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How Much Financial Protection Do Marketplace Plans Provide in States Not Expanding Medicaid?

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Abstract The Affordable Care Act's premium subsidies and cost-sharing reductions have helped to reduce out-of-pocket costs for low-income people enrolled in marketplace plans. This financial protection has been particularly important for people with incomes above 100 percent of poverty who live in states that have not expanded Medicaid. However, a key question for policymakers is how this protection compares to Medicaid. This brief analyzes a sample of silver plans offered in the largest markets in 18 states that use the federal website for marketplace enrollment and have not expanded Medicaid eligibility. It finds that marketplace enrollees at this income level in most plans analyzed are at risk of incurring premium and out-of-pocket costs that are higher than what they would pay under Medicaid. For people with significant health needs, costs are estimated to be much higher in marketplace plans than what they would be under Medicaid.

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BACKGROUND

The Affordable Care Act allows more people to get Medicaid, by expanding eligibility to people earning up to 138 percent of the federal poverty level—$16,243 for an individual and $33,465 for a family of four. However, the Supreme Court made the Medicaid expansion optional for states. As a result, 19 states have yet to expand eligibility for their Medicaid programs. In those states, people with incomes between 100 percent of poverty ($11,770 for an individual) and 138 percent of poverty are eligible to receive premium subsidies for private plans sold through the marketplaces (Exhibit 1). They also are eligible for lower deductibles and other cost-sharing assistance if they select silver tier plans.[1] But people with lower incomes—below 100 percent of the poverty level—who live in states that have not expanded Medicaid are ineligible for these subsidies and would pay the full price for a marketplace plan.

Exhibit 1

Affordable Care Act Coverage Provisions, Expansion vs. Nonexpansion States, 2016

				ACA marketplace plans		
FPL	Income	Medicaid expansion state	Medicaid nonexpansion state	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: silver plan
<100%	S: <$11,770 F: <$24,250	Eligible for Medicaid	Not eligible for marketplace plan subsidies	No subsidy, pays premium in full	S: $6,850 F: $13,700	70%
100% – <138%	S: $11,770 – <$16,243 F: $24,250 – <$33,465	Eligible for Medicaid	Eligible for marketplace plan subsidies	2.03%	S: $2,250 F: $4,500	94%

Notes: FPL refers to federal poverty level. Income levels based on 2015 FPL. Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plans. Individuals with incomes below 100 percent of poverty are not eligible for the reduction in out-of-pocket limit for marketplace health plans.

Sources: IRS, Internal Revenue Bulletin: 2014-50, "Rev. Proc. 2014-62" (Internal Revenue Service, Dec. 8, 2014); U.S. Department of Health and Human Services, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2016; Final Rule" *Federal Register,* Feb. 27, 2015 80(39); and "Reduced cost-sharing for individuals enrolling in qualified health plans," 42 U.S.C. §18071(a)(2).

This analysis focuses on the costs that people in nonexpansion states with incomes above 100 percent of poverty could potentially face for health insurance and health care and compares them to the costs a consumer might face in Medicaid. We use the example of a 40-year-old, nonsmoking man who earns $13,000 a year (about 110% of poverty) and chooses the second-lowest-cost silver plan in the largest city in each of the 18 nonexpansion states that use the federal website for 2016 marketplace enrollment.[2] We used HealthCare.gov's consumer cost comparison tool to provide a rough estimate of out-of-pocket costs.[3] This brief builds on a prior Fund analysis, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* using a selection of health plans offered in the marketplaces in states that employ the federal HealthCare.gov website for 2016 enrollment.[4]

STUDY FINDINGS

For someone earning about $13,000 annually, there are significant differences between the premiums and cost-sharing in Medicaid plans and those in marketplace plans. Overall, cost-sharing protections are greater in Medicaid as compared to marketplace plans.

