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In Retrospective: The ACA's Individual Market Health Insurance Exchanges through a Latino Lens

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Abstract

Stakeholders, the media, and policy makers have heavily slated the functionality of the health exchanges' individual insurance markets established by the Affordable Care Act (ACA). Since its implementation, numerous large insurers have left the marketplaces and premiums have increased in many parts of the country. This dynamic has caused some consumers to have fewer and at times more expensive health insurance options. Latinos are no exception, with the highest uninsured rate in the nation among racial groups. This paper analyzes the crossroads of Latinos' coverage needs and the performance of the individual health insurance marketplaces. Through a careful policy analysis, it is found that the functionality of the marketplaces can improve by boosting Latino enrollment. Further, any alternatives to the current marketplace structure need to strongly consider the importance of bolstering enrollment outreach as a tool to stabilize the individual insurance market. Policy makers need also consider broader changes to foster more competition and expand the risk pool, such as opening the individual market to low-wage individuals with employer-sponsored insurance.

Introduction

The Patient Protection and Affordable Care Act (PPACA), also known as ACA, has undeniably impacted the nation's health

coverage. Since the law was enacted, the percentage of Americans without health insurance has fallen from 16% in 2010 to a historically low 8.6% in the first quarter of 2016¹. A significant portion of this coverage expansion is due to the establishment of health insurance exchanges, also known as marketplaces, where individuals can shop for health insurance and can qualify for income-based tax credits to pay for it. The viability of these health insurance marketplaces largely depends on market competition to lower costs and provide consumer choice. However, the withdrawal of several large insurers from the exchanges for the year of 2017 and the failure of most health insurance co-ops has left many Americans, including Latinos, with fewer choices^{2,3}. In addition, less healthy than expected consumers have surprised insurers' risk assessments and as a result premiums have increased⁴. In short, due to this situation, the health insurance affordability and accessibility aspects the ACA championed for have been publicly scrutinized. This paper examines Latinos' coverage challenge and their place in this highly complex policy conundrum.

A vibrant and young Latino population with the highest uninsured rate in the country among racial groups, 16.2% according to the latest census data⁵, has too much at stake to not influence policy initiatives. Through a primer on the

exchange based individual marketplace and subsequent policy analysis, the following recommendations are made herein to improve the performance of the individual insurance market and health insurance coverage among Latinos: (1) Boost enrollment by enacting legislation to increase funding for in-person-assistance programs; (2) any potential policy replacing the individual health insurance marketplace should strongly consider a robust and sustainable enrollment program as a tool to stabilize the functionality of the individual insurance market; and (3) consider making broader policy changes, such as opening the individual exchange market to low-wage workers with employer-sponsored insurance.

Policy Background

The ACA: Transforming American Health Insurance

The ACA has drastically changed the health insurance panorama across the country through three main provisions: first, the individual mandate requires everyone to have health insurance or else pay a penalty that increases annually; second, it gives states the option to expand Medicaid, the state sponsored health coverage program for low-income Americans, largely through federal dollars; last, it establishes state health insurance exchanges, where consumers can shop for coverage and receive subsidies in the form

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of tax credits to afford a private policy of their choosing. Altogether, these policies have had a groundbreaking impact on health insurance coverage across the nation.

Largely due to the law, the uninsured rate fell by around 40% for Americans in all income groups for 2010 through 2015; around 20 million uninsured have gained health insurance coverage as of early 2016⁶. Further, since 2010, non-elderly adults in all age groups have seen substantial decreases in uninsured rates. Among 18-25 year olds, there has been a 52% reduction, mainly due to the ACA provision that children under 26 can remain in their parents' health insurance policy; among 26-34 year olds there has been a 36% reduction as of the end of 2015. The law has also resulted in significant reductions in the uninsured rate for non-elderly adults across all ethnic groups: 59% reduction among Asian non-Hispanic, 47% among non-Hispanic Blacks, 46% among non-Hispanic Whites, and 35% among Hispanics. In general, greater gains in coverage have been seen in states that chose to expand their Medicaid programs; however, between 2010 and 2015, the overall uninsured rate still decreased by nearly 32% in states that chose not to expand, primarily due to the exchanges.

