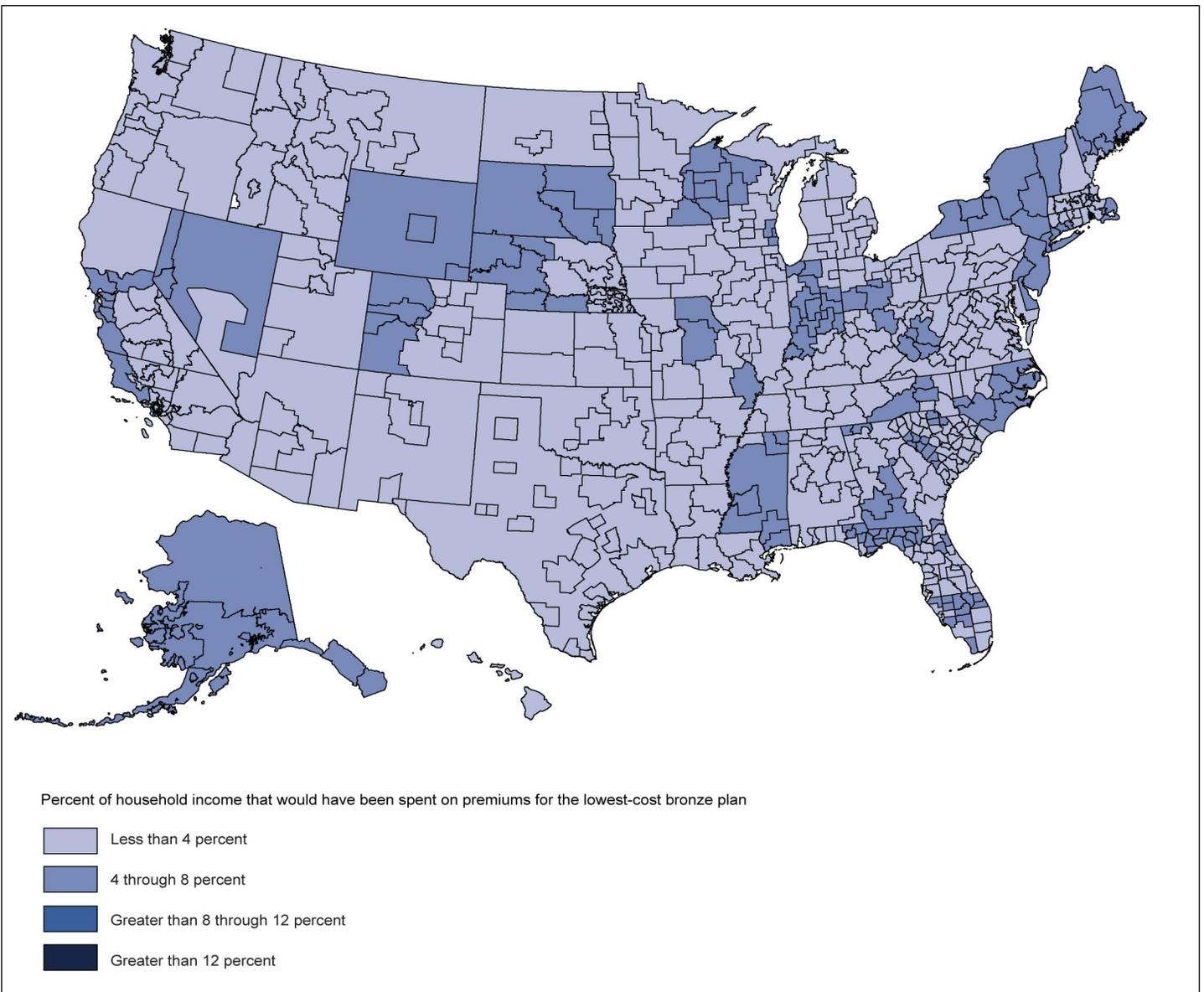
Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum.