Medicaid Premiums and Cost-Sharing

For Medicaid beneficiaries with incomes below 150 percent of poverty ($17,655 for an individual and $36,375 for a family of four), federal law prohibits charging premiums (Exhibit 2). Under Section 1115 waiver authority, however, the federal government has allowed five Medicaid expansion states (Arkansas, Indiana, Iowa, Michigan, and Montana) to charge premiums of 2 percent of income, or flat fees that range from $10 to $25 per month, to enrollees with incomes between 100 percent and 138 percent of poverty.[5]

Exhibit 2 shows how federal law limits cost-sharing for health care services and prescription drugs in Medicaid to nominal amounts.[6] But Indiana, under its 1115 waiver, is permitted to charge

Exhibit 2

Financial Responsibilities for an Individual with $13,000 Annual Income, Marketplace Plans vs. Medicaid

	Houston, Texas silver plan	Virginia Beach, Virginia silver plan	Traditional Medicaid expansion state	1115 Medicaid expansion states, as of June 2016
Premiums/ Enrollment fees	2.03% income	2.03% income	Not permitted for beneficiaries with incomes below 150% FPL	**NH:** none* **AR:** $10/month into HSA, which may be used toward cost-sharing expenses **IA:** $10/month starting in year 2 of enrollment **IN and MI:** 2% of income into HSA **MT:** 2% of income, credited toward copayments
In-network deductible	$0	$150	Minimal (approximately $2.65 in FY 2013), and included in the cost-sharing limit	Included in the cost-sharing limit
Prescription drug deductible	$0	$250		
Copayments/ Coinsurance				
Primary care visit	No charge	$15	Up to 10% of cost paid by Medicaid	Copayments and coinsurance same as traditional Medicaid in AR, IA, MT, and NH **AR, IN, MI, and MT:** monthly premium contributions may be used toward cost-sharing **IA:** premiums in lieu of cost-sharing, except for nonemergency use of emergency department **MI:** copayments paid into HSA based on average services used in past six months**
Specialist visit	$10	$30	Up to 10% of cost paid by Medicaid	
Inpatient stay	10%	10% coinsurance after deductible	Up to 10% of cost paid by Medicaid	
Preferred drugs	$8	50% coinsurance after deductible	Up to $4	
Nonpreferred drugs	10%	50% coinsurance after deductible	Up to $8	
Emergency department visit	$100	20% coinsurance after deductible	Up to $8 for nonemergency use	**IN:** additional cost-sharing for nonemergency use
Out-of-pocket limit	$2,250	$600	Premium and cost-sharing no more than 5% of income, applied monthly or quarterly	Same as traditional Medicaid in AR, IA, IN, NH, MI, or MT (see Appendix Table 1 for more detail)

* New Hampshire is expected to submit a proposal to increase financial obligations later in 2016.

** Under Michigan's 1115 waiver amendment, approved December 17, 2015, the state is required to submit and obtain CMS approval of updated program protocols in order to implement an alternative cost sharing model and healthy behaviors requirement, which would begin April 1, 2018. P. Boozang, and M. Lipson, "Manatt on Medicaid: CMS Approves Michigan's Waiver Amendment to Implement Reforms to ACA Medicaid Expansion" (Manatt, Phelps & Phillips, LLP, Dec. 23, 2015).

Sources: S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?* (The Commonwealth Fund, May 2016); D. Machledt and J. Perkins, "Medicaid Premiums and Cost Sharing" (National Health Law Program, March 26, 2014); Centers for Medicare and Medicaid Services, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule," *Federal Register,* July 15, 2013 78(135); and Centers for Medicare and Medicaid Services, "Cost Sharing Out of Pocket Costs," Medicaid.gov.

higher cost-sharing than the program traditionally allows.[7] Michigan plans to apply higher cost-sharing under its waiver in 2018, subject to approval by the Centers for Medicare and Medicaid Services.[8]

Federal law also prohibits Medicaid premiums and cost-sharing for all individuals in a household from exceeding 5 percent of income, applied either on a monthly or a quarterly basis.[9] For someone earning $13,000, this would amount to about $54 in a given month or $163 in a quarter, or about $650 a year whether the limit is applied monthly or quarterly. All states, including those with 1115 waivers, adhere to this cap (Appendix Table 1).