The Exchanges' Individual Insurance Market

The exchange based individual insurance markets were established to foster competition among health insurers, decrease and control the cost of health insurance, and to expand health coverage for the general population. The exchanges provide consumers with a shopping experience when buying individual health insurance coverage, which allows them to compare plan design aspects such as deductibles, copayments, provider networks (hospitals and doctors), and monthly premiums. While the focus of this paper is on

the individual market, there is also the Small Business Health Options Program (SHOP), a health insurance market also under the exchanges offering small group plans. The SHOP provides increased access to health coverage for small businesses through tax credit incentives for their employees' health plans. Additional policy analysis, outside the scope of this paper, would be helpful in assessing the effectiveness of the SHOP marketplace and its impact on Latino owned small businesses, which account for the majority of national small business growth⁷.

Under the ACA, states have the option to run their own health insurance exchanges, have the federal government run them, or enter collaboration partnerships with the federal government that vary by the degree in which the state is involved. For the 2017 market year, there are 11 state-based marketplaces (including the District of Columbia) in which the states run the marketplace and are responsible for performing all administrative functions, including the operation of the marketplace's website in which consumers can shop. Twenty-eight states have federally facilitated marketplaces in which the U.S. Department of Health and Human Services (HHS) performs all functions and consumers use the Healthcare.gov marketplace website. Five states have a state-based marketplace-federal platform, in which they are responsible for performing all marketplace functions for the individual market and the SHOP, with the exception of a federally facilitated Marketplace IT platform; consumers in those states still apply for and enroll in coverage through Healthcare.gov. Finally, six states are state partnership marketplaces, in which states conduct plan management and may administer in-person consumer assistance. For this case, the federal government performs the remaining marketplace functions; for example: consumers apply for and enroll in coverage through

Healthcare.gov. These definitions will be relevant in determining in-person assistance funding proposals in the recommendations section⁸.

Aside from fostering health insurance market competition and consumer choice, the individual exchange market offers subsidies to consumers in the form of Advanced Premium Tax Credits (APTCs) to pay for their policies. These APTCs can become available to the consumer to pay insurance premiums, the monthly cost of the policy, or be acquired when the consumer files his or her taxes in the form of a lump sum. Depending on size, households with incomes between 100% and 400% of the Federal Poverty Level (FPL) may receive APTCs. Cost-sharing-reduction (CSR) subsidies are also available to pay for out-of-pocket costs which include deductibles, copayments, and co-insurance for households with incomes between less than or equal to 150% FPL, this figure can vary depending on whether the state expanded Medicaid or not, and 250% FPL⁹. As of March 31, 2016, about 11.1 million consumers had effectuated health insurance marketplace coverage, of which 85% were receiving APTCs¹⁰. By that same time, the average APTC subsidy for enrollees who qualified for financial assistance was \$291 per month¹¹. 56% of them (nearly 5.9 million consumers) were benefiting from CSRs to make their coverage and out-of-pocket costs more affordable¹².

The Exchanges' Challenges

Withdrawal of Insurers and Failing Co-ops

The exchanges' effectiveness largely depends on the number of health insurers offering plans to consumers. The more health insurers there are in a given marketplace, the more choices consumers have, and the more competition there is in that market; by classic economic thought, this in turn should lower

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premium prices. This expected economic functionality, however, has been widely criticized by the media, stakeholders, and policy makers, as major health insurers have decided to withdraw participation from exchanges across the country. Industry players such as Aetna, United Healthcare, Humana and CIGNA reduced their marketplace participation in 2017, citing significant financial losses. The majority of Consumer Operated and Oriented Plans (Co-op), designed by the ACA to create non-profit member-controlled health insurance plans, have also failed due to financial pressures.