**Appendix III: Affordability of the Lowest-Cost Bronze Plan, by Rating Area**

Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

**Figure 7: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 27-Year-Old Individual with Household Income at 500 Percent of the Federal Poverty Level (2014)**



Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

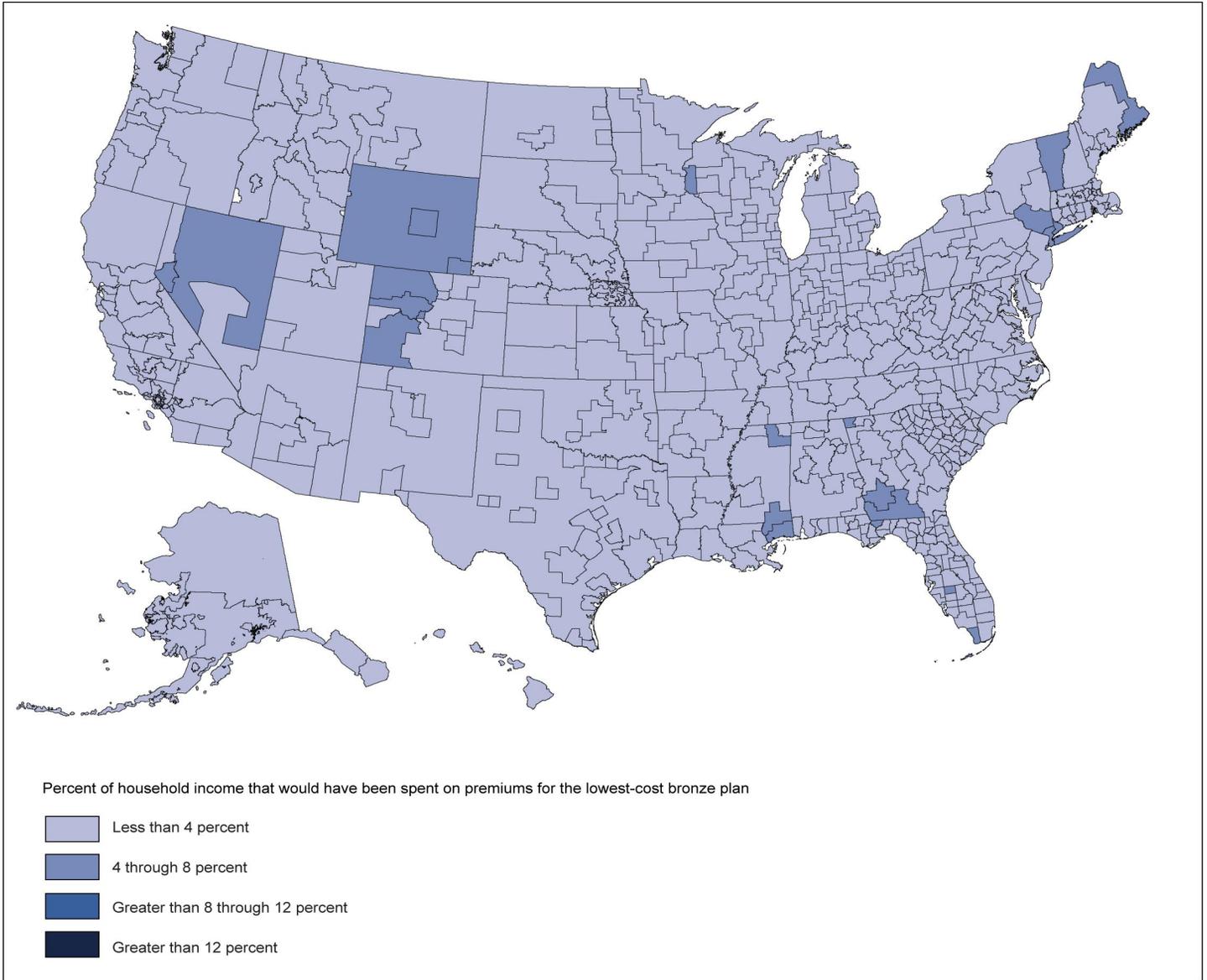
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**Appendix III: Affordability of the Lowest-Cost  
Bronze Plan, by Rating Area**

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Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