Marketplace Premiums and Cost-Sharing

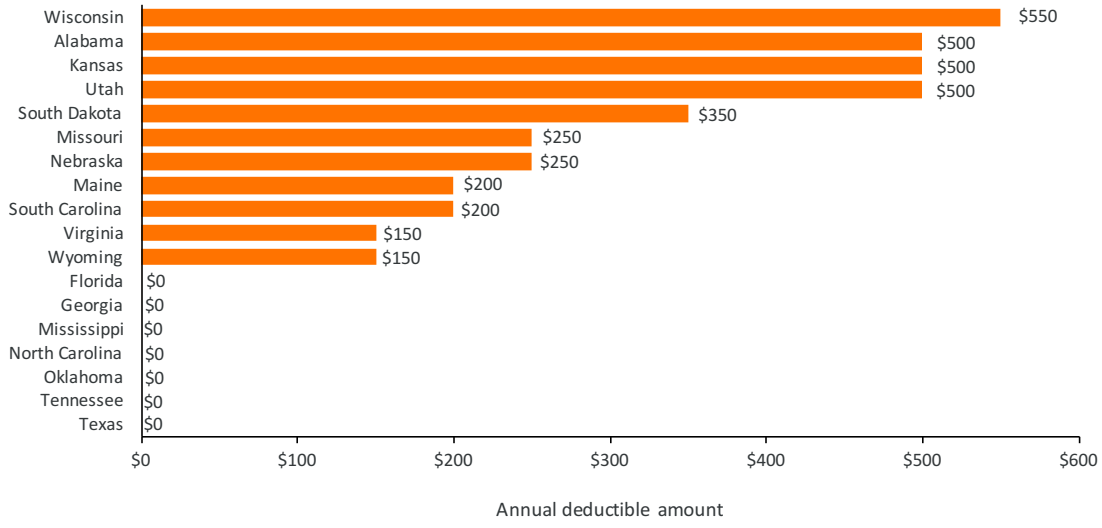
In the marketplaces, premium contributions for people with incomes of $13,000 enrolled in the second-lowest-cost marketplace plan are capped at 2.03 percent of income. This amounts to about $22 per month, $66 in a quarter, or about $264 for the year.

People at this income level who are enrolled in silver plans also are eligible for cost-sharing reductions that increase the average share of costs covered by the plan—the so-called "actuarial value"—from 70 percent to 94 percent (Exhibit 1).

To reach this higher actuarial value, insurers can lower deductibles, copayments, and out-of-pocket limits. Plans use different combinations of these cost-sharing mechanisms and, as a result, we see variations across plans in deductibles (Exhibit 3), out-of-pocket limits (Exhibit 4), and copayments and coinsurance (Appendix Table 2). For plans with deductibles, there also was variation in the number and type of services excluded from the deductible. For such excluded services, enrollees do not have to pay the full cost even if they have not yet met their deductible.[10]

Exhibit 3

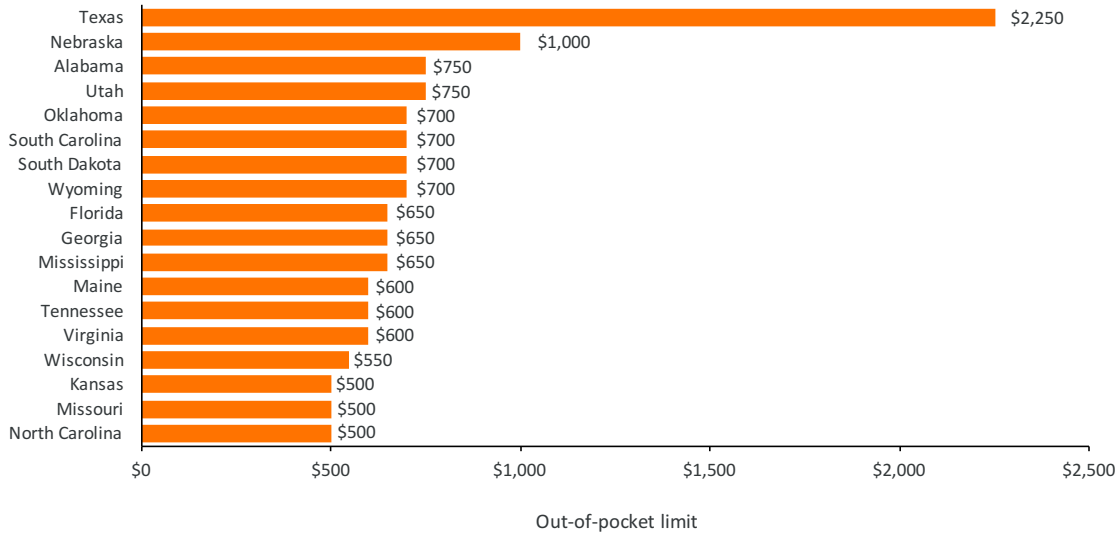
Deductibles for Low-Income People in Silver Plans, Largest City in Nonexpansion States