HHS announced in late 2016 that 15 new insurers would enter the exchanges in 2017, while 83 would cease their participation¹³. With this major withdrawn participation, the exchanges' forecast is at best tepid. Based on estimates as of late 2016, 19% of enrollees would have one choice of insurer in the 2017 market year¹⁴. The Kaiser Family Foundation estimated that just 62% of enrollees in 2017 would have a choice of three or more insurers, compared to 85% of enrollees in 2016. In addition, the number of counties with a single marketplace insurer is likely to rise, from 225 (7% of counties) in 2016 to 974 (31% of counties) during 2017. This drastic increase is largely due to United-Health's withdrawal, as the company was often the second insurer in rural areas¹⁵. Overall, approximately 6 in 10 counties could have two or fewer marketplace insurers. These strong indications of fewer choices for consumers are bad news for the ACA exchanges and ultimately threaten the affordability and product choice the law was designed to achieve.

Rising Premiums

Another policy underperformance for the exchanges lies in the drastic increases in premiums across all metal tiers. Metal tiers are categories of plans by actuarial value, which reflect how much the health

insurer will pay for coverage. Bronze, silver, gold, and platinum marketplace tiers correspond with respective actuarial values of 60%, 70%, 80%, and 90%. For example, if a person chooses a plan within the silver tier, he/she can expect the plan to cover 70% of medical costs. If that person is also receiving cost sharing reductions, the government helps pay for the consumer's out-of-pocket costs, and therefore the actuarial value increases. Consumers with incomes less than or equal to 150% FPL can enroll in a silver plan, in which the actuarial value is increased from 70% to around 90% thanks to the cost sharing reductions.

According to a HHS report, premiums for the second-cheapest silver plan, which is used as the benchmark to determine premium subsidies, would rise by 25% in 2017. This cost is a lot higher than the 7.5% average price increase in 2016, and 2% in 2015¹⁶. Premiums can vary widely across the country; according to 2016 estimates based on insurer participation, premiums were anticipated to rise by 40% or more in at least 11 states in 2017¹⁷. For instance, in Oklahoma, average individual premiums were predicted to increase by 76%¹⁸. While the increases could be drastic, it is necessary to also account for premium subsidies that the majority of exchange customers will continue to qualify for. HHS estimates that nearly three-quarters of exchange customers will be able to find a plan for \$75 a month or less after subsidies¹⁹. Supporting this, a McKinsey study found that the net premium change for the subsidy eligible population is actually modest: \$-.09 for 100-200% FPL, \$1.75 for 200-300% FPL, and \$5.99 for 300-400% FPL²⁰.

However, because subsidies go in tandem with premium increases, the government will be forced to spend more to help lower costs of health insurance for the subsidy eligible population. These costs and the

rising trend in premiums will eventually present an unsustainable market in the long run. Consumers who are not eligible for any subsidies will ultimately feel the blunt of rising health insurance costs. Not all is bad news for the exchange based individual market, a recent study by the Urban Institute found that in 2016, more than three fourths of states and more than 80% of metropolitan areas had lower unsubsidized marketplace premiums than those of employer sponsored coverage, where the majority of Americans get their health insurance²¹. While this speaks to the relative affordability of marketplace health insurance plans, the overall premium increases the exchange based individual markets have exhibited cannot be ignored and utterly reflects insurers' profit instability.

To this end, one of the biggest challenges for industry stakeholders is known as the "80-20 rule", in which 20% of any large insured population tends to account for 80% of all health care spending on that population; this is essentially what is happening in the exchanges. Insurers initially underpriced their policies because they were not anticipating the adverse risk selection in the market²². In other words, they did not expect the situation in which sicker than average people purchase health insurance while the younger and healthier do so to a much lesser extent. This problem becomes even worse for insurers, as under the ACA they cannot deny coverage on the basis of preexisting conditions or health status. Driven by profits, the industry has been wary of participating in the marketplace, which results in consumer distrust and unfavorable criticism for the law.

Stabilizing the Marketplace

The ACA designed three main programs to stabilize premiums and mitigate risk during the implementation of the health insurance marketplace. The programs

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primarily avoided (1) adverse selection, the phenomenon where the sicker patients are more likely to enroll in health insurance; and (2) risk selection, in which health insurers compete on the basis of recruiting the healthier patients and avoid the sicker ones. Two of these programs, reinsurance and risk corridors, were meant to stabilize the market in the first few years of the exchanges and expired at the end of 2016. Reinsurance provided payments to plans that enrolled higher-cost individuals; and risk corridors set limits on insurer losses and gains beyond an allowable range by redistributing moneys from plans with a lower number of claims to plans with a higher number of claims based on predetermined targets.