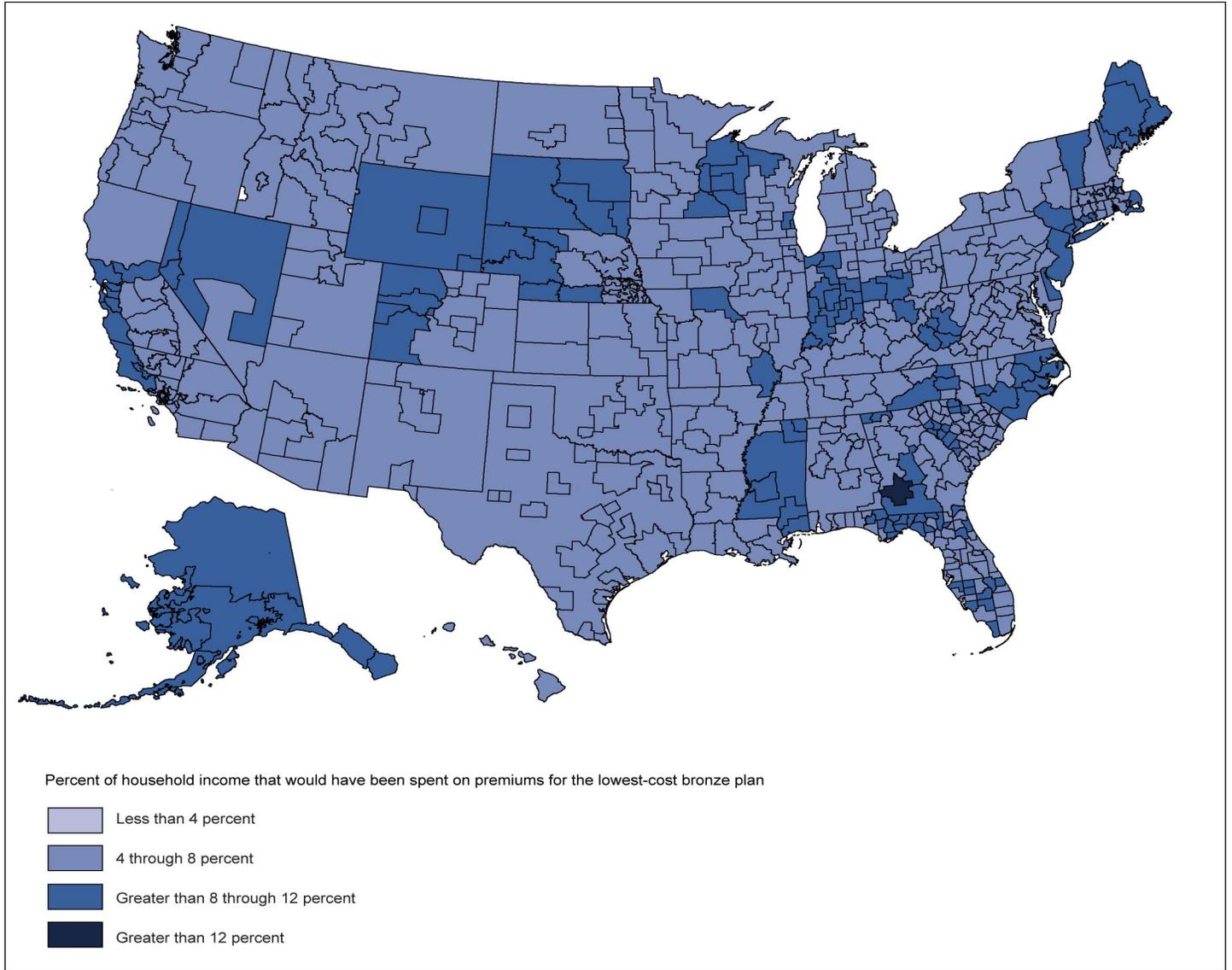
Figure 8: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 27-Year-Old Individual with Household Income at 600 Percent of the Federal Poverty Level (2014)



Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

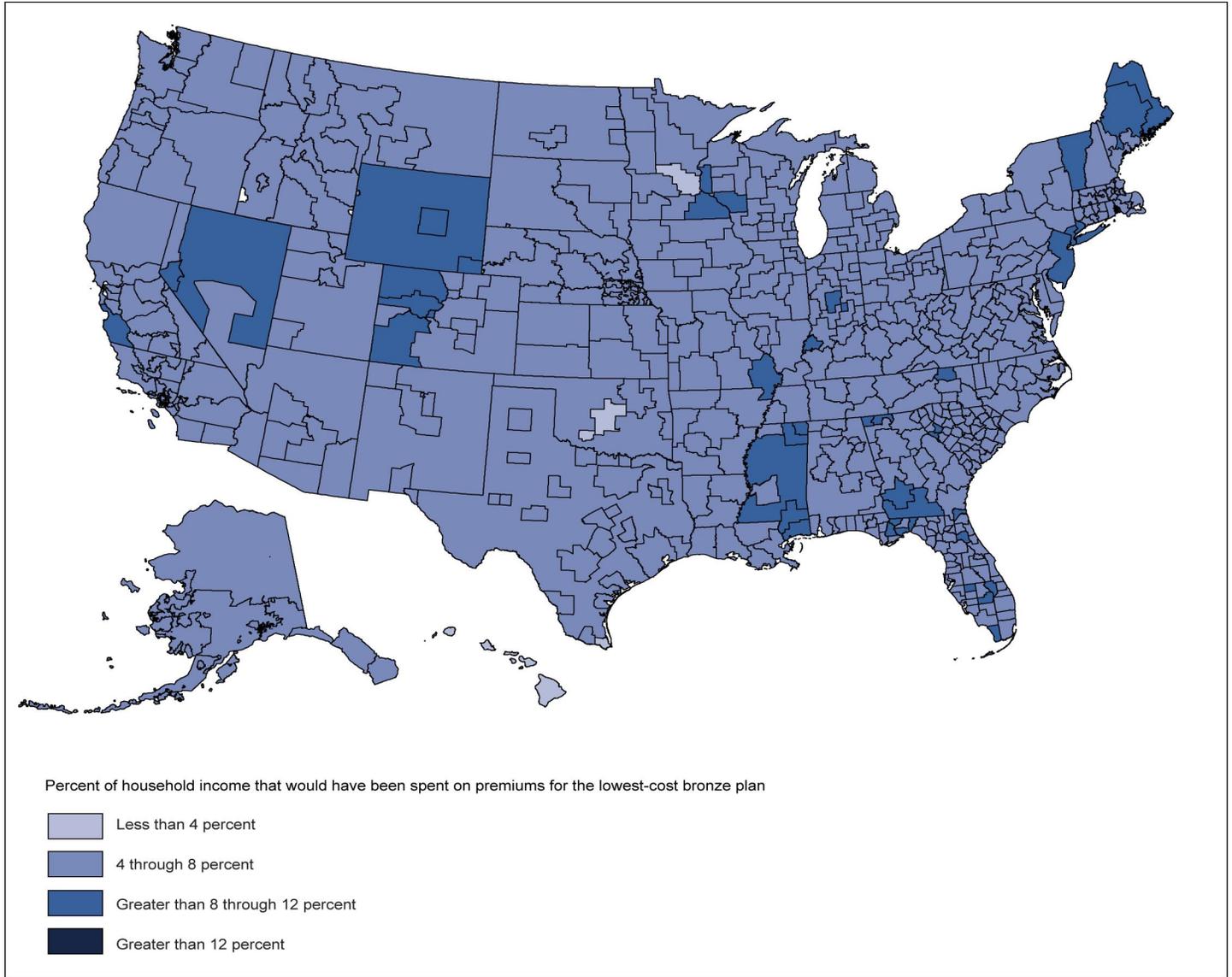
Figure 9: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 40-Year-Old Married Couple with Two Children Under 21-Years-Old and Have Household Income at 450 Percent of the Federal Poverty Level (2014)



Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

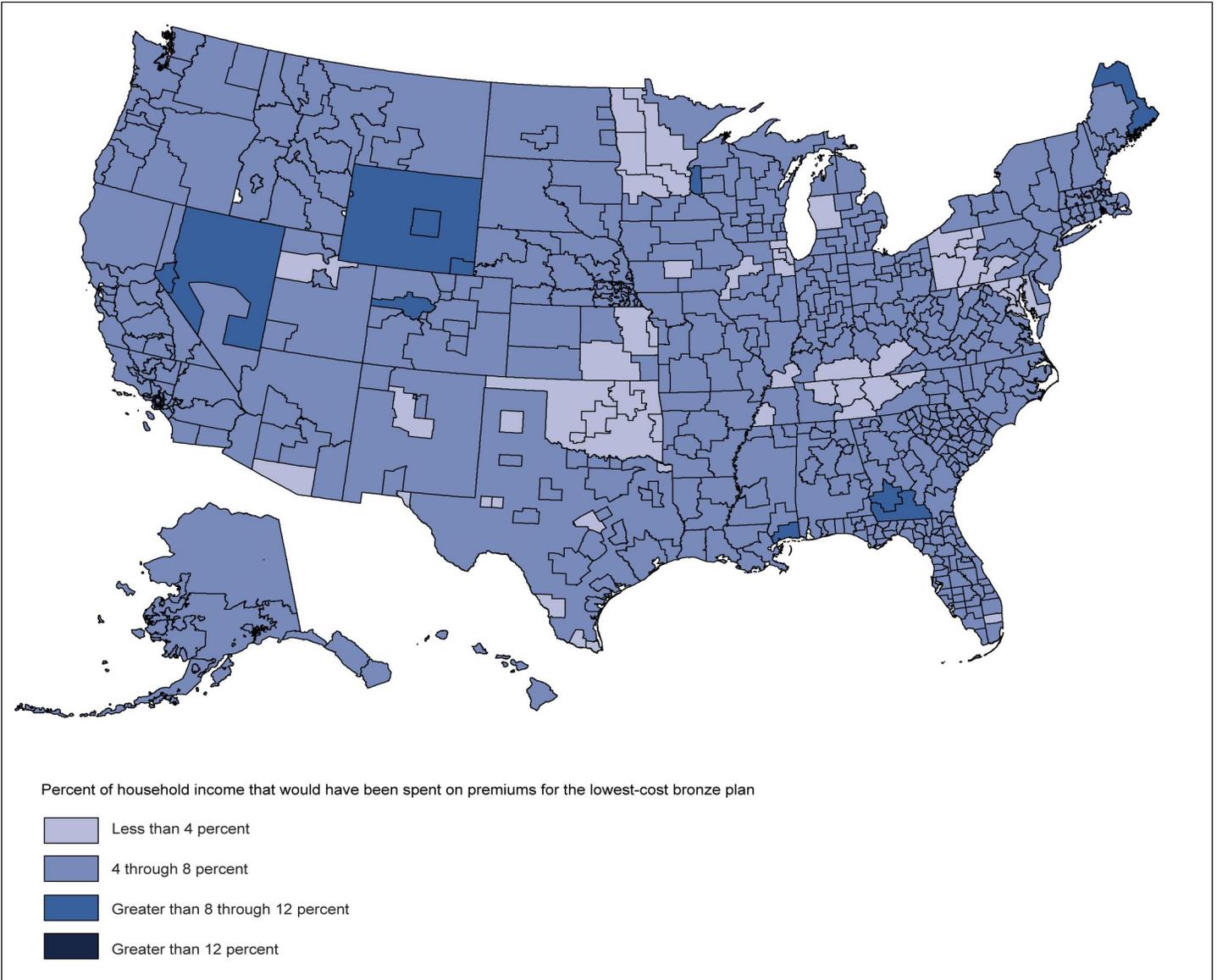
**Figure 10: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 40-Year-Old Married Couple with Two Children Under 21-Years-Old and Have Household Income at 500 Percent of the Federal Poverty Level (2014)**



Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

Figure 11: Percentage of Household Income That Would Have to Be Spent on Premiums for the Lowest-Cost Bronze Plan for a 40-Year-Old Married Couple with Two Children Under 21-Years-Old and Have Household Income at 600 Percent of the Federal Poverty Level (2014)



Sources: GAO analysis of The Henry J. Kaiser Family Foundation data and New York state individual exchange data (data); Map Resources (map). | GAO-15-312

Note: Depending on the portion of health care costs expected to be paid by the health plan, qualified health plans are categorized into one of the following “metal tiers”: bronze, silver, gold or platinum. Bronze plans cover an average of 60 percent of health care costs, silver plans cover 70 percent, gold plans cover 80 percent, and platinum plans cover 90 percent. The boundary lines depict the rating areas within each state except for Alaska. In Alaska, the boundary lines depict the three-digit zip codes in the state. In addition, due to how two zip codes are defined in Idaho, there are two areas in the state that were not assigned to a rating area and thus were left blank.

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

John E. Dicken, (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

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## Staff Acknowledgments

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