Note: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker; $13,000 annual income; "medium" user of health care; largest city in state.
Data: HealthCare.gov; website displays information for all nonexpansion states except for Idaho, which operates its own state-based marketplace.

Exhibit 4

Out-of-Pocket Limits for Low-Income People in Silver Plans, Largest City in Nonexpansion States



Note: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker; $13,000 annual income; "medium" user of health care; largest city in state.
Data: HealthCare.gov; website displays information for all nonexpansion states except for Idaho, which operates its own state-based marketplace.

Comparing Coverage in Medicaid and Marketplace Plans

To determine whether Medicaid or marketplace plans provide better coverage for someone with an annual income of $13,000, we compare the benefits, premiums, and cost-sharing in two silver marketplace plans (in Houston, Texas, and Virginia Beach, Virginia) to traditional Medicaid. We also point out differences in the 1115 waiver states.

Traditional Medicaid overall offers greater financial protection in three major areas: the ban on premiums, the number of benefits covered, and overall limits on out-of-pocket spending (Exhibit 2).

Premiums. Our hypothetical consumer will pay no more than 2.03 percent of his income on premiums in the Houston and Virginia Beach plans, or about $22 per month. In contrast, with the exception of some 1115 waiver expansion states, he would pay nothing in premiums for Medicaid.

Covered benefits. The Affordable Care Act established benchmark coverage standards for Medicaid's newly eligible adult population, as well as for qualified health plans sold in the health insurance marketplaces. These standards ensure that 10 categories of essential health benefits are part of the benchmark coverage for each market (Exhibit 5).[11] But the benefits for newly eligible Medicaid enrollees exceed what is required in qualified marketplace plans.

In addition to the required benefits, a 2015 analysis by Sara Rosenbaum and colleagues found that most states enhanced their coverage by raising it to the level of coverage available under their pre-ACA Medicaid plan.[12] This included supplemental drug coverage that is significantly higher than required under the essential health benefit standard for private plans.

Exhibit 5

Covered Services in Qualified Health Plans vs. Medicaid Benchmark Coverage

Qualified health plans sold in the marketplaces	Medicaid benchmark coverage
10 essential health benefits:	All 10 essential health benefit categories
Ambulatory patient services	Additional benefits:
Emergency services	Early and periodic screening, diagnostic, and treatment for enrollees up to age 21
Hospitalization	Free choice of family planning providers
Maternity and newborn care	Nonemergency medical transportation
Mental health and substance use disorder services*	Federally qualified health center and rural health clinic services
Prescription drugs	At state option, any other treatments or services covered under the state's traditional Medicaid plan
Rehabilitative and habilitative services and devices	
Laboratory services	
Preventive and wellness services and chronic disease management	
Pediatric services including oral and vision care	

* Mental health parity rules apply.

Source: S. Rosenbaum, D. Mehta, M. Dorley et al., *Medicaid Benefit Designs for Newly Eligible Adults: State Approaches* (The Commonwealth Fund, May 2015).