The third and permanent program is risk adjustment, which primarily functions to stabilize premiums²³. Simply put, it redistributes funds from plans with lower risk enrollees to plans with higher risk enrollees, spreads financial risk across markets (in and out of exchange), and manages actuarial risk, which an insurance policy carries based on enrollees' characteristics. Under risk adjustment, plans enrolling individuals with lower actuarial risk (having a healthier pool of individuals) make payments to plans with higher actuarial risk (having a sicker pool of individuals). To mitigate the need for these payments and to stabilize premiums, it is essential that a healthier pool of individuals enroll in health insurance marketplace plans to balance the risk pool. In other words, as more healthy and young people enroll in the marketplace, there will be fewer plans with an exceedingly number of high-cost sicker individuals. Therefore, if the individual insurance market is to function properly, enrollment needs to be maximized and sustained. Reaching out to marketplace-eligible highly uninsured populations, i.e. Latinos, is crucial for the stability of the individual market.

To this end, there is a significant opportunity to enroll people. In 2016, based on current marketplace eligibility, HHS estimated that 3.5 million uninsured individuals and 1.1 million with out-of-market coverage could be marketplace eligible²⁴. According to the report, 84% of the uninsured have family incomes between 100% and 400% FPL, making them eligible for APTCs. While more than half (57%) have incomes between 100% and 250% FPL and may also qualify for cost sharing reductions in addition to the APTCs. More than a third (40%) fall between the ages of 18 and 34, a figure that becomes increasingly relevant to the need of enrolling younger people. And 40% are people of color (25% being Hispanics). The Kaiser Family Foundation supported these estimates, finding that 33% of the nonelderly Hispanic uninsured could be eligible for coverage in the marketplace²⁵.

Latinos' Coverage Challenge

According to the latest projections by the U.S. Census Bureau, Latinos represent 17% of the national population up from 3.5% in 1960²⁶ and are expected to reach 28.6% by 2060. There are 55 million Latinos living in the United States today, of which 35 million are U.S.-born citizens and about 19 million foreign-born²⁷. The majority of foreign-born Latinos are naturalized citizens or permanent residents, with an estimated remaining 8.1 million undocumented²⁸. Permanent residents and naturalized citizens are marketplace eligible; hence about 85% of Latinos are eligible for marketplace insurance purely based on immigration status. In the context of marketplace enrollment, this is highly significant.

Nearly six in ten Latinos are millennials or younger (26% are between the ages of 18-33), making them the nation's youngest racial group with a median age of 28, compared to blacks (33 years), Asians (36),

and whites (46)²⁹. Latinos are unequivocally defined by their youth, and according to the 2014 National Health Interview Survey, only 12% of Hispanics consider their health status to be fair or poor³⁰. As far as income, 71% of Hispanic households make less than \$65,000 a year³¹, a threshold that depending on household size could make them marketplace eligible; a family of four could receive tax credits with an annual income of up to \$95,400. While national statistics paint an optimistic enrollment panorama for Latinos, their support for the ACA is at best lukewarm. Research has found that price sensitivity and affordability are still major issues for this population, as well as their low awareness of the law and the impact it has on their lives³².

Given these factors, it is no surprise Hispanics are more likely to report that they do not need health insurance compared to other racial and ethnic groups³³, an attitude that likely contributes to their dampened marketplace participation. Low levels of health insurance literacy also constitute another major barrier to Hispanic enrollment³⁴. As a result, those who looked or were planning to look for information related to marketplace insurance tended to seek more direct forms of assistance; for instance, Hispanics were more likely than other racial groups to recur to a call center, an in-person-assistor, and even family and friends. Only 60% used or planned to use a website, compared with 77% of non-white non-Hispanic adults and 84% of white non-Hispanic adults³⁵.

