I. Introduction

The Patient Protection and Affordable Care Act as modified by the Health Care and Education Reconciliation Act of 2010, collectively known as the Affordable Care Act, was signed into law on March 23, 2010, and represents the biggest change to the U.S. health care system since Medicare was enacted in 1965. The act expands the Medicaid program, requires most individuals to obtain insurance or pay a penalty, provides subsidies to individuals who have low to moderate incomes and no affordable source of coverage, and imposes fines on business with more than 50 employees that do not offer adequate coverage to their workers if those workers seek federally subsidized coverage as an alternative. To ensure that all individuals and small businesses are able to obtain health insurance policies, the Affordable Care Act also introduces new federal regulations in the nongroup (privately purchased) and small group (small employer) health insurance markets that limit insurers' ability to deny coverage or to charge differential prices based on certain enrollee characteristics. Although there are some exceptions for plans that existed prior to the Affordable Care Act's enactment and have not made substantial changes to cost-sharing or other requirements over time, most small group and nongroup plans will be required to adhere to the new regulations.

Separately, to facilitate competitive shopping for qualified insurance plans, the law encourages states to set up and run health insurance exchanges for the small group and nongroup insurance markets. These exchanges—designated the Health Insurance Marketplaces (HIMs)[4] for individuals and the Small Group Health Insurance Options Program (SHOP) Exchanges for firms—will include online portals to help individuals and small employers shop for, select, and enroll in health insurance plans and will offer subsidies and tax credits to qualified individuals and firms. While states are encouraged to implement health insurance exchanges on their own, they may allow this administrative role to fall to the federal government if they decline to establish a Marketplace, and some states are setting up state and federal partnership exchanges. Whether the exchanges are state-run or federally run, those tasked with setting up exchanges must make many regulatory and implementation decisions. Two significant decisions that states are currently grappling with include whether to combine the small group and nongroup markets for the purposes of risk pooling and whether to expand their Medicaid programs to cover all adults with incomes below 138 percent of the federal poverty level (FPL).

While the Affordable Care Act initially required states to expand Medicaid to all individuals with incomes below 138 percent of the FPL, the Supreme Court ruled in June 2012 that a requirement to expand was unduly coercive, and states may therefore opt out of the expansion of Medicaid if they prefer. The decision to opt out of the Medicaid expansion will have implications for exchange enrollment, since individuals with incomes between 100 and 138 percent of the FPL will become eligible for federal exchange subsidies—formally known as advance premium tax credits (APTCs)—if states opt out of the Medicaid expansion. APTCs are not generally available for individuals with incomes below 100 percent

[4] Previously, these marketplaces were referred to as the Affordable Insurance Exchanges (AIEs).

of the FPL, although there are exceptions for recent immigrants who would not qualify for Medicaid even if the state expanded.

Because the federal government must establish regulations and provide guidance to states that choose to operate their own exchanges, and because some states may opt to default to the federally facilitated exchanges, policymakers at both the state and federal levels may need estimates of potential exchange-related outcomes to facilitate planning. Key outcomes of interest include the number of people projected to participate in exchanges, the number of enrollees who are subsidy-eligible, exchange premium prices, and aggregate federal spending amounts. In this report, we use RAND's Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model to analyze these outcomes, focusing on ten representative states—Florida, Kansas, Louisiana, Minnesota, New Mexico, North Dakota, Ohio, Pennsylvania, South Carolina, and Texas. These states were selected by our client, the Centers for Medicare & Medicaid Services' (CMS's) Center for Consumer Information and Insurance Oversight (CCIIO). For sensitivity analyses, we added an eleventh state: New York.

Core questions addressed in this report include the following:

- How many individuals and employees of small businesses are likely to obtain coverage on the newly regulated small group and nongroup markets? Of those participating, how many are eligible for exchange-based subsidies or tax credits?
- What are the risk profiles, income levels, and prior coverage patterns of potential exchange enrollees?
- What are the projected premiums for exchange plans, including both the HIMs and the SHOP exchanges?

We also conduct sensitivity analysis to explore the potential consequences of states opting out of the Medicaid expansion for exchange enrollment and premiums and to address the implications of decisions regarding risk-pool composition on nongroup and SHOP premium prices.