Overall limits on out-of-pocket spending. The most important difference between marketplace plans and Medicaid is the out-of-pocket limit. Because cost-sharing and premium limits are applied on either a monthly or quarterly basis in Medicaid, beneficiaries have additional financial protection against large medical bills that might hit in a given month or quarter.[13]

For instance, let's say our hypothetical consumer with Medicaid coverage experiences a health issue and spends the night in a hospital, resulting in a Medicaid bill of $3,000 for his stay and treatment. If the state Medicaid agency applies 10 percent cost-sharing on the service, his cost would come to $300. But with the Medicaid cost-sharing and premium limit, in a state that applies the cap on a monthly basis, an individual with an annual income of $13,000 could be charged no more than $54 (5% of $1,083 monthly income) for the service. A Medicaid enrollee with the same income living in a state that applied the cap on a quarterly basis could be required to pay no more than $163 (5% of $3,250 quarterly income).

In contrast, if the same person was enrolled in the Virginia Beach silver plan, he would first have to meet his $150 deductible and then be charged 10 percent of the remaining cost. Assuming the price of the inpatient stay is also $3,000, his total cost would come to $435,[14] below his $600 out-of-pocket limit for the year. With his premium contribution of $22, his total spending for the month would be 42 percent of his monthly income. If he were enrolled in the Houston plan, he would be charged $300 at 10 percent coinsurance, which is substantially below his annual out-of-pocket limit of $2,250. With his premium contribution of $22 per month, he would spend $322, or 30 percent of his monthly income, on health insurance and care.

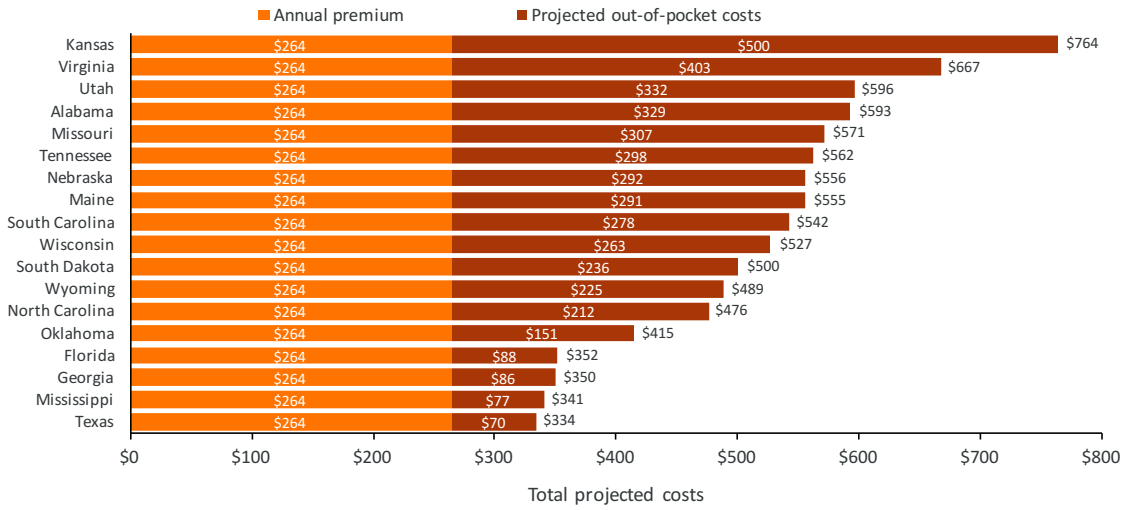
All six states that have expanded coverage under 1115 waiver authority apply the 5 percent cap on cost-sharing and premiums (Exhibit 2, Appendix Table 1). In addition, the monthly premiums or enrollment fees in Arkansas, Indiana, Michigan, and Montana can be used toward cost-sharing expenses; in Iowa, the premiums replace other cost-sharing obligations, except for nonemergency use of the emergency department starting in the second year of enrollment.[15] Enrollees in Iowa, Indiana, and Michigan also can reduce their financial obligations through state healthy behaviors and wellness initiatives.[16]

How Much Will Our Consumer Spend in a Marketplace Plan vs. Medicaid?