According to the 2015 Latino National Health Survey by the University of New Mexico Health Policy Center, 22% of survey participants tried to enroll or buy health insurance through the marketplace. Results showed that for these consumers enrolling was a challenge; only about 35% were able to enroll "easily," while the rest experienced various

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roadblocks, including not understanding the information on the exchanges and having eligibility problems. Highlighting the demand for more direct assistance forms, half of those surveyed used a call center, and 44% used in-person help to enroll³⁶.

As aforementioned, lack of awareness of the marketplace among Latinos is another major coverage barrier. Despite the fact that in 2015, HHS tripled its spending on paid media targeting Latinos and teamed with Enroll America and other national enrollment groups, it is estimated that one in four Latinos still does not know about "Obamacare" health insurance options³⁷. A recent study by the Commonwealth Fund recently confirmed this, finding that Latinos are the least informed, compared with white, black, and other respondents about the coverage options under the ACA. This finding is alarming, since it is well known that awareness of the individual marketplace is a powerful predictor of whether a person ultimately applied for and obtained coverage³⁸.

While organizations have undertaken tremendous efforts that have resulted in the greatest gains in coverage for Latinos (as compared to other racial groups) since the implementation of the marketplaces, there is no doubt this population still lags behind national enrollment rates^{39,40}. Recent data released by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) shows that the uninsured rate for Latinos decreased from 43% in 2010 to 28% in 2015. A more up-to-date analysis by the Centers for Medicaid and Medicare Services (CMS) found that 24.7% of Hispanics were uninsured in the first nine months of 2016⁴¹. Albeit these are clear improvements, Latinos' uninsured rate is still higher by double digits compared to that of Non-Hispanic Asians, Non-Hispanic Blacks and Non-Hispanic Whites, making them the biggest

opportunity for targeted enrollment⁴². Latinos only made up 14% of Health-Care.gov (the federal marketplace platform) plan selections and 15% of new enrollees as of January 2016⁴³.

Looking at data alone will not depict the entire national health coverage panorama for Latinos. For instance, unless immigration reform is seriously considered in Congress, marketplace eligibility will remain uncertain for undocumented immigrants and Deferred Action Childhood Arrivals (DACA) recipients, who are generally not eligible for public health insurance assistance programs, including the marketplace. Policy solutions for this sector of the population need to be explored proactively, as has been the case in the state of California; otherwise this issue will be a persistent challenge for millions of Latinos' health coverage needs.

The Importance of Enrollment Programs

Considering Latinos' barriers in attaining health insurance and their low awareness of the ACA, increasing enrollment through direct outreach proves indispensable. Looking back at policy lessons from the launch of Medicare Part D, the federal prescription coverage for the elderly, there was strong financial support for states to provide consumers with one-on-one help. In order to maintain and increase enrollment in the individual market, a similar and ongoing commitment to consumer assistance is essential⁴⁴. Doing this will improve the performance of the marketplace by expanding the risk pool. Direct consumer enrollment will also close the knowledge gap Latinos have about the health insurance exchanges and help abate the health insurance illiteracy problem among underserved populations.

Like the difference types of marketplaces, in-person-assistance programs also vary in

their funding mechanisms and structures depending on the extent to which states collaborate with the federal government. Two main types of in-person-assistance programs are: (1) Navigators, referring to assister programs that are funded by their respective marketplace and work directly with state-based marketplaces or with federally facilitated ones to provide free enrollment assistance to consumers; and (2) Certified Application Counselors (CACs), which also provide free enrollment assistance, but to which marketplaces are not required to provide funding to; most of these programs are privately funded and/or supported by their own sponsoring organizations⁴⁵.

Since CACs do not get funding through the marketplaces, but largely from private initiatives, the basis for any policy action should be focused on the navigator programs. In 2015, the CMS provided \$67 million for navigator programs in 34 federally facilitated and partnership marketplaces, compared to \$60 million in 2014 and \$67 million in the first year of open enrollment⁴⁶. While this amount may seem portentous, funding for navigators in roughly 10 state-based marketplaces, which have complete autonomy over their enrollment programs, was around \$185 million dollars just in the first two years of the marketplaces⁴⁷.