Using HealthCare.gov's cost comparison tool for our sample of plans in 18 states, we estimated costs for our hypothetical consumer.[17] The premium contribution for someone with a $13,000 income is fixed for the second-lowest-cost plan at about $264 for the year; for a medium user of health care services, out-of-pocket costs ranged from $70 in Texas to $500 in Kansas (Exhibit 6).

Exhibit 6

Estimated Total Out-of-Pocket Costs for Low-Income Medium User of Health Care in Silver Plan, Largest City in Nonexpansion States



Note: Second-lowest-cost silver plans for 2016; 40-year-old male nonsmoker; $13,000 annual income; "medium" user of health care; largest city in state. In some markets, the annual premium amount exceeded what a person at this income level could be required to pay by law. In these instances, the limit for the premium contribution as a share of income ($264) was used instead, with the reduced amount also reflected in the plan's total expected cost. If the estimated out-of-pocket costs exceed a consumer's out-of-pocket limit, then we report the out-of-pocket limit, rather than the out-of-pocket costs.
Data: HealthCare.gov; website displays information for all nonexpansion states except for Idaho, which operates its own state-based marketplace.

Potential out-of-pocket costs in marketplace plans were higher for people with greater health care needs and reached the out-of-pocket limit in all the health plans analyzed. Out-of-pocket costs, not including premiums, ranged from $500 in the Kansas, Missouri, and North Carolina plans to $2,250 in the Texas plan (data not shown).[18] Had the higher-use consumer enrolled in traditional Medicaid, and assuming that he hit Medicaid's 5 percent spending cap every month or quarter (which would total about $650 a year), his overall costs would be lower than they would be in each of the 18 plans analyzed. This is partly because of Medicaid's better cost protection and partly because he would not have to make a premium contribution.

The result is similar for someone who uses fewer services. For example, if our consumer is a medium-level user of health care and is enrolled in Medicaid—assuming the same level of utilization as HealthCare.gov and applying traditional Medicaid cost-sharing—his out-of-pocket costs for the year are approximately $148.[19] His out-of-pocket costs for the year might exceed those he would incur in the silver marketplace plans in four states (Florida, Georgia, Mississippi, and Texas) (Exhibit 6). But because he would also pay a premium of $264 a year in a marketplace plan, his total costs for health insurance and care in traditional Medicaid would be less than in all 18 marketplace plans.

CONCLUSION AND POLICY IMPLICATIONS

One major advantage of Medicaid over marketplace plans is that people with incomes under 138 percent of poverty do not pay a premium, except in the five 1115 waiver states that have gained federal approval to do so. Findings from The Commonwealth Fund's tracking survey show that the primary reason people with low incomes do not enroll in marketplace plans is that they find the premiums unaffordable.[20] Another critical advantage is that Medicaid's cost-sharing protections recognize that people with low incomes have very little savings to tap into in the event of a major illness or accident.[21] Private plans, even with cost-sharing subsidies, make no such adjustment to their out-of-pocket limits. A shift to traditional Medicaid expansion in the remaining 19 states will boost enrollment as well as provide greater cost protection for low-income families.

Appendix Table 1

Out-of-Pocket Limit (Including Both Premiums and Cost-Sharing) in 1115 Medicaid Expansion States, as of June 2016

Arkansas	Indiana	Iowa	Michigan	Montana	New Hampshire
Monthly contributions to "health independence accounts" and cost-sharing limited to 5% of monthly or quarterly household income.	Monthly contributions to "Personal Wellness and Responsibility" (POWER) health saving accounts and cost-sharing limited to 5% of quarterly household income.	Premiums (beginning in second year of enrollment) and cost-sharing limited to 5% of quarterly household income.	Premiums and cost-sharing limited to 5% of quarterly household income. Beginning April 1, 2018, state may implement an alternative cost-sharing model and healthy behaviors requirement, for which the state would need to submit and obtain CMS approval of updated program protocols.	Premiums and cost-sharing limited to 5% of quarterly household income.	Cost-sharing limited to 5% of monthly or quarterly household income. Beneficiaries do not pay premiums.