According to a recent survey by the Kaiser Family Foundation, during the 2015 open enrollment period, 22% of assister and navigator programs had to turn consumers away because of the high demand⁴⁸. More recently, in 2016, the assister to customer ratio was 1:174, demonstrating the manpower constraint facing current assistance programs, especially given the amount of time it takes to enroll people. In addition, assister program budgets remain mostly modest, and the majority face uncertainties as to funding resources for the following operational year⁴⁹.

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Immediate Recommendations

CMS funds the federally facilitated marketplace with a mixture of user fees, paid by insurers selling health plans in the marketplace and annual appropriations. The budget request estimate for FY2017 marketplace spending totals \$2.145 billion, made up of \$1.610 billion in user fees and \$535 million in appropriated funds. Funding from the appropriations component, however, cannot be used for navigator and enrollment assistance grants as stated under section 230 of the 2016 Labor-HHS Appropriation Act⁵⁰. Consequently, money for these programs is constricted to funds from user fees, which are also used for other vital marketplace functions.

Due to the funding complexity and restrictions for navigator programs, any increase in funding would benefit from legislative action, which could be in the form of a stand-alone bill or an amendment to section 1311(i) “Navigators” of the ACA that would make for increased funding and authorize the use of appropriated funds for marketplace enrollment. Ideally, the funding amount would be distributed based on states’ uninsured rates and be determined on the basis of comparable funding levels used in successful state-run marketplaces.

As an example, California’s state based marketplace program, Covered California, destined \$30.7 million for FY 2016-2017 to their outreach and sales division⁵¹. The division’s mission focuses on providing support to maximize and sustain marketplace enrollment. Its programs encompass numerous types of enrollment initiatives including direct outreach and enrollment through navigators, certified insurance agents, certified application entities, and plan based enrollers. According to CMS, as of March 31, 2016, California’s effectuated marketplace enrollment stood at 1.4 million people⁵². Based on this enrollment, and the previously mentioned funding

level, it could be roughly estimated that about \$22 are being spent on enrollment per person. In contrast, CMS’s 2015 navigator grant announcements totaled \$67 million⁵³, and the enrollment figures as of March of 2016 totaled 11 million people⁵⁴, which would roughly translate into around \$6 per enrollee being spent on federally run marketplace direct enrollment efforts.

Further, CMS predicts that on average around 11.4 million individuals will effectuate coverage over the course of 2017⁵⁵. Based on this estimate, if the federal government was to spend the same level of money Covered California spends on enrollment efforts, the navigator grants should total approximately \$250 million annually, which is a significant increase from the \$115 million budget request for FY2017. Recognizing these figures are whiteboard estimates from basic calculations, they should not be relied on for their accuracy, but rather be referred to as the basis of a future policy agenda.

An alternative option to increase in-person-assistance funding is through Federally Qualified Health Centers (FQHC), designed to attend the health needs of underserved and poor communities across the country. FQHC funding has had strong bipartisan support in the past and for this reason may prove to be a viable funding mechanism for enrollment assistance. Section 330 of the Public Health Act awards the Health Resources and Services Administration (HRSA) billions of dollars to support FQHC operations⁵⁶. This funding was supplemented and enhanced under ACA section 10503, “Community Health Centers and The National Health Service Fund,” through FY2015 by establishing the Community Health Center Fund. From this fund, in 2013, \$208 million were proportionally awarded for outreach and enrollment to health centers across the country already receiving section 330 grants. In 2014, additional funds were annualized

for ongoing outreach and enrollment activities⁵⁷.

Congress provided additional funding for the Community Health Center Fund through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) section 221 “Extension of Funding for Community Health Centers, The National Health Service Corps, and Teaching Health Centers.” However, this funding was only authorized through FY2017. The Community Health Fund is crucial for outreach and insurance enrollment assistance since it allows FQHCs to use the money to provide services to establish eligibility for and gain access to federal, state, and local programs that provide or financially support medical services. In other words, the funding can be used for marketplace enrollment without much restriction. New legislation to boost in-person-assistance could focus on guaranteeing the availability of the Community Health Fund by directing HRSA to allocate at least \$250 million (based on previous calculation) specifically for outreach and enrollment in publicly funded insurance programs.