Note: New Hampshire is expected to submit a proposal to increase financial obligations later in 2016.

Sources: S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?* (The Commonwealth Fund, May 2016); Kaiser Commission on Medicaid and the Uninsured, "Medicaid Expansion in Arkansas" (Henry J. Kaiser Family Foundation, Feb. 12, 2015); Kaiser Commission on Medicaid and the Uninsured, "Medicaid Expansion in Indiana" (Henry J. Kaiser Family Foundation, Feb. 3, 2015); Kaiser Commission on Medicaid and the Uninsured, "Medicaid Expansion in Iowa" (Henry J. Kaiser Family Foundation, Nov. 20, 2015); Kaiser Commission on Medicaid and the Uninsured, "Medicaid Expansion in Michigan" (Henry J. Kaiser Family Foundation, Jan. 8, 2016); D. Bachrach, P. Boozang, and M. Lipson, "Manatt on Medicaid: CMS Approves Michigan's Waiver Amendment to Implement Reforms to ACA Medicaid Expansion" (Manatt, Phelps & Phillips, LLP, Dec. 23, 2015); Kaiser Commission on Medicaid and the Uninsured, "Medicaid Expansion in Montana" (Henry J. Kaiser Family Foundation, Nov. 20, 2015); and Centers for Medicare and Medicaid Services, "Special Terms and Conditions, New Hampshire Health Protection Program (NHHPP) Premium Assistance, Waiver approved March 4, 2014" (CMS).

Appendix Table 2

Copayments and Coinsurance for Various Health Care Services, for the 2016 Silver Plan in Largest City in HealthCare.gov States for a 40-Year-Old Nonsmoking Male with $13,000 in Annual Income, by State

State	Primary care provider visit	Specialist visit	Generic drugs	Preferred drugs
Alabama	$5	$15	$6	$25
Florida	$1	$10	$1	$25
Georgia	$1	$10	$1	$25
Kansas	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Maine	$10	20% coinsurance after deductible	$5	$20
Mississippi	$1	$10	$1	$25
Missouri	10% coinsurance after deductible	10% coinsurance after deductible	$5 copayment after deductible	$10 copayment after deductible
Nebraska	No charge after deductible	No charge after deductible	$5 copayment after deductible	$35 copayment after deductible
North Carolina	$20	$40	$10	$40
Oklahoma	$10	$30	$0	$50
South Carolina	$0	$30	$0	$30
South Dakota	$5	$10	$1	$5
Tennessee	50% coinsurance	50% coinsurance	$3	50% coinsurance
Texas	$0	$10	$3	$8
Utah	$5	$15	$6	$25
Virginia	$15	$30	$15 copayment after deductible	50% coinsurance after deductible
Wisconsin	$1	$5	$1	$25
Wyoming	$5	No charge after deductible	$2	$25 copayment after deductible

Notes: Data are for the second-lowest-cost silver plan in 2016 plans for a 40-year-old male nonsmoker in the largest city in each of the 18 states that have not expanded Medicaid and that use HealthCare.gov as their enrollment platform for the 2016 open enrollment season. We analyze plans in these states for adults with incomes of $13,000, as adults in the remaining states would qualify for Medicaid at this income level.

Source: HealthCare.gov.

Notes

[1] S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* (The Commonwealth Fund, March 2016).

[2] HealthCare.gov displays plan information for all the nonexpansion states except for Idaho, which operates its own state-based marketplace.

[3] For detail on methods, see S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* (The Commonwealth Fund, March 2016).

[4] See also: M. Gunja, S. R. Collins, and S. Beutel, *How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services* (The Commonwealth Fund, March 2016).

[5] S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?* (The Commonwealth Fund, May 2016).

[6] Medicaid cost-sharing amounts are for fiscal year 2014. Beginning October 1, 2015, maximum allowable cost-sharing amounts under the program are increased each year by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) for the period of September to September of the preceding calendar year. See Centers for Medicare and Medicaid Services, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule," *Federal Register,* July 15, 2013 78(135). From September 2014 to September 2015, the unadjusted percent change in the medical care component of the CPI-U was 2.5. The maximum allowable cost-sharing amounts under traditional Medicaid would therefore increase to $4.10 for preferred drugs ($4 with 2.5% inflation), and $8.20 ($8 with 2.5% inflation) for nonpreferred drugs, and nonemergency use of the emergency department. M. Crawford, J. Church, and B. Akin, *CPI Detailed Report, Data for September 2015* (Washington, D.C.: U.S. Bureau of Labor Statistics, Division of Consumer Prices and Price Indexes, Sept. 2015).

[7] S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?* (The Commonwealth Fund, May 2016).

[8] D. Bachrach, P. Boozang, and M. Lipson, "Manatt on Medicaid: CMS Approves Michigan's Waiver Amendment to Implement Reforms to ACA Medicaid Expansion" (Manatt, Phelps & Phillips, LLP, Dec. 23, 2015).

[9] Centers for Medicare and Medicaid Services, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule," *Federal Register,* July 15, 2013 78(135).

[10] The South Dakota plan, for example, excluded 10 services from the deductible; the Kansas, Nebraska, and Missouri plans excluded no services. See Table 1 in M. Gunja, S. R. Collins, and S. Beutel, *How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services* (The Commonwealth Fund, March 2016).

[11] S. Rosenbaum, D. Mehta, M. Dorley et al., *Medicaid Benefit Designs for Newly Eligible Adults: State Approaches* (The Commonwealth Fund, May 2015).

[12] Ibid.

[13] D. Machledt and J. Perkins, "Medicaid Premiums and Cost Sharing" (National Health Law Program, March 26, 2014).

[14] The sum of his $150 deductible and $285 (10% of the remaining cost of $2,850).

[15] S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?* (The Commonwealth Fund, May 2016); and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Expansion in Iowa" (Henry J. Kaiser Family Foundation, Nov. 20, 2015).

[16] S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?* (The Commonwealth Fund, May 2016).

[17] The tool helps consumers shopping for plans estimate what they might pay in a given year for their health insurance and health care. It includes different estimates for low, medium, and high levels of health care use.

[18] S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* (The Commonwealth Fund, March 2016).

[19] In 2016, the national limit for Medicare reimbursement of a complete blood count with differential white blood count is $10.58 (HCPCS code 85025) (under federal law, state Medicaid payments for laboratory tests cannot exceed what Medicare pays). Centers for Medicare and Medicaid Services, "Clinical Laboratory Fee Schedule." In 2013, average enrollee cost-sharing for a physician visit averaged about $2.70 in 17 of the states analyzed (data not available for South Dakota), ranging from $0 in North Carolina, Tennessee, and Texas, to $20 in Tennessee (cost-sharing in Tennessee ranged from $0 to $20). Medicaid and CHIP Payment and Access Commission, "State Medicaid Fee-for-Service Physician Policies" (MACPAC, Oct. 2014). As shown in Exhibit 2, cost-sharing in traditional Medicaid for preferred drugs is $4, and $8 for nonpreferred drugs. Out-of-pocket costs for our "medium" user of health care (assumed services for a 40-year-old nonsmoking male defined on HealthCare.gov as four doctor visits, one lab or diagnostic test, six prescription drugs, and $100 in other medical expenses) were calculated by adding $1.1 (10% of the cost for a blood test), $2.70 (the average amount for a physician visit) x four visits, $4 (cost-sharing for preferred drugs) x three refills, $8 (cost-sharing for nonpreferred drugs) x three refills, and $100 ("other medical expenses"), reaching a total of about $148.

[20] S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not* (The Commonwealth Fund, Sept. 2015).

[21] V. Powell, B. Saloner, and L. Sabik, "Cost Sharing in Medicaid: Assumptions, Evidence, and Future Directions," *Medical Care Research and Review,* published online Nov. 24, 2015.

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