In general, having strong enrollment programs correlates with satisfactory marketplace functionality, state-based marketplaces can attest to this⁵⁸. California’s uninsured rate has been cut in half, and CMS has described the state’s marketplace as having the healthiest risk pool. California’s health plans have succeeded financially, and premiums have been kept at no more than 7% annual rate increase⁵⁹. In the other hand, as this paper evidences, the federally run marketplaces had mishaps in their performance and have encountered hurdles in diversifying their risk pools, especially in incorporating communities of color. To this end, enrollment programs offer a viable policy option to improve the individual health insurance market.

In-person-assistance insurance enrollment is a proven and necessary policy tool that not only reaches consumers, but can contribute to an effective and balanced a risk pool.

Looking Ahead : Future Considerations

While the above recommendations offer reliable solutions to improve the current state of the marketplace individual insurance market and the uninsured rate among Latinos, Congress' intent for a budget reconciliation process in 2017 indicates potential changes for the ACA's health insurance reforms. Without the marketplace or with significant modifications to it, such as changing subsidy structures, consumers' adaptability to the new policy will prove crucial in future open enrollment periods. Considering this, lawmakers should pay attention to strategies that work. In-person-assistance insurance enrollment is a proven and necessary policy tool that not only reaches consumers, but can contribute to an effective and balanced a risk pool. Therefore, any reforms to the individual insurance market should consider a strong enrollment component. In its absence, it is likely reforms encounter serious shortfall in intended enrollment.

To this end, policy makers should also consider broader changes that can bring sizeable enrollment increases to the individual market. Traditionally, most Americans attain their health insurance coverage through their employers, including Latinos⁶⁰. Much like with the ACA's individual market, in employer-sponsored health insurance (ESI), the premium contributions younger and healthier employees make are used to subsidize their less healthy colleagues⁶¹. While the encompassing system to balance risk is similar to that in the individual health insurance market, ESI has been the cornerstone of American health insurance access because of its historic income tax advantage. Typically, employer premiums and the portion of premiums paid by employees are exempt from federal income and payroll taxes⁶². This tax advantage, however, offers greater monetary gains to higher

income earners than it does to those with lower wages⁶³. ESI's tax exclusion also costs the federal government an estimated \$260 billion annually, making it the single largest expenditure⁶⁴.

Given this, and the fact that there are an estimated 150 million Americans with ESI, there is opportunity to carve out individuals from this market to individual insurance. Based on data from the Current Population Survey for the year of 2013, there are approximately 51 million individuals with incomes between 138% and 350% of FPL, for whom the value of an exchange based subsidy would roughly equal the tax exemption under ESI⁶⁵. To put this into perspective, the median personal earning for Hispanics based on 2014 data was \$30,000, which is well within 138%-350% FPL⁶⁶.

This situation does not necessarily mean all these individuals would opt out of ESI to enroll in the individual marketplace; other circumstances come into play like combined household income and the plan's premium price and design. In addition, the economic effect of too many individuals leaving the ESI market could have detrimental consequences for employer based premiums. However, if the government was to set a defined contribution for all individuals falling under 138%-350% FPL and allow ESI individuals to opt for health insurance in the marketplace, then health insurers would be competing solely on the price of their premiums, health plan characteristics, and provider networks across the group coverage (ESI) and the individual insurance markets. As a result, the risk pool will significantly expand, individuals will have more options, and companies would be incentivized to reassess their benefit plans so as to mitigate the impact, if any, of employees potentially moving to the individual market in search of better policies. Recognizing this proposal is broader, it should be taken

as the basis of further analysis and research rather than a defined policy solution.

Conclusion

The need for health insurance coverage and the immediate challenges facing the Latino community in attaining it are eminent. The final tally for the fourth open enrollment period, which concluded in January 31st, 2017, was 9,201,805 plan selections in states that use Health-care.gov, down by 427,177 individuals as compared to the open enrollment period for 2016⁶⁷. The speculative policy environment surrounding health insurance reforms and the recent executive orders that hampered media outreach efforts clearly contributed to the decrease in enrollment. Policy makers need to be bold in implementing changes that incentivize consumers to enroll and build public trust for the law, as well as be creative in the development of a stable individual health insurance market in the long-run